Erasmus School of Health Policy & Management

Respected physician in Syria, Unemployed refugee in the Netherlands

An analysis of medically-educated Syrian refugees' integration in the Dutch medical field using Bourdieu's capital theory

Author: J.J. Postmes
Student ID: 443554

Supervisor: Dr. R.L. Medeiros
Co-reader: Prof. Dr. R.A. Bal

Master: Health Care Management
Theme: 10 - Health and Migration
Faculty: Erasmus School of Health Policy and Management
Institution: Erasmus Universiteit Rotterdam

Word count (excl. ref.): 17456
Date: August 10th, 2020
Place: Rotterdam

Preface

This thesis is the final product of my Master's degree in Health Care Management at the Erasmus University Rotterdam. As a medical student with little research experience, writing a thesis was challenging. The outbreaking COVID-19 pandemic provided some extra unexpected challenges, which makes me even prouder of the final result I present today.

Achieving this, and staying sane whilst doing so, would not have been possible without the continuous support and enthusiasm of my thesis supervisor, Dr. Regianne Rolim Medeiros. I honestly owe my final result to your dedication, sharp critical thoughts and often-needed re-assurance that I actually was on the right track. You had the patience to teach me how qualitative research works and guide me throughout the process of finding out which direction to move in. When we couldn't meet in person, you were always available to answer my questions over email or in Skype sessions, even whilst your home-bound children eagerly joined our conversations. Thank you so much for this.

On top of this professional guidance, my friends and family members were willing to think along or simply allowed me to blurt out my thoughts and experiences, which contributed to my internal processing of all the data. Thank you for that, you know who you are.

Besides proper guidance and support, I needed to gather enough data to write a credible thesis. Luckily, I found people willing to help me approach participants. I owe a big thanks to Dr. Nafise Ghalandari, head of the *Vereniging Buitenlands Gediplomeerde Artsen* (VBGA), for reaching out to her members. Moreover, I owe a special thanks to Stannie Maessen and Petra Veldman from the *Universitair Asiel Fonds* (UAF) for thinking along and taking the time to contact all the Syrian doctors the UAF has supported in the past years.

But most of my gratefulness goes out to all Syrian doctors without whom this thesis would not have been possible. You were willing to tell me about your lives in Syria and the Netherlands, and about the struggles you encountered along the way. Most of you had a lot to share, and some of the interviews even lasted three hours, making me feel the urgency of the topic. This sense of importance was further increased by the gratitude you often showed me, simply for being heard. Thank you for your time and openness.

After many interviews I experienced a mixture of excitement about the interesting insights I had gathered and a feeling of being overwhelmed. The topic is political and complicated, the bureaucracy of the assessment process is large, and it seems unlikely the system will change soon. How did I think I was going to have something reasonable to add to this complex discussion? What would it matter if I highlight issues, if nothing will change nevertheless? So there were many times that I did not know what to write or how to respond to Syrian doctors telling me what they had to endure, both in Syria and here. Many of their stories described stress, hopelessness and feelings of being isolated after arriving in the Netherlands. But for me the most touching element was the perseverance they showed; the dedication to regain the right to practice their profession, help people and contribute to the Dutch society. After years of studying and working in Syria and losing everything they had there, they are able to take all the hurdles this requires. I find that impressive and I see their dedication as a source of inspiration for what kind of doctor I want to become in the future. But, more importantly, I hope my thesis can play a role in their voices being heard and ignite a change so their integration in the Dutch medical field will improve.

Julia Postmes, August 10th 2020

Summary

In recent years, the Syrian civil war forced many Syrians to flee to the Netherlands, including physicians. These medically-educated Syrian refugees (MESRs) are expected to integrate in Dutch society and find employment, but struggle to return to the medical field here. Before they are allowed to practice medicine and receive a physician's registration, they must undergo an *assessment procedure* (AP) and possibly do internships. In the AP, their competence as a physician is assessed, which determines the length of internships they must do. This is a measure of the Dutch medical professional group to secure quality of healthcare, but appears to be a big hurdle for MESRs' integration in the Dutch medical field.

This thesis aimed to gain an in-depth understanding of MESRs' experiences when obtaining their Dutch physician's registration, finding a job and integrating in the workplace. Interviews were conducted with seventeen MESRs in different stages of this integration process. Participants' experiences were analysed through the lens of Bourdieu's theory on how *economic capital* (assets), *cultural capital* (knowledge, skills, experience and diploma's), *social* capital (connections) and *symbolic capital* (status) are interrelated and determine an individuals' societal position. This revealed how MESRs inevitably lose much social, economic and symbolic capital by their flight, and their cultural capital is devalued because their medical degree is not recognised in the Netherlands. Through the AP, this devalued cultural capital can partly be re-valued. However, being a competent physician requires different skills and knowledge here than in Syria, so MESRs also need to acquire new cultural capital in the shape of Dutch language skills, a Dutch style of practising medicine and knowledge on the Dutch healthcare system. MESRs experience the AP as a difficult time because it is based on self-studying, takes long and ignores their working experience in Syria. Self-studying appears to be an ineffective way to attain this new cultural capital, which contributes to the long duration of the AP and perpetuates MESRs lack of social, economic and symbolic capital.

Moreover, MESRs' also struggle after completing the AP. When applying for competitive specialisation positions, MESRs generally cannot compete with Dutch physicians for reasons related to their limited social and cultural capital, and their older age. Therefore, MESRs generally end up in less-popular, slower-paced specialisms and/or remote regions. Once employed, MESRs need time to adjust and gain experience with the Dutch medical practice, but they generally are satisfied with their own workplace integration. Through their work, they are finally able to rebuild their social, economic and symbolic capital.

Both MESRs and Dutch society benefit when MESRs' integration in the Dutch medical field improves. Based on my findings, I conclude that certain challenges for MESRs are inevitable, but by offering an internship before the assessment of MESRs skills, their capital acquisition might improve. This would facilitate their integration in the Dutch medical field, without compromising quality assurance. Moreover, healthcare organisations should allow MESRs time to adjust and provide guidance. Future research should investigate experiences of MESRs who withdrew from (or never started) the AP and assess the perspectives of patients and healthcare organisations who encounter MESRs in practice.

Table of contents

1

Introduction

The COVID-19 pandemic has highlighted the importance of the medical profession and created an urgent shortage of skilled healthcare workers all around the world, including the Netherlands (Waterval, 2020). In response, over 170 migrants with foreign medical qualifications applied to help in Dutch healthcare organisations in March this year, but their offer was declined because these physicians had not yet obtained a Dutch physician's registration (De Zwaan, 2020). To assure their competence, physicians with medical degrees obtained outside Europe are obliged to undergo the *Assessment Procedure* (AP) which takes multiple years and costs thousands of euros, before they are allowed to practice medicine in the Netherlands (Herfs, 2018). In the AP their foreign diploma is verified and their medical knowledge and skills; Dutch and English language skills; and knowledge on the Dutch healthcare system are assessed. Additionally, after this assessment, foreign physicians can be obliged to do extra internships before receiving their registration (Nuffic, n.d.).

There is not much information available on the origins of the migrant physicians who are currently going through the AP. However, Syrian physicians make up a significant proportion of this group of migrant doctors, as in recent years the majority of asylum applicants in the Netherlands were Syrian (Vluchtelingenwerk Nederland, 2019). The cause of this surge in Syrian refugees is the civil war that broke out in Syria in 2011 and continues until today. What started with peaceful protests against their president Bashar al-Assad escalated into a full-scale war. By the end of 2018 at least 360,000 people had died, over six million Syrians were internally displaced, and another 6,7 million had sought refuge abroad (Vluchtelingenwerk Nederland, 2019). On top of the general threat of a civil war, Syrian physicians endured strategic targeting of healthcare institutions, which resulted in a healthcare worker being killed either by bombs, torturing or executions every other day in 2014 (Abbara et al., 2015).

As a result, many physicians were forced to seek to refuge outside Syria (Abbara et al., 2015; Heisler et al., 2015). Although most Syrians refugees reside in neighbouring countries, over a million have taken on the dangerous journey through Greece towards Europe (Abbara et al., 2019).

By the end of 2018, over 90,000 Syrians were living in the Netherlands (Vluchtelingenwerk Nederland, 2019). Currently, there seems to be no perspective on either a resolution of the conflict or an improvement of the living circumstances in Syria. Even if peace would be in immediate sight, rebuilding Syria and creating a sustainable infrastructure and economy could take a long time (Özdemir et al., 2017). Therefore, a prompt return to their homeland does not seem realistic (Van Heelsum, 2017). This perspective requires Syrian refugees to integrate and sustainably rebuild their lives in the Netherlands.

Integration can be described as the settlement process, interaction with the host society, and the social change after immigration (Penninx & 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 (Konle-Seidl & Bolits, 2016; Papademetriou & Benton, 2016; Alencar, 2018). 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 (Centraal Bureau voor de Statistiek, 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, since Syrian refugees are a relatively well-educated refugee group: twenty percent has finished higher education (Sociaal Economische Raad [SER], 2019). 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 & Zorlu, 2009). Indeed, in 2019, 42% of the employed Syrians in the Netherlands reported to be working below their qualification level (Dagevos et al., 2020).

One of the professions in which entering the labour market indeed appears 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 medically-educated Syrian refugees in the Netherlands, but Dutch media did show that they struggle with the assessment procedure (Paauw, 2017; Aerts & Van Beemen, 2019; Wittenberg, 2019).

A smoother integration in the Dutch medical field would benefit both MESRs and the Dutch society. In the Netherlands, 43% of higher-educated Syrian refugees reports to have a poor mental health (Dagevos et al., 2020). Refugees often experience an existential feeling of being stuck and failing to move forward in the first years after arriving in new country and not being able to work (Bygnes, 2019). Getting back to work helps them become independent, gain a sense of self and move forward (Papademetriou & Benton, 2016). Moreover, if MESRs integrate well in the Dutch medical field, Dutch society benefits as MESRs can utilise their medical knowledge and experience and no longer depend on social welfare.

By gaining an understanding of MESRs integration process and the challenges they encounter, their integration in the Dutch healthcare system can be improved in two ways. Based on their identified needs and challenges, proper support systems could be installed by healthcare organisations. Moreover, their experiences could be used to assess whether the AP and internships effectively assure the competence of MESRs, and explore whether the AP could be revised in a way that facilitates MESRs' integration without compromising this quality assurance.

The experiences of migrant physicians' in the AP, without specifying their origin, have been investigated by Herfs (2009; 2013; 2018). According to Herfs (2013), migrant physicians generally understand the necessity of an assessment of their skills and knowledge, but they do encounter problems in the AP. One of the main issues is the procedure's long duration, especially due to long waiting times in between steps. This keeps them out of the medical practice for a long time (as they cannot practice during the AP) and might contribute to their reluctance to start with the procedure altogether (Herfs, 2018). Moreover, issues with lack of information on the procedure and high costs are also mentioned, as the exams alone cost over 2000€ (Herfs, 2018).

In this thesis, the perspective of medically-educated Syrian refugees (from now on referred to as *MESRs*) on their own integration in the Dutch medical field is investigated. This research reaches beyond the available literature in two ways: by specifically investigating Syrian refugees in the Netherlands and analysing their full integration process.

Firstly, Herfs evaluates the Dutch AP without specifying foreign physicians' motive for coming to the Netherlands and their country of origin. Herfs (2018) does mention that refugees have no other options than to stay in the Netherlands but does not distinguish between experiences of refugee and non-refugee migrant doctors, or between doctors of different nationalities. The motive of foreign physicians, however, is likely to influence their integration experiences. Refugees have usually less deliberately chosen which country to move to and are less well-prepared for living in a new environment (Gericke et al., 2018). Also, refugees in the Netherlands might have experienced traumatic war situations, they live with uncertainty during the asylum procedure and – once granted a refugee status – have limited freedom to move to another country, which can hinder their socio-economic integration (Bakker et al., 2014).

Moreover, this thesis specifically looks at medically-educated refugees from Syria. This is relevant because healthcare systems and medical education differ per country, so physicians with different backgrounds might differ in what skills and knowledge they possess which could influence their integration in the Dutch medical field. Literature is available on MESRs' integration in Germany where they also have to undergo an assessment procedure and experience cultural and linguistic barriers, issues with bureaucracy and long delays in obtaining and ratifying diplomas (Abbara et al., 2019). However, given differences in healthcare systems, medical education and the AP's (and historical-political differences) between the Netherlands and Germany (Herfs, 2009; Mossialos et al., 2016) MESRs experiences here might be different than in Germany.

Secondly, the work of Herfs (2009; 2013; 2018) is strongly focussed on the AP in itself, concentrating on the procedural challenges and issues for participants. However, the AP is part of a broader integration process, which starts at MESRs arrival in the Netherlands and only ends when they are functioning well in Dutch healthcare organisations. To gain an in-depth understanding of MESR's integration, I investigate their experiences and challenges

throughout this process (before, during and after the AP) and connect them using Bourdieu's notion of economic, cultural and social capital. Only by combining these insights, I can assess whether the challenges MESRs encounter throughout their integration process are necessary for assuring their competence, or whether the AP can be revised to be less challenging without compromising quality of care. Moreover, insights in and awareness of MESRs challenges throughout their integration could help healthcare organisations better support their integration.

Consequently, the main research question is:

How do MESRs experience their integration in the Dutch healthcare system?

And the underlying subquestions are:

Q1. *Which official procedures and legislation affect MESRs' integration in the Dutch healthcare system?*

Q2. *Which experiences do MESRs have and which challenges do they encounter before they obtain a Dutch physician's registration?*

Q3. *Which experiences do MESRs have and which challenges do they encounter after they have obtained a Dutch physician's registration and start working in the Netherlands?*

These research questions will be answered throughout this thesis. In the next chapter, a theoretical framework is composed using literature on integration, medical professionalism and capital theory. Chapter three describes and justifies the research methods I applied. In chapter four, MESRs' experiences throughout their integration process are outlined and analysed using the theoretical framework. And, in the final chapter, I reflect on these findings and compose answers to the research questions, whilst also discussing limitations of this study and proposing angles for further research.

2

Theoretical framework

In order to place MESRs' integration in context, I start by exploring the scientific concept of integration and the Dutch historical-political context, and analyse the nature of the Dutch medical profession. Then, as I aim to apply Bourdieu's capital theory to MESRs integration process, I elaborate on this theory and explore how it has been linked to integration and medical professionalism in existing literature.

2.1 Integration

Integration of refugees has been a widely debated topic in both politics and academics in the Netherlands and the rest of the world for many years (Entzinger, 2006; Bakker et al., 2016). However, there is no consensus on what *integration* should precisely entail (Bakker et al., 2016; Alencar, 2018; Char, 2019).

2.1.1 Scientific dimensions of integration

In scientific literature often a general distinction is made between *socio-economic* and *socio-cultural* integration. Hereby, *socio-economic integration* refers to the degree to which migrants participate in institutions, including the labour and housing market, the educational system and politics, whereas *socio-cultural* integration refers to the social ties that migrants have with society as a whole, and their cultural adaptations to that society (Bakker et al., 2014). Within these dimensions, labour market participation is often described as one of the most important indicators for successful integration (e.g., Konle-Seidl & Bolits, 2016; Papademetriou & Benton, 2016; Alencar, 2018; Gericke et al., 2018). Working helps migrants become independent, gain a sense of self, overcome cultural differences and improve their well-being (Papademetriou & Benton, 2016; Gericke et al., 2018). Working could therefore be considered both as a marker and a means of integration (Ager & Strang, 2008).

However, labour market participation is macro-level oriented and only describes whether or not migrants are employed, while it overlooks the degree of functioning and integration on the workplace, the micro-level. Castagnone and Salis (2015) introduce the concept of *workplace integration* when investigating migrant healthcare workers' integration across Europe. Within healthcare organisations, they argue, is where the interaction between migrant healthcare professionals and native majorities takes place and where problems can potentially arise. When investigating the workplace integration at the level of the individual migrants, they analysed their subjective wellbeing, perception and degree of satisfaction of own workplace integration, valorisation of own skills, career perspectives and professional development opportunities, and discrimination on the base of own cultural and religious background.

2.1.2 Historical and political context of integration in the Netherlands

Beyond the scientific debate, the concept of *integration* is also shaped by social and political context, which influences society's perceptions on when migrants or refugees are considered to be "integrated" in the host society (Entzinger, 2006; Bakker et al., 2016). Entzinger (2006) provides us with a comprehensive analysis of the recent history of integration in the Netherlands and shows that the approach and ideas on integration have indeed shifted significantly over the years.

In the 1960s and 1970s the main immigrants in the Netherlands were guest workers from Morocco and Turkey. As they were expected to be staying only temporarily, the government did not really have any policies on integration and aimed for migrants to retain their own identities to facilitate a smooth return to their homelands. In the 1980s, the government acknowledged that this approach might actually limit migrants' social participation. They installed policies aimed at emancipating these ethnic minorities, by promoting equal treatment whilst preserving their cultural identities. This approach has later been named "multiculturalism" and presumes that different cultures can coexist within a society, so migrants can retain their own cultures whilst living in a host society with a different culture (Entzinger, 2006).

In the 1990s, caused both by economic and political changes[1], attention was increasingly paid to the lack of economical participation of migrants, which politicians linked to their poor knowledge of Dutch culture and language. This gave rise to the concept of *inburgering* (civic integration) and incited the "assimilationist" tendency of current Dutch integration policies (Entzinger, 2006). The idea of *assimilation* is that migrants should totally culturally adjust to the host society, which is a one-way process performed by the migrants taking over the culture of the host society (Char, 2019). The *Wet Inburgering Nieuwkomers* (Law on Civic Integration of Newcomers), installed in 1998, marked the beginning of the new Dutch approach on integration. This law obliged immigrants – except for labour migrants – to follow integration courses on the Dutch culture and society, which were free of charge (Bonjour, 2013). In the beginning of the 20th century, populist anti-immigrant parties were gaining popularity, who professed the idea that Dutch multiculturalism had failed (Entzinger, 2006). The debate arose about the compatibility of the Dutch culture with migrants' – especially Muslim's – cultures, which was only reinforced by the terrorist attacks in New York on September 11th, 2001 (Entzinger, 2006). The government responded to these sentiments by making immigration policies even more restrictive (Bonjour, 2013) and in 2006 the Law on Civic Integration was replaced by the *Wet Inburgering* (Integration Law), by which the obligation to *participate* in integration courses changed into an obligation to *pass* civic integration exams. Since then, migrants receive a fine and are denied permanent residence permits when they fail to pass these exams. Additionally, the responsibility to prepare and pay for the exams shifted to the migrants themselves, although loans and – for certain groups including refugees – financial support are available (Bonjour, 2013). Although recently more attention is being paid to the idea that integration is a two-way process in which both the migrant and the host society play a role and adjust to one another (Garcés-Mascareñas & Penninx, 2016), migrants are still expected to take the lead in their own integration in the Netherlands.

[1] A restructuring of Dutch industry in the 1980s left many labour workers unemployed, including many immigrants. And high delinquency rates among certain immigrant communities exposed their lack of integration and lack of opportunities. Simultaneously, the Liberal Party (VVD) became parliament leader and the Christian Democrats (CDA) were excluded from the government coalition for the first time in a century. CDA had traditionally been a big supporter of pillarisation and VVD was much more economically oriented (Entzinger, 2006).

In conclusion, labour market participation and workplace integration are important indicators of successful integration, and migrants are held responsible for their own integration in the Netherlands. Applied to MESRs, integration in the medical field is key to their integration in Dutch society, which entails not only finishing the AP and finding employment, but also integrating well in the workplace after that.

2.2 Medical professionalism

For MESRs, labour market and workplace integration involves integration in a legally-protected professional group. Hence, the nature of the medical profession influences their integration process.

2.2.1 Professional autonomy and professional identity

Professionalism has received much attention in recent decades and has its roots in sociology and philosophy. Although it is difficult to strictly define a *profession* (Swick, 2000), all professions are occupations which characterised by having gained control over determining the substance of their own work and thus being autonomous and self-directing, based on trust in the professionals' ethicality and knowledgeable skills (Freidson, 1988). The professionals are granted some sort of monopoly over their work, as they are assumed to be best able to determine what the problem is and how they should solve it (Swick, 2000). In medicine, this *professional autonomy* gives healthcare professionals full independence to shape the medical profession and its boundaries, whilst society trusts these professionals to have a moral compass and possess all required knowledge to provide the best care (Dupuis, 2000; Swick, 2000). Healthcare professionals are allowed to regulate their own professional group by determining physicians' educational standards, care quality standards and protocols, disciplinary laws and rules for physicians, and – relevant for this research – the selection criteria for being allowed into their professional group (Hoogland & Jochemsen, 2000).

This professional autonomy demands a high entry barrier for (potential) new physicians, as the profession must assure that all physicians are competent and knowledgeable, and that they operate in an accountable, reflective and collegial manner (Swick, 2000). The

professional group, therefore, develops their own educational standards to provide each medical student with the proper medical knowledge and skills, and with a *professional identity* so that they will "think, act, and feel like a physician" Merton (1957, p.5). This *professional identity* is considered to be crucial for being a competent physician and is a acquired through a socialisation process in which medical students internalise the values and norms of the medical field (Cruess et al., 2014). The professional group aims to further assure care quality by developing their own protocols and disciplinary measures, which are often secured in national laws (Hoogland & Jochemsen, 2000). Moreover, the regulation of foreign physicians' entry in the Dutch medical field can be understood from this professional duty to guarantee quality of physicians.

2.2.2 The Dutch medical profession

The Dutch medical-professional group has also established a high standard of education. The medicine study has a strict admission procedure and normally lasts six years, and becoming a specialist usually requires four to six more years of training (Ten Cate, 2007). In return, Dutch medical professionals earn relatively high salaries throughout their career (Paauw, 2018).

Before physicians from outside Europe are allowed to enter the Dutch medical field, their competence has to be assessed in the AP. Based on this assessment, a committee of physicians determines whether these foreign physicians need to complete (up to three years of) internships to receive a Dutch physician's registration (Centraal Informatiepunt Beroepen Gezondheidszorg [CIBG], n.d.-a). Therefore, the AP and (for many also) internships are an evitable step in MESRs' integration in the Dutch medical field.

2.3 Capital and societal position

As MESRs cannot directly work as physicians, they become unemployed refugees once they settle in the Netherlands. The road to employment and regaining their original societal position appears to be tough (Paauw, 2017; Aerts & Van Beemen, 2019; Wittenberg, 2019). Potentially, the ideas of French sociologist and philosopher Pierre Bourdieu on societal mobility and capital could provide insights into the challenges MESRs encounter.

2.3.1 Bourdieu's capital theory

Societal position is a complex phenomenon, with many causal factors and mechanisms involved (Pinxten & Lievens, 2014). According to Bourdieu, individuals take up positions of dominance, subordinance or equivalence within a *field* according to the amount and composition of the *capital* they possess (Ihlen, 2009).

Bourdieu's *fields* are the social spaces or networks of relationships in which individuals take up positions. Within these fields, individuals compete to acquire or increase their overall capital, either by accumulation, conservation or conversion of their different types of capital (Bourdieu & Wacquant, 2007). The social world exists of many of those fields, for instance the academic field or the business field. Interestingly, different types or capital are valued differently in specific fields, as economic capital is very important in business for example and much less relevant in academia. Therefore, capital is not always transferable between fields (Ihlen, 2009).

Bourdieu (1986) 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 & Lievens, 2014; Stephens, 2008). Although *capital* is a broad concept and Bourdieu mentions many different types of capital in his earlier work (Ihlen, 2009), in his article "The Forms of Capital" he narrowed these down to three main types of capital: *economic capital* (money, assets), *cultural capital* (knowledge, skills, educational qualifications) and *social capital* (connections, group membership) (Bourdieu, 1986). These types of capital each have their own logic and are non-replaceable: the value of cultural capital generally cannot directly be replaced by economic capital, e.g. (Huang, 2019). One type of capital can, however, facilitate the acquisition of other types of capital. And meanwhile, when these three types of capital are recognised and legitimised, they provide an individual with a fourth type of capital: *symbolic capital* (status, prestige). All in all, these four types of capital are inevitably interconnected (Bourdieu, 1986):

Economic capital is the root of all other sources of capital, according to Bourdieu (1986). It's the most straight-forward capital type: the money and assets one possesses. Using these

resources an individual can obtain education, sophistication and social relations, thereby converting economic capital into other types of capital (Ihlen, 2009).

Bourdieu's *cultural capital* encompasses an individual's culturally-authorised body of knowledge, skills, qualifications and taste, which is acquired through an individual's surrounding and both formal and informal education (Huang, 2019). Bourdieu distinguishes three different shapes of cultural capital: embodied, objectified or institutionalised. The *embodied state* entails one's skills, habitus, conversation style and posture, whereas the *objectified state* deals with possession of material objects, such as books or paintings, and the *institutionalised state* consists of recognised certificates or diplomas (Bourdieu, 1986). Together this cultural capital shapes an individual's view, behaviour and values, and can create a sense of collective identity with those who share the same cultural capital (Huang, 2019). Institutions, such as schools and libraries, can play an important role in shaping and storing cultural capital (Bourdieu & Wacquant, 2007).

Whereas economic capital can be used to acquire cultural capital, (institutionalised) cultural capital can also increase one's economic capital and social capital, by providing access to a well-paid job (Huang, 2019).

There are multiple definitions of *social capital* used in literature with slightly different angles (Stephens, 2008; Ihlen, 2009). Bourdieu (1986, p. 248) defined social capital as "the aggregate of the actual or potential resources which are linked to possession of a durable network of more or less institutionalized relationships of mutual acquaintance and recognition – or in other words, to membership in a group". He considers *social capital* as the resources an individual can access through their connections and/or membership of a network. The amount of an individual's social capital depends both on the number of network connections they have, and on the volume and types of capital possessed by these connections.

Social capital can help create or maintain economic capital (Carpiano, 2006) and the benefits individuals can derive from a network create solidarity amongst its members (Bourdieu, 1986). Besides these positive attributes of social capital, Bourdieu also elicits the potential negative consequences of a lack of social capital. As with any resource, people will compete for it, which can lead to individuals being excluded from a network and its resources (Carpiano, 2006; Stephens, 2008). And, interestingly, social capital has been reported to

influence an individual's (mental) health, as differences in one's social capital correlate with differences in self-rated health and depression (Ziersch, 2005; Stephens, 2008).

Bourdieu's last type of capital is *symbolic capital* which he defined as "a reputation for competence and an image of respectability and honourability" (1984, p. 291). Symbolic capital explains the amount of prestige an individual possesses once their other types of capital are acknowledged, and legitimises power relations (Bourdieu, 1990). Institutions also play a role in creating symbolic capital, because they have the power to impose recognition of cultural capital and assure its legally guaranteed value (Bourdieu, 1986; Ihlen, 2009). It can sometimes be difficult, however, to wholly separate symbolic capital from the other types of capital (Ihlen, 2009).

2.3.2 Linking Bourdieu's capital theory to integration

Although Bourdieu's ideas were originally developed to understand how elite social classes preserve their privileges over generations and understand (the limits of) social mobility (Huang, 2019), his types of capital – and related concepts – have also been used to understand migrants' societal position (Erel, 2010). There is a vast body of literature analysing specific capital types of specific migrant groups (e.g. Friedberg, 2000; Schuller, 2001; Alba & Nee, 2009; De Vroome & Van Tubergen, 2010; Erel, 2010; Soontiens & Van Tonder, 2014; Gericke et al., 2018). Many of these articles link migrants' labour market participation to their so-called *human capital* and social capital, and discuss how capital might be lost or devalued by their migration itself.

Human capital refers to the skills a person has in areas of education, employment, and language, which are relevant for their economic activity (Alba & Nee, 2009). Although *human capital* is more economically-focussed than Bourdieu's concept of *cultural capital* and does not include cultural taste and references, both concepts are similar (Schuller, 2001). Therefore, as I believe the cultural element is important in migration studies, I will remain using *cultural capital* in this research, but both literature on human and cultural capital can be used in the same line of reasoning. Alba and Nee (2009) highlight that migrants bring substantial educational credentials, professional training, and other forms of human capital which influence their position in the host society. However, their capital is not always fully

transferable (De Vroome & 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 embodied and institutionalised 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 & Van Tonder, 2014). In the Netherlands as well, many highly skilled and highly educated migrants appear to end up in a profession below their original employment level for reasons related to human capital (De Vroome & Van Tubergen, 2010).

Social capital has also been associated with migrants' labour market participation, as migrants generally leave the majority of their social network behind in their home country. Albeit less emphasised, Alba and Nee (2009) also discuss how migrants' lack of social capital in their host country can constrain their employment opportunities, thereby also influencing their economic capital.

Although there is no literature available which specifically discusses the economic, cultural or social capital of Syrian refugees in the Netherlands, Dagevos et al. (2020) did gather relevant information on their low labour market participation here. In their survey, unemployed Syrians suggested the following reasons for their unemployment: lacking Dutch language proficiency, having foreign diploma's, being occupied by schooling or the civic integration courses and lacking professional networks, which indicates a lack of (transferrable) cultural and social capital. And unemployment itself contributes to (or perpetuates) a lack of economic capital.

2.3.3 Linking Bourdieu's capital theory to professionalism

Moreover, as mentioned before, MESRs encounter extra challenges entering the labour market because of the professional nature of the medical field. Bourdieu's capital theory might provide further insights in how professionalism complicates MESRs' integration process.

Gomes and Rego (2013) conclude that the medical field can be seen as a *field* in the way that Bourdieu defined it: it is a socially structured place where physicians and medical students take up places with more or less prestige according to their medical knowledge, "professional behaviour" and relationships in the field. Their medical knowledge and professional behaviour (with internalised norms and values) could be considered as their embodied cultural capital and their relationships in the medical field as their social capital. Their medical degree functions as institutionalised capital which provides access to the medical field. And, as healthcare professionals generally earn good salaries, membership of the professional group becomes a source of economic capital.

The professional group itself functions as an institution which determines and defines the value place on each type of capital, enabled by their professional autonomy. This way, the medical field shapes and reproduces cultural capital through its designing its own educational programme and determining what "professional competence" entails (Brosnan & Turner, 2009), thereby also shaping symbolic capital. Such notions of competence can be the source of protectionist policies of professional groups (Erel, 2010), which is the case in the medical field. As the Dutch medical fields has its own requirements of the skills and knowledge one needs to be competent, they actively exclude foreign physicians from the Dutch medical field, even if they do meet the requirements of their homeland. Since medical professional legislation is drawn up nationally, the boundary of Bourdieu's medical "field" would lie at each national border.

In conclusion, economic, cultural and social capital might play an important role in the integration process of highly-educated Syrian refugees in the Netherlands. For MESRs, integration entails entering a legally-protected professional group with their own power dynamics and valuation of capital, which might challenge their integration in the Dutch medical field.

3

Methodology

In this thesis, I used a qualitative approach to analyse MESRs' experiences. In qualitative research, a researcher aims to "make sense of and recognize patterns among words in order to build up a meaningful picture without compromising its richness and dimensionality" (Leung, 2015, p.324) and develops empirical knowledge by collecting and interpreting data (Corbin & Strauss, 2014). This approach is suitable for gaining insight in the complicated process and variety of personal experiences of MESRs' integration in the Dutch medical field. In this chapter, I discuss my methods of data collection and analysis, and explore my role as researcher.

3.1 Data collection

In this thesis, two qualitative research methods were applied: document analysis and semi-structured interviewing. Document analysis is a systematic procedure for evaluating or reviewing documents, in which data contained in documents is collected, selected, appraised and synthesised in order to draw conclusions (Bowen, 2009).

For this research a brief document analysis was conducted to outline the procedures MESRs encounter after their arrival in the Netherlands, and their legislative basis. The analysed documents include Dutch policies and laws on the asylum procedure, civic integration, and AP. Gathered data was used as background knowledge in interviews and is summarised in the results chapter to provide context to MESRs' experiences.

Semi-structured interviewing is an empirical method in which participants are interviewed using an interview guide based on existing literature. This guide helps to direct the conversation towards designated research themes, yet simultaneously allows for spontaneous dialogue in the interviews and new concepts to emerge throughout the research

process (Kallio et al., 2016). Thereby, this method is suitable for studying MESR's perceptions and opinions without limiting their responses to a pre-determined theoretical framework (Barriball & While, 1994; Wengraf, 2001). This way, I retained control over the interviews without restricting the scope of this explorative research.

For this research, two interview guides were developed: one for MESRs who are currently occupied by the AP or internships, and one for MESRs who already started working (*Appendix A*). Before interviews, these guides were tested by peer researchers and adjusted where necessary. Throughout the research process, they were further developed as new themes emerged or the importance of certain themes was emphasised by interviewees.

The original aim was to conduct all interviews in person, to create a safe environment and to engage interviewees in in-depth conversations. However, after one interview, COVID-19 safety regulations were installed which obliged me to conduct all other interviews using Skype or regular phone calls. By taking the time to introduce myself and my research, ensure anonymity and emphasise the right to withdraw or skip questions, I attempted to still create a climate of trust in this digital setting. Moreover, all interviews were audio-recorded, for which interviewees signed an informed consent form or gave verbal consent which was then re-confirmed on the audio recording. I took observational notes and wrote a summary of key points after each interview to facilitate my data analysis.

The interviews were conducted with Syrian refugees who were medically educated before arriving here and are currently integrating in the Dutch medical field. Participants were reached through the *Universitair Asiel Fonds* (UAF) and the *Vereniging Buitenlands Gediplomeerde Artsen* (VBGA). UAF is a Dutch organisation that helps academically-schooled refugees re-enter the academic labour market. They sent personal participation invitations to 37 MESRs in the AP and 22 MESRs who completed the AP. VBGA is a Dutch association of physicians with foreign degrees – from anywhere in the world – with the aim of sharing experiences and information. They posted my participation request on their Facebook platform, with circa 1000 members (including an unknown number of Syrian refugees). Using these broad sampling strategies, I aimed to acquire a representative sample of MESRs.

The final sample existed of seventeen MESRs. Given the qualitative nature of this thesis and relatively small population of MESRs in the Netherlands, this seems to be an accurate sample size to gain a comprehensive overview of their experiences. All interviews took place in March and April 2020 and lasted 115 minutes on average. Four interviews were conducted

in English, the other thirteen in Dutch, according to participants' preferences. When Dutch interviews are quoted in the results chapter, responses are literally translated to English.

At the time of the interviews, nine participants were engaged by the AP, three were doing their obliged internships, and five were working in Dutch healthcare facilities, see *Table 1*. Since MESRs make up a small community in the Netherlands, the provision of specific characteristics of each interviewee is limited and demographic data are only presented of the group as a whole to ensure anonymity.

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%
Specialising physician	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%
Internship	3	18%
Basic physician/ ANIOS	3	18%
Specialising physician	2	12%
Average time until employment in the Netherlands	5	4.5 years

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

3.2 Data analysis

After conducting the interviews, all audio recordings were transcribed using the intelligent verbatim style. This means that stuttering, filling words and repetitions were removed unless they were interpreted to emphasise what interviewees were saying. This style was chosen because most interviewees were not entirely proficient in Dutch or English, so a strict verbatim transcription would distract from the interview content.

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 & Shannon, 2005). Based on the data and personal reflections, 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 (*Appendix B*). Through this emersion and inductive approach, I have aimed to increase internal validity of my findings.

3.3 Role of researcher

Due to the non-numerical data and phenomenological interpretation, any qualitative analysis is inevitably bound to subjectivity. Emotions and personal perspectives from both researcher and interviewees can lead to undesirable bias, but are simultaneously essential and inevitable and might add an extra dimension to the research (Leung, 2015). I indeed noticed my own influence throughout the research. As I am studying to become a physician myself, I felt a strong sense of empathy with participants and could – to some extent – relate to their (medical) experiences, which might have influenced the direction of the interviews. My background also influenced participants, who showed confidence in my understanding of medical topics, and sometimes even addressed me as their future colleague, which could have contributed to their willingness to share experiences or might have affected how they communicated them. This does not necessarily impact the reliability of my findings, but can be taken into account when interpreting them.

As is common with interview-extracted data, the influence of my personal role as an interviewer and the specificity of the setting, however, make it difficult to replicate this thesis. This does challenge its reliability, but I have attempted to limit this effect by applying two strategies. Firstly, I formulated non-directionally questions in my interview guide to avoid misinterpretations and steering of answers (Mortelmans, 2013). Secondly, by inducting codes and themes from my transcripts and including many quotes in the results section, I have aimed to limit the subjectivity of the selection and formulation of results (Green & Thorogood, 2018).

4

Results

In this chapter, a chronological overview is provided of the gathered data. I start by analysing interviewees' experiences and capital in Syria, and then move on to their integration process in the Netherlands, divided into four phases: the asylum procedure and civic integration exams; the assessment procedure; and – for those who have reached these stages – the job search in the Dutch medical field; and their employment as physicians.

4.1 Life in Syria: studying medicine and working as a physician

MESRs have to rebuild their lives in the Netherlands, but obviously carry their professional education, working experience and wartime experiences from Syria with them. Medical professionals enjoy a high status in Syria and the participants acquired a capital-rich position in society before migrating to the Netherlands.

4.1.1 Experiences of the Syrian medical education

As in the Netherlands, medical education in Syria[2] has rigorous admission requirements and consists of three years of theory and three years in practice. The strict admission and high workload of medical schools in Syria contribute to physicians' image of being highly intelligent. And, although it lies outside my thesis' scope to make an exhaustive comparison between the Syrian and Dutch education system, I will briefly discuss two notable differences mentioned by interviewees.

Firstly, nearly all interviewees were very satisfied with the quality of their education and actually believe that Syrian medical students generally acquire more medical knowledge than

[2] Although five participants studied in (non-European) countries outside Syria, I focus on experiences in Syria.

Dutch students (except for some specific subjects, e.g. psychiatry, which are less extensively discussed). This might be explained by the fact that Syrian physicians must gain patients' trust by knowing everything by heart. The content of medical education reflects which knowledge and skills are valued and constitute cultural capital (Brosnan & Turner, 2009) and apparently in Syria extensive medical knowledge is highly valued. Interviewees emphasise that the actual knowledge and skill level, however, differs per person and confirm Gomes and Rego's (2013) conclusion that physicians' acknowledged cultural capital level influences their reputation and position in the field.

> *"I think we practice and we learn more than here. I remember how many pages I studied in the last year. I studied 8000 pages, or maybe even 10000 pages, to pass the final exam of medical school..."*
> – Participant 8

> *"Here [in the Netherlands] it's no problem if you say "I will look it up," and then you have to look up the most suitable antibiotic for instance, but in Syria you cannot do that, because people will think you don't know anything. Then your image is ruined."*
> – Participant 6

Secondly, interviewees noted that medicine in Syria is taught in Arabic, giving them a disadvantage in reading scientific papers. Also, little attention is being paid to conducting and processing research in general.

4.1.2 Experiences as a Syrian medical professional

After these six years of education, Syrian medical students take an exam which assesses everything they have learned and determines their final graduation grade. Based on this grade, they can apply for certain specialisations. Interviewees explained that, in Syria, it is normal to directly start a specialisation after finishing medical school, as opposed to the Dutch system of being a non-specialising basic doctor first.

While specialising and later as a specialist, they earned generous salaries, built their professional network and gained practical experience and skills, thus acquiring economic, social and more cultural capital. In their neighbourhoods, they were well-known and people would consult them on the streets as well. Altogether, their membership of the professional

group gave them a respectable status in society, which Bourdieu (1986) considers symbolic capital:

> *"Actually, in Arabic we don't use the word doctor, that's an English word. In Arabic doctors are called, "Hakim", I don't know if you've heard that before, it translates as "wise person". (…) When things are really, really complicated between families, they take the wisest person, which is normally a very old person or they take the next best thing, which is the physician."*
> – Participant 10

> *"People look at you, as a physician, a bit as though you're holy. So you can contribute in conflicts between people as well. And for sure you are very prominent within your family, they'll say: 'This is my son, he is physician'. (…) And physicians are involved in many things in society, in politics, in everything, I think. (…) It's really special to be a physician there."*
> – Participant 1

In Syria, the healthcare system consists of free public hospitals with long waiting times and many private clinics owned by specialists. This system instigates Syrian specialists to work very autonomously, without consulting colleagues. When Syrian physicians do cooperate, they do so in a very hierarchic manner. During their specialisation, for instance, residents can only converse with residents one year above them and the younger-year residents are assigned most night and weekend shifts. In Syria, this meant working a normal workday, then directly a nightshift and another dayshift, thus being on the job for thirty hours straight. This makes the specialisation exhausting but did provide specialising physicians with lots of practical experience:

> *"Basically, it's very, very, very intense. So basically, the usual day is from eight o'clock in the morning until three o'clock in the afternoon and then your shift starts - until eight o'clock in the next morning - and then in the next morning you have to work from eight until three. That's the standard and then you go home and spend the night and the next day it starts all over again. And in emergency, because it's a public healthcare system, you have an enormous influx of patients. At one side it's really exhausting, we get out of our specialty with a diploma, but we graduate totally exhausted. But at the same time, we graduate with tons of experience…"*
> – Participant 10

After their specialisation, interviewees continued to acquire embodied and institutionalised cultural capital, economic capital and social capital through their profession, and thus attained a high societal position with power and prestige. Not surprisingly, most participants never considered leaving Syria before the war.

4.1.3 Experiences in the Syrian civil war

For all participants, the root cause for leaving Syria was the war. Obviously, experiencing a war is horrible for anyone in a country. Having to witness your country being torn apart, cities being destroyed and losing friends and family members is agonising. On top of that, Syrian physicians experience these horrors front-row (Heisler et al., 2015). Although not discussed in-depth, some interviews reveal bits of the heavy work they had to deliver and the long hours they had to work.

> *"[In the field-hospital] I have done surgeries in the corridor, next to the entrance of the hospital. After an airstrike 60-70 people come at the same time and you always had to choose who to help first, and then you picked the youngsters and then the elderly. I really had to decide, there were no paramedics. People were brought by a pick-up, 20-30 people at the same time. As a doctor unconsciously you will pick people and thereby one third of the patient dies. Some people bleed to death on the sidewalk in front of the hospital. You do what you can, but every once in a while, you feel powerless, especially when a child dies, it's sensitive, but this is what you can do as a doctor."*
>
> – Participant 13

Additionally, MESRs had to deal with even more horrible matters, as their profession created extra danger for them (Abbara et al., 2015; Heisler et al., 2015). Some interviewees mentioned the risk of being kidnapped for ransom and losing colleagues through this; being forced to choose sides in the conflict and thereby becoming a target – themselves or their families –, or running the risk of being arrested and tortured.

> *"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 people with 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."
– Participant 13

Strikingly, many interviewees emphasised how valuable – despite the atrocities – it was to be able to help, how the lives they saved mean so much to them, and how these experiences taught them how to deal with emergencies and scarcity. The war made their work even more valuable and respectable, potentially even further increasing their symbolic capital.

"I've had people in my hands, shot in the head, shot in the chest, and I tried to resuscitate them. I couldn't resuscitate them and they died in my hands. But that wasn't… I wouldn't say it wasn't traumatising and I remember being sad. I remember crying when I saw an 18-year-old boy, dead in my hands, because he was shot in the shoulder and the bullets penetrated his lungs. And I remember crying at that moment. But then at the same time, I received another person and I intubated that person and I put him on the ventilator and five days later, he was activated, he started breathing and then he went home after 16 days. So, I didn't suffer… in the sense of trauma that much, if I can say."
– Participant 10

Although the precise reasons differ per person, for nearly all interviewees these wartime experiences forced them to leave Syria, sometimes overnight and often without preparation or having ever considered working abroad.

"One day before I went here [the Netherlands], I was just working, so I was done at 10 PM and the next morning at 8 I had to flee."
– Participant 15

Therefore, many interviewees had to abruptly leave their social networks and many possessions behind in Syria, which inevitably decreased their economic and social capital.

4.2 Becoming a refugee in the Netherlands

Most interviewees 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 interviewees – who arrived between 2013 and 2018 – have yet found employment in Dutch healthcare organisations, which took them, on average, 4.5 years after arriving. These years

are occupied by the asylum procedure, civic participation courses and exams, and – mainly – the AP and internships. I briefly outline these procedures, before discussing data gathered in the interviews.

4.2.1 Dutch procedures and legislation

Upon arrival in the Netherlands, Syrians become asylum seekers when they apply for a refugee status. Since 1951 Geneva convention, a refugee is defined as someone who fled war, violence, conflict or persecution, and crossed an international border to find safety in another country, which gives them the right to protection (United Nations High Commissioner for Refugees, 2010). During the asylum procedure, they are accommodated in *asielzoekerscentra* (*AZC*, centres for asylum seekers) and have limited access to the labour market and no access to education (Bakker et al., 2014). When they obtain a refugee status, they receive a five-year residence permit, are assigned a house and gain the full right to work (Bakker et al., 2014). As refugees, they are obliged – by the Integration Law – to pass civic integration exams on the Dutch culture, history and language (and they can get a loan for preparatory courses). If they do not achieve this within three years, they risk a fine, have to repay their loan and cannot apply for a permanent residence permit or the Dutch nationality (which they normally can after five years) (Integratie en Naturalisatiedienst [IND], n.d.; IND, 2017; SER, n.d.). Until they receive a permanent residence permit or the Dutch nationality, they cannot work outside the Netherlands (IND, 2017).

Although MESRs are allowed to work, they cannot directly practice medicine due to the legal protection of medical profession through the *Wet op de beroepen in de individuele gezondheidszorg* (Wet BIG, literally translated 'Law for professions in the individual healthcare') imposed in December 1993. This law requires practising physicians to be registered in the so-called *BIG-register* (Wet BIG, 1993), and medical specialists require a registration of the acknowledged organisation of the specific specialisation, on top of the BIG-registration.

Dutch medical students receive their BIG-registration after successfully finishing a Dutch Medicine Bachelor and Master. In the BIG-law (1993) the procedures for foreign-educated physicians to acquire a registration are also outlined. Depending on their country of

education, physicians undergo different procedures. Physicians with degrees obtained at recognised European universities are directly enrolled after showing proof of Dutch proficiency, whereas physicians with not-acknowledged European degrees undergo an additional procedure in which their medical education is compared to the Dutch education and an adjustment-internship might be obliged. The third, and most extensive, procedure is for physicians with non-European degrees – which applies to MESRs – and requires physicians to obtain an *Erkenning van vakbekwaamheid* (Certificate of competence).

To acquire a *certificate of competence,* MESRs must undergo the AP which was mentioned in the introduction and is outlined in full in *Appendix C*. The AP assesses skills and knowledge through two main exams and is governed by the *Commissie Buitenslands Gediplomeerden Volksgezondheid* (CBGV, literally translated "committee foreign graduates public health"). Before being admitted into the AP, the CBGV verifies a physician's documents, diploma and motivation. The AP itself exist of two exams. The first is the *AKV*-test (general knowledge and skills test) in which Dutch and English language skills and knowledge on the Dutch healthcare system are assessed by the external examination organisation Babel (CBGV, 2019a). A C1 Dutch language level is required to pass the AKV-test and participants are advised by Babel (n.d.) to finish the language exam on a B2 level in advance. When a participant fails the AKV-test, they have to repeat it until they pass it. The second exam is the *BI-test* (professional knowledge test) which includes three separate tests which assess basic medical knowledge (the same exam Dutch medical students make after six-years); clinical knowledge; and clinical skills. This BI-test is the actual assessment and can only be conducted once (CBGV, 2019b). Based on the AKV- and BI-test result, the CBGV decides whether the medical degree of a participant is equivalent (1), partly equivalent (2) or not equivalent (3) to a Dutch degree. Based on this decision, participant respectively receives a certificate of competence (1) after working under supervision for three months; (2) after additional internships for a certain number of months or years; (3) only after completely re-doing medical school. With the certificate, they can apply for a BIG-registration and become basic physicians (Wet BIG, 1993). To become a medical specialist, they usually have to follow the full specialisation track in the Netherlands (Herfs, 2009).

AP participants are required to pay 2760 Euros in total for the examinations (CIBG, n.d.-b). However, refugees can apply for support from UAF, which provides guidance throughout the AP and offers financial support for the examinations and preparatory courses (UAF, 2019).

4.2.2 Experiences after their arrival in the Netherlands

For most participants, the first phase after arrival is dominated by the asylum procedure and civic participation courses and exams. Generally, Syrians rather quickly receive a refugee status and housing (Dagevos et al, 2018). However, interviewees who came during the surge of Syrian refugees experienced waiting times of about a year, which they experienced as frustrating because they could not do much. As a refugee, their first main priority lies at finding safety and settling here:

> "*We came as refugees, not as physicians. Concerning priorities your first thought is "I'm a refugee" and at one point the fastest procedure was in the Netherlands. 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.*"
>
> – Participant 1

Moreover, interviewees struggle with becoming unemployed refugees after a life as healthcare professionals in Syria. Whereas MESRs obtained a very high societal position in Syria, their flight and refugee status inevitably impact their capital and societal position. By leaving Syria, they lost their social network and their membership of the medical profession, decreasing their social capital to a minimum. Their economic capital is also decreased as they leave many belongings behind and generally spend much money reaching Europe. What MESRs do bring is their medical qualifications, knowledge, skills and experience. Yet, their medical degree and experience is not recognised in the Netherlands and their medical knowledge and skills have to be assessed before they are allowed to work. MESR's cultural capital is thereby also devalued by their migration and needs to be converted to regain its value. This thereupon hinders their economic capital acquisition, as they become dependent on social welfare until they are employed. Altogether, MESRs societal position and status as physician vanish in the Netherlands, which is difficult for them:

"In one of the AZCs my daughter was sick and I asked for medicines and she received a suppository 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."

– Participant 3

"At one point you think that you are a physician in a country, that you're good, at a high level, working with people, you have everything. Because when you finish your studies and you start working, your future is building ahead, everything is improving, but here – in one moment – everything is below zero. Absolutely below zero."

– Participant 9

Therefore, once in safety, their next priority quickly becomes to acquire their physician's registration. Only around this time, most interviewees become aware of the tough AP they then have to undergo:

*"On day one or day two in the asylum seekers' centre I bought a sim card with internet and started looking what I will do as a physician. And then I thought: "Oh sh*t, this will take long." Because I had no idea of the whole procedure, of the system in the Netherlands."*

– Participant 1

MESRs must decide whether or not to make this effort. In fact, some respondents did consider leaving their profession and many told me about acquaintances who cease (or never started with) the AP, because it was too difficult and took too long or they fear limited career opportunities. As refugees cannot work outside the Netherlands in the first five years, completing the AP is the only way to become a physician again. MESRs thereby lack alternatives for regaining a higher societal position. Without having a recognised degree, their chances of finding highly-skilled employment to regain their economic, social and symbolic capital are slim. Choosing another profession further diminishes their cultural capital, as their medical knowledge is worthless in most other fields. This was painfully illustrated by one participant (a former medical specialist) who could not find employment here, even after obtaining a Dutch public health master's degree.

"I looked for jobs in the GGD, I look for jobs in the RIVM, I look for jobs in any way that is even remotely related to that area. But, it's hard. It's really hard. And, I didn't get accepted anywhere. (…) The Dutch labour market is not really friendly with outsiders. (…). It [the Dutch master degree] doesn't make a difference. I applied. I sent hundreds of applications literally, literally hundreds. If you want, I can forward you every little rejection I received."

– Participant 10

4.3 Regaining their physician's registration

The aim of the AP is to guarantee quality of care by assessing the current knowledge and skills of foreign physicians, in order to estimate whether and how much internships they need to do to bridge the gap with the required level of knowledge and skills. Nearly all interviewees justify the existence and aim of the AP, but there is much frustration about its actual execution and the big impact it has on their lives.

"Yes, we are doctors, and it's about patients, so you have to prove that you can do it, I understand that, but not this way."

– Participant 12

They experience three issues with the AP: it does not acknowledge experience, it is based on self-studying, and completing it takes really long.

Firstly, the AP assesses MESRs knowledge and skills, but ignores their cultural capital in the shape of working experience is mostly neglected. The clearest illustration of this is the lack of a special procedure for medical specialists. Therefore, MESRs who acquired many years of clinical experience as specialists, still become basic physicians after completing the AP. Participants experience this as painful and a waste of their specialised expertise and knowledge. Additionally, this means that they are examined on their basic non-clinical knowledge, such as cell biology and anatomy, which they have not had to use in many years, which feels unfair and is difficult to re-study.

"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..."
– Participant 10

To make matters worse, by the time they receive their Dutch certificate, their age makes it almost impossible to be admitted in specialisation tracks (which I will come back to), which prevents them from fulfilling their specialism again.

Secondly, interviewees struggle with the fact that the procedure has no teaching elements. Dutch authorities only arrange the exams and MESRs are supposed to study by themselves. This can be understood in the political context of migrants being responsible for their own integration (Bonjour, 2013), but is experienced as a big challenge. Participants have to study from books, as internships are only arranged for them after the assessment of their skills. Although MESRs are allowed and encouraged to arrange internships for themselves, in reality – with a limited network, no BIG-registration and already crowded hospitals – this is very difficult to arrange.

"The man at the information session on the procedure, said that it's very good to intern or to observe in practice. But if somebody asks: 'How can I do that?' they'll say right away that they cannot fix it for us, they say: 'You have to arrange it yourself, through your network, via via.' But here are some problems: we're new here, we're new physicians. Except for being physicians, we're new, so we have no network. (…) They say: 'Go ahead,' but it's really difficult, I tried a lot."
– Participant 12

Therefore, MESRs are generally bound to attain the knowledge and skills that are considered as *competence* by the Dutch professional field from within their homes. For refreshing medical knowledge, self-study appears to be an appropriate method, and interviewees generally do not have issues with this, as they gained much knowledge in Syria. But they are also expected to show a Dutch-style clinical skills (which include a Dutch professional identity and behaviour), knowledge on the Dutch healthcare system and (medical) Dutch language proficiency, without being allowed into the Dutch medical field. Given the principle that a medical professional identity is acquired through socialisation (Cruess et al., 2014), it is very difficult to acquire this new cultural capital. In Syria, for example, physicians never shake hands with patients and are less required to be empathic, and interviewees highlight that they

can adjust to the Dutch style, but that they need to experience what the Dutch style is and be allowed time to adjust. This illustrates the lack of transferability of cultural capital which migrants often experience (De Vroome & Van Tubergen, 2010), as MESRs' Syrian professional identity, Arabic language skills and Syria-specific knowledge becomes worthless here. Moreover, there is only little information provided on what is expected from them in exams and how to best prepare. In the (scarce) information sessions many questions remain unanswered. (It must be noted, however, that interviewees who started more recently experience much less issues with this as information provision has improved.) Altogether, many interviewees believe they underperformed in the AP, because they were not properly prepared and did not know what was expected of them.

> *"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, I believe. (…) If you weren't taught, you will make mistakes, for sure, and then you unjustly hear that you cannot do it."*
>
> – Participant 12

As these quotes illustrate, language plays a complicated and important role in the AP, as it impacts MESRs' cultural capital in two ways. Firstly, language is an important part of the required competence of a physician, as they always have to be able to clearly communicate with patients. MESRs native language skills completely lose their value in the Netherlands – at least during the AP – and MESRs have to learn to speak Dutch fluently. Most interviewees find it difficult to reach the (high) required Dutch level without being in practice. And secondly, language also influences the assessment of medical skills and knowledge, as these are examined in Dutch. Poor Dutch proficiency thus is a lack of cultural capital and devalues cultural capital in the shape of medical knowledge as well.

> *"I have to know the language well, but I cannot do that without being in touch with people, right? I can read a book for thousands of hours, but without contact with people I cannot learn the language."*
>
> – Participant 2

"It's medical language and then in another language. If you don't understand it well… maybe you could give a good answer when you read the question in Arabic, but because it's in Dutch… If you read the question a bit differently, you will give a different answer."

– Participant 9

All in all, through self-studying is becomes very difficult to achieve the expected level of competence, which contributes to the long time the AP takes, especially when long periods of internships are required due to poor results in the AP.

This contributes to the third main issue of the AP: it generally takes several years. Interviewees describe how they were advised by the UAF to study and prepare for months or even years in an effort to minimise the eventual internship duration, and how waiting times between each step and before the internships further increased the AP's duration, which is equivalent to Herfs (2009) conclusion. All this time MESRs are excluded from the medical field for a long time, which is problematic for several reasons. Firstly, interviewees feel as though they are losing medical knowledge and experience, so the AP would actually somewhat decrease MESRs cultural capital, rather than improve it.

"*It's hard for us, because I have not seen a patient in four years, only as translator. (…) I enjoy that, it's fine, but you are not practising your profession. My hands have not investigated the belly of a kid for four years, that's what I mean."*

– Participant 16

"Every day that I don't have an internship or need to wait longer, I forget many things, much information. That really influences my knowledge, the medical knowledge I have. I was finished with my exam and had to wait nine months. Nine months I didn't do anything. That really influences my level, my knowledge level."

– Participant 9

Furthermore, the exclusion from the medical field has an impact on their economic capital. Although most interviewees received financial support from the UAF for the costs of the

procedure[3], interviewees also need to make a living. Being full-time occupied by the AP, they remain dependent on social welfare and cannot regain their economic capital. This is painful for MESRs, which is worsened by pressure the municipality puts on finding employment.

> *"I'm poor. Part of my income comes from the salary of my wife, and the other part comes from the 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."*
>
> – Participant 10

> *"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."*
>
> – Participant 16

Moreover, as MESRs have to study from home, many participants experience the AP as a long period of isolation, in which they do not obtain many social connections. And their exclusion for the medical field inhibits their professional network building. Thereby, the AP hinders their social capital acquisition as well, which might challenge their integration in the field:

> *"I don't know any physicians, any Dutch physicians, except for my GP, that I go to when I have a problem. So, when I will try to be involved in the labour market, after this whole procedure is finished, I don't have a network to go to."*
>
> – Participant 10

Altogether, experience the AP as a very difficult time in their lives, even though they are grateful to live safely in the Netherlands. Their loss of social, economic and cultural capital and their struggle to regain these, seems to have a significant impact on MESRs wellbeing. They experience stress, depressed feelings and fear of never being able to work as a physician

[3] Receiving support from UAF is based on a selection procedure. One interviewee did not receive support from UAF because his Dutch proficiency was insufficient, which created financial struggle and – ironically – restricted him from taking medical language courses.

again. Although it is hard to precisely unravel the ways the AP impacts their wellbeing, there are multiple explanations. Firstly, the impact of a lack of social capital on mental health described in literature (Ziersch, 2005; Stephens, 2008) could partly the negative effect of the AP on wellbeing. Moreover, participants explain that long duration of the AP feels as a waste of their lives and increases their fear of poor career perspectives in the Netherlands, as they are getting older and are out of practice for a long time.

> *"My biggest fear is that when I've had the nationality and when I have the Dutch qualification that I will have a huge gap in my practice. (…) And my biggest fear that when I apply, they will say: "You didn't practice for a really long time. We cannot take you." That is literally my daily nightmare."*
> – Participant 10

Furthermore, the exclusion from the medical field is difficult for MESRs because they attained a professional identity in Syria which has become part of who they are (Merton, 1957). Participants struggle with not knowing when and if they will be a professional again and feel purposeless without working in hospitals and contributing to society, which is in sharp contrast with their hard work and great responsibilities in Syria. The lack of teaching and the endless waiting times further increases participants' perception of not being needed, and even makes them feel unwelcome in the Dutch medical field.

> *"I lost this reputation. Because if you are working in one place in Syria for a year, a lot of people in a neighbourhood or a lot of doctors, nurses, they would know you. (…) But when you leave everything and you come here without doing anything, that makes me miss that actually. Sometimes I look at old pictures and remember these old days. And it was not that easy, I was working very hard, but I was doing something very, very good. I was helping many people and they were very happy with my help and thanked me very much."*
> – Participant 8

> *"I think that if they'd want us, it will be a different story. You get the feeling that you're not welcome in the system, sometimes. (…) You get the signal from some people 'Why are you doing this?' or 'Go back to your own country.' I have that feeling actually."*
> – Participant 4

These feelings illustrate the powerful role the medical profession plays in physicians' lives, and that their position within the medical field is not only a source of welfare but also contributes to their wellbeing.

> *"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. Without working as physicians, we are literally in an identity crisis."*
>
> – Participant 10

Remarkably, many of these feelings seem to be enlarged by the current corona pandemic as they feel called upon to serve their host country, to help their "colleagues" and to save patients' lives, but they are not allowed to. Some of them link experiences in the current pandemic to their wartime experiences in Syria.

> *"When the war started, I didn't need admission to help people. Here, there's a high need of healthcare professionals, but they don't look at our situation. Why not? That's an important question to answer. We can help the Dutch people just like other Dutch people can, we can contribute to this society, we can do everything as doctors. In the end language is not necessary for relations… Language doesn't have to be perfect to be human."*
>
> – Participant 11

To improve their wellbeing and still acquire some economic, social and/or cultural capital, interviewees take on different coping strategies during the AP. Some share information and study to together with fellow MESRs. Many join the VBGA, the association for foreign doctors, which shares information and organises workshops on how to prepare for the exams. On top of that, interviewees explain how they try to build a professional network by reaching out to physicians and medical students, some more successfully than others, to acquire information or gain practical experience. And many decided to take on medicine-related voluntary jobs to be closer to the medical field. And, mainly, as they have little influence on the procedure, they just persevere and continue studying.

"I try everything, I want to do my best to really have a place in the Dutch healthcare. I understand that it's difficult, I understand that there are many boundaries, many requirements, things, but I will not surrender. No."
– Participant 9

Although I will not discuss all suggestions for revising the AP, I must note that nearly all interviewees emphasised that they would prefer to do an internship before their knowledge and skills are assessed (after acquiring a minimal level of Dutch). This would provide them with cultural capital through socialisation and could potentially decrease the time it takes to receive a practising license, thereby also decreasing the negative impact on their economic capital. Additionally, the internships could provide valuable connections within the medical field, allowing them to rebuild their social capital. Altogether, an internship could smoothen their integration in the Dutch medical field.

"The internship: from the time this person gets the permit, throw them in the hospital! It will solve so many problems, the gap problem, the network problem. They will be integrated with the healthcare system. They will be familiar with how things work in a hospital. It will solve so many problems."
– Participant 10

Interestingly, interviewees often mentioned that they know MESRs in Germany who quickly integrated in the medical field and were able to keep their specialisation. In Germany, MESRs can work in a hospital for three years after passing the equivalent of the Dutch AKV-test, so they can gain experience in the field before making the equivalent of the BI-test. And there is a special procedure for specialists. Many interviewees believe a similar system in the Netherlands would really benefit their integration process.

After the AP, most MESRs are required to do internships, ranging from a few months to more than a year. Generally, MESRs were glad to finally be in the medical field again and acquire practical experience and connections. However, due to poor organisation of the internships, many participants lost several extra months waiting, in which they do not receive a salary. Moreover, some interviewees struggled attaining the identity of a student, whilst feeling like a physician.

"You imagine that you do the assessment examination and then life is good. I got six months internships result and this is really outstanding. But then you get the result and you have contacted some university for the internships. And here begins the other suffer because you go back as a student while your mindset is that you are a doctor."
– Participant 5

4.4 Finding a job

After the AP and the internships, MESRs receive their certificate of competence, which finally allows them to obtain a BIG-registration. Their cultural capital becomes institutionalised, which officially provides them access to the professional group. And, officially, refugees should have equals chances on the labour market (Bakker et al., 2014), but MESRs experience difficulties finding employment nonetheless, at least in some fields of medicine. Whereas in Syria basic physicians directly start specialising, Dutch physicians usually work as a basic physician for a few years and then compete for specialisation spots, based on their credentials, (research) experience and, usually, their network. Participants in the AP fear this moment of competition with native Dutch physician, and the five interviewees who employed in Dutch healthcare organisations confirm the challenge of finding employment in their desired (or previous) specialism.

As mentioned before, physicians' position in the medical field is determined by their cultural and social capital (Gomes & Rego, 2013), which explains MESRs challenges. Although their certificate guarantees a basic level of knowledge and skills, MESRs do not have the same level of cultural capital as Dutch physicians who are fluent in Dutch and acquire knowledge on the Dutch healthcare system and Dutch professional behaviour in their education. MESRs simply cannot reach the same level through the AP and internships alone. Altogether, the selection committee will often prefer the Dutch candidate, perhaps unintentionally.

"I don't think it's intentional discrimination. I think it's more some sort of distrust for the outsider. Because you don't know how their education works. Because you don't know how he was trained, because you don't know."
– Participant 10

"Your background and culture are being watched, and not only your medical knowledge, but also how you talk, how you behave, how you dress. It is a free country but everything is seen. Here, the entry requirements for the intensive care

are not just medical, also the rest of your life. (…) So, I have to show that I can adjust, but that's a nice challenge."
– Participant 16

Moreover, Dutch physicians generally have more social capital as they grew up in the Netherlands and have been educated in the Dutch medical field, whereas MESRs have only lived here shortly and were excluded from the field most of that time. As Bourdieu's (1986) noted, the value of social capital depends on the resources of one's connections. Although many participants do build a network of other MESRs, their social capital is limited because they lack a network within the field (which have resources to help them secure employment). MESRs' lack of social capital increases their competitive disadvantage.

A third capital-unrelated issue MESRs encounter is related to disadvantage of their older age compared to Dutch physicians, as most of them have worked for years in Syria and then spend years obtaining their BIG-registration. In MESRs experience, their younger Dutch competitors are preferred by hospitals because they might have more energy and less family-responsibilities; require lower salaries; have young minds who can handle the work pressure; and have a longer working life ahead of them (which makes educating them more rewarding). Whereas their lack of cultural and social capital can somewhat be decreased by MESRs making extra efforts, they cannot change this age difference and the AP only increases this issue.

Naturally, MESRs struggle with not being able to enter certain specialisms, but they somewhat understand their competitive disadvantage and find ways to cope with it. One strategy they apply is moving to remoter regions where specialists are scarce. Another is to apply for positions in less-popular specialism, which generally have a lower work pace, such as geriatrics or insurance medicine. Of the five employed participants, only two secured a specialisation spot, both not in their original specialism.

"You're not well-prepared and that's why you see that Syrian doctors choose the easy things, they go to the GGD [public health], to geriatrics, cosmetic medicine or insurance. They always choose the easy things, because they cannot compete, they cannot show their knowledge because of their lack of language skills and things like that."
– Participant 2

"It remains a dream, that I can do my specialisation again, but the reality is something else, I can say."
– Participant 4

4.5 Working in Dutch healthcare facilities

Finding employment is an important milestone for MESRs, but after that their integration process continues and their workplace integration begins (Castagnone & Salis, 2015).

"*So, in the Netherlands, you are integrated when you take the integration exam. (…) And then you are integrated and after five years, you get a nationality. I really don't think integration should be this way. And the same applies to integrating senior physicians in the healthcare system. It shouldn't start with learning the language and it shouldn't end by taking a test. No, it will have to take longer, it will have to be a daily process*."
– Participant 10

All five employed interviewees who generally quite satisfied with their integration in their healthcare organisation. However, especially in the beginning, they still encounter challenges as they do not yet possess all skills and knowledge needed to function well in the Dutch medical field given the differences with Syrian healthcare.

Firstly, MESRs have to practice medicine in Dutch now. Although their Dutch level acquired in the AP is sufficient in general, the language barrier remains a challenge in certain situations, such as heated discussions, phone calls, helping patients with strong accents, or writing reports. Language learning simply takes time and especially in the beginning interviewees needed extra time to do consultations or write reports. Also, it really helped that colleagues generally were supportive, which relates to MESRs looking for a job in slower-paced professions.

A second important difference with Syrian healthcare is the strict regulation of healthcare through laws and protocols which describe a wide range of procedures, from medical interventions to administrative duties. MESRs note that it takes time to know apprehend how the Dutch healthcare system operates and learn which rules they must adhere to. Especially

the administrative burden and extensive use of ICT-systems requires them to develop new skills.

> *"Foreign physicians, especially Arabic ones, really struggle with typing. We right 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."*
> *– Participant* 9

> *"We barely use a computer during a consultation for example. Here you have to work with Epic, and I really hated this computer program. [Laughs] But that was just in the beginning, now I can do everything, I have no issues with Epic or I will ask a nurse or someone else, my colleague. But what I find weird is that many doctors here are writing on the computer while they talk to the patient. For me that used to be difficult."*
> *– Participant* 9

The final – and potentially biggest – challenge for MESRs is to attain the Dutch professional identity, and make it compatible with their original professional identity, culture and personality. In the Netherlands, communication and relationships with patients and colleagues are very different than in Syria. Patients have more to say, which means they can disagree and refuse treatment, and they should be actively involved in the decision-making process. And the relationship with colleagues is much more cooperative and physicians are expected to discuss their patients, which is considered a weakness in Syria. All employed interviewees highlight that they needed time to get accustomed to this Dutch way of working, but generally appreciate the Dutch style.

> *"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."*
> *– Participant* 16

Moreover, there are cultural differences in the broader sense as well, as the Netherlands is progressive and has legalised abortion and euthanasia, which both are strictly forbidden in Syria. And there are more nuanced differences as well, such as the tendency to be selective in whether or not to actively treat patients based on their characteristics. These cultural

differences touch upon core ethical decisions and cultural/religious values, as the Islam for instance implies that doctors should do everything they can to save a life. However, the interviewees emphasise that they understand the Dutch practice and believe they should adjust, sometimes by actively blocking their Syrian culture to provide care the Dutch way. And they make sure the patient is helped by a colleague if they are asked to do something they really cannot do.

> *"I certainly understand euthanasia, but I don't know if I would do it myself, of that I would refer to another physician. I don't know. I really understand that it happens here, and I've experienced it a few times that a patient does not want to be resuscitated. That's not allowed in Syria. Yes. But life is a decision of the patient themselves, not mine, I certainly understand that. Sometimes you have so much pain that you cannot do it anymore. I understand, but maybe I cannot do it myself. That might not only be my culture, but also my personality."*
> *– Participant* 12

> *"I'm willing to quit the therapy, but to propose it, to convince the patient that there is no purpose in treating them, that I still find difficult. So in most cases I ask my supervisor to do so.' "*
> *– Participant* 1

However, although they need time and room to adjust and benefit from receiving guidance throughout this process, all interviewees find their work very rewarding and believe they are adjusting well. MESRs feel welcome in the medical field now, as patients are generally very grateful and welcoming, and (most) colleagues are willing to help. Their job provides them with an income, is a source of social contacts and their cultural capital finally is acknowledged (and increased), giving them their identity as physicians back. Through their work, they regain economic, social and cultural capital and are thereby finally able to improve their societal position. This also improves their wellbeing.

> *"[That I am working again] is the most important, it's the core of my life, it was the goal of my life to work here as a doctor. It's very important, essential for me. (…) It was a matter of time and patience."*
> *– Participant* 3

"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 has a lot of impact [that I'm working as a doctor], 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."
– Participant 13

Altogether, being employed is both an accomplishment of and a stimulation of MESRs' integration in Dutch society, by being in touch with natives and being able to contribute to Dutch society. Moreover, all participants stress that they see their future in the Netherlands and not in Syria. MESRs' experiences thus are in line with Ager and Strang's (2008) conclusion that working is both a marker and means of integration.

"Without work no integration. There is no other option. Without work no integration. (…) Many people – refugees and Dutchmen – think integration is about speaking Dutch. No, that's not integration, it's no integration to go to the supermarket or buy food or speak a few sentences with your neighbour. Integration really is to work."
– Participant 7

"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."
– Participant 4

5

Discussion and conclusion

The main aim of this thesis was to gain an in-depth understanding of MESRs' experiences during their integration in the Dutch healthcare system. In this final chapter, I first discuss my findings and link them to theory in order to answer my research questions. Thereafter, I draw my final conclusion and discuss the implications of these findings. Lastly, I address limitations and potential directions for further study.

5.1 Discussion

In recent years, the Syrian civil war brought many medically-educated Syrian refugees to the Netherlands. As refugees, they are expected to integrate in Dutch society but struggle to re-enter their profession. Previous studies of Herfs (2009; 2013; 2018) looked at the experiences of migrant physicians in the AP and found issues with the long duration, costs and lack of information. I focussed on refugees specifically, as I assumed their integration experiences are influenced by their different migration motives, lack of preparation and limited freedom to leave the Netherlands. I further specified my target to Syrian refugees, because – most importantly – they are the large group of refugees in the Netherlands and because medical education is country-specific. By investigating all phases – from obtaining a Dutch physician's registration and finding a job, to integrating in the workplace – I aimed to gain a thorough understanding of MESRs' experiences and challenges when integrating in the Dutch medical field. Therefore, I formulated three subquestions:

Q1. *Which official procedures and legislation affect MESRs' integration in the Dutch healthcare system?*

Q2. *Which experiences do MESRs have and which challenges do they encounter before they obtain a Dutch physician's registration?*

Q3. *Which experiences do MESRs have and which challenges do they encounter after they have obtained a Dutch physician's registration and start working in the Netherlands?*

The document analysis revealed the procedures MESRs encounter after arrival in the Netherlands. They must undergo the asylum procedure to receive a protected refugee status and a temporary residence permit, and must complete civic participation exams to apply for a permanent residence permit (IND, 2017). With a (temporary) residence permit, they are allowed to work. However, to receive a physician's registration and work in the medical field, they have to undergo the AP and possibly do internships (Wet BIG, 1993). After that, they have the same rights as Dutch basic physicians.

The main results from this thesis stem from the interviews, which I analysed using theory on integration and medical professionalism, whilst applying Bourdieu's notions of economic, social, cultural and symbolic capital.

To understand MESRs' situation upon arrival in the Netherlands, I first touched upon participants' experiences in Syria. By studying medicine and working as a physician, they gained significant cultural, economic and social capital. Moreover, despite the horrible war experiences, their work as physicians during the war provided them with extra practical experience and made their work even more important. Given their large amount of capital, they attained a high status in society, which can be described as symbolic capital according to Bourdieu (1986). However, because of general and physician-specific war threats, they were forced to leave all this behind and rebuild their lives in the Netherlands.

According to literature relating Bourdieu's theory to migration, migrants need to bring or acquire economic, social and cultural capital to integrate and regain a respectable position in their host society. In the interviews, it became apparent that MESRs inevitably lose economic and social capital by leaving their social networks and many possessions behind in Syria. They do bring their medical degree (what Bourdieu would call *institutionalised cultural capital*) as well as medical knowledge, skills and experience (what in Bourdieu's theory can be defined as *embodied cultural capital*). Yet, based on the BIG-law (Wet BIG, 1993), the Dutch medical field must assure professional competence of its physicians and does not directly allow

physicians with foreign degrees to enter the field. Therefore, MESRs' cultural capital loses its value until their embodied cultural capital is re-institutionalised in the shape of the certificate of competence. All in all, MESRs attain a very low-capital position in Dutch society after their arrival.

Employment is an important source of economic capital (salaries), social capital (professional connections) and potentially cultural capital (experience and new knowledge) (Ihlen, 2009) and, thereby, an important marker and means of integration (Ager & Strang, 2008). However, until completing the asylum procedure, civic participation exams and the AP, MESRs cannot be employed as physicians and thereby cannot restore their capital loss. Although the asylum procedure and civic participation exams contribute to the long duration of MESRs unemployment, interviews revealed they are not difficult to complete for MESRs. The big hurdle for MESRs' integration in the Dutch medical field is the AP, as it takes several years of studying, waiting and making exams. Until completing the AP, their lack of (acknowledged) cultural capital, refrains them from being employed and regaining their higher position in society.

In the AP, MESRs' competence as physicians is assessed: Dutch and English language skills, knowledge on the Dutch healthcare system, basic medical knowledge, clinical knowledge and clinical skills (CBGV, 2019a; CBGV, 2019b). The Dutch medical field thereby act as an institution that determines what *competence* entails (Brosnan & Turner, 2009). Although participants were competent in Syria and generally describe to have sufficient medical knowledge, they lack Netherlands-specific clinical skills (on the Dutch style of practising medicine and communicating) and non-medical skills and knowledge (Dutch language and how to navigate the Dutch healthcare system). Consequently, MESRs' cultural capital is poorly transferable and they need to acquire new skills and knowledge, rather than just have their existing knowledge assessed. Although all participants more or less justify the existence of the AP, they highlight three main issues with its current execution (which influence their capital valuation and acquisition).

Firstly, the AP neglects MESRs' specialisations. In the interviewees' experience, their assessment scores and required duration of internships are solely based on their performance

on the exams. This devalues their cultural capital in two ways: their specialised knowledge and working experience are not assigned value and their basic medical knowledge is assessed, even though they have not used this knowledge for many years.

Secondly, MESRs have to acquire knowledge on the Dutch healthcare system and attain the Dutch professional identity and manner of practising medicine from home, whereas a professional identity generally is acquired through socialisation (Cruess et al., 2014). Being assessed before being allowed to obtain practical experience negatively influences their scores in the AP. Moreover, studying the Dutch language from home is difficult, which appears to have a dual negative effect, in line with what has been seen in other migrant groups: not only is language proficiency a skill which is assessed itself, it also influences the assessment of other knowledge and skills (Soontiens & Van Tonder, 2014). All in all, it appears to be difficult for MESRs to achieve the expected level of competence through self-studying. Thereby, their lack of cultural capital keeps them out of the medical field, but being outside the field keeps them from acquiring this capital. This vicious cycle seems to increase the length of the AP (as they need more time to prepare the exams from home) and the duration of internships they are assigned to complete before receiving their certificate of competence (because they obtain lower scores, often mainly due to poor communication skills).

This relates to MESRs third issue: the AP's long duration. During the procedure, MESRs are away from the medical field and full-time occupied with studying and making tests. This interferes with their capital acquisition. Not only do they remain dependent on social welfare, they also lose their practical experience and struggle with building a (professional) network. Consequently, they are stuck in their low-capital position, which also influences their wellbeing. Many interviewees report stress, isolation and depressed feelings, which could be explained to the negative impact lack of social capital can have on mental health (Ziersch, 2005; Stephens, 2008) and the fear not succeeding in finishing the AP. Moreover, being a physician is a special profession as physicians obtain a professional identity through their education (Merton, 1957), and MESRs struggle with losing this identity and feeling purposeless. The difficulty and duration of the AP increase their sense of not being welcome and needed in the Netherlands, which is in stark contrast to their high status and importance in Syria. Altogether, this makes the AP a difficult time for MESRs.

Nearly all participants believe that an internship before the assessment of their skills would improve their result in the AP and decrease the duration of their unemployment. This internship would allow them to get acquainted with the Dutch system and way of practising medicine, and improve their (medical) Dutch language proficiency. Also, it would allow them to be part of the medical field and build a professional network. Thus, this would allow MESRs to acquire cultural and social capital faster, and by decreasing the length of the AP, also allow them to earn a salary and rebuild their economic capital sooner.

The long and heavy AP made some participants consider leaving their profession (and, according to them, has caused other MESRs to do so). But doing so would further diminish the value of their cultural capital and leave them with little perspective on finding highly-skilled employment to regain their economic, social and symbolic capital. Fuelled by their passion and purpose to be a physician, interviewees persevere.

By obtaining the certificate of competence, MESRs finally acquire access to the Dutch medical field. Although this is an important step towards their integration, they now have to acquire a position within that field. This appears to be challenging as well, especially when they aim to work in highly-desired and competitive specialisms. By obtaining the certificate, they acquire institutionalised cultural capital and they are assumed to have sufficient knowledge, skills and experience (thus embodied cultural capital) to provide care safely in the Netherlands. However, in application procedures they still lag behind native Dutch physicians when it comes to cultural and social capital. And their age is a third challenging factor. Remarkably, most interviewees truly understand that native physicians are selected and switch their attention to applications in remote regions in the Netherlands, or in less popular and slower-paced specialisms.

Once in practice, MESRs mainly highlight that they still need to adjust. Big differences are the Dutch language, the Dutch healthcare system and the Dutch culture and professional behaviour. Therefore, MESRs still have to acquire more cultural capital to function well in the workplace. They need a supportive environment of both colleagues and patients who allow them to adjust and work somewhat slower in the adjustment period. In slower-paced

specialisations there generally is more room for this, which contributes to MESRs ending up in these specialisms.

Through their work, MESRs are finally able to improve their societal position and wellbeing. Generally, MESRs feel welcome as nearly all colleagues are helpful and patients are very tolerant as well. And through their membership of the profession they gain practical experience; knowledge on the Dutch healthcare system and style of practising medicine; a professional network; and – not irrelevant – a salary. Altogether, through this cultural, social and economic capital, they can finally work towards a higher societal position, and also regain their sense of purpose and identity as physicians. Working thus contributes to their wellbeing and integration in the Dutch society.

5.2 Conclusion

MSERs attained capital-rich positions in Syria before the war forced them to leave their homeland and settle in the Netherlands, but their integration in the Dutch medical field proves to be difficult.

MESRs inevitably lose social and economic capital by their flight and experience a devaluation of their cultural capital because of the differences between healthcare in Syria and the Netherlands. To regain their high societal position in the Netherlands, they need to regain these types of capital. Employment is an important source of economic and social capital, but the nature of the medical profession and MESRs' lack of (applicable) cultural capital restrains them from being employed. They need to undergo the AP, to re-institutionalise their cultural capital (in the shape of medical knowledge and skills) and acquire additional country-specific knowledge and skills, before they are allowed to practice medicine.

Their entry in the medical field is restricted based on the responsibility of the professional group to assure quality of physicians. Although most MESRs understand and justify this quality assurance, they have issues with current execution of the AP which hinders MESRs' acquisition of social and economic capital and is not beneficial for their acquisition of cultural capital either.

Consequently, when MESRs finally obtain their certificate of competence, they cannot compete with native physicians for competitive specialisation positions due to a lack of social and cultural capital. An additional issue they encounter is that their higher age (given their flight and the AP) negatively influences their chances of being hired. Therefore, MESRs generally have to settle for less popular regions or specialism.

Once employed, interviewees have the impression to be well-integrated in the workplace, but they need time to adjust and further acquire language skills and knowledge on the Dutch healthcare system and style of practising medicine. Altogether, MESRs are very grateful to be working again and through their employment they finally are able to regain capital and truly integrate in Dutch society.

Dutch society will benefit when MESRs integrate better and quicker, as their talents, knowledge and skills are not wasted and they are allowed to contribute to society rather than be dependent on social welfare. Although some of these conclusions might also apply to non-refugee foreign physicians in the Netherlands, MESRs' situation and the Dutch governments' responsibility towards them is different. MESRs come involuntarily and have no perspective nor intention to return to Syria, they lose much capital when they come here and they have limited freedom to move abroad, which challenges their integration and limits their alternatives. Moreover, they have a right to protection and equal labour chances, so it could be argued that the Dutch government has a duty to facilitate MESRs' integration and should put effort into solving their issues.

An important consideration to make, however, is whether the struggles MESRs encounter during the AP are inevitable (given their loss of capital caused by their migration and the duty of the professional group to assure competence of its physicians), or whether these struggles are truly worsened by the current design of the AP. Currently, the AP assesses competence without teaching it, whilst MESRs do need to acquire new skills and knowledge to become competent. An analysis of MESRs' experiences and capital throughout their integration suggests that providing an internship (before assessing their medical skills and knowledge) could accelerate their acquisition of these skills and knowledge whilst simultaneously

improving their capital-situation. This would promote their integration without jeopardising (or even contributing to) the quality assurance, and might improve their ability to compete with Dutch physicians for specialisation positions.

Nonetheless, as research in Germany suggest, even with an internship before the assessment, MESRs might still encounter challenges related to their cultural capital in their integration process (Abbara et al., 2019). Therefore, MESRs successful integration in the Dutch medical field also requires proper support from healthcare organisations. The findings of this thesis illustrate that healthcare organisations who employ MESRs should allow them time to adjust and provide them with guidance in the meantime.

Moreover, although this is an explorative study on MESRs' experiences, which is not primarily aimed at gaining new or confirming existing theoretical insights, it does illustrate Bourdieu's (1986) idea of the inevitable interconnectedness of different types capital, which underpins the importance of taking all types of capital into account in migrant studies.

5.3 Limitations and recommendations for further study

Based on my selection criteria that MESRs were all either engaged in the AP or employed, I only included MESRs who were able to start and continue the AP. Thereby I might have missed certain issues or challenges with the AP which cause MESRs to quit or never commence with the integration process. Unfortunately, within the time frame of this thesis, I could not include MESRs who decided not to participate in the AP or dropped out. It would, however, be interesting to conduct further research on their experiences as well.

This explorative research also provides many tools for further research on the MESRs who do integrate in the Dutch medical field. I only reached two women, it would be interesting to explore why that is: are there fewer female physicians in Syria, less female MESRs in the Netherlands, less females deciding to undergo the AP, or are they less willing or able to talk to researchers? Additionally, it would be relevant to follow-up on MESRs' experiences in practice and their further career development in the Netherlands, to gain a broader understanding of their workplace integration. And, lastly, this research investigated MESRs

perspectives, but it might also be relevant (in light of the quality assurance) to investigate the perspective of patients and Dutch healthcare organisations on MESRs' integration and functioning in practice. These findings could be used to further improve MESRs integration and to make sure that all stakeholders are involved and all perspectives concerning MESRs integration are taken into account.

References

Abbara, A., Orcutt, M., & Gabbar, O. (2015). Syria's lost generation of doctors. *BMJ*, *350*, 1-2. DOI: 10.1136/bmj.h3479

Abbara, A., Rayes, D., Omar, M., Zakaria, A., Shehadeh, F., Raddatz, H., & Tarakji, A. (2019). Overcoming obstacles along the pathway to integration for Syrian healthcare professionals in Germany. *BMJ Global Health, 4*(4), 001534. DOI: 10.1136/bmjgh-2019-001534

Aerts, L., & Van Beemen, C. (2019, June 19). Medisch specialist én vluchteling: auto met chauffeur in Syrië, onderaan de ladder in Nederland. *Volkskrant*. https://www.volkskrant.nl/mensen/medisch-specialist-en-vluchteling-auto-met-chauffeur-in-syrie-onderaan-de-ladder-in-nederland~be6bce2e/

Ager, A., & Strang, A. (2008). Understanding integration: A conceptual framework. *Journal of Refugee Studies*, *21*(4), 166–191. DOI: 10.1093/jrs/fen016

Alba, R. D., & Nee, V. (2009). *Remaking the American mainstream: Assimilation and contemporary immigration*. Harvard University Press. DOI: 10.4159/9780674020115

Alencar, A. (2018). Refugee integration and social media: A local and experiential perspective. *Information, Communication & Society*, *21*(11), 1588-1603. DOI: 10.1080/1369118X.2017.1340500

Babel (n.d.). *Medisch assessment – AKV-toets voor academici*. https://www.babel.nl/cursusoverzicht/medisch-assessment-akv-toets/

Bakker, L., Cheung, S. Y., & Phillimore, J. (2016). The asylum-integration paradox: Comparing asylum support systems and refugee integration in the Netherlands and the UK. *International Migration*, *54*(4), 118-132. DOI: 10.1111/imig.12251

Bakker, L., Dagevos, J., & Engbersen, G. (2014). The importance of resources and security in the socio-economic integration of refugees. *Journal of International Migration and Integration*, 15(3), 431-448. DOI: 10.1007/s12134-013-0296-2

Barriball, K. L., & While, A. (1994). Collecting data using a semi-structured interview: a discussion paper. *Journal of Advanced Nursing-Institutional Subscription*, *19*(2), 328-335. DOI: 10.1111/j.1365-2648.1994.tb01088.x

Bonjour, S. (2013). Governing diversity: Dutch political parties' preferences on the role of the state in civic integration policies. *Citizenship Studies*, *17*(6-7), 837–851. DOI: 10.1080/13621025.2013.834136

Bourdieu, P. (1984). *Distinction: A social critique of the judgement of taste* (R. Nice, Trans.) Routledge. https://monoskop.org/images/e/e0/Pierre_Bourdieu_Distinction_A_Social_Critique_of_the_Judgement_of_Taste_1984.pdf

Bourdieu, P. (1986). The forms of capital. In J. G. Richardson (Ed.), *Handbook of theory and research for the sociology of education* (pp. 241–258). Greenwood.

Bourdieu, P. (1990). *The logic of practice* (R. Nice, Trans.). Cambridge, UK: Polity.

Bourdieu, P., & Wacquant, L. J. D. (2007). *An invitation to reflexive sociology*. Polity Press.

Bowen, G. (2009). Document analysis as a qualitative research method. *Qualitative Research Journal, 9*(2), 27-40. DOI: 10.3316/QRJ0902027

Brosnan, C., & Turner, B. S. (2009). *Handbook of the sociology of medical education*. Routledge.

Bygnes, S. (2019). Not all Syrian doctors become taxi drivers: stagnation and continuity among highly educated Syrians in Norway. *Journal of International Migration and Integration*, 1-14. DOI: 10.1007/s12134-019-00717-5

Carpiano, R. M. (2006). Toward a neighborhood resource-based theory of social capital for health: Can Bourdieu and sociology help? *Social Science & Medicine*, *62*(1), 165–175. DOI: 10.1016/j.socscimed.2005.05.020

Castagnone, E., & Salis, E. (2015). *Workplace integration of migrant health workers in Europe. Comparative report on five European countries*. FIERI. https://workint.fieri.it/wp-content/uploads/2015/09/Comparative-research-report_FINAL.pdf

Centraal Bureau voor de Statistiek (2018, April 7). *11 Procent van statushouders heeft werk*. https://www.cbs.nl/nl-nl/nieuws/2018/16/11-procent-van-statushouders-heeft-werk

Char (2019). *Explaining the different direct socio-economic integration of Afghan and Syrian refugees in the Netherlands* (Master thesis). Leiden University. https://openaccess.leidenuniv.nl/bitstream/handle/1887/68918/Char%2C%20Jasmin-s1533541-MA%20Thesis%20POWE-2019.pdf?sequence=1

Centraal Informatiepunt Beroepen Gezondheidszorg (n.d.-a). Beoordeling en besluit. https://www.bigregister.nl/buitenlands-diploma/procedures/erkenning-beroepskwalificaties/beoordeling-en-besluit

Centraal Informatiepunt Beroepen Gezondheidszorg (n.d.-b). Certificate of competence. https://english.bigregister.nl/foreign-diploma/procedures/certificate-of-competence

Commissie Buitenslands Gediplomeerden Volksgezondheid (2019a, October 16). *Reglement AKV toetsen CBGV*. https://www.bigregister.nl/binaries/bigregister/documenten/publicaties/2017/03/03/regelement-akv-toetsen/CBGV+reglement+AKV+toetsen+oktober+2019.pdf

Commissie Buitenslands Gediplomeerden Volksgezondheid (2019b, October 10). *Reglement BI toetsen CBGV*. https://www.bigregister.nl/binaries/bigregister/documenten/publicaties/2017/03/03/reglement-beroepsinhoudelijke-toetsen/CBGV+reglement+BI+toetsen+oktober+2019.pdf

Corbin, J., & Strauss, A. L. (2014). *Basics of qualitative research: Techniques and procedures for developing grounded theory*. Sage publications.

Cruess, R. L., Cruess, S. R., Boudreau, J. D., Snell, L., & Steinert, Y. (2014). Reframing medical education to support professional identity formation. *Academic Medicine*, *89*(11), 1446-1451. DOI: 10.1097/ACM.0000000000000427

Dagevos, J. M., Huijnk, W., Maliepaard, M., & Miltenburg, E., M. (2018). *Syriërs in Nederland*. Sociaal en Cultureel Planbureau. https://www.labyrinthonderzoek.nl/wp-content/uploads/2018/06/Syri%C3%ABrs-in-Nederland_WEB_DEF.pdf

Dagevos, J., M., Miltenburg, E., de Mooij , M., Schans, D., Uiters, E., & Wijga, A. (2020). *Syrische statushouders op weg in Nederland: De ontwikkeling van hun positie en leefsituatie*. Sociaal Cultureel Planbureau. https://digitaal.scp.nl/syrische-statushouders-op-weg-in-nederland/samenvatting

De Vroome, T., & Van Tubergen, F. (2010). The employment experience of refugees in the Netherlands. *The International Migration Review, 44*(2), 376-403. DOI: 10.1111/j.1747-7379.2010.00810.x

De Zwaan, I. (2020, April 4). Syrische arts staat klaar om zijn Nederlandse collega's te helpen: 'Er is zoveel dat ik nu zou kunnen doen'. *Volkskrant*. https://www.volkskrant.nl/nieuws-achtergrond/syrische-arts-staat-klaar-om-zijn-nederlandse-collega-s-te-helpen-er-is-zoveel-dat-ik-nu-zou-kunnen-doen~b101a2db/

Dupuis, H. M. (2000). Professional autonomy: a stumbling block for good medical practice. An analysis and interpretation. *Theoretical Medicine, 21*(5), 493-502. DOI: 10.1023/a:1009929523944

Entzinger, H. (2006). Changing the rules while the game is on: From multiculturalism to assimilation in the Netherlands. In *Migration, citizenship, ethnos* (pp. 121-144). Palgrave Macmillan, New York. DOI: 10.1057/9781403984678_7

Erel, U. (2010). Migrating cultural capital: Bourdieu in migration studies. *Sociology*, *44*(4), 642-660. DOI: 10.1177/0038038510369363

Freidson, E. (1988). *Profession of medicine: A study of the sociology of applied knowledge*. University of Chicago Press.

Friedberg, R. M. (2000). You can't take it with you? Immigrant assimilation and the portability of human capital. *Journal of labor economics*, *18*(2), 221-251. DOI: 10.1086/209957

Garcés-Mascareñas, B., & Penninx, R. (2016). Introduction: Integration as a three-way process approach? In B. Garcés-Mascareñas, & R. Penninx (Eds.), *Integration processes and policies in Europe: contexts, levels and actors* (pp. 1-9). Springer Open. DOI: 10.1007/978-3-319-21674-4_1

Gericke, D., Burmeister, A., Löwe, J., Deller, J., & Pundt, L. (2018). How do refugees use their social capital for successful labor market integration? An exploratory analysis in Germany. *Journal of Vocational Behavior, 105*, 46-46. DOI: 10.1016/j.jvb.2017.12.002

Gomes, A. P., & Rego, S. (2013). Pierre Bourdieu and medical education. *Revista Brasileira de Educação Médica*, *37*(2), 260-265.

Green, J., & Thorogood, N. (2018). *Qualitative methods for health research*. SAGE Publications.

Hartog, J., & Zorlu, A. (2009). How important is homeland education for refugees' economic position in the Netherlands? *Journal of Population Economics, 22*(1), 219-246. DOI: 10.1007/s00148-007-0142-y

Heisler, M., Baker, E., & McKay, D. (2015). Attacks on health care in Syria—normalizing violations of medical neutrality? *New England journal of medicine*, *373*(26), 2489-2491. DOI: 10.1056/NEJMp1513512

Herfs, P. G. P. (2009). *Buitenlandse artsen in Nederland* (PhD dissertation). Utrecht University. http://paulherfs.nl/wp-content/uploads/2013/03/Proefschrift.pdf

Herfs, P. G. P. (2013). *De assessment procedure voor buitenlandse artsen: een balans na 7 jaar*. ERCOMER. https://www.researchgate.net/publication/261285138

Herfs, P. G. P. (2018). Evaluatie van de toelating van buitenlandse artsen; hoogste tijd voor verbetering van procedure en organisatie. *A&MR 2018*(5), 212-218.

Hoogland, J. and Jochemsen, H. (2000). Professional autonomy and the normative structure of medical practice. *Theoretical Medicine, 21*(5), 457-475. DOI: 10.1023/a:1009925423036

Hsieh, H. F., & Shannon, S. E. (2005). Three approaches to qualitative content analysis. *Qualitative health research*, *15*(9), 1277-1288. DOI: 10.1177/1049732305276687

Huang, X. (2019). Understanding Bourdieu - Cultural capital and habitus. *Rev. Eur. Stud.*, *11*(3), 45-49. DOI: 10.5539/res.v11n3p45

Ihlen, Ø. (2009). On Pierre Bourdieu: Public relations in field struggles. In Ø. Ihlen, B. van Ruler & M. Fredriksson (Eds.), *Public relations and social theory: Key figures and concepts* (pp. 71-91). Routledge.

Integratie en Naturalisatiedienst (2017). *Rechten en plichten verblijfsvergunning asiel voor bepaalde tijd.* https://ind.nl/documents/rechten_plichten_vvabep_nederlands.pdf

Integratie en Naturalisatiedienst (n.d.). *Inburgering in Nederland.* https://ind.nl/Paginas/Inburgering-in-Nederland.aspx

Kallio, H., Pietilä, A. M., Johnson, M., & Kangasniemi, M. (2016). Systematic methodological review: Developing a framework for a qualitative semi-structured interview guide. *Journal of advanced nursing*, *72*(12), 2954-2965. DOI: 10.1111/jan.13031

Konle-Seidl, R., & Bolits, G. (2016). *Labour market integration of refugees: Strategies and good practices: Study*. European Parliament. http://www.europarl.europa.eu/RegData/etudes/STUD/2016/578956/IPOL_STU(2016)578956_EN.pdf

Leung L. (2015). Validity, reliability, and generalizability in qualitative research. *Journal of family medicine and primary care*, *4*(3), 324–327. DOI: 10.4103/2249-4863.161306

Merton, R. K. (1957). Some preliminaries to a sociology of medical education. In R.K. Merton, L.G. Reader, P.L. Kendall (Eds.), *The student physician: Introductory studies in the sociology of medical education* (3rd edition, pp. 3-79). Cambridge: Harvard University Press.

Mortelmans, D. (2007). *Handboek kwalitatieve onderzoeksmethoden*. Acco.

Mossialos, E., Wenzl, M., Osborn, R., & Sarnak, D. (2016). *2015 International profiles of health care systems*. Canadian Agency for Drugs and Technologies in Health. https://da7648.approby.com/m/679d3f31e43c2e4e.pdf

Nuffic (n.d.). *Information for refugees about diplomas*. https://www.nuffic.nl/en/subjects/information-refugees-about-diplomas/

Özdemir, V., Kickbusch, I., & Coşkun, Y. (2017). Rethinking the right to work for refugee Syrian healthcare professionals: a call for innovation in global governance. *BMJ*, *357, 1-4*. DOI: 10.1136/bmj.j2710

Paauw, S. (2017, April 8). Syrische artsen willen snel weer aan het werk. *Medisch Contact*. https://www.medischcontact.nl/nieuws/laatste-nieuws/artikel/syrische-artsen-willen-snel-weer-aan-het-werk.htm

Paauw, S. (2018, April 19). Wat ga je verdienen als je arts bent? Inkomens van artsen in Nederland. *Medisch Contact*. https://www.medischcontact.nl/arts-in-spe/nieuws/ais-artikel/-wat-ga-je-verdienen-als-je-arts-bent.htm

Papademetriou, D., & Benton, M. (2016). *Towards a whole-of-society approach to receiving and settling newcomers in Europe*. Migration Policy Institute. https://www.migrationpolicy.org/sites/default/files/publications/Gulbenkian-FINAL.pdf

Penninx, R., & Garcés-Mascareñas, B. (2016). The concept of integration as an analytical tool and as a policy concept. In *Integration processes and policies in Europe* (pp. 11-29). Springer.

Pinxten, W., & Lievens, J. (2014). The importance of economic, social and cultural capital in understanding health inequalities: using a Bourdieu-based approach in research on physical and mental health perceptions. *Sociology of health & illness*, *36*(7), 1095-1110. DOI: 10.1111/1467-9566.12154

Schuller, T. (2001). The complementary roles of human and social capital. *Canadian Journal of Policy Research*, *2*(1), 18-24.

Sociaal Economische Raad (2019). *Werkwijzer vluchtelingen - Werk en onderwijs*. https://www.ser.nl/nl/thema/werkwijzer-vluchtelingen/feiten-en-cijfers/arbeidsmarkt

Sociaal Economische Raad (n.d.). *Inburgering – Wetten en Regels*. https://www.ser.nl/nl/thema/werkwijzer-vluchtelingen/inburgering/wetten-regels

Soontiens, W., & Van Tonder, C. (2014). Human capital and workplace integration: A reflection of South African migrants in Australia. *Procedia-Social and Behavioral Sciences, 143*, 1031-1040. DOI: 10.1016/j.sbspro.2014.07.549

Stephens, C. (2008). Social capital in its place: using social theory to understand social capital and inequalities in health. *Social Science & Medicine*, *66*(5), 1174–1184. DOI: 10.1016/j.socscimed.2007.11.026

Swick, H. M. (2000). Toward a normative definition of medical professionalism. *Academic medicine*, *75*(6), 612-616.

Ten Cate, O. (2007). Medical education in the Netherlands, *Medical Teacher*, *29*(8), 752-757. DOI: 10.1080/01421590701724741

United Nations High Commissioner for Refugees (2010). *Convention and protocol relating to the status of refugees.* https://www.unhcr.org/3b66c2aa10

Universitair Asiel Fonds (2019, November 8). *Stappenplan voor gediplomeerde artsen van buiten de EU*. https://www.uaf.nl/kennisbank/wil-je-aan-de-slag-als-arts/

Van Heelsum, A. (2017). Aspirations and frustrations: Experiences of recent refugees in the Netherlands. *Ethnic and Racial Studies*, *40*(13), 2137-2150. DOI: 10.1080/01419870.2017.1343486

Vereniging Buitenlands Gediplomeerde Artsen (2019, March 15). *Het Assessment*. https://www.vbga.nl/het-assessment

Vluchtelingenwerk Nederland (2019). *Vluchtelingen in getallen 2019 - Rapport*. https://www.vluchtelingenwerk.nl/sites/default/files/Vluchtelingenwerk/Cijfers/20190722_vwn_vluchtelingen-in-getallen.pdf

Waterval, D. (2020, April 9). De arbeidsmarkt na één maand corona: enorme overschotten aan personeel én grote gaten. *Trouw*. https://www.trouw.nl/economie/de-arbeidsmarkt-na-een-maand-corona-enorme-overschotten-aan-personeel-en-grote-gaten~b70b5c27/?referer=https%3A%2F%2Fwww.google.com%2F

Wengraf, T. (2001). *Qualitative research interviewing: Biographic narrative and semi-structured methods*. Sage.

Wet inburgering 2006. https://wetten.overheid.nl/BWBR0020611/2020-07-01

Wet inburgering nieuwkomers 1998. https://wetten.overheid.nl/BWBR0009544/2005-01-01

Wet op de beroepen in de individuele gezondheidszorg 1993. https://wetten.overheid.nl/BWBR0006251/2020-07-01

Wittenberg, N. (2019, February 4) In Syrië had arts Hanaa haar eigen medisch laboratorium - In Nederland moet ze opnieuw stage lopen. *De Correspondent*. https://decorrespondent.nl/9136/in-syrie-had-arts-hanaa-haar-eigen-medisch-laboratorium-in-nederland-moet-ze-opnieuw-stage-lopen/608804768-f9e817fb

Ziersch, A.M. (2005) Health implications of access to social capital: findings from an Australian study. *Social Science & Medicine, 61*(10), 2119–31. DOI: 10.1016/j.socscimed.2005.01.015

Appendix A:
Interview guides

Interview guide 1: For participants in the assessment procedure

Basic information	
Interviewee:	_____
Date:	_____
Male/Female:	M / F
Age:	_____ years
Language:	Dutch / English

Education and working experience in Syria	
Getting to know them	- When did you decide to become a doctor (in Syria)? - Why did you decide to study medicine?
Education	- Where in Syria did you study medicine? - How is the medicine study organised in Syria? What does it take to become a doctor in Syria? - How many years of education did you receive in Syria? - How do perceive the quality of a doctors' education in Syria? - Did you specialise in Syria?
Working experience	- What working experience did you gain in Syria? o How many months or years? o Which department(s)? o What kind of healthcare organisation(s)? - How did your working life look like? - How do you perceive the quality of care in Syria?
Role of a doctor	- What is the role of a doctor in a healthcare organisation? - What is the average patient-doctor relationship? - What is the societal role of a doctor in Syria, outside the hospital? What does it mean to be a doctor in Syria? - How do Syrian people look at doctors? - What did it mean for you to be a doctor?

The assessment procedure	
Basic	- When did you arrive in the Netherlands? - In which stage of the assessment procedure are you? - How long have you been occupied by the procedure up until now? - How do you experience the assessment procedure? - Do you perceive the assessment procedure as justified?

	○ Do you believe an assessment is necessary? ○ What do you hope to learn in the procedure? ○ What should be the goal of the assessment procedure?
Elements	- Which parts of the assessment do you believe to be relevant? - Which parts of the assessment procedure are irrelevant in your opinion? - How do you think about the way the elements were tested and assessed?
Skills, knowledge and experience	- How well do you think your medical knowledge and skills are acknowledged in the assessment procedure? - Do or did you acquire new knowledge or skills during the assessment procedure? - How well do you think your medical experience in Syria is acknowledged in the assessment procedure?
Language	- Did you master the English language before arriving in the Netherlands? - What do you think about the English language being part of the assessment procedure? - How did you experience learning Dutch? - Do or did you receive Dutch language classes during the assessment procedure? - When applicable: How did you experience the language exams?
Impact of the assessment procedure	- How does the assessment procedure influence your life? - What is the emotional impact of the assessment procedure? Do emotions like fear or insecurity play a role in this period? - What does it mean for you that your education/experience/status in Syria is questioned in the Netherlands? - Do you experience a loss in status in the Netherlands? - How does it affect you that you are a student again? - How does the time the procedure takes affect your life?
Support	- Which support do you receive during the assessment procedure? ○ Do you know about UAF/ do you receive support from UAF? ○ Or another organisation? - Where you satisfied with the support you receive? - Do or did you ever feel the need for more support?
Obstacles	- What struggles do you experience during the assessment procedure? - Which parts of the assessment do or did you struggle with? - Have you ever considered to stop with the procedure? - How much does the procedure cost you? Are costs an obstacle for you? - How do you perceive the availability of information on the procedures and what to study? Is it clear what is expected of you?
Conclusions	- What would you want to change about the assessment procedure? - What do you appreciate about the assessment procedure?

Workplace experiences in the Netherlands (during observatory, voluntary or required internships)	
General	- Do you have any experience in the Dutch medical practice? - How many days or weeks have you been in practice through an (observatory/ voluntary/ required) internship? - How did you experience this time in practice?
Comparison with Syrian healthcare	- What was your first impression of the Dutch healthcare system? - What are main differences between healthcare in Syria and the Netherlands? - What are main differences between the doctor-patient relationship in Syria and the Netherlands? - Does your own culture influence the way you would provide care in the Netherlands? - Does your Syrian background have advantages or disadvantages when working as a doctor in the Netherlands?
Assessment procedure as preparation: skills and knowledge	- What does a Syrian doctor need to learn to function in a Dutch healthcare organisation? - Do you feel like you currently have enough medical knowledge to work in the Netherlands? Do you feel like you miss relevant knowledge? o On what subjects does a Syrian doctor have less knowledge compared to native Dutch doctors? o Did you acquire this knowledge in Syria or during the assessment procedure? o On what subjects does a Syrian doctor have more knowledge compared to native Dutch doctors? - Do you feel like you have enough non-medical knowledge to work in the Netherlands (e.g. on systems)? - Do you feel like you have enough skills to work in the Netherlands? Do you feel like you miss relevant skills? o Which skills does a Syrian doctor lack compared to native Dutch doctors? o Did you acquire these skills in Syria or during the assessment procedure? o Which extra skills does a Syrian doctor have which compared to native Dutch doctors? Arabic language?
Language	- Do you experience difficulties with the Dutch language during the internships? At which moments? - Do you experience difficulties with the Dutch language when helping patients? - Do you use the English language during your internship in the Netherlands?
"Future integration in the workplace"	- How do you experience your internship/working relationships with: o Patients? o Colleagues?

	○ Superiors? - How do you perceive your chances to build a career in the Netherlands? - How do you perceive the opportunities for your professional development in the Netherlands?
Obstacles during the (observatory) internship	- Do you experience difficulties during the internships in the Dutch healthcare organisations? - Do you experience any difficulties because of your different cultural background whilst interning in the Netherlands? - Do you experience any difficulties with the different role of doctors in the Netherlands? - Do you experience discrimination: ○ By patients? ○ By colleagues? ○ By superiors?
Support / social network	- How would you describe your social network in the Netherlands? - What was the impact of losing your social network in Syria? - How important is contact with other Syrian doctors in the Netherlands for you? - How important is contact with native Dutch doctors for you? - Which support do or did you receive during the internships in Dutch healthcare institutions? - When do or did you feel the need for more support?
Impact of being able to work and integration in society	- How important is it for you to work as a doctor in the Netherlands? Why? - When would you consider yourself to be integrated in the Dutch society? Does being able to work in the Netherlands influence that? - Do you consider yourself to be a Netherlander? ○ If yes: since when? ○ If no: why not? when would that be? - Do you wish to grow old in the Netherlands or would you want to return to Syria one day?

Sensitive questions (only if appropriate)	
Influence of war experiences	- Did you ever consider working abroad before the war started in Syria? - In the media a light has been shed on the attacks on hospitals in Syria, did you experience that as well? How does that influence you as a doctor? - If you want to answer, in what ways do your experiences in the Syrian war affect you and your work in the Netherland?

Interview guide 2: For participants working in Dutch healthcare institutions

Basic information	
Interviewee:	_____
Date:	_____
Male/Female:	M / F
Age:	_____ years
Language:	Dutch / English

Education and working experience in Syria	
Getting to know them	- When did you decide to become a doctor (in Syria)? - Why did you decide to study medicine?
Education	- Where in Syria did you study medicine? - How is the medicine study organised in Syria? What does it take to become a doctor in Syria? - How many years of education did you receive in Syria? - How do perceive the quality of a doctors' education in Syria? - Did you specialise in Syria?

Working experience	- What working experience did you gain in Syria?
	  o How many months or years?
	  o Which department(s)?
	  o What kind of healthcare organisation(s)?
	- How did your working life look like?
	- How do you perceive the quality of care in Syria?

Role of a doctor	- What is the role of a doctor in a healthcare organisation? - What is the average patient-doctor relationship? - What is the societal role of a doctor in Syria, outside the hospital? What does it mean to be a doctor in Syria? - How do Syrian people look at doctors? - What did it mean for you to be a doctor?

The assessment procedure	

Basic	- When did you arrive in the Netherlands?
	- How long did your assessment procedure take?
	- What was you final advice of the CBGV: were you obliged to do internships in the Netherlands?
	- How did you feel about the decision whether or not you had to do internships?
	- How do you look back on the assessment procedure?
	- Do you perceive the assessment procedure as justified?
	  o Do you believe an assessment is necessary?
	  o What did you hope to learn in the procedure?

	○ What should be the goal of the assessment procedure?
Elements	- Which parts of the assessment do you believe to be relevant? - Which parts of the assessment procedure are irrelevant in your opinion? - How do you think about the way the elements were tested and assessed?
Skills, knowledge and experience	- How well do you think your medical knowledge and skills are acknowledged in the assessment procedure? - Did you acquire new knowledge or skills during the assessment procedure? - How well do you think your medical experience in Syria is acknowledged in the assessment procedure?
Language	- Did you master the English language before your arrival in the Netherlands? - What do you think about the English language being part of the assessment procedure? - How did you experience learning Dutch? - Did you receive Dutch language classes during the assessment procedure? - How did you experience the language exams?
Impact of the assessment procedure	- How did the assessment procedure influence your life? - What was the emotional impact of the assessment procedure? Did emotions like fear or insecurity play a role in this period? - What does it mean for you that your education/experience/status in Syria is questioned in the Netherlands? - Did you experience a loss in status in the Netherlands? - How did it affect you that you were a student again? - How did the time the trajectory took affect your life?
Support	- Which support did you receive during the assessment procedure? ○ Did you know about UAF/ receive support from UAF? ○ Or another organisation? - Where you satisfied with the support you received? - Did you ever feel the need for more support?
Obstacles	- What struggles did you experience during this time? - Which parts of the assessment did you struggle with? - Did you ever consider to stop during the procedure? - How much did the procedure cost you? Were costs an obstacle for you? - How did you perceive the availability of information on the procedures and what to study? Was it clear what was expected of you?
Conclusions	- Looking back, what would you want to change about the assessment procedure? - Looking back, what did you appreciate about the assessment procedure?

Workplace integration in Dutch healthcare organisations	
General	- What is your current situation? - How old are you? - Are you working? Do you have experience in practice in the Netherlands? - How many months/ years of working experience did you gain already in the Netherlands? - How do you experience working in a Dutch healthcare institution?
Comparison with Syrian healthcare	- What was your first impression of the Dutch healthcare system? - What are main differences between healthcare in Syria and the Netherlands? - What are main differences between the doctor-patient relationship in Syria and the Netherlands? - Does your own culture influence the way you provide care in the Netherlands? - Does your Syrian background have advantages in working as a doctor in the Netherlands?
Assessment procedure as preparation: skills and knowledge	- What does a Syrian doctor need to learn to function in a Dutch healthcare organisation? - To what extent does the assessment procedure assess the skills and knowledge a Syrian doctor requires to function well in a Dutch healthcare organisation? - To what extent did the assessment procedure prepare you for working in the Netherlands? - Which elements of the assessment procedure contribute to the care you deliver today? - Do you feel like you have enough medical knowledge to work in the Netherlands? Do you feel like you miss relevant knowledge? o On what subjects does a Syrian doctor have less medical knowledge compared to native Dutch doctors? o What new medical knowledge did you acquire during the assessment procedure? o On what subjects does a Syrian doctor have more medical knowledge compared to native Dutch doctors? - Do you feel like you have enough non-medical knowledge to work in the Netherlands (e.g. on systems)? - Do you feel like you have enough (medical) skills to work in the Netherlands? Do you feel like you miss relevant skills? o Which skills does a Syrian doctor lack compared to native Dutch doctors? o What new skills did you acquire during the assessment procedure? o Which extra skills does a Syrian doctor have which compared to native Dutch doctors? Arabic language?

Language	- Do you experience difficulties with the Dutch language whilst working? At which moments? - Do you experience difficulties with the Dutch language when helping patients? - Do you use the English language during your work in the Netherlands?

Integration	- How well do you consider yourself to be integrated in the organisation you work at?
	  o Did you consider yourself as an outsider?
	  o Are you satisfied with this degree of integration?
	- Which policies/measures facilitate or hinder your integration?
	- How do you experience your working relationships with:
	  o Patients?
	  o Colleagues: Are Dutch doctors open to cooperate with you?
	  o Superiors?
	- How do you perceive the opportunity to build a career in the Netherlands?
	- How do you perceive the opportunities for professional development in the Netherlands?

Obstacles	- Do you experience difficulties working in the Dutch healthcare organisations?
	- Do you experience any difficulties because of your different cultural background whilst working in the Netherlands?
	- Do you experience any difficulties with the different role of doctors in the Netherlands?
	- Do you experience discrimination:
	  o By patients?
	  o By colleagues?
	  o By superiors?

Support / social network	- How would you describe your social network in the Netherlands? - What was the impact of losing your social network in Syria? - How important is contact with other Syrian doctors in the Netherlands for you? - How important is contact with native Dutch doctors for you? - Which support did you receive during the time working (or doing internships) in Dutch healthcare institutions? - When did you feel the need for more support? - What support or help should healthcare organisations provide to Syrian doctors in the beginning of their career in the Netherlands?
Concluding questions: Impact of being able to work	- How do you feel now that you can finally work as a doctor in the Netherlands? - How important is it for you to work as a doctor in the Netherlands? Why? - How well do you consider yourself to be integrated in the Dutch society? Do you experience working in the Netherlands to influence that?

	- Do you consider yourself to be a Netherlander?
	  o If yes: since when?
	  o If no: why not? when would that be?
	- Do you wish to grow old in the Netherlands or would you want to return to Syria one day?

Sensitive questions (only if appropriate)	
Influence of war experiences	- Did you ever consider working abroad before the war started in Syria? - In the media a light has been shed on the attacks on hospitals in Syria, did you experience that as well? How does that influence you as a doctor? - If you want to answer, in what ways do your experiences in the Syrian war affect you and your work in the Netherland?

Appendix B:
Final coding tree

Main codes and sub codes			
Experiences in Syria			
	Syrian education: abroad		
	Education in Syria	Syrian education: admission	
		Syrian education: foreign specialists teaching	
		Syrian education: influence of war	
		Syrian education: specialisation	
		Syrian education: study build up	Syrian education: theory
			Syrian education: practice
	Healthcare in Syria	Syrian healthcare: doctor-patient relationship	
		Syrian healthcare: public/private	
	Motivation in Syria to become a doctor		
	Societal position in Syria	Syria: economic capital	
		Syria: human capital	
		Syria: social capital	
		Syria: symbolic capital	
		Syria: wellbeing	
	Wartime experiences in Syria	Wartime: general experiences	
		Wartime: physicians experiences	Wartime in hospitals: danger for doctors
			Wartime in hospitals: victims
			Wartime in hospitals: work pressure
	Working experience in Syria		
	Working experience outside Syria		
Experiences in the flight to the Netherlands			
Experiences in the Netherlands			
	Before the assessment procedure	Before: experiences	Bef. Exp: AZC and refugee symbolic capital
			Bef. Exp: decision to do assessment
			Bef. Exp: civic integration
			Bef. Exp: language learning
		Before: impact on capital	Before: impact cultural capital
			Before: impact social capital
			Before: impact symbolic capital
			Before: impact wellbeing

			Before: impact economic capital	
		Before: legislation		
	During the assessment procedure	During: experiences	D. Exp.: expectations about working	
			D. Exp: (voluntary/side) jobs	
			D. Exp: education	
			D. Exp: internships	D. Exp. Int: interaction with doctors
				D. Exp. Int: interaction with patients
			D. Exp: justification	
			D. Exp: no track for specialists	
			D. Exp: not being needed	
			D. Exp: other countries	
			D. Exp: other options to become a doctor	
			D. Exp: refugee	
			D. Exp: relevance of exams	D. Exp Rel: AKV
				D. Exp Rel: BI
				D. Exp Rel: Language
			D. Exp: self-study	
			D. Exp: support organisations	
			D. Exp: time it takes	
			D. Exp: unfairness	D. Exp Unfair: Unclarity
			D. Exp: working experience	
		During: impact	During: coping with impact	
			During: economic capital impact	
			During: human capital impact	Dur. Hum: language
				Dur. Hum: medical knowledge
				Dur. Hum: medical skills
				Dur. Hum: system knowledge
			During: social capital impact	
			During: symbolic capital impact	
			During: wellbeing impact	Dur. Wellb: emotions
				Dur. Wellb: identity
		During: legislation		

	Finding a job	Finding: expectations	
		Finding: experiences	Find. Exp: competition
			Find. Exp: difficulties
			Find. Exp: network
		Finding: Impact and coping mechanisms	
		Finding: legislation	
	Working in the Netherlands	Working: differences	Work. Dif: culture
			Work. Dif: language
			Work. Dif: system
		Working: experiences	Work. Exp: (no) discrimination
			Work. Exp: career perspectives
			Work. Exp: influence of Syrian culture
			Work. Exp: influence of war experiences
			Work. Exp: interaction with colleagues
			Work. Exp: interaction with patients
			Work. Exp: language issues
			Work. Exp: time to adjust
			Work. Exp: workplace integration
		Working: impact	Work. Imp: economic capital
			Work. Imp: human capital
			Work. Imp: social capital
			Work. Imp: symbolic capital
			Work. Imp: wellbeing
		Working: coping mechanisms	
Other			
	Corona		
	Family		
	Gender		
	Integration in society	Back to Syria	
	Interviewer influence/addressed		
	Other jobs		
	Politics	Municipality pressure	
	Religion		
	Unused potential		
	Syrians as patients		
	Trust		

Appendix C:
Overview of the assessment procedure

The assessment procedure consists of two main exams which consist of subtests:

- The first main exam is the general knowledge and skills test ('*Algemene kennis en vaardigheden toets*' or 'AKV-toets' (CBGV, 2019a; VBGA, 2019)
    - This is a practical exam which consists of the following individual tests:
        - Part A: summary and presentation
        - Part B: interview and medical report
        - Part C: Reading proficiency in English
        - Part D: Knowledge of the Dutch healtcare system
    - This exam assesses:
        - Dutch language skills, which should be at level C1 of the Common European Framework of Reference for Languages
        - English language skills, which should be at level B2/C1 of the Common European Framework of Reference for Languages
        - Knowledge of the legislation of the Dutch healtcare system: Wet BIG, ethics and the Dutch culture
- The second main exam is the professional knowledge test ('*Beroepsinhoudelijke toets*' or 'BI-toets'). (CBGV, 2019b; VBGA, 2019)
    - Basic medical knowledge test (equal to the test sixth-year Dutch medical students make '*Deeltoets Interuniversitaire Voortgangstoets*', '*iVGT*') which is a written five-hour-long exam that assesses theoretical knowledge on 17 different basic subjects:
        - ANA - Anatomy
        - BCG - Biochemistry, genetics, histology and molecular cell biology
        - CHI - Surgery
        - DOK - Dermatology, otorhinolaryngology and opthalmology
        - EMS - Epidemiology, statistics
        - FAR - Farmacology
        - FY - Fysiology
        - GER - Geriatrics
        - GYN - Gynaecology and obstetrics
        - HG - Family care
        - INT - Internal medicine
        - KG - Kindergeneeskunde
        - MET - Ethics and diversity
        - NEU - Neurology
        - PA - Pathobiology, immunobiology and microbiology
        - PS - Psychiatry and psychology
        - SG - Social medicine

- Clinical knowledge test ('*Deeltoets Klinische Kennis'* or '*DKK'*) is a written six-hour-long exam that assesses practical knowledge using cases on 9 different subjects:
    - Internal medicine (approximately 25 cases)
    - Surgery (approximately 20 cases)
    - Pediatrics (approximately 15 cases)
    - Gynaecology and obstetrics (approximately 10 cases)
    - Psychiatry (approximately 10 cases)
    - Neurology (approximately 5 cases)
    - Otorhinolaryngology (approximately 5 cases)
    - Opthalmology (approximately 5 cases)
    - Dermatology (approximately 5 cases)
- Clinical skills in practice test ('*Deeltoets Klinische vaardigheden* or '*DKV'*) is a practical exam. It consists of ten patient consultations which last 30 minutes, in which 8 clinical skills are assessed:
    - Taking medical history (anamnesis)
    - Performing a physical examination
    - Communicating with a patient
    - Professional behaviour
    - Writing a written report (in Dutch)
    - Composing a problem list
    - Composing a differential dianosis
    - Composing a treatment and diagnosis plan

After finishing both the AKV-test and the BI-test, a participant is invited by the CBGV for an "advice-conversation" in which the CBGV announces which outcome the participant has attained and which advice they will give the ministry of health on the value of the participants degree. This advice is non-negotiable and includes an indication of whether and if so, in what departments and for which duration internships should be completed by the participant before being admitted in the BIG-registration (Herfs, 2009).