

A new start?

Lack of professional recognition and status inconsistency among refugee physicians.

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Foreword

This is it. My research is finally finished. Just under one and a half year ago I began thinking about which subject I would like to explore. I quickly came up with the idea of writing about immigrants, especially after I had taken Prof. H. Entzinger's course "Migration". Migrating is not unfamiliar to me, self being a foreigner living just under four years in the Netherlands. The difficulties dealing with the Dutch bureaucracy, learning the language, and getting familiar with a new society is something that I am very familiar with. I could not help thinking how it must be for other immigrants who come from completely different cultures and have to deal with much more difficulties when it comes to gaining residency permissions, recognition of their diplomas and learning a language which does not in the slightest resemble their own language. Whereas I, as an Icelander, had little difficulties in getting a residency permit, my university diploma was valued as equal to the Dutch diploma, and I had studied German for three year in high school. I had the good fortune of studying Dutch at the Albeda College in Rotterdam. There I was in a class with people from all over the world. After getting to know them I understood how lucky I am for having an Icelandic passport, because traveling, living, studying and working around the world are luxuries which are preserved for few. Once having decided which direction my research would take and that I would like to do a qualitative research, the only question was; what exactly did I want to explore. After having spoken to Enny Kraaijveld, coordinator at the Albeda College, about this dilemma she told me about how difficult it seemed for foreign, and then especially refugee, physicians to learn the Dutch language. These highly educated individuals seemed to have much more problems than other students. And that is how I my research took on its shape. Despite some changes during the course of the year the central focus of the research, the refugee physician and his specified problems, did not change.

There are a number of people who I would like to thank for their contribution to the research. First of all I would like to thank Enny Kraaijveld for all the help she has given me, as well as giving me a permission to interview her students. She and Trudy Meijerink, language teacher at Albeda College, gave me an invaluable insight into the research group, alongside practical information which I am very grateful for. Anja Veerman at the Erasmus University Admission Office and Ted Splinter, educational director by the medical faculty at the Erasmus MC, deserve thanks for their contribution to the research. I had the good fortune of meeting Dr. Folke J. Glastra and Dr. Petra E. Schedler from the Social Science department in the University of Leiden at the beginning stages of my research and as they were doing a research on a similar subject to mine they invited me to join their research group, TOG. That meant getting valuable feedback for my own research as well as information about how they and their students were tackling their own researches. Being a part of their group meant a lot to me.

I would like to thank my mentor Prof. Han Entzinger for his professional guidance during the last year. He managed to motivate me when I needed it the most, especially during the early days when my thoughts about the subject were still cloudy and changed as it seemed every two days.

My husband Davíð has been my biggest supporter ever since I started my study at the Erasmus University. His unshakable faith in me has helped me through some difficult times during the writing of this research. Finally I would like to thank all of my

interviewees. Their willingness to tell their story was not only valuable to my research, but gave me an insight into a world which I did not know.

This research I would like to dedicate to my unborn child. His constant kicks and movements during my time behind the computer seemed to me as being not only competition for space, but a reminder that the pressure is on to finish the research before his birth. And that has been accomplished!

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Elín Gunnsteinsdóttir

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1. Introduction

The integration of refugees in any society can present various problems. Not only are refugees uprooted individuals who, in some cases, have been forced to leave their homes, jobs, families and friends but they also have to deal with all kinds of physical and psychological traumas which makes the transition process more difficult than for other kinds of immigrants. According to Ward et al. (2001: 235) refugees face social isolation, status inconsistency, pre-migration trauma, 'cultural shock', acculturation pressures, accelerated modernization and minority status, along with having to deal with the loss of their country and culture. Refugees are therefore more disadvantaged than other immigrants when it comes to integrating into the Dutch society.

Refugees come from all kinds of backgrounds but what they do have in common is the prospects of a long and sometimes difficult struggle to integrate into their host society, once they have been accepted as genuine refugees and given a residency status. In the case of highly educated refugees the integration process can be particularly difficult because if they want to work at a level similar to their previous employment they need to master the Dutch language excellently as well as having their diplomas and work experience evaluated according to Dutch standards. This process can be long and complicated and it does not always yield satisfactory results. Learning the Dutch language can be a hurdle and the evaluation of their diplomas and work experience disappointing. It is not only a waste of human capital and talent when professionals and highly educated individuals are not able to work in their profession or at their level of competence, but also a personal defeat and disappointment. It is therefore important that refugees are given an opportunity to develop their talents and expertise in the Netherlands which eventually would make them able to resume work in their chosen occupation or educational level. But even given that opportunity their employment integration does not always go as smoothly as hoped for.

Refugee physicians will be the focus group of this research. As a group of highly educated professionals they are easily identified within the refugee population. The medical profession has also long been a subject of social research as it is perceived to be the most powerful and successful of all established professions and approximates most closely the sociological criteria of what professions are and do. As well as having to deal with problems related to being refugees, refugee physicians seem to be dealing with very specific problems related to their background as professionals, the main one being the fact that their medical diploma is not recognized as being equivalent to the Dutch medical diploma. It is evaluated as a three year medical study which means that if refugee physicians want to resume their work in the Netherlands they usually need to begin their medical study in the fourth year. Even if they pass the NT-2 there are only limited numbers of placements within the medical faculties. Many refugee physicians are therefore faced with the prospects of never being able to work in the Netherlands as physicians. That is difficult to accept for anyone who has invested many years in their professional career.

1.1 Theoretical context

During a process of change, which is inherent in migration, the sense of the self is undermined, and the most urgent and profoundly felt need of any immigrant is to reestablish a sense of identity. Immigrant physicians are most concerned with reestablishing themselves in their chosen occupation. That is the first step in reestablishing a sense of self as their self-concept is so closely tied to their professional identity (Shuval and Bernstein, 1997: 12). The professional identity is produced through a shared and common educational background and professional training. Distinctions between work and non-work are blurred, as members of some professions are always “on call” (Elliott, 1972: 131). The professional is committed to his occupation and derives satisfaction from the work itself, and not simply from the extrinsic conditions of the work. He wants to belong to the profession and work within it as there are elements of pride in being associated with a “high” calling, and identification with a certain professional collectivity (Moore, 1970: 109).

Henry Tajfel’s social identity theory explores how important it is for individuals to feel that they belong to a certain group or category (1981: 255). Rosenberg refers to the social identity as being composed of six categories: social status (for example sex, age, and occupation), membership group, social labeling, derived statuses, social types and personal identity. Many of these elements are socially ranked and evaluated and therefore the individual’s sense of personal worth or value is often dependent on the prestige of these identity elements, as for example the ranking order of ethnic groups, occupations and social classes (1979: 10-13). Individuals strive for a positive social identity and when their social identity is affected by personal experiences such as losing a job or a partner, and entering a new society or culture it can result in a loss of capability, power and self-esteem.

Social categorization refers to how individuals identify with certain categories. When people feel they are treated unjustly as a result of an inappropriate categorization, such as when high-performing individuals are included in a group that is low in status, they might express anger, but also suffer from low self-esteem and depression (Ellemers et al., 1999: 41).

Relative deprivation is another theoretical angle, which explains what occurs when individuals experience a decline in status or employment opportunities. Their value standards might be their own past condition and unfavorable comparisons between an individual’s own past status or expectancies and the present one can result in feelings of deprivation. When the individual’s value expectations remain relatively constant but their value capabilities are perceived to decline they might experience anger over the loss of what they once had or thought they could have, and experience relative deprivation by reference to their own past condition (Gurr, 1970: 46).

In order to understand the importance of occupational integration of refugee physicians some considerations need to be given to some general issues relating to the professional role. What is the meaning and structure of professional roles, why is being a professional

so central to the self-concept and why is it so difficult for professionals to face displacement and devaluation of their credentials. With regard to the professional roles it is also interesting to explore how occupational status and prestige can play an important role in the lives of individuals. Established professions, such as cabinet member, or a scientist, rank high on the prestige scale of occupations. The prestige does not have to have anything to do with their income or class status, but is more linked to their occupation and their “professionalism”.

Status inconsistency is another term which could be applied to refugee physicians as it refers to a situation in which people who hold a certain status in one hierarchy hold a position of very different status in another hierarchy (Tang and O’Brien, 1990:1445). Lenski (1966: 87) suggested that status could be measured by income, education, occupation and ethnic position. He found that people who experienced disparity in status were dissatisfied or frustrated with the situation and wanted it to change.

In this research the term “status inconsistency” will be defined as the difference in occupational status from the refugees’ last position in their homeland to their present position.

1.2 Aim of the research

Refugee physicians are affected by all kinds of obstacles connected with their refugee status as well as their professional background. These highly educated individuals face different obstacles to other refugees because of their educational and employment background. The aim of this research is to find out what these obstacles are and how they affect the refugee physicians.

Several important factors might be able to give insight into their experiences, feelings and thoughts about their past, present and future. The first factor of interest is personal investment in the profession. Their professional background and their reasons for choosing the medical profession, should give a picture of their investment and commitment to the profession. Lack of academic and professional recognition constitutes the second factor of interest. How do they feel about the evaluation of their medical diplomas and professional experiences? Other factors of interest are changes in status; how do they regard their situation now compared to how it was; how motivated are they in becoming physicians in the Netherlands; what do they feel about the language program that they are currently following; how strong is their professional identity and how has it been affected; what is their support system; are they experiencing any personal problems; what is their attitude towards the Dutch society, in particular the medical society; and finally what is their future perspective? A further insight needs to be given into what is the likelihood that refugee physicians are able to successfully resume their work in the Netherlands? Essential to their integration and chances of resuming their profession in the Netherlands is an adequate knowledge of the Dutch language. Which factors facilitate a successful acquisition of the Dutch language and which do not? Is it possible that their age is affecting their success in resuming their work in the Netherlands, whether it would be in mastering the language, or getting a placement in a university?

In order to find the answers to these questions a number of areas have to be explored. It is for example important to find out what kind of institutional limitations refugee physicians have to deal with in order to be able to resume their work in the Netherlands. It is also important to find out how the refugee physicians themselves feel about these limitations and deal with them. The plan is to interview refugee physicians who are either studying the Dutch language at the time of the interviews, or if they have passed their Dutch proficiency exams, have not yet been accepted into any of the Dutch medical faculties. By interviewing them at this stage the aim is to gain an insight into their thoughts and feelings at a stage in their lives where their future is still unknown and their hope of becoming physicians in the Netherlands is still a possibility.

1.3 Central Questions

Here above some thoughts have been presented with regard to the group. These thoughts have lead to the two main questions of the paper:

1. With regard to their professional background, what institutional barriers and social-psychological issues are refugee physicians facing during their initial integration into the Dutch society?

This question is of a descriptive nature and to answer it, it is important to find out what it is exactly that a refugee physician needs to do in order to be able to work in the Netherlands as a licensed physician. What are his chances of successfully gaining an access into one of the seven medical faculties in the Netherlands and what is currently being proposed in order to change the integration process of foreign physicians into the Dutch healthcare system? Second of all an insight needs to be given into issues related to being a refugee, as well as changes in identity and self-concept, which these individuals are possibly affected by.

Initial integration into the Dutch society is understood in the research as being the period in which refugee physicians are preparing for the NT-2 exams and/or the selection interview for a fourth year placement in a medical faculty.

Institutional barriers are understood as being any kind of bureaucratic, educational, or other external hindrances that the refugee physicians face in their effort to become licensed physicians in the Netherlands. Social-psychological issues are on the other hand hindrances they face due to their personal experiences as being refugees as well as unemployed highly educated individuals whose educational and professional achievements are not recognized by the Dutch society.

2. In what way do the institutional barriers and the social-psychological issues, affect the refugee physicians?

This question relates to the refugee physicians own experiences as being highly educated refugees in the Netherlands. To find an answer to this question the physicians need to be interviewed and asked questions related to their situation as refugees physicians.

Two research questions are associated with the second central question. They are:

How important is it to the refugee physicians to resume their work as physicians in the Netherlands, and why?

Which factors are most likely to contribute to the refugee physician's success in mastering the Dutch language?

Successfully mastering the Dutch language is understood as passing all four parts of the NT-2 exam. Further details of the NT-2 exam will be given in chapter five.

1.3 Outline of the paper

In chapter two the design of the research, the research group, the outline of the interviews, and the nature of the questionnaire alongside methodological accountability will come on board. Chapter three outlines the theoretical context of the research, where theories related to the concept of identity, status and professionalism will be elaborated in detail. In chapter four the employment integration of refugees in the Netherlands will be discussed alongside the refugee's decision to emigrate, his work motivation and the general employment integration process of refugees. Chapter five concentrates on the refugee physicians themselves and the institutions they need to consult in their effort to resume their medical license in the Netherlands. The research findings will be presented in chapter six and in chapter seven they will be discussed in the light of the theories introduced in chapter three. Finally some recommendations will be presented in chapter eight.

2. Data and Methodology

2.1 Design of the research

Refugee physicians form a well-defined and distinct group of highly educated professionals within the refugee population. They share a similar educational background, as well as being part of an internationally recognized profession that is respected and held in esteem all over the world. This makes them an ideal target group for studying as well as tracking down for interviewing.

As a language institution for foreign students Albeda College at Rusthoflaan in Rotterdam holds a record over the educational background of its students. Those individuals who fell under the research criteria were approached with the help of Enny Kraaijveld, a coordinator in the Albeda College.

There were four basic criteria under which the research subjects needed to fall. The first one was that the interviewees had finished their basic medical training. The second criterion was that they had to be recognized by the Dutch authorities as being refugees, or being in the process of recognition. The third criterion was that they had to be studying the Dutch language at the time of the research or had just finished their language study. The fourth and perhaps the most important criterion was that they had not been accepted into any of the medical faculties. This criterion guaranteed that they were all facing an uncertain future with regard to their professional career as physicians in the Netherlands. As stated above approaching potential interviewees was relatively easy as Enny Kraaijveld was able to supply information over which individuals, who were studying at the college, were suitable candidates for the research. The “snowball” technique was used in one instance when an interviewee recommended and contacted another potential interviewee, who consequently went on to take part in the research.

As well as interviewing refugee physicians several other individuals were interviewed because of their knowledge of the research group. Those who were interviewed were Enny Kraaijveld a coordinator at the Albeda College, Anja J. Veerman administration worker at the Erasmus Admission Office, and Ted Splinter educational director by the medical faculty at the Erasmus MC. Other research material, such as information about the research population and other important data, was gathered from various institutions such as the admission office in Erasmus University, the Albeda College in Rotterdam, UAF, and Nuffic. Various internet sites and libraries played an important role in providing essential material for the research.

At the time of the interviewing process most of the interviewees were preparing for the NT-2 exams that were to be held in the beginning of March 2004. Although many hoped to pass the NT-2 exams in March, most were aiming at passing them in June, considering the March exams being more as test exams. It is worth noting that not every interviewee had to take all of the four parts of the NT-2 exams, as some had passed one, two or three parts of the exams in previous years. Two of the interviewees had passed all four parts

and of them one was still following courses other than language courses within the “Artsenproject” at the Albeda College and the other interviewee was no longer a student.

2.2 The research group

In approaching prospective interviewees a rough content of the interviews was revealed as well as the guarantee of anonymity and protection of privacy.

Fourteen refugee physicians were interviewed in the period from 19th of January until the 5th of May 2004. Four women and ten men, ranging in age from 36 to 53 years old, were interviewed. The average age of the interviewees was 42 years. All of the interviewees were studying at the Albeda College in Rotterdam, except for one, who had finished her study at the college two years earlier. Ten interviewees were taking part in the “Artsenproject” at the college and the rest, or three interviewees, were following the regular “schakel” year program (see chapter five for further detail of these programs).

The research population originated from six countries. Some of the interviewees had been living for a number of years outside their native country before coming to the Netherlands as they had either been working abroad or lived in exile. Out of the fourteen interviewees seven originated from Afghanistan, three from Chechnya, and the remaining four from Palestine, Yemen, Iraq and Azerbaijan.

Table 2.1 An overview of the interviewees’ country of origin, age and gender

<u>Country of origin</u>	<u>Age</u>	<u>Gender</u>
Afghanistan	38	female
Chechnya	36	male
Afghanistan	39	female
Afghanistan	47	male
Afghanistan	36	male
Afghanistan	38	male
Palestine	42	male
Azerbaijan	37	male
Yemen	53	male
Chechnya	50	male
Afghanistan	43	male
Chechnya	53	female
Afghanistan	39	male
Iraq	46	female

The interviewees had been staying on average for five years in the Netherlands when the interviews took place. Their present residency statuses varied: four of the interviewees had received the Dutch nationality; six had a limited status, and four had an unlimited status. Individuals with a limited status have to wait for three years before they are able

to apply for an unlimited status. Despite having a limited status they are able to work, receive benefits, study and are provided with an accommodation.

The number of interviewees was limited to fourteen. The reason for not continuing searching for more candidates was twofold. By interviewing individuals who were studying or had been studying at the Albeda College in Rotterdam, and had therefore followed a similar language program as well as planning on studying at the Erasmus University, an attempt was made to limit the affects of exogenous factors (such as that of different language programs and admission regulations for different universities). The second reason, and perhaps the more important one, had to do with the fact that it was clear that not a lot of new information was being extracted from the interviewees. A certain saturation point had been reached which meant that interviewing more candidates would probably not have resulted in any new revelations regarding the research group.

2.3 The interviews

By conducting a semi-structured personal interview with the interviewees the main data of the research was collected. The advantages of personal interviews are for example the chance to notice and correct misunderstandings, and to probe inadequate or vague responses in order to obtain complete and meaningful data, which improves the quality of the data (Judd et al., 1991: 218). The nature of the interviews was such that the interviewees were encouraged to express themselves freely about each topic they were presented with. Similar to an in-depth interview, the interviews did not always have a clear beginning and end, the question order was suited to the interviewee, an interest was showed in the answers, the interviewees were allowed to deviate from the subject, and the course as well as the tempo of the interview was determined by the interviewee and the interviewer jointly (Braster, 2000: 104).

The interviews lasted from forty minutes up to two hours, with the average interview lasting around one hour. Each interview was recorded with the permission of the interviewee. All of the interviews, except for one, were conducted in Albeda College where a special room had been reserved for the purpose of privacy. One interview was held at the home of the interviewee. The interviews were conducted in the Dutch language, apart from one interview, which was partly conducted in English and partly in Dutch.

The interviewees were told that the research was about the experiences of refugee physicians in the Netherlands so that they were aware of the general subject of the research, but the central research questions were deliberately refrained from being presented. The opening question was:

“Why did you choose a medical education in your country of origin?”

2.3.1 The nature of the questionnaire

The interviews were not completely unstructured, as the starting point for each interview was a questionnaire. By using a semi-structural mode of interviewing the questionnaire was used as a guide during the interview process, and not meant to restrict the interviewees in their answers. The questionnaire was constructed with references to the theoretical frame of the research as well as the central and the associated research questions.

The questionnaire included nine factors: commitment to the profession, lack of academic and professional recognition, changes in status, motivation, the language program, support systems, personal problems, cultural problems and identity problems. Several open-ended as well as closed-ended questions supported each factor. The nine factors formed the basis for the four themes that resulted from the data analyze.

The questionnaire used in the research is found in appendix A.

2.4 Methodological accountability

There are several methodological limitations linked to the research. These limitations need to be addressed as they might raise some concerns regarding the internal and external validity of the research.

2.4.1 Internal validity

Drop-out rate

Some concerns might be raised regarding the dropout rate as the interviewing process took place in the second half of the school year. Some physicians might have already left the program, which would have left only the most motivated to take part in the research. This potential problem was solved by the fact that those physicians taking part in the “Artsenproject” and the “schakel” program had committed themselves to the program and their attendance was closely monitored. This meant that at the time of the interviewing process all the potential interviewees were still attending the lessons. Only one interviewee was not attending regularly, but did despite that agree to be interviewed.

Different nationalities

By interviewing refugee physicians of different nationalities it is possible that a number of exogenous factors might have affected the research. But as their professional status was the focus of the study appeal was made to the fact that medicine, wherever practiced and taught, has certain universal features. It is considered a high status occupation, there is always a long educational process involved, which means investment in time and money, and most physicians have invested a certain emotional commitment to their career. According to Shuval and Bernstein (1997) is it possible to view medicine as a transnational phenomenon, which is essentially independent of social, cultural, and political context: “(E)mpirical evidence suggests that it is probably more fruitful to consider the nature of medicine in terms of a universalistic culture overlaid with particularistic qualities that are rooted in local cultures” (p. 10). There was also a

practical problem related to interviewing physicians from only one nationality. Because the focus of the study were refugee physicians studying, or those who had been studying, at the Albeda College in Rotterdam it became difficult to gather enough refugee physicians from any one country that were studying, or had recently studied at the Albeda College, at the moment of the research. In order to fulfill the requirements of sufficient number of participants, different nationalities needed to be approached and interviewed.

The Dutch language

The interviews were conducted in the Dutch language, which might present some concerns. Valuable information might have been lost due to language problems such as misunderstandings between interviewees and interviewer, and the interviewees' lack of ability to express themselves freely in the Dutch language. The reason for deciding to conduct the interviews in Dutch was a practical one. Not only would it have been expensive to hire translators for each of the six nationalities that took part in the research, it would also have been very time consuming to translate all of the interviews during the interviewing process. Using a translator might also have distorted the free pace of the interview with its constant interruptions. All of the interviewees had been in the Netherlands for some time before they started their study, so they did have certain command of the Dutch language. By interviewing them not at the beginning but later in their study, or in January until May 2004, they had been studying the Albeda College for several months and improved their language proficiency, in some cases, considerably.

2.4.2 External validity

Gender and age distribution of the sample

When the gender and age distribution of those who register as physicians by the Erasmus admission office is examined it is clear that it does not emulate that of the research group (see chapter five for further detail). There are for example equal numbers of men and women who register as foreign physicians each year at the Erasmus Admission Office; while the percentage of women in this research is only 28%. The average age of those who have registered at the Erasmus University, in the last four years, has been around 37, 5 years; meanwhile the average age of the interviewees in the research is 42 years. A possible explanation for these differences might be that the target group for the research are only refugee physicians and those who register, as foreign physicians at the Erasmus University, are not only refugees. Many of those who register are young women from the former Soviet Union countries. By looking at the gender and age distribution in the "Artsenproject" program at the Albeda College it was clear that most of those physicians that did not qualify to take part in the research were young women, many originating from the former Soviet Union countries. That is why not only the gender distribution, but also the age distribution, of this research is different to that of the Erasmus Admission Office register.

Sampling procedure

A non-probability sampling procedure was employed in finding suitable interviewees for the research. Because the sampling procedure does not emulate that of a probability sample the results may not be wholly representative of the population they are meant to

represent. Nevertheless it does provide an insight into the refugee physician lives, expectations and adjustment experience.

3. Theories

3.1 Identity

The term identity derives from the Latin root *idem* implying sameness and continuity. Since the ancient Greeks, who first thoughts on the self date back to, researchers and philosophers have debated over the physical and nonphysical aspects of being human.

Among them Descartes who so famously dicted “I think, therefore I am” (Tesser, 2000: 1). In the second half of the twentieth century many theorists have studied the concepts ‘self’ and ‘identity’. Research related to the self and the identity can be found in disciplines such as clinical psychology, communication, developmental psychology, social psychology and sociology. Discussions of identity have been prominent in sociology and have resulted in huge literature on the subject.

The essentialist and the constructionist approach towards identity constitute two very different views of the identity. The essentialist approach views individuals and groups identities as static and fixed in reference to their cultural and social contexts. The constructionist approach on the other hand views identities to be fluid, situational and multidimensional (Ghorashi, 2001: 20). In this research the concept of identity is inspired by the constructionist approach.

3.1.1 Social identity, Personal identity and multiple identities

Both social and personal features characterize every individual: the social features define the social identity of a person and the personal features define his personal identity. Each individual is a unique combination of personal features, such as appearance, experience and intellect, and these features combine his personal identity. Social identity refers on the other hand to a feeling of similarity to others (Worchel et al. 1998:1-2). Although the social identity seems to contradict the personal feelings of uniqueness, the individual is still capable to encompass these two feelings within his identity.

Social identity specifies the relationship between the individual and the society. The social identity gives information about who a person is and how he is recognized and judged by other. Individuals tend to classify themselves and others into social categories and that can have an important affect on social interactions (Ghorashi, 2001: 27).

Henry Tajfel defines social identity as “that *part* of an individual’s self-concept which derives from his knowledge of his membership of a social group (...) together with the value and emotional significance attached to that membership” (Tajfel, 1981: 255). According to Tajfel the individual needs to find, create and define his place in existing networks. The individual strives to develop a social identity, knowing that he belongs to a certain social group and that knowledge will form a part of his view of himself.

The concept of multiple identities refers to the notion that the identity is a configuration of different identities that are interdependently related to each other. The way in which an identity becomes dominant or marginalized depends on time and context (Ghorashi, 2001: 23). The individual is likely to emphasize a certain identity rather than another

depending on the situation he is in. For example the individual's gender identity is not always predominant except in situations where gender is an issue or is felt as an issue by the individual.

To summarize: social identity is not unique to the individual as it encompasses traits that are similar or the same to other individuals, whereas the personal identity can never be anything else but unique to the individual. Multiple identities encompass all of the individual's identities, which can be presented simultaneously or emphasized discriminately depending on the context.

3.1.2 The self-concept

The self-concept is composed of many different parts such as the personal identity, the social identity and self-esteem. Most individuals strive for a positive self-concept. An individual may gain or ensure a positive self-concept for example through identification with social categories and subsequent social comparisons might reflect the fact that his own category is positively distinct from other categories (Capozza and Brown, 2000: 34). The self develops out of the individual's social experiences and interactions in the different social contexts of the life course. Although the individual perception of the self is experienced internally, it is a product of social interaction. Despite having a certain feeling of "self", a person can have many social selves which he shows selectively to different groups (Mecca et al., 1989: 34).

Rosenberg (1979) defines his use of the term "self-concept" as "the totality of the individual's thoughts and feelings having reference to himself as an object" (p. 7).

The self-concept consists of social identity elements, dispositions, and physical characteristics. The social identity elements can be divided into six categories (Rosenberg, 1979: 10-11):

1. *Social status*: Universal bases of social classification and self-definition. These can be for example sex, age, and occupation.
2. *Membership group*: Individuals are subdivided into groups based on voluntary association, similarity of belief or interest, sharing of culture or origin. It could be based on cultural identity (being a Greek man/woman), a religious identity (Muslim, Catholic), or on a sociopolitical identity (democrat).
3. *Social labeling*: If individuals have behaved in a way that is contrary to social norms, his or her behavior is defined as deviant. The label constitutes an additional element of his social identity.
4. *Derived statuses*: Rooted in the individual's history and derives essentially from other statuses or membership groups. A person can therefore be classified as an ex-convict, divorcee or a war veteran.
5. *Social types*: These are some kind of syndrome of interests, attitudes, or characteristics, which are socially perceived as hanging together. A person may be an intellectual, a playboy or a Don Juan. The place of these types in the self-concept is complex as they may refer to how the individual sees himself, wants others to see him or how he wishes to see himself.

6. *Personal identity*: Refers for example to the individuals name or his social security number.

These social identity elements are membership groups or categories and do not represent reference groups. The individual may not identify with the group, status, or social category (reject the group and wish he was not part of it), but he has no choice but to recognize himself as a member if he has been defined so by the society (Rosenberg, 1979: 13). Many of these elements are socially ranked and evaluated and therefore the individual's sense of personal worth or value is often dependent of the prestige of the identity elements, as for example the ranking order of ethnic groups, occupations and social classes. Although it is not possible to assume that social identity evaluation equals self-evaluation, it is clear that people respond in various ways to the social evaluation of their identity elements.

Further it is worth noting that the social identity element is more than just a category. It is also a social model that serves as a standard for self-assessment. The ideal contains many elements such as traits, attitudes, values norms and codes of honor that defines the role model. The image or the role model of the physician is someone who is a dedicated, hardworking, kind, intelligent and an upstanding individual. "To some extent, the individual's feeling of personal worth may hinge on the degree to which he lives up to the role model" (Rosenberg, 1979: 14). When a physician is not able to help someone who is suffering or does not feel sympathetic towards someone who is ill, he might experience guilt, self-hatred or self-contempt, because he has fallen short of the culturally defined role ideal, which he has internalized.

3.1.3 Social- and self-Categorization

Social categorization introduces simplicity and order into a world full of complexity and random variation. Individuals identify with certain social categories that contribute both positively and negatively to their self-image. Those aspects of an individual's self-concept and self-esteem that are anchored in his social category are referred to as his social identity (Tajfel, 1978: 105). The social identity is an important aspect of the general system of differentiations between an individual's own group and other groups, and the social categorization can be considered as an orientation system that helps the individual to create and define his place in the society (Tajfel, 1981: 255).

When identity is recognized in a socially defined terms several consequences regarding group membership can be detected. Tajfel describes two of them as follows (1981: 256):

It can be assumed that an individual will tend to remain a member of a group and seek membership of new groups if these groups have some contribution to make to the positive aspects of his social identity.

If a group does not satisfy this requirement, the individual will tend to leave it *unless*: ...leaving the group is impossible (...).

It is therefore possible to conclude that according to Tajfel's theory adequate conditions within a group need to be available for the preservation of a positive social identity, otherwise the individual will leave it objectively, psychologically or both.

According to Turner (1987) the self-categorization theory "is a set of related assumptions and hypotheses about the functioning of the social self-concept" (p. 42).

Individuals categorize themselves as members of social categories and define, describe and evaluate themselves in terms of these categories (Worchel et al. 1998: 93). They identify more with certain categories than others, but the identification is fully dependent on the context. Some categories can be highlighted within certain situations; such as the social category "ethnicity" which is more prominent in racially divided society than it would be in a racially homogeneous society.

Self-categorization begins with giving oneself a certain label: a teacher, a father, a Turk and so forth, and each label carries another meaning and different expectations within different contexts (Verkuyten, 1999: 56). When individuals see themselves as members of a particular class or category, they perceive themselves to be more or less equivalent to others in that category, and more or less distinct from other categories (Haslam, 2001: 45). This means that when people categorize themselves as physicians they acknowledge their equivalence to other physicians and their difference from for example sociologists or electricians. When individuals have defined themselves as members of a certain group the group characteristics give the individual guidance with regard to how to think and act. For example a certain type of behavior is expected of a teacher or a physician so individuals who belong to these categories tend to take over the stereotypical characteristics of these groups and make them their own (Verkuyten, 1999: 57).

3.1.4 Categorization Threat

Social categorization involves the assignment of stereotypical group characteristics to the individual group member. By categorizing people into groups their social identity can be threatened (especially if they are being categorized against their will) and that may affect individual's self-esteem. There are many different social situations in which people wish to be judged in terms of their personal characteristics or merits. When individuals are categorized in terms of their group membership and primarily treated in terms of that membership (for example in terms of their gender or ethnic background) they might resist it and feel they are victims of prejudice, rather than seen as a unique individual (Ellemers et al., 1999: 37). As every individual can be categorized in many different ways, he might prefer to be considered in terms of certain social group, rather than another.

When high-performing individuals are included in a group that is low in status, disidentification is likely to result. Anger, depression and other forms of distress might occur in individuals who have been categorized in a group by which they do not identify with. When people feel they are treated unjustly as a result of an inappropriate categorization they might express anger, but also suffer from low self-esteem.

Categorization based on a poorly performing group may actually harm people's own performances (Steele, 1997: 613-29). Being categorized, as a member of a group may

therefore be a threatening experience, if the individual does not identify with that group, or derives little self-esteem from it (Ellemers et al., 1999: 41).

3.1.5 Social comparison and Relative deprivation

According to Festinger's theory of social comparison it is inherent in all humans to evaluate their abilities in comparison to other individuals. Incorrect opinions and/or inaccurate appraisals of the individual's abilities can be devastating if the individual's own opinion and beliefs of his abilities are different to other peoples (1954: 117). The principal assumption of social comparison is that the positive or negative value connotations of group membership can only be derived through comparisons with other relevant social groups (Tajfel, 1978: 9). Social comparison is an important concept when it comes to relative deprivation. Relative deprivation is defined by Gurr (1970: 24) as "actors' perception of discrepancy between their value expectation and their value capabilities". Individual's value standards might be his own past condition and unfavorable comparisons between individual's own past status or expectancies and the present one can result in feelings of deprivation. When individual's value expectations remain relatively constant but their value capabilities are perceived to decline they might experience anger over the loss of what they once had or thought they could have, and experience relative deprivation by reference to their own past condition (Gurr, 1970: 46). This can occur for example because of decline in status or decline in opportunities such as employment opportunities.

3.2 Professionals

"A man's work is as good a clue as any to the course of his life and to his social being and identity" (Hughes, 1958: 7).

A man's work is one of the most important parts of his social identity. Hughes (1958) calls it his "fate" in the one life he has to live (p. 43). People want to be of worth in the society. It matters to people if their work is seen to be clean, honorable, respectable, and prestige giving. Paid work is capable of giving people financial security, status and certain identity, as well as giving structure, rhythm and regularity to their lives (Kroft et al., 1989: 7).

Individual's evaluation of themselves as well as their self-esteem and self-confidence, will to some extent depend on their occupational choice and performance. Many individuals seek self-actualization and self-fulfillment within the spheres of work. They are motivated by intrinsic needs as for them work is more than about making a living. It gives them fulfillment and emotional satisfaction, and if they did not have to work, for financial reasons, it would be hard for them to give it up. Others work because of extrinsic needs, that is, their work is a means to a financial end (Taylor, 1968: 395). This is of course a simplification of the matter, as intrinsic and extrinsic needs often are combined, and therefore it is impossible to say that one is more important to a particular occupation than the other. Traditionally it is considered that professionals are more intrinsically motivated than those occupying low pay and low status work that do not

require a high educational level. For professionals work is often a way of life. They often value their work as central in their life and often an end in itself. Work for example influences the lives of many professionals, such as physicians and teachers, to the extent that those occupying these positions must behave in a certain way, which the society has defined as appropriate for such a status. The individual must therefore commit himself to a certain pattern of thought and behavior, and if the role is sufficiently internalized, it may influence his entire personality structure. His interaction with others will therefore also be influenced by the nature of his occupation (Rosenberg, 1957: 2-3).

3.2.1 Professions

Medicine is one of the most powerful and successful of all established professions and should approximate most closely the sociological criteria of what professions are and do. Eliot Freidson (1970) calls the health profession the most professionalized of all the human services (p. xi). That is one of the reasons for the centrality of medicine in the sociology of professions.

Professions are occupations with special power and prestige. Society grants these rewards because professions have special competence in esoteric bodies of knowledge linked to central needs and values of the social system, and because professions are devoted to the service of the public, beyond material incentives (Larson, 1977: x).

The general dimensions and composition of the ideal-type of profession can be summarized as a body of knowledge and techniques, which the professionals apply in their work. Training is necessary to master such knowledge and skills, and the professionals are granted a privilege of self-regulation by the society. Because of the distinctiveness of the professions the occupation tends to become a “real” community, whose members share a relatively permanent affiliation, an identity, personal commitment, specific interests, and general loyalties (Larson, 1977: x). Most established professions, such as a cabinet member, or a physician, rank high on the prestige scale of occupations. The prestige does not have to have anything to do with their income or class status, but is more linked to their occupation and their “professionalism”.

The professional derives satisfaction from the work itself, and not simply from the extrinsic conditions of the work. He is interested in work for its own sake. Some professions even stress the need for a vocation if the professional is to be fully involved as well as committed to the professional tasks (Elliott, 1972: 137). There are also elements of pride in being associated with a “high” calling, and identification with a certain professional collectivity (Moore, 1970: 109).

Professionals can be viewed as a class, especially if class is reduced to its indicators, socioeconomic status and occupation. But by placing emphasis on their cognitive mastery, the professionals are more at home in the stratum of the educated and “socially unattached” intellectuals, whom Karl Mannheim (1936) described in these terms (p. 138):

Although they are too differentiated to be regarded as a single class, there is, however, one unifying sociological bond between all groups of intellectuals, namely, education, which binds them together in a striking way. Participation in a common educational heritage progressively tends to suppress differences of birth, status, profession, and wealth, and to unite the individual educated people on the basis of the education they have received.

The concept of career is particularly relevant to the professions. Empirical studies have shown that many professionals are not only concerned with helping people, but are also interested in the high income and prestige that they expect from their professional careers (Freidson, 1970:153). The professional expects of his professional career that it will grow, in proficiency, wisdom, and recognition. The ideal is not a “fixed position of competent service, but a career that shows progress” (Moore, 1970: 80). Success is thought to be available to individuals on the basis of their personal achievement. They can hope to achieve wealth, power or status for themselves (Elliott, 1972:106).

3.2.2 Professional identity

What makes an individual a professional is whether or not he has internalized certain professional values (Freidson, 1970: 81). The internalization of the professional values takes place through professional socialization. Professional socialization involves acquiring the essential knowledge, skills and sense of occupational identity and internalization of occupational norms (Moore, 1970: 71). The student is “socialized” to become a professional and filled with values, behaviors, and viewpoints of the profession. The educational process is supposed to produce the “true professional” (Olesen and Whittaker, 1968: 5). Philip Elliott (1972) defines the professional socialization process as follows (p. 93):

Socialization itself can be treated as a form of selection through which the individual is directed, or learns to direct himself, along particular paths. The processes of commitment (...) continue through the period of institutionalized professional training. This training shapes and consolidates the aspirant’s ideas on his future occupational identity.

Students find many sources of information about the profession, for example in how other people act and view their new role in the society. They acquire new views of themselves along with the appropriate role behavior. The longer the students have been in professional training the more likely they are to have a self-image of themselves as members of the profession. This development is closely related to how others (the faculty, the clients, colleagues) behave towards them (Elliott, 1972: 87).

Socialization does not only involve the recognition of an assumed identity by the outside world. It also involves the individual’s recognition of the identity within himself (Olesen and Whittaker, 1968: 247). When the individual is met by a society that legitimates his claim as a professional, he is forced to integrate the self with the professional role. He is forced to view himself in a new and different way:

The psychological reality of the successfully socialized individual thus verifies subjectively what his society has objectively defined as real. He is then no longer required to turn outside himself for 'knowledge' (...) He can obtain that result by simple introspection. He 'knows who he is'. He feels accordingly (Olesen and Whittaker, 1968: 263).

Within the medical culture there are some conceptions about the proper role of the physician. The individual must be initiated into the status of the physician, accept and learn to play the part. Not only can he learn the basic science and their application in the treatment of the sick, but he also needs to learn what others expect of him and how they will react to his words and action (Becker et al., 1992: 4). Initiation into a new role is therefore as much a part of medical training as learning the techniques. Hughes (1958) defines the nature of social roles as following: "A role is what a man expects of himself and what others expect of him in certain situations" (p. 125). The physician is for example expected to be a man of understanding, patience, confidence, advice, and of strength. This has nothing to do with his skills as a physician but his role as a physician in the society.

An individual's professional self is only one component in his overall identity, but this component is generally viewed as a highly salient one (Shuval and Bernstein, 1997: 167). Losing an occupational status or being unemployed can therefore present a serious identity threat and endanger the main axis of the professional's self- concept (Colic-Peisker and Walker, 2002: 356). In the case of the professional immigrants, who usually face unemployment and loss of occupational status in the new society, their most urgent need is to reestablish a meaningful sense of identity, which usually means reestablishing themselves in their chosen occupation (Shuval and Bernstein, 1997: 12).

Sociological literature on the professions and professional identity has tended to emphasize aspects of professional unity and homogeneity. Professional identity is assumed to be associated with a sense of shared experiences, understandings and expertise. This identity is produced and reproduced through a shared and common educational background and professional training (Olgiate et al., 1998: 57). Professions provide a sense of identity and belonging, as the professional community shares certain norms, values, a way of thinking and so forth which sets boundaries as to who are on the inside and who are not (Shuval and Bernstein, 1997: 12).

The professional identity has a range of meanings for the individual's self-image as the professional needs to meet various requirements that are likely to extend outside working hours. The public recognizes that a particular occupation is responsible for some area of life and this makes the practitioner a recognizable social type in the society. Distinctions between work and non-work become blurred, as members of some professions are always "on call". The professional himself "is aware that general standards of behavior or a particular life-style are required of him because of his professional identity and status" (Elliott, 1972: 131).

3.3 Status

According to the Blackwell Dictionary of Sociology (Johnson, 2000: 309) the concept “status” has two definitions. Max Weber equates status with prestige. His definition of the status concept has to do with a particular type of society where social inequalities are arranged in a certain way, such as during the feudal period (Benschop, 1987: 55). Most sociologists define status as a position occupied by an individual in a social system. That can for example be status in the marital system (husband) or in the occupational system (electrician). Statuses exist independently of the particular individuals who occupy them which mean that the social system cannot be reduced to the people who participate in them. The sum of all the statuses that the individual occupy is called status set. The status set locates individuals in relation to the multidimensional network of social systems that make up the social world (Johnson, 2000: 309).

Statuses can be defined as being latent and manifest depending on the social situation. Latent status means that in a given social situation a certain status that the individual holds is not important to that particular situation, such as being a physician during a game of golf. Manifest statuses on the other hand are relevant in a certain social situation, such as the status of a father during a family gathering.

Occupying any position or status in the society can have profound influences on the individual and affect his thoughts, feelings and behaviors. These influences are exerted through the role that is attached to the position in question (Johnson, 2000: 310). Status is therefore in a sense equivalent to the social role.

3.3.1 Social status

The term social stratification refers to the division of society into layers (or strata), where different social roles perform certain function contributing to the welfare of the society (Barber, 1957: 1). According to Sorokin (1959: 12) there are numerous forms of social stratification. The majority of them can be reduced to three classes: the economic, the political and the occupational stratification. Although it is common that those who occupy the upper strata in one class also happen to be in the upper strata in another class, it is not always so. That makes the actual picture of social stratification in any society very complex.

Status refers to a person's position in the system of stratification. The positive or negative honor, prestige, power, et cetera, which are attached to a position within in the social stratification system, is often referred to as social status (Jary and Jary, 1991: 494). Social status is defined by William Scott as “the evaluation of the characteristics of a given position relative to other position with which it is compared” (1970: 170).

There are four central processes that are involved in the creation and perpetuation of a status structure. These are: differentiation, ranking, evaluation and rewarding. Status differentiation is the process by which social positions are defined and distinguished from one another by assigning to each a distinctive role and a set of rights

and responsibilities. Once statuses have been differentiated it becomes possible to compare them. Statuses can be ranked on three criteria: personal characteristics that are believed to be necessary to play the role effectively, trained skills and abilities which are required to discharge a role efficiently, and consequences or effects of the role upon others and upon the society at large (“social function” of the role). The third process is the process of evaluation that involves assigning value or worthiness to various statuses. Some statuses become superior or inferior to others. Superior statuses hold certain degree of prestige, are more preferable and popular than other statuses. A process of rewarding involves rewarding statuses depending on their ranking and evaluation. Each society distributes different rewards to different statuses according to sets of rules and norms. The rewards can be both of intrinsic or material nature (Scott, 1970: 175-182).

3.3.2 Occupational status

Occupations are everywhere ordered into status hierarchies. They are differentiated on the basis of for example cleanness, income, rights and privileges. While some might say that occupations vary in their importance to the society, others argue that all occupations are important to the society in order to ensure its survival (Taylor, 1968: 164). Studies have shown that people all over the world seem to agree on the prestige of social roles/statuses. A list of occupation has been rated many times by different nations and the results have shown to be stable over both time and place. Because occupational roles play a central role in people’s lives they have a clear notion about which jobs are “better” and which are “worse” (Stark, 1987: 408-9).

Davis and Moore (1945: 243) suggest that there are two determinants of positional rank. The first one is a matter of function. The greatest rewards and the highest ranks go to those occupations that are of the most importance for the society. The second one is a matter of means. Occupations which require the most training and talent are awarded the highest rank. It is misleading to concentrate only upon the economic aspects of occupation when using it to measure social status. People seem to have notions about who are in superior or inferior occupations, and this notion is drawn from some shared meanings and values of the jobs concerned. Different occupational roles have different symbolic meanings and often this meaning has nothing to do with economical rewards the occupation enjoys (Coxon and Jones, 1978: 24-5). An example of that are the tax collector and the teacher. The tax collector might enjoy higher salaries than the teacher but he has a lower social status.

Certain types of service occupation are distinguished by the fact that practitioners meet their clients in situations where the practitioner’s occupational skill is highly esoteric and vital for the client’s well being. Medicine and law are examples of this kind of occupations. An occupation that allows people to give commands rather than taking them is often considered more prestigious. And the perceived social usefulness of the job is also helpful to rank occupations according to their prestige (Coxon and Jones, 1978: 27). The social usefulness of some occupations can vary from one historical circumstance to another. For example during a war and during times of peace, the social

usefulness of a soldier is perceived to be different, whereas the social usefulness of the physician has stayed relatively constant throughout the recent times.

3.3.3 Status inconsistency

The term 'status inconsistency' was introduced by Benoit-Smullyan. According to him it applied to a situation in which people who hold a certain status in one hierarchy hold a position of very different status in another hierarchy (Tang and O'Brien, 1990:1445). Status inconsistency can also be described as a condition that occurs "when individuals have some status characteristics that rank relatively high and some that rank relatively low" (Johnson, 2000: 311). People's positions in the stratification system are based on several characteristics such as occupational prestige, income, education and sometimes race, gender, ethnicity and age. Because there are several dimensions of inequality affecting the individual some of the characteristics can dominate as for example when gender becomes a "master" status in an employment interview. When individuals are affected by status inconsistency they are more likely than others to suffer mental health problems. Status inconsistency can result in frustration and uncertainty that can lead to problems such as low self-esteem and other forms of psychological distress (Stark, 1987: 234).

Lenski (1966) suggested that status could be measured by income, education, occupation and ethnic position. He found that people who experienced disparity in status were dissatisfied or frustrated with the situation and wanted it to change. An individual with inconsistent statuses or ranks has, according to his theory, a tendency to think of himself in terms of the status, which is the highest; while others treat him in terms of his lowest status or rank (p. 87).

For refugees status inconsistency can be especially important. To reduce dissonance high status-inconsistency refugees must find jobs that match their previous prestige or reduce their personal expectations to allow them to accept their present position (Tang and O'Brien, 1990:1450). There is evidence that high levels of pre migration education, particularly in connection with previous employment in professional occupation, may lead to problems in post migration adaptation. Refugees who were involved in high status professions in their homeland may have unrealistic expectations of upward mobility and therefore have difficulties coping with the low status occupations available to them after resettlement (Ward, Bochner, and Furnham, 2001:236). Recent refugees or immigrants are usually faced with language barriers and the fact that only low status jobs are available to them. They are often unsuccessful at finding high-prestige positions and the only way to reduce their dissonance is by reducing their expectations. Status inconsistency can affect the refugee's adaptation to a new society and the incongruence in statuses has also been linked to various psychosocial malfunctions (Tang and O'Brien, 1990: 1445-6).

4. Refugees in the Netherlands

Immigration is not a new phenomenon in the Netherlands as the country has attracted immigrants throughout the centuries and continues to attract them for diverse reasons. The immigration process is neither static nor even predictable as the kind of immigration and composition of the immigrants has been constantly changing.

In the 17th century people of Jewish origin searched for a safe refuge in the Netherlands and within the Dutch society they were able to build up their own community. The economical importance of the Dutch cities in the 17th and the 18th century lead to a large scale immigration of workers who came with the intention of working temporarily, but many never returned to their homes and consequently integrated into the Dutch society (Minister voor Grote Steden- en Integratiebeleid, p. 3). With the development of the mine industry in the beginning of the 20th century workers were for the first time recruited on a large scale from abroad. These workers came mainly from Italy, Poland, and Slovenia. After the Second World War the cultural and ethnical composition of the Dutch society began to change considerably. With the increasing flow of citizens from the former Dutch colonies, such as Surinam and Indonesia, and workforce from Mediterranean countries such as Italy, Spain, Turkey and Morocco in the 60's and 70's, the Dutch society changed into a multicultural and multiethnic society.

Immigration in the form of refugees asking for a refuge has become a larger factor in the immigration process in the Netherlands, especially in the last decades of the 20th century as refugees began to arrive from various parts of the world. In the 1990's the influx of refugees increased considerably. The war in the former Yugoslavia contributed substantially to the refugee flow, but also politically dangerous situations in countries such as Afghanistan, Sri Lanka and Somalia (Mattheijer, 2000: 2). However in the last five years the number of refugees looking for a refuge in the Netherlands has been rapidly diminishing. This is due to factors such as tightening regulation on who is granted a refugee status as well as relative stable situation in countries that in previous years had the largest outflow of refugees to the Netherlands.

4.1 The refugee

According to The United Nations convention on the status of refugees (1951) a refugee is defined as:

(...) any person who owing to well-founded fear of being persecuted for reasons of race, religion, nationality, membership of a particular social group or political opinion, is outside the country of his nationality and is unable or owing to such fear, is unwilling, to avail himself of the protection of that country (Ward et al., 2001 :220).

This classification is rather narrow and does not include people who are forced to flee because of indiscriminate violence, nature disasters and famine.

A wide range of life changes and the major sources of stress are part of the refugee experience. They face, among other things, social isolation, status inconsistency, pre-migration trauma, 'cultural shock', acculturation pressures, accelerated modernization and minority status, along with having to deal with the loss of their country and culture (Ward et al., 2001: 235).

According to Ward et al. (2001) a number of factors contribute to the fact that refugees can be considered the most disadvantaged of all of the relocating groups (p. 222):

1. They have been exposed to overwhelmingly stressful pre-migration experiences in their country of origin, which may strongly affect their subsequent adjustment.
2. Their migration is involuntary and largely motivated by 'push' rather than 'pull' factors, which increases the risk of psychological and social adjustment problems.
3. Their displacement is usually permanent.
4. They often come poorly prepared for the cross-cultural transition and are frequently under equipped with tangible resources to deal with life in a new culture.
5. They are likely to originate from cultural backgrounds that are extremely different from those of the receiving countries.

In the light of these factors it is not surprising to see that many comparative studies have shown that refugees exhibit more symptoms of psychological distress, such as anxiety and depression, than members of the host society (Ward et al., 2001: 222-3). Any adjustment problems that refugees face in the host country do not necessarily have to be consequences of a psychological distress. Eisenbruch (1991) offers a different theoretical perspective on the refugee experience. He proposes that cultural bereavement may be a more appropriate framework for understanding the difficulties of refugee resettlement. He defines cultural bereavement as "the experience of the uprooted person or group resulting from loss of social structures, cultural values and self-identity" (p. 674).

4.2 The decision to emigrate

People decide to emigrate to another country or area for various reasons. Sometimes their decision is not so much a choice but a necessity, as in the case of most, if not all, political migrants.

Borjas's "Human Capital-Model" explains migration from an economical standpoint: people migrate to places where their human capital, such as education and training, will attract higher profits. The migrant assesses whether or not it is efficient for him to emigrate. If he increases the net worth of his human capital by emigrating than it is in his interest to emigrate (Burgers and Engbersen, 1999: 56). This model cannot be applied literally to refugees, who do not migrate voluntarily, but according to the theory they still make an economical decision on how to use their human capital once they arrive in the host country (Colic-Peisker and Walker, 2003: 339).

Borjas's model is able to explain the emigration decisions of the refugee because the fundamental determinants of the migration decisions are the same for the political and the economical migrant; the individual benefit is higher in the land of destination than in the

country of origin. The political migrant emigrates because of exogenous factors such as civilian war, or threats based on race, religion or political differences. He is mainly influenced by 'push' factors, and therefore forced to emigrate whereas the economical migrant is influenced by 'pull' factors and bases his emigration on free choice rather than forced one. Although the decision to emigrate is based on political reasons or 'push' factors, the choice of destination is determined by economical 'pull' factors. Not all refugees flee to peaceful neighboring countries or safe havens within their region. Many refugees migrate to countries that lie far outside their region, such as the numbers of non-European refugees that arrive every year to European Union countries show. The EU countries are more attractive for economical reasons, so therefore it is difficult to speak of pure political reasons behind the migration as economical reasons do also play a part in deciding where to migrate (Mattheijer, 2000: 48-9).

4.3 The integration of refugees

As well as having to adjust to being uprooted from their country, home, friends and families, most refugees find themselves in a culture with completely different values, norms and customs to their own. Other more practical adjustment problems that refugees are typically experiencing are connected with information- and language inferiorities, housing and employment. According to the learned helplessness model refugees are:

(...) thrust into a passive, victimized roles during flight, displacement and resettlement (...) they are frequently forced to surrender control to various organizations and bureaucracies; and that unpredictability and lack of control become a way of life. In such circumstances refugees may come to believe that efforts on their part to regain control and to improve the quality of their lives are largely futile. This could account for the passivity sometimes observed in resettled refugees and explain the prevalence of depressive disorders in refugee communities (Ward et al, 2001: 229).

The evaluation of work experiences and level of education is very important to the refugees in order for them to be able to continue work or study in the Netherlands. Their diplomas and work experiences are frequently not evaluated as equivalent to their Dutch counterpart. Many arrive in the Netherlands without their papers and diplomas, and consequently need to wait a long time for their diploma evaluation (Brink et al. 1996:57).

There are different factors that can be of hindrance as to whether or not a refugee is able to follow an education in the Netherlands. First of all their age. The average age of UAF-students when they start their study is 28, 9 years (UAF, 2003: 12). Because the Dutch government does not provide financial help to those students who are older than 30 years old, many refugees are dependent on the UAF for financial support. The second important hindrance is income. Most refugees are dependent on assistance or unemployment benefits. Thirdly, the government policy of spreading refugees onto different municipality throughout the country has resulted in some refugees ending up in an area where they are not able find work in their sector of work, or where there is a lack of educational institution in a reasonable distance. The fourth problem is that many

refugees are not capable of, or simply do not want to prepare themselves for a permanent stay in the Netherlands. They might for example be affected by psychological problems, or they want to return to their country of origin once the situation over there has improved.

Once having started their education many refugees seem to be unable to continue their study. According to a research done by Prins and Linden (1999: 50) one of the most important reasons for delaying or terminating a study has to do with concentration problems, or in 53 percent of the cases. Many refugees have also difficulties in coping with their low social position. Learning the Dutch language is also a hurdle for many, as well as lack of information over what for knowledge and capacities are needed for a certain study or a job. Because of these problems the many refugees do not finish or even start their study within the Dutch educational system (Mattheijer, 2000: 88).

In 1998 a new law (Wet Inburgering Nieuwkomers) was introduced that obliges most immigrants to take part in an integration program (“Inburgeringsprogramma”). The purpose of the program is to give immigrants, including refugees, a head start in their integration by teaching them the Dutch language and educate them about the Dutch society and the employment market (Mattheijer, 2000:3-4). By obligating immigrants to take part in the program the Dutch government aims to stimulate the employment participation of immigrants as cross-cultural transition and adaptation has been shown to be more effective when a refugee is equipped with language skills. Language skills do not only facilitate social interaction but also economic security as literacy and fluency predict employment (Ward et al., 2001: 235). It is expected that by participating in the program the immigrants Dutch human capital will increase and giving them a better opportunity to take part in the Dutch employment market as well as the Dutch society as whole (Mattheijer, 2000:57).

Of all the newcomers that take part in the program, refugees seem to form apart group. They have on average a higher level of education and work experience, and a high level of motivation to work, but at the same time many of them have to deal with psychological problems because of their traumatic past. Despite this, refugees are not treated any differently to other immigrants (Mattheijer, 2000:3-4).

4.4 Employment integration of refugees

Integration could be understood as equal chances on the employment market, were any immigrant is capable of getting a suitable employment that fits their educational level but also participate on the employment market at the same proportional level as the Dutch population.

There seem to be relatively few refugees who manage to get into the Dutch employment market within the first two years of their stay in the Netherlands. Those who are successful in finding employment are usually employed in jobs that are not equivalent to their previous work experiences and educational level (Brink et al., 1996: 41). A concept that could be used to describe this occurrence is the “brain waste” concept. Different to

“brain exchange”, which means that a highly skilled individual is able to use his skills and qualifications in a new location, the “brain waste” concept describes the deskilling that occurs when highly skilled workers migrate into forms of employment not requiring the application of the skills and experience applied in the former job (OECD, 1997:5).

Employment is one of the central concerns of immigrants and successful employment is thought to be crucial to their integration (Shuval et al., 1975: 152). Employment can provide financial security, time structure, social contacts, status, social identity and purpose in life. The sudden absence of employment can therefore have profound and devastating effects on a person’s psychological well-being and may cause reactions such as depression, anxiety, uncertainty about the future, loss of self-esteem and unhappiness. For new immigrants employment can be helpful in order to settle into and adapt to their new settings. Integration can be stimulated if the immigrants are working, and it has been shown that when individuals who consider work to be a central part of their lives their satisfaction with life is largely affected by their satisfaction with their work (Berman, 1984: 429). This means that having a job, which the immigrant is satisfied with, could affect the overall adaptation and integration of the immigrant into the host society.

It seems that older refugees with high educational background have more expectations when it comes to employment opportunities than others and have more difficulties to accept that perhaps they will not be able to get an equivalent job to what they held previously. Older refugees need more time to learn the Dutch language, and it is necessary for those who aim for high-level jobs to speak excellent Dutch. This can lead to frustrations as many are not willing to study further in order to gain their previous position as they feel they are either too old to study, or that they feel that there is no need as they have already followed an education (Brink et al., 1996: 58). Studies have shown that older refugees are less likely to be employed than younger refugees. Employers usually prefer younger applicants, so for many refugees, who on average tend to be older, it can be difficult to find an employment. Males over the age of forty, particularly those of professional and managerial backgrounds, exhibit a sharp fall in the labour force participation rate. This has been attributed to their difficulties in accepting a far lower occupational status than they previously held (Waxman, 2001: 488).

According to some findings newly arrived male refugees have up to 20 percent higher probability of unemployment than the next most unemployment prone group (Waxman, 2001: 473). Their weak competition position has to do with a number of factors. The asylum process as well as adapting to the Dutch way of life takes at least two years for most refugees. Only when they have been assigned a status are they allowed entering the employment market. Some refugees, predominantly women, are not looking for paid employment, others have to deal with physical and psychological problems which are possible to trace back to their background as refugees. Problems such as concentration problems, sleeping problems, headaches, and feelings of guilt over those family members left behind are common among refugees (Brink et al., 1996: 53).

Their Dutch language proficiency can also create a problem when it comes to finding an employment. Some refugees do not believe that their language ability is good enough for finding an employment. Those who are highly educated seem to be less satisfied with their language proficiency and because of that feel more insecure. Many feel that lack of social contacts affects their ability to be able to exercise their Dutch. Another hindrance to the employment market is the fact that their diploma as well as their work experience is often not valued as equal to its Dutch equivalent. Many refugees wait a long period of time for an evaluation of their credentials, which is frequently disappointing. The results are that many, especially older refugees, have difficulties in finding employment that is compatible to their previous employment (Brink et al., 1996: 55-7).

4.5 Work motivation of the refugee

Refugees have on average higher work motivation than economical immigrants. That is because the refugee will invest more on the whole in the host country than the economical immigrant. According to Mattheijer (2000: 58-9) there are three reasons which can explain this. First of all, because of the insecurity of a future in their country of origin, they are more likely to want to build up a secure existence in their host country. Second of all, they have, in theory, a high level of education and that means that they have a better chance of getting a job with a training component in it. Finally, refugees usually come from countries where their skills are less compatible to the ones needed in the Dutch society. This means that refugees who want to stay in the Netherlands need to invest more in their human capital, than many other immigrants, if they want to be able to participate in the Dutch society.

According to Brink et al. (1996) most refugees want to work in the Netherlands. Wanting to be economically independent, lack of social contacts, feeling a need for creating their own place in the society as well as wanting to feel at home in the Netherlands are some of the things that motivate them to get back on to the employment market (p. 43). Hulshof et al. (1992) conducted a research among 677 refugees who were interviewed during their stay in refugee centers to find out (among other things) what their wishes were during their stay in the center. When asked whether or not they were interested in learning the Dutch language, to work or follow an education, 92 percent wanted to learn the Dutch language, 86 percent wanted to follow an education and 86 percent wanted to work (p. 88). This implies that the refugees themselves are concerned about their stay in a refugee center and the lack of integration possibilities.

Persistence, initiative and motivation are important qualities when it comes to being successful. Refugees who do not have any future plans, are drawn back or not capable of taking the first initiatives seem to be less successful in finding their way within the Dutch society than those who have a clear goal for which they aim for. Persistence and dare are characteristics that are needed especially for people such as refugees who need to keep on pushing and attempt to get what they are entitled to despite continuous disappointments (Brink et al., 1996: 49).

5. Refugee physicians

Physicians asking for a refuge the Netherlands and hoping to be able to work in the Netherlands as physicians have to deal with many obstacles. It can take many years before they are accepted into a medical faculty as waiting for a refugee status, learning the Dutch language, dealing with the bureaucratic system and finding finances takes time, in some cases years. The average time from entering the country to beginning their medical study is over three years (Arkel and Engelkes, 2003: 8). This means that most, if not all, refugee physicians have to wait for a considerably long period before they are able to work again in their profession.

The physician profession is an ‘article three profession’ which means that anyone who wants to practice medicine in the Netherlands needs to be legally registered in the BIG register, otherwise known as the “Wet op de Beroepen in de Individuele Gezondheidszorg” (Ministry of Health, Welfare and Sport: 2). For those physicians who have diplomas that are officially recognized by the Ministry of Health, Welfare and Sport registering is not a problem. Those who hold a diploma, which is not officially recognized, need to apply for a declaration of professional competence by the ministry (Scholten, Mak and Teuwsen, 2003: 4). The first step is to register by the “Verwijspunt” which is a reference point set up for foreign diploma holders by the ministry. There they are required to gather various information about their study, such as which books they used, and what work experience they have (Arkel and Engelkes, 2003: 10). This process does not only require much time and effort, but it can also be complicated by the fact that some refugees do not have all the relevant information or even diplomas by them once they entered the country. Once the “Verwijspunt” has gathered all relevant information the dossier is sent on to the BBD (Bureau Buitenlandse Diplomahouders). There it is reviewed and an advice is given, in cooperation with Nuffic (Department for International Credential Evaluation) and CBGV (Commissie Buitenlands Gediplomeerden Volksgezondheid), whether or not the diploma is equivalent to the Dutch medical diploma. The evaluation of the diploma can lead to three conclusions (Scholten, Mak and Teuwsen, 2003:4):

1. The professional competence is equivalent: registration in the BIG registration. This means that if the physician in question has never worked in the Netherlands, he is required to work for six months under supervision in order to get to know the Dutch healthcare system.
2. The professional competence is nearly equivalent: registration with limitation. The physician is required to work for two years under supervision.
3. The professional competence is not equivalent: no registration. The physician needs to apply for admission to a Dutch training institute.

Refugee physicians fall in 90% of the cases in category three (not equivalent) which means that most of them need to resume their medical education. Around 10% are evaluated as category two (nearly equivalent). It is only in exceptional cases that their professional competence is considered as equivalent to that of a Dutch practitioner in their profession (Arkel and Engelkes, 2003: 11).

In 2002 303 physicians outside the European Economical Area requested a registration in the BIG-registration. Of those 303 physicians 31 were considered holding an equivalent diploma to the Dutch medical diploma, 114 were considered to hold a diploma that was evaluated as nearly equivalent, and 158 physicians were refused a BIG registration.

Table 1 shows a summary of those seven countries with the largest number of physicians who requested a registration in the BIG-registration (Centraal Informatiepunt Beroepen Gezondheidszorg, 2003, p.10-12).

Table 5.1 Evaluation of foreign physician’s diplomas

Country	Total	Equivalent	Nearly equivalent	Not equivalent
Afghanistan	33		2	31
Iraq	15	1	2	12
Ukraine	17		2	15
Poland	28	7	19	2
Russia	33		4	29
Suriname	17	4	11	2
South-Africa	44	11	32	1

Since 1996 the CIBA (Commissie Instroom Buitenlandse Artsen) has assisted foreign physicians in finding a place in one of the seven medical faculties in the Netherlands. Each year 115 places are available in the seven medical faculties; where anything from 10 to 18 individuals are accepted per faculty (Scholten, Mak and Teuwsen, 2003:5). Because of the limited number of placements available, some foreign physicians need to wait some time before they get accepted into a faculty (Arkel and Engelkes, 2003: 11).

5.1 The language program

5.1.1 Albeda College Rotterdam

The Albeda College at Rusthoflaan in Rotterdam serves as a language center for foreign students. There are three different language programs taught at the college and one of them is the so-called “schakel” project. Only those who are enrolled in a higher educational institution are accepted as students for the “schakel” project. Its aim is to prepare the foreign student for a study in a Dutch higher educational institution. The students are prepared for the NT-2 exams, which they are expected to pass at the end of the one-year study. This means that the “schakel” year program is extremely intensive and only suitable for those who have a higher educational background.

The “Artsenproject”

In previous years every physician that studied Dutch at the Albeda College has followed the “schakel” project. In 2003 a project specially aimed at foreign physicians was introduced. This project, the so-called “Artsenproject”, was started at the initiative of

Emplooi and the “Sociale Zaken en Werkgelegenheid” in Rotterdam. Emplooi gives advice, SZW pays for the program and Albeda College carries it out. The reason for initiating a special physicians program was that many of those involved with foreign physicians felt that it would be beneficial for them to follow a special program aimed at their specific needs.

The module for the “Artsenproject” includes apart from the general Dutch language lessons and preparation for the NT-2; medical Dutch, introduction to the Dutch medical sector, biology, basic computer training, solicitation training, and English. They students are also encouraged to study mathematics and medical terminology on their own (Kraaijveld, 5.4. 2004).

In the school-year 2003-2004 twenty foreign physicians were taking part in the “Artsenproject” of which around half were refugees.

5.1.2 The NT-2 exam

The NT-2 or “Nederlands als Tweede Taal” is an exam that is held by the “Informatie Beheer Groep” three times a year. The exam includes four parts: listening, writing, speaking and reading. In Albeda College students take regular exams during the one-year study to measure their Dutch language skills. The exams are supposed to reveal on which level the student is currently on, but the levels begin at zero and end at level five. In order to be able to pass all four parts of the NT-2 exams the student needs to have reached what equals level four or five. Those planning to follow a study in the Dutch language in any of the Dutch universities are required to have passed all four parts of the NT-2 exam.

5.2 The medical faculties

Every year around 10 to 18 physicians are accepted into one of the medical faculties as “higher-placed-sideways-enterers” (Arkel and Engelkes, 2003: 12). When the professional competence has been evaluated as non-equivalent, the medical faculty has the sole right to decide in which year the physician can enroll and what he needs to do to acquire the Dutch qualification for the relevant profession (Ministry of Health, Welfare and Sport: 6). That means that the admission requirements differ per faculty as well as the duration of the study. All faculties request that the applicant has passed the NT-2 exams, some request an English exam as well, and soon a special course that focuses on the medical Dutch will be a requirement to enter any of the medical faculties. If an applicant is accepted into the faculty after a solicitation interview, most begin their study in the 5th year, or in the clerkships phase which could be described as a type of practical rotation (“co-schap”). Other faculties oblige the applicant to take some of the third and fourth year subjects as well as the practical rotation, and other evaluate the applicants by the use of a knowledge- and a progress exam, where depending on the results, an applicant can even be exempt from doing the practical rotation (Arkel and Engelkes, 2003: 12).

Since all of the interviewees that took part in the research applied for admission at the Erasmus University medical faculty there will only be given a further insight into the admission procedures that applies in the Erasmus University.

5.2.1 Admission into the Erasmus University: The Admission Office

According to Anja Veerman, administrative worker by the Admission Office in Erasmus University in Rotterdam, anyone who wants to study at the medical faculty has to have passed the NT-2 exams as well as being a legal resident in the Netherlands. That means that it does not matter what kind of status they have (limited, unlimited or are waiting for one) as long as they have started the application process.

Once a physician has applied for admission into the medical faculty he is required to make an appointment with the admission office and bring with him his original diploma as well as a list of grades and subjects, an official translation of his diploma, Curriculum Vitae and residency document. Once the physician has passed all four parts of the NT-2 exams and the medical faculty has decided in which year he is allowed to begin, he will receive an official declaration of admission (Beschikking van Toegang) from the administration (College van Bestuur). Most applicants receive an admission to the fourth year, but since there is only a limited number of placements a selection interview takes place in August every year.

Table 2 shows an overview of how many declarations were issued in the years 2001-2004 by the Admission Office. It has to be noted that not all of the applicants are necessarily refugees as refugee status is not registered by the Admission Office. A rough estimate of the number of refugees is around 60%.

Table 5.2 Number of applicants as opposed to number of declaration in 2001-2004

Year	Number of applicants	Number of declarations
2004	56	16
2003	74	19
2002	59 ¹	23
2001	59 ¹	19

It takes some physicians many years to qualify for a declaration. They need to pass all of the four parts (writing, speaking, listening and reading) of the NT-2 exam in order to qualify. This means that some of the applicants apply for admission year after year before completing the exams. There is therefore some overlap of applicants between the years.

¹ In 2002 and 2001 the total number of applicants was 118. It was not possible to separate how many applicants applied for admission in each of these two years.

Table 5.3 Applicants in 2001-2004 and in which year they first applied for admission**The year of first application**

Year	1998	1999	2000	2001	2002	2003	2004	2005
2004	1		2	10	14	8	18	3
2003	1	3	4	17	18	21	10	
2001-2002	2	11	17	40	37	11		

Most of those who apply for admission do not pass all of the four parts of the NT-2 in the first year. There are, according to Veerman, various factors that might possibly explain the refugee physician's failure to learn Dutch. Refugee physicians are struggling with several handicaps that other applicants do not have. One of them is their age: refugee physicians are on average older than other applicants, and older students have more difficulties in learning the Dutch language. Those who have been working for a long time seem to find it harder to begin a study, than those who have recently finished their medical degree. Younger physicians also seem to be more motivated and persistent than the older physicians. They are also experiencing extreme status changes as well as having to start their study all over again. Many of the applicants also have families which makes it harder for them to find time to study. Getting through the administrative jungle can also prove to be a struggle for some, and Veerman did also mention the fact that refugee physicians have, in her opinion, lower self-esteem than other physicians.

Table 5.4 Average number of applicants who passed all, one, two or three, or none of the four NT-2 parts in 2001-2004

Year	Passed all	Passed one, two or three parts	Did not pass any parts	Results unknown	Total
2004	16 (29%)	22 (39%)	18 (32%)		56 (100%)
2003	22 (30%)	19 (26%)	32 (43%)	1 (1%)	74 (100%)
2001-2002	44 (38%)	23 (19%)	45 (38%)	6 (4%)	118 (99%)

According to Veerman it seems that because refugees have in most cases been in the Netherlands for some time before they are allowed to begin either work or study (including language studies), many have picked up some bad habits with regard to the language. It is, according to her, more difficult to learn Dutch once you have learned some aspects of the language instead of starting straight from the beginning.

Table 5.5 The average age of the applicants and gender

Year	Average age	Male	Female
2004	37	28 (50%)	28 (50%)
2003	38	36 (48%)	38 (52%)
2001-2002	38	58 (49%)	60 (51%)

It seems that the average age as well as the ratio between men and women in 2001-2004 has stayed fairly constant.

According to Veerman refugees are “a group that is undervalued”. Once accepted into the study they seem to thrive. She knows many physicians who once accepted they change, not only psychologically but also physically. They begin to hold their head high as if they have gotten back “a piece of self-respect and self-confidence” (Veerman, 2. 3. 2004).

5.2.2 Admission into the Erasmus University: The medical faculty

Once the refugee physician has passed all four parts of the NT-2 exams he will receive an official declaration of admission from the “College van Bestuur” through the admission office at the Erasmus University. With the official declaration the applicant has an opportunity to apply for one of the approximately 15 placements that are reserved for foreign physicians whose medical diploma has been valued as not equal to the Dutch diplomas. Every year around 30 to 40 foreign physicians take part in a selection interview where a special commission selects 15 individuals that are able to start their medical education in the fourth year. The selection commission consists of a medical professor, a Dutch language teacher and a representative for the Commission Special Admissions. According to Ted Splinter, head of the selection commission and educational director at the medical faculty at the Erasmus MC, the main and the most important selection criterion is the applicant’s command of the Dutch language. The Dutch language teacher assesses whether their language problems are of a structural nature or not. If the problems are structural it is next to impossible to correct them, which means that they will never be able to use the Dutch language at a level that is required in order to work as physicians in the Netherlands. A second criterion is their level of competence. What is their educational background when did they graduate and what have they done professionally since then.

Once accepted into the medical faculties the new entrants begin their studies in the fourth year where they take part in a shortened program especially designed for foreign physicians. The program consists of a course in social healthcare, medical Dutch and a course in attitude and communication. After the fourth year they begin their clerkship rotations just like any other medical student. The clerkship lasts for two years and consists of a rotation between ten different departments in order for the medical student to get an experience in as many different hospital departments as possible. After a six years study and clerkships the medical student graduates as a basic physician. Then

anything from three to six years' specialization as well as up to three years super specialization awaits him. That means that the average physician is likely to be busy as little as nine years and as much as fourteen years with their education. In the case of the refugee physicians, who are exempted from the first three years in the Erasmus University, their Dutch medical education will last anything from six to eleven years (Splinter, 21.6. 2004).

5.3 Improvement schemes

Because the admission requirements for foreign physicians differ between the Dutch medical faculties different institutions have put forward improvement schemes that aim at unifying the integration procedures.

Nuffic and the University in Utrecht worked on a pilot project where the development of a portfolio was central. The aim of the project was to encourage the use of portfolio during the selection interviews, and use it as a tool in assessing in which year the applicant should start their medical education. A portfolio was expected to give a better insight into the foreign physician's former experiences and competence (Scholten, Mak and Teuwsen, 2003: 3).

In 2003 the UAF published a report where improvements regarding the integration procedures of foreign physicians were proposed. Their proposal consisted of an orientation phase and a national exam, as well as the use of portfolio, which would be able to lead to a shorter and more efficient integration process.

A project group led by Ted Splinter published a report in 2003 where new guidelines for the integration of foreign physicians were introduced because of lack of an integrated policy regarding the medical licensure of foreign-trained physicians. The project was set up by the "Onderwijs Commissie Geneeskunde van het Discipline overleg Medische Wetenschappen" (OCG-DMW) and the group consists of representatives from the Ministry of Health, Welfare and Sport as well as from all of the seven university medical faculties. Their proposal is to set up a national system where several medical exams will determine in which year the physicians are able begin their study. The foreign physicians will have to finish certain courses, such as medical Dutch, NT-2, English and communication, before taking the exams. In which year they then would be able to start their medical study would depend on the results of the exams. By unifying the procedures it is also hoped that the foreign physicians are able to orientate themselves as soon as arriving in the Netherlands by receiving information about what is required of them in order to resume their career in the Netherlands (OCG-DMW, 2003: 4-8).

5.4 Social and job support

Social support can come from many different sources, such as from spouse, family, the refugee's ethnic community and the larger community. Social support can be very important as evidence has shown that refugees who are satisfied with their social support

suffer less psychological distress than those who are dissatisfied (Ward, Bochner, and Furnham, 2001:237).

More formalized sources of social and economic support are available through special programs that are designed to assist refugees in making successful cross-cultural transitions. As the Dutch government does not have any special policies regarding the integration of refugees onto the employment market (Mattheijer, 2000:38), private organizations, such as the UAF, SIBIO, and VluchtenlingenWerk Nederland, have set up their own mediation bureaus to help refugees to find jobs suited to their past experience or that help them to build up useful experiences, for example by means of an education, to further their chances in the future.

5.4.1 UAF

UAF has since 1948 supported refugees in beginning or to continue their study in the Netherlands. Their support includes financing their study, individual support by study advisors, and supporting those refugees that have finished their study to find a job (UAF folder, 2001). What kind of financial support an individual can rely on depends on many different factors, such as his residency status, age and his study plans (full-or part-time study). If a student is not eligible for a study financing by other institutions, such as the government (which only supports students financially until the age of 30), the UAF offers the student a financial support (UAF folder, 2003).

Refugee physicians form a special group within the UAF. They are not able to study part-time and because of their age they are not able to receive study financing by the government. Because of these restrictions they get a monthly study grant from the UAF. The UAF pays their study fees, as well as paying for their books and part of their traveling expenses (UAF, 2003:14). At the end of 2002 358 physicians were registered as clients of the UAF. Of those 165 were preparing for being accepted into a medical faculty while the rest were studying at one of the Dutch medical faculties. Most of these physicians had work experience before they came to the Netherlands (Arkel and Engelkes, 2003: 8).

Job Support specializes in assisting UAF clients in finding an employment. Their aim is to find highly educated refugees an employment that fits their educational background and work experience. Job Support supports those refugees that have finished their study in the Netherlands with the assistance of UAF as well as those who finished their study in their land of origin. Within one year of graduation more than 80% of the UAF clients find employment via Job Support that both suits their wishes and capability (http://www.uaf.nl/uaf/pagina.asp?paginaam=werk_jobsupport).

5.4.2 SIBIO

Because of the difficulties that physicians face trying to find work or a supervised placement within the Dutch healthcare system, the “Stichting Interculturele Bedrijfsaspecten en Intercultureel Ondernemerschap” (SIBIO) in 1997 began a special

program called “Artsenproject”². Its aim is to help physicians who come from countries outside the EU to find a supervised placement (www.inburgernet.nl).

The SIBIO has four programs for foreign physicians. The first one is a supervised placement for those whose professional competence has been evaluated as nearly equivalent. The second program is a placement within the healthcare system, for those physicians whose professional competence has been evaluated as equivalent. The third program is for those who are waiting for an evaluation of their professional competence. Its aim is to introduce the physicians to the Dutch healthcare system by placing them in a language training course in a healthcare institution, as well as helping them to finding a suitable language course and training for the NT-2 exams. The fourth program prepares those whose professional competence has been evaluated as non-equivalent, and consequently do not want to follow a study at a university level, for an education or practical training in another area. SIBIO offers those individuals a support in choosing a different educational path and helps them with the registration procedures (www.sibio.nl).

5.4.3 VluchtelingenWerk Nederland

VluchtelingenWerk Nederland serves the interests of those refugees that arrive in the Netherlands. The organization assists refugees with various practical problems such as the asylum process, finding their way within the community, assisting with educational choices, finding an employment, the upbringing of their children, and so on. VluchtelingenWerk Nederland also works as a communication aid between the refugees and various organizations. In addition to assisting refugees they publish and distribute information about the legal as well as social position of the refugee within the Dutch society and strive to eliminate some of the prejudice towards refugees.

VluchtelingenWerk Nederland strives for equal treatment for refugees, not only with regard to the asylum process but also within the Dutch society (www.vluchtelingenwerk.nl).

² This program is different to the “Artsenproject” at the Albeda College.

6. Research findings

The interviews provided rich array of empirical data that forms the core of the analysis. Not all of the data was directly related to the research itself but in most cases the respondents did not stray far from the subject at hand.

Four central themes dealing with the experiences, feelings and thoughts about their past, present and future situation as refugee physicians emerged from the analyses of the interviews. These were:

1. Personal investment in the medical profession
2. Evaluation of their credentials
3. Personal and social background
4. Language and integration

The first theme has to do with the interviewees personal background as physicians; what is their professional background, what measurements are they taking in achieving their goals in the Netherlands and how do they view themselves (how strong is their professional identity). The second theme deals with how they experience the evaluation of their qualifications, how the Dutch (medical) society views them and what their personal feelings are about that evaluation. The third theme focuses on their personal and social background in order to give a picture of their personal and social situation in the Netherlands. The last theme aims to give an insight into their integration process. The integration process is very important as it is one of the first and most important step they take on their path to become physicians in the Netherlands. It deals with for example their feelings towards the Dutch society and their success in mastering the Dutch language.

Although each theme might initially be discussed separately it is important to note that they do not exist independently from each other. Their interrelated nature will be discussed in the discussion chapter.

6.1 Personal investment in the medical profession

Personal investment in their profession is determined by looking at several different aspects of their professional career before and after their migration to the Netherlands. Personal investment before migration is measured by analyzing their reasons for choosing the profession, the length of their education background as well as by looking at the nature of their professional background.

Personal investment in the medical profession after migration is measured by analyzing their initiatives in finding employment in the healthcare sectors and how serious they are in pursuing a medical license in the Netherlands. Finally their professional identity will be analyzed.

6.1.1 Personal investment before migration

6.1.1.1 Reason for choosing a medical study

All of the interviewees have wanted to study medicine long before their medical study begun. Some from a very young age, other later in their teens. Sometimes their decision was influenced by their school prestige, as high grades meant that they could be accepted to a medical study.

“Choosing an education is different in Afghanistan. If someone in Afghanistan gets high grades it means that he or she has a chance to follow a difficult education”.

“After the study there are special exams that decide which faculty you can enter. If you get high grades then you are able to enter the medical faculty”.

From many of their stories it becomes evident that their families, especially parents, have approved and encouraged them from an early age to become physicians.

“I have wanted to be a doctor since the age of seven. On my father’s side there are no doctors. He wanted me to become a doctor”.

“From a young age everyone, including my mother, said that I had to become a doctor”.

Other factors were also mentioned as being persuasive in their decision to study medicine, such as wanting to work with people, being interested in subjects related to medicine, being attracted to its high status and salaries.

“I love the specialization and I love working with people. I wanted to help people”.

“First of all it was I that wanted to become a doctor. My family, my father, my mother also wanted me to become a doctor. I found it a good position, a good job and good salaries. It is a top position in our country”.

“In Afghanistan everyone wants to become a doctor. A doctor, a musician or a star”.

6.1.1.2 Educational background

The average educational career of the interviewees lasted eight years, varying from six years up to thirteen years. Their basic medical study lasted on average six to seven years, and those who specialized had to study further one to six years, with the average specialization program lasting two and a half years.

By the time of the interviews all of the interviewees had finished a basic medical study, but not all of them had completed a specialization. Seven of the fourteen interviewees had not started or managed to finish a specialization program. Of them one started his specialization but stopped after two years, one had plans to do so but they did not go through, and one interviewee said that it had been too expensive for him to specialize. Of those interviewees that had specialized three had specialized in gynecology, one in anesthesia, two in surgery, and one in dermatology. The remainder of the interviewees called them selves’ specialists in a certain area without specifying further on the program

they had followed. It seemed that their specialization was more of a work experience rather than a special program in a university hospital.

“If you have just graduated then you cannot choose where to work. The government tells you where you have to work for the next two years. That way you get adequate work experience. So I worked in surgery, internal medicine and pediatrics. Then you have to take exams in the direction you want to specialize in. I took the exams and passed them, and then I worked for three years in the specialization surgery”.

6.1.1.3 The nature of their professional background

The interviewees had on average eight years work experience before they were either not able to work any more because of political situation or because they had fled their country. One interviewee did not have any practical experience as licensed physician since graduating from medical school, as the authorities did not accept his medical diploma. Other interviewees had anything from one up to thirteen years experience working as physicians. Their experiences varied as some had worked only in one particular medical sector, whereas others had experiences in many different sectors.

“After the study I went back to my country to work. But not only as a pediatric surgeon but also as gynecologist, therapist, pediatrician ... I did everything”.

Two of the interviewees had not only worked as physicians but also in management and directorial positions. One had worked as director of the hospital alongside his general work as surgeon. The other interviewee had stopped his work as gynecologist in 1990 in order to work as deputy head of the ministry for health, and later head of the social ministry in his country.

Their experience in many different areas was sometimes out of necessity of the situation they were working in rather than their own choice as the following quote illustrates.

“If you are specialized in one area you need to know about other areas as well, about everything. There were not enough doctors and you could meet patients with different traumas and you cannot say: “oh sorry I am a cardiologist; I cannot do anything for you”.

Working under difficult situations, such as war and oppression, was not uncommon work experience for some of the interviewees. Their stories give an insight into how their professional life has been shaped by difficult, and sometimes, extreme situations. Working under difficult circumstances, and in some cases without basic medical necessities, was a reality for many of the interviewees.

“Every ten days I went to the front. There were new doctors having to face blood, wounds, injections, small operations and give drugs for the pain. I was always busy with these things and then I went home for ten days. The hospital was destroyed. There were about four or five experienced doctors for a population of 400-500 thousand”.

“After the study I returned to the war zone. In a war situation you have to do everything yourself in very tough situations. I remember how I once did an operation with only local anesthetics, without medicine (...) I did not leave my department. People fled the

village but I was behind with my patients. I needed to flee, but I did not do it. I have sworn the Hippocrates oath”.

“You know that in a country where there is war there are many problems. For example I worked in a big hospital for ten years, and during those ten years there was no electricity. I have operated on people without electricity”.

6.1.2 Personal investment after migration

6.1.2.1 Initiatives in finding work in the healthcare sectors

At the time of the interviews the interviewees had not worked as physicians for a long period of time. It ranged from four up to fourteen years, with the average time of last employment as physicians being six years ago. Many of the interviewees had not worked in related areas since arriving in the Netherlands, and some had never even visited a Dutch medical institution.

Six of the fourteen interviewees had some experience working within the Dutch healthcare system. Although their experiences seemed to be varied it was clear that their work opportunities were limited to basic care work. Two had worked as volunteers in nursing homes, one interviewee as patient transport assistant in a hospital, one as care worker for a local football club, one as assistant in a nursing home and various hospitals and one had worked as care worker in different hospital wards as well in a hospital laboratory. Those who had found work in medical related sectors seem to share a strong need to get acquainted with the Dutch healthcare system.

“Yes, that is why I am working in Dijkzigt. Everything has changed. Lots of things have changed just in the last six months, so you can just imagine how much has changed in the last five years”.

“I saw that there was so much for me to learn: a strange country, a different culture, and a different language. Also about different diseases and different equipments. I could not see the difference between this and that, so the first months I had lots of problems. I knew for example the difference between certain diseases, what they are and what the cause of them is. But not enough. The treatments are for example different here as well as causes. So the first six months were very difficult for me”.

“I am acquainted with all of the Dutch institutions. In the beginning I could not understand why I needed to study for three more years. But now I find it very important to study. I have been working for a year and two months in a nursing home. I am not required to go but I go there every day and work until six o'clock. Because I did not work for three, almost four years it is very interesting for me to work again”.

Not only did the interviewees want to get acquainted with the Dutch healthcare system but they were also motivated by the need to learn the Dutch language better.

“Now I know for sure that it is not so easy, because to learn the Dutch language you need a lot of time. Every day you hear new words, especially from the old people”.

Many of those who had found work within the Dutch healthcare system had worked previously as volunteers in the refugee center where they had been staying. That indicates their determination from early on to work and simply do something during their stay in the Netherlands.

“In the first center I worked as a translator (...) Because of my character I cannot just sit and do nothing. When I was a child I was very active. I cannot just wait”.

One interviewee was so unhappy with his lack of opportunity to work during his stay in the refugee center where he was initially placed that he asked for a transfer to another center where he had an opportunity to work as a volunteer.

Those interviewees who had not had any experience working in the Dutch healthcare seemed to want to find work but did not have time to do so because of family commitments or commitment to the Dutch language study. But the most common explanation was that they did not feel confident enough to find (voluntary) employment because of their (own perceived) problems with the Dutch language.

“I do not speak very good Dutch. That is why it is difficult for me to work in a hospital. I want to improve my Dutch first and then I might have a chance”.

“My Dutch is not so good. People want to be able to speak with foreigners (...) I want to work, but how can I go to a volunteer organization and ask if I may follow a training or work as a volunteer. I think it is too early”.

Only three of the interviewees were working at the time of the interviews. Two were working in healthcare related sectors and one in production. The demands of the language study were too great for most of them to be able to work alongside their study.

6.1.2.2 Seriousness in pursuing a medical license in the Netherlands

All of the interviewees want to become physicians and practice medicine in the Netherlands. They are willing to learn the Dutch language, begin in the fourth year in the medical study and basically do what it takes to pursue their goal. When asked whether or not they could consider any other career within the healthcare system if their goal of becoming physicians would not become a reality, nine of the interviewees were prepared to take on other positions such as nursing or care assistance.

“First I want to become a doctor; otherwise I will look for another job, for example as a nurse. But I do not want to work in an elderly home. Nursing is closer to my profession”.

“I will do everything to become a doctor. That is my aim. If I do not succeed then I really would like to work within the healthcare sector. I have experience in that sector”.

“Life is really just a chance. If it does not work out I would really want to work within the healthcare structure. That would not be a problem for me”.

The remaining five interviewees were not prepared to work within the healthcare except as physicians.

“I could only work within the healthcare sector as a doctor. I might perhaps choose another profession, but that would never be a profession within the healthcare sector”.

When asked whether or not they would be prepared to work in a completely different sector if their goal to become physicians would not become a reality the interviewees expressed mixed emotions. Some pointed out that in order to be able to pursue a career in another sector they would need an education. Otherwise they would be destined to find work in low pay sectors.

“If I follow a different education it will cost me time. For example a teacher education: that will cost me many years and I do not have any experience in that field. That is why I want to be able to follow the medical education. The language is difficult but on the other hand I do have experience. Working in a factory, which is what awaits me now, would also be a waist of my time”.

“I want to work within my profession. It is easier for me than if I would follow another education. I’ve got 50% and I need 50% to become a doctor. If I will choose another profession then I need 100% and that is difficult”.

Just under half of the interviewees said they were willing to work in another sector if they would not be able to find work within the healthcare sector. The main reasons simply wanting to work and contribute to the Dutch society.

“This country has helped me and now I want to do something. Wanting to give something back is a bad phrase because that is too little. But I want to do something in order to say thank you”.

“I came to this country only to live. I want to do something for this society in order to prove that we are able to work. Honest work for the future of the Netherlands”.

There was no noticeable difference between those who were willing to work in completely different sector to the healthcare sector if they had to, and those who felt that they could not work in any other sector than the medical sector. What was noticeable was that many of the interviewees were very indecisive with their answers as it seemed as if they found it difficult to answer the question. Those who said that they were willing to work in another sector also expressed that it was not something they really wanted. And those who said they were not willing to work in non-medical sectors were also hesitant in their answers as to what if working in the healthcare sector would not become a reality. So a clear and decisive answer to that particular question was rarely found in any of the interviews.

6.1.3 Professional identity

As a result of uprooting and displacement the interviewees have experienced lots of changes in their lives during the past few years. Some of these changes may have

affected them more than others. This part of the research focuses on how their professional identity has been affected.

The interviewee's professional identity was not examined by the use of specific questions during the interviewing process, as individual's identity is not easily summed up by asking a few questions. Attempts to find out how strong their professional identity was were therefore made by asking them why it is so important to them to resume their work in the Netherlands.

Professional identity is the product of education, professional training and sometimes years of employment. All of the interviewees had invested many years in their medical education, or on average eight years, and most had worked as physicians for several years before coming to the Netherlands.

“Yes, I love my profession. That comes first. I studied for 18 years in Afghanistan and then I worked for ten years”.

“I want to work within my specialization without any pay (...) Why have I studied for twelve years and do not work?”

When asked why they want to become physicians in the Netherlands some pointed out that not working as physicians was very difficult. It seemed as if not being able to practice medicine was having negative influences on their general well being.

“I have wanted from an early age to become a doctor and I worked as a doctor for ten years. That is why I want to become a doctor in the Netherlands. I want to help patients; I am used to helping patients (...) that is why I always think about the patients. Maybe I cannot do anything else”.

“I need to work. I think that a doctor without a job is not important”.

“I think that if you are a doctor and are not able to help people you have a problem. I have to help people”.

It is as if they regard the medical profession to be a part of them. It is their profession and without it some interviewees seemed to feel demoralized.

“I have worked in production, but I am a doctor. (...) I cannot work in production or in cleaning. I am a doctor”.

“I cannot do anything else. I am a doctor and I want to work as a doctor. Sometimes at home I think about what else I can do. Nothing. If I cannot become a doctor it will mean that I am nothing. If I have to work as a salesman or a cleaner... I cannot work as a computer salesman. I have no other choice”.

One interviewee said that if he would not become a physician in the Netherlands it would be very difficult for him psychologically as he is used to being approached by fellow physicians for advice as a physician. Another interviewee found it very difficult to see other physicians working, knowing that despite his work experience he was not allowed

to work in the Netherlands. Not belonging to the medical community seemed to affect them and make them feel as outsiders.

“I cannot think about not working as a doctor. Difficult. My colleagues work as doctors and I don’t”.

Being able to work as a physician was for some interviewees explicitly mentioned as extremely important. One interviewee expressed very strong feelings about this with the following statement:

“As it is important for a painter to make paintings that is how important it is for a doctor to be a doctor. It is a way of living. It is not only an occupation. If you are a doctor it means that you look at people in a different way”.

6.2 Evaluation of their credentials

Evaluation of their credentials was something that all of the interviewees were faced with once they decided to pursue their professional career in the Netherlands. For most refugee physicians that means a negative evaluation as their qualifications are not evaluated as equivalent to the Dutch medical diplomas.

Their lack of recognition as physicians in the Netherlands was measured by looking at three aspects related to their professional background as physicians. Firstly by asking their opinion on the diploma evaluation and how they feel about having to retrain as physician in order to be able to work in the Netherlands. Secondly by exploring how they experience what could be defined as a status change. That is, how does it affect them not being currently employed as physicians? And finally by finding out what they feel about the integration system for foreign physicians as it is today, and if there is anything that needs to be improved or changed in their opinion.

6.2.1 Views on retraining as physicians

Retraining was understood by the interviewees as well as the interviewer as having to begin their medical study in the fourth year. Eight interviewees had their medical diploma evaluated as equivalent to a three-year medical study in a Dutch medical institution. That meant that if they were to be accepted as medical students at the Erasmus University they would begin in the fourth year and follow a special program designed for foreign physicians. Further details of this program are found in chapter five. The remaining six interviewees who had not yet had their medical diploma evaluated were asked to express their feelings about retraining in the case their medical diploma would be evaluated as equivalent to a three year study in a Dutch medical faculty.

Eight out of the fourteen interviewees were positive with regard to having to retrain as physicians in the Netherlands. The remaining six did not want to retrain but all of them expressed willingness to do so because they wanted to become licensed physicians in the Netherlands.

Many of those who were positive with regard to retraining expressed an understanding for why their diploma had not been evaluated as equivalent to the Dutch medical diploma.

“I do not find it so strange, because I come from an old country, a country that during the last 25 years has been in a war. The Dutch healthcare system uses a lot of modern instruments that are new to me”.

“It is logical as the education in my country is different than in European countries, such as the Netherlands. We do not know many instruments and we do not know the latest medical technology. That is why it is no problem that we have to study for two more years”.

“I understand it. I have been here for many years and have not received any practical experience. (...) Everything has changed. A lot of things have changed in the last six months. Imagine how much has changed in the last five years. That is why I agree with them”.

“Yes, of course. Foreign physicians might have finished a program but after they received their diplomas they went to work in small hospitals or polyclinics where they did not receive a good education”.

Those interviewees who disapproved of the evaluation of their diploma felt very strongly about what they perceived to be injustice to their educational background and medical experience.

“Not fair, people have studied for a long time. Medicine is the same everywhere. If I have to take fourth year classes it is not fair. Every doctor wants to work in a hospital, in order to help people”.

“Why do I have to go back to school? I passed all the exams for my profession”.

“No, I am not happy. The medicine and the human body is the same all over the world. Whether learned in East-Europe, America, or in Africa: medicine is the same. We are not from a different planet”.

“When I came to the Netherlands I did not know anything about the evaluation. I thought that perhaps my diploma would be evaluated as equal to the Dutch diploma. (...) I thought that perhaps the methods here would be totally different, but now I have followed a training course and then I saw that they are not different. So now I am a bit disappointed. Why is my diploma not equal to the Dutch diploma? (...) Methods are the same all over. Medical science is always in development, so each day is different. It is true, the methods here are sometimes not the same as I am used to, but that is so for everyone. Also for the Dutch doctors because tomorrow there might be some new equipment and different treatments, so I am not happy. But I am very happy about the fact that now I am able to study and if it works out I will go to the university”.

Although they were not happy about the evaluation of their diploma, all of them wanted to begin in the fourth year at Erasmus if they would get the chance to do so. It seemed as

if they had come to accept the fact that their future as physicians in the Netherlands could only be realized as long as they completed the required training at the university.

One interviewee had previously found it very unfair that her diploma had not been valued as equal to its Dutch counterpart but after she had worked within several Dutch healthcare institutions she had changed her mind:

“Yes, at first I found it...yes...not fair but when I had worked in a hospital I realized that we have to because the Dutch language is very difficult and the patients do not want someone who does not have a good command of the Dutch language. (...) And the NT-2...well, we do not have a good command of the language. After I passed the NT-2 and started to work in the nursing home I could not speak with the patients. I had studied very hard but could not speak the language. (...) In the beginning I could not understand why I needed to study for three more years. But now I think it is very important”.

Not everyone knew that their diploma needed to be evaluated once they arrived in the Netherlands. It was not their main concern once they had to flee their country.

“When I came to the Netherlands I had political problems. I could not think about work or diploma evaluation. I had to leave my country”.

“I thought only of other things. There were other problems that came first such as my family. That was my problem. I did not think about diplomas or such things. (...) Important to me was my family and whether or not they could stay here”.

By looking at the interviewees' average age, work experience in a Dutch healthcare institution and average length of work experience as physicians, there was no noticeable difference between those who were positive with regard to retraining as physicians and those who were negative. Only two interviewees expressed serious concerns about their age being a possible hindrance as to whether or not they could become physicians in the Netherlands. Other interviewees felt that their age could be at their advantage.

“I still feel young so seven years, including clerkship and specialization, does not have such a big impact on my study or work plans. I am in my mid forties years old and I have still got time to study some more. Repetition is not a problem for me”.

6.2.2 Status change

Any perceived change in status was not explicitly mentioned in the questionnaire except when the interviewees were asked whether they felt that there was a difference in the physician's status in their country of origin and in the Netherlands. This meant that any feelings they expressed regarding their lack of recognition as physicians and the consequent status change could only be traced throughout the interviews within various contexts and not as a result of a specific questions.

Status is understood in this research as an occupational position in the society. The physician occupies what is regarded in many societies as a high status position. That means that when the interviewees lost their position as physicians, whether it was

voluntarily or not, they inevitably experienced a change in status. It can be assumed that almost any occupational change with regard to physicians can be viewed as a decline in status. The main interest of this part of the research is to find out how they viewed their status previously and how they view it now.

According to over half of the interviewees the physician status in their country of origin is very high, and not comparable to the physician's status in the Netherlands.

“Because of the culture everything is different. The status of the Dutch doctor is not so different to other people. In Afghanistan the doctor has a special status”.

“It is a high status work. Not everyone can become a doctor. Very difficult. It is a high science profession”.

Many reported that their salaries had been on average very high, which set their occupation apart from other occupations in their society. Only soldiers were mentioned by some of the interviewees as being better paid than physicians. Other interviewees, such as those out Chechnya, said that the physician used to occupy a special position in their society but in the last years, due to war and increased poverty, their position in the society had not become any different to other occupation. That meant for example that their salaries were no longer high compared to other occupations.

Some interviewees expressed feelings of despair if they could not become physicians in the Netherlands. In some cases they repeatedly pointed out what they felt to be great injustice if their medical career could not be resumed.

“If they do not accept me I do not know what to do. (...) If I do not get a chance then I might have to abandon my profession. I will have to start a new education. (...) I have worked in production, but I am a doctor. I cannot work in production or work as a cleaner. I am a doctor. I cannot do it”.

“I am not jealous, but when I see other colleague's busy working (...). I have lots of work experience and perhaps I will end up working as a cleaner or on the streets. I am not afraid of working. There are many highly educated people working in the catering business”.

As reported earlier in the chapter only five interviewees were not prepared to work within the healthcare system as anything other than physicians. They were more willing to go on to do something completely different than taking on a different role within the healthcare structure.

“Within the healthcare sector I can only work as a doctor. I would perhaps choose a different profession but that would not be within the health sector”.

“No, nursing is below my status. Perhaps as a doctors assistant but as a nurse, no”.

Because physicians occupy one of the highest ranks within the healthcare system this could indicate that they are not prepared to accept any other position within the health care system as they would perceive it to be a lower status position.

Feelings of worthlessness were not uncommon as some interviewees felt that their existence without being recognized as physicians meant that they were nothing in the eyes of the Dutch society.

“The last five years without work have been a very difficult time for me. I worked in Afghanistan for ten years, from nine in the morning to nine in the evening (...). Why am I now a housewife? I was always busy with patients and my profession. Now I am unemployed and a bit worthless human being”.

“I have done many things. I have won prizes in Russia and here in the Netherlands I am suddenly nothing”.

Some interviewees pointed out the difficulties having to flee and leave everything behind them in their country of origin.

“If you have everything in your country, why do you flee? If you have a good status in your country, why would you flee to another country? For nothing”.

“I had a good job and good salaries in Afghanistan. Here I have nothing”.

“I worked the whole day and my job involved a lot of responsibilities. (...) I am not a poor person. I have everything people want. I’ve got houses in big cities and in villages, and two cars. So previously I had everything that people want (...). But my family, my children were the most important thing. More important than whether or not I could work”.

Being seen primarily as refugees or foreigners in the Netherlands rather than educated individuals seemed to trouble some of the interviewees.

“Some people say to me: “Dirty Turk, go away”. They do not know the difference between me and other people. Certainly not between highly educated people and guest workers or criminals. Sometimes these things hurt a bit”.

“Four years ago I was very happy. Laughing, going to the movies, listening to music, but not now. (...) When I came to the Netherlands I changed. I am no longer a student. In Bulgaria I was a student and was respected as such. But here I am an asylum seeker, a foreigner. (...) If you are an asylum seeker it means that you are only half human. Not a real human being. I feel that way here. (...) When I came here I left everything behind, including my happiness”.

Despite expressing clear feelings about wanting to become physicians in the Netherlands none of the interviewees who were working or had been working either in healthcare related sectors or in other sectors expressed negative feelings about having to work in occupations that could be perceived as below their status. Some were even thankful for being able to work and not be entirely dependent on unemployment payments. This

might indicate that despite regarding themselves as being physicians and so to speak “high status” professionals, they also knew that achieving their goal would not be easy and had accepted the fact that before they could resume their work as physicians they would have to take on work that might be regarded as below their status. To many of the interviewees working was extremely important as it brought with it certain financial independence as well as being a welcome change from a long unemployment period, which had been for some an especially difficult period.

6.2.3 Changes that need to be made regarding the integration of foreign physicians

Many of the interviewees expressed their feelings about what, in their opinion, needed to change with regard to the professional integration of foreign physicians. They were not explicitly asked about it so any comments that they had generally came spontaneously in the course of the interviewing process.

Some interviewees had very strong feelings about what they felt could be done differently in the Netherlands.

“The problem is that there are no common rules for foreign doctors. (...) If you look at Germany or England, their rules are more logical. It is easier to integrate into the medical society there than here. Because you have a possibility to do an exam to show what you know, and then you work with colleagues and they can decide and look for what is your quality. In England they have a special program to integrate doctors into the medical society. In any country the medical society is closed and it is always difficult to integrate. As a doctor you are in a high position within the society and any medical society is trying to protect their profession. Make it hard to get in”.

“My proposition is that when someone comes to the Netherlands it is best if he is able to follow a path. It is tiring for people. (...) I do not understand why the Dutch government does not simply give people a chance to study. (...) My proposition is that the Dutch government would choose a simple path for the refugees and the foreign doctors. For example a special course for the doctors. (...) That way they would get an experience. It is also good for people mentally to be able to work as well as for the economy. (...) The government has to do something for the doctors. My colleague’s that are here in Albeda have in some cases been in the Netherlands for 6-7 years. What will happen to them? Six year doing nothing and at that age. What can the Dutch government do with these people? They are doctors, with a long education and they cannot work in a factory like people with little or no education. This is making people very emotional. Every day they are degraded and that makes them sick”.

Rules and regulations regarding their admission to any of the medical faculties were unclear and not enough information about different entry requirements meant that they felt as if their chances might be higher somewhere else without their knowledge.

“Each university has their own rules. I do not understand it. (...) We need information over other universities. What the rules are in other provinces. Perhaps, if I don’t have a chance here I might have a chance in a university in Maastricht, Amsterdam or in Groningen. At least some information, as until now I have only received information about the Erasmus University”.

Living in uncertainty was mentioned as being difficult by some of the interviewees. One interviewee spoke of a letter that he had recently received which stated that he would need a different residency permit to be able to study at the Erasmus University than what he had. This was having a great effect on him as he was experiencing physical problems such as head- and stomachaches since receiving the letter. The confusion regarding his application was taking its toll on him psychologically:

“This is a difficult situation for me. I have done many things but sometimes there is nothing I can do. I have gone from one place to another. I am under psychological pressure”.

6.3 Personal and social background

Personal and social background of the interviewees touches upon several features of their lives since arriving in the Netherlands. By exploring areas such as personal problems, support system in the Netherlands, financial situation and their feelings about their stay in the refugee centers, the aim is to give a better insight into their current situation as well as their personal feelings and experiences.

6.3.1 Personal problems

During the interviews not a lot of emphasis was put on their experiences as refugees or other difficult personal experiences they might have encountered. The interviewees were given a choice to speak about whether or not they had any personal problems that might be affecting their study, but there were no further questions related to that kind of personal issues. Despite not forcing the issue of personal difficulties on the interviewees many felt a need to express themselves about some of their physical, mental or other problems they were experiencing or had been experiencing.

Five of the interviewees felt that they had no personal problems that were affecting their ability to concentrate on their study. One interviewee even mentioned that because of her study she is able to keep her mind off her problems:

“No, now it is much better for my daughters. Not so scared anymore as our problems are over. I do not think too much about them. Last year I was constantly busy thinking about our problems but now I am calmer. Now my children and I are studying and that is so much better for us”.

Another interviewee felt that his character helped him to cope with the negative occurrences that he had experienced in his life:

“I have to say that I have seen war and many bad things. Some people become stronger because of it, other weaker. I am that kind of person who has become stronger”.

The rest of the interviewees had different stories to tell. Their ability to concentrate fully on their study was affected by various factors. Their experiences as refugees were mentioned by some of the interviewees as affecting their ability to study.

“We have lost lots of family and friends in the war. We have many problems and therefore cannot only think about our study. We still have families living in Afghanistan. What is happening to them? In the last five years I have thought a lot about them. I have no contact with them”.

“I think about the problems and because of that I cannot concentrate easily. I think that everyone has that problem. I think that every refugee has concentration problems, because every problem sits in your head. Of course you think about what is happening over there”.

Leaving friends and family in their country of origin was also mentioned as being very difficult and affecting them in different ways.

“I think a lot about my family’s difficulties. My wife and children’s difficulties as well as my mother’s, father’s and brother’s difficulties. Their problems are my problems”.

“I came to the Netherlands because there was war in our country: fighting and every day people were dying. (...) Finally it became clear that my sister suffered from brain malaria and because of the stupid doctors she became blind. I was over here and I began to cry every day: why am I here? It would be better to die. I am a doctor and I had to help my sister. I became almost ill because now my sister has no opportunities. Suddenly one night I heard that my younger brother had been killed (...). Why is this happening?”

Other personal problems that were mentioned by the interviewees involved having to take care of their family. Two of the interviewees had relatives who were dealing with serious mental health problems, and that was affecting their ability to concentrate on their Dutch language study. Three of the four women who took part in the research discussed their lack of time to study due to family responsibilities.

“I have less time to study because I am a mother. That is my problem. (...) It is really a problem for people if they are mothers; the children want attention, play, and to be helped. I have to do everything”.

“It is hard of course but I have to. I have to do everything in order to follow the study. I have difficulties because the children don’t do anything. Everyone wants me to do everything in the household”.

The men on the other hand did not mention that their family obligations were affecting their ability to concentrate on their study.

Coming from a war torn country and having experienced a range of difficulties which finally resulted in them fleeing to the Netherlands had taken its toll on the interviewees.

“I was 17 years old when the war started. I have grown up with the war: worked, studied. It is a part of me”.

“Refugees, such as me, have gone through much emotional trauma. I grew up in the war and that is not so easy”.

6.3.2 Financial situation

Six of the interviewees were clients of the UAF (Foundation for Refugee Students). The UAF paid the Dutch language study for four of interviewees as well as paying for their study books, travel expenses and the NT-2 exams. The social service paid the language study for other interviewees.

The UAF clients were generally very happy with the help they had received, or were receiving, from the organization.

“Because of the UAF I get a chance to study. So this organization plays a very important role in my life”.

“Without the UAF I would not be able to do anything. I am supported by the UAF. If UAF did not exist I would not be able to study”.

But despite being helped financially by the UAF or the social service, the interviewees expressed mixed emotions about the financial help they were receiving. Some of the interviewees mentioned that they were having troubles getting by financially, while others said that they were content with the amount of financial help they were receiving.

6.3.3. Support system in the Netherlands

Support system was recognized in the research to be the amount of social contact the interviewees have in the Netherlands. This could be in the form of having family members living either with them or elsewhere in the country as well as the amount and frequency of contact with friends and acquaintances.

Twelve of the fourteen interviewees had some kind of family living in the Netherlands. In most cases it was their spouse and children, while others had siblings and in-laws living either with them or elsewhere in the Netherlands. Most of the interviewees reported that their support system usually consisted of individuals from their country of origin. Others had friends from different nationalities sometimes including Dutch friends.

Their support system was generally not extensive according to the interviewees. They frequently spoke of having difficulties in getting to know the Dutch people, as well as feeling isolated and wanting more friends and acquaintances.

“I want to have many friends, as it is good for people if they have many friends. It is also better for the children and the family. I want to have contact with other people as it would be very beneficial for me”.

“You know how it is in the Netherlands. No one can help you. Everyone is really busy, and has their own problems with their study or they have to work”.

Two interviewees had no relatives living in the Netherlands.

“I am alone. I do not have any contact with Dutch people. People from Aruba and Morocco show no interest in having a contact with me. Their culture is different. I am alone and their culture is family orientated. If I would have a family here things might be different. Here people have little contact with those who are alone”.

6.3.4 Their stay in refugee centers

The interviewees had stayed in refugee centers anything from few months up to three years, with the average stay being one and a half year. Those who stayed for a short period of time in the center felt that because they had only been there for a relatively short time it had not been so difficult. Others felt that it had been very difficult to stay in the centers, especially not being able to work or to study.

“It was really difficult. I had previously worked the whole day and my work involved lots of responsibility. But the most important things in my life were my children. I told myself: not working is a real problem, but my children are still alive. That is the most important thing. It is of course difficult to sit in a refugee center without work, with people from different cultures. It is really difficult, but at least your children are alive”.

One interviewee mentioned the wait in uncertainty as having affected him and his family:

“I did not want to work; I only wanted to get a status in order to stay here. (...) We had no permit to stay and we had to wait. I thought that perhaps tomorrow I would get a permit. All the waiting affected me very badly”.

6.4 Language and integration

Integration can take on many different forms. In this research the interviewees commitment to the Dutch language, their attitude towards the Dutch society as well as their future perspective will serve as an indication as to how their integration process is fairing. Integrating into the Dutch society can be a long process that in the case of all of the interviewees had been in a sense delayed by a relatively long period (on average one and a half year) in the refugee centers.

6.4.1 Commitment to the Dutch language

Although their average stay in the Netherlands was five years, most had not started their Dutch language study until two years ago. The reason for that was mainly the fact that during their stay in refugee center they were not permitted to either study or work. That meant that except for the Dutch lessons given one hour per week by volunteers at the refugee centers they had no chance of learning the language properly until they had been given a residency status in the country.

At the time of the interviews their Dutch language proficiency varied. Two had already passed all four parts of the NT-2 exam, two had passed three parts, two had passed two parts and one had passed one part of the NT-2. The remainder of the interviewees had Dutch language proficiency varying from level 2 to level 4.

For most their first proper Dutch lessons came in the form of the “Inburgering” course, which they were obliged to follow. Many felt that the course had been a waste of their time and not been helpful when it came to learn the Dutch language. According to them interviewees the level of Dutch that was taught was too low for them due to the fact that people with different educational backgrounds were put together in groups. They felt that they had not been able to gain enough knowledge of the Dutch language during the “Inburgering” year because others in the class had been holding them back.

“I find the “Inburgering” course a good thing, but there have to be different groups. Groups for those who have little education and groups for those who are highly educated”.

“The “schakel” year is really good. I cannot compare it with the “Inburgering” course. That was so sloppy. I do not know what I was doing there. There were people there with different levels of education and for some it was not so easy. It was not easy to make a program for the group. (...) I wasted my time during the “Inburgering” course”.

All of the interviewees seemed to be very committed to learning the language. Some had begun with private lessons before being able to start at the Albeda College; others were trying to improve their Dutch by means of reading books and watching television. The majority of the interviewees, apart from those two who had already passed all four parts of the NT-2, were attending their Dutch language lessons on regular basis. Only one interviewee had been attending irregularly due to personal problems.

The single most important reason for learning the Dutch language was, according to the interviewees, their desire to resume their work in the Netherlands.

“If I want to become a doctor here in the Netherlands I need to learn the language. I have to speak to Dutch patients and Dutch doctors (...). The language is very important. If I do not have a good command of the language I will not be able to follow the lessons, or if patients want to speak to me I will not be able to understand them”.

“In order to be able to work in the Netherlands one needs to learn the language first. That is the main reason why I really want to learn the Dutch language. That is the main and the most important reason, as I want to be accepted into Erasmus University”.

Other reasons that were frequently mentioned were wanting to be able to communicate with the Dutch people and their plans of building themselves and their family a future in the Netherlands.

Those who were struggling the most with the Dutch language often mentioned their age as being a constraining factor.

“Self-study is for me a bit difficult. I am also a bit old and at my age I am not able to compete with the young people who are able to study much more easily. I have to read everything three times, but they only once”.

“Let’s consider my age. I am (...) years old and my study is going reasonably well. When I begun I thought that it would go quicker because I compared it to my work experience: I am able to work quickly. But it does not go as quickly as I first thought it would”.

By looking at the average age of those who had not passed any of the NT-2 parts, but have a Dutch proficiency at a level 2-4, the average age is 46 years. Meanwhile the average age of those who had passed one or more parts of the NT-2 exam is 39 years. Bearing in mind the average age of the interviewees being 42 years, it is evident that those who might be considered more successful in mastering the Dutch language are on average younger than those who are not.

Some of the interviewees mentioned a need for more contact with Dutch people in order to improve their language skills. Some had found employment in the hope of being able to improve their language skills; others had built up relationships and friendships with Dutch speaking people.

Not everyone seemed to be successful in making contact with the Dutch people. Five interviewees said that they had a lot of contact with the Dutch people, including friendships and work relationships. Of those five, only one had a level 3 in Dutch, the other four had passed two, three or all four of the NT-2 parts. Nine interviewees said that they had either none or very little contact with the Dutch people. Little contact consisted mainly of conversations with, mostly elderly, neighbors. Of those nine interviewees three had passed one, two or three parts of the NT-2 exam, meanwhile the remaining six had a Dutch proficiency level ranging from level two up to level four. This seems to indicate that those interviewees that consider themselves having a lot of contact with Dutch people seem to have done better in their previous NT-2 exams than those who say that they have little or no contact with the Dutch.

These findings cannot be explained by the length of stay in the Netherlands as there is no connection between how long the interviewees have been living in the Netherlands and their Dutch language proficiency. Both those who have passed one or more NT-2 exams as well as those ranging between level 2 and 4 have been living in the Netherlands on average for 5 years.

6.4.2 Attitude towards the Dutch society and future perspective

By asking the interviewees how they feel about the Dutch society an attempt was made to find out their attitude towards their stay in the Netherlands. Would they for example consider themselves happy and do they feel welcome in the Netherlands? Whether or not they felt that their future was in the Netherlands was also intended to give picture of their orientation towards their current home.

The respondents had been staying in the Netherlands anything from three and a half years up to eight years, with the average stay lasting just over 5 years, at the time of the interviews.

None of the interviewees spoke outright negatively about the Dutch society. All wanted to become part of the society one way or another. Wanting to be able to work and contribute positively to the society was mentioned by some, others wanted to learn the language, and others mentioned that their children's future was in the Netherlands and therefore they had to integrate.

“The Dutch society is totally different to our society. It is in every sphere different: the language, food, culture, religion, everything. But now we live in the Netherlands and I am trying to integrate into the society. For example: I need to learn the language and get to know the culture. (...) Because I live here. Otherwise I will have to go back to my own country. If I am going to live here I am going to do everything. I am thinking about my grandchildren: they are going to be Dutch citizens”.

The Dutch society had, in many of the interviewees eyes, both negative and positive sides.

“I find the society both positive and negative. People are able to live side by side in the Netherlands but at the same time the biggest negative factor is that fact that people are not able to live together”.

Most interviewees were on the whole very positive regarding the Dutch society. The democracy and the general freedom that they were encountering were met with mixed emotions:

“Democracy has both its positive and negative sides. For some people freedom is important. But I am afraid for my children. If they grow up here and get into trouble when they reach the age of sixteen. (...) That is one of the disadvantages of the democracy but it has also its advantages. If someone is free he is able to do many positive things”.

“The Netherlands is a democratic country. Everyone has his or her own religion and own culture. That is not a problem for the society and we have to accept that. Different cultures, different religions: we need to respect other people, other religions and cultures. That is not a problem. More than 86 different nationalities live in Rotterdam”.

“The only thing that I do not find so good is the freedom. They want everyone to be equals and that is a bit annoying for me. It has its roots in the nature of the country. The Netherlands is a flat country. There are no mountains and that means that everyone has to be equal. For me that is a bit of a disadvantage”.

The negative and positive sides of the free manner of living in the Netherlands were mentioned frequently and then in the same instance as the upbringing of Dutch children.

Some of the interviewees felt that it was too lenient and that children were not thought to respect their parents and others in the society.

“The freedom depends on what the individual perceives freedom to be. It can be both positive and negative. In my country there was no freedom. Not for women, and if someone said something against the government he went straight to prison. Here it is not so as everyone has to have their own meaning and own life. I find that very good, but not for the children. For them it is a bit excessive”.

“Every advantage has its disadvantages. For example parents and teachers have to have lots of influences on the children. Because of the freedom they do and say what they want to. I find that a disadvantage. The rest is positive”.

The need to integrate was another subject that was occupying some of the interviewees.

“Foreigners have to have time to integrate into the society. (...) But I think that if someone lives here he has to accept the norms and values of the society”.

“Some people speak a lot about integration, but these same individuals are against integration. For example: if you do not speak perfect Dutch they immediately start speaking English to you. Here you are a foreigner”.

Despite not working within their profession, the under-evaluation of their credentials and subsequent expressions of negative feelings regarding their professional situation, majority of the interviewees felt that they were welcome in the Dutch society. They did not mention any bad experiences, on the contrary they frequently pointed out how generous the Dutch society has been to them. This contradiction might indicate that despite having problems accepting their professional situation, the interviewees feel as refugees welcome in the Netherlands.

“I am able to study, I have my own apartment and I have opportunities. That means that I am welcome in the Netherlands. If you don't have any opportunities it means that you are not welcome”.

“In Holland I was born again. New language, new people, everything was new. (...) There are many good people helping us. People come from all over the world to the Netherlands and here they find understanding and help. That is very good for us”.

When asked whether or not they would consider themselves happy at the moment not everyone felt they could give a straightforward answer to that question. Happiness was not something they felt they could easily define.

“Yes, in comparison to my people I am happy. My children can go to school and I am not in prison. In order to be happy a lot of things need to change. First of all in my country: the war must stop. Then I might be happy”.

“On the whole yes. The last three years I have not had any work, no salaries. I do not know what being happy means. On the one hand I am happy. I feel safer here than in my own country. On the other hand I am unemployed”.

Four of the interviewees expressed clearly that they felt unhappy in the Netherlands. Their uncertain future in the Netherlands was mentioned as the main reason.

“No, not really. I had problems in Afghanistan and therefore I am happy here. But I am alone. I am not happy, I am unhappy. My future is not bright and it is unknown. In the present situation I feel unhappy”.

“If I will not be able to work I will not be happy in the Netherlands. If I can get work I will be happy. Without work it will be very difficult to live in the Netherlands”.

Twelve interviewees regarded their future to be in the Netherlands. If they would be able to find work they would want to stay in the country. Settling in the Netherlands was important to them as well as for their children. Some felt that their future was in the Netherlands because they did not want to or could go anywhere else.

“Yes, I hope so because I have had many problems and now I do not want any more problems. I do not wish to go somewhere else. That will cost me time, and life is not so long. I find the Dutch society a good society”.

“No, I will not go to another country. I will stay here. I am tired. All my life I have been traveling: from my home country, from Israel to Kuwait, to Rumania, from Rumania to Sudan, from Sudan to Rumania, back to Sudan, from Sudan to the Netherlands. I am tired. I am not going anywhere”.

But despite envisioning their future in the Netherlands several interviewees expressed their mixed emotions about it, as they perceived difficulties regarding ability to fore spell the future:

“This is a difficult question. If people come from a war situation it is difficult for them to have a future. (...) I am here and I feel at home. I do not know what will happen tomorrow. Tomorrow I might die. So it does not depend on me. But of course, my children go to school, they speak Dutch and I think that their future is here”.

“I do not know, not exactly. It depends on me and the people that I come across”.

Only two interviewees expressed feelings of wanting to return to their country of origin if the situation there improved.

“If my family cannot come to the Netherlands and I will not be able to work here, or I will not be able to follow an education it would be better for me to return to my own country. If it is safe then it will be all right to return”.

“If there will be a real democracy in Afghanistan...”
(Will you then return? EG)

“Of course. In Afghanistan I have everything. I am not poor”.

As this chapter demonstrates the interviews offered a rich array of information. These findings will be discussed in further detail in the following chapter, where they will also be discussed in light of the theoretical context presented in chapter three.

7. Discussion

In this chapter the main findings of the research will be discussed within the theoretical framework presented earlier in the paper as well as in the light of other research findings. The first aim of the chapter is to discuss each of the four themes that were presented in chapter six. The second aim of the chapter is to answer the two central questions of the paper as well as the associated research questions.

7.1 Theme 1: Personal investment in the medical profession

Commitment and personal investment

When individuals have invested a lot of time, money and effort in achieving their professional status or role they are likely to be highly committed to it. If the occupational position is highly valued and enjoys a high status in the society, such as the physician position, individuals are likely to be even more committed to it. The interviewees' personal investment and commitment to the medical profession was on average very high if their educational background and work experience counted as commitment to the medical profession. All of the interviewees had finished their medical study and all but one, had worked as physicians, on average for eight years. Many of the interviewees worked in their profession under extreme and difficult circumstances, due to war and poverty, which might have enforced their commitment to it. The interviewees' strong commitment to the profession is therefore the result of various factors. For some of the interviewees their attachment stems from the fact that they feel that medicine for them is a 'calling', others see it as something they are good at and has been a major part of their lives, still others see it as prestigious and respectable way of earning a living and therefore find it hard not to be seen by others as someone occupying a physician position. Because of their commitment to their profession they resist and resent abandoning it even when the circumstances force them to.

On average six years had passed since the interviewees were last employed as physicians. That is a long time for anyone to be unemployed, let alone someone like a physician who, at least according to western standards, needs to be constantly refreshing his skills and knowledge. Despite this long gap only six interviewees had worked in healthcare related jobs since arriving in the Netherlands. That means that just under half of the interviewees had shown any initiative and success in finding healthcare related employment since their arrival in the Netherlands. For some of the interviewees' lack of initiative stemmed from a lack of self-esteem and confidence in finding employment, lack of command of the Dutch language or personal problems. Other interviewees had not shown any initiative because they were not willing to work within the healthcare sector as anything else but as physicians. So efforts in finding healthcare related employment after settlement did not prove to be a good indicator as to whether or not a refugee physician was committed to the medical profession.

Professional identity

It is important to note that the individual's identity is neither one dimensional nor static and that the refugee physicians are most likely negotiating between several identities. Whether or not one identity is dominant is most likely dependent on the circumstances. By focusing on their educational and professional background during the interviews their professional identity became significant and perhaps more dominant than other identities the interviewees hold.

When the interviewees initially arrived in the Netherlands they were not able to begin rebuilding their professional identities or start their integration process as they had no legal status in the country. Bureaucratic and administrative agencies thrust upon them the identity of a refugee, which is almost always seen as undesirable. By undergoing such physical and psychological changes it is understandable that the interviewees want to attempt to remain 'themselves' as much as they can. As Shuval and Bernstein reported in their research about immigrant physicians, being 'themselves' is to retain and reestablish the occupational component of their identity in the new society (1997: 167). Holding on to at least one important aspect of their former lives; their education and work experience, is not only practical with regard to their employment and financial situation, but also important in order for them to be able to remain 'themselves'. They have lost so much, and losing what they have invested a lot of time, money and effort in is hard to accept.

The study shows evidence that the interviewees are not able to let go of their professional identity. They regard themselves as physicians and they are willing to do anything to be able to practice their profession in the Netherlands. They had chosen the medical profession from a relatively early age and this early choice of a study makes the profession a central element of their self-identity, according to Shuval and Bernstein (1997: 66). During their medical study the interviewees went through a socialization process where their professional identity was further instated. Their professional identity has therefore been reinforced by their interactions with other people, first as aspiring physicians, then as medical students and finally as physicians. The interviewees seem to be adamant in their quest to become physicians in the Netherlands but at the same time they are faced with so many obstacles that they are forced to confront a reality that does not conform to their desires and wishes; the possibility that they will have to work in other areas within the healthcare sector or even outside it, if they do not get accepted into the fourth year of medical study.

During the interviews the interviewees' future was relatively unknown. They had not yet given up hope of getting a placement at the Erasmus University and eventually becoming physicians in the Netherlands. Failing to learn the Dutch language and passing the NT-2, or passing the NT-2 and still not be accepted into the fourth year at Erasmus University will have enormous impact on the interviewees' lives. Their profession seems to be a central component of their identity as the findings illustrate. All of the interviewees were willing to accept an initial status decline in their professional career and begin in the fourth year. It seems to be a price they are willing to pay in order to be able to practice their profession in the Netherlands.

It is possible that the interviewees were at different stages in coming to terms with their situation at the time of the interviews. Each individual might have gone through a period of shock, a period filled by optimism and hope, and a period of pessimism, anxiety and distress. These periods do not have to follow a certain order or even affect every refugee physician. Depending on various factors such as how long the interviewees have been in the Netherlands, when they started to learn the Dutch language and generally how long it is since they began thinking about becoming physicians in the Netherlands might affect how they felt at the time of the interview. This makes it difficult to assess whether or not someone has a strong or a weak professional identity. An interviewee who says to be willing to work in another occupation does not necessarily have any weaker professional identity than someone who is determined to become a physician in the Netherlands and says he is not willing to work in any other occupation. They could be going through different stages, one being pessimistic, and the other optimistic.

7.2 Theme 2: Evaluation of their credentials

Lack of academic and professional recognition

Migration is, according to Shuval et al. (1975: 151), a form of social change, which imposes new demands on the individual and renders much of his past expertise obsolete. In the case of refugees these new demands and lack of recognition of past experience can be even more profound than for regular immigrants as many refugees are not able to prepare their migration beforehand or even choose where to go, due to the circumstances of their migration.

The interviewees' human capital, or their education and work experience, was in some cases extensive; on average eight years study and eight years experience working as physicians. Once they arrived in the Netherlands they were not able to benefit from these aspects of their human capital. Their experience as physicians is not valued and their educational background is evaluated as equivalent to a three years basic medical study. It is therefore possible to speak of a "brain waste" in the case of this group. On the other hand it is questionable whether or not their knowledge and expertise is extensive enough and up to standard for the Dutch medical system.

According to Ted Splinter, head of the selection commission and educational director at the medical faculty at the Erasmus MC, there is certainly a need for physicians (more specifically specialists) in the Netherlands but refugee physicians do not meet the standards that are required of them to be able to work as physicians in the Dutch medical sector. Their inferiorities to their Dutch counterparts are in the areas of language, communication, attitude and medical knowledge (21. 6.2004).

The occupational integration of foreign physicians and the provision of the highest possible level of healthcare can result in a potential conflict. The quality of the medical education that the interviewees have received either in their home country or elsewhere (mainly in the former Soviet Union) is not only poorer than what the Dutch medical system offers but for most of the interviewees a relatively long time had passed since they finished their formal education. Specialization was also in many cases ambiguous

and did not meet the standards of specialization such as they are in the Netherlands. Formal residency or specialization programs seemed to be either lacking or quite different and not up to the Dutch standards. For example very short programs that do not take place in a university hospital as is required in the Netherlands. The quality of their training is therefore questionable. Isolation and backwardness is another problem many of the physicians had to deal with during their employment as physicians. Not only with regard to medical equipment but also in any advantages or discoveries that have been made in the medical field. Apart from the problems mentioned here above there are many other disadvantages that the foreign physicians are faced with. According to Splinter the biggest adjustments for the refugee physicians have to do with: the demands of a technology that is different or new to them and medical ethics; how patients are approached, as well as how communication between physicians and other members of staff are conducted. Consulting female colleagues or having females as their superiors have also presented problems for foreign (male) physicians.

Command of the Dutch language is also a major problem for foreign physicians. They need to be capable of understanding the patient and explain to other colleagues what the problem is. According to Splinter the NT-2 exams do not fulfill the language requirements that are required in order to be able to work as physicians in the Netherlands. Some aspects of their medical experience is not useful in the Netherlands, as some diseases and type of injuries that they have frequently had to deal with are not common or even known in the Netherlands. Some physicians, especially women, have worked in a very limited area of specialization for most of their working life which makes their experience limited and their knowledge of other medical areas outdated. That is why, despite shortage of physicians in the Netherlands, foreign physicians are difficult to employ. Their knowledge and experience are so different and inadequate to what is needed within the Dutch healthcare system, not to mention the cultural differences, that retraining is in most cases necessary. Many refugee physicians have trouble accepting what they feel is an under-evaluation of their medical diploma. But according to Splinter they understand soon after they start their clerkship rotations and really get to know the Dutch medical system that retraining is necessary. They realize that there is a great difference between the medical service in their country of origin and in the Netherlands.

Status and categorization

Refugees' adjustment to a new society is a gradual process. For many refugees one aspect of the adjustment process is accepting an employment that is below their abilities and training. Tang and O'Brien's (1990: 1450) study into the adaptation of Indochinese refugees showed that those refugees who had held high-status positions in their homelands were experiencing greater difficulties in adapting to low-status positions than those refugees who had held low-status positions in their homeland. Other studies have shown that by accepting an employment below previous occupational status can result in a serious threat to the refugee's identity (Colic-Peisker and Walker, 2003: 356).

To reduce the discrepancy between the previous and present status the interviewees need to find employment which will match their previous prestige (preferably as physicians) or

reduce their personal expectations and accept employment opportunities other than their former position. Within the healthcare sector those employment opportunities would most likely be considered to be lower in status than that of a physician which could result in feelings of status inconsistency. The majority of the interviewees were willing to work within the healthcare sector as something other than physicians if the circumstances would force them to. That indicates a willingness to reduce their personal expectations although everyone agreed that that would only happen if their goal of becoming licensed physicians would not be achieved.

The interviewees identify with the social category “physician” and want to be able to view themselves as members of that category but are denied membership by the Dutch medical society. The social categories to which they now belong to are categories such as that of refugees, unemployed, and students. The study shows that the interviewees want to finish their study and get a placement in the medical faculty. They want to be viewed as physicians by the Dutch society, and they mention feeling as if they are ‘nothing’ in the Netherlands. The interviewees might be experiencing what has been called ‘categorization threat’. They are high-performing individuals who have been placed in low status categories that do not contribute positively to their self-esteem. They are seen as foreigners, refugees, and uneducated by the Dutch society and they are not willing to accept that. Therefore it is important for them to be able to reinstate their status as physicians.

Those refugees with high human capital, such as professionals articulate more often than other refugees’ feelings of uneasiness about being classified as refugees, which they perceive as a socially disadvantaged and culturally distant social category. Refugee status has been listed as a major psychosocial stressor and in order to shed the refugee identity and status, aspects of social identity and people’s previous statuses and roles need to be rebuilt (Colic-Peisker and Walker, 2003: 346). Although the interviewees were not explicitly asked about their feelings about their status as refugees it is possible to assume that the refugee status is lower than the status of a physician. Being a refugee is something that the interviewees recognize as being a category to which they belong. It is a label that can be a hindrance to them, but at the same time they seem to recognize that being a refugee is also something that is positive in the sense that because they fled their home country (and consequently became refugees) they are alive and have been welcomed in the Netherlands. The category is therefore simultaneously negative and positive, depending on the situation in which the refugees want to present themselves.

Status of the physician in the Netherlands and the status of the physician in the interviewees’ countries of origin seem to be somewhat different. Only those from Chechnya said that it was no longer a high status profession, other said that it had very high status and was a much respected occupation. This means that if they do get into the medical study and will graduate as physicians they will experience to a certain degree a different kind of status decline as the status of the Dutch physician is not the same as they might be used to in their country of origin. In the Netherlands the physician’s status is not as high as it used to be as the physician is for example no longer viewed as someone who knows all and cannot be questioned. This change might prove to be difficult for

them, as for example communication with both personnel and patients might be radically different to what they are used to.

Nine interviewees preferred an employment within the healthcare sector to employment outside it even though it would most likely be classified as lower in status than the physician's position. Many of these jobs available to them will still require them to retrain and undergo formal qualification procedures. The interviewees would also need to adjust psychologically to accepting instructions and criticism from physicians or other personnel who occupy positions of authority.

7.3 Theme 3: Personal and social background

The interviewees had been staying in the Netherlands on average for five years at the time of the interviews and were finding their way within the Dutch society. Aside from trying to establish themselves as physicians in the Netherlands they are beset with various problems stemming for example from their personal background as displaced individuals, their unfamiliarity with a new society and culture, alongside other factors such as their relatively high age, family commitments, loss of extended family, psychological trauma stemming from their refugee experience, lack of support network, lack of language skills, and physical and/or mental health problems.

The effect social support and personal problems have on the Dutch language acquisition
Poor acquisition of the Dutch language makes it difficult to pass the NT-2 exams, which is a requirement in order to get an interview at the Erasmus University. The majority of the interviewees reported that they were dealing with personal problems that were affecting their language study. Concentration problems, lack of contact with other people, having to care for sick relatives, family responsibilities and worrying about relatives and friends that had been left behind in their country of origin, as well as delays and other difficulties regarding their residency status were mentioned as affecting their ability to concentrate fully on their study. The study shows that those who considered themselves having no personal problems were more successful in learning the Dutch language than those who reported having no personal problems. The study further shows that those who were the most pessimistic of becoming registered physicians were also experiencing difficulties in their personal lives, such as social isolation as well as feeling that their age was a major hindrance to their success.

Availability of social support, such as financial assistance or support network of family and friends, seemed to make a difference to the interviewees. The interviewees did not have extensive family network in the Netherlands. If they had any relatives in the Netherlands they were usually scattered around the country. The interviewees were on the whole not happy with the extent of their support network. Many complained about not having enough contact with other people, and especially with Dutch people. They felt that it would be beneficial for them especially with regard to learning the Dutch language. As the study showed, those individuals who felt they had a lot of contact with Dutch people were on average more successful learning the language than those who felt they little or no contact with the Dutch people.

The stay in a refugee center

Staying in refugee centers can have enormous impact on the refugees because the time spent there is usually long and unproductive. The interviewees stayed in a refugee center on average for one and half year, ranging from few months up to three years. The study shows that some interviewees were not prepared to do 'nothing' during their stay in the refugee centers. They were concerned about not being able to work and the lack of opportunity to learn the Dutch language. Others on the other hand were glad to be able to do nothing during this time. It gave them time to recuperate from their experiences and take time out to orientate themselves. They were more concerned about having reached safety than the lack of opportunities to work, diploma evolutions and so on.

As further time passes since their last employment as physicians their chances of getting a placement in the fourth year at the Erasmus University are diminished. According to Splinter many refugees have not worked as physicians for many years, partly due to a long stay in a refugee center, and he finds it is very difficult to justify giving a fourth year placement to such individuals. He mentioned to comparison that Dutch physicians who have not worked within their profession for more than four years are taken off the Dutch Medical Register (21.6.2004).

The effects of age and gender

Changes and adaptations resulting from migration are said to make older refugees especially vulnerable (Shoval et al., 1975: 151). While most refugees share a common experience of displacement, older refugees encounter more difficulties living outside of their native country, whereas younger refugees are more resilient and effective in coping with the transition process (Ward et al., 2001: 236).

The average age of the interviewees was forty-two years. Studies have shown that it is difficult for professionals who are forty years or older to regain their previous occupational status (Brink, Pasariboe and Hollands, 1996: 47). Older interviewees are likely to have held a higher position in the medical system as well as enjoyed the benefits and status increases that usually come with an extensive career. That means that they are likely to experience a greater downward occupational mobility than younger physicians even if they are able to continue their professional work in the Netherlands.

The Dutch language could be viewed as a major barrier for many of the older refugees who want to continue their professional career in the Netherlands. As the study shows, the older interviewees seem to have more difficulties in learning the language than the younger ones. Frustration and sense of inability to cope was found by some of the interviewees, especially the older ones who found themselves having problems studying the language, as having difficulties learning was not something they were used to.

Their age is also a hindrance when it comes to getting a placement at the medical faculty. According to Splinter it is difficult to accept individuals into the retraining program when there is not much left of their expected working life as becoming a basic physician will take them three years and specialization further six or more years. The younger

physicians are therefore viewed as more re-trainable than older physicians. Younger physicians are also more likely to be accepted for a residency post. Being over the age of forty can therefore prove to be an obstacle when it comes to getting a placement in the fourth year but at the same time it is still a young age to retire.

Studying the Dutch language and following the “Artsenproject” seemed to be more difficult for the women who took part in the study than the men. Of the four women who took part in the research three spoke of difficulties in combining the Dutch study with family obligations. Some women might be self-selecting themselves out of the medical profession once they arrive in the Netherlands as they are able to fall back on socially acceptable roles such as that of a mother or a housewife. That could explain why there were such few women participating in the “Artsenproject” and the “schakel” project at the Albeda College.

7.4 Theme 4: Language and integration

Integration

Entering a new society inevitably triggers stressors that require refugees to put to use their coping and resources skills, especially when coming from countries that are culturally very different to the host country. The interviewees are therefore inundated with a number of problems stemming from unfamiliarity with a new society and culture while trying to establish themselves as physicians.

Their integration into the Dutch society had just begun at the time of the interviews even though they had been for a number of years in the Netherlands. The time spent in uncertainty has passed and they are free to participate in the Dutch society. Their most important goal, fleeing an impossible situation and getting themselves and in some cases their family to a safe country, has been accomplished. Now they can focus on their own choices and decisions and their most important goal is now to resume their work in the Netherlands. Proper settlement is in the eyes of many of the interviewees difficult without being able to work and then preferably in their chosen profession: medicine.

A successful integration might be considered to be when the refugee himself has a general feeling of well-being in the host country. Being employed in a chosen profession is one parameter for feeling of well-being as studies have shown (Berman, 1984: 417). Most of the interviewees found it difficult to answer whether or not they considered themselves happy in the Netherlands. They felt that in order to be properly happy they would need to be able to work as physicians. On the other hand they were not able to say that they were unhappy because they were alive, their children were being educated, and in comparison to their previous situation they were happy. The word ‘happy’ is perhaps not the best word to describe very complex and difficult emotions that the interviewees were feeling regarding their current situation. Describing what it is like being unemployed refugees struggling to learn a new language at a relatively old age in a society which was perhaps not their chosen destination can never be captured in a simple adjective. Feelings of happiness and sadness must be very close in a situation like this.

Few interviewees reported discrimination or not feeling part of the society, as most said that they had not had any negative experiences in the Netherlands. Not regarding the under-evaluation of their diploma and other frustrations that they expressed throughout the interview as being discrimination or negative experience might indicate that they felt welcome in the Netherlands as refugees. They have been given an opportunity to start a new life and for that they are thankful. Being seen as foreigners on the other hand seemed to frustrate some of the interviewees as they said that they would always be considered to be strangers in the Netherlands no matter how well they would integrate.

Language skills

The situation in which the refugee physicians were at the time of the interviews could be described as being temporary. They will not permanently be Dutch language students, and their future is ambivalent as they do not know whether they will be accepted into the Erasmus medical faculty. They are so to speak between two worlds, one of their past achievements and one that could open up the door to an employment in their area of specialty. The language acquisition is the major facilitator in bridging these two worlds. A recent research into the economical adjustment of refugees showed that there is a significant relationship between language competency and the likelihood of being gainfully employed (Waxman, 2001: 472). Learning the Dutch language is therefore the first step in a successful integration process if success is measured as being employed.

For most the first proper introduction to the Dutch language was in the form of the “Inburgeringscursus” which is supposed to increase their human capital and give them a head start on the Dutch employment market. According to the majority of interviewees who had taken part in this course it was not beneficial to them. They felt that their high level of education and needs had not been considered as they were put in mixed groups with for example people who were analphabetic. They felt that the course was trying to accommodate everyone, but at the same time failing most. The language course in Albeda College in comparison was much better suited to their needs and abilities.

Their Dutch proficiency skills will to some extent determine how well they are able to integrate into the Dutch society, but perhaps more importantly determine whether or not they will be accepted into the fourth year in Erasmus University. Current language proficiency does not seem to be related to how long the interviewees had been in the Netherlands, but, as reported earlier in chapter six, seemed to be influenced by a combination of factors such as age, quality and number of Dutch language programs they have followed, contact with Dutch people and personal circumstances.

According to Anja Veerman, administrative worker by the Admissions Office in Erasmus University in Rotterdam it is easier for immigrants to begin their study at the Albeda College with next to no knowledge of the Dutch language. Without any proper language lessons their Dutch language skills might be affected by what they have learned on the street, so to speak. Grammatical errors are picked up that are difficult to correct once learned. This means that many find it very hard to get past level 3 in the Dutch language proficiency (2.3. 2004). Splinter speaks of a structural problem in this connection, which is very difficult and next to impossible to correct. A Dutch language teacher is therefore

always present in the selection interviews as he is able to detect those individuals who will never be capable of speaking Dutch at a level required for the medical practice (21.6.2004).

All of the interviewees seemed to be very motivated to learn the Dutch language. They believed that it was necessary to learn the Dutch language, not only with regard to their integration, but perhaps more importantly because they want to practice medicine in the Netherlands. Some felt that their language abilities were not good enough for finding an employment, and others wanted more social contact with Dutch people in order to be able to practice the language. It seems that they were stuck in a vicious circle where their inability to find an employment or social contacts were affecting their language skills, but their language skills were in turn affecting their confidence in finding these same contacts.

Future perspective

It is difficult for the interviewees to see the world as stable and predictable. They come from a situation where their only option was to flee an intolerable situation and find a future in another country. Now they are in a situation where they feel they have little or no control over. Constant interaction with the Dutch bureaucracy is difficult to handle for anyone, let alone a foreigner who can hardly speak the language. Uncertainties' regarding their future when residency status is not yet determined as well as not knowing whether or not they will be accepted into the fourth year is difficult for them. So many disappointments and so many hurdles have been thrown at them that it is not surprising that some of the interviewees were feeling low and discouraged at the time of the interview. However it is important to note that although they have been through difficult experiences, refugees are those individuals with the strongest sense of survival. That is why they managed to flee to the Netherlands in the first place. They are quick to point out the positive side to their situation, such as being alive and safe, their family is safe, they have an accommodation, opportunities and so on. So despite feelings of limited control, they do find a sense a control by focusing on becoming physicians in the Netherlands. That is their goal, and as long as they have that goal they are able to envision their future.

The results from the NT-2 exams in June

Of the twenty foreign physicians who participated in the "Artsenproject" in Albeda College only five passed all of the four parts of the NT-2 in June. They then went on to take part in the selection interview at the Erasmus University in addition to a participant who had already passed the NT-2 exams a year earlier. Of those six individuals only two took part in the research and neither of them was accepted into the fourth year. Of those two, one was soliciting for the second time. Of the remaining four, two were accepted into the medical faculty. That means that of the twenty participants only two (neither of them a refugee) were successful in gaining a fourth year placement at the Erasmus medical faculty. One interviewee who was no longer a student at the Albeda College and had already passed the NT-2 exams two years earlier solicited, for the second time, for a fourth year placement, but was not accepted. The remaining interviewees had not passed

all parts of the NT-2 in June, and were therefore not eligible for taking part in the selection interview.

7.5 The central and the research questions

In this chapter the research findings have been discussed in detail, both within the theoretical frame presented in chapter three, as well as being compared to other research findings. In this section the focus will be on the central and the associated research questions. They have been answered in detail throughout this chapter as well as in chapter six, but now a summarizing answer will be given.

1. With regard to their professional background, what institutional barriers and social-psychological issues are refugee physicians facing during their initial integration into the Dutch society?

Refugee physicians come across numerous institutional barriers during their initial integration. First of all the difficulties they face as being displaced individuals. Refugees wait up to many years in refugee centers for a residency status, and even when they receive a status they are left waiting in uncertainty as many receive residency for a limited period of time and after that they need to apply for an unlimited status which is not always automatically given. While waiting for a residency status the refugee is not able to work or get an education. Dutch language lessons are limited to volunteers who teach them basic Dutch for one hour, once a week. The time spent in the refugee centers is therefore not productive when it comes to expanding the refugees' Dutch human capital. It can even be regarded as being counterproductive if the refugee adopts imperfect language skills which later can be difficult to counteract once he starts to attend proper Dutch language courses. Foreign physicians are always subjected to evaluation of their medical diploma. In the case of refugees, the majority is left with an evaluation which renders their diploma as equal to a three year basic medical study as well as no recognition of their work experience. Once the refugee physicians have decided to resume their work in the Netherlands they are required to resume their medical education in one of the seven Dutch medical universities. Each university has its own rules and regulations when it comes to the admission of foreign physicians. Some have exams which indicate in which year the physician can begin, others have special programs which every foreign physician is required to follow. There are no common rules that apply to all of the universities with regard to the re-training of the foreign physician, and there is lack of information for the physicians themselves as to what kind of entry requirements there are for different universities.

The refugee physicians are likely to be facing a number of social-psychological problems, especially during their initial years in the Netherlands. Apart from having to deal with problems related to their position as refugees, such as the loss of their home, culture, family and friends, they have to deal with issues related to their professional background. Not being recognized as physicians can have profound affects on their identity, as being a physician is such an important part of their overall identity. They also have to deal with enormous status changes, as they go from having relatively high status

and being respected members of the society to being refugees. Once they have decided to pursue their career in the Netherlands and attend medical study, they are still left in uncertainties as to whether or not they will succeed. First they need to learn the Dutch language which can be difficult for this group as their average age is relatively high and therefore they have more difficulties learning the language. Once having passed the NT-2, which is a requirement in order to gain an entry to a Dutch university, the physicians are faced with the fact that there are only limited placements each year for foreign physicians, which means that the majority of the applicants are left without a placement. Uncertainties, disappointments and constant battles with the Dutch bureaucracy, coupled with social-psychological problems, status inconsistency and changes in identity can make the transition process for the refugee physician particularly difficult.

2. In what way do the institutional barriers and the social-psychological issues affect the refugee physicians?

The time spent in the refugee centers was difficult for the interviewees, especially those who had stayed there longer than a few months. They felt that their time there was wasted and many wanted to be able to work or to begin their study. The majority of the interviewees had followed an “Inburgeringcursus” and most of them agreed that this as well had been a waste of their time as their level of education had not been taken into consideration. As a result they had been put into groups with people who were practically analphabetic and that had slowed their Dutch language acquisition down. Learning the Dutch language was not something they considered a burden, on the contrary all of the interviewees were eager to learn Dutch. They believed it was important not only with regard to being able to resume their profession in the Netherlands, but also in order to integrate properly into the Dutch society.

Despite having invested many years of training and gaining experience in the medical profession, all of the interviewees were willing to retrain as physicians in order to resume their professional career in the Netherlands. The majority was even positive with regard to having to retrain, although it is possible that they had not always felt that way and in the course of the years their attitude has simply changed. The interviewees were displeased with the lack of information about the entry requirements into the medical universities. They feared that their chances of getting a placement might be better elsewhere without them knowing about it. As well as wanting information about other universities and entry requirements some of the interviewees felt that there was need for a different approach to their problems. They felt that the integration of foreign physicians into the Dutch medical profession needed to be made easier and that special programs were needed where their expertise and knowledge could be put into use. Working was considered to be extremely important, even without getting paid, as being able to work even though only as assistants would help them to regain some of their self-respect.

The interviewees were experiencing radical changes to their identity. They considered themselves physicians although they were no longer able to practice medicine. They found it difficult to accept this change and being regarded as foreigners, refugees and uneducated by the Dutch society. They felt that in order to become properly happy in the

Netherlands they would have to be able to resume their work as physicians. Despite them placing so much importance on their previous status they were willing to take on other work if they would not succeed in becoming physicians in the Netherlands. This apparent contradiction indicates that they want to be able to contribute to the Dutch society, if not as physicians than in other ways, and that they have come to accept that their chances of becoming physicians in the Netherlands are slim.

Nine interviewees reported having some personal problems that were affecting their Dutch language study. These problems originated mostly from their background as refugees, such as concentration problems due to for example their experiences as refugees, guilt of having left family and friends behind or because of the ongoing conflicts in their country of origin that were occupying their thoughts. Other problems were related to family commitments, caring for children or sick relatives, financial problems and lack of social contact.

The associated research questions:

How important is it to the refugee physicians to resume their work as physicians in the Netherlands, and why?

It seems very important to the refugee physicians who took part in the research to resume their professional work in the Netherlands. It is of course not possible to generalize these findings as those who took part in the research are those individuals who have decided to pursue that goal. They are learning the Dutch language and taking part in the “Artsenproject” and the “schakel” program especially with returning to their profession in mind. They are incredibly motivated even though they do realize that only small percentage of them will actually be accepted into the Erasmus University. Their age and lack of command of the Dutch language is for example hardly mentioned by the interviewees as being a hindrance, as if they do not realize that these factors are likely to reduce their chances. The interviewees have invested so much time and emotional commitment in the medical profession that letting go of it is not an option.

Being a physician is to them not only a job; it is a part of them. The interviewees repeatedly referred to themselves as being physicians throughout the interviewees. Being a physician seems to be an intrinsic part of their self-concept such as being male, female or a parent. It is simply something that is fundamental to their identity. Since the interviewees fled an unbearable situation in their country of origin and had to give up a considerable part of their lives, it is not surprising that they feel a need to hold on to at least their human capital; their education and work experience. Even though they have to retrain, that is a small price to pay in order to regain some sense of familiarity and security in their lives.

Which factors are most likely to contribute to the refugee physician’s success in mastering the Dutch language?

Commitment to their profession and extreme motivation to learn the Dutch language in order to be accepted into the Erasmus University does not seem to affect their actual success in mastering the language. All of the interviewees wanted to learn the language and were studying hard in order to do so. As an evidence of that all, but one interviewee, were attending the language lessons in Albeda College regularly.

Factors, other than commitment to their profession and motivation were affecting their success in mastering the Dutch language. Age seems to be one of the most decisive one. The average age of those who had the highest level of Dutch language proficiency was lower than the average age of those whose Dutch language proficiency level was low (39 versus 46 years old). The length of stay in the Netherlands does not seem to affect their success in mastering the language. Contact with Dutch people on the other hand seemed to be important as those who considered themselves to have a lot of contact with Dutch people had on average higher level of Dutch proficiency than those who considered themselves having little or no contact.

Starting a proper language program as soon as possible is also likely to affect their ability to pass the NT-2 exams as those who pick up the Dutch language without proper lessons have more problems getting past Dutch proficiency level 3 than those who begin their study with next to no knowledge of the Dutch language.

8. Conclusion and Recommendations

8.1 Conclusion

This research presents a qualitative study of refugee physicians during their initial integration period. An initial integration period was understood as the being the period in which they were preparing for being accepted for a fourth year placement at the Erasmus medical faculty. A data was collected in the form of personal interviews with fourteen refugee physicians who were either studying or had been studying the Dutch language in Albeda College Rotterdam.

For highly qualified professionals, such as refugee physicians, social mobility is blocked without a good command of the Dutch language and lack of recognition of their professional qualifications and experience. The requirements to practice medicine in the Netherlands are for many refugee physicians too high and difficult to attain which means that many will never be able to instate their professional status in the Netherlands. For refugee physicians most occupational change indicates downward occupational mobility, and as the research shows that can result in psychological distress and affect their satisfaction with life in general. The refugee physicians are affected by their situation in different ways. They are no longer able to practice their profession, which was and still seems to be a very big part of their self-identity. They have also found themselves faced with a new and what could be viewed as a low status identity; the identity of a refugee.

The physicians who took part in the research could all be considered to be serious in pursuing a medical license in the Netherlands as they were all attending or had been attending language classes in order to pass the NT-2 exams and were highly motivated to improve their language skills in order to be able to secure a placement at the Erasmus University. Despite their seriousness in pursuing a medical career their ability to do so and success is affected by personal problems, relatively high age as well as lack of command of the Dutch language. Even when they pass the NT-2 exams and are able to secure an interview with the selection commission they are not guaranteed a placement.

Refugees can be important contributors to the society and the economy if their human capital is put into use, either by providing them with appropriate education or helping them to find an employment which at some level takes aim of their previous acquired competence. Many refugees are forced to find work that is far beneath their capabilities and without career counseling and the availability of suitable language courses during the transition period highly educated refugees, such as refugee physicians, will continue to be underemployed or unemployed. That is not only important for the Dutch society but for the social and psychological welfare of the refugees themselves.

8.2 Recommendations

This research concludes with a number of recommendations focusing in particular on the need for early intervention with adequate Dutch language tuition, educational and skill training, and career counseling which would help to assist refugees, professional or not, to find employment or an educational path suitable to their capabilities and experiences.

8.2.1 The initial reception of the refugees

Refugee centers play a major role in the reception of refugees. More attention needs to be paid to the length of stay in the centers as well as how the refugees are able to spend their time whilst staying there. Being inactive for a long period of time, as many refugees are forced to be during their asylum process, can have negative effect on their future employment market integration. Many people choose to be busy and active in order to give their daily life a structure. It is therefore important that their initiatives are supported and allowed to develop. In the case of refugee physicians being unable to practice their profession or at least work in related areas for several years can have negative consequences. In the medical profession it is crucial to be active and gain knowledge through the career. Being inactive in the refugee center is not only damaging for the personal well-being of refugee physicians themselves but also affects their chances of later being accepted into the medical faculties.

Career counseling needs to be provided during the initial integration period. It has to be made sure that the refugees have all the information that they need in accordance with their educational, professional and employment background. Which institutions do they need to consult and why and what requirements do they need to fulfill in order to pursue an education or an employment. When it comes to status-inconsistent individuals, such as highly educated refugees, it is important that they will be made to understand as early as possible that it will be difficult for them to attain their previous professional status in the Netherlands. This orientation needs to take place as soon as possible so that false hopes and unreal expectations are not created. The refugee physicians need to be made aware that resuming their profession in the Netherlands is likely to be a long and difficult process, and that their chances of succeeding are slim. But if they decide despite that knowledge to pursue their goal of regaining their medical license they need to know exactly what they will have to do. Learning the Dutch language is for example the first thing they will need to do and therefore it is important that they are given a proper opportunity to learn the language as soon as possible. At the moment refugees are not allowed to work or follow an education while their application for a refuge is processed. Either the application process will have to take less time or the refugees need to be given an opportunity to attend proper language lessons during their wait. Not one hour lesson per week, given by volunteers but adequate language training which would not only help them to get a grip on the basic grammatical structure of the language early on but also give them a structure to their daily lives and a future perspective.

8.2.2 Language

Because the acquisition of the Dutch language is essential to a successful integration of any immigrant the availability of language classes needs to be a top priority right from the beginning of the refugee's settlement in the Netherlands, whether the settlement initially takes place in a refugee center or elsewhere. Learning the Dutch language is vital to the refugee physicians' chances of resuming their profession in the Netherlands. Their acceptance into the medical faculties is largely dependent on their language skills. Passing the NT-2 exams does not seem to be enough as the selection commission pays a close attention as to whether or not they have an ability to further their knowledge and improve their Dutch language skill. Having started their Dutch language tuition so late in their settlement it is likely that they will never be able to learn the language properly. What they learned, or did not learn, during their initial settlement period is likely to affect the rest of their language acquisition.

Not only do the language courses need to start as soon as possible but classes of different levels are necessary to accommodate different educational level among the participants. By acknowledging the difference in educational level the intensity and continuity of the courses will be able to run at a pace that suits everyone's needs. Without acknowledging these differences between the participants the language courses will be inefficient as the needs of the highly educated individuals are different to the needs of those who have a different or perhaps no educational background.

8.2.3 Reentering the medical profession

The devaluing of diplomas and work experience ensures that the refugee physicians are not able to fully capitalize on their human capital once they get settled in the Netherlands. When it comes to the employment integration of refugee physicians there is a need to reconcile two very important social values: providing appropriate employment for refugee physicians that are in accord with their prior occupational training and experience as well as maintaining a high quality of professional practice according to the standards of the best scientific knowledge available. Neither of these values can be compromised, although at the moment it seems like the second one takes priority to the first one. That is understandable especially when it seems that many of the refugee physicians are simply not capable of working within the Dutch healthcare system with their current medical and employment background. Retraining is necessary but at the moment only a fraction of those physicians who apply for admission gets admitted to the fourth year at the medical faculties. If refugee physicians are not able to find their place within the society in the form of an employment or educational route, preferably within the healthcare sector, there is a danger that they will end up in jobs in which none of their skills and abilities will be utilized. For the Dutch society it is a waste of potential asset for the society and its economy, but for the individuals involved it can be degrading and affects them emotionally and psychologically, which in turn can have negative affects on their further integration.

If it is not possible to increase the number of “sideways” placements for foreign physicians other options need to be on offer for foreign physicians who do not qualify for those placements available. They must to be given a chance to follow educational paths and/or find other types of employment opportunities within the healthcare system. That is if they are willing to accept job and educational opportunities other than that of becoming a physician. Career counseling in the early stages of their integration process could prove to be an important instrument in helping them to explore other options, especially if the procedures and entering requirements into the medical faculties are unified on a national level, as the OCG-DMW proposes to do. That way it will be easier for foreign physicians to orientate themselves once they arrive in the Netherlands and prepare their route of becoming registered physicians. By informing them early on they are given some control over their future and disappointments can be avoided once they realize that becoming a registered physician is likely to be difficult and will only be achieved by few.

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Appendix A: The Questionnaire

Naam

Geslacht

Leeftijd

Land van herkomst

Status

Hoe lang bent/woont u al in Nederland?

Wanneer kon u het Nederlandse les beginnen?

Heeft u de inburgeringcursus gevolgd?

Wat vindt u ervan?

Welke Nederlandse taalcursussen heeft u gehad?

Op welke niveau heeft u toetsen behaald?

Heeft u in een vluchtelingen centrum gezeten? En hoe lang?

Hoe was het om in een vluchtelingen centrum te wonen?

Was het uw keuze om naar Nederland te komen?

I will start the interview process with a fairly open question. I will first ask them to confirm that they are physicians and want to resume their work here in Holland. Then I will ask them to tell me about their experiences here in Holland, but begin with their background:

Waarom heeft u voor artsopleiding gekozen in uw eigen land?

Ouders arts?

3. Commitment to the job/profession:

Zou u mij iets willen vertellen over uw achtergrond als arts?

Administratie werk?

Was het moeilijk om een arts te worden?

Hoe lang heeft u een opleiding gevolgd voordat u naar Nederland bent gekomen, en welke opleiding heeft u gedaan?.

Hoe lang heeft u als arts gewerkt in uw geboorteland?

Wat voor ervaring heeft u?.

4. Lack of academic and professional recognition

Is uw arts diploma gewaardeerd?

Bent u tevreden met de waardering van uw arts diploma?

Toen u naar Nederland kwam wist u dat uw diploma gewaardeerd moest worden?

Hoe ervaart u het dat uw diploma en uw ervaring niet helemaal gelijkwaardig wordt beschouwd als diploma's uit Nederland?

Was het totaal onverwacht of had u andere verwachtingen?

Denkt u dat het effect heeft voor uw Nederlands studie? Bent u minder of meer gemotiveerd?

Voelt u zich boos of heeft u het al geaccepteerd dat u waarschijnlijk in het 4de jaar moet beginnen?

Hoe voelt u zich over het feit dat niet iedereen die het NT2 haalt een plek krijgt binnen de geneeskundige opleiding?

Wat vindt u van het Portfolio programma? Zou dat u kunnen helpen om een plek te krijgen bij het Erasmus?

5. Changes in status

Zijn er grote verschillen tussen het arts zijn in ... en in Nederland? Bvb. wat betreft de status van een arts in de twee samenlevingen?

Hoe belangrijk is het voor u om uw werk als arts te hervatten?

6. Motivation

Waarom wilt u arts worden in Nederland?

Wat motiveert u om uw opleiding en uw baan hier te hervatten?

Zou u zich kunnen voorstellen dat u niet als arts meer kan werken?

Als we pessimistisch zijn en u in de toekomst niet als arts kunt werken, wat dan?

Werkt u of heeft u gewerkt? Bvb. als vrijwilliger, in een ziekenhuis enz?

7. De taal cursus

Wat vindt u van het NT-2 programma die u nu volgt?

Vindt u het nuttig om Nederlands te leren? Of ziet u het vooral als een noodzaak?

Hoe gaat het met uw studie?

Vindt u dat uw situatie veel anders is dan die van andere artsen die niet vluchtelingen zijn?

8. Support systems: teacher's support, family and friends, social service, their faith, UAF etc.

Wat is uw support systeem hier in Nederland?

Heeft u familie, gezin of vrienden hier in Nederland?

Heeft u contact met andere vluchtelingen artsen (behalve hier in Albeda)?
Bvb. artsen die nu al werken in een ziekenhuis.

Heeft u hulp gekregen van organisaties zoals het UAF, en wat voor hulp dan?

Zijn de docenten hier in Albeda behulpzaam?

Wat vindt u in het algemeen van de hulp die u krijgt? Is het voldoende?
Wat zou u willen?

9. Personal problems (physical or mental problems, experiences as refugees)

Heeft u persoonlijke problemen waarvan u denkt dat die van invloed kunnen zijn op uw mogelijkheden om arts hier in Nederland te worden?

Bijvoorbeeld:

Leeftijd: om Nederlands te leren?

Slechte ervaringen in uw land van herkomst?

Concentratie problemen die effect hebben op uw studie?

Gezondheidsproblemen, mentaal of lichamelijk?

Moeilijkheden op het gebied van hun privé situatie (denk aan kinderen, werk, geld, rustige plek voor huiswerk, genoeg tijd om thuis huiswerk te maken, enz) ?

10. Cultural problems and (lack of) commitment to the Dutch society

Attitude towards the Dutch society

Wat vindt u van het Nederlandse samenleving? NB. Positieve en negatieve punten!!

Voelt u zich welkom hier in Nederland?

Wat is het grootste verschil tussen Nederland en uw land van herkomst, wat cultuur/godsdienst betreft?

Acceptatie van de vrije manier van leven (normen en waarden)

Bent u gelukkig in Nederland? Denkt u dat u ooit gelukkig zal worden in Nederland?

Wat zou u gelukkig maken?

Orientation to the future

Hoe ziet u uw toekomst?

Welke veranderingen ziet u in uw leven na de NT2 studie?

Werken als arts?

Zou u tevreden zijn als u in een andere sector (dan als arts) binnen het gezondheidssysteem werk zou vinden? Bijvoorbeeld als verpleegkundige, verpleeghulp, bij de thuiszorg, of op een huisartsenpost als assistent?

Zou u kunnen werken in een hele andere sector?

Bent u van plan om in Nederland te blijven wonen?

11. The identity factor:

Als u terugkijkt naar alle veranderingen die u heeft meegemaakt, hoe voelt u zich?

Wat vindt u van alle veranderingen in uw leven die u heeft meegemaakt de laatste jaren?

Heeft u uw situatie (voor een deel) geaccepteerd?

Final questions:

Mag ik na het NT2 examen in Juni weten of u het heeft gehaald?

Kent u andere vluchtelingen artsen die nu zijn ook bezig met hun Nederlandse studie?

Wilt u iets meer zeggen dat u belangrijk vindt en waar ik niet over heb gevraagd?