

International Medical Graduates in the Netherlands

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Content

	Preface	8
1	Introduction and research questions	10
1.1	Introduction	10
1.2	Immigrants in the Netherlands	11
1.3	The integration of medical graduates in the Netherlands	12
1.4	Recognition of foreign medical certificates	13
1.5	Research questions	15
2	Migration of International Medical Graduates	17
2.1	Abstract	17
2.2	Large-scale migration of International Medical Graduates to Australia, Canada, UK and USA	18
2.2.1	Introduction	18
2.2.2	Brain drain and/or brain gain?	18
2.2.3	The Assessment procedures for IMGs in Australia, Canada, the United Kingdom and the USA	20
2.2.3.1	IMG assessment in Australia	20
2.2.3.2	IMG assessment in Canada	20
2.2.3.3	IMG assessment in the United Kingdom	21
2.2.3.4	IMG assessment in the United States of America	21
2.2.4	Conclusions	22
2.2.4.1	The necessity for “importing” countries to train more medical students	22
2.2.4.2	The necessity for a European policy	22
2.2.4.3	The necessity for a policy to reverse the brain-drain	23
2.2.4.4	The necessity to upgrade the working conditions of medical doctors in the new EU countries	24
2.2.5	Practice points	25
3	International Medical Graduates in the United Kingdom and the Netherlands: similarities and differences	26
3.1	Abstract	26
3.2	Introduction: IMG influx in the United Kingdom and the Netherlands	27

3.3	Methods	28
3.4	Pull factors for IMGs to choose for the UK and the Netherlands	28
3.5	Results and discussion	29
3.6	Conclusions	34
3.7	General conclusions (chapter 2 and 3)	34
4	Dutch policy towards foreign doctors	39
4.1	Legal admission procedures by the Department of Health since 1984 for holders of foreign certificates	40
4.2	Information for foreign graduates	43
4.3	Comments on the handling of requests for recognition by the Health Secretary	48
4.4.	Future developments in streamlining additional training programmes for foreign doctors	52
4.5	Assessment of quality requirements	59
4.6	Admission to the medical profession	60
5	The influx of International Medical Graduates to the Dutch labour market	63
5.1	Introduction	63
5.2	The role of the Department of Health in dealing with recognition requests	64
5.3	Admission to the medical faculties through CIBA and entry to the labour market after graduation	65
5.4	Methods	66
5.5	Survey results	66
5.6	Interview results	70
5.7	Additional information: data triangulation	71
5.8	Discussion	72
5.9	Conclusion	74
6	Non-EEA-doctors in EEA-countries: doctors or cleaners?	77
6.1	Abstract	77
6.2	Introduction	78
6.3	Methods	79
6.4	Results	80
	6.4.1 Results on country policies and practices	80
	6.4.2 Results on university policies and practices	84
6.5	Discussion and practice points	89
7	Self-assessment by CIBA doctors regarding their competences at the start of their medical training in the Netherlands	92
7.1	Summary	92
7.2	Introduction and research question	92
7.3	Methods	96

7.4	Results	97
	7.4.1 Response	97
	7.4.2 Results of closed questions	97
	7.4.3 Discussion of the results of the open question	100
7.5	Discussion and conclusions	101
8	Problems encountered by International Medical Graduates during their re-training at Dutch Medical schools	105
8.1	Abstract	105
8.2	Introduction	105
8.3	Methods	107
8.4	Results	108
	8.4.1 Course-related problems of 5th year students in a random control group	108
	8.4.2 General results	108
	8.4.3 Course-related problems faced by IMGs	109
	8.4.4 Secondary, non course-related problems	110
8.5	Discussion	111
8.6	Conclusions	112
9	Results of a new Dutch assessment procedure for international medical graduates	115
9.1	Abstract	115
9.2	Introduction	115
9.3	The new assessment for IMGs in the Netherlands	116
9.4	Results of IMGs participating in the assessment procedure	117
9.5	Conclusions	119
10	Final discussion	122
10.1	Introduction	122
10.2	Conclusions concerning the approach by the Department of Health towards foreign doctors and the recognition of their diplomas	122
	10.2.1 Conclusions	125
10.3	Preconditions for the successful implementation of the new assessment procedure	126
	10.3.1 Introduction	126
	10.3.2 Possible undesirable consequences of the assessment procedure	127
	10.3.3 Conclusions	131
10.4	Conclusions regarding the employment of CIBA doctors	132
10.5	Discussion of the policies by the Department of Health regarding foreign doctors in the multicultural Netherlands	134
10.6	Suggestions for further research	138
	10.6.1 Suggestions for an international comparative study	138

	10.6.2	Suggestions for a study on the accessibility of the assessment procedure	140
11		Summary	141
		References	146
	Appendix 1:	List of abbreviations (in English and <i>Dutch</i>)	156
	Appendix 2:	Annual Reports, Department of Health	159
	Appendix 3:	Recognition requests dealt with by CIBA since its establishment	168
	Appendix 4:	Questionnaire for graduated CIBA-doctors	169
	Appendix 5:	Overview of foreign diplomas per medical faculty (Career study 2004)	172
	Appendix 6:	Questionnaire for national policymakers and university policymakers concerning foreign educated medical doctors	174
	Appendix 7:	An international comparison between policies of some European countries and universities in dealing with foreign medical doctors	180
	Appendix 8:	Retention Policy for Ethnic Minority Students	227
	Appendix 9:	Parliamentary motion proposed to the Second Chamber of the States General by C. Hermann (of the <i>Groen Links</i> party) on 6 December 2001	239
	Appendix 10:	Questionnaire on the inclusion of foreign doctors	240
	Appendix 11:	Basic Test Medical Dutch	241
	Appendix 12:	Inventory of problems regarding study progress	242

Preface

The book in front of you is a reworking of my doctoral thesis. I defended my thesis on 31 March 2009 at Utrecht University. It is the result of my work on behalf of foreign doctors in the Netherlands.

In the early 1990s I came into contact with foreign doctors in my work as a student counsellor and an admissions officer at Utrecht University. Initially I only rarely met a foreign doctor, but this group of doctors became bigger and bigger. This increase led to frequent consultations in committees of student counsellors and student advisers. In 1995, the student counsellors and student advisers of universities with a medical faculty presented a joint advice to the national Medical Sciences Board (DMW), which argued for the implementation of a central application body for foreign doctors. The Medical Sciences Board approved of this implementation and in 1996 the Commission for the Influx of Foreign Doctors (CIBA) was founded. I participated in this commission as an adviser from the time CIBA was founded. In the 11 years that CIBA existed (1996-2007), more than 1,000 doctors from non-EEA countries were offered the chance to work as doctors in the Netherlands after having been admitted as medical students.

Before I could take some definitive steps towards my PhD research, I had some preliminary and guiding talks with four colleagues, who I would like to thank for their support. The first is the former rector of Utrecht University, Prof W.H. Gispen, who encouraged me to carry out this research. In addition, I was advised and assisted by Nathan Deen (professor emeritus in student counselling at Utrecht University), Han Entzinger (professor in migration and integration studies at Utrecht University) and Henk Nederhand (teacher of Dutch as a second language at the James Boswell Instituut). I am very grateful to them all.

I would also like to thank my supervisors Prof J.R.E. Haalboom (University Medical Centre Utrecht) and Prof D. Kruijt (Utrecht University) for their vital assistance in the realisation of my thesis. In addition, I would like to thank my co-supervisor Dr C. Boonman and my paranymphs ¹A. Kruijshoop and W. van der Endt.

The translation of my thesis has been made possible by financial support from a number of foreign doctors. In addition, the Stichting Seacrest has contributed to the funding of this translation.

I am also grateful to the translator, Fulco Teunissen of Twelvetrees Translations, for the way he has carried out this translation.

This thesis describes how the Health Department and the medical faculties have dealt with foreign doctors during the past 20 years (1990-2010). A comparison has been made between the (large-scale) manner in which immigration countries such as Australia, Canada, the UK and the USA deal with migrating doctors and the (small-scale) manner in which the

¹In Dutch universities, a paranymph is a person who accompanies and assists someone who presents his/her thesis.

Netherlands deals with migrating doctors. Australia, Canada, the UK and the USA are dependent on foreign doctors, and to a large degree this determines the willingness in these countries to invest in the accessibility of the medical professions for foreign doctors. Dutch healthcare is not dependent on foreign doctors. As a result, the willingness of the Dutch government to invest in foreign doctors has been very limited throughout the years.

One of the matters described in the research chapters is whether foreign doctors, after completing their additional medical training, succeed in finding work as doctors.

In addition, a comparative study has been carried out into the policies of European countries and European universities with regard to non-EEA doctors (Chapter 6). In Appendix 7, I have indicated who, in which country, and from what capacity have given me support.

In December 2005 a new assessment procedure came into force. Chapter 7 describes how the final cohorts of foreign doctors before the implementation of this new assessment procedure judged their own general and medical competences. Chapter 8 presents an inventory of the problems that confront foreign doctors during their additional medical training. Chapter 9 shows the consequences for foreign doctors of the implementation of the new assessment procedure. Since 2006, entry to additional medical training has all but been blocked due to the lack of a suitable admission route. Incidentally, Chapter 9 was not included in my original thesis.

This book describes the manner in which the Netherlands has dealt with foreign doctors who have permanently settled in this country, refugees as well as partners of Dutch citizens. Practically all the doctors who obtained a Dutch doctor's diploma after completing their additional medical training have succeeded in finding work as doctors. Of course this is not only the result of the efforts by their trainers, but also of the foreign doctors themselves. As a result of favourable labour market perspectives, Dutch healthcare and society have been enriched.

The experiences in the Netherlands may well be of great interest to many different people, such as policymakers at the Health Department, education developers at medical faculties, people working at organisations that support migrants and employees of language institutes, both inside and outside of Europe.

Paul Herfs,
1 February 2011

1 Introduction and research questions

1.1 Introduction

This dissertation discusses medical graduates in the Netherlands who obtained their qualifications in non-EU countries. I first worked with medical graduates when I was a counsellor of foreign students at Utrecht University. In the early 1990s medical graduates only occasionally approached us. However, from the mid 1990s the number of doctors requesting admission to medical training started to rise. I became interested in their situation and have remained so ever since. These doctors were nearly always people who had permanently settled in the Netherlands and who wanted to work as doctors in this country, too. Together, these doctors and I have been trying to find the shortest route to reach their goal. This has not always been easy. Many different institutions were involved in different parts of the integration process, which led to situations that demanded a great deal of resourcefulness, creativity and strategic thinking. For example, medical graduates may have had to deal with the Department of Health (for recognition of status), the Netherlands Organisation for International Cooperation for Higher Education NUFFIC (for the assessment of qualifications), the Immigration and Naturalisation Service IND (for residence permits), the municipal social services (for the preparation for a study or for following a university programme while receiving benefits), a university language institute (for learning the Dutch language), and the city council (for housing). Although these doctors were still learning Dutch, they had to convince the authorities of the value of their medical certificates and of their desire to work as doctors in the Netherlands, too. In this process the doctors were faced with an enormous amount of bureaucracy. Moreover, on many occasions Dutch civil servants showed great disdain regarding the level of foreign medical studies.

It also came to the attention of my fellow student counsellors at universities with a medical faculty that the number of foreign medical graduates was rising. Study advisers at medical faculties also noticed an increase in foreign medical graduates wanting to study at their faculty. Similarly, the University Asylum Fund (UAF) found that the number of medical graduates was increasing among their clients. There was a need for cooperation and for joining forces, and this led to requests for a national registration point at the Medical Sciences Board (*Disciplineoverlegorgaan Medische Wetenschappen*) of the Association of Universities in the Netherlands (VSNU). In 1996, the VSNU created the Committee for the Influx of Foreign Doctors (*CIBA*), which laid the foundation for a national, harmonised approach of medical graduates by medical faculties and also led to greater professionalism of student counsellors with respect to this special type of student.

The integration of immigrants in the Netherlands has been a topic of fierce debate for years. As early as the 1990s there were various signals of dissatisfaction regarding the influx of immigrants. Bolkestein (of the right-wing VVD party) was the first to put to paper his worries about the failure of immigration. At the time he was on his own. Ten years later, Paul Scheffer (of the left-wing PvdA party) published his article 'The multicultural drama' (2000). He wrote that there was a growing gap between the immigrant subclass and the rest of society. The friction that had been caused by the admittance to Dutch society of large groups of immigrants was neither recognised nor acknowledged in politics. For a left-wing politician the publication of 'The multicultural drama' was a highly explosive enterprise. In leftist circles, the acknowledgement of the less successful aspects of the multicultural society was one of the last taboos. Whoever chose to acknowledge these aspects ran the immediate risk of being branded a right-wing racist, which is the reason why for years no open debate had been possible about the integration of immigrants. Then, a number of incidents fanned the flames of the debate on immigration. In the Netherlands, the politician Pim Fortuijn and outspoken film-maker Theo van Gogh were murdered in 2002 and 2004, respectively. Globally, attacks by Muslim terrorists on civil targets in the United States of America, Spain, the United Kingdom and Russia led to polarisation between Muslims and other ethnic groups.

Immigrant Muslims' ideas about native Dutch people still show large cultural differences. The 2005 Annual Immigration Report of the Netherlands Institute for Social Research (SCP) observes that half the Turkish and Moroccan immigrant population is of the opinion that "the Western way of life is incompatible with the Muslim way of life and that there is a clear rejection of each other's family values and way of living" (SCP/WODC/CBS, 2005) Half of the Dutch population thinks that there are too many immigrants in the Netherlands. A closing of the gap between immigrants and the native Dutch population is not close at hand.

The aforementioned SCP report also observes that many immigrants have no prospects on the labour market due to their poor command of the Dutch language and their low levels of education. This inevitably leads to high unemployment rates and dependence on benefits. This gloomy picture can be completed by considering the high crime rates among immigrants and, consequently, their negative image.

Iranian people take up a special place in this story. The SCP has found that they are often highly educated. Moreover they are often oriented towards the West, which has led to many contacts with native Dutch people and a reasonable position on the labour market. This Western orientation appears to be the key to integration. As a result, their children's school success is similar to that of native Dutch children.

In December 2002, as a reaction to the dissatisfaction in Dutch society regarding the poor integration of immigrants, Dutch parliament created the Temporary Committee on Integration Policy. In January 2004, this committee published its final report, 'Building bridges'. The report met with fierce criticism. Many political parties regarded the conclusion that "the integration of many immigrants has been partly or completely successful" as an

utter denial of the problems regarding the multicultural society. It was established that Dutch immigrants topped the wrong leagues (such as crime, wife beating, unemployment, and dependence on benefits).

The topics that the parliamentary committee investigated included integration, work and income, education, female emancipation and organisations for and of ethnic minorities. Due to the elaborateness of the subjects investigated in the report, it is impossible to present a limited number of major conclusions. Even if only education and the recommendations pertaining to education are considered more closely, it is striking that no or hardly any mention is made of the integration of the higher educated immigrants (partners of Dutch nationals and asylum seekers/refugees). Research is mostly aimed at immigrant pupils who enter the educational system at the lower end of the scale (in primary education). However, this is beyond the scope of this dissertation, which focuses on highly educated immigrants who enter the educational system at higher level (in tertiary education).

1.3 The integration of medical graduates in the Netherlands

This dissertation focuses on foreign medical graduates and especially on the question whether the integration of this special category of immigrants is part of the multicultural drama or whether it is rather a multicultural success story.

It was decided to limit the research population to foreign doctors because they are by far the largest group of highly educated people requesting permission to carry out their profession in the Netherlands. To a much lesser extent foreign pharmacists, obstetricians and dentists request recognition. For medical graduates with a medical certificate who are citizens of a country that belongs to the European Economic Area² (EEA), recognition guidelines have been drawn up by the European Council (Council Directive 93/16/EEC and Council Directive 2005/36/EC). This study does not take these people into consideration.

In the past decades, the Netherlands has dealt with changes in the influx of migrants (Entzinger, 2002). Among the new groups, there have been highly educated migrants with foreign medical or paramedical certificates. The migratory backgrounds of these highly educated migrants can be roughly divided into:

1. Asylum seekers and refugees
2. Family makers

² Until 1 May 2004, the European Economic Area comprised the 15 EU member states together with Liechtenstein, Iceland and Norway. Switzerland has not formally joined the EEA, but this country has a status which is comparable to EEA membership. On 1 May 2004, the following countries joined the European Union: Cyprus, Estonia, Hungary, Latvia, Lithuania, Malta, Poland, Slovenia, Slovakia and the Czech Republic.

Asylum seekers and refugees hail from countries that do not belong to the EEA. Refugees with medical or paramedical certificates who asked for asylum in the Netherlands from the 1990s, and subsequently requested recognition of their certificates by the Department of Health mostly originate from hotbeds such as the former Yugoslavia, Iran, Iraq, Afghanistan and Somalia.

Family makers who had obtained their asylum status as a result of marriage or partnership with a Dutch man or woman generally come from all over the globe. However, a considerable number of family makers with medical or paramedical certificates originate from eastern European countries, such as the former Soviet Union and the new EU countries. The number of family makers has been growing since 2001.

1.4 Recognition of foreign medical certificates

This chapter focuses on the recognition in the Netherlands of medical certificates that were obtained in countries outside the European Union (EU) or the European Economic Area. Refugees or family makers who have graduated as doctors will at some point ask whether their medical certificate is recognised in the Netherlands and which institution is responsible for the recognition procedure. The Department of Health is responsible for dealing with requests for recognition of foreign doctors' testimonials. If requested, bearers of medical certificates from one of the 'old' EEA countries can obtain a declaration of professional competence from the Health Secretary. They are enrolled in the BIG register, provided they also have the nationality of the EEA country in question. A request to the Department of Health for recognition of foreign medical certificates can result in any of the following three outcomes:

1. *Equivalence* of the foreign medical certificates with Dutch medical certificates: doctors are fully qualified. This group is referred to as Category I doctors.
2. *Near equivalence* of the foreign medical certificates with Dutch medical certificates. People from this category³ can be temporarily admitted to the profession, but with limitations. This entails that for a maximum of two years medical graduates have to work under the supervision of a Dutch doctor, who they have to find themselves. Finding a colleague who is willing to act as a supervisor for one or two years has turned out to be an extremely difficult task. This group is referred to as Category II doctors.
3. *No equivalence* of the foreign medical certificate with Dutch medical certificates: rejection. The people concerned are referred to the Committee for the Influx of Foreign Doctors (CIBA), a joint venture of eight Dutch universities with a medical faculty.⁴ This group is referred to as Category III doctors.

³ The assessment procedure by the Department of Health, which came into force on 1 December 2005, brought an end to Category II.

⁴ In September 2007 CIBA was abolished as a result of the new assessment procedure by the Department of Health, which came into force in December 2005.

An increasing number of doctors who had been educated outside the EU and EEA presented themselves at one of the eight Dutch universities with a medical faculty. University student counsellors noticed that foreign doctors displayed shopping behaviour: they submitted admission requests at several medical faculties at the same time. From an efficiency point of view this was an undesirable development; therefore, in 1996 a national registration agency was created: the Committee for the Influx of Foreign Doctors (CIBA). Its aim was to regulate the distribution of admission requests by foreign doctors. Every medical faculty had a representative in CIBA.

CIBA determined a number of criteria that the requests should meet.

1. The doctor had to have submitted a request for recognition with the Department of Health and the verdict needed to be 'no equivalence' (Category III).
2. The doctor had to have a permanent residence permit for the Netherlands (as a refugee or as a result of having a Dutch partner).
3. The doctor had to have passed the State exam Dutch as a foreign language (NT2; programme 2).

The CIBA divided the requests over the eight medical faculties. However, the final decision on the admission to a medical training programme was not taken by CIBA but by the executive board of the University or by the board of the medical faculty. The number of available places for entry into a higher year of medical training was limited. This non-central and therefore inconsistent decision-making process led to the situation that the exam committee at one university could reach a different conclusion about the same diploma than the exam committee of another university. It was expected that closer co-operation between the eight medical faculties within CIBA would lead to more uniform inclusion results.

Section 7.54a of the Dutch law on higher education and scientific research (WHW) states that an institution can limit admission to the post propaedeutic phase. Most medical faculties set aside a limited number of places (10-15) in the post propaedeutic phase of medical training for students who did not need to acquire a place through allocation of lots by the Central Application and Admission Office (CBAP) of the Ministry of Education. These students had at least to have exemption from the propaedeutic medical exam and they had to have important reasons for continuing their medical training in the Netherlands. Such important reasons included a permanent stay in the Netherlands resulting from recognition as a refugee and/or from having a Dutch partner, in combination with a foreign medical certificate. From 1996-2007 the CIBA dealt with more than 1,000 requests for admission by foreign doctors.

The CIBA focused mainly on foreign doctors who had been delegated by the Department of Health to Category III (no equivalence). As a matter of course, the ministry referred these people to CIBA. In previous years most medical graduates from eastern Europe, Asia and Africa had been assigned to Category III. Until 2002, the Department of Health only dealt with requests for recognition. Doctors who had been classified as Category II (near equivalence) were referred to SIBIO, an organisation for intercultural business aspects and intercultural entrepreneurship. The results of this organisation were certainly not always a great success. A number of doctors who had reached a dead end with SIBIO, later reported to CIBA where there was more chance of obtaining a Dutch medical certificate. Until 2002,

little priority was given at the Department of Health to policy-making with regard to foreign doctors. This may well have been a result of the huge success of the university CIBA route.

1.5 Research questions

These are the questions that will be investigated in this research:

1. How can we guarantee that a foreign doctor, who wants to work as a doctor in the Netherlands, has the necessary quality with regard to knowledge, skills and attitude? In other words, how has the assessment of foreign doctors been arranged for these different aspects?
2. Have doctors who were trained outside the European Economic Area, after having been given permanent residence in the Netherlands, been admitted to the profession for which they are qualified in their country of origin or in another non-EEA country? If these doctors are not allowed to practise their profession, are there other possibilities to obtain this assent? In particular, it has been determined which obstacles doctors encounter in their attempts to be admitted to the Dutch health market and which additional education may be necessary. In addition, it has been investigated how (nine) other EEA countries deal with people holding foreign medical certificates who have obtained permanent residence as a migrant (refugee or family maker).

This research presents a survey of the obstacles that foreign doctors in the Netherlands encounter in their attempts to be admitted to the Dutch health market. After an exploration of the literature in chapters 2 and 3, chapter 5 presents a study which focuses on the question whether foreign doctors succeed in finding work as doctors after they have graduated as doctors in the Netherlands. Chapter 6 presents an international (European) comparison of the activities undertaken by EEA countries and their universities with regard to foreign doctors whose medical certificates are not recognised. Chapter 7 describes how the last two CIBA cohorts (2004 and 2005) considered their competencies with regard to their command of the Dutch language, the English language, ICT knowledge, etc., at the start of their medical training. Chapter 8 presents a survey of the problems that were registered for foreign doctors during the first year of their additional medical training at five medical faculties. To this end, the complete files have been examined of the yearly cohorts of foreign doctors who were admitted to five medical faculties in the years 2002 and 2005. Chapter 9 describes the results of the new assessment procedure in the period 2005-2009.

The background of the problem, its consequences and the direction of the solution will be described:

- *What is the problem?*
Until 2005 there was no real government policy with regard to foreign doctors whose medical certificates were assessed as 'non-equivalent'.
- *What are the consequences?*
Universities with a medical faculty have produced their own solutions, since there was no national policy regarding foreign medical graduates who requested

recognition of their medical certificates. This resulted in inequality in admission decisions and solutions, which led to additional training projects that showed great differences in length and content. For individual students placement in a lengthy training programme had very negative consequences (such as higher debts and the possible revocation by the local social service department of the permission to study while retaining unemployment benefits).

- *What has caused the problem?*

In the absence of a national policy there has been no fully fledged entry programme for foreign doctors. The entry programmes of the medical faculties were actually driven by necessity. Until mid-2002 there were hardly any consultations between faculties with regard to entry programmes for foreign doctors. At the end of 2002, during the discussion of the Health budget, Hermann proposed a parliamentary motion which called on the Health Secretary to give the universities the opportunity to facilitate additional programmes for foreign doctors. This more or less forced the ministry to develop a national policy regarding foreign doctors whose certificates were judged as 'non-equivalent' or 'nearly equivalent'.

- *How can this problem be solved?*

There should be agreement about the way to assess the level of knowledge of foreign doctors. In addition there should be agreement about the content of bridging programmes and additional medical training.

I want to provide more insight into the obstacles that foreign doctors encounter during their integration process into Dutch society. Based on first-hand experience in the past 15 years, I will explain the painstakingly slow progress (sometimes even complete lack of progress) in the procedures aimed at quickly deploying foreign doctors in Dutch society. The conclusions and suggestions in the final part of this study will also involve the experiences with foreign doctors in other European countries. Moreover, attention will be given to the new assessment procedure for foreign doctors, which came into force in the Netherlands on 1 December 2005.

2 Migration of International Medical Graduates

2.1 Abstract

This review describes the migration of medical graduates. Part I focuses on the effects of large-scale migration of International Medical Graduates⁵ (IMGs) to Australia, Canada, the United Kingdom and the United States of America. In the second part a description is given of experiences with small-scale migration of IMGs to continental Western European countries.

Chapter 2 presents a study into the effects of brain drain for source countries (ie the IMGs' countries of origin) and the brain gain effects for host countries. Many international medical graduates (IMGs) leave their country of origin for economic reasons. They try to settle in a new country, where they hope to find more opportunities (medical career, further medical education, wealth and a welfare system etc.). In most cases the IMGs leave a poor country to settle in a rich country. We have found a dichotomous distribution between countries in which public health is dependent on the influx of IMGs and those where public health is in no way dependent on IMG influx. In at least four rich western countries public health is dependent to a large extent upon the influx of IMGs. In Australia, Canada, the United Kingdom and the United States of America at least 20% of the medical workforce have obtained their medical degrees outside the host country.

Chapter 3 describes experiences with the small-scale migration of IMGs to continental Western European countries. In most countries of the European Economic Area (EEA), except the UK, large-scale migration of International Medical Graduates (IMGs), i.e. those with diplomas obtained outside the EEA, does not occur. Of all the doctors in practice in the United Kingdom, 31% were educated outside the UK, as compared with less than 5% in Germany and France. In most EEA-countries⁶ health care is not dependent on the influx of IMGs. The aim of this part of the study is to present data comparing the ratio of medical doctors per 100,000 citizens in Western countries to those countries from which IMGs originate, i.e. their source countries. A special focus has been put on the Netherlands. Most EEA-countries have a ratio of doctors of about 300 per 100,000 citizens. In countries at war such as Afghanistan and Iraq and in the former Dutch colonies, Indonesia and Surinam, the ratio of doctors drops below 60 per 100,000.

⁵ International Medical Graduates can be defined as medical doctors who obtained their medical degree in a certain country, the source country, and leave this country in order to migrate to and settle in another country, the host country. International Medical Graduates are not foreign students.

⁶ The European Economic Area (EEA) comprises all (27) European Union countries plus Iceland, Liechtenstein and Norway. Switzerland has a status comparable to an EEA-country.

Most IMGs in EEA-countries either have a refugee status, or have entered the country as spouses/partners of EEA-citizens. For countries at war, with a low ratio of doctors, even the migration of small numbers of medical doctors, can be detrimental for health care. In new EU-countries (e.g. Hungary and Poland) there is a fear that medical doctors might leave their countries of origin and move to countries with higher standards of living.

2.2 Large-scale migration of International Medical Graduates to Australia, Canada, UK and USA

2.2.1 Introduction

In international literature on the migration of doctors educated abroad or international medical graduates (IMGs), two important perspectives are usually brought forward. The first perspective concerns the brain drain which results from the large scale migration of international medical graduates, focusing on the so-called source countries, i.e. those that see a large number of their doctors leave the country. The other perspective focuses on the brain gain, or the assessment of the level of the international medical graduates in the host countries. We will discuss how a migrating medical graduate is assessed to check whether he/she meets the quality requirements set in a limited number of host countries. The influence of IMG-migration on public health is beyond the scope of this article.

2.2.2 Brain drain and/or brain gain?

A number of Western countries are highly dependent on the migration of international medical graduates, the most significant ones being Australia, Canada, the United Kingdom and the United States of America. The migration of medical graduates to these four countries takes place on a grand scale. This typification is used when at least 20% of the doctors at work in the host country have been trained elsewhere. The migration of medical graduates to other Western countries (either as refugees or to be with their spouses) takes place on a much smaller scale and the health care system in those countries is not dependent on these foreign graduates.

Eastwood et al. (2005) have typified these migrations of IMGs as a “medical carousel”. Looking for better training opportunities, working conditions and higher salaries medical graduates migrate from Tanzania, Kenya and Nigeria to South Africa. South African doctors leave their country - due to an increasing level of insecurity - and settle in the United Kingdom. Doctors from the United Kingdom migrate to Canada and the United States of America, while Canadian doctors migrate to the USA. Every medical graduate leaving the African continent constitutes a loss of US \$ 184,000 (€ 156,170), according to the UN Conference on Trade and Development (Ogowe; 1996). At the same conference it was

announced that 56% of all IMGs come from developing countries and migrate to developed countries.

In the UK 31% of all doctors in practice were educated abroad and in the USA 23%, whereas in Germany and France the number is less than 5% (Eastwood *et al.*, 2005). The costs of educating a doctor in the UK amounts to ca £ 250,000 (€ 380,000). Every overseas doctor migrating to the UK represents, therefore, a gain of £ 250,000 for the UK. Eastwood *et al.* have called on the World Health Organisation to come to an agreement as soon as possible on a standardized minimum number of medical graduates to be trained in developed countries: "Without such internationally agreed minimum training targets for developed countries, the most vulnerable countries will continue to lose a large proportion of their health workers." (Eastwood *et al.* 2005). In an Editorial Comment in the *Lancet* an even stronger appeal is launched: "Every rich country can afford and should aim to train as many health-care workers as it needs. To poach and rely on highly skilled foreign workers from poor countries in the public sector is akin to the crime of theft." (Lancet; 2005).

Australia, too, is highly dependent on IMGs, especially in the scarcely populated outback areas. Around 20% of all practising doctors in Australia were educated abroad (Australian Medical Workforce Advisory Committee, 2004; Spike, 2006). In spite of an increase in the number of available places at medical schools from 1300 to 2100 (from 2010), Australia will still be dependent on IMGs in the future. The editors of the *Medical Journal of Australia* (Van der Weyden & Chew; 2004) blame the Australian government for greatly underestimating the need for medical doctors since the early nineties. The ethical issues surrounding the recruitment of medical graduates from developing countries by rich countries such as Australia are explained away by Spike: "Countries involved in the active recruitment of doctors from the developing world often need to place these doctors in areas where local graduates will not usually work. Such recruitment policies, by a range of providers with vested interests, offer a relatively inexpensive, quick solution to inadequate resource planning at a local and national level."

The USA are dependent on doctors trained outside the country to a high degree. In 1995 the Pew Health Professions Commission strongly advised reducing the dependence on IMGs. In that year 23% of the doctors practising in the American health care system were educated abroad. Mullan *et al.* (1995) pointed out that a large number of medical students visiting the USA as part of an exchange programme did not return to their countries of origin but stayed to work as doctors in the USA. As, at that point, a surplus of doctors was expected, the American government was advised to prevent IMGs from permanently settling in the USA. Mick *et al.* (1997), however, emphasises that foreign doctors form a safety net for the scarcely populated areas. Ten years later the situation has not changed and the American health care system is still dependent on IMGs. The Educational Commission for Foreign Medical Graduates (ECFMG), the central organisation responsible for certifying foreign medical diplomas and the assessment of foreign doctors, calculated that of the estimated 800,000 doctors practising in the USA 23% were educated abroad (Hallock *et al.* 2007).

In Canada, too, 23% of all registered medical doctors have a foreign diploma (Crutcher *et al.*, 2003). This high percentage indicates that Canada is also highly dependent on IMGs. In fact, the South African government has requested that the Canadian government refrain from actively recruiting South African medical graduates (Ehman *et al.*, 2001).

2.2.3 The Assessment procedures for IMGs in Australia, Canada, the United Kingdom and the USA

Due to the large influx of foreign doctors in Australia, Canada, the UK and the USA, these countries have been forced to develop highly sophisticated assessment procedures to determine whether migrating medical doctors meet the quality requirements. Below, we will describe briefly the assessment procedures used by the four countries mentioned.

2.2.3.1 *IMG assessment in Australia*

Australia has set an assessment procedure for medical doctors educated abroad who wish to set up practice permanently and, therefore, request full registration (Spike, 2006). Apart from checking the immigration requirements, the Medical Council has the candidates tested as to their proficiency in the English language and asks them to produce a certificate of moral conduct. The next stage, a medical knowledge test, is used to determine whether an IMG has the required knowledge, skills and level of professional behaviour in order to be permitted to work as a doctor in Australia. The last stage is a clinical examination and a supervised training period in a hospital.

Occasionally, IMGs are employed on a conditional status and set to work in the health care system before they have gained full registration. The reason for cutting the assessment procedure short in these cases is the enormous shortage of doctors in the scarcely populated outback areas.

Apart from the route leading to full registration with a permanent residence permit, there is an alternative route for IMGs. Australian hospitals and health care centres can recruit IMGs with a temporary residence permit directly and without any real assessment, except for a credentials check, taking place. This alternative route around the official assessment procedure for IMGs is reason for concern (McGrath, 2004; Van der Weyden *et al.*, 2004; Spike, 2006).

2.2.3.2 *IMG assessment in Canada*

In Canada there are several licensing procedures for foreign medical doctors, as the ten provinces and three territories have each developed their own assessment procedures (O'Meara, 2004). The Medical Council of Canada has recently decided to allocate CAN \$ 554,000 to a consortium whose task it is to realise one uniform national assessment procedure for IMGs. Canada has a medical licensing exam: the Medical Council of Canada Qualification Examination. All 'regular' Canadian medical students have to pass this test at the end of their fourth year of medical school.

In British Columbia, for example, this standard exam is part of the assessment procedure

for IMGs. After having their residency requirements checked, as well as their proficiency in the English language, IMGs are required to take the Medical Council of Canada Qualification Examination in order to prove that their basic medical and clinical knowledge is sufficient. This test is then followed by a six hours Objective Structured Clinical Examination, during which the IMGs take case histories and perform physical examinations. Their doctor-patient communication skills are also assessed. Finally, their medical and clinical skills, as well as the way they work together in a multi-disciplinary team, are evaluated during a practical working period of 6 weeks (Andrew & Bates, 2004).

2.2.3.3 *IMG assessment in the United Kingdom*

IMGs seeking registration as medical doctors in the UK are required to pass the Professional Linguistic and Assessment Board-Exam (General Medical Council, 2006). The exam consists of a language test, i.e., the International English Language Testing System exam (IELTS), and two medical knowledge and skills tests: PLAB (part 1 and 2). For the IELTS-exam an overall score⁷ of 7 is required. This relatively high score requirement is indicative of the importance attached by the General Medical Council to the level of language proficiency of IMGs. In addition, as part of the certifying process, checks are carried out to ascertain whether the foreign medical school issuing the certificate is listed in the WHO-directory.

2.2.3.4 *IMG assessment in the United States of America*

The migration of foreign medical doctors to the USA is not a new phenomenon. Half a century ago the Educational Commission for Foreign Medical Graduates (ECFMG) issued a certificate to a foreign doctor in the USA for the first time (Cain *et al.*, 2005). An international medical graduate seeking to practise medicine in the USA has to follow the ECFMG assessment procedure. The ECFMG uses the United States Medical Licensing Examination (USMLE, 2006) to test medical knowledge and skills. Furthermore, the IMG's medical education credentials are verified. Among other things a check will be carried out to conform that the medical school that issued the certificate is listed in the International Medical Education Directory (IMED).

⁷ An IELTS overall score of 7 is by no means a walk in the park; the maximum overall score is 9. To illustrate this, most universities in the Netherlands demand an overall score of 6 from students seeking admission to graduate programmes in English.

2.2.4 Conclusions

2.2.4.1 *The necessity for “importing” countries to train more medical students*

Countries “importing” International Medical Graduates on a large scale should take measures to reduce their shortages of medical graduates. By doing so the attraction of IMGs from developing countries could be reduced. The American Association of Medical Colleges has already called for a 30% increase in enrollment. In her speech at the OECD conference in Turkey, Dr. Margaret Chan (2007), the Director-General of the World Health Organisation, drew attention to the fact that rich countries “increase the burden on health systems at a time when the health workforce has been depleted. The WHO estimates that an additional 4 million doctors, nurses and other workers are urgently needed to maintain essential care in 57 countries.”

Where IMGs have been additionally trained in one of the four “importing” countries, more attempts should be made to encourage them to return to their home countries after finishing their training.

2.2.4.2 *The necessity for a European policy*

Countries with a long-standing migration tradition are more experienced in assessment procedures. The Educational Commission for Foreign Medical Graduates in the USA, for example, has over 50 years of experience in assessing medical degrees. As public health care systems in Australia, Canada, the UK and the USA are dependent on IMG-influx it is not surprising that these countries have well-developed assessment procedures. Countries like the Netherlands and France only developed and introduced an assessment procedure for IMGs in 2005 (Herfs *et al.*, 2007). Public health in most EEA-countries, except the UK, is not at all dependent on the influx of IMGs.

Over the last two decades migration waves (refugees and those who wish to be with their spouses or partners) have also brought IMGs to western countries that did not have a long-standing migration tradition. Western European countries without sophisticated assessment procedures are, without any international coordination, reinventing the wheel regarding IMG-assessment. The European Commission could play a valuable role in the co-ordination of IMG assessment procedures.

2.2.4.3 *The necessity for a policy to reverse the brain-drain*

It is evident that the health care systems in Australia, Canada, the UK and the USA are highly dependent on incoming IMGs (Mullan, 2005). The four countries mentioned draw on a rather large number of medical doctors educated abroad, much more so than other Western countries. The number of medical doctors educated in these countries is by far insufficient to meet national demand. What makes this especially difficult to digest for the source countries is the fact that the host countries need not put any effort into reducing these shortages. English speaking IMGs from developing countries will always seek ways of improving their living and working conditions, with or without active recruitment. Hagopian *et al.* (2004) estimate that 64% of all IMGs in the USA come from “low income or lower-middle income countries”. Of all the medical doctors from sub-Saharan countries practising in the USA, Canada and the UK, 86% originate from three countries: Nigeria, Ghana and South Africa. It is estimated that nearly half of all South African medical graduates emigrate to English-speaking Western countries.

This large scale migration has disastrous consequences for the source countries (Bourassa Forcier *et al.*, 2004). Chen *et al.* (2005) even speak of “fatal flows” inflicted upon African sub-Saharan countries by “doctors on the move”. It has been suggested that countries which are actively recruiting medical graduates from poor, underdeveloped countries be required to subsidise the source countries (Stilwell *et al.*, 2003; Hagopian *et al.*, 2004; Van der Weyden *et al.*, 2004). Pang *et al.* (2002) mention the fact that Ireland and Thailand have reached an agreement to reverse the brain drain, through which Thailand is compensated for the loss of medical doctors and nurses by receiving research funding and monetary incentives.

Although the conclusion sounds somewhat disheartening, it is probably an illusion to think that IMG-migration can be regulated or even stopped. For IMGs the pull factors of rich countries (a medical career and education, wealth, welfare) are too strong to prevent them from leaving their countries of origin. Of course we agree with the editorial board of the *Lancet* (2005), that all rich countries “should aim to train as many health-workers as it needs.” Our data (see table 2.1) show, however, that in relative terms the UK trains the very lowest number of medical doctors in the countries of the European Economic Area.

Table 2.1: Number of doctors per 100.000 citizens in 18 EEA-countries⁸

Country	Total number of doctors	Number of doctors per 100.000 citizens
Austria	27.413	338
Belgium	46.268	449
Denmark	15.653	293
Finland	16.446	316
France	203.487	337
Germany	277.885	337
Greece	47.944	438
Iceland	1.056	362
Ireland	11.141	279
Italy	241.000	420
Luxembourg	1.206	266
Netherlands	50.854	315
Norway	14.200	313
Portugal	34.440	342
Spain	135.300	330
Sweden	29.122	328
Switzerland	25.921	361
United Kingdom	133.641	230

So, even without active recruitment, IMGs know for certain that they can build up a medical career in the UK, the USA, Canada and Australia.

2.2.4.4 *The necessity to upgrade the working conditions of medical doctors in the new⁹ EU countries*

Since May 2004 medical graduates from 10 'new' European Union member states have been free to move to, live and to work in most of the 'old' EU-member states. In January 2007 the EU expanded again with two new countries. In some new EU-member states there are great concerns that large numbers of their medical work force might leave their country of origin. However, it will not be easy for a Polish or Czech medical doctor to become a fully-qualified doctor in another EU-country and, last, but surely not least, become fluent in the language of the new EU-country. Medical graduates can only be stopped from leaving their country en masse if they can build up a (medical) career and a standard of living in general that is comparable to that which could be built up outside the country of origin.

⁸ According to the World Health Organisation (<http://www.who.int/globalatlas/dataquery/home.asp>) and De Grote Bos-atlas (Wolters-Noordhoff; 2001).

⁹ The new EU-countries per May 2004 are: Cyprus, Estonia, Hungary, Latvia, Lithuania, Malta, Poland, Slovenia, Slovakia and Czech Republic. As from January 2007 Bulgaria and Romania entered the EU as well.

2.2.5 Practice points

- Western countries should be aware of the disastrous effects large scale migration of doctors can have on health care in the source countries.
- Western countries should in principal train as many doctors as these countries need. By doing so they can lower the attractiveness for IMGs to migrate to western countries.
- IMGs should be enabled to pursue additional training in western countries, provided that they return to their home countries after finishing the training programme.
- Western countries and source countries ought to consider introducing measures to compensate for the departure of health workers from their home/source countries.

3 International Medical Graduates in the United Kingdom and the Netherlands: similarities and differences¹⁰

3.1 Abstract

In most countries of the European Economic Area (EEA), except the UK, large-scale migration of International Medical Graduates (IMGs) i.e. those with diplomas obtained outside the EEA, does not occur. In the United Kingdom health care is in part dependent on the influx of IMGs. Of all the doctors in practice in the United Kingdom, 31% were educated outside the UK, as compared with less than 5% in Germany and France. In most EEA-countries health care is not dependent on the influx of IMGs.

Recently the UK Health Secretary decided to restrict entry of overseas medical graduates. As four new medical schools have started it is no longer necessary to accept overseas graduates into specialist training posts.

The aim of this study is to present data concerning the changes in IMG migration in the UK since the extension of the European Union in May 2004. Furthermore data on the ratio of medical doctors per 100.000 citizens in Western countries and in those countries from which IMGs originate, i.e. their source countries, are compared with that of the Netherlands.

For this study data from the the General Medical Council in the UK, the World Health Organisation (WHO) and the Dutch Department of Health were used.

The influx of IMGs in the UK is changing due to changes in the UK policy towards non-EEA doctors. The influx of IMGs in the Netherlands is described in detail. Most EEA-countries have a ratio of doctors of about 300 per 100.000 citizens. In countries at war such as Afghanistan and Iraq and in the former Dutch colonies, Indonesia and Surinam, the ratio of doctors drops below 60 per 100,000.

Health care in most EEA-countries is not dependent on IMGs, with the exception of the UK. Measures have been taken to diminish the dependancy on overseas medical graduates. Since April 2006 non-EEA medical doctors need working permits to specialize in the UK. This measure was disputed by many non-EEA doctors. Most IMGs in EEA-countries other than the UK have backgrounds either as refugees or as spouses/partners of EEA-citizens. For countries at war, with a low ratio of doctors, even the migration of small numbers of medical doctors, could be detrimental for health care. In new EU-countries (e.g. Hungary and Poland) there is a fear that medical doctors might leave their countries of origin and move to countries with higher standards of living. In 2005 744 Polish doctors and 320 Hungarian doctors asked registration with GMC. Two years later this numbers had decreased to 339 respectively 194.

¹⁰ Prof. Jeen Haalboom (University Medical Centre Utrecht), Prof. Dirk Kruijt (Utrecht University), Dr. Peter Trewby (Darlington Memorial Hospital and University Hospital of North Durham) and Prof. John Eastwood (University of London) contributed greatly to this chapter.

Over the last two decades international medical graduates (IMGs) with diplomas obtained in third world countries have been moving towards countries of the EEA. Most EEA-countries do not actively recruit IMGs; the numbers of international medical graduates working in EEA-countries, with the exception of the UK, are small.

In Australia, Canada, the United Kingdom and the United States of America, however, the migration of IMGs takes place on a large scale. The expression *large-scale IMG-migration* is used when at least 20% of the doctors at work in the host country have been trained elsewhere. The large-scale IMG-migration movements in Australia, Canada, the UK and the USA were categorised as a *medical carousel* (Eastwood *et al.* 2005). Looking for better education opportunities, working conditions and higher salaries, IMGs leave their countries of origin such as Tanzania, Kenya and Nigeria and settle in South Africa. Medical doctors from South Africa leave their country, due to increasing unsafety, and settle in the United Kingdom. Medical doctors from the UK migrate to Canada and the USA and Canadian doctors migrate to the USA. The net result is that the number of doctors, especially in African countries decreases, with serious detrimental effects on those countries. Furthermore, these doctors do not return to their native country after getting a full license in the country they went to.

In the UK solutions for this "medical carousel" phenomenon have been developed. Four new medical schools have started and furthermore the UK recently changed its policy towards IMGs from outside the EEA. Since April 2006 IMG's (non-EEA) who are applying for a specialty training programme need a working permit. Only when UK- and EEA-citizens are not applying and training positions are left over it is possible that non-EEA IMGs can obtain a training position and working permit. This enactment was challenged by many IMGs (mostly from India and Pakistan). But the High Court decided on the 9 February 2007 that the new guidance was lawful. The consequence is that IMGs can only obtain a specialty training position if no one in the UK or in other countries of the EEA is available (Dyer, 2007).

A survey study of George a.o. (2007) showed that of 1617 IMGs 76% said that the main reason for migration to the UK was further training. Cutting of the training route for non-EEA doctors is strongly criticised (Dyer, 2007).

Most IMGs in e.g. the Netherlands are either refugees or individuals who want to join their spouses/partners. A study of Herfs and Haalboom (2008) showed that in 2002 the majority (71%) of IMGs starting with their additional training at medical schools had a refugee status, while in 2005 the majority (57%) had a status as spouses of Dutch citizens. The changes in IMGs backgrounds are a result of the policy changes in Dutch immigration law. Recruitment of medical doctors hardly occurs in the Netherlands. However, there was one exception to this rule; the recruitment of medical doctors from South Africa due to short term shortages in Dutch hospitals. Recently, in February 2007, a Dutch recruiter of South African doctors was sentenced to 8 months in prison due to a breach of immigration regulations in the period 1999-2002.

The *medical carousel* phenomenon is not applicable to EEA-countries with small-scale IMG-migration. Nevertheless, source countries which many doctors leave, in order to settle

permanently in other countries, may end up with a low ratio of doctors. For the source countries the sum of the small numbers of migrating doctors to EEA-countries might be large.

3.3 Methods

In order to gain an insight into the number of IMGs present in the United Kingdom and the Netherlands, data from the General Medical Council and from the Dutch Department of Health were studied. In this study we used the term “ratio of doctors” to represent the number of doctors per 100.000 citizens of a country. The aim of this study was to compare the ratio of doctors in the Netherlands and other Western countries with that of ‘source countries’ i.e. countries, mainly from the third world, whose trained medical doctors leave to work elsewhere. To that end, data on the IMG influx from both the Dutch Department of Health and from the World Health Organisation (WHO, 2007) were studied. The WHO has developed records on health care workers in all the countries in the world. Based on these WHO data, estimations were made about possible shortages of doctors in the countries that are compared in this study. For the UK data on IMGs were gathered from the General Medical Council¹¹.

3.4 Pull factors for IMGs to choose for the UK and the Netherlands

IMGs may have very different reasons to migrate to either the United Kingdom or the Netherlands. Medical migration from and to the United Kingdom is very old (Trewby, 2008). Since 1599 British medical doctors migrated overseas to India. In the 18th century British doctors started to train Indians in Western medicine. Two-sided medical migration processes are a direct result of the British colonial history. Although the Netherlands too have a colonial history, medical migration was never that extensive as in the UK. In the following “property space” we present the differences in migration pull factors for IMGs to establish themselves in the UK or the Netherlands.

¹¹ The General Medical Council (Herfs, 2007) provided the following statistics:

2002:	4456 overseas qualified doctors registered with the GMC
2003:	9336 overseas qualified doctors registered with the GMC
2004:	686 overseas qualified doctors registered with the GMC

Table 3.1: Property space: pull factors for IMGs

Pull factors for IMGs	United Kingdom	Netherlands
Long-lasting history of medical migration	yes	no
Same language as in country of origin	yes	no
Quick assessment procedure	yes, since 1975	yes, since 2005
Medical schools experienced in additional training of IMGs	yes	no
After medical study: working permit necessary for non-EEA doctors	yes, since 2006	yes, unless permanent visa
After medical study: possibilities for consultant training position	yes; until 2006	yes, but only for locally trained IMGs
Medical staff in hospitals is international	yes	no
Health care is dependent on IMGs	yes	no
Better remuneration than in country of origin	yes	yes
Primary reason to migrate: further medical education	yes	no

3.5 Results and discussion

The total numbers of IMGs seeking recognition in the Netherlands are listed in table 3.2. In the year 2000 a total of 257 IMGs, originating from 51 countries, requested recognition¹². Relatively large numbers came from South Africa (33), Afghanistan (23), Iraq (17), the former USSR (26), Poland (20), Romania (10) and Surinam (8).

Table 3.2: Numbers of IMGs asking recognition at the Dutch Department of Health

Year	Number of International Medical Graduates
1995	292
1996	362
1997	357
1998	337
1999	274
2000	257
2001	no annual report available
2002	303
2003	no annual report available
2004	no annual report available

¹² Out of these 257 doctors 44 received direct recognition, 97 partial recognition and 116 had to obtain a medical license via the universities. From these 116 IMGs, 47 (40%) came from countries at war, such as Afghanistan and Iraq. The remaining 69 (59%) were not from countries at war, but merely wished to settle with their spouses or partners. This picture is mirrored in other EEA-countries.

An international comparison showed that the number of migrating IMGs to the UK was incomparably higher than that of other EEA-countries (Herfs, Kater & Haalboom, 2007). In the UK the number of IMGs seeking recognition in 2003 amounted to a total of 13.967 (see table 3.3).

Table 3.3: IMG-registration figures from the General Medical Council (2002-2007)

Country	2002	2003	2004	2005	2006	2007
Bulgaria	14	14	37	48	27	92
Czech Rep	28	31	228	270	137	110
Cyprus	0	0	0	0	0	0
Estonia	1	1	12	25	12	2
Hungary	21	41	189	320	228	194
Latvia	3	4	21	52	25	11
Lithuania	1	2	38	129	65	31
Malta	17	18	32	39	55	40
Poland	21	19	498	744	532	339
Slovakia	3	5	49	85	76	42
Slovenia	0	3	3	5	7	3
Romania	31	37	65	74	87	175
Total international applicants	6828	13967	10407	9934	6159	5055
United Kingdom	4398	4734	4333	5164	5620	6133
Total	11226	18701	14740	15098	11779	11188

This represents no less than 10,5% of all UK-doctors (see table 3.4). In the Netherlands in 2002 a total of 303 IMGs applied. Had they all been recognised, they would have represented only 0,5% of all Dutch doctors. Had this number been repeated in 2003, then, with the two years combined, they would only have represented about 1% of all Dutch doctors.

The same pattern holds true for the IMG influx into Scandinavian countries, Austria and Belgium (Flanders only). In the above-mentioned EEA countries, the countries of origin of the IMGs appeared to be very similar. All countries received requests for recognition from IMGs originating from Afghanistan, Iraq, Russia and other former Eastern bloc countries. However, in the UK, by contrast, the majority of requests came from IMGs originating from countries belonging to the British Commonwealth (Herfs, 2009). The UK pattern of large influxes of IMGs from Commonwealth countries has changed since the ending of 'section 19' in 2003. Section 19 gave de facto recognition of overseas qualifications. This allowed doctors with qualifications obtained in the Commonwealth countries to obtain full registration in the same way as those who held a UK primary medical qualification i.e. without entrance examinations. The termination of section 19 in 2003 explains the higher figures for that year. Since the termination of section 19, the number of source countries for UK IMGs has tended to diversify more, to include a higher number of other European countries.

More than 20% of medical doctors in countries with large-scale IMG-migration, i.e. Australia, Canada, the UK and the USA, have foreign medical degrees (Herfs *et al.* 2008). For these countries this could imply that a shortage of medical personnel is effectively replenished with IMGs. In most EEA-countries, with the exception of the UK, the shortage is less obvious. The data in table 3.4 show that, in the United Kingdom, the ratio of indigenous doctors is lower than in other EEA-countries.

Table 3.4: Number of doctors per 100.000 citizens in 18 EEA-countries

Country	Total number of doctors	Number of doctors per 100.000 citizens
Austria	27.413	338
Belgium	46.268	449
Denmark	15.653	293
Finland	16.446	316
France	203.487	337
Germany	277.885	337
Greece	47.944	438
Iceland	1.056	362
Ireland	11.141	279
Italy	241.000	420
Luxembourg	1.206	266
Netherlands	50.854	315
Norway	14.200	313
Portugal	34.440	342
Spain	135.300	330
Sweden	29.122	328
Switzerland	25.921	361
United Kingdom	133.641	230

The average ratio of doctors for these 18 EEA-countries is 336, for the United Kingdom it is 230.

Table 3.5 shows the numbers of medical doctors and the ratio of doctors in three G8 (*Group of Eight*) countries and in Australia. In these countries the number is more similar to the United Kingdom than to the numbers in the other EEA-countries.

Table 3.5: Numbers of doctors per 100.000 citizens in 4 non-EEA countries

Countries	Total number of doctors	Number of doctors per 100.000 citizens
Canada	66.583	214
USA	730.801	256
Japan	251.889	198
Australia	47.875	247

With regard to the countries from which many IMGs originate i.e. the *source countries*, the data regarding remaining medical doctors and the the ratio of doctors are listed in table 3.6.

Table 3.6: Numbers of doctors per 100.000 citizens in countries of origine of IMGs settling in the Netherlands

Country	Total number of doctors	Number of doctors per 100.000 citizens
Afghanistan	4.104	19
China	1.364.000	106
Iran	60.791	87
Iraq	17.022	66
Russian Federation	609.043	425
Ukraine	143.202	295

Afghanistan, a country with a very low ratio of doctors, has, during the last 10 years, been confronted with a large emigration of medical doctors to mostly Western European countries. The same movement occurred in Iraq. The Netherlands and other Western European countries granted many Afghan and Iraqi refugees permanent residency and enabled the refugee-doctors to obtain doctors licenses in these host countries. These relatively massive flows of Afghan and Iraqi doctors could possibly have serious consequences for the health care in their native countries, as can be deduced from the data in table 2.6. In countries where the ratio of doctors was already low before the start of emigration, even the migration of a limited number of medical doctors can have severe consequences. After the normalization of living conditions in these countries, refugees might consider returning to their country of origin. But as yet (2007), no signs of normalization of living conditions can be noticed in these two countries and there is no demonstrable return of doctors. In 2008 the Iraqi government requested their doctors, who had fled the country during the war, to return home because of a severe shortage of medical doctors.

Due to the relatively high ratio of doctors in the Russian Federation and the Ukraine, the emigration of medical doctors will presumably not damage health care in these countries to the same extent as in countries such as Afghanistan and Iraq.

Because of the former relations of the Netherlands with Indonesia and Surinam, some data concerning the numbers of medical doctors in these two countries are also presented (table 3.7).

Table 3.7: Numbers of medical doctors per 100.000 citizens in the former Dutch colonies

Country	Total number of doctors	Number of doctors per 100.000 citizens
Indonesia	29.499	13
Surinam	191	45

The fact that a certain percentage of the total number of medical doctors are leaving Indonesia and Surinam in order to settle in the Netherlands, may damage health care provision in those countries. In Surinam, the consequences of migrating IMGs could be particularly severe.

On May 1 2004 ten more European countries joined the European Union. On January 1 2007 the European Union extended with Bulgaria and Romania. The numbers of medical doctors and the ratio of doctors in these countries are represented in table 3.8.

Table 3.8: Numbers of doctors per 100.000 citizens in 12 new EU-countries

Country	Total number of doctors	Number of doctors per 100.000 citizens
Bulgaria ¹³	28.128	56
Cyprus	1.864	234
Czech Republic	35.960	351
Estonia	6.118	448
Latvia	6.940	301
Lithuania	13.682	397
Hungary	32.877	333
Malta	1.254	318
Poland	95.272	247
Romania	42.538	190
Slovakia	17.172	318
Slovenia	4.475	225

In these “new” EU-countries the average ratio of doctors is 310, which is comparable with the “old” European Union countries (with an average of 336). Medical doctors in these countries (except Bulgaria and Romania), who started their medical education after May 1 2004 will be covered by Directive 2005/36/EC of the European Parliament and of the Council of 7 September 2005, regarding the recognition of professional qualifications. This implies that after graduating as medical doctors they can apply successfully for recognition of their degree in any EU-country. For medical doctors who graduated before the extension of the European Union, successful recognition is not guaranteed. The pending “easy” recognition leads to the fear in some new European Union countries, e.g. Hungary (NRC¹⁴, 2005) and Poland (NRC, 2004), that large numbers of medical doctors will eventually leave their country to settle in European countries with higher social standards and, especially, higher salaries. Groups of medical doctors and nurses in Poland have already demonstrated in 2006 for higher salaries; they threatened to leave the country if their terms were not met.

¹³ Bulgaria and Romania joined the European Union per January 1 2007. The other 10 countries joined the EU per May 1 2004.

¹⁴ NRC is the abbreviation for the *Nieuwe Rotterdamse Courant*; a quality newspaper in the Netherlands.

1. The composition of the groups of IMGs in Western European countries, with the exception of the UK, is fairly uniform. They consist of both refugees and those seeking to be with their spouses/partners. In the UK many IMGs originate from Commonwealth countries. IMG migration to the UK decreased after 2003 (the end of “section 19” recognition of overseas qualifications). After the extension of the EU in 2004 the influx of IMGs originating from the new EU-countries grew strongly. Especially Polish and Hungarian doctors came in great numbers to the UK. In 2005 744 Polish doctors and 320 Hungarian doctors went overseas. However in 2007 these numbers decreased to respectively 339 and 194.
2. In some of the new European Union countries, e.g. Hungary and Poland, it is feared that large numbers of medical doctors will leave after these countries have joined the European Union as recognition will easily be covered by an EU-directive. It appeared that this fear was not misplaced.
3. In contrast with Australia, Canada, the UK and the USA, there is no large-scale IMG-migration in most Western countries. In these four countries there seems to be a dependency on the IMG-influx; more than 20% of practising medical doctors are holders of foreign medical degrees. In Western European countries with small-scale IMG-influx health care is not dependent on IMGs.
4. Since the source countries of IMGs with a non-European background have as a rule a low ratio of doctors, the emigration of doctors to Western countries could have severe consequences for their health care provision.
5. In an action plan launched in the summer of 2007, the European Commission calls on its members to educate as many medical personnel as they each need, so as to prevent them from recruiting medical personnel from developing countries (Hel, 2006).
6. There are remarkable differences between the IMGs going to the UK and those going to the Netherlands. In the UK foreign trained medical professionals are handed on a silver platter. The UK government facilitates their access to the medical profession. In the Netherlands however their access is not easy at all. Their educational background is often questioned. Besides IMGs coming to the Netherlands do not master the national language as opposed to the IMGs going to the UK.
7. Since October 2008 the influx of Eastern European citizens in the UK is rapidly changing due to the global financial crises. The consequences of this crises could imply a tendency of return migration.

1. The migration of IMGs is probably an unstoppable phenomenon and it creates great problems for the so-called source countries. The direction migration goes in is mainly from poor to rich countries. This applies to countries importing IMGs on a large as well as on a small scale. However, the motives of IMGs for settling in those countries which import on a large scale are different from those of IMGs who settle in countries which import on a small scale. The latter are either refugees or they are

joining their spouses or partners. Mostly these IMGs are not familiar with the language of the country they settle in, so they are not primarily seeking residency as medical doctors, but as husbands, wives or partners.

IMGs who wish to settle in Australia, Canada, the UK or the USA do so as to benefit from better training, working and living conditions. In many cases the principal objective is to gain residency as a medical doctor. Moreover, many IMGs already have a thorough command of the English language.

2. All countries, especially those which import IMGs on a large scale, should train as many doctors as they need. By reducing shortages in the medical workforce, IMGs from poor countries will not be encouraged to leave their countries. IMGs holding temporary residency for additional medical training should be encouraged to return to their countries after finishing their medical training.
3. IMG migration is a global and very complex problem. The source countries, especially those where English is the first or second language, are confronted with massive IMGs migration flows. The World Health Organisation (WHO, 2008) could again try to advocate to the host countries a change of policy concerning the importing of IMGs and encourage agreements to reverse the brain drain.

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References

- Andrew, R. & Bates, J. (2000): Program for licensure for international medical graduates in British Columbia: 7 years' experience. *Canadian Medical Association Journal*; 162 (6): 801-3.
- Australian Medical Workforce Advisory Committee (2004): *Annual Report 2003-04*. AMWAC Report. Sydney.
- Bourassa Forcier, M., et al. (2004): Impact, regulation and health policy implications of physician migration in OECD countries. *Human Resources for Health*; 2:12. <http://www.human-resources-health.com/content/2/1/12>.
- Cain, F.E., et al (2005): Obstacles to maintaining licensure in the United States. *British Medical Journal*; 330: 1443-1445.
- Chan, M. (2007): *Health spending: getting the balance right*. Second OECD World Forum on Statistics, Knowledge and Policy. Istanbul, Turkey.
- Chen, L.C. & Boufford, J.I. (2005): Fatal flows – Doctors on the Move. *The New England Journal of Medicine*, volume 353: 1850-1852; number 17.
- Crutcher, R.A., et al. (2003): Characteristics of international medical graduates who applied to the CaRMS 2002 match. *Canadian Medical Association Journal*, 168 (9); 1119-23.
- Directive 2005/36/EC of the European Parliament and of the Council of 7 September 2005 on the recognition of professional qualifications. Brussels, Belgium.
- Dyer C: High Court rejects overseas doctors' challenge for UK work restrictions. *BMJ* 2007; 334(7589):333. doi:10.1136/bmj.39125.369178.DB.
- Dyer O: Doctors criticise proposals to cut specialist training for non-EU graduates. *BMJ* 2007;335:849. doi:10.1136/bmj.39378.5908222.13.
- Eastwood J.B., et al. (2005): Loss of health professionals from sub-Saharan Africa: the pivotal role of the UK. *The Lancet*, volume 365; 1893-1900.
- Ehman A.J. & Sullivan, P. (2001): South Africa appeals to Canada to stop recruiting its MDs. *Canadian Medical Association Journal*, 164 (3).
- General Medical Council (2006): *Guidance for PLAB test candidates*. London.
- George JT, Rozario KS, Anthony J, Jude EB, McKay GA (2007): Non-European Union doctors in the National Health Service: why, when and how do they come to the United Kingdom of Great Britain and Northern Ireland? *Human Resources for Health* 2007, 5:6. doi:10.1186/1478-4491-5-6
- Hagopian, A., et al. (2004): The migration of physicians from sub-Saharan Africa to the United States of America: measures of the African brain drain. *Human Resources for Health*, 2:17.

Hallock, J.A., McKinley, D.W., and Boulet, J.R. (2007): Migration of doctors for undergraduate medical education. In: *Medical Teacher*, 29:2-3, 98-105.

Hel, M. van der (2006): Europees actieplan om personeelstekort in gezondheidszorg te verminderen. *Medicus Tropicus*, 44, 8.

Herfs, P.G.P. (2009): Buitenlandse artsen in Nederland. Dissertation. Utrecht University.

Herfs, P.G.P., Kater, L., & Haalboom, J.R.E. (2007): Non-EEA-doctors in EEA-countries: doctors or cleaners. *Medical Teacher*, 29:4, 383-389.

Herfs PGP, Kater L, & Haalboom JRE (2008): Large-scale migration of International Medical Graduates to Australia, Canada, UK and USA. Submitted.

Herfs, P.G.P., Haalboom, J.R.E. (2008): Studievoortgangsproblemen van buitenlandse artsen die instromen in een hoger jaar van de opleiding geneeskunde. In: *Tijdschrift voor Medisch Onderwijs*. 27:2, 90-97.

Lancet (2005): *Migration of health workers: an unmanaged crisis*. Editorial comment in Volume 365; 1825.

McGrath, B.P. (2004): Integration of overseas-trained doctors into the Australian medical workforce. *Medical Journal of Australia*, 181; 640-2.

Mick, S.S. & Lee, S.Y.D. (1997): The safety-net role of International Medical Graduates. *Health Affairs*, Volume 16, number 4, 141-150.

Ministerie van Volksgezondheid, Welzijn en Sport (2001): *Jaarverslag 2000 inzake buitenslands gediplomeerden volksgezondheid*. Den Haag.

Mullan, F. (2005): The metrics of the physician brain drain. *The New England Journal of Medicine*. Volume 353: 1810-1818; number 17.

Mullan, F., et al. (1995): Medical migration and the physician workforce. International Medical graduates and American medicine. *Journal of the American Medical Association*, Number 273 (19); 1521-7.

NRC (2004): Uittocht van Poolse artsen. NRC 25-6-2004.

NRC (2005): Hongaarse artsen massaal op drift. NRC 16-11-2005.

Ogowe, A. (1996): Brain drain: colossal loss of investment for developing countries. *The Courier ACP-EU*, 159: 59-60.

O'Meara, D. (2004): Foreign-trained physicians need residency spots. *Canadian Medical Association Journal*, 170 (8); 1216.

Pang, T., et al. (2002): Brain drain and health professionals. *British Medical Journal*, 324; 499-500.

Pew Health Professions Commission (1995): *Critical challenges: revitalizing the health professions for the twenty-first century; third report of the Pew Health Professions Commission*. University of California at San Francisco; Center for the Health Professions.

Spike, N.A. (2006): International medical graduates: the Australian perspective. *Academic Medicine*, 81 (9); 842-6.

Stillwell, B., et al. (2003): Developing evidence-based ethical policies on the migration of health workers: conceptual and practical challenges. *Human Resources for Health*, 1:8. <http://www.human-resources-health.com/content/1/1/8>

Trewby P (2008): International medical graduates: lessons from the past and hopes for the future. *Clinical Medicine*, 8, 283-7.

United States Medical Licensing Examination (2006): *Bulletin of Information*. Philadelphia.

Van Der Weyden, M.B. & Chew, M. (2004): Arriving in Australia: overseas-trained doctors. *Medical Journal of Australia*, volume 181, number 11/12. Sydney.

WHO estimates of health personnel (2004): physicians, nurses, midwives, dentists and pharmacists (<http://www.who.int/globalatlas/dataquery>; last updated 26 October 2004).

WHO (2007): *World Health Statistics 2007*; Switzerland.

WHO (2008): The WHO code of practice on the international recruitment of health personnel. Draft for discussion; 18 August 2008. Switzerland.

Wolters-Noordhoff (2001): *De Grote Bos-atlas*. 52^e druk. 2001; WN Atlas Productions; Groningen.

This chapter discusses the Dutch policy regarding the reception of foreign doctors. There will be a chronological discussion of all the central academic and policy publications in this field since 1990. The most important problems of the past twenty years will become evident. Two policy priorities are of major importance:

1. How can it be ensured that a foreign doctor, who wants to work as a doctor in the Netherlands or in a third country, has the required quality with regard to knowledge, skills and attitude? In other words, how is the assessment of foreign doctors arranged for these aspects?
2. There are foreign doctors who have been trained outside the European Economic Area and who have been granted permanent residence in the Netherlands. Have these doctors been admitted to the profession in the Netherlands (with a qualification obtained in their country of origin or in another non-EEA country)? If these doctors are not allowed to practise their profession, is it still possible to obtain this admission in any way?

In this chapter four types of policy documents will be discussed:

- Documents relating to the rules regarding holders of foreign certificates (4.1)
- Document aimed at giving information to holders of foreign certificates (4.2)
- Comments on the way recognition procedures have been carried out by the Health Secretary (4.3)
- Documents on future developments regarding streamlining additional training programmes for foreign doctors (4.4)

Until 1993, it was possible for foreign doctors to work as doctors, even if their certificate was judged 'non-equivalent'. Hospitals could hire foreign doctors even if these doctors had obtained a negative verdict from the Department of Health. All this changed in 1993. Since then, there has been a steady growth of the number of foreign doctors requesting admission to a higher year of medical training at one of the medical faculties. Slowly but surely, the medical faculties have begun to play a more important role in the reception of foreign doctors. At this point, foreign doctors were absolutely not a policy priority for the Department of Health. Since the mid-1990s, this ministry has increasingly limited its role to only being responsible for the evaluation of certificates. Moreover, most foreign doctors received a negative judgement ('non-equivalent' doctor's certificate), so that these doctors tried *en masse* to enrol at the medical faculties for additional training. It is not surprising that the need arose for national fine-tuning between the different medical faculties. That is the reason that in 1996 the universities with a medical faculty founded the Committee for the Influx of Foreign Doctors (CIBA). As early as 1984, the Junior Health Minister expressed his worries about the command of the Dutch language of foreign doctors (EU and non-EU) who were working in health care; however, no action was taken. On the initiative of Dr J.R.E. Haalboom (University Medical Centre Utrecht), a Dutch language training programme for foreign doctors was developed at Utrecht University (Palenstein Helderman-Susan, 2000). From the moment this programme was completed, the course in Medical Dutch became mandatory for all foreign doctors entering one of the medical faculties. As this programme was aimed at a national problem for all EEA and non-EEA foreign doctors and medical specialists, the Department of Health was asked for a financial contribution,

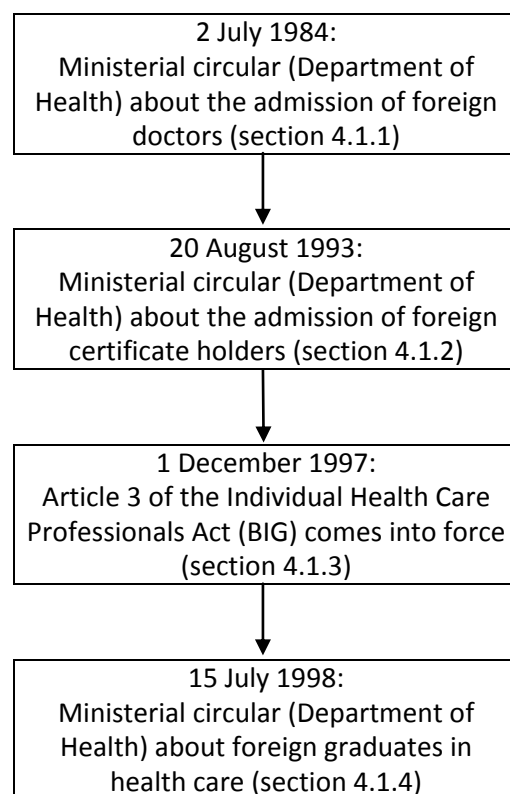
unfortunately without result.

It was only after the Dutch parliament expressed its displeasure with the attitude of the Department of Health with regard to foreign doctors by means of a motion (see Appendix 9) that the ministry was forced to take responsibility for the additional training of foreign doctors in cooperation with the medical faculties. Eventually this led to the introduction of the assessment procedure in December 2005. Since 2005, the Department of Health, rather than the medical faculties, has been ultimately responsible for foreign doctors.

4.1 Legal admission procedures by the Department of Health since 1984 for holders of foreign certificates

For reasons of clarity, legislation has been presented schematically. The regulatory framework of the Department of Health will be presented chronologically and will be discussed briefly. Figure 4.1 presents an overview of regulations and ministerial circulars.

Figure 4.1: Regulations from the Department of Health regarding foreign medical and paramedical graduates



4.1.1 The ministerial circular of 9 July 1984 (Department of Health) makes a distinction between on the one hand doctors who have a certificate as well as the nationality of the EU member state, and on the other hand doctors who have certificates

from outside the EU and who do not have an EU nationality. Based on EU directives of 16 June 1975, foreign holders of EU medical certificates were fully qualified to practise medicine in the Netherlands. It was no longer necessary for these doctors to obtain a ministerial order. However, for graduates from non-EU member states such an order was still necessary. The ministry was reluctant to grant these orders, which becomes clear from the following considerations:

“Also in the light of increasing unemployment among doctors, a request for such an admission will only be granted if at least one of the following criteria is satisfied:

- The presence of the foreign doctor serves an essential interest regarding Dutch healthcare.
- There is an official bilateral exchange programme in the context of international cultural relations.
- There is a training project (that has been or will be approved by the government) in the context of development assistance or humanitarian assistance to another country.
- Residence in the Netherlands of the person concerned has a permanent character, for example by marriage to a Dutch national, reunion of family, refugee status, or if asylum has been granted.
- There are ‘acquired rights’ (i.e. for several years the person concerned has been granted permission to serve as a holiday locum at a hospital).”

The Junior Health Minister added the following passage:

“Finally, I would like to state that the boards of institutions consider it - in my view correctly - an obstacle if foreign doctors do not speak the language of the country in which they practice their profession. In such cases, boards do not appoint the foreign doctors. Such measures are within the responsibility of the management of an institution.”

Incidentally, it is remarkable that the Junior Minister makes this reservation for medical graduates from non-EU member states but does not make the same reservation for medical graduates from within the European Union. Even though a sufficient command of the language was considered important as early as 1984, no policy instrument was developed to follow this up.

4.1.2 A second ministerial circular, replacing the one of 2 July 1984, was published on 20 August 1993 and was given the title ‘Admission of foreign graduates’. This was the motivation for the new circular:

“Replacement is necessary because the circular of 2 July 1984 permits holders of foreign certificates to practice their profession in this country, even though their training is considered inferior to the Dutch basic medical training. From the viewpoint of quality of care this is an undesirable development.”

Until this circular came into force, the Health Secretary could make a negative decision about a request for granting total competence, based on a foreign medical certificate.

However, at the same time he could permit an employer in health care to appoint the same medical graduate as a doctor. So in practice there could be an appointment in spite of rejection by the Health Secretary. On the other hand, civil servants considered this practice unacceptable from the viewpoint of quality of care. This second circular put a stop to it being possible for an employer to appoint foreign medical graduates whose certificate was judged 'non-equivalent'. The new circular stated that:

"The Health Secretary can

1. allow a doctor to practise medicine in the Netherlands for a limited period with restrictions; and
2. grant a doctor the qualification to practice medicine in the Netherlands.

The Committee on Foreign Doctors, established by Royal Decree of 27 August 1965 (Staatsblad 436), can be requested to advise the Minister in the execution of both these jurisdictions. The committee is free to decide its methods of working."

4.1.3 On 1 December 1997, the Individual Health Care Professions Act (BIG) came into force. This act, which is still in force, is aimed at promoting and monitoring the quality of professional practice in individual health care and at protecting patients against incompetent and negligent practices. A system of title protection was introduced for a number of professions. Practitioners of a legally regulated profession are allowed to carry a title which is protected by public law. Practitioners have to meet a number of legal demands, of which the most important ones relate to their training. The law regulates eight professions: pharmacists, doctors, physiotherapists, health psychologists, psychotherapists, dentists, obstetricians and nurses. For these eight professions the government has created registers, the *BIG registers*. Only registered people are allowed to carry the professional title and only they are subject to disciplinary rules. Practitioners who want to be registered need to submit a request to the Health Care Inspectorate, and this is only granted if the applicant satisfies all the demands, of which the most important one relates to the training followed.

4.1.4 In 1998, a new circular was published.¹⁵ This dealt with enrolment by foreign graduates in the BIG register. Enrolment in one of the BIG registers was not only open to holders of Dutch certificates, but also to holders of foreign certificates. The circular contained a list with certain medical certificates of countries which were part of the EEA:

"If this concerns a certificate that has been obtained in a country that forms part of the EEA and which is named in the regulation mentioned above, there is the requirement that the graduate also holds the nationality of a country that is part of the EEA. Foreign graduates who appeal to the Regulation for the Categorical Designation of Foreign Health Care

¹⁵ Several other circulars were published; the most recent came into force on 5 May 2006. The most important difference with previous circulars is the bigger role of knowledge and skills tests in the procedure for the assessment of professional competence for doctors.

Certificates can directly submit a request at the BIG register. Foreign graduates who do not hold a certificate that is mentioned in the Regulation for the Categorical Designation of Foreign Health Care Certificates or who have such a certificate but not the nationality of an EEA country, can, if they wish to be eligible for enrolment in our register, request a statement as meant in Article 41, section 1, subsection B, of the Individual Health Care Professions Act (BIG) (declaration professional competence) from the Minister (Foreign Graduate Office).”

This clause rules out that a non-EEA national with a medical degree from for example Germany or Italy can enrol as a doctor in the Dutch BIG-register. By contrast, an EEA national with a medical degree from an EEA-country could (and can still) invoke a so-called categorical settlement (Council Directive 93/16/EEC and Directive 2005/36/EC). These settlements imply that there will be no assessment of individuals. There has never been a categorical settlement regarding the quality of professional practice for non-EEA nationals with a medical degree from a non-EEA country. Appendix 2 presents an overview, taken from the annual reports of the Department of Health, of the non-EEA countries from which doctors originated who requested a statement regarding the quality of their professional practice.

4.1.5 Since 1984, the policy for the admission of foreign doctors has gradually been tightened. For example, the admission to professional practice in the Netherlands for foreign graduates was made more difficult when the circular regarding the admission of foreign graduates came into force in 1993. Before 1993, a foreign doctor who found an employer could work as a doctor, despite rejection by the Department of Health. After 1993 this was no longer possible. Moreover, the civil servants at the Department of Health increasingly reached the conclusion that there was non-equivalence (Category III) of foreign medical certificates. This meant that a foreign doctor whose certificate was judged ‘non-equivalent’ could only work as a doctor in the Netherlands after following an additional university programme as a student of medicine. Appendix 2 presents the subsequent annual reports of the Department of Health, which make clear that the majority of foreign medical certificates were assessed as ‘non-equivalent’ to Dutch basic medical certificates.

4.2 Information for foreign graduates

The information for foreign graduates was often not helpful either. Foreign doctors who wanted to be admitted to the Dutch healthcare system approached the Department of Health for information. To analyse the quality of this information, I will discuss the most important brochures.

4.2.1 In 1991 the first information leaflet ‘Foreign graduates’ appeared; it was subtitled ‘Information regarding the admission to the Netherlands of foreign graduates as

pharmacist, pharmacy assistant, doctor, paramedic, dentist, obstetrician, nurse, and carer' (Department of Health, 1991). During the first half of the 1990s, this leaflet was the only written source of information available to foreign medical graduates. In the leaflet, the Office for the Admission of Foreign Graduates presented information about the then current procedures regarding the admission to professional practice in the Netherlands of foreign graduates in the medical field. The authors of the leaflet distinguished between subjects with medical or paramedical certificates from within and from outside the European Union. As a result of European Council guidelines, mutual recognition of the certificates of doctors, pharmacists, dentists and obstetricians was well-regulated and caused few problems. In contrast, a request for the admission of a non-EU graduate was only granted if at least one of the criteria of the 1984 circular (cf. section 4.1.1) was satisfied. To these, one new criterion was added, namely that the person concerned had the Dutch nationality.

After these criteria had been checked, the foreign doctor could be admitted (with or without restrictions) to professional practice. The doctors concerned could file a request to the Health Secretary for complete qualification after they had worked in the Netherlands for a considerable time (mostly about two years). If a positive advice was given by a committee of experts¹⁶, by ministerial order these doctors would be granted the qualification to practise their profession in the Netherlands. "The committee of experts gave the Minister advice based on information regarding education, command of the Dutch language, and any circumstances which would be undesirable for professional practice in the Netherlands."

4.2.2 In 1996 the Committee for the Influx of Foreign Doctors (CIBA) was founded. Due to the ever increasing number of foreign graduates requesting admission, the committee deemed a new information document indispensable. This was the policy document 'Recognition of foreign medical certificates' (Herfs, 1996).¹⁷ It described the recognition procedure of the Department of Health, as well as the possible outcomes of such a request. The document stated that a request for the recognition of foreign medical certificates by the Department of Health could have three different outcomes:

1. *Equivalence* of the foreign medical certificates with Dutch medical certificates: these doctors were fully qualified.
2. *Near equivalence* of the foreign medical certificates with Dutch medical certificates. People from this category could be temporarily admitted to the profession (for a maximum of two years), but with limitations.
3. *No equivalence* of the foreign medical certificate with Dutch medical certificates: those people received a rejection letter. The people concerned were referred to the official

¹⁶ The composition, tasks and approach of this committee were described in the Ministerial Order Foreign Healthcare Graduates (Staatsblad 1006, 69). The advice of this committee was primarily based on submitted documents and on information from the department for the evaluation of foreign credentials of the Netherlands Universities Foundation for International Cooperation (NUFFIC) about the applicant's prior education.

¹⁷ The author was a member of the CIBA, along with M. Sturkenboom and A. Kruijshoop, both of the Utrecht University medical faculty.

secretary of the Committee for the Influx of Foreign Doctors (CIBA), based at the medical faculty of Utrecht University.

The CIBA was founded as the national registration point by the Medical Sciences Board (DMW) of the Association of Universities in the Netherlands (VSNU), in order to prevent 'shopping around' by foreign doctors. Some doctors submitted admission requests to several medical faculties at the same time. Such behaviour was observed by the Association of Medical Student Counsellors (STOG) and the Committee of Deans of Foreign Students (KBS) of the National Committee of Student Advisers, which led to proposals for a national registration point for foreign doctors. These proposals were submitted to the Medical Sciences Board (DMW) of the Association of Universities in the Netherlands (VSNU). The DMW decided by letter of 28 June 1995 that a national registration centre, the CIBA, could be realised. Every medical faculty was requested to appoint a representative for the CIBA. It was emphasised that the CIBA would focus on doctors whose certificates were judged 'non-equivalent' by the Health Secretary. Doctors whose certificates were judged 'nearly equivalent' could no longer count on entry into a higher year of medical training. Furthermore, doctors who were judged 'nearly equivalent' had to find supervision places themselves. The DMW appealed to the professional organisations of the Royal Dutch Medical Association (KNMG) to provide supervision places.

During the inaugural meeting of the CIBA in February 1996, some conditions for the admission requests were determined:

1. The doctor must have submitted a request for recognition with the Department of Health and the verdict must be 'no equivalence' (Category III).
2. The doctor must have a permanent residence permit for the Netherlands. There must be permanent residence in the Netherlands; in other words, the doctor concerned needs to have the A or C status.¹⁸ A foreign doctor may also have a permanent status as a result of having a Dutch partner.
3. The doctor needs to have passed the State Exam Dutch as a second language (NT2; Programme 2). A doctor who wants to be admitted to medical training has to show that he has a sufficient command of the Dutch language.

The document also contained standard forms needed for the submission of the request to the Department of Health, the declaration of non-suspension¹⁹, and the CIBA registration form. In addition, the document contained a step by step plan for the foreign doctor and a list of abbreviations. The CIBA expected that close cooperation between the eight medical faculties would lead to a more uniform approach. However, in practice there were great differences between the different faculties. A short evaluation can be found below.

¹⁸ Refugees with an A status (permanent residence permit on the grounds of recognised refugee status) or a C status (permanent residence permit on humanitarian grounds) had a permanent residence status until 2001, when the Aliens Act 2000 came into force. The Minister of Justice has power of decision regarding residence permits.

¹⁹ By filling in a declaration of non-suspension, a foreign doctor notifies that he has not been suspended from carrying out his medical profession.

4.2.3 In October 1997, when the CIBA had existed for nearly two years, it published its second policy document, entitled 'The CIBA: looking back and looking forward' (Herfs, 1997). This document was meant to evaluate the activities of the committee and it identified several problems. First of all, foreign doctors were often sent from one institution to the next (from the universities to the Department of Health and vice versa). Secondly, foreign doctors were still submitting admission requests to sometimes as many as four different medical faculties. Thirdly, among the eight medical faculties there were great differences in the inclusion of foreign doctors, for example regarding the length of the training and the exams to be taken. This led to the situation that a foreign doctor who had been admitted to 'University X' often also requested admission at 'University Y'. A fourth problem was that the number of available places for the post-propaedeutic phase of medical training was sometimes so small that there were waiting lists. As a result, some foreign doctors heard from 'University U' in 1995 that they would have to wait five years until they could be admitted. These doctors then requested admission at universities where they could be placed earlier. Fifthly, 'University Z' used a very strict regional criterion²⁰; this led to a situation in which foreign doctors who had been rejected based on this regional criterion applied for places at universities that were much further away from their place of residence.

The document mentioned above also presented an overview of the distribution of foreign doctors among the eight medical faculties since the foundation of the CIBA. Being assigned by the CIBA to a medical faculty was no guarantee of admission, as admission could still be refused if the candidate concerned did not pass the State Exam Dutch as a second language (NT2; Programme 2). The author of the document drew several conclusions, including:

- 'shopping around' was effectively discouraged;
- the eight medical faculties were prepared to make it possible for foreign doctors to enter a medical faculty; greater uniformity could be effected as a result of the increased experience in inclusion;
- greater uniformity could be achieved if exam committees informed each other of their inclusion advice;
- cooperation within the CIBA lead to greater expertise with regard to the evaluation of foreign certificates, residence issues and demands regarding the command of the Dutch language.

4.2.4 In October 1998, the magazine *Medisch Contact* published an article on the inclusion of foreign doctors in Dutch medical schools (Haalboom & Herfs, 1998). The authors had wide experience regarding the inclusion of foreign doctors. The article described the different ways of inclusion used by the eight medical faculties. Table 4.1 presents the distribution of foreign doctors among the faculties by the CIBA in 1996 and 1997.

²⁰ This means that the applicant lives within 15 kilometres of the university in question.

Table 4.1: The distribution of foreign doctors by CIBA per medical faculty²¹

University	1996	1997	total	%
(both) Amsterdam Universities ²²	17	24	41	28
Radboud University Nijmegen	7	14	21	14
Maastricht University	3	8	11	7,5
University of Groningen	9	8	17	12
Leiden University	2	5	7	4,8
Utrecht University	17	21	38	26
Erasmus University Rotterdam	4	7	11	7,5
Total	59	87	146	100

The manner of inclusion differed strongly for each faculty. The evaluation of foreign medical training as well as the inclusion depended wholly on the receiving exam committee. No fine-tuning took place at all. Moreover, the numbers of foreign doctors admitted in accordance with Article 7.54a of the Higher Education and Research Act differed greatly. In addition, the article discussed how the influx might suddenly change due to foreign developments. From 1992 to 1996, there was a relatively great influx of doctors from the former Yugoslavia. From 1994 onwards, there was a great influx from countries such as Iran, Iraq and the former Soviet Union. Still later mainly Afghan doctors requested recognition; many had Russian medical certificates. The authors of the article analysed the inclusion of foreign doctors into Utrecht University. The problem was not so much a lack of knowledge and skills, but rather an insufficient command of the Dutch language. Foreign doctors who were placed in a higher year of medical school had to deal with patients relatively quickly; therefore, improving their level of Dutch was essential. As a result, in cooperation with the James Boswell Institute²³ of Utrecht University, a new language module was developed especially geared towards foreign doctors. For this an inventory was made of idiom including parts of the body, such as 'getting something off your chest', 'putting your foot down' and 'being on your last legs'. For the development of this module, Dutch language experts from the institute mentioned above attended ward visits, outpatient visits and doctor's visits and included as many typical Dutch medical words and sentences as possible. The authors of the article also identified another obstacle, which they described as 'cultural white noise', in other words a culturally determined behavioural repertoire; for example, a doctor who is afraid of losing face and therefore does not dare to admit that he does not know the answer to a particular question. In internship groups, there were also problems which sprang from differences in cultural background and/or attitudes. For example, an Islamic student complained about non-Muslims drinking alcohol during Friday afternoon drinks.

²¹ The distribution of foreign doctors over the different medical faculties for the years 1996-2004 can be found in Appendix 3.

²² In the initial stages of CIBA, the Amsterdam universities themselves distributed the students allocated to both Amsterdam Universities.

²³ The James Boswell Instituut is part of Utrecht University and offers supplementary education (e.g. in Dutch, English, mathematics, chemistry and physics).

4.3 Comments on the handling of requests for recognition by the Health Secretary

This section discusses publications by people who were directly involved in the handling of recognition requests by foreign graduates. Some of these publications were compiled by people who were professionally involved with recognition requests, whereas other publications were written by researchers or ‘hands-on’ experts.

4.3.1 In 1995, an article was published on the admission of doctors from outside the EEA and the possibilities available to practise their profession in the Netherlands (Dokter & Storm, 1995).²⁴ This article described the legal situation of foreign doctors who wanted to practise their profession in the Netherlands (cf. section 4.2.1). The Committee for Foreign Doctors (CBG) worked as follows. Only foreign doctors who were judged as ‘equivalent’ or ‘nearly equivalent’ were admitted to professional practice. The CBG advised the Health Secretary on temporary admission. The applicant's level of expertise was established, based on documents such as certificates, study programmes (content and length), work experience and scientific work. The CBG also regularly requested advice from the Department for the Evaluation of Foreign Credentials (IDW) of NUFFIC in the Hague. The references given by an applicant were contacted, and in difficult cases an applicant was invited to take a test. Sufficient command of the Dutch language was considered to be of great importance by the CBG. The State Exam Dutch as a second language, a university entry condition for foreign students, was seen as the most appropriate.

Applicants judged ‘nearly equivalent’ had to find their own supervisor. Any doctor qualified in the Netherlands could serve as a supervisor. Together, supervisor and applicant agreed on a work and training programme of a maximum of two years. Every six months the supervisor was to write an assessment of the applicant’s functioning as a doctor, which was submitted to the Health Secretary and the Health Inspection Service. If the results were unsatisfactory, the supervisor cancelled the agreement. If the judgement was favourable, the Minister could grant complete competence. For applicants seeking registration in the Register of Medical Specialists, the Register of General Practitioners and Nursing Home Doctors or the Register of Social Physicians, an assessment procedure of the applicable KNMG registration committee was of great importance. The authors of the article noticed that it was sometimes useful to combine both assessments (of the Department of Health and of KNMG) by using the admission supervision as an assessment internship within the register framework.

Some problems were mentioned in the article. Firstly, in the CBG there were some mixed feelings if a positive advice was to be given about a South African or Surinamese doctor. The question arose whether “mankind would not be better served if such a doctor stayed in his home country”. This was the first time that the modern phenomenon now known as

²⁴ Storm was the secretary and Professor Dokter was the chairman of the Committee for Foreign Physicians of the Department of Health.

brain drain was discussed. Secondly, the CBG noticed that occasionally an asylum seeker was admitted to medical training while retaining his unemployment benefit; in other words, without any financial consequences for the employer. Finally, the committee stated that vacancies resulting from insufficient numbers entering specialist training were too easily filled by people from outside the EEA. Non-EEA doctors regularly practised medicine without being qualified.

4.3.2 In 1996, the Health Secretary ordered Maastricht University to investigate the admission of non-EEA graduated doctors and dentists in the Netherlands (Govaerts & Wijnen, 1997). This was occasioned by the circular of 20 August 1993 (cf. section 4.1.2) that needed to be evaluated 18 months after taking force, and also by the strong increase of the number of non-EEA doctors requesting recognition by the Health Secretary. In 1993, 70 non-EEA doctors requested admission, and in 1994 and 1995 this number rose to 201 and 198, respectively. Originally, the research report was meant for internal use only, but the Minister made it public after a reporter had appealed to the Government Information Act. The initial reservations about making the report public resulted from the criticism expressed towards the Department of Health. The investigation consisted of case studies and interviews with some of the doctors concerned.

There were several points of criticism in the report. First of all, the time needed to deal with the request was on average 42.5 weeks, with a range of 7 weeks to more than 2 ½ years. Secondly, the minister's assignment to NUFFIC regarding the assessment of foreign medical certificates was not adequate. The CBG was supposed to have advised the minister on the equivalence of foreign medical certificates when compared to the Dutch medical certificate. However, NUFFIC was now also being asked to make a statement about the equivalence of the *preliminary* education that gave access to medical training and the equivalence of the foreign medical training in comparison to the Dutch doctoral exam in medicine. (Chapter 10 gives more information on this subject.) Thirdly, it was determined that the interpretation of NUFFIC advice by foreign doctors sometimes led to great confusion, especially if their knowledge of the Dutch language and of education structures was limited. Moreover, the advice by NUFFIC was not decisive for the CBG. Fourthly, the results of the knowledge tests (in Utrecht) were affected negatively by the extremely high levels that were demanded with regard to the applicants' reading skills. Fifthly, the researchers established that in similar cases the advice given by the CBG was inconsistent. Sixthly, it was determined that the CBG lacked insight into the levels of the different foreign study programmes and that there were great problems regarding the assessment of skills and knowledge. The advice given by NUFFIC was expected to fill this gap, but NUFFIC proved unable to meet this expectation. Seventhly, the researchers stated that the lack of predetermined criteria and judgement guidelines presented a problem. Eighthly, it was highlighted how important it was to inform the applicants right at the beginning of the procedure of the value of a good command of Dutch.

There were two different perspectives in the recommendations. The first perspective was aimed especially at improving the administrative organisation. Researchers focused on monitoring the time used for processing the application, improving the efficiency of data collection and data management, and monitoring output quality. With regard to producing recommendations, the researchers proposed the adoption of verifiable judgement criteria

and systematic registration of relevant information on behalf of comparable cases. It was also proposed to record practice data that had been systematically collected by the different medical faculties.

The second perspective was aimed at a complete overhaul of admission policies. The researchers were in favour of an admission policy in which the assessment of skills and knowledge would constitute if not the main part, then at least a standard item. Using tests would minimise subjectivity in the judgement procedure. The researchers proposed that every applicant take a test, something which is common practice in the United Kingdom and in the United States. The outcome would then determine whether the applicant was to be admitted to professional practice (supervision route) or was to be referred to one of the medical faculties for additional training.

4.3.3 The article ‘Supervision is not working for foreign doctors’ (Merkelbach, 1999) was written, in a private capacity, by the former chairman of the Foreign Healthcare Qualifications Commission (CBGV). The content of the article was not endorsed by all his colleagues at the Department of Health. In the article, Merkelbach describes the route followed by foreign doctors who have been judged ‘nearly equivalent’ (Category II). These doctors were allowed to be enrolled in the BIG register ‘with restrictions’. This so-called ‘enrolment with clauses’ could last for two years at most. Until October 1993, every foreign doctor was admitted with the restriction ‘supervision’ if an application was filed by the employer. In these cases, the application for complete qualification was made several years later. The 1993 circular put a stop to this practice (cf. section 4.1.2).

For this article, the dossiers were examined of 143 foreign graduates who had been judged ‘nearly equivalent’ in the years 1994-1997 and who had been allowed to work under supervision. Roughly one third of these 143 doctors had been unable to find a supervisor. It was concluded that no legal arrangements had been made regarding supervision. In a legal procedure (the Department of Health versus Bitan), it was remarked by the Dutch *Raad van State* (Council of State) that the ministry “attempted to make arrangements using private law, as no arrangements have been made in public law”. In the supervision agreements there were no demands regarding work permit, residence permit, contract, salary, contractual relation with health insurance companies, professional liability insurance, or professional relationship. As a result, supervisor and supervisee often had completely different ideas about the interpretation of their agreement. The supervisor’s working programme was not clearly outlined and there was no check on how it was carried out. Moreover, Merkelbach concluded that supervision reports were regularly sent to the Department of Health long after they were due, and that the content was often rather insubstantial.

Doctors enrolled in the BIG register ‘with clauses’ have the same rights and duties as other doctors. They are also responsible for their actions in disciplinary jurisdiction; however, it is unclear whether the supervisor, if supervision has been inadequate, is responsible in disciplinary jurisdiction and civil law. In the article, doubts were raised regarding this situation, since the Central Medical Disciplinary Tribunal had said in a verdict that an instructor had to initial every note made by an assistant physician. Assistant physicians are doctors enrolled in the BIG register without clauses.

Due to the autonomy of the players in the field, i.e. the Committee for the Registration of Medical Specialists (MSRC) and the various scientific associations, it was impossible for the Department of Health to make any demands regarding supervision. In effect, only half the successful evaluation internships led to enrolment in the specialist registers concerned.

The conclusions of the article were far-reaching. It was advised that the Health Secretary should no longer apply the supervision instrument, until the guidelines had been specified further and had been given a legal basis. It was also advocated that foreign doctors were assessed objectively, and that this assessment should be followed by a tailor-made additional training at a university medical school; here, the article referred to the practice outlined by Haalboom and Herfs in 1998. They recommended testing and inclusion in a university programme, as long as there was no clear definition of supervision in the BIG Act.

4.3.4 In 2002 Hubert Smeets published his book *Welcome to the Kingdom: captured in medico-judicial bureaucracy*.²⁵ Five years earlier, he had already published a forerunner of this critical book (Smeets, 1997). In both publications, Smeets showed himself to be an angry and frustrated citizen. He describes what he calls the 'agony' that foreign specialists have to endure when they apply for recognition. Smeets is married to Olga Polsatsjova, a Russian allergologist, who emigrated to the Netherlands after their wedding in 1994. The pair expected the highly respected medical specialist to receive recognition in the Netherlands. Smeets surmised that as soon as the various routes of the labyrinth became clear, recognition would be within reach. His wife was less convinced, as her trust in governmental authorities had never been very great. Smeets could not and would not believe that Dutch governmental and semi-governmental authorities behaved in ways reminiscent of Soviet Russian authorities.

Smeets and his spouse ran up against the 'double route' of recognition. If there is an application for recognition, the Health Secretary rules on equivalence, near equivalence or no equivalence of the medical certificate to the Dutch basic doctor's certificate. However, the minister does not rule on the recognition of a medical specialism. That authority lies with the Committee for the Registration of Medical Specialists (MSRC). Foreign specialists receive recognition if they can convince the MSRC of having sufficient skills and knowledge and an adequate command of the Dutch language. Of course, this only applies to recognised medical specialisms. If there is a positive ruling by the MSRC, the Department of Health adopts this ruling, and the foreign specialist can be enrolled in the BIG register. In Polsatsjova's case, the *Concilium Allergologicum*, the scientific professional body of allergologists, decided that there were substantial discrepancies between specialist training in Russia and in the Netherlands. Moreover, allergology was not recognised as a clinical specialism in the Netherlands. On 12 August 1996, allergology became part of internal medicine; as a result, allergologists need to have completed their training as an internist. However, Dutch training for internal medicine lasts three times as long as Russian training, which is a difference that cannot just be compensated by an assessment internship.

²⁵ This text has been included in this dissertation to illustrate how some of the people concerned experienced the inclusion method used at the time. Although this book has no scientific pretensions, it has been included as additional information.

According to the professional association of allergologists, Polsatsjova's twelve year-long professional practice as an allergologist had been exceedingly one-sided. The *Concilium Allergologicum* rejected the request for an assessment internship, and it was impossible to appeal against this verdict because the scientific professional association of allergologists is not a governmental body. Of course the MSRC could not ignore the advice given by the professional association, and so Polsatsjova was back at the Department of Health. Subsequently, the Health Secretary judged the Russian medical training as 'non-equivalent'. Polsatsjova was advised to contact the medical faculty of Utrecht University for an inclusion interview. Eventually, the result of this 'double route' was two rejections: firstly, rejection by the MSRC, and so no recognition as a specialist; secondly, rejection by the minister, and so no recognition as a Doctor of Medicine. After several meetings and after several appeals, the couple even spoke to the Health Secretary, Els Borst, who acknowledged that "the procedure is extremely complicated and even has some Kafkaesque characteristics, but that it certainly was not and is not meant to keep out foreign doctors."

4.4. Future developments in streamlining additional training programmes for foreign doctors

In a relatively short period of time, between 2001 and 2003, several publications appeared regarding the additional training of foreign doctors. The organisations responsible for these publications were the Department of Health, the Foreign Healthcare Qualifications Commission (CBGV), the Medical Sciences Board (DMW), NUFFIC, and the University Asylum Fund (UAF).

4.4.1 In 2001, a report was published with the title 'No more waiting: fewer obstructions for the admission to the medical profession' (*Werkgroep Toetredingsbelemmeringen Medische Beroepen*, 2001). The report was commissioned by the Dutch government. The assignment for the interdepartmental working party Free market, Deregulation and Good law-making (MDW) was worded as follows: "making an inventory of the obstacles for the admission to professional practice for doctors (general practitioners as well as specialists), dentists, physiotherapists and obstetricians, as well as formulating proposals to adapt or remove unwanted obstacles." The report discussed the *numerus clausus* restrictions²⁶ at regular medical and dentistry faculties, obstacles at specialist training, and ways to increase the number of places for medical training. Only a small part of the report dealt with the admission of foreign graduates. It was stated that "there was a justification for the obstacles for foreign health practitioners based on the public interest of protecting health care clients. It is desired that there is a preventive quality inspection by the government, since health care clients (i.e. patients) generally only

²⁶ Numerus clausus restrictions are determined by the Ministry of Education. They concern the maximum number of students admitted to some studies, including the studies of medicine, dentistry and veterinary medicine.

have limited medical knowledge.” Therefore, the working party concluded that it was necessary to have a quality assessment procedure before admission to the Dutch health care market was possible. Moreover, the working party thought that professional associations had too much influence on the admission of foreign graduates. Therefore, they suggested replacing the advice given by the Foreign Healthcare Qualifications Commission (CBGV) by an admission test for foreign graduates. Such an exam would reveal any gaps in the practitioner’s skills and knowledge, which could be filled during tailor-made additional training.

4.4.2 In 2001, the Foreign Healthcare Qualifications Commission published the report ‘Competence without borders’ (CBGV, 2001). This report was the logical consequence of the report ‘No more waiting’ (cf. section 4.4.1), which was written by civil servants from the Departments of Health, Education, Culture and Science, Economic Affairs, Finance, and the Ministry of Justice. One of the recommendations of this interdepartmental working party was to develop an admission exam for every medical or paramedical foreign graduate. In its advice to the Health Secretary, the CBGV abandoned the term ‘admission exam’ and used ‘assessment procedure’ instead. Due to the international treaty on the recognition of certificates from the European Economic Area, the emphasis was on graduates from outside the EEA. The minister was advised to expressly involve education organisations in the determination of professional competence.²⁷ Three factors were discussed that were of eminent importance for the successful conclusion of the assessment procedure by a foreign graduate: first of all, a good command of the Dutch language; secondly, an adequate preliminary training; and thirdly, legal residence status. About the command of the Dutch language, the report argued that the level of the State Exam Dutch as a second language (Programme 2) was not sufficient for following and successfully rounding off medical training. A good command of the Dutch language was also required for taking progress tests. In the report, the authors drew attention to some clauses in the Medical Treatment Contracts Act (WGBO) that stated that health care workers should be able to communicate in the language of the patient and of the other health care workers. Moreover, a good command of the Dutch language is also essential because the WGBO obliges caregivers to keep a record for each patient with a view to health care continuity. The authors remarked with regard to residence status that a quarter to a third of the applicants of a certificate of professional competence did not have a Dutch residence permit.²⁸ Dutch residence regulations do not require a residence permit for filing an application or for the processing of this application by the Health Secretary. At first, the implementation of the assessment procedure was to be aimed at doctors, dentists, nurses, obstetricians and physiotherapists. It was indicated that the implementation would lead to great improvements: more equality before the law, greater simplicity, accelerated procedures and quicker assessment of competences. The assessment procedure would contribute to determining whether a health care practitioner who had

²⁷ This was totally different from previous reactions. Never before had the Department of Health demonstrated any willingness, let alone any need to cooperate with the educational institutions with regard to additional training by foreign doctors.

²⁸ For admission to a higher year of the study of medicine, assessing the (permanent) residence status is a standard part of procedure.

graduated abroad was competent enough according to Dutch standards. This was not only established according to whether someone held a certificate, but also by considering professional experience. Skills and knowledge can be determined by testing. During such testing, attention would have to be paid to the special characteristics of Dutch health care, in structure as well as in culture, attitudes and professional behaviour. The CBGV also advocated the use of so-called APL procedures (Accreditation of Prior Learning). These procedures referred to competences acquired during professional practice, but for example also during voluntary work. These competences could be shown in a portfolio. Such a portfolio describes what formal and informal learning activities have taken place and what additional skills and knowledge have actually been acquired. The CBGV was of the opinion that assessment could not be based on a single admission exam, but had to be based on a process of data collection, aimed at determining learning results and competences. Therefore, the CBGV preferred the term 'assessment procedure' to 'admission exam'.

4.4.3 January 2003 saw the publication of 'Refugee doctor from waiting room to consulting room' (Van Arkel & Engelkes, 2003). This report was commissioned by the University Asylum Fund (UAF). This publication was subsidised by the Dutch Department of Health and the European Refugee Fund; these organisations wanted the UAF to conduct research (or commission research) into improving the procedures surrounding the influx of refugee doctors into Dutch health care. The UAF is an organisation for refugee students which was founded in 1948. It pays special attention to refugee doctors, as a large part of its clients are doctors. By the end of 2002²⁹, 358 doctors were registered as UAF clients. Of these, 165 were preparing their admission procedure, whereas 193 were already enrolled in a Dutch medical faculty.

The report drew five important conclusions. Firstly, procedures regarding the assessment of professional competence and admission to Dutch health care take too long, are inefficient, are non-transparent and exceedingly fragmented. Secondly, among the medical faculties there are great differences in assessment procedures and in admission to medical training programmes. Thirdly, the work experience and specialisation of the refugee doctor is generally not taken into account, and there is no APL assessment. Fourthly, there are hardly any specific individual training programmes. Fifthly, the organisation of assessment internships for specialists leaves much to be desired.

To tackle these shortcomings, it was advised that an Assessment Institute for Physicians (AIM) was established to promote a speedier influx of doctors who had graduated outside the EEA. The AIM would be given tasks such as compiling dossiers, disseminating information, evaluating certificates, testing skills and knowledge, assessing professional competence, and determining the necessary additional training. During the initial phase, a portfolio would have to be compiled for each individual. It was also proposed that representatives of all medical faculties together develop one national skills and knowledge test.

²⁹ In January 2005, 278 foreign doctors were registered as clients of the UAF. Of these, 182 were enrolled as students of medicine and 96 were preparing for admission.

4.4.4 In 2003, the report 'Towards a streamlined approach to foreign doctors' was published (Splinter et al, 2003). This report was produced by a committee composed under the authority of the Medical Sciences Board (DMW) of the Association of Universities in the Netherlands (VSNU). This 'Splinter Committee' was named after its chairman Professor T. Splinter (Erasmus University Rotterdam) and was given the task to develop a streamlined approach to foreign doctors. In December 2001 it was decided to establish a project group which was to propose measures leading to, first of all, an increased speed in the handling of applications from and procedures for doctors in Categories II (nearly equivalent) and III (no equivalence); secondly, better, more uniform testing of these doctors in order to improve the determination of their skills and knowledge; thirdly, more uniformity in the additional requirements for foreign doctors, e.g. by determining in what areas additional training is necessary; fourthly, greater uniformity in the demands made during training and the time necessary for teaching. It is important to consider what training should be offered at one central location, what education could be offered in different locations with similar materials and /or methods, and what education should be offered individually.

The Medical Education Committee (OCG) of the Medical Sciences Board (DMW) made the decision to establish the Splinter Committee as a result of discussions in society. These discussions took place on three different levels. First of all, there were discussions on a political level. Regularly, parliamentary questions were asked and motions were put forward that dealt with the question how foreign doctors could be used effectively to solve the shortage of doctors in the Netherlands. At the instigation of the Association of University Hospitals (VAZ) and the DMW, the number of students admitted under *numerus clausus* was raised from 2,140 in 2001 to 2,550 in 2002 and 2,800 in 2003 to alleviate this shortage. Unfortunately, the effect of this increased influx of doctors will only become clear after ten years. In the shorter term, alleviation can be achieved by means of lateral influx followed by a condensed training programme; this could apply both to students with a biomedical background, e.g. students of SUMMA in Utrecht, and to foreign doctors. In the Netherlands there are approximately 1,200 doctors with a foreign certificate, and every year this number increases by 200. From 1996, there have been approximately 1,000 doctors that have graduated, are still following training at one of the University Medical Centres, or are on a waiting list at one of these UMCs.

Secondly, it was difficult to understand for foreign doctors that the Dutch authorities and medical faculties did not welcome them with open arms nor immediately offered them training for a place in health care, especially with a view to the shortage of doctors mentioned above. Instead, foreign doctors were confronted with extensive regulations and with a great variety of institutions, such as the Ministry of Justice, the Central Information Office for Health Care Professions (CIBG) and the Foreign Healthcare Qualifications Commission (CBGV), both part of the Department of Health, the Department of Education, Culture and Science (OC&W), the Committee for the Influx of Foreign Doctors (CIBA), the University Asylum Fund (UAF), the Agency for Refugee Assistance (*Stichting Vluchtelingenwerk*), the 'Emplooi' Foundation, the Agency for Intercultural Business and Intercultural Entrepreneurship (SIBIO), various municipal bodies and eight medical faculties (UMCs). The procedure for the BIG registration often takes a long time, from one to five years, and is sometimes not completely finished at all. Financial support during training depends on municipal policies and on the UAF. Moreover, this whole process is emotionally charged as a result of the low esteem in which foreign certificates are held in the Netherlands, notwithstanding years of experience in health care and the concurrent high

status in the country of origin; not surprisingly, the current situation of asylum seekers and refugees in the Netherlands also plays an important role.

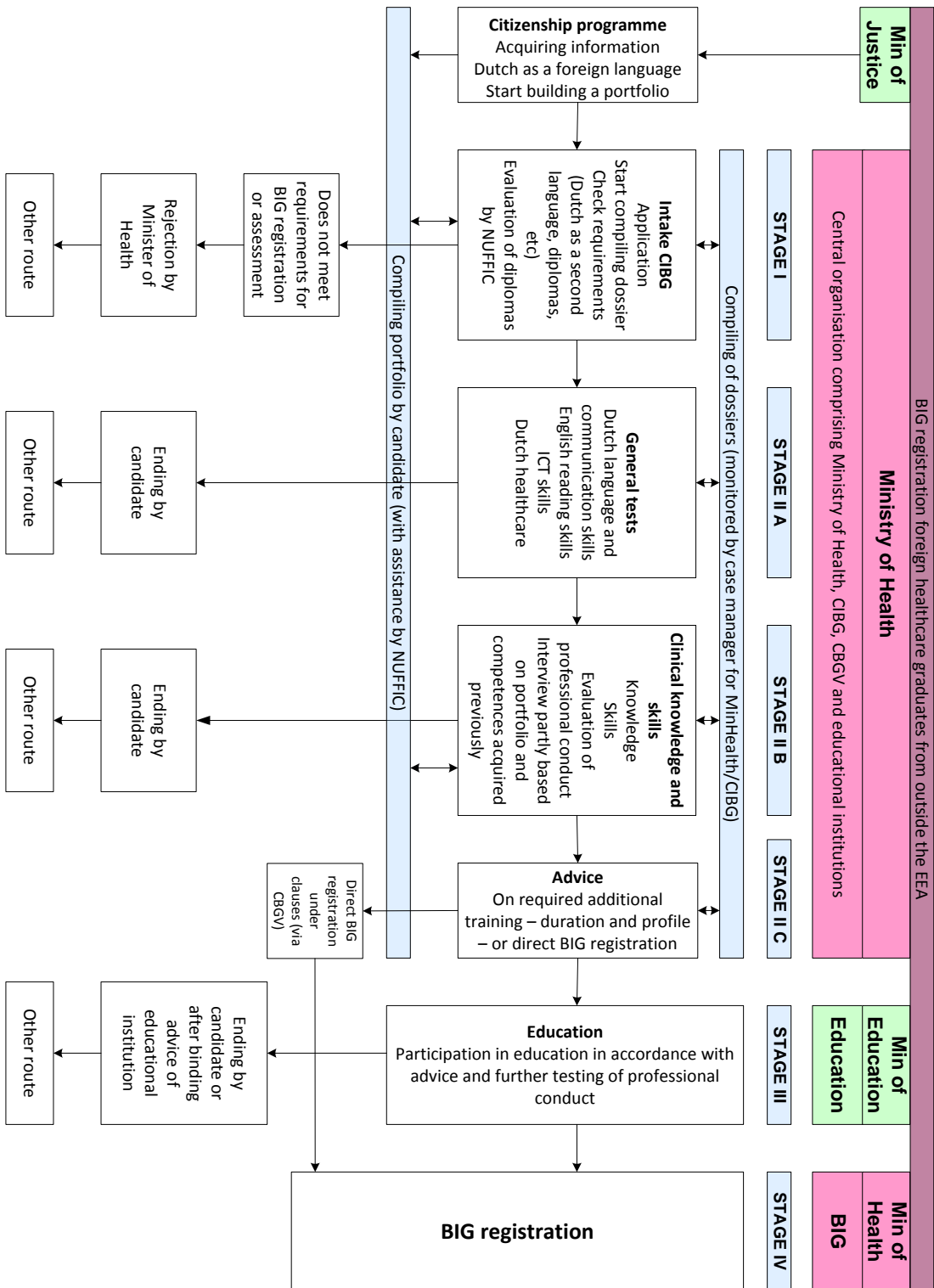
Thirdly, there were discussions in the University Medical Centres. The numbers of foreign doctors entering laterally³⁰ into UMCs grew from an average of 8 per year for each UMC in 1996 to 15 on average from 2000.³¹ There has been a similar increase in the interest in the training of foreign doctors, and various training programmes have been developed at the UMCs. These programmes were based on doctors' estimated skills and knowledge and the shortcomings experienced (by them or their co-workers) during their medical training. The UMCs were confronted with several problems. Firstly, the level of the State Exam Dutch as a second language is certainly insufficient to communicate with a patient. Secondly, foreign doctors need to have a greater knowledge of the structure of Dutch health care, ethical issues and modern diagnostics. Knowledge of the English language (especially reading skills) is often insufficient or completely lacking. Furthermore, the individual estimation of skills and knowledge is a great problem. There are several reasons for this, including the fact that most foreign doctors have not worked as a doctor for four years or more, and that in their country of origin they may have been working in a very limited section of their specialism; for example, for many years one gynaecologist had worked only as a midwife. Fourthly, attitudes towards patients, especially patients of a different sex, often differ from Dutch doctors' attitudes, and attitudes towards colleagues, nurses and educators is often not conducive to the customary way of collaborating in the Netherlands. Together with communication problems, this may place foreign doctors in an exceptional position with a negative effect on the result of the training.

On 17 June 2002, the project group organised a round table conference to develop building blocks to achieve a more streamlined policy regarding foreign doctors. The new procedure was to be based on the idea that the medical faculties are no longer responsible for examining the command of Dutch, medical skills and knowledge, and for the eventual inclusion of foreign doctors in medical training. After following a civic integration course, foreign doctors are referred to a central organisation responsible for information on the procedures, intake, compilation of dossiers, organisation of basic tests, organisation of skills and knowledge tests and the resulting advice. This central organisation was to be formed by the Department of Health and by CIBG, CBGV and the medical faculties. The building blocks that were presented during the round table conference were subsequently incorporated into a flow chart by the Splinter Committee.

³⁰ People entering 'laterally' can be compared to people entering from the base. People entering from the base start their study of medicine in the first period of the first year. People entering laterally have studied medicine elsewhere and, as a result of exemptions, enter at a later phase of the study. Appendix 8 presents a clear overview of the different categories of immigrant students in Dutch higher education.

³¹ Appendix 3 presents the inclusion data up to and including 2004. Until 2005 there were no great differences in the annual influx.

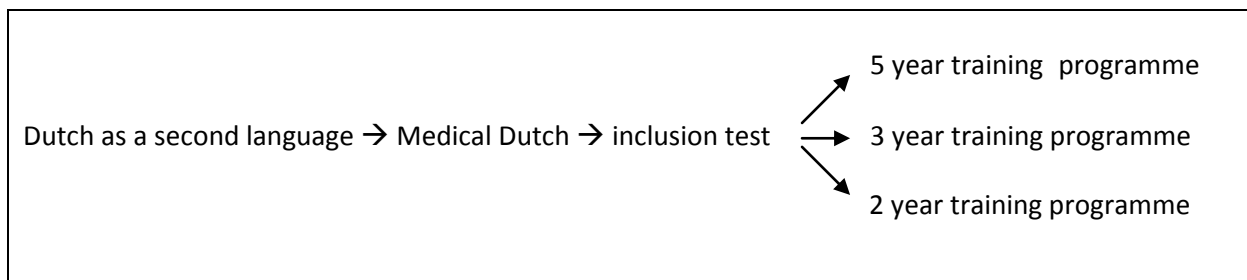
Figure 4.1: Flow chart foreign doctors (Source: Department of Health)



4.4.5 In 2003, a report was published with the title 'Portfolio for foreign medical graduates in a training-centred APL procedure'. This NUFFIC report had been commissioned by the EVC, the Knowledge Centre for the Accreditation of Prior Learning, which is financed by the Ministry of Economic Affairs and by the Ministry of Education, Culture and Science and which promotes APL procedures in various sectors of society. APL procedures make use of portfolios in which clients describe their learning and work experience (acquired in a foreign country or in the Netherlands), so that entry into the labour market can take place in a more effective and efficient way.

The report suggested that after foreign doctors had been admitted to medical training, there was hardly any tailor-made inclusion. The authors were of the opinion that the medical skills and knowledge that foreign doctors had acquired during their training and/or work experience was hardly taken into account during the inclusion procedures. Therefore, it was investigated by means of a pilot at the medical faculty of Utrecht University as to whether a portfolio might be helpful in arriving at a more tailor-made training programme.

The proposed inclusion procedure for foreign doctors at Utrecht University would be as follows:



The preconditions for admission to the inclusion test were passing the State Exam Dutch as a language and successful participation in the course 'Medical Dutch'. The outcome of the inclusion test in part determined the length of the training programme. If the portfolios appeared to be successful, they could also be taken into consideration when the length of the additional training programme was determined.

The portfolios of the foreign doctors who participated in the pilot included the following items:

- Personal data
- Non-vocational education
- Medical education
- Education in the Netherlands
- Work experience abroad
- Work experience in the Netherlands
- Professional development
- Reflections on health care in the Netherlands and abroad

The foreign doctors participating in the project had quite a few problems with this portfolio. Some of these problems involved the use of the computer for the various items, other problems involved the reflection on the work performed in health care. More was required than simply giving information about the topics of the portfolio. It became clear that the doctors needed assistance in building a portfolio, as this was completely new to most of them.

4.5 Assessment of quality requirements

At the beginning of this chapter, two policy priorities were mentioned, and sections 4.5 and 4.6 will describe the experiences regarding these priorities. The first priority was: how can it be ensured that a foreign doctor, who wants to work as a doctor in the Netherlands or in a third country, has the required quality with regard to knowledge, skills and attitude? In other words, how is the assessment of foreign doctors arranged for these aspects?

Of course, this is not a problem that is limited to the Netherlands. From a study on large scale migration of IMGs to Australia, Canada, the United Kingdom and the United States, which is described in chapter 2, it has become clear that countries that are highly dependent on migrating foreign doctors have heavily invested in the development of assessment procedures. In the Netherlands the new assessment procedure has been in force since December 2005. The *United States Medical Licensing Examination*-procedure (USMLE) was to a large extent the model for the Dutch procedure. The USMLE procedure was developed by the Educational Commission for Foreign Medical Graduates (ECFMG) 50 years ago. All foreign doctors, whatever their country of origin and whatever certificate they hold, are obliged to successfully round off the USMLE before they are qualified to work as doctors. The United Kingdom also has a central assessment procedure: the Professional and Linguistic Assessment Board Exam. Canada has a decentralised assessment procedure which is organised at province level; the Canadian authorities want to develop a centralised assessment procedure. In Australia there is a centralised assessment procedure for foreign doctors wanting full registration. Still, this procedure is sometimes by-passed: if a far-off hospital opts for a temporary licence for a foreign doctor, only the authenticity of the doctor's certificate is checked.

The same study describes which items are tested in the assessment procedures of the countries mentioned above. Doctors are required to have a residence permit and during this procedure their doctors' certificates will be checked; moreover, doctors are assessed on their command of the English language, medical knowledge, clinical skills and knowledge, attitude towards patients, communication skills and general good behaviour. The Dutch assessment procedure comprises two tests: the general skills and knowledge test examines the command of the Dutch language and communication skills, English reading skills, ICT skills and knowledge of Dutch health care; the professional competence test assesses basic medical knowledge, clinical skills and clinical knowledge. The advice by the Foreign Healthcare Qualifications Commission (CBGV) is based on the outcomes of these two tests.

4.6 Admission to the medical profession

The second policy priority dealt with the following issue. There are foreign doctors who have been trained outside the European Economic Area³² and who have been granted permanent residence in the Netherlands. Have these doctors been admitted to the profession in the Netherlands (with a qualification obtained in their country of origin or in another non-EEA country)? If these doctors are not allowed to practise their profession, is it still possible to obtain this admission in any way? Since the 1990s, there have been fewer possibilities for foreign doctors to work in Dutch health care. Eight problems regarding this development will be described below.

Problem 1

Before 1993, foreign graduates who had been trained outside the EEA could only work as a doctor in the Netherlands if they found an employer who was prepared to give them a job. Moreover, the employer had to be willing to file a request for professional practice with the Department of Health (cf. section 4.1.1). After 1993, a new circular from the Department of Health came into force, which only allowed this route for graduates who had been judged 'nearly equivalent'. This caused great problems for those doctors judged 'non-equivalent' (Category III) because they no longer had any perspective of working as a doctor in the Netherlands.

Problem 2

Graduates who have been judged 'nearly equivalent' and who have to work under supervision, need to find a supervisor themselves. For this, they cannot fall back on the Department of Health or any of the professional doctors' associations (cf. section 4.3.3). The supervision route is not a guarantee for success, and this has caused the ex-chairman of the Foreign Healthcare Qualifications Commission (CBGV) to utter his preference for the CIBA route over the supervision route. This problem is that doctors who have been judged 'nearly equivalent' (Category II) have to find their own supervisor and often do not succeed in finding one.

Problem 3

In 1996 the procedure was described that foreign doctors from outside the EEA had to follow when submitting a request for the recognition of their foreign medical certificate and the possible outcomes of this procedure (cf. section 4.2.2). Doctors whose qualifications had been judged 'non-equivalent' or 'nearly equivalent' could be admitted to a higher year of medical school via the CIBA. The subsequent admission and inclusion took place under the authority of the eight exam committees. There was no coordination regarding such subjects as the evaluation of certificates, the evaluation of work experience or the determination of additional training (cf. section 4.2.3). The problem remains that after the recognition requests from foreign doctors have been dealt with by the Department of Health, there is no longer any governmental responsibility for these doctors. However, after

³² The European Economic Area comprises the EU member states together with Liechtenstein, Iceland and Norway. Switzerland has not formally joined the EEA, but this country has a status which is comparable to EEA membership.

the foundation of an interuniversity admissions centre (CIBA), a medical career in Dutch health care is still possible for these doctors, even if they have been rejected by the Department of Health.

Problem 4

The handling of recognition requests by foreign doctors leads to complaints and lawsuits. The Department for Educational Development and Educational Research of Maastricht University was commissioned by the Department of Health to investigate how the ministry deals with recognition requests. Their report included many points of criticism (cf. section 4.3.2). One problem mentioned was that the process takes an excessively long time. Moreover, there was unclarity about the evaluation of foreign doctor's diploma, which includes an evaluation of secondary education by NUFFIC. However, the main complaint dealt with inconsistencies regarding advice; in other words, similar cases received different advice.

Problem 5

The installation of CIBA in 1996 created the possibility to include foreign doctors (Category III) in the medical faculties. Nevertheless, there were great differences between the eight medical faculties. Initially, there was a great variety in the number of places for each faculty, which caused problems. After 2-3 years, every medical school admitted 10 foreign doctors. In addition, there were huge differences in the inclusion procedure, which led to a considerable diversity in the time needed for the training. A problem that was common to all faculties was the poor command of the Dutch language. In the late 1990s, Utrecht University started developing a course 'Medical Dutch for foreign doctors' (cf. section 4.2.4).

Problem 6

The procedures that need to be followed are extremely time-consuming and non-transparent (cf. sections 4.3.3 and 4.3.4). The problem is that foreign doctors appeal to the Dutch government and/or professional associations of medical specialists and get the impression that they are being sent from pillar to post.

Problem 7

More and more foreign doctors who have been rejected by the Department of Health find their way to the interuniversity admission centre CIBA, which is increasingly being confronted with capacity limitations. Although the number of training places has increased, the demand has grown even stronger. The Department of Health persists in its viewpoint that foreign doctors who have received a negative decision (Category III) are no longer the ministry's responsibility (cf. section 4.4.1). The problem was that Category III doctors were at a loose end after receiving the negative decision by the Department of Health. There was no way in which they could rely on Dutch governmental support for a necessary additional medical training programme. A parliamentary motion by Hermann (of the left *Groen Links* party) that received almost unanimous support during the budget debate in 2001, forced Health Secretary Els Borst to facilitate medical faculties in the organisation of additional training for doctors in Categories II and III. The implementation of the new assessment procedure is a direct consequence of Hermann's motion.

Problem 8

Within a short period of time, three reports on foreign doctors became available from three different organisations. These organisations were the Foreign Healthcare Qualifications Commission (of the Department of Health; cf. section 4.4.2), the University Asylum Fund (cf. section 4.4.3) and the medical faculties (cf. section 4.4.4). The common conclusions of these three reports led to the implementation of the assessment procedure. The Department of Health and the medical faculties decided to cooperate in the development of an additional training programme for foreign doctors, thus acting upon the motion by C. Hermann. This meant an end to the situation in which the medical faculties had to shoulder the ultimate responsibility for the inclusion programmes for foreign doctors. Since December 2005, the Department of Health has been ultimately responsible for the assessment procedure for foreign doctors in the Netherlands. Chapters 9 and 10 also deal with the new assessment procedure.

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5.1 Introduction

From the mid-1990s, Dutch medical faculties gave additional training to foreign doctors from outside the EEA. This was necessary because these doctors' medical diplomas were not acknowledged by the Health Secretary. With a questionnaire, it was investigated whether foreign doctors who had graduated in the period 2000-2004 had found work as doctors in the Netherlands. In that period 191 foreign doctors graduated. Of the 36% who responded, 94% had found a job as a doctor and all had received their BIG registration. It has become clear from the labour participation of foreign doctors that their efforts and those of the training institutes have not been in vain.

In general, the influx of ethnic minorities into the Dutch labour market leaves much to be desired. This is not only true for the low educated but also for the highly educated (Klaver & Odé, 2003). In a report from 2005 by *Vluchtelingenwerk Nederland* (Dutch Council for Refugees) it was concluded that it is difficult for refugees to enter the labour market. It was also remarked that attaining a Dutch diploma has a favourable effect: 71% of the refugees with a Dutch higher education diploma has found a job. In a recent study of *Regioplan Policy Research* it was remarked that "the influx into healthcare of refugees with a medical background is a laborious process" (Desain & Hello, 2006). The present research does not restrict itself to refugees, however. Among the doctors described here, there are also people whose residential status is dependent on their Dutch spouse. In this respect the population of this research differs from the population in the research by *Vluchtelingenwerk Nederland* and *Regioplan Policy Research*.

This chapter describes the role played by the Department of Health in recognition requests by foreign doctors. For those foreign doctors whose diplomas are not recognised, the medical faculties organise additional medical training. It has been examined with the help of a survey whether foreign doctors could find a job as a doctor in the Netherlands after concluding their additional medical training. In addition, it has been investigated by means of interviews what problems foreign doctors encountered when trying to find work as a doctor. This chapter describes the results of this research.

5.2 The role of the Department of Health in dealing with recognition requests

The Department of Health is responsible for processing recognition requests by foreign doctors. Until the assessment procedure came into force in December of 2005, the Department of Health played a rather limited role with regard to foreign doctors from outside the European Economic Area. Many doctors' diplomas were judged not equivalent by the Foreign Healthcare Qualifications Commission (CBGV), the advisory body of the Department of Health. This commission followed the advice of the department for the evaluation of foreign credentials of the Netherlands Universities Foundation for International Cooperation (NUFFIC). In most cases NUFFIC concluded, based on a lower secondary school level at the start of medical training, that the foreign medical training was equivalent to the theoretical doctor's exam of Dutch medical training; in these cases, the Health Secretary judged that the former training was inadequate by two years in comparison to the Dutch basic doctor's diploma and was therefore not equivalent. In 2000, 116 of the 257 doctors' diplomas offered were regarded as not equivalent. In 2002, this was true for 158 of the 303 doctors' diplomas. If these foreign doctors wanted to carry out the profession for which they had been trained in their country of origin, they had no choice but to follow medical training again. In the mid-1990s, there was an enormous increase in the number of requests for influx into a higher year of medical training by foreign doctors who had been rejected by the Department of Health. The Medical Sciences Board (DMW) established the Commission for the Influx of Foreign Doctors (CIBA) to streamline and distribute these recognition requests (Herfs, 1996). The CIBA only considered requests by foreign doctors if the Health Secretary had judged their diplomas as non-equivalent. Moreover, there had to be "compelling reasons" to continue medical training in the Netherlands. Residential stay as a refugee or with a Dutch spouse, in combination with a negative decision by the Department of Health, was regarded as a compelling reason to continue medical training at one of the medical faculties. Foreign doctors with an EU nationality and an EU diploma were not admitted; after all, these doctors would be able to appeal successfully to the EU directive on the recognition of professional qualifications (Directive 2005/36/EC). Requests by foreign medical practitioners with a residence permit on the grounds of study were not taken into consideration either. They were referred to the drawing of lots procedure (for *numerus clausus* education), carried out by the Central Application and Admission Office (CBAP) of the Ministry of Education in Groningen. The former chairman of the CBGV even observed that there was an increase in the number of doctors whose diplomas were judged not equivalent (Merkelbach, 1999). He considered this a consequence of the additional training programme, which had been made possible by the cooperation between the medical faculties. As a result of the CIBA route, the Department of Health could limit its role to judging foreign doctors' diplomas. In all the cases that this judgement was negative, the doctors could be referred to the medical faculties. Even without the specific request from the Department of Health, the medical faculties offered many immigrant doctors the perspective of working as a doctor in the Netherlands.

5.3 Admission to the medical faculties through CIBA and entry to the labour market after graduation

Up to and including the year 2006, CIBA referred 1071³³ foreign doctors³⁴ to the eight medical faculties to obtain the necessary additional medical training to be a basic doctor (see Table 5.1). Most of the additional training programmes lasted 3 to 4 years.

Table 5.1: Applications distributed by CIBA since 1996

Year	Applications distributed by CIBA	Cumulative
1996-1997	113	
1997-1998	97	210
1998-1999	127	337
1999-2000	132	469
2000-2001	136	605
2001-2002	118	723
2002-2003	126	849
2003-2004	99	948
Total	948	

In the period 1996-2004, 261 CIBA doctors graduated. The other doctors were still engaged in the preparation for admission (including Dutch as a second language and medical Dutch) or in their additional medical training (including doing their internships). In the year 2000, a study was conducted into the careers of the first CIBA doctors who had graduated in the Netherlands during the period from 1996 to August of 2000 (Herfs et al, 2001). During this investigation, 70 CIBA doctors graduated, and all the respondents found jobs as doctors in the Netherlands.

With a view to the great investment made by the medical faculties (as well as by the foreign doctors) regarding these additional training programmes, it seemed sensible to conduct further research into the opportunities and possibilities for graduated CIBA doctors in the labour market. The 2001 study was repeated in 2004. This time it involved all foreign doctors who had graduated from September 2000 to August 2004. In total, 191 foreign doctors were involved who had graduated from one of the eight medical faculties. The research question was: Do CIBA doctors find jobs as doctors in the Netherlands after graduation, and what problems do they encounter in finding work and during their work?

³³ CIBA's official secretary has calculated that approximately 70% of all foreign doctors who request admission through CIBA eventually start an additional medical study at one of the eight medical faculties.

³⁴ Foreign doctors who request admission to medical training through CIBA can be divided into refugees and people with a Dutch spouse. The ratio between these two categories has changed as a result of the Aliens Act, which came into force in the year 2000. In 2002, 71% of the influx of foreign doctors had refugee status; in 2005, the majority of foreign doctors seeking admission to medical training had a Dutch spouse (57%; see Herfs & Haalboom, 2008)

5.4 Methods

At the eight medical faculties, the names and addresses³⁵ were requested of all CIBA doctors who had graduated in one of the academic years 2000-2001, 2001-2002, 2002-2003, and 2003-2004. With a view to privacy, the medical faculties at Groningen and Maastricht preferred to send the questionnaires from their own institutions. In total, 191 doctors were involved (see Table 5.2).

Table 5.2: Graduated foreign doctors and the response per medical faculty

University	Number of graduates	Number of respondents
University of Amsterdam	19	8
VU Amsterdam University	16	3
Leiden University	9	5
Erasmus University Rotterdam	52	18
Utrecht University	20	6
University of Groningen	35	13
Radboud University Nijmegen	20	9
Maastricht University	20	7
Total	191	69

A questionnaire was used with questions on age, origin and preliminary education. In addition there were questions on graduation, BIG registration, work and how much the doctors worked. The final question was to what extent this work met the respondent's expectations. The list had been used previously in comparable research (Herfs, Haalboom, Kruijshoop & Yari, 2001). The respondents were also requested to give their telephone numbers for an interview by telephone. During this interview, respondents were asked specifically about any problems they had experienced, for example in finding a job, or regarding language, writing skills, and relations with other professionals. Respondents were also asked whether they had been coached.

5.5 Survey results

From 1 October 2004 until 11 January 2005, a total of 69 (36%) completed questionnaires were returned. Seven questionnaires came back undeliverable. It was checked to what extent the doctors who responded corresponded with the total population with regard to age and origin. The age distribution was comparable (see Table 5.3).

³⁵ It has to be mentioned that the address files of the eight medical faculties were probably dated and consequently contained incorrect addresses. In particular for the doctors from the first few cohorts, there was a considerable chance that they had moved house after graduation.

Table 5.3: Age categories in numbers and percentages for respondents and total population

Age category	Respondents		Total population	
	N	%	N	%
26-30 years old	9	13	29	15
31-35 years old	25	36	65	34
36-40 years old	22	32	57	30
41-45 years old	13	19	27	15
> 45 years old			11	6
Totals	69	36	191	100

There were considerable differences in the distribution of the origin of the doctors' diplomas (see Table 5.4).

Table 5.4: Distribution among the continents of doctors' diplomas in numbers and percentages

Diplomas from	Respondents		Total population	
	N	%	N	%
Asia	30	43	120	63
Eastern Europe	28	40	57	30
Latin America	4	6	6	3
Africa	3	4	8	4
Not given	4	6		
Totals	69	36	191	100

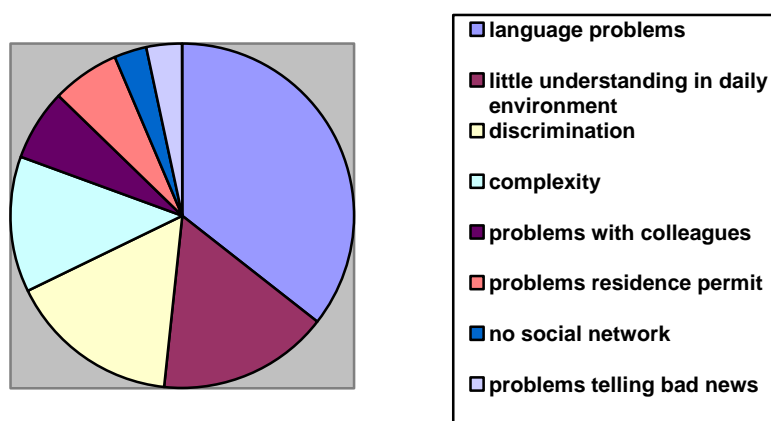
Of the respondents, 43% had an Asian diploma (mainly from Afghanistan and Iraq); for the total population this was 63%. In addition, 40% of the respondents had an Eastern European diploma; for the total population this was 30%. At the time of the survey, all 69 CIBA doctors were working as doctors and were enrolled in the BIG register. The time needed to find work after their doctor's exam was comparable to that of Dutch basic doctors (STOGO, 1998). Of 69 respondents, 65 found a job within 3 months (94%), 3 doctors took 4-6 months (4%), and one doctor needed nearly 12 months. Of the respondents, 55 worked full time (80%), and 14 worked part time (20%); 27 doctors were working without simultaneously following training (41%). The other 41 doctors were in training (59%). The professional areas are presented in Table 5.5.

Table 5.5: Overview of doctors in training and doctors not in training

Doctors not in training	N	Doctors in training	N	N total
Hospital doctor	10	General practitioner	13	
Nursing home doctor	2	Nursing home doctor	7	
Area Health Authority doctor (GG & GD)	5	Psychiatrist	5	
Home care physician	4	Internist	3	
Health and Safety medical examiner	2	Lung specialist	2	
Doctor at residential home	2	Anaesthesiologist	2	
Pharmacological research	1	Paediatrician	2	
Private practice doctor	1	Medical examiner	2	
Acupuncturist at health centre	1	Dermatologist	1	
		Doctor for the mentally deficient	1	
		Microbiologist	1	
		Pharmacologist	1	
		Sexologist	1	
Total	28		41	69

Of the respondents, 41 doctors stated that their job met their expectations (59%). For 22 doctors this was only true to a lesser extent (32%), and 4 doctors said that it did not meet their expectations at all (6%). One respondent failed to answer this question. Forty-three doctors stated that they had not encountered any obstacles (62%); 26 doctors had experienced problems (38%). These problems were mostly related to language; they are presented in Figure 5.1.

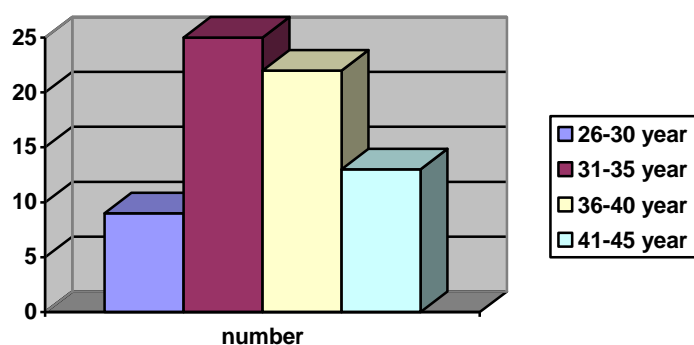
Figure 5.1: Obstacles regarding work as a doctor



The respondents were shown to have diplomas from 25 different countries. Figure 5.2 presents the age distribution of CIBA doctors at graduation in the Netherlands. The gender division for the total cohort 2000-2004 was 62% male and 38% female³⁶.

³⁶ A recent study by Herfs & Haalboom (2008) showed a reverse sex ratio (66% female and 34% male). In addition, the ratio between refugees and people with a Dutch spouse was found to have changed in 2005. The refugees fell from 71% in 2002 to 43% in 2005, whereas the percentage of people with a Dutch spouse increased from 29% in 2002 to 57% in 2005. The research population in the study mentioned concerned all foreign doctors who had started at five medical faculties in 2002 and in 2005.

Figure 5.2: Age distribution at graduation of responding foreign doctors



Additional suggestions

Some remarks are presented in full:

“For me the internships were a total waste of time. I feel that I wasted two years of the most productive period of my life. This has been a cruel abuse of my time, energy and abilities.”

“CIBA has been a very successful project. It is not so hard to find a job. But competing with Dutch doctors for a training position seems like a very difficult task. Further research into these problems is necessary.”

“The admission procedure is very complicated. I would have been able to start studying and working much earlier, but I was forced to wait for a very long time.”

“Foreign doctors should be given the chance to take an exam before they start their internships. I hope that you can prove with your research that the level of foreign doctors is comparable to that of our Dutch colleagues.”

“I would like to add a question about the value of training: Has this training at one of the universities improved your medical knowledge? My answer to that question is: No.”

“As a member of the commission for International Relations of the VNVA (the Dutch Organisation of Female Doctors), I intend, together with other members, to propose to the Department of Health a more practical and less frustrating route regarding the recognition of foreign doctors’ diplomas. However, we are only in the initial stages of the project. My idea is based on the pragmatic and realistic example provided by the USMLE (United States Medical Licensing Examination), which gives doctors the opportunity to start working after a thorough evaluation of their skills and theoretical knowledge. I am very optimistic but I am also aware of the fact that it is difficult to execute such a plan.”

The idea that there were only a few problems in finding work was confirmed in the 20 interviews by telephone. A Russian paediatrician said: "I had to do everything again; well, four years. It was easy to find work. I am now being trained as a general practitioner. But I would rather be a paediatrician in the Netherlands because that was my profession in Russia."³⁷ A colleague remarked: "It wasn't hard to find a job. During the interviews people knew me well because I had done my internship at the same department. I am now in my third year of internal medicine training." Another colleague indicated that being known from the internships was of great importance for finding work: "It was extremely easy for me to find a job. I had done an internship in scientific research in Eindhoven. The director of the institute approached me to offer me work at a nursing home; eventually, I was given the job. Working as a nursing home doctor is really a combination of specialisms: you are an internist as well as a psychiatrist as well as a rehabilitation specialist. In Russia I was a rehabilitation specialist. The atmosphere at my department is extremely pleasant. After concluding my internship, I was asked to return." It also became clear from the interviews that 18 respondents had a supervisor or a coach. Respondents discussed both medical and non-medical affairs with their coaches.

Several remarkable answers were given to the question whether respondents had had special experiences in the workplace: "I speak Arabic and therefore Iraqi and Moroccan parents and children are regularly referred to me. This is pleasant for the patients, the parents, and also for me." And: "I have had some good experiences. I was a cardiologist in Azerbaijan, but I am pleased that I made this choice (to train as a general practitioner). I can use all my knowledge and skills. I have no regrets that I cannot be a cardiologist any more."

It also became clear from the interviews that learning the Dutch language was an extremely difficult task. A foreign doctor who had found a job in Groningen remarked about his oral language skills: "Yes, I communicate well with my colleagues and my patients. At first this was very difficult because most patients speak a dialect. That is why I had to ask my colleagues to interpret for me now and then. These days I have less difficulty with the Groningen dialect." Another doctor stated: "My colleagues think my language skills are sufficient, but I don't agree. I can express myself less well than highly educated Dutch people. And I don't like this." With patients, the experiences regarding oral language skills are quite positive. Some doctors remarked that most patients have no difficulty in accepting their accent and any language mistakes. By contrast, many foreign doctors felt that their written language skills left much to be desired. Many foreign doctors ask secretaries to

³⁷ It is not easy to compare medical training in Russia (and the former USSR) with Dutch medical training. Training in Russia may have a comparable structure and duration, but often does not. After two years of training, some Russian medical schools make a division into two streams: a stream for 'paediatricians' and a stream aimed at medicine for adult patients. The training duration for a Russian 'paediatrician' who has followed this separate stream is comparable to the training duration for a basic doctor in the Netherlands. In Russia, most parents with a sick child visit such paediatricians, whose training duration and training level is completely incomparable with a Dutch specialist in paediatrics. Outside Russia, these differences may lead to great confusion (source: K. Wigleven, NUFFIC, department for the evaluation of foreign credentials).

check their letters for language mistakes. Moreover, some doctors follow individual language training courses by Dutch language teachers. As one doctor remarked: "My written language is better than my spoken language. I was in the first group that used the book *Hoe zit het met staan?* It was a very good idea to write that book." The Afghan doctor, who was trained in Ukraine, remarked: "My written language skills are better than my spoken skills. When I'm writing, I have more time to think. The method *Hoe zit het met staan?* was very good. In my opinion, the course should have been longer. In Ukraine we had a nine-month course in medical Russian before training started. It would be better to do the same here." The issue of the command of the Dutch language by foreign doctors will be discussed further in section 5.8.

The respondents were also asked whether their foreign background (education, cultural background, command of a foreign language) was judged as positive in their current working environment. Opinions differed. One doctor remarked: "This is certainly considered an added bonus, although it didn't play any role when I was taken on. The advantages of my foreign background are especially seen in the treatment of foreign patients. In addition, colleagues often ask my advice about foreign patients." An Iraqi doctor said: "I do not know what my colleagues think. Patients appreciate that somebody with their own ethnic background is working as a doctor. They surmise that I, with my Iraqi background, have a better understanding of their disease. It is very doubtful whether that is true." Another Iraqi doctor remarked: "My colleagues are not really bothered one way or another. What I sometimes do notice is that I have more experience in surgery than my trainer. That is useful sometimes. The patients' reactions often depend on their level of education. Highly educated patients realise how difficult it must have been for their doctor to achieve this position. They think it is great that I have reached this position by hard work. Patients with a lower educational level are sometimes suspicious, as they notice that my Dutch is rather limited. It only happens sporadically that Arabic speaking patients come to me because of the language."

5.7 Additional information: data triangulation

The low response of the survey could lead to questions about how representative the outcome of the career study is. It might be thought that foreign doctors who failed to find a job as a doctor had not responded. Therefore, additional information has been found through data triangulation. Data on the entry into the labour market has been unearthed, so that the results could be confirmed or disproven. To that end, representatives of CIBA (best informed experts) were asked in 2007 to provide additional information about the careers of foreign doctors after graduation. Not all the experts were able to provide this information. Of the eight experts, only three had clear and reliable information at their disposal.

Experts of University Medical Centre Groningen (UMCG)

The experts of the UMCG reported that at most 10% of their graduated doctors do not find work as a doctor.

Experts of Maastricht University

At Maastricht University research was undertaken into the careers of all 57 foreign doctors who had graduated in Maastricht (Huijskens, Hooshiaran, v. d. Horst & Scherpbier, 2007). Of these 57 doctors, 74% were located, all of whom were working as a doctor.

Experts of University Medical Centre St Radboud (Nijmegen)

Since the start of CIBA in 1996, the University Medical Centre St Radboud has kept a record of where foreign doctors eventually ended up. Of 4 out of 71 graduated foreign doctors, it is unknown whether they have found employment as a doctor. All the other doctors found jobs as doctors (94%).

These additional data confirm the representativeness of the results of the career study of 2004. This information also shows that foreign doctors who have obtained a Dutch doctor's diploma are very successful in finding employment as doctors.

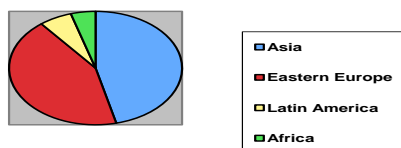
5.8 Discussion

This chapter has discussed the possibility of foreign doctors being admitted to the Dutch labour market. To that end, 191 doctors from the cohorts 2000-2004 were approached in writing. The 70 doctors who had graduated in the period 1996-2000 had been questioned in an earlier study. The total number of doctors in the period 1996-2004 is 261. Their response rate for the present study was 36% (69/191). At first glance, this looks like a low response, which may be a limitation of this study. There are several possible explanations. Firstly, it is likely that the address files of the eight medical faculties are dated because people have moved house. As a result, a number of questionnaires will have been sent to wrong addresses. This is especially true for doctors from the first study cohorts. Secondly, it proved impossible to use the BIG register; in its refusal, the Department of Health referred to section 12 of the BIG Act, which prohibits revealing the names and addresses of people on the BIG register (Individual Health Care Professions Act, 1993). Thirdly, it is possible that doctors who have not found suitable employment do not want to come forward for reasons of their own, and have therefore not responded. However, the information found through data triangulation is completely in line with the results found.

Mindful of these limitations, it is possible to draw some conclusions from this study. The most important conclusion is that nearly all graduated foreign doctors enter the Dutch labour market as doctors. All respondents have found work as a doctor and were on the BIG register. Thus, they proved to have aimed at working as a doctor in Dutch healthcare. The fear, aired 10 years ago, that foreign doctors who were trained at Dutch medical faculties would mostly find employment abroad has not been confirmed in this study (Herfs, 2000).

The respondents were found to have diplomas from 25 different countries. The country where the doctor's diploma was obtained is not always the same as the doctor's country of origin. For example, a doctor from Afghanistan may have an Afghan or a Russian diploma. It can also be concluded that the population of foreign doctors reflects global hotbeds during the period under scrutiny. This concerned mostly Asian and Eastern European doctors (see Figure 5.3).

Figure 5.3: Distribution of doctors' diplomas among the different continents



In this situation it was also important that before the collapse of eastern European Communist regimes, training of foreign students from 'friendly' developing countries was a common type of aid. Of the doctors with diplomas from former Eastern block countries, only two had diplomas that were obtained in countries that joined the European Union on 1 May 2004 (i.e. Hungary and Latvia). On 1 January 2007, Bulgaria and Rumania joined too; Croatia is likely to follow suit in 2011. Currently, there are six doctors with diplomas from newly joined EU countries on our files.

It is not surprising that the age distribution of the respondents reflects an older population than regular Dutch medical students. Of the 69 doctors, 9 were younger than 30 at graduation (13%), 25 were between 31 and 35 years old at graduation (36%), and 22 were between 36 and 40 years old (32%; see Figure 5.2). More than 86% was older than 30. In the career study on the period 1996-2000, this percentage was 67% (Herfs et al, 2001). This increase may be explained by the fact that there were fewer refugees and more immigrants with a Dutch partner among the foreign doctors from later cohorts.

The major part of the respondents succeeded in finding a job within three months; 80% of them work full-time. Of the doctors working part-time, 64% works 80% or more. Therefore, the limited labour participation of graduated basic doctors mentioned by Haalboom in his inaugural lecture (2005) does not hold true for foreign doctors. There is a greater diversity of employers. The respondents work at hospitals, general practice training institutes, residential care homes, nursing homes, Health and Safety services, Area Health authorities and home care institutions. The majority of doctors are following specialist training (59%). Considering their graduation age, it is remarkable how many doctors follow specialist training. Most Dutch basic doctors who follow such training start before they are 30 (STOGO, 1998).

Most of the respondents were satisfied with the job they had found. The problems that were mentioned most frequently were related to the command of the Dutch language. Although using the course *Nederlands voor buitenlandse artsen* (Dutch for foreign doctors;

Van Palenstein Helderman-Susan & Bekedam, 2000; Bekedam & Van Palenstein Helderman-Susan, 2006) has been a clear improvement on the situation before the year 2000, the situation is still not satisfactory in the eyes of some foreign doctors. In the international literature it is also frequently observed that doctors need to have a high command of the language in their new country (Hall, Keely, Dojeiji, Byszewski & Marks, 2004; Kramer, 2006; Spike, 2006). Besides good language skills, the importance of good communication skills is increasingly underlined, along with knowledge of the culture and customs in the new country of residence (UMC-Utrecht krant, 2006).

5.9 Conclusion

Notwithstanding the limited response, we can conclude that foreign doctors succeed in finding work as a doctor in the Netherlands. This is confirmed by the information found after data triangulation. Entry into the labour market is not different for foreign doctors compared to native Dutch doctors. The labour participation of foreign doctors shows that the efforts of the doctors as well as the educational institutes have not been in vain. Our results show that the results of the studies by Klaver et al (2003) and Desain et al (2006) are not tenable for foreign doctors.

The Netherlands has not opted for a set-up in which foreign doctors receive additional medical training at one specific faculty, which is what happens in for example Denmark, Norway and Sweden (see Chapter 6). For additional training, foreign doctors have to rely on regular training programmes. This means that in their internship group they are always the only foreign doctor. Their language skills are usually less good; when doing doctor's visits in groups and in other forms of group training, this may lead to an embarrassing situations and even loss of face for these foreign doctors. It is not to be expected that the inclusion of foreign doctors in the existing medical curriculum will change in the near future. Moreover, the success rate of foreign doctors entered through CIBA in the period 1996-2006 is relatively high (75%).

To further simplify the inclusion of foreign doctors in the Netherlands, there should be an unrelenting emphasis on basic skills such as Dutch language skills, medical Dutch and communication skills. This seems to be accommodated by the new assessment procedure by the Department of Health that came into force in December 2005 (CBGV, 2006).

References

Bekedam, L.M., Palenstein Helderma-Susan, L.H.M. van: *Hoe zit het met staan? Cursus Nederlands voor anderstalige artsen*. Tweede herziene druk. Bohn Stafleu en Van Loghum; Houten; 2006.

Commissie Buitenslands Gediplomeerden Volksgezondheid: *Kennis en vaardigheden getoetst; elke arts een gelijke en eerlijke kans om te laten zien wat hij waard is*. Ministerie van Volksgezondheid Welzijn en Sport. Den Haag; 2006.

Desain, E.J.P., Hello, E.: *De arbeidsmarktpositie van hoger opgeleide vluchtelingen*. Regioplan Beleidsonderzoek in opdracht van het ministerie van Sociale Zaken en Werkgelegenheid. 2006.

Directive 2005/36/EC of the European Parliament and of the Council of 7 September 2005 on the recognition of professional qualifications.

Haalboom, J.R.E.: *Verwondering en respect*. Oratie. Universiteit Utrecht. Uitgeverij Benecke N.I. te Amsterdam; 2005.

Hall, P., Keely, E., Dojeiji, S., Byszewski, A., Marks, M.: Communication skills, cultural challenges and individual support: challenges of international medical graduates in a Canadian healthcare environment. In: *Medical Teacher* 2004; 26:2; 120-125.

Herfs, P.G.P.: *Erkenning van buitenlandse artsdiploma's; een verhaal apart*. Afdeling Studentenzaken; Universiteit Utrecht; 1996.

Herfs, P.G.P.: Symposiumverslag Spreektaal Medisch Nederlands. In: *Tijdschrift voor Medisch Onderwijs*; 6: 225-230. Bohn Stafleu Van Loghum; Houten. 2000.

Herfs, P.G.P., Haalboom, J.R.E.: Studievoortgangproblemen van buitenlandse artsen die instromen in een hoger jaar van de opleiding geneeskunde. In: *Tijdschrift voor Medisch Onderwijs*; 2008;2.

Herfs, P.G.P., Haalboom, J.R.E., Kruijshoop, M.A., Yari, P.: *Onderzoek naar de loopbanen van "CIBA-artsen"*. In opdracht van DMW van de VSNU; Universiteit Utrecht; 2001.

Huijskens, E.G.W., Hooshiaran, A., Scherpbier, A.J.J.A., Horst, F. v.d.: Barriers and facilitating factors in the professional careers of international medical graduates in the Netherlands. In: *Medical Education* 2010; 44: 795-804.

Klaver, J., Odé, A.: *De arbeidsintegratie van vluchtelingen; een verkenning van problemen en oplossingen*. Regioplan Beleidsonderzoek in opdracht van de Raad voor Werk en Inkomen. 2003.

Kramer, M.: Educational challenges of international medical graduates in psychiatric residencies. In: *the Journal of the American Academy of Psychoanalysis and Dynamic Psychiatry* 2006; 34: 163-171.

Merkelbach, J.W. (1999): *Supervisie werkt niet voor buitenlandse artsen*. Medisch Contact; 54^e jaargang, 30 april 1999, nr. 17.

Palenstein Helderman-Susan, L.H.M. van, Bekedam, L.M., Haalboom, J.R.E., Herfs, P.G.P., Pescher-ter Meer, A.: *Hoe zit het met staan? Cursus Nederlands voor anderstalige artsen*. Bohn Stafleu en Van Loghum; Houten; 2000.

Spike, N.A.: International medical graduates: the Australian perspective. In: *Academic Medicine* 2006; 81:9; 842-6.

STOGO: *Arbeidsmarktmonitor faculteit geneeskunde 1998*. STOGO Onderwijs en Advies; faculteit Sociale Wetenschappen Universiteit Utrecht; 1998.

Vluchtelingenwerk Nederland: *Integratie Barometer 2005; een onderzoek naar de integratie van vluchtelingen in Nederland*. Amsterdam; 2005.

UMC-Utrecht krant: Wij vinden het dan gewoon geen goede arts; buitenlandse artsen en Nederlandse studenten over cultuurverschillen. *UMC krant* 2005; 6. UMC Utrecht.

Wet op de Beroepen in de Individuele Gezondheidszorg. Ministerie van Volksgezondheid, Welzijn en Sport. *Staatsblad*, nummer 665; 1993.

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6.1 Abstract

Objective To examine how 10 EEA-countries (abbreviation: European Economic Area) deal with non-EEA doctors in the period until 2005. Both country and university policies towards non-EEA doctors have been examined.

Design Qualitative study based on two structured questionnaires. One was used for staff members of Departments of Health and the other for staff members of Medical Faculties.

Participants Staff members from Departments of Health from Mid- and Northern European countries and from the Medical University of Vienna (Austria), University of Ghent (Belgium), University of Copenhagen (Denmark), University of Lille 2 (France), University of Leipzig (Germany), University of Oslo (Norway), Karolinska Institute Stockholm (Sweden), University of London (United Kingdom), University Complutense of Madrid (Spain) and Utrecht University (the Netherlands).

Results There is no EEA-directive concerning non-EEA doctors. Each EEA-country, therefore, has devised its own policy towards non-EEA doctors. In order to enable non-EEA-doctors to obtain a full license, thereby preventing them from ending up as unskilled labourers, the Departments of Health in the Nordic countries and the UK have developed a fast track for non-EEA doctors. In Austria, Belgium and the Netherlands, non-EEA doctors are more dependent on programmes offered by medical faculties. Germany holds a position in between. As a rule the programmes for non-EEA doctors in Belgium, Germany and the Netherlands are two to three times (18-36 months) longer than in the Nordic countries (12-18 months). In most countries financial aid is not available.

Conclusions As the influx of non-EEA doctors is increasing, harmonisation within the EEA is strongly advisable. As long as there is no EEA-directive for non-EEA doctors, the assessment procedures (diploma evaluation and medical knowledge tests, language requirements, length of additional programmes, etc.) need to be co-ordinated.

6.2 Introduction

The process for integrating non-EEA doctors (European Economic Area³⁸) requires standardisation due to their increasing numbers: Is their education of an equal standard to that of EEA doctors? Is their working experience valid? Is their knowledge of the (new) language sufficient? The migrating doctors may enter EEA-countries either as refugees or to be with their spouses. Because of this background most of the third country doctors (TCDs) have permanent residency in their host country. Unlike other EEA-countries, only in the UK is the medical health care system dependent on migrating TCDs (Herfs *et al*, 2009). In the 10 EEA-countries involved there is an average of 327 medical doctors per 100.000 inhabitants, except for in the UK (see table 6.1).

Table 6.1: Number of medical doctors per 100,000 inhabitants in 10 EEA-countries³⁹

Country	Total number of medical doctors	Number of medical doctors per 100,000 inhabitants
Austria	26,286	324
Belgium	42,978	418
Denmark	19,600	366
Germany	297,893	361
France	196,000	329
Netherlands	52,602	329
Norway	15,978	355
Spain	130,300	319
Sweden	26,979	304
United Kingdom	95,395	230

In the UK there are only 230 medical doctors available per 100.000 inhabitants. Thus the UK trains fewer medical doctors than the country needs. Therefore, TCDs' reasons for migrating to the UK are not exactly comparable to those of TCDs migrating to other EEA-countries.

Not every foreign doctor will eventually find a job in the same profession in a new country. In every European country examples are known of foreign doctors even working as unskilled labourers such as cleaners, albeit in health care institutions! In this study we are concentrating on TCDs who obtained their diplomas outside the European Economic Area. Doctors trained within EEA-countries and holding EEA-passports are allowed to work in other EEA-countries; a special European Council directive (Directive 2005/36/EC of the European Parliament) has provided for this. There is no such EEA-directive for TCDs. As a

³⁸ The European Economic Area consists of 27 EU-countries plus Iceland, Liechtenstein and Norway. Switzerland has a status comparable to an EEA-country.

³⁹ According to the World Health Organisation (<http://www.who.int/globalatlas/dataquery/home.asp>) and De Grote Bos-atlas (Wolters-Noordhoff; 2001).

consequence every EEA-country has its own procedure for foreign doctors who apply for permission to work there. For TCDs it is very difficult to understand why in one country admittance is easy, while in another it could take a long process of renewed medical and language study. Moreover, even within one country policies between universities may differ. These differences could well influence the choice of the country and the university the TCDs apply to. In 2005, in order to obtain more information about the admittance procedures, we performed a limited, comparative study of the policies and practices of 10 European countries towards TCDs (Herfs, 2009). A strong need was felt to disseminate the outcome of this study, as it could have a great social impact on EEA-countries.

6.3 Methods

The national policies concerning unrecognised medical degree holders were investigated together with the policies and practices of several non-randomly chosen universities with medical schools in 10 EEA countries (see table 7.2). For this research we selected 11 (*old*) EEA countries that had much experience with the immigration of non-Europeans. This selection was based on the data for global refugee trends of the United Nations High Commissioner for Refugees (UNHCR, 2005) and the Eurostat sources on migration in EU-countries.

Our starting point in each country was a university that co-operates within the “Utrecht Network”, an international framework for student exchange. All universities we approached were willing to co-operate except for the University of Bologna in Italy. In some countries it appeared that the university co-operating within the Utrecht Network had no experience with TCDs. In those situations, we were referred and introduced to a university in the same country that had ample experience with TCDs.

Two questionnaires were used. The *first questionnaire* was about the country policy and contained questions about the following; central registration, availability of information on recognition procedures, responsibilities for a centralised or decentralised procedure, numbers of applicants, assessment on the basis of a medical test and/or on the basis of diploma evaluation, work experience and assessment, the qualifications of those assessing the TCDs, the policy in case of non-recognition and the availability of special programmes at medical schools for TCDs. Sources were staff members of the Departments of Health of the countries involved.

The *second questionnaire* concerned university policy and contained questions about recognition and admission, length of programmes or recognition procedures, (non) co-operation of medical faculties, sufficient mastery of the language, support and opportunities on the labour market after qualifying as doctors. Sources were staff members from the medical faculties.

6.4 Results

6.4.1 Results on country policies and practices

In table 6.2 the results are presented.

Table 6.2: Country policies towards third country doctors

Countries	United Kingdom	Denmark	Norway	Sweden	Germany	Austria	Spain	France	Belgium	the Netherlands
Country level										
Registering body concerning recognition foreign degrees	yes	yes	yes	yes	no	yes	yes	yes	yes	yes
Information about recognition by Dep. of Health (DoH)	yes	yes	yes	yes	decentral	yes	unknown	yes	yes	yes
Recognition responsibility with Dep. of Health (DoH)	yes	yes	yes	yes	decentral	yes	no	yes ⁴⁰	yes	yes ⁴¹
Assessment & recognition on the basis of test	yes	yes	yes	yes	no	no	yes	yes	no	yes
Assessment & recognition procedure without test	no	no	no	no	yes	yes	no	no	yes	no
Department of Health procedure successful	yes	yes	yes	yes	(dec) yes	unknown	unknown	unknown	unknown	no
after Dep. Health-rejection: university route possible	no	no	no	no	yes	yes	no	yes	yes	yes
Length of programme for third country doctors	0 months	12-18 months	12-18 months	18 months	12-24 months	12-18 months	not applicable	24 months	24-36 months	18-36 months
Responsible for third country doctors programme	General Med Council	Dep of Health	Dep of Health	Dep of Health	University	University	not applicable	University	University	University

⁴⁰ Since 2005 the Department of Health in France has introduced an assessment procedure for third country doctors.

⁴¹ Since 2005 the Department of Health in the Netherlands has introduced an assessment procedure for third country doctors. The Dutch results are based on the situation before its introduction on December 1 2005.

In all countries involved in this research a specific assessment procedure exists for medical degree holders. In most countries assessment takes place on the basis of a medical knowledge test, in some countries preceded by diploma evaluation. In the Nordic countries and the United Kingdom the procedures are co-ordinated by the Departments of Health. Systems are developed in which a TCD can prove he has the required level of medical knowledge. Mastery of the language of the country is tested, either by means of a language test or by presenting all medical examinations in the language of that country. When a candidate fails to pass the tests, which, in the Nordic countries, are extended in some cases by a fixed-term probationary period, the procedure is terminated. After a failure to complete the assessment procedure, admission to a medical school as a 'regular' medical student almost never occurs in Denmark, Norway, Sweden and the United Kingdom. The majority of TCDs in these countries follow procedures organised by the respective Departments of Health. Since the initial route in the Nordic countries and the UK is highly efficient, there is no great demand for a second route through the universities.

In Austria, Belgium and the Netherlands the role of the Departments of Health is less clear. Universities in those countries offer a second route to TCDs in case of non-recognition of the foreign medical degrees.

In order to be admitted to Austria the TCD should have studied medicine for at least five years. In Belgium and the Netherlands rules are less rigid; every university has its own procedure. In France and the Netherlands new assessment procedures were introduced in 2005. Under these new procedures, the Departments of Health not the universities have the major responsibility in assessing foreign medical degrees. Work experience as a medical doctor in the country of origin does not play a significant part in the assessment procedures in the countries that participated in this research. In France, Sweden and the United Kingdom, however, there are even separate recognition routes for specialists. France has even developed a list with a quota of certain desired specialists. When, for instance, 15 internists are needed, then only 15 internists can apply and they must then pass an examination.

In the Nordic countries the programmes are organised by the respective Departments of Health. For the content of the programmes they rely on the professors in medical schools (University of Copenhagen, University of Oslo and the Karolinska Institute in Stockholm). In the United Kingdom a special programme has been set up for Refugee and Overseas Qualified Doctors at the Queen Mary University in London. This programme consists of a doctors' study club, structured PLAB-courses (Professional and Linguistic Assessment Board-exam), clinical experience and career advice services.

In Belgium, France, Germany and the Netherlands the TCDs will be enrolled in a higher year of the regular programmes at one of the medical schools. After graduation in one of these four countries a TCD will receive a 'new' medical degree from the respective EEA-country school. In the other countries the foreign medical degrees of the TCDs eventually are recognised. In Austria each medical university is autonomous in determining the additional medical programme for a TCD. Under the Austrian Universities Act every university in that country has to offer a recognition procedure to holders of foreign credentials (National Council of the Republic of Austria, 2002).

6.4.2 Results on university policies and practices

In table 6.3 the results are presented.

Table 6.3: University policies towards third country doctors

University level	United Kingdom	Denmark	Norway	Sweden	Germany	Austria	Spain	France	Belgium	the Netherlands
Responsible for third country doctors programme	no	no	no	no	yes	yes	yes	yes	yes	yes
Length of programme for third country doctors	0 months	12-18 months	12-18 months	18 months	12-24 months	12-18 months	no standards	24 months	24-36 months	18-36 months
Graduation with 'new' medical degree	no	no	no	no	yes	no	no	yes	yes	yes
Necessity of second route to work as a doctor	no	no	no	no	yes	yes	yes	yes	yes	yes
Mastery of the language required	explicit	explicit	explicit	explicit	explicit	implicit	implicit	implicit	explicit	explicit
Courses in medical language available	no	no	yes	yes	no	no	no	no	no	yes
Cooperation medical schools conc. third country doctors	no	no	no	no	no	no	no	no	yes	yes
Chances of third country doctors on the labour market	not equal	not equal	unknown	unknown	unknown	not equal	equal	equal	equal	equal

In Nordic countries and the UK there is just one route stipulated for migrating TCDs who have obtained permanent residency. Programmes for TCDs in the Nordic countries are only offered by a limited number of universities/medical schools, on special request by their respective Departments of Health.

In Denmark, Norway, Sweden and Germany relatively large groups of applicants end up with recognition of their foreign medical degrees. In the Province of North Rhine-Westphalia (Germany) between 2000 and 2003 1,471 TCDs were recognised. Sweden recognized around 700 TCDs in the same period. Norway recognized 538 TCDs in 2003 and 2004. Exact figures for Denmark are not available. In the UK 9,336 TCDs were registered with the General Medical Council in 2003. This was the last year in which doctors from countries of the Commonwealth could obtain full registration without entrance examinations. Experience shows that relatively short additional programmes can result in recognition of foreign medical qualifications. This explains the fact that in the Nordic countries and the United Kingdom the second route to gain recognition - enrolment as a regular student in medical schools - has not really been developed. In building jargon the medical faculties in the Nordic countries are *subcontractors*, while the Departments of Health are the *contractors*. In Germany both routes are available.

In Germany and the United Kingdom the Department of Health and the General Medical Council respectively have both developed procedures to assess the medical qualifications of TCDs. If, in Germany, the outcome of direct assessment is negative, TCDs are allowed to request admission to a medical school. The Medical Faculty of the University of Leipzig admits approximately 30 TCDs per year, as they can only accept 8% of foreign students in the total number of 340 medical students enrolled at the medical faculty per year. In the United Kingdom, after a negative outcome in the assessment procedure, TCDs can apply to one of the medical schools, but hardly ever do so in view of the costs. One year of enrolment at a medical school might cost an overseas student 25,000 British pounds (nearly 38,000 euros). Some years ago the Queen Mary University of London started a so-called Refugee and Overseas Qualified Doctors' Programme, in which TCDs were prepared for the PLAB-exams.

In Austria, Belgium, France and the Netherlands medical schools offer additional medical programmes to TCDs after initial negative assessments. Apparently the routes through the Departments of Health in those countries are not as effective as in the Nordic countries and the UK. In fact, the route through the medical schools is the most significant one there. In building jargon, the universities in Austria, Belgium, France and the Netherlands⁴² act as *contractors* and there are no *subcontractors*. Before the introduction of the new assessment procedure, the Medical Faculty of the University of Lille 2 received 50 applications on a yearly basis, of which 10 were admitted, following a selection procedure. The Medical University of Vienna receives nearly 50 requests per year. In the last two years the Flemish Interuniversity Council has admitted 70 TCDs to their procedure. Up until 2005 the 8 Dutch medical faculties used to admit about 110 TCDs per year.

⁴² In France and the Netherlands new central assessments procedures were introduced by the Departments of Health only in 2005 (the universities now are subcontractors, while the Departments of Health are contractors). Therefore no results of these procedures can yet be reported.

Admission options

In the Nordic countries and the United Kingdom universities hardly ever admit TCDs with the exception of the University of London. In Austria the Medical University in Vienna starts recognition procedures for all TCDs who have permanent residency in Austria and request recognition. If the outcome of the assessment, based on transcript comparison, shows deficiencies or a level equalling less than five years of medical study, the candidate will not be admitted in Austria.

In Belgium the Flemish universities⁴³ with medical schools start an admissions procedure for those TCDs whose recognition requests to the Department of Health ended in rejections. Most of the applicants have permanent residency in Belgium. Once an applicant has successfully completed a standard assessment procedure (medical knowledge test and interview) organised by the Flemish Interuniversity Council, he is free to start at any medical school in Flanders.

The board of the medical school decides the duration and content of the programme to be completed.

In Spain, after non-recognition of a medical degree, a TCD may apply for partial recognition at a medical school. After sitting an examination, a TCD can proceed with a programme that is based on the outcome of that examination.

In Germany, after non-recognition by the Department of Health, the Medical School of the University of Leipzig allows TCDs to apply for admission. The request is re-evaluated and only excellent students are admitted. In the Netherlands medical schools co-operate over the admission and dispersal of TCDs throughout the 8 universities with medical schools. The programmes the TCDs have to follow, however, may vary from university to university.

Sufficient mastery of the language

In every country sufficient mastery of the language of the country is a major requirement. In Denmark, France and Spain mastery of the language is an implicit demand (no specific language test involved). For instance, examinations on medical knowledge in the Danish procedure of recognition cannot be passed successfully without sufficient mastery of the Danish language. This also holds true for the procedures in France and Spain. In all other countries proof of mastery of the language is an explicit demand; failing the language exam results in the refusal of admittance to the medical course of study. In every country admittance to the medical study cannot be granted if that requirement is not fulfilled. Medical language programmes for TCDs have only been developed in the Netherlands, Norway and Sweden.

⁴³ There are no facts known about procedures at universities in the French speaking part of Belgium.

Length of programmes or recognition procedures

The Danish procedure (Danish National Board of Health; 2001) leading to permanent authorisation consists of two different probationary periods in a Danish clinical hospital, each lasting for at least three months, a verbal test of general medical knowledge and three medical examinations (in social medicine, Danish legislation about the practice of medicine and legislation about the prescription of pharmaceuticals). The examinations are all set in Danish. In Denmark and Norway the whole procedure can be completed within one year. In Sweden the TCD-programme takes a year and a half. In the United Kingdom the average time needed to pass for the PLAB 1 and 2 exams is about 18 months (Butler *et al*, 2005). In Austria the length of the programme at the Medical University of Vienna is at least one year (four exams taking each about three months). In Belgium the minimum programme will last for two years. In the Netherlands the length of programmes (under the old procedure) depended on the medical school the TCD was appointed to. The shortest programme took 18 months, the longest more than 3 years. In France (under the old procedure) the programme at the Medical Faculty at Lille University took two full years. Only in Belgium and the Netherlands do medical schools co-operate on the subject of policies towards TCDs. In the Nordic countries and the UK there is hardly any university involvement in the procedures.

Support for third country doctors

Most of our sources are not aware of any organisations in their country that could help TCDs financially in finding their way to the recognition procedure organised by the Department of Health or the route through medical school. Most countries do have a welfare system that provides refugees with a social security benefit. In the UK the Refugee Doctor Programme at Queen Mary University of London helps TCDs find financial assistance for the PLAB-exams. In Germany the *Otto Benecke Stiftung* helps TCDs seeking to become medical doctors in Germany. In the Netherlands a non-governmental organisation called the University Asylum Fund (UAF) supports refugees and asylum seekers wishing to enter university and/or the labour market, giving study and career advice, financial support, etc. In the other countries these organisations seem to be absent or at least to be quite hard to find.

Finding work as a medical doctor

Most sources stated that TCDs will have the same chances as indigenous doctors of finding work practising medicine after successfully graduating in their new countries. Some experiences, however, challenge these impressions. In the United Kingdom studies showed that equal opportunities for ethnic minority health workers were jeopardised simply by having the wrong name and skin colour (Esmail *et al*, 1997 and Cooke *et al*, 2003). In Denmark it was shown that TCDs and dentists who had been through the Danish system for recognition experienced severe problems in finding work (Sjouwerman, 2002). In the Netherlands TCDs who obtained a Dutch medical degree

succeeded quite easily in finding work as doctors. A study showed that four months after completing the medical study more than 90% had a medical appointment (Herfs, *et al*, 2001). The specialisation options of TCDs are quite diverse and are often associated with the profession in their home country.

6.5 Discussion and practice points

At the start of this investigation it proved to be difficult to trace the correct people, who were best informed about country and university policies concerning TCDs in the countries involved. The sources at Departments of Health and universities/medical faculties were all very eager to learn about the policies towards TCDs in other EEA-countries. It became obvious that there was no co-operation whatsoever between countries on this specific subject. Only in Belgium (Flanders) and in the Netherlands is there co-operation between medical schools regarding TCDs. All countries and/or universities are re-inventing the wheel of assessment and recognition of third country medical degrees, admission of TCDs, and the development of additional programmes for TCDs. The premise of every person involved in this study, however, was quite similar; they all felt a major responsibility for the quality of the TCDs to be accepted in their society. In view of the large influx of TCDs from outside Europe, the procedures for acceptance and/or training for generally accepted degrees need to be co-ordinated. Until now, there has been no all-European approach. This means that there are significant differences between countries. In January 2007 the EEA expanded again. It would be useful to extend this enquiry to all EEA-countries. This study could be a first step towards a better understanding of all the systems already in place in EEA-countries to assess and additionally train TCDs in order to include them in our society as doctors, not as cleaners. EEA-countries should not waste or flush away medical talents.

Practice points:

- There needs to be an EEA-directive concerning doctors with non-EEA-diplomas.
- Standardisation of procedures to deal with third country doctors within EEA-countries is strongly advisable. Until now it is unclear if a TCD who is authorised to work in a certain EEA-country can migrate to another EEA-country and work there under the same conditions as an EEA-doctor.
- Assessment procedures and additional programmes for non-EEA-doctors, who want to work as doctors in EEA-countries, differ greatly.
- Mastering the language at the highest possible level is the third country doctors' key to success in their new (EEA-)countries.

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References

- Butler, B. & Eversley, J. (2005): *Refugee Doctor Programme Evaluation Network (UK); More than you think: refugee doctors in London: their numbers and success in getting jobs*. London, United Kingdom.
- Cooke, L., Halford, S. & Leonard, P. (2003): *Racism in the medical profession: the experience of UK graduates*. British Medical Association; Health Policy and Economic Research Unit. London, United Kingdom.
- Danish National Board of Health (2001): Guidelines concerning the authorization of doctors trained outside Denmark. Copenhagen, Denmark.
- Esmail, A. & Everington, S. (1997): Asian doctors still being discriminated against. In: *British Medical Journal*; 314: 1619.
- European Parliament and the Council of the European Union (2005). Directive 2005/36/EC of the European Parliament and of the Council of 7 September 2005 on the recognition of professional qualifications. Off J Eur Union L255 of 30.09.2005: 22. Brussels, Belgium.
- Herfs, P.G.P. (2009): *International Medical Graduates in the Netherlands*. Dissertation. Utrecht University. The Netherlands.
- Herfs, P.G.P., Haalboom, J.R.E., Kruijshoop, M.A. & Yari, P. (2001): Career research on non-EEA doctors in the Netherlands. Under the authority of the Dutch Federation of Universities. Utrecht University; the Netherlands.
- Herfs, P.G.P., Kater, L. & Haalboom, J.R.E. (2009): Migration of International Medical Graduates. In: *Medical Teacher (submitted)*.
- National Council of the Republic of Austria (2002): *University Organisation and Studies Act, University Organisation Amendment Act and Universities of the Arts Organisation Amendment Act*. Federal Ministry of Education, Science and Culture. Vienna, Austria.
- Sjouwerman, P. (2002): Danmark: migrant university graduates do not succeed in finding work. In: *Contrast*; nummer 11/12; Utrecht, the Netherlands.
- United Nations High Commissioner for Refugees (2005): *2004 Global Refugee Trends; overview of refugee populations, new arrivals, durable solutions, asylum-seekers, stateless and other persons of concern to UNHCR*. Geneva.
- World Health Organisation (2001): Global health atlas. Available at <http://www.who.int/globalatlas/dataQuery/default.asp> (accessed 14 June 2007)

7 Self-assessment by CIBA doctors regarding their competences at the start of their medical training in the Netherlands

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7.1 Summary

Under the responsibility of the Department of Health, an assessment procedure has been developed for all foreign doctors with a diploma obtained outside the European Economic Area (EEA) who want to work as doctors in the Netherlands. This procedure came into force on 1 December 2005 and aims to improve the quality of the doctors entering Dutch healthcare, and bring the quality of these doctors more in line with Dutch standards. The assessment can be divided into two parts: testing of general knowledge and skills (including Dutch language and communication skills, English reading skills, ICT skills, and knowledge of Dutch healthcare) and testing of medical and clinical knowledge and skills. There are six possible results: equivalence, an obligatory additional training programme of six months or one, two or three years, or a complete study of medicine.

This study focuses on foreign doctors who entered Dutch medical training via CIBA in the last two years before the new assessment procedure came into force. It has investigated how these doctors judged their own competences at the start of their additional medical training. A total of 157 foreign doctors were contacted, and 106 (68%) responded. In general they think that the level of their general and medical knowledge and skills corresponded fairly well with the demands made by Dutch healthcare. This is in contrast with the trainers' impressions; they indicate that the doctors' command of the Dutch language is the greatest problem. In their view, it is essential to improve the doctors' Dutch language skills during medical training and even afterwards.

7.2 Introduction and research question

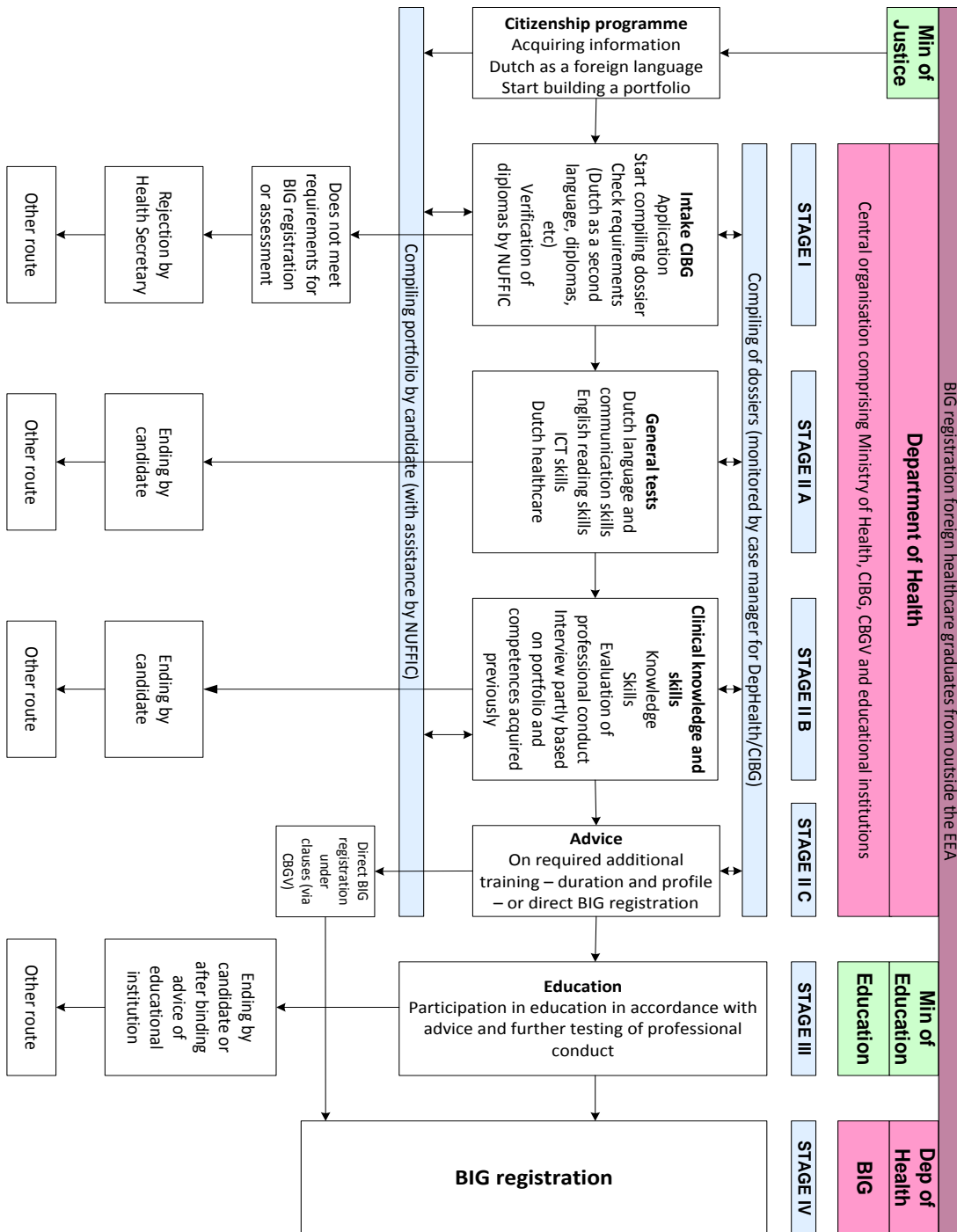
In cooperation with the medical faculties, the Department of Health developed a new assessment procedure for foreign doctors, which came into force on 1 December 2005. Before this date, if a foreign doctor asking for recognition was rejected by the Minister, this meant the end of the involvement of the Department of Health (Herfs, 1996; CBGV, 2003; Splinter et al, 2003; Arkel et al, 2003). In those cases, the medical faculties took over the responsibility for these rejected foreign doctors. As a result, there was no uniform inclusion of foreign doctors in the existing education programmes of the eight medical faculties. Every faculty had its own inclusion programme. In some faculties, inclusion took place

without any reliable information about the knowledge and skills of the doctors concerned; in those cases the exam committees usually chose to 'play it safe'. Other faculties administered the so-called *Maastricht progress test*⁴⁴ or a similar test. The new assessment procedure has ended this situation.

In 2002, the Department of Health decided to "facilitate medical faculties in the organisation of additional training of foreign doctors within the framework of the approach regarding the capacity of medical professionals." The committee developed a new streamlined approach for foreign doctors, which was adopted by the Department of Health. The realisation of this report from 2003 was preceded by a round table conference in 2002, at which all medical faculties were represented: at this conference, an inventory was made of the problems with foreign doctors. At the end of 2005, this led to a feasible and streamlined programme and approach for all foreign doctors with a diploma and nationality from outside the EEA who wanted to work in Dutch healthcare (Department of Health, 2005). The new assessment procedure is presented in the Flowchart foreign doctors (Figure 7.1) with the most important players: the Department of Health, Central Information Office for Health Care Professions (CIBG) and the educational institutes. The flowchart gives insight into the different stages that foreign doctors have to go through.

⁴⁴ The *Maastricht progress test* assesses a medical student's medical knowledge.

Figure 7.1: Flowchart foreign doctors (source: Department of Health)



The new assessment procedure differed greatly from the procedure that had been used from the establishment of the CIBA in 1996. Foreign doctors judged as nearly equivalent were now also obliged to take part in the new procedure, whereas previously only the doctors judged as not equivalent by the Department of Health received placement by CIBA. This meant a broadening of the target group, which accommodated the serious objections to the supervision route for foreign doctors who had been judged as nearly equivalent (Merkelbach, 1999).

The assessment procedure had the following aims:

- improved influx of qualified medical professionals (according to Dutch standards) from outside the EEA into Dutch healthcare;
- equality of rights for the applicants;
- simpler, quicker and more transparent procedure;
- specific advice on additional training, based on tests;
- lightening of the administrative burden;
- improved results.

The characteristics of the new assessment procedure are *standardisation* (all candidates from outside the EEA are treated equally) and *speed* (the recognition procedure can be finished within six months); it comprises a general knowledge and skills test as well as a medical knowledge and skills test. The procedure is based on the recommendations made by the Splinter Committee.

A recent study by Tromp et al (2007) concluded that foreign doctors included into Dutch healthcare by the old CIBA route showed some shortcomings during medical training. Tromp et al emphasise that these foreign doctors have shortcomings in both their command of the Dutch language and in their professional behaviour (for example communication with patients, cooperation with nursing staff and colleagues, being open to criticism, and knowing their own limitations).

The shortcomings that were signalled by the trainers have been converted into concrete parts of the assessment procedure. The general part consists of tests on Dutch language and communication skills, ICT skills, English reading skills and knowledge of Dutch healthcare. The medical part comprises tests on basic medical knowledge, knowledge of clinical subjects, and clinical skills. On a voluntary basis, participants can compile a portfolio.

Evaluation of the tests can lead to one of the following results (based on inadequacies observed earlier):

- There is no need for the candidate to follow additional medical training, but in order to evaluate professional conduct, a 12 week internship must be followed.
- The candidate has to follow additional medical training for six months (30 ECTS).
- The candidate has to follow additional medical training for one year (60 ECTS).
- The candidate has to follow additional medical training for two years (120 ECTS).
- The candidate has to follow additional medical training for three years (180 ECTS).
- The candidate receives no exemption from medical training; the candidate has to follow the complete study of medicine.

In the new assessment procedure, foreign doctors are tested on their knowledge and skills prior to admission to medical training. Every foreign doctor goes through the same procedure in which the duration of possible additional programmes as well as the exclusion from certain parts depends on the candidate's achievements. The examining boards of the eight medical faculties comply with the judgement of the committee responsible for the assessment procedure. All the eight faculties are represented in this committee. In the new procedure, it is no longer important to which medical faculty a foreign doctor has been allocated. The new procedure appears to be an important step towards a more professional assessment of the competences of foreign doctors.

Foreign doctors did not play a substantial role in the establishment of this new procedure. It is unknown how the foreign doctors who started their additional medical training just before this new assessment procedure came into force would have judged their own knowledge and skills when they started their additional training. The present study tries to answer this question. The research question is twofold: How do foreign doctors who are to enter Dutch medical training judge their own general and medical competences, and do their judgements match those of their trainers?

7.3 Methods

In September 2004 and September 2005, the two final cohorts of totally 157 foreign doctors who were subject to the old CIBA procedure were allocated to one of the eight medical faculties in the Netherlands. Allocation took place only after it had been checked if the foreign doctor had passed the exam on Dutch as a second language, held a doctor's diploma from outside the EEA, and had been given a permanent residence permit for the Netherlands. With the assistance of the CIBA (which provided names and addresses), both cohorts were contacted in March 2006.

Besides the questionnaire, these foreign doctors were also given background information on the new assessment procedure. The questionnaire (see Appendix 10) contained one open question and eight closed questions (on a five-point Likert scale) on the competences at the start of medical training (basic skills and medical knowledge and skills). This questionnaire was tested for clarity by foreign doctors who were not involved in this study. In the questionnaire, 1 represented 'no match at all' and 5 stood for 'a good match'. Values 2, 3 and 4 were in-between values. Value 3 was neutrally formulated and stood for 'neither a good nor a bad match'. The open question was aimed at one or more shortcomings which had most hindered the foreign doctors at the start of medical training. SPSS was used for statistical calculations (Nie et al, 1975). Based on the experiences of the eight faculties with the inclusion of foreign doctors in previous years, no significant differences were expected between students of the eight medical faculties.

7.4 Results

7.4.1 Response

Of the 157 questionnaires sent, 106 were returned, which is a response rate of 68%. Table 7.1 shows the response per university.

Table 7.1: Response per university

University	Response N	Response %
University of Amsterdam	13	59
VU University Amsterdam	13	65
University of Groningen	9	53
Leiden University	10	59
Maastricht University	10	67
Radboud University Nijmegen	17	81
Erasmus University Rotterdam	13	72
Utrecht University	20	74
Totals	105	67
Missing	1	1
Totals	106	68

7.4.2 Results of closed questions

Table 7.2 presents the average scores per university.

Table 7.2: Histogram presenting the average scores of each variable per university

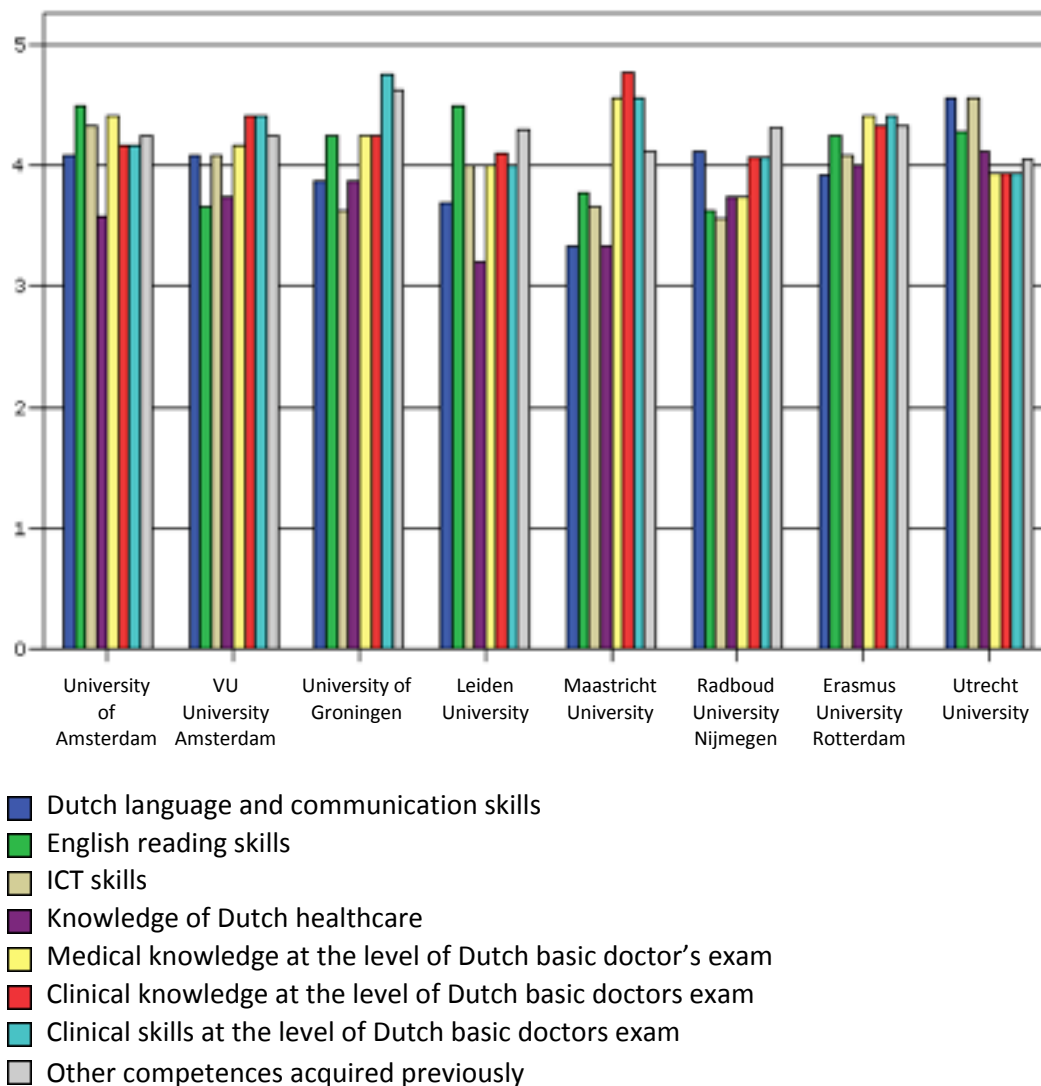


Table 7.3 presents the mean scores per university and per variable of the foreign doctors who had entered one of the eight medical faculties. No significant differences were found. However, some observations can be made. On the variable *Dutch language and communication skills*, students at Maastricht University score a full point lower than those at Utrecht University (3.40 and 4.40, respectively). On the variable *English reading skills*, students at Radboud University Nijmegen scored lower (3.59) than the students at the University of Amsterdam (4.46). On the variable *ICT skills*, students at Radboud University Nijmegen scored lower (3.56) than those at Utrecht University (4.50).

Table 7.3: Mean scores per university per variable

University		Dutch language and communication skills	English reading skills	ICT skills	Knowledge of Dutch healthcare	Medical knowledge at the level of Dutch basic doctor's exam	Clinical knowledge at level of Dutch basic doctor's exam	Clinical skills at level of Dutch basic doctor's exam	Other competences acquired previously
University of Amsterdam	Mean SD	4.08 .64	4.46 .77	4.33 .77	3.62 .87	4.46 .66	4.08 .76	4.08 .86	4.23 .92
VU Amsterdam University	Mean SD	4.08 .49	3.69 .94	4.08 .66	3.54 1.12	4.00 .70	4.23 .83	4.23 .83	4.23 .43
University of Groningen	Mean SD	4.00 1.0	4.33 1.11	3.67 .86	3.89 1.0	4.33 .70	4.33 .70	4.78 .44	4.63 .74
Leiden University	Mean SD	3.70 1.25	4.50 .85	4.00 .66	3.20 1.03	4.00 .94	4.10 .87	4.00 1.15	4.30 .67
Maastricht University	Mean SD	3.40 1.07	3.70 .82	3.67 1.22	3.40 1.17	4.60 .51	4.80 .42	4.60 .51	4.10 .56
Radboud University Nijmegen	Mean SD	4.12 .69	3.59 1.0	3.56 1.03	3.71 .84	3.76 .90	4.00 1.0	4.06 .96	4.29 .68
Erasmus University Rotterdam	Mean SD	4.00 .57	4.31 .94	4.15 .80	4.00 .91	4.42 .66	4.33 .77	4.42 .66	4.38 .76
Utrecht University	Mean SD	4.40 .75	4.10 .96	4.50 .60	4.00 .72	3.94 .63	3.94 .80	3.94 .87	4.00 1.12
Total	Mean N SD	4.03 105 .82	4.06 105 .96	4.04 101 .87	3.70 105 .95	4.15 102 .76	4.19 102 .81	4.22 102 .85	4.24 104 .79

Table 7.4 gives an overview of total scores per variable.

Table 7.4: Total scores per variable

	Dutch language and communication skills	English reading skills	ICT skills	Knowledge of Dutch healthcare	Medical knowledge at the level of Dutch basic doctor's exam	Clinical knowledge at level of Dutch basic doctor's exam	Clinical skills at level of Dutch basic doctor's exam	Other competences acquired previously
N valid	106	106	102	106	103	103	103	105
Missing	0	0	4	0	3	3	3	1
Mean	4.03	4.04	4.03	3.70	4.14	4.17	4.20	4.23
SD	.82	.98	.87	.94	.76	.82	.85	.80

The average scores for the general knowledge and skills test are not significantly lower than the average scores on the medical knowledge and skills test. The scores are lowest on the variable *Knowledge of Dutch healthcare*.

Table 7.5 presents the mean scores per university for all the variables. Nijmegen has the lowest score (3.90), and Rotterdam has the highest score (4.21). The differences between the average scores per university (see Table 7.4) are not significant (ANOVA).

Table 7.5: Mean scores per university for all the variables

University	Mean	N	SD
University of Amsterdam	4.18	12	.40
VU Amsterdam University	4.10	12	.41
University of Groningen	4.18	8	.61
Leiden University	3.97	10	.64
Maastricht University	4.01	9	.27
Radboud University Nijmegen	3.90	16	.51
Erasmus University Rotterdam	4.21	12	.36
Utrecht University	4.17	18	.52
Total	4.09	97	.47

7.4.3 Discussion of the results of the open question

The open question refers to the subjective shortcomings that potentially impeded the success of the foreign CIBA doctors. This question was answered by 78 of the 106 respondents (74%). Table 7.6 presents a categorisation of the shortcomings experienced by the doctors at the start of their additional training.

Table 7.6: Shortcomings experienced by foreign doctors

Shortcomings	N
Dutch language and communication skills	37
Low estimation of foreign doctor's diploma	11
Very slow admission procedure Department of Health and CIBA	10
Long duration of additional training	9
Negative approach of CIBA doctors	8
Lack of coaching by university	8
Insufficient knowledge of healthcare	6
Cooperation with assistant physicians	6
No appreciation of foreign specialism	5
Little contact with patients during additional training	5
No possibility to experience working in healthcare prior to start of training	5
Limited knowledge of the English language	5
Lack of ICT skills	4
Having to combine education with having a family	4
Lack of any bridging education	4
Lack of valid knowledge or skills assessment	3
No knowledge of the Limburg dialect	3
Level of Dutch language course was insufficient	2
Financial problems	2
Presenting skills	2
Very slow asylum procedures	2

7.5 Discussion and conclusions

The study population consists of foreign doctors who started their medical training at one of the eight medical faculties via CIBA in 2004 at 2005, and who, as a result, did not participate in the new assessment procedure of the Department of Health. It was expected that the respondents' ideas would hardly correspond with the trainers' ideas (Splinter et al, 2003; Tromp et al, 2007). After all, people who are requested to judge their own competences are not always as objective and honest as they should be. Consequently, the reliability of self-judgement is disputable. A study by Eva et al (2004) determined that there is little correlation or even a negative correlation between self-assessment and the subject's actual achievements. However, the results of self-assessment become more reliable if they do not have important consequences (Gardner, 1999). Before the start of this study, the participating student doctors were told explicitly that the results would have no consequences for them at all.

It is certainly possible that the perception of their own competences was higher than their trainers' judgements. Immediately after sending the questionnaires, seven of the contacted CIBA doctors asked if there was any possibility for them to be transferred to the new Department of Health assessment procedure; they probably did so because they were convinced that they would only have to follow a 12 week programme in the new procedure.

These doctors had quite a high regard of their own competences. It is highly unlikely that these doctors gave socially desirable answers in the questionnaire. After all, someone who opts for a different route where knowledge is tested will do so out of conviction.

The statistical calculations show that the foreign doctors think that for all the parts of the assessment procedure their knowledge corresponds fairly well with the knowledge required at the start of their additional medical training. The trainers have a different opinion. They have regularly reported that the foreign doctors have an insufficient command of the Dutch language. The scores on parts of the general knowledge and skills test were lower than the scores on the parts of the medical knowledge and skills test, but these differences were also non-significant. There is no direct explanation for the minor differences between some faculties for the variables *Dutch language and communication skills* and *English reading skills*. There may be a relation with the level of the bridging education that had been followed prior to the additional medical training.

This study found no significant differences between the medical faculties for the variables tested. For all the parts of the medical and clinical knowledge test and the clinical skills test, the foreign students/doctors think that their foreign education corresponds fairly well with Dutch medical training and that there are only few differences. It is impossible to assess how these opinions correspond with reality.

With regard to the open question about the shortcomings experienced at the start of medical training, 47% of the respondents concluded that the Dutch language was the main obstacle. The extra attention given to improving Dutch language skills during medical training is justified. The general verdict on all competences together gave an average score of 4.09 (in other words, they corresponded fairly well); still, knowledge of the Dutch language was found to be the most important shortcoming, especially in the eyes of foreign doctors. This is an important argument in favour of continued Dutch language training (further deepening and fine-tuning) both during and after finishing medical training.

This study was held among all the foreign doctors who entered Dutch medical faculties through CIBA in 2004 and 2005, just before the new assessment procedure came into force. It shows that the foreign doctors hold the view that:

- The level of their general knowledge and skills (Dutch language and communication skills, English reading skills, ICT skills, knowledge of Dutch healthcare) corresponds fairly well with what is required by Dutch healthcare. This is in contrast with their trainers' views.
- The level of medical knowledge and skills corresponds fairly well with the level of the Dutch basic doctor's exam. This is also in contrast with their trainers' views.
- Command of the Dutch language is the greatest problem at the start of additional medical training. This view is shared by the trainers.

Foreign doctors and their trainers have different opinions about the level of both the doctors' general and medical knowledge and skills. In the new assessment procedure, all foreign doctors are tested on this knowledge and these skills. The results are now objective and the length of the additional training will be based on these assessment results. It is a great improvement on the situation before this procedure came into force. It was not only the government, politicians and medical faculties who wanted to professionalise the assessment of the professional competence of foreign doctors; the same wish was also

voiced by interest groups and by the foreign doctors themselves. Foreign doctors criticised the obscure and subjective procedure for diploma evaluation by the Department of Health as well as the advisory role played by NUFFIC (Haaksman, 2005).

Command of the Dutch language is the greatest problem, also in the experience of the foreign doctors. We think that this final conclusion is of great importance. The performance of foreign doctors in Dutch healthcare can be optimised if permanent attention is given to improving their command of the Dutch language.

References

Arkel P van, Engelkes E. Gevluchte arts van wachtkamer naar spreekkamer; een onderzoek naar de mogelijkheden van een efficiëntere instroom van gevluchte artsen in de Nederlandse gezondheidszorg. Stichting voor Vluchteling-studenten UAF; Utrecht; 2003.

Commissie Buitenslands Gediplomeerden Volksgezondheid: Vakbekwaamheid zonder grenzen? Verslag invitational conference Buitenslands Gediplomeerden Volksgezondheid gehouden op 26 maart 2003 te Utrecht. Den Haag; 2003.

Eva KW, Cunnington JPW, Reiter HI, Keane DR, Norman GR. How can I know what I don't know? Poor self-assessment in a well-defined domain. In: *Advances in Health Sciences Education*. 9: 211-224; 2004.

Gardner D. Self-assessment for autonomous language learners. University of Hong Kong. 1999.

Haaksman D. De NUFFIC onder vuur. In: *D&C Nieuwsbrief*; nummer 4. NUFFIC, Den Haag. 2005.

Herfs PGP. Erkenning van buitenlandse artsdiploma's; een verhaal apart. Afdeling Studentenzaken; Universiteit Utrecht; 1996.

Merkelbach JW. Supervisie werkt niet voor buitenlandse artsen. In: *Medisch Contact*; 1999; 54^e jaargang, nr 17.

Ministerie van Volksgezondheid, Welzijn en Sport: Plan van aanpak Project Assessment buitenslands gediplomeerden gezondheidszorg. Den Haag; 2005.

Nie NH, Hull CH, Jenkins JG, Steinbrenner K, Bent DH: *Statistical Package for the Social Sciences* (edition 2). New York: McGraw-Hill.1975.

Splinter TAW, Herfs PGP, Ruijs AJEM, Luijk SJ van, Wijkhuijs NP. Naar een nieuwe stroomlijn voor buitenlandse artsen; een rapport van de Opleidingscommissie Geneeskunde van het Disciplineoverlegorgaan Medische Wetenschappen (OCG-DMW); 2003.

Tromp F, Rademakers JJJM, Ten Cate ThJ. Development of an instrument to assess professional behaviour of foreign medical graduates. In: *Medical Teacher*; volume 29: 2&3, 150-155. 2007.

8 **Problems encountered by International Medical Graduates during their re-training at Dutch Medical schools**

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8.1 Abstract

International Medical Graduates in the Netherlands often fail to get their medical degrees recognised by the Dutch Department of Health. They then have no option other than to re-train, starting an additional course in medicine at one of the medical schools in the Netherlands. Only after obtaining a Dutch medical degree do they have the right to work as a doctor in the Netherlands. Over the last ten years more than 1,000 IMGs have requested admission to a medical school through a special committee, the Committee for the Influx of Foreign Doctors (CIFD). In 2004 it was estimated that nearly 90% of IMGs started medical re-training.

No data were hitherto available regarding course-related problems experienced by these IMGs during their additional medical training. Therefore, research was done into the re-training experiences of all 99 IMGs who started in the years 2002 and 2005 at five medical schools. Information about the study careers of these 99 IMGs was obtained through the study advisors of the 5 medical schools. It appeared that 38 IMGs experienced problems on their courses. The majority, 61 IMGs, had no such difficulties. In those situations where problems did arise, two major problems were observed: insufficient mastery of the Dutch language and inadequate medical knowledge and skills. Problems related to students' attitude were also noted. However, study advisors observed not only course-related problems but also noticed problems concerning residency and issues related to students' stage of life (for example, the lack of study grants, housing problems, care for a partner and/or children). It is noteworthy that in 2002 71% of the IMG-influx came to the Netherlands as refugees, while in 2005 the majority (57%) came as a partner or spouse to a Dutch national. The average age of IMGs when starting their medical re-training was 35. As the CIFD was disbanded in 2007, it is surely advisable that IMGs should not have to forego the invaluable expertise of course advisors in guiding IMGs through their re-training. It would also appear prudent that medical schools focus on offering additional language training to IMGs.

8.2 Introduction

In most Western countries IMGs cannot enter the medical profession without some kind of assessment. IMGs from a country within the EEA (European Economic Area) who have a

medical degree can appeal to a European Directive (Directive 2005/36/EC) for recognition of their professional qualifications. The Dutch Department of Health does not usually recognise medical degrees from outside the EEA. This article concerns IMGs whose medical degrees were obtained from outside the EEA. For the vast majority of IMGs residing in the Netherlands it is necessary to obtain Dutch medical degrees. Without a Dutch medical degree it is virtually impossible to ever practise medicine in the Netherlands. Therefore, admission to a medical school for re-training is a pre-requisite for acceptance into the Dutch healthcare system. After having passed bridging programmes (Dutch language courses) and undergoing a formal assessment of their diplomas and background, a number of IMGs were admitted to Dutch medical schools (see table 8.1).

Table 8.1: Number of requests received by the CIFD onwards 1996

Year	Requests received by the CIFD	Cumulative
1996-1997	113	
1997-1998	97	210
1998-1999	127	337
1999-2000	132	469
2000-2001	136	605
2001-2002	118	723
2002-2003	126	849
2003-2004	99	948

The distribution of IMGs over the 8 Dutch medical faculties was done by the Committee for the Influx of Foreign Doctors (CIFD). This committee was established by the Board of the Dutch Medical Faculties in 1996 (Herfs, 1996). The assimilation of IMGs into the Dutch system seems to have become more and more difficult over the last ten years. This has coincided in tandem with an increase in doctors fleeing war in Iraq and Afghanistan. Current procedures for admission were deemed to be no longer satisfactory. Language problems and cultural problems manifested themselves frequently (Haalboom et al, 1998).

This led the Board of the Dutch Medical Faculties to set up a committee which would create a new assessment procedure for IMGs in the Netherlands (Splinter et al, 2003). In December 2005 this new procedure came into force. Before 2005 Haalboom et al. and Splinter et al. had already reported course-problems experienced by IMGs in Dutch medical schools. After the new assessment procedure came into force, Tromp et al. (2007) published an article bemoaning IMGs' lack of professional behaviour in the Netherlands.

The nature and frequency of IMGs' course-related problems in Dutch medical schools were never systematically investigated. In this article we will examine the nature and frequency of the problems experienced in the first year of enrolment. This investigation was carried out before the new assessment procedure came into force. We shall examine the differences between our conclusions and those opinions which led to an introduction of a new assessment procedure for IMGs in the Netherlands.

Five medical schools were approached with a request for co-operation on a research project regarding IMGs' re-training problems. We felt that data from five (out of a total of eight) medical schools would give a reliable presentation as Dutch medical schools do not vary greatly. The similarity between the lengths of medical re-training programmes for IMGs at different medical schools is mostly based on the experiences of members of the Committee for the Influx of Foreign Doctors. From the start it was agreed that the names of the relevant medical schools⁴⁵ would not be made public. In this manner we could guarantee that the privacy of the IMGs concerned was respected. In fact, this guarantee could only be given if there were medical schools that did *not* participate in our research project. If all medical schools had participated, each IMG who had started in either 2002 or 2005 could have been found in the final report.

The board of examinations at each of the five medical schools was asked for the student files of all the IMGs who started re-training in the academic year 2002/2003 and 2005/2006. Each medical school had 15 to 20 IMGs who had started the first year of their medical re-training programme in 2002 and 2005. We chose the students who started in 2002 as this was the earliest group of student on whom files were still available. We also chose the students who started in 2005 as these IMGs were the last ones to enter medical schools through the CIFD. There was another reason for our choices, however: due to a new immigration law in 2001 (Staatsblad, 2001), there was a drastic change in the kind of background recent IMGs came from. In 2002 the majority of IMGs were refugees; in 2005 the majority of IMGs had gained legal residency in the Netherlands due to their partnership with a Dutch citizen.

These data were found in student files. The files were interpreted by using the competencies described by the Splinter committee, as it became known. This committee provided the materials for the new assessment procedure. The study advisor at the medical school concerned read all the IMGs' files. The study advisor would ascertain the existence and nature of any course-related problems. Our researcher did not have access to student files out of respect for student privacy. For each medical school and for each IMG we made an inventory of course-related problems found in student files.

At two medical schools random control groups of 15 students were set up. Among 30 randomly chosen files from 5th year medical students we investigated the nature and frequency of course problems. We chose fifth year students because there was a greater chance that they would be at a similar stage in life to the IMGs expected significant. We wanted to give an idea of the kind of course-related problems experienced by a random group of Dutch medical students, although we did expect that they would differ significantly from those of IMGs.

⁴⁵ The list with the names of the cooperating medical schools has been presented to the (former) Rector Magnificus of Utrecht University, prof. dr W.H. Gispen.

Research data were gathered from the period March-September 2007. Our sample was not big enough to carry out statistical tests. Therefore the results have been written down without having being tested for statistical significance.

8.4 Results

8.4.1 Course-related problems of 5th year students in a random control group

From a random sample of 30 fifth year medical students (non-IMGs) from two different medical schools it appeared that ten students had course-related problems. The nature and frequency of the problems for medical students in the control group are presented in table 8.2.

Table 8.2: nature and frequency of problems for 5th year students in a random control group

Nature and frequency of problems	2005
Health problems of student, partner or child	6
Medical knowledge	2
Planning of studies	2
Total	10

8.4.2 General results

The general data on IMGs who started their medical re-training programme in 2002 and 2005 is presented in table 8.3.

Table 8.3: General data on IMGs who started in 2002 and 2005

	2002		2005		2002 + 2005	
	N	%	N	%	N	%
Total	52		47		99	
Men	25	48	16	34	41	41
Women	27	52	31	66	58	59
Working experience as a doctor	43	83	38	81	81	82
No working experience as a doctor	8	15	9	19	17	17
Working experience as a consultant	15	29	21	45	36	36
Legal residency as refugee	37	71	20	43	57	58
Legal residency as partner of a Dutch citizen	15	29	27	57	42	42

In 2005 the number of female IMGs increased. It appeared that the majority of IMGs already had working experience. The average age of IMGs starting their medical re-training is 35. A discrepancy in the IMGs' backgrounds could be observed. The number of refugee IMGs decreased while the number of IMGs with a Dutch partner increased.

8.4.3 Course-related problems faced by IMGs

Table 8.4 contains the number of students who experienced course-related difficulties in the first year of enrolment. In 38 files such problems were observed; 44% in 2002 and 32% in 2005.

Table 8.4: Number of study problems of IMGs in 2002 and 2005

Course-related problems	2002		2005		2002 + 2005	
	N	%	N	%	N	%
Yes	23	44	15	32	38	38
None	29	56	32	68	61	62

In table 8.5 the different types of study problems per group of IMGs are described. All course-related problems were given a score. Some of the students had multiple problems. In 2002 we found 38 problems in student files; in 2005 there were 36 problems. In total 74 problems in 38 files were reported.

Table 8.5: Nature of course-related problems in 2002 and 2005

Nature of the problems	2002	2005
Dutch language	6	8
Medical Dutch	0	2
Communication problems	4	4
English language (reading capacity)	4	3
Medical knowledge	13	5
Medical skills	3	3
Knowledge of Dutch health care system	0	0
Knowledge of ICT	1	2
Attitude problems towards patients	2	3
Attitude problems towards teachers	1	4
Attitude problems towards fellow students	1	1
Attitude problems towards other health care workers	0	1
Limited study skills	1	0
Fear of failure	2	0
Total	38 (N=23)	36 (N=15)

8.4.4 Secondary, non course-related problems

We also asked study advisors to mention secondary problems reported in the files. These problems are not really related to the medical course of study, but their occurrence can influence the success of the course. In table 8.6 we present the secondary problems observed. Multiple scores per student were possible.

Table 8.6: Secondary, non course-related problems

Nature of secondary problems	2002	2005
Financial problems	4	2
High traveling costs and/or long distance between university and home	1	3
Uncertainty about residence permit	3	1
War trauma	2	1
Severe health problems of student, partner or child	5	7
Combination of studies and family chores	1	3
Housing problems	1	3
Assessment problems	1	1
Problems with patients' regional accents	1	0
Problems in the start-up phase	0	2
Total	19	23

In this research project the problems experienced by two groups of IMGs, who started either in 2002 or 2005, were systematically and quantitatively listed. Former (qualitative) studies by Splinter et al. (2003) and Tromp et al. (2007) had mentioned the nature of IMGs course-related problems but not their frequency.

As of December 2005 a new assessment procedure for IMGs from outside the European Economic Area came into force. In the first part of this procedure candidates are tested on their general knowledge (Dutch, reading proficiency in English, ICT competence, etc.). After passing the Step 1 exams, candidates are tested on their medical knowledge and skills. Our research shows that most of the problems encountered can be found in the competencies tested during the assessment procedure.

In 2002 and 2005 a total of 99 IMGs were admitted to five medical schools. All the course-related problems experienced by these students were listed. During these years a change took place in the sort of backgrounds from which IMGs came. In 2005 the majority had residence permits to be with their partners while in 2002 the majority were refugees. Of all IMGs who started in 2002 and 2005, 38% experienced course-related problems. The majority of those problems reported could be divided into language and communication problems on the one hand and problems concerning medical knowledge and skills on the other hand, (32% and 32% respectively). We compared these problems with our control group of 5th year medical students. From our control group 33% of students sought help from the study advisors. Their problems, however, are mostly connected to health issues.

The linguistic problems mentioned above are consistent with results reported in former studies (Haalboom et al, 1999 and Herfs, 2006). The study advisors reported a remarkable phenomenon: IMGs with a Dutch partner appeared to have a better mastery of the Dutch language than those who came to the Netherlands as refugees. IMGs with a Dutch partner learn the Dutch language faster and to a higher level than their counterparts with a refugee background. A very likely explanation is that refugees in their private surroundings have limited access to the Dutch language.

Problems regarding medical knowledge were reported 18 times (24%). This outcome might be influenced by the fact that 36% of the IMGs had already worked as consultants in their country of origin. In the Step 2 exams they were confronted with general medical knowledge that might have faded into the background. The Netherlands does not have a direct and specific assessment procedure for specialist or consultant doctors. IMGs have to take an assessment at the level of doctor of medicine. After successfully finishing this general assessment, a specialist may continue with a (second) assessment procedure for specialists (Kooij et al, 2010).

Attitude problems towards patients, doctors and students were reported 13 times (18%). Secondary, non course-related problems were listed 42 times. These problems were strongly connected to the IMGs' stage of life and residence permits.

The average age of IMGs entering Dutch medical schools was 35. As a result, most of them are no longer eligible for study grants from the Dutch government. Financial aid is often required. Sometimes local social services support IMGs. Refugees in the Netherlands are

supported by the University Asylum Foundation. Being older at the beginning of a course, IMGs often have partners and children. The combination of following a medical course and having family responsibilities may result in problems in both domains.

Refugees are frequently confronted with multiple problems; for instance, they face uncertainty as to their residency, they have limited access to language and other preparatory programmes, they cope with financial and housing problems, they are not eligible for study grants, etc. IMGs may turn to study advisors and faculty deans for advice and support.

8.6 Conclusions

The majority (62%) of IMGs examined in this research project do not have study problems after entering Dutch medical schools. However, problems were reported for 38% of the IMGs who started in 2002 and 2005. Two types of problems were mentioned mostly; language problems and problems regarding medical knowledge and skills.

These results concur with the outcomes of previous studies and underline the importance of continuous attention to the mastery level of the Dutch language during additional medical training (Haalboom et al, 1998, Tromp et al, 2007 and Herfs, 2006). Mastery of the Dutch language is necessary for IMGs who want to work as doctors in the Dutch health care system. The Dutch language appears to be a tough stumbling block for IMGs. The focus in additional medical training lies, however, on medical knowledge and skills, not on additional language training.

During their additional training, IMGs are evaluated on their professional conduct towards patients and colleagues. It is, therefore, of great importance that attitude problems can be discussed and properly solved. This accords with the advice of a task group from the Board of the Dutch medical schools regarding this specific issue (Projectteam Consilium Abeundi, 2002).

IMGs bear little resemblance to average Dutch medical students. They already have qualifications and diplomas, albeit foreign ones, they are 10 years older than most of their fellow medical students and they are at another stage of life. Among the IMGs we find students who have experienced war trauma, students who combine their medical study with domestic care, students with residential problems, students with financial problems, etc. Their backgrounds are bound to influence their progress during re-training at medical school.

Since the mid 1990s IMGs whose medical degrees have not been recognised have been entering Dutch medical schools. Those medical schools were then confronted with problems that they had not seen before. In 1996 the Committee for the Influx of Foreign Doctors (the CIFD) was established. The medical school each sent a study advisor to represent them at the CIFD. These advisors also were charged with guiding IMGs at their medical schools. In September 2007 the CIFD was dissolved due the introduction of a new

assessment procedure. Although the numbers of IMGs entering Dutch medical schools has significantly decreased, it is important to offer those that remain specific guidance. Therefore, the role of the study advisor in guiding IMGs is invaluable and should be preserved.

References

Directive 2005/36/EC of the European Parliament and of the Council of 7 September 2005 on the recognition of professional qualifications. Brussels, Belgium; 2005.

Haalboom JRE en Herfs PGP: De inpassing van buitenlandse artsen in het Nederlandse medische curriculum. *Medisch Contact* 1998;53: 44.

Haalboom JRE en Herfs PGP: Utrecht ontwikkelt module voor bijscholing buitenlandse artsen. *Transfer* 1999;6 (7). Nuffic, Den Haag; 1999.

Herfs PGP: Erkenning van buitenlandse artsdiploma's; een verhaal apart. Utrecht: afdeling Studentenzaken, Universiteit Utrecht; 1996.

Herfs PGP: Is Nederland toe aan een Nt2-examen programma 3? In: Schoordijk FMC en Taal- Apelqvist L (redactie): Nederlands leren na het Staatsexamen Nt-II. Symposiumbundel ter gelegenheid van het afscheid van Hans Maureau van het INTT. Universiteit van Amsterdam; 2006.

Kooij LR, van Reenen RGM: Registratie van buitenlandse specialisten. KNMG Opleiding & Registratie. 2010.

Projectteam Consilium Abeundi: Professioneel gedrag; onderwijs, toetsing, begeleiding en regelgeving. Eindrapport en bijlagen. In opdracht van de VSNU, Utrecht; 2002.

Splinter TAW, Herfs PGP, Ruijs AJEM, Luijk SJ van, Wijkhuijs NP: Naar een nieuwe stroomlijn voor buitenlandse artsen; een rapport van de Opleidingscommissie Geneeskunde van het Disciplineoverlegorgaan Medische Wetenschappen (OCG-DMW); 2003.

Staatsblad, 495: Vreemdelingenwet 2000. Sdu; 2001.

Tromp F, Rademakers JDDJM, Ten Cate ThJ: Development of an instrument to assess professional behaviour of foreign medical graduates. In: *Medical Teacher* 2007; 29(2&3): 150-5.

9 Results of a new Dutch assessment procedure for international medical graduates

9.1 Abstract

Aim Due to political pressure the Dutch Department of Health (DoH) was forced in 2001 to take responsibility as a main contractor in organizing additional training programs for international medical graduates (IMGs). The Department of Health and the 8 medical faculties cooperated in the development of a new assessment procedure in order to preserve IMGs for Dutch health care and to facilitate additional training for IMGs at medical schools. In 2005 this new procedure came into force.

Method The new assessment procedure for IMGs is described.

Results The results of the new assessment procedure are compared with the results of IMGs who were admitted under the old procedure. It appears that under the new assessment procedure a great number of IMGs were excluded. Exclusion was based on questionable grounds. The assignment of the Lower House was exactly the opposite of the results obtained after 4 years experience with the new assessment.

Discussion The new Dutch assessment procedure contains many growing pains. The majority of IMGs participating in the new assessment procedure are actually expelled. IMGs in the Netherlands pay a high prize for a badly functioning assessment system. As long as it functions badly one should be modest in presenting the Dutch assessment as a model for other European countries dealing with assessment of IMGs.

9.2 Introduction

In the late nineties of the last century it became quite obvious that the policy of the Dutch DoH in dealing with IMGs was no longer tenable. In fact the DoH did not do much more than evaluating foreign medical degrees. In 1997 a crushing report on the policy of DoH towards foreign doctors and dentists was published (Govaerts et al. 1997). The release of this report was obstructed. DoH was forced to release it but nevertheless the outcomes were ignored.

The majority of non-EEA-doctors received a non-equivalence decision by the minister of Health. It led to quite a number of appeals against the DoH-assessments. Furthermore these non-EEA-doctors were referred to one of the medical schools. As the number of applicants increased from the midst of the nineties the medical schools established a special committee to divide all IMGs equally into the 8 medical schools. The so called Committee Influx Foreign Doctors (Dutch abbreviation: CIBA) allocated more than 1.000 IMGs to the Dutch medical schools (Herfs, 2009). On a yearly basis 118 IMGs were

allocated. From 1996 until 2006 universities with medical schools played a major role in organizing additional training for IMGs. In fact the medical schools solved the problem of the integration of IMGs in Dutch health care without any request to do so by the DoH. The DoH simply passed the IMGs onto the medical schools.

Because of the fact that medical schools had limited capacities to additionally train ever growing numbers of IMGs in combination with an increasing number of appeals against DoH assessments discussions in Dutch parliament were initiated about IMG-policy by the DoH. Against this background on December 6 2001 the DoH was assigned to develop a new assessment procedure in order to preserve IMGs for Dutch health care and to facilitate additional training for IMGs at medical schools. The DoH and the 8 medical schools started their efforts to establish a new assessment procedure with the following characteristics: fair, time-limited, competence based and equal treatment (Splinter et al. 2003). In a kick-off meeting of professionals involved with IMGs the following problems with IMGs were listed:

1. limited mastery of the Dutch language
2. attitude problems towards patients and paramedics
3. limited reading ability English
4. no knowledge of Dutch healthcare
5. no assessment of medical knowledge and skills

The “Splinter report” at last lead to the introduction of a new assessment procedure for IMGs in the Netherlands in December 2005.

9.3 The new assessment for IMGs in the Netherlands

A taskforce from the DoH and from the medical schools made a thorough study of the assessment as executed by the Educational Commission for Foreign Medical Graduates (ECFMG) in the United States of America. In a certain stadium there even was rumour that Dutch IMGs were to undergo the United States Medical Licensing Examinations. These examinations however can only be made in the USA. Due to developments after 9-11 immigration problems in the USA for (Dutch) foreign doctors with a Muslim background were expected. These plans then were abandoned. The Dutch assessment procedure for IMGs is in many respects a copy of the ECFMG-procedure.

It consists of the following steps or phases:

Figure 9.1: the assessment procedure in candidates perspective:

phase 1	phase 2	phase 3	phase 4
<p>Preparation:</p> <p>Sending in foreign medical diploma to the DoH and registration for the assessment procedure</p>	<p>General (non-medical) assessment:</p> <p>Medical Dutch, reading proficiency English, ICT and knowledge of Dutch healthcare</p>	<p>Medical assessment:</p> <p>Medical knowledge, clinical knowledge and clinical skills</p>	<p>Additional training:</p> <p>½ year 1 year or 2 years or 3 years</p>

In December 2005 the new assessment procedure came into force. In the four years it took the DoH to develop the assessment procedure major changes in immigration patterns occurred. First of all on May 1 2004 10 mostly Eastern European countries became EEA member states. Medical doctors in these countries who started their education after May 2004 will be covered by Directive 2005/36/EC (European Parliament and the Council of the European Union, 2005). Second, due to tighten up immigration laws the number of refugees in the Netherlands decreased. As a consequence the number of international medical graduates asking for registration as doctors at the Department of Health decreased also. Exact figures however are not available as DoH does no longer present data on migrating doctors, dentists, pharmacists, nurses, etc. since 2002. Until 2002 annual reports were published containing data on these professional groups. After 2002 transparency on recognition requests of medical and paramedical groups in the Netherlands is lacking.

9.4 Results of IMGs participating in the assessment procedure

Since December 2005 the Department of Health is responsible for the implementation and execution of the assessment procedure. DoH is the main contractor, while before that time the medical schools were responsible for the admission and additional training of IMGs. From the beginning it was clear that important differences between the old and the new procedure would arise. In my (Dutch) thesis (Herfs, 2009) I presented a 'Then and Now comparison' of the assessment of IMGs in the Netherlands.

Table 9.1: Old-new comparison on the assessment of IMGs in the Netherlands

CIFD (1996-2005)	DoH-Assessment (since 2005)
IMG is “customer” of a medical school	IMG is not yet assigned to a medical school
Bridging courses available at university	Bridging courses absent
IMG makes use of study advisor and/or dean of students	IMG makes no use of student services as he or she is not yet assigned to a medical school or university
Admission to the medical training occurs on the basis of: 1. foreign medical degree 2. language exam Dutch (level B2) 3. compelling reasons (like citizenship because of partnership or refugee status)	Admission to the medical training occurs on the basis of general and medical tests of the assessment procedure: 1. language exam Dutch (level C2) 2. reading proficiency English 3. ICT knowledge 4. Knowledge of healthcare 5. Medical knowledge 6. Clinical knowledge 7. Clinical skills
Course Medical Dutch is part of the additional IMG training program and is paid by the Medical School	Course Medical Dutch is no longer part of the additional IMG training program and must be paid by the participant
Medical knowledge test after admission to medical school	Medical knowledge test before admission to medical school
Duration of additional program nearly always 3 years	Duration additional training can vary from ½ a year to 1, 2 or 3 years.
Duration of additional training is dependent on medical school	Duration of additional training is dependent on the outcomes of the medical assessment
Costs of CIFD-procedure: zero	Costs assessment procedure: € 2.200,- to be paid by the participant
Preparation time: unlimited	Phase 2 examinations must be finished within one year. If a candidate fails for one or more exams, all exams must be done in the next year. The candidate has to pay once again for the exams.

The majority of IMGs who were admitted under the CIFD regime passed the final exams and received a Dutch MD-degree. Nearly all IMGs found work as medical doctors (Herfs, 2009; Veltman and Both, 2010) after obtaining a Dutch MD-degree. They were retained for Dutch healthcare.

The outcomes of the assessment procedure after 4 years of experience are quite disappointing. The results of candidates participating in the assessment procedure are not published in annual reports of the Department of Health. Indirectly, the outcomes of phase 2 exams were gathered. In the period of 2006 until 2009 77 candidates participated in phase 2 exams. Only 19 passed and could continue the exams in phase 3 exams. Two factors account for the disappointing results:

1. bridging courses are absent
2. the level of the language exam

Ad 1; the Department of Health is responsible for the execution of the assessment procedure. They are not responsible for organizing bridging courses. Although it was well-known that bridging courses were not available, IMGs were asked to prepare themselves on the phase 2 exams.

Ad 2; the highest level of state exams in the Dutch language is on level B2 in terms of the European Framework (Council of Europe, 2001). The level of the assessment exams in the Dutch language is on level C2. During information campaigns organized by DoH candidates are told that the Dutch language state exam (at level B2) is not obligatory. After successfully passing the language state exam Dutch, candidates might think that the assessment exam in the Dutch language can be made easily. They make a big mistake.

Because of the fact that DoH did not present data on results of the assessment in the end of 2009 I have send a questionnaire to the 8 Dutch medical schools. I asked them to inform me about the candidates that passed the assessment procedure and were referred to their medical schools for additional training. I received the following information:

Table 9.2: IMG admission on the basis of a DoH-decision

Medical school	2006	2007	2008	2009	Total
Amsterdam MC	0	0	0	4	4
VU Amsterdam	0	1	0	0	1
Leiden UMC	1	0	2	0	3
UMC Utrecht	0	2	0	1	3
UMC Nijmegen	0	1	1	1	3
Erasmus MC Rotterdam	0	0	3	2	5
UMC Groningen	0	1	1	2	4
UMC Maastricht	0	1	1	0	2
Total	1	6	8	10	25

This number gives even a flattering picture of the situation as 6 IMGs withdrew from admission to the medical schools. So in 4 years time 19 IMGs were admitted to medical schools. In the pre-assessment period Utrecht medical school only would admit this number of IMGs in one year! The source dried up.

9.5 Conclusions

In the years before the assessment procedure came into force the medical schools admitted an average of 118 IMGs per year. Due to the absence of bridging courses in combination with high level exams in the Dutch language a major part of the participants fails for the assessment. As passing the phase 2 exams is obligatory for continuation of the phase 3 exams the passage for IMGs is obstructed. Many IMGs gave up their belief in ever passing the phase 2 exams.

It was quite astonishing to read that Sonderen et al. (2009) were presenting phase 3 exams

as good practice for other European countries. Out of 200 participants entering the assessment procedure 161 (80%) failed “mainly because of insufficient mastery of the Dutch language”. Although Sonderen et al. tried to convince the reader that the clinical skills assessment (phase 3 exams) was valid and reliable, no attention at all was given to the validity and reliability of the general skills test (phase 2 exams).

Countries which are dependent on IMG-influx, like Australia, Canada, the UK and USA offer bridging courses to assist migrant professionals in the new healthcare system (Hawthorne, 2008). The Dutch assessment misses this very important preparation phase.

The assignment of the Lower House in December 2001 was to develop a system that would facilitate medical schools to additionally train IMGs and by doing so retain them for Dutch healthcare. The results of 4 full years of experience with the new assessment procedure show exactly the opposite. The assessment procedure leads to exclusion of IMGs on questionable grounds. Those responsible for the development of an assessment procedure for IMGs in the Netherlands failed to build a fair procedure.

Practice points

- The Dutch assessment procedure for IMGs failed due to the absence of bridging programs. Australia, Canada, the USA and the UK offer bridging programs for their migrating doctors. Why did the Dutch Department of Health copy the framework of the USMLE without copying the access road (bridging courses)?
- Presenting the Dutch clinical skills assessment as an example of good practice for other European countries is more than premature.
- A thorough evaluation of the outcomes should be presented to the Lower House. Transparency about numbers of migrating doctors, dentists, pharmacist and nurses in the Netherlands must again be given by the Department of Health annually. The same goes for the results of candidates participating in the assessment procedure.
- During 4 years IMGs in the Netherlands paid a high price because of the introduction of a quite unfair assessment procedure. The Dutch authorities are advised to redress the consequences of a failing procedure.

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References

Council of Europe (2001): Common European Framework of reference for Languages: Learning, Teaching, Assessment. Cambridge: Cambridge University Press.

European Parliament and the Council of the European Union (2005): Directive 2005/36/EC of the European Parliament and of the Council of 7 September 2005: On the recognition of professional qualifications. Office J European Union L255 of 30.09.2005. Brussels, Belgium.

Govaerts, M.J.B. & Wijnen, W.H.F.W. (1997): Onderzoek inzake de toelating van niet-EER-gediplomeerde artsen en tandartsen tot de uitoefening van hun beroep in Nederland; eindrapport. Vakgroep Onderwijsontwikkeling en Onderwijsresearch; Universiteit Maastricht. [Evaluation study into the admission of non-EEA-doctors and dentists to health care jobs in the Netherlands. Final report. University Maastricht.]

Hawthorne, L. (2008): Quality assurance and mutual recognition of qualifications; final summary of expert group meeting nine-country audit. UNESCO report on Migration and Education.

Herfs, P.G.P. (2009): Buitenlandse artsen in Nederland. Proefschrift Universiteit Utrecht. [International Medical Graduates in the Netherlands. Thesis Utrecht University.]

Sonderen, M.J., Denessen, E., Ten Cate, O.T.J., Splinter, T.A.W. & Postma C.T. (2009): The clinical skills assessment for international medical graduates in the Netherlands. *Medical Teacher*, 31, 11: 533-538.

Splinter, T.A.W., Herfs, P.G.P., Ruijs, A.J.E.M., Van Luijk S.J. & Wijkhuis N.P. (2003): Naar een nieuwe stroomlijn voor buitenlandse artsen. Rapport Opleidingscommissie Geneeskunde van het Disciplineoverlegorgaan Medische Wetenschappen OCG DMW. [Towards new admission procedures for foreign medical graduates. Report of the Educational Council of the associated Dutch medical Disciplines.]

Veltman, P. & Both, J. (2010): Gevluchte artsen verrijken de Nederlandse gezondheidszorg. University Asylum Fund; Utrecht. [Refugee doctors in Dutch Healthcare: an enrichment].

10 Final discussion

10.1 Introduction

This study describes the way in which foreign doctors educated outside the European Economic Area have been treated in the Netherlands over the past 20 years. At the end of the 1990s, the medical faculties and interest groups increased the pressure on the Department of Health to provide an adequate assessment procedure. This Department of Health assessment procedure came into being in December 2005. The number of non-EEA doctors applying for admission has diminished as a result of geopolitical developments and the effects of Dutch immigration policy.

Section 10.2 deals with the recognition of foreign doctors' diplomas and the result of this recognition for the procedures that foreign doctors have to go through. For this, the results of the international comparison described in Chapter 6 will be used.

Section 10.3 presents the conclusions regarding the preconditions for a successful implementation of the assessment procedure of the Department of Health. This assessment procedure replaces the CIBA route.

Section 10.4 discusses the positive results of the integration of foreign doctors into Dutch society. It is concluded that studies on the integration of minorities in Dutch society tend to present negative results. It seems that positive exceptions, such as the integration of foreign doctors, have not yet registered with researchers and civil servants.

Section 10.5 deals with the policies of the Department of Health regarding foreign doctors in a multicultural Dutch society. It was only after a parliamentary motion was passed in December 2001 that the Department of Health was forced to play a coordinating role in the organisation of additional training programmes for foreign doctors.

Section 10.6 presents suggestions for further research.

10.2 Conclusions concerning the approach by the Department of Health towards foreign doctors and the recognition of their diplomas

There are three possible outcomes of the Department of Health route for the recognition of the non-EEA doctors' diplomas (see Chapter 4):

I: equivalent

II: nearly equivalent

III: not equivalent

Category I:

According to the Health Secretary, doctors who have been educated abroad and assigned to Category I are professionally competent and can enter the Dutch labour market without restrictions. Appendix 2 (annual reports of the Department of Health) shows the native countries of the foreign doctors who have been judged as equivalent. It is noteworthy that at the end of the 1990s, a number of eastern European graduates was judged completely competent. The 1999 annual report of the Department of Health shows that three Yugoslavian doctors, two Bosnian doctors and one Polish doctor were judged as completely competent. A few years later they would probably have been assigned to Category III. These foreign doctors, judged as completely competent, had not been tested on their command of the Dutch language. In principle it is still possible that a foreign doctor who has little or no understanding of Dutch will be enrolled in the BIG register (Professions in Individual Healthcare). The Department of Health is responsible for the assessment of professional competence; this does not entail assessing whether a doctor's command of Dutch is sufficient to work as a doctor in the Netherlands. However, it is to be expected that most doctors will be referred to the assessment procedure.

Category II:

Foreign doctors who have been assigned to Category II can be enrolled in the BIG register. Supervision of this register falls under the responsibility of the Health Secretary. By working in healthcare under the supervision of a Dutch doctor during a predetermined period, foreign doctors can show that they are sufficiently competent to work as doctors in the Netherlands. In practice this route does not work well.⁴⁶ A large number of Category II doctors could not find a supervision post. The most important reasons for the impracticality of the supervision route are inadequate supervision agreements. No demands were made with regard to work permits, contracts, salary, or contractual relations with health insurance companies; moreover, as a rule there was no professional liability insurance. In the case of a serious mistake by the supervisee, it was unclear whether the supervisor was responsible under disciplinary rules and/or civil law. It was concluded that as long as supervision was not described more accurately in the BIG Act, it was better to include the foreign doctors in a university curriculum. The article by Merkelbach led to commotion within the Department of Health. The policy unit responsible for advising the Health Secretary on the inclusion of foreign doctors was unpleasantly surprised, especially because another important advisory body of this Minister, i.e. the Foreign Healthcare Qualifications Commission (CBGV), indicated that part of the Department of Health procedure functioned badly and even expressed a preference for the route via the universities. Similar criticism had already been voiced by interest groups and by the doctors concerned.

Category III:

To the foreign doctors whose diplomas were judged as not equivalent, CIBA offered entry to one of the eight medical faculties. After finishing a reduced study of medicine, foreign doctors could thus obtain their Dutch doctor's degree. With regard to foreign doctors, the Department of Health interpreted its duties rather narrowly. Even though Category II doctors could be enrolled in the BIG register with clauses, assistance in finding supervision

⁴⁶The then chairman of the Foreign Healthcare Qualifications Commission, Dr J. Merkelbach, argued – in a personal capacity - in an article in *Medisch Contact* (1999) that the supervision route for foreign doctors does not work well (see Section 4.3.3).

posts was out of the question. The Department had an even more limited interpretation of its duties and services with regard to Category III doctors. After a negative evaluation of a foreign doctor's diploma, the graduate had to find out for themselves what possibilities there were to practice as a doctor in the Netherlands. Because the Department of Health did not wish to take responsibility for the additional training of foreign doctors, the medical faculties decided to join forces. Up to and including 2007, more than 1000 foreign doctors have successfully appealed to CIBA. In the end a parliamentary motion (see Appendix 9) forced the Health Secretary to support the medical faculties in the organisation of additional training of foreign doctors (Categories II and III).

An international comparison (see Chapter 6) makes clear that in a number of European countries the main responsibility for the recognition of foreign doctors diplomas and subsequent additional training lies with the Department of Health. If an additional route has been developed and offered by a medical faculty, this takes place at the request of the Department of Health. This is the case in the United Kingdom, Denmark, Norway, Sweden and Germany. Austria takes an intermediate position, and the situation in Belgium (Flanders) is comparable to the situation in the Netherlands. It is interesting that the evaluations of foreign doctors' diplomas are more positive for foreign doctors in the Scandinavian countries, Germany and the United Kingdom. In fact, these countries take recognition of the doctors' diplomas for granted; the Department of Health offers them a route which leads to a recognition of professional competence after approximately 18 months. In the United Kingdom, the list of Medical Schools (World Health Organisation) serves as a guideline for the General Medical Council. Every foreign doctor with a diploma from one of the medical schools on this list is admitted to the IELTS and PLAB exams. This is fundamentally different from the situation in the Netherlands. Here, partially based on the advice of the NUFFIC department for diploma recognition and certification, the Department of Health does not consider doctors' diplomas obtained outside the EEA equal to Dutch basic doctors' diplomas. One important cause is that NUFFIC does not only consider foreign medical training but also prior education. Since the highest level of secondary education in large parts of the world (e.g. Eastern Europe, Asia, Africa, North and South America) is judged to be at Dutch HAVO level⁴⁷, NUFFIC assumes that a medical student from these regions is by definition two years behind his/her Dutch counterpart. If the CBGV asks NUFFIC to evaluate a foreign doctor's diploma with six years' education, the judgement will be negatively affected by the system used for diploma recognition. The report by Govaerts and Wijnen (1997; see section 4.3.2) already criticised this approach. They argued that NUFFIC should limit itself to the evaluation of medical training without involving preliminary education. Nevertheless, until the assessment procedure came into force in 2005, preliminary education kept playing a role in the judgment by NUFFIC, and this led to a situation in which many foreign doctors' diplomas were judged to be equivalent with only four years of university medical study. Generally, this judgement by NUFFIC would lead to a verdict of non-equivalence by the CBGV. The role that the NUFFIC evaluations play in the final judgement by the Health Secretary has regularly been criticised (Melchior, 2005; Haaksman, 2005). A number of foreign doctors even started a website with the title ENuffic (enuffic.web-log.nl).

⁴⁷Graduating from school at HAVO level gives students entry to higher education in the Netherlands, but not at university level (for which a VWO school leaving certificate is required).

In future NUFFIC should limit itself to advice regarding the comparability of foreign doctors' diplomas without taking secondary education into account as well. The United Kingdom and the Scandinavian countries consider only medical training. If a doctor's diploma was obtained at a medical faculty recognised by the WHO, this leads to recognition of the doctor's diploma. The results of the assessment procedure will then make clear whether this recognition was justified. It is and remains important that NUFFIC also takes non-medical subjects in foreign medical training (such as Knowledge of Marxism) into account in its evaluation. However, the evaluation of tertiary education diplomas should focus on medical training, especially if a foreign doctor has a great deal of work experience.

It is increasingly important to check doctors' diplomas for authenticity. Globally there is an increase in so-called degree mills, where university certificates ranging from Bachelor to PhD diplomas can be purchased at a relatively low price, without the need for any academic achievement (Ezell & Bear, 2005). Globalisation and internationalisation have led to an unprecedented mobility of students and scientific staff. Degree mills take advantage of the increased mobilisation and provide people with fake MD and PhD degrees. In the academic world, it is not usual to check diplomas for authenticity (Hageman, 2005); however, this should change as a result of the developments surrounding degree mills. The NUFFIC Department for diploma recognition and certification could play an important role in this. Institutions for higher education, ministries and employers should submit diplomas for verification to NUFFIC much more often than at present. It is clear that such a development will also lead to demands regarding the speed of the authenticity checks. In addition, it will have to be decided what should happen if fraudulent documents appear to have been used.

10.2.1 Conclusions

Great numbers of recognition requests from holders of foreign doctors' diplomas end in non-equivalence (Category III). This can be explained by the fact that most foreign doctors' diplomas are not recognised by NUFFIC. Besides, it has become clear that the route via the universities (the CIBA-route) was more successful for foreign doctors than the supervision programme.

The absence of an exam (such as the Professional and Linguistic Assessment Board Exam in the United Kingdom and the exams in Denmark, Norway and Sweden) eventually leads to much longer training programmes (see Chapter 6 and Appendix 7). In the Scandinavian countries and the United Kingdom, the evaluation of foreign doctors' diplomas does not play any meaningful role. It is standard procedure to recognise the foreign doctors' diplomas, provided they have been issued by medical faculties which are on the WHO list of medical schools. Subsequently, these doctors enter a procedure (exams, possibly in combination with internships). In these countries, the routes that a foreign doctor has to follow before being able to work as a doctor are on average two years shorter than in the Netherlands. Based on the advice by NUFFIC, the Department of Health (together with the medical faculties) does not give these doctors the benefit of the doubt, but comes to a negative decision about the diplomas of foreign doctors when in doubt. In the new

assessment procedure by the Department of Health, the duration of the additional training programmes has become variable and dependent on the knowledge and skills displayed by the foreign doctors.

10.3 Preconditions for the successful implementation of the new assessment procedure

10.3.1 Introduction

The success of the new procedure depends to a great extent on the existence of courses, course materials and the access to these courses for foreign doctors. When the assessment procedure was developed, the developers disregarded the need for preparatory courses. After all, course development is not one of the responsibilities of the Department of Health or of the university medical centres.

In the new assessment procedure, candidates need to take a number of tests for which they have to prepare well. Before the start of the assessment procedure, it is preferable that the candidate has already passed the State Exam Dutch as a second language (programme 2)⁴⁸; in fact, passing this State Exam is an absolute requirement. The General knowledge and skills test (AKV) assesses whether a foreign doctor's command of Dutch is sufficient to communicate with patients. In addition, the AKV assesses whether a foreign doctor's command of English is sufficient to read literature in his field, and whether he has sufficient ICT skills. Finally, the test assesses whether the applicant's knowledge of Dutch healthcare is sufficient. The assessment procedure comprises the following items:

General knowledge and skills test (AKV):

- Dutch language and communication skills (including Medical Dutch)
- ICT skills
- Knowledge of Dutch healthcare
- English reading skills

If the candidate successfully finishes these four tests, he proceeds to the next step: the Medical knowledge and skills test (MKV), which assesses clinical and preclinical knowledge and skills:

- Knowledge of basic medical subjects
- Clinical knowledge
- Clinical skills

⁴⁸The Department of Health cannot legally enforce participation in the State Exam Dutch as a second language (programme 2). However, passing this exam is a presupposition for successful participation in the Medical Dutch course and exam. For admission to an additional training programme, successful participation in a language test has been made compulsory by the medical faculties (see Herfs, 2006).

In addition, on a voluntary basis the candidate can compile a portfolio, describing his work experience as a doctor of the past five years. The final advice can only be drawn up after all the tests have been taken.

The assessment procedure is followed by the advice on additional medical training. This advice may take six different forms:

1. There is no need for the candidate to follow additional medical training, but in order to evaluate professional conduct and clinical patient management, a 12 week internship must be followed.
2. The candidate has to follow additional medical training for six months (30 ECTS).
3. The candidate has to follow additional medical training for one year (60 ECTS).
4. The candidate has to follow additional medical training for two years (120 ECTS).
5. The candidate has to follow additional medical training for three years (180 ECTS).
6. The candidate receives no exemption from medical training; the candidate has to follow the complete study of medicine.

The medical faculties comply with the Health Secretary's advice. Additional training will be provided by the medical faculties (outcomes 1-5). If no exemption from medical training is given (outcome 6), the candidate can apply for the drawing of lots procedure (at the CBAP in Groningen) to gain access to the study of medicine. In this case, access to the study of medicine cannot be guaranteed.

10.3.2 Possible undesirable consequences of the assessment procedure

It can be conceived that, besides the many advantages, the new assessment procedure also has undesirable consequences. It is absolutely necessary to be well prepared in order to be successful in the various tests. However, there are no possibilities to prepare for the tests. In addition, a number of candidates experience a lack of financial security before and during the assessment route.

Foreign doctors enrolling in a higher year of the study of medicine are either refugees or have a Dutch partner. Both groups of non-EEA doctors experience problems regarding the recognition of their diplomas, their Dutch and English language skills, and their lack of a social network (see Appendix 8). Although people with a Dutch partner can also experience problems in the acquisition of a permanent residence status, the position of refugees is extremely troubling. In some aspects, the position of refugee doctors is particularly disadvantageous (Klaver&Odé, 2003; Van Arkel & Engelskes, 2003), for example regarding the lengthy uncertainty about their asylum requests and the consequent impossibility to afford preparatory courses. Moreover, without the financial support of private organisations, it is hardly possible for them to finance their travel and study costs. The medical study of a great number of refugee doctors takes place with support of the

University Asylum Fund. In February 2006, this organisation announced: “40 of our students have been waiting for a residence permit for 10 years, and 240 of our students have been waiting for more than six years.”⁴⁹ Besides causing feelings of great uncertainty as a result of this endless wait for a residence permit, the lack of speed in dealing with asylum requests displayed by the Ministry of Justice’s Immigration and Naturalisation Service (IND) also has its consequences with regard to integration and social security. After an initial negative decision by IND concerning the asylum application, the Central Agency for the Reception of Asylum Seekers (COA) excludes the applicant from language activities; as a result, he cannot prepare himself for those important tests. In fact, there is a sequential accumulation of problems with several governmental bodies:

1. Ministry of Justice (Immigration and Naturalisation Service)

- Very slow processing of asylum procedures by IND, especially regarding asylum seekers who were included in the procedure before the Aliens Act 2000 came into force on 1 April 2001.
- During their stay at a COA Reception Centre, after initial rejection of asylum application: isolation from Dutch society, moving house frequently, and a lack of opportunities to learn the Dutch language.
- Lengthy interruption of career as a result of which medical knowledge cannot be kept up-to-date.

2. Ministry of Justice (Department for the Coordination of the Integration of Minorities)

- Integration after receiving a residence permit.
- Until recently, applications for Dutch language courses were arranged by Regional Training Centres (ROCs). In practice, these ROCs placed highly educated newcomers together with illiterate newcomers in non-differentiated groups. In the past, the extensive expertise of university language institutes has been used insufficiently with regard to highly educated newcomers. The referral of highly educated newcomers to university language institutes would mean a substantial improvement for both students and trainers.
- The final level of Dutch reached in the integration procedure is neither sufficient for further studies at university (SCP/WODC/CBS, 2005) nor for participation in the assessment procedure.

3. Ministry of Social Affairs and Employment

- The benefits agency aims to guide people to the labour market in accordance with the Work and Social Assistance Act. To this end reintegration advice was composed by the Centres for Work and Income.

⁴⁹These numbers refer to all refugee students supported by the UAF, not exclusively to refugee doctors.

- The authority to grant benefits has been decentralised to municipal level. As a result, different towns may have different interpretations of the Act regarding the permission for studying while retaining benefit.⁵⁰ Refugee students who want to study while retaining their benefit have to convince the municipal Social Services that they have to prepare for the assessment procedure. Subsequently, they will have to argue that they need time to prepare for the General knowledge and skills tests and the Medical knowledge and skills tests. After that, the length of the additional training programme will be decided. In all, this will take a minimum of two and a half years (one year of preparation, one year of testing and six months of additional training) and a maximum of five years (one year of preparation, one year of testing and three years of additional training).⁵¹

4. Department of Health, Welfare and Sports

- The preliminary programme of the assessment procedure for foreign doctors starts with the preparation for the State Exam Dutch as a second language (programme 2). Over the years it has become clear that preparation for this exam takes at least one year.
- Stage IIA of the assessment procedure comprises several tests (Medical Dutch and communication skills, ICT skills, English reading skills and Knowledge of Dutch healthcare). Candidates have to pass the General knowledge and skills tests within one year of taking the test for the first time. If candidates fail one or more parts of the General knowledge and skills test after this year, they will have to retake all the tests.
- Stage IIB of the assessment procedure comprises tests on medical knowledge and skills. After completing Stages I, IIA and IIB, and after the interview relating to the portfolio, candidates receive advice from the Health Secretary. Candidates who need to follow additional training will be told to follow a programme of six months, or one, two or three years.

The table below shows the main differences between the admission of foreign doctors via the 'old' CIBA route and via the 'new' Department of Health assessment procedure.

⁵⁰In 2004 a motion was tabled in the municipal council of Amsterdam by Sargentini (of the Groen Links party). The text was: "The council, having heard the discussion about the policy framework work and reintegration (...) decides that refugee doctors with residency status who only need to do their internships will be allowed two years to finish their studies while retaining their benefits, in order to stimulate these doctors to find work in Amsterdam after graduating" (Kagie, 2004).

⁵¹For the sake of convenience, we assume that the educational institutes offer additional training programmes that correspond with the advice given by the Health Secretary; whether this assumption is correct remains to be seen.

Table 10.1: Comparison of the old situation and the current situation regarding the admission of foreign doctors to the Netherlands

CIBA (1996-2006)	Department of Health (from 2005)
The doctor is a 'client' of a university with a medical faculty	The doctor is a 'client' of the Department of Health, not yet of a medical faculty
Preliminary programme at a university	No preliminary programme for general tests
The doctor is a 'client' of student counsellors/deans	The doctor is not a 'client' of student counsellors/deans
Inclusion in the study of medicine based on: <ol style="list-style-type: none"> 1. Foreign doctor's diploma 2. Exam Dutch as a second language (programme 2) 3. Compelling reasons 	Inclusion in the study of medicine based on assessment procedure: <ol style="list-style-type: none"> 1. Exam Dutch as a second language (not unequivocally required) and Medical Dutch 2. English reading skills 3. ICT skills 4. Knowledge of healthcare 5. Basic medical knowledge 6. Clinical knowledge 7. Clinical skills 8. APL portfolio (work experience of previous five years)
Medical Dutch course after admission to study of medicine; paid for by the faculty	Medical Dutch course preceding assessment procedure; paid for by the applicant
Medical knowledge tested after admission to study of medicine	Medical knowledge tested before admission to study of medicine
Additional training programme of nearly always 3 years	Training programme ranging from 6 months to 3 years, depending on the outcome of assessment procedure
Category II doctors: no admission to CIBA procedure	Category II doctors: admission to assessment procedure; in other words ending of this 'obscure' category
Inclusion programme depends strongly on admission by faculty	Inclusion programme independent of admission by faculty
Cost of CIBA procedure: nil	Cost of assessment procedure: €2200; paid for by applicant
Preparation time: unlimited	Completing General knowledge and skills test: within one calendar year. Candidates who fail to achieve this, can do a retake in a later year. Items that have already been passed expire, and the test has to be paid anew.
Some municipal Social Services allow studying while retaining benefit	It is still unknown how Social Services will deal with requests by foreign doctors to study while retaining their benefit. By the separation of the Department of Health assessment and the future study, it will become more difficult for foreign doctors to convince their Social Service to grant them permission for the assessment procedure and the additional medical training.

10.3.3 Conclusions

The assessment procedure assumes a quick and adequate processing of the recognition request. After entering the procedure, it is possible for a candidate to have finished all the tests within one year. One of the main attainment targets since the development of a new streamline for foreign doctors (Splinter et al, 2003) was to guide foreign doctors quickly through the procedure.

Still, especially refugee doctors can experience serious delays before the assessment procedure actually starts. Asylum procedures of more than five years are no exception. In this period, learning the Dutch language is neither encouraged nor facilitated. Moreover, during a stay at an asylum seekers' centre there are no possibilities for doctors to keep their medical knowledge up-to-date. After gaining resident status, the integration phase starts. In this phase, sometimes valuable time is wasted when highly educated newcomers are placed in heterogeneous educational groups. The final level of Dutch that highly educated newcomers reach at the end of their integration programme is not at all sufficient to follow additional training at a university. With a view to the expertise of university language centres in educating highly educated foreigners, it is preferable to refer foreign doctors during their integration programme to these centres rather than to the Regional Training Centres (ROCs).

There is no integral education programme to prepare candidates who want to take part in the assessment procedure for the General and Medical knowledge and skills tests. The Department of Health gives information on the various tests that are part of the assessment procedure. Neither the Department of Health nor the University Medical Centres feel responsible for the development and organisation of courses in preparation of the tests. Still, the Department of Health could urge educational institutions to develop an integral programme in preparation of the assessment procedure.

The (still missing) preparatory educational programme (stage IIA in the flowchart) is positioned before entry into the University Medical Centres. The support given by student counsellors and/or deans to prospective participants in the CIBA procedure is no longer offered in the new situation. It is unknown whether foreign doctors participating in the assessment procedure can appeal to university services. They can only enrol as university students after they have completed the whole assessment procedure. Only with the inclusion advice of the Health Secretary will they be able to enrol as a student of medicine at one of the eight University Medical Centres.

High fees are demanded for participation in the assessment procedure. Since 2006, the fee for participating (once) has been €2200. These are prices that are out of all proportion for foreign and/or refugee doctors. Consequently, for some foreign doctors these high costs may be a factor that restricts the accessibility of the assessment procedure.

Foreign doctors participating in the assessment procedure are tested on two languages, namely Dutch and English. It takes a long time to learn two languages from scratch. Moreover, it is debatable whether the majority of foreign doctors will ever be able to

succeed in learning two new foreign languages at a high level. In addition, asylum seekers are hardly capable of learning a language during the time they are staying at an asylum seekers' centre. The preparatory programme can take 3 to 5 years, during which time the foreign doctor is not able to keep his original profession up-to-date. The choice for a test of English at a high level (a TOEFL score of 600 or an IELTS score of 6.5) means that there is only limited access to the assessment procedure for a large group of Category III doctors. For many Russian, Iraqi and Afghan doctors, the English reading skills test at such a high level can mean an end to the possibilities of them working in Dutch healthcare. Experience shows that many doctors trained in these countries know hardly any English at all. For foreign doctors who have to start learning English from scratch, the requirement to pass all four General knowledge and skills tests within one year may lead to a situation in which they have to take these tests year after year, and may even lead to them dropping out of the procedure.

Before the Department of Health assessment procedure came into force, foreign doctors followed the CIBA route to gain access to the medical faculties. Municipal Social Services in university cities (and the surrounding municipalities) knew about the inclusion procedures for foreign doctors and the duration of the additional training programmes. It remains to be seen how these Social Services will deal with social security applications by foreign doctors who need to take part in the new assessment procedure (two years of preparation and testing, followed by a training programme of 6 months or 1, 2 or 3 years). A report on the social policies of Dutch municipal authorities by the Federation of Netherlands Trade Unions shows that only 20% of these authorities allow refugee students to obtain a Dutch diploma while retaining their benefits (FNV, 2006). The report states that municipal Social Services choose increasingly for immediate availability for the labour market, with the slogan 'work first'. This short-term policy is at odds with the policy of giving immigrants the opportunity to follow a training programme that builds on their expertise.

On the whole, foreign doctors who have graduated from a medical faculty succeed in finding jobs as doctors (see Chapter 5). Investment by the municipality in a medical study leads to people permanently terminating their benefit. According to the report by FNV, this will lead to an annual saving of €14,000 for each person entitled to social security.

10.4 Conclusions regarding the employment of CIBA doctors

In 2001, a study described whether and how foreign doctors entered the Dutch labour market (Herfs et al, 2005). This concerned only a random sample, but the results were positive: all the foreign doctors who had entered training via the CIBA programme and had graduated found work as doctors in the Netherlands. They did not leave for other EEA countries. Personal remarks made clear that more attention for the Dutch language would be desirable, as well as the recognition of foreign specialisms, the recognition of work experience abroad, and the admission to specialist training. It was considered preferable to determine the level of knowledge with the help of a test or exam; in that case, inclusion would take place based on objective results rather than the standard judgements used until

then, which were based on subjective evaluation of educational documents and testimonials.

In the study of 2001 (Chapter 5), the number of doctors who had obtained a place in medical training was still limited. Only one foreign doctor was found to be admitted to general practice training. The report urged training institutes for general practice to admit more foreign doctors.

The Department of Health was requested to play a central role in the recognition of requests and additional programmes. The department was also asked to develop an objective system for evaluating the knowledge and experience of foreign graduates. The department only reacted when the Hermann motion was passed by Parliament in 2001, which forced the then Health Secretary, Borst, to support universities in the realisation of additional medical programmes for foreign doctors (Categories II and III). At last, the Department of Health took primary responsibility for foreign doctors from the end of 2001.

In 2004-2005, research was again conducted into the careers of so-called CIBA doctors (see Chapter 5); this time it was not commissioned by the Medical Sciences Board (DMW), but it was part of the research for this doctoral thesis. The cohorts of foreign doctors who graduated in the periods 2000-2001 up to and including 2003-2004 were contacted with the request to provide information about their medical career after graduation. The total number of doctors who graduated was 191, of which 69 (36%) responded; this can be regarded as a reasonable response for social science research. The results were more positive than in 2001. All the doctors had succeeded in finding a job, and more doctors were following specialist training. This time 13 doctors (19%) were following general practice training. This increase may be attributable to an improvement in attitude and a better command of the Dutch language. The doctors participating in the first career study (Herfs et al, 2005) had not been able to use the course manual *Dutch for non-native doctors* (PalensteinHelderman-Susan et al, 2000), as this manual was not yet available then. Nearly all the foreign doctors participating in the second career study (Chapter 5) participated in the course Dutch for non-native doctors after having passed their exam Dutch as a second language (programme 2). A number of foreign doctors felt that still more attention should be given to Dutch language skills, even though there is now a course manual *Dutch for non-native doctors* and it is obligatory to follow a Medical Dutch language course for all doctors entering a higher year of the study of medicine at a University Medical Centre. When doctors were asked about their work as doctors, they often mentioned language problems. From the telephone interviews, it became clear that some doctors had even taken private language lessons (writing or speaking in Dutch) on their own initiative after graduating. Other doctors made creative use of their near colleagues (doctors, nurses, secretaries) to improve their command of the Dutch language. The answers in the questionnaires and reactions during the interviews made clear that foreign doctors are aware of the great importance of a good command of the Dutch language. Even after graduating as a doctor, many of them actively try to improve their Dutch language skills.

From the international comparison (see Chapter 6 and Appendix 7), it has become clear that the pre-assessment stage of the additional training programme for foreign doctors in the Netherlands (and in Flanders) is considerably longer than in most other European countries. On the other hand, this longer additional programme means that participants find work as doctors in the Netherlands sooner. Several foreign doctors remarked that they had already been approached by their current employers during their internships.

The longer training programme means that there is more time to work on the command of the Dutch language and that possible barriers for employers to appoint a foreign doctor can be removed.

In 2004, the national Temporary Committee on Integration Policy published a report in which 30 years of integration policy was qualified as “wholly or partially successful”. This conclusion was contested by four Dutch political parties (CDA, VVD, LPF and SP), who characterised this conclusion as a complete denial of the problems regarding the Dutch multicultural society. After a visit to the Netherlands and several discussions with top civil servants from the Ministries of Education and Justice, a member of a similar French advice committee, J. Costa-Lascoux, talked of “the total failure of the integration of ethnic minorities” (NRC, 2 February 2004).

Nevertheless, there are also some positive conclusions to be drawn. A large number of foreign doctors (refugees and doctors with a Dutch partner) have found work as doctors in the Netherlands as a result of the establishment of the Committee for the Influx of Foreign Doctors (CIBA) and the development of the language course *Dutch for non-native doctors*. Neither is mentioned in the report ‘Building bridges’. This is due to the fact that the activities of the medical faculties on behalf of foreign doctors took place beyond the range of the department responsible for minority policies. Something similar can be said about the researchers of the Verwey-Jonker Instituut, who conducted research into the integration of minorities which was commissioned by the Temporary Committee of Integration Policy mentioned above. Apparently it is easy to overlook successful initiatives undertaken by non-ministerial bodies.

10.5 Discussion of the policies by the Department of Health regarding foreign doctors in the multicultural Netherlands

In the past 20 years, the Netherlands has been confronted with an increasing number of newcomers, including doctors trained abroad. In the early 1990s, they became part of Dutch healthcare via individual arrangements. Later, the inclusion of foreign doctors in medical training programmes changed as a result of the strong alterations in the origin, culture and education of this group as well as growing differences between the Dutch/European medical training and practice and the training and practice experienced by these doctors. The medical faculties were responsible for the implementation of the inclusion of foreign doctors. There has only been some coordination since 2002 (Splinter committee), and since December 2005 the inclusion takes place in accordance with a new assessment procedure (Chapter 9). There is still no European coordination whatsoever.

This doctoral thesis on the inclusion of foreign doctors in Dutch healthcare describes a period of 20 years in which global politics were characterised by some major problem areas and hotbeds. In the early 1990s, a relatively large number of doctors arrived from the former Soviet Union, the former Yugoslavia and Romania. From 1995 the influx from countries such as Iraq and Afghanistan increased sharply, and since the year 2000 there has been a strong increase in doctors from South Africa. The data from Chapter 8 show that

there are still doctors from the former Soviet Union who apply to the Health Secretary for recognition, but now they do so no longer as asylum seekers or refugees but as people with Dutch partners. The characteristics of foreign doctors have changed as a result of the changes in their countries of origin; for example, doctors from Romania, Yugoslavia and the Soviet Union, often with a Christian background, were characterised by a culture which was not fundamentally different from the Dutch culture. Language problems were not the main issue. If a foreign doctor did not speak Dutch fluently, communication was possible in German, French or English. In addition, these doctors usually learnt Dutch quickly. The main differences with these eastern European doctors were found in the quality of the education; for example, they often had less experience with advanced pharmacotherapy and/or high-tech equipment. Also, the manner of dealing with gender differences between doctors and patients were not fundamentally different from the situation in the Netherlands. In addition, the faculty members involved in this inclusion became more and more experienced with the different levels of the individual foreign medical training programmes. For example, they knew what the differences were between most Russian faculties and also that, due to their relative subordinate position in their country of origin, Hungarian-Romanian doctors functioned better and picked the language up quicker than ethnic Romanians. After all, they had also been selected in Rumania because they provided extra quality; they had to perform better than others. These factors played a role in the inclusion procedure.

From the mid-1990s, cultural differences became more apparent. The foreign doctors now came from Islamic countries that were conservative to a greater or lesser extent. Subsequently, at the medical faculties there were increasing doubts about the level of education. For example, some doctors had only very basic knowledge of physiology and anatomy, and knowledge of cellular biology and genetics was often completely absent. Moreover, in contrast with the situation with the Eastern European doctors, acquiring the Dutch language was found to be a serious problem. Communication in other European languages was mostly impossible. Often there was not even elementary knowledge of the English language (which was sometimes considered 'the language of the devil'); for example, Afghan doctors used Russian medical textbooks. For some time this was accepted due to the Dutch political climate, which was characterised by the tendency not to discuss thorny issues. It was only after 2001 that the language course Medical Dutch was made obligatory in addition to Dutch as a second language (programme 2); however, this was not even the case for all faculties. Increasingly the educators communicated that the inclusion of these foreign doctors was problematic. Besides language problems, there was also the totally different attitude. In European training programmes it is usual that doctors learn to question their own knowledge and skills; in Islamic countries such an attitude is often seen as a sign of weakness and ignorance. In addition, asking questions during training is seen as a lack of knowledge.

There were also quantitative differences. For example, an Afghan ophthalmologist was found to be an expert at operating cataracts but unable to perform ophthalmoscopy. In foreign doctors this sometimes led to feelings of bitterness or even anger about the apparent denial of their qualities by their Dutch trainers. This was an attitude that was not experienced with the Eastern European doctors. Especially with Afghan doctors, dealing with gender differences between doctor and patient was found to be completely different from what is usual in the Netherlands. In several countries, people feel differently about nakedness in the relationship between doctor and patient. The article 'Naked' describes

how in Afghanistan (under Taliban rule) a male doctor examined a female patient from behind a partition made of frosted glass with a small square hole in it (Gawande, 2005).

Simultaneously, there was also a change in attitude in Dutch society towards the 'new Dutch people'. In January 2000, a manifest was published on the multicultural drama, which presented a warning for the major problems in the multicultural Netherlands (Scheffer, 2000). The problems that were indicated here had been taboo subjects for a long time. In as early as 1992, Bolkestein had already tried to open the discussion of the growing cultural differences within Dutch society, but he was denounced by both the political left and the political right. Criticism of the multicultural society was often regarded as a right-wing viewpoint. It is remarkable that it was Scheffer, who was involved in the left-wing PvdA, who eventually succeeded in starting the discussion of the multicultural society. One of the things Scheffer described in this article is the idea expressed by some people that when Amsterdam had a Jewish mayor, Muslims did not have to conform to the laws of the city; after all, the city was governed by a Jewish person. In a similar vein, in the year 2000 an Iraqi (Islamic) student doctor refused to examine a Jewish patient during his internship.

After the equivalence of foreign doctors' diplomas had been evaluated by NUFFIC, it was expected that the Department of Health would coordinate subsequent procedures and play a key role. Nevertheless, the department only started to play such a role when it was forced by a parliamentary motion on 6 December 2001. In previous years, the Dutch government had not been overly interested in foreign doctors trained outside the EEA. The majority of recognition requests submitted to the Health Secretary resulted in negative decisions. An international comparative study (Chapter 6) shows that during the same period Scandinavian countries, the United Kingdom and Germany had a much more positive view of foreign doctors and their diplomas than the Netherlands. Moreover, there is no discussion, let alone coordination, at a European level. Doctors' diplomas on the list of the World Health Organisation are recognised in the United Kingdom and the Scandinavian countries, but not in the Netherlands.

In 2000-2001, there were only a few foreign doctors following specialist training, and only one doctor had been admitted to general practice training. An exceptional (and missed) opportunity for policy development occurred during the Kosovo crisis (2000-2001). The Dutch authorities devised an emergency plan to take in thousands of expected asylum seekers and allocated three asylum seekers' centres for this: Ermelo, Raamsdonksveer and Ter Apel. At the Department of Health it was feared that there would be insufficient general practice care at these centres. The local general practitioners who had admitted people from these centres to their own practice had communicated that they were unable or unwilling to meet the increased demand for medical care. Not only logistic aspects played a role, but also financial aspects. It became clear from consultations between some parties in this process⁵² that some of the care at the asylum seekers' centres could be given by foreign doctors, often compatriots of the other asylum seekers; this was to take place under the supervision of the local general practitioners. After a certain period of working at an asylum seekers' centre, these foreign doctors were to obtain a training place in general practice

⁵²The then Healthcare Inspector for Minorities of the Department of Health, Voogd, organised an emergency meeting with Haalboom (University Medical Centre Utrecht) and Herfs (CIBA), and with Hermans, who was responsible for regulations regarding medical expenses of asylum seekers.

training. A classic example of a win-win situation: healthcare in the asylum seekers' centres was ensured, and the foreign doctors could gain experience in Dutch healthcare and become a permanent part of it. It is important to remark that in January 2001 the Medical Sciences Board (DMW; see section 5.5) recommended that more CIBA doctors were admitted to general practice training. At that moment only one CIBA doctor had been admitted to such training. The proposal was rejected by the Registration Commission for General Practice and Nursing Home Doctors (HVRC) on the grounds of its discriminatory character; after all, a distinction was being made between foreign and Dutch doctors. This way of thinking was totally in line with the politically correct way of thinking prevalent at the time. The win-win situation, as described above, was not recognised as such by the HVRC. Moreover, doubts were cast on the results of the DMW study. It was claimed that research by the HVRC had shown that 10% of general practitioners in training were foreign. However, the closer look at the category 'doctors participating in general practice training who come from abroad (by country of origin and doctor's diploma)' made clear that this group also contained Dutch and EEA-doctors with foreign testimonials. Dutch citizens with a Turkish or Moroccan background were probably also considered 'doctors who come from abroad'. Thus the HVRC unintentionally confirmed that of the total number of general practitioners in training on that particular day (1,018 on 1 March 2001) less than 1% had a non-EEA education and a non-EEA nationality. When the Kosovo crisis came to a sudden end in the spring of 2001, no more attention was given to the proposal to use CIBA doctors for the provision of general practice care in asylum seekers' centres. Without any further communication the emergency consultations were discontinued.

It is surprising that in a period with an expected shortage of doctors in the Netherlands, a group of doctors was treated so carelessly. In 2003, the Splinter report (see Chapter 3) emphasised that the assessment procedure should lead to a considerably faster processing of the influx of foreign doctors in education or the labour market. It was a particularly undesirable situation that foreign doctors sometimes had to spend more than five years waiting for residential status and completing their preparatory programme (including a Dutch language course with participants comprising both barely literate and highly educated immigrants). For the speed of the processing of residence permit applications, the Department of Health and the medical faculties are dependent on the Ministry of Justice. It can only be concluded that in previous years the Dutch government (Ministries of Justice and Health) mainly created barriers for foreign doctors, and opposed outside organisations that tried to support such doctors. Repeatedly, initiatives and incitements to policy-making were not granted. For example, in 1997 a report was published by Govaerts and Wijnen (Maastricht University). This report, commissioned by the Department of Health, was made public only after a journalist appealed to the Government Information Act. It contained serious criticism of the practices at the Department of Health regarding foreign doctors. This report already advised introducing a knowledge and skills test (see Splinter Committee). These recommendations were ignored by the department.

Subsequently, in 1998, invited by the Department of Health, Haalboom and Herfs advised introducing a central training institute for foreign doctors (as a caricature this institute was referred to as *Woerden University*). This would contribute to the expertise regarding the diploma evaluation, which had been very fragmented until then. In addition, it would be possible to have doctors follow differentiated educational programmes, thus ending the non-equivalent inclusion programmes that the different faculties imposed on foreign doctors. This advice was also pushed aside; it has never been referred to again.

The proposal to develop a central training institute was neither new nor unique. In Scandinavia such a model has been used to great satisfaction (see Chapter 6). In 1998, at the end of her internship with the Department of Health, Altink-De Beer made a case for a central training institute. In addition, she argued for the introduction of a knowledge and skills test to establish the equivalence of the different studies. Moreover, she found that there was a strong increase in the rejections of recognition requests, and that these increasingly led to legal procedures. "Although the assessment of the application considered individual circumstances and every person's individual qualities, the decisions that were based on these amounted more or less to categorical rejection."

In 1999, Brunink also advised the establishment of a central training institute. Subsequently, for all applicants there was to be a preparatory year with a number of common, obligatory subjects and specifically Dutch subjects, including jargon and culture. A test was to bring to light any gaps in the doctor's medical knowledge; this test was to determine the inclusion of the foreign doctor in medical training. The advice by Altink-De Beer and Brunink on the introduction of a knowledge and skills test and the establishment of a central training Institute was not followed (Altink-De Beer, 1998; Brunink, 1999).

No follow-up at all has been given to any of these four pieces of advice, which were probably not equally important regarding weight and social support. This may be explained by the fact that at all government departments there was a climate during the mid-1990s that was extremely hostile towards asylum seekers. It is likely that this was related to this idea published in the Outline Document on Integration Policy regarding Ethnic Minorities: "The Cabinet concludes that the future is extremely worrying. The reasons for this concern are a stagnant economic development and continuous integration - especially of asylum seekers - and their far-reaching consequences for the social support for our policies" (Ministry of Home Affairs, 1994). Every policy proposal, from whatever ministerial department, that might be interpreted by potential asylum seekers as an incentive or an invitation to choose the Netherlands as their country of destination was immediately cast aside if an employee spoke the dreaded words 'encouraging effect'. The thing that external advisers, interest groups and internal trainees could not bring about was eventually enforced by Parliament (the Hermann motion), which ordered the Department of Health to develop a policy regarding foreign doctors in cooperation with the medical faculties. As a result, the Splinter Committee was established. Nevertheless, it was only as late as December 2005 that the new assessment procedure for foreign doctors came into force.

10.6 Suggestions for further research

10.6.1 Suggestions for an international comparative study

Chapter 6 (and Appendix 7) describes an international European comparative study on national and university policy on the influx of foreign doctors trained outside the European Economic Area. It was found that there was hardly any knowledge about the policies in

other EEA countries regarding these doctors. In country A there was no knowledge about the procedures in countries B and C and vice versa. It was also found that there was a great demand for an international publication on this comparison. This idea was also communicated by the *Comité Permanent des Médecins Européens*, the umbrella organisation of national doctors' organisations in Brussels.

The Dutch assessment procedure is based mostly on what happens in the United States, i.e. the USMLE, and to a much lesser extent on what happens in the other EEA countries. The additional programmes (theory and practice) that are offered to foreign doctors in Denmark, Norway, Sweden and Austria have not been involved in the procedure. Such programmes can be completed in 12-18 months. In the United Kingdom, foreign doctors can pass the Professional and Linguistic Assessment Board Exams 1 and 2 after an average preparation time of 18 months. There is no reason to assume that foreign doctors perform worse in these countries than in the Netherlands, where an additional training programme lasts approximately 3 years.

From 1 December 2005, all doctors trained outside the EEA who want to work in Dutch healthcare have to follow the assessment procedure. For medical specialists trained outside the EEA, having to follow this assessment procedure may have serious disadvantages. They may have very specialist knowledge and still perform poorly on the Medical knowledge and skills tests. It is worth considering developing exams specifically for medical specialists, like in France, the United Kingdom and Sweden (see Chapter 6 and Appendix 7). To gain access to such an exam, a candidate may be asked to prove that he has worked as a medical specialist for a minimum of five years (for example), besides submitting diplomas and other documentation. Medical specialists who do not pass this specific exam may later still participate in the assessment procedure.

Incidentally, in the past it has been found repeatedly that the term 'medical specialist' can be rather confusing. For example, the Splinter report described a gynaecologist who had been trained in Afghanistan and whose expertise was comparable to that of a Dutch obstetrician. An international follow-up study could specifically examine which best practices have been developed for medical specialists.

It should be described how countries that were part of the EEA until 1 May 2004 deal with foreign doctors trained outside the EEA. The European Commission may well be interested in this follow-up study. Alignment of the policies regarding migrant foreign doctors (from outside the EEA and from the 'new' EEA countries) is certainly desirable. The study in Chapter 6 can be seen as a pilot study on behalf of more extensive research into the policies of the 19 'old' EEA countries. It could be investigated how foreign doctors' and specialists' diplomas are evaluated, and how work experience could be taken into consideration in the evaluation of foreign testimonials; APL procedures may also play a role in this. In addition, it could be examined how the different EEA countries determine the level of medical knowledge and skills. Finally, it is important to establish what level of language skills the country of destination demands, and how foreign doctors achieve that level.

10.6.2 Suggestions for a study on the accessibility of the assessment procedure

The Department of Health and the medical faculties have gone to great lengths to develop a reliable high quality system to objectively assess the level of foreign doctors trained outside the EEA. In Chapter 7, foreign doctors who had been admitted via CIBA in 2004 and 2005 assessed their own competencies at the start of their additional medical training; these competencies would have been tested explicitly in the new assessment procedure. Section 10.3 described the preconditions for a successful implementation of the new assessment procedure. It was found that the results were mediocre in the first nine assessment sessions. The evaluation study by Schmitt Jongbloed and Duchatteau (2007) has provided too few relevant data. The follow-up study into the influx of foreign doctors from the moment the assessment procedure came into force (see Chapter 9) until 2010 shows that foreign doctors are effectively being excluded. In those four years, only 19 foreign doctors were admitted for additional studies at one of the Dutch medical faculties.

It is of great importance to determine from the start of the assessment procedure how many candidates apply, how many candidates complete the procedure within 12 months, and how many candidates do not succeed in that and for what reasons. Special attention needs to be given to the viewpoints of the municipal Social Services with regard to granting foreign doctors permission to participate in the assessment procedure (two years) and the additional training programme at a medical faculty (six months to 3 years) while retaining their social security benefits.

It is also important to evaluate whether the fixed programmes (six months, or 1, 2 or 3 years) are sufficiently differentiated and whether they are in accordance with the ideas of the education committee responsible for the additional training programme. It cannot be ruled out that due to the educational structure (modules) of the medical curriculum it will be impossible to complete some programmes within the appointed time (of six months, or 1, 2 or 3 years). Of course, the medical faculties will have to be made to comply with their instructions to offer additional training programmes in accordance with the training duration laid down in the advice by the Health Secretary.

In this chapter the main conclusions of the previous chapters are listed.

In chapter 1 the investigation focuses on the recognition and admission procedures for foreign doctors (educated outside the European Economic Area (EEA)). From the early nineties the number of foreign doctors residing in the Netherlands either as refugees or as family reunifiers has risen steadily. Foreign doctors who wish to practise medicine in the Netherlands must obtain a declaration of professional competence, issued by the Department of Public Health, Welfare and Sports (VWS). A considerable number of foreign doctors, trained in and having the nationality of countries outside the European Economic Area, have requested recognition and received negative decisions by the Health Department. They are not allowed to practise medicine in the Netherlands. As a result, from the mid nineties, a growing number of foreign doctors applied to the medical faculties for admission as medical students in order to obtain a Dutch medical degree. Therefore, in 1995, it was decided to institute the *Commissie Instroom Buitenlandse Artsen* (CIBA), a central placing committee for foreign doctors. Between 1996 and 2007 the CIBA has processed over a 1000 admission requests. Until 2002, in spite of the imminent shortage of doctors, the Department of Health had done little to enhance the use of the expertise brought in by the foreign doctors for the benefit of Dutch society.

The focus of this investigation has been: 1. How is guaranteed that foreign doctors meet the medical quality standards (knowledge, skills, attitude), or how is the assessment of these qualities measured. And 2. After obtaining permanent residency in the Netherlands, do foreign doctors, trained outside the EEA, have access to the profession for which they had qualified before in their country of origin or another non-EEA country? More specifically, the obstacles have been researched that foreign doctors run into when attempting to gain access to the Dutch public health market and/or required additional training programmes.

In chapter 2 international research about International Medical Graduates (IMGs) is described. This chapter describes the effects of large-scale migration of IMGs to Australia, Canada, the United Kingdom and the United States of America. Chapter 2 contains a study into the effects of the brain drain for source countries (i.e. the IMGs' countries of origin) and the brain gain effects for host countries. Many international medical graduates (IMGs) leave their country of origin for economic reasons. They try to settle in a new country, where they might have more opportunities (medical career, further medical education, wealth and a welfare system etc.). In most cases the IMGs leave a poor country to settle in a rich country. On the basis of literature studied we found a dichotomous distribution between countries in which public health is dependent on the influx of IMGs and those where public health is in no way dependent on IMG influx. In Australia, Canada, the United Kingdom and the United States of America public health is dependent to a large extent upon the influx of IMGs. At least 20% of the medical workforce in these countries have obtained their medical degrees outside the host country. Over the years these countries developed sophisticated assessment procedures for IMGs.

In chapter 3 a comparison is made between the UK, a country with large-scale IMG-migration, and the Netherlands, a country with small-scale migration of IMGs. Of all the doctors in practice in the United Kingdom, 31% were educated outside the UK, as compared

with less than 5% in Germany and France. The aim of this part of the study is to present data comparing the ratio of medical doctors per 100.000 citizens in Western countries and in those countries from which IMGs originate, i.e. their source countries. The influx of IMGs in the Netherlands is described in detail. Most EEA-countries have a ratio of doctors of about 300 per 100.000 citizens. In the UK the ratio of doctors is 230 per 100,000. The doctors' density explains the high influx of IMGs in the UK. Most IMGs in EEA-countries are there either as refugees or as spouses/partners of EEA-citizens. In the UK IMGs migrate in the first place as doctors. In new EU-countries (e.g. Hungary and Poland) there is a fear that many medical doctors might leave their countries of origin and move to countries with higher standards of living.

Chapter 4 contains the relevant (national) documentation on foreign doctors published after 1990. In 1993 the rules and regulations concerning non-EEA doctors was greatly amended. That year, the Department of Health issued a new set of rules which put a stop to the practice of health care employers taking on non-EEA doctors without having had their medical degrees evaluated and judged sufficient by the Department. In 1997 the Individual Health Care Professions Act came into force. It was devised to regulate quality control in the Health Care sector. Any doctor, either foreign educated or not, can only practise medicine in the Netherlands after having registered with the so-called *BIG-register*. The department of Education Development and Research of Maastricht University carried out an evaluative investigation into the procedures foreign doctors and dentists had to follow. On the basis of their findings, the Maastricht researchers strongly advised to revise the entire recognition procedure and to implement knowledge and skill tests similar to the ones in use in the United Kingdom and the United States of America. In the years 2001-2003 several documents were published aimed at streamlining the additional programmes for foreign doctors. Late 2001, as a result of the motion Hermann being passed in Parliament during the Health budget deliberations, the Department of Health and the medical schools were stimulated to cooperate in order to improve the additional training programmes for foreign doctors. This motion led to the new assessment procedure for foreign doctors that came into force in December 2005.

Chapter 5 contains a study on the medical careers of foreign doctors. Between early 2000 and late 2004 191 foreign doctors graduated and completed a Dutch medical degree. The overall results were positive. 65 out of 69 doctors (response rate 36%) that responded had found a job in their profession within three months. The other four needed more time, but all of them found a job as a doctor and they had all registered with the *BIG-register*. There were, however, some significant differences with regard to the investigation of 2000. 41 foreign doctors (59%) had gained access to a specialisation programme, 13 of which in the general practitioners programme. To the question which had hindered them most in their medical careers, again, many reported that the Dutch language was their main obstacle, for which they have found a number of creative solutions (invoking the help of secretaries, having interns check their written reports, using the spelling checker on the computer, etc.). A number of foreign doctors took private language lessons, during which special attention was paid to improving their writing skills.

Chapter 6 contains a comparative study into the policies towards medical doctors, trained outside the European Economic Area (EEA) in ten EEA-countries. The following countries were involved in this study: Austria, Belgium, Denmark, France, Germany, the Netherlands, Norway, Spain, Sweden, and the United Kingdom. The results show that there are

enormous differences between the respective countries. One of the most conspicuous differences was the role of the Departments of Health in the evaluation of foreign medical degrees. In the Scandinavian countries, the United Kingdom, and Germany, the assessment of foreign medical degrees is primarily the responsibility of the respective Departments of Health. The universities in the Scandinavian countries organise additional training programmes for non-EEA doctors on special request by their Departments of Health. In these countries the relation between the Departments of Health and the universities is, in building industry terms, comparable to the one between a (main) contractor and a subcontractor. In Denmark, Norway and Sweden only one university per country organises these additional training programmes for non-EEA doctors. In Austria, Belgium, France, Germany, the Netherlands, and Spain, upon receiving a negative answer to a recognition request a foreign doctor can apply for admission to any medical school or university. The universities are absolutely autonomous in dealing with these requests. The additional training programmes differ greatly in duration. The shortest additional training programmes were found in the Scandinavian countries and Austria (12-18 months), whereas the longest ones (24-36 months) were found in Belgium and the Netherlands. In 2005, both France and the Netherlands introduced entirely new assessment procedures. The primary responsibility for these procedures has shifted from the universities to the Departments of Health. In all participating countries it was deemed very important for the migrating foreign doctor to have mastered the language to a sufficient degree. The study reveals that the participating EEA-countries are largely unaware of the assessment procedures regarding non-EEA doctors in other countries.

Chapter 7 describes the self-evaluation of professional competencies by foreign doctors who entered the medical programmes before the new assessment procedure came into force. With the coming into force of this new procedure, the previous procedure (via *CIBA*, a medical schools network) was abolished. The last group of foreign doctors assigned via *CIBA* started their additional programmes in september 2006. As from 2007 all (new) incoming foreign doctors will follow the new VWS assessment procedure. It seemed interesting to ask the foreign doctors who had started their additional training in 2004 and 2005, in view of the competencies that are specifically tested in the VWS assessment procedure, for their opinions about their own competencies at the beginning of their medical programmes in the Netherlands. In 2006 all 157 foreign doctors who, in 2004 and 2005, had started at one of the eight medical schools were presented with a questionnaire with a 5 point scale. The response rate was 68%. The medical schools had reported earlier on the doubts the medical staff had about the competencies of the foreign doctors as to a number of the elements that are tested in the assessment procedure. Therefore, it was interesting to investigate whether the foreign doctors agreed with the opinion expressed by the medical staff on their shortcomings. The results show that the foreign doctors who were admitted via the *CIBA* procedure were positive about their competencies. The average score on all variables was 4.09, indicating that the foreign doctors think their competencies were reasonably compatible with the demands of the Dutch health care system.

In chapter 8 study problems of international medical graduates during their additional medical training in the Netherlands have been described. They were not studied systematically before. In the last decade more than 1000 international medical graduates, whose medical degrees are not recognised, applied for admittance to medical schools in the Netherlands. Some 90% of them were actually admitted. We made an inventory of the types of problems and the frequency of their occurrence for all 99 international medical

graduates entering five Dutch medical schools in 2002 and 2005 as reported by the study advisors. Problems were reported for 38% of the foreign graduates, while the majority (62%) had no problems. Language problems and problems related to deficiencies in medical knowledge and skills were reported most frequently. In 2002, the majority (71%) of international medical graduates had a background as a refugee, while in 2005 the majority (57%) had a visa to stay with their spouses or partners. Apart from study-related problems, there were also problems related to the phase of life of the students, whose average age on entering medical school was 35 years, such as problems in obtaining a study grant, housing problems and the responsibility for a partner and/or children. Continuous attention for mastery of the Dutch language is important. Furthermore, counselling expertise relating to foreign medical graduates should be maintained among study advisors in order to meet the specific needs of these students.

Chapter 9 is an evaluative study into the results of a new Dutch assessment procedure for International Medical Graduates. In December 2005 a new assessment procedure came into being. A comparison of the former and new procedure was made. Under the new assessment procedure a far greater number of IMGs have failed to gain acceptance into the Dutch healthcare system. Two factors account for the disappointing results:

- 1) the lack of bridging courses
- 2) the level of the language exam

The responsible authorities are advised to redress the consequences of a failing system.

In chapter 10 general conclusions are presented. In paragraph 10.2 the methods used by the Department of Health to evaluate foreign medical degrees was reviewed. The conclusion reached is that in many cases the results of the evaluation of foreign diplomas by the department turned out to be more negative than they would have been in the United Kingdom, the Scandinavian countries and Germany. An important part in this underevaluation of foreign medical diplomas by the Department of Health was played by the NUFFIC section of Diploma Evaluation and Certification.

Paragraph 10.3 offers a preview of the preconditions of a successful implementation of the new assessment procedure. The first pleas for the introduction of an objective method to determine the level of knowledge and skills of foreign doctors who want to practise medicine in the Netherlands were made more than five years ago. The completion of the new procedure is a joint accomplishment of both the Department of VWS and the medical schools. However, the "old" pitfalls still exist and new ones are looming on the horizon. One of those "old" pitfalls, and one that neither the Department of Health nor the medical schools can influence to any extent, are the endless procedures asylum seekers and refugees are confronted with. As long as asylum seekers have no formal status, it is virtually impossible for them to learn Dutch or keep their professional knowledge and skills up-to-date. Whereas in the developmental stage of the assessment procedure the medical schools and the Department of Health go for speed, valuable time is lost in the earlier preparatory stages (asylum procedure and integration programme). New pitfalls are the lack of intermediate education or preparatory courses (*NT2-II*, Medical Dutch, English, computer skills), the high costs of the assessment procedure, the lack of any link between the procedure candidates with a university, and the pressure the candidates are under to pass the basic tests in time. As yet it is not clear whether in the future local social services will allow foreign doctors to study while receiving social benefits.

Paragraph 10.4 sheds more light on the career surveys/investigations (chapters 5 and 6). They show that foreign doctors succeed in finding jobs in their profession once they

complete the additional medical training programmes successfully. It is probably due to the availability now of a special course Medical Dutch for non-native speakers, that the number of foreign doctors being admitted to the specializations, among which the GP-programme, has increased. In times when the positive experiences with the integration of ethnic minorities are rarely highlighted, the successful integration of foreign medical doctors deserves more attention.

Paragraph 10.5 describes the policy of the Department of Health in multicultural Netherlands in the last 20 years. It shows that the role of the department concerning international medical graduates was never a very active one. The Department of Health was forced to coordinate additional training of international medical graduates at medical schools by a motion of the Lower House in December 2001.

Paragraph 10.6 describes the evaluationstudy (quick scan) which was done by order of the Health Department. It appeared however that the results did not have much of an empirical basis.

Finally, in paragraph 10.7 two proposals for further investigation have been made. The first one is to investigate within the European Union the policies of the EU-countries towards non-EEA doctors and specialists, an investigation that might lead to the harmonisation of the policies towards non-EEA doctors. The second proposal concerns the evaluation of the assessment procedure. An evaluative study should focus on the accessibility of the procedure. During the General Deliberations in Parliament on labour market policies and foreign educated Health Care workers that took place on 1 June 2006 Health Secretary Hoogervorst stated that he would see to it that such an investigation be held.

References

- Altink-de Beer, C. (1998): *De erkenning van buitenslands gediplomeerden volksgezondheid; een verkenning van regelgeving, gronden, procedures en praktijk*. Afdeling Gezondheidsrecht van de Faculteit der Rechtsgeleerdheid van de Rijksuniversiteit Leiden. Leiden.
- André de la Porte, H. en Zegveld, L. (1995): *Het Europa van de student; Studentenmobiliteit binnen de Europese Unie*. In: Aers Aequi, jaargang 44-9.
- Andrew, R., and Bates J. (2000): *Program for licensure for international medical graduates in British Columbia: 7 years' experience*. In: Canadian Medical Association Journal; 162 (6): 801-3.
- Arkel, P. v. en Engelkes E. (2003): *Gevluchte arts van wachtkamer naar spreekkamer; een onderzoek naar de mogelijkheden van een efficiëntere instroom van gevluchte artsen in de Nederlandse gezondheidszorg*. Stichting voor Vluchteling-studenten UAF; Utrecht.
- Australian Medical Workforce Advisory Committee (2004): *Annual Report 2003-04*. AMWAC Report. Sydney.
- Baehr, L.D., Konrad T.R. and Miller J.S. (1999): *The need of community health centers for international medical graduates*. In: American Journal of Public Health; volume 89, number 10, 1570-1574.
- Bekedam, L.M. en Palenstein Helderma-Susan, L.H.M. van (2006): *Hoe zit het met staan? Cursus Nederlands voor anderstalige artsen*. Tweede herziene druk. Bohn Stafleu en Van Loghum; Houten.
- Berlin, A., Gill, P. and Eversley J (1997): *Refugee doctors in Britain: a wasted resource*. In: British Medical Journal; volume 315.
- Bourassa Forcier, M., Simoens, S., Giuffrida A. (2004): *Impact, regulation and health policy implications of physician migration in OECD countries*. In: Human Resources for Health; 2:12. <http://www.human-resources-health.com/content/2/1/12>.
- Bruning, J.M. (1999): *De integratie van buitenslands gediplomeerde artsen in de Nederlandse gezondheidszorg*. Instituut voor Sociaal Economische Geschiedenis van de Faculteit Letteren van de Universiteit Utrecht. Utrecht.
- Butler, B. and Eversley, J. (2005): *Refugee Doctor Programme Evaluation Network (UK); More than you think: refugee doctors in London: their numbers and success in getting jobs*. United Kingdom, London.
- Cain, F.E., Benjamin, R.M. and Thompson, J.N. (2005): *Obstacles to maintaining licensure in the United States*. In: British Medical Journal; 330: 1443-1445.

Cate, Th.J. ten, Kooij, L.R. (2008): *Artsen met een buitenlands diploma in de Nederlandse patiëntenzorg: de nieuwe assessmentprocedure*. Nederlands Tijdschrift voor Geneeskunde;152: 899-902.

Centraal Bureau voor de Statistiek (2004): *Allochtonen in Nederland*. Voorburg/Heerlen.

Centraal Informatiepunt Beroepen Gezondheidszorg (2001): *Vakbekwaamheidsverklaringen voor in het buitenland gediplomeerden in de gezondheidszorg. Jaarverslag 2000*. Den Haag.

Central Consultants and Specialists Committee (2004): *Tackling racism in medical careers: the role of consultants*. British Medical Association. London.

Chan, M. (2007): Health spending: getting the balance right. Second OECD World Forum on Statistics, Knowledge and Policy. Istanbul, Turkey.

Chen, L.C. and Boufford J.I. (2005): *Fatal flows – Doctors on the Move*. In: The New England Journal of Medicine. Volume 353: 1850-1852; number 17.

Choenni, C.E.S. (1997): *Allochtonen en Universiteiten*. Den Haag; B&A Groep.

Commissie Buitenslands Gediplomeerden Volksgezondheid (2001): *Jaarverslag 2000*. Den Haag.

Commissie Buitenslands Gediplomeerden Volksgezondheid (2002): *Vakbekwaamheid zonder grenzen? Een advies over een assessmentprocedure voor buitenslands gediplomeerden die willen werken in de Nederlandse gezondheidszorg*. Den Haag.

Commissie Buitenslands Gediplomeerden Volksgezondheid (2003): *Vakbekwaamheid zonder grenzen? Verslag invitation conference Buitenslands Gediplomeerden Volksgezondheid gehouden op 26 maart 2003 te Utrecht*. Den Haag.

Cooke, L., Halford S. and Leonard, P. (2003): *Racism in the medical profession: the experience of UK graduates*. British Medical Association; Health Policy and Economic Research Unit. London.

Council Directive 93/16/EEC of 5 April 1993 to facilitate the free movement of doctors and the mutual recognition of their diplomas, certificates and other evidence of formal qualifications. Brussels, Belgium.

Crul, M. (1999): *De sleutel tot succes. Over hulp, keuzes en kansen in de schoolloopbanen van Turkse en Marokkaanse tweede generatie jongeren*. Dissertatie; Universiteit van Amsterdam.

Crutcher, R.A., Banner, S.R., Szafran, O, Watanabe, M. (2003): *Characteristics of international medical graduates who applied to the CaRMS 2002 match*. In: Canadian Medical Association Journal; 168 (9); 1119-23.

Danish National Board of Health (2001): *Guidelines concerning the authorization of doctors trained outside Denmark*.

Danish National Board of Health (2001): *Advisory notes about probationary clinical appointments for foreign-trained doctors who wish to obtain permanent authorization to practise medicine in Denmark, and who are not covered by the EU Doctors' Directive or the Nordic Agreement.*

Directive 2005/36/EC of the European Parliament and of the Council of 7 September 2005 on the recognition of professional qualifications. Brussels, Belgium.

Dokter, H.J. en Storm J.R. (1995): *Toelating van artsen van buiten de Europese Economische Ruimte; mogelijkheden tot beroepsuitoefening in Nederland.* Medisch Contact; 50^e jaargang, 31 maart 1995, nummer 13.

Eastwood, J.B., Conroy, R.E., Naicker, S., West, P.A., Tutt, R.C. and Plange-Rhule, J. (2005): *Loss of health professionals from sub-Saharan Africa: the pivotal role of the UK.* In: The Lancet; volume 365.

Ehman, A.J. and Sullivan P. (2001): *South Africa appeals to Canada to stop recruiting its MDs.* In: Canadian Medical Association Journal. 164 (3).

Entzinger, H.B. (2002): *Voorbij de multiculturele samenleving.* Koninklijke Van Gorcum; Assen.

Esmail, A., and Everington S. (1997): *Asian doctors still being discriminated against.* In: British Medical Journal; volume 314: 1619.

Expertmeeting over de problemen van artsen en verpleegkundigen met een buitenlands diploma (2002): *Hoe zit het met staan?* Den Haag.

Ezell, A. and Bear, J. (2005): *Degree mills: the billion-dollar industry that has sold over a million fake diplomas.* Amherst, New York: Prometheus Books.

FNV (2006): *Lokale monitor werk en inkomen 2006; onderzoek sociaal beleid gemeenten.* Stichting FNV Pers.

Gawande, A. (2005): *Naked.* In: *The New England Journal of Medicine.* 353 (7): 645-8.

General Medical Council (2006): *Guidance for PLAB test candidates.* London.

Govaerts, M.J.B. en Wijnen W.H.F.W. (1997): *Onderzoek inzake de toelating van niet-EER-gediplomeerde artsen en tandartsen tot de uitoefening van hun beroep in Nederland; eindrapport.* Vakgroep Onderwijsontwikkeling en Ondewijsresearch; Universiteit Maastricht.

Haaksman, D. (2005): *De NUFFIC onder vuur.* In: D&C Nieuwsbrief; nummer 4. NUFFIC, Den Haag.

Haalboom, J.R.E. (2005): *Verwondering en respect.* Oratie. Universiteit Utrecht. Uitgeverij Benecke N.I. te Amsterdam.

Haalboom, J.R.E. en Herfs P.G.P. (1998): *De inpassing van buitenlandse artsen in het Nederlandse medische curriculum*. Medisch Contact; 53^e jaargang, 30 oktober 1998, nummer 44.

Haalboom J.R.E. en Herfs P.G.P. (1998): *Buitenlandse artsen in de opleiding tot arts*. Bulletin Medisch Onderwijs. December 1998, volume 17, nr. 4. Universitaire Pers Maastricht.

Haalboom J.R.E. en Herfs P.G.P. (1999): *Utrecht ontwikkelt module voor bijscholing buitenlandse artsen*. Transfer jaargang 6, nr. 7; maart 1999. Nuffic, Den Haag.

Hageman, E. (2005): *De lucratieve handel in status: nepdiploma's*. In: Trouw – De Verdieping 12 augustus. Amsterdam.

Hagopian, A., Thompson, M.J., Fordyce, M., Johnson, K.E. and Hart, L.G. (2004): *The migration of physicians from sub-Saharan Africa to the United States of America: measures of the African brain drain*. In: Human Resources for Health; 2:17.

Hall, P., Keely, E., Dojeiji, S., Byszewski, A. and Marks, M. (2004): *Communication skills, cultural challenges and individual support: challenges of international medical graduates in a Canadian healthcare environment*. In: Medical Teacher; vol. 26, no. 2, 120-125.

Hallock, J.A., McKinley, D.W., and Boulet, J.R. (2007): *Migration of doctors for undergraduate medical education*. In: Medical Teacher, 29:2-3, 98-105.

Harmesen, J.A.M. (2003): *When cultures meet in medical practice; improvement in intercultural communication evaluated*. Rotterdam Intercultural Communication In Medical setting. Dissertatie; Erasmus Universiteit Rotterdam.

Hel, M. van der (2006): Europees actieplan om personeelstekort in gezondheidszorg te verminderen. *Medicus Tropicus*, 44, nummer 6.

Herfs, P.G.P. (1992): *Ontwikkelingen m.b.t. het wettelijk verplicht gestelde examen Nederlands*. Interne notitie t.b.v. de Commissie Buitenlandse Studerenden van het Landelijk Beraad Studentendecanen. Universiteit Utrecht.

Herfs, P.G.P. (1996): *Student Counseling at Utrecht University*. In: International Journal for the Advancement of Counseling; 18-4.

Herfs, P.G.P. (1996): *Erkenning van buitenlandse artsdiploma's; een verhaal apart*. Afdeling Studentenzaken; Universiteit Utrecht.

Herfs, P.G.P. (1997): *De toelating van studenten met een buitenlandse vooropleiding aan de Universiteit Utrecht*. Afdeling Studentenzaken; Universiteit Utrecht.

Herfs, P.G.P. (1997): *De Commissie Instroom Buitenlandse Artsen; terugblik en toekomstvisie*. Studenten Service Centrum; Universiteit Utrecht.

Herfs, P.G.P. (2000): *Symposiumverslag Spreektaal Medisch Nederlands*. Tijdschrift voor Medisch Onderwijs; nummer 6. Bohn Stafleu Van Loghum; Houten.

Herfs, P.G.P. (2001): *Buitenlandse artsen en de erkenning van hun diploma's in Nederland*. VNVA-krant; jaargang 29, nummer 6.

Herfs, P.G.P. (2001): *De toelating van buitenlandse studenten tot het wetenschappelijk - en Hoger Beroepsonderwijs: het Staatsexamen Nt2 II als gemeenschappelijke taaleis*. In: Les; jaargang 19, nummer 114.

Herfs, P.G.P. (2006): *Is Nederland toe aan een Nt2-examen programma 3?* In: Schoordijk F.M.C. en Taal-Apelqvist L. (redactie): *Nederlands leren na het Staatsexamen Nt-II*. Symposiumbundel ter gelegenheid van het afscheid van Hans Maureau van het INTT. Universiteit van Amsterdam.

Herfs, P.G.P., J.R.E. Haalboom, M.A. Kruijshoop, P. Yari (2001): *Onderzoek naar de loopbanen van "CIBA-artsen"*. In opdracht van DMW van de VSNU; Universiteit Utrecht.

Instituut voor Toetsontwikkeling (1992): *informatiebulletin examen NT2; nummer 1*. CITO, Arnhem.

Jaarverslag van het Verwijspunt Buitenslands Gediplomeerden Volksgezondheid, Vakbekwaamheidsverklaringen Buitenslands Gediplomeerden Volksgezondheid, Commissie Buitenslands Gediplomeerden Volksgezondheid en BIG-register (2004): *Beroepsbeoefenaren in de gezondheidszorg; informeren, beoordelen en registreren in 2003*. Albani drukkers BV, Den Haag.

Jonker, B. (2004): *Resource Project; refugees' contribution to Europe*. Education Action International – RETAS. London.

Kagie, R. (2004): *Artsen zonder kansen*. In: Vrij Nederland d.d. 14 augustus 2004.

Kenniscentrum Grote Steden/Kennisnet Integratiebeleid en Etnische Minderheden (2004): *Vooruit met hoogopgeleide vluchtelingen! Kansen en knelpunten op de arbeidsmarkt*. Den Haag.

Klaver, J. en Odé, A. (2003): *De arbeidsintegratie van vluchtelingen; een verkenning van problemen en oplossingen*. Raad voor Werk en Inkomen. Den Haag.

Kramer, M. (2006): Educational challenges of international medical graduates in psychiatric residencies. In: the Journal of the American Academy of Psychoanalysis and Dynamic Psychiatry. Vol. 34; 163-171.

Lancet (2005): *Migration of health workers: an unmanaged crisis*. Editorial comment in Volume 365; 1825.

McCreeedy, J. (2001): *Expertmeeting hoger opgeleide vluchtelingen op de arbeidsmarkt*. Ministerie van Sociale Zaken en Werkgelegenheid; directie Arbeidsmarktbeleid Bijzondere Groepen. Den Haag.

McGrath, B.P. (2004): *Integration of overseas-trained doctors into the Australian medical workforce*. In: Medical Journal of Australia; 181; 640-2.

Melchior, M. (2005): *Frustraties en bureaucratie; een buitenlands artsdiploma maar niet aan de slag*. Medisch Contact 60^e jaargang, 22 april 2005, nr. 16.

Merkelbach, J.W. (1999): *Supervisie werkt niet voor buitenlandse artsen*. Medisch Contact; 54^e jaargang, 30 april 1999, nr. 17.

Mick, S.S. and Lee, S.Y.D. (1997): *The safety-net role of International Medical Graduates*. In: Health Affairs. Volume 16, number 4, 141-150.

Ministerie van Binnenlandse Zaken (1994): *Contourennota integratiebeleid etnische minderheden*. Den Haag.

Ministerie van Onderwijs en Wetenschappen (1991): *Certificaten Nederlands als Tweede Taal*. Eindrapport van de Adviescommissie Invoering Certificaten.

Ministerie van Welzijn, Volksgezondheid en Cultuur (1984): *Circulaire Toelating buitenlandse artsen*. Rijswijk.

Ministerie van Welzijn, Volksgezondheid en Cultuur (1991): *Buitenlandse Diplomahouders; informatie met betrekking tot de toelating van houders van een buitenlands diploma van apotheker, apothekers-assistent, arts, paramedicus, tandarts, verloskundige, verpleegkundige en ziekenverzorgende in Nederland*. Rijswijk.

Ministerie van Welzijn, Volksgezondheid en Cultuur (1993): *Circulaire Toelating buitenlandse diplomahouders*. Rijswijk.

Ministerie van Volksgezondheid, Welzijn en Sport (1996): *Jaarverslag 1995 inzake buitenslands gediplomeerden volksgezondheid*. Den Haag.

Ministerie van Volksgezondheid, Welzijn en Sport (1997): *Jaarverslag 1996 inzake buitenslands gediplomeerden volksgezondheid*. Den Haag.

Ministerie van Volksgezondheid, Welzijn en Sport (1998): *Jaarverslag 1997 inzake buitenslands gediplomeerden volksgezondheid*. Den Haag.

Ministerie van Volksgezondheid, Welzijn en Sport (1999): *Jaarverslag 1998 inzake buitenslands gediplomeerden volksgezondheid*. Den Haag.

Ministerie van Volksgezondheid, Welzijn en Sport (1999): *Met een buitenlands diploma werken in de Nederlandse gezondheidszorg*. Den Haag.

Ministerie van Volksgezondheid, Welzijn en Sport (2000): *Jaarverslag 1999 inzake buitenslands gediplomeerden volksgezondheid*. Den Haag.

Ministerie van Volksgezondheid, Welzijn en Sport (2005): *Project ABGG; Plan van Aanpak deelproject Artsen (versie 3)*. Den Haag.

Ministerie van Volksgezondheid, Welzijn en Sport (2005): *Project ABGG; Plan van Aanpak assessment buitenslands gediplomeerden gezondheidszorg*. Den Haag.

Ministerie van Volksgezondheid, Welzijn en Sport (2006): *Verklaring vakbekwaamheid buitenslands gediplomeerden volksgezondheid*. Den Haag.

Muche F., Kelo M., Wächter B. (2004): *The Admission of International Students into Higher Educuations; policies and instruments*. ACA papers on International Cooperation in Education. Lemmens Verlags- und Mediengesellschaft; Bonn.

Mullan, F. (2005): *The metrics of the physician brain drain*. In: the New England Journal of Medicine. Volume 353: 1810-1818; number 17.

Mullan, F., Pollitzer, R.M., David, C.H. (1995): *Medical migration and the physician workforce. International Medical graduates and American medicine*. In: Journal of the American Medical Association. Number 273 (19); 1521-7.

National Council of the Republic of Austria (2002): *University Organisation and Studies Act, University Organisation Amendment Act and Universities of the Arts Organisation Amendment Act*. Federal Ministry of Education, Science and Culture. Vienna.

Nie N.H., Hull C.H., Jenkins J.G., Steinbrenner K., Bent D.H. (1975): *Statistical Package for the Social Sciences*. (edition 2) New York: McGraw-Hill.

Ogowe, A. (1996): *Brain drain: colossal loss of investment for developing countries*. In: the Courier ACP-EU; 159: 59-60.

O'Meara, D. (2004): *Foreign-trained physicians need residency spots*. Canadian Medical Association Journal. 170 (8); 1216.

Oost, H.A. (1999): *De kwaliteit van probleemstellingen in dissertaties*. Proefschrift. Universiteit Utrecht.

Palenstein Helderman-Susan L.H.M. van, Mans E.M., Bleys R.L.A.W., Spee-Brand R. (2000): *Van aambeeld tot zwijgplicht. Woordenlijst medisch Nederlands*. Bohn Stafleu Van Loghum; Houten.

Palenstein Helderman-Susan, L.H.M. van, Bekedam, L.M., Haalboom, J.R.E, Herfs, P.G.P. & Pescher-ter Meer, A. (2000): *Hoe zit het met staan? Cursus Nederlands voor anderstalige artsen*. Bohn Stafleu en Van Loghum; Houten.

Pang, T., Lansang, M.A., Haines, A. (2002): *Brain drain and health professionals*. In British Medical Journal; 324; 499-500.

Pew Health Professions Commission (1995): *Critical challenges: revitalizing the health professions for the twenty-first century; third report of the Pew Health Professions Commission*. University of California at San Francisco Center for the Health Professions.

Projectteam Consilium Abeundi (2002): *Professioneel gedrag; onderwijs, toetsing, begeleiding en regelgeving*. Eindrapport en bijlagen. In opdracht van de VSNU; Utrecht.

Raad van de Europese Gemeenschappen (1993): *Richtlijn 93/16/EEG van de Raad van 5 april 1993 ter vergemakkelijking van het vrije verkeer van artsen en de onderlinge erkenning van hun diploma's, certificaten en andere titels*. Brussel.

Raad voor Maatschappelijke Ontwikkeling (2005): *Eenheid, verscheidenheid en binding; over concentratie en integratie van minderheden in Nederland*. Advies 35. Sdu Uitgevers Den Haag.

Raad voor Maatschappelijke Ontwikkeling (2005): *Niet langer met de ruggen naar elkaar; een advies over verbinden*. Advies 37. Sdu Uitgevers Den Haag.

Scheffer, P. (2000): *Het multiculturele drama*. NRC, 29 januari 2000.

Schmitt Jongbloed, L.J., Duchateau, D.C. (2007): *Resultaten quickscan assessment Buitenlands Gediplomeerden Volksgezondheid*. Leiden: LSJ Medisch Projectbureau.

Scholten, A.M., Teuwsen, R., Mak, A.M.A. (2003): *Portfolio in een opleidingsgerichte EVC-procedure voor buitenlandse gediplomeerde geneeskunde studenten*. In opdracht van het Empowerment centre EVC te Houten. Nuffic. Den Haag.

Scholten, A.M., Teuwsen, R., Mak, A.M.A. (2004): *Stilstaan bij portfoliogebruik voor buitenlandse artsen*. Nuffic. Den Haag.

Schoordijk, F.M.C. en Taal-Apelqvist, L. (2006): *Nederlands leren na het Staatsexamen Nt-II*. Symposiumbundel ter gelegenheid van het afscheid van Hans Maureau van het INTT. Universiteit van Amsterdam.

SCP/WODC/CBS (2005): *Jaarrapport Integratie 2005*. Den Haag.

Sjouwerman, P. (2002): *Denemarken: allochtone academici stuiten op glazen plafond*. In: Contrast; nummer 11/12; Utrecht.

Smeets, H. (1997): *Op zoek naar een bestuurlijk beginsel; een minister zonder kleren*. In De Gids, nummer 11/12. Uitgeverij Meulenhoff.

Smeets, H. (2002): *Welkom in het Koninkrijk; gevangen in de medisch-juridische bureaucratie*. Mets & Schilt, Amsterdam.

Sociaal Cultureel Planbureau (1999): *Rapportage minderheden 1999; positie in het onderwijs en op de arbeidsmarkt*. Den Haag.

Spike, N.A. (2006): *International medical graduates: the Australian perspective*. In: Academic Medicine; 81 (9); 842-6.

Splinter, T.A.W., Herfs, P.G.P., Ruijs, A.J.E.M., Luijk, S.J. van, Wijkhuijs, N.P. (2003): *Naar een nieuwe stroomlijn voor buitenlandse artsen; een rapport van de Opleidingscommissie Geneeskunde van het Disciplineoverlegorgaan Medische Wetenschappen (OCG-DMW)*.

Stillwell, B., Diallo, K., Zurn, P., Dal Poz, M.R., Adams, O., Buchan J. (2003): *Developing evidence-based ethical policies on the migration of health workers: conceptual and practical challenges*. In: Human Resources for Health; 1:8. <http://www.human-resources-health.com/content/1/1/8>

STOGO (1997): *Arbeidsmarktmonitor Universiteit Utrecht; Faculteit Geneeskunde*. STOGO Onderwijs en Advies; Faculteit Sociale Wetenschappen van de Universiteit Utrecht.

STOGO (1998): *Arbeidsmarktmonitor Faculteit Geneeskunde 1998*. STOGO Onderwijs en Advies; Faculteit Sociale Wetenschappen van de Universiteit Utrecht.

Task Force IIB (2005): *Proposal for the assessment of medical knowledge and skills of foreign medical graduates entering The Netherlands. Draft 2*. UMC Utrecht.

Tijdelijke Commissie Onderzoek Integratiebeleid (2004): *Bruggen bouwen; eindrapport*. Sdu Uitgevers. Den Haag.

Tinto, V. (1997): *Classrooms as Communities: Exploring the Educational Character of Student Persistence*. In: Journal of Higher Education 68 6.

Trewby, P. (2008): *International medical graduates: lessons from the past and hopes for the future*. In: Clinical Medicine, 8, 283-7.

Tromp, F., Rademakers, J.J.D.J.M. & Ten Cate, Th.J. (2007): *Development of an instrument to assess professional behaviour of foreign medical graduates*. In: Medical Teacher; volume 29: 2&3, 150-155.

UMC krant (2005): *Wij vinden het dan gewoon geen goede arts; buitenlandse artsen en Nederlandse studenten over cultuurverschillen*. UMC krant, nr. 6. UMC Utrecht.

United Nations High Commissioner for Refugees (2005): *2004 Global Refugee Trends; overview of refugee populations, new arrivals, durable solutions, asylum-seekers, stateless and other persons of concern to UNHCR*. Geneva.

United States Medical Licensing Examination (2006): *Bulletin of Information*. Philadelphia.

Van der Weyden, M.B. & Chew, M. (2004): *Arriving in Australia: overseas-trained doctors*. In: Medical Journal of Australia; volume 181, number 11/12. Sydney.

Veltman, P. & Both, J. (2010): *Gevluchte artsen verrijken de Nederlandse gezondheidszorg; een onderzoek naar de loopbaan van gevluchte artsen in Nederland*. University Asylum Fund; Utrecht.

Veltman, P., Geers, C., Elsen, I. van den, Bleichrodt, K. (2008): *ingezonden brief n.a.v. het artikel Artsen met een buitenlands diploma in de Nederlandse patiëntenzorg: de nieuwe assessmentprocedure*. Nederlands Tijdschrift voor Geneeskunde: 152: 1699.

Vluchtelingenwerk Nederland: *Integratie Barometer 2005; een onderzoek naar de integratie van vluchtelingen in Nederland*. Amsterdam; 2005.

Vreemdelingenwet 2000 (2001). Staatsblad, 495. Sdu Uitgevers.

Werkgroep Begeleiding Allochtone Studenten. *Eindrapportage*. Utrecht University, 1994.

Werkgroep Toetredingsbelemmeringen Medische Beroepen (2001): *Nooit meer wachten; minder toetredingsbelemmeringen voor medische beroepen*. Den Haag.

Wet op het Hoger onderwijs en Wetenschappelijk onderzoek (1992). Staatsblad 593. Sdu. Den Haag.

Wetenschappelijke Raad voor het Regeringsbeleid (1989). *Allochtonenbeleid*. Sdu. Den Haag.

Wieringen, J.C.M. van, Kijlstra, M.A., Schulpen, T.W.J. (2001): *Interculturalisatie van het Medisch Onderwijs in Nederland; een inventarisatie bij de faculteiten geneeskunde*. In opdracht van het Stimuleringsprogramma Gezondheidsonderzoek. Centre for Migration and Child Health; WKZ-UMC Utrecht.

Wildevuur S.E. (1996): *Vechten om een plaats*. Medisch Contact; 51^e jaargang, 30 augustus 1996, nr. 35.

Wolters-Noordhoff (2001): *De Grote Bos-atlas*. 52^e druk. WN Atlas Productions; Groningen.

World Health Organisation (2004): *Global Health Atlas*. New York.

Appendix 1: List of abbreviations (in English and Dutch)

ABGG	Project Assessment Foreign Healthcare Graduates (<i>Project Assessment Buitenslands Gediplomeerden Gezondheidszorg</i>)
AGIO	Trainee Medical Specialist (<i>Assistent Geneeskunde In Opleiding</i>)
AGNIO	Medical Assistant not in Training (<i>Assistent Geneeskunde Niet In Opleiding</i>)
AIM	Assessment Institute for Physicians (<i>Assessment Instituut voor Medici</i>)
AKV-test	General Knowledge and Skills Test (<i>Algemene Kennis- en Vaardighedentoets</i>)
APL	Accreditation of Prior Learning
AZC	Asylum Seekers Centre (<i>Asielzoekerscentrum</i>)
BIG Act	Individual Healthcare Professions Act (<i>Wet op de Beroepen in de Individuele Gezondheidszorg</i>)
CBGV	Foreign Healthcare Qualifications Commission (<i>Commissie Buitenslands Gediplomeerden Volksgezondheid</i>)
CIBA	Committee for the Influx of Foreign Doctors (<i>Commissie Instroom Buitenlandse Artsen</i>)
CIBG	Central Information Office for Health Care Professions (<i>Centraal Informatiepunt Beroepen Gezondheidszorg</i>)
COA	Central Agency for the Reception of Asylum Seekers (<i>Centraal Orgaan opvang Asielzoekers</i>)
DMW	Medical Sciences Board (<i>Disciplineoverlegorgaan Medische Wetenschappen</i>)
ECFMG	Educational Commission for Foreign Medical Graduates (USA)
ECTS	European Credit Transfer System
EEA	European Economic Area (<i>Europese Economische Ruimte</i>)
EU	European Union
FAIMER	Foundation for Advancement of International Medical Education and Research

GG&GD	Municipal Health Authority (<i>Gemeentelijke Geneeskundige & Gezondheidsdienst</i>)
HAIO	General Practitioner in Training (<i>Huisarts in Opleiding</i>)
HVRC	Registration Commission for General Practice and Nursing Home Doctors (<i>Huisarts en Verpleeghuisarts Registratie Commissie</i>)
IELTS	International English Language Testing System-Exam (University of Cambridge)
IMG	International Medical Graduate
IMED	International Medical Education Directory
IND	The Ministry of Justice's Immigration and Naturalisation Service (<i>Immigratie en Naturalisatie Dienst van het ministerie van Justitie</i>)
ITN	Interuniversity Dutch Language Admission Exam (<i>Interuniversitair Toelatingsexamen Nederlands</i>)
IWTN	Interuniversity Working Party on the Dutch Language Admission Exam (<i>Interuniversitaire Werkgroep Toelatingsexamen Nederlands</i>)
KBS	Committee for Foreign Students (department of the LBS) (<i>Kommissie Buitenlandse Studerenden</i>)
KNMG	Royal Dutch Medical Association (<i>Koninklijke Nederlandsche Maatschappij tot Bevordering der Geneeskunst</i>)
LBS	National Board of Student Counsellors (for higher education at research universities) (<i>Landelijk Beraad Studentendecanen</i>)
LOS-HBO	National Council of Student Counsellors (for higher education at universities of applied science) (<i>Landelijk Overleg Studentendecanen in het Hoger Beroepsonderwijs</i>)
MDW	Free Market, Deregulation and Good Law-making (<i>Marktwerking, Deregulering en Wetgevingskwaliteit</i>)
MKV-test	Medical Knowledge and Skills Test (<i>Medische Kennis- en Vaardighedentoets</i>)
MSRC	Committee for the Registration of Medical Specialists (<i>Medisch Specialisten Registratie Commissie</i>)
Nt2	State Exam Dutch as a Second Language, Programme 2 (<i>Staatsexamen Nederlands als tweede taal, programma 2</i>)

NUFFIC	Netherlands Universities Foundation For International Cooperation
OCG	Medical Education Committee (<i>Opleidingscommissie Geneeskunde</i>)
OC&W	Ministry of Education, Culture and Sciences (<i>Ministerie van Onderwijs, Cultuur & Wetenschappen</i>)
PLAB-exam	Professional and Linguistic Assessment Board-Exam
RIBIZ	Registration and Information for Healthcare Professionals (<i>Registratie en Informatie Beroepsbeoefenaren in de Zorg</i>)
SIBIO	Organisation for Intercultural Business Aspects and Intercultural Entrepreneurship (<i>Stichting Interculturele Bedrijfsaspecten en Intercultureel Ondernemerschap</i>)
SPSS	Statistical Package for the Social Sciences
STOGO	Organisation for Applied Geographical Research (<i>Stichting Toegepast Geografisch Onderzoek</i>)
TCD	Third Country Doctor
TOEFL	Test of English as a Foreign Language
UAF	University Asylum Fund (<i>Stichting voor Vluchteling-Studenten</i>)
USMLE	United States Medical Licensing Examinations
VAZ	University Hospitals Association (<i>Vereniging van Academische Ziekenhuizen</i>)
VSNU	Association of Universities in the Netherlands (<i>Vereniging van Samenwerkende Nederlandse Universiteiten</i>)
VWS	Health Department (<i>Ministerie van Volksgezondheid, Welzijn en Sport</i>)
WGBO	Medical Treatment Contracts Act (<i>Wet op de Geneeskundige Behandelings Overeenkomst</i>)
WHO	World Health Organisation (United Nations)
WHW	Higher Education and Research Act (<i>Wet Hoger onderwijs en Wetenschappelijk onderzoek</i>)
WVC	Health Department (old name) (<i>Ministerie van Welzijn, Volksgezondheid en Cultuur</i>)
WWB	Labour and Social Security Act (<i>Wet Werk en Bijstand</i>)

Appendix 2: Annual Reports, Department of Health

Non-EEA-doctors annual report DoH 1995

Country	Equivalent	Nearly equivalent	Non equivalent	Under consideration
Afghanistan	0	2	1	4
Algeria	0	0	1	2
Argentina	1	0	0	1
Australia	0	1	0	0
Brazil	0	1	0	1
Bulgaria	0	1	2	4
Canada	2	0	0	2
China	0	1	1	4
Colombia	0	0	0	2
Dom. Republic	0	0	0	2
Ecuador	2	0	0	0
Egypt	1	4	0	8
Ethiopia	0	0	0	1
Hungary	1	2	0	4
India	1	0	0	2
Indonesia	0	2	0	2
Iraq	1	3	2	17
Iran	0	1	1	5
Israel	0	1	0	1
(former) Yugoslavia	4	10	5	22
Latvia	0	1	0	1
Lithuania	0	1	0	0
Malaysia	0	0	0	2
New Zealand	0	1	0	0
Pakistan	0	0	0	1
Poland	6	6	0	7
Romania	2	1	2	9
Somalia	0	0	2	4
Sri Lanka	0	0	0	2
Surinam	7	2	0	4
Czechoslovakia	2	1	0	5
Turkey	1	0	4	18
Uganda	0	0	0	1
USA	1	0	0	2
(former) USSR	1	5	6	32
Zaire	0	0	0	1
Zimbabwe	0	2	0	0
South Africa	6	1	0	3
Total	39	50	27	176

Non-EEA-doctors annual report DoH 1996

Country	Equivalent	Nearly equivalent	Non equivalent	Under consideration
Afghanistan	0	3	4	21
Algeria	0	1	1	1
Argentina	0	0	0	1
Australia	0	1	0	0
Brazil	2	0	0	2
Bulgaria	0	3	1	3
Canada	2	1	0	3
China	0	1	2	3
Colombia	0	1	1	1
Dom. Republic	0	1	0	3
Ecuador	1	0	0	2
Egypt	0	4	2	7
Philippines	0	1	0	0
Hungary	1	3	0	2
India	0	0	1	3
Indonesia	0	0	1	6
Iraq	0	7	3	32
Iran	2	1	2	4
Israel	0	1	0	0
Japan	0	0	0	1
(former) Yugoslavia	7	11	8	19
Latvia	0	0	1	1
Malaysia	1	0	0	1
Morocco	0	0	0	2
Mexico	1	0	0	1
Pakistan	0	1	1	3
Poland	3	2	0	6
Romania	3	3	4	8
Somalia	0	0	2	4
Sri Lanka	1	0	0	1
Surinam	4	3	0	5
Syria	0	0	1	0
Tanzania	0	0	0	1
Czechoslovakia	4	0	2	6
Tunisia	0	0	0	1
Turkey	1	4	5	8
Uganda	0	0	0	1
Uruguay	0	0	1	0
USA	1	2	0	2
(former) USSR	3	5	19	22
Zaire	0	0	0	2
South Africa	1	9	0	4
Total	38	69	62	193

Non-EEA-doctors 1997

Country	Equivalent	Nearly equivalent	Non equivalent	Under consideration
Afghanistan	0	3	6	20
Algeria	0	1	1	3
Brazil	0	0	1	2
Bulgaria	0	0	1	0
Canada	0	1	0	1
Ceylon	0	0	0	1
China	0	0	1	4
Colombia	0	1	1	3
Dom.Republic	0	1	0	3
Ecuador	0	1	0	2
Egypt	0	3	1	5
El Salvador	0	0	0	1
Philippines	0	0	0	1
Hungary	0	1	1	4
India	0	1	2	0
Indonesia	0	3	0	7
Iraq	1	3	12	45
Iran	0	0	3	4
Israel	0	1	0	0
Japan	0	1	0	0
(former) Yugoslavia	0	4	1	17
Latvia	0	0	0	2
Macedonia	0	0	0	1
Malaysia	0	1	0	0
Morocco	2	2	0	0
Mexico	0	0	0	4
Nigeria	0	0	0	2
Uganda	0	0	0	1
Ukraine	0	0	0	1
Pakistan	0	0	3	1
Poland	1	5	1	7
Romania	0	0	4	9
Slovakia	0	1	0	2
Sudan	0	0	0	1
Somalia	0	1	0	4
Surinam	0	0	0	9
Syria	0	0	0	1
Tanzania	0	0	0	1
Czechoslovakia	0	1	0	6
Tunisia	0	0	0	1
Turkey	1	3	1	9
Uruguay	0	0	1	0
USA	0	0	0	4
(former) USSR	0	0	16	41
Venezuela	0	0	0	1
Vietnam	0	0	0	1
Zaire	0	0	2	0

South Africa	0	2	0	7
Switzerland	0	1	0	1
Total	5	42	69	241

Non-EEA doctors 1998

Country	Equivalent	Nearly equivalent	Non equivalent	Under consideration
Afghanistan	1	1	20	4
Albania	0	0	0	1
Algeria	1	0	2	0
Armenia	0	0	2	0
Argentina	0	0	0	1
Australia	0	1	0	0
Azerbaijan	0	0	1	0
Benin	0	0	0	1
Bosnia	1	3	3	2
Bulgaria	0	1	5	1
Canada	0	2	0	0
Ceylon	0	1	1	1
China	0	2	2	1
Colombia	0	2	2	0
Cuba	0	0	0	1
Ecuador	0	2	0	1
Egypt	1	1	2	5
Georgia	0	0	1	1
Hungary	2	0	2	2
India	0	2	0	1
Indonesia	2	5	0	4
Iraq	2	4	31	33
Iran	0	0	1	0
Japan	0	0	0	1
Yugoslavia	1	6	1	7
Kazakhstan	0	0	1	0
Croatia	0	0	1	0
Latvia	0	1	0	0
Malaysia	0	1	0	1
Morocco	0	2	0	0
Mexico	1	0	0	1
Nicaragua	0	1	0	0
New Zealand	0	1	0	1
Nigeria	0	0	1	2
Ukraine	0	1	4	0
Pakistan	0	0	0	1
Poland	2	12	0	5
Romania	0	1	2	8
Serbia	1	1	1	1
Slovakia	1	0	1	1

Sudan	0	0	1	1
Somalia	0	2	3	2
Surinam	0	3	0	6
Tadzhikistan	0	0	1	0
Czech Republic	0	1	3	3
Tunisia	0	1	0	0
Turkey	2	2	3	0
Uganda	0	0	0	1
USA	2	3	0	0
USSR	1	1	19	18
Vietnam	0	0	1	0
Zimbabwe	0	2	0	0
South Africa	3	3	0	1
Switzerland	0	1	0	1
Total	25	73	117	122

Non-EEA-doctors 1999

Country	Equivalent	Nearly equivalent	Non equivalent	Total
Afghanistan	1	0	21	22
Albania	0	0	1	1
Algeria	2	1	0	3
Armenia	0	0	2	2
Australia	0	1	0	1
Azerbaijan	0	0	1	1
Bangladesh	0	0	1	1
Bosnia	2	2	2	6
Bulgaria	0	0	4	4
Ceylon	0	1	0	1
China	0	2	2	4
Colombia	0	1	0	1
Cuba	0	0	1	1
Dom. Republic	1	0	0	1
Ecuador	1	1	0	2
Egypt	0	3	1	4
Philippines	0	0	1	1
Georgia	0	0	2	2
Hungary	0	2	0	2
India	0	5	2	7
Indonesia	1	0	2	3
Iraq	2	2	48	52
Iran	0	0	1	1
Israel	1	2	0	3
Japan	0	1	0	1
Yugoslavia	3	6	2	11
Korea	0	0	1	1
Croatia	0	0	1	1

Latvia	0	1	0	1
Malaysia	0	1	0	1
Morocco	2	1	0	3
Mexico	1	0	0	1
New Zealand	0	2	0	2
Nigeria	0	1	0	1
Ukraine	0	0	4	4
Pakistan	0	1	0	1
Poland	1	16	4	21
Rhodesia ⁵³	1	0	0	1
Romania	0	3	5	8
Shanghai	0	0	1	1
Slovakia	0	0	2	2
Sudan	0	0	4	4
Surinam	3	11	1	15
Syria	0	1	2	3
Togo	0	0	1	1
Czech Republic	1	3	0	4
Turkey	2	0	7	9
Turkmenistan	0	0	1	1
USA	0	1	0	1
USSR	0	0	26	26
Uzbekistan	0	0	1	1
Vietnam	0	0	1	1
Belarus	0	0	1	1
Switzerland	5	15	0	20
Total	30	87	157	274

Non-EEA-doctors 2000

Country	Equivalent	Nearly equivalent	Non equivalent	Total
Afghanistan	1	2	20	23
Algeria	1	0	1	1
Argentina	0	0	2	2
Armenia	0	0	2	2
Australia	1	0	0	1
Azerbaijan	0	0	1	1
Bosnia	1	2	0	3
Brazil	1	0	0	1
Bulgaria	1	1	2	4
China	0	0	1	1
Colombia	1	0	2	3
Costa Rica	1	1	0	2

⁵³In this table by the Health Department, the use of the name Rhodesia is probably due to the name on the doctor's diploma. Nevertheless, the name Zimbabwe should have been used in this overview.

Dom. Republic	1	0	0	1
Ecuador	1	0	0	1
Egypt	1	0	1	2
Philippines	0	0	1	1
Gabon	0	1	0	1
Hungary	1	3	1	5
India	0	3	6	9
Indonesia	4	3	2	9
Iraq	1	3	13	17
Iran	0	0	4	4
Israel	0	0	1	1
Yugoslavia	3	4	1	8
Kazakhstan	0	0	1	1
Croatia	1	3	1	5
Libya	0	0	1	1
Macedonia	0	1	0	1
Morocco	1	0	0	1
Nigeria	0	2	0	2
Ukraine	0	1	5	6
Pakistan	0	1	2	3
Peru	1	0	1	2
Poland	4	16	0	20
Romania	0	7	3	10
Russia	0	0	5	5
Slovakia	0	1	0	1
Sudan	0	0	2	2
Somalia	2	0	0	2
Surinam	1	6	1	8
Syria	0	1	2	3
Tadzhikistan	0	0	1	1
Tanzania	0	1	0	1
Czechoslovakia	1	1	4	6
Turkey	2	3	1	6
USA	0	2	0	2
USSR	1	3	22	26
Uzbekistan	0	0	3	3
South Africa	8	25	0	33
South Korea	0	0	1	1
Switzerland	2	0	0	2
Total	44	97	116	257

Non EEA-doctors: recognition requests 2002

Country	Equivalent	Nearly equivalent	Non equivalent	Total
Afghanistan	0	2	31	33
Argentina	0	1	0	1
Armenia	0	0	2	2

Australia	0	2	0	2
Azerbaijan	0	0	1	1
Bosnia	1	0	0	1
Brazil	0	0	1	1
Bulgaria	0	0	6	6
Canada	0	1	0	1
China	0	0	1	1
Colombia	1	0	2	3
Costa Rica	0	0	2	2
Egypt	1	0	2	3
Ecuador	0	0	1	1
Philippines	1	2	0	3
Gabon	1	1	0	2
Ghana	0	1	0	1
Hungary	0	6	0	6
India	0	2	1	3
Indonesia	0	3	3	6
Iraq	1	2	12	15
Iran	0	0	2	2
Israel	0	2	0	2
Japan	0	1	0	1
Yemen	0	0	2	2
Yugoslavia	0	4	2	6
Kazakhstan	0	0	1	1
Croatia	0	3	2	5
Macedonia	0	1	0	1
Mali	0	0	1	1
Morocco	0	1		1
Mexico	0	0	1	1
Moldavia	0	0	1	1
Myanmar	0	0	1	1
Namibia	1	0	0	1
Ukraine	0	2	15	17
Uzbekistan	0	0	2	2
Pakistan	0	0	1	1
Poland	7	19	2	28
Romania	2	2	7	11
Russia	0	4	29	33
Rwanda	0	0	1	1
Singapore	0	1	0	1
Sudan	0	0	5	5
Somalia	0	0	1	1
Suriname	4	11	2	17
Syria	0	1	0	1
Tadzhikistan	0	0	1	1
Tanzania	0	1	0	1
Czech Republic	0	1	0	1
Czechoslovakia	0	1	2	3
Turkey	0	1	9	10
Turkmenistan	0	0	1	1
USA	0	2	0	2

Vietnam	0	0	1	1
Belarus	0	1	0	1
South Africa	11	32	1	44
Total	31	114	158	303

In the annual reports for 2001, 2003 and 2004 there were no tables presenting the requests per nationality.

Appendix 3: Recognition requests dealt with by CIBA since its establishment

Table 1: Number of applications dealt with by CIBA since 1996

Year	Applications dealt with by CIBA	Cumulative
1996-1997	113	
1997-1998	97	210
1998-1999	127	337
1999-2000	132	469
2000-2001	136	605
2001-2002	118	723
2002-2003	126	849
2003-2004	99	948
Total	948	

University of Amsterdam

Allocated by CIBA since 1996:	122
Candidates who have not yet started studying ⁵⁴ :	21

VU Amsterdam University

Allocated by CIBA since 1996:	112
Candidates who have not yet started studying:	17

University of Groningen

Allocated by CIBA since 1996:	127
Candidates who have not yet started studying:	25

Leiden University

Allocated by CIBA since 1996:	85
Candidates who have not yet started studying:	9

Maastricht University

Allocated by CIBA since 1996:	95
Candidates who have not yet started studying:	14

Radboud University Nijmegen

Allocated by CIBA since 1996:	142
Candidates who have not yet started studying:	30

Erasmus University Rotterdam

Allocated by CIBA since 1996:	104
Candidates who have not yet started studying:	23

Utrecht University

Allocated by CIBA since 1996:	176
Candidates who have not yet started studying:	11

⁵⁴There are several different reasons why candidates do not start their studies: they may have personal reasons or may be placed under supervision after all (Category II). They may also still be working on Dutch as a second language or be admitted to another faculty.

Appendix 4: Questionnaire for graduated CIBA-doctors

1. Which Dutch medical faculty did you graduate from?

VU Amsterdam University	
University of Amsterdam	
Leiden University	
Erasmus University Rotterdam	
Utrecht University	
University of Groningen	
Radboud University Nijmegen	
Maastricht University	

2. In what country did you obtain your foreign doctor's diploma?

If you do not have or did not have the nationality of the country where you obtained your foreign doctor's diploma, what was your nationality when you were studying medicine?

3. When did you graduate? How old were you?

2000	2001	2002	2003	2004

How old were you when you graduated?

26-30	31-35	36-40	41-45	46-50

4. Did you enrol in the BIG-register after graduating?

Enrolment in the BIG-register	Yes	No
-------------------------------	-----	----

If you did not enrol in the BIG-register, what was the reason?

5. Have you found work as a doctor?

Found work?	Yes	No
Most important reason why you have not found work?		

If you did find work as a doctor, can you indicate how long after graduating you found a job?

How long after graduating did you find work as a doctor?	0-3 months	4-6 months	7-9 months	10-12 months	Unknown

Are you employed full-time or part-time?

Full-time	Part-time

6. If this is part-time employment, how many hours do you work?

<20 hours	24 hours	28 hours	32 hours	36 hours

7. How many different employers have you worked for since graduating?

8. At which organisation did you find work? (For example Gelrepoort Hospital or Groningen Health Authority (GG&GD).

9. Is your job part of a training programme? (For example, general practice training or medical specialist training).

Yes	No

If so, what training are you following?

10. Have you been given assistance in finding employment, or did you find this job on your own?

Assistance	No assistance

11. If you received assistance, who or what organisation helped you?

University Asylum Fund (Stichting voor Vluchtelingstudenten)	
Centre for Work and Income (CWI)	
Integration bureau	
Employment agency	
Other:	

12. Does your job meet your wishes?

Yes	No	partly/ to an extent

13. If your job does not fully meet your wishes, what would you rather do?

Present job	Preferred job

14. Is there any possibility of finding a job and/or trainee position that comes closer to what you really want?

Yes	No	Not applicable

15. Have you experienced any obstacles during your work as a doctor in the Netherlands? If so, what were they?

16. Do you have any additional suggestions or remarks regarding this study?

If you are prepared to give us additional information during a telephone interview, please write your name below and the telephone number at which we can contact you in the evening.

Appendix 5: Overview of foreign diplomas per medical faculty (Career study 2004)

For each university, the left-hand side presents the countries that issued the diplomas of the foreign doctors. If doctors had a different country of origin, this country is given in italics on the right-hand side.

VU Amsterdam University (3)

Brazil
Nigeria
Iraq

University of Amsterdam (8)

Hungary *Iran*
Russia
Croatia
Armenia *Syria*
Afghanistan
Iraq 2
Not given 1

Leiden University (5)

Iraq 2
Venezuela
Russia 2

Erasmus University Rotterdam (18)

Belarus
Bulgaria
Latvia
Ukraine 2 *Afghanistan* 1
China
Brazil
Russia 2 *Afghanistan* 1
Iraq 3
Afghanistan 2
Colombia
Armenia
Not given 2

Utrecht University (6)

Iran
Tadzhikistan *Afghanistan*
Iraq
India
Syria
Romania

University of Groningen (13)

Iraq 4
Sudan
Belarus 2
Turkmenistan
Uzbekistan
Afghanistan 2
Bulgaria
Russia

Afghanistan 1

Afghanistan 1

Radboud University Nijmegen (9)

Iraq 4
Ukraine
Azerbaijan
Russia
Syria
Not given 1

Afghanistan

Maastricht University (5)

Azerbaijan
Iraq 3
Kenya
Romania
Belarus

Appendix 6: Questionnaire for national policymakers and university policymakers concerning foreign educated medical doctors

Introduction

Many refugees and family reunifiers (or formers) who come to European countries hold academic or professional qualifications and have considerable work experience. Among these migrants there are medical degree holders whose diplomas are not acknowledged or recognised by the Ministers/Secretaries of Health in the countries that granted them asylum, or where they obtained permanent residence on grounds of partnership.

In our research project we investigate possibilities for foreign educated medical doctors - either refugees or other types of newcomer - to receive, if necessary, additional medical training after which they can obtain European medical degrees that enable them to work as medical doctors in the country that granted them permanent residency. In the Netherlands the eight medical faculties have developed a special route for medical doctors whose qualifications are not acknowledged by the Minister/Secretary of Health. A new assessment procedure for medical degree holders is being developed by the Ministry of Health and the medical faculties.

There is no systematic registration of policies of EU countries concerning medical degree holders who obtained their – unacknowledged – medical degrees outside the European Union. In this research we investigate national policies on unacknowledged medical degree holders as well as the policies and practices of several non-randomly chosen universities with medical schools in a number of EU countries. The universities we approached with a request to participate in this research project are members of the Utrecht Network⁵⁵. Nearly all Utrecht Network universities have medical schools.

⁵⁵ The Utrecht Network consists of 26 universities in Western and Central Europe that cooperate in a wide range of activities. The activities carried out by the Utrecht Network cover the entire spectrum of internationalization of higher education, especially student mobility, staff exchange, the internationalization of curricula, summer schools, etc.

Questionnaire concerning national policies on foreign educated medical doctors

Does your country have a registering body that deals with recognition of medical qualifications?

Does the Ministry of Health provide foreign educated medical doctors with information (brochures, websites) on recognition procedures for persons holding foreign medical degrees?

Is the Ministry of Health responsible for dealing with recognition requests by holders of foreign medical degrees, or is there no national centralized procedure?

How many people with permanent residence in your country and holding medical degrees obtained in countries outside the European Union asked for recognition of their diplomas in 2001, 2002, and 2003?

In order for someone's medical degree to be recognized are these persons tested as to their medical knowledge or does the recognition take place on the basis of information provided by credential evaluators like the Educational Resources Information Center (ERIC) and the National Recognition Information Centers (NARIC)?

Is there a special assessment procedure in your country for holders of medical degrees?

Is working experience as a medical doctor in the country of origin taken into account in the recognition procedure, in addition to the medical diploma and other qualifications obtained?

What are the qualifications of the credential evaluators? Are there any medical doctors involved in the recognition process?

In your country, is there a policy on medical degree holders whose diplomas are not acknowledged as equal to the degrees of medical doctors trained in your country?

Are medical degree holders whose diplomas are not acknowledged referred to a university with a medical faculty in order to receive additional medical training? If not referred to a medical faculty, are they referred to another organization?

Are there medical faculties in your country that have developed additional medical programmes for medical degree holders whose diplomas are not (fully) recognised?

Has the Ministry of Health requested medical faculties to develop additional programmes for foreign educated medical doctors? If not, are there any (non) tailor-made programmes available at medical faculties?

Is there a shortage of medical doctors in your country? Are foreign educated medical degree holders seen as part of the solution to diminish the shortage of medical doctors?

Questionnaire concerning university policies and practices on foreign educated medical doctors

Recognition and admission requests

Has the university or medical school received any requests for admission from holders of foreign medical degrees with permanent residency in order to obtain a medical degree at this university?

What is the major reason for these foreign educated medical doctors to request admission at your medical school? Is it the fact that their foreign medical degree was not recognized by the Ministry of Health?

Do you frequently receive this type of requests? How many foreign educated medical doctors did apply for admission to your medical school in 2001, 2002, and 2003?

What countries did these medical doctors come from? Did they obtain their medical degrees in their countries of origin or in a third country?

What is the status of these medical doctors in your country? Are they refugees or have they gained residency on grounds of partnership (marriage/cohabitation)?

Admission options

Can foreign educated medical doctors whose diplomas are not recognised be admitted to your medical school?

Is medicine a limited enrolment programme in your country?

If not, what are the reasons for not admitting foreign medical doctors to your medical school?

Is the university itself, not the government, responsible for the (non-)admission of foreign medical doctors?

If a foreign doctor is admitted, does he or she have to start all over again with the medical study, from the very beginning?

If a foreign doctor is admitted, how many years will it take for him or her to obtain a medical degree from your university?

Is the assessment of their medical knowledge used as a tool to tailor their programmes to their needs?

Does the age of someone asking admission have any influence on the way their request is dealt with?

Is sufficient mastery of the (national) language a prerequisite for admission of a foreign medical doctor?

Do the medical schools in your country in one way or another cooperate when it comes to dealing with foreign medical doctors whose degrees are not recognized?

Is there an organisation in your country that supports foreign medical degree holders in finding their way into a medical school?

How will newcomers/foreign educated medical doctors pay for their living and study expenses if they have to study for some more years in order to obtain a medical degree in their new country?

Experience with foreign medical doctors

Assuming the medical school admits foreign medical doctors to regular programmes, what experiences do the staff have with these students?

If a language exam is a prerequisite for admission of a foreign medical doctor, does this exam guarantee a sufficient level of language proficiency for the medical doctor, once admitted, to be able to properly communicate with local patients, professors and other medical students during internships?

Is there a specific medical language programme available for foreign medical students that have to take an additional programme at a medical school?

Would a foreign medical doctor, after gaining admission and obtaining a medical degree at your university, succeed in finding work as a medical doctor in your country?

For whom would it be harder to find a job as a medical doctor after graduating from your university: a native of your country or a foreigner?

Appendix 7: An international comparison between policies of some European countries and universities in dealing with foreign medical doctors

1.1 Introduction

Many refugees and family reunifiers (or formers) who come to European countries hold academic or professional qualifications and have considerable work experience. Among these migrants there are medical degree holders whose diplomas are not acknowledged or recognised by the Ministers/Secretaries of Health in the countries that granted them asylum, or where they obtained permanent residence on grounds of partnership.

In our research project we investigate possibilities for foreign educated medical doctors - either refugees or other types of newcomer - to receive, if necessary, additional medical training after which they can obtain European medical degrees that enable them to work as medical doctors in the country that granted them permanent residency. In the Netherlands the eight medical faculties have developed a special route for medical doctors whose qualifications are not acknowledged by the Minister/Secretary of Health. A new assessment procedure for medical degree holders is being developed by the Ministry of Health and the medical faculties.

There is no systematic registration of policies of EU countries concerning medical degree holders who obtained their – unacknowledged – medical degrees outside the European Union. In this research we investigate national policies on unacknowledged medical degree holders as well as the policies and practices of several non-randomly chosen universities with medical schools in a number of EU countries. The universities we approached with a request to participate in this research project are members of the Utrecht Network⁵⁶. Nearly all Utrecht Network universities have medical schools. It appeared however that the Utrecht Network was at some times nothing more than a starting point, although a useful one. To find someone at the department level and at the university level who were well informed about the policies concerning foreign medical degree holders proved to be enormously complicated. It was a long search to trace out the right people in all the countries (ministries and universities) that were involved in this particular part of our research project.

In order to be able to present the precise information about the situation in Austria I received support from Dr Johannes Streicher (Medical University of Vienna), Mrs Mag Christine Thornton (Medical University Graz), Mrs Mag Sabine Pendl (Office of International Relations at the University of Graz) and Dr Josef Leidenfrost (Ombudsman Task Force at the Ministry of Education, Science and Culture).

⁵⁶ The Utrecht Network consists of 26 universities in Western and Central Europe that cooperate in a wide range of activities. The activities carried out by the Utrecht Network cover the entire spectrum of internationalization of higher education, especially student mobility, staff exchange, the internationalization of curricula, summer schools, etc.

In order to be able to present the precise information about the situation in the Flemish part of Belgium I received support from Prof Dr Walter Michielsen (Faculty of Medicine at the University of Ghent), Prof Dr Leo Bossaert (Faculty of Medicine at the University of Antwerp), Mrs Dr Isabel de Smet and Mrs Dr Liesbeth Hendrix (both Flemish Interuniversity Council Brussels) and Mrs Patricia de Clopper (Office of International Relations at the University of Antwerp).

In order to be able to present information about the situation in Denmark I received support from Mrs Mette Brandenborg (International Secretariat of the University of Aarhus), Mrs Benedicte Baumgarten (International Coordinator at the Faculty of Health Sciences at the University of Aarhus), Mrs Suzanne Andersen (International Relations at the Faculty of Health Sciences at the University of Copenhagen) and Mrs Karin Scavenius (Danish National Board of Health in Copenhagen).

We received the information about the situation in France from Prof Dr François René Pruvot. Prof. Pruvot is the Vice Dean for International Affairs at the Université du Droit et de la Santé à Lille: Université Lille 2. I also got assistance from Béatrice Delpouve (International Relations Office of Université Lille 1), Phillippe Cordonnier (International Relations Office of Université Lille 2) and Françoise Deregnacourt (assistant of the Vice Dean for International Affairs).

In order to be able to present information about the situation in Germany I received support from Mrs Jutta Schmidt (International Relations Office at the Ruhr University in Bochum), Mr Svend Poller (International Relations Office at the University of Leipzig), Mrs Sabine Klimmek (International Relations Office at the University of Leipzig) and Mr Rainer Godry (Ministry of Health of the Province of North Rhine-Westphalia).

In order to be able to present information about the situation in Norway I received support from Mrs Etelka T. Dahl (University of Bergen), Mr Kjell S. Skålbones (Norwegian Registration Authority for Health Personnel), Mrs Cathrine Emblem and Mrs Carol Østby (both working at the Secretariat for Foreign Medical Doctors of the Faculty of Medicine of the University of Oslo).

The information about foreign medical degree holders in Spain was found with support from Prof Dr Carlos Seoane Prado (Facultad de Quimica) and Prof Dr Jesus Tresguerres (Facultad de Medicina) both from the Universidad Complutense Madrid.

The information about foreign medical degree holders in Sweden could be found with support from Mrs Renée Valeri (International Relations Office of Lund University), Dr Erling Myhre (Director of International Studies at the University Hospital Medical Centre in Lund), Mr Leif Gudmundson (the National Board of Health and Welfare in Stockholm) and Mrs. Birgitta Rundquist from the Karolinska Institute in Stockholm.

The information about foreign medical doctors in the United Kingdom could be found with help from Prof Tim Birtwistle (Leeds Metropolitan University), Prof Trudie Roberts (Faculty of Medicine of the University of Leeds), Mrs Jessica Watson and Mrs Ceri Butler (both Programme Administrators of the Refugee and Overseas Qualified Doctor's Programme at the University of London) and Mrs Lisa Bond from the Registration and Education Directorate of the General Medical Council.

1.2 Part I: questionnaire concerning national policies on foreign educated medical doctors

1. Does your country have a registering body that deals with recognition of medical qualifications?

Austria

Yes. The German name for the responsible institution is *Ärztchamber*. In English: the Medical Association. Besides the Medical Association the NARIC is responsible for dealing with recognition requests of medical qualifications. NARIC is responsible for evaluation of foreign diplomas and admissions. NARIC is part of the Ministry of Education, Science and Culture.

Belgium

In the Flemish Community of Belgium a subdivision of the Ministry of Education, is responsible for dealing with equivalency requests of foreign medical doctors. In case of doubt about equivalency of a foreign medical degree the NARIC staff of the Ministry of Education puts forward a request for advice to the Equivalence Committee Foreign Medical Degrees of the Flemish Interuniversity Council (abbreviation in Dutch: VLIR). Every Flemish university with a medical school has a delegate (professor of medicine) in this committee.

Denmark

Yes. The Danish National Board of Health (*Sundhedsstyrelsen*).

France

Yes. The Ministry of Education is responsible for recognition of (all) foreign qualifications.

Germany

There is no central registering body in Germany due to the constitution. The provinces (Länder) have this competence and are responsible for dealing with recognition requests from medical doctors trained outside the European Union/ European Economic Area.

Norway

Yes, the Norwegian Registration Authority for Health Personnel (*Statens Autorisasjonskontor For Helsepersonell*).

Spain

Yes. The Ministry of Education is entitled to do recognitions not only for the medical diplomas but for every type of diploma from secondary or higher studies.

Sweden

Yes. The National Board of Health and Welfare is the competent authority in Sweden for all regulated health professions.

United Kingdom

Yes. The General Medical Council (GMC).

2. Does the Ministry of Health provide foreign educated medical doctors with information (brochures, websites) on recognition procedures for persons holding foreign medical degrees?

Austria

Yes. By NARIC.

Belgium

Yes. Brochures for foreign medical doctors are available.

Denmark

Yes. For this purpose a brochure is published entitled: "Guidelines concerning the authorization of doctors trained outside Denmark". Besides that there is a memo entitled: "Advisory notes about probationary clinical appointments for foreign-trained doctors who wish to obtain permanent authorization to practise medicine in Denmark, and who are not covered by the EU Doctors' Directive or the Nordic Agreement".

France

In 2005 the Ministry of Health finished the development of an assessment procedure for foreign educated medical doctors. Third country doctors with degrees from outside the European Economic Area may apply for recognition of their degree after successfully ending the assessment procedure.

Information about this procedure can be found at the departmental website:
www.sante.gouv.fr

Germany

Every province has internet sites to inform foreign medical doctors about procedures.

Besides these internet sites the so-called *Bundesärztezimmer* (the German Medical Association) gives information to foreign medical doctors about working as a medical doctor in Germany (www.baek.de).

Norway

Yes. The internet sites with the applicable information are:

www.safh.no and <http://www.med.uio.no/medfak/utenlandsmed/>

Spain

This is unknown.

Sweden

This kind of information is provided by the Board.

United Kingdom

Yes. There is some information on the Department of Health's website but most internationally qualified doctors consult with the General Medical Council, the British Medical Association (BMA) and the newly established ROSE website www.rose.nhs.uk for refugee and overseas qualified health professionals.

3. Is the Ministry of Health responsible for dealing with recognition requests by holders of foreign medical degrees, or is there no national centralized procedure?

Austria

In case of equality of foreign medical qualifications the Ministry of Education, Science and Culture (NARIC) is responsible. In case of inequality of foreign medical qualifications the medical universities are responsible for the recognition procedure (in German: "Nostrifikation").

Belgium

The Ministry of Education is responsible for dealing with recognition requests. The Ministry of Education however makes use of the Flemish Interuniversity Council (VLIR) if there is need for advice on foreign medical degrees.

Denmark

Third country doctors have no rights guaranteed by treaty or automatic recognition as a doctor. There is, however, a possibility for individual assessment for third country doctors.

France

Yes, since 2005 the Ministry of Health is responsible for an assessment procedure for third country doctors in France.

Germany

In Germany there is no centralized procedure. All provinces (Länder) have their own authority to develop an assessment procedure for foreign medical degrees in order to grant a license to practise as a medical doctor.

Norway

Yes (indirectly; the SAFH is subordinated to the Directorate of Health and Social Affairs, which again is subordinated to the Ministry of Health.)

Spain

The ministry of Health is responsible for the recognition of specialities but not for recognition request of a medical degree. The ministry of Education is responsible for these requests.

Sweden

This is the responsibility of the Board.

United Kingdom

No, the General Medical Council deals with these requests.

4. How many people with permanent residence in your country and holding medical degrees obtained in countries outside the European Union asked for recognition of their diplomas in 2001, 2002, and 2003?

Austria

Numbers are unknown.

Belgium

In the period from July 2003 until March 2005 the Flemish Interuniversity Council admitted 71 third country doctors to their procedure.

Denmark

Numbers are unknown.

France

In 2005 about 2.000 third country doctors did an application for recognition.

Germany

In the period from 2000 until 2003 in total 1471 medical doctors from outside the European Union/European Economic Area got recognition of their medical degrees in *Bundesland* North Rhine-Westphalia.

Norway

SAFH is unable to present data how many foreign doctors applied.

212 doctors educated outside the EU/EEA were issued their final Norwegian license to practise in 2003 and 326 in 2004. These doctors had to complete the compulsory additional training required for doctors educated outside the EU/EEA.

(Numbers for earlier years are not available because they were then not counted separately.)

Spain

unknown

Sweden

The responsible authorities in Sweden granted recognition to third country doctors:

2001: 197

2002: 224

2003: 295

United Kingdom

The General Medical Council provided the following statistics:

2002: 4456 overseas qualified doctors registered with the GMC
2003: 9336 overseas qualified doctors registered with the GMC
2004: 686 overseas qualified doctors registered with the GMC

Please note that in 2003, it was the end of 'section 19' recognised overseas qualification (this allowed doctors with qualifications obtained in the Commonwealth countries to obtain full registration in the same way as those who held a UK primary medical qualification i.e. without entrance examinations) and there was a big rush to register, hence the higher figures for that year.

5. In order for someone's medical degree to be recognized are these persons tested as to their medical knowledge or does the recognition take place on the basis of information provided by credential evaluators like the Educational Resources Information Center (ERIC) and the National Recognition Information Centers (NARIC)?

Austria

Those medical degree holders whose diplomas are evaluated and considered equivalent to Austrian medical degrees are not tested. Those medical degree holders, whose diplomas are considered unequal to Austrian medical degree holders, are obliged to undergo a test.

Belgium

The first step for a foreign medical doctor is to put forward a recognition request to the Ministry of Education (NARIC). In case of doubt and in case of non-recognition NARIC sends the file to the Flemish Interuniversity Council (VLIR).

Denmark

A third country doctor whose qualification is considered to be equivalent to a Danish medical qualification can be granted a temporary authorization. If a third country doctor wants to apply for a permanent authorization this doctor is required to be employed for probationary periods in two different Danish clinical hospital departments. Each period must last for at least three months. Without a temporary authorization one cannot commence a probationary appointment.

During the probationary employment the applicant is required to pass a verbal test on general medical knowledge and three examinations (in social medicine, the Danish law about the practice of medicine, and the law about the prescription of medicines) at a Danish university. The verbal test and the three examinations are arranged by a Danish university, and carried out in the Danish language. There must be at least one positive assessment of the doctor's overall performance during a period of probationary employment before enrolment for the test and the examinations can be allowed.

The applicant is required to be sufficiently proficient in the Danish language to be able to work effectively and safely as a doctor. This is assessed in the course of each period of probationary employment and also during the verbal test of general medical knowledge and the three examinations; a specific language test is not required.

France

Yes, there is a medical assessment procedure available. Before 2005 there was no test available in France. For specialists or consultants who seek to work and live in France there are even fixed quota per year. They have to take an exam before they can be recognized. The language used in all examinations is French. Without a thorough knowledge of the French language a foreign candidate cannot pass the exams successfully.

Germany

There is a special procedure in which the level of equivalence is investigated. If there is uncertainty about the equivalence a special test must be taken by the foreign medical doctor. Former work experience as a medical doctor is not taken into account. The results of the test are assessed by a committee of four professors in medicine.

Norway

Applicants are tested by means of a compulsory additional training programme at the University of Oslo.

The following requirements have to be satisfied successfully:

- Course and examination in the Norwegian language and in communication for foreign medical doctors
- Written medical examination in seven clinical subjects (internal medicine, surgery, psychiatry, gynaecology/obstetrics, pediatrics, neurology, clinical pharmacology). The examination lasts for 3 hours and consists of 90 multiple choice questions. A minimum of 67% correct answers is required to pass the examination.
- Radiology course and examination. Twice a year a six day course is organised on this subject. There is an oral examination at the end of the course.
- Course in the use of antibiotics. The course is arranged twice a year and lasts for one day.
- Practical experience in Norwegian hospitals. Doctors with a foreign medical degree must work as a physician in a Norwegian public hospital for at least six months. It is the candidate's responsibility to find a subordinate position in a Norwegian public hospital. Candidates must have a temporary license from *Statens Autorisasjonskontor For Helsepersonell* (SAFH) for the practical experience.
- Course and examinations in the "National Subjects", like community medicine, forensic psychiatry, forensic medicine and writing prescriptions.
- Clinical examinations (if found necessary)
- The faculty of Medicine also requires that all medical students have assisted at three or more births.

All courses and examinations are held in Norwegian. Candidates may sit the same examination a maximum of three times.

Spain

This is different according to the countries of origin. With several countries there are previous agreements in order to recognize titles (some Latin American countries). With others if these arrangements do not exist, validated programs of the matters are requested from the different Universities. In some cases an additional exam (*prueba de conjunto*) is performed twice a year in order to get information about those matters in which a certain lack of substance can be detected in the programs.

Sweden

The Board uses instruments for testing medical knowledge. Doctors without a specialty have to pass a medical exam (arranged by the Karolinski Institute on the Boards request) and undertake internship training in order to be registered. Specialists work under supervision during a six months probationary period. They have to obtain a favourable assessment.

United Kingdom

No, it depends on whether their medical school is on the WHO World Directory of Medical Schools.

6. Is there a special assessment procedure in your country for holders of foreign medical degrees?

Austria

Yes.

Belgium

Yes. The Flemish Interuniversity Council (VLIR) arranges twice a year (in March and September) a multiple choice test. If a candidate has a positive score of at least 6 out of 20 questions the candidate will be invited for an interview. The results of both the test and the interview will lead to a binding advice. With this advice the candidate can go to any Medical School in Flanders. The Medical School will follow up the advice of the Council. The candidate is free to ask for admittance at the Medical School of Ghent, Leuven, Antwerp, etc.

Denmark

Yes.

France

Yes.

Germany

Yes.

Norway

Yes.

Spain

No. Either the studies are accepted, or need to be assessed in a few matters by a special examination (*prueba de conjunto*), or not accepted. No special assessment is carried out in a similar way as the American foreign examination.

Sweden

Yes.

United Kingdom

Yes, all overseas qualified doctors (non-EEA) must go through an International English Language Testing System (IELTS) examination. The majority then take PLAB (Professional and Linguistic Assessment Exam) whilst some are exempted based on their speciality and years in that speciality.

7. Is working experience as a medical doctor in the country of origin taken into account in the recognition procedure, in addition to the medical diploma and other qualifications obtained?

Austria

No. A special arrangement has been made for the medical doctors from the ten new member states who joined the European Union since May 1 2004. There will be a special transitional arrangement in which working experience will be taken into account in the evaluation of the medical degree.

Belgium

In the interview the professors look at the career of the candidate. Working experience will be taken into account when the Council advice is determined.

Denmark

unknown

France

It is conceivable that in a supervision route a third country doctor will have a shorter programme due to solid medical knowledge.

Germany

Working experience is not taken into account in the assessment procedure.

Norway

To some extent it could, but since there is a compulsory additional training program at the University of Oslo that (with very few exceptions) all doctors educated outside the EU/EEA have to go through it will not have any significant bearing.

Spain

No.

Sweden

The probationary period requires substantial working experience; at least five years within a specialty.

United Kingdom

Yes, but really only for those seeking exemption of PLAB and going down a specialist route. For others it is an indicator of their previous experience, it helps to guide tutors and course organisers to the level of expertise and also offers the opportunity for those doctors with particular specialisms to teach/present on their speciality to other refugee/overseas qualified doctors. There are moves towards bringing in formal recognition of previous experience but at present there is no system; so refugee doctors are often frustrated to find they are competing for jobs with British-trained/overseas qualified doctors with no real clinical experience when they may have ten or more years experience.

8. What are the qualifications of the credential evaluators? Are there any medical doctors involved in the recognition process?

Austria

NARIC will probably seek advice from professors of the Medical Universities.

Belgium

The NARIC-staff will probably not have medical backgrounds. All the members of the Flemish Interuniversity Council (VLIR) are professors in medicine.

Denmark

The assessment is made by the Danish National Board of Health on the basis of a recommendation by the Faculty of Health Sciences of a Danish university.

France

All evaluators are professors in medicine.

Germany

After rejection of the recognition request there is a possibility to sit a medical exam. The medical exam is evaluated by four professors in medicine.

Norway

Yes (since the additional training programme for doctors educated outside the EU/EEA is run by the Medical Faculty at the University of Oslo).

Spain

Normally university professors are responsible for partial recognition of studies at university level and civil servants at the ministry of education are responsible for degree recognition.

Sweden

The evaluators are all medical doctors.

United Kingdom

Yes. The General Medical Council's Governing body is made up of doctors, the public and academics. Each committee within the GMC also has representation from medical doctors who are involved both in deciding the recognition process but also in lobbying for change.

9. In your country, is there a policy on medical degree holders whose diplomas are not acknowledged as equal to the degrees of medical doctors trained in your country?

Austria

Yes. The so called "Nostrifikations-procedure" (recognition procedure).

Belgium

Yes. Via the Ministry of Education (NARIC) foreign medical doctors will be referred to the Flemish Interuniversity Council in order to make admission to a Medical School possible if a certain level of medical knowledge has been assessed.

Denmark

Applicants whose foreign training is considered not equal to a Danish medical training may approach a Danish university to receive guidance about the possibilities of seeking admission to medical studies.

France

No.

Germany

No.

Norway

Yes.

Spain

If a medical degree is finally accepted the holder has the same rights as the local educated doctor. There are no programmes for holders of unrecognised medical degrees.

Sweden

The doctors with a third country qualification will be placed on equal footing with Swedish doctors when they have passed the supplementary training programme.

United Kingdom

Generally speaking, unless individuals can make a special case to the General Medical Council, if they wish to return to practice medicine they must re-do their medical training in the United Kingdom.

10. Are medical degree holders whose diplomas are not acknowledged referred to a university with a medical faculty in order to receive additional medical training? If not referred to a medical faculty, are they referred to another organization?

Austria

Yes. But there must be a minimum level of recognition of five years of medical studies. They will get information from NARIC about how to proceed at Medical Universities.

Belgium

Yes. After having got an advice from the Flemish Interuniversity Council a foreign medical doctor is in principle admissable to a medical school.

Denmark

Unknown.

France

No.

Germany

No.

Norway

Referred to the University of Oslo.

Spain

They are only referred to medical faculties for the special examination (*prueba de conjunto*).

Sweden

They are referred to this Board.

United Kingdom

Not certain, but there are a few key Universities that are well known for their work with refugee doctors – Queen Mary, University of London, St George’s Medical School and Liverpool School of Tropical Medicine – where doctors are usually referred to. Also the British Medical Association and local voluntary organisations are key in the information process for doctors. In the United Kingdom there is a unique collaboration between voluntary, statutory and the government bodies in trying to increase the integration of refugee health professionals in the United Kingdom.

11. Are there medical faculties in your country that have developed additional medical programmes for medical degree holders whose diplomas are not (fully) recognised?

Austria

Yes. The programmes foreign medical degree holders have to do differ according to the medical university they will be admitted to.

Belgium

Yes. The programmes are standardized and are not tailor-made for the foreign medical doctors.

Denmark

No.

France

Yes. Third country doctors may take two examinations in order to become a doctor. First, they have to sit for an examination at the end of year 1 (PCEM1). After passing this PCEM1-exam they get exemptions for the examinations at the end of year 2, 3, 4 and 5 (PCEM2-DCEM1-DCEM2 and DCEM3). And second, the third country doctor must sit for the final exam at the end of year 6 (DCEM4). These exams are all national exams.

Germany

No.

Norway

Yes, at the Medical Faculty at the University of Oslo.

Spain

No.

Sweden

No.

United Kingdom

Not explicitly. However St George's Medical School ran a United Examining Board (UEB) course between 1994 and 2002 for doctors who had qualified in other countries to re-qualify in the United Kingdom. This course was due to be relaunched in June 2005 but one's medical degree must be from the list of 'recognised' World Directory of Medical Schools.

12. Has the Ministry of Health requested medical faculties to develop additional programmes for foreign educated medical doctors? If not, are there any (non) tailor-made programmes available at medical faculties?

Austria

Under the University Organisations and Studies Act (Universities Act, 2002) universities are obliged to start a recognition procedure if a student is allowed to specialize or to work in Austria.

Belgium

At the Flemish Universities with a Medical School there was a strongly-felt need to cooperate and coordinate the way in which the medical schools dealt with foreign educated medical doctors. Not the numbers of applicants was the cause for starting the Equivalence Committee of the Flemish Interuniversity Council two years ago, but the complexity of equivalency requests.

Denmark

Not applicable.

France

No. There are no tailor made programmes available in France.

Germany

Not applicable.

Norway

The University of Oslo runs a specific programme that in principle is applied to all applicants educated outside the EU/EEA.

Spain

No.

Sweden

No.

United Kingdom

The Department of Health has not requested that faculties develop additional programmes. The majority of initiatives tend to be created by devoted individuals who then go on to seek funding from either central (government) sources or their Universities or local health authorities.

1.3 Part II: questionnaire concerning university policy and practice regarding foreign educated medical doctors

Recognition and admission requests

1. Has the university or medical school received any requests for admission from holders of foreign medical degrees with permanent residency in order to obtain a medical degree at this university?

Austria

Yes. Medical Universities, however, will not start a recognition procedure if a person has no permanent residency in Austria.

Belgium

Yes. The majority of the foreign medical doctors have permanent residence in Belgium because of refugee status. Some of the applicants do not yet have permanent residency. The procedure with the Flemish Interuniversity Council (VLIR) is only accessible for foreigners with permanent residency.

Denmark

None, but we do admit students who can transfer exams and/or mandatory courses.

France

Yes. The Medical School of the University of Lille gets nearly 50 demands per year of third country doctors applying for admission. The University of Lille accepts about 10 of them each year.

Germany

Yes, the university has had these requests.

Norway

Occasionally foreign degree holders ask the Secretariat for foreign medical doctors if they can enrol as regular students in the medical faculty, to either gain a Norwegian medical degree or to supplement their education. We direct them to the Admissions Office but have the impression that they have little chance of being admitted. As they already have a degree and there is a system in place to have a foreign medical degree recognised they will be given very low priority and there is strong competition for places.

Spain

This is not possible. They should request partial recognition of studies. They can complete the non-recognized ones. There is the possibility of performing some master degrees or doctorates but not entitling them to work in our country: this is interesting and important for people coming from Latin America.

Sweden

In Sweden it is the National Board of Health and Welfare who is dealing with recognition of medical qualifications. So doctors with diplomas from outside the European Union should turn to them and follow their complementary training program, which is in short as follows:

A person with a medical degree from a country outside the European Union has to

1. learn Swedish and pass a language test showing that he/she has a certain level of Swedish to be able to communicate with the future patients and colleagues.
- 2.

A. Specialists (having worked in their country of origin for at least 5 years) work under supervision during six months as a probationary period. If he/she obtains a favourable assessment, he/she will then be able to work as a specialist.

B. Doctors having worked less than 5 years in their home country pass an exam called the TULE-test. The TULE-test is organised by the Karolinska Institute including a written test in five subjects (medicine, pediatrics, obstetrics and gynecology, psychiatry and surgery) and two practical tests. After passing the TULE-test, he/she can apply for internship training (about 18 months).

3. Pass a test in Swedish legislations (special courses available).

United Kingdom

No. The situation in the United Kingdom is that foreign medical doctors (diplomas obtained outside the European Economic Area) must go through a procedure at the General Medical Council. If recognition is not granted, after doing tests on general medical knowledge (PLAB), sufficient knowledge of English (International English Language Testing System) and clinical competencies, than a medical doctor will not be registered by the General Medical Council. In that case a medical doctor can not practise.

If a medical doctor in such a position would like to register as a 'regular' student it would cost this student £ 24.000 (nearly € 36.000,-) per year, being an overseas student. Therefore it never occurs.

2. What is the major reason for these foreign educated medical doctors to request admission at your medical school? Is it the fact that their foreign medical degree was not recognized by the Ministry of Health?

Austria

Non recognition of their medical degrees. Therefore they will start a recognition procedure. A recognition procedure always will be dealt with by a Medical University.

Belgium

The fact that their foreign medical degrees are not recognized.

Denmark

Not applicable.

France

Non recognition of foreign diplomas is the major reason for third country doctors to ask for admission.

Germany

After rejection of the recognition request by the *Landesprüfungsamt* (central recognition office), it is possible that holders of degrees will be admitted to complete the practical year (11th and 12th semester) or more. Russian medical programs are evaluated equal to 10 semesters in medicine. Chinese medical programs however are evaluated equal to 6 semesters in medicine. Russian medical degree holders therefore have to enroll in the practical year. Sometimes medical degree holders will be enrolled in an earlier semester, e.g. the medical doctors from China, Syria, Jordan, etc. The staff of the medical school that is responsible for admission of foreign degree holders will adopt the outcome of the evaluation by the *Landesprüfungsamt*. No additional exam has to be made.

Norway

Reasons mentioned to the Secretariat for foreign medical doctors are that they wish to find a way to avoid the stringent tests given in the recognition process, that they have used up the maximum number of attempts (3) at an exam in the recognition process or are not confident that their medical qualifications will be recognised in Norway.

Spain

Yes, after non-recognition of their medical degree, they ask for partial recognition at university level.

Sweden

We sometimes have requests from doctors with foreign medical degrees, who have not been able to pass the TULE-test successfully (approximately 1 or 2 times a year).

United Kingdom

They wish to do some training in the UK. It has nothing to do with non-recognition of their degree by the Department of Health. At the University of London we have not come across doctors with foreign degrees that are not accepted, but some may feel the PLAB-exams are insurmountable.

3. Do you frequently receive this type of requests? How many foreign educated medical doctors did apply for admission to your medical school in 2001, 2002, and 2003?

Austria

Yes. The Medical University of Vienna receives nearly 50 requests for the recognition and admission procedure per year.

Belgium

In the period of July 2003 until March 2005 the Flemish Interuniversity Council admitted 71 third country doctors to their procedure.

Denmark

None.

France

In the past years nearly 50 third country doctors requested for admission. The staff of the medical school of Lille University expects this amount to decline because of the introduction of a national assessment procedure for third country doctors.

Germany

We often receive these requests. Approximately 30 a year.

Norway

The Admissions Office may be able to answer these questions where applications for admission to regular studies are concerned. The Secretariat for foreign medical doctors receives many applications for the recognition procedure. Applicants are not admitted to the procedure as a whole but must apply for each part of the procedure separately, after fulfilling the requirements for the individual parts of the procedure. For example an applicant will not be registered for the written medical test until he/she has passed the tests at the end of the course in the Norwegian language and in communication for foreign medical doctors. In 2001 261 foreign medical doctors got recognition. In 2002 249 doctors got recognition and in 2003 279 foreign medical doctors got recognition.

Spain

Unknown

Sweden

Unknown

United Kingdom

No.

4. What countries did these medical doctors come from? Did they obtain their medical degrees in their countries of origin or in a third country?

Austria

The majority of the medical degree holders are from:

1. Serbia
2. China
3. Iran
4. Afghanistan
5. Ukraine

Other requests come from doctors with degrees obtained in Iraq, Russia, Egypt, Nigeria and the Philippines.

Belgium

The majority originates from the former Soviet Union. A minority originates from former Warsaw Pact countries like Poland, Hungary, Romania, Moldavia, etc. Requests also come from medical doctors who have African nationalities but diplomas obtained in the former Soviet Union. Once in a while medical doctors from Latin America put forward a request for admission.

Denmark

Not applicable.

France

Most third country doctors are coming from the Francophone countries in Africa like Algeria and Maroc. Others are third country doctors (most of them female) who originate from the former Soviet states, like the Ukraine, Belarus, Russia.

Germany

They hold degrees and/or nationalities from Russia, China, Syria, Jordan, Iraq, etc.

Norway

Not applicable.

Spain

In Spain many requests come from Latin American doctors and also some from doctors from Arab countries.

Sweden

The doctors with medical degrees from outside the European Union come from all countries outside the EU, but mainly from Iraq, Iran, the former Soviet Union, Romania and Bulgaria. Many of these doctors have studied in another country than their country of origin.

United Kingdom

Refugee doctors who have attended courses at Queen Mary come from a wide range of countries. Of the 102, 31% were from Iraq, 6% Russia, 6% Iran, 5% Afghanistan, 5% Pakistan, 5% Ukraine, 5% Congo, 4% Algeria, 4% Somalia and others as seen below:

Table 1: Students by Country of Origin in the UK

Country of Origin	%	Country of Origin	%
Afghanistan	5.0	Kenya	1.0
Albania	2.0	Kosova	2.0
Algeria	4.0	Moldova	1.0
Azerbaijan	1.0	Nicaragua	1.0
Bangladesh	1.0	Pakistan	5.0
Bosnia	3.0	Peru	1.0
Bulgaria	1.0	Romania	1.0
Burma	2.0	Russia	5.9
China	2.0	Slovak Republic	1.0
Colombia	1.0	Somalia	4.0
Congo	5.0	Sudan	1.0
Czechoslovakia	1.0	Libya	1.0
Ethiopia	2.0	Turkey	1.0
India	2.0	Uganda	1.0
Iran	5.9	Ukraine	5.0
Iraq	30.7		

The majority of students gained their degrees in these countries but there are a few doctors who attended Universities in a third country. One doctor from the Congo attended University in Germany. Another from Somalia undertook their degree in Italy. There are also cases where doctors from Iraq trained in Iran and vice versa.

5. What is the status of these medical doctors in your country? Are they refugees or have they gained residency on grounds of partnership (marriage/cohabitation)?

Austria

The estimate is that 30% are refugees, while 70% is enjoying residency on the basis of partnership.

Belgium

The majority has permanent residency on the basis of refugeeship. A minority has permanent residency on the basis of partnership with a Belgian national.

Denmark

Not applicable.

France

The third country doctors from Africa are mostly immigrants. The third country doctors originating from the former Soviet states often gained residency on grounds of partnership. It is quite rare that a third country doctor has a status of a refugee.

Germany

They can simply apply for these positions. But they can also have permanent residency on the basis of refugeeship or partnership.

Norway

Applicants to the recognition process are not required to provide the Secretariat with this information.

Spain

Because they have gained residency.

Sweden

Applicants are both refugees and persons who enter Sweden on grounds of marriage/cohabitation.

United Kingdom

To be eligible to join the programmes at Queen Mary, doctors must have settled or refugee status. Doctors in the process of seeking asylum are eligible to attend the Study Group but not the PLAB-programmes. In the last year Queen Mary has shifted from focusing purely. In terms of the status of medical doctors in the country as a whole. There will be a significant number of doctors who have entered on work/study permits and those figures may be obtained from the General Medical Council. Data held by the British Medical Association (BMA) on a voluntary register highlights that of the 1027 on their database:

Table 2: Residency in the UK

Asylum seekers	304
Discretionary leave to remain	1
Indefinite leave to remain	371
Exceptional leave to remain	174
Humanitarian protection	2
Refugee status	117
Other	58

Admission options

6. Can foreign educated medical doctors whose diplomas are not recognised be admitted to your medical school?

Austria

Yes. The recognition procedure at the Medical University in Vienna consists of the following:

1. evaluation of the full range of papers of the candidate (diploma, transcript, subjects studied, etc.)
2. a multiple choice random sample test about 15 clinical subjects.

If the outcome of the evaluation and the multiple choice test shows that a candidate has a level of less than five years of study the candidate will not be admitted in a special programme. These students will have to start from the very beginning. Students who have a level of five years of study will have to do at least four exams in:

1. forensic medicine
2. pharmacology
3. hygiene
4. social medicine

For each exam a student gets three months preparation time. Extra exams might be imposed because of the results on the multiple choice test. So the minimum programme takes one year. The exams are all in the German language. So without knowledge of the German language a foreign medical degree holder does not stand a chance from the very beginning.

Belgium

Yes. They have to follow the so-called VLIR-procedure.

Denmark

Yes.

France

Yes.

Germany

After passing through the recognition procedure by the *Landesprüfungsamt* they may apply to a medical school. There is however a limitation of studyplaces available for third country doctors. A maximum of 8% of all the studyplaces is available for students from outside Germany and other countries of the European Economic Area. The applicants must have excellent marks.

Norway

Occasionally foreign degree holders ask the Secretariat for foreign medical doctors if they can enrol as regular students in the medical faculty, to either gain a Norwegian medical degree or to supplement their education. We direct them to the Admissions Office but have the impression that they have little chance of being admitted.

Spain

After obtaining partial recognition, admission is possible.

Sweden

If a person has done the TULE-test three times (which is the maximum) and has passed the practical part and the written part except for one or at most two subjects, the National Board of Health and Welfare can decide that the person can apply to follow those specific courses at a Swedish medical university. After that the person can continue with the internship etc. We try to find space for these doctors, although it may take a while, as the courses are normally full.

United Kingdom

Only as undergraduates (to re-take their primarily medical qualifications).

7. Is medicine a limited enrolment programme in your country?

Austria

No.

Belgium

Yes. But there is no limitation in enrolment for those foreign medical doctors who came through the VLIR-procedure.

Denmark

Yes.

France

No, the study of medicine has an unlimited enrolment.

Germany

Yes.

Norway

Yes.

Spain

Medicine in Spain has a limited enrolment. Above that medicine has a limited number of foreigners that can be admitted also.

Sweden

It is very difficult to enter a medicine programme in Sweden. You have to be a top student and even so you might not succeed in entering a medical school. Some Swedish students therefore try to enrol in a medicine programme abroad. Many go to other EU-countries and some to countries outside the European Union.

United Kingdom

Yes. The number of doctors to be trained is set centrally by the government (probably the Department of Health or the Department of Education).

8. If not, what are the reasons for not admitting foreign medical doctors to your medical school?

Austria

If the evaluation procedure has an outcome of less than five years of medical study the candidate will not be admitted to the special and shortened procedure.

Belgium

Not applicable.

Denmark

Not applicable.

France

Not applicable.

Germany

Not applicable.

Norway

Not applicable.

Spain

Not applicable

Sweden

Not applicable

United Kingdom

Multiple. Firstly they don't normally apply for medical degree course admission. Secondly competition is high and the preferred candidate is younger and very articulate and has UK 18+ school qualifications.

9. Is the university itself, not the government, responsible for the (non-)admission of foreign medical doctors?

Austria

Admission or non-admission is the responsibility of the university.

Belgium

The university is responsible for the final admission. An additional requirement is a Dutch language test.

Denmark

Yes.

France

The university is responsible for (non-)admission of third country doctors.

Germany

Based on the prescribed percentage for international students in these programmes (authority of the government), the universities choose their candidates themselves.

Norway

The University of Oslo is responsible for admission or non-admission.

Spain

Yes, the university is responsible for admission after partial recognition.

United Kingdom

Yes, universities have their own admissions policies. The government is involved only in so far as the individual has the right to remain or study in the UK for the duration of their course (for example it is dependent on their Immigration control)

10. If a foreign doctor is admitted, does he or she have to start all over again with the medical study, from the very beginning?

Austria

If an evaluation shows that a candidate has a level of at least five years of the medical study, the candidate will have to take a programme of at least one year (four exams with a preparation time of three months each).

Belgium

No. The advice on the specific medical programme to be completed depends upon the outcome of the test and the interview. The decision about the medical programme is a very differentiated process. In principle admission in year 2 until year 6 is possible. The medical programme in Belgium lasts for seven years. Admission in year 7 hardly ever occurs.

Denmark

Not necessarily. He or she may apply for equivalence of exams.

France

They have to pass for the final exams at the end of year 1 and year 6.

Germany

It depends upon what credentials have been recognized by the *Landesprüfungsamt*.

Norway

Admission as a regular student does not occur very often as there is a special procedure for medical degree holders.

Spain

No. Some matters or subjects can be recognized. Otherwise if no matters are recognized, he should enter from the very beginning and this is nearly non-existing.

United Kingdom

It depends upon whether their qualifications are "recognised".

11. If a foreign doctor is admitted, how many years will it take for him or her to obtain a medical degree from your university?

Austria

After a positive evaluation the candidate will have to take a programme of at least one year.

Belgium

That depends upon the advice on the programme the applicant is required to complete.

Denmark

It depends on how much he or she can transfer from his/her foreign degree programme.

France

Two years.

Germany

It depends on what credentials have been recognized. In total any medical student in Germany will have to complete successfully twelve semesters of training. So a Russian doctor will have to complete only semester 11 and 12 in Leipzig, while a Chinese doctor will have to complete semester 7 up to 12 (three years).

Norway

The recognition process for holders of foreign medical degrees takes a minimum of one year because of the frequency of courses. If the holder fails one or more of the steps of the process, then it can take longer. Resits (three attempts in all are allowed) will require more time.

Spain

This is dependable upon the matters or subjects that are recognised.

United Kingdom

It hardly occurs. But if someone would have to start from the very beginning it would cost him or her five years to obtain a primary medical qualification.

12. Is the assessment of their medical knowledge used as a tool to tailor their programmes to their needs?

Austria

Yes.

Belgium

Yes. In year 6 and 7 of the medical programme the internships take place. These internships are obligatory for most of the foreign candidates. The programmes are not tailor-made. In case of doubt about the theoretical medical knowledge a foreign doctor has to start in year 4. Foreign medical doctors who had to start in year 4 afterwards said that the decision to let them start in year 4 was a good one.

Denmark

They must pass all exams and mandatory courses in the normal medical programme if they did not receive equivalence transfer.

France

No.

Germany

The decision is based on the recognized credentials by the *Landesprüfungsamt*.

Norway

An assessment is made to see whether extra clinical tests are required.

Spain

No.

United Kingdom

That is an option, indeed.

13. Does the age of someone asking admission have any influence on the way their request is dealt with?

Austria

In case a candidate already reached the age of retirement the application request will not be dealt with. The age of retirement in Austria is 65.

Belgium

No. In principle we deal with admission requests indiscriminately. Age, sex, race, religious belief, nationality, etc. does not play any role in the process of recognition and admission.

Denmark

No.

France

Yes.

Germany

No.

Norway

No.

Spain

No.

United Kingdom

No, applications from mature students are often encouraged but in the case of medicine there is generally a ceiling of around 50/55 given that it will take 5 years to get through medical school and then another 2-4 years of training in a speciality.

14. Is sufficient mastery of the (national) language a prerequisite for admission of a foreign medical doctor?

Austria

Sufficient mastery of the language is an implicit demand. As the exams are in German, a candidate must have reached a high level of mastery of the German language. A candidate who fails (one of) the four exams will not succeed in having his medical degree recognised.

Belgium

Yes. In Belgium we distinguish seven levels of mastery of the Dutch language. Level five is the lowest level that a foreign medical doctor must meet in order to become admissible. Someone who does not pass the level five test will not be admitted to the medical programme.

Denmark

Yes.

France

Implicitly, it is. There is no language test that has to be taken. But it is impossible to get admission if the mastery of the French language is not sufficient. Foreign students who apply for admission through a French Embassy are tested on their level of mastery of the French language. If this level is not sufficient the student will not receive a visa.

Germany

Yes.

Norway

Yes.

Spain

Of course. All exams are performed in the Spanish language.

Sweden

Yes.

United Kingdom

Yes. The University and the General Medical Council require an IELTS-score of 6.5 (some clinical courses require 7.5) and 7.0 respectively.

15. Do the medical schools in your country in one way or another cooperate when it comes to dealing with foreign medical doctors whose degrees are not recognized?

Austria

Admission officers inform the colleagues at other medical universities if a certain candidate could not be admitted, for instance, on the basis of suspicious documents. If an admission procedure is stopped in Vienna it will not be opened at the Medical University in Graz or Innsbruck.

Belgium

Yes. In the Flemish Interuniversity Council (VLIR).

Denmark

No.

France

No.

Germany

No.

Norway

Two other universities in Trondheim and Tromsø together provide a course and exams that are equivalent to one of the steps in the recognition procedure. The University of Oslo will recognise passes in this step at these two other universities as part of the procedure.

Spain

No.

United Kingdom

Rarely.

16. Is there an organisation in your country that supports foreign medical degree holders in finding their way into a medical school?

Austria

The medical association and NARIC inform foreign medical doctors. There is no information on any support organization.

Belgium

It appears there is an organization that supports foreigners or migrants. We do not know what organization exactly that is.

Denmark

No.

France

No. The Ministry of Health refers third country doctors who failed for the assessment procedure to medical schools.

Germany

It is unknown.

Norway

Probably not.

Spain

No.

United Kingdom

Perhaps the British Medical Association/General Medical Council/Royal Colleges.

17. How will newcomers/foreign educated medical doctors pay for their living and study expenses if they have to study for some more years in order to obtain a medical degree in their new country?

Austria

Foreign medical doctors who came to Austria on the basis of partnership will get support from their partner. Sometimes the foreign medical doctor works as a paramedic and earns a salary. There are no special study grants for foreign medical doctors.

Refugee students will have a welfare grant. Tuition fees in Austria are relatively low (about 600 euros per year).

Belgium

There is a Welfare organization that supports political refugees who have to study for a limited number of years.

Others who will have to study for a number of years will be supported by their partners.

Denmark

As a minimum students receive ordinary state educational grants.

France

That is unknown. The fees for studying are quite low (€ 200 per year). There are no scholarships available for foreign students. They have to pay all their expenses themselves.

Germany

By using savings, by applying for scholarships, loans, etc.

In Germany a foundation is helping third country doctors to become medical doctors in German society. The *Otto-Benecke-Stiftung* supports third country doctors in preparing for the medical knowledge assessment test and by giving grants.

Norway

The courses of four weeks duration may qualify a candidate for a study loan.

Spain

They will have to find work in order to pay for their study and living costs.

United Kingdom

With extreme difficulties. There is a great deal of lobbying taking place to ensure that refugees and asylum seekers do not face the harsh international fees laid down by the universities. In the case of the medical school at Queen Mary, for year's 1 and 2 international fees are £13,640 per annum rising to £22,330 for years 3-5 (this compares with a maximum of £3,000 for UK/EU students). Living costs in London are estimated at £7-10,000 per year so for the majority of refugees and asylum seekers returning to university is impossible.

It is also the case the young refugees and asylum seekers that attended schools in the UK and took their A-levels here are still faced with international fees. This may change in the future as more pressure is placed by lobbyists and refugee organisations.

Experiences with foreign medical doctors

18. Assuming the medical school admits foreign medical doctors to regular programmes, what experiences do the staff have with these students?

Austria

During the period candidates are doing the one year programme it is quite rare for professors to report problems with the foreign medical doctors. There is, however, a significant difference between two groups of students. About 40% never shows up to do the one year programme. The other group is finishing the one year programme quite swiftly.

Belgium

The study results of most of the foreign medical doctors are poor. The major reason for these poor study results is a poor mastery of the Dutch language. In most cases the medical knowledge is reasonable.

Denmark

There are no experiences with holders of a full degree.

France

Experiences are not very well. Some of the admitted third country doctors are doing well, but a considerable group fails and drops out. Out of the group of 10 admitted each year at the medical school of Lille University 3 or 4 will eventually pass the final exam.

Germany

Unknown.

Norway

It is difficult to know if the Secretariat has any special experiences with the candidates in the recognition procedure as we only deal with these candidates and not with regular students.

They have language difficulties, particularly at the start of the procedure. There are also greater or lesser cultural differences for them to master, depending on how different their own culture is from the Norwegian one. They have a great deal to learn. Not only a new language and a new culture, but also about the practice of medicine in Norway. The pre-practice period of at least six months is considered very important, not only in order to assess a candidate's medical knowledge and skills, but also to allow the candidate time to acclimatise.

Spain

Experiences are not very good. It is for them frustrating to repeat matters that they have already performed at home. Therefore they are not very motivated.

United Kingdom

We have found no more problems than with our own students. If there is a (home) currency devaluation this can cause financial problems.

19. If a language exam is a prerequisite for admission of a foreign medical doctor, does this exam guarantee a sufficient level of language proficiency for the medical doctor, once admitted, to be able to properly communicate with local patients, professors and other medical students during internships?

Austria

A good command of the German language is a prerequisite for passing the multiple choice test. During the one year programme the communication skills improve.

Belgium

No. The level of mastery of the Dutch language is not sufficient. That is especially true for contact with patients. In addition, foreign medical students experience obstacles in communication during meetings with fellow doctors and/ or students.

Denmark

All foreign students must pass the exam in the Danish language in order to apply for admittance.

France

There are no language problems.

Germany

Yes.

Norway

The course for foreign medical doctors in the Norwegian language and in communication is intended to enable the candidate the required level of language proficiency. There are no guarantees. However, evaluations can be made at various stages of the recognition procedure, and as a consequence, adjustments to the recognition requirements can be made.

Spain

Yes.

Sweden

In the complementary training programme organised by the National Board of Health and Welfare, language training is one part. The language exam should be at a level so that the doctor can communicate with both patients, colleagues etc.

United Kingdom

Yes, students (non-EEA) must pass an IELTS-test with an overall score of 6.5 to obtain place at university. However, doctors (unless their primary medical qualification is from the European Economic Area) must have an overall score of 7.0 to gain registration from the General Medical Council.

20. Is there a specific medical language programme available for foreign medical students who have to complete an additional programme at a medical school?

Austria

No.

Belgium

No. The book developed in the Netherlands for foreign medical doctors is unknown in Belgium.

Denmark

No.

France

There are no specific medical language courses available.

Germany

Students can follow a special course in the German language during their first two years.

Norway

The course in the Norwegian language and communication for foreign medical doctors.

Spain

No.

Sweden

There are specific medical language courses for foreign medical students who follow the program for foreign doctors according to the National Board for Health and Welfare. These specific medical language courses are no longer compulsory. Nowadays also some other courses in the Swedish language are accepted.

United Kingdom

Universities run additional language courses for all students. In the case of Queen Mary, there are intensive courses available (at cost) prior to commencing degree courses. Specific courses on medical English are run by further education courses, such as Southwark College, and not centrally within the university system.

21. Would a foreign medical doctor, after gaining admission to and obtaining a medical degree at your university, succeed in finding work as a medical doctor in your country?

Austria

After finishing the one year programme a foreign medical doctor will not obtain a new, Austrian, medical degree. A special note from the Medical University will be added to the original medical diploma stating that the foreign medical degree holder has proven to have reached the same level as an Austrian medical degree holder.

Belgium

Yes. The labour market for medical doctors in Belgium is very good.

Denmark

Yes.

France

Yes. There is hardly any unemployment under doctors in France.

Germany

Yes.

Norway

We do not have access to this kind of information.

Spain

No work as a doctor in the public sector (95% of total) is possible in Spain without an internship of a minimum 3 years as a family doctor. After fulfilling this internship, he surely will succeed in finding work as a doctor.

United Kingdom

Yes.

22. For whom would it be harder to find a job as a medical doctor after graduating from your university: a native of your country or a foreigner?

Austria

For a foreign medical doctor the labour market is harder to enter. The labour market in Austria for medical doctors is not very good.

Belgium

It depends upon their personal backgrounds.

Denmark

There is no difference between foreigners or Danish doctors. All new doctors are guaranteed a job through the postgraduated training organized by the state.

France

There is no difference. If there are no language problems, than a third country doctor will find a job as easy as a French doctor.

Germany

It would depend on their qualifications, experiences, etc.

Norway

We do not know for whom it would be harder to find a job as a medical doctor in Norway.

Spain

It would be equal for both categories.

United Kingdom

Whilst the United Kingdom does have shortages in a number of fields, these shortages are generally at consultant/specialist level. Competition for junior posts is intense for all graduates regardless of country of qualification but perhaps more so for those that qualified overseas. If overseas doctors qualified in the United Kingdom then their chances would be similar to British-born graduates.

That said, there is historic evidence of racism and discrimination within the National Health

Service. Research conducted by Esmail and Everington in 1997 into racism in the medical profession concluded that 'people's careers and livelihoods are jeopardised simply because they have the wrong name (and hence the wrong skin colour)'.

A recent survey conducted by the British Medical Association on 476 doctors, of whom 76 were from a black or minority ethnic background, suggested that ethnicity was a significant factor in barrier to medical training, early career opportunities, access to specialities and in career advancement. The survey not only found that prejudice on the basis of ethnicity is experienced by UK trained doctors but also that amongst all ethnic groups there was an awareness of racism in the profession (see: Cooke, Halford and Leonard (2003): *Racism in the medical profession: the experience of UK graduates.*)

However, the extent to which refugee and asylum seeker doctors are discriminated against is, as yet, difficult to prove.

1.4 Comments on national policies

Registering bodies

All countries involved in this research but one have in one way or another a central registering body that deals with recognition requests of third country medical doctors. In Germany there is no central authority; every province (Länder) has its own authority to deal with recognition requests of third country doctors.

Brochures and/or websites

Nearly all countries developed information brochures and/or websites that inform foreign medical doctors about the recognition procedure.

Centralized or decentralized procedure

In the Nordic countries the recognition procedure is completely centralized. The Departments of Health in Denmark, Norway and Sweden are responsible for the recognition procedures. If there is a role for one of the medical schools, it is because of the fact that the Department of Health requested a medical school (e.g. Faculty of Medicine at the University of Oslo) to organize a medical track for third country doctors. The Nordic countries have chosen to put the responsibility for third country doctors in the hands of the Department. In the United Kingdom the procedure of recognition is centralised too. The General Medical Council is responsible for recognition of all health professionals trained outside the United Kingdom. In France an assessment procedure for third country doctors was developed and introduced by the Department of Health in 2005.

In other countries like Austria and Belgium there are sequential responsibilities. After a negative decision from the Department of Health in Austria or Belgium a medical university (e.g. Vienna) or the joint venture of medical schools in Flanders can start an admission procedure to a medical school for a third country doctor. In Spain the Ministry of Education is responsible for the recognition of medical degrees. If a foreign doctor meets the standards for admission he/she can be admitted to the medical school in Austria, Flanders and Spain.

Numbers of applicants

Although we could not get exact information from all countries about the numbers of third country doctors applying for recognition, we received useful information from the Department of Health in Norway and Sweden. Also the Department of Health from the Province of North Rhine-Westphalia could give us information about the number of applicants. Besides the information we received from the several Departments of Health we obtained information on applicants from the Flemish Interuniversity Council. The Norwegian Department of Health issued 212 licenses to practise in 2003 and 326 licenses to practise in 2004. The Swedish Department of Health received 716 requests for recognition in a three year period. The Department of Health in North Rhine-Westphalia granted 1.471 third country doctors recognition in the period from 2000 until 2003.

In France about 2000 third country doctors applied for recognition in 2005, the year of introduction of the assessment procedure.

The Flemish medical schools granted admission to 71 third country doctors in the period of July 2003 until March 2005.

These numbers, although not completely comparable, show that substantial numbers of third country doctors enter the countries involved in this research project as refugees or as family reunifiers. The countries concerned have developed a procedure after which recognition can be granted. For the countries of origin the loss of these numbers of medical doctors is a substantial braindrain (see Eastwood; 2005). For the countries these medical doctors migrate to it can turn into a braingain.

Assessment on the basis of a medical test or on the basis of NARIC-evaluation

All countries involved in this research have developed a specific assessment procedure for medical degree holders. In most countries assessment takes place on the basis of a test on medical knowledge and on a NARIC-evaluation. In Austria and Belgium a negative decision on a NARIC-evaluation by the Department of Health might lead to the next procedure: the admission procedure to a medical school and a medical track. The Nordic countries and the United Kingdom have developed systems during which a third country doctor can prove that he/she has a thorough medical knowledge. Explicitly and implicitly sufficient mastery of the language of the country is tested. France introduced an assessment procedure in 2005. Before 2005 no test was available in France. Mastery of the French language is an implicit demand.

Spain has agreements with several Latin American countries concerning recognition of doctors degrees. Mastery of the Spanish language is an implicit demand.

In the United Kingdom candidates must pass the International English Language Testing System-test (IELTS) with an overall score of at least 6.5. In the Nordic countries, if a candidate does not succeed in passing the tests and the probationary appointments in a defined period of time it means the end of the procedure. After a failure to finish the assessment procedure organized by the Department of Health, admission to a medical school as a 'regular' medicine student hardly occurs in Denmark, Norway, Sweden and the United Kingdom. In the United Kingdom it would be extremely hard to pay the fees, as these students would have to pay the fees of international students. The University of London would charge them £ 94.270 for five years of study.

Working experience and assessment

Working experience as a medical doctor in the country of origin does not play a role at all in the assessment procedures in the countries that participated in this research. Indirectly it plays a role during the probationary appointments in Denmark and Norway.

In the United Kingdom specialists can be exempted for the Professional and Linguistic Assessment Board-exam (PLAB 1 and 2) based on their years of work in a certain speciality. One of the Royal Colleges could be asked to advise the General Medical Council in an exemption request. In Sweden recognition of a speciality is possible if someone evidently has been working for more than 5 years as a specialist.

In France a foreign specialist who wants to work as a specialist must pass an examination in the field of the specialism. The Department of Health has set quota for several specialists according to the needs in France.

Qualifications of the credential evaluators

In all countries the evaluators at the departments of health are in one way or another advised by professors in medicine. The NARIC-evaluators themselves in most cases do not have a background in medicine.

Policy in case of non-recognition

In case of non-recognition Austria and Belgium do offer a second route to third country doctors. In order to be admitted in the Austrian recognition procedure at a medical university the level of a third country doctor should at least be five years of the medical study. The Belgians are less rigid in setting criteria for admission to the procedure of the Flemish Interuniversity Council. In Spain at least partial recognition of the foreign medical programme should be granted by the university. If partial recognition is not the case, admission to a medicine study in Spain is impossible. The majority of third country doctors in Denmark, Norway and Sweden are admitted to the procedures that are organized by the respective Departments of Health. So, in fact, in the Nordic countries, there is not a great demand for a second route, as the first route is highly sufficient.

In case of non-recognition by the Department of Health in Austria and Belgium (Flanders) third country doctors are referred to one of the medical universities (Austria) or to the Flemish Interuniversity Council (Belgium).

In case of non-recognition by the Department of Education in France a third country doctor may apply for admission to a medical school.

Special programmes at medical schools for third country doctors

In Belgium the third country doctors will be enrolled in the regular programmes at one of the medical schools. The medical school will follow the advice of the Flemish Interuniversity Council. The procedure for third country doctors by the Flemish Interuniversity Council was not started due to a request of the Department of Health in Belgium. It was an initiative of the Flemish universities with a medical school.

Under the Austrian Universities Act every university in that country has to offer a recognition procedure to holders of foreign credentials. In Austria a medical university is autonomous in specifying the content of the additional medical programme for a third country doctor.

In the Nordic countries the programmes are organized by the respective departments of health. It is obvious that with regard to the content of the programmes the Departments of Health rely fully on the professors in medical schools (e.g. Faculty of Medicine of the University of Oslo or the Karolinska Institute in Stockholm).

In Spain third country doctors must at least have “partial recognition” before being eligible for a special examination (*prueba de conjunto*). After making this examination a third country doctor has to take an additional programme at a medical school that is based on the outcomes of the examination.

In France third country doctors who did not receive recognition, can enrol as medical students in year 1 and year 6 of a medical school.

In the United Kingdom a special programme has been set up for Refugee and Overseas Qualified Doctors at Queen Mary University of London. This programme consists of a doctors study club, structured PLAB-courses, clinical experiences and careers advice services.

Table 1: Country policies towards third country doctors

Countries	Austria	Belgium	Denmark	France	Germany	Norway	Spain	Sweden	United Kingdom	the Netherlands
Country level										
Registering body concerning recognition foreign degrees	yes	yes	yes	yes	no	yes	yes	yes	yes	yes
Information about recognition by Dep. of Health (DoH)	yes	yes	yes	yes	decentral	yes	unknown	yes	yes	yes
Recognition responsibility with Dep. of Health (DoH)	yes	yes	yes	yes ⁵⁷	decentral	yes	no	yes	yes	yes ⁵⁸
Assessment & recognition on the basis of test	no	no	yes	yes	no	yes	yes	yes	yes	yes
Assessment & recognition procedure without test	yes	yes	no	no	yes	no	no	no	no	no
Department of Health procedure successful	unknown	unknown	yes	unknown	(dec) yes	yes	unknown	yes	yes	no
after Dep. Health-rejection: university route possible	yes	yes	no	yes	yes	no	no	no	no	yes
Length of programme for third country doctors	12-18 months	24-36 months	12-18 months	24 months	12-24 months	12-18 months	not applicable	18 months	0 months	18-36 months
Responsible for third country doctors programme	University	University	Dep of Health	University	University	Dep of Health	not applicable	Dep of Health	General Med Council	University

⁵⁷ Since 2005 the Department of Health in France introduced an assessment procedure for third country doctors.

⁵⁸ Since 2005 the Department of Health in the Netherlands introduced an assessment procedure for third country doctors. The Dutch results are based on the situation before December 1 2005 (introduction of the assessment procedure).

Recognition and admission

Some countries have just one route stipulated for migrating third country doctors who obtained permanent residency. Responsible for this route is the Department of Health in these countries. Universities with medical schools in the United Kingdom, Denmark, Norway and Sweden seldomly admit third country doctors, as they will refer these doctors to the General Medical Council (UK) or the Department of Health (Nordic countries). If a medical school in the Nordic countries organises a programme for third country doctors it is because the medical school was requested by the Department of Health to do so. In Norway a special programme for third country doctors is organized by the Faculty of Medicine of the University of Oslo, while in Sweden the Karolinska Institute in Stockholm takes care of that task.

The results in Denmark, Norway, Sweden and Germany are very promising, because large groups of the applicants end up with recognition of the foreign medical degree. North Rhine-Westphalia recognized between 2000 and 2003 1.471 third country doctors. Between 2001 and 2003 Sweden recognized 716 third country doctors. Norway and Denmark have similar results. These experiences show that relatively short additional programmes can result in recognition of foreign medical qualifications. It is therefore not surprising that in the Nordic countries and the United Kingdom the second route - through medical schools - to gain recognition has not really been developed. In Germany both routes are available. In Germany and the United Kingdom the Department of Health and the General Medical Council respectively have developed procedures to assess the medical qualifications of third country doctors. Since 2005 the Department of Health in France has introduced an assessment procedure for third country doctors. If the outcome of an assessment in Germany and France is negative, third country doctors might request admission to a medical school. The Medical Faculty of the University of Leipzig receives approximately 30 requests for admission from third country doctors. The medical faculty of Leipzig University can accept at most 8% foreign students of the total number of medical students enrolled at the medical faculty. The Medical Faculty at the University of Lille 2 receives nearly 50 requests for admission each year. Only 10 of them will be accepted.

After a negative outcome of the assessment procedure in the United Kingdom third country doctors can apply at one of the medical schools, but as it is extremely expensive this hardly ever occurs. Some years ago the Queen Mary University of London has started a so-called Refugee and Overseas Qualified Doctors' Programme, in which third country doctors are prepared for the PLAB-exams.

After negative assessments in Austria, Belgium and the Netherlands (universities with) medical schools offer additional medical programmes to third country doctors. Apparently the routes through the Departments of Health in these countries are not so effective as in the Nordic countries. In fact the route through the medical schools in these countries is therefore the most significant one. In Spain the Ministry of Education is responsible for the recognition of medical degrees. Some medical degrees from doctors from Latin American countries are recognised. In case of non recognition these doctors are referred to universities with medical faculties.

Medical schools in Denmark, Norway, Sweden and the United Kingdom hardly ever admit third country doctors as regular students. The Flemish medical schools admitted 71 third country doctors in a period of 20 months. The Medical University in Vienna receives nearly 50 requests for admission per year and the Medical Faculty of Leipzig University receives approximately 30 requests for admission per year. The medical school of the University of Lille received yearly about 50 requests for admission. In Lille they expect this number of applicants to decline due to the introduction of a national assessment procedure.

The applicants come from all over the world. Third country doctors obtained their degrees mostly in Iraq, Afghanistan, the former Soviet Union, China and former Eastern Europe countries like Romania, Poland, Hungary, Serbia, etc.

In Austria nearly 30% of the applicants are refugees, while 70% is enjoying residency on the basis of partnership. In Belgium the majority of the applicants has residency on the basis of refugee status.

In France the majority of the applicants come from Francophone countries in Africa. In Spain most requests come from doctors originating from (Spanish speaking) Latin American countries.

Data held by the British Medical Association in the United Kingdom show that out of 1027 third country doctors 421 (40,9%) have a background as refugee or asylumseeker.

Admission options

Universities in the Nordic countries and the United Kingdom hardly admit third country doctors. We learned from the Faculty of Medicine of the University of Oslo that only occasionally an applicant who failed to pass the third country doctors' programme tries to enrol as a student in medicine. In Sweden third country doctors have three chances to pass the assessment tests. If, after three attempts, they fail, they are referred to a medical school. They are however seldomly admitted as in Sweden the competition for study places in medicine is harsh.

Except to the Refugee and Overseas Qualified Doctors' Programme at the University of London, the British universities hardly admit third country doctors. One year of enrolment at the medical school at the University of Leeds medical school would cost an overseas student 25.000 British pounds, which equals nearly 38.000 euros.

The Medical University in Vienna starts recognition procedures for all third country doctors that have permanent residency in Austria and request recognition. If the outcome of the assessment (evaluation of diploma, transcript, subjects studied, etc. and the outcome on a medical knowledge test) shows a level of less than five years of study in the field of medicine the candidate will not be admitted.

On request the Flemish universities with medical schools start an admission procedure for third country doctors whose recognition requests with the Department of Health ended in rejections. Most of the applicants have permanent residency in Belgium. After following a standard assessment-procedure (medical knowledge test and interview) organized by the Flemish Interuniversity Council an applicant who passed the assessment is free to start at any medical school in Flanders.

The Medical Faculty at the University of Lille admits on a yearly basis 10 students out of 50 applicants. After participating in a selection procedure the staff decides who can be admitted.

The Medical School at the University of Leipzig allows third country doctors to apply for admission. The University of Leipzig treats this type of request like any request they receive from an international student: they will pick out excellent students as this is their policy in general.

The University Complutense Madrid receives requests for admission from doctors trained in Latin American countries (majority) and from doctors from Arab countries (minority). Only in case of partial recognition of the medical programme, foreign doctors can be admitted.

Length of programmes or recognition procedures

The length of the programme at the Medical University of Vienna is at least one year (four exams taking each about three months to prepare for). At Flemish medical schools the minimum programme will last for two years. The Danish procedure leading to permanent authorization (Danish National Board of Health; 2001) consists of two different probationary periods in a Danish clinical hospital for at least three months, a verbal test of general medical knowledge and three medical examinations (in social medicine, the Danish law about the practice of medicine and the law about the prescription of medicine). All the examinations are carried out in the Danish language. The whole procedure in Denmark can be completed within one year. The same goes for the recognition procedure in Norway. In Sweden the procedure takes one and a half year. The average time in the United Kingdom to pass for the PLAB 1 and 2 exams is about 18 months (Butler and Eversley, 2005). At the Medical School of the University of Lille the programme takes 2 years. First the admitted student has to enrol in year 1 and pass the exams of year 1. After passing the exams of year 1 the years 2, 3, 4 and 5 will be exempted. The student enrolls again in year 6 and has to take the final (national) exam of this year

(Non-) cooperation of medical faculties

In the countries that were involved in this research cooperation between medical schools concerning policies towards third country doctors was largely absent. An exception to this rule was Belgium.

Sufficient mastery of the language

Sufficient mastery of the language of the country where the third country doctors want to practise medicine is a major demand in all the countries and medical schools involved. Sometimes mastery of the language is an implicit demand. Examinations on medical knowledge, for instance in the Danish procedure of recognition, can not be passed successfully if the mastery of the Danish language is insufficient. France and Spain have implicit language demands; the examinations are in French respectively in Spanish. Without a thorough knowledge of the language third country doctors do not stand a chance. The majority of applicants at the University Complutense Madrid (Spain) are coming from Spanish speaking countries in Latin America. For these applicants the language is no problem at all.

In other countries, for instance in Norway, Sweden and the United Kingdom, proof of mastery of the language is an explicit demand. In every country there is a great awareness of the importance of language proficiency by third country doctors.

The study of Butler and Eversley (2005) showed that third country doctors after their arrival in the United Kingdom needed on average 44 months to pass the International English Language Testing System-exam. During these years they had others matters at hand too, as they had to rearrange their lives and of their familymembers in a new country.

Support for third country doctors

Most of our informants were not aware of any organisations in their country that could help third country doctors financially in finding their way to the recognition procedure organised by the Department of Health or the route through medical school. Most countries do have a welfare system that provides refugees with a social security benefit. The Refugee Doctor Programme at Queen Mary University of London in the United Kingdom supports third country doctors to find financial assistance for the PLAB-exams. In Germany the *Otto Benecke Stiftung* supports third country doctors to become medical doctors in Germany. In the Netherlands a non governmental organisation called the University Asylum Fund (UAF) supports refugees and asylumseekers to enter university and/or the labour market (study and career advice, financial support, etc.).

Experiences with third country doctors

Not all the informants could present data about experiences with third country doctors after they had been admitted. Informants reported most of all that third country doctors had severe problems with the language. The Norwegian informants also reported cultural problems. In Norway, Sweden and the Netherlands special medical language courses have been developed for third country doctors.

At the Medical Faculty of the University of Lille the experiences with third country doctors were not always positiv. Out of 10 foreign students (third country doctors) who were admitted each year only 3 or 4 would finish the programme.

Finding work as a medical doctor

Most informants hold the opinion that third country doctors after succesfully graduating in their new country will have the same chances as natives to find work as a medical doctor. Studies in the United Kingdom by Esmail and Everington (1997) and by Cooke, Halford and Leonard (2003) showed that equal opportunities for ethnic minority health workers were jeopardised just by having the wrong name and skin colour. Studies in Denmark showed that third country doctors and dentists after completing the Danish procedure for recognition experienced severe problems in finding work as a health worker in Denmark (Sjouwerman; 2002).

Table 2: University policies towards third country doctors

Countries	Austria	Belgium	Denmark	France	Germany	Norway	Spain	Sweden	United Kingdom	the Netherlands
University level										
Responsible for third country doctors programme	yes	yes	no	yes	yes	no	yes	no	no	yes
Length of programme for third country doctors	12-18 months	24-36 months	12-18 months	24 months	12-24 months	12-18 months	no standards	18 months	0 months	18-36 months
Necessity of second route to work as a doctor	yes	yes	no	yes	yes	no	yes	no	no	yes
Mastery of the language required	implicit	explicit	explicit	implicit	explicit	explicit	implicit	explicit	explicit	explicit
Courses in medical language available	no	no	no	no	no	yes	no	yes	no	yes
Cooperation medical schools conc. third country doctors	no	yes	no	no	no	no	no	no	no	yes
Chances of third country doctors on the labour market	not equal	equal	not equal	equal	unknown	unknown	equal	unknown	not equal	equal

Appendix 8: Retention Policy for Ethnic Minority Students

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Tribune

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The question of the retention of ethnic minority university students in universities in the Netherlands, especially at the University of Utrecht, is examined. In particular, the cases of Surinamese, Antillian, and Aruban students, foreign refugee students, particularly medical doctors, and Turkish and Moroccan locally educated students are examined. Although each category may have specific problems, ethnic minority students, taken collectively, are not problem students. Given targeted support, they will perform as well as native Dutch students.

Introduction

The Dutch authorities are concerned about the limited participation of migrant (minority) students in higher education. According to the "Migrant Policy" report (Wetenschappelijke Raad voor het Regeringsbeleid, 1989) the Scientific Board for Government Policy has ascertained that "the highest attained educational level of the major migrant groups is substantially lower than that of the general Dutch population". Concern over this low participation rate of migrant (minority) students in higher education is shared by many in the Netherlands. The emotional consultation at the end of 1999 in the "Tweede Kamer" with State Secretary of Education K. Adelmund, when considering the lower level of academic results of minority students, has made this situation more than clear. The same is true in considering Scheffer's contribution in one of the leading Dutch newspapers (in this case, the *NRC* of 29 January 2000) on the "the multicultural drama", and the many reactions that followed.

It is estimated that about 2 percent of all the students enrolled in institutions of higher education are minority students. In the Higher Education and Research Draft Plan 1998, the Minister of Education, Culture, and Sciences dictated that "the flow of migrant students to higher education needs much more attention". According to the minister, the portion of migrants heading towards higher education has risen 4 percent for the institutes of professional higher education (the HBO's), and 2 percent for the universities.

This article⁵⁹ refers to the Final Dispatches of the Guiding Migrant Students Project (BAS) of Utrecht University (Werkgroep Begeleiding Allochtone Studenten, 1994) and the more recent research report by Choenni (1997).

The theoretical framework

The “Final Dispatches” of the “Guiding Migrant Students” Project of Utrecht University

In the summer of 1993, the Board of Utrecht University set in motion the Guiding Migrant Students Project (BAS). The project was under the direction of Professor H. Entzinger. The author was, at that time, taking part in the project as a student counsellor and policy maker. The assignment was to undertake an investigation into the entrance and progress of migrant (minority) students at Utrecht University and to make recommendations in order to facilitate this process.

The investigation that the BAS project undertook was groundbreaking because there had been no earlier distinctions made in the Netherlands between the different categories of ethnic minority students. The research took place among freshmen students in the Faculties of Medicine, Pharmacy, and Arts, whereby three distinct student categories were identified:

1. native Dutch students;
2. *locally educated* ethnic minority students;
3. *foreign educated* ethnic minority students.

The BAS investigation was particularly groundbreaking because an explicit distinction between *locally educated* ethnic minority students and *foreign educated*⁶⁰ ethnic minority students had, possibly, never been made before. Literature about ethnic minority students often reflected, as a basic assumption, the ethnic backgrounds of students. However, a Turkish student with a Dutch VWO-diploma⁶¹ will have, without question, a happier future in Dutch higher education than a Turkish student with a Turkish *Lise Diploması*,

⁵⁹ It results from the written elaboration of a lecture presented at the mini-conference on Ethnic Minority Policy in Scientific Education 2000+, organized by the Association of Dutch Universities (VSNU) and the Expertise Centre for Ethnic Minority Students in Dutch Higher Education (ECHO) on 10 March 2000.

⁶⁰ The author wishes to thank Professor Vincent Tinto of Syracuse University (USA) for helping him to derive proper English translations for these concepts.

⁶¹ Dutch secondary education is highly competitive. Three major streams can be distinguished:

- *Stream A*: the vocational stream lasting four years and leading to a VBO/MAVO-diploma;
- *Stream B*: general secondary education, five years in duration, leading to a HAVO-diploma. The HAVO-diploma gives direct admission to institutions for professional education (HBO).
- *Stream C*: pre-scientific education, six years in duration leading to a VWO-diploma. Only the Dutch “VWO”-diploma gives direct admission to Dutch universities. Some studies, *e.g.*, medicine, have special entry requirements which mean that the qualifying pre-scientific programme should further include certain obligatory subjects (*e.g.*, physics, chemistry, and biology).

supplemented with special entrance examinations (for students without formal Dutch educational qualifications) entering Dutch higher education.

The most important outcome of the BAS investigation was as follows: “migrant students who have been in the Netherlands more than five years and who have obtained their elementary and secondary school education/diplomas in the Netherlands have essentially no problems that distinguish them from native Dutch students in their freshman year”.

A second important outcome of the BAS investigation was as follows: “Ethnic minority students with a Dutch elementary and secondary school education can by no means be synonymously pigeon-holed as problem cases. Most appear to experience no study problems.”

A third important outcome was that: “foreign educated ethnic minority students seem to experience very specific study problems. In particular, they have problems with the degree of difficulty of university education, with the Dutch and English languages, and, to a lesser degree, with the pace of studies.

A corresponding problem of locally and foreign educated ethnic minority students was their isolation within their course programmes (Werkgroep Begeleiding Allochtone Studenten, 1994).

The ECHO Research Report “Migrants and Universities” undertaken by C. Choenni

Choenni (1997) carried out a fact-finding investigation regarding the position of *locally educated ethnic minority students* and how they are doing in Dutch universities. He accomplished this task on assignment with the Expertise Center for the Ethnic Minority Students in Dutch Higher Education (ECHO). In the support committee of the investigation were, among others, Professor R. Penninx and the author of this article. Choenni collected research data both through interviews held with university employees (policy makers, student counsellors, teachers, and personnel officers) from all fourteen Dutch universities and through interviews held with fifty-four *locally educated ethnic minority students* from Erasmus University in Rotterdam, the Catholic University of Brabant, and the University of Amsterdam.

Choenni has estimated that of a total student university enrolment of 208,521 (including students in the Open University) 6,600 (3.2 percent) ethnic minority students are registered. Moreover, he assumes that half of the ethnic minority students are *locally educated ethnic minority students* and that the other half are *foreign educated ethnic minority students*.

Considering the lack of registration, on the one hand, and difficulty in understanding registration systems, on the other, Choenni had to be satisfied with approximate figures. On the question as to whether or not *locally educated ethnic minority students* experience specific bottlenecks more frequently than their native Dutch counterparts, the university staff replied that migrant (minority) students fall into an isolated two-sided position, i.e., their home situation and the academic world they experience. Furthermore, a number of university staff members who were interviewed observed that certain ethnic minority students experience difficulty with command of the Dutch language and problems related to study skills. Ethnic minority students who were interviewed also stated that indeed there is the matter of isolation at home and within the universities. Owing to the isolation in

which certain ethnic minority students find themselves, ethnic minority student associations satisfy an important need. Mention was also made of neglect, prejudice, and discrimination. Most minority students are satisfied with the specific migrant student services provided for them. Students experience the virtual absence of ethnic minority lecturers in their universities as a great loss.

In his final chapter, Choenni argues in favour of registration and monitoring. Likewise, he argues for the involvement of minority alumni and migrant students at information meetings. The guidance of younger migrant students could be taken over by older students. Choenni also proposes to create funds for migrant students who have experienced financial hardship as a result, for example, of measures taken by the ministry.

Ethnic minority students in (Dutch) university education

The ethnic minority student group, while small in size, is most varied. Some of these variables are taken up in the overview presented below. Using these variables, an attempt has been made to ascertain which ones are or are not applicable to particular ethnic minority students. It must be emphasized here that we are working with generalizations. What applies, for instance, to one Surinamese student does not automatically apply to other Surinamese students. Table 1 reflects the model used to determine variables in specific cases.

To say something meaningful about the moving-on policy for ethnic minority students, four different categories of ethnic minority students are represented schematically. This representation shows clearly that differentiation is unavoidable.

Table 1: Variables in the situations of ethnic minority group students (applicable variables would be shown in bold; however, sometimes neither the left nor the right category is applicable)

<i>Locally educated ethnic migrant students</i>	<i>Foreign educated ethnic minority students</i>
VWO-diploma that prepares one for Dutch higher education	Foreign diploma that is not preparatory for Dutch higher education
No problem with diploma recognition	Problem with diploma recognition
No problem with the Dutch language	Problem with the Dutch language
Right to financial aid	No right to financial aid
A good knowledge of English	Lack of knowledge of English
No residency problems	Residency problems
After graduation: the Dutch labour market	After graduation: departure from the Netherlands
Existing social network	No social network
Unlimited additional income—student jobs	Very limited additional income—student jobs

Table 2: Surinamese locally and foreign educated ethnic minority students (applicable variables are shown in bold; sometimes neither the left nor the right category is applicable)

<i>Locally educated Surinamese students</i>	<i>Foreign educated Surinamese students</i>
VWO-diploma that prepares one for Dutch higher education	Foreign diploma that is not preparatory for Dutch higher education
No problem with diploma recognition	Problem with diploma recognition
No problem with the Dutch language	Problem with the Dutch language
Right to financial aid	No right to financial aid
A good knowledge of English	Lack of knowledge of English
No residency problems	Residency problems
After graduation: the Dutch labour market	After graduation: departure from the Netherlands
Existing social network	No social network
Unlimited additional income—student jobs	Very limited additional income—student jobs

Surinamese *foreign educated ethnic minority students* applying for admission to Dutch university education have no problems with the recognition of their diplomas. By placing the Surinam VWO-diploma on the so-called five-year VSNU-list, it is recognized as the

equivalent of the Dutch VWO-diploma. In addition, Surinamese students usually do not have problems with the Dutch language.

However, Surinamese students with Surinamese passports are often faced with problems concerning their residential status and finances. Family members residing in the Netherlands usually take care of a niece or a nephew, but the pressures on these families often become overwhelming, and the student is slowly but surely pushed in the direction of the university in order to seek financial aid.

The problems concerning residential status and finances are major reasons among this group of students for lagging behind in their studies. The student adviser who makes a note only of the ethnic background of a Surinamese student runs the risk that the real problem might not come to light. But how does the student adviser for the Faculty of Pharmacy, for instance, distinguish the Surinamese *locally educated* student from the Surinamese *foreign educated* student? A student's feeling of shame in talking about financial and residency problems can lead to a wrong judgment of the situation.

Table 3: Antillian and Aruban locally and foreign educated students (applicable variables are shown in bold; sometimes neither the left nor the right category is applicable)

<i>Locally educated Antillian and Aruban students</i>	<i>Foreign educated Antillian and Aruban students</i>
VWO-diploma that prepares one for Dutch higher education	Foreign diploma that is not preparatory for Dutch higher education
No problem with diploma recognition	Problem with diploma recognition
No problem with the Dutch language	Problem with the Dutch language
Right to financial aid	No right to financial aid
A good knowledge of English	Lack of knowledge of English
No residency problems	Residency problems
After graduation: the Dutch labour market	After graduation: departure from the Netherlands
Existing social network	No social network
Unlimited additional income—student jobs	Very limited additional income—student jobs

Antillean and Aruban students who, after successfully completing their secondary school studies in Curaçao or Aruba, come to the Netherlands to continue in higher education do not have problems with the recognition of their diplomas. With their Dutch VWO-diplomas, Antillean and Aruban students are considered to be *locally educated students* (Table 3).

There are, however, arguments for considering them as *foreign educated* owing to the fact that until their arrival in the European part of the Dutch kingdom, their bilingual upbringing and education place them within a totally different culture.

As Dutch citizens, the Antillean and Aruban students have a right to apply to the Dutch government for study grants, and they do not have residential problems. After they have graduated from a university, the Dutch job market is open to them.

They too, however, have their share of problems. Many lecturers think that these students speak Dutch with the same fluency as native Dutch students because they have been accepted with their VWO-diploma. Few lecturers know that Dutch is not used within Antillean and Aruban social life. Thus, for these students Dutch is not their native language but just a second language. Therefore, additional language support and extra attention to study skills are certainly very necessary at the start of their studies.

Familiarity with the guidance apparatus (student counsellors, student advisers, and student psychologists) is usually limited and therefore it is also recommended that faculty members and administrators be on the alert in order to prevent these students from becoming isolated.

The refugee student is the epitome of the *foreign educated ethnic minority student* (Table 4). Those foreign doctors with qualifications gained outside the European Economic Area⁶² have problems with the recognition of their diplomas. The Minister of Health, Welfare, and Sports categorically rejects applications for recognition from doctors who come originally from Afghanistan, Iraq, Iran, and the countries of Eastern Europe. These refugees are referred to the Commission for the "Matriculation" of Foreign Doctors (abbreviation in Dutch: CIBA), a body involving the co-operation of all eight medical faculties and having the principal purpose of dividing equal numbers of applications among themselves. Once permanent residence status is granted, after a long asylum period, the refugee has to learn Dutch. Between the moment of arrival in the Netherlands and actual admittance to a medical course in a senior year, three, four, or even five years may pass.

Problems concerning financial aid might occur during the period of study. Refugees over the age of thirty, for instance, who do not have a right to a study grant, are not allowed (in some municipalities) to continue receiving unemployment benefits while studying.

⁶² Until May 1 2004 The European Economic Area consists of Austria, Belgium, Denmark, Finland, France, Germany, Greece, Ireland, Italy, Luxembourg, the Netherlands, Portugal, Spain, Sweden, the United Kingdom, and Iceland, Norway and Liechtenstein.

Table 4: ‘Locally’ and foreign educated refugee students/foreign doctors (applicable variables are shown in bold; sometimes neither the left nor the right category is applicable)

<i>‘Locally’ educated refugee students/foreign doctors</i>	<i>Foreign educated refugee students/foreign doctors</i>
VWO-diploma that prepares one for Dutch higher education	Foreign diploma that is not preparatory for Dutch higher education
No problem with diploma recognition	Problem with diploma recognition
No problem with the Dutch language	Problem with the Dutch language
Right to financial aid	No right to financial aid
A good knowledge of English	Lack of knowledge of English
No residency problems	Residency problems
After graduation: the Dutch labour market	After graduation: departure from the Netherlands
Existing social network	No social network
Unlimited additional income—student jobs	Very limited additional income—student jobs

The members of this group of students not only have difficulties with Dutch but often with English as well. With regard to the problem of Dutch medical terminology, Utrecht University has recently developed a specific language module (Palenstein Helderman-Susan and Bekedam, 2000). This module helps in resolving a nationally recognized problem. In CIBA’s five years of existence, more than 600 foreign medical doctors have been assigned to one of the medical faculties.

Until recently, Turkish and Moroccan students with scientific backgrounds who were awarded a Dutch VWO-diploma formed a relatively small group (Table 5). This group came into being specifically through the small flow from primary education schools to the higher streams of Dutch secondary education (Kardux, 1994; Distelbrink and Veenman, 1994; SCP, 1999). Without having obtained a VWO-diploma, these students would not have had direct admission to university education.

Turkish and Moroccan students who start with a VWO education do not perform better or worse in comparison to native Dutch students. Nevertheless, student counsellors are, now and again, confronted with students—especially women—who have serious problems with their parents.

Table 5: Turkish and Moroccan locally and foreign educated students (applicable variables are shown in bold; sometimes neither the left nor the right category is applicable)

<i>Locally educated Turkish and Moroccan students</i>	<i>Foreign educated Turkish and Moroccan students</i>
VWO-diploma that prepares one for Dutch higher education	Foreign diploma that is not preparatory for Dutch higher education
No problem with diploma recognition	Problem with diploma recognition
No problem with the Dutch language	Problem with the Dutch language
Right to financial aid	No right to financial aid
A good knowledge of English	Lack of knowledge of English
No residency problems	Residency problems
After graduation: the Dutch labour market	After graduation: departure from the Netherlands
Existing social network	No social network
Unlimited additional income—student jobs	Very limited additional income—student jobs

The father usually considers studying to be a totally useless experience and, on the whole, study activities are not encouraged. Appointments with counsellors and psychologists must be made on the sly.

In other respects, the situation of these students is comparable to that of native Dutch students: a right to study grants awarded by the Dutch government, no residency problems, and, considering the labour shortage in the Netherlands, an increased chance of finding employment.

Basic assumptions for a retention policy

According to the results of the research undertaken for the BAS project, Choenni's research, and the above-mentioned characterizations, a number of basic assumptions relating to a retention policy for ethnic minority students can be listed:

1. *The locally educated migrant (minority) student is not a problem student.* One of the most important conclusions of the final report of the Guiding Migrant Students Project of the University of Utrecht is that ethnic minority students are by no means to be considered problem cases. Research has revealed that most locally educated ethnic minority students have no stereotypical study problems. An identical conclusion was drawn from the presentation on 27 February 1995 of the research report relating to the success of the "Assure Your Future" project (De Jong et al., 1996). Moreover, it appears that those locally educated ethnic minority students, broadly speaking, do well.

These students study hard, switch their majors less than native Dutch students, and appear to be more motivated than the latter. What did become apparent is that these particular ethnic minority students maintained fewer social contacts and participated less on boards and in student organizations.

The conclusion of the Guiding Migrant Students Project and the "Assure Your Future" project did not lose any credibility despite the results of Choenni's ECHO research. This observation, of course, has consequences in regard to the formulation of a specific policy for ethnic minority students in institutions of higher education.

Locally educated ethnic minority students cannot, solely on the basis of their ethnic backgrounds, be invited to partake, for example, in language training programmes. Specific guidance must be offered only to an individual ethnic minority student after evident signs of a problem (see also 3. and 4.).

2. *Associations for and by ethnic minority students.* Diverse student associations for ethnic minority students have been established in a relatively short time, particularly in the Randstad (the four major cities of the Western Netherlands). These initiatives were facilitated (assignment of meeting rooms, subsidies for activities, etc.) by the institutes themselves. Ethnic minority student associations appear to be the best means of bridging the gap between the isolated ethnic minority students (Werkgroep Begeleiding Allochtone Studenten, 1994; Choenni, 1997; De Jong, 1996; Tinto, 1997) and the rest of the university community. Boogaard states that "the existence of similar student associations offers them the possibility, without their being categorized as a 'problem group', to bring to light their wishes and requirements. In this manner, the student associations can contribute to the realization of a multicultural and internationally oriented university education" (Boogaard, 1997, p. 243).

In Utrecht, close co-operation exists between the student association, *Cosmicus*, and the higher education institutions. The *Cosmicus Foundation* is, for instance, active in the area of homework guidance for ethnic minority pupils in secondary education, mentor projects, and information activities. Turkish students in *Cosmicus* function as role models for the younger generation. According to Crul (1999), the importance of support from their own ethnic group has been proved.

3. *Specific guidance possibilities for ethnic minority students.* It is said that what is right for students in general is also right for ethnic minority students. Furthermore, specific measures can be taken if necessary. These results can be found in the report of the Utrecht University education conference entitled "The Mastery of Education" (Universiteit Utrecht, 1993).

Observed bottlenecks in the practice of education must stimulate the development of a new policy and/or new provisions. In relation to the revision of the student grants system, the developments that were set in motion by the Minister of Education, Culture, and Sciences in the last decade are worth mentioning. In 1990, freshmen still had the right to study grants for six years while the generation of freshmen in 1996 and later only had the right to partial study grants for four years. In addition, throughout the years, the grants have been substantially trimmed. Herfs (1996) has written in the *International Journal for the Advancement of Counselling* about the consequences of these measures regarding questions of support for students.

Reducing the right to financial aid can lead to further negative consequences for ethnic minority students. A fear of overwhelming study debts along with possible parental pressure can lead ethnic minority students with a VWO-diploma not to apply for admission

to a university. The longer study duration that most ethnic minority students must experience prior to graduation also has consequences for their rights to study grants. In the future, the flow of migrant (minority) students from universities for professional education (HBO) to the research universities will decrease. The ethnic minority students who, via the HAVO, and HBO-*propedeutic* (= first) year, want to continue their studies at a (research) university, will, even at a nominal rate of progression, be one year short of what is needed for a study grant. The effects of categorical measures (reductions of both the level of study grants and the period wherein one has the right to a grant) on specific groups remain relatively uncharted (see Choenni, 1997, p. 134). That the above-mentioned effects are at odds with the encouragement policy of the Ministry of Education, Culture, and Science, with regard to the increase of matriculation and graduation of ethnic minority students in higher education, needs no further argument.

4. *The setting up of a monitoring system for migrant (minority) students.* Setting up such a system would give clear and especially timely information on the study progress of those involved. A side-effect of such a monitoring system would be that more would be known about the real problems faced by locally educated ethnic minority students as well as by foreign educated ethnic minority students. Early awareness of problems is key to the prevention of student drop-out. The establishment of workgroups, consisting of both faculty officials (lecturers and student advisers) and ethnic minority students, which aim directly at factors that hamper the progress of ethnic minority students, will, in all probability, lead to an improvement and therefore to:

- An increasing number of ethnic minority students in higher education; as well as
- an increasing number of ethnic minority graduates of higher education.

One well-functioning example within university educational practice is the Workgroup Migrant Guidance (abbreviation in Dutch: WAB) of the Faculty of Medicine of Utrecht University. The workgroup consists of three lecturers, one student adviser and two migrant students. The purpose of the Workgroup Migrant Guidance is to offer advice to those individual ethnic minority students (locally or foreign educated) who need and want this service. Advice is offered by:

- WAB members who are all easily accessible for advice and consultation, so with hardly any thresholds;
- The student adviser who gives individual study progress counselling after each round of examinations;
- Special examination facilities (oral examinations, extra time during examinations, use of a dictionary, etc.) which can be offered if desired;
- Referral to relevant language and/or study skills courses;
- Regular consultations between WAB and the Interaction and Orientation workgroup (an association of ethnic minority and native Dutch medical students);
- Making students aware of the presence of WAB during information meetings and by informing tutors and mentors about the policy with regard to ethnic minority students (see: Choenni, 1997, p. 96).

References

Boogaard, M. *Van buiten, geleerd. Allochtone en buitenlandse studenten in het Nederlandse hoger onderwijs*. Doctoral dissertation, Utrecht University, 1997.

Choenni, C. E. S. *Allochtonen and Universiteiten*. The Hague: B&A Groep, 1997.

Crul, M. *De sleutel tot succes. Over hulp, keuzes en kansen in de schoolloopbanen van Turkse en Marokkaanse tweede generatie jongeren*, Doctoral dissertation, University of Amsterdam, 1999.

De Jong, U., Voorthuis, M. E., and Kievit, K, de. *Twee jaar verder: met succes op weg*. SCO Rapport 421. Amsterdam: Stichting Centrum voor Onderwijsonderzoek, 1996.

Distelbrink, M. J., and Veenman, J. *Hollandse nieuwe, allochtone jongeren in Nederland*. In opdracht van de Raad voor het Jeugdbeleid. Utrecht: De Tijdstroom, 1994.

Herfs, P. G. P. *Student Counseling at Utrecht University*. In: International Journal for the Advancement of Counseling 18 4 (1996).

Kardux, W. *Nota in en doorstroom sluit oriënterende fase af*. In: Nederlands Centrum Buitenlanders (1994).

Palenstein Helderma-Susan, L. H. M. van, and Bekedam, L. M. *Hoe zit het met staan? Cursus Nederlands voor anderstalige artsen*. Houten: Bohn Stafleu Van Loghum, 2000.

Scheffer, P. *Het multiculturele drama*. NRC (29 January 2000).

Sociaal Cultureel Planbureau (SCP). *Rapportage minderheden 1999. Positie in het onderwijs en op de arbeidsmarkt*. Den Haag: SCP, 1999.

Tinto, V. *Classrooms as Communities: Exploring the Educational Character of Student Persistence*. In: Journal of Higher Education 68 6 (1997).

Universiteit Utrecht. *Het Onderwijs Meester: conferentieverslag*. Utrecht: Utrecht University, 1993.

Werkgroep Begeleiding Allochtone Studenten. *Eindrapportage*. Utrecht University, 1994.

Wetenschappelijke Raad voor het Regeringsbeleid. *Allochtonenbeleid*. The Hague: SDU, 1989.

**Appendix 9: Parliamentary motion proposed to the Second Chamber of the States General
by C. Hermann (of the *Groen Links* party) on 6 December 2001**

The text of the motion was:

“The House,

having taken into consideration that it is desirable for doctors and nurses from outside the EU who have come to the Netherlands as asylum seekers or family reunifiers to be able to practice their profession as soon as possible;

having taken into consideration that this is also of importance to Dutch healthcare;

having taken into consideration that the Health Department restricts itself to the assessment of the equivalence of diplomas and to referring to the Commission for the Influx of Foreign Doctors (of the universities);

having taken into consideration that there is insufficient possibility for additional training and supervision at the universities;

requests the government, within the context of the approach of the capacity of medical professionals, to facilitate the medical faculties in the organisation of additional training for foreign doctors,

and proceeds to the order of the day.”

Appendix 10: Questionnaire on the inclusion of foreign doctors

If you look back at your qualities at the start of your medical studies in the Netherlands, to what extent did these qualities meet the demands made by Dutch healthcare? This question refers to the following qualities:

	did not meet these demands at all ⁶³			fully met these demands	
	--	-	-/+	+	++
your Dutch language and communication skills	1	2	3	4	5
your English reading skills	1	2	3	4	5
your ICT skills	1	2	3	4	5
your knowledge of Dutch healthcare	1	2	3	4	5
your medical knowledge at the level of the Dutch doctor's exam	1	2	3	4	5
your clinical knowledge at the level of the Dutch doctor's exam	1	2	3	4	5
your clinical skills at the level of the Dutch doctor's exam	1	2	3	4	5
other competencies that you had previously acquired ¹	1	2	3	4	5

What were the shortcomings that were the greatest obstacle for you? These may be shortcomings in totally different fields than the ones mentioned above.

Answer:

⁶³ The numbers mean the following:
 1 = did not meet the demands at all
 2 = did not meet the demands
 3 = did not really meet the demands
 4 = met the demands to an extent
 5 = met the demands fully

Appendix 11: Basic Test Medical Dutch

The test takes three hours and comprises the following parts:

1. *The ability to read a text and identify its main theme*

The candidate reads a text about a general medical topic. The idea is that the text is not aimed at medical knowledge, is understandable for a layman and is not too long. This text is the basis of the other parts of the test. The candidate must produce a written summary of the main ideas of the text. The candidate is tested on their ability to produce an understandable Dutch text with correct vocabulary, word order, spelling and grammar.

2. *Giving a presentation and participating in a discussion*

The text and the summary mentioned above are the basis of a presentation, which is given to two teachers of Dutch. This presentation should be a maximum of five minutes, and should be followed by a short discussion. The candidate must be able to give a coherent presentation in understandable Dutch, and be able to react adequately to questions and remarks while making use of Dutch in a correct manner.

3. *Maintaining a conversation with a patient*

This conversation is a role play between a patient suffering from the affliction described in the text and a doctor. The candidate receives a description of the doctor's role, the patient's case history and the structure of the interview. Two questions are central to the interview:
How is the patient feeling?
How does the patient envisage his/her future?

The candidate is told to consider the way in which the patient experiences the illness. The candidate must be able to sufficiently understand everyday Dutch and, therefore, what the patient tells him/her.

4. *Writing a report*

After the interview with the patient, the candidate must write a short report in which the two questions that were central to the interview are reported adequately. The candidate must be able to understand what the patient has told him/her.

5. *Doing a vocabulary test*

The candidate is tested on his/her knowledge of everyday words and expressions, and on academic vocabulary and Medical Dutch.

Appendix 12: inventory of problems regarding study progress

Student data

Year in which medical training started (in the Netherlands)

Age at which medical training started (in the Netherlands)

Sex

Duration of preparation*

Has worked as a doctor in country of origin*

Has worked as a specialist in country of origin*

Residence status (*if known*)

General

Problems regarding study progress	yes	no
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Specific

Dutch language

Medical Dutch

Communication problems

English language (reading skills)

Medical knowledge

Medical skills

Knowledge of Dutch healthcare

ICT skills

Attitude problems towards patients

Attitude problems towards trainers

Attitude problems towards fellow students

Attitude problems towards other healthcare workers

Other