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Labour Market Integration of Refugee Health Professionals in Germany: Challenges and Strategies

Sidra Khan-Gökkaya* and Mike Mösko*

ABSTRACT

Refugee health professionals are a vulnerable group in a host country's labour market as they experience several barriers on their path to labour market integration. This study aims to identify challenges refugee health professionals and their supervisors experience at their workplaces and strategies they have developed to overcome these barriers. Semi-structured interviews were conducted with refugee health professionals who have been living in Germany for an average of four years and their supervisors (n = 24). The interviews were analysed using qualitative content analysis. Nine themes were identified: (1) recognition of qualifications, (2) language competencies, (3) differing healthcare systems, (4) working culture, (5) challenges with patients, (6) challenges with team members, (7) emotional challenges, (8) discrimination and (9) exploitation. Results indicate the need to implement structural changes in order to improve the labour market experiences of refugee health professionals.

BACKGROUND

The global healthcare workforce is facing skilled labour shortage. The World Health Organization (WHO) estimates a global shortage of 14.5 million health professionals by 2030 (World Health Organization, 2006). The European Commission estimates a shortfall of 1 million health workers in Europe by 2020 (European Commission, 2012), and employment agencies in Germany predict a nationwide lack of health professionals (Bundesagentur für Arbeit, 2018). In order to address this shortage, nearly all European countries depend on the recruitment of foreign-trained health professionals (Organisation for Economic Co-operation and Development (OECD), 2017). Another strategy that has been implemented by the German government to address this shortage is the so-called "activation of domestic potential" (Bundesregierung, 2018). With that, the German government aims to address those groups that have difficult access to the labour market, such as refugees in order to improve their employability and use them to fill shortages (Bundesregierung, 2018). As the number of refugees in Germany has increased since 2015, the German government has recognized the need to address their labour market integration (Bundesregierung, 2016). However, refugees belong to a particularly vulnerable group in the labour market facing unemployment or underemployment (Tanay et al., 2016).

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The barriers and difficulties that refugees face in the context of their labour market integration are multidimensional and manifold. First, their access to the labour market in Germany is restricted and depends on their legal status and the likelihood of getting a residency permit which in turn depends on the country of origin (Bundesministerium für Arbeit und Soziales, 2019). In Germany, there is a ban on employment for all refugees within the first three months. After three months, their access to the labour market is dependent on the individual residency status. As of the fourth month, refugees need work permission from the foreign authority office in Germany and the local employment agencies in order to work (Bundesministerium für Arbeit und Soziales, 2019). Their access to language courses depends on their legal status and the likelihood of receiving a residence permit (Bundesministerium für Arbeit und Soziales, 2019). Moreover, participating in job-related language courses is described as challenging either due to long waiting times or course availability (United Nations High Commissioner for Refugees-Organisation for Economic Co-operation and Development (UNHCR-OECD), 2016). Second, refugee health professionals need to go through a difficult and long recognition process (Körtek, 2015; Desiderio, 2016) which is described as the starting point for permanent downward mobility (Hawthorne, 2002). Moreover, refugees may not be able to provide identity documents (Bucken-Knapp et al., 2019) or official documents about their education (Bloch, 2008) due to the flight which impedes the recognition process. Third, a lack of information about career pathways (Cohn et al., 2006), such as knowledge about job search strategies (Willott and Stevenson, 2013) and unfamiliarity with the healthcare system of the host country (Ong et al., 2004), are reported barriers. Fourth, due to their flight they may have had a break in their professional career and/or experienced the loss of their professional status (Willott and Stevenson, 2013) which is related to the loss of professional identity (Peisker and Tilbury, 2003). It may also result in deskilling (Stewart, 2003), loss of self-confidence (Willott and Stevenson, 2013), high levels of frustration (Mozetic, 2018) and negative psychological impacts (Cohn et al., 2006). Additionally, the lack of recognition of their previously gained experiences leads to a feeling of being disadvantaged compared to locally trained team members (Mozetic, 2018) which might be intensified by the experience of multiple forms of discrimination (Jirovsky et al., 2015) and exclusion (Bloch, 2008).

Studies in Germany have also focused on the working experiences of migrant physicians and international nurses from within the European Union as well as from non-European countries. They report similar barriers as the above-mentioned. A study on migrant physicians (Klingler and Marckmann, 2016) describes difficulties in three fields. The first field refers to the organization of healthcare institutions and other institutional difficulties such as insufficient support or being assigned to tasks below their level of expertise. Moreover, difficult career advancement opportunities and unfair treatment of migrant physicians were mentioned as institutional difficulties. The second field relates to experienced difficulties with own competencies such as language competencies and knowledge about the healthcare system. The third field relates to difficulties in interpersonal relations and interactions such as inadequate treatment of patients and co-workers. In this context, a study on the workplace integration of internationally recruited nurses in Germany points out that conflicts often arise between migrated nurses and locally trained team members. These conflicts arise because locally trained team members either hold back or do not comprehensively share key information in order to organize their work. Thus, the incorporation of migrated nurses into daily work routine is impeded and the potential for conflicts in everyday work is increased (Pütz et al., 2019). These studies illustrate that international healthcare professionals and refugee healthcare professionals experience similar barriers at their workplaces. However, refugees were forced to flee by the circumstances of their home countries (Yarris and Castañeda, 2015), whereas internationally recruited health professionals may be considered as voluntary migrants. This distinction between refugees and voluntary migrants has effects on the barriers they experience. While voluntary migrants were most likely able to prepare for their migration, refugees had to flee under extreme conditions (Jackson et al., 2004). Stressors of the flight, the loss of family members, traumatic experiences and the

uncertainty about their residency permit (Carlsson and Sonne, 2018) may also influence their prerequisites to work. Rather, in comparison to other highly qualified migrants, highly qualified refugees are more likely to stay in jobs they are overqualified for which mainly relates to the fact that documentation of their education is missing (Tanay et al., 2016). Moreover, some other barriers, such as housing, health, absence of networks or childcare, may indirectly influence employment outcomes (OECD/UNHCR, 2018).

The European Parliament recommends qualification programmes to prepare refugees for work and strengthen their employability (Konle-Seidl, 2016). These recommendations comprise individually tailored programmes to the specific needs of refugees. Amongst others, it is recommended to provide (occupational specific) language courses combined with working opportunities, skills assessment, mentoring and career advice. For highly skilled refugees, it is especially recommended to increase availability of on the job trainings, recognize existing qualifications and offer vocational training. However, in order to implement tailored programmes that match the host countries' legal and social requirements it is essential to identify and analyse the barriers refugee health professionals face when entering the labour market. While the legal situation of refugees and their access to the labour market in Germany is documented through policy papers (European Commission, 2012; Platonova and Urso, 2012; Konle-Seidl, 2016; Tanay et al., 2016; UNHCR-OECD, 2016; OECD, 2017; United Nations Department of Economic and Social Affairs Population Division, 2017; UNHCR, 2017; Bundesministerium für Arbeit und Soziales, 2019), little attention has been paid to the challenges they face in everyday working life and their own perspective and strategies. Thus, in this study, refugee health professionals and their supervisors across Germany were interviewed about the challenges they faced at their workplaces as workplaces are a "key site of sociocultural incorporation" (van Riemsdijk et al., 2016). Moreover, this paper advances this field by giving recommendations for healthcare providers and organizations based on the experiences of refugee health professionals and their supervisors in order to implement changes on structural levels and improve the working environment. These changes refer to establishing supporting structures as well as measures of diversity management and anti-discrimination.

METHODS

The reporting of methods is in accordance with the consolidated criteria for reporting qualitative research (COREQ) guidelines (Tong et al., 2007).

Researcher characteristics

Qualitative research depends on the personal qualities of the researcher and the theoretical sensitivity that the researcher brings to a research (Strauss and Corbin, 1990). Thus, it is important to reflect on the researcher's characteristics and its impact on the interview situation. All interviews were conducted in person by the first author, female, person of color, PhD student of the Department of Medical Psychology at the University Medical Center Hamburg-Eppendorf. The first author is trained in cultural studies, international migration and intercultural studies and has several years of training in conducting qualitative studies. For transparency reasons, participants were informed that the study was part of a PhD study.

Recruitment

Major educational organizations and projects for the labour market integration of refugee health professionals (RHPs) across Germany were identified through internet research. The organizations

(n = 15) were contacted and informed about the study. Their consent was obtained. Three of the major organizations agreed to participate in the study. Participants were divided into RHPs and supervisors as the refugees' self-perception about their experiences might differ from the supervisors' perception. Since the group of RHPs comprises different professions, we decided on subdividing the stratum of RHPs into two groups: physicians and other health professions. In terms of data saturation, it is recommended to conduct six to twelve interviews per stratum (Guest et al., 2006). Thus, 24 interviews were conducted in three major cities in Germany (Hamburg, Hannover and Frankfurt). All three organizations provided persons that matched the inclusion criteria with information on this study and either arranged appointments or provided participants with the researchers' contact information. Inclusion criteria for participants referred to the following aspects:

Target group¹:

- Refugees (regardless of their residency status and form of protection) who have obtained a qualification in a health profession in their home country or a country other than Germany;
- Supervisors that were responsible for the integration of refugee health professionals, their supervision or support

Language competencies:

- Required minimum level of German language competencies on the European Reference level of A2-B1²

Working experiences in Germany:

- RHPs must have had contact with the German healthcare system with a minimum duration of one month – be it a steady job, an internship or job shadowing
- Supervisors had to work in jobs with close contact with refugee health professionals regardless of their hierarchical status. They must have had supervised RHPs at their ward or as an external supervisor

Context:

- RHPs and supervisors in all healthcare institutions comprising primary, secondary and tertiary care were included

Providers were informed about the inclusion criteria and selected fitting participants. All interviews were conducted in German. In one case the inclusion criteria did not match as the participant was a student of the educational organization without sufficient working experience. Participants that matched the inclusion criteria were approached via phone followed by an invitation to live interviews. Participants received two consent forms: one for their participation in the study and one for their consent to audio recording. The consent form and the study information were orally explained prior to the interview.

Data collection

The interview guide was developed based on literature focused on the daily work experiences of refugee health professionals using the SPSS³ approach by Helfferich (2009). The interview guide was sent to experts in the field of migration research to be critically reviewed. Based on this review, the authors discussed and adapted the interview guide. Finally, the interview guide was

piloted with two migrant nurses that resulted in the specification of some questions. The interview guide was structured into six main themes:

- (1) General experiences while working in a hospital
- (2) Experiences with team members and supervisors
- (3) Experiences with patients
- (4) Experiences with the working culture
- (5) Experiences with the healthcare system
- (6) Suggestions for improvement

In each interview, the same semi-structured guide was used. After the interview was finished and the audio recorder was switched off, demographic data were retrieved. The interviews lasted from 00:18 to 00:55 min with a median range of 00:40. Some ($n = 4$) interviews were transcribed by a student researcher but the majority ($n = 20$) of the interviews were transcribed verbatim by a professional agency. All transcripts were proofread by the first author.

Data analysis

The interviews were analysed using content analysis (Mayring, 2015). The first author coded all interviews by means of a computer-based coding programme (MAXQDA, version 10). Deductive codes were derived from the interview guide but as an explorative approach was preferred more inductive categories were derived from the material. Code memos were created for all codes including a description of the code and typical quotes. For the purpose of quality assurance, a research assistant coded a random selection of one-quarter of all interviews. Differences in coding were discussed until a consensus was reached that led to the creation of some new sub codes and a revision of the category system. Results were presented and discussed with other experts in an interdisciplinary research colloquium to ensure comprehensibility and intersubjective reproducibility. The revised system was then crosschecked by the main author in a second round of coding taking all interviews into consideration.

Description of sample

Sixteen RHPs and 8 supervisors participated in the study. Two interviews were conducted via telephone due to reduced mobility of the participants. The sample is described in Table 1.

RESULTS

In general, nine major challenges could be identified which either RHPs or supervisors described as relevant: (1) the recognition of professional qualifications, (2) language competencies, (3) different healthcare systems, (4) working culture, (5) challenges with patients, (6) challenges with team members, (7) emotional challenges, (8) discrimination, (9) exploitation. Table 2 provides an overview of the identified fields and their specifications.

Recognition⁴ of professional qualifications

Both supervisors and RHPs pointed out the challenges they faced with regard to the recognition process of their professional qualifications. Supervisors especially emphasized the difficulties regarding the recognition process. They criticized the long waiting times for the recognition process

TABLE 1
SAMPLE DESCRIPTION (REFUGEE HEALTH PROFESSIONALS AND SUPERVISORS)

Refugee health professionals (RHPs)						
Participant	Sex	Age	Country of birth	Occupation	Working experience in Germany	Working experience in birth country
A1	m	26	Iran	Nurse	1 month	6 years as a nurse
A2	m	23	Iraq	Physician	3 months	2 years as a general physician and 3 years as a surgeon
A3	m	28	Syria	Physiotherapist	2 years	4 years as a physiotherapist
A4	m	28	Syria	Physician (specialized in Anaesthesia)	8 months	2,5 years as a medical assistant in surgery
A6	m	33	Syria	Physician	5 months	5 years as a physician
A7	m	38	Afghanistan	Physician	one year	1 year as a medical assistant, 3 years in public health department
A8	w	29	Syria	Physician	1,5 years	1 year as a physician
A9	m	30	Afghanistan	Physician	3 months	1 year as a medical assistant
A10	m	44	Syria	Physician (specialized in anaesthesia)	3, 5 years	4 years as a medical assistant, two years as a senior physician, 9 years as a chief physician
A11	w	52	Afghanistan	Physician (specialized in gynaecology)	6 months	23 years as a gynaecologist (also as a chief gynaecologist)
A12	m	39	Yemen	Physician	4 months	10 years as a physician
A13	m	45	Afghanistan	Physician	2 years	2,5 years as a physician
A14	m	51	Syria	Dentist	3 months	21 years as a dentist
A15	m	39	Afghanistan	Physician (specialized in otorhinolaryngology)	6 weeks	3 years as an ear-nose-throat (ENT) specialist
A16	w	33	Senegal	Midwife and Nurse	3 months	eleven months as a midwife, 15 years as a nurse
A17	w	36	Azerbaijan	Nurse	3 months	2 years as a nurse
Supervisors						
Participant	Sex	Age	Country of birth	Education	Current job	Experience
B1	m	34	Germany	Physiotherapist	Part time physiotherapist, part time supervisor for RHPs and migrants	5 years as a physiotherapist, 1 year as a supervisor

TABLE 1
(CONTINUED)

Supervisors						
Participant	Sex	Age	Country of birth	Education	Current job	Experience
B2	m	64	Germany	Librarian and editor	Commissioner for refugees at the medical association in lower Saxony	2,5 years as a commissioner
B3	m	64	Germany	Physician	Physician and Supervisor for RHPs	34 years as a physician, one year as a supervisor
B4	m	73	Germany	Physician	Supervisor for RHPs/retired	47 years as a physician, 2 years as a supervisor
B5	w	50	Germany	Nurse and professional advisor	Professional advisor	15 years as an advisor
B6	w	54	Germany	Nurse	Nurse and supervisor	37 years as nurse and supervisor
B7	w	38	Germany	Nurse and Psychologist	Psychologist	seven years as a psychologist
B8	m	52	Germany	Physician, Medical journalist	Managing director of refugee and migrant education centre	2 years as managing director

(B2-B4, B8) and noted that the bureaucratic procedures for recognition in Germany were not clear and prolonged the recognition process (B4, B7, B8). RHPs also criticized the length and complexity of the recognition process (A4, A7, A8, A11, A12). Two supervisors (B4, B8) criticized that former positions such as leadership titles of RHPs were not recognized in Germany. They also criticized that RHP's specialist medical training or their internships in Germany were not considered for recognition as working experiences. Furthermore, in one case there was confusion about the legal foundations of the responsible authorities' bodies:

One colleague receives a temporary work permit [from the recognition authority] but federal medical council law and health insurance company's law contradict each other which inhibits him from working as a physician unless he has a full licence to practise medicine. But he can only acquire the full license after taking an exam. Taking that exam is on hold because the [recognition] authorities are understaffed. (B3)⁵.

RHPs (A1, A11, A13, A15) also indicated their anxiety regarding the licensing examinations as they feared the examination would be too difficult.

Language competencies

Supervisors and RHPs considered acquiring German language proficiency and German technical and medical language as a major topic. Supervisors emphasized especially the need to learn the

TABLE 2
CHALLENGES EXPERIENCED BY REFUGEE HEALTH PROFESSIONALS

Recognition of professional qualifications	Difficulties in the context of the recognition process Non-recognition of former experiences Examinations for recognition
Language competencies	Knowledge of everyday language Knowledge of technical language Feelings and consequences of lacking language competencies
Different healthcare systems	Unfamiliarity with and differences between the healthcare systems Unfamiliarity with bureaucratic procedures within the healthcare system Consequences of differences and unfamiliarity
Working culture	Adaption to formal aspects of work Adaption to cultural aspects of work Intercultural and interpersonal differences
Difficulties with patients	Language difficulties Difficulties in delivering bad news Distrust from patients
Difficulties with team members	Difficulties during internships Interpersonal and interprofessional difficulties
General Emotional Difficulties	Discouragement Negative feelings of RHPs in the context of labour market integration.
Discrimination	Discrimination by patients Discrimination by team members
Exploitation	Financial exploitation of RHPs in the context of work. Professional exploitation of RHPs in the context of work

technical language. They (B1, B5, B8) described that RHPs were afraid to admit there were parts they did not understand and continued to say “yes” in order to maintain the conversation flow. This has often led to misunderstandings. RHPs described difficulties in speaking everyday language and technical language. They (A1, A2, A4) found it difficult to understand handover reports from physicians or keep up in meetings and written documentation. They (A1, A3, A7, A12) were also afraid of not being able to understand the language which influenced their behaviour:

I am afraid if [a patient] someone rings the bell. [...] Because my language is not [well] enough and I am afraid of understanding something wrong or not being able to answer [the patient's question]. That's why I remain seated and others [colleagues] keep asking me “why are you always sitting?” (A1)

One of them also expressed their fear of being deemed to be incompetent due to their language competencies: “They think I have learned it wrong in Iran. But in fact I couldn't understand what they were asking me” (A1). Moreover, RHPs (A1, A3, A12) felt their language competencies held them back as they were reluctant to share their opinion: “If we discuss a patient's case and someone has a contradicting opinion on that patient's case I am afraid to discuss our opinions as I fear they will say ‘I can't express myself’” (A3).

Different healthcare systems

Supervisors and RHPs described challenges that derived from differing standards in the home and host countries' healthcare system. All supervisors described that RHPs would have to familiarize themselves and catch up with the healthcare system in Germany. Eleven RHPs (A1, A2, A8, A9, A11-17) emphasized the difference in the medical equipment, the names of

medication and working habits and the feeling to need to familiarize themselves with these differences. In this context, supervisors referred especially to the differing professional role of nurses in Germany:

They mostly come from countries where nursing care is much higher regarded as a profession, it gets a very high recognition. And here they have to understand this in such a way that the job description or the professional role is not so highly regarded. (B6)

RHPs (A1-4, A7, A9-A10, A12-A15) criticized bureaucratic procedures in hospitals in Germany as it was challenging to keep up with all the procedures of them. They (A4, A17, A16) did not know about occupational law and were also insecure about their rights and obligations in their professional duties. During internships or work, they (A2, A3, A8, A9, A10, A13-17) felt held back as some of them were not allowed to work either because of their status as interns or because they did not have their license yet:

Yes, the situation was unpleasant that I could not do anything alone. And if I wanted to do something, someone had to stay with me, a senior physician or chief physician. That was a bit uncomfortable for me because I already graduated from university and I also worked as an assistant physician in my home country for a year. But I didn't have a solution. I had to come to Germany and here, the rule is if someone doesn't have a license he has to cooperate with a chief physician or with a senior physician. (A9)

Working culture

Supervisors described two facets of working culture that they found important in the context of their experiences with RHPs: formal and cultural aspects of work and RHPs adaption to these aspects. They emphasized formal aspects such as being punctual, submitting holiday applications correctly, calling in sick, being polite and committed to work. Some of the supervisors (B1, B2, B3, B6, B7, B8) criticized some of these aspects in the context of RHPs as deficits. With regard to cultural aspects, supervisors mentioned that RHPs had different values that sometimes inhibited their integration such as examining other-sex patients (B1, B6-B8), taking off headscarves for several reasons (B1, B8), dealing with homosexuality (B1) or accepting female superiors (B1-B4, B7). These values were often attributed to cultural differences although they may result from context-specific causes, as one supervisor who had a mediatory role describes:

The [female] colleague shouted at him [the RHP] in front of the patients [...] Luckily, we heard about it and picked it up [...] she said he was a macho and suggested women were worth less than men. The trigger was a basic nursing situation which is difficult for our participants as they haven't learned it in their home countries. And she gave instructions that were too brief, for example "wash" and he didn't know what to do with that instruction. [...] And that caused the escalation spiral. (B7)

RHPs were also asked about their experiences in the context of working culture. They pointed out that formal aspects of work, such as being punctual and committed, were universal. However, they (A1, A3, A8, A13, A16) experienced differences on the intercultural and interpersonal level, such as the value of families and treating other sex patients, and developed several strategies to get adapted to it:

I was born in an Islamic country. I am not Muslim but born there and I grew up there. And sometimes I think, maybe the [female] patient is embarrassed. Or I ask may I look, may I do. Because

maybe the other colleague does not say anything at all but for me it is a bit ok – maybe she has problem with men and so on, so I ask. (A1)

Challenges with patients

RHPs experienced difficulties with patients especially if patients did not speak clearly due to their illness, their age or their way of speaking:

The problem was that I couldn't understand. For example, the patient said "bring me this and that". And the problem was that they spoke very unclearly and for German people it [is] also difficult to understand and for me of course [it is] especially difficult. (A1)

Some described that talking to patients' relatives was a new challenging experience especially if they were furious (A8) or if they had to pass bad news to them (A7). Another challenge was associated with distrust from patients: "Maybe they don't trust the foreign physicians as much but that's general [generally the case]. All patients are like that, almost all of them. [...] You can tell, they're a little scared or something" (A4).

Challenges with team members

Almost all supervisors (B2, B4-8) mentioned the important role of internships in the context of team integration. However, one supervisor reported that finding internship placements became more and more difficult due to lower capacities of the hospitals (B4). During some internships, participants were not given appropriate tasks or were not supervised (B2, B5, B7, B8) as "it is associated with effort to take along someone" (B7). Sometimes local trained team members were not aware of what RHPs were allowed or permitted to do which often led to misunderstandings (B5, B7, B8). Almost all of the RHPs mentioned several other challenges in the context of teamwork, such as a distanced relationship towards local trained team members (A8, A11, A15, A16), their expectation that RHPs could do and know everything and wrong ideas of them and their education (A1, A9, A10).

General Emotional challenges

Some of the RHPs (A3, A8, A16) experienced discouragement on their path to reintegration. They were told by their employment agency consultants that they could not succeed as health professionals in Germany and were advised to pursue other career options:

I wanted to go to the hospital and see how this works. And I wasn't sure if I could do that again. I thought it is not possible. Because everywhere where I had asked [they said]: "No, you can't do that. Do another one. Do a retraining and so on. Do some care. But you can't do midwife." And I came to my ward. I saw it, it is the same thing. (A16)

Additionally to being discouraged, supervisors thought RHPs felt impeded (B4), afraid (B5, B7, B8), frustrated (B1, B6), under pressure and isolated (B1) as a consequence of the experienced barriers. Moreover, they acknowledged RHPs' loss of their professional status and mentioned that RHPs were reduced to their language deficits (B1, B6, B7) which influenced their self-perception and made them question themselves (B7).

Discrimination

RHPs experienced several forms of discrimination. One supervisor reported that RHPs were sometimes rejected and ignored in decision-making. He describes a situation between a refugee physician and a locally trained nurse:

I can give you an example: my [refugee] physician is treating a patient. Another [locally trained] nurse has a question about that patient. He [the nurse] is standing in front of my [refugee] physician and tells him: "I don't want to clarify this with you. I will talk to your colleague who understands me." And that is a nice form of rejection. There are even more blatant cases. (B1)

Five supervisors (B1, B5, B6, B7, B8) and six RHPs (A1, A2, A3, A7, A10, A15) also reported discrimination from patients towards foreign health professionals: "I was in the room, I had to take [a] blood [sample] and the patient and also her husband said: 'No, you may not come here. We do not want a foreign physician here'" (A15). However, supervisors differentiated between open discrimination and subtle racism from patients. They also differentiated between patients who did not fully trust RHPs and patients who treated them in a racist manner from the beginning. In the context of foreign-trained health professionals, one supervisor described intersectional discrimination as some patients racially and sexually harassed female nurses from Thailand:

There was a situation where an older "fascist grandfather" in quotation marks somehow said he didn't want that or the Thai ladies – how shall I say, perhaps sexualised? So, with Thai participants or Asian looking participants, the gentlemen often become a little bit, how can you say, more cheeky. (B1)

Although this quote does not explicitly refer to refugee health professionals, it is likely that RHPs also experience intersectional discrimination.

Additionally, RHPs (A3, A4, A8, A10-A13, A15) experienced discrimination from senior team members as one female physicians describes:

I was at that interview with the chief physician and at the end he said: "Your German is well, [...] but there is something negative. [...] You have this headscarf. You are Muslim and there are a lot of (tourist? terrorists? [incomprehensible]). How can the patients be sure that you are not a (tourist? terrorist?)" That moment was horrible for me. (A8)

The physician described that she refused the position afterwards due to this experience and started working in a catholic hospital as her headscarf is not a problem there "because nuns also wear a headscarf" (A8).

Exploitation

In addition to the discrimination faced by patients and team members, two supervisors (B2, B8) described experiences of exploitation:

There are hospitals who misuse the situation of RHPs. There are hospitals that pay below the pay scale (Tarifvertrag), very far below the scale. I will give you an example. There are hospitals in the [anonymized] region who employ physicians from Afghanistan, Syria, Iraq. They hire them formally as assistants, pay them 800 to 1200 Euros for a full time job, but they work as normal physicians and are involved in normal hospital routine. No plaintiff, no judge⁶. For the RHP it is at least something. He can work as a physician after a long time and familiarize with procedures, improve his language and do what he is qualified to do. But, by our standards, that is exploitation. (B8)

This would also affect RHPs' claims for benefits after terminating the employment (B8). Additionally to financial exploitation, one supervisor also mentioned that RHPs were sometimes hired as gap fillers not correspondingly to their qualifications and did not have a long-term perspective (B8). RHPs did not explicitly mention being exploited. However, many of them were not yet permanently working and one reported doing unpaid overtime, as he did not know about working rights in Germany (A4).

Resources and strategies

RHPS and supervisors described several strategies they had developed in order to address the experienced barriers. These strategies refer to individual strategies of RHPs, strategies in the context of education and support, strategies on the team level and strategies on the organizational and societal level.

Individual strategies

All RHPs described several individual strategies to cope with challenges they had faced such as being patient (A1, A2, A6, A9), trusting and believing in their own power resources (A3, A13, A16) or pre-/post-processing relevant professional content (A1, A7, A12, A16). They also actively engaged with their colleagues, asked them questions, demanded feedback (A9, A16) in order to cope with language deficits. Furthermore, RHPs developed several strategies to cope with patients' discrimination. They either tried to reassure patients (A10, A12), accepted patients' wishes and called a team member (A4), ignored (A7) or avoided patients that rejected them (A16). In dealing with discrimination from team members, some RHPs would focus on their goal instead of focusing on conflicts and try not to think too much about these experiences (A12, A15). Others would use humour in order to unburden a tensed situations with jokes (A10). Staying silent was described as a strategy as well:

I didn't do anything and I didn't say anything because I knew that if I said something, the situation would get worse and I didn't want that to happen. Yes, I was very calm and I wanted this nurse to go home and think for herself, then she would understand. [...] Yes, later she was a little better. All beginnings are difficult. (A9)

Supervisors pointed out individual competencies of RHPs in dealing with the barriers. They emphasized RHPs' great commitment and their positive working attitudes. They also highlighted the competencies of RHPs such as their intercultural competence (B4, B8), their openness to new experiences (B1, B6, B7), a high motivation to work (BB7, B4, B3, B2), their cooperation capability (B3), their gratefulness (B5) and their fighting spirit (B7).

Strategies in the context of education and support

In the field of education, supervisors demanded: mandatory, well organized, on the job programmes for all RHPs that are funded (B8), career advice services (B6, B7), follow-up support (B7), more resources and equipment for the training of RHPs (B4, B6, B7), material and support for language training.

Strategies on the team level

Generally speaking, positive contact towards patients and team members was perceived as very helpful. One supervisor described RHPs' and patients' relationships as "a mutual connection as they are stronger dependent on each other" (B7) than in other cases. Likewise, team members were described by all RHPS to be open, interested and supportive: "They were all friendly and every

morning when I came to work they smiled at me and said ‘good morning’. And that I find really important for a newly arrived” (A12). Almost all of them (A1-A4, A7-A9, A11-A14, A16-A17) emphasized that colleagues were forthcoming if they had questions and that they benefitted from their induction and their feedback. Two of them (A8, A11) pointed out the role of other (locally trained) interns and students who helped them in their free time. Supervisors focused more on structural resources for teams. They suggested training for local team members and mediators (B1, B7), more personnel and more time to induct RHPs (B3, B6, B7), clear contact persons that RHPs can talk to (B1, B4) and clear instructions of team members (B3). They also mentioned time to familiarize for RHPs (B1, B2, B6, B7), less patients to care for at the beginning (B7) and sensitization and reflexivity of locally trained team members (B1, B3, B7).

Strategies on an organizational and societal level

On an organizational and societal level, supervisors suggested enhancing an overall integration approach so that RHPs can have a quick arrival in the system (B1), build up networks (B1, B6) and earn their own money (B1). They also mentioned an opening welcoming culture (B1), public sensitivity actions and support from the management boards (B7):

But we also need the attitude from above [the management board] that says: “We want that [the labour market integration of RHPs], and we also provide time and resources, and teams also get a benefit for getting involved”. (B7)

One supervisor referred to the commitment of supervisors and the healthcare providers when observing racism and sexism: “If the hospital positions itself clearly and says ‘take your documents and go home because we are not going to treat you’. Great, because that is a clear line. But if they talk around the issue the patient will continue to show racist behaviour” (B8).

DISCUSSION

This paper aimed to explore the barriers and resources RHPs faced at their workplaces. The broad range of identified barriers and difficulties indicates that their experiences depend very much on their employers and their working environment. Moreover, as understaffing is a common problem in health care (Angerer et al., 2011; Deutscher Gewerkschaftsbund (DGB), 2018), it is questionable to what extent only RHPs are affected by these experiences or if they are a consequence of the precarious staffing situations. Moreover, it remains open to what degree the migration status influences the experienced challenges. Since no questions were asked about their flight, their psychological well-being or their residency permit and none of the participants mentioned it in the context of their workplace experiences, it is not possible to state whether only refugees experience these barriers. Instead, our results indicate that when focusing at their workplaces, RHPs face similar barriers as internationally recruited professionals and voluntary migrants (Humphries et al., 2013; Jirovsky et al., 2015; Klingler and Marckmann, 2016; Pütz et al., 2019). Nine major challenges were identified: 1) recognition of qualifications, (2) language competencies, (3) different healthcare systems, (4) working culture, (5) challenges with patients, (6) challenges with team members, (7) emotional challenges, (8) discrimination and (9) exploitation. These challenges illustrate that hiring RHPs should not be a quick response to filling shortages. Instead, the integration process should be carefully prepared in order to prevent some of these challenges. Labour market integration is a two-sided process that requires not only a welcoming culture but also welcoming structures (Knuth, 2019). Educational providers, employers as well as authorities need to address these barriers and implement structural changes in order to contribute to a sustainable labour market integration of RHPs.

Both RHPs and supervisors emphasized the challenges with the recognition process. This is consistent with previous findings that many legal and formal barriers inhibit a successful labour market integration and prevent organizations to invest in RHPs integration (Schmidt, 2019).

RHPs and supervisors both stressed the role of acquiring the language and the consequences of lacking language competencies. RHPs suffered from not speaking German fluently, and it affected their self-esteem. Likewise, the knowledge and familiarization with the local healthcare system is an important prerequisite in order to deliver a good working performance. Both barriers are reported to be common challenges in the context of labour market integration of refugees as well as other migrant groups (Cohn et al., 2006; Bloch, 2008; Leblanc et al., 2013; Klingler and Marckmann, 2016). This indicates a stronger need for occupational specific language courses and information on the healthcare system of the host country. This would not only concern educational providers but also employers. In order to maintain a good quality of care and prevent misunderstandings or mistreatment due to language barriers (Klingler and Marckmann, 2016), employers can invest in further education of their RHP employees. Although this would mean additional financial investment from the employer, a corporate study indicates that those investments would pay off within a year (Baic et al., 2017).

In the context of working culture, a fast adaptation to local standards was expected by supervisors and team members. Deviations from these local standards were seen as problematic and obstructive. This coincided with results from other studies (Klingler et al., 2018; Pütz et al., 2019). However, it remains problematic due to several reasons. Firstly, the term “local standards” presumes shared standards (Klingler et al., 2018). However, it remains unclear if these standards refer to professional standards, legal regulations, norms, cultural aspects or hospital routines. Secondly, the knowledge about certain established standards may be tacit and implicit (Sakamoto et al., 2010) thus unspoken. As RHPs are unaware of these unspoken standards, deviations in behaviour can lead to frustration, conflicts and exclusion (Lai et al., 2017). Thirdly, most of the perceived differences in the context of working culture from the supervisors were culturalized. Supervisors saw the causes of conflicts in cultural distinctions, although they could as well be interpreted situation and person specifically or result from differing concepts of work. This is consistent with previous findings (Pütz et al., 2019) that in the process of labour market integration differing concepts attributed to work clash. These concepts may be influenced by stereotypes and prejudices. As a result, on the one hand immigrated employees identify themselves as the “outsiders” contrary to local employees. On the other hand, an enhancement of the existing working culture that could have been adaptable to a new environment is excluded (Steinberg et al., 2019). Fourthly, the performance of RHPs is measured according to their adaption and stabilization to the system. But the potential that RHPs bring along is wasted if adaption and stabilization are the only possible and acceptable outcomes since they bring along important working experiences and attitudes that may enrich local standards. Thus, it is important to verbalize standards and address them before or ideally concomitant to RHPs labour market integration (Sakamoto et al., 2010). At the same time, it is important to offer local team members opportunities to reflect on their own standards of work and their expectations. This could also contribute to an overall improvement of the working atmosphere and reduce the challenges experienced with team members. However, difficulties with team members were also attributed to a lack of supervision during internships. Results indicate that most of the time, individual team members were intrinsically motivated to support RHPs and engaged in their induction. But the responsibility of integrating RHPs should not only be outsourced to committed employees or in the worst case, as described in the results, to unwilling employees. The support of RHPs should be implemented on a structural level. It is estimated that a one and a half additional hours of individual support per month are sufficient to generate good integration prospects (Baic et al., 2017). However, it remains open to question if team members who provide individual support should be further trained and/or remunerated for their effort. In order to expand the support possibilities, mentoring programmes could also be helpful in supporting RHPs. These findings are

consistent with recommendations given by the German Employer Association stating that mentoring programmes are a classical approach towards integrating foreign workers (Robra and Böhne, 2013).

In general, more acknowledgement and empowerment for RHPs is needed. This is consistent with previous findings describing the loss of RHPs' professional status (Leblanc et al., 2013) resulting in deskilling (Stewart, 2003), the loss of self-confidence (Jirovsky et al., 2015), feelings of frustration (Mozetic, 2018) and negative psychological impacts (Cohn et al., 2006). Results in this study further indicate that RHPs experience several forms of discouragement, discrimination as well as disparagement, although they are fully educated and bring along valuable human capital (A9). Although RHPs have already developed several strategies in dealing with negative feelings and the barriers they face, organizations and educational institutions could further engage in strengthening RHPs' professional identity, acknowledge their strategies and/or make the potential of RHPs visible in order to empower them.

In the light of the discrimination that RHPs faced by team members and patients, healthcare providers need to promote measures of diversity management as discrimination may be one result of poor diversity management (Dickie and Soldan, 2008). Discrimination influences the motivation and job satisfaction of RHPs and in the long term, it can also have negative psychological impact and lead to leaves of RHPs (Bouncken et al., 2015). On the contrary, a diversity climate within the organization can enrich the psychological capital of refugee employees and contribute to their commitment (Newman et al., 2018). Nevertheless, several forms of discrimination from patients and colleagues were commonly mentioned topics consistent with previous findings on RHPs' experiences (Cohn et al., 2006; Bloch, 2008; Jirovsky et al., 2015). According to the federal German law "General Act on equal Treatment," employers are legally obliged to protect their employees from discrimination (Allgemeines Gleichbehandlungsgesetz, 2006). But especially experiences of racism are often denied in health care as "the illusion of non-racism" exists and impedes progressive policies (Johnstone and Kanitsaki, 2008). Progressive policies may refer to promoting equal opportunity policies (Wrench, 1999) and prevent any form of discrimination (B8). Condemning racist comments (B8), establishing anti-discrimination commissioners, setting up transparent complaint systems and offering anti-discrimination and empowerment workshops could be first steps (Wrench, 1999) towards an inclusive and healthier working environment for both staff and patients.

Similarly, the exploitation of RHPs needs to be addressed and employers as well as policymakers should take responsibility for it. Due to their uncertain legal status, foreign workers are at high risk of being exploited (Rights, 2010). Labour unions have recognized that and demanded that refugees must be given access not only to the labour market but also to career advice services (Deutscher Gewerkschaftsbund (DGB), 2015) in order to increase awareness of their working rights. Another way for employers to prevent exploitation could be to appoint an integration commissioner for their organizations. These commissioners could monitor the integration process and ensure compliance with working rights. Educational providers working with clinics could inform RHPs as well as clinics on the legal rights and duties of RHPs. In any case, this finding points to a severe grievance that has not been reported in previous studies in this context. Further research is necessary to find out if these are selective experiences or structural problems in the health care sector.

In general, results indicate the need to reflect on the term integration itself. Several migration scholars criticize the term for numerous reasons. Firstly, in Germany the term "integration" mostly refers to regulatory policies which focus on integrating migrants into the existing social orders (Karakayali and Bodjadzijeve, 2010). However, social orders are predefined and shaped by members of the majority group (Essed, 2000). Secondly, the term is based on negative narratives about the unwillingness or failed integration of migrants which contributes to the fact that new demands are constantly being claimed on migrants (Mecheril, 2011). Hence, the term puts migrants into the focus while structural and institutional deficits as well as power asymmetries within the host countries are ignored. Subsequently, the experiences of racism and exploitation that RHPs describe in

this study point to the need to focus research on structural and institutional inequalities, power asymmetries and intersectional discrimination. For further research in this context, it would be helpful to consider the Critical Race Theory (CRT) as it is based on principles of race equity and social justice and provides tools in order “to elucidate contemporary racial phenomena, expand the vocabulary with which to discuss complex racial concepts and challenge racial hierarchies” (Ford and Airhihenbuwa, 2010). Furthermore, activists and scholars who contributed to the CRT study and transform the relationship between race, racism and power (Delgado and Stefancic, 2017). However, for the purpose of this study it can be concluded that equal participation in the labour market and society requires equal treatment, equal opportunities and protection against discrimination (Uslucan, 2017).

Policy recommendations

Refugee health professionals face personal, structural and institutional barriers at their workplaces. Although they have developed strategies to overcome these barriers, structural and institutional changes are needed in order to improve the working environment. In the following, the most important conclusions from this study are pointed out as recommendations in order to contribute to a better labour market and workplace integration of refugee health professionals. First, there is a need to offer job-specific language courses and courses addressing formal and cultural aspects of work (as it is done for example in Sweden (Ministry of Employment and Sweden, 2016)). Similarly, local team members need to be sensitized for cooperation with refugee health professionals in order to decrease the potential for conflict. Second, structural changes within teams need to be implemented in order to supervise refugee health professionals and ensure a proper induction at the beginning. Third, in light of the experienced barriers, the discrimination and the exploitation, there is a need to empower refugee health professionals and make their qualifications and their potential visible. Fourth, measures of diversity management and anti-discrimination need to be implemented and supported by the management board. Fifth, compliance with working rights must be ensured and team members as well as refugee health professionals need to be informed about their working rights.

Strengths and limitations

This study identified major challenges in the context of the working experiences of RHPs. By choosing an explorative approach, a broad range of topics could be identified which provide a basis for further research and in-depth analysis of the difficulties in the identified fields. The perspective of RHPs and their supervisors were integrated in order to get an insight into the field of health professions and the labour market integration into health professions. For further research, it could also be helpful to interview colleagues of RHPs and focus on specific healthcare settings. Participants in this study were selected from rural as well as urban areas and comprised several health professions. Another strength of this study lies in the methodology. Discussing data with an interdisciplinary group ensures comprehensibility and critical reflection. Nevertheless, as participants were not recruited representative and most participants worked only for a short time in Germany, there might be a selection bias and results are questionable in terms of generalizability. Another limitation is the compilation of the sample as more physicians and more men in urban areas were interviewed. Intersectional barriers, language competencies, training experience and other demographic-specific aspects were neglected. Hence, no conclusions could be drawn for subgroups. Furthermore, although a certain language competency was required, language barriers and socially desirable answers may have influenced the interview process. However, due to the researchers' background and the reflection of her characteristics, a trustful interview situation could be created and reflected afterwards.

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NOTES

1. The terms “refugee health professionals” and “supervisors” were selected as they describe a shared experience. However, it should be noted that both terms reduce these persons to only one aspect of identity. The terms do not reflect the multiple aspects of identity and the social and ethical dimensions of the workplace identity that all interviewed person and health care professionals have.
2. The Common European Framework of Reference for Languages: Learning, Teaching, Assessment (CEFR) is a reference system to describe six levels (A1, A2, B1, B2, C1, and C2) of language proficiency from beginners (A1) to experts (C2).
3. SPSS is an abbreviation for Sammeln, Prüfen, Sortieren and Subsumieren (Collect, Check, Sort, Subsume).
4. Health professions are registered professions in Germany which is why foreign health professionals need to have a full or temporary license before they can practise. In order to obtain a license, they have to go through a recognition process. The first step of the recognition process is an equivalence assessment. Based on this assessment, recognition bodies grant full recognition, no recognition or partial recognition. If qualifications are only partly recognised, foreign health professionals can participate (professional groups like nurses must participate) in adaption training programmes or internships and prove their required knowledge through language and proficiency tests. The proficiency tests covers internal medicine and surgery. However, based on the equivalence assessment authorities may also evaluate other subjects.
5. As the interviews were conducted in German, citations in this section were translated one-on-one from German to English. If terms were not equivalent in English, then those terms were translated one-on-one and supplemented with further explanations in the reference mark (Koller, 2011 *Einführung in die Übersetzungswissenschaft [Introduction to translation science]*, Francke, Tübingen; Basel.).
6. “No plaintiff, No judge” (German translation: Wo kein Kläger, da kein Richter) is a common phrase in German. It describes that certain irregularities or grievances remain uncovered as no one complains about them.

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Yarris, K. and H. Castañeda

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