An Exploration of Cultural Capital, Labour Market Position and Work Experiences of Migrant and Refugee Doctors in the UK

Dr Eleni Hatzidimitriadou

Dr Maria Psoinos

Faculty of Health and Social Care Sciences
KINGSTON UNIVERSITY • ST GEORGE'S, UNIVERSITY OF LONDON

swan
SouthWest London
Academic Network

Interprofessional Institute
(Health & Social Care)

Background

- International migration of medical doctors is a growing phenomenon worldwide

- United Kingdom: non-UK trained doctors make up approximately 33% of all NHS doctors (deVries et al., 2009)

- Increasing research interest in migrant and refugee doctors' labour market position and employment-related experiences (Bach, 2003; Cohn et al., 2006; Rechel, et al., 2006; Oikelome & Healey, 2006; Smith et al., 2006)

- Most studies either draw on one-sided sociological theories (focusing on social closure) or lack theoretical basis

Rationale of the study

- Strong evidence of under-utilisation of health and social care services and poor health outcomes amongst migrant and refugee populations in the UK
- Assumption that migrant and refugee professionals will provide more 'culturally sensitive/competent' services

Research question: do migrant and refugee health and social care professionals merely fill in vacancies their British colleagues do not take up? Or can they also enhance the UK health and social care workforce with their cultural knowledge and experience?

Aims: to explore the experiences of migrant and refugee health and social care professionals in the UK and the relevance of cultural capital to their labour market positions and their professional development

Objectives : a) to explore the challenges these professionals face when employed, which can distort and/or devalue the cultural capital they bring and b) to identify the ways in which these professionals, by making use of their cultural capital, effectively cope with these challenges.

Theoretical background

- Focus on professionals who 'have made it through the system' – acknowledge not only difficulties and challenges but also positive experiences

- Pierre Bourdieu's Cultural Capital (1986): non-financial resources people 'inherit' (e.g. from the family) or consciously acquire over time (e.g. through formal education)

  Formal/institutionalized cultural capital - education, accredited professional training, recognised work experience

  Informal/incorporated cultural capital – social and professional networks both in their country of origin and the host country, as well as the work ethics they bring along

- Michelle Lamont (2002): cultural capital is not just a 'residual category' but is also stemming from people's self-concept

Methodology

- **3 professional groups:** medical doctors, nurses and social workers who have been trained in their home countries & have work experience in the UK health and social care sector

- **Target** : 5 people per group; total number = 15 participants

- **Qualitative approach:** biographical narrative depth interviews

- **Purposeful sampling:** recruiting participants through our professional networks

For the purposes of this presentation, we will focus on medical doctors

Sample of Medical Doctors

	Gender	Age	Region of origin	Year of entry in UK	Migration status	Education – Home country	Education - UK
MD1	Male	34	Southeast Asia	2007	Refugee status	University Degree – Medical School	Studying for MA in International Health
MD2	Male	50	South-central Asia	1990	Refugee status	University Degree – Medical School	Obtained Diploma in Nutrition
MD3	Female	42	Eastern Europe	2005	EU Citizen	University Degree – Medical School	n/a
MD4	Male	34	Southern Europe	2003	EU Citizen	University Degree – Medical School	Specialised in Oncology
MD5	Male	29	South Asia	2005	Economic migrant with work permit	University Degree – Medical School	Obtained MA in International Health Policy and Health Economics

Interviews

Generative narrative question:

“*I would like to ask you to tell me the story of your educational and professional life before and after you came to the UK. A good way to do this would be to start talking about the education you received in your home country and any work experience you had there, and then about your education and work experience in the UK until today. After that you can also tell me about your thoughts about your professional future. You can take your time in doing this, and also give as many details as you want because I am interested in everything that is important for you*”

Specific narrative inquiries:

- Experiences with UK institutions (e.g. employment agencies);
- Social networks (e.g. relations with colleagues or co-ethnics);
- Individual coping resources

Narrative Analysis

Mishler (1995):

- Focus on the *content* of the narrative
- Focus on *form/structure*
- Focus on the *broader interactional social context*

Focus on content:

The narrative material was classified into (Elliott, 2005) :

1. The sequence of past experiences and situations in the narrator's life (for capturing formal cultural capital)

2. The narrator's point of view (as per Lamont's conceptualisation of informal cultural capital, i.e. focus on self-concept)

3. The socio-cultural context to which the narrator responds (as per Bourdieu's conceptualisation of formal/informal cultural capital, i.e. focus on structures which sustain inequalities)

Issues related to labour market position

- Restricted versus unrestricted use of educational credentials:

  Restricted use can be observed to the cases where there is an issue with immigration status, i.e. with refugees, however all but one participants have pursued additional further education/specialisation qualifications in the UK.

- The length and sequence of the entry process and career progression:

  Whether entry to labour market and career progression is *direct* or occurs via *intermediary transitions* or *search and orientation phases*. In this case, the question also arises as to what extent cyclical dynamics set in, with the respective start of one phase leading to other phases in succession.

- Link of career entry to changes in an individual's private life (partnership, children, family or other personal issues) insofar as these emerge as relevant

Participants' educational and career trajectories

MD1

University Degree at home country → Public Health doctor at NGO → Migration in Thailand – Working for NGO → Scholarship to study in Switzerland – Diploma and MA in Tropical Medicine → Refugee Status in UK → Project Officer in PCT → Studying for MA → Currently looking for suitable posts in UK and Thailand

MD2

University Degree at home country and India → Army Medical Officer/Hospital doctor → Refugee Status in UK → Diploma in Nutrition → Adviser in local authority → No longer looking for jobs to match qualifications

MD3

University Degree at home country → Psychiatrist in hospital → Economic migration to UK → NHS Psychiatrist → Migration to New Zeeland

MD4

University Degree at home country → Hospital doctor → Economic migration to UK → Specialised in Oncology → NHS Oncologist

MD5

University Degree at home country → Healthcare Manager in private sector → Economic migration to UK → MA in Health Policy and Economics → Consultant in pharmaceutical company → NHS Strategy Manager

First analytic area: the sequence of past experiences and situations in the narrator's life

THEMES:

- Educational career in home and host countries
- Professional accreditation of educational qualifications acquired in home country
- Labour market participation experiences in the UK

Restricted use of Formal Cultural Capital in UK

- Recognising one's overseas obtained qualifications depended on each participant's *migration status*:

*"…because I'm from that country and we're classified in that bracket so obviously it's a much tougher road for medical professionals wanting to carry on with providing clinical services in this country… and I think that you know, **the sort of roadblocks that you have in terms of the delays to entry can actually be very painful because you know that you've got a skill and you can actually contribute and yet there is a lot of red tape around it** but then you actually have a lot of people coming here from the EU who don't have those legislations, and they can just come in and start working from as soon as they get a job…I'm not sitting here criticising the system but I still feel that they could actually… it's just a different yardstick for different people with the same qualification…"* (MD5, male, work permit, strategy manager in the NHS)

Further Education in Host Country as Formal Cultural Capital

- Further education/specialisation qualifications obtained in the UK *entitle* migrant/refugee doctors for specific positions on the labour market:

*"So I came over here and I tried a lot, because I had no document, so I was not eligible to update my training or to continue my training and to follow registration. So I was just waiting for my status to be clarified by the Home Office. After that two years, with the help of X University, they sent my diplomas and everything for recognition to the British Council. The British Council doesn't recognise my qualification and they say that because of the gap…**And they said that if any university accepts you for higher education you can go for that to get diploma and certificate…so that was my aim…I was delighted that two Universities accepted me …**"* (MD2, male, refugee status, health advisor in local authority)

Second analytic area: the narrator's point of view

THEMES:

- Motivations to pursue professional career in the UK
- Professionals' views of their own informal cultural capital
- Values in professional practice
- Strategies for changes at the workplace

The attraction of the UK education and labour market contexts

- Shared perception of the UK educational system and labour market context as much more advanced than the one in their home country:

*"… obviously many young people from my country were emigrating to the UK at the time so it was a sort of a promised land…and I thought well let's give it a go because…my partner and I could speak English and it was the reality of the economy at the time and the availability of jobs it was much easier so, yeah, that's why it was the UK…**Also I decided to leave because I couldn't cope in [my country's] system. There it's very hierarchical so the doctor is God in a way.** And doctors in particular in psychiatry have power and they use the power with the patient…it's quite patronising. So this is the sort of attitude there and obviously **in the UK, it's far more equal and you have rights and the doctors have to take into consideration the cultural background and the patient's own belief system and share the understanding and the decision making process…So the patient has to be part of the process and that's why I embraced it once I landed there**"* (MD3, female, EU citizenship, psychiatrist in the NHS)

The challenge of making use of informal cultural capital

- They acknowledge the culturally-specific professional expertise they bring and the fact that there is a different professional culture in the UK:

"Before, when the patient was coming into the hall by walking and coming to us, we were diagnosing what problem he might have, we were discovering all of this, but now, if you go to the doctor, tell the problem, he'll ask you what is your problem. **And it was shameful actually to ask a patient "what's your problem?"***, number one. Number two, the experience which we had was general, now if a doctor is in medicine, they don't know to do an injection, we were studying all these courses, how to inject, where to inject, what to inject, why…So we were like a multivitamin but now they're only vitamin B or D…* **So these are the things that have been separated, everything, we were just like a multivitamin for the body, for a patient, so we knew everything because we were studying extensively. But now, it's different, so now they want us to be specialised in pieces…***This is the problem now with us, we are not fitting to that requirement"* (MD2, male, refugee status, health advisor in local authority)

Informal cultural capital gained in UK

- The altruistic values they held regarding professional practice are enhanced whilst working in the UK:

"…*the oncology job… I never had exposure and I thought it was something I was not familiar with and I was a bit defensive at the beginning… I was very comfortable then with hyperacute medicine and cardiology, and acute medicine and then going to oncology was like a different speed of life, chronic patients, patients that we are allowing them to die instead of being very active… But at the end I enjoyed it so much.* **I liked the holistic qualities. I liked the fact that I didn't have to rush, I could see the patient and talk with them.** *I liked the close interaction with different teams, not only what is medical but palliative care, psychology, counselling, social care. I thought it was very holistic, a lot of interaction with the patients and the relatives, with this background. So I thought it kind of agreed with me so I just clicked that I could do this for the rest of my life and so after that I had a senior role as an SHO I started to focus only on getting oncology jobs and I got this job here*" (MD4, male, EU citizenship, oncologist in the NHS)

Third analytic area:
the socio-cultural context to which the narrator responds

THEMES:

- Impact of organisational/structural barriers on career progress
- Relations with co-workers and co-ethnics
- Responding to the changes and new regulations within the UK medical profession

Organisational barriers to meaningful contribution

- Even when they are allowed to implement effective strategies for change at the workplace, they still feel it is impossible for them to make a more significant contribution:

*"But having the knowledge and having the change management role I still feel that I can't make the right contributions. I mean **I would probably like to say a contribution that would probably make me proud I would probably have to be in a different job. So clearly there's a conflict there…**And it doesn't help at all in terms of confidence building…I don't think that anything that I do will probably make a good or a bad impact in the sort of future course for this organisation in a way… unfortunately changes always in these organisations come from top down and so unless of course you are actually making the right noises at the top nothing ever changes. That's just the way it works"*(MD5, male, work permit, strategy manager in the NHS)

Structural barriers impeding career progression

- The medical career provides a restrictive way into the profession which is only *vertically permeable*, i.e. migrants are not able to rise up to more senior positions easily:

  *"The other thing the organisation, this organisation, doesn't do well is talent management…clearly I've managed quite a few things and, you know, silly turnaround times and I've actually done well on things like the change management programmes and yet every time an opportunity comes by I'm never considered and every time they need somebody **I'm always seconded into it so clearly when the need arises I'm always approached. But when I actually try and go out to make that as a permanent career I'm always told no there isn't… there isn't a permanent need** and so that kind of pushes me back a few paces, yes, as to what your organisation's all about and I'm still confused. So clearly, you know, there's a disparity of sorts in terms of what the organisation wants long term and what the organisation needs in the shorter term and they do all they can to get me into those places and then they… quickly they get me out so as to… I don't know why but they do that. They've done it many times""* (MD5, male, work permit, strategy manager in the NHS)

Pressures to perform 'beyond and above duty'

- Experiences of tension and competition within the workplace were also discussed by some of our participants. The following quote of a migrant doctor from our sample is indicative of these negative types of interactions with colleagues and employers.

*"The problem is you need to be prepared of working more than 12 hours a day, you need to be prepared of making sacrifices. If you read the book they say that they want doctors who are focused and who have a private life and they are happy blah, blah, blah but that is not true… **I mean they know that if you want to get there, you need to make sacrifices… And if you say to one of the bosses for example look, this is out of hours and I'm not going to do this because of my private life they will see that as a sign of weakness. Colleagues and others will think you're not motivated, you don't have the aptitude… And I've come across that here quite a lot"*** (MD4, male, EU citizenship, oncologist in the NHS)

Barriers to using informal cultural capital

- Structural barriers hinder professionals from providing services to their co-ethnics:

"If they don't want us to work in the general public, they should give us at least chance to do work for our own community, if I'm going to the market, everyone is saying "hello Dr", knowing me from the back home. And giving me the title of my profession, saying "hello Dr, you are a doctor, you're a military doctor, we are seeing you, you were working over there but what has happened to you now you are walking on the street doing nothing?" ***So it's a shame for us also, a shame for the profession and shame for all those people who are seeing us like that****, number one. Number two, okay, for our own community, please give us to work, establish a clinic or something like that you know for the whole community of mine to work because they know me and they know my skills.* **They will be preferred to come to me rather than going to a doctor or a GP which, okay, straight out of medicine school, he has to go to the help of the computer, he can't write a prescription without the help of computer...** *"* **(**MD2, male, refugee status, health advisor in local authority)

Conclusions

- Participants' labour market trajectories are shaped by their use or not of cultural capital which involves their self-worth.

- When it comes to motivations, practising in an advanced and less hierarchical healthcare system is more important than simply being in a job that pays well.

- Also, being able to participate in planning and decision-making in one's area of expertise is more important than merely holding a prestigious post.

- The exploration of the role of cultural capital in the experiences and views of migrant/refugee medical doctors is an interesting and fruitful approach in considering the influence of both the personal and structural barriers and facilitators of their labour market participation.

- Further work in our analysis will be focussed on the comparison between the professional groups and the ways that cultural capital is facilitating career development and contributions to UK health and social care workplaces.