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AN EXAMPLE CASE OF HIGH-SKILLED REFUGEES: SYRIAN DOCTORS IN TURKEY

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AN EXAMPLE CASE OF HIGH-SKILLED REFUGEES: SYRIAN DOCTORS IN TURKEY

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I hereby declare that all information in this document has been obtained and presented in accordance with academic rules and ethical conduct. I also declare that, as required by these rules and conduct, I have fully cited and referenced all material and results that are not original to this work.

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ABSTRACT

AN EXAMPLE CASE OF HIGH-SKILLED REFUGEES:

SYRIAN DOCTORS IN TURKEY

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Master of Science, Migration Studies

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This thesis explores the employment experiences of Syrian refugee doctors in Turkey and analyzes the embodiment of their intersecting refugee and professional identities. The employment model of Syrian doctors at the Migrant Health Centers (MHCs) under the SIHHAT Project is used as a focal point to study their career rebuilding efforts in Turkey. The thesis is a qualitative research on Syrian doctors and its results represent only the sample. This study found that participants were experiencing a combination of the challenges encountered by high-skilled migrants and refugees. Refugee doctors are not homogeneous in their skill levels and their resistance capacities to deskilling are different. Limitations of being a refugee, welfare sector's strict regulations, and host country's standardized skill recognition criteria increased the odds of being deskilled and overqualified in employment for the participants. Thus, heterogeneous policies are needed for integrating Syrian refugee doctors into the Turkish healthcare system.

Keywords: High-skilled migration, Deskilling, Syrian refugee doctors, Migrant Health Centers in Turkey, SIHHAT project.

ÖZET

YÜKSEK NİTELİKLİ MÜLTECİLER ÖRNEĞİ:

TÜRKİYE'DEKİ SURİYELİ DOKTORLAR

Betül Merve Topaloğlu

Yüksek Lisans, Göç Çalışmaları

Tez Yöneticisi: Prof. Dr. Kezban Çelik

Ocak 2022

Bu tez, Suriyeli mülteci doktorların Türkiye'deki istihdam deneyimlerini inceleyerek, onların kesişen mülteci ve mesleki kimliklerinin somutlaşmasını analiz etmektedir. SIHHAT Projesi kapsamındaki Göçmen Sağlık Merkezlerindeki (MHC) Suriyeli doktorların istihdam modeli, bu doktorların Türkiye'de kariyerlerini yeniden inşa çabalarını araştırmak amacıyla bir odak noktası olarak kullanılmıştır. Bu tez, Suriyeli doktorlara ilişkin nitel bir araştırmadır ve sonuçları sadece örneklemi temsil etmektedir. Bu çalışma, katılımcıların, yüksek nitelikli göçmenler ile mültecilerin karşılaştığı zorlukların bir kombinasyonunu yaşadıklarını ortaya koymuştur. Mülteci doktorların beceri düzeyleri homojen değildir ve vasıfsızlaşmaya karşı direnç kapasiteleri farklıdır. Mülteciliğin getirdiği kısıtlamalar, refah sektörünün katı düzenlemeleri ve ev sahibi ülkenin nitelik tanımaya ilişkin standartlaştırılmış kriterleri, katılımcıların vasıfsızlaşarak veya fazla nitelikli olarak istihdam edilmeleri ihtimalini artırmıştır. Bu itibarla, Suriyeli mülteci doktorların Türk sağlık sistemine entegrasyonun sağlanması için heterojen politikalara ihtiyaç vardır.

Anahtar Kelimeler: Nitelikli göç, Vasıfsızlaşma, Suriyeli mülteci doktorlar, Türkiye'deki Göçmen Sağlığı Merkezleri, SIHHAT projesi.

To my Mom and Dad,

who have raised me with endless love, guidance, and support;

to my dear Husband and Son,

who are my happiness and with whom I share the adventure of life;

and to all Doctors,

whose bravery, perseverance, and love for others

inspire and restore faith in humanity.

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TABLE OF CONTENTS

PLAGIARISM iii

ABSTRACT iv

ÖZET v

DEDICATION vi

ACKNOWLEDGMENTS vii

TABLE OF CONTENTS viii

LIST OF ABBREVIATIONS xii

1 INTRODUCTION 1

2 LITERATURE REVIEW 8

2.1 What is the high-skilled migration? 8

2.2 Theoretical framework of high-skilled migration 11

2.2.1 Demand and supply driven migration systems 13

2.2.2 Deskilling 15

2.3 Literature on Highly Skilled Refugees 17

2.3.1 Refugees 18

2.3.2 High-skilled Refugees 20

2.4 Academic relevance and contributions of the thesis 22

3 BACKGROUND 25

3.1 The Syrian Civil War 25

3.1.1 The Exodus of Syrian People 26

3.1.2 Persecution of Syrian doctors 26

3.2 Turkey, Migration and Refugees 29
3.2.1 Migration in Turkey 29
3.2.2 Syrian refugees in Turkey 30
3.2.2.1 Work permits for Syrian refugees 32
3.2.2.2 Right of access to healthcare and education 34
3.3 Syrian Refugee Doctors in Turkey 35
3.3.1 Work permits for foreign doctors 36
3.3.2 Work permits for Syrian Refugee Doctors 37
4 METHODOLOGY 41
4.1 The reasoning behind the selection of the subject 41
4.2 Methods 42
4.3 Study Setting 43
4.4 Sample Selection 44
4.5 Participants 45
4.6 Data Collection 46
4.7 Data Analysis 46
4.8 Ethical Considerations 47
5 FINDINGS & DISCUSSION 49
5.1 Being a doctor in Syria 49
5.1.1 Before the Syrian War 49
5.1.1.1 How to become a doctor in Syria 49
5.1.1.2 Working as a doctor in Syria 51
5.1.2 After the war and becoming a refugee doctor 52
5.1.2.1 Resistance to anti-democratic policies and practices 52
5.1.2.2 Being forced to leave Syria 56

5.1.2.3 Border Crossing and the choice of destination 58
5.2 Being a refugee doctor in Turkey 61
5.2.1 Challenges in employment as a doctor 62
5.2.1.1 Getting the equivalence as a doctor of GP 62
5.2.1.2 Getting the license as a doctor of specialty 65
5.2.1.3 Bureaucratic uncertainties 68
5.2.1.4 The dilemma of legal vs. illegal work 72
5.2.2 Challenges of being a refugee 77
5.2.2.1 Limitations of temporary protection status 77
5.2.2.2 Difficulties in obtaining legal documents as refugees 80
5.2.2.3 Individual perceptions of being a refugee 81
5.3 Future-oriented plans as a Syrian refugee doctor 87
5.3.1 Staying in Turkey 87
5.3.2 Going to another country 90
5.3.3 Returning to Syria 91
6 CONCLUSION 93
6.1 Implications of the study 93
6.2 Limitations of the study 98
6.3 Recommendations for future studies 99
REFERENCES 100
APPENDICES 112
A. Interview Questions 112
B. Profiles of the Participants 113
C. Summary Demographics of the Participants 114
D. Ethical Committee Approval of TED University 115

E. Informed Consent Form 117

F. Original Turkish Excerpts..... 119

LIST OF ABBREVIATIONS

DGMM	Directorate General of Migration Management
EU	European Union
IOM	International Organization for Migration
GDP	Gross Domestic Product
GP	General Practitioner
MHC	Migrant Health Center
MoH	Ministry of Health
MoLSS	Ministry of Labor and Social Security
MSF	Doctors without Borders *(Médecins Sans Frontières)*
NGO	Non-Governmental Organization
PHR	Physicians for Human Rights
RAM	Guidance and Research Center *(Rehberlik ve Araştırma Merkezi)*
STEM	Science, Technology, Engineering, Mathematics
STS	Level Determination Examination *(Seviye Tespit Sınavı)*
TPS	Temporary Protection Status
TUS	Exam of Specialty in Medicine *(Tıpta Uzmanlık Sınavı)*
UNHCR	the United Nations High Commissioner for Refugees
WHO	World Health Organization
YÖK	Council of Higher Education *(Yükseköğretim Kurulu)*

CHAPTER 1

INTRODUCTION

A bundle of belongings is not the only thing a refugee brings to his new country. Einstein was a refugee.

— UNHCR

Higher skills are limited in volume by its nature and if locally not available sufficiently, the value attributed to them increases. In today's knowledge-based economies, higher skills are associated with better adaptation to the latest technologies and to the competitive environment of newer methods of working. Besides, the rapid developments in technologies create both shortages and constant demand for higher skills (Batalova, 2002). Globalization has facilitated the fulfillment of such skill shortages through immigration, thus catalyzed the steady growth of international talent migration in the last decades (Habti & Elo, 2019; Raghuram & Kofman, 2002). For instance, technological developments and the aging population in high-income countries have created further demand for foreign work force in sectors such as computer technologies and healthcare (Bailey & Mulder, 2017; Leblanc et al., 2013). The traditional patterns of highly skilled migration from global South to global North preserved its dominance, but talent flows from south to south and from north to south have also become more visible (IOM & OECD, 2014; Kerr et al., 2016).

The highly skilled migrants and the continuity of skill inflows are contributive to better outcomes in national productivity, innovation, and the global competitiveness of the host states (Bailey & Mulder, 2017; Chiswick, 2011; Kerr et al., 2016; Oliinyk et al., 2021; Ouaked, 2002). Taking the beneficial return value of

high-skills into consideration, state migration policies have been redesigned to be more competitive in attracting highly skilled migrants and their contribution to national innovation capacity (Batalova, 2002; Borjas, 2005; Czaika & Parsons, 2017). Policies that are more "welcoming" and bureaucratically less cumbersome eased the mobility of highly skilled professionals. However, for highly skilled people, the value of their skills in another country is not the sole factor for migrating. Besides the migration policies of destination countries, there are other pull and push factors, both structural and personal, for high-skilled migration. For example, better education and employment prospects, higher salaries, freedom of opinion and on life-style choices, democratic values, higher life standards, etc. can be cited as the pull factors that attract high-skills toward developed countries.

Globalization is both a pull and push factor for high-skilled migration since it simultaneously creates foreign workforce demand in destination countries and contributes to the creation of skill shortages in the origin countries (Garcia Pires, 2015; Humphries et al., 2013). The micro-level push factors for high-skilled migration are commonly observed as low salaries, inadequate career perspectives, limitations on personal freedoms, and lack of education/training opportunities. While, structural push factors are low level of economic development, unemployment, discrimination, lower status of living, as well as wars, armed conflicts, political instability and corruption, political persecution, environmental problems, and natural disasters (Dimant et al., 2013; Docquier et al., 2012; Docquier & Rapoport, 2004; Kumpikaitė -Valiūnienė et al., 2021).

Parallel to the increasing migratory flows, the interest of academia for the highly skill migrants has substantially grown. Migration policy outcomes and the labor market integration of highly skilled migrants emerged as frequently researched topics. The studies have accumulated on certain migrant profiles and employment sectors such as the professionals in high-tech industries of science, technology, engineering and mathematics (STEM), corporate managers, expatriates, and students in higher education (Czaika & Parsons, 2016; Facchini & Lodigiani, 2014; Kofman, 2000). The literature associates the "success" of the high-skilled migration with the skill level-appropriate employment of the migrant (Garcia Pires, 2015; Oliinyk et al.,

2021). The opposite case is “deskilling”. Deskilling is the status of underemployment or unemployment of the highly skilled migrants in destination countries (Agnew et al., 1997; IOM, 2012; Man, 2004). A similar form of deskilling is described as “overqualification”, in which the skills of a migrant are much higher than the ones required doing the tasks of the employment. Both deskilling and overqualification are related to lower productivity and lower labor market outcomes and skill waste, lower social integration, adverse psychological effects on the migrant, and higher economic and social costs. The negative consequences of deskilling affects all parties of the migratory movement, the agent, the host country, and the origin country (Bygnes, 2019; IOM, 2012; Man, 2004).

Although the high skilled migration is a well research topic in the literature, some highly skilled migrants rarely appear with their professional identities in the mainstream studies of high-skilled migration. The knowledge about these migrant groups is dispersed and presented within various academic disciplines in different studies on refugees, development, gender, and social integration (Briddick, 2020; Docquier et al., 2012; Duda-Mikulin, 2020; Edeh, 2019; Fleury, 2016; Garcia Pires, 2015; IOM, 2012; IOM & OECD, 2014; Iredale, 2005; Ressia et al., 2017). Furthermore, this found knowledge is in a non-continuous form and usually not readily available to be used for the analyses on the high-skilled migration. This is partly related to the fact that certain migrant profiles are difficult to fit in the existing theoretical definitions and assumption about highly skilled migrants.

A significant example of such neglected profiles is the refugee doctors, who are highly skilled professionals and forced migrants, who leave their home countries and take refuge in other ones. Doctors represent an important share of the global population of the high-skilled migrant professionals (Hoyler et al., 2014). The transferability of the medical knowledge and skills across borders is expected to be high because of the universal nature of medicine. However, as highlighted in the literature, factors such as host country market regulations, credential recognition criteria, knowledge of the local language, as well as other social, cultural, and psychological elements play important roles for the successful integration of migrant doctors (Humphries et al., 2013; Raghuram & Kofman, 2002, 2002; E. Stewart,

2003). Besides, being a refugee adds an outer layer to all these factors. As thick as the integration barriers for a highly skilled refugee get, the more difficult it becomes to reach skill-appropriate employment opportunities in the host country. If the refugee professional cannot find employment or deskilled, this result is called as the "refugee gap" (Ozekmekci et al., 2020).

The issue of refugee gap has been a significant concern for this study. Besides, the large Syrian refugee population in Turkey provided a natural research venue and there is a literature gap on the experiences of Syrian refugee doctors in Turkey (Ozekmekci et al., 2020; Sürmeli et al., 2021). Before explaining the methodology of this research, I would like to present the background developments briefly regarding the presence of Syrian refugees in Turkey. The ongoing Syrian War has created the largest refugee crisis in the last decades (UNHCR, 2020). The protests started in 2011 with the demand for a more democratic rule in the Syrian Arab Republic. However, the conflict became violent and not much later developed into a complex civil war which involved state and non-state actors and external powers. The Syrian War led to a massive destruction of the country and the displacement of its people within and beyond its borders. Turkey, Syria's northern neighboring country and on the migration routes extending to Europe, experienced a massive exodus from Syrian. Today, more than half of all Syrian refugees in the world corresponding to 3.6 million Syrians are under temporary protection in Turkey.

Returning to the subject of Syrian refugee doctors, according to the estimations, around 20,000 Syrian doctors initially came to Turkey as refugees, but 15,000 of them moved on to other countries such as Germany for various reasons (AA, 2018; Loss et al., 2020). Among the various state regulations and practices implemented for the efficient management of the Syrian migration to Turkey, the formation of Migrant Health Centers (MHC) has been the most important initiative in the healthcare sector (Sihhat Project, 2021). Ozekmekci et all. (2020) defined these centers as an innovative project to make use of the skills of refugee doctors and an exceptional example of refugee integration. These centers are established to provide state health care to Syrian refugees and their creation was funded by the

European Union (EU). Within SIHHAT project, the Ministry of Health started collaboration with the World Health Organization (WHO) in 2017 and 731 Syrian doctors were employed at these centers by 2021.

As mentioned above, currently, there are around 5,000 Syrian doctors in Turkey, but there has been no study that specifically focuses on the employment prospects and professional experiences of these refugee doctors. This thesis aims to shed light on the individual migration experiences of Syrian refugee doctors in Turkey, with a focus on the reestablishment of their professional career. The research is designed as an exploratory study by using the qualitative method and semi-structured interview that loosely directed the conversation topics. An in-depth exploration of the problems through the narratives of these doctors is aimed. The sample is composed of 9 Syrian doctors who come to Turkey as forced migrants because of the Syrian War and who were working at the MHCs, in private clinics, or in non-medical jobs in Turkey. The flexible study structure enabled updates when the necessity felt and the narratives generated 97 page-long transcribed raw and rich data for the analysis.

It is hoped that the study findings will help to determine the labor market integration processes of Syrian refugee doctors in Turkey. Second, the assumptions described in the literature about these migrant identities will be reviewed based on the case of refugee doctors. Last, the elaboration of their struggles about professionally rebuilding themselves is believed to contribute to filling the literature gap on the high-skilled refugees, through comparing the similar and distinct attitudes of their intersecting migrant identities: high-skilled migrants and refugees.

With these aims, the following questions are going to be explored in this thesis:

1. How do Syrian refugee doctors cope with challenges of being high-skilled?
2. How do Syrian refugee doctors rebuild their lives professionally in Turkey?
3. How do Syrian refugee doctors cope with the challenges of displacement?

This thesis comprises six chapters. The first chapter is the introduction and summarizes the research topic. The reasons for choosing the subject and

methodology of the study are elaborated and the research questions are presented. Last, the organization of the study is summarized in the order of chapters.

The second chapter provides the theoretical framework that covers research questions put forward in the introduction chapter. In the first and second sub-sections, the definition of a high-skilled migrant and a summary literature on the high-skilled migration are presented. The focus of the literature is on the pull-push factors of highly skilled migration and the problem of deskilling. Later, the definition of being a refugee and the conceptual placement of refugees within the high-skilled migration literature is discussed. Last, the academic relevance of this thesis and the study's expected contribution to the literature is stated.

In the third chapter, the background developments of this study's focus subject are presented. First, the developments that led to the Syrian civil war and its repercussions on the Syrian people and Syrian doctors are briefly covered. Second, Turkey's approach to the Syrian refugee crisis are explained. Last, the official status of Syrian refugees in Turkey, with an emphasis on Syrian doctors are elaborated.

In the fourth chapter, the design of the study, the methods of data collection and analysis are summarized. This research is a qualitative study, using a narrative inquiry approach to learn from the personal experiences of the participants, who are high-skilled refugees in Turkey. Purposive sampling is employed for the selection of participants. The data is collected via semi-structured in-depth interviews. Afterwards, the processes of transforming the narratives into data and analyzing this data are explained. Finally, the consideration given to the ethical issues of the research will be discussed.

In the fifth chapter, the important findings are presented with the help of quotes from the narratives of 9 Syrian refugee doctors. These findings are classified by the temporal sequence of the migratory movement. First, the lives of participants as doctors before and during the war in Syria are depicted. Second, their lives in Turkey as refugees are elaborated. Finally, a glance at their migratory plans is provided. All the analyses of these findings are conducted within the framework of

the literature on high-skilled migration and refugees and are presented in each section.

The sixth and the last chapter conclude the thesis study by presenting the summary of prominent research implications. Research aims and questions are answered in light of the findings and study's contribution to the literature is highlighted. The limitations of the study are reviewed and future research areas are mentioned.

CHAPTER 2

LITERATURE REVIEW

2.1 What is the high-skilled migration?

One of the classification schemes of migrants in the literature and by policymakers is done according to their skill possession as “skilled” or “unskilled” (Chiswick, 2011, p. 28). Skilled migrants are further categorized as high or medium-skilled based on the value attributed to their skills. High-skilled migration is a significant section of the international movement and it has been reviewed with increasing interest by academia and policymakers (Iredale, 2005, p. 7). Historically, the skilled migration flows departed from former colonies and less developed countries to a handful of developed countries, namely the United States, the United Kingdom, Australia, and Canada (Kerr et al., 2016, p. 84).

After the Second World War, traditional immigration countries such as the US, Canada, Australia, as well as the ones Europe, softened their immigration policies and contributed to the growth of high-skilled migration. Especially after 1990s, the advancements in computer and science technologies, transportation, and communication played an important role in its further acceleration (Chiswick, 2005). The globalization of the international economy and the expansion of multinational companies' operations around the world not only increased the volume of high-skilled migration but also enlarged its patterns and new streams of high-skilled migration developed. In this regard, Asia, the Gulf region, and southern Europe emerged as additional immigration destinations. However, the enlargement was also in the migrant profile. The number of women high-skilled professionals has also grown and in 2010, when the number of female high-skilled migrants has surpassed the number of high-skilled males for the first time in history (Docquier et al., 2012).

The migration theories, such as neoclassical approach, pull and push, historical-structural use various lenses of macro, meso, and micro-levels to explain

the rationality behind the high-skilled migration (UNHCR, 2002). The literature defines migrants as rational agents who decide to move abroad based on the cost-benefit calculations on the returns they would receive for their economic, social, and human capital (Massey et al., 1993). In this perspective, components of highly skilled migration are conventionally defined as the skill set of the agent and the calculated value of his/her skills in the destination country. The primary attribution of high-skilled migration is commonly linked to the economic drivers (Bourdieu, 1986; Massey et al., 1993). Furthermore, the globalization of economy and globally improved higher education opportunities in the last decades also had a profound growing effect on high-skilled migration (Ozden et al., 2017). It is noteworthy that the definition of a "high skill" is not universal or static and may change from country to country and time to time (Chiswick, 2011). The terms "high-skilled migrant", "international talent", or "international professional" are used interchangeably in the literature, policy papers, and in media to denote the highly skilled migrant individuals and it will be the case in this thesis, as well.

How is it determined that a migrant doctor, an engineer, a teacher, an architect, a pharmacist, or a master's student is highly skilled or not? Or why does the image of an international talent belong to certain fields and professions? According to International Organization for Migration's (IOM) Glossary on Migration, a high-skilled migrant is someone who has earned the level of skills or qualifications typically needed to practice a highly skilled occupation by higher-level education or occupational experience (IOM, 2019, p. 91). Still, this conceptual definition is too broad to acknowledge a migrant as "highly skilled" or "qualified" by default. For instance, having tertiary education is a common denominator for categorizing migrants as highly skilled, but tertiary education, even together with professional experience does not place migrants in the highly skilled category. Main criteria for the level or value of a skill are closely related to its potential to increase a country's international competitiveness and innovational infrastructure (Iredale, 2001). In this regard, migration policies, skill shortages, and labor market demands of destination countries play important roles for defining the migrants as high skilled.

It is essential to acknowledge that individuals might be highly skilled in their countries, but they only become international talents when they are officially recognized by the destination countries. As immigrants, they can legally practice their profession and be highly skilled migrants only with the relevant type of visa. Majority of labor-importing countries and the OECD states reserve their highly skilled categories most commonly for entrepreneurs, managers of multinational companies, as well as professionals and experts working in the fields of science, technology, engineering, and mathematics (STEM) (Cuban, 2016, p. 244). The focus of high-skilled migration literature is similarly condensed on these highly skilled migrants, but less touched upon the many highly skilled migrants working in welfare sectors such as health, education, judiciary, and social work (Mozetič, 2015, p. 12; Raghuram & Kofman, 2002, pp. 2–3). The regulatory differences between the financial and welfare sectors explain this tendency (IOM & OECD, 2014).

Financial markets are usually self-regulated and they can have demand elasticity in defining and evaluation the high skills of immigrants. In welfare sectors, skill definitions and employment criteria for high-skilled migrants are usually fixed and strictly controlled by the government regulations (Kofman, 2000; Raghuram & Kofman, 2002). For instance, it is easier for an IT professional to transfer his/her skills abroad and get employed in another country thanks to the self-regulating and flexible mechanisms in IT related markets.

In welfare markets, the process of skill transfer is costly, cumbersome, and a longer process because of strict government regulations for foreign professionals. In the aging context of post-industrial nations, for example, there is a shortage of and a related demand for medical professionals (Duda-Mikulin, 2020; England & Henry, 2013). While this "care gap" and the number of highly skilled international workforce fulfilling this gap is raising (Raghuram & Kofman, 2002, p. 2074), there are many medical professionals that cannot meet or complete the official criteria in destination countries because of the visa policies, sectoral regulations, or salary thresholds to get their skills acknowledged (Man, 2004; McGregor, 2007). The strict and stable criteria are independent of the labor market dynamics in welfare sectors. That is why research on the experience of high-skilled migrants in welfare sectors is

more focused on the problems of skill recognition, deskilling (Bakker et al., 2017; Bygnes, 2019), racism (Allan, 2017; Raghuram & Kofman, 2002), and gender (Charsley et al., 2012; Cuban, 2016; Docquier et al., 2012). There is also research that uses a macro perspective by reviewing issues such as the brain-drain from the source countries to developed ones in welfare professions (Garcia Pires, 2015; Humphries et al., 2013; Iredale, 2001).

2.2 Theoretical framework of high-skilled migration

Theories on international migration typically approach high-skilled migration through macro-, meso-, and micro-level analyses, rather than differentiating by skill categories. The macro and meso-level approaches describe the international landscape for migrants. The macro-level approach provides a general framework on the pull and push factors, which are closely linked to economic and labor market conditions in source and destination countries, as well as some security-related concerns such as a civil war or political oppression in the source country (European Commission & OECD, 2016, pp. 3–4). Meso-level approach focuses more on the historically or socially established links between countries. In meso-level theories, migration drivers are explained by describing the migration patterns, chains, and networks. These drivers are significant pull factors that affect the decision making of immigrants and refugees. The migration flows from former colonies to Europe is an example for meso-level approach. Micro-level theories elaborate and analyze the personal reasons of migrants move to other countries and its consequences. Still, none of these three levels of analyses are mutually exclusive because of the complex nature of migration itself.

The macro-level research mostly covers topics of immigration policies, the developmental consequences of high-skilled migration for sending countries, and economic and labor market effects of highly skilled immigration in destination countries (Borjas, 2014; Johansson & Śliwa, 2014; Kunz, 1975; Ressia et al., 2017; Somerville & Walsworth, 2009). Highly skilled migrants are by far the most favorably regarded immigrant group by receiving countries and societies. Popular destination countries of international migration such as the USA, the UK, Canada,

and Australia, employ immigration policies that focus on attracting and selecting highly skilled applicants. These policies and government planning have a significant impact on high-skilled migration. Massey et al. (1993) highlight the complexity of migration in their studies and state the need for interdisciplinary and multi-level approaches to understand migration in its entirety.

In this vein, micro-level studies provide a different perspective on high-skilled migration and cite its drivers as professional job opportunities, higher living standards, as well as the possibilities of furthering professional attainments and network connections in the destination country (Papademetriou & Hooper, 2009; Gross & Schmitt, 2006). In addition, the fairness of the immigration system, duration of residency permits, the general quality of life, and family reunification entitlements are other significant factors for highly skilled migrants (Papademetriou & Hooper, 2019). Therefore, inability to attain their professional goals has serious effects on the migration trajectory, self-happiness, and satisfaction from migration, besides the social and economic consequences of migration on macro levels for host and source countries.

The conduct of research on the causes and consequences of high-skilled migration varies by the academic disciplines of economics, politics, and sociology, each having particular lenses and methodologies (de Haas, 2010). Their methodological differentiation, together with the multidisciplinary character of migration leads to an overlook on the experience of certain high-skilled migrant groups with intersecting identities that are analyzed by different academic disciplines (Massey et al., 1993). Among these neglected migrant groups, highly skilled refugees represent a precious example: they work neither in financial sector but in welfare sector; nor they are voluntary migrants but they are refugees. Welfare and refugee studies are usually elaborated only by their related academic disciplines and therefore the professionals of these sectors are rarely chosen for career-related analysis in high-skilled migration literature. (Aydemir, 2020). Being a high-skilled refugee generates outcomes that differ from the outcomes of high-skilled migrants and lower skilled refugees. This thesis aims to contribute to this literature gap by employing a micro-level analysis of refugee doctors, who are the professionals in welfare sector.

2.2.1 Demand and supply driven migration systems

Migration is a multi-sided and multi-layered phenomenon and host nations' attitudes towards immigration not only depend on the skill level of immigrants and their positive market outcomes. The host society's perception regarding the highly skilled migrants is also affected by gender, age, ethnicity, race, religion, politics, culture, etc. Therefore, drawing parallels to the public opinion, state migration policies may facilitate the migration experience of highly skilled immigrant or hinder their job prospects and negatively affect their migration trajectory via rules and regulations (Aydemir, 2020). In the last twenty years at least, regardless of their structure based on demand or supply, migration policies favored high-skilled migration over the low-skilled one (Tzeng & Tsai, 2020). High-skilled immigrants are considered having higher potential of social, cultural, and economic integration to their host countries and have better job prospects (Aydemir, 2020; Kerr 2019; Brücker et al. 2012). In their study, Tzeng and Tsai (2020) compared the public perceptions of immigrants in six developed countries and found that high-skilled immigrants are relatively better received and welcomed by the public than the lower-skilled ones. That is because besides the policymakers, the host societies also look on high-skilled immigrants as having capacities to contribute to the national economy and owning backgrounds that are non-threats to their social integrity and well-being (Tzeng & Tsai, 2020). Yet, these results do not suggest that high-skilled immigrants are entirely well received in host countries and societies.

The migration policies are shaped by the national economic outcome goals, social cohesion needs, and national and border security, as well as the public opinion of the destination states. There are two types of migration policy that design the actual process of obtaining visas for high-skilled migrants: the first type is a demand-driven migration policy, work visas are granted to highly skilled migrants to fulfill the specific demands of the domestic labor market. In this approach, the applicant needs a pending job offer to apply for a visa. The employer has an active role in starting the migration process as the sponsor. Demand-driven migration systems are practiced in the US and in many European countries (including the European Blue Card). However, a demand driven approach often cannot answer the immediate labor

market needs, since this system is prone to time-consuming and costly bureaucratic procedures for both the employer and the migrant. As a solution, countries provide occupational shortage lists to speed up the employment process, especially for sectors with critical labor demands (Aydemir, 2020).

The second type of migration policy is based on a supply driven design and uses a point-based evaluation system (PBS) to determine migrant visa applicants. PBS is a set of selection criteria independent of the job offerings of the domestic labor market. In PBS, the applicants need to score a certain number of points defined to measure the overall personal and professional qualifications, such as educational attainment, job experience, potential earnings, language proficiency, age, and sex. The main aim of this policy is to attract talented international professionals to the domestic labor market. Canada, Australia, the UK, Japan, and New Zealand are some countries that employ supply driven migration policies and use PBS (Czaika & Parsons, 2016). Nevertheless, migrants admitted by a supply driven system have been observed to fail addressing the critical shortages in a host country's labor market (Aydemir, 2020). That is why various countries have been granting additional points in the PBS, if the applicant has a suitable job offer from the sectors with skill shortages (Czaika & Parsons, 2016). Supply driven systems are considered a more effective way to attract highly skilled migrants, while there is also an increasing tendency to implement a hybrid approach in the selection of highly skilled migrants. (Facchini and Lodigiani 2014).

Saxenian (2002) highlights that the movement of highly skilled migrants from less developed countries to developed ones is increasingly being referred to as "brain circulation", instead of the dichotomous terminologies of brain drain-brain gain. The research on high-skilled migration supports his findings that high-skilled migrants contribute to the source country through economic and social remittances (Tejada, 2016), expertise sharing, and network building for more practical business with the source country (Docquier & Rapoport, 2004). However, this positive consequential relation between high-skilled migration and its benefits to host and origin countries is closely linked to the ability of highly skilled migrants to use their skills in the destination country. While, the rise in the number of high-skilled migrants does not

imply a corresponding increase in the employment absorption capacities of developed countries or destination states though (Heisig, 2009, p. 1639). Instead, there is a more visible correlation between the number of high-skilled migrants and the tightening of migration policies (Freeman & Kessler, 2008). These policies have been frequently updated by the states to control and curb immigration and to select the highly skilled migrants. However, the efficacy of these policies is hotly debated by the academia, media, and policymakers in various contexts of national economy, international competitiveness, social integration of migrants, and national security (Czaika & Parsons, 2016; European Commission & OECD, 2016; Freedman et al., 2017). The adverse consequences of these policies on high-skilled migration are covered in the next section.

2.2.2 Deskilling

For high-skilled migrants, the principal skill and capital is their higher education, knowledge, and knowhow; so, not being able to make use of these skills in the destination country is a paramount concern (Siar, 2013). Strict state policies and regulations on the employment of migrants in highly skilled jobs could lead to skill waste or deskilling. In high-skilled migration, deskilling occurs when the immigrant is employed in a lower position, which requires less skills, education, training, or professional experience than he/she has (Heisig, 2009, p. 1641; Siar, 2013). Examples of deskilling are abundant in real life. It is not rare to come across the stories of immigrants who were engineers, university teachers, doctors, lawyer, or judges back in their country, but working as taxi drivers, nannies, house cleaners, or medical technicians in their destination country. That is why deskilling presents a significant juxtaposition between the aims and outcomes of migration for high-skilled migrants, since it is closely associated with a downward mobility, which could be occupational, economic, social or all of them together.

Deskilling is probably the largest obstacle to get productive results from high-skilled migration. First, non-utilization of a diverse range of qualifications and extensive professional experience possessed by the highly skilled migrants is a waste of talent and it decreases the potential of international competitiveness of the host

country (Batalova & Bachmeier, 2016; Garcia Pires, 2015). Second, when high-skilled migrants are underemployed, they earn less than what they would have earned in a middle- or high-skilled jobs annually. While, the underemployment or unemployment of migrants increase social benefits they receive from the host-state. The combination of these two dimensions leads to lower national productivity. Third, there are social and psychological costs of immigrant deskilling affecting individuals and host society. Fourth, for source countries, the emigration of highly skilled individuals seriously hinders human capital development and economic growth. Last, highly skilled migrants send remittances back to their countries and contribute to their countries' GDP, only if they can work (Legrain, 2016).

Another notion that draws many parallels with deskilling is overqualification (Brynin, 2002, p. 643). Within the framework of high-skilled migration, overqualification occurs when a highly skilled immigrant's degree of tertiary education or experience is much higher than the job requires (European Commission & OECD, 2016, p. 26). Although overqualification is globally quite common in the employment ways of the immigrants, the likelihood of being overqualified for the employed position increases rapidly for high-skilled refugees. Accordingly, in the EU area, 60 percent of high-skilled refugees employed are overqualified for their jobs. This high occurrence is mostly related to the little knowledge of host-country's language and lack of accreditation of their high-skills gained before their arrival to destination labor markets (Bratsberg et al., 2016; European Commission & OECD, 2016, pp. 30–31).

Last, another important perspective on high-skilled migration is related to the gender. The literature on migrant women's employment is concentrated on lower-skilled sectors (Parrenas, 2001; Hochschild, 2000; Allan & Larsen, 2003; Yeates, 2004; Charsley et al., 2012; England & Henry, 2013; Fleury, 2016; Föbker, 2019). This underrepresentation of women as high-skilled migrants in the past is partly because of the inherited gender-bias innate in migration theories (Cuban, 2016, p. 246). Indeed, most highly skilled migrant women are being categorized as family migrants, dependents of the migratory male "agent", or "trailing wives" (IOM & OECD, 2014; Kirkwood, 2009). On the other hand, there are increasing numbers of

professional migrant women with career motivations and dual-career households, in which women are also labor migrants (Kerr et al., 2016; Wheatley, 2012). Studies show that the employment ratio of high-skilled women in welfare sectors such as health, education, public administration, and law is higher than STEM sectors. Docquier et al.'s (2009) research on the immigrants in OECD countries shows that average emigration rate of international professionals is 17 percent higher for women than men. However, defining high-skilled women as the primary economic agents of migration is relatively recent in migration studies. (Docquier et al., 2012; Kofman, 2012; Raghuram & Kofman, 2002). Besides, high skilled or not, there are legal and professional market barriers that women face (IOM, 2012).

2.3 Literature on Highly Skilled Refugees

The category of highly skilled migration is determined according to the employment type of migrants and the way they entered the host country, rather than their skill possession (Bratsberg et al., 2016; Czaika & Parsons, 2016; Iredale, 2005). Since the skill possession is not a definitive aspect by itself for determining the type of migration movement, various highly skilled migrant groups cannot be analyzed fully since they fall into more than one migrant category. For instance, the case of high-skilled refugees is a significant example for this pattern. The migration theories and common assumptions on highly skilled migrants exclude high-skilled refugees from their analysis. Being a refugee is a specifically defined status according to the entry-mode of the migrant to the destination country; hence, the skill level of the refugee is not a defined attribution of his/her official migrant status. Highly skilled refugees are usually not counted as high-skilled migrants in the literature and by policymakers even though they are international talents according to their skill level. This thesis aims to contribute to literature by studying the experiences of high-skilled refugees, a group of migrants excluded from skilled-migration studies by default because of their entry-mode to the host country.

There are some structural reasons that lead to an overlook of highly skilled refugees. High-skilled migration and refugee studies are conducted by different academic disciplines and methods. Therefore, the case of high-skilled refugees does

not have a good theoretical fit with the assumptions related to highly skilled international professionals. Most refugee studies do not differentiate migrants according to their skill level, but by the way they entered the country or the legal status they are given (Black, 2001; Kivilcim, 2016; Kunz, 1975). The refugee studies focusing on the professional and career related issues and the skill level of refugees are very rare (Bakewell, 2008). As a result, there is a knowledge gap in the literature on the experiences of highly skilled refugees. In the following sections, a brief literature on refugees and the reasons pertaining to the exclusion of high-skilled refugees from international talent studies are presented.

2.3.1 Refugees

The term refugee evokes images of people trying to cross international waters in overcrowded boats, people carrying their children and possessions on feet beside the roads, desperate crowds look through fences at border crossings, and people living in camps with harsh living conditions. In literary works and policy-related documents, refugees are frequently classified as "forced migrants", people who are displaced beyond national borders because of natural disasters, famine, or armed conflicts (Kerr et al., 2016; Papademetriou & Hooper, 2009). The concept of "forced migrant" emphasizes the involuntary nature of migration and the presence of non-economic incentives (Mozetič, 2015, p. 11). However, not all forced migrants are *de facto* refugees.

Unlike a forced migrant, a refugee has a legally defined status in the host country. According to 1951 Refugee Convention, a refugee is "someone unable or unwilling to return to his/her country of origin owing to a well-founded fear of being persecuted for reasons of race, religion, nationality, membership of a particular social group, or political opinion" (UNHCR, 2021). Following a lengthy evaluation process by the authorities of the destination country, refugee status is given to migrants who cannot or do not want to return their home because of a well-founded fear of being persecuted (UNHCR, 2002). Another term frequently used in refugee contexts is the "asylum-seeker". UNHCR defines an asylum-seeker as a migrant who has taken sanctuary in a country to be officially recognized as a refugee, but whose protection

request is pending to be completed. Refugees and asylum-seekers are granted certain international protection and livelihood rights, the rights of not to be deported (non-refoulment), freedom of movement, and to work. The extent of these rights is determined by the regulations of host states, rather than international laws on refugees (Fiddian-Qasmiyeh et al., 2014, p. 102).

Host countries may employ different protection regimes for refugees and asylum seekers (Mozetič, 2015, p. 11). The last point of the terminology is regarding the status of temporary protection. Temporary protection is an entitlement envisioned by 1951 Refugee Convention and institutionalized further in the UNHCR's (2014) Guidelines on Temporary Protection or Stay Arrangements as a status given to people escaping from humanitarian disasters for sanctuary. The earlier implementations of temporary protection status were seen in the 1990s, when the Central and Western European states used this status for refugees generated by the wars in Yugoslavia and Kosovo (Öztürk, 2017). In this thesis, the term refugee is used as a general denominator and not in the legal sense for refugees, asylum seekers, and the people under temporary protection.

As of mid-2020, there are 26.3 million refugees and 4 million asylum-seekers across the world, and these numbers are constantly increasing (UNHCR, 2020). In 2017, the global refugee situation was described as "the biggest humanitarian crisis since the formation of the UN, right after the Second World War" (UN Security Council, 2017, p. 4). Although there is no statistical data on the skill level of these refugees, there are many high-skilled people among them which is showed in a few country specific studies that put forward the experiences of displaced talents around the world (Betts et al., 2017; Eastwood et al., 2006a; Özdemir et al., 2017; Piętka-Nykaza, 2015). Studies show that the higher skills these refugees possess differentiate their migration trajectory from the refugees with lower skills (Arie, 2017; Bygnes, 2019; Iredale, 2001; Mozetič, 2015).

2.3.2 High-skilled Refugees

Refugee studies usually take a macro-level perspective and examine the economic, social, and policy related outcomes of this migratory movement on refugees and on host and source countries (Black, 2001). A micro-level approach to analyze the match between professional backgrounds of refugees and their employment types in host societies is relatively limited in the literature, except for race and gender studies (Yu et al., 2007, p. 22). To better understand the experience of highly skilled refugees, trying to answer this question through the research is indeed quite necessary: Are they high-skilled migrants or are they refugees? The dominant identity of their migratory movement provides insights about their migration trajectory for policymaking and literal analysis. A need for a deeper understanding of the experiences of talented refugees is acknowledged in Yu et al.'s (2007) study on refugee integration in Canada. They pointed out the need for further research to discover the underlying reasons of lower economic performance of refugees by elaborating family, gender, and trauma related factors (Yu et al., 2007, p. 22).

The movement of high-skilled refugees is not primarily induced by labor market mechanisms of destination country such as higher wages, better living conditions, and prospective career opportunities as it is in high-skilled migration. Neither it is realized as part of certain governmental agreements between the sending and receiving countries (Massey et al., 1993). The migration of refugees is forced upon them rather than planned voluntarily by them. Like all refugees, high-skilled refugees also leave their countries because of armed conflicts, violence, human right violations, or political persecution and become refugees not by choice but as forced migrants (Amnesty International, 2021). While, they move to other countries together with their professional knowledge and experience like high-skilled migrants, thus they expect to use their human capital appropriately. Besides, high-skilled economic migrants plan their migration process carefully prior to their international move to ensure that their skills are transferable to the destination country. They usually apply for job vacancies suited to their skill level in destination country and sometimes even receive a relevant job offer before moving there. High-skilled

migrants aim to use their skills fully for the best returns expected from migration. Whereas, high-skilled refugees migrate abruptly and unprepared (Richmond, 1988) and face with structural and individual restrains that hinder their professional integration to the host labor market (Leblanc et al., 2013; Yu et al., 2007).

The European Commission and OECD (2016) highlight that in Europe, the employment rate of refugees increases as their skill level rises. Moreover, up to 69 percent of high-skilled refugee women can find jobs in their immigration country. This employment statistic is slightly higher than high-skilled refugee men and immigrant high-skilled women and all these figures signify the importance of gender perspective in literature on high-skilled migration (European Commission & OECD, 2016, p. 20). Still, according to the research, the refugees reside at the top of the spectrum of deskilling in the host labor markets among all highly skilled migrant populations (Bakker, 2016; Bakker et al., 2017; Bygnes, 2019; Duda-Mikulin, 2020; IOM, 2012). There are several explanations for this high share of deskilling for highly skilled refugees. Refugees face systemic entry barriers to exercise their professions in the host country. The obstacles of high-skilled refugees come forward as lack of credentials, lack of financial resources for licensing and training, difficulties to access employment opportunities, absence of support networks, poor host country language skills, restrictive rights of refugees on residence and paid work, as well as discrimination (Ager & Strang, 2008; Arie, 2017; Bakker et al., 2017; European Commission & OECD, 2016; Hynes, 2003; Piętka-Nykaza, 2015).

The lengthy asylum procedures create uncertainty about their legal and economic status in the host country and eventually limit their options to pursue activities of personal and professional development towards a better integration to labor market and society. For high-skilled refugees, the physical and emotional conduct of migration is much more different from highly skilled economic migrants. Refugees often move because of traumatic events and are highly prone to develop some health risks afterwards (Richmond, 1988). It is common that many high-skilled refugees find themselves in a negative feedback loop that pushes them to social exclusion and affects their productivity, mental health, and social integration (Bygnes, 2019; Bakker et al. 2013; WHO, 2016). In the presence of such factors,

high-skilled refugees are in a way compelled to accept working at jobs that are under their skill level, informal, or interim, or they will be unemployed (Batalova & Bachmeier, 2016, p.2).

2.4 Academic relevance and contributions of the thesis

For the aims of this study, refugee doctors are chosen for deeper examination from an employment perspective to bridge a related gap in the literature. Healthcare services given by doctors is one of the most heavily regulated welfare sectors in most of the countries. As a result, the regulations of healthcare sector are strictly national in each country, thus medical education standards and requirements differ around the world. However, acquiring the skills needed to become a doctor is universally an enduring process. It is long and costly. Besides, there is a global scarcity of doctors and medical personnel, including the developed, developing, and under-developed countries likewise (OECD & WHO, 2010). Even though the strict regulations complicate the employment possibilities to a large extend, among all refugees, refugee doctors are the most likely group to be incorporated in the host country's labor market following their entry into the country by the immediate issuance of work permits, (Raghuram & Kofman, 2002). As a result, refugee doctors represent a special case that has higher likelihood of being employed appropriate for their professional skills.

For this study, Turkey is chosen as the venue of the research to analyze the migratory experiences of highly skilled refugees. As of today, the refugee population in Turkey is close to 4 million (UNHCR, 2021) and 3.6 million of all these refugees are Syrian. There are various source countries and regions to international refugee crisis; however, the ongoing Syrian War erupted in 2011 heavily aggravated the problem and affected its wider region. The war created an abrupt and acute movement of people who fled from Syria towards its neighboring countries and beyond. As a result, an exodus of Syrians, Syria's northern neighbor Turkey has become the world's highest number of refugee and asylum seeker hosting country in the world. For an academic research, the presence of Syrian refugees and doctors

among them make Turkey a natural location for analyzing highly skilled migrants and refugees.

Furthermore, the official employment model of Syrian refugee doctors in Turkey represents quite an interesting example of academic research. The term 'Syrian doctors' refers to Syrian citizens who got their medical training and license of practicing medicine in Syria but leave there because of the Syrian War and came to Turkey after 2011. Some Syrian doctors are officially employed at Migrant Health Centers (MHC) to serve Syrian refugees and other immigrants. MHCs are within the public health service framework under the Ministry of Health of the Republic of Turkey. The employment model is actualized as part of an EU-collaborated project named SIHHAT that values the high-skills of Syrian doctors and aims to provide an opportunity to make use of these skills. Thanks to this project, the Syrian doctors employed in MHCs can practice their profession legally; however, they are not integrated into the national health system in Turkey yet. As a result, Syrian doctors in MCHs do not have the same labor market opportunities that the Turkish doctors have. The details of the employment scheme at MHCs and Syrian refugees' status in Turkey will be provided in Chapter 3.

International migration of doctors, either voluntary or forced, exacerbates the shortages in the world, especially in less developed countries with high emigration rates (OECD & WHO, 2010, p. 6). According to an estimation made in 2006 by the World Health Organization, 57 countries had a critical shortage of health staff in the world and 36 of them were from Sub-Saharan Africa. Brekke and Mastekaasa (2008) found that investing in human capital such as increasing language proficiency and host labor market experience through trainings are necessary and beneficial for high-skilled refugees in finding a job and making a living that corresponds to their skill and profession level. Preventing the skill loss of medical doctors is for the benefit of greater good.

Several studies mention the Syrian refugee doctors in Turkey; but their focus is on the healthcare provision to Syrian refugees. Syrian refugee doctors and medical personnel are touched upon as service providers within the perspectives of reproductive health of Syrian refugee women in Turkey (Samari, 2017; Çöl et al.,

2020), management of the well-being of Syrian refugee children (Şahin et el. 2021), healthcare services at refugee camps (Sahlool, Sankri-Tarbichi & Kherallah, 2012), and Turkish health legislation and Syrian refugees (Ekmekci, 2016). There are two studies analyze the migratory experiences of Syrian refugee doctors in Turkey. Dağcioğlu et al. (2020) conducted a study with the participation of 799 Syrian medical doctors living in Turkey and explored their social adaptation status. Ozekmekci et al. (2020) studied the integration of Syrian refugee doctors into the Turkish healthcare system from a migration policy perspective and by making comparisons with the integration practices regarding refugee doctors in other immigration countries such as Sweden, the UK, and the US. Last, Kayali (2020) interviewed Syrian refugee doctors working in a private clinic in Istanbul and focused on the evolution of unofficial healthcare provision by the Syrian refugee doctors and the problems of this informal practice. However, none of these studies focuses only on the migration experiences of Syrian doctors who were forced to leave their countries and came to Turkey as highly skilled refugees. To provide deeper understanding about the migration trajectories of refugee doctors and to contribute to bridge the knowledge gap in the literature, this thesis aims to analyze the migration experience of Syrian refugee doctors in Turkey.

CHAPTER 3

BACKGROUND

3.1 The Syrian Civil War

The Syrian Civil War (Syrian War onwards) started as peaceful protests demanding democratic reforms in March 2011 in the southern city of Deraa of the Syrian Arab Republic. The protests were inspired by the wider demonstrations held in the neighboring Arab countries. Protests were the continuation of the so-called "Arab Spring" (Lesch, 2011). However, from the beginning, the response of the Syrian Government has been overwhelmingly violent against the protesters. The Syrian police and military opened fire and killed many peaceful protesters to suppress the movement at once (Heydemann, 2013). Neither side of the tension stepped back and the situation escalated quickly. Security forces of the Syrian regime intensified imprisoning, torturing, and killing protesters, as well as anyone who was deemed to helping those protesters, including the medical personnel (SNHR, 2019). The anti-government sentiments turned against President Bashar al-Assad and protests demanding resignation of the President spread rapidly across the country. In a six-month period, the larger scale of the public unrest and violent crackdown against it by the Syrian regime developed into an armed rebellion as of October 2011. The conflict, which began as a peaceful protest in Deraa, turned into a protracted civil war that entered its 10th year in March 2021 (and is ongoing at the time of writing this study).

The unceasing armed conflict in Syria resulted in power vacuums all around the country and drew violent non-state actors such as Islamic State of Iraq and Syria (ISIS/Daesh), al-Qaeda, and the Kurdish Democratic Union Party (PYD) and its armed wing People's Protection Units (YPG) to Syria (Ergun, 2018; Oktav et al., 2018). Besides the war itself, the actions of these terrorist organizations beyond Syria heated the political tensions among regional and international powers. The political

and military involvement of external states, the two “superpowers” the United States and Russia into the Syrian War, further exacerbated the conflict and the polarization of ethnic and sectarian divisions in Syrian society (Ergun, 2018). Because of all these adverse developments, Syria became a venue for great destruction and violence exercised by its own regime, a land of proxy wars of external powers, and a training and recruitment base for foreign terrorists from all over the world.

3.1.1 The Exodus of Syrian People

Syrian regime’s extreme brutality against its citizens protesting the government and the involvement of other foreign actors into the war resulted in a genuine human tragedy and suffering. It not only took a severe toll on the Syrian people and the country, but also it led to the largest exodus in recent history. Because of the war, half of Syria’s before-war population of 23 million was displaced, and hundreds of thousands of people have been killed, kidnapped, and tortured since 2011. Besides, millions of Syrians have been seeking refuge in other countries for a safer and better future, while many Syrian asylum seekers died or have gone missing during the desperate and perilous journeys at the country borders or in the Mediterranean Sea. As of today, the Syrian refugees make up the largest refugee group originate from a single country in the world. There are 6.6 million people from Syria that seek international asylum. Most of the Syrian refugees live in neighboring countries of Turkey (55 %), Lebanon (13%), Jordan (10 %), Iraq (5 %), and Egypt (2 %) and also in Germany (%10) (UNHCR, 2021c, 2021a).

3.1.2 Persecution of Syrian doctors

Many Syrian medical doctors became refugees during the Syrian War. It is not known how many of these Syrian refugee doctors can still perform their profession in their host countries. From the perspective of high-skilled migration, what happened to the careers of Syrian refugee doctors who were forced to emigrate is a relevant subject. This study specifically focuses on Syrian refugee doctors in Turkey with an employment perspective. For a better understanding of the migration

experience of Syrian refugee doctors, a brief review of war related developments and the changing medical work environment in Syria would be provided in this section.

The hospitals and medical facilities in opposition-controlled zones in Syria have become the deadliest war spots in the country. Working in these places means the greatest life risk for the doctors and other medical personnel. This illustrates a discordant situation with the international humanitarian law. There are four Geneva Conventions of 1949 adopted by every country in the world and universally applicable as a major source for international humanitarian law regarding the protection of civilians (Shaw, 2020). These conventions aim to protect the civilians, medical personnel, humanitarian workers, as well as the wounded or imprisoned military personnel by defining the rules of conduct of war to restrict the savageness of armed conflicts (ICRC, 2010). The framework of these conventions not only openly states the illegality of attacking physicians and the people providing medical help, but also forbids targeting of hospitals, health facilities, and ambulances (Aron Lund, 2019).

However, targeting medical personnel and their activities in Syria has been used as a weapon of war and terrorization by the Assad regime (Aron Lund, 2019, p. 1; Karasapan, 2016). There were some international efforts to prevent this practice though. Through UN, the clandestine locations of medical facilities in opposition held areas in Syria were voluntarily shared with UN only to prevent targeting of health and humanitarian facilities in 2015. However, following Russia's involvement in the Syrian War as an ally of Assad's regime in September 2015, the frequency of aerial attacks on specific hospital locations increased (United Nations, 2018, p. 16). According to the PHR (2021), Syrian regime and its allies were the culprit of 91% of the attacks on health facilities. Many concerns arouse about the misuse of the shared location data at the UN by accusing Russia (Amnesty International, 2016) and whether the sharing of such information actually led to the targeting of medical facilities in Syria (Charbonneau, 2019). Following, some organizations, including the medical-humanitarian organization Médecins Sans Frontières (MSF) stopped sharing with data about hospitals in the opposition-controlled areas Syrian and Russian authorities (Kareem Shaheen, 2016).

Before the war, the health-system of Syria was one of the best among the Arab countries (Cousins, 2015, 931). However, the availability of medical services varied significantly between metropolitan and provincial areas (Karasapan, 2016). However, the situation has changed drastically with the war. The study of Kherallah et al. (2012) states that even during the earliest period of the war in Syria, the vital infrastructure for health services was destroyed, especially in opposition zones. Accordingly, the quantity, functionality, and capacity of hospitals decreased very early and caused a grave deterioration of the general quality of health care services in the country. According to MSF of Germany, more than half of the hospitals and around 80% of the ambulances in the country were damaged by military attacks and most of them were in the areas controlled by the opposition (Naomi Conrad, 2013, para. 4). In 2016 only, the number of the air strikes targeted hospitals reached to 108, which corresponded to roughly one bombing to a health facility in every 4 days (Gordon & Perugini, 2019, p. 440). Besides, the non-seizure of the armed conflicts created serious shortages on medical drugs and supplies in the country. Essential maintenance works of the medical equipment were also interrupted critically (Karasapan, 2016).

Regarding the deterioration of the health system in Syria, the significant decrease in the number of Syrian doctors and the medical staff was perhaps the most detrimental development. Before the Syrian War, there were about 31,000 doctors in Syria (Naomi Conrad, 2013). Currently, how many Syrian doctors are displaced is not exactly known. According to the estimations, hundreds of them were detained or killed by the Syrian regime, and half of them fled the country (Karasapan, 2016). The regime's assault on doctors started as arresting the ones who were fulfilling their duties at the emergency services and the operation rooms of the hospitals. Within the initial year of the conflict, there were already 190 of doctors were killed and many others were detained and tortured by the Syrian regime (PHR, 2021). Physicians for Human Rights (PHR) (2021) reported that at least 930 medical personnel were specifically killed during the decade-long Syrian War. 510 medical personnel were killed via airstrikes and 143 medical professionals were killed by detention, torture, and execution in the prisons by the Syrian regime (PHR, 2021). It should be noted

that these numbers reflect only the documented killings and there are still hundreds of disappeared Syrian health personnel whose fates are unknown.

3.2 Turkey, Migration and Refugees

3.2.1 Migration in Turkey

The Republic of Turkey, founded in 1923, historically was not an eminent immigration country prior to the Syrian War. In their research on the migration history of Turkey, İçduygu & Aksel (2013) define four mainstream periods pertaining to the dominant characteristic of migratory movements in and out of the country. As their study highlights, in the period from 1923 till 1950s that corresponds to the immediate afterwards of dissolution of the Ottoman Empire and foundation of the Republic, both emigration and immigration took place as part of the nation-building process of modern Turkey. During that period, immigration of Turkish communities was facilitated by the state with the aims to increase country's post-war population, as well as Turkifying it.

From 1950s to 1980s, a huge emigration from Turkey to mainly Europe and to other industrialized countries took place. A significant part of this emigration was realized within the frameworks of state-sponsored bilateral labor-agreements between Turkey and the European countries, who were trying to recover from the World War II. After 1980s and until 2000s, a new pattern of immigration of "foreigners", who were non-Turkish origin unlike the previous immigrants distinguishably emerged because of the globalization and some domestic and international developments, such as the 1980 military intervention in Turkey, the collapse of the Soviet Union, the Iran-Iraq War, and Afghanistan's refugee crisis in the surroundings of Turkey. This new immigration flow transformed Turkey into a transit country for asylum seekers and refugees, coming from Asia and aiming to reach Europe (Huddleston, 2013). Starting from 2000s, Turkey's migration policies updated by a more pro-active and systematic approach by the state to manage both emigration and immigration and this new approach characterized the fourth period

(İçduygu & Aksel, 2013). However, the Syrian War has had a drastic effect on Turkey's migration policies and transformed Turkey's status as a refugee hosting country. Considering these developments, it can be suggested that Turkey, starting from 2012, has entered the fifth period in its migration history.

When the Syrian War began in 2011, there was a visa-free regime between Turkey and Syria, meaning Turks and Syrians could travel between the two countries without a visa. During the initial phase of the war, the Syrian regime's brutal undertakings led to a swift escalation of tension in society, causing a dramatic increase in the humanitarian needs of Syrians. Following these adverse developments, Turkey quickly adopted an "open door policy" in October 2011 for Syrian citizens who flee the war and generously accepted all Syrians without exception and has confirmed the non-refoulment policy (Karakoç Dora, 2020). Within a short period, Turkey received waves of mass migration from Syria and eventually has become the largest refugee hosting country in the world (UNHCR, 2021d). That the number of refugees in Turkey is higher than the total number of refugees in all EU countries is significant to understand and compare the scale of Turkey's Syrian refugee population (Leghtas, 2019). The visa-free regime for Syrians continued unchanged until 2016. From 2016 onwards, Turkey has tightened its border controls and to reduce the arrival of further refugee Syrians from other countries, imposed a visa restriction for Syrians coming from third countries by air or sea. Turkey also built a wall on its Syrian border to prevent illegal crossing and trafficking (Anadolu Agency, 2018). The open-door policy for Syrian refugees who are coming from Syria via land borders is still in force as of 2021.

3.2.2 Syrian refugees in Turkey

Turkey is party to 1951 Refugee Convention and its 1967 Protocol with a geographical limitation. According to this limitation, Turkey grants refugee status only to asylum seekers originating from the member states of the Council of Europe. For people coming from non-European states, Turkey provides a temporary asylum by defining them as conditional refugees under temporary protection, a status defined until their resettlement in a third country or voluntary return to their home countries.

Within this legal background, Syrians who fled their country because of war and came to Turkey do not have the internationally defined refugee status. Since the early days of Syrian migration to Turkey, Syrian immigrants have been officially referred as “guests”, or “Syrians under temporary protection” (Abdelaaty, 2021).

According to the UNHCR (2021), there are 3.6 million Syrians living in Turkey. The Turkish Government established new institutions and laws to increase the capacity and infrastructure of refugee management. Especially following the initial years of the war and the absence of an end foreseen to it, the need to approach the refugee issue with a longer and sustainable perspective became clearer and the Government took significant steps towards that end (ILO, 2021). In addition, the Turkish Government has established cooperation with various domestic and international non-governmental institutions in the efforts aiming to improve the living conditions and resilience of Syrian refugees in Turkey, as well as to curb the irregular migration towards Turkey. In 2013 the “Law: 6458 on Foreigners and International Protection” *(Law No. 6458 here after)* was approved. This law provided an important legal foundation for the management of regular and irregular migration and defined the framework of international protection measures for irregular migrants in Turkey. Under the Law No. 6458, the Directorate General of Migration Management (DGMM) was constituted to coordinate the state admission and accommodation of Syrian refugees under the Ministry of Internal Affairs (DGMM, 2021).

Law No: 6458 states that “Temporary protection may be provided for foreigners who have been forced to leave their country, cannot return to the country that they have left, and have arrived at or crossed the borders of Turkey in a mass influx situation seeking immediate and temporary protection” (DGMM, 2021, para. 9). All Syrians requesting asylum from Turkey are needed to be registered in temporary protection status to stay in Turkey legally. This status gives its holders various entitlements such as access to health, education, social assistance, interpretation services, (since 2016) labor market and work permit access through employers, as well as the right of non-refoulment (DGMM, 2021; ILO, 2020). In

addition, Syrians under temporary protection may apply Bar Associations for legal representation and legal aid (UNHCR, 2021).

Apart from these rights, the Law No. 6458 regulates the obligations of temporary protection that its holders need to abide. Accordingly, residence and work permits of Syrians under temporary protection are only valid within the cities they have been registered to. They must declare changes in address, family, civil and employment status to the General Directorate of Civil Registration and Nationality of their registered cities. If they are to travel to other cities, they need to get a travel permit from the Provincial Directorate of Migration Management prior to their trip. Last, if they want to leave Turkey temporarily or for good to resettle in a different country, they need an exit permit from the related Turkish authorities (Refugee Rights, 2017, p. 13)

3.2.2.1 Work permits for Syrian refugees

The labor market integration of refugees is vital for both the refugees and the host country. Syrians under temporary protection have the right to work in Turkey and can access to labor market in a variety of sectors (UNHCR, 2021b). Turkey has taken important steps to facilitate the involvement of Syrian refugees in the labor market through various procedures (AIDA, 2021). According to ILO (2021) there are 2.16 million Syrians at the working age (15-65) in Turkey and one million of them are employed (Kirişci & Uysal, 2019). Yet in Turkey, only 1.5% of Syrians work formally (ILO, 2021). Right to work is a key factor that substantially improves the living conditions of refugees by preventing labor exploitation via informal recruitment, ensuring official minimum wage for refugees, and entitling them to receive certain social benefits (Demirguc-Kunt et al., 2019).

Syrian refugees can apply for work permits 6 months after receiving the ID card of temporary protection status. Various vocational training courses, skill-training programs and Turkish language courses are provided for Syrian refugees free. For self-employment through entrepreneurship or owning a private business, shop etc. Syrians refugees can get work permits by themselves. For contracted jobs,

work permit requests are needed to be lodged by the employers to the Ministry of Labor and Social Security. The fees for work permit applications are also needed to be covered and renewed every year by the employers. For some sectors, there are specific procedures or exemptions for Syrian refugees regarding the work permits. For instance, seasonal agricultural and animal breeding jobs are exempted from work permits for Syrian refugees, so being formally employed is possible via a document of job registration (MHD, 2017, p. 2).

The vast number of Syrian refugees in Turkey created a sui generis case, which accommodates significant job opportunities for highly skilled Syrians such as doctors, academics/teachers, and entrepreneurs in the provision of professional services to Syrians living in Turkey. For instance, a Syrian doctor who gets Turkish medical work permit could have a potential or even established clientele among the Syrian refugee community or other Arabic speaking immigrants in Turkey. However, within all the employed Syrians in Turkey, the high-skilled ones with tertiary education are estimated to be around 9% and only 3% of them are working in their profession (Pinedo Caro, 2020).

The limitations of law create structural difficulties for high-skilled refugees in Turkey to find employment suitable to their skill and profession level. For instance, the cost and bureaucratic procedures of work permits create reluctance among employees to employ Syrian refugees formally (ILO, 2021). Another important limitation regarding getting a work permit is the location of the job, since Syrian refugees with TPS are allowed to work only in their city of registration. This obligation may hinder employment opportunities for applicants, especially for the ones living in smaller cities or in cities with less Syrian refugee population in Turkey.

In 2017, the Government decreased work permit fees employers pay to overcome the tendency of informal recruiting and these efforts were welcomed internationally (AIDA, 2021; Murray, 2016; Pinedo Caro, 2020). Yet, many Syrians are still working informally and in jobs requiring lower skill levels than the ones they have (ILO, 2021). There are multi-layered problems associated with informal employment of refugees. First, informal jobs have poor conditions, such as lower

wages, longer work hours, and fewer benefits (Rygiel et al., 2016). Second, the low cost of Syrian labor inevitably has led to a crowding out effect for natives from the informal sectors, especially in cities with higher refugee population (Tumen, 2016). While, Pinedo Caro (2020) found that the labor of Syrian refugees in Turkey is complementary to the native labor. Third, even the net effect on the labor market is complementary, negative labor market outcomes of natives especially during economic recession times contribute to the anti-immigrant sentiments in host societies due to sectoral crowding out effect (Ozekmekci et al., 2020).

Furthermore, for certain professionals working in welfare sectors such as doctors and teachers, an approval of the related Ministry is required in order to apply for a work permit for Syrians (UNHCR, 2021b). Besides, all foreigners, including Syrian refugees are prohibited to practice certain professions such as dentistry, veterinary medicine, pharmacy, notaryship and judicial professions in Turkey and these limitations affect mostly the high-skilled refugees having careers in those sectors. Other barriers for highly skilled Syrian refugees that lead to deskilling originate from the lack of accreditation of their Syrian degrees and trainings in Turkey and not knowing Turkish language (Pinedo Caro, 2020). Deskilling, as well as the sector-related limitations of TPS, slows down the integration process of highly skilled Syrians to the Turkish labor market (Rygiel et al., 2016).

3.2.2.2 Right of access to healthcare and education

For healthcare, Syrian refugees can directly apply to Migrants Health Centers (MHC), local family physicians and public hospitals free in their registered provinces. MHCs are specifically created a few years later of the Syrian War as a better healthcare project for Syrian refugees in Turkey by the Ministry of Health (MoH) and funds of the EU. This project is named SIHHAT (meaning health in Turkish) and its first implementation phase was realized in the period of 2017-2021. SIHHAT project aims to improve health status of the Syrian refugees by providing first and some second-level healthcare services free and in their mother tongue Arabic (Yıldırım et al., 2019).

Within the framework of SIHHAT project, 177 Migrant Health Centers (MHC) were established in 29 Turkish cities with higher Syrian refugee population. In addition, Arabic speaking personnel were employed in 10 Community Mental Health Centers as part of SIHHAT project. The scope of the services of MHCs covers immunization systems, prevention of infectious diseases and epidemics, tuberculosis control, environmental health services, women's and reproductive health, and child and adolescent health services (Sihhat Project, 2021). Currently, 96% of all Syrian population in Turkey is within the reach of this service (2021). SIHHAT project is planned to continue for a 2nd term in order to develop healthcare services for Syrian refugees in Turkey (Sihhat Project, 2021).

Last but not the least, in Turkey, the laws allow all children, including the foreigners to receive free public education of primary and secondary school. Under the supervision of Ministry of National Education, Temporary Education Centers (TEC) were established for Syrian refugees, and Syrian teachers have been working there voluntarily. TECs follow Syrian curriculum and the language of education is Arabic, while Turkish lessons are also included in the curriculum (ILO, 2021). However, Syrian refugee children can also be registered at public schools and knowledge of Turkish is not required for enrollment. The Turkish Government provides free Turkish courses to Syrians under temporary protection at Public Education Centers. There is also financial support for education by certain eligibility criteria. For university education, Syrian refugees may apply to Turkish Universities if they have the language requirements and academic prerequisites for higher education.

3.3 Syrian Refugee Doctors in Turkey

To work in healthcare sector in Turkey, Syrian refugee doctors need to be officially recognized for their medical skills. Within the aims of this study, the analysis of the career projections of Syrian doctors and the impact of migration on their profession will be examined according to the employment procedures of foreign medical professionals in Turkey. The following subsections will present the official credential recognition procedures for foreign and Syrian doctors in Turkey.

3.3.1 Work permits for foreign doctors

There is not a universal process in getting medical license equivalence for migrants. Each country has different examinations and prerequisites to recognize foreign medical diplomas and professional trainings (Ozekmekci et al., 2020). Turkey's migration policy regarding immigrant doctors is a supply based model since there are strict regulations of the national health sector that make integration of non-nationals to the healthcare system difficult and cumbersome. In fact, until 2011, foreign doctors could not work in Turkey. However, in 2011, an amendment was made in the related law and since then, foreign doctors fulfilling certain criteria are being granted permissions to legally work in private healthcare sector in Turkey (HG, 2021). Immigrant doctors need to apply to the Ministry of Labor and Social Security (MoLSS) for issuing work permits in order to work legally in Turkey.

However, the main authority to decide on the skill level of a foreign doctor is the Ministry of Health (MoH). That's why immigrant doctors in Turkey need to get a permission document from the MoH before applying to the MoLSS for work permits but getting the approval of MoH is a long procedural process, which takes 8 to 12 months the quickest (Sezer & Yıldız, 2009; Study Abroad Aide, 2020). First, foreign doctors are required to get equivalence (in Turkish *denklik*) for their medical diplomas of other countries. Equivalence is obtained by passing "the Medical Level Determination Exam" (called *STS* or Seviye Tespit Sınavı) and subsequently performing 6 to 9 months of medical training at a University Hospital. STS exam is conducted twice a year. Upon the completion of this initial part of the equivalence, foreign doctors are being recognized as General Practitioners (GPs). After obtaining GP equivalence, there are further steps for immigrant doctors to be recognized in their professional medical specialties. In this second phase, documents regarding the specialty training are needed to be submitted to the MoH. If documents are approved, the applicants then enter an oral examination to get the license of specialty.

If the documents of specialty training are not approved by the MoH for various reasons, as with many Syrian refugees who fled their countries unprepared and without the required documentation of skill recognition, then foreign doctors

cannot get license of specialty in Turkey. Here, the only way to practice as a doctor of specialty is retraining in the specialty, i.e. becoming again a resident doctor in Turkey. To become residents, Turkish and immigrant doctors are subjected to the same process. They need to pass the Exam of Specialty in Medicine (TUS or *Tıpta Uzmanlık Sınavı)*. The TUS exam is announced as the world's second hardest exam by the research at Princeton University and requires quite a good effort (DSN, 2016). Though, it should be noted that there are 10 percent additional seats in residency programs for foreign doctors (GH Group, 2021). *A*ccording to their score on TUS and the preference of specialty, they can start residency training, which takes 3 to 5 years. For immigrant doctors who are already specialists, such as a general surgeon or a pediatrician, doing residency for the second time to get the license of specialty is a concrete example of deskilling. Specialty doctors are already overqualified for such training in the same medical specialty. Last but not the least, foreign doctors also need to fulfill B level proficiency in Turkish and get the permits of residency and work to start practicing medicine formally in Turkey.

3.3.2 Work permits for Syrian Refugee Doctors

In line with the implementation of new migration management policies and regulations of the Turkish Government, the issuing of work permits for Syrian refugee doctors evolved in time. Syrian refugee doctors in Turkey can currently legally practice as GPs at the MHCs or if they got their medical diploma equivalence *denklik* they can work privately. However, getting *denklik* is a grave problem for Syrian doctors due to war-related circumstances back in their home country (Kayali, 2020). Starting from 2011, the increasing Syrian refugee population has created a natural demand and opportunity for Syrian and other Arabic speaking doctors in Turkey. Until the establishment of Migrant Health Centers in 2015, there were not any state health care facilities specifically designated for refugees. All refugees were receiving health care from Family Health Centers and public hospitals. However, especially considering the high population of Syrians, the language barrier has become one of the biggest obstacles for health service provision to refugees who do not speak and understand Turkish (Ozekmekci et al., 2020). Several private or NGO-

supported clinics were opened to fill the enlarging gap in health care provision services to refugees. In these private clinics, Syrian refugee doctors and Syrian medical staff were recruited to provide service in Arabic (Kayali, 2020).

Some private Syrian clinics operated with license and the ones without a license were to some extent tolerated by the state until 2018, due to the patient overcapacity problems of state health care facilities especially in Istanbul and in southern cities with high refugee population and close to Syrian border (Kayali, 2020). In addition, Sürmeli et al. (2021) mentioned that there were Syrian refugees who could not receive state healthcare service since they either did not have temporary protection status or they were not in their registered cities. Thus, for unregistered Syrian refugees, there was a *de facto* structural service gap in health care. This period was significant for the Syrian refugee doctors because they continued working in their profession by filling this structural gap in health sector. However, starting from 2015, the Turkish Government tightened the regulations and inspections on refugee health care. While the state capacity in providing free-of-charge health care to refugees was being increased, licensing of private clinics seized and some trials were opened against the Syrian doctors who continued to work informally in health clinics without Turkish license (Kayali, 2020).

Other examples around the world suggest that Syrian refugee doctors, as highly skilled professionals could contribute to the Turkish health system which has a *de facto* service gap for refugees (Eastwood et al., 2006b; Sürmeli et al., 2021). However, since they worked without Turkish diploma equivalence *denklik,* they could not register themselves in the national system. The informal work is problematic: Without official licenses, Syrian doctors are forced to work under the name of another Turkish medical doctor. They neither bear the responsibility of their patients, they nor receive the full credit for their work. The informality of the clinics creates uncertainties about the sustainability of the operations and services. Furthermore, illegal clinics are dangerous as a work environment, since Syrian doctors need to work clandestinely and can face the risk of being arrested because of its illegality (Kayali, 2020; WHO, 2016).

To fill the health care service gap for refuges and to improve the overall health status of Syrian refugees, Turkish Government collaborated with the EU and World Health Organization (WHO), as well as the NGOs. In 2016, the first implementation of the SIHHAT Project started with the opening of MHCs via EU funding. Beginning in 2018, as a joint project with the WHO, MoH invited Syrian refugee doctors, as well as nurses for a 6-week long adaptation- training program on family medicine. Following the successful completion of the training program, Syrian doctors and nurses were employed in the MHCs around Turkey (Ozekmekci et al., 2020). As of 2021, over 1,200 Syrian doctors have completed their training and around 700 of them are currently working at the MHCs (Sihhat Project, 2021). The SIHHAT project not only helped to overcome the barriers of language and culture in primary care for refugees, but also provided a legal opportunity for Syrian refugee doctors to work professionally without the prerequisite of a Turkish diploma equivalence, *denklik* (Sihhat Project, 2021). Thus, it has been a successful initiative to increase refugee health and integrate refugee doctors professionally into the health system of the host country (Coşkun et al., 2016). SIHHAT project is an innovative example of global health governance and health diplomacy to overcome global inequalities because of the migration patterns of health professionals (Chattu & Chami, 2020; Ozekmekci et al., 2020; WHO, 2016).

From the professional perspective for Syrian doctors, MHCs offer a limited employment opportunity because of the framework of these centers. First, although MHCs allow Syrian refugee doctors to work legally in Turkey without diploma equivalence, the staff capacity of MHCs is less than the population of Syrian refugee doctors in Turkey (Sürmeli et al., 2021). Second, the current service areas of MHCs do not cover medical specialty professions except the pediatrics, gynecology, and internal medicine (Sihhat Project, 2021). All other doctors are employed as GPs and Syrian specialty doctors are overqualified for GP positions. Third, with no prospects about a future career possibility of being integrated into the national health system, MHCs offer a temporary career solution for many Syrian doctors, whose professional careers are central to their migrant identities.

Özekmekçi et al. (2020) state that refugee doctors should be categorized differently than the regular immigrant doctors, since refugee doctors cannot choose a destination country and get prepared accordingly before moving. Instead, most commonly they leave their countries abruptly and without necessary documents related to their profession and credentials. Besides, refugees go through traumatic experiences and they represent a more fragile migrant group (WHO, 2016). Although the Turkish Government's generous infrastructure investments for refugees, validating medical skills and being recognized as doctors remain as the biggest obstacle that prevents Syrian refugee doctors from working legally in Turkey.

As mentioned in the previous section on foreign doctors' work permits, there are similar steps and prerequisites for Syrian refugee doctors to get diploma equivalence about their profession in Turkey. First step is to be recognized as a GP. The process comprises a written examination (STS) and a successive unpaid training of 6-9 months at a University Hospital. The Council of Higher Education (YÖK) conducts STS exam twice a year and in Turkish. After being recognized as a GP, the second step of obtaining training equivalence is related to the medical specialty. For this second step, there is not a written examination, but the applicants need to present their legally approved documents by the Syrian authorities and then pass an oral examination on their specialty. This second step of obtaining the certificate of equivalence for their medical specialization becomes an unsolved problem for Syrian refugee doctors in Turkey. Their refugee status makes it very difficult if not impossible for them to both gather and get approved their medical certifications and documents by the authorities of Syrian regime. Without passing these two steps, Syrian doctors cannot work legally in Turkey as medical specialty professionals except in the MHCs. Syrian doctors working in the MHCs are exempted from this diploma equivalence process and registered as medical doctors by the MoH via their Syrian diplomas (HG, 2021).

CHAPTER 4

METHODOLOGY

4.1 The reasoning behind the selection of the subject

Since the start of the Syrian War, Syrian refugees have been a constant agenda item for policymakers and the Turkish society. Syrians in Turkey, with a population of nearly 3.7 million, represent the largest refugee group living in a single country (UNHCR, 2021d). They form around 5% of the Turkish population and are quite visible in daily life across Turkey (DW, 2020; Kazancı, 2021). Not surprisingly, the subject of Syrian refugees has become a constant agenda item in policy making in various fields, such as international politics, economy, security, social relations, integration, education, and public health. The academic research in Turkey on Syrians has also been growing since 2013.

Being such a large population, the Syrian refugees in Turkey are not homogeneous in terms of their skill levels, besides other characters such as age, sex, economic and social background, etc. The effect of the skill level on their migration experiences has been a rare topic of interest. That is why I chose a high-skilled refugee group, which is the group of Syrian medical doctors in Turkey, as the sample of this study to learn more about the migration trajectories of refugees from a professional and skill-focused perspective. The Syrian refugee doctors in Turkey and their recruitment at the newly established health care units of MHCs provide a natural setting to conduct this research. In this study, the first aim is to acknowledge the outcomes of forced migration on the preservation and utilization of skills that are possessed by the migrants. Second, the interplay between the highly skilled migrant and refugee identities of Syrian doctors will be analyzed.

4.2 Methods

A qualitative method with purposive sampling is used by conducting semi-structured in-depth interviews with 9 Syrian doctors, who came to Turkey after the Syrian conflict started in 2011. The interviews were conducted online in June-July 2021. To reach possible participants, three different ways were used: First, I contacted a couple of refugee institutions by phone and e-mail and asked for their help to share my study invitation for Syrian doctors working at the MHCs. However, they informed me they were disseminating only the invitations of the research conducted under their capacities. Their documentation requests, mentioned evaluation process, and time constrains for the research dissuaded me from applying them as a researcher, unless other ways would not generate results to reach enough participants. Second, I tried to reach potential participants individually through their contact information posted on web pages about Arabic speaking doctors working privately in Turkey. I sent my research invitation in English and Arabic to ten Syrian doctors, but I did not get any reply.

Last, I contacted with participants through snowball sampling technique. The snowballing strategy proved to be the only effective way since, all participants were reached via this method. Initially, I received phone numbers of three Syrian doctors from my social network and contacted with them via WhatsApp, the mobile messaging application. In my message to them, I introduce myself and mentioned the person who referred me. Later, I briefly described the study and invited them to take part in it. If requested, I explained the study further on the phone to the potential participant. After receiving an affirmative response for participation, I sent the "Informed Consent Form" which was approved by TED University via e-mail/WhatsApp. Then, we scheduled online meetings if the contacted doctor accepted to take part. At the end of the interviews, doctors kindly referred me to their friends and the rest of six participants were reached thanks to their references. Being referenced by acquaintances of the participants provided a ground for building trust and interest in the research and the researcher.

Within the framework of the study, the participants were asked about their personal migration experiences as being refugee doctors, with the emphasis on their career. Main subjects covered during the interviews were related to their personal information, life in Syria before and after the conflict, the migration process, arrival in Turkey, settling in, being a refugee doctor, professional experience in Turkey, comparisons of work environment in Syria and in Turkey, and plans for the future. The semi-structured format helped to collect brief life biographies and accumulate consistent data useful for analysis for the study. The interviews aimed to find common patterns between the experiences of the participants as refugee doctors, as well as to highlight the differences pertaining to their individual attributes professionally and personally.

4.3 Study Setting

During the period of research and interviews, the COVID-19 pandemic and state-imposed restrictions for in-person meetings provided a serious restraint for interviews. Finding an optimal venue, which was silent enough for voice recording and suitable for social distancing due to COVID-19 was a daunting task. These challenges, in a way, dictated the online format of the interviews. I offered participants to conduct the semi-structured interviews in English and/or Turkish. 4 interviews were done in Turkish and 5 were done in English. The interviews lasted between 40 minutes to 1.5 hour. With the consent of all participants, audio recording of the interviews was taken and later transcribed.

Making interviews online facilitated scheduling of meetings for both the researcher and the participants. The online format eliminated safety concerns of COVID-19 and other related measures, such as social distancing and wearing masks. Online interviews made it possible to include participants from different cities to the study, without incurring additional costs or need to travel. Besides, virtual meetings enabled participants to allocate their free time, whether early in the morning, late in the evening, or at the weekend for the interview. Last, all participants were free to join online interviews from the venues of their choices. This practice saved both

sides from the cumbersome organization embedded in face-to-face meetings and possible privacy concerns affiliated with a third location for participants.

4.4 Sample Selection

At the beginning of the research, the aim was to interview only Syrian refugee doctors working or worked at the Migrant Health Centers (MHC) in Turkey. However, after a few interviews, I have abandoned this workplace limitation and extend the sampling criteria to include all Syrian doctors working at the MHCs or not. Since some of the Syrian doctors were purposefully rejected employment at MHCs. With the aggregation of the data, it became clearer that Syrian doctors who were not working at the MHCs also provided significant insights about the ways to preserve their skills. Therefore, the enlargement of sampling was in line with the purpose of this research.

The snowball sampling technique is not based on random selection, so does not provide a representative sample of Syrian refugee population in Turkey. The purposeful sample selection, targeting only Syrian refugee doctors living in Turkey, made it possible to collect data from participants who had similar backgrounds, common memories, and experience of war from their origin country. Besides, all participants experiencing a common push factor, running away because of a war, facilitated comparing their migration trajectories, as well as highlighting the significance of their individual experiences with a focus on the skill sets and profession. There were 21 Syrian doctors who were reached and invited to the study. 3 of them were females. Out of 21 doctors, 9 of them agreed to take part in the study; only 1 of them was female. Still, the sample of the study included a group of participants with diverse profile characteristics of age, sex, city of residence in Turkey, medical expertise, and sector of employment.

After completing the ninth interview, for the reasons of content saturation and not being able to expand my reach to other female Syrian doctors, I ended my data collection endeavor. Ultimately, the employment seeking efforts of all participants had a crossing with the recruitment option at an MHC. In summary, the study sample

comprised 4 doctors working/ previously worked at the MHCs, 1 doctor applied and accepted to work at an MHCs and waiting to work, 1 doctor wanted to work at a MHC but missed the last recruitment period, and 3 doctors who were invited to work at the MHCs but did not prefer to do so.

4.5 Participants

The demographics of participants are summarized in two tables in Appendices B and C. There were 9 participants in this study (1 female/8 male). The ages of participants varied from 20s to 50s. Only 1 participant was single and the other 8 were married with children. Participants had been living in Turkey for 2 to 8 years. 5 participants received Turkish citizenship, while the other 4 were staying in Turkey with TPS. At the time of their arrival in Turkey, 7 participants were already the graduates of Syrian medical faculties and professional doctors. While, the other 2 participants were medical students in 2011 in Syria but with the war, their studies were interrupted. After coming to Turkey, these 2 participants got enrolled in a Turkish medical faculty and graduated with Turkish medical diplomas. The years of participants' professional experience prior to the war ranged from none (for students) to 24 years. At the time of the interviews, 4 participants were working in the public sector and the other 5 were in the private sector. 7 participants were working as doctors, while 2 of them were working as non-doctors. Participants were living in 5 different cities in western and southern Turkey, including the cities with the largest Syrian population, namely Istanbul, Gaziantep, and Hatay (Özdemir, 2021).

The combination of specific information of participants on the age, expertise, location, and employment place was considered as a risk of being identified. Therefore, to ensure the anonymity of the interviewees, all participants are referred by pseudonyms to keep their identities confidential. In the table of Summary Demographics (Appendix A), the locations of participants are described as regions of Turkey instead of the exact cities and participants are placed in 10-year range age categories, which were 4 in total: 20-30, 30-40, 40-50, and 50-60.

4.6 Data Collection

In qualitative studies, face-to-face interviews are used most commonly to capture verbal expressions, nonverbal information, and visual cues during the conversations (Novick, 2008). 8 interviews were realized by using mobile instant messaging application (WhatsApp) and 1 interview was conducted on Zoom, the video meeting platform upon the suggestion of the participant. 7 interviews were realized by videoconferencing, while the other 2 of them, including the one with the female participant were over the phone. Admittedly, in phone interviews, observation and interpretation possibilities were more limited compared to the videoconference meeting. However, since phone interviews were realized upon the preference of the participants, they permitted a more comfortable environment, in which the participants expressed themselves openly and shared their personal experience without being bothered about the concerns of privacy during the conversations.

4.7 Data Analysis

In qualitative research, the reality is not objective and independent of the values and interpretation of the researcher, but it is constructed (Andrews, 2016). The aim of a researcher is to transform the data collected via people's stories into knowledge that can contribute to a systematic understanding (Froggatt, 2001, p. 434). The narrative analysis is conducted to identify, examine, and evaluate the personal stories by finding embedded patterns and themes within the everyday experiences of the interviewees (Basit, 2003, p. 143). Although individual narratives are limited in their capacity to be generalized or reflect the issue in a full range of dimensions, they can clarify the central issues on the intersection of different identities (Johansson & Śliwa, 2014, p. 23). In light of these considerations, in-depth data based on personal perspectives about the migration trajectories of the participants were collected via semi-structured interviews (see Appendix A). The questions (i.e. "Is being a doctor a factor in …?", "Would you consider working at the …?") were consciously chosen to uncover the participants' subjective interpretations about being high-skilled refugees. Then, these patterns and themes were interpreted together with the broader

structural factors such as the employment opportunities, legal rights, limitations of refugeetude, and social integration prospects of foreign doctors in Turkey.

The interviews provided a collection of 97 page-long raw data. Transcribing the narratives is a cumbersome and time-consuming task, but this process helps the researcher to get familiar with and immersed in the data. Transcribing also enables capturing nonverbal cues and interactions and adding them to the data (Burnard, 1991, p. 462). In this phase, automatic transcription software "Descript" was used to speed up the data preparation process. However, "Descript" could only generate the transcriptions of conversations in English. Nonetheless, it facilitated the preparation of a uniform raw data in a shorter time and made it easier to study the data. Turkish interviews were transcribed manually.

Coding of the data enables to categorize patterns under different sections of the narrative (Froggatt, 2001, p. 435). The open-ended questions helped to navigate data and explore various aspects of the individual stories during the analysis phase. All transcripts were revisited repeatedly and interesting parts, words, or sentences were highlighted as codes of the data. These codes from all transcripts were compared and reviewed multiple times, unnecessary codes were eliminated, and similar ones were combined for data reduction. In addition, some quotes of participants were highlighted to be used as a way of data presenting in the research. Furthermore, for the analysis and coding, Turkish narratives were translated into English by the researcher with due diligence to stay true to the meaning of the original narrative of the interviewee. Finally, the themes that would make sense of the narratives in the best way were selected and defined. Last, the demographic and career related data compiled separately on a spreadsheet to prepare a profile table, which was useful to review participants in summary.

4.8 Ethical Considerations

Ethical considerations are vital for any academic research to preserve the scientific integrity (Hwang, 2017, p. 594). In studies on human subjects like this thesis, the researcher bears the responsibility of causing no harm to the participants.

The ethical approval of this study was given by TED University on June 2021. From research methodology to data collection, and from analysis to presentation, all stages of the study were designed according to the guidelines provided by the ethics committee. In this regard, from the initial contact with potential participants, the researcher explained the purposes of the study, informed about the anonymity of participant identities, and shared the "Informed Consent Form" (see Appendix D) with the ones showing interest for this research. At the beginning of each interview, the permission request for voice recording for transcription purposes was taken and participants' freedom to walk away from the study at any time without adverse consequences was highlighted. All participants took part in the study voluntarily and gave consent for voice recording. During the analysis of the data, any detail or combination of them with a potential to disclose the identity of participants were changed by pseudonyms or omitted to preserve anonymity.

The responsibility of not harming the participant was a substantial concern for the researcher. A great deal of attention was dedicated to planning of interviews to prevent an unpleasant experience for the participants. Questions were very general and to keep the informed on the consent dynamic, participants were told that they were free to provide as little or as much information as they wanted, including not answering to questions at all (Iphofen, 2013, p. 34). Since the personal stories of the participants included sensitive topics such as memories of war, loss of family and friends, forcefully leaving homeland, the researcher avoided leading question. With the accumulation of data from each interview, the researcher noticed certain topics and used this information on successive ones to further clarify participant's opinion by asking further questions without being intrusive as far as possible if needed (Iphofen, 2013, p. 2). All the participants completed interviews on positive feelings and thanked the researcher for showing interest in and aiming to voice their stories. Participants shared a couple of contact numbers with the researcher regarding other potential participants. This kindness was an illustration of achieving the aim of the principle of research ethics, i.e. not doing harm to participants during the interviews (Iphofen, 2013, p. 12).

CHAPTER 5

FINDINGS & DISCUSSION

While every refugee's story is different and their anguish is personal, they all share a common thread of uncommon courage – the courage not only to survive but also to persevere and rebuilt their shattered lives.

– António Guterres

5.1 Being a doctor in Syria

5.1.1 Before the Syrian War

5.1.1.1 How to become a doctor in Syria

The participants were first asked about why they wanted be doctors and then about becoming a medical doctor in Syria. They mentioned high career prospects, high economic status, desire to help others, prestige of being a doctor, and owning a private clinic as the most important reasons for wanting to become a doctor. All participants emphasized that entering a medical faculty and becoming a doctor was a merit-based education option for Syrian students. The economic status of their families was not the decisive factor since public universities in Syria were free or had minimal fees. Participants highlighted that only students who were bright and had high grades at secondary school could get into medical faculty. In addition, the medical education was a lengthy and challenging process:

I like biology, people, and animals. I also wanted to help people. [i] *(Ali)*

Firstly, it was for the social status, since all the community respects doctors. My uncle was a doctor. My teachers all the time said that I would be a great doctor, because I was a hardworking student. Also, my family encouraged me... (Fatima)

I wanted to be a doctor to have my own clinic and work privately like lawyers, engineers... (Suleiman)

The answers of the participants showed they become doctors depending upon conscious decisions such as love for humans, family support, desire to own a clinic, and achieve socio-economic aims, as well as unconscious decisions such as the influence of the family, associations between the school success and medical career, and expectations about being a doctor (p.149). These findings are in line with the analysis of Millan et al. (2005) who studied the reasons for choosing a medical career. Millan et al. (2005) highlight that to be recognized for their help by others and strong humanitarian values are other important reasons that were also present in the narratives of Syrian doctors.

When participants were asked about the gender aspect of a being a doctor, they implied that medical education was exceeding the limitations of gender:

If their children have high scores, families will do their best to send him to the medical school. In general, families allow the girls as well. But sometimes, if families do not want their daughters to travel outside the city, they would push them for dentistry by saying "You will be a doctor as a dentist..." (Fatima)

Maybe in some specialties, like in general surgery, there are very few women. But in other specialties, the number of women is much more than men, so number of doctor women is a normal variant. (Ahmad)

Another finding was regarding the career path projections of Syrian doctors. They mentioned the absence of family care centers and primary care units in Syria. Syrian doctors were most commonly doing residency training and getting specialized in a certain field of medicine. The ratio of GP doctors was very low among all Syrian doctors:

Turkish health system is different from the Syrian system. In Syria the numbers of GPs are very few and there are no such types of family care centers as the ones in Turkey. Syrian patients directly go to the specialists. (Jamal)

In Syria, most of the doctors, if you can say over 90% are high-qualified doctors, who are trained in vascular surgery, neurosurgery, general and laparoscopic surgery, orthopedics, urology, pediatrics, rheumatology, and endocrinology… (Fatima)

Last, the self-perceptions about being highly skilled were more dominant for the participants who were established doctors in their medical specialties and who had greater international experience. They were also more vocal about the high value of medical skills of Syrian refugee doctors.

5.1.1.2 Working as a doctor in Syria

Syria is a poor country in general. If you are an engineer, a teacher, or a faculty member, you will be poor in Syria, but if you are a doctor, you will have a good life. (Ali)

Being a doctor was associated with a high standard of living by all the participants. When they were in Syria, 5 participants had their own clinics. The participant doctors with longer careers had better economic and social status in Syria.

In Syria, every doctor has a private clinic. When I open a clinic, the income is mine and it is much higher than here (in Turkey). For instance, the surgeons were earning 20, 30, even 60 times more, while others such as pediatricians were earning maybe 10, 15 times more in Syria compared to Turkey. The economic status of Syrian doctors was much different in Syria. We owned our houses; we had our cars...[ii] *(Yousef)*

Furthermore, their long tenure in the profession enabled them to migrate as high-skilled professionals and establish good networks before becoming refugees. 3 of them had previous international job experience and worked in Saudi Arabia (SA), the US, and the UK, as a doctor or a faculty member. For instance, at the beginning of her career, Fatima and her husband, who was also a doctor, worked in SA for a couple of years and accumulated the financial capital they needed to open their clinic in Syria.

I traveled to many countries: United Arab Emirates, Saudi Arabia, and the UK. I completed my education over there. Finished a membership of Royal College of Ireland, and then came back to Syria and started to work as a teacher (at the university), in addition to working in my private clinic. (Jamal)

By becoming refugees, participants lost their existing clinics or the prospect of having a private clinic. This was a disappointment since the clinics represented an important career achievement and a life free of economic struggles.

5.1.2 After the war and becoming a refugee doctor

5.1.2.1 Resistance to anti-democratic policies and practices

From the beginning of everything, starting from the initial period of demonstrations, Syrian doctors found themselves at the very center of the conflict and the following anti-democratic executions of the state. The Syrian government's violent suppression on protesters brought the wounded people to their doorsteps. Majority of the participants emphasized that initially they were being loyal to their Hippocratic oaths as doctors and solely treating wounded or dying people regardless of any political opinion (Al-Khaled, 2012). Ahmad explains his feeling of responsibility as below:

> *I have seen many patients who were shot while just demonstrating. I am a surgeon and it was my duty to help these needy people… We were doing operations even at homes, with no convenient out any convenient situation. We established some places just to be able to perform lifesaving procedures for those who were just demonstrating. Unfortunately, they (Assad regime) knew that I was helping some people. (Ahmad)*

MSF described the suppressive practices of the security forces of Assad regime, such as prohibiting doctors from treating wounded people as a "tool" of war (Gulland, 2012). The narratives described that while the violent crashing of security forces was increasing continuously, the doctors were forced and terrorized by the laws to not treat people and witness everything passively. All participants said that they searched for ways to provide medical help to the people in need. As doctors, participants found themselves at the target of the Assad regime's aggression within a short period. Al-Khaled (2012) states that doctors, even the ones supporting the Assad regime were forced to prove their commitments by letting people die or via mistreatment of the wounded people. Jamal mentioned the killing of more than 900 health personnel in Syria by the Assad regime and gave the example of a hospital

accountant who was tortured in prison for five years, simply because he was working in a hospital and "helping" the opposition.

> *At the beginning, we did not have any political opinion. My husband was arrested because he was doing his duty as a doctor by treating people. He was helping in some field hospitals, providing them with medical equipment. Some of the treated people were not even related to the opposition, but they were wounded or injured by some other people. We just were practicing our duty. (Fatima)*

These narratives of the participants are consistent with the reports and research papers that revealed the persecution of Syrian doctors and health personnel by the Syrian regime (Aron Lund, 2019; Karasapan, 2016, UN, 2018; Kareem Shaheen, 2016). In their experience, being highly skilled people as doctors became the major push factor that eventually led to their forced migration.

Faisal described the Assad regime had always been anti-democratic, even before the "revolution". According to him, being randomly arrested because of unfounded claims or suspicions about affiliation with the opposition once in a life was like an unwritten rule in Syria. However, these arrestments of the regime forces got much aggressive with the war. For Faisal, being a medical student was the reason for his arrestment:

> *I was leaving a tension area where a field hospital was located and there was a near regime checkpoint. There, they stopped me and asked for my ID card and about the status of my military service. I told them I was a medical student. I showed my student ID, but they got suspicious of me. They saw bloodstains I did not notice before on my shoes. Then they accused me of working as a doctor there, helping the "terrorists". They arrested me. In late 2012s, being arrested was not a joke. I got out of the jail thanks to an influential acquaintance. Otherwise, I would be dead for sure. Arrested people, especially the ones providing medical help were dying. Many friends of mine died like that...* [iii] *(Faisal)*

Another example of criminalization of doctors by the Assad regime was Hussein's case. He was literally dragged into the opposition side by the regime forces. In 2013, when he was still a resident doctor of neurology at the Damascus University, his roommate working at the emergency department as a doctor got arrested and later killed by the regime. This tragic incident led Hussein to join the

opposition. As a doctor, he helped the people in liberated areas for the following 6 years:

> *The regime forces entered the emergency department and arrested him (his roommate). Unfortunately, two months later he was killed…Later, I went to Aleppo because the number of doctors was very low there and I worked in hospitals treating people needing urgent health care. After Assad regime seized the entire city, we got out from Aleppo in 2017. Then I worked in Idlip until 2019. (Hussein)*

Some participants were already not happy with the anti-democratic ruling of the country and after the ignition of protests; they joined the opposition immediately. Aware of its risks, they helped protestors willingly. Ali, Mostafa, Yousef, and Jamal were opposing the regime since the beginning of demonstrations. Ali was a 5th year medical student in 2011 and already had some medical experience via his education. He believed that being a doctor played an important role in his opposition to the regime, because he was "witnessing a lot". Since protesters were deprived of the hospital services by the security forces, he wanted to help those people via his medical knowledge and stated that they were not wrong in demanding a more democratic life. On the other hand, working under the tight control of the regime in Damascus was tough:

> *They (the regime) had their people who carried them latest news and took pictures of people in the streets, everywhere. It was so hard. I secretly worked in Damascus for a year, but then they knew me. I believe Syria could be much better than what it is. Assad is not the choice of us and he did not bring anything good for Syria. There are many good things in Syria, but they are not because of Assad. So, I thought that we had to try. But it became a disaster. I believe we were not wrong, but the war has been much worse than what we thought it would be. (Ali)*

Mostafa said with the "revolution", he started to work in the underground hospitals and treated people wounded by the regime forces. However, he got arrested and stayed in prison for two months. When he is out, he was preparing to leave his city, but his district got bombed and once again being a doctor made him a "traitor" in the eyes of the regime:

> *They caught me because there was a report about me stating that I helped people who were against the regime…They took me directly from the operation room of the university hospital. After I got out of prison, I lived in*

> *revolution places for a short while and worked at the university. Then a bombing happened, many people got wounded. Those people needed help and came to me asking for help. I am a surgeon. What should I have to do? Of course, I helped them. Because of that help, later there was a new report about me saying that I was a traitor. (Mostafa)*

According to Jamal, the aim of the Assad regime was clear from the beginning of the protests, but so as his stance:

> *Maybe the world does not see it that way, but this is a revolution. So, I joined the "revolutionists". I thank God that I have been a member of this revolution against that dictatorship. We are looking for our freedom and want to live in our country in democracy; these are our rights as human beings… I am a surgeon, I started to talk to those patients in the hospitals and do the surgeries. (Jamal)*

There are many studies about the relation between health provisions and politics. The political structure in a country such as being democratic or authoritarian is influential on the construction of a health system and the formation of global inequalities in healthcare through migration (Hersh & Goldenberg, 2016). In addition, in micro-level, the political beliefs of doctors are found to be effective in their assessment of their national healthcare status, as well as their treatment approach in politically sensitive healthcare issues such as drug use, elective abortion, firearm safety, and Covid-19 vaccination (Knight, 2020; Ruger, 2005). Ruger (2005) explains that the strength of democratic rule in a country plays a significant role in national healthcare through its reducing effect on social inequalities, increased individual freedoms that enable higher political participation and vocalization of the problems related to the poorest. Since doctors perform their profession through interaction with their patients, they can observe the physical, psychological, and social wellbeing of their patients. Therefore, they are aware of the needs for an improved health status of their society and needed reforms.

However, Weinberg (2019) explains that doctors' political opinions about the ruling regime in their country play an important role in their perspectives and actions against the rulers. In his study, Weinberg (2019) examined the behavior of medical doctors during the military regime in Brazil and found that the ones opposing the authoritarian ruling and state-sponsored repression were regarded as "subversives" and were severely penalized by being purged, tortured, and killed. This is very

similar to what happened in Syria. Since authoritarianism benefits from limited social development and regressive individual rights, doctors who believe in the improved health of society and who are pro-democracy are exposed to state-repression (Ruger, 2005). This is a great structural challenge that can endanger their lives with their non-compromise of their views. Eventually, state-repression evolves into the major push factor for doctor's (forced) migration as in the case of the participants of this study.

5.1.2.2 Being forced to leave Syria

The Syrian War, earlier or later, forced all the participants to leave Syria. Some participants were arrested and released once or more by the regime and left Syria to run away from the risk of another arrest and a probable death. For instance, as a medical student, Faisal got arrested five times. He and his family decided that it would be best for him to leave Syria because of safety concerns for his life. Yousef, who defined himself as working with the opposition secretly in Damascus against the "dictatorship" in Syria, left the country abruptly in a day after learning the arrestment of his friends and him being wanted by the regime. Fatima's husband got arrested and when he was released, they swiftly left Syria. Similarly, Ali was wanted by the regime in 2012, so he left Syria and went to the US to practice medicine there. However, in less than a year, he decided to go back to Syria to support opposition. For the next 5 years, he worked voluntarily as a doctor in field hospitals in opposition-controlled areas until he was forced once more to leave:

> *I could not stay in the US because the situation in Syria was too bad. Some of my friends died, some of them got arrested. I went back to Syria in 2012. I stayed there about five years until 2018. Of course, the regime closed all the borders to us: there was not enough food, medicine, no electricity, nothing... Then Russia came and forced us. I mean Russian troops told us to go away from Damascus. They provided (evacuation) passes for us. (Ali)*

After his release from the prison in 2011, Mostafa continued his residency program in general surgery and in 2012, he had completed the 5 years of training, but could not attend his final thesis defense physically due to the risk of being arrested again. That is why; he could not get his diploma as a surgeon. However, he worked

as a general surgeon for an international NGO in an opposition-held area of Damascus for 6 years. Towards the end of his stay in Syria, he and his wife became concerned about their youngest toddler's psychological wellbeing and related it to war conditions, bombings, and stress. Not much later, Mostafa left Syria to provide care for his son and a safe place for his children to grow up.

> *I left Syria for my children. I had to go with my children and find the diagnosis report about my child. He needed MRI; he needed a specialist of neurology… (Mostafa)*

Jamal and Hussein first moved their families to Turkey for their safety but continued to work in various field hospitals in Syria. Jamal worked in the field hospitals as a surgeon for 5 years in war-ridden Syria. When he received a prestigious fellowship grant from the US in 2016, he traveled to the US. A year later returned to Turkey to be united with his family. In Turkey, he continued traveling to Syria to work as an educator at the medical university established by the Syrian opposition:

> *I took my family and my kids here to Turkey in 2013. Meanwhile, I was going back and forth to Aleppo, working in my city, helping my people, and working in a hospital there until 2016. It was somewhat risky for me, but was not a big deal. (Jamal)*

Others left Syria since there were no safe places anymore to survive because of the constant bombings of the regime and its allies.

> *In Aleppo, my home was in the regime-controlled area but my clinic became under opposition control. I closed the clinic for a month. Then, the armed conflict exacerbated between the two lines and we moved next to the clinic. But bombings got intensified in this area and the clinic got bombed… Later, we moved to other cities, but there got bombed too, and my brother's wife was martyred... There was no running away from it. There was not any other choice than leaving. (Suleiman)*

> *We did not want to leave our cities. What they did was a real crime against humanity. There left no cities, everything was destroyed. They came with aircraft, with enormous armies, and they forced us to go. Leaving was not by choice. (Ali)*

The narratives of the participants reveal that leaving their home country was not a planned and pre-determined choice for them, besides emotionally being a very

difficult one. Davenport, Moore, and Poe (2003) studied the reasons for leaving homelands for refugees and internally displaced people. According to their findings, state threats and executions to personal integrity are the primary cause of leaving one's home country (Davenport et al., 2003). The participants endured state-led violence and repression, such as imprisonment and torture that targeted them because of performing their ethical duties as doctors. Their reasons to leave were in line with the knowledge regarding the migration of refugees (as mentioned in Sections 2.3.1 and 3.1).

However, for some of them, their high skills were beneficial to define the character of their movement, which was something like the migration of highly skilled people. For example, Ali went to the US and integrated to the licensing system in the US for foreign doctors. If he stayed there, he had the opportunity to have a medical career. Fatima moved to Turkey from Jordan as a highly skilled "trailing wife" as elaborated in Man's (2004) study, since his doctor husband found a job in an NGO in Turkey. However, both her husband and Fatima were refugees in Jordan in the sense that they did not have the right to work officially like a migrant doctor. They continued to live in the limitations of being refugee such as not having permits to work as doctors in Turkey.

Last, some participants such as Jamal, Hussein, and Fatima kept returning Syria ad interim to treat people in opposition-controlled areas. This behavior is out of the traditional refugee definition of the international law (Section 2.3.1) and like highly skilled migration realized by the agent's choice.

5.1.2.3 Border Crossing and the choice of destination

The way of crossing the Turkish border and the choice of destination of participants varied. 7 participants crossed the border regularly: Jamal, Hussein, Faisal, and Suleiman passed the land border with their passports; while Yousef, Ahmad, and Fatima came to Turkey by air. Ali and Mostafa crossed the Turkish-Syrian land border irregularly. Ali came to Turkey irregularly by a car with the help of an NGO that was working with Syrian doctors. Mostafa came to Turkey by

passing the border irregularly after 2016, when some restrictions to the open-door policy were introduced:

> *I escaped from Syria and entered Turkey irregularly. I jumped over the wall (sarcastically laughing). I do not have a passport, because I escaped. Twice I got caught by the gendarmerie. I tried again and yes; we walked for three hours for the last time and we were successful. (Mostafa)*

Faisal, Ali, and Hussein were in northern Syria surrounded by the regime. Turkey was the one and only destination that they could choose to leave Syria. On the other hand, Jamal, Ahmad, Fatima, Yousef, and Suleiman chose Turkey consciously. Jamal wanted to stay close to his homeland and moved his family to a southern city close to Syrian border in Turkey. He worked in Syria but regularly come to Turkey by his car. According to him, border crossings from liberated areas of Aleppo were not difficult until 2016, but afterwards they became riskier. As a doctor, he got a border-crossing permit and for doctors, it was even possible to cross the border with expired passports. Like Jamal, Hussein moved with his family to southern Turkey, but continued to work in Syria part-time:

> *I got married in Syria then brought my wife to Turkey. We lived in southern Turkey. I continued my work in Syria on my off days, until I started to work in Migrant Health Center in 2019 full-time. (Hussein)*

Participants of this study left Syria to go to either Turkey or Jordan. Ali went to the US for his first-time leaving Syria, but years later, he left Syria second time in Turkey. Jordan is the third ranking country that accommodates Syrian refugees in the world (UNHCR, 2020). Fatima and Ahmad first went to Jordan. They lived in Jordan with their families for 3-4 years, at the early phase of the Syrian War, but later they moved to Turkey. Fatima received a scholarship from Germany at the beginning of the war, but she believed the conflict would soon end and she did not want to be far from her country and stayed in Syria. However, later they left their country and went to Jordan as a family.

Both Fatima and Ahmad chose Jordan because of its proximity to Syria, since at that time they were trying to escape. They worked as doctors in Jordan and treated Syrian war casualties. Following his arrival in Jordan, Ahmad got together with other Syrian doctors and they formed a medical team to operate Syrian war casualties. He

said they were supporting the Jordanian health system by treating Syrian refugees and helping Syrian people thanks to the donations they received from international organizations including UNHCR. In three years, they conducted more than 5,000 operations on war casualties free. Fatima worked with a group of doctors to help Syrian refugees outside of the camps for mental health and psychological support. They both said that the restrictions on work permits for Syrian doctors in Jordan were tightened and some Syrian doctors were even deported back to Syria. In addition, the negative sentiments towards Syrians within the Jordanian society started to be vocalized in time. They decided to leave Jordan. For Ahmad Turkey's geographic proximity to Syria and for Fatima, the job offer her husband got from an NGO in Turkey were the reasons.

> *We were practicing in Jordan illegally unfortunately, since there was no solution for us as doctors. Even though we had good experience in our specialty, we were not able to receive work permits. We were always working under the name of Jordanian doctors. After 3 years, we heard complaints such as "Syrians were a big load on Jordan". Also, the number of Syrian war casualties in Jordan decreased. I got some job offers from United Arab Emirates and from Europe to go there. I did not want to go far away from my country, since if I did I would not be able to help my people. I decided to come to Turkey. (Ahmad)*

The way participants decided on their destination is a significant example of the interplay between their refugee and high-skilled migrant identities (Arie, 2015; Piętka-Nykaza, 2015). First, being a refugee immensely narrowed the options they could have as highly skilled professionals. They were running away from state violence and their aim was leaving Syria as quickly as possible. Turkey's open-border policy and geographic closeness to Syria was an important reason to choose Turkey. Second, the ways they crossed the Turkish border and chose it as a destination were in line with the refugee movements. Still, as high-skilled professionals, their decisions were nuanced from the ones of refugees and economic migrants (Batalova, 2002; Chiswick, 2011; Czaika & Parsons, 2017). They did not prefer destinations that are potentially more promising financially and professionally such as western European countries or the US, although they had the opportunity to go there, but preferred to stay close to their home country. Unlike refugees, some

participants continued to travel back and forth to their homeland, even though the conditions causing their forced migration were still valid.

On the other hand, there were other pull factors in Turkey besides the open-door policy and proximity. The narratives of participants also suggest that Turkey was considered as a destination to pursue their professional and educational goals as doctors. The formation of MHCs for instance, was an important legal employment opportunity for Syrian doctors and the participants acknowledged that. Especially for the junior doctors, MHCs were considered as a good transit job until they got work permits as doctors. Moreover, the presence of millions of Syrians in Turkey was another pull factor, since it was creating social networks and a demand for Arabic speaking medical professionals. Some participants had relatives and friends in Turkey. Last but not the least, Turkish culture was close to their native culture and they shared the Islamic religious beliefs with Turkish people.

5.2 Being a refugee doctor in Turkey

All participants defined themselves as doctors and their professions and careers resided at the center of their migration trajectories. The personal narratives were proved quite valuable in illustrating both the converging and diverging aspects between the actual experiences of refugee doctors and the assumptions of high-skilled migrants and refugees in the literature. Following their arrival in Turkey, participants faced with many problems in their personal, professional, social, and educational life. Their problems varied but except the ones graduated in Turkey, namely Ali and Faisal, participants shared the challenge of being recognized as doctors in Turkey. As explained in Section 3.1.1, foreign doctors needed to get the official equivalence of being GP doctors by passing STS exam to practice in Turkey. Later, they should get the license of specialty to work for instance as a surgeon or pediatrician. Some participants succeeded in getting the diploma equivalence, but none of them could get the license of specialty. The individual qualifications and skill levels of participants played an important role in the way of dealing with this challenge.

5.2.1 Challenges in employment as a doctor

The narratives showed that the level of medical experience, i.e. being an experienced specialist, a resident, or a student before migration had a definitive effect on the labor market efforts of the participants, as well as on their social and labor market integration choices as refugee doctors in Turkey.

5.2.1.1 Getting the equivalence as a doctor of GP

The participants of the study had various strategies to cope with the challenges they encounter during their labor market integration process. These strategies were very similar to the ones of the highly skilled migrant professionals: exploring job opportunities, starting the skill recognition process, learning the destination county language (Turkish in this case), relaying on professional networks, and taking entrepreneurial initiatives such as opening private clinics. The major difference between the strategies of the participants and high-skilled economic migrants was about the timing of execution, since the participant doctors were following taking these actions not before but after their arrival in Turkey. The participants brought their skills of medicine and Arabic and they believed both skills were in demand by the Syrian refugees in Turkey. However, they were yet to practice as doctors integrated into the Turkish systems. The medical specialties and the years of professional experience of the participants varied. There were 3 general surgeons (Ahmad, Fatima, and Jamal), a pediatrician (Yousef), and a radiologist (Suleiman). Mostafa was a "general surgeon without the diploma" since he completed his 5-year residency training, but could not get his certificate. Hussein was a 3rd resident in neurology. Last, Faisal and Ali were medical students when the war interrupted their education. They completed their medical studies in Turkey at Akdeniz University. Furthermore, Mostafa, Hussein, and Ali worked as doctors in the field hospitals of Syrian opposition more than 5 years before coming to Turkey, so they already had 6 to 11 years of post-graduation medical experience.

As mentioned before, Faisal and Ali had Turkish medical diplomas that give the right to practice as GPs in Turkey. 5 of the participants (Ahmad, Fatima, Jamal,

Mostafa, and Yousef) got equivalence by passing the *STS* exam. Suleiman and Hussein did not have the equivalence as doctors, but they were legally working at MHCs with their Syrian diplomas due to the related regulations (Section 3.2.2).

The participants did not oppose to the idea of needing to take tests in their specialty to be able to get a work license in Turkey. However, STS was in Turkish and the language barrier was quite challenging for Syrian doctors who were not Turkophones. On the other hand, they all criticized the bureaucratic procedures and practices of *STS* exam and its required hospital training requirement. Since this whole process was taking years to be recognized only as a GP:

> *Passing STS was a big struggle for me. I started studying Turkish despite I am an old man. My kids were asking me: "What are you doing daddy? Are you studying again?" (laughing)... We made many requests to MoH: "Please make it in English". It is very acceptable to test my knowledge in English, which I am fluent and there are many colleagues who are fluent in English. It is the international language. (Jamal)*

> *I passed on my third time. I have been a surgeon for almost 20 years, but they wanted me to apply for an examination like a new graduate. The exam was not related to my specialty and it was in Turkish... (Ahmad)*

Ahmad described his experience with *STS* as a process not helping him or Turkey since the exam was not helping with the evaluation of the medical skills. He was in the process of hospital training post-STS:

> *I am a well-known doctor in Syria and I have a good experience. Even here, when we do operations in private, we receive the trust of Turkish doctors, nurses, all the medical staff that are working with us. Unfortunately, I have been here now for 6 years, but I cannot practice even as a GP. (Ahmad)*

Similarly, Jamal passed the exam on his third attempt and it took 3 years. After the exam, he applied for hospital training and waited for appointment to a university hospital for another 2 months. Afterwards, he did an 8-month long training and finally received his diploma equivalence*:*

> *Look at this time loss! After 3 years and 8 months, I am a general practitioner, not a specialist (!) So now, I must start a similar process once again for my specialty equivalence. (Jamal)*

All participants compared themselves with Syrian refugee doctors who went to other countries, especially to Germany. They talked about how their colleagues and friends in Germany got work licenses as doctors of specialty years before them and with easier procedures:

> *This friend of mine came to Turkey in 2014, now in Germany. There, he got his license as a GP. After that, he got his diploma as a pediatrician. Now he is further studying pediatric oncology. I mean, he is studying his 3rd specialization. Another friend in Germany studied general surgery and now doing one more residency while working directly with a professor. I got my GP equivalence 4 months ago. When I said it to my friends in Germany, Spain, the US, they laughed at me saying that they were finishing their 2nd specialty. This is a problem.* [iv] *(Yousef)*

> *We started the equivalence process over 3 years ago but it is not yet finished. Actually, this is the reason that makes us feel frustrated. Not only me but also other Syrian doctors, because they could not practice medicine legally. (Fatima)*

Mostafa concentrated his efforts on studying Turkish and preparing for STS as soon as he came to Turkey. Getting the diploma equivalence took him a year and 8 months, which was the fastest duration among all participants who got it. He believed that getting the equivalence would speed up his resettling in Turkey, but it did not:

> *In 2019, nearly one year later I came to Turkey, I have been successful on STS exam. Then, I completed the training in a hospital for 8 months. On August 2020, I got my equivalence. Since then, I am trying to work, searching for work... My friend, with whom I came to Turkey together, has already got Turkish citizenship 6 months ago. He did not get the equivalence. I thought, if I get equivalence, it would accelerate my processes. But it did not (laughing). (Mostafa)*

Another difficulty related to the getting medical equivalence was their financial circumstances. Most of them lacked the economic capital or they spent theirs in time while trying to get the equivalence. They had to find alternative ways to earn income. Whether they worked at MHCs legally or practiced their profession illegally, they had a life standard that was much below their standards in Syria economically, socially, and professionally. The narratives showed that as highly skilled professionals, their adaptation skills were adequate to learn the local language, passing examinations, and integrating into the Turkish labor market.

5.2.1.2 Getting the license as a doctor of specialty

For Syrian refugee doctors in Turkey, the second step of obtaining the equivalence of specialty is still an unsolved problem (as of the time of this research) due to the sui generis case of these refugee doctors. Like other foreign doctors, Syrian doctors in Turkey need their Syrian documents to be approved by the Ministry of Health (MoH) when they apply for the equivalence of specialty. If their submitted documents are approved, they need to pass an oral exam on their specialization and after they can get the equivalence and right to practice in Turkey. For this approval, all foreign documents must first be confirmed for their authenticity by the related country issuing those documents. Without the authentication, they cannot be submitted to the MoH. At this point, a question may arise: why is document authentication not needed at the diploma equivalence stage but needed for specialty equivalence? The difference in requirements originates from the responsible institution that evaluates the submitted documents. The medical diploma equivalence (*denklik)* is issued by YÖK. Indeed, YÖK also requires the authentication of foreign documents, but it updated its rules by exempting the applicants "who take refuge in Turkey because of a state of emergency in their country" from this prerequisite (Hande Özgen, 2018, para. 6). While, specialty equivalence is issued by the MoH and until today there is not an exemption for Syrian refugees for the authenticity confirmation.

> *Now there is a new obstacle, but now it is big. It is MoH's decision, which is very strange. You must get your documents stamped at the Syrian Consulate to apply for specialty equivalence. In Germany or other countries, if you can go to your Embassy (and receive your documents with no trouble), then you are not considered a refugee, since, you do not have a problem with your country. Because I am opposing Assad, because I am a doctor, I am a "criminal" according to Assad. So how do they think that my country would approve my documents? I am checking the status of my application online and it says "Your document is under assessment". When will this assessment finish? I do believe it will not finish. Maybe I must wait 10 years! (Jamal)*

Syria has not joined the Hague Apostille Convention and the only way of legalizing Syrian documents is through the Syrian Consulate in Istanbul (Nikolaeva, 2021), which is the only Syrian diplomatic mission in Turkey However, so far none

of the participants were able to authenticate their documents in Syrian Consulate. It was mentioned in the narratives that interviews that by the decision of the Foreign Ministry in Assad regime, the Syrian state institutions were banned from stamping the documents of refugee doctors and other highly qualified Syrians. The diplomatic authentication requirement for the documents was perceived by the participants as a mountainous task since they did not think that the government institutions of Assad regime would make their lives easier abroad by confirming their documents or diplomas via stamping:

> *MoH already has doctors who passed the national exam, but does not allow them to work as medical specialists. MoH can test Syrian doctors by any Turkish professors or in any university hospital to see whether these doctors are really well experienced and can treat people or not. (Ahmad)*

Mostafa knew more than 40 Syrian doctors who got diploma equivalence in Turkey and were waiting for a solution about the authentication problem of documents to apply for specialty equivalence:

> *We cannot get the equivalence for our specialization. Why did we stay in Turkey? I do not want to work as a GP. I want to work as a general surgeon. Now I am just waiting for what? I do not know really. (Mostafa)*

Jamal said that he had paid $500 just to get his academic transcript. However, he was uncertain that these costly documents would be enough to eliminate the stamp requirement of the MoH. Participants also mentioned that some doctors tried to get the stamp directly from Syria but could not since "the regime's officials had asked for $4,000 for the authentication of each document".

Since the document authentication is a pending for a solution, the only way for participants to practice as doctors of specialty in Turkey is to re-do the residency training, in other words beginning the career from scratch. Such a cumbersome repetition would take a serious amount of time, would be challenging in many ways, and stressful. Mostafa mentioned that resident doctors who went to went to Germany were able to continue their training from where they left off, or repeated only a part of their trainings, but they did not repeat the whole program:

> *In Germany, they just did the language training and they continued their specialization from where they left. We could not do that here, of course! If I*

> *studied five years in the Syria, but do not have the diploma, I cannot do anything (in Turkey). I must do it again from the beginning… I must enter TUS exam and do that training for 5 years again. I will never do that! In Turkey, there is not a law about this (Mostafa)*

Despite its hardships, Hussein decided to study neurology in Turkey. After getting his medical equivalence, he planned to enter *TUS* exam. The rest of the participants did not mention entering *TUS* and redoing residency as an option, since they were already complaining about losing time and did not find it acceptable to be a resident again for 4-5 years:

> *I know in Turkey, many of my colleagues are now restarting their training. An ophthalmologist, a general surgeon, a urologist for instance… They will go as residents again for 5 years to be qualified by Turkey. Why? (Jamal)*

As mentioned in sections about deskilling and work permits for immigrant doctors in Turkey (Sections 2.2.2 and 3.1.1) re-training in their professions from scratch is a significant example of deskilling (Section 2.2.2). Re-training is a way of skill waste for experienced doctors and takes a lot of efforts and time. Such a waste of talent is likely to be a counter-productive process for the participants, since it is neither psychologically nor economically viable for these high-skilled refugees. Besides, the literature suggests the effect of skill waste is negative for the national economics of host countries (Batalova, 2002; Garcia Pires, 2015; Legrain, 2016). Within the welfare sector, the health system rules and regulations are strict in Turkey for foreign doctors (Section 3.3) and Syrian doctors face a specific problem related to the refugeetude.

In the narratives, it is also noted that Syrian refugee doctors around the world were in communication with each other and were following the professional status of their peers in other countries. These communication networks provided the participants a way to compare and assess their career progressions as refugees and provided inputs to their decision making about their next steps.

5.2.1.3 Bureaucratic uncertainties

The narratives showed that uncertainties arising from bureaucratic procedures were embedded in many aspects of their lives and not knowing how long they need to wait for a settled life was consuming their strength and hope. It was also creating psychological stress for the participants, since they were living in prolonged uncertainty. As refugees, they needed to meet certain requirements in their daily lives and get and present some documents or permissions regularly. They envisaged an unpredictable future for themselves most prominently because of the bureaucratic uncertainty about their employment and their TPS in Turkey. They were trying to meet bureaucratic requirements with great efforts, however; inability to attain the expected results for reasons of unfamiliarity with the system, language barrier, the complexity of the task, long processing time, limitations of TPS, etc. was demoralizing:

> *There are no relations between Turkey and Syria, but we are expected to have all our papers 100% complete…My papers are not complete and my situation is this! We hope that the MoH will study the special case of Syrian doctors. In Germany, in Europe, they are studying special cases of refugee doctors. For instance, I have a diploma from the Temporary Government of Syria, the Revolution Government. These diplomas are now being discussed by Turkey and Qatar for recognition. (Mostafa)*

Fatima described their state of mind as distressed because of not being able to work as a doctor and waiting too long with not improvement in their situation:

> *We regret staying in Turkey from time to time, when we feel too much frustrated and have depression…When I saw my colleagues abroad and what they achieved, they became professors, did PhDs in their specialties, I feel some pain. (Fatima)*

The requirement of consular authentication of their documents was an externality that the participants were unable to solve by themselves and they just have to wait for a solution that was beyond their capacity to bring. Hainmueller, Hangartner and Lawrence (2016) analyzed the effects of asylum process length on the economic integration of refugees in Europe and found that the longer the waiting in limbo for asylum decision, the lower the rate of employment for refugees. Too much waiting for asylum process is found to be related with a psychological

disappointment of the refugees, rather than the skill loss they experience (Hainmueller et al., 2016). As time passes without improvement in their skill recognition issue, the participants' hopes for rebuilding their lives in Turkey diminish. Besides, they could not find an explanation for the fact that their high-skills were not valued as they expected:

> *I am a well-known doctor in Syria. For instance, the World Bank and the President of Portugal invited me to attend a conference, because they knew our role and experience in treating wounded people in Jordan. Now, I just put all my experiences aside.... Two times I got a mark on STS that was just 0.4 points lower than what is needed to be eligible. I sent the reference letter given to me from the state hospital I did training, but YÖK refused to even consider... (Ahmad)*

Mostafa got the diploma equivalence as a GP, but he was not allowed to open a private clinic as a non-Turkish doctor due to regulations. He applied for Turkish citizenship; however, if he receives the citizenship, he would need to complete a two-year compulsory medical service in a state healthcare facility to get the right of opening a private clinic. He said that every step he completed rebuilding his life was introducing newer problems and requirements. He believed that his life would be much easier if he was not a surgeon since other people of professions could start working after a short period, but he needed to pass exams and do trainings before being able to work.

Ali was accepted to work at an MHC but after 4 months passed, he was still waiting to work:

> *After graduating, I started to work in a private clinic immediately. If I was to wait for MoH to call me, I would go hungry. It is so difficult not knowing about the date to start my new job. I even went to Ankara to get information about this, but I could not meet with anyone there. (Ali)*

Jamal explained he could practice abroad such as in Saudi Arabia, in the UK, or in France as a general surgeon with his diplomas starting from "tomorrow", but in Turkey he could not do that because of the consular stamp requirement on them:

> *Losing 2-3 years for the STS is okay, but what is next? Even if the stamp issue is solved, there is another training requirement for my specialty. Maybe it will take another 2 years?? Altogether, it will be 5 years of waiting. Who has*

the patience to wait for 5 years? I may quit and find another job in another city... (Jamal)

Participants mentioned the bureaucratic uncertainties as collective troubles of high-skilled Syrians living in Turkey. It was inferred from the narratives that Syrian doctors were communicating with each other through online platforms such as WhatsApp groups to disseminate information about the bureaucratic procedures on their legal status, updates of their professional recognition processes, job opportunities, exam preparation, etc. Another finding of this study is that most of the participants expressed solidarity with other Syrian doctors in Turkey during the interviews. Refugee studies highlights that social support among the compatriots is a method used by the refugees to cope with the stress of migration and its associated challenges (M. J. Stewart et al., 2010). Jamal showed empathy for other high-qualified Syrian refugees whose professions were also not recognized in Turkey:

I think that the Turkish Government should think more about how to get benefit from high skilled Syrian immigrants. I do not think that there is a country in the world that does not need high skills. Turkey is keeping those who are unskilled, who cannot travel away and end this problem. People of lower-level jobs are working here in Turkey; it is fine for them. But what about the highly skilled Syrians whose skills are not recognized in Turkey? What are they going to do if cannot work? After waiting a long time, many of them are now traveling out. Why? (Jamal)

Like Jamal, Faisal also criticized the way Syrian doctors were "neglected" in Turkey. Although he welcomed the opening of MHCs, he viewed this initiation as too late. According to him, many Syrian doctors came to Turkey at first, but because they could not find legal employment opportunities, they left for Europe and lower-skilled Syrians whose burden was heavier remained in Turkey:

I heard it is around 5,600 doctors that got licenses in Germany. I think this is a big loss for Turkey. [v] *(Faisal)*

Participants were not alone in their thinking about the bureaucratic inertia of the situation of highly skilled refugees. In an interview with the former Minister of Family and Social Policies of the Turkish Government Fatma Şahin, who is the current Mayor of Gaziantep, the southern Turkish city that hosts the second largest Syrian population confirmed this reality by saying that Turkey was late in issuing

work permits for highly skilled Syrian migrants and therefore lost that high-skilled workforce (IHA, 2021). Some participants talked about a scarcity of medical doctors in the Turkish health system and Syrian doctors could be useful to fill that health gap in Turkey:

> *They opened the Çam and Sakura Hospital[1] for example. It is a huge hospital and there is a shortage of doctors there. (Ahmad)*

> *Sometimes I am looking for a doctor of specialty at the hospital, but there are very few and it is difficult to find a Turkish one in my city. I think, there can be a good opportunity to benefit from Syrian doctors of high specialty for Turkey. (Fatima)*

Still, participants were quite appreciative regarding the humanitarian migration policies of Turkey towards Syrians and the welcoming shown to them by the Turkish society. For instance, Ahmad was in Jordan before Turkey as a refugee doctor and he expressed his gratitude for the hospitality shown to them in Turkey. To create efficient solution to their problems, participants were trying to make their voices heard by related Turkish authorities. In this respect, during the interviews, all participants thanked for this research that focused on their professional problems in Turkey:

> *What we are receiving in Turkey is much better than what we have seen in Jordan, where although we were talking the same language (Arabic) there. We think the Government of Turkey is trying to help us and the hospitality of Turkish people is much better. The main problem is that there are no channels between the Syrians and the authorities who decide about the Syrians. If they have listened to the Syrian people that are experienced, trustable, to whom they granted Turkish citizenship… (Ahmad)*

> *I know this may help other doctors in the future. In Germany, the manager of the hospital can decide about the eligibility of foreign doctors and the level of training they would require those doctors. But here in Turkey, the papers must go Ankara for deciding about the skills of doctors. A new law is needed for the special cases as ours. (Mostafa)*

[1] Located in Istanbul, "Başakşehir Çam and Sakura Hospital" is the third largest healthcare facility of Turkey and opened in May 2020.

Cangià et al. (2021) state that the displacement inevitably affects the career conceptions of the highly skilled refugees and therefore the idea of a linear or stable track turns into an interrupted and uncertain path. This is an important difference between the migration outcomes of high-skilled migrants and high-skilled refugees conceptually. However, high-skilled migrants are also prone to deskilling and this is a common result of high-skilled refugeetude and high-skilled migration in this study.

5.2.1.4 The dilemma of legal vs. illegal work

All participants were employed. In the sample, the only dual-income family was Fatima's family and rest of them had single-income households. Other than Fatima and Jamal, the rest of the participants were practicing medicine as doctors. It was 7 participants that were working officially. Fatima was working at an NGO and doing managerial work. Jamal had a business related to the medical field and continued to work in opposition-held Syria. Hussein, Suleiman, and Yousef were working at MHCs, Faisal was working in a state hospital, and Ali was working in a private medical clinic. Ahmad and Mostafa were working unofficially as in private clinics.

Legal work options for Syrian doctors in Turkey are currently very limited. They can either work at MHCs (if new recruitments are done) or they can work in private clinics as GPs. Participants of this study said that the *de facto* state of work at MHCs was not a medical profession. Only Suleiman did not complain about his job at the MHC, except stating that he was not working as a radiologist there. He was a very experienced radiologist with a long career. When he came to Turkey, he could not find a job and was unemployed for 1.5 years. Later, he was appointed to his MHC. Since then, he was working there. He spoke very little Turkish and was not planning to apply for STS for diploma equivalence. Faisal, on the other hand, was a fresh doctor who had the Turkish diploma. He worked at an MHC for a year and then quit. He criticized the job at MHC harshly:

> *I did not like it at all. It was not the job of a doctor. Working at an MHC was not stressful, since no critical patients were coming there. Patients were coming only prescription. However, the workload was too much that the job*

> *became horrible because the doctor examination and medicine were free. Since there is no fee, there is no value of the service either. In winter times, I was receiving 100-150 patients every day. That was not a logical number for a doctor. The salary for this workload was not good, too. The biggest problem for me was the disrespectful attitudes of the facility managers towards me, as if I was not a doctor.* [vi] *(Faisal)*

Hussein was also working at an MHC but considering his employment as interim until he passes the STS. His economic situation was not promising, but his aim was not "money" but to complete his study. He complained about the staff shortage and free healthcare service, which was counter-productive for everybody, including the Turkish people:

> *Firstly, there is the overcrowding issue in these centers. The number of doctors and nurses is low compared to the refugee population. Second, a free medical service is a problem. Some people visit MHCs 5-6 times per month, only because it is free. They take the drugs and do not use it. Third, if we say anything non-pleasing to a patient, he or she shouts at us and makes a fuss at the center. (Hussein)*

The need for a steady income required participants to work. None of them wanted to work illegally and hoping to work as recognized doctors in Turkey soon. Some of them found employment out of medicine. Fatima described their economic status in Turkey as "not too bad, but incomparable to what they had in Syria". In addition, their economic status was not getting better. She explained why she did not want to work at an MHC:

> *As a general surgeon, the MHC is not the place that I can practice my profession. I must go to a hospital, not to a primary healthcare clinic… However, I have to work in this NGO to earn money to survive. Only one person working in the family will not be enough for us to sustain an acceptable life as doctors... (Fatima)*

Jamal and Ahmad described their economic status as like what they had in Syria. They were invited to apply to the SIHHAT Project to work at the MHCs. However, they did not want to work there:

> *Even if I was selected for the project, I would be needed to go through a course as a GP. But I am a general surgeon and I refused to do that. It is allowed for obstetric gynecologist and pediatricians to work as specialists, but only for the clinic cases. I know dermatologists, cardiologists, even an*

ophthalmologist working in these centers as GPs, just prescribing antibiotics or paracetamol[2]*. That is it. (Jamal)*

Jamal did not want to unofficially either since working under the name of a Turkish doctor was being disrespectful to himself, his skills, and his work:

First of all, this is illegal. Secondly, I will be hidden behind of a Turkish doctor. Why? If you work like this, you do not have the right to open a clinic, you do not a have right to work in a hospital, and you are just somebody under the cover of a Turkish doctor. At the end of the day, this is not acceptable. Turkish doctor will also have two-thirds of your money! (Jamal)

Ahmad said that in his initial years in Turkey, he was not familiar with the diploma equivalence process and the *STS* exam. Therefore, he focused on finding a job. As being experienced from Jordan, he got together with 32 Syrian doctors and they opened a private clinic in Istanbul. They treated Syrian refugees with very low fees. He worked at that clinic as a general surgeon there for three years. The clinic was working almost non-profit. However, it was not licensed and closed in 2017. Ahmad told he was well known as a surgeon among Syrians and already had a Syrian clientele in Turkey. He found a new job in a private hospital and started to work unofficially (under the name of a Turkish doctor). His economic situation was better compared to other participants:

Even if I had to work in a gas station, I would not work at these centers (MHCs). I am a university teacher and they want me to work as a GP, a position I do not have the experience. To treat kids, this is very far from my experience in the medical field. So how can they want me to work there, but do not want me to work in the field that I am very experienced? I will not work in such centers even if I must quit being a doctor. (Ahmad)

Other participants described their economic status as lower than what they had in Syria. This was also true for some other Syrian doctors:

I have a colleague working at an MHC, but he seriously considers moving to Somalia (!). He tried to convince me and asked what I was thinking about going to Libya or Somalia? He said to me: "They would give us maybe

[2] A common painkiller used to treat fever and moderate pain.

$2,000-$3,000, you know?" (laughing). So, you can see the bad situation for Syrian doctors. It has been 10 years without improvement. The children were 2 or 3, but they are now 13, 14... (Fatima)

When Mostafa came to Turkey, the recruitments for MHC were closed so he could not apply to SIHHAT project. As a Syrian with TPS, he could not get registered in Istanbul. He moved to the neighboring city of Istanbul but there could not find a job as a Syrian doctor. Then he found a job in Istanbul, where he was not allowed to work due his TPS. Travelling every workday to Istanbul took around 4-5 hours, which was tiring mentally and physically. Besides, their expenses increased rapidly because of the health condition of his younger child. Economic hardships pushed him towards trying other ways of making money. He tried to export medical products; but could not do it because of lack of financial capital. His savings had finished the end of their 3rd year in Turkey:

The main problem is about the money. We have no money for living. Here in Turkey, I could not work legally, so I have to work illegally. But illegal work is dangerous. Some of my friends got arrested because of that and now waiting for a court decision, which could sentence them to prison for 3 to 5 years. (Mostafa)

For instance, Faisal came to Turkey without his family and without financial capital. He had to work while studying in Turkey:

When I came to Turkey, I was not a doctor. I worked in a construction; I worked as a waiter, as a translator in tourism sector. I still do not know does it worth the endeavor. Money need is a big problem for people with families. Though not enough, I think opening of MHCs was important… Instead of being unemployed, a doctor can work there and have an income, while studying for STS.[vii] *(Faisal)*

Last, participants highlighted the importance of practicing their profession, since staying away from fieldwork caused losing some of their skills or further progressing. That is why; they tried to create practice opportunities to "stay in form" as specialty doctors:

I lost some of my skills, but not all of that, because sometimes I go to Syria and do some surgical operations. It is not regular, since I have a family here and my children are young. I have to stay most of the time herein Turkey. (Fatima)

> *I will send my documents to the UK to practice some surgeries there. It is called a locum job[3], only for a month or two weeks, it depends. I will go there for a week / two weeks and then return to Turkey, until to be able to practice here legally. (Jamal)*

Yousef was a pediatrician and came to Turkey not much after the beginning of the war. For 1.5 year, he worked as an academic researcher in a research center. Afterwards, he worked in several private Syrian health policlinics as a doctor. He described that period as difficult, since the clinics were unlicensed and clinics were being closed frequently. Then he worked as a doctor for an NGO for more than a year. Finally, 4 years ago, he started his current employment at an MHC as a pediatrician. He has recently passed the *STS* and would do hospital training to complete his *denklik* process. Unlike other participants who were working at the MHCs as GPs, he was working as a specialist at the MHC, but evaluated his job experience as such:

> *For the last 4 years, I have been examining the kids for coughing, diarrhea, vomiting, cold, and that is it. This is not medicine; I mean, not all of it. If a specialist is not working at the hospital, he is going backwards every day. I have not entered a hospital for 8 years; have not worked in units of intensive care (IC) and with the incubator. If today the war in Syria ends and I go back, I must review my working knowledge on IC, incubator, serious patients of oncology, metabolic disorders etc. for 6 months...* [viii] *(Yousef)*

Younger participants and junior doctors were more eager to work at MHCs, but experienced ones such as Jamal, Ahmad, and Fatima have refused working as GPs since the beginning. These participants were also the ones that had the experience of being highly skilled migrants abroad or experienced international network connections while working as a doctor in Syria. For instance, Suleiman and Jamal were about the same age and both were medical specialists with a long tenure. However, Suleiman considered his job at an MHC was "good enough". The level of efforts Suleiman and Jamal made for integrating to Turkey were quite the opposite.

[3] A locum doctor is a fully qualified doctor who is temporarily covering a position (Doctors' titles explained, 2021)

Therefore, the participants with multi-sided careers before the displacement were more insistent about preserving the value of their skills and less eager to give up their professional status despite the challenges. They were actively trying to find ways to rebuild their careers in Turkey by utilizing their personal, social, and cultural capital fully. Second, the narratives of participants also revealed that the reasons to work at MHCs for Syrian refugee doctors were the need for a steady income, having a legal job, and the ability to work without the requirement of diploma equivalence. According to the narratives, the coping strategies of the Syrian refugee doctors with the career related challenges were acceptance, compromise, and living with the dilemma of skill waste.

5.2.2 Challenges of being a refugee

State control on the way of living and being displaced as refugees is an important stress factor (Chase 2013; Allsopp et al. 2015; Pearlman 2017; Bucken-Knapp et al. 2018). These challenges were present in everyday life of the participants and affecting them individually or as a family.

5.2.2.1 Limitations of temporary protection status

All participants applied for Turkish citizenship at different times. 5 participants (Jamal, Ahmad, Fatima, Hussein, and Faisal) and received it, while the other 4 (Yousef, Suleiman, Ali, and Mostafa) were still waiting and had TPS. The duration of receiving citizenship ranged from 14 months to 4 years. Participants believed that receiving citizenship earlier or later was by chance. Having Turkish citizenship saved participants from the bureaucratic tasks and obligations of TPS such as renewing residency permit, getting travel permits, etc.

For instance, after graduation Faisal worked at an MHC. When he received Turkish citizenship after a year, he began his residency training as a Turkish doctor and become free of bureaucratic challenges related to his refugee status. He was the only participant who was able to integrate into the Turkish health system fully as a medical doctor. Being young facilitated his integration through different

circumstances: he came to Turkey as a student and got fluent in Turkish. He was single and therefore he had no family obligations that other participants had. He could focus on the development of his future career.

TPS allows working only in the city of registration and this administrative limitation was a challenge for Mostafa and Suleiman. There are many clinics in cities with high Syrian population, such as Istanbul, Gaziantep, and Hatay, where Syrian doctors can find work easier; but registration to those cities are closed. Mostafa and Suleiman could not find jobs in their registered cities. Suleiman stayed unemployed and had economic hardships until getting employment at an MHC. Despite the legal and personal challenges, Mostafa kept working in Istanbul, but he also had another problem due to his TPS. He could not enroll his youngest child, who was diagnosed with autism after two years of difficult search, to the specific public education center named Guidance and Research Center[4] (RAM). Even though he got the required official medical report about his child's condition, he learnt that for non-Turkish people, the enrollment to RAMs was not possible. He applied to several legal institutions that regulate TPS in Turkey, but he could not find a solution. Then he moved to Istanbul, although living outside the registration city was also illegal for TPS holders. Luckily, six months later, he legalized his residence in Istanbul via registering himself at the Istanbul Chamber of Medicine. He also found a special Syrian center to enroll his child:

> *Everybody wanted to help but they could do nothing. The Red Crescent called me, "What happened to your problem? Oh, did it not resolve? Ok, thank you sir. We will call you later…" just like this. Why it is like this? They should solve this problem but they did nothing… I cannot register my child in these RAM centers because I do not have citizenship. Now, I broke the law for my child, left my registration city, and came to Istanbul because in Istanbul there are special centers for these children. My problems are complicated, really… (Mostafa)*

[4] A Guidance and Research Center (RAM) operates under the Ministry of National Education and provides psychological counseling to families and special education to the children free of charge.

Ali had TPS and having a Turkish diploma was a partial solution for him to pursue a medical career as a doctor. As a foreigner, he had no right to open a private clinic in Turkey. Furthermore, if he wanted to continue his career as a resident doctor, as a foreign doctor he would be entitled only to the half salary of residency (Specialist Residency Programs, 2021). That amount of the salary four 4-5 years was not enough to provide for his family. Instead, he chose an academic career and started a master's program in microbiology. With an academic degree, he believed to have the chance to further his career as a foreigner in Turkey:

> *Thank God, I have the Turkish medical diploma and can legally work as a doctor. But I do not have so many choices to improve myself. I did not think about TUS because if I get good points at TUS, I will work for 4-5 five years with the half of salary. So, I will work full time from morning till night and receive about ₺3,000-4,000[5] in a month. My house rent is ₺3,000… How can I feed my children and my wife then? That is why I am doing masters, so that I can work and I can study. (Ali)*

Last, Yousef was working at an MHC as a pediatrician:

> *We are not the doctors here. I mean, it is difficult to work like this. We work just like the Turkish doctors under the same circumstances, but it is different for us. For instance, when the Covid-19[6] started, MoH gave 20-30% extra payment to doctors due to the increased workload. We also worked as doctors during Covid-19 and got infected by corona virus. We asked about why they would not pay us the same extra. They said that we were only working with a protocol and entitled to receive only the indicated salary.* [ix] *(Yousef)*

Although he was recognized for his medical specialty within the employment model of SIHHAT project, he was still experiencing the limitations of TPS and not being integrated to the national health system due to his refugee status.

[5] ₺: Turkish Lira.
[6] Coronavirus disease (COVID-19) pandemic

5.2.2.2 Difficulties in obtaining legal documents as refugees

Participants left Syria abruptly and left everything behind. They all believed that the Assad regime would arrest them if they were to return to Syria. Being unable to return to homeland because of the fear of persecution, in other words, being a refugee brought many hardships to their lives. Obtaining legal documents from Syria was a major challenge. The lack of documents or any kind of legal paper from Syrian origin that identify them, acknowledge their skills, show their education, allow them to travel, and get residency permit etc. were difficult. Furthermore, the Syrian regime increased the passport fees from $9 to $330-$830, in 2012 and made the Syrian passport the most expensive national passport in the world (Dambach, 2017). The validity periods of a passport and other official documents issued by this Consulate were decreased to 2 years in 2017 (Canada IRB, 2017). Furthermore, to request a document, Syrians need to pass security and background checks at the Consulate (Dambach, 2017). Many Syrian refugees who fled their country did not have passports and other documents, and the only way of renewing is via the Syrian Consulate in Istanbul (Yusuf, 2015, para. 12):

> *Some of my friends did not have their documents (medical diploma etc.). They had to pay a great deal for them. (Ali)*

Jamal said that renewing the Syrian passports was as a lengthy, costly, and uncertain procedure. Fatima mentioned that she once went to the Syrian Consulate in Istanbul to register her Turkey-born daughter, but failed to do so. Some Syrians stay in Turkey with a residency permit, instead of TPS. Residency permits are issued yearly and enable its holders to travel freely (Yusuf, 2015). In order to get residency permit, an applicant needs to meet certain conditions such as having a valid passport, insurance, a bank account with a specified minimum cash etc. (Refugee Rights, 2017, p. 11). As mentioned throughout this chapter, documentation issue became a "bureaucratic nightmare" for Syrian refugees due to the punishing regulations of the Assad regime (Carrié & Zayat, 2017).

5.2.2.3 Individual perceptions of being a refugee

For refugees, the level of integration is an important indicator of the resettlement success (Ager & Strang, 2008). Life experiences before, during, and after migration are important components that affect integration efforts. In Syria, participants were treating patients and helping others. All participants were living in their own communities, which they cared and were in their homeland. The ones who were faculty members were able to educate the future doctors of Syria. With the start of the war, they chose selflessly to continue helping their compatriots who needed medical help and realize their ethical responsibilities. During the war, they lost family members and friends and eventually had to leave their countries.

By becoming refugees, they were detached from their families and communities. The respective value of their skills diminished in a foreign country. Despite the efforts on skill recognition and their determination to rebuild their lives life in Turkey, they could not reestablish themselves professionally yet. After leaving Syria, their life standards decreased sharply. Having the capacity of helping others was an important driver of why they became doctors in the first place, however, their power of helping others eroded. They started to struggle economically and socially. All these factors were psychologically heavy for the participants, and consuming their patience and strength. Faisal described being a refugee as a big trauma since every family in Syria lost someone. Fatima's description of being a refugee summarized many thoughts that were mentioned in the narratives:

> *As if, our lives have stopped for 10 years (laughing ironically). There is no advancement in our career, no improvement in our social, economic situation... We are far from our families, from my father and mother. I could not see them in the last 10 years... The rest of my family, my brothers, and sisters are in different countries, Germany, Saudi Arabia, and France. So, I cannot see them regularly. Everything is a challenge and we do not know what the future is for us. (Fatima)*

According to Ali, the most difficult part of being a refugee was not being in one's own place, but being a foreigner all the time. Similarly, Suleiman said in Syria he had his own clinic and the greater family, thus being a refugee was being alone and difficult; but they were safe in Turkey and he was content with it. Yousef said that in Syria; they lived in the same houses that their fathers lived. By becoming a refugee, he left all his life in Syria. All his memories were gone and his children did not know where he lived his whole life before. His family and neighbors were

scattered around the world. His sisters were now living in Canada, Germany, and Syria and he did not see any of them in the last 6 years. Their children could not communicate since they all were speaking different languages:

> *Yesterday my daughter asked me this "Daddy, don't you have any photos from your wedding? I said: "Yes I had. I even had the film of it, but they were all staying at home". Then they were stolen. It is very difficult. Your old life is lost and you start everything from scratch.* [x] *(Yousef)*

An important part of being a refugee is also about the experience of living in a life in a foreign country. Participants had positive and negative experiences, as well as unexpected challenges in Turkey. Faisal said that coming to another country without knowing its language and its rules were though. He was grateful for many things he received in Turkey:

> *I received extensive help from our friends and our teachers at the university. Because of our humanitarian situation, our trauma, our foreignness, none of them wanted us to fail in oral exams. I love and respect them, I am thankful to Akdeniz University. This is not only the result of my efforts. Maybe all of this was thanks to my mother's prayer. At the hospital, for example, we are 13 residents and I am the only Syrian. I never felt myself like a foreigner.* [xi] *(Faisal)*

For Ali, the war and becoming a refugee affected his career:

> *When I started studying medicine, I did not think that I would ever study microbiology (laughing). I was thinking about chirurgery, internal medicine, maybe pediatrics… But I saw too many wounded people in Syria; I hated being a surgeon and the surgical instructions. (Ali)*

Participants believed that being doctors differentiated their migration experience from the other Syrians in certain ways. According to Yousef, being a doctor made his life easier as a migrant, since there were illnesses everywhere and doctors were needed. Hussein believed thanks to being a doctor; he got Turkish citizenship earlier than his non-doctor Syrian relatives did. They felt Turkish people respected them more after learning about their profession. They witnessed a change of attitude towards them when people learn their profession:

> *People really respect me when I say I am a doctor. When I say I am a Syrian, they say different things (laughing) (Ali)*

Hussein shared a racist attitude he encountered and how being a doctor made a difference for him. He went to the Provincial Directorate of Migration Management in his city to update his ID card. He was waiting in line with other 4 Syrians, when a staff of the Directorate spat on other Syrians. Hussein defended them by criticizing the behavior of the staff:

> *I told him he could not spit. Then he yelled at me! Then I told him he was not allowed to yell at me and the other Syrians. When the manager came and learned that I was a doctor, he apologized to me, but not from other Syrians. (Hussein)*

Moreover, Hussein believed that such ill-treatment or unfriendliness that Syrians encountered was because of the perceptions about the free allocation of state resources to Syrians:

> *Turkish people are very very very good. Especially in locations where the number of Syrians is low (laughing). Government provides many free services to Syrians such as education, healthcare, etc. Turkish people pay a certain fee for healthcare services, but for Syrians it is free. Some Turks hated this. Also, if one Syrian does a bad thing, people think all Syrians are like that. (Hussein)*

Most of the participants used Arabic in their work environments because they were treating Arabic speaking patients, mostly Syrians. Speaking Arabic at work, in other words, most of the day hindered the chances of improving their Turkish. On the contrary, knowing the local language poorly slows down the social integration of refugees (Cheng et al., 2021, p. 10). Suleiman told that his relation with Turkish society was almost non-existent since all his patients at the MHC were Syrians. He was living in a small setting that contained his family, relatives, and Syrian patients in Turkey. Similarly, Mostafa had difficulty passing the *STS* exam since he could not improve his Turkish at work. According to Ahmed's (2004) study, lack of social interactions with the local population affects the asylum seeker to become "other" in the eyes of host society and could serve as a catalysis for racist behavior against them. In addition, Ager and Strang (2008) state that not speaking the local language is defined as a structural integration barrier that overcoming it requires further efforts of the refugees and the wider society. Indeed, knowing Turkish played a positive role

in participants' social lives and the way they were treated. Ali spoke Turkish fluently and emphasized its contribution to his life as a refugee:

> *Turkish is a secret key in Turkey (laughing). If I can speak Turkish, I can communicate with everyone. Yesterday, I was at the Migration Directorate. When they saw I could speak Turkish very well, they treated me differently (laughing). (Ali)*

As Ager and Strang (2008) suggested, the contribution of wider society was affective to diminish the structural language barriers and providing comfort to both participants. Hussein and Jamal mentioned that Turkish people living in southern Turkey knew Arabic. This was the only topic that during all the interviews that jokes were made by the participants. This demonstrated the facilitating role of speaking the same language with the immigrants for the integration:

> *I speak Arabic not most of the time, but ALL the time. Even in downtown, in the garden, I mean in life. In my city, most Turks speak Arabic, thus learning Turkish is difficult. When I speak in Turkish, they reply me in Arabic (laughing). (Hussein).*

> *We used to say this joke: "Even 'our Turkish' are speaking Arabic in Reyhanlı and Kilis now[7]" (laughing). (Jamal)*

Jamal narrated an anecdote in which he felt that talking Turkish and having citizenship was not enough to be treated as a non-foreigner and to conduct a conversation with the locals:

> *I received a phone call for advertising. I said to the caller "Please slow down, because my Turkish is not good that much". She said "Ahh, you are a Syrian. No need to talk to you!" Then she hung up! That is normal (laughing). (Jamal)*

Faisal was fluent in Turkish. Unlike other participants; his was working in Turkish, with Turkish co-workers and treating Turkish patients. When he was asked about his problems as a Syrian doctor in Turkey, he said that his problems were the same as the ones Turkish doctors had. Unexpectedly though, he said knowing

[7] Reyhanlı and Kilis are located near the Turkish border with Syria.

Turkish was “terrible”, since it always caused him trouble at work. He mentioned that against the disrespectful and discriminative attitudes of the building administrators at MHCs, he argued with them and later he had to change his workplace a couple of times. What he described in his narrative was his ability to defend himself. Being able to acknowledging one’s own rights and standing up for them was signifying the higher self-esteem of a refugee who had accomplished a good level of integration in the host country (Cheng et al., 2021, p. 8):

> *During a problematic encounter with a patient at the hospital, sometimes I may argue with him. Afterwards my colleagues say to me things like: “You became a genuine Turk indeed” (laughing)…. (At work) I do not disrespect anyone, I just do my job. Since I know Turkish, I can defend myself, however because of this I had serious problems. Other Syrian doctors do not speak loud because of either not knowing enough Turkish or not having a choice.* [xii] *(Faisal)*

About their relations with Turkish people, participants gave similar answers. They preferred to interact with other Syrians. Faisal said he could “happily” chat for hours with his Turkish colleagues at the hospital, since they had common job experiences and could understand each other. Other than those doctors, his conversations with Turkish people were very limited, mundane, and mostly on similar topics such as the events in Syria, Faisal’s journey to Turkey, and his experiences as an immigrant. Therefore, he preferred to socialize with Syrians, with whom he spoke the same language and had a common history. Yousef was a Turkmen and was fluent in Turkish. He could interact with Turkish people comfortably, but had no interest in socializing with them. Since he did not need to make extra efforts to learn Turkish, he did not consider working in Arabic only as problematic as other participant did:

> *I am working at an MHC and all patients are Syrians. So, there is no problem with the language (laughing).* [xiii] *(Yousef)*

One of the important findings of this study is that none of the participants expressed discrimination in relation to the cultural and religious values. For instance, in their recent study on the medical licensing experiences of Syrian doctors in Germany, Loss et al. (2020) highlighted that female participants encountered discriminatory behavior during their job applications and being rejected because of

wearing headscarves (p. 9). In addition, the discriminatory behaviors of the German employers were the reflection of prejudices about the beliefs of Muslim women doctors and its potential effects on the way they practice medicine (Loss et al., 2020, p. 11). Whereas the studies on Syrian refugees in Turkey found that religion and culture helped to diminish prejudices and discriminatory discourse against Syrians (Terzioğlu, 2017). The narratives supported Terzioğlu's (2017) findings.

Ahmad and Jamal shared common characteristics: they were both faculty members in Syria, they were experienced surgeons, they treated many war casualties of the Syrian War, and they were actively supporting the education endeavors of new generation Syrian doctors in opposition-controlled areas Syria. Their relatively higher financial status might be a factor that facilitates spending efforts on collective matters. Overall, even though they had their own hardships and problems, they continued to perceive themselves as highly skilled doctors, who aimed to heal other people or help them ease their troubles.

> *Many Syrian patients go to Turkish doctors, but health system will not understand them, because there is the language barrier. Let me give a tiny example: I took my sister to the hospital. The doctor said, "I'm going to do this type of surgery to her". I have told him I was a surgeon and his treatment suggestion was wrong. So how many wrongs could happen for those patients who are unable to explain their problems? How many doctors do they need to understand them? While there are plenty of Syrian doctors who are just waiting for, let me say honestly, a silly decision. (Jamal)*

Last, the narratives showed the interplay between being a doctor and a refugee in the case of Syrian refugee doctors in Turkey. The perception of being refugees is closely related to the level of success in integration. Employment is the major contributor to integration, since for especially highly skilled refugees, the conversion of skills and qualifications is the most central factor that influences many other issues from social integration to psychological well-being (Ager & Strang, 2008). Clearly, the participants did not consider themselves as refugees, since they find the strength from their profession. The most important agenda they had was the deadlock regarding their recognition issue and their integration to Turkish health system as doctors. They did not accept the connotations associated with refugees such as being a burden to host society and criticized the structural factors such as the

regulations of licensing and recognition foreign degrees, bureaucratic regulations regarding TPS, working conditions at MHCs, etc. that prevent the reestablishment of their professional careers. They wanted to contribute to the society by working, by providing healthcare to Syrians and Turkish people, and by raising opinion about social issues regarding Syrian's integration. The narratives of Ahmad and Jamal revealed they had close communication with other Syrian doctors in Turkey and were very aware of the problems encountered regarding employment. They had a greater feeling of responsibility to find a solution for not only themselves, but for the high skilled Syrian community that they deeply care. They answered most of the questions by mentioning the collective problems of highly skilled Syrians in Turkey.

5.3 Future-oriented plans as a Syrian refugee doctor

According to Tumen (2016), Syrian refugees left Syria in two different ways: the first one was for the immediate safety and sudden. The second way was a more prepared and calculated decision with considerations about job opportunities, family integration, and housing reasons. Like Tumen's (2016) analysis, the participants' plans about future were found to be based on the migration selectivity; since the challenges they face in Turkey differ from the ones they had in Syria. If they migrate again, the economic and work-related reasons are likely to be the driving factors. Their narratives reflected three main perspectives: continuing to stay in Turkey, going to a third country, or returning to Syria.

5.3.1 Staying in Turkey

Participants wanted to stay in Turkey for similar reasons pertaining to cultural and social reasons and being close to Syria. They were waiting for a solution about their skill recognition issue with diminishing patience. Fatima mentioned they had the US visa and option to go to Europe. However, the decision to leave Turkey was not that simple anymore because of her children. Their adaptation to another country was a serious concern for her. However, if there would be no improvement in their situation, then they would seriously think about leaving Turkey. Similarly, Yousef

wanted to stay for his daughters. His daughters, the eldest one in 8th grade, wore headscarves and they had no problems with it in Turkey. On the other hand, the recent political debates in Turkey about Syrian refugees and anti-refugee discourse made them nervous. He said that their children never experienced an explicit assault or any other problem at school until now in Turkey, but current political debates were affecting their children:

> *This is very difficult for our children. You live in a place and everyone says that you are not wanted. We try to stay patient; I do not know what else we can do... On the other hand, in Turkey it is the same culture of Syria, same religion, prayers at mosques, etc. I did not want to go to Germany because headscarf is problematic there. However, if my children were smaller, I would have left for Germany immediately (laughing), since we were not given the Turkish citizenship.* [xiv] *(Yousef)*

Participants were asked about whether they faced discrimination in Turkey. They unanimously said that there were occasional discriminatory or racist attitudes that upset them, but they considered them individual and random acts expected to be seen in any country that hosts a big refugee/immigrant population. They mentioned disrespectful attitudes of some younger Turkish doctors during the hospital trainings, unfair and disrespectful behavior of the work place administrators at MHCs, having difficulty in renting houses as Syrians, some physical and verbal reactions in public places directed to them, as well as certain structural discrimination due to regulations of TPS (lower salaries, not being entitled to extra payments as doctors at the MHCs, not being able to enroll their children to *RAM* centers). However, they all acknowledged this nuance: being a doctor or a highly skilled immigrant shielded them from most of the discriminatory acts directed at Syrians.

> *Yesterday I was on the bus. An Azerbaijani fellow got on the bus. He could not scan his Covid-19 code* [8]*. The driver requested him to get off the bus and try once again to scan his code. At that moment a woman on the bus said with a manner that "There is no Turk left in Turkey anymore!"* [xv] *(Yousef)*

[8] Covid-19 HES code (*Hayat Eve Sığar* – Life Fits Into Home) is a personal code created by Turkish MoH to show the latest risk status for Covid-19 of the code owner (MoH, 2021).

I was standing in a queue to print a page at the court. A person came and stood in front of me. He said: "You are Syrian; you'll have to go back. I am Turkish; I'll stand in front of you!" I asked "Why are you saying this?" But many other Turkish people shouted at him and said that he himself had to move back and I was a human waiting in the queue like everyone else. Also, he had to respect me... (Jamal)

Despite having the option to live in other countries, Jamal preferred staying in Turkey since it was the closest to Syria physically and culturally. Second, he did not want his family to experience a culture shock and Turkey was a good option to raise his children. He mentioned that the city they live in southern Turkey was very similar to his hometown Aleppo. Although he could not legally practice medicine in Turkey yet, he was keeping himself occupied with business projects, giving classes at the local medical faculty, and contributing the efforts focusing on the building of educational infrastructure in northern Syria.

Hussein and Ali were projecting a professional future for themselves in Turkey. Hussein wanted to be a neurologist and Ali hoped to work as a teacher at universities or a researcher at laboratories:

When I came to Turkey, I taught basic sciences like biology, microbiology, and anatomy to Arab students. After the COVID-19, I decided to study microbiology. In a way, I find myself in this field... (Ali)

In 2018 and 2019, I was with the doctors in liberated areas of Idlib, Afrin, and El-Bab. I worked there enough. I will complete my study and take neurology lessons, because I love neurology so much. (Hussein)

Mostafa said that if he could find solutions to his problems, he would prefer to stay in Turkey for his children and cultural reasons:

My wife wants to stay here. The culture is the same. She does not want to go to Europe; because we are afraid of our children growing up there… I think I may work in a beauty center to do things like laser, filler, etc. I do not want to start again the general surgery for 5 years. No, no, of course not! What I need here is the citizenship…(Mostafa)

The participant doctors' choice of staying in Turkey, despite other opportunities to go to more career-promising destinations, was not in line with the assumed motivations about the highly skilled migrants. They were waiting for a

solution about their license recognition issue, since they valued highly the social and cultural drivers in Turkey.

5.3.2 Going to another country

Mostafa, Faisal, and Ali said that they would consider going to a third country. Mostafa was challenged by the structural factors of not having work permits and citizenship and felt himself forced to leave Turkey. He was studying German and getting prepared to go to Germany. Although he wished to stay, he lost his hopes of overcoming his problems in Turkey. He also mentioned that he was having troubles to get the required exit permit leaving Turkey and believed that being a doctor prevented him from getting it:

> *I applied to the refugee organization about my child with have autism. They want to me to go to Canada or the UK for this situation. But because I am a doctor under TPS, my application to go abroad has been refused. If I go to Germany, I can get a diploma of general surgeon and become a specialist. But without Turkish citizenship, I even may not go to Germany as a Syrian doctor with TPS. (Mostafa)*

Faisal said that if there was an opportunity for a better life abroad, he wanted to go. He said his reasons were probably the same as the reasons of a Turkish doctor. Nonetheless, he was happy in Turkey and it would sadden him if he would leave:

> *Doctors in Turkey would generally say that they want to go. I wish I also had that opportunity. So, wanting to go is not only my opinion. Working conditions are heavy in Turkey, too much task, but compensation is not matching. I would go to another country, since being a doctor in Turkey is really difficult. If I have the opportunity, I would go to other countries.* [xvi] *(Faisal)*

For participants, the main reason for leaving Turkey was the better job prospects, especially in Germany. They described the professional opportunities there for themselves as almost too perfect to be true. They gave examples of Syrian doctors who took refuge in Germany and had very promising career developments or a smooth transition. Even for Yousef, who attributed higher significance to the cultural/religious values in Turkey preferred to be in Germany. When asked about the culture factor in Germany, Mostafa mentioned that some of his friends in

Germany did not like the culture there and after obtaining the medical diploma, they were planning to move to other Arab countries. Since the German diploma would provide a solution to the documentation problem about their skills.

Since the participants were moving with their families, they attributed value to the host culture as much importance as they did for their career perspectives. For instance, Fatima and Jamal were keen on their career and comparing their situation with the Syrian doctors in Germany, still they preferred to stay in Turkey and wait for a solution in Turkey about their skill recognition problem. In their cases, the cultural values, family integration, and closeness to the homeland had been more important than their careers until now.

5.3.3 Returning to Syria

Returning to Syria was related to the security the participants would have there. All participants believed that without the end of Assad regime, they could not go back to Syria because of the high risk of being arrested and maybe even killed. Hussein worked in north Syria for 2 years while residing in Turkey, but currently he focused on his career development in Turkey. Fatima, Jamal, and Ahmad were performing some operations in northern Syria by going back and forth from time to time. Suleiman said that he could return to Syria if the situation there would be better. Ali mentioned he had no family members other than his wife and children in Turkey. His mother and father were in Syria. He wanted to take care of his aging parents and considered this his duty to them. Therefore, he would return to Syria, if he could. Last, even if the regime changes Mostafa and Yousef stated they did not want to go back to Syria:

> *You need 10 years to repair Syria. The problem is not just about the buildings. It is in the spirit. It is between the people... (Mostafa)*

> *Unless Assad is out of the government, I cannot return to Syria, because if I go back I will be arrested immediately. Moreover, I do not want to return. We have two problems in Syria: security and the regime. Even if the regime changes, without security we will not return, since after a war it could take 10-20 years to bring back security.* [xvii] *(Yousef)*

As far as the return to Syria is considered, the main criterion of the participants was related to the security situation there. Unlike a refugee movement, the circumstances in Syria, such as the presence of opposition-controlled areas, made temporary visits to Syria and performance of medical operations there possible. However, a permanent return is unlikely for the participants unless there is a regime change in Syria, or even there is a regime change.

CHAPTER 6

CONCLUSION

This thesis aimed to analyze the career rebuilding efforts of Syrian refugee doctors in Turkey by elaborating on the interplay of their two separate identities: being a high-skilled migrant and being a refugee. To this end, in-depth information was collected via semi-structured interviews exploratively and then the narratives were analyzed. The Syrian War created a breakpoint in the lives of Syrian refugee doctors and initiated their migratory movements. Thus, the war was used as a temporal guide to explore the migration trajectories of the participants and the analysis was conducted by focusing on the before-war and after-war experiences of Syrian refugee doctors. The study offered a perspective on the subjective experiences Syrian of refugee doctors who were struggling to re-establish their professional identity and lives in Turkey.

6.1 Implications of the study

In-depth information collected from the narratives revealed that the migratory movement of the participant Syrian doctors was not a calculated choice, but it was forced upon since none of them had plans to leave their countries if the war did not happen. They did not have economic reasons or labor market drivers. The suppression of the Syrian regime against its people, created by the anti-democratic practices such as banning medical treatment to wounded people pushed Syrian medical doctors into a situation of Sophie's choice: they either would provide medical help to people harmed by state violence and risk their own lives or they would not treat the wounded people by dishonoring their Hippocratic oaths. They stayed loyal to their ethical duties as doctors; however, they became targets of state persecution by doing that. Eventually, they ran away from those direct threats to their well-being and safety and became refugees.

As highlighted in the literature, the transferability of skills from one country to another is the most important driver of high-skilled migration. Unlike the migrant

professionals working in financial sectors such as computer technologies, the highly skilled migrants of the welfare sectors and of traditional jobs, i.e. doctors and educators need to comply with strict state regulations in the destination countries. Inability to comply with these prerequisites is one of the major reasons for deskilling and the increased share of overqualification of high-skilled migrants. In Turkey, the healthcare labor market has only recently and partially opened to foreign medical professionals. Therefore, access to the labor market for foreigners is still very limited and the power of regulating official bodies of healthcare is very high. Furthermore, the sectoral regulations on skill recognition encompass uneasy licensing procedures and examinations that demand serious time, effort, and material costs. All these aspects were influential on the career rebuilding experiences of Syrian doctors in Turkey. The narratives of the participants were in line with the literature in terms of the challenges they faced in labor market integration in the welfare sector as highly skilled professionals. To sum up, the participants of the study were struggling with deskilling and being overqualified because of the heavy rules and regulations of the Turkish healthcare sector.

The challenges in skill recognition further implied that Syrian doctors were subjected to additional structural difficulties that other foreign doctors did not have. As mentioned throughout the thesis, licensing of foreign doctors in Turkey is composed of two stages: getting diploma equivalence via passing the medical degree exam (*STS*) and getting specialty equivalence for the medical expertise. The first step takes at least a couple of years for the participants to pass, while it is a universal process for highly skilled migrants and high-skilled refugees alike and based on the personal efforts of the applicants. Some participants already passed this stage. On the other hand, none of the participants succeeded in completed the second stage and getting recognized for their medical expertise.

In this second stage, the recognition of the applicant's medical specialty is realized through documentation of the related training. The Turkish MoH requires all Syrian documents to be authenticated with the stamp of the Syrian diplomatic mission in Turkey. However, the participants being refugees were *de facto* denied the right of document authentication at the Syrian Consulate. This is a structural limitation as state punishment and eliminating it is out of the power of participants. This example indicates that a homogeneous application of the standard skill recognition criteria to refugee medical professionals and immigrant medical professionals contributes to the deskilling or unemployment of participants in this study. Considering the special circumstances of the refugee doctors, specific

adjustments in the skill recognition criteria for refugee medical professionals are needed to help to overcome the bureaucratic and political factors that impede the skill transferability and labor market integration of Syrian doctors in Turkey.

The study showed the ways becoming refugees interrupted the careers of participants. Their professional skills were still waiting to be recognized in Turkey, and even receiving citizenship did not help to relieve the problem. Nevertheless, the adaptation abilities of Syrian doctors were high and they were willing to integrate into the Turkish healthcare system. One way or the other, all of them were working. This sample of 9 Syrian doctors, despite its humbleness, provided valuable insights into the Syrian refugee doctors' perspectives on working in Turkey and on being employed at the MHCs. The employment of Syrian doctors at the MHCs, which operate under the framework of the SIHHAT project, was a significant initiative of the Turkish MoH, together with the EU and WHO. However, this employment model was not appealing to all participants. They all were medical doctors whose careers were interrupted; but their previous experience, age, and other skills differentiated their decision-making and work choices.

For instance, the self-perceptions about being a highly skilled professional were dominant for the participants who were established doctors in their medical specialties and who had greater international experience. They were more resistant to the work options that involved deskilling. Especially the surgeons among participants rejected working at MHCs as GP doctors, with the considerations of overqualification and "irrelevance". Instead, they preferred to work either as surgeons, albeit with its illegality, or out of the medical service. On the other side, the participants who were junior doctors or who were unemployed were more appreciative of the employment at MHCs, since these centers offered economic stability. In summary, the approaches of the participants to the employment at the MHCs can be regarded as a litmus test. Some of them welcomed the opportunity, while some of them rejected it. Their choices imply that integrating Syrian doctors to Turkey is unlikely to be realized by homogeneous employment policies and the non-uniformity of Syrian doctors in skill level and medical specialty needed to be taken into consideration for more effective policymakings.

Despite the modest size of the sample, the age variety of participants implied an age-related migration pattern for the labor-market integration. For young and junior doctors, who had less professional experience and a long career ahead, the adaptation requirements of the host-country labor market were more likely to be accepted as they were. In this regard, only the youngest participants repeated medical studies in Turkey or planned to repeat their specialty training. On the other hand, middle-aged and elder doctors were more resilient to deskilling practices since they were at a mid-point to their career, they had greater family obligations, and starting from scratch by re-studying/re-training was a strategy for them. Instead, they relied on their prior experience and already acquired skills and prefer to continue searching for a feasible solution to their skill recognition problem.

The heterogeneity of Syrian refugee doctors in Turkey is also related to their official status of residence in the country. Participant doctors who received Turkish citizenship are free from several bureaucratic procedures that significantly ease their way of living in Turkey, as well as increase their profession-appropriate work options. Being under TPS was a constant reminder of their refugee status due to the legal requirements and limitations that TPS brings. Having the Turkish citizenship or not, participants still bore the consequences of being refugees in their professional lives. They were yet to reach the point of being recognized for their skills and as highly skilled professionals, without being deskilled and without the limitations of being refugees who ran away from state violence. Yet, an important implication was that none of the participants perceived themselves as "refugees" in the sense that they were needed to be taken care of. Their self-perception as care providers and their professional identities as doctors, combined with their work experience, were exceeding their Syrian identity. Despite all the heterogeneous characteristics they possessed in experience, area of expertise, age, sex, and official status, they were homogeneously perceived themselves as professional Syrian doctors but not Syrian refugees. This finding was an important consideration for the title of this thesis, in which the participants were referred to as "refugee doctors". However, given their professional struggles, their work-related experiences in Turkey were better defined by the limitations of refugeetude, instead of problems related to high-skilled migrants.

Last, in this thesis, the professional integration struggles of Syrian refugee doctors were analyzed at the micro-level, based on their subjective narratives. Participants mostly focused on the skill recognition problems in Turkey, and the heterogeneity of Syrian refugee doctors partly explains their problems regarding their market integration. However, it is equally important to acknowledge the current problems of the Turkish health system that the participants want to be part of. For instance in Turkey, the issuing of work permits to foreign doctors has been being practiced only since 2010. There are also certain details of the stages of getting the equivalence that are worth of further consideration: Refugee doctors are exempted from the diplomatic stamp requirement on their documents only for medical diploma of GP, but not for the further medical specialty. These practices are most likely the results of macro state decisions, based on supply and demand dynamics of the healthcare labor market in Turkey. Thus, the matter of integration of the Syrian refugee doctors is not immune from the sectoral needs, gaps, and difficulties that also challenge the Turkish doctors. Besides, recently the number of Turkish doctors leaving Turkey and emigrating to other countries such as Germany and the UK has been increasing rapidly. Indeed, most currently, the resigning of Turkish doctors one after another has become a hotly debated topic of public discussions and is likely to be the indicator of significant systemic problems. All these are interesting developments in the Turkish healthcare sector that necessitate further consideration and would provide a wider perspective on the employment prospects of Syrian doctors in Turkey.

To sum up, by answering the initial research questions of the study, this thesis provides insights into the professional migration experience of Syrian refugee doctors and their coping strategies with the challenges of being high-skilled in Turkey and being displaced. It is believed that the study may contribute to the highly skilled migration literature in three areas: first, by detailing the interaction between the two different identities of the high-skilled refugees (professional migrant vs. refugee); second, by refining assumptions about highly skilled migrants and refugees, and third, by clarifying the labor market struggles of Syrian refugee doctors in Turkey. The analysis showed that the assumptions in the literature about refugees and highly skilled migrants were not enough to explain the problems, needs, and

ways of dealing with them for Syrian doctors. Elaboration of their market integration problems and views about the employment at MHCs pointed to the heterogeneity of the Syrian doctors and to the need for varied/custom-made practices and policies to prevent deskilling and skill wasting. Working in the welfare sector and being refugees, Syrian doctors were prone to additional barriers during their integration processes and therefore to deskilling. Last, it was also important to acknowledge that in the 10th year of the Syrian War; the participants were willing to practice medicine in Turkey and did not consider leaving for another country despite the challenges they face. However, their integration problems cannot be fully understood without understanding the concerns of the Turkish healthcare system.

6.2 Limitations of the study

By the nature of the qualitative study, the findings of the study are not representative of all Syrian refugee doctors in Turkey. Rather, it collects the individual experiences of the participant doctors. An important limitation of the study was the ongoing Covid-19 pandemic. The spreading-prevention measures, such as social distancing and travel limitations did not allow data collection via face-to-face interviews. Covid-19 measures also limited the opportunities for in-person meetings with potential candidates during the sampling process. Another limitation of the study was gender-wise since the sample included 1 female participant. Gender studies show that familial and social norms affect skilled female migrants differently than male ones. Having only 1 female participant did not provide data for analyzing the gender dimension of study subject. Last but not the least, the experiences of Syrian refugee doctors in licensing and skill recognition processes is cannot be considered independent of the labor market dynamics of Turkish healthcare sector and the work-environment troubles of the Turkish doctors. However, the scope of this study was framed to cover the individual experiences of the participants; therefore, the effects of the labor market dynamics of health sector were not present in this study.

6.3 Recommendations for future studies

Further research could be built upon the finding of this thesis. For instance, a study on the immigration and health sector protection policies of Turkey regarding foreign workforce could provide a wider picture about the employment struggles of Syrian doctors in Turkey. Second, a gender perspective on the experiences of highly skilled doctors is an important gap in the literature with no previous studies yet. Last, a longitudinal study on the experiences of Syrian doctors in Turkey would be interesting to observe the evolution of struggles on skill recognition and their integration process to Turkish health system.

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APPENDICES

A. Interview Questions

Personal ID

1. Can you briefly tell me about yourself? (age, family, medical expertise, city)
2. What is your migrant status in Turkey? (i.e. visa, under temporary protection, refugee)

Life in Syria as a doctor before the War

3. How and why did you become a doctor?
4. Can you describe your education and career until now?
5. How was your social status as a doctor?
6. Do you think females in Syria have the same opportunities that males have to work as a doctor?
7. What changed with the war in your environment?

Migrating to Turkey

8. Why did you decide to come to Turkey?
9. Can you describe your journey to Turkey?
10. Was being a doctor a major factor for your immigration?

Being a doctor in Turkey

11. Did you have to work in another job in Turkey (not as a doctor)?
12. How did you start working as a doctor in Turkey?
13. Can you compare your work environment in Turkey and Syria?
14. What are the obstacles you face as a doctor in Turkey because you are Syrian?
15. How is your career affected by coming to Turkey?
16. Do you know about the Migrant Health Centers? Do you want to work there?

Being a migrant

17. Can you compare your life in Turkey immediately after the migration and now? What are the differences?
18. How do you feel about your status today in Turkey?

About the Future

19. Expectations and dreams about the future
20. Anything you would like to add...

B. Profiles of the Participants

Pseudonym	**Sex**	**Age group**	**Marital status**	**Location in Turkey**	**Living in Turkey**	**Legal status in Turkey**	**Medical specialty (as described by the participant)**	**Professional stage pre-War (2011)**	**Year of obtaining Turkish medical license**
Ahmad	Male	45-50	Married	West	6 years	Turkish citizen (2 years)	General surgeon	11 years	2020 - by STS[a]
Ali	Male	30-35	Married	West	3 years	TPS	General practitioner	5th year medical student	2020 (has Turkish diploma)
Fatima	Female	40-45	Married	South	6 years	Turkish citizen (4 years)	General and laparoscopic surgeon	10 years	2021 - by STS
Jamal	Male	50-55	Married	South	4 years	Turkish citizen (4 years)	General and trauma surgeon	21 years	2020 - by STS
Mostafa	Male	40-45	Married	West	3 years	TPS	General surgeon	4th year resident[b] in general surgery	2020 - by STS
Yousef	Male	40-45	Married	West	8 years	TPS	Pediatrician	5 years	2021 - by STS
Hussein	Male	35-40	Married	South	2 years	Turkish citizen (1 year)	General practitioner	3rd year resident in neurology	-
Suleiman	Male	55-60	Married	West	7 years	TPS	Radiologist	24 years	-
Faisal	Male	25-30	Single	South	6 years	Turkish citizen (1 year)	General practitioner	4th year medical student	2019 (has Turkish diploma)

[a] STS (Level Determination Examination) is the written examination of assessment in the field of medical doctorate. STS is in Turkish and held twice a year.

[b] A resident is a doctor who is graduated from medical faculty and still training in his specialty program for 3 to 7 years.

C. Summary Demographics of the Participants

	Variant
Number of participants	9
Median age (years)	43
Sex distribution	
Female	1
Male	8
Marital status	
Married	8
Single	1
Medical Specialty	
General Surgeon	4
Radiologist	1
Pediatrician	1
General Practitioner	3
Place of Living (5 cities in total)	
Western Turkey	5
Southern Turkey	4
Legal status	
Owning Syrian citizenship	9
Owning both Syrian & Turkish citizenship	5
Under temporary protection	4
Employment sector	
Public	4
Private	5

D. Ethical Committee Approval of TED University

İnsan Araştırmaları Etik Kurulu 2021/06
Etik Kurul Kararları

TED ÜNİVERSİTESİ
İNSAN ARAŞTIRMALARI ETİK KURULU
ETİK KURUL KARARLARI

Toplantı Tarihi	28.05.2021
Toplantı Sayısı	2021/06
Toplantı Yeri	Dekanlık Toplantı Odası
Toplantı Saati	
Toplantıya Katılanlar	

Raportör:

Gündem: Ted Üniversitesi İnsan Araştırmları Etik Kurulu Toplantıları COVİD-19 salgını nedeni ile online yapılmış olup kararları toplu olarak yazılıp e-imza ile imzaya açılmıştır.

GÖRÜŞME MADDELERİ

G.13: TED Üniversitesi, Sosyoloji Bölümü Öğretim Üyesi Prof. Dr. Kezban Çelik'in "Bir Mülteci Nitelikli Göçmen Örneği: Türkiye'de Göçmen Sağlığı Merkezlerinde Görev Yapan Geçici Koruma Altındaki Suriyeli Hekimler" başlıklı çalışmasının araştırma etiğine uygunluğu görüşüldü.

Karar 2021-06/13: TED Üniversitesi, Sosyoloji Bölümü Öğretim Üyesi Prof. Dr. Kezban Çelik'in "Bir Mülteci Nitelikli Göçmen Örneği: Türkiye'de Göçmen Sağlığı Merkezlerinde Görev Yapan Geçici Koruma Altındaki Suriyeli Hekimler" başlıklı çalışmasının başvurunuzun araştırma etiğine uygun olduğuna

OYBİRLİĞİ ile ONAY KARARI VERİLDİ

Toplantı saat 12:00'de sona erdi.

E. Informed Consent Form

Dear Participant,

This thesis study is carried out by Betül Merve Topaloğlu, a student at the Graduate Program of TED University Migration Studies (Ankara) under the advisory of Prof. Dr. Kezban Çelik. The aim of the study is to learn about the migration experience of Syrian Physicians, who as high-skilled refugees have the temporary protection status and work in Turkey at the Immigrant Health Centers or anywhere else.

If you approve, you will be a participant in this study titled "High-skilled Refugees: The Case of Syrian Physicians working at Immigrant Health Centers in Turkey" between 01/06/2021 and 01/12/2021. Accordingly, you will be invited to a scheduled interview (face-to-face, via videoconference, or via telephone) by the researcher. Without your permission, your identity will not be shared with anyone other than the researcher during and after the study. If you permit, the audio recording of the interview will be taken and this recording will only be used for making a transcription of the conversation. If you do not allow the audio recording, the researcher will take hand notes of the conversation with your consent. The scientific outcomes of the study will be presented only by the researcher in scientific publications, presentations, and for educational purposes. Your name will be deleted from the collected data and this data later will be kept in an encrypted computer file, until the completion of the research. After the study is completed, all the data collected will be deleted and terminated.

Participation in this study is completely voluntary. Please be aware that if you decide to take part, you may stop participating at any time and you may decide not to answer any specific question. Your participation in this research may not make a direct contribution to you. Nonetheless, it may inform you about how your personal migration experience is academically researched and can contribute to scientific information. During this 40-minute interview, some questions may remind you of your experiences, causing you to feel more stress than daily stress. If for any reason you feel uncomfortable, you are free to suspend or leave the interview without explanation. If you decide to quit research, there will not be any negative consequences. In case of an exit, the information you provided during the interview will be used only if you give consent to it. At the end of the form provided the contact information of the institutions and organizations, where you can get free psychological support and help in case you feel emotional stress.

Thank you in advance for your participation in this research. If you have any questions, you can contact the researcher Betül Merve Topaloğlu

I participate in this work voluntarily and I know that I can quit the research whenever I want. I know that I will take part in a conversation about my personal experiences within the scope of this study. I accept the information I provide to be

used in scientific publications. If my voice recording is taken during the interview, I know that this voice recording will not be used anywhere else.

I want to participate in the study. Yes / No

I accept voice recording of the interview. Yes / No

I agree to notes taken by hand by the researcher during interview. Yes / No

Participant's Name Surname:.....

Participant's Signature: .....

Date: .....

With thanks,

Researcher's Name, Surname and Signature

Betül Merve Topaloğlu

If you have questions about your participation in the research and the protection of your rights, or if you believe that you are at risk or will be exposed to stress in any way, you can contact TED University Human Research Ethics Committee

Institutions and Organizations that Provide Free Psycho-social Support Services

...

F. Original Turkish Excerpts

i. Aslında ben biyolojik şeyleri çok seviyorum. İnsanlar, hayvanlar, genel olarak çok seviyorum. Bir de ben insanlara yardım etmeyi çok seviyorum. (Ali)

ii. Suriye'de her doktorun özel muayenehanesi vardı. Yani ben açıyordum, parası bana aittir. Mesela cerrahlar, buradan en az 20 kat, 30 kat, belki 60 kat daha fazla alıyordu. Biz çocukçular, belki 10 kat, 15 kat daha fazla alıyorduk. Maddi durum Suriye'de çok daha farklıdır. Evlerimiz, arabalarımız vardı... (Yousef)

iii. Sıkıntılı bir yerden çıkıyordum, orada bir ilk yardıma katılmıştım, bir sahra hastanesinde. Sonra bölgeden çıkıyordum, rejimin kontrol noktası vardı. Çıkarken kimlik denetimi yapılıyordu, kimliğimi verdim. Askerlik olayını sordular. Tıp öğrencisiyim dedim. Öğrenci kimliğimi verdim, o zaman da şüphelendi. Ayakkabımda kan noktaları vardı, ben de dikkat etmedim. Onu gördükten sonra "Sen içerde çalışıyordun doktor olarak, muhaliflere, terörist yani onların tabiriyle, yardım ediyordun" dedi. Beni tutukladılar. Torpil olayı ile çıktım hapisten, yoksa torpil araya girmeseydi ben orada öldürdüm. Çünkü olay 2012'nin sonunda oldu. O zaman tutuklanan direk ölüyordu, şakası yoktu yani. Özellikle bu suçlar da, insanlara, muhaliflere özellikle tıbbi yardımda bulunan insanlar gerçekten ölüyordu yani. Benim tanıdığım çok arkadaşım ölmüştü yani.(Faisal)

iv. Benim arkadaşım 2014'te buraya geldi. Şu anda Almanya'da. Diplomasını pratisyen hekim olarak aldı, ondan sonra çocuk diplomasını kazandı. Şu anda çocuk onkoloji çalışıyor. Yani üçüncü uzmanlık yapıyor. Diğer arkadaşım şu anda Almanya'da genel cerrahi çalıştı. Genel cerrahiden sonra ikinci bir uzmanlık yaptı. Şu anda kendi hastanesinde profesörün altında direk kendisi çalışıyor. Ben denklik sınavını dört ay önce kazandım. Arkadaşlarım Almanya'da var, İspanya'da var, Amerika'da var. Dediler:Zekeriya biz şu an uzmanlığı bitirdik, ikinci uzmanlığı bitirmeye yakın olduk. Sen sadece pratisyen gibi daha bitirmedin. Daha böyle yani, sıkıntı var.

v. Şu an 5600 civarında denklik alan Suriyeli doktor varmış. Bence bu Türkiye için çok büyük bir kayıptır. (Faisal)

vi. Hiç sevmiyordum. O iş doktorluk değil. Göçmen sağlığı merkezlerinde çalışmak stressiz bir iş çünkü kötü hasta gelmiyor. Sadece ilaç yazdırmaya geliyor hastalar. Ama gerçekten iş yükü çok fazla iğrenç bir iş,.Neden? Muayene ücretsiz olduğu için, ilaçlar ücretsiz olduğu için herkes ilaç yazdırmaya geliyor. Ücreti yok çok da bir değeri yok. Ama rahat bir iş. Kış

aylarında günde 100-150 hasta baktığımız oldu. Mantıklı bir rakam değil bu. İş yükü bu rakama göre maaş çok iyi değildi. Türkiye'de bu maaş alan başka bir doktor yok heralde. Beni en çok rahatsız eden sıkıntı, müdürlerin ya da sorumluların tarafından doktor yerine konulmamak idi. Ezmeye çalışılmak, saygısızlık yapılması. (Faisal)

vii. İlk geldiğimde doktor değildim. İnşaatta çalıştım, garsonluk yaptım, turizmde çalıştım, tercümanlık yaptım. Bu kadar uğraşmaya değer mi, bilemiyorum. Geçim, ailesi olan insanlar için çok büyük sıkıntı. GSM projesi çok kafi değil ama bence önemli birşey. Adam işsiz kalacağına GSM'de çalışsın, STS'ye hazırlansın, para kazansın. (Faisal)

viii. Şu anda biz 4 yıldır çocuklar öksürüyorlar, ishal, kusma, nezle bitti. Bu tıp değil, hakikaten bu tıp değil. Yani sadece böyle yani. Yani uzman hastanede çalışmadıysa, her gün arkaya dönüyor bilgisi. Şu anda ben 8 yıldır hastaneye girmedim. Yoğun bakımda çalışmadım. Küvez Şubesinde çalışmadım. Bu bene çok sıkıntı. Şu anda bugün Suriye'de savaş bittiyse, Suriye'ye döndümse, en az bir 6 ay bilgilerimi tekrar almak zorundayım. Yoğun bakımda çalışmak nasıl, küvezde çalışmak nasıl, ciddi hastalarda, onkolojide, metabolizma hastaları yani farklı. (Suleiman)

ix. Şu anda biz burada hakikaten doktor değiliz. Biraz zor, yani böyle çalışmak zor *(gülüyor)*. Bazı zamanlarda, bazı arkadaşlarımız aynı Türk doktor gibi çalışıyor ama bize farklı. Şu anda mesela corona başladı, corona başladıktan sonra biliyorsunuz Sağlık Bakanlığı dedi herkes çalışıyor, maaşların %20'si, %30'u daha fazla verdiler. Sonra dedik "Bize niye vermiyorsunuz aynı şekilde çalışıyoruz? Corona herkesi etkiledi, arkadaşlarımız corona kazandılar." Bize dediler "Siz anlaşma sadece. Maaşınız bu kadar"... (Yousef)

x. Dün benim kızım diyordu, baba senin evlendiğin zamanda fotoğraf yok? Dedim vardır, hatta film vardı, ama bütün fotoğraflarım, bütün eşyalarım evde kaldı. Sonra Çalındı. Yani çok zor. Eski hayatın tamamen kayboldu Şu an sen sıfırdan başlıyorsun. (Yousef)

xi. Ama bu sadece benim çabam değil. Gerçekten karşılaştığım insanların sayesinde. Öğrenciykende gerçekten çok büyük yardımlar yapıldı bize. Hocalarım tarafından, sınıf arkadaşlarımız tarafından. Hatta Suriyeliz diye, sözlü sınavlarımız vardı okulda, hocalar gerçekten yardım ediyordu. İnsani durum olduğu için, yabancı olduğumuz için, büyük bir travma yaşadığımız için, gerçekten bizi bırakmak isteyen hocalar yoktu. Akdeniz Üniversitesine genel olarak çok büyük bir teşekkürüm var. Bu sadece benim kendi çabam değil, belki benim annemin duası. Şu an çalıştığım bölümde 13 kişiydik, bir ben Suriyeliyim. Ama gerçekten onların arasında kendimi hiçbir kere olsun yabancı hissetmedim. (Faisal)

xii. Bazen hastanede çalışırken mesela bir hastayla sıkıntı yaşıyoruz, hastayla tartışıyorum ya da kavga ediyorum. Sonra çalışma arkadaşlarım gelip sen tam Türk olmuşsun falan diyorlar Hiç kimseye saygısızlık yapmıyorum, işimi yapıyorum yani. Türkçe bildiğim için, savunma yapabildiğim için çok büyük bir sıkıntı yaşadım. Diğer doktorlar böyle çok fazla Türkçe bilmedikleri için, ya da başka bir seçeneği olmadığı için çok sesini çıkaramıyor. (Faisal)

xiii. Şu anda ben göçmen sağlığı merkezinde çalışıyorum, sadece Suriyelilerle çalışıyorum. Sıkıntı yok (gülüyor).

xiv. Bizim çocuklarımız için bu çok zor yani. Bir yerde yaşıyorsan, herkes sana diyor istemiyorum seni, yani biraz zor. Ama sabır yani bilmiyorum ne yapacağız, bilmiyorum. Diğer taraftan, Türkiye'de Suriye'nin aynı kültürü var; dini kültürü, camilerde namaz falan. Bunun için gitmedim çünkü benim kızlarım başısı kapatmış,yani hicap. Almanya'da sıkıntı var yani. Ama benim çocuklarım küçükse ben direk Almanya'ya çıkarım yani (gülüyor). Çünkü burada bize vatandaşlık vermediler, biraz sıkıntı… (Yousef)

xv. Dün mesela otobüse çıktım (bindim). Bir tane arkadaş Azerbaijani de çıktı. Maskesini taktı. Hes kodu bağlantı değildi. Şoför, kendisine otobüsten inin, hes kodunuzu bağlayın sonra binin dedi. Bir tane Türk kadın ne dedi? "Türkiye'de bir tane Türk kalmadı." (Yousef)

xvi. Yani bu soruyu aslında bir Türk hekimine sorarsanız aynı cevabı verebilir. Doktorlar olarak herkes gitmek istediğini söyleyecek, keşke fırsatım olsa gidebilsem. Yani bu bana has bir şey değil. Çalışma şartları kötü. İş ki çok fazla, karşılığı değil. Fırsatım olsa ben giderim. Yani başka bir ülkeye geçerim çünkü doktorluk yapmak Türkiye de gerçekten zor. Fırsatım olursa başka bir yere geçmeyi düşünüyorum.

xvii. Beşar Esat hükümetten çıkmadığı sürece ben dönemem. Dönmek istesem de dönemem çünkü direk hapishaneye çıkarım. Ayrıca Esat gitmeden dönmek istemem. Siyasi durum İyileşirse dönebiliriz. Suriye'de şu an iki sıkıntımız var: güvenlik ve rejim. Rejim değişse bile güvenlik yoksa gitmiyoruz, çünkü biliyorsunuz savaştan sonra güvenlik sıkıntısı bir 10-20 yıl sürebilir. (Yousef)