Piet Groot

Born abroad studied here

a historical and psychological account of migrant doctors integrating

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a historical and psychological account of migrant doctors integrating

In het buitenland geboren, maar hier opgeleid: een geschiedkundig en psychologisch verslag over de integratie van migrant-artsen

(met een samenvatting in het Nederlands)

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Chapter 1

General introduction: On the transdisciplinary study of migrant integration

"Door Vreemdelingen moeten, ten deezen respecte, verstaan worden, alle dezulken, die hier ter Stede niet geleerd hebben, en waar van des het Gilde, nimmer eenig voordeel genooten heeft."[a]

Reglement voor het chirurgijnsgilde (1796), p. 19

Opening

People have migrated since the dawn of humankind. But the nature and volume of migration has been subject to change. It is estimated that in 2020 about 3.6 per cent of the global population – a whopping 281 million people – could be categorized as an international migrant (IOM, 2022). That is an 83% increase since 1990, which exceeds the rate at which the global poplation has grown in that same period (from 5.3 billion to 7.8 billion, or rougly 48%). Wars, poverty, and climate change may come to mind as causes for recent surges in international migration, and these are indeed contributing factors – just think of the many international refugees resulting from the Syrian and Russo-Ukrainian wars (UNHCR, 2022). This seems like a recent development, but once we take a step back, it becomes clear that international migration has been seeing a rising trend ever since the Second World War. Advancing technology like cars and aeroplanes meant that international migration became affordable to more and more people, and that it became easier to stay in touch with distant relatives through telecommunication. In addition, the collapse of the Soviet Union and the subsequent easing of tensions between former East and West European countries meant that barriers to migration, such as visa requirements, were reduced. Simultaneously, many countries of the Global South, previously backed by the Soviet Union or Western countries, like Afghanistan or Zaire (now the Democratic Republic of Congo), fell prone to economic decline and internal turmoil. The increase in international migration resulting from these technological and political developments is sometimes referred to as the 'second wave of globalisation' (Jennissen et al., 2018).

Not only did this second wave of globalisation come with more international migration than ever before, it has also led to a *more diverse* migration. This can be felt in the countries that receive many international migrants, such as the Netherlands. Whereas traditionally the Netherlands had received migrants primarily from neighbouring Belgium and Germany, and later from a select few countries like the former Dutch Indies, Surinam, Morocco, and Turkey, this picture as of late has become much more diverse. In what is called the 'post-industrial wave' of migration (White, 1993), the Netherlands has seen an increase in asylum seekers, irregular migrants, but also highly skilled migrants. These groups of migrants come from a large range of countries (Jennissen et al., 2018). The diversity in cities like Amsterdam, The Hague, or Rotterdam is such, that if currently any two random people

[a] English translations of quotations can be found in the Appendix to the General Introduction (pp. 40-41).

were to bump into each other on the street, there is an over 70 per cent chance that they have different origins.[b]

This diversification does not come without challenges. A carefully planned study in the Netherlands has shown that people living in ethnically diverse neighbourhoods experience less social cohesion, feel more unsafe, and less at home than people living in ethnically homogeneous neighbourhoods (Jennissen et al., 2018). There may be multiple causes for this finding, of which the relatively poor position of migrants in the Netherlands – compared to native Dutch – perhaps comes to mind first. And indeed, in 2018, migrants had not profited from the recent economic growth: they were 2 to 3 times more often unemployed than their native Dutch counterparts, and earned on average €4 less per hour worked (W. Koolmees, public communication, 2018).

Importantly, however, this was not just the case for low-skilled migrants but also (although to a lesser extent) for highly educated migrants (Huijnk & Andriessen, 2016). This points to causes which go beyond differences in the structural position of migrant workers. Despite scoring well on structural measures of integration such as education level, for example, many people with a migration background in the Netherlands report feeling unwelcome in Dutch society (Dagevos et al., 2022). And accordingly, the finding that people living in ethnically diverse neighbourhoods experience lower social cohesion, feel less safe, and less at home, was not just observed in poor neighbourhoods with low average education level, but also in relatively wealthy and educated neighbourhoods, such as those with a high percentage of labour migrants who call themselves 'ex-pats' (Jennissen et al., 2018).

If we consider social cohesion to be an important aspect of society, this finding poses a problem. The Netherlands is projected to become even more diverse in the future, but it would be bad if this led to feelings of diminished social cohesion. Understanding under which conditions ethnic diversity does lead to social cohesion is therefore important. To study this, the current dissertation focuses on a group of highly skilled migrants, and their integration into their local social and professional surroundings: doctors. Since positive expectations exist about doctors (Nicolas et al., 2022), and migrant doctors are actively recruited by many Western countries (Baker, 2019; Negin et al., 2013), this group of highly skilled labour migrant may perhaps not be the first to come to mind when thinking of the challenges associated with migrant integration. However, migrant doctors face considerable and often enduring challenges in trying to fit in their new work environment (Dywili et al., 2012; Jalal et al., 2019). Furthermore, medical students with a migration background have been found to experience negative treatment on the basis of their background (Waldring et al., 2020), which hinders their academic performance (Stegers-Jager et al., 2012). In other words, migrant doctors are facing problems with their integration despite their relatively strong position on the labour market compared to other migrants. Studying the integration

[b] In this particular case, 'origin' is defined as one of 18 clusters of countries where someone, or one or both of their parents, was born. E.g., 'Netherlands', 'Turkey', 'Morocco', 'Anglo-Saxon', 'Arabic countries', 'Sub-Sahara-Africa', 'South-Asia', etc. Source: Jennissen et al., 2018

of doctors into their professional and social surroundings could thus reveal some of the more "hidden" processes behind migrant integration.

Integration, I will argue in this dissertation, is a complex phenomenon, making it difficult to study in its entirety. By focusing on the medical profession, the dissertation narrows the scope. Still, there is enough ground to be covered: the medical profession is a world in and of its own, with explicit and implicit expectations of what medical students and doctors are supposed to act like, formalised procedures that guide the entry of newcomers, and an extensive and heavily specialised education track. The integration of migrant doctors, therefore, results from a combination of education, institutional arrangements, and psychological processes that guide the behaviour of migrant doctors and their social surroundings.

This lends itself for a multi-disciplinary or transdisciplinary approach, in which institutional arrangements are investigated in tandem with the psychological processes that accompany the reception and integration of migrant doctors. For this purpose, I will present a method based on an at first sight unlikely combination of academic disciplines: social history and social psychology. This method, presented in the remainder of this General Introduction, consists of several parts. First, I outline a number of challenges associated with the study of integration, namely: defining who we speak of when we speak of 'migrants', choosing the correct level of analysis when studying integration (the level of the institution, the group, and the individual), and factoring in the effect of the time period in which we study integration. To address these challenges, I present a definition of integration that places mutual acceptance at its core, allowing me to make comparisons across levels and time periods. I then discuss the transdisciplinary academic approach, and how I used this approach by combining insights from social history and social psychology to address the topic of integration.

The General Introduction is followed by four empirical chapters in which I try to answer the following research question from different angles: *What are the institutional-, group-, and individual-level aspects of the process leading to mutual acceptance between migrant doctors and their social surroundings?* To be more specific, I study how individuals with a migration background become medical professionals through receiving medical education in the country of destination, and how this impacts their career opportunities, outlook on the medical profession, and their acceptance by their social surroundings. The reader may be surprised to find that the first two chapters take a historical approach, while the latter two chapters take a psychological approach. These two approaches complement each other, by focusing on different aspects of integration. In essence, the first two chapters focus on the structural aspects of newcomer integration: how do institutional arrangements guide the entry of newcomers into a local professional community, and what role does receiving local education play therein? The setting in which this question is studied is 18th-century Holland, with a focus on the Amsterdam Surgeons' Guild.

The final two chapters expand on an aspect of integration that was uncovered in the historical studies, namely the importance for migrant doctors of receiving education in the

destination country. If receiving medical education in the destination country facilitates the integration of migrant doctors and their social surroundings, what psychological mechanisms then accommodate this? The psychological chapters investigate how receiving education in the destination country influences migrant doctors' outlook on the medical profession, and, respectively, patients' evaluation and acceptance of migrant doctors. The setting in which this question is studied is the 21st-century, focusing on the Netherlands and the UK. By uncovering the psychological processes that accompany the integration of migrant doctors, the final two chapters pave the way for interventions targeting the formerly hidden thoughts that lead to the acceptance of migrant doctors, and thus help to improve their integration.

The foremost argument for approaching the integration of migrant doctors into their social and professional surroundings from a transdisciplinary perspective is that such an approach does more justice to the complexity of the phenomenon that is integration. Of course, taking such an approach does not come without risks – of which the biggest one is perhaps that the answer to the research question is fragmented into two parts, a historical one and a psychological one. There indeed exists a methodological and theoretical distance between the two disciplines, and the question before attempting this dissertation was whether this distance could be bridged. In that sense, the dissertation before you could be considered an experiment of whether social history and social psychology can inform each other. In the remainder of this General Introduction, I will describe how I have attempted this experiment, by combining findings from the two disciplines. The results, I hope, provide a more holistic answer to what is integration and how it can be facilitated, at least for the group of highly skilled migrants that are doctors, than could have been given using either of the two disciplines alone. Understanding the process behind the integration of this group of migrants could generate much-needed insights for dealing with the increase in ethnic diversity that is projected to take place in the near future for the Netherlands and other European countries.

On Integration

Before we can address the integration of migrant doctors into their social surroundings, it is first necessary to describe what is meant by integration, and what are some of the better-known factors that impede or facilitate it. Here, we are met by a triple challenge illustrating the complexity of the phenomenon integration. To start, when speaking of *integration*, it is first necessary to define who we mean by speaking of *migrants.* This is a group of people that is more diverse than the simple definition – anyone can be defined a migrant who moves away from their home to live in another place – seems to suggest.[c] A second challenge is that more than one academic field studies integration, and

[c] The International Organization for Migration (IOM), part of the United Nations, notes that there is no internationally recognized legal definition for "migrant". Instead, "migrant" is an umbrella term, commonly understood as "a person who moves away from his or her place of usual residence, whether within a country or across an international border, temporarily or permanently, and for a variety of reasons." (Source: IOM, 2022)

that each presents different kinds of explanations for successful (or unsuccessful) integration. These differences stem from the varying methodological and theoretical scopes between academic disciplines, most of all the 'level of analysis' at which fields identify problems and propose solutions. The second challenge therefore comes from specifying the level – or levels – of analysis at which to study the topic of integration. A final challenge may be labelled 'the temporal dimension', and comes from the fact that migration and integration have been going on for a long time, and so have the discussions about the need for, or benefit of, integrating migrants. Not only has the public discourse about integration changed over time, potentially affecting the integration process itself, but integration has also been shown to be a long-term process taking place over several years or even generations.

To tackle this triple challenge – related concepts, levels of analysis, and temporal dimension – I contacted several experts in the area of immigration and integration. Among the ten people I contacted were several historians and sociologists, one HR advisor, and one cardiologist. These were kind enough to let me interview them, and their names can be found in the appendix to this General introduction; fragments of these interviews may furthermore be found throughout. My aim with these interviews was to get a quick overview of the multi-faceted phenomenon that is integration. More specifically, I was interested in the question of what, exactly, is integration? And what factors impede or facilitate it? The answers to these exploratory questions also form the basis for this dissertation's definitive research question.

A tangle of concepts: Migrants, refugees, labour migrants, 'allochtonen', migration background, ..., etc.

"Als we het over migratie hebben, kunnen we drie groepen onderscheiden; eigenlijk heb ik het liever over "migraties". Een eerste categorie bestaat uit arbeidsmigranten: deze groep komt omdat ze hier komen werken. Een tweede categorie bestaat uit vluchtelingen/asielzoekers. Deze termen zijn in de praktijk inwisselbaar. De laatste categorie, of eigenlijk de "grote tussencategorie" bestaat uit migranten die zijn toegelaten op humanitaire gronden. Denk aan gezinshereniging of een huwelijk. De "categorie" van een migrant is van grote invloed op het soort procedures die de migrant moet doorlopen, wettelijke status, etc., en beïnvloedt zijn kansen op de arbeidsmarkt." Rinus Penninx

Before being able to speak of integration, it is necessary first to discuss who are the parties that need to do the integrating. Earlier I introduced the group of migrants as "anyone who moves away from their home to live in another place". This is a broad definition that, upon closer inspection, harbours different groups of people. Within this group of migrants we may, for example, discern people whose primary goal of migration is to find employment: these may be called labour migrants. They are not to be confused with people whose primary goal of migration is to escape war, commonly referred to as refugees or

asylum seekers.[d] The latter group differs in many respects from the first, not only in the personal experience that they take with them, but also in the way in which their social surroundings respond to them. Refugees have often had an arduous journey, from which they may be traumatised; but more importantly, they face a long bureaucratic procedure upon arrival in the Netherlands, which severely limits their opportunities to find employment (see, for critical reports, Engbersen et al., 2015, 2020). This distinguishes them from labour migrants, who often already have found employment even before migrating to the Netherlands. And finding employment, it turns out, hugely impacts the speed at which migrants may integrate into society (Dagevos, 2001; Hagendoorn et al., 2003; Huijnk et al., 2015).

A different way to speak of integrating parties is by referring to them as 'foreigners' versus 'natives' (or to use two fancy Dutch words: 'allochtonen' versus 'autochtonen'[e]). While it may seem intuitive to divide the world into insiders and outsiders, the experts currently advise against using such a simplistic distinction. 'Allochtoon' has become a stigmatised word in the Netherlands, and it does not do justice to the plurality of origins among the people who are considered such. It would be better to speak of allochtonen as 'a person with a migration background', where 'migration background' may also be further specified as, e.g., 'Turkish background' or 'West-European background'. Of course, this solution still implies that some sort of generalisation is taking place, as the 'Turkish' category harbours, for example, Alawites and Sunnites, and the 'West-European' category lumps together the French, Belgians, and Germans. The discussion about which clusters to use continues, but scientists and policy makers are advised to be as specific about someone's origins as is practically feasible and theoretically relevant (Bovens et al., 2016; Engbersen et al., 2020).

Related to the problem of how to cluster people with a migration background, is the question *when* to include them in this category in the first place. A person born, hypothetically, in an airplane from Damascus to Amsterdam, should they be classified as someone with a 'migration background' or with a 'Dutch background'? Seeing as how one's entire upbringing would be in the Netherlands (assuming that they stayed there), they might very well consider themselves to have a 'Dutch background'. But the Dutch central statistics authority (Statistics Netherlands) is much stricter, and will only consider anyone who was born in the Netherlands, *and both their parents*, to have a 'Dutch background'.[f] So,

[d] These two terms are not, strictly speaking, the same. A refugee may become an asylum seeker if they manage to migrate to another country, and ask asylum there.

[e] These words are derived from ancient Greek, where ἄλλος (allos) means 'other' and αὐτός (autos) means 'self'. Source: 'Allochtoon', Wikipedia, 2022

[f] Recently, Statistics Netherlands has dropped this classification altogether, in favour of a classification system where 'migrants' (i.e., people born abroad) are distinguished from 'children of migrants' (i.e., people with one or more parents who were born abroad). The current dissertation was not up to speed with this new development, and still uses 'migration background' to refer to migrants and children of migrants as if they were more or less one group. Children born in the Netherlands of two Dutch parents are still considered the only group to have a 'Dutch origin'. Source: Statistics Netherlands, 2022

regardless of whether someone was born in the sky above Syria or above Holland, if their parents were not also born within the Netherlands, they will have a 'migration background'. In other words, the 'migration background' category differs from the term 'migrants', in the sense that it harbours first generation migrants (i.e., actual migrants) as well as second generation migrants (i.e., the children of migrants).

Only third generation migrants and onwards (i.e., the grandchildren and great-grandchildren of migrants) are considered to have a 'Dutch background'. This makes some sense, as second generation migrants often deal with some of the same challenges that their parents dealt with or are still dealing with, on a structural level and on a psychological level (Kalter et al., 2018). The integration process, in other words, does not stop at the first generation: although second generation migrants do often improve their position compared to their parents, they also indicate that they still do not always feel 'at home' in their social surroundings (Dagevos et al., 2022).

The distinction between first generation and second generation migrants touches upon an aspect that is often overlooked when speaking of migrants. The term 'migrants' as well as the term 'migration background' namely confound someone's birthplace with the place they were brought up in. The term 'migrant' does so by implying that someone was born and raised abroad, even though it is perfectly possible for migrants to have followed education in the country they migrated to. 'Migration background' does so by lumping together first and second generation migrants, of which the second group almost per definition received education in the destination country. Where a migrant has received their education is not a trivial detail, as I will argue in the remainder of this dissertation, but contributes to the way in which migrants perceive themselves and their social surroundings, and to the way in which their social surroundings perceive and accept them.

All these decisions about how to cluster the broad group of migrants into smaller units ('labour migrants' versus 'refugees', 'Turkish migration background' versus 'West-European migration background', 'first generation' versus 'second generation', 'educated abroad' versus 'educated in the Netherlands') impact the results one will obtain when studying integration. A different classification will yield different 'origin effects': that is, the daughter of a German labour migrant will possess a different set of characteristics and skills than a first generation Syrian refugee. How to categorise 'migrants' has therefore become much more problematic than the simple definition of "someone who moves away from their home to live in another place" would suggest. Setting the boundaries of who to include in this category will impact the subsequent analyses regarding their integration, and is something that should be carefully considered by anyone who studies integration. Let us, for now, keep the word 'migrant' and its definition intact, but expand our toolbox also with the concepts 'migration background', 'labour migrants', and 'place of education'.

The current dissertation is mainly concerned with the highly skilled labour migrants that aim to become – or indeed already are – doctor. However, the category 'students with a migration background', rather than 'migrant students' is used in one empirical chapter, to broaden the pool of potential research participants. The two historical chapters study groups

of migrants, but in contrast to the usual interpretation consider anyone a migrant who moved from one town or city to another, rather than from one country to another. Finally, the education background of migrants receives attention in all four chapters.

Levels of analysis: The institution, the group, and the individual.

"In de literatuur worden vaak meerdere vormen van integratie onderscheiden. Zo is er structurele integratie, wat o.a. wil zeggen dat een migrant een baan heeft. Dan is er culturele integratie, sociale integratie, en tenslotte psychologische integratie. Een bekend model van Milton Gordon gaat ervan uit de verschillende niveaus van integratie in een vaste volgorde plaatsvinden. Het belangrijkste is dat een migrant werk vindt (structurele integratie); daarna kan de rest volgen." Maykel Verkuyten

Now that I have illustrated some of the complexity behind the word 'migrant', it is time we move on to the main show that is 'integration'. While deciding the manner in which we cluster our group of migrants will impact the results we obtain about their integration, it is but the first important step. Next comes the task of deciding which factors to focus on that may have an effect on the integration of migrant doctors into their social surroundings. Not only do these appear to be myriad, but they also turn out to work at different 'levels', that is: at the institutional, the group, and the individual levels.

First, there is the analytical level of the institution. Institutions are, broadly speaking, "humanly devised structures of rules and norms that shape and constrain human behaviour" (Caporaso & Jupille, 2022). Think of them as an organisation with specific rules, for example about which newcomers get to enter the organisation, and what rights they will obtain from doing so. Institutions can either take an open or a closed stance towards newcomers, and this not only affects how strict the entry criteria are for newcomers in general, but also how selective those entry criteria are for specific groups of newcomers (e.g., people with a migration background, Muslims, or women).

At the highest institutional level, international law, the Netherlands is committed to international treaties that govern the rights of migrants and state the obligations of the Dutch state towards immigrants. The Geneva convention and the Dublin Regulation, for example, explicate the rights of refugees seeking asylum in European countries including the Netherlands. Likewise, trade commitments, formalised in multilateral trade treaties such as GATS and CETA, determine the rights of labour migrants; etc. (Carrera et al., 2017). If the Netherlands were to decide unilaterally to change their policy towards, say, asylum seekers, it might come into conflict with these international treaties (as indeed recently happened, when the Dutch government tried to extend the waiting period before asylum seekers could be reunited with their families, a plan which did not hold up in court, Jaeger, 2022). Zooming in on the Netherlands, there are also other, lower-level institutions that impact the integration of migrants. Labour unions and employer associations are in a constant tug of war to determine the labour conditions of employees, including those with a migration

background. Sometimes, institutions – or the absence thereof – can disadvantage migrants. Labour migrants with temporary contracts, for example, who do not enjoy the protection of a union and occupy a weak position on the labour market, have recently been reported to be the victim of "labour exploitation and severe disadvantaging" (Nederlandse Arbeidsinspectie, 2022, p. 5). Public and private employment agencies are another type of institutions which mediate between migrants seeking employment and vacant jobs – something that also does not always happen fairly, as investigations into labour market discrimination have shown (Andriessen et al., 2012, 2020, 2021). Then there are institutions in the Netherlands, such as SBB and Nuffic, tasked with the validation of diplomas, something that is of great practical importance for some international migrants (SBB, 2022; Nuffic, 2022).

One particularly interesting type of institution for the integration of migrants into the labour market are educational institutions such as vocational training centres and universities. These prepare individuals (be they migrant or not) for their professional career, and as such they form an important point of entry into the Dutch labour market. These institutions struggle with the question of how to select and incorporate newcomers. Universities, for example, have the ambition to diversify their student and employee bases so that they become more representative of the population (e.g., Leiden University, 2022; University of Amsterdam, 2022). This, however, requires that the university makes some structural changes, for example in the way they recruit employees (by making the procedure more robust against the personal biases of interviewers), or by improving the introduction of new employees to the organisation, stimulating the use of spoken English in formal and informal settings, 'decolonising' the curriculum, and providing training about inclusivity at work.

With regard to the research population of the current dissertation, migrant doctors, there are some indications that medical institutions may struggle with their integration. Illustrative for this struggle is what happens when doctors who have completed their training in a different country than the Netherlands want to continue their medical career in the Netherlands. The Dutch medical institutions have strict requirements for what they consider to be sufficient medical skill for migrant doctors. Among those requirements is that doctors speak Dutch that is of a sufficiently high level to communicate with colleagues and patients (Herfs, 2009, 2022). While this formal requirement demands an advanced grasp of the Dutch language, practice demands an even better command of the language: even small mistakes in the use of language can lead to doctors being taken less seriously by their patients. Control of the Dutch language is therefore an important skill that influences how the social surroundings (e.g., patients) will respond to migrated doctors, which continues to play a role even after passing the institution's official assessments. Institutions are aware of this, and try to develop courses that teach migrant doctors Dutch language skills applied to the medical context (Herfs, 2022).

"Men moet een belangrijk onderscheid maken tussen in Nederland opgeleide (tot en met VWO) personen met een migratieachtergrond (ook wel bekend als 'onderinstromers') en de

in het buitenland opgeleide artsen (zogenaamde 'zij-instromers'). Het voornaamste probleem onder artsen met een migratieachtergrond is taal. Dit geldt uiteraard meer (of uitsluitend) voor de zij-instromers, die de taal niet van jongs af aan hebben meegekregen. Daar komt bij dat als zij in een gezinssituatie verblijven waarbij de voertaal niet Nederlands is maar Arabisch, Farsi, enz. zij zich de Nederlandse taal slechts langzaam eigen maken." Paul Herfs

While the research by Paul Herfs emphasises the importance of learning the Dutch language, there are more factors that may thwart the integration of migrant doctors. One important source of difficulty form the many unwritten rules and norms that come with working in the medical sector, which may be more obvious to native than to immigrated doctors (Leyerzapf et al., 2015). These may be better known to doctors who have had the privilege of having been born in the Netherlands, because of the many informal networks that they have built over the years (de Muijnck et al., 2021). Rooting these differences out may be difficult for medical institutions, as they are influenced not only by institutional structures but also by more subtle group-level processes.

As opposed to institutions, groups do not have to be governed by any formal rules. In their most basic form – so-called 'minimal' groups – merely suggesting that people are part of a group can be sufficient to create them. Famously, this was done in experiments where the researcher suggested that people in 'Group A' preferred paintings by the artist Klee, and people in 'Group B' preferred paintings by Kandinsky (Tajfel, 1970). This was enough to influence people's behaviour positively towards members of their own group, despite the fact that this grouping was based on a trivial, or even merely suggested, aesthetic preference. Of course, not all groups need to be as minimal as in that example, and when groups adopt more formal entry requirements, they can become more akin to institutions. The main difference between the two, is the subjective way in which individuals *perceive* others or themselves to be part of a certain group. This perception, or subjective identification, has been shown to be a more important predictor of behaviour towards the group than formal group membership in many instances (Ellemers et al., 1999, 2004). Whether someone belongs to a group is often determined by a personal desire to be a part of the group, and by the decision of others to acknowledge them as a group member (Ellemers & Jetten, 2013).

Such personal desire and the acknowledgement of others – how one sees oneself and how others see them – do not always overlap. Take doctors, for instance. People generally perceive doctors as warm and competent people (Nicolas et al., 2022); no wonder, then, that medical students would rather subjectively identify with the group 'doctors' than with the group 'students' – a more positive image namely exists about the former group than about the latter (Burford & Rosenthal-Stott, 2017). Identifying with the group 'doctors' may buttress medical students' self-esteem, seeing as how this represents a desirable and respected group. However, there is also evidence that medical students experience high pressure due to the expectation of patients, doctors, society, family, and friends to conform to this positive image (Stubbing et al., 2019). This may be even more relevant for medical students with a migration background, who have been found to face a high "burden of

expectation" from their social surroundings (Michalec et al., 2017). Another threat that these students need to deal with comes from other medical students, who may perceive medical students with a migration background as a passive and problematic 'Other', rather than as accepted group members. In response to this threat, medical students with a migration background have been shown to emphasise their professional identity (Kristoffersson & Hamberg, 2022; Slobodin et al., 2021). Being perceived as part of the group 'migrants' or 'doctors', in other words, impacts how medical students, including those with a migration background, present themselves to their social surroundings. Group-level phenomena, such as the way in which people from a certain group are perceived and act in response to that perception, therefore also constitute potentially important mechanisms for the study of integration.

The friction between how a person sees themselves versus how others see them finally brings us to the third 'level' at which integration may be studied, namely the individual. Groups and institutions are made up of individual people, whose desires and thoughts about themselves and others impact their interpersonal behaviour. Being part of an institution or group likely influences these desires, thoughts, and behaviours; but in order to know how, the individual's thoughts will have to be made explicit. Take, for example, the impressions that people have of each other. It is thought that any impression, be it about oneself or someone else, a person or a group of people, is composed of evaluations on a limited set of basic attributes, about a person's competence, sociability, and morality[g] (Abele et al., 2021; Ellemers, Pagliaro, et al., 2013; Landy, 2015; Leach et al., 2007). Of these, sociability captures someone's general likability or friendliness, whereas morality specifically conveys information about that person's "goodness". Competence, finally, may be understood as someone's ability to act upon their intentions (Abele et al., 2021). Personal impressions in terms of someone's sociability, morality, and competence can have strong implications for how people approach each other. Impressions of someone's morality, for example, determine people's willingness to trust, help, include, or depend on that person (Brambilla et al., 2013; Brambilla & Leach, 2014; Pagliaro et al., 2013). Evaluations of competence, in contrast, correlate with perceived status, power, skill, and class (Abele et al., 2021). How migrants and members of their social surroundings perceive each other in terms of these attributes can thus impact how willing they are to engage with, accept, and respect each other.

Unfortunately, many ethnic groups and people with a migration background are evaluated unfavourably by majority group members in terms of their competence, sociability, morality, or all three attributes. Asian Americans, for example, have been found to be evaluated by other Americans as competent but cold (of which the latter may be considered a combination of low sociability and low morality), which can come across as threatening, reducing others' willingness to interact with them (Awale et al., 2019). Poor Blacks, Turks, and Arabs living in the US are often evaluated as cold and incompetent, which elicits scorn in others, who may subsequently avoid or even harm them (Fiske, 2010). This likely limits the

[g] There is an ongoing discussion about how to label these basic attributes, see Abele et al., 2021.

potential for these groups to interact with and integrate into their social surroundings. In other words, psychological mechanisms, such as the personal evaluations that people make on others based on their assumed group membership, are therefore another relevant level at which the integration of migrant doctors may be studied.

The current dissertation studies how the institution, the group, and the individual each play a role in the integration of migrant doctors and their social surroundings. With regard to the institution, this dissertation examines how city councils and the Guild of Surgeons steered the entry of migrant newcomers into local communities. Group-level characteristics include demographic variables such as a migrant's occupation, place of birth, and place of education. Individual-level variables include patients' perceptions about migrant doctors' sociability, morality, and competence, as well as their willingness to accept migrant doctors. Finally, the individual perceptions of medical students about themselves and the medical profession in terms of perceived sociability, morality, and competence are also measured, to examine their view of the medical professional identity.

The temporal dimension: Integration then and integration now.

"Er zijn sindsdien misschien fouten gemaakt op het gebied van migratie, maar altijd met goede bedoelingen. Wat is het alternatief? Niets leren van WOII, en terug naar rassendiscriminatie? Dat vind ik geen alternatief. (...) We waren wellicht te optimistisch over migratie en integratie. We hebben de culturele omslag niet voorzien: de houding van mensen ten opzichte van migratie. En we hebben ook niet voorzien wat een zware gevolgen de economische crisis van '88 zou hebben: hele groepen migranten werden daardoor werkloos."
Jan Lucassen

After distinguishing between different groups of migrants, and different levels of analysis, it is useful to place migration and integration in a historical perspective, as this may identify longer-term processes, or provide a benchmark with which to compare current-day issues. It is the final challenge to overcome in order to answer the question 'what is integration'. Some integration processes appear to develop gradually over time, while others remain remarkably similar over long time spans.

Starting with group-level characteristics, there is a gradual process among migrant groups, in which they improve their labour market position over the course of generations. Whereas the first generation of migrants do not yet speak the language, lack networks, and possess skills that do not match the requirements of the host country, their children tend to do much better on all these aspects. Growing up in a country and attending the local schools leads to a huge improvement of human capital among the children of lower-schooled labour migrants (i.e., second generation migrants; Dagevos et al., 2022).

The stance of the receiving society towards migrants also matters. Currently, the public opinion might be negatively biased towards migration, or certain groups of migrants, but this hasn't always been the case. After WWII, the official stance of the Dutch

government was that "the country is full" – housing shortages resulting from the devastation of the war and a significant baby-boom, combined with high unemployment, meant that there was deemed to be less need – and indeed room – for immigration. In fact, Dutch nationals were actively encouraged to emigrate. This image changed during the 1960s, however, when labour markets recovered, and the Dutch government recruited sizeable numbers of labour migrants from Spain, and later Turkey and Morocco. From 1965 until 1995, the general opinion was that immigration was a good thing, and cultural differences should be celebrated. This stance later changed again, when political parties openly started to question the compatibility between Dutch and migrant culture (Engbersen et al., 2020; Penninx, 2016).

When we go further back in time, we encounter some interesting parallels with the current-day situation. We might, for example, observe that the current influx of immigrants to the Netherlands is comparable to the situation in the 17th century, when the Dutch Republic received large numbers of religious and political refugees from neighbouring countries. Around that time, Dutch cities took a welcoming approach towards migrants, whom they needed in a fast-growing economy. But these bountiful times did not last: towards the end of the 17th century, and during most of the 18th century, the economy stagnated. As a result, many cities became more protective – instead of being seen as bringing prosperity, migrants were more and more often regarded as a burden on already strained local charities and public welfare programmes. Amsterdam was the major exception to this rule, and continued to see migrants as important contributors towards prosperity – but the public welfare system in Amsterdam was, not by coincidence, less generous than in other cities (Lucassen, 2012).

In those days, the city council was not the only institution to concern itself with the immigration and integration of newcomers. At a more local level, craft guilds played an important role, too. These were collective groups of people who all shared the same occupation. The guild of shoemakers, to take an example, contained all shoemakers in a city – for to become a shoemaker, one had to be a member of the shoemaker's guild. Since these guilds were also responsible for the training of new craftsmen (in this example: shoemakers), they played an important role in the incorporation of newcomers.

Some experts have likened the current-day medical education to these ancient craft guilds, and indeed there are some parallels. Like in ancient craft guilds, where would-be surgeons started as a menial 'servant' or 'student', then became a wage-labourer known as a 'journeyman', before finally being granted the right to undergo the master test leading to the status of 'master surgeon', current-day medical students need to go through a couple of stages before they can call themselves a medical specialist (i.e., a doctor who has specialised in a certain direction, e.g., cardiology, after completing their basic training). At each stage, fewer medical students progress, resulting in a select and highly coveted group of medical specialists, perhaps comparable to the somewhat exclusive group of master surgeons in the ancient Surgeons' Guild. Moreover, the selection for that final stage largely takes place in informal circuits, where 'specialist associations' determine the number of graduate students

into the advanced track to becoming a medical specialist. In setting the conditions to become a medical specialist, these specialist associations, united in the Netherlands under the Federation of Medical Specialists, have a degree of control over the influx of new members that resembles or even exceeds that of the ancient craft guilds. Perhaps the most striking parallel between craft guilds and current-day specialist associations, however, comes from their shared emphasis on the student—master relationship. During their specialisation track, medical graduate students heavily depend on a small number of seniors for personal guidance and education. This system brings to mind the old student—master system employed in ancient craft guilds, where junior craftsmen were personally overseen by a senior master craftsman – even living with them under the same roof in many instances.

"Ik ontving veel belangrijke hulp van mijn seniors gedurende mijn promotie en specialisatie tot cardioloog. Een van hen was mijn promotor, die tijdens mijn promotietraject intensief met me van gedachten wisselde en mijn werk becommentarieerde. En er waren er meer, zoals bijvoorbeeld een professor en een oudere collega. Ik deel het gevoel dat de meester—leerlingverhouding erg aanwezig en belangrijk was. Ik ontving niet alleen hulp en instructies van mijn hoger geplaatste collega's, maar zij beoordeelden daarnaast ook de kwaliteit van mijn werk. Als ik ondermaats presteerde, had ik een probleem! Tijdens deze periode in mijn carrière had ik nooit tentamens, dus mijn voortgang werd altijd persoonlijk beoordeeld door mijn seniors." Anonieme cardioloog

By studying the integration of migrant doctors in a historical setting, it is possible to investigate processes that took place over a longer period of time, something that is more difficult using psychological studies. This may allow us to identify novel mechanisms of integration that may be transferrable to the contemporary setting. For example, if the Amsterdam Surgeons' Guild placed a heavy emphasis on local education, this finding may be a good point of departure for further psychological studies about the effects of education on migrant doctors' acceptance. By testing the same mechanism of integration in a historical setting and in a contemporary setting, it is furthermore possible to investigate whether this mechanism has stayed consistent over a long period of time, despite the changing circumstances. This adds a sort of 'temporal' robustness to any contemporary psychological findings. Vice versa, contemporary psychological studies might support the existence of psychological processes (e.g., receiving local education leads to a higher acceptance of migrant doctors) that may explain a certain outcome in the historical setting (e.g., locally educated migrants more often become master surgeons) that would be difficult to prove using historical data alone.

A suitable definition of 'integration'. To accommodate the multi-faceted nature of integration we need a definition that is flexible enough to include different groups of integrating people, at different levels of analysis, and across different time periods. Penninx & Garcés-Mascareñas (2016) explain that integration is a much contested concept within the academic fields that study it. While some researchers have traditionally focused primarily on

the newcomers and their ideas and behaviours, others have instead concentrated on the reaction of the receiving society towards newcomers. The studied dimensions of integration also differ, ranging from the legal-political to the cultural-religious, and so do the levels of analysis, which range from the individual to the institutional. Much of this research furthermore assumes that the immigrant needs to adapt to the norms of the receiving society, and not the other way around. Society is, in this respect, portrayed as a more or less homogeneous social environment in which the immigrant needs to integrate. This does not do justice to the fact that society is in reality made up of a pluralistic collection of groups, organisations, and local identities. Instead of conceptualising integration as a one-way process of adapting to the "core culture" or national society as a whole, researchers should, according to Penninx & Garcés-Mascareñas (2016), take a disaggregated approach that considers multiple reference populations and distinct processes occurring at different analytical levels.

In recognition of the fact that integration is a multi-faceted phenomenon, involving a plurality of actors, analytical levels, and processes that develop over time, this study will use the following definition of integration:

Integration is the process leading to mutual acceptance between migrants and their social surroundings.

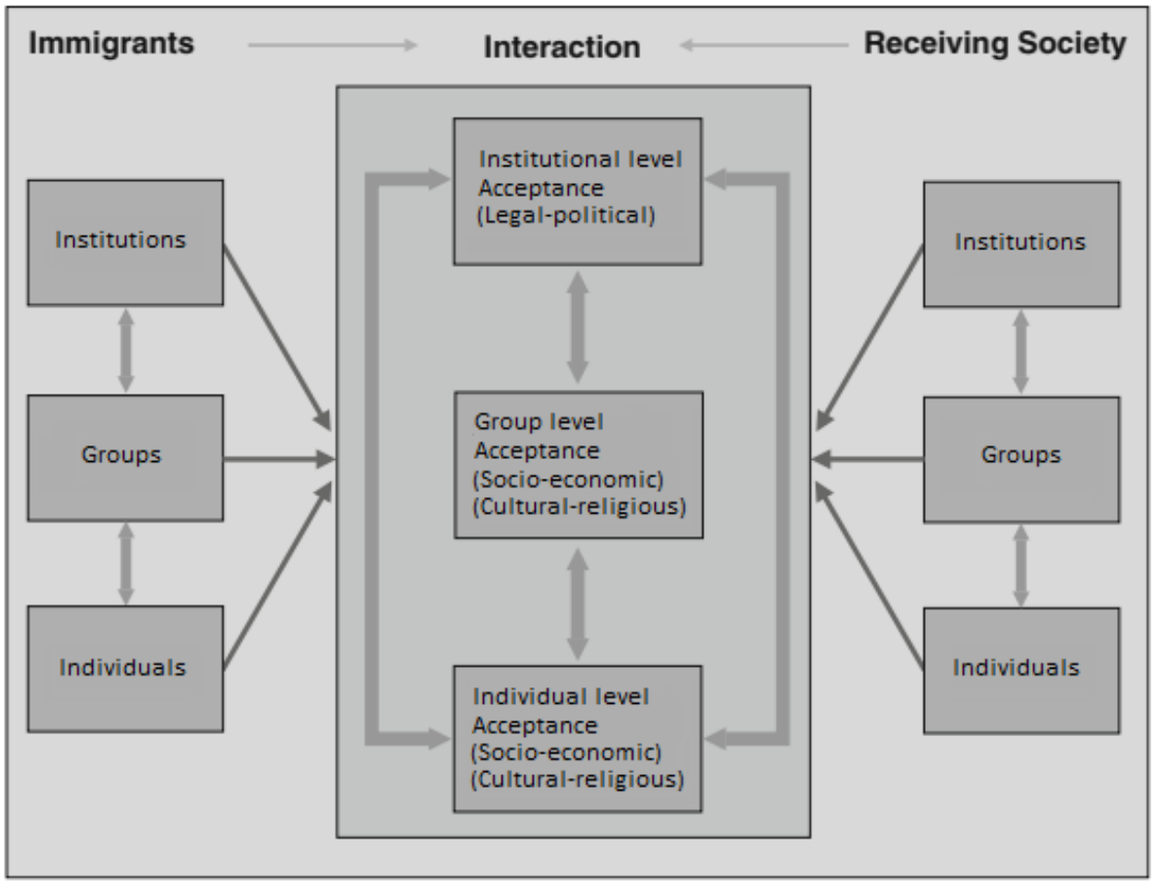
This definition follows Penninx and Garcés-Mascareñas (2016), with some alterations. The original authors had defined integration as "The process of becoming an accepted part of society" (p. 14). Central to this definition is the notion of acceptance, which may take place through different mechanisms operating at different analytical levels. My own definition adds an emphasis on the mutual aspect of this process, and identifies the integrating parties: the migrant and their social surroundings. This notion of mutuality was already present in the paper by Penninx and Garcés-Mascareñas (2016), but not made explicit in their definition. The definition of integration formulated for this dissertation has a number of important qualities:

1. It emphasises that integration is a ***two-way street***, involving not just the migrant, but the receiving society as well, as emphasised by the words 'mutual' and 'between'. Note that "migrants" is meant here as a container concept, and may also indicate people with a migration background, first generation migrants, labour migrants, etc.
2. It places ***acceptance*** in the centre of integration. Acceptance can take place at the level of the institution (through fair procedures and an open stance towards migrants), the group (by allowing individuals to take on group membership and a shared identity), and the individual (by deciding to trust the person in front of you, to interact). Thus, the definition satisfies the criterion that it should accommodate multiple levels of analysis.
3. It emphasises that integration is a ***process***, that is: something that happens over time. In emphasising the temporal aspect of integration, it satisfies the criterion that it

should leave room to investigate different time periods. It also creates space to investigate the mechanisms that drive this process (see also point 4).

4. The definition is ***non-normative***. That is, it leaves open what the two parties need to do in order to become accepted. By leaving this open in the definition, we create space to investigate these precise conditions that lead to acceptance and integration. The conditions for integration become themselves the object of study.

Figure 1: A graphical representation of the concept "integration"



Source: Adapted from Penninx & Garcés-Mascareñas (2016) p. 16.

Figure 1 graphically displays the relationship between immigrants and the receiving society, following the formulated definition. According to this model, integration takes place as a result of an interaction between the individuals, groups, and institutions of immigrants with those of the receiving society. This does not only recognise the fact that there are different mechanisms that may lead to integration, depending on the analytical level that is being observed, but also that mechanisms occurring at one level – say the individual – may interact with mechanisms occurring at another level – say the institutional. Institutions set the formal rules that determine the direction in which a group or organisation may develop itself, illustrating how mechanisms at the institutional level can impact mechanisms operating at the level of the group. This naturally also has consequences for the individual who wishes to join a group or organisation. Conversely, individuals may mobilise to

challenge the existing norms within a group, or even contribute towards making changes in the institutional arrangements of the group, illustrating how individual-level processes can aggregate to the group or institutional level (Penninx & Garcés-Mascareñas, 2016, p. 18).

At the centre of the model is acceptance on the three different analytical levels. It is important to note that in the original model the authors make a distinction between different dimensions of integration, namely the legal-political, the socio-economic, and the cultural-religious. This refers to the fact that acceptance can take place in several ways: in a legal-political way, acceptance can, for example, refer to the number of rights obtained by an individual migrant or group of migrants, or to the formal recognition of a migrant institution. In a socio-economic way, acceptance can refer to a migrant's access to education and employment, and can be measured using broad indicators such as education level, employment status, or monthly income. In a cultural-religious way, finally, acceptance can refer to the ideas that migrants hold about themselves, and the ideas that the receiving society holds about migrants. Measuring acceptance in this dimension requires that migrants and members of the receiving society are asked to describe their view of their own culture and values, and those of the other party, and their willingness to interact with the other party.

The legal-political, socio-economic, and cultural-religious dimensions of integration do not overlap completely with the three analytical levels of the institution, the group, and the individual. Cultural values can, for example, exist in the mind of an individual as much as they can exist in the form of a group norm or in an institution's set of formal rules. In this dissertation, I will nevertheless make a slight simplification by focusing primarily on the legal-political dimension when discussing institutions, and on the socio-economic and cultural-religious dimensions when discussing groups and individuals. I use the word 'acceptance' to refer to the primary outcome of the integration process. While acceptance can thus take place on any level of analysis, it is important to keep in mind that it comes in different forms when occurring at the institutional level or at the group or individual level.

By defining integration as 'the process leading to mutual acceptance between migrants and their social surroundings', the exploration of what is integration is concluded. From this definition, a research question may be formulated that captures this dissertation's ambition to understand how migrant doctors integrate into their social and professional surroundings. In recognition of the fact that the research question should be about migrant doctors, and should accommodate mechanisms operating at different analytical levels, the research question thus becomes the following: *'What are the institutional-, group-, and individual-level aspects of the process leading to mutual acceptance between migrant doctors and their social surroundings?*'

Integration According to Social History and Social Psychology

To address this dissertation's research question, a multi-faceted approach is needed. One that is capable of studying different groups of integrating people, at different levels of analysis, and across different time periods. From the conceptual exploration of the

phenomenon integration, it became clear that integration is a big and complex real-world phenomenon, that does not stick neatly to theoretical and methodological lines as defined in any single academic discipline. The approach towards studying integration should match that wide scope.

Proponents of multi-, inter-, or transdisciplinary collaboration believe that many social problems are too complex to be solved by any specific discipline, but hope that cleverly combining theories and methods from multiple disciplines will lead to a better understanding of complex societal problems (Borkert, 2018). Transdisciplinary scholarship is arguably the approach that requires the strongest integration of methods and theories from various academic fields, and is otherwise noteworthy for the inclusion of extra-scientific actors or stakeholders, and for placing a heavy emphasis on practical applicability of the research findings. This approach starts out by identifying a "real-world" or "societal" problem that needs to be addressed, like the mutual acceptance between migrant doctors and their social surroundings. It then involves researchers from several disciplines to explore the boundaries of the problem, often in collaboration with extra-scientific actors and stakeholders. When a consensus about these has been established, the researchers will attempt to combine their theoretical and empirical findings in order to come up with a solution that is informative for practice, while also contributing to the advancement of science (Jahn et al., 2012). To quote three prominent transdisciplinary scholars: "Transdisciplinarity is a reflexive research approach that addresses societal problems by means of interdisciplinary collaboration as well as the collaboration between researchers and extra-scientific actors; its aim is to enable mutual learning processes between science and society; integration [of academic theories and methods] is the main cognitive challenge of the research process." (Jahn et al., p. 4, text in brackets added).

The current dissertation is part of a transdisciplinary research project called SCOOP – the Sustainable Cooperation Project. SCOOP represents a consortium of researchers from several different disciplinary domains, actively involves extra-scientific stakeholders, and strives to disseminate its research findings among societal stakeholders. Admittedly, the current dissertation does not involve extra-scientific actors; however, since it does involve scientific stakeholders from multiple disciplines (i.e., history and psychology, and a collaboration with Utrecht University's academic hospital, the UMC), seeks to address a societal problem from an angle that transcends individual academic disciplines, and is part of a larger research project that aims to disseminate this dissertation's findings among societal stakeholders, the label transdisciplinary feels more appropriate than multi- or interdisciplinary.

In keeping with the transdisciplinary ambition of SCOOP, the current dissertation aims to combine methods from social history and social psychology to arrive at a more thorough investigation of the integration of migrant doctors than would be possible through either discipline alone. History and psychology may seem like an unlikely combination, but the rationale behind using both disciplines is that they can each deliver unique insights about the problem, and supplement each other's methodological shortcomings. Specifically,

social history delivers the insight that different institutional arrangements can be found throughout history that may impact the capacity of migrants to integrate into their local social surroundings. Through the historical method, we may describe the interaction between migrants and institutions from a relative distance, situated within the context of their time, allowing for the identification of long-term processes. However, while the historical discipline excels at identifying the many formal conditions that different types of institutions may impose upon migrant newcomers, and the effects thereof on macro-level outcomes such as the number and socio-economic status of migrants in a given community, the psychological discipline is needed to investigate the effect of such conditions on the individual. As opposed to social history, which is limited to describing past events, social psychology utilises experiments like randomised controlled trials, in which certain variables are manipulated in a controlled environment prior to data collection. This allows for the investigation of causal relationships between, for example, certain migrant characteristics (e.g., their place of education) and evaluations by members of their social surroundings. Both disciplines can thus inform each other, by linking formal institutional arrangements (e.g., education) to the psychological acceptance of migrants on a more personal level.

To understand how social history and social psychology both contribute to answering the research question of this dissertation, it is first necessary to outline how each discipline approaches the subject of integration. In short, social history has attempted to describe how certain institutional arrangements, such as craft guilds, helped or hampered people to assume the role of active citizens. Whether these institutions were 'open' or 'closed' towards migrant newcomers is a crucial aspect of this discussion, as this may impact their integration into local communities. Social psychology, on the other hand, is interested in the psychological question of how being part of a specific group impacts judgements by, and about, the individual. People evaluate each other on the basis of perceived group membership, which may involve the activation of certain group stereotypes. With regard to integration, the question is how becoming part of an institutional arrangement, for example through following education in a craft guild or a modern-day medical educational institution, impacts the formation of a migrant's professional identity, and, consequently, the image that others form about migrants.

Social History.

"In feite was de macht van het gilde beperkt. Ze hadden wel een monopolie, namelijk op wie er een bepaald beroep uit mocht oefenen, maar niet op hoeveel mensen dat beroep uit mochten oefenen. Iedereen mocht een meesterproef aanvragen, mits hij of zij aan alle voorwaarden voldeed. Elke poging van gilden om de markt "op slot" te gooien, werd tegengehouden door de stadsbestuurders. Die stonden wel zekere privileges toe aan de gilden, omwille van de lieden die met nijverheid hun brood moesten verdienen, maar lieten zelden gebeuren dat de gilden zo machtig werden dat ze de prijs van hun goederen te veel gingen opdrijven. Dat was immers in het nadeel van de andere burgers." Maarten Prak

Social history excels in describing how a phenomenon – such as integration – is shaped by the societal context of its time. As an explanatory mechanism for how the societal context shapes integration, social historians[h] use the notion of institutions to describe how individuals are adopted in local society. In his most important work to date, *Citizens without nations*, Maarten Prak sets out to investigate the role of citizenship in pre-modern societies across Europe and other continents (Prak, 2018). Contrary to popular belief, the people living in European cities before the advent of modern democracies were already actively involved in local governance. This involvement can be described through the term *citizenship*, which Prak defined as a set of practices in the legal, political, economic, social, and military domains. Through participation in local institutions, such as churches, charities, neighbourhoods, guilds, civil militias, and the town council, citizens fulfilled their obligations towards local society, while also reaping certain rights and benefits from doing so. Through local institutions, citizens thus had an important role in maintaining the social fabric of society.

The question is whether partaking in these institutions also served as mechanisms towards the integration of migrants into their local social surroundings. Almost by definition, being an active citizen implies a high level of integration, as this involves active participation in local institutions. The prerequisite for taking part in these institutions is, however, that they be open for newcomers to join them. If the institutions described by Prak were in practice closed-off, difficult to get into for 'outsiders', then these very institutions which appear to be so conducive for active citizenship and – by extension – integration, could in fact be hindering migrants to integrate into local communities. Much, therefore, depends on the question how 'open' or 'closed' local institutions were to outsiders, including migrants.

There is an ongoing debate about this very question among historians. Much of this debate focuses on craft guilds, which, with their power to set the conditions under which newcomers could enter a particular craft, also had a potentially large influence on how easy it was for migrants to become part of the local community. Crucially, guilds and their members had vested interests that they needed to protect. Not only was guild membership presented to the outside world as a mark of quality, meaning that guild members needed to be of a sufficient skill level to uphold the guild's good name, but becoming a guild member also came with benefits like social security – insurance against illness, a widow's pension – and a social network with which to share such things as feasts and funerals (Bos, 2006; Epstein, 2008; Thijs, 2006). While Prak and colleagues present these vested interests as legitimate concerns for the continued well-being of the guild and its members, and in fact as important aspects of active citizenship, others have taken a more critical approach. Most notably Sheilagh Ogilvie, who maintains that the barriers towards entry into a craft guild – unnecessarily long and dull apprenticeship training, expensive and useless social activities, high entry fees, and the exclusion of specific groups like Jews and women – were excuses to

[h] Or to be precise: the group of social historians whom I have had the pleasure to work with, who may not be representative for the entire field.

restrict entry to the 'rents' (benefits) attached to membership, protecting the vested interests of guild members effectively at the cost of newcomers (Ogilvie, 2008, 2019).

Here, social history encounters a methodological limitation. While it is good at describing the official stance of institutions such as guilds towards newcomers, using guild bylaws[i] and other preserved documents, and the effects thereof on newcomer influx over a long period of time, it has more difficulty describing the individual attitudes of established guild members and migrant newcomers towards each other. Personal accounts of how migrants experienced their treatment by the guild are scarce.[j] This makes it difficult to prove how the institutional conditions imposed on migrant newcomers impacted their integration process, especially when it comes to their personal experiences. It is well possible that the institutional conditions required adaptation from the migrant newcomers to the norms and customs of the local craft guild, and that this adaptation process influenced migrants' personal view on the guild. Simultaneously, it is very much possible that the institutional conditions imposed on migrants also affected the view of settled guild members on migrant newcomers. Perhaps this view even changed over time, as the migrant newcomer became accustomed to the local setting of the guild, adopted local norms and practices, and expanded their network. Using historical sources it is difficult, however, to recover the motivation and behaviour of individual guild members, let alone reconstruct the causal relationships between guild openness, the thoughts and behaviour of individual guild members, and the integration of migrant newcomers.

Social Psychology.

"Those who are made to feel they will never truly belong – or will not be respected whatever they do – have nothing to lose. They are the ones we should fear most: excluding them from our moral circle inevitably leads them to exclude us from theirs. When they no longer care about our judgments, let alone our needs, fates, or outcomes, all checks fall away. Putting people in this position thus is the worst we can do. Acknowledging the role of groups as moral anchors can save us from making that mistake." (Ellemers, 2017, p. 247)

To take a closer look at what the causal relationship between institutional openness and migrant integration may look like, we need the type of data that we just cannot obtain through archival research. Data that tells us: what happens to migrants once they have entered an organisation – to their self-image, to their perception of their social surroundings,

[i] This is the word used for the rules and regulations of a guild, as encoded in their own written manual.

[j] For one amusing anecdote that did survive, see the account of the disgruntled German surgeon Johan Herman Francken, who was denied access to the Amsterdam Surgeons' Guild in 1716, on account of missing credentials. He was not allowed access before obtaining a special letter of recommendation from the surgeons' guild in Groningen, where he had been an apprentice. His story can be found in *Stadsbelang en standsbesef. Gezondheidszorg en medisch beroep in Groningen 1500-1730* (Huisman, 1992).

their image of their profession – and what happens to the way in which migrants are perceived by their social surroundings? For this, we need the help of an academic discipline that specialises in explaining how people perceive each other, conditional on their group membership. This may help us to test whether the mechanism suspected at the institutional level – institutional openness leads to integration of migrants over time – indeed happens through *psychological* mechanisms, such as: following education inside a medical institution influences the image that migrant doctors have about themselves and their profession; and improved stereotypical perceptions about migrant doctors after following local education lead to increased acceptance by patients.

Central to the discipline of social psychology is the question how individuals perceive each other. In her book *Morality and the regulation of social behavior: Groups as moral anchors*, Naomi Ellemers describes the important role of groups in this process (Ellemers, 2017). Groups are instrumental in shaping human perception and behaviour. Although they are so in many ways, two are important for the current discussion about the integration of skilled migrants.

First of all, being part of a group – or rather, *perceiving oneself as being part of a group* – impacts the way in which people perceive themselves. Most importantly, being part of a group can provide people with a sense of self: that is, people can subjectively identify with the group to which they belong (Tajfel & Turner, 2004). That can be any group, and there can also be more than one: I, for example, currently see myself as a PhD student, a social scientist, a young man, a partner, and a Dutch citizen. This has some positive outcomes: seeing oneself as part of groups such as these provides people with a sense of belonging, and may boost their self-esteem (Greenaway et al., 2016). In fact, being part of groups is so important for people, that they are willing to bring their views and behaviour in alignment with group norms. This includes acting in line with the group's shared goals (Ellemers, Sleebos, et al., 2013), and adopting the group's stereotypical traits as if they were one's own (van Veelen et al., 2016). This latter strategy may come at a cost, however, since it also means that if the stereotypes that exist about the group to which we try to belong are negative, this can reflect negatively on our self-image (Barreto & Ellemers, 2003).

Second, people also treat others differently based on those other people's inferred group membership. Since people do not immediately know a person when they meet them, they often rely on stereotypes about the group to fill in missing information about the individual (Yzerbyt, 2016). These stereotypes contain a set of ideas about a group, such as that people in that group tend to be lazy or hardworking, clever or dumb, warm or cold. This information is thought to convey to the observer, first of all, whether people from a certain group are likely to have good intentions or not, and second, whether they are capable of acting upon those intentions (Abele et al., 2021). Accordingly, when a stereotype exists that says that the people in a certain group are cold and incompetent, others are inclined to avoid members of that group, or even to scorn and harm them (Fiske, 2010). Being part of a group about which a negative stereotype exists therefore has negative consequences for the individual, since others will judge the individual on the basis of that group stereotype.

Knowing that people alter their behaviour based on their *own* group membership, and treat others differently based on *their* group membership, can be informative for the study of the integration of migrant doctors. It is known that about migrants, negative stereotypes regarding their warmth and competence prevail (e.g., Cuddy et al., 2008). This means that about the group 'migrants' certain ideas exist that may influence how individual migrants perceive themselves, as well as how they are treated by their social surroundings. Indeed it is known that being perceived as a migrant can lead to negative outcomes, such as discrimination on the labour market. When applying for jobs, migrants are persistently being discriminated against, even if their qualifications match those of non-migrants (for an overview, see Zschirnt & Ruedin, 2016). Meanwhile, when migrants themselves become aware of the negative way in which their group is perceived, this triggers an adaptive response from them as well. Some migrant groups, for example, have been found to respond to a negative stereotype existing about them by behaving in a way that conforms to that very stereotype. While this may allow them to rebel against a society that appears to reject them, it ironically also strengthens the negative stereotype (Kamans et al., 2009). Another, more individualistic strategy that migrants may use to combat negative stereotypes, is to try their best to disprove the stereotype. Unfortunately, however, such compensatory behaviour has often been found to backfire, because it may lower individual performance (Steele & Aronson, 1995).

In contrast to the often negative or mixed stereotypes about the group 'migrants', a positive image exists about the group 'doctors' (Nicolas et al., 2022). The negative stereotypes about migrants thus conflict with the positive stereotype about doctors, making it difficult to predict how people will respond to migrant doctors. What is missing from social psychological literature, however, is an analysis of how becoming a doctor influences the stereotypical beliefs that migrant have about themselves, and others about migrants.

Here, insights from social history may be used to create a novel angle. Social history delivers the insight that throughout history, different institutional configurations have contributed to the integration of migrant newcomers. By studying these institutional configurations, we may uncover structural factors that help migrants integrate into their social surroundings. One such structural factor could be, for example, that migrants were required to receive training inside the locally operating Surgeons' Guild. This raises the psychological question how receiving professional education in a fixed location influences the professional identity formation of migrants, their outlook on the medical profession, and their subsequent reception by their social surroundings. This has not yet been explored in great detail, as psychological research often focuses on migrant birthplace or ethnicity to explain their integration or lack thereof. By including the structural component 'place of education', a novel angle is created in which migrants are not just regarded as an unknown 'Other', but as people transitioning from outsiders to insiders. The local setting – in this case, medical education in a specific town or country – becomes part of the explanation for the way in which migrant doctors perceive the medical profession, and for how relevant others such as patients perceive migrant doctors. This makes sense, considering that medical

practice differs slightly from country to country, making it plausible that locally educated doctors are better attuned to the needs and requirements of their local professional environment.

Overview of Chapters

In what follows, I will summarise how I addressed the research question *'What are the institutional-, group-, and individual-level aspects of the process leading to mutual acceptance between migrant doctors and their social surroundings?*' by combining insights from social history and social psychology. Specifically, the historical setting studied in the first two chapters of the current dissertation – 18th-century Holland – is characterised by locally organised institutions that govern the inflow and socialisation of newcomers. These local institutions, such as craft guilds and city councils, placed a heavy emphasis on active citizenship, protecting the reputation of the guild, and maintaining the welfare of the city; this affected their approach towards migrant newcomers. Guilds and cities varied in how open they were to migrants, which had an impact on the number of migrants who could gain access to the local labour market. Group-level variables such as the occupation of the migrant and their marital status interacted with these regulations to create unique migration patterns.

An in-depth analysis of the surgeons' guild of Amsterdam revealed an unexpected but crucial condition for the structural integration of migrants into the guild: education. While the Amsterdam Surgeons' Guild was open to migrants during the early stages of their career, the institutional arrangements were such that migrants needed to invest much time and money in their Amsterdam-based education if they wanted to progress to the highest career step of becoming a master surgeon. So, while the Amsterdam Surgeons' Guild was easy for migrants to get into, it was tougher to make a career in. Meanwhile, the investment made by migrants in their education may have been a vehicle towards their socialisation in the local guild, altering their perception, as well as that of their social surroundings, about them as surgeons.

The finding that Amsterdam-based education and experience was apparently valued over education and experience gained outside Amsterdam, inspired the latter two chapters of this dissertation. Extending the setting of the surgeon's guild to the current day, these chapters investigate the impact of where a migrant doctor has received their medical education: in their country of origin, or in the destination country. In doing so, these chapters transfer an important observation from the historical setting studied in the first two chapters to current-day practice, namely that where migrant doctors were educated, not just where they were born, impacts the extent to which they are accepted by members of the receiving society. This is a novel insight that has received limited attention so far within the medical and psychological literatures, which usually focus on birthplace or ethnicity. As an explanatory mechanism, the two psychological chapters also investigate whether receiving education in the destination country changes the stereotypical images that medical students with a migration background have about themselves and other

important actors within their profession. The answer to that question forms part of an explanation for why migrant doctors who received education in the destination country are accepted to a higher extent than migrant doctors who received education abroad. Another part of the explanation comes from exploring the question how a doctor's place of education impacts the images held by patients about the migrant doctor, which are causally related to their acceptance of that doctor.

Together, the four chapters explore how gaining access to and following education inside a local medical institution alters the perception of migrant doctors about themselves and their profession, and the perception of members of the receiving society about migrants doctors.

What links the fields of social history and social psychology is that they both consider the tensions between different analytical levels to some extent. Social history investigates the tension between citizens and institutions, while social psychology investigates the tension between individuals and groups. The combination of the two disciplines is important, because social history may reveal institutional factors, such as the requirement of receiving local education for migrant newcomers, which may have an impact on group-level psychological variables such as the stereotypical image which people have about migrant doctors. Importantly, acceptance at the institutional level does not automatically lead to acceptance at the individual level; to understand whether and why this does lead to personal acceptance, we need to grasp what psychological processes underlie the integration of migrant doctors in an institution. In the four empirical chapters presented in this dissertation, I investigate the relationship between acceptance at the institutional level, the group level, and the individual level in the following way:

Chapters 1 and 2. Chapters 1 and 2 focus on the interplay between guild and city policy, migrant group characteristics, and individual migrant career trajectories. Cities and guilds were the institutions that, with their laws and bylaws, exercised a good deal of control over which migrants got to enter and settle in a certain locality. To phrase it in terms of the definition of integration chosen for this dissertation: the laws and bylaws of a city or guild could either be *accepting* of migrants, or *not* (although, in reality, we may prefer to see this as a spectrum rather than a dichotomy).

In Chapter 1 of this dissertation, I give a detailed analysis of the reception of newcomers by the Amsterdam Surgeons' Guild. In this chapter, I show that this guild did, with its bylaws, create a dichotomy between more 'local' or 'settled' guild members, versus a group of more 'mobile', migrating individuals. This was likely because of the fact that an early introduction into the guild led to career building of migrants within the guild, whereas migrants who arrived to the guild at a later stage typically did not climb the career ladder. Crucially, the Amsterdam Surgeons' Guild was very accepting of migrants at early stages in their careers, but also put a heavy emphasis on local education. Combined, these two strategies resulted in the curious fact that migrants had as good a chance of becoming a 'master surgeon' as did locals, but only if they had spent a sufficiently lengthy period studying within the Amsterdam Surgeons' Guild. In other words, acceptance of migrants at

an *early* stage of their career led to retention of those migrants within the guild at a *later* stage.

Chapter 2 zooms out from Amsterdam, to describe how institutional arrangements might have influenced migration and settlement patterns in a larger geographical area. To this end, together with my co-author, I combine data collected from several historical sources about a group of early-modern wage labourers called journeymen. We compare journeymen going to The Hague, Haarlem, and Amsterdam, to identify differences between these cities, and between different groups of journeymen. We show that city legislation had an effect on the migration patterns of journeymen in 18th-century Holland. Some cities were more accepting of migrants, which interacted with migrant group-level characteristics, like type of occupation, and individual-level characteristics, like age of marriage, to produce settlement for some migrants, and further migration or re-migration for others. Integration, I claim here, starts with acceptance at the level of institutions, but also depends on characteristics of the migrant such as their occupation, skill-level, origin, and marriage pattern.

Do these findings mean that migrating to a town that was accepting of newcomers, and becoming a guild member there was an excellent vehicle towards integration for migrants? Chapters 1 and 2 cautiously suggest that this may indeed have been so, under the condition that cities and guilds were welcoming towards migrants, and that migrants were willing to invest plenty of time in a certain locality. This finding is half the answer to my research question – to improve integration, we need welcoming institutions, and mutual investment by the migrant and the institution into the education of the migrant. Receiving education, then, appears to be a crucial aspect of migrant integration. Perhaps the prolonged and multitude interactions of migrants and their educational environment contributes to the development of a locally situated professional identity among migrants, and the recognition thereof by their social surroundings. The next question then becomes: does receiving education indeed make one a representative member of one's professional organisation, and does this then really lead to acceptance of that migrant by others, and thus integration? This could not be supported using the historical data alone, prompting a different, more psychological approach.

Chapters 3 and 4. Whether it is truly the case that receiving education in a local organisation leads to acceptance, I investigate in Chapters 3 and 4. Chapter 3 deals with the question how having a migration background (as compared to having a Dutch background) influences medical students' stereotypes of the medical profession, including the image they hold of themselves. If receiving medical education in the Netherlands coincides with socialisation of the student as a Dutch medical professional, we expect to find a convergence of beliefs amongst medical students, regardless of migration background. If, however, subjectively identifying, or being treated, as a migrant conflicts with the formation of such a Dutch medical professional identity, we might expect a divergence of beliefs between students with a Dutch background and students with a migration background. For that latter possibility, I and my co-authors found, however, no support: medical students with a

migration background held very similar stereotypical beliefs about the medical profession to students with a Dutch background, while identifying as a 'non-Dutch' person even boosted the opinion about medical professionals in the Netherlands across the board.

If medical students in the Netherlands all adopt similar beliefs about the medical profession, regardless of migration background, does this then also imply that receiving medical education in the country of destination can lead to higher acceptance of migrant doctors by the local population? This is the final question, addressed in Chapter 4. We asked random people to imagine choosing a new general practitioner (GP) as their doctor from four eligible candidates. Each participant saw the introductory pages of four different GPs, who were equally qualified. The only difference: some GPs had been born abroad, but educated in the destination country, while others had been born abroad and educated there as well. When people were asked to choose one of the four doctors as their next GP, they were more inclined to accept the doctor as their new GP who had been educated in the destination country. The place where a doctor had received education, in other words, not just where they were born, impacted acceptance by their patients.

In an attempt to uncover the mechanism behind these findings, the participants were also asked to indicate how competent, sociable, and moral they thought each of the doctors were. According to those ratings, the higher acceptance of a doctor educated in the destination country was fuelled by higher expectations of that doctor's competence, but not of morality or sociability, after receiving education in the destination country. This does not mean, however, that morality and sociability were not important contributors towards doctor acceptance. In general, the ratings of doctors' competence, morality, and sociability were very high. In an attempt to uncover which of these three characteristics was more important for acceptance, we added contrasting information about the doctor's morality, friendliness, or competence – namely that he was *not* moral, friendly, or competent. When we did so, the acceptance of that doctor plummeted, but most sharply for when the information was about the doctor's morality. So although receiving education in the destination country boosted patients' perceptions of a migrant doctor's competence, and not of their sociability and morality, this was likely the case because expectations about that doctor's sociability and competence were already high. If these positive expectations were violated by contrasting information, patients were less likely to accept their migrant doctor. With this chapter, we thus show that receiving medical education in the destination country leads to higher acceptance of migrant doctors by the local social surroundings, through higher expectations about the doctor's competence. However, appearing moral and sociable remains important for migrant doctors as well, as signals that a doctor is immoral or unsociable can seriously harm acceptance.

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Appendix to Chapter 1

Expert Interviews

I express my gratitude to the following experts who were kind enough to let me interview them on the topics of migration and integration (in alphabetical order):

Dr. Paul G.P. Herfs – Senior researcher, ERCOMER; former Ombudsman at Utrecht University

Prof. dr. Frank G. Huisman – Professor in the history of medicine, Maastricht University / UMC Utrecht

Prof. dr. Jan M.W.G. Lucassen – Professor emeritus of international and comparative social history, VU Amsterdam

Prof. dr. M.J.A. (Rinus) Penninx – Professor emeritus of ethnic studies, Amsterdam University

Prof. dr. Maarten Prak – Professor emeritus of economic and social history, Utrecht University

Drs. Marlien Rietkerk-van Zandbergen – Project manager & policy advisor Learning & Development, Utrecht University

Dr. S. – Anonymous retired cardiologist of a regional Dutch hospital

Prof. dr. Frank van Tubergen – Professor of theoretic and empirical sociology, Utrecht University

Prof. dr. Maykel Verkuyten – Professor of relations between cultures and groups, Utrecht University

Quotations (translated)

"For Strangers must, in this respect, be understood all those, who did not in this here City studied, and of whom the Guild has never reaped any benefits." Amsterdam Surgeons' Guild, guild statutes, p. 19 (1796)

"When speaking of migration, we can discern three groups; actually, I would rather speak of "migrations". A first category consists of labour migrants: this group comes here in order to perform some form of labour. A second category consists of refugees/asylum seekers. These terms are, in practice, interchangeable. The final category, or actually the "big between-category" consists of migrants who have been admitted on humanitarian grounds. Think of family reunification or marriage. The "category" to which a migrant belongs is of large significance for the sort of procedures that the migrant needs to go through, on their legal status, etc., and influences their chances on the labour market." Rinus Penninx

"In the literature, multiple forms of integration are identified. There is, for example, structural integration, meaning amongst other things that a migrant has a job. Then we have cultural integration, social integration, and finally psychological integration. A well-known model by Milton Gordon assumes that these different levels of integration take place in a

fixed order. The most important thing is that a migrant finds a job (structural integration); the rest may follow after." Maykel Verkuyten

"We ought to make an important distinction between doctors with a migration background who were educated in the Netherlands (known otherwise as 'primary entrants'), and doctors who were educated abroad (so-called 'side-entrants'). The foremost problem among doctors with a migration background is language. This is of course more true, or exclusively true, for side-entrants, who were not raised with the Dutch language (as opposed to primary entrants). In addition to this problem, side-entrants living in families where not Dutch but Arabic, Farsi, etc., is the spoken language will acquire the Dutch language only at a slow pace." Paul Herfs

"Some mistakes have perhaps been made since then on the terrain of migration, but always with good intentions. What is the alternative? Learn nothing from WWII, and go back to racial discrimination? I do not believe that to be an alternative. (…) We were perhaps too optimistic about integration. We did not foresee the cultural reversal: the way in which people related themselves to the topic of migration. And we also did not foresee the big effect that the economic crisis of '88 would have: whole groups of migrants became jobless as a result of that." Jan Lucassen

"I received a lot of important help from seniors during my promotion and specialisation track. One of them was my supervisor who, during my PhD, intensively sparred with me and checked my work. There were others as well, like a professor, and a senior colleague. I feel that this relationship between master and student was very much present and important. Not only did I receive help and instructions personally from my seniors, but they also judged the quality of my work. If I performed below-par, I could get in trouble! During this stage of my career there never were any exams, so my progression was always personally judged by superiors." Anonymous cardiologist

"The power of the guild was in fact limited. They had a monopoly, namely on the terrain of who was to exercise a certain craft, but not on the number of people who were eligible. Anyone could request to perform their masterpiece [*a test that determined whether craftsmen were of sufficient level to become a master craftsman,* Piet], assuming that they met the conditions. Any attempt to "lock the market" was blocked by the city magistrates. Those magistrates did grant certain privileges to the guilds, so that those who earned a living being a craftsman could earn a proper wage, but they rarely allowed the guilds to become so powerful that they were in the position to bump up their prices too much. That was, after all, to the detriment of other citizens." Maarten Prak


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Chapter 2

Newcomers, Migrants, Surgeons: Making Career in the Amsterdam Surgeons' Guild of the Eighteenth Century

Based on: Groot, P. J. (2020). Newcomers, Migrants, Surgeons: Making Career in the Amsterdam Surgeons' Guild of the Eighteenth Century. *TSEG - The Low Countries Journal of Social and Economic History*, *17* (3). https://doi.org/10.18352/tseg.1107

Author contributions: Piet Groot uncovered the guild data from the archives, performed statistical analyses, and authored the manuscript. Maarten Prak provided invaluable input during all stages of the investigation, and edited several versions of the manuscript.

Abstract

Like many modern organizations, the Amsterdam Surgeons' Guild recruited its members during the eighteenth century from the ranks of locally born citizens as well as migrants. But how a surgeon's migration status impacted his chances of being admitted by, and making a career within, the Surgeons' Guild, remains a mystery. This article analyses enrolment lists of apprentices, journeymen, and master surgeons in order to find out how a surgeon's birth-place influenced his chances of a career within the Amsterdam Surgeons' Guild. By looking at the guild's official stance towards newcomers, and pairing this with the actual career paths of migrants within the Amsterdam Surgeons' Guild, this article demonstrates that migrants could be retained for the guild if they received their apprenticeship training in Amsterdam. In other words, it was not so much origin, but rather the geography of education and work that shaped careers. These results reveal mechanisms of integration that can be generalised to cases outside the Amsterdam Surgeons' Guild.

Introduction

Trouble in the surgeons' guild. In 1732 a crisis engulfed the Amsterdam Surgeons' Guild. Several petitions were presented by angry guild members to the guild's board of directors: two petitions signed by 61 master surgeons,[1] one by a group of 50 barbers,[2] another one by a dozen Jews,[3] and still another by a handful of surgeon's widows.[4] But while the barbers, the Jews, and the widows demanded from the Board a more equal treatment as members of the Surgeons' Guild, the master surgeons wanted the exact opposite. They claimed that barbers and Jews should not have been admitted to the guild in the first place: with their cheap and unskilled labour they were unfair competition, and would also undermine the reputation of the Amsterdam surgeons among the public. This argument resounded in the report of the special committee tasked with settling the matter: the illegal admittance of *unskilled* barbers and Jews into the guild's membership was mentioned as the explicit reason for removing the Guild's board members from their office in 1732.[5] The appeal of the master surgeons had clearly won the day, and the barbers (and Jews) were subsequently again excluded from the guild.

This story highlights a problem that is as relevant today as it was almost three hundred years ago. Members are essential to any organization, but how should the organization select and integrate new members? Nowadays it is no longer allowed to refuse employees based on their religion or ethnicity, but it is no secret that in the Dutch labour market discrimination based on these attributes persists.[6] Craft guilds, however, differed from modern organizations in how they integrated new members – be they migrants or locals. Crucially, craft guilds were involved with the vocational training of prospective members, often from a young age, through the system of apprenticeship.[7] This differs from current day practice, where the Dutch state takes responsibility for the education of youngsters under eighteen years, while medical doctors are subsequently trained at university. In theory, migrants under the guild system would have had a longer time to be socialized into the local community, potentially leading to a better local career perspective.

We know from recent studies that guilds and towns sometimes privileged locally trained apprentices over those who were trained elsewhere.[8] This could be taken as a sign that the local training provided by craft guilds indeed served the purpose of integrating and retaining migrants within the organization. So, did it? The primary goal of this paper is to investigate whether a craft guild—specifically, the Amsterdam Guild of Surgeons—distinguished between locals and migrants at different stages of the guild career ladder (i.e., apprentices, journeymen, and masters), and whether the guild's training programme contributed towards the retention of migrants within the guild. This paper supports the idea that a distinction can be made between a group of more 'local' or 'settled' individuals in craft guilds, versus a group of more 'mobile', migrating individuals.[9] However, it also argues that an early introduction into the guild led to retention of migrants within the guild – possibly to the benefit of those migrants. By doing so, this paper provides a new element of discussion to the ongoing debate about guild openness to outsiders.[10]

In the following pages I will first examine potential explanations for why craft guilds might have favoured locally trained craftsmen over those who had completed their apprenticeship in a different town. I will then introduce my case study of the Amsterdam Surgeons' Guild, starting in the year 1736 with the printing of new Guild Regulations. These were the result of the guild's attempt to resolve its issue with corrupt board members, and to consolidate the reforms that were to safeguard the guild's continued existence until 1798. During this period, the Amsterdam Surgeons' Guild maintained an impressive administration, including lists of individuals seeking entry to the guild, allowing me to answer the following two research questions: *How open was the Amsterdam Surgeons' Guild to migrant newcomers in the eighteenth century?* and *How did the Amsterdam Surgeons' Guild's admittance and training policy affect the retention of migrants within the guild?*

Theory

Craft Guilds. In much social and economic history research about late medieval and early modern Europe, craft guilds take centre stage, as they played an important role in the occupational and social structure of urban life. For over two centuries now, historians and economists have debated whether this role was more benign or more detrimental to urban society, and this discussion continues today. Relevant studies focus on whether or not craft guilds were conducive to technological innovation, whether they wielded political power, whether the apprenticeship system was effective, how guilds impacted daily social life, and indeed whether they manipulated labour markets, whether they were open or closed to newcomers, and what kind of entry barriers they maintained.[11] Recently, the focus of historical research has shifted towards the interplay between craft guilds, urban and national policy makers, and migration patterns.

A recurring theme in this research deals with how craft guilds handled the continuous influx of newcomers into their organizations. Migration was a ubiquitous phenomenon in late medieval and early modern Europe: youngsters moved in search of occupation from rural areas to urban centres, which welcomed them to compensate for their negative birth

ratio; trained journeymen moved between towns in search of work and experience, or a place to settle down.[12]

Source: Detail from *Jacob Franszn (ca 1635-1708) and family in his barber-surgeon shop*, by Egbert van Heemskerck (ca 1634 - 1704), Amsterdam Museum.

Craft guilds often negotiated with city authorities about the entry conditions for these migrants. While governments believed that it was in the best economic interest for their city to maintain a welcoming stance towards migrants, craft guilds sought to control the number of newcomers so as to reduce the competition between practitioners of their craft. Determining how many—and which kind of—newcomers were optimal was, however, complicated, as it depended on external factors as well as on power relations within guilds and between guilds and the city government.[13] For example, the city of Antwerp experienced an economic and population boom during the sixteenth century, causing the city council to attract masons from outside the city. This was much to the discontent of the Masons' Guild, which feared a rise in competition and a drop in wages. A compromise was reached by creating a distinction between locally trained ('free') journeymen who had the prospect to become master mason, and foreign trained ('unfree') journeymen who could be

hired only for a limited time and who did not qualify to become a master mason. This solution did not, however, manage to prevent much competition between masons, until after the Sack of Antwerp in 1576 demand for foreign masons plummeted.[14]

The observation that some craft guilds distinguished between locally trained and foreign trained apprentices touches on an unexplored but potentially important aspect of craft guilds' attitude toward outsiders. Becoming part of the guild required an investment of time and money on the part of the applicant.[15] A point could be made that this worked to the advantage of locally born individuals, since they would have had more time and opportunity to master local rules, become part of the guild network, and work their way up within the organization. In practice, however, craft guilds held numerous migrants within their ranks. In the Low Countries, guilds recruited 42 per cent of their members from outside the town, in England this was 55 per cent, and in Germany 62 per cent.[16] For guild apprentices there is less data, but findings also point to a relatively open guild policy towards migrants.[17] These data suggest that craft guilds managed to attract and retain migrants, despite the fact that they first needed to be socialised into the local community. Why, then, was there sometimes a need to distinguish between 'free', locally trained apprentices, and 'unfree' ones trained elsewhere? Or, put in the words of De Munck and Davids: 'In which trades was apprenticeship an entry to the status of free journeyman or, rather, to the status of master, and how does this affect our understanding of [craft guilds'] attempts to bind apprentices to the trade?'[18]

Craft guilds' preference for locally trained craftsmen might be explained in several ways. Perhaps the most obvious is that craft guilds believed that their own apprenticeship training resulted in superior skill.[19] However, one study about the city of Antwerp comparing locally trained gold- and silversmiths and shearers with those who were trained elsewhere, found that the latter ended up having the more successful careers. Of the craftsmen who completed their apprenticeship locally –whom the city authorities rewarded with free citizenship – most ended up working for foreigners who did buy their own citizenship. The craftsmen who were given free citizenship were also unlikely to hold guild board positions or become famous wealthy merchants.[20] So although the city of Antwerp found the locally trained migrants important enough to retain by granting them free citizenship, it was not likely due to their superiority in skill.

Perhaps something less tangible than skill underlies the preference for locally trained craftsmen, or even distrust of craftsmen who were trained in a different town or city.[21] When during the second half of the seventeenth century English and German cities welcomed many Huguenot refugees in order to replenish their war-struck populations, there was often a strong reaction from local craftsmen against these newcomers. At stake was not so much competition, but a perceived threat to the concept of *Nahrung*: the set of guild-specific customs including the ideal of distributing income in order to protect members against poverty. Huguenots could not always prove that they had the right set of skills to be deemed worthy of the guild, and neither could they – as refugees – always prove their 'honest birth'. Guilds were at risk of losing reputation by admitting such individuals.[22] Local

training could therefore perhaps take on the function of a rite of passage, or a period through which an apprentice proves that he is trustworthy enough to become part of the guild community.

There were indeed many benefits to being a guild member: social activities like guild funerals and shared meals were common throughout, for example, the Low Countries, though more so in the South than in the North.[23] And many craft guilds – be it with varying success – also managed to develop primitive social security systems, designed to support sick or poverty stricken guild members, and guild members' widows.[24] Not only did guilds have a strong commitment to their members, they also contributed to the society outside the guild: guild members provided public services like fighting fires, defending the city against invaders, and keeping the peace. As responsible members of society, guilds had a reputation to maintain within the local community.[25] These might have been reasons for craft guilds to favour individuals whom they had known and trained for a longer time.

Amsterdam and the Amsterdam Surgeons' Guild. Although a distinction emerged between free and unfree, locally trained and non-locally trained, journeymen in parts of the Southern Netherlands over the course of the seventeenth century, the same was not true for the Northern Netherlands.[26] But the Northern Netherlands, and especially Amsterdam, differed from the Southern Netherlands and the rest of Europe in other respects as well. It has been argued that the relatively weak representation of craft guilds in local government led to a more open policy towards migrants, and a subsequent technological advantage.[27] For the city of Amsterdam this was true throughout the early modern period, even in the eighteenth century when other major cities in the Northern Netherlands such as Leiden tried to close themselves off for migrants.[28] Perhaps as a consequence of this open policy, Amsterdam was the only major city in the Northern Netherlands to maintain a stable population during the economically challenging eighteenth century.[29]

The overall impression is that cities and craft guilds in the Northern Netherlands were relatively welcoming towards migrants. In the North, entry fees for craft guilds were generally lower than in the South, and guilds spent less of that money on symbols of corporate identity such as guild halls, and instead invested in social security. Nor did North-western cities impose high citizenship fees on Jews and Catholics, compared to Eastern and Southern regions.[30] Unexpectedly though, in the Northern Netherlands – and not in the Southern Netherlands – craft guilds often charged migrant apprentices higher fees than locally born apprentices.[31] And what is more telling, in the Northern Netherlands a smaller percentage of guild members was recruited from out of town than in Germany and England.[32] So although cities in the Northern Netherlands have a reputation of being more open towards migrants than neighbouring regions in the early modern period, this may not hold true for craft guilds.

Moving on to the Amsterdam Surgeons' Guild: this guild may have had some reason to distrust surgeons who were not trained in Amsterdam. First of all, being a surgeon was a respected profession in the seventeenth and eighteenth centuries. Although not as respected as university trained *medicinae doctores*, autonomous practitioners like master

surgeons stood in relatively high regard. They could also occupy positions of importance in local society such as country doctor, general surgeon, major surgeon or company surgeon in the army or at sea, or become part of the supportive staff in the military. Between 1700 and 1747, about 33 per cent of Amsterdam-based master surgeons were migrants, mostly from the Eastern Netherlands and German regions: regions with generally few economic opportunities. This may be an indication that youths migrating to Amsterdam saw the profession of surgeon as an opportunity to attain a higher social status.[33]

Second, a negative stereotype about travelling practitioners developed during the seventeenth century, and these practitioners had trouble gaining entry to the guild. One disgruntled German surgeon, Johan Herman Francken, who immigrated to Amsterdam in 1716, found access to the Surgeons' Guild blocked for this reason. In order to prove that journeymen who completed their apprenticeship were in fact respectable individuals, the city of Groningen supplied them with a special letter or *gildenbrief* in evidence of this fact.[34] Keeping these potential reservations towards migrants in mind, the following section will examine the Amsterdam Surgeons´ Guild´s admittance policy with respect to local and migrant newcomers.

Case Study: The Amsterdam Surgeons' Guild

Sources, measures, and method. Information about apprentice surgeons, journeyman surgeons, and master surgeons was obtained from enrolment lists kept by the Amsterdam Surgeons' Guild between 1747-1798 (apprentices), 1761-1775 & 1789-1798 (journeymen), and 1734-1798 (masters). I limited the study to 100 apprenticeship entries between 1759-1761, 500 journeyman entries between 1761-1765, and 354 master entries between 1761-1797. Thanks to the overlapping time periods, this method allowed me to track any apprentice and/or journeyman progressively throughout his career within the Amsterdam Surgeons' Guild – that is, from apprentice to journeyman to master. A limitation of using cohorts in this way is that journeymen and masters could not be traced backwards (from master to journeyman to apprentice).

The information provided in the written records of apprentice, journeyman, and master surgeon enrolment include starting date, given name, surname, contract duration in years, town of origin, and, for apprentices and journeymen, also the name of the master under whom they would serve. Additionally, for apprentices and journeymen the entry fee paid to the Amsterdam Surgeons' Guild was known – which could vary from case to case based on whether the apprentice or journeyman had to pay for registration, *lesbrief* (tuition money), or a botanical garden badge. Since the tuition money only had to be paid once in Amsterdam, it serves as a proxy for journeyman newcomership to the Amsterdam Surgeons' Guild (i.e., journeymen who did not have to pay this tuition money upon enrolment must have already done so at an earlier stage, meaning they had a track record within the guild). A second variable that I added to this source material was the distance travelled in kilometres, as the crow flies, between the surgeon's town of origin's coordinates (obtained from Google Maps) and Amsterdam. Furthermore, since enrolment date and age at the time of

enrolment was known for most masters, I could calculate master age and experience at the time a journeyman contracted with a master. Specifically, master experience was calculated by counting the number of years that had passed between the master's first enrolment into the guild and the date that he contracted an apprentice or journeyman. Likewise, master age was calculated by adding his experience in years to his age at first enrolment.

Statistical analysis of the quantitative data was done in two separate stages. First, differences between surgeons born in Amsterdam, the Netherlands, and outside were examined on the variables mentioned in the previous paragraph. For example, whether journeymen of different birth place differed in terms of contract length or type of master for whom they worked was examined. This was done visually through boxplots, for which a Chi^2 test provided a further statistical test, and through analysis of variance (ANOVA). In the second part, the variables that were found to differ between surgeons of Amsterdam, Netherlands, or foreign birth place were used as independent variables predicting the probability that an apprentice surgeon appeared also on the list of journeyman surgeons, or that a journeyman surgeon appeared also on the list of master surgeons. The statistical analysis used for this step was logistic regression, which tries to predict the outcome on a binary variable (in this case: promotion within the guild, yes or no). In other words, in the first step simple differences were examined between surgeons of Amsterdam, the Netherlands, and foreign birth place; and in the second step, it was examined whether those differences also predicted career making in the Amsterdam Surgeons' Guild (defined as moving from apprentice to journeyman, or from journeyman to master).

Formal distinctions: apprentices, journeymen, masters. When investigating how the Amsterdam Surgeons' Guild dealt with the admittance and integration of migrant newcomers, it makes sense first to determine which different ranks existed within the guild, and how the guild guarded the entry into each of those ranks. If we, for a moment, forget about the widows, wives, Jews, quacks, vendors, board members, professors, and other individuals connected to the Amsterdam Surgeons' Guild in one way or another, we are left with a core of three different groups: apprentices, journeymen, and masters. Of these, only the master surgeons were accredited with full guild membership, as is evident from the fact that only masters were consistently referred to as 'brothers' or 'guild brothers' in the guild's statutes; also the parts of the statutes pertaining to the admittance of new members referred exclusively to master surgeons.[35] With this membership came the right to claim sick leave, and alimentation money for their widows, but also obligations to pay annual contributions and attend guild funerals. Most importantly, master surgeons were allowed to start their own practice: display the signs of the Surgeons' Guild, hire apprentices and journeymen, and treat patients. They were no longer mere assistants, but independent surgeons. Apprentices and journeymen were part of the guild in the sense that they were being trained by – and worked for – the masters.

In order to prepare surgeons for their responsibilities as master surgeon or surgeon-at-sea, the Amsterdam Surgeons' Guild obliged surgeon's apprentices and journeymen to attend lectures throughout their training in Amsterdam. Besides weekly lectures in surgery

and anatomy, there was the possibility to attend lessons in the botanical gardens, during which surgeons learnt about the healing properties of plants and medicines, which also took place weekly. Together with a minimum two years of working as an apprentice and three years as a journeyman, this would ensure the experience necessary to become a master surgeon. Whether a surgeon had indeed achieved a sufficient level of skill during his formative apprentice and journeyman years, was tested by the Surgeons Guild through a series of examinations. These exams were optional in the sense that they only had to be completed if a surgeon wanted to become master surgeon; until the moment of examination, skipping the mandatory surgical lessons had no consequences for the apprentice or journeyman other than hampering his chance to ever become a master surgeon. At the start of the apprenticeship period, only a small registration fee of 3 florins had to be paid to the guild, along with a fee of 2.5 florins to pay for the weekly surgical and anatomical lessons. This fee had to be paid only once during a surgeon's career, after which he received his so-called *lesbrief*, an attestation that he had paid to attend the lessons. A botanical garden badge cost 4 florins.[36]

Journeymen were subjected to almost the same conditions as apprentices, in that they had to pay the guild 3 florins for registration (at the start of each contract) and 2.5 florins for their *lesbrief,* or proof of tuition (if they had not already done so during their apprenticeship). In addition, journeymen had to be able to prove, through the attestations of their former master, that they had completed an apprenticeship period of two consecutive years. Since journeymen were considered more capable than apprentices, they received pay from their master. Contracts typically lasted two to three years. Like the apprentices, journeymen had to attend weekly surgical and anatomical lessons, and could decide to pay 4 florins to follow lessons in the botanical garden for a year.

The more difficult career step seems to have been from journeyman surgeon to master surgeon. As stated before, the entry into the rank of master surgeon was guarded by a series of examinations: this was the litmus test indicating whether a surgeon had actually mastered the right surgical skills during his formative years. First there was a formal demand that only Amsterdam citizens could perform the test that led to the promotion to master surgeon; citizenship could, however, be obtained relatively easily and cheaply.[37] A second, more formidable obstacle was the amount of money that needed to be raised in order to perform the examinations that led to the title of master. In 1733 these costs were set at 250 florins: 10 for the attending professor, 60 for the guild board members, 6 for the guild servant, 1 for the poor, and 173 for the guild's social security funds.[38] Even if we count the 173 florins as a personal investment (health insurance), it was still a huge sum compared to the enrolment fee of apprentices and journeymen, which cost just 3 florins. If born a citizen's son or a master surgeon's son, one could get a discount of 8 or 15 florins respectively (see Table 1 on the next page).

Table 1. Entry fees for apprentices, journeymen, and masters as of 1733

	Apprentice	**Journeyman**	**Master**
Registration fee	*f* 3	*f* 3	*f* 250
Lesbrief	*f* 2.5	*f* 2.5	-
Botanical badge	*f* 4	*F* 4	-
Discount: citizens / sons of masters	- / -	- / -	*f* 8 / *f* 15

Note: The *lesbrief* and botanical garden badge needed to be bought only once during either the apprenticeship or the journeyman stage. *Source:* SAA366/231.

A final but substantial hurdle was the successful completion of the exams themselves. These consisted (as of 1597) of one theoretical exam about the art of surgery, one practical exam at the hospital on bandages, and one mixed exam where the examinee had to perform phlebotomy and answer questions. These exams were not a mere formality as is evident from the many second or even third attempts that examinees had to make; sometimes an examinee gave up efforts altogether.[39] Besides passing the exams, a candidate master surgeon also had to show that he had faithfully attended lectures of anatomy, surgery, and botany, during his apprenticeship and journeyman stage, if those stages were completed in Amsterdam. If not, he had to pay a fine of 8 florins for missing the botanical lessons, and 50 florins for missing the surgical and anatomical lessons. This fine was meant to encourage apprentices and journeymen to really attend their lectures.[40] Upon graduating, the fresh master surgeon received a printed copy of the Guild Regulations (for the price of 1.2 florins).

Migrant newcomers attending the master surgeon's exam were, in contrast to locals, exempt from the requirement to have attended lectures of surgery, anatomy, and botany in Amsterdam.[41] All they needed was the attestations of former masters, to show that they had at least five years' worth of experience outside the city of Amsterdam. This recognition of foreign experience, it can be argued, made it easier for migrant newcomers to become a master surgeon in Amsterdam straight away. On the other hand, would-be masters still needed to pass the examinations barring the way to guild membership in Amsterdam; for this, it may have been to their disadvantage that they never enjoyed any training or attended lessons in Amsterdam.

Newcomer admittance in practice. Now that we have established that there were different ranks within the guild, each with their own formal entry criteria, it is time to investigate how open the guild was to migrant newcomers at each of those three ranks. How did the formal entry criteria of the Amsterdam Surgeons' Guild translate to admittance in practice?

The relatively open policy toward migrant apprentices and journeymen is reflected in the Surgeons' Guild's admission numbers (Table 2, second column). What strikes us immediately is the varying proportion of migrants among apprentices, journeymen, and masters. From pre-marriage contracts, we know that between 1760 and 1800 approximately 48 per cent of the population of marrying men in Amsterdam was native to that city; the largest migrant groups at the time accounting for 23 per cent (Dutch other than Amsterdam)

and 22 per cent (Germans) of the marrying male population.[42] If we take these percentages to reflect the settled male population in Amsterdam, we must conclude that the German community living in Amsterdam delivered fewer apprentice surgeons than was to be expected based on their population numbers. At the apprenticeship stage, Amsterdam-born were overrepresented.

Table 2. Origin and other personal characteristics of apprentices, journeymen, and masters enrolled in the Amsterdam Surgeons' Guild between 1759-1761, 1761-1765, and 1761-1797 respectively

Apprentices

Origin	N (%)	Contract duration in years (*SD*)	Son of master N (%)
Amsterdam	62 (63%)	2.8 (.5)	7 (11%)
Netherlands	20 (20%)	2.5 (.5)	1 (5%)
Germany	10 (10%)	2.4 (.5)	1 (10%)
Other	4 (4%)	2.5 (.6)	0
Unknown	2 (2%)	3 (1.4)	0
Total	**98**	**2.7 (.5)**	**9 (9%)**

Journeymen

Origin	N (%)	Contract duration in years (*SD*)	Son of master N (%)	First time enrolment
Amsterdam	134 (29%)	2.4 (.6)	10 (7%)	11/134 (8%)
Netherlands	193 (42%)	2.3 (.6)	4 (2%)	126/193 (65%)
Germany	102 (22%)	2.2 (.5)	1 (1%)	80/101 (79%)
Other	14 (3%)	2.2 (.6)	0	11/14 (79%)
Unknown	16 (3%)	2.4 (.6)	0	14/16 (88%)
Total	**459**	**2.3 (.6)**	**15 (3%)**	**242/459 (53%)**

Masters

Origin	N (%)	Avg. distance in km (*SD*)	Avg. starting age in years (*SD*)	Avg. time until promotion in years (*SD*)
Amsterdam	161 (46%)	0 (0)	25.7 (3.8)	8.2 (2.8)
Netherlands	115 (33%)	72 (41)	28.0 (4.4)	8.7 (6.3)
Germany	66 (19%)	219 (119)	29.6 (5.2)	11.0 (1.9)
Other	8 (2%)	1208 (2656)	27.3 (3.7)	-
Unknown	4 (1%)	-	23 (0)	-
Total	**354**	**92 (426)**	**27.2 (4.5)**	**8.5 (4.6)**

Sources: Apprentices: SAA366/255, Journeymen: SAA366/252, Masters: SAA366/246

Among journeyman surgeons, the tables seem to have turned, with a relatively high proportion of journeymen having been born outside the city of Amsterdam. This could be an

indication that at the journeyman stage there were many migrant newcomers supplementing the workforce of the Amsterdam Surgeons' Guild. This indeed appeared to be the case: of journeymen registering between 1761 and 1765, about half had to buy their *lesbrief* (proof of tuition), indicating that they enrolled into the Amsterdam Surgeons' Guild for the first time (Table 2, mid section, final column). This was almost completely on the account of a large influx of Dutch and German migrants at this stage. Among Amsterdam-born journeymen only eight per cent had to buy a *lesbrief*, indicating that most of them had indeed completed their apprenticeship in Amsterdam. Statistically, the percentage of first enrollers among journeymen differed significantly between journeymen born in Amsterdam, the Netherlands (outside of Amsterdam), Germany, and other places in Europe.[k]

Comparing the birth places of masters with apprentices and journeymen (Table 2, second column), we see that Dutch and German migrants were better represented among masters than among apprentices, but less so than among journeymen. Apparently, the huge influx of migrants at the journeyman stage also resulted in an improved representation of migrants among masters—meaning that at least some of the migrant journeymen became masters in Amsterdam—but this compensated only partially for the fact that fewer migrants were trained as apprentices in Amsterdam from the start.

Migrant Career Trajectories: Who Trained Whom?

A major concern for any apprentice was in finding a suitable master surgeon to live with. The master was to provide the apprentice with food, lodgings, and training. The same was true for journeymen. If master surgeons discriminated against hiring migrant apprentices and journeymen, then we would expect to find few migrant newcomers among those ranks. Since this was only the case (to an extent) among apprentices, but not at all so among journeymen, there may have been different processes going on in both groups.

Apprentices. As can be seen in Table 2 (top section, third column), apprentices coming from Amsterdam appeared to contract themselves, on average, for longer periods of time per contract; however, this trend did not reach significance when subjected to statistical analysis.[l] Amsterdam-born apprentices surprisingly also did not work for their own father more often than migrant apprentices, though the small number of observations make it hard to make firm conclusions (Table 2, top section, fourth column).[m] Table 3 (p. 56) displays some characteristics of the masters under whom apprentices trained. The first column shows the origin of the apprentice, while the second column shows the distribution of apprentices over masters of different origins. Interestingly, apprentices of differing origin

[k] Crosstabs with newcomer status (yes vs. no) on the columns and journeyman origin category on the rows showed an uneven distribution, a fact that was statistically significant: $\chi^2(3) = 142.7$, $p < .001$. See also Table 2, middle section, final column.

[l] Crosstabs with contract duration (2, 3, or 4 years) on the columns and apprentice origin category on the rows showed an even distribution, $\chi^2(6) = 10.3$, $p = .113$. See also Table 2, top section, third column.

[m] Crosstabs with 'works for father' (yes vs. no) on the columns and apprentice origin category on the rows showed an even distribution, $\chi^2(3) = 1.1$, $p = .768$. See also Table 2, top section, fourth column.

were not divided evenly over masters of differing origins: apprentices from Germany, for example, all worked for masters from Germany.[n] The masters training Amsterdam-born and Dutch migrant apprentices also appeared to have been younger than the masters who trained foreign apprentices (Table 3, top section, third column). However, if younger, these masters were not less experienced than those training foreign apprentices (Table 3, top section, fourth column).[o] Finally, the fifth column of Table 3 shows that masters who contracted apprentices over the investigated three year period (1759-1761), contracted on average 0.4 apprentices per year. If that number is to be interpreted as a proxy for more successful masters (who could train more apprentices), then we see that apprentices of differing origins trained with masters who were all similarly successful.

Journeymen. For journeymen, a similar approach can be used. Journeymen contract lengths did not appear to differ much for journeymen of different origins (Table 2, middle section, third column).[p] Journeymen from Amsterdam however did work for their own father relatively more often than journeymen originating from outside Amsterdam, which not so surprisingly points to the fact that few migrant journeymen had fathers working as master surgeon in Amsterdam (Table 2, middle section, fourth column).[q] Looking at other characteristics of the masters for whom journeymen worked, we again find some differences for journeymen coming from Amsterdam, the Netherlands, and outside (Table 3, bottom section, second to fifth columns). Just as was the case with apprentices, journeymen of different origins were not divided evenly across masters of different origins. This effect was only found if German and Other origin journeymen were aggregated to form one group of 'foreign' journeymen, but if done so, then the foreign journeymen worked more often than would be expected by chance for foreign masters.[r] And again, just as with apprentices, the

[n] Crosstabs with master origin on the columns and apprentice origin on the rows showed that apprentices of different origins were not equally distributed over masters with different origins, $\chi^2(9) = 27.1$, $p = .001$.

[o] Since the German origin group and the 'other origin' group both had a small number of observations, i.e., 7 and 3 respectively, they were added to form a group of 'foreign' apprentices. Analysis of variance (ANOVA) was performed to check whether master age differed between apprentices coming from Amsterdam, the Netherlands, and outside ('foreign'). The ages of masters appeared to differ between those group, but did not reach statistical significance, $F(2) = 3.08$, $p = .052$. A similar analysis yielded no significant effect of apprentice origin on master experience, $F(2) = .284$, $p = .753$.

[p] Crosstabs with contract duration (1, 2, 3, 4, or 5 years, rounded to the nearest year) on the columns and journeyman origin on the rows showed an even distribution: $\chi^2(12) = 15.4$, $p = .222$. See also Table 2, top middle section, third column.

[q] Crosstabs 'with works for father' (yes vs. no) on the columns and journeyman origin on the rows showed that the distribution of journeymen who worked for their father was uneven across journeymen origin categories, $\chi^2(3) = 10.1$, $p = .018$

[r] Crosstabs with master origin (Amsterdam, Netherlands, or Foreign) on the columns and journeyman origin (Amsterdam, Netherlands, or Foreign) on the rows showed that journeymen of different origins were equally distributed over masters with different origins, $\chi^2(4) = 10.4$, $p = .035$.

masters for whom journeymen worked were of different age (column three), but similar in terms of experience (column four), and success (column five).[s]

Table 3. Characteristics of masters split by the origin of the apprentices and journeymen that they trained

Masters who train apprentices

Apprentice Origin	Master origin	Master age (*SD*)	Master experience (*SD*)	Avg. Apprentices hired/year (*SD*)
Amsterdam	**A**16 **N**24 **G**14 **O**1	38.6 (9.6)	11.4 (8.2)	0.4 (0.2)
Netherlands	**A**6 **N**10 **G**3 **O**0	34.4 (7.3)	10.0 (8.3)	0.4 (0.1)
Germany	**A**0 **N**0 **G**7 **O**0	44.0 (6.0)	12.8 (9.4)	0.4 (0.2)
Other	**A**3 **N**0 **G**0 **O**0	40.3 (8.4)	9.7 (4.9)	0.3 (0.0)
Unknown	-	-	29.0 (-)	0.5 (0.2)
Total	**A**25 **N**34 **G**24 **O**1	**38.2 (10.8)**	**11.3 (8.4)**	**0.4 (0.2)**

Masters who hire journeymen

Journeyman Origin	Master origin	Master age (*SD*)	Master experience (*SD*)	Avg. Journeymen hired/year (*SD*)
Amsterdam	**A**38 **N**35 **G**27 **O**3	39.7 (11.1)	12.2 (9.3)	0.7 (0.4)
Netherlands	**A**67 **N**54 **G**27 **O**4	37.8 (10.2)	10.5 (8.6)	0.8 (0.5)
Germany	**A**33 **N**20 **G**28 **O**3	41.7 (10.1)	12.8 (9.1)	0.7 (0.5)
Other	**A**2 **N**4 **G**6 **O**0	40.3 (6.3)	11.3 (6.4)	1.0 (0.6)
Unknown	**A**5 **N**3 **G**4 **O**0	38.0 (12.2)	9.3 (8.4)	0.7 (0.4)
Total	**A**145 **N**116 **G**92 **O**10	**39.3 (10.5)**	**11.5 (8.9)**	**0.8 (0.5)**

Note. 'Master origin' displays how the total number of apprentices and journeymen from each origin category was distributed over masters with different birth place origins, where A = Amsterdam, N = Netherlands, G = Germany, O = Other master origin. *Sources:* Apprentices: SAA366/255, Journeymen: SAA366/252, Masters: SAA366/246

The Steep Path to Mastery

We have now established that the Amsterdam Surgeons' Guild, at a formal level, was very open for apprentices and journeymen, but less so for master surgeons, and that it made little to no formal distinction between native and migrant newcomers. In practice, however, migrant apprentices were underrepresented, while migrant journeymen were overrepresented within the guild. Furthermore, migrant apprentices and journeymen coming from outside the Netherlands trained with masters that were more often also foreigners, less often their father, and slightly older in age, but not less experienced. Next we

[s] Three separate analyses of variance (ANOVA) were performed in order to test whether journeymen of different origin categories (Amsterdam, Netherlands, or Foreign) ended up with masters of different age, experience, and success (in terms of average number of journeymen hired per year). Test results pointed out that this was indeed the case for master age, $F(2) = 3.72$, $p = .025$; but not for master experience, $F(2) = 2.06$, $p = .129$, or success, $F(2) = 1.42$, $p = .243$.

can ask: how did this apparently different career path of some of the migrant apprentices and journeymen, combined with the steep learning curve to becoming a master surgeon, affect their chances of becoming master surgeon within the Amsterdam Surgeons' Guild?

Of the initial 98 apprentices serving between 1759-1761, 55 (57 per cent) also contracted themselves as journeyman in Amsterdam in the following years (Table 4). It is not clear from these data if the remaining 43 per cent dropped out, or if they decided to become journeyman outside Amsterdam. However, the dropout ratio of apprentices in a comparable guild (the Leiden Surgeons' Guild) has been established at 40 per cent.[43] If Amsterdam surgeons' apprentices dropped out roughly as often, then that would imply that most of the apprentices who did finish their term (an estimated 60 per cent of the total) moved on to become journeyman in Amsterdam.

Table 4. Apprentices advancing to journeyman in Amsterdam, percentage of newcomers among journeymen, and journeymen advancing to master in Amsterdam

Birth place	**% Apprentices who became journeymen**	**% Newcomers among journeymen**	**% Journeymen who became masters**	
			Oldtimer	Newcomer
Amsterdam	58%	8%	15%	0%
Netherlands	60%	65%	18%	6%
Outside Netherlands	50%	79%	4%	5%
Total	57%	52%	15%	5%

Sources: Apprentices: SAA366/255, Journeymen: SAA366/252, Masters: SAA366/246.

Did the chance to become a journeyman differ between apprentices of different origin? A binary logistic regression analysis was carried out to predict the probability that an apprentice surgeon would continue his career as a journeyman surgeon in Amsterdam. In a first step, apprentice origin distance (a continuous variable containing the distance between an apprentice's hometown and Amsterdam measured in kilometres) was added to the model, to see if apprentices had a different chance to become journeyman in Amsterdam based on their origin. The result was not significant, indicating that apprentices had an equal chance to become journeyman in Amsterdam regardless of how far away their initial birth place was from the Amsterdam (see also Table 4, first column).[t] In a second step, average contract length, and the age and origin of the master hiring them were added as independent variables to the model, to see if these career aspects influenced the chance to become journeyman. Adding these variables did not lead to a better model.[u] In other words, apprentices had similar chances to become journeyman in Amsterdam regardless of their birth place, and although we have previously established that Amsterdam-born and migrant

[t] Logistic regression (method = enter) with origin distance in km as predictor variable yielded no significant model improvement over the intercept model, $\chi^2(1) = 1.93$, $p = .165$. See Appendix, Table A.

[u] When these predictor variables were entered simultaneously (method = enter), they made no significant improvements to the model, $\chi^2(4) = 1.13$, $p = .889$.

apprentices trained under different masters (i.e., German apprentices trained more often with German and older masters), these career aspects did not affect their chances of becoming a journeyman in Amsterdam either.

A next step in a surgeon's career could be to move up from journeyman to master surgeon in Amsterdam. The requirements set up by the Surgeon's Guild for becoming a master surgeon were, however, significantly more formidable than those for becoming a journeyman. That these criteria had a real effect on who could (or wanted to) become a master surgeon, is reflected in the number of journeymen, working in Amsterdam between 1761 and 1765, who eventually enrolled as master surgeon: of these, only 43 out of 441 (approximately 10 per cent) made it to become master.

With the step from journeyman to master being so much steeper, it is conceivable that migrants suffered a larger disadvantage at this stage. At first glance this indeed appeared to be the case. A binary logistic regression model, with the probability of a journeyman surgeon being promoted to master surgeon as an outcome variable, yielded an effect of journeyman origin distance (distance between a journeyman's hometown and Amsterdam in kilometres) on his probability to become master surgeon.[v] In a next step, the variables which had previously been found to differ between journeymen of differing origin groups (i.e., 'works for father', master age, and master origin) were added to see if they explained why journeymen coming from outside Amsterdam had a smaller chance to become master. However, adding these career variables did not improve the model, indicating that if migrant journeymen had smaller chances to become master surgeon it was not due to missing out on the option to work for their own father, or due to working for foreign and younger masters.[w]

In search for another explanation of why migrant journeymen had a smaller chance to become master, two variables were added that can be taken as proxies for a journeyman's experience gathered within the Amsterdam Surgeons' Guild. *Newcomership* is a dummy-coded variable indicating whether a journeyman had or did not have any past experience with the Amsterdam Surgeon's Guild, at the initiation of a journeyman contract in the period between 1761 and 1765. *Number of contracts* is a variable counting a journeyman's total number of contracts initiated in Amsterdam in the period between 1761 and 1765. Adding these variables to the binary logistic model, previously containing only journeyman origin distance (in kilometres), significantly improved the model.[x] However, of these two predictors, only newcomer status made a significant impact.

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[v] Binary logistic regression predicting probability to become master. Adding journeyman origin distance in km. (method = enter) made a significant improvement to the model, $\chi^2(1) = 4.44$, $p = .035$. See Appendix, Table B

[w] Adding 'works for father', master age, and master origin as predictors to the model already containing journeyman origin distance in km., did not lead to an improved model. $\chi^2(4) = 2.76$, $p = .599$. See Appendix, Table B

[x] Binary logistic regression predicting probability to become master. Adding journeyman newcomer status and number of journeymen contracts to the model previously only containing journeyman origin distance in km. (method = enter) made a significant improvement to the model, $\chi^2 (1) = 7.71$, p

The final two columns of Table 4 display the relationship between journeyman birth place, newcomership, and the probability to become master in Amsterdam. Journeymen born in Amsterdam and other places of the Netherlands clearly benefitted from being an old-timer within the Amsterdam Surgeons' Guild, while this link was missing for foreign journeymen. Taken together, being a newcomer had a large effect on a journeyman's odds to become master later on: Journeymen who already had a track record within the Amsterdam Surgeons' Guild were 2.56 times more likely to become master in Amsterdam. The negative effect of journeyman origin should therefore be understood as stemming from the fact that many migrant journeymen arrived new to the guild. Many of them perhaps did not plan to make career within Amsterdam beyond being a journeyman, or went back to their home town after a while. In contrast, those journeymen who did have a previous track record in Amsterdam, for example because they had completed their apprenticeship there, more often stayed to become master. In other words, it was not so much origin, but rather the geography of education and work that shaped careers.

Conclusion

This paper set out to answer the questions *How open was the Amsterdam Surgeons' Guild to migrant newcomers in the eighteenth century?* and *How did the Amsterdam Surgeons' Guild's admittance and training policy affect the retention of migrants within the guild?* Taking these questions in conjunction, the answers are that a) the Amsterdam Surgeons' Guild, as an institution, differentiated between apprentices, journeymen, and master surgeons: between these stages the entry requirements were lower for apprentices and journeymen than for masters. b) At neither stage (apprentice, journeyman, or master) did the Surgeons' Guild make much distinction, in terms of entry criteria, between native and migrant newcomers, sometimes even lowering requirements for migrants. c) Migrant apprentices coming from outside the Netherlands, and also migrant journeymen, followed a somewhat different career path than locals. In comparison, they less often worked for their father, more often worked for older masters, and those masters were more often foreign. d) These slightly different careers did not, however, predict the chance to become journeyman or master in Amsterdam. e) What did predict the tendency to become master surgeon was whether or not migrants came new to the Amsterdam Surgeons' Guild during the journeyman stage, or whether they already had a track record. Journeymen who came as newcomer to the Amsterdam Surgeons' Guild between 1761 and 1765 were less inclined to become master surgeon in Amsterdam, compared with those who already had previous experience with the Amsterdam Surgeons' Guild. While being a migrant indeed predicted career opportunities within the Amsterdam Surgeons' Guild, this effect was explained by the fact that many migrants were newcomers to the Guild at a moment when there were already competitors – migrant or native – with more local experience.

= .021. Journeymen who had a track record within the guild were 2.56 times more likely to become masters than journeymen who had to pay tuition fee (and were therefore new to the guild), p = .015. See Appendix, Table C

Having the right skills to be a master surgeon seems to have been important to the Amsterdam Surgeons' Guild. Not only were the entry exams for master surgeon difficult to pass, but the guild also provided anatomical and botanical lessons, not just for the master surgeons, but also for apprentices and journeymen to attend.[y] However, a distinction between the locally trained and the non-locally trained surgeons becomes visible at this point. Perhaps due to the fact that the Amsterdam Surgeons' Guild did not distinguish *formally* between locals and foreigners at the journeyman stage, many migrating journeymen found occupation within the guild. The guild seemed to recognize that those migrants were needed, by keeping registration fees low, and by waiving the obligation to take the local lessons in anatomy and botany. Of these migrant journeymen, however, only few eventually became master surgeon in Amsterdam. The image arises that although the Amsterdam Surgeons' Guild did not make any formal distinctions between the foreign trained and the locally trained (like the distinction between 'free' and 'unfree' journeymen in Antwerp)[44], the locally trained surgeons were in practice more effectively prepared for the position of master surgeon in Amsterdam.

Missing from this analysis is the perspective of the migrants who came to Amsterdam to work in the Surgeons' Guild. The question is whether many of the migrant journeymen indeed intended to become master surgeon in Amsterdam, or not; but given that only about ten per cent of all journeymen eventually became master surgeon in Amsterdam, it is likely that many were satisfied with staying a journeyman, or moving to another city. In fact, a recent publication investigating the migration patterns of journeymen in the Northern Netherlands has suggested that the more highly skilled journeymen often travelled from town to town in order to gather experience, before settling.[45] Knowing more about the motivation of migrating journeymen to come to Amsterdam and other cities is therefore important, if one is to understand why some migrants did and some did not become master surgeon in Amsterdam. The current case study does not provide the opportunity to look more in depth into the motivation of the migrants that came to Amsterdam. However, in taking on the perspective of the Amsterdam Surgeons' Guild, this article hopes to demonstrate that craft guilds seemed to care about the training and education of their members, and, perhaps as a result of that training and education, managed to retain at least some of those migrants who were introduced to the guild as apprentices.

Another element that has so far only been touched upon briefly, is the economical position of Amsterdam during the eighteenth century. During the majority of this age, the Dutch economy was in decline.[46] Many Dutch towns responded by raising entry barriers for migrants and, perhaps as a consequence, saw their populations diminish. Amsterdam was an exception to this rule, however, and managed to maintain a steady population during the eighteenth century. By 1800, the Amsterdam population still existed for 24 per cent of

[y] For a beautiful illustration of a seventeenth-century lesson in anatomy provided by the Amsterdam Surgeons' Guild, see Rembrandt van Rijn's *The Anatomy Lesson of dr. Nicolaes Tulp*, 1632 (The Hague, Mauritshuis).

foreign born—more than double the number of foreign born in Leiden, Dordrecht, and Rotterdam.[47]

It is known that the open policy of Amsterdam towards migrants, coupled with economic decline, led to the formation of a group of impoverished labourers in Amsterdam, alongside the more settled or well-off population.[48] Such a policy, in which migrants find easy access to a city, but only gradually acquire the benefits of the welfare state through participating in the local labour market, has previously been described as a 'Tantalus Torment' system of immigration.[49] The case study described in this article shows that the Amsterdam Surgeons' Guild contributed to such a 'Tantalus Torment' system of immigration, by setting low entry barriers for migrant journeymen—a group of labourers that received few social benefits from the guild, and often worked on a temporary basis. At the same time, by also keeping entry barriers to migrant apprentices low, and by investing in professional education of apprentices and journeymen, the Amsterdam Surgeons' Guild offered a way for migrants to climb the ranks of the organizational ladder and obtain a more secure position.

Implications

One of the goals of this paper was to contribute to the discussion about the openness of craft guilds to outsiders in general. Put simply, that discussion portrays guilds either as closed-off organizations, purposely limiting the inflow of newcomers in order to boost the financial gains of a select few; or as a social club, proud of its craft and members, averting newcomers only where they threaten the well-being of the organization in general. Needless to say, the truth is more nuanced. This paper consciously focused on three different groups of newcomers (apprentices, journeymen, and masters), and distinguished between institutional openness and career paths in practice. In this way, this paper could demonstrate that craft guilds could be open to some newcomers (apprentices, journeymen) more than others (masters); and that craft guilds could be migrant-friendly at the institutional level (through rules and regulations), while at the same time putting the locally educated on the path that leads to master surgeon. With these distinctions, this paper hopes to add that guild *openness* is as much connected to training as it is to geography.

As for the actual openness of the Amsterdam Surgeons' Guild toward different sorts of newcomers, this paper maintains that newcomers' experience specific to the Amsterdam Surgeons' Guild was the most important selection criterion. With this finding, this paper hopes to question what it means to be a 'migrant' or a 'newcomer'. While these terms are often used interchangeably, the case study of the Amsterdam Surgeons' Guild shows that the two can be conceptually distinct. While the Guild harboured surgeons who had been born outside the city of Amsterdam—in other words: migrants—among its apprentices, journeymen, and masters, these migrants differed in the amount of experience they had gathered within the Amsterdam Surgeons' Guild. Some migrants entered the Amsterdam Surgeons' Guild already at the apprentice stage, while others came new to the city during the stage of journeyman. These 'newcomers' were less likely to later become master surgeon in Amsterdam. One could suggest that the Amsterdam Surgeons' Guild's internal

education system aimed to socialise newcomers, regardless of whether they were migrant or native, into experienced surgeons. This sets apart migrants from newcomers: migrants will never be natives—in the sense that they cannot change where they were born. But being a migrant is just one way in which one can be new to an organization, and through gaining experience within the organization a newcomer can become an old-timer.

This study's findings may have some implications for the debate about current-day hiring and discrimination practices of migrant newcomers by companies. A recent study of discrimination of migrant job applicants in the Netherlands, in which fictitious curriculum vitae were sent to real job openings, showed that Turkish migrants had a fifteen per cent lower chance to get a positive call-back after sending in their resume than native Dutch applicants.[50] This was despite the fact that these fictitious applicants had migrated to the Netherlands at the age of six, had followed their secondary education in the receiving country, spoke the language, and had the relevant qualifications and work experience for the job. This seems to contradict the findings in this study about the Amsterdam Surgeons' Guild, where experience obtained in the city of destination appeared to improve migrants' chances of making career within the organization. This raises the question whether there are perhaps also more hidden processes at work when it comes to the acceptance of migrants, even if they did accrue experience in the country of destination. Future studies should investigate how migrants with experience accrued in the country of destination are perceived by their social environment, versus those who accrued their experience outside the country.

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[18] De Munck and Davids, 'Beyond exclusivism', 208.

[19] Such as was the case with the Antwerp coopers' guild. R. De Kerf, 'The early modern Antwerp Coopers' Guild. From a contract-enforcing organisation to an empty box?', in: Davids and De Munck, *Innovation and creativity,* 261.

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[34] F. Huisman, *Stadsbelang en standsbesef. Gezondheidszorg en medisch beroep in Groningen 1500-1730* (Rotterdam 1992).

[35] I base myself on the printed version of the guild statutes of 1736. See SAA366/231.

[36] SAA366/231:P131, 135-136, 145

[37] As of 1668, if one was unable to pay 50 florins for Amsterdam citizenship, a small fee of just 2.4 florins could be paid for the right to practice a profession. See https://archief.amsterdam/indexen/poorters_1531-1652/handleiding/index.nl.html

[38] SAA366/231:P146

[39] SAA366/247:P11-15: Jan Abraham le Clerk first tries the theoretical exam on July 18, 1741, but is found incapable. He is bid to return on August 1st, where he will be given a final chance to prove himself; however, he is found to be so incapable that he is denied again. On February 2, 1742 the headstrong Le Clerk passes the theoretical exam on his third attempt, but subsequently fails the practical examination on bandages and anatomy. He may only return after attending a live demonstration of a dissection of a dead body. On April 13, 1742, Le Clerk successfully performs phlebotomy, and is admitted to the guild as a master surgeon. P16: On June 8, 1742, Willem van Aalst tries the theoretical exam, but is so unanimously found incompetent both in anatomy and in surgery, that he is never gain seen to make any attempt after.

[40] SAA366/231:P136

[41] SAA366/231:P151, only those '*who had lived here and attended lessons here'* were required to prove that they had actually attended the lessons.

[42] Dataset *Ja, ik wil*-project (unpublished), Research Team Institutions for Collective Action, Department of History and Art History, Utrecht University. This dataset will be accessible in due time via http://www.collective-action.info/datasets-various-types-institutions and is a result of the *Ja, ik wil!*-project, part of the VIDI-project 'Nature or nature? A search for the institutional and biological determinants of life expectancy in Europe during the early modern period' funded by the Dutch Organization for Scientific Research (NWO) (276–53-008).

[43] R. Schalk, 'Apprenticeships with and without Guilds. The Northern Netherlands', in: Prak and Wallis, *Apprenticeship in Early Modern Europe,* 202.

[44] De Munck and Davids, 'Beyond exclusivism', 205-6; De Kerf, 'The early modern Antwerp Coopers' Guild', 248-252.

[45] Groot and Schalk, 'Journeymen Migration and Settlement in Eighteenth-Century Holland', under review.

[46] Israel, *The Dutch Republic*, 998-1016.

[47] Lucassen, 'Gated communities?', 223.

[48] Kuijpers, *Migrantenstad. Immigratie en sociale verhoudingen in 17e eeuws Amsterdam*, 332-5.

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Appendix to Chapter 2

Table A. Predictors of apprentices' promotion to journeyman in Amsterdam: Birth place distance to Amsterdam, contract length, master's origin

			Block 1			
Predictor	**β**	***SE* β**	**Wald's χ^2**	***df***	***p***	**e^{β} (odds ratio)**
Constant	.392	.245	2.556	1	.110	1.480
Distance	-.001	.002	.233	1	.629	.999
Test			**χ^2**	***df***	***p***	
Omnibus test of model coefficients (step)			1.926	1	.165	

			Block 2			
Predictor	**β**	***SE* β**	**Wald's χ^2**	***df***	***p***	**e^{β} (odds ratio)**
Constant	-.869	1.468	.350	1	.554	.420
Distance	-.001	.002	.218	1	.641	.999
Contract length	.318	.440	.523	1	.470	1.375
Master age	.006	.028	.040	1	.841	1.006
Master origin: Amsterdam			.228	2	.892	
Master origin: Netherlands	.256	.574	.199	1	.656	1.291
Master origin: Foreign	.257	.669	.147	1	.701	1.293
Test			**χ^2**	***df***	***p***	
Omnibus test of model coefficients (step)			1.133	4	.889	

Table B. Predictors of journeymen's promotion to master in Amsterdam: Birth place distance to Amsterdam, works for father, master's origin

Block 1

Predictor	**β**	***SE* β**	**Wald's χ^2**	***df***	***p***	**e^{β} (odds ratio)**
Constant	-2.118	.261	65.672	1	.000	.120
Distance	-.005	.003	3.219	1	.073	.995
Test			**χ^2**	***df***	***p***	
Omnibus test of model coefficients (step)			4.440	1	.035	

Block 2

Predictor	**β**	***SE* β**	**Wald's χ^2**	***df***	***p***	**e^{β} (odds ratio)**
Constant	-3.091	.842	13.494	1	.000	.045
Distance	-.005	.003	3.002	1	.083	.995
Works for father	.754	.835	.816	1	.366	2.125
Master age	.025	.020	1.616	1	.204	1.025
Master origin: Amsterdam			.161	2	.923	
Master origin: Netherlands	-.201	.501	.161	1	.688	.818
Master origin: Foreign	-.096	.534	.032	1	.858	.909
Test			**χ^2**	***df***	***p***	
Omnibus test of model coefficients (step)			2.761	4	.599	

Table C. Predictors of journeymen's promotion to master in Amsterdam: Birth place distance to Amsterdam, journeyman is newcomer, number of journeyman contracts

Block 1

Predictor	**β**	***SE* β**	**Wald's χ^2**	***df***	***p***	**e^{β} (odds ratio)**
Constant	-1.914	.205	87.433	1	.000	.147
Distance	-.004	.002	3.918	1	.048	.996
Test			**χ^2**	***df***	***p***	
Omnibus test of model coefficients (step)			5.125	1	.024	

Block 2

Predictor	**β**	***SE* β**	**Wald's χ^2**	***df***	***p***	**e^{β} (odds ratio)**
Constant	-2.166	.567	14.578	1	.000	.115
Distance	-.002	.002	.752	1	.386	.998
Newcomer	-.939	.387	5.878	1	.015	.391
Number of contracts	.410	.442	.859	1	.354	1.506
Test			**χ^2**	***df***	***p***	
Omnibus test of model coefficients (step)			7.710	2	.021	

Note: if odds ratio for newcomers is .391, then odds ratio for old-timers becomes 1/.391 = 2.56


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Chapter 3

Journeymen Migration and Settlement in Eighteenth-century Holland

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Author contributions: Piet Groot and Ruben Schalk contributed equally to this chapter, and share first authorship in the accompanying paper. Piet Groot wrote the sections *introduction, on journeyman migration patterns, journeymen and the Amsterdam Surgeons' Guild,* and *conclusion,* collected the data for those parts, and performed the data analysis therein. Ruben Schalk wrote the sections *journeyman migrants in The Hague, mobility and settlement of migrant journeymen in The Hague,* and *journeymen in Haarlem*, collected the data for those parts, and performed the data analysis therein. In addition to making the tables and figures in the sections written by him, Ruben Schalk also provided Figure 4 made with data provided by Piet Groot. Both authors commented on each other's sections, and Piet Groot was responsible for the final editing.

Abstract

Many crafts in premodern Europe depended on migratory journeymen. Little is known about these workers, or how craft guilds and urban authorities affected their movement. By employing novel data on thousands of journeymen from different crafts and cities in Holland, we provide the first systematic overview of journeymen migration and settlement patterns in The Dutch Republic. We find that migration and settlement patterns differed significantly by occupational sector, marital status, and skill level. The stance of urban authorities towards migrants significantly affected settlement patterns as well. This interrelation of group-level characteristics, craft guilds, and urban regulation demonstrates the significance of examining these elements in tandem.

Introduction

On the eighth of June 1761, Johan Borchard from Basel arrived in the Dutch city of The Hague to work as a journeyman printer. After being granted access, he worked there for over a year, after which he left for an unknown destination in France. Jan Klompf, a single journeyman tailor from the small German town of Darmstadt, had quite a different experience. Between leaving Darmstadt and arriving in The Hague in October 1764, he had already worked in London. He was allowed to stay in The Hague for two years but was fortunate enough to acquire citizenship rights already in 1765, suggesting he became master tailor here and settled in The Hague. Wessel Elsers followed yet another trajectory. Having learnt watch-making in his birth town of Deventer in the east of The Dutch Republic, he left for The Hague in 1759, where he stayed for one year as a journeyman watchmaker. Afterwards he re-migrated back to Deventer, possibly to settle in his hometown.

Like Johan, Jan, and Wessel, many youth in premodern Europe spent time away from home before marriage and setting up their own households.[51] Among youngsters, up to 60 per cent would find employment as a servant of some kind.[52] These young servants also often migrated to find a suitable employer, albeit not often too far from their home town.[53] In Cambridge between 1619 and 1632, for example, 72 to 79 per cent of servants were born outside the city, while for Toulouse, Bordeaux, and Paris in the 18th century the number of servants originating from out of town even exceeded 90 per cent.[54] Outside of Western Europe, in Northern Italy for example, servanthood has also been found to coincide with migration.[55] For many young people, it appears, migrating to a different household after reaching a certain age – often located in another nearby town or city – was a crucial aspect of their lives.

This paper focuses on a particular group of migrating servants: journeymen. Having completed their apprenticeship, often under the auspices of a craft guild, they formed a group of semi-independent skilled labourers who contracted themselves to master craftsmen. These journeymen were numerous. Since barriers to masterhood were often substantial, probably most who completed an apprenticeship remained journeymen throughout their working lives.[56] The vast majority of premodern craftsmen, when organized in a guild, thus consisted of journeymen.

Since journeymen were generally not allowed to own shops – this privilege was reserved for master craftsmen – they were free to move from place to place to earn money and experience. This is, however, assuming that craft guilds and town councils did not try to limit such movement and settlement – but in reality, there are many signals that they attempted to do just this. Here, two lines of literature meet: one on craft guilds and one on premodern cities, both arguing that barriers existed to limit or control migration and access to skilled work. Crucially, these attempts, when successful, may have affected the migration and settlement patterns of labour migrants in premodern societies. This makes it all the more important to better understand the movement of these skilled craftsmen between different cities and regions.

Our contribution to the literature consists of several parts. First, we introduce rich micro-level data of individual journeymen to the debate about guilds and journeymen tramping (see Table 1). With few exceptions, journeymen have by and large been absent from this literature, even though they were likely the largest group of craftsmen. Second, we focus on a relatively 'liberal' region – Holland – with innovative craft industries, whereas the few studies on journeymen tramping so far have mainly focussed on Central Europe. Although craft guilds in Holland did not demand that journeymen go tramping for a certain period, like guilds in Germany did, they could nevertheless have set entry requirements for outsiders, begging the question how these affected journeymen tramping and settlement. Third, within this region, we can compare between different cities as well as different crafts. Together, this allows us to isolate local conditions, such as rules and regulations by guilds and urban authorities, from journeymen's individual-level characteristics, such as marriage status, origin, and craft, enhancing our understanding of why journeymen may have tramped, and why some groups may have tramped more than others. As Ogilvie recently stated, many journeymen were not required to travel at all, but many apparently still did so.[57] As we will demonstrate, even within the relatively small province of Holland and even within a single city or craft, the experiences of journeymen varied enormously, thus signifying the importance of concentrating on the local level instead of trying to generalize about the effects of guilds as a whole.

Since most craft guilds did not keep records on journeymen, it has, thus far, been difficult to investigate their movement. To remedy this, we employ novel data for several cities in 18th century Holland, encompassing almost 2,000 journeymen. We compare journeymen from several crafts, associated with different amounts of skill, working in different towns in the Northern Netherlands, together with their migration patterns.

The aim of this paper is to provide an overview of the migration and settlement patterns of migrant journeymen from different crafts in eighteenth-century Holland. The focus is primarily on what the migration patterns of these different groups looked like: what occupations did they have; where did they come from; where did they travel to; how long did they stay – rather than on why they displayed such behaviour. With the data at hand, the best we can do is to make an informed guess about their actual motives. We do, nonetheless, explore some potential explanations for patterns we find, derived from the

literature on craft guilds and journeymen, and from studies on cities' attempts to regulate migration and poor relief. These will be discussed in the next section first.

Table 1. Overview of source characteristics.

	The Hague	Haarlem	Amsterdam
Source type	*Settlement register*	*Guild list*	*Guild list*
Full name	Yes	Yes	Yes
Occupation	Yes	Yes	Yes
Place of birth	Yes	Yes	Yes
Marital status	Yes	No	No
Religion	Yes	No	No
Next destination	Yes	No	No
Length of stay	Yes	No	No
Son of master	No	No	Yes
Contract length	No	No	Yes
Master experience	No	No	Yes
Master age	No	No	Yes
Master shop size	No	No	Yes
Entry fee	No	No	Yes

In the third and fourth parts of the paper we present our empirical findings on journeymen migration behaviour to and from the city of The Hague, using novel data from settlement registers. Occupations associated with different skill levels coincide with different journeyman migration patterns: one more locally oriented for the lower skilled occupations, and one more internationally oriented for the higher skilled occupations. The 'locals' stayed, on average, for a shorter duration in The Hague than the 'internationals' and were less likely to acquire citizenship. We explore whether this pattern might be explained by local poverty insurance rules imposed by The Hague. In section five these findings will be contrasted to journeymen migration to the nearby city of Haarlem.

In the final part of the article, we contrast The Hague with our case of the metropolis of Amsterdam. This time we zoom in to the highly skilled occupational group of journeyman surgeons, using guild enrolment data. Amsterdam attracted many journeyman surgeons from outside the city, but not, as expected, from the group of 'internationals'. Our analysis reveals that although it was easy for migrant journeymen to get into the Amsterdam Surgeons' Guild, becoming a master surgeon here proved more difficult. Section seven concludes.

On Journeymen Migration Patterns

To understand the position of journeymen on the early modern labour markets, we will first elaborate on craft guilds and their formal training system involving apprentices, journeymen, and masters. During this period, many occupations were governed by craft

guilds, which were present in most moderately sized towns and larger cities. Its members were independent shop owners – master craftsmen – whose distinguishing trait was that they all shared a similar occupation, e.g., pastry baker.[58] Crucially, craft guilds oversaw the education and certification of new members. If someone wanted to become, say, a pastry baker, he would have first needed to register himself (craft guilds rarely accepted women) as an apprentice at the pastry baker's guild. Then, after a few years (varying between two to five years, with a notable exception for England) of working and learning as an apprentice, he would earn the title of journeyman.[59] Although not all occupations were governed by guilds, the apprenticeship system served as a template that was widely implemented – inside and outside craft guilds – and recognized by citizens and authorities. Prak and Wallis summarize the position of apprentices as follows: "Their agreement with their master distinguished them from other servants and employees. Completing training meant acquiring some form of rights in the labour market [...]"[60]

Most important of the rights that journeymen acquired after completing their apprenticeship training was the right to contract oneself as a wage labourer. Journeymen drew up contracts – usually with a master craftsman as the employer – in which the specific kind of labour for which they were hired was stated.[61] While working as a wage labourer allowed journeymen to earn the money that was necessary to sustain themselves, it can also be considered as a career stage. The Amsterdam surgeons' guild, for example, required locally employed journeymen to attend lectures on surgery, anatomy, and botany before allowing them to attempt the exam for master surgeon; and while journeymen coming from outside Amsterdam were exempt from these studies, they were required to show proof of having at least five years of experience.[62] Although not all guilds imposed the same requirements as the Amsterdam surgeons, there were often formal and informal hurdles to be taken before becoming a master craftsman. Journeymen could therefore – in theory at least – use the period of working as a wage labourer to acquire the skills and money that were necessary to enroll as a master craftsman and set up shop.

What is known from studies of craft guilds, however, showed that this career path was not trodden by most journeymen. In England, for example, only about 40 per cent of journeymen would later become a master. Also, the selection procedure to become journeyman in this country was exceptionally tough (and as an effect, many individuals dropped out already during the apprenticeship phase, which lasted seven years). In countries where it was easier to become journeyman, it has been found that an even smaller portion of only about one fifth (France) to one third (Dutch Republic) of journeymen eventually became master.[63]

The observation that only a proportion of journeymen became masters raises the question why so many did not. Were they content, perhaps, with their position of wage labourer – or, conversely, were they being held back by guild rules and customs, or city poor relief laws? Two intertwined literatures attempt to provide an answer to that question. The first focuses on the role of craft guilds and their attempts to regulate the influx of members into the organization. The second literature focuses on cities, and deals with a similar

question: how did city councils deal with immigrants and their inclusion in the city's social and welfare systems?

Since many journeymen had vocations that were monopolized by guilds it makes sense to look at the inclusion practices of guilds for a plausible explanation of journeyman migration. Many authors have indeed done so for apprentices and masters, giving rise to opposing views on the motives behind craft guild admission policy. The 'rent-seeking' view maintains that craft guilds raised entry barriers mainly so that its members could profit from their privileged position as insiders, at the expense of outsiders. Authors defending this view have brought forward that apprenticeship training was often unnecessarily long and not more efficient than other forms of training; social activities such as shared meals were devised to incur extra costs on would-be members, entry fees were high, and specific groups such as Jews and women were even completely excluded.[64]

Others have provided a more positive picture of craft guilds. They claim that craft guilds' inclusion practices often fulfilled needs for financial safety, consistent product quality, and community.[65] They also question the effectiveness of craft guilds' attempts to maintain their privileged position. Lis and Soly, for example, suggest that journeymen during the eighteenth century managed to organise so well – organizing "strikes" in and around London – that they could force higher wages and shorter working days from their masters.[66] Prak and colleagues, furthermore, have brought forward that despite the existence of entry barriers, craft guilds held a remarkably high proportion of migrants under their ranks, averaging 42 to 62 per cent depending on the region.[67]

Craft guilds, though no doubt influential, were still but one of the many actors shaping premodern (journeyman) migration. Cities harboured labourers, entrepreneurs, merchants, artisans, relief recipients, church communities, and magistrates, among others, and these often had opposing interests with regard to migration and incorporation. The overlap between social groups embodying these different interests, and the power relationships between them, interacted with the social and economic context to shape the practice of urban migration.[68] During a period of economic expansion, such as in Antwerp during the early to mid-sixteenth century, city magistrates may have been enticed to lower immigration barriers in spite of protests from craft guilds.[69] But the opposite was also possible, such as for most Dutch cities during the economically challenging 18th century. Leiden, a Dutch town once rich from its cloth industry but now struggling with high unemployment rates, imposed strict conditions on newcomers to prevent its already stretched poor relief system from collapsing. One of those conditions was that newcomers had to carry an *act of indemnity*, containing evidence of their legal settlement outside of Leiden, or had to become full citizens of Leiden if they wanted to settle there permanently. Probably one of the few Dutch cities that did not impose strict entry conditions on newcomers was Amsterdam, which not coincidentally had a poor relief system that was more bare-boned than Leiden's.[70] In summary, it was not just craft guilds that potentially influenced journeymen migration, but general urban policy – which itself was a result of a negotiation between different groups under ever-changing circumstances.

Although studies looking at the actual migration patterns of journeymen are scarce, the ones that have been conducted reveal – perhaps not surprisingly, given the multitude of potential push and pull factors – a multi-faceted picture: different patterns of migration, settlement, and career could be observed between journeymen, depending on their craft and place of birth. Sonenscher, for example, used entry registers from labour bureaus in eighteenth-century France to track journeymen as they moved from town to town. He concluded that "The apparent continuities of corporate life were [...] the product of a complex combination of inheritance, migration, apprenticeship, further migration as a journeyman, marriage, and the acquisition of [guild mastership]. There were many possible variations within this range of alternatives. [...] Not all journeymen became masters in the towns in which they had been born; neither were all masters immigrants from other localities".[71]

The plurality of migration patterns of French journeymen is confirmed by Reith for journeymen in early modern Germany. Reith discerns five "types" of journeyman migration patterns, each corresponding more or less to a unique set of crafts.[72] The building trades, for example, relied on a core of sedentary, often married, journeymen, supplemented by a large number of tramping journeymen coming from distant rural regions. Placement was not mediated by a guild, and consequently there were some tensions between the local and tramping journeymen. Trades in the food services, by contrast, such as bakers, brewers, millers, and so on, drew most of their workforce from the surrounding region; journeymen lived in the households of masters, and their placement was mediated by the guild. Another, radically different, pattern appeared for journeymen operating in specialized crafts such as bookbinders, belt makers, gold beaters, and ribbon weavers. Shops dealing in those trades could only be found in larger cities, were quite sparse, and their demand for labour fluctuated. Consequently, journeymen in these trades were forced to travel long distances in search of employment; hence, a tramping culture emerged. These examples, corresponding to three of the five types of journeyman migration patterns identified by Reith, illustrate that factors such as the availability and the nature of work, as well as the presence or absence of a craft guild in a sector, influenced journeyman migration patterns.[73]

In the 18th century the Dutch economy was in decline. All major cities – with the notable exception of Amsterdam – took a conservative approach towards migrants.[74] Settling therefore might have been difficult. At the same time, it has been argued that, despite the economic downturn, the Northern Netherlands still held an exceptional position within Europe, with relatively open guilds.[75] This would make it easier for journeymen to travel between towns. But did that also mean that journeymen were able to find a master to work for or even settle here?

Journeymen Migrants in The Hague

To begin our examination, we employ a unique source that holds a wealth of information on migrant journeymen. As explained, from the beginning of the eighteenth century many Holland cities demanded an *act of indemnity* (*'acte van cautie'*) from

immigrants.[76] Authorities did so to check that immigrants would not call upon provisions for local poor relief, and that their hometown or church diaconate would provide, or refund, this relief in case a migrant should fall to poverty. Migrants who could not provide this *acte van cautie* within a couple of months needed to leave the city. City messengers oversaw migrants within the city walls, in cooperation with neighbourhood representatives, and reported back to the urban clerks keeping the registers. Once the *acte van cautie* had been accepted, a deed of settlement ('*acte van admissie*') was provided which allowed the migrant to stay.

Some cities meticulously kept track of each step of this procedure: from the moment a migrant arrived up to the point he or she left or settled in the city. A few Holland cities additionally listed individual characteristics of migrants, such as their marital status, their place of birth, and their occupation. The city of The Hague was one of these. With about 38,000 inhabitants in 1750 The Hague was a relatively modestly sized Dutch city. However, it did house the Estates General and the court of the Stadtholder, which may have attracted migrants who provided services to the elite next to those from more common crafts. Whether local authorities relaxed settlement for those serving the elite will be explored by contrasting the careers of different journeymen arriving in The Hague.

For The Hague, settlement registers were kept from 1750 to 1804. The benefit of the registers is that they were kept by urban authorities, whereas usually they are scattered, and often partially lost, among church diaconates.[77] This means that in theory all migrants entering the city were recorded, regardless of their religion, and that we do not miss migrants due to patchy sources. The registers give full names, marital status, occupation, religion, place of birth, place of origin (more rare), and if applicable, also their destination after leaving The Hague. Because the registers use the adjective '*knecht*' or '*gezel*' when recording occupations, which translates to journeymen, we can classify journeymen with certainty. The outcome of the settlement procedure – stay (either with or without citizenship) or go – was also recorded and dated. This not only allows us to examine which groups of journeymen were particularly mobile, but also to compute how long re-migrants actually stayed in the city before leaving again and see which occupational groups were most likely to settle and even become citizen of The Hague.[78]

For the period 1751-61 all migrants were collected from the register. Halfway through the 1761-69 register we switched to taking a random sample using half of all pages.[79] The registers are first ordered by neighbourhood and then alphabetically, so the sample should be representative. This leaves us with 3,228 migrants arriving at The Hague between 1751 and 1778, of which 1,255 can be identified as journeymen. Comparing the sampled journeymen (n = 434) with the full collection of journeymen (n = 821) shows that distributions of sex, religion, occupation (coded in HISCO), length of stay, and obtained citizenship, are not significantly different between the two sets.[80]

Places of birth and if available places of origin (i.e., last stop before The Hague), and place of destination were manually linked to modern place names and georeferenced. To infer if city size mattered for migration trajectories, historical urban population figures were

retrieved from an expanded version of the Baghdad to London dataset, selecting 1750 as benchmark year.[81]

To compare the distribution of journeymen across occupations with the overall composition of the labour market, the occupations of all grooms marrying in The Hague during 1811-15 are used (*n* = 1,385). These indexed marriage certificates were retrieved from Openarch.[82] Like the occupations of journeymen, the occupational titles of grooms were automatically coded into HISCO.[83] Since Dutch industrialisation only set in around 1850 and guilds were not formally abolished until 1820, the interval between the marriage certificates and the settlement registers should not be an issue.

Table 2 gives an overview of the distribution of migrant journeymen for the top-15 occupational groups in terms of journeymen migrants entering The Hague using their HISCO code. The table captures the main characteristics of each group. It also compares the occupational distribution of migrant journeymen with the overall composition of the labour market, going by the marriage certificates (last two columns). The column 'Description' gives the most frequently observed occupational title within each HISCO group.

Table 2. Occupational groups of journeymen migrants arriving at The Hague, 1751-1776.

HISCO 2-digit	Description	N	Distance PoB	Left again	Foreign	Married	Citizen-ship of stayers	Journey-men distr.	Marriage distr.
			median km	*%*	*%*	*%*	*%*	*%*	*%*
79	Tailors	276	192	58	67	36	35	21.99	7.32
95	Carpenters	257	63	55	24	27	28	20.48	10.42
80	Shoemakers	120	283	51	63	29	31	9.56	4.98
83	Blacksmiths	83	208	49	68	36	17	6.61	1.36
88	Jewellers	81	342	47	70	21	39	6.45	1.36
81	Cabinet Workers	69	167	57	55	21	25	5.50	2.42
75	Fabric Dyers	49	162	47	46	61	16	3.90	2.57
77	Grain Millers	34	107	29	27	52	0	2.71	5.66
82	Stone Masons	32	183	81	75	13	67	2.55	0.15
57	Wigmakers	27	376	54	73	48	45	2.15	0.23
98	Coachmen	23	104	13	41	91	11	1.83	3.92
92	Bookbinders	21	166	45	38	40	18	1.67	1.66
72	Metal Pourers	19	97	41	41	47	0	1.51	0.38
16	Sculptors	17	56	69	41	18	50	1.35	0.08
93	House Painters	17	56	50	24	18	38	1.35	0.98

Sources: Migrant journeymen from Gemeentearchief Den Haag, Archief Oud-stadsbestuur, inv. nos. 1121-1 through 1122-8. Marriage certificates from https://www.openarch.nl/exports/5cfb55ebaf9fe5aaf216f6da1229c632/files/hga.bsh.1970-01-01.2017-03-31.csv.zip [last accessed January 15, 2020].

From the last two columns it appears that the distribution of journeymen over the labour market was generally in line with the overall composition of the labour market: occupational groups that were the largest in The Hague also received most migrant journeymen.[84] There are some differences. It is perhaps not a surprise that crafts in high demand, such as carpentering and tailoring, attracted a relatively large number of, possibly seasonal, journeymen. Vice versa, it is also apparent that a number of relatively specialized crafts, most notably stone masons, sculptors, and wigmakers, relied on migrant journeymen in particular, as indicated by a high share of journeymen compared to the distribution of grooms' occupations. The dominance of wigmakers and jewellers can possibly be explained by the presence of the court and the Estates General, which attracted a large elite. Perhaps not surprisingly, capitals like Paris and London figured prominently among their place of birth, suggesting that the presence of a sizeable elite was required to sustain occupations like these in a city.

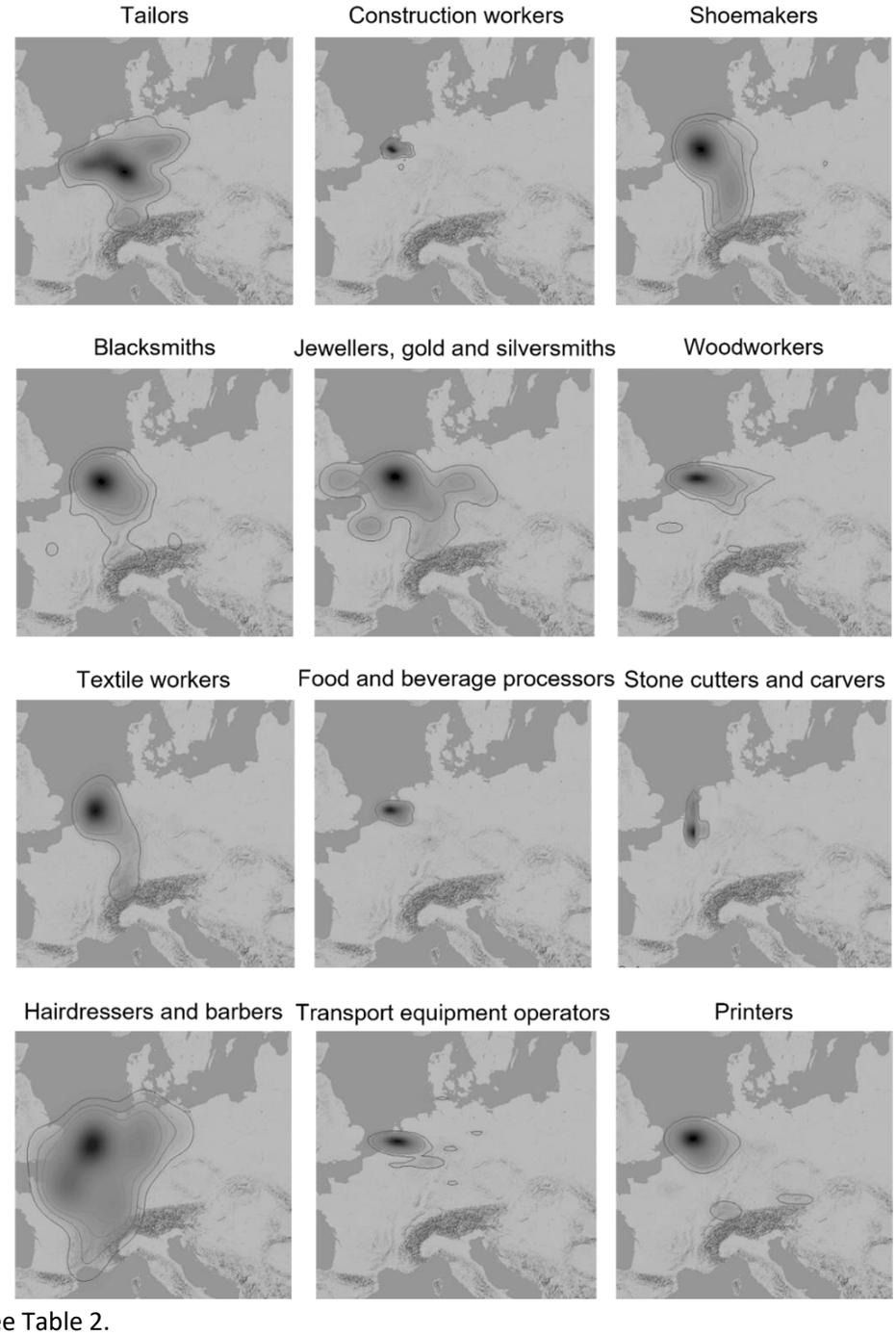
Table 2 further displays some pronounced differences between crafts. For example, stone masons and sculptors consisted of a large group of migrant journeymen, which can likely be attributed to the cyclical or condensed demand for their skills during construction work. Whereas carpenters and masons were required throughout the process, these two groups were only needed for a relatively short period when the decorative pieces of the building were needed.[85] This also shows in the share of stone masons and sculptors who left again, which was relatively high at 81 and 69 per cent respectively.

Several other characteristics deserve highlighting as well. Touching upon the previous distinction in construction work is the pronounced regional origin of journeymen carpenters and house painters. Reith showed that tramping construction workers in Germany came from distant rural regions.[86] Those arriving in The Hague, conversely, came from a median distance of only about 60 kilometres. Since their skills were probably less cyclically oriented and in high demand in the dense urban network of Holland, there was little need for them to travel far for their next job. Moreover, journeymen carpenters with a recorded destination stayed within a range of 40 kilometres, even if they did not return to their place of birth.

The low share of foreign journeymen (immigrants from outside The Dutch Republic) in construction work stands out as well. This could have been related to guild regulations. In Amsterdam, foreign journeymen carpenters were only allowed to be hired if no locals were available.[87] For The Hague, guild ordinances are not available, but the relatively low share of foreigners, also in comparison with other local crafts, suggests comparable rules may have been in effect here as well. A similar reasoning could apply to the low share of foreign journeymen among grain millers – which is in line with findings by Reith. Milling was a strictly regulated craft in Holland because authorities wanted to prevent food shortages.[88] This may have affected the share of migrant miller journeymen in general compared to the share of local millers at the labour market of The Hague (2.71 vs. 5.66 per cent). Nevertheless, of the six journeymen bakers arriving at The Hague – also a strictly regulated craft – three were foreign, and all three settled in The Hague.

Figure 1 plots the places of birth of migrant journeymen for the top-12 most common occupational groups as a density map. The outer line denotes the boundary of the catchment area, and red indicates the dominant region of origin (measured by place of birth).

Figure 1. Places of birth of migrant journeymen in The Hague (1751-1776) per occupational group.



Source: See Table 2.

Note. Maps ordered in descending order of observations from left to right, top to bottom.

The figure shows that most journeymen came from within the Dutch Republic and even Holland, but that, as discussed, catchment areas differed significantly per craft. The local recruitment of construction workers clearly shows. The dominant recruitment area for stonemasons was the Southern Netherlands, and jewellers came from large cities in particular (such as London, Paris, Frankfurt, Berlin).

Many crafts attracted journeymen from far and wide, as can be seen for shoemakers and tailors especially, who both came mostly from Germany and the Rhine region. The dominance of migrants among tailors and shoemakers has been established for early modern Amsterdam as well and is likely explained by a combination of patterns of chain-migration, specialization in their home region, and the relatively low status of the occupation in urban Holland.[89] Foreign tailor and shoemaking journeymen in The Hague indeed originated from inland Germany and not coastal areas. According to Knotter and Van Zanden the economic structure of these inland regions was characterised by a combination of agrarian labour and craftwork, where occupations as tailoring and shoemaking could easily be combined with seasonal agricultural work.[90] Many of them probably moved to Holland in the footsteps of friends and kin. For example, at least eight tailor journeymen came from the relatively small German town of Dillenburg and four came from Nordrhein-Westfalen.

Migration and settlement patterns may have been related to the level of specialisation required. Most journeymen jewellers were foreign, single, and born in large cities far away (with a mean population of 138 thousand), whereas journeymen coachmen were often married, and born in small towns closer to The Hague (with a mean population of twelve thousand). Jewellers were unlikely to stay, but coachmen rarely left again. Moreover, jewellers that did stay acquired citizenship in relatively large numbers, but coachmen, even though they often stayed, rarely did so. Possibly the few jewellers that settled did so because they were talented enough to vie for a position as master artisan, for which citizenship was a prerequisite. Coachmen were not organized in guilds in The Hague so for them citizenship was not necessary. We observe similar differences between other occupations. For example, most fabric dyers were married, stayed, and when leaving left for medium-sized cities. Sculptors, on the other hand, were generally single, often left again, and moved on to large cities. Also, they acquired citizenship in relatively large numbers when staying in The Hague, as did the stone masons.

Mobility and Settlement of Migrant Journeymen in The Hague

To examine these different patterns further, we turn to three of the key characteristics of journeymen in our dataset: skill level, marital status, and coming from outside the Dutch Republic or not. Note that even though our data allow us to examine differences in mobility and settlement, providing an *explanation* for these patterns would be outside our scope. For instance, a relation between being single and the level of skill required for a craft can be explained in two ways: it can signal that these journeymen made use of open labour markets and moved around to hone their skills before settling down. Conversely, specialisation may

as well have been related to smaller labour markets and rent-seeking guilds, preventing outsiders from settling, and marrying, in a particular locality.

To categorize journeymen according to skill levels, we employ a method developed by Feldman and Van der Beek, who used Robert Campbell's manual for prospective apprentices, *The London Tradesman* (1747) to evaluate the skill required for different crafts.[91] For each craft in eighteenth-century London, Campbell listed the average wages that could be earned, and provided a qualitative assessment of the skills required. On a wig maker, Campbell writes: "His Business is governed but by a few Rules, and it requires Experience to be Master of them; the continual Flux and Reflux of Fashions, obliges him to learn something new almost every Day. There is a good deal of Ingenuity in his Business as a Wigg-Maker, and a considerable Profit attends it".[92] Feldman and Van der Beek distinguish three binary categories for each occupational group (classified using HISCO): whether a craft consisted of non-routine work, if ingenuity and solid judgement was required, and whether it involved mechanical tasks.

Although Campbell's manual was intended for England, we think it is the best measure available to distinguish between levels of skill required for a craft. More detailed information, such as the length of apprenticeships or apprenticeship premiums are not available. It is likely that the tasks performed by, say, a carpenter in eighteenth-century London did not differ much from his contemporary in The Hague. What is more, the publication of the manual falls right within our period of observation.

Every occupation has been assigned a skill based on the sum of the categories 'non-routine' and 'ingenious'. The category 'mechanical' was omitted because, unlike Feldman and Van Beek, we are not interested in observing the onset of industrialisation. Since industrialisation only occurred a century later in Holland, this category likely does not capture additional skill – milling in the eighteenth century was much alike a century before. Additionally, since it is difficult to argue that 'non-routine' captures more skill than 'ingeniousness' or vice versa, we consider them to be equal. This means that our skill classification consists of three groups: low skilled when both categories are zero; medium skilled when one of the two categories takes a value of one, and high skilled if both take a value of one. The classification of occupations can be found in appendix Table A1. The three groups consist of 378, 446, and 431 migrant journeymen respectively.

Table 3 groups the migrant journeymen according to skill and marital status. The latter seems a good predictor of journeymen mobility. Married migrant journeymen re-migrated much less often in all skill groups, confirming the classical image of the single tramping journeyman. Although married journeymen did travel to The Hague in large numbers as well, they seem to have aimed for settlement in much larger numbers than singles. Re-migration of singles was related to skill: medium and high skilled journeymen were significantly more likely to leave The Hague again than low skilled journeymen.[93] When staying, high skilled single journeymen acquired citizenship much more often than medium and low skilled single journeymen. Married journeymen in general opted for citizenship less often. We can only guess why, but perhaps they did not aim at setting up shop as a master –

at least not in the short run. Also standing out is the low share of migrants from outside the Dutch Republic among medium skilled journeymen, and the relatively long stay of medium skilled Dutch journeymen. The share of foreigners displays a clear u-shape: medium skilled journeymen often came from relatively nearby and tramped between the cities of Holland and their place of birth, whereas more foreigners were present among both low skilled and high skilled migrant journeymen.

Table 3. Migrant journeymen trajectories by skill level and marital status, 1751-1776.

Marital status – skill level	Total migrants		Left again %		Mean length stay if leaving (months)		Citizenship of stayers %	
	Dutch	*Foreign*	*Dutch*	*Foreign*	*Dutch*	*Foreign*	*Dutch*	*Foreign*
Single – high	84	187	65	70	23.5	34	54	53
Single – medium	204	119	67	66	44.5	27.5	35	44
Single – low	87	102	62	55	27	26	30	38
Married – high	52	84	23	28	20	37	16	26
Married – medium	64	42	33	39	52	28	15	4
Married – low	60	102	25	31	34	24	18	16

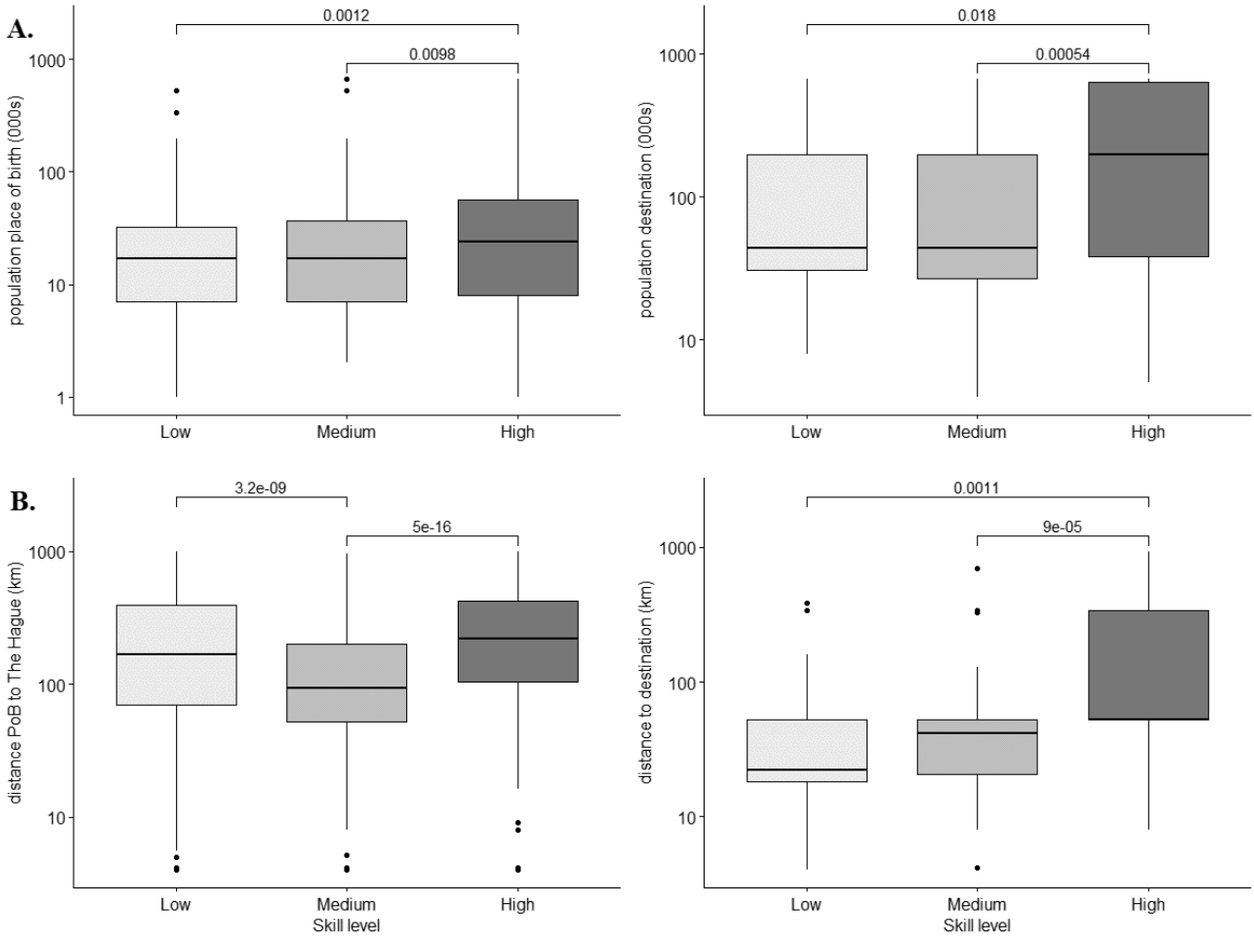
Source: See Table 2.

To further differentiate migration patterns by skill we take city size and travelled distances into account. Regrettably, destinations of migrant journeymen upon leaving The Hague are underrecorded, probably because urban clerks did not really care where migrants went to once they had left the city. Also their last place of origin, if other than their place of birth, was often not recorded. This notwithstanding, travelled distances and the size of cities frequented by journeymen, even with relatively poor documentation, were markedly different. This can be seen in Figure 2. Panel A shows per skill level the distribution of population sizes in 1750 of frequented places. The same ordering applies to panel B, but instead gives the distribution of distances travelled between journeymen's place of birth to The Hague, and from The Hague to their next destination. When significant, the p-values of the skill group comparisons are given above the boxplots.[94] Those returing to their place of birth have been omitted in panel A because this would bias the results in favour of high skilled journeymen, who were generally born in larger cities.

Higher skilled journeymen were generally born in larger cities and, when leaving The Hague, left for larger cities as well – even if not returning to their hometowns. These were markedly larger cities, such as London or Paris. Amsterdam was a popular destination especially for the high skilled. The preference for large cities among higher skilled journeymen is not surprising. Large cities provided a customer base large enough to sustain these specialised crafts. Somewhat surprisingly, more migration is associated with increasing city size, for all skill groups. Those that left The Hague on average moved to significantly larger cities than The Hague or than where they had been born. This effect was most

pronounced for the higher skilled who moved from places of birth with about 78k inhabitants to destinations with well over 250k inhabitants. For low and medium skilled these figures were 35k to 121k, and 45k to 94k respectively.

Figure 2. City size and travelled distances of journeymen by skill, 1751-1778



Sources: See Table 2. Population figures from expanded version of the dataset presented in Bosker et al., 'Baghdad to London', courtesy of Eltjo Buringh. Dataset DOI: 10.24416/UU01-Y3FHKZ.

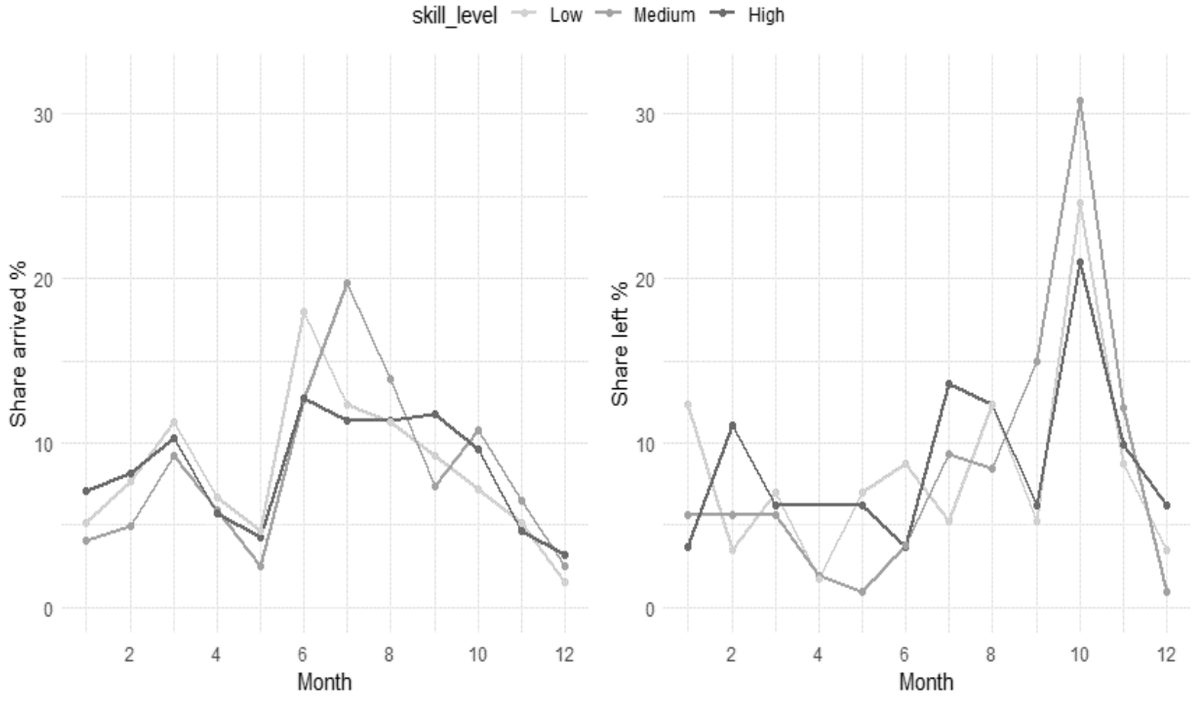
Next to the somewhat smaller cities they frequented, medium skilled migrant journeymen were most regionally oriented. As panel B demonstrates, these journeymen came from quite nearby and often left for cities nearby as well, such as Leiden or Delft. Higher skilled journeymen travelled much farther to their next place of work. Although both lower skilled and higher skilled journeymen on average had travelled significantly longer distances to The Hague, only the higher skilled would continue this 'long-distance, big cities' trajectory when leaving The Hague.

This suggests that once migrant journeymen had moved to Holland, they took advantage of its dense urban network in search of work. The median travelled distances for lower and medium skilled journeymen, when not returning to their place of birth, were no more than 50 kilometres. Only higher skilled journeymen escaped this pattern and more

often moved to large cities far away. Whether the higher skilled moved to ever larger cities to become more specialised is difficult to say, but their distinct mobility pattern at least suggests that their reasons for tramping may have been different from their lower skilled peers.

An additional method to examine differences in mobility between groups of journeymen is to look at seasonality in hiring patterns. Were single tramping journeymen, as Reith suggested, primarily a source for short-term labour supply in times of high demand, only to let go afterwards? We can use month of arrival and departure, and length of stay to examine this. First, there was no discernable difference in arrival and departure patterns between foreigners and Dutch journeymen. Figure 3 plots the share of single journeymen arriving and departuring by month, grouped per skill level. Beginning with month of arrival, we see that journeymen, apart from some months, arrived relatively evenly throughout the year. The high skilled journeymen seem to display the most even arrival pattern across the year: from July trough October more or less the same share arrived every month.[95] For low and medium skilled journeymen there were somewhat more pronounced peaks of arrival in June and July respectively, yet their pattern of arrival was not significantly different from the high skilled. [96]

Figure 3. Month of arrival and departure of single migrant journeymen in The Hague (1751-1776).



Source: See Table 2.

It is clear that most journeymen left in October. The decrees of the urban authorities provide an answer as to why. After implementing the settlement procedure in 1750, the authorities of The Hague enforced these rules in 1761 when enforcement became more

strict due to the large numbers of poor migrants within the city walls. From then on, representatives of neighbourhoods had to visit all houses every three months to check their occupancy. Earlier this check had been every four months. Moreover, they had to keep track of inhabitants in a register, and present these to the local magistrates after every round. They were also specifically prevented from allowing the housing of migrants withouth a settlement deed. The last round of annual neigbourhoud checks was to take place in November. Unlike before, uncooperative representatives faced a fine when misreporting the housing of strangers in their neighboorhood or when failing to present their register.[97] As before, migrants who could provide proof of employment in The Hague, or had proven rights to poor relief in their home town, were still given a deed of settlement.

While enforcement remained lenient migrants could prolong their stay in the city, which explains why before 1761 no specific spike in departure can be observered for a certain month. Quite likely, the enforcement of 1761 revealed migrant journeymen without employment and those without jobs were forced to leave the city. For many this was likely not surprisingly around October: when the summer peak of work had ended.[98] The absence of an earlier departure peak suggests these journeymen left at this time because they had no work, and not because leaving around this time was common practice for migrants. The October peak indicates that, at least for many journeymen, their labour had a distinct seasonal character.

Since enforcement of settlement rights became more stringent from 1761 onwards, we can use this 'natural break' to assess if some migrant journeymen faced more difficulties in the local labour market than others. The focus here is on unmarried journeymen because they were the most mobile. Stricter enforcement possibly affected journeymen with a precarious position relatively hard. Journeymen with low-skilled work may have had more difficulties in obtaining a certificate of indemnity from their hometowns. Those from far away may have had fewer local ties to local masters and hence more trouble to secure employment – and thus settlement rights.

Nevertheless, for medium and high skilled single journeymen, there was no significant relation between travelled distances and how long they were able, or willing, to stay in The Hague from 1761 onwards. For low skilled migrant journeymen this relation was even positive and significant: the longer their journey to The Hague, the longer their stay.[99] Within each skill group, distances travelled to The Hague, or being from abroad, did not affect chances of i) staying in The Hague or ii) becoming citizen of The Hague from 1761. Also *between* skill groups few differences can be found: length of stay before obtaining settlement or citizenship was alike for all journeymen; their initial allowed stay (before providing a certificate) was also comparable; and the share that left was alike between skill levels. After removing outliers, the average length of stay was also not different between skill groups, for single journeymen.

All this suggests that there is very little evidence that certain groups of migrant journeymen outperformed others in the local labour market, once local magistrates clamped down on who was allowed to stay. Every, say, a single migrant carpenter seems to have been

treated alike, no matter where he came from. Everyone, either from close-by or far away, from low or high skilled crafts, had to adhere to the same rules, and when they did, were allowed to stay in The Hague.

The only other thing standing out is the very low share of foreigners (33 per cent) amongst the group of medium skilled single migrant journeymen – already noticeable before 1761. Yet the foreigners that were present in this group did not face more adverse conditions than their peers from close-by The Hague. All key variables were alike between foreign and journeymen from within the Dutch Republic: comparable lengths of stay; the same share left; same share became citizens, etc. This indicates that the low share of foreign journeymen in these crafts was likely not caused by active labour market discrimination. Instead, these crafts appear to simply have been regionally oriented (see also Figure 1) instead of one in which hiring of journeymen from more distant regions was actively discouraged.

To a large extent this can be explained by the presence of many construction workers in this group: masons and carpenters figure here prominently. As observed by Knotter and Van Zanden, also in seventeenth-century Amsterdam these workers were primarily recruited from the region. They explain this by the relatively high concentration of masons in the coastal regions of Holland. These were also more familiar with building stone houses than those from the (eastern) countryside, where houses were mainly built using timber and clay. Moreover, because these regions were relatively developed, the share of construction workers in the labour force was also high there.[100]

The absence of a preference for particular migrant journeymen is mirrored by the relatively relaxed citizenship rules of The Hague. At least from 1770, but likely earlier, anyone could buy citizenship, although foreigners did pay more than those from the Dutch Republic (fl. 30 vs. fl. 15). The latter fee represented about the monthly earnings of a journeymen in Holland.[101] With some saving, then, settlement in The Hague was a real possibility for migrant journeymen. Single high skilled journeymen may have opted for citizenship more often because of the opportunities The Hague, with its court and Estates General, provided for them in particular, enticing them to try and become master - for which citizenship was a prerequisite. Nevertheless, in eighteenth-century The Hague the chances of acquiring citizenship or settlement, as well as the chances of leaving again, were not affected by where migrant journeymen had come from. The most notable variable explaining journeymen's settlement in The Hague was not given in by labour markets, it seems, but by marital status.

Journeymen in Haarlem

A striking contrast is provided by Haarlem a city just some 60 kilometres to the north. Records for the pastry bakers' guild survive (1693-1752) that are detailed enough to directly or indirectly infer where its journeymen had come from. This is of interest since guilds in Holland rarely registered journeymen. If they did, often only full names were recorded, without information on their origin, their length of stay, or subsequent careers in the guild.

Because the Haarlem pastry baker's guild differentiated journeymen by origin, it is possible to observe whether locals were more successful than outsiders, both in terms of access to the guild and in their chances to become master. Full names of journeymen registered at this guild were matched against the list of masters' tests.

Table 4 compares the careers of Haarlem pastry baking journeymen by origin, ordered by closeness to the local guild. It shows that more than half of all journeymen came from outside Haarlem. Locals, and especially sons of masters, had highest chances of becoming master, and were also employed for longer periods on average. Sons of masters very likely had to wait until they inherited the bakeries of their fathers, which explains their higher master share as well as their longer contracts. This certainly applied to Jan Mensinck, who was employed by his father and then by his widowed mother for no less than 30 years before becoming a master pastry baker himself. The Haarlem-born also had an advantage over outsiders. Next to lower chances to become master, outsiders had shorter contracts and were employed by fewer masters.

Table 4. Origin and careers of journeymen in the Haarlem pastry bakers' guild, 1693-1752.

Origin	N	Mean years employed (*SD*)	Mean number of masters	Becomes master in Haarlem (%)	Mean population size origin (000s)
Sons of masters	15	9.47 (8.3)	1.6	40	37
Haarlem	73	4.53 (3.1)	1.5	24	37
Holland	44	2.43 (2.0)	1.1	4.50	29
Dutch Republic	77	2.78 (3.0)	1.3	9.10	9
Foreign	19	3.47 (2.7)	1.1	5.30	5

Sources: Noord-Hollands Archief Haarlem (NHA), Archief Gilden, inv. 82. Population figures see Fig. 3.
Note. Origin groups are mutually exclusive.

Whether outside journeymen came from far away or from within Holland did not really matter for their chances within the guild. The opposite may have been true as journeymen from parts of the Dutch Republic outside Holland were somewhat more successful in becoming master in Haarlem than those from within Holland. The ten journeymen from outside Haarlem that made it to master came from significantly smaller places than their co-workers who did not, perhaps indicating that the size of their hometowns affected their decisions to stay in Haarlem. Becoming a master pastry baker was probably difficult for journeymen in general. Setting up a bakery involved quite some capital which likely was more easily secured by local journeymen, and especially sons of masters. Achieving masterhood was not straightforward for locals either, with only one in four succeeding.

Haarlem settlement rules seem to have been stacked against outsiders more than in The Hague. The 1749 ordinance of the pastry bakers' guild states that locals had to serve at

least three years at a Haarlem master, and that this was set at five years for outsiders. Outsiders also needed to have been Haarlem citizen for at least three years to be allowed to take the masters' test.[102] Although also in The Hague journeymen from outside the city, and sometimes those from outside Holland, had to pay more for taking a masters' test, no single surviving guild ordinance required a minimum stay as citizen before being allowed to take the test.[103]

The same restrictions probably applied earlier in Haarlem, as revealed by the request from Jan Wagenaar van Gijzen, a pastry baker from Frankfurt – who also appears in the journeymen records of this guild. In 1734 he requested to be granted access to the masters' test directly, on account of his marriage to the master pastry bakers' widow Rachel Blommert.[104] The Haarlem magistrates denied his request and Van Gijzen was required to take the formal route, eventually passing his masters' test only four years later. The same source demonstrates that many other comparable requests coming from outsiders in different crafts were either denied by the Haarlem magistrates or redirected to the corresponding guild.[105] Unlike The Hague, it seems that masterhood and citizenship was noticeably more difficult to obtain for outsiders.

Perhaps as a result, the settlement registers of Haarlem demonstrate that few tramping journeymen opted for this city. The Haarlem settlement registers are comparable to those of The Hague, although here clerks only registered arrivals. For the period 1714-76 all migrants have been collected (*n* = 1,011 of which 793 males).[106] Not only did fewer migrants register here annually (13 versus 70 in The Hague), the share of journeymen among them was also much lower (16 per cent versus 68 per cent in The Hague). In the 1750s, for which both sources overlap and The Hague is not sampled, more than 450 journeymen arrived in The Hague and only 46 in Haarlem. The majority of migrant journeymen arriving in Haarlem were also low skilled, compared to less than 30 per cent in The Hague. This could suggest that Haarlem may have been more attractive to unskilled migrants, such as textile workers, for which citizenship rules and minimum stay requirements were likely less of an issue. They were rarely aiming to become master craftsmen anyway. More skilled journeymen probably had relatively bleak prospects in securing a future career in Haarlem.

The Hague was a relatively small city for the services it provided, most notably its housing of the court of the Stadtholder and the Estates General. Perhaps this caused magistrates and guilds to be relatively welcoming towards migrant craftsmen, knowing that local craftsmen alone would not suffice to provide services to its relatively sizeable elite presence. In that regard its labour market may have been more comparable to large metropoles like Amsterdam or Paris than to Haarlem.

Journeymen and the Amsterdam Surgeons' Guild

Being a metropolis with more than five times the inhabitants of Haarlem, Amsterdam had a stronger and further-reaching pull on migrants.[107] Whether the resulting inflow of migrants encouraged the relatively elite Amsterdam Surgeons' Guild to be open to outsiders is the question we turn to last. We utilise a unique aspect of our source that allows us to

determine the effect of locally acquired experience on the journeyman's chances to become a master surgeon – and thus settle in Amsterdam permanently.

Like the Hague, Amsterdam maintained a relaxed policy towards migrants throughout the 18th century, and even more radically so: the permission to work (though not formally citizenship) could be acquired for a mere 28 *stuyvers* (2.4 florins), and no settlement deeds were required from immigrants.[108] Amsterdam was unique in this respect, which may explain why this city continued to attract migrants throughout the economically challenging 18th century – in contrast to once flourishing cities like Haarlem and Leiden. This open policy was, however, coupled with a markedly weaker system of social benefits compared to those cities that were stricter on immigration.[109] The result, at least in the 17th century, was that many migrants ended up in poverty.[110] What opportunities, then, awaited skilled journeymen in Amsterdam during the 18th century? Did the open migration policy also allow for career building and settlement?

Whether Amsterdam offered highly skilled journeymen an attractive place to settle and build their careers, can be examined by looking at the well-preserved enrollment lists of the Amsterdam Surgeons' Guild.[111] Not only did this guild register apprentices and masters, but also journeymen for the period 1761-1775, which partially overlaps with the enrollment lists for apprentices and masters. Within this period, we entered the first 619 entries, which yielded 555 unique journeymen enrolling between September 1761 and August 1766.[112] For these journeymen, name, birthplace, and contract length were recorded, as well as the full name of the master for whom the journeyman would be working. These rich data allow us to look for patterns among journeymen surgeons: not just in where they came from, but also whom they worked for. The birthplaces of the masters who employed them were also known. Furthermore, by linking the two files, we could track which journeymen would later be promoted to master by the guild.[113]

Table 5. Geographical breakdown of journeymen in the Amsterdam surgeons guild, 1761-1766.

Place of Birth	*N* (%)	Mean population origin city in (*SD*)	Mean distance in km (*SD*)	First time enrolment %
Amsterdam	151 (27)	198 (0)	-	8
Netherlands	239 (43)	15 (19)	71 (39)	62
Germany	130 (23)	9 (17)	223 (111)	77
Other	20 (4)	24 (27)	310 (270)	85
Unknown	15 (3)	-	-	93
Total	555 (100)	97 (93)	95 (119)	51

Sources: Stadsarchief Amsterdam, Archief Gilden, inv. 252, inv. 246. Population see Figure 2.
Note. Population figures in 000s.

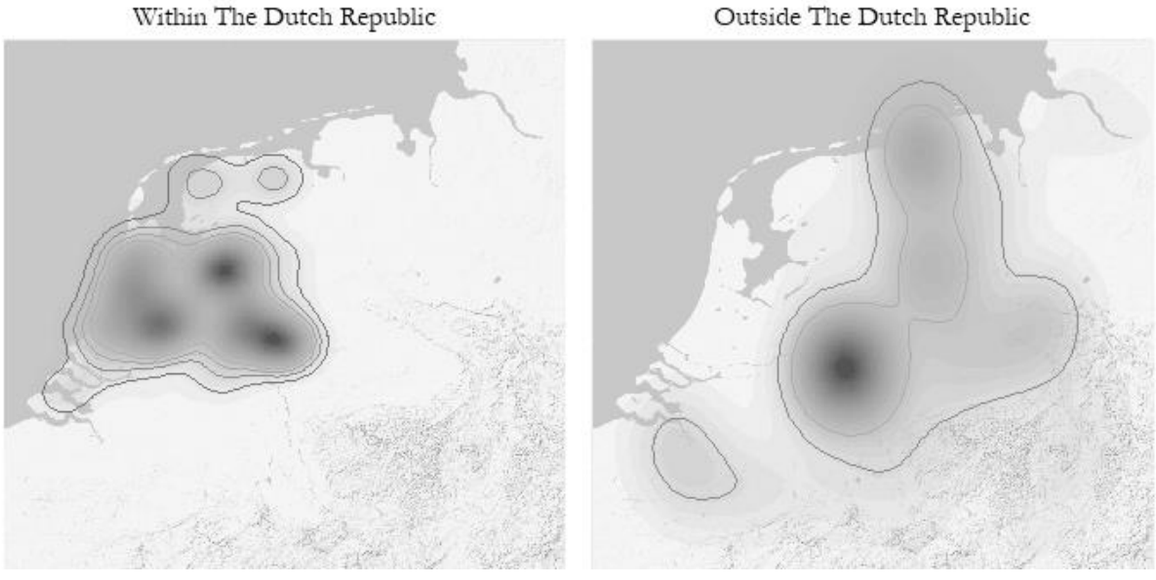
A first look at the geographical breakdown of journeymen surgeons shows the dominant migratory character of this group: Only 27 per cent of these journeymen originated from within the city of Amsterdam, the rest were migrants (Table 5). This figure is even more pronounced if we compare this to a large sample of recently indexed pre-marriage contracts of Amsterdam for 1760-1800: in this period, about 48 per cent of married men were native to the city, suggesting that men native to Amsterdam were underrepresented among journeymen surgeons.[114] These numbers do not exclude the possibility that some of the migrant journeymen were already living in Amsterdam prior to becoming a journeyman surgeon there. Previous research on this matter has shown that this was indeed the case, as some non-native journeymen surgeons had previously been registered as apprentice surgeons.[115] However, there was also a sizeable group of new journeymen who came to Amsterdam after completing their apprenticeship elsewhere.

As with the Haarlem pastry baker journeymen, Amsterdam journeyman surgeons originating from out of town served, on average, shorter contracts than journeyman surgeons born in Amsterdam: 2.2 years per contract vs. 2.4.[116] This may have to do with the fact that a subset of Amsterdam-born journeymen had the possibility to work in their father's shop, whereas for immigrating journeymen this option was mostly unavailable.[117]

When looking at other variables, though, there was little difference between journeymen born in Amsterdam, the Dutch Republic, Germany, and other regions. Migrant journeymen did not work for different types of masters when considering the ages of master surgeons (39.4 vs. 39.2 years old), experience (12.0 vs. 11.3 years), origin (1.93 vs. 1.91 on a scale where 1 = Amsterdam, 2 = Dutch Republic, 3 = Germany 4 = Other), or shop size (3.5 vs. 3.7 employees). From this we can conclude that migrant journeymen were apparently not at a disadvantage when it came to finding masters that were experienced or had larger shops; nor did migrant journeymen work exclusively for migrant masters. Differently put, migrant journeymen do not appear to have been discriminated against (based on their origin) by local, experienced, or large-shop masters. This open stance, by the Surgeons' Guild and its members, towards migrated journeymen might explain why so many journeymen surgeons came to Amsterdam.

To check whether journeymen surgeons going to Amsterdam also fit the pattern that we previously uncovered for skilled journeymen going to The Hague, we georeferenced the birthplaces of journeymen surgeons to obtain population figures.[118] The journeymen surgeons show a unique pattern that does not fit well with the hypothesis. First, journeymen surgeons came mostly from smaller towns and villages: averages lie between 9 and 24 thousand inhabitants (which is likely to be an overestimation, given that towns whose population size was unknown – usually the smaller ones – are not included in this average). Remarkably few came from nearby towns in the province of Holland, while there are two major hubs to the east: one to the north-east around the former Hanseatic town of Kampen, and one on the border region near Nijmegen. Smaller hubs appear around Utrecht, Lingen and Münster (Figure 4).

Figure 4. Places of birth of Dutch and foreign surgeon journeymen registered in Amsterdam, 1761-1766.



Source: see Table 5.

All these towns, except Utrecht, had fewer than ten thousand inhabitants at the time. These patterns fit better with the hypothesis that large cities were supplied by workers from the rural surroundings, than with the hypothesis that high skilled artisans travelled from one major city to another. This could also explain why there are no observations of journeymen coming from the south of the Dutch Republic, as those individuals had nearby alternatives (Ghent, Brussels, Antwerp).[119] Culturally, the inhabitants of Brabant may have felt closer to the Catholic South than to the Protestant North. For journeymen coming from the eastern border region, there simply was no big city nearby at the time other than Amsterdam; besides, they spoke a similar language and were of similar Protestant religion.[120]

This raises the question how suitable Amsterdam was for an ambitious, skilled journeyman to further one's career in, and, by extension, how tempting a place it was to settle down in. To make the step from journeyman to master surgeon, a journeyman first had to invest time in working for the Amsterdam Surgeons' Guild.[121] Journeymen surgeons migrating to Amsterdam were, in this sense, disadvantaged to those who had already completed an apprenticeship there, even though completing an apprenticeship in Amsterdam was not a formal requirement of the guild, so that migrant journeymen were in theory equally eligible to become master surgeons. It is not a wild suggestion that a migrant journeyman needed time to acquire the human capital needed to become a master surgeon – the entry exam, for example, was both difficult and expensive.[122]

The relationship between journeymen's experience and their chance to become master surgeons is illustrated in Figure 5. Journeymen who had to pay an entry fee to the guild were coded as having no previous work experience in Amsterdam, while those who did not have to pay such a fee were considered as having previous work experience in

Amsterdam. This determination is based on the assumption that the latter must have already paid an entry fee at some earlier point in time: either at the start of their apprenticeship or at the start of a previous journeyman contract. The number of Amsterdam-born journeymen who had to pay an entry fee was very low (8%), which is in line with the expectation that most Amsterdam-born journeymen had previous Amsterdam-based work experience, most likely because they had completed their apprenticeship here. Of these Amsterdam-born journeymen who had also been an apprentice in Amsterdam, approximately 14% later became master, while this was zero per cent for Amsterdam-born journeymen who had completed their apprenticeship outside Amsterdam.

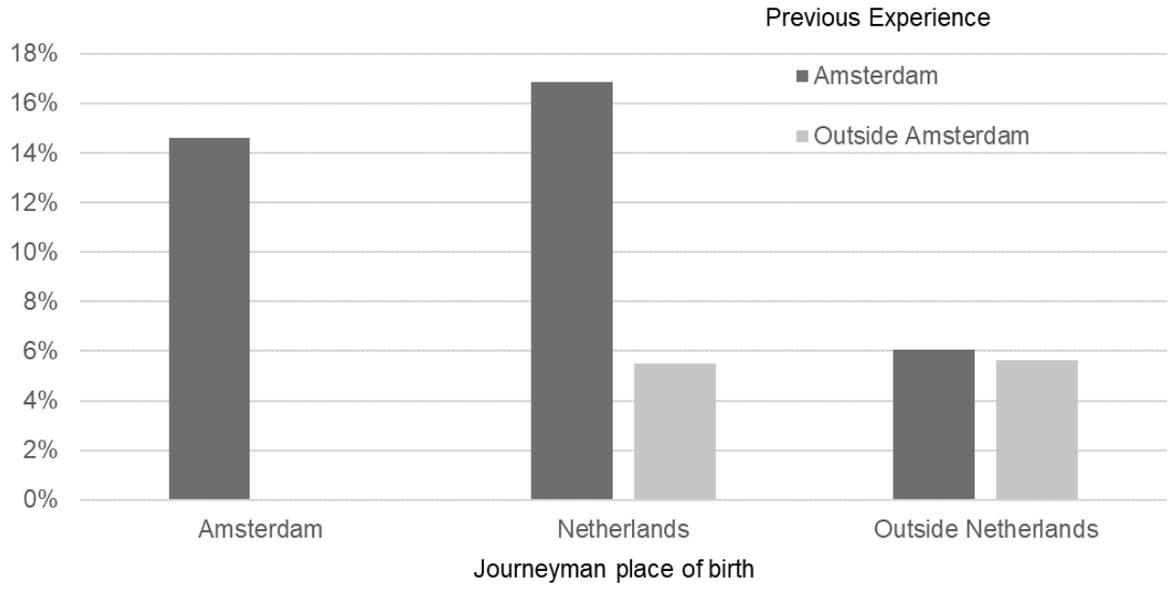
Having previous experience within the Amsterdam Surgeons' Guild was an important determiner of whether a journeyman could become a master there, for locally born journeymen, but also for immigrants. Of journeymen born outside Amsterdam but within the Dutch Republic, 38% did not have to pay an entry fee to the Amsterdam Surgeons' Guild, meaning that they had completed an apprenticeship there or had been contracted as a journeyman before. Of these immigrant journeymen with Amsterdam-based experience, almost 17% became master: on par with – even exceeding – the proportion of journeymen who became master but were born and raised in Amsterdam (Figure 5). That was decidedly *not* the case for immigrant journeymen who had no previous experience with the Amsterdam Surgeons' Guild: of these, only about 5% became master. This suggests that Amsterdam-gained experience – perhaps from completing one's apprenticeship there – was a prerequisite for journeymen wishing to become master surgeons in Amsterdam. One might expect to find a similar effect for journeymen immigrants from outside of the Dutch Republic, but for this group Amsterdam-based experience does not seem to have made any difference.

When reflecting on the city of Amsterdam as a suitable place to migrate to and settle in, for journeyman surgeons, the following picture emerges. First, many journeymen surgeons came to Amsterdam and found work. Of all the contracts made between masters and journeymen in 1761-1766, 51% went to these migrating newcomers (see Table 5). This resonates with the relatively open policy of the city towards migrants. This number rises to 73% if migrants who had located to Amsterdam already during the apprenticeship stage are included. However, not many of them became master surgeons. We reason that this was not likely the result of active discrimination by the Surgeons' Guild or the city council since we found little evidence for such practices. Instead, locally acquired experience – not a history of migration – is what determined whether journeyman surgeons would become masters. It is fair to assume, then, that those migrating journeymen who wanted to settle in Amsterdam needed to invest time and effort to do so, in spite of the otherwise welcoming stance of this city towards migrants.

Overall, this image fits partially with the hypothesis proposed by Sonenscher, namely that those who were born in a big city had the best chances (and reason) to stay there, while many temporary workers came from out of town.[123] However, the Amsterdam case also shows that those who came during an earlier moment during their lives – as apprentices –

had as good a chance of settling down as the local-born. This hints at the fact that the group of travelling journeymen surgeons did not perhaps intend to stay in Amsterdam, or they could have made the move earlier. Nevertheless, the more likely explanation is that Amsterdam served as a 'training hub' for migrant journeymen. Those that did not become master surgeons in Amsterdam may have taken the training they received from the guild – in the form of lectures, anatomical lessons, and lessons in botany – back to their hometowns.[124] That would also explain why most journeymen that frequented Amsterdam came from regions that were culturally and linguistically relatively similar, but not populous enough to organise their own surgical training.

Figure 5. Percentage of surgeon journeymen becoming master in Amsterdam depending on birthplace and experience, 1761-1769.



Source: See Tab. 5.

Conclusion

In this paper we presented an overview of the migration patterns of journeymen coming from different parts of Europe to three major cities in 18th century Holland: The Hague, Haarlem, and Amsterdam. Although these vocational labourers fulfilled an important role in European society of that time – as they provided skilled labour, travelled, gained experience, and ultimately could become master craftsmen – not much is known about the actual behaviour of this group. We aimed to uncover patterns in their migration and settling behaviour: what occupations did they have; where did they come from; where did they travel to; how long did they stay? We tried to explain these patterns by looking at how easy or difficult cities and craft guilds made it for migrating journeymen to arrive and settle down.

From our investigation, a diverse image emerged of journeymen travelling to and living in 18th century Holland. Some, mostly lower skilled, journeymen came from abroad, and after they had arrived, travelled between several cities in the highly urbanized province

of Holland. Others, in higher skilled occupations, came from large cities in Europe, stayed for some years in The Hague, and then left again for another large capital somewhere. Yet others came from nearby regions with a specialisation in a certain craft like masonry. This plurality of patterns is akin to the plurality of patterns observed by Sonenscher for journeymen travelling in France and by Reith for journeymen in Germany, which depended on the occupation and birthplace of the journeyman.[125] Crucially, observing similar patterns in settings with and without mandatory tramping suggests that tramping regulations by guilds probably had little impact on the actual movements of journeymen.

Of all these travelling journeymen, a proportion settled in the city they travelled to. We examined whether this could be explained by the openness of cities and guilds towards migrants, thereby tying our observations in with ongoing debates. According to Epstein, many journeymen travelled from workshop to workshop to acquire skills, and only settled afterwards – either as master or journeyman.[126] Building on this argument, De la Croix et al. argued that the 'journeymen tramping model' of moving around Europe was conducive to the spread of technical knowledge and human capital formation since journeymen learned from non-kin and often settled somewhere outside their place of birth.[127] Conversely, Ogilvie has argued that many guilds did not see the need for human-capital driven journeymen tramping, and that some guilds 'discriminated against non-local youths who had migrated from elsewhere'.[128]

Although we do observe a 'long-distance, big cities' trajectory for highly skilled journeymen in particular, we lack the data to tell if this was conducive to human capital formation or the spread of technical knowledge. Our analysis does reveal that local legislation did impact journeyman migration and settlement. Importantly, this effect could go either way: from stimulating settlement to deterring migrant journeymen from staying. Starting in The Hague, we found pronounced differences with respect to migration and settlement between journeymen of different skill levels, marital status, and foreign status. Single journeymen were much more mobile than married ones. Importantly, though, legislation in The Hague did not discriminate between particular categories of journeymen. While this legislation was tough on outsiders in general – those without work, settlement rights, or citizenship were ruthlessly evicted – it did not affect outsiders with low skills differently than those with high skills, or foreign migrants differently than domestic migrants. The different migration and settlement patterns we observed in The Hague between journeymen of different crafts were, consequently, more likely the result of variations in regional orientation inherent to those crafts, in combination with their marital status, just as was the case for journeymen travelling in France and Germany.[129]

The importance of local legislation is further illustrated by our case studies of Haarlem and Amsterdam. Struck by economic decline, Haarlem maintained strict policies towards migrants. Some of these policies were imposed by local craft guilds and backed by city magistrates. Perhaps as a result, few journeymen travelled to Haarlem compared to The Hague. Those who did, were also less likely to become a master pastry baker than Haarlem-born pastry bakers – especially sons of masters. Contrast this to the liberal city of

Amsterdam, which maintained an open policy towards migrants throughout the 18th century. This successfully allowed the Amsterdam Surgeons' Guild to attract and employ a great number of migrating journeymen, mainly from the rural eastern regions.

A closer examination of the career pattern of Amsterdam-based journeymen surgeons furthermore revealed that although finding employment there as a journeyman was easy – we found little discrimination towards migrants both in theory and in practice – becoming a master surgeon was not, as this required local experience. We think it likely, then, that Amsterdam functioned as a training hub: migrants coming to the city, intent on settling, could acquire the training that was needed to become an Amsterdam master surgeon, and if they did invest that time, they were as successful as the local-born. Many journeymen, however, likely stayed only temporarily, taking their experience back to their hometowns – although we lack the data to confirm this.

In conclusion, we found that, even in the relatively small region that we studied, there were marked differences between cities and guilds in how open they were to migrants, and that this likely affected the migration behaviour of journeymen. In addition to other relevant push and pull factors, then, historians trying to understand journeymen migration and early modern urban labour markets should expand their scope and take urban settlement policies into account as well, since these may well have been more important than guild regulations.[130] Moreover, the interconnectedness of group-level characteristics, craft guilds, and urban regulations indicates that we should try to move away from binary interpretations of craft guilds, and instead study these elements in tandem at the local level.

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[94] Performed as an unpaired student's T-Test.

[95] There are no significant differences in month of arrival between journeymen leaving again and those staying in The Hague, also not when taking skill into account.

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[104] NHA, Archief Stadbestuur van Haarlem (Stadsarchief Haarlem), inv. 68, request no. 133.

[105] NHA, Archief Stadbestuur van Haarlem (Stadsarchief Haarlem), inv. 55 through inv. 79.

[106] NHA, Archief Stadbestuur van Haarlem (Stadsarchief Haarlem), inv. 1575, inv. 1576.

[107] Kuijpers, *Migrantenstad*, 21.

[108] Kuijpers, *Migrantenstad*, Chapter 3.

[109] Lucassen, 'Gated Communities?', 224-229.

[110] Kuijpers, *Migrantenstad*, 325-340.

[111] For an introduction to this guild see W.T.M. Frijhoff, "'Non satis dignitatis...' Over de maatschappelijke status van geneeskundigen tijdens de Republiek", *Tijdschrift voor Geschiedenis* 96 (1983), 379-406.

[112] The difference of 64 comes from journeymen who enrolled themselves more than once during the six year period that we sampled.

[113] The two datasets were manually merged based on full names and year of arrival, recorded in both sources.

[114] With courtesy of René van Weeren and Tine de Moor. Dataset Ja, ik wil-project (unpublished), Research Team Institutions for Collective Action, Department of History and Art History, Utrecht University. This dataset will be accessible in due time via www.collective-action.info/ja-ik-wil/dataset and is a result of the 'Ja, ik wil!'-project, part of the VIDI-project 'Nature or nature? A search for the institutional and biological determinants of life expectancy in Europe during the early modern period' funded by the Dutch Organisation for Scientific Research (NWO) (276–53-008).

[115] Groot, 'Newcomers, migrants, surgeons, 25-27.

[116] Analysis of variance revealed significant linear terms for journeymen coming from Amsterdam, Dutch Republic, Germany, and other places, indicating that the number of years per contract decreased the further away a journeyman originated from Amsterdam, $F(1) = 6.4$, $p = .012$ and $F(1) = 13.3$, $p < .001$.

[117] Chi square comparing journeymen from Amsterdam, Dutch Republic, Germany, and other regions on whether they were sons of Amsterdam masters was significant, $\chi^2(3) = 10.0$, $p = .018$.

[118] Using the same method and urban population dataset as described above.

[119] Antwerp indeed attracted many migrants from that region during the second half of the eighteenth century; A. Winter, 'De microcontext van stedelijke groei. Posities en trajecten van immigranten op de Antwerpse arbeidsmarkt in de tweede helft van de achttiende eeuw' *Stadsgeschiedenis* 1, 2 (2006), 122–147.

[120] J. Roding and L. Heerma van Voss, eds., *The North Sea and culture (1550-1800): Proceedings of the International Conference Held at Leiden 21-22 April 1995* (Hilversum, 1996).

[121] Groot, 'Newcomers, migrants, surgeons, 27-29.

[122] Groot, 'Newcomers, migrants, surgeons, 19-21.

[123] Sonenscher, *Work and wages*, 120.

[124] Cf. W.T.M. Frijhoff, M. Prak, and M. Carasso-Kok, eds., *Geschiedenis van Amsterdam: centrum van de wereld 1578-1650* (Amsterdam 2004), 90-92.

[125] M. Sonenscher, 'Journeymen's migrations and workshop organization in eighteenth-century France', in *Work in France: representations, meaning, organization, and practice* (Cornell, 1986), 74-96; Reith, 'Circulation of skilled labour.

[126] Epstein, 'Craft guilds in the pre-modern economy', 155-174.

[127] D. De La Croix, M. Doepke, and J. Mokyr, 'Clans, guilds, and markets: apprenticeship institutions

and growth in the preindustrial economy,' *Quarterly Journal of Economics* 133, 1 (2018), 1–70.

[128] Ogilvie, *The European guilds,* 448-456, quote from p. 454.

[129] Sonenscher, 'Journeymen's migrations and workshop organization in eighteenth-century France'; Reith, 'Circulation of skilled labour'.

[130] Cf. Prak et al. 'Access to the trade'.

Appendix to Chapter 3

Table A1. Coding of skill levels per HISCO microgroup.

MICROGROUP	NON-ROUTINE	INGENUITY	SKILL_LEVEL	HISCO_LABEL
6110	1	1	2	General Surgeon
16120	1	1	2	Sculptor
39310	0	1	1	Office Clerk, General
42220	1	0	1	Buyer
45130	0	0	0	Retail Trade Salesperson
51020	0	0	0	Working Proprietor (Hotel and Restaurant)
53190	0	0	0	Other Cooks
54010	0	0	0	Domestic servant, general
54020	0	0	0	House servant
55240	0	0	0	Chimney Sweep
57090	1	1	2	Other Barbers, Hairdressers, Beauticians and Related Workers
58320	0	1	1	Officer
58340	0	0	0	Other Military Ranks
59950	1	1	2	Practical Aid (Pharmacy)
62105	0	0	0	Farm Worker, General
62400	0	0	0	Livestock Worker, Specialisation Unknown
62700	0	0	0	Nursery and Garden Workers unspecified
72420	0	1	1	Metal Pourer
75400	0	0	0	Weaver, Specialisation Unknown
75452	1	1	2	Lace Weaver (Hand or Machine)
75622	0	0	0	Yarn, Fabric or Garment Dyer
77120	0	0	0	Grain Miller
77330	0	0	0	Meat Cutter
77610	0	0	0	Baker, General
77660	0	1	1	Confectionery Maker
77810	0	0	0	Brewer, General
77890	0	0	0	Other Brewers, Wine and Beverage Makers
78100	0	0	0	Tobacco Preparers, Specialisation Unknown
79100	1	1	2	Tailor, Specialisation Unknown
79190	1	1	2	Other Tailors and Dressmakers
79310	0	1	1	Hat Maker, General
79565	0	0	0	Embroiderer, Hand or Machine
80110	0	1	1	Shoe-maker, General
80320	0	1	1	Saddler and Harness Maker
81120	0	1	1	Cabinetmaker
81190	0	0	0	Other Cabinetmakers
81230	0	0	0	Wood Turner
81925	0	1	1	Cartwright
81930	0	1	1	Cooper
82000	0	1	1	Stone Cutter or Carver, Specialisation

				Unknown
83110	0	0	0	Blacksmith, General
83915	0	1	1	Cutler
83920	1	1	2	Gunsmith
83930	1	1	2	Locksmith
84222	1	1	2	Watch and Clock Assembler or Repairer
87105	0	0	0	Plumber, General
87330	0	0	0	Coppersmith
87340	0	0	0	Tinsmith
88010	1	1	2	Jeweller, General
88050	1	1	2	Goldsmith and Silversmith
89100	0	0	0	Glass Former, Potter or Related Worker, Specialisation Unknown
92110	0	1	1	Printer, General
92120	0	1	1	Hand Compositor
92625	0	1	1	Bookbinder (Hand or Machine)
93120	0	0	0	Building Painter
93920	1	1	2	Brush-Painter (except Construction)
94160	1	1	2	Organ Builder
94990	0	0	0	Other Production and Related Workers Not Elsewhere Classified
95120	0	0	0	Bricklayer (Construction)
95160	0	0	0	Paviour
95320	0	0	0	Slate and Tile Roofer
95410	0	1	1	Carpenter, General
95440	1	1	2	Wood Shipwright
95455	0	0	0	Ship's Carpenter
95925	0	0	0	Paperhanger
97125	0	0	0	Loader of ship, truck, wagon or airplane
98190	0	0	0	Other Ships' Deck Ratings, Barge Crews and Boatmen
98620	0	0	0	Animal-Drawn Vehicle Driver (Road)
99900	0	0	0	Worker, No Further Information
99920	0	0	0	Day-Labourer

Sources: Derived from https://druid.datalegend.net/HistoryOfWork/historyOfWork-all-latest (last accessed April 8, 2022). For coding, see text.

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Chapter 4

Mapping the medical stereotype: Similarities and dissimilarities between migrant and non-migrant medical students in the Netherlands as a function of their stereotypical view of the profession.

Based on: Groot, P.J., Spaans, I., & Ellemers, N. (in prep). Mapping the medical stereotype: Similarities and dissimilarities between migrant and non-migrant medical students in the Netherlands as a function of their stereotypical view of the profession.

Author contributions: Piet Groot took the lead in designing the survey used to collect the data for this chapter. He also analysed the data and authored the manuscript. Isabella Spaans commented on the design of the survey, and contributed substantially towards the data collection. Naomi Ellemers provided input on the data analysis and the overall structure of the manuscript. She also edited various versions of the manuscript. Piet Groot would like to express his gratitude towards the bachelor students who contributed towards the design of the survey used in this study, and who helped to collect the data: Bente Bruijniks, Eva van den Broek, Loes Brust, Mérin Knaapen, Anouk Stulen, Manoah de Haan, Maud van Meer, and Susanna Tan.

Abstract

Background. During their studies, medical students develop a professional identity. However, whether different groups of students (e.g., those with a migration background and those with a native background) develop the same professional identity thus far remains unknown. To remedy this, the current study uses theory about stereotypes to create a detailed "map" of medical students' professional identity as it develops during their education. We ask the question: What medical stereotype do medical students studying in the Netherlands maintain about the medical profession? In a second step, we compare the medical stereotype map of students with a migration background to that of students with a native background. *Method*: Medical students studying at different universities in the Netherlands (26% migration background) filled in a survey about their perceived medical stereotype. Specifically, students scored a prescriptive stereotype, descriptive stereotype, meta-stereotype, and self-stereotype in terms of competence, sociability, and morality. *Results*: Students with a migration background maintained a remarkably similar medical stereotype to students with a native background. The only exception to this was to be found among students who identified strongly with their other-than-Dutch background. This group appeared to have even higher standards. Overall, students maintained strongly positive prescriptive stereotypes, descriptive stereotypes, and meta-stereotypes about the medical profession, in which morality, competence, and sociability, in that order, were deemed important. Students' self-stereotypes followed this pattern, but a discrepancy was observed for students' self-ascribed competence. *Conclusion*: Medical students receiving education in the Netherlands maintain a strongly positive medical stereotype. It appears that students with a migration background develop the same positive professional identity as do students with a native background. The role of education in this process is discussed.

Introduction

The medical profession is held in high regard by many, as is reflected by the positive image that people have of doctors. When asked to score doctors on attributes such as warmth and competence, for example, people rate them very positively on both these aspects (Nicolas et al., 2022). Similarly positive expectations about doctors have been found to exist among patients (Groot & Ellemers, in prep.), medical students (Burford & Rosenthal-Stott, 2017; Draper & Louw, 2007; Stubbing et al., 2019), and, last but not least, doctors (Minicuci et al., 2020; Roland et al., 2011). When there are certain fixed beliefs about a group of people, as there appear to be about doctors, we may speak of these beliefs as *stereotypes* (Yzerbyt, 2016). About doctors, then, a positive stereotype might exist that we may label the "medical stereotype". The existence of such a positive medical stereotype could be of consequence for the many medical students who aspire to become doctors, especially those with a migration background. However, thus far there have been no direct

attempts to map the contents of the medical stereotype – if indeed there exists one – among medical students.[z]

Mapping the medical stereotype among medical students could help to amend a long-standing problem regarding the integration of migrant doctors into the destination country's medical professional work force. Western countries are becoming increasingly dependent on migrant doctors, but migrant medical students report negative experiences stemming from their migration background, such as being discriminated against, lacking a sense of belonging, and feeling excluded from existing networks (Waldring et al., 2020). Such experiences correspond with lower academic performance, hampering the potential of an important group of future doctors (Stegers-Jager et al., 2012). But although there has been plenty of research investigating the adjustment of migrant doctors to the destination country's medical setting (Dywili et al., 2012; Harris, 2014), the personal experience of migrant doctors and perceived barriers in the medical sector (Batnitzky & McDowell, 2011; Groutsis & Arnold, 2012; Hawthorne, 2015; Isik et al., 2021; Leyerzapf et al., 2015), and patients' preference for doctors of certain ethnicities (Shen et al., 2018; Street et al., 2008; Thornton et al., 2011), there is a dearth of research focusing on the formative influence of medical education on the professional development of medical students with a migration background. Students develop a professional medical identity during their education to become doctors, which consists of internalised beliefs about who they are as a medical professional and how they should act (Cruess et al., 2015; Kay et al., 2019). As such, following medical education in the country of destination could be an important step towards the socialisation of students with a migration background into that country's medical sector. It is not a given, however, that medical students with a migration background develop the same professional identity as do medical students with a native background. The question is, given their unique experience, whether medical students with a migration background develop the same professional identity as the rest of the student population. Unfortunately, not much is known about the professional identity formation of medical students with a migration background (Fyfe et al., 2022; Wyatt et al., 2021).

Mapping the medical stereotype among medical students with or without a migration background could mitigate this. Stereotypes have several qualities that make them well-suited to describe medical students' developing professional identity. To start, they capture a more-or-less fixed configuration of beliefs about a specific group. These beliefs are thought to go back to a limited set of basic attributes; hence, almost any stereotype can be measured through a combination of evaluations about, for example, a group's competence, morality, and sociability (Abele et al., 2021; Landy, 2015; Leach et al., 2007). Which information a stereotype contains about these three attributes is highly influential for how people approach a group member to whom the stereotype applies. Groups about which a stereotype exists that they are incompetent, immoral, and unsociable are usually avoided or shunned, while groups about which a stereotype exists that they are competent, moral, and

[z] For a study that did explicitly map medical stereotypes, but among medical professionals rather than students, see Kämmer & Ewers (2021).

sociable are admired (Cuddy et al., 2007; Ellemers, 2017; Fiske, 2010). Mixed stereotypes are also possible, for example if a group is thought to be competent but immoral; such stereotypes will elicit different approach behaviour than a group about which the stereotype exists that they are incompetent but moral. Although medical literature has previously attempted to describe people's expectations of doctors in an applied medical setting, resulting in a range of different attributes to describe doctors, it has thus far ignored these more fundamental stereotypical attributions (cf. Draper & Louw, 2007; Hillen et al., 2012; Lagro-Janssen & van den Muijsenbergh, 2007; Losch & Schulze, 2016; Minicuci et al., 2020; Tsai et al., 2007). Measuring medical students' medical stereotype in terms of competence, morality, and sociability could provide a more theory-driven and fundamental description of how they perceive the medical profession and, hence, inform us about the professional identity that they might strive toward.

A second, and perhaps more important, strength of stereotypes is that they can come in different, related, forms, which may be used to describe unique aspects of the medical profession. The standard form of stereotype is called the descriptive stereotype, and this is the kind that is evoked when people are asked to describe a group in terms of their stereotypical attributes. As mentioned previously, people determine their approach towards the stereotyped group in accordance with the perceived positivity or negativity of those attributes. Although these descriptive stereotypes have proven to be very persistent (Ehrlich, 1973), they are not normative in the sense that deviation from a stereotype is not punished. Under certain conditions, however, a descriptive stereotype about a group can become so accepted that it becomes a guideline for how people in the stereotyped group *should* act. Deviation from the stereotype, even if the stereotype is negative and deviation could be considered desirable, can then be met with disapproval (Berdahl & Min, 2012). We can call this form of stereotype a prescriptive stereotype. A third form of stereotype concerns not what one person thinks of a group of people, but what he thinks that *other* people think about *him*. This may be called a meta-stereotype, as it represents the views that the members of a given group (often a dominant group) believe exist about them in the eyes of another group (often a minority group; Vorauer et al., 1998). Depending on whether the meta-stereotype is positive or negative, people may either become more friendly or more hostile towards the group that they believe is stereotyping them (Matera & Catania, 2021). Finally, self-stereotyping may occur when a person internalises the stereotypes that they believe others hold about them. This may result either in acting in line with those stereotypes, or in attempts to disprove them (cf. Burkley & Blanton, 2009; Steele & Aronson, 1995). Taken together, descriptive stereotypes, prescriptive stereotypes, meta-stereotypes, and self-stereotypes maintained by medical students can be measured to provide a detailed description of the expectations that they have about important aspects of the medical professional identity, such as how doctors typically act and are supposed to act, what others such as patients may expect of doctors, and, finally, how well they as medical students succeed in living up to these different expectations.

To explore whether medical students with a migration background develop the same professional identity as medical students with a native background, the current study thus applies theory from social psychology about stereotypes to create a detailed "map" of the medical stereotype maintained by medical students. In doing so, the current paper hopes to present a nuanced and theory-driven overview of the medical students' professional identity as it develops during their education. The first contribution from social psychological theory comes from the recognition that stereotypes can be measured using basic constructs, like competence, morality, and sociability, which have been proven to influence people's perception of stereotyped groups outside the medical setting (Abele et al., 2021; Landy, 2015; Leach et al., 2007). Measuring how medical students perceive the medical stereotype in terms of these aspects could inform us of their stance towards the medical profession, and point to the aspects of being a doctor that they might wish to internalise as part of their professional identity. The second contribution from social psychological theory comes from the recognition that stereotypes come in different forms, which can be applied to unique aspects of the medical profession. These include expectations of how medical professionals generally behave, how they should behave, how others expect them to behave, and of whether students can live up to these expectations. These different types of expectations have been found to yield unique influences on people's behaviour in settings outside the medical sector, which motivates including them as separate aspects of the medical stereotype. To our knowledge, the current study is the first to map the medical stereotype in this way among medical students.

The current paper will address the following two research questions: 1) What "medical stereotype" do medical students studying in the Netherlands maintain about the medical profession? and 2) Do students with a migration background and students with a native background maintain different renditions of this medical stereotype? Answering these questions helps to determine whether medical students with a migration background develop a similar professional identity to medical students with a native background, and provides a detailed view into what this identity looks like.

On Stereotypes

When someone evaluates a person or group, they often resort to a pre-existing mental image of what that person or group is like. These mental images are referred to as stereotypes, and they catch a certain configuration of beliefs about a group of people (Yzerbyt, 2016). This information, it is currently believed, may be grouped into three evaluative dimensions: sociability, morality, and competence (Abele et al., 2021; Landy, 2015; Leach et al., 2007). Sociability and morality are thought to convey information about a person's intentions towards others. They differ somewhat, in that sociability captures someone´s general likability or friendliness, whereas morality specifically conveys information about that person's 'goodness'. Evaluations of someone's sociability and morality determine people's willingness to trust, help, include, or depend on others (Brambilla et al., 2013; Brambilla & Leach, 2014; Pagliaro et al., 2013). Competence, on the

other hand, may be understood as someone's ability to act upon their intentions; evaluations of competence correlate with perceived status, power, skill, and class, among other things (Abele et al., 2021). The relative importance of one dimension as compared to the others may differ depending on who is being evaluated (e.g., the self, one's own group, a rival group), and there is also still some controversy about the exact number of dimensions and their labels; however, scientists agree that evaluations on all three of the dimensions bear consequences for the person or group under evaluation (Abele et al., 2021). Stereotypes can thus affect how people perceive and approach others.

Starting with *descriptive stereotypes*, these are the stereotypes that determine how people generally perceive each other, and consequently also feel and act towards each other. Groups about which a descriptive stereotype exists that is positive in terms of sociability, morality, and competence, are likely to elicit warm feelings and approach behaviour from others. Groups about which a descriptive stereotype exist that is mixed or negative, in contrast, are met with feelings of disgust and contempt; others may choose to passively neglect these people, or even actively harm them (Fiske, 2010; Cuddy et al., 2007, 2008). About poor blacks, Turks, and Arabs living in the USA, for example, stereotypes exist that convey that these groups are incompetent and cold (which may be thought of as a combination of poor sociability and poor morality). Such an unambiguously negative stereotype generally elicits the emotion of scorn from others. The stereotype about Americans of Asian descent, on the other hand, is mixed: while being perceived as cold, Asian Americans are also considered highly competent, a combination that elicits not scorn but envy (Fiske, 2010). Such competent but cold groups can come across as threatening, reducing others' willingness to interact with them (Awale et al., 2019). Morality is also an important aspect of descriptive stereotypes, as evaluations of morality have been found to be especially important to determining which group someone wants to belong to: more than competence or sociability, people want to be part of groups that appear moral, and derive pride from membership of such groups (van Prooijen et al., 2018; van Prooijen & Ellemers, 2015). Likewise, groups use perceptions of morality to determine which newcomer to help or to accept into their midst (Ellemers, 2017; Pagliaro et al., 2013).

Whereas descriptive stereotypes mainly serve to convey information about a group, *prescriptive stereotypes* add a layer of justification to that description (Yzerbyt, 2016). The more general principle may be said to go back to Hume (1739), who distinguished 'what is' from the ethically charged 'what ought to be'. The latter stereotypes are normative, in the sense that they do not only describe how the social world is, but how it should be; violations of a prescriptive stereotype may therefore lead to negative responses from others. East Asians living in the United States, for example, are often described to be competent, but not dominant. This descriptive stereotype has been found to co-occur with the prescriptive stereotype that they should not act in a dominant way. When East Asians do act counter-stereotypically – i.e., in a dominant fashion – they are disliked (Berdahl & Min, 2012).

When people anticipate the stereotypical expectations held by others about themselves, we can also speak of *meta-stereotypes*. These represent the views that the

members of a given group (often a dominant group) believe exist about them in the eyes of another group (often a minority group; Vorauer et al., 1998). In general, people expect that the beliefs that out-group members hold about them are negative, leading to anxiety towards the out-group (Vázquez et al., 2017; Yzerbyt, 2016). Under some circumstances, groups may respond to this anxiety by legitimizing the behaviour described in the negative meta-stereotype. This has been found, for example, for Moroccan-Dutch teenagers in the Netherlands (Kamans et al., 2009). In a similar vein, the activation of negative meta-stereotypes among migrant children in China led to frustration and aggressive behaviour directed at other children (Huang et al., 2019). Among international PhD students in Italy, positive meta-stereotypes led to psychological adjustment and increased contact with the Italian population, while negative meta-stereotypes led to the opposite (Matera & Catania, 2021). In a medical setting, negative expectations of patients about the stereotypes held by doctors about them led to decreased trust, increased intergroup anxiety, and a worsening of the doctor—patient relationship (Xu et al., 2021).

Finally, *self-stereotyping* occurs when a person belonging to a stereotyped group describes themselves with traits belonging to that group, rather than with traits that are irrelevant to the group stereotype (Latrofa et al., 2012). In the face of discrimination or rejection by a dominant out-group, self-stereotyping may help to protect a discriminated person's well-being (Branscombe et al., 1999; Latrofa et al., 2012). While there are thus some benefits for people who self-stereotype, researchers have warned that these benefits are often outweighed by the costs (Burkley & Blanton, 2009). While self-stereotyping may help to promote a sense of group belonging, it may, for example, simultaneously discourage people to pursue counter-stereotypical goals. In the long run, the endorsement of negative self-stereotypes may thus discourage people to effect social change, while perpetuating the negative stereotype existing about their group (Burkley & Blanton, 2009).

Endorsing negative self-stereotypes often follows confrontation with a negative descriptive stereotype or meta-stereotype about one's group. This can hamper the task performance of people who self-stereotype. Women, for example, when confronted with subtle cues of discrimination – in which it was suggested that they were not hired due to their gender – responded by endorsing that they were dependent, attentive, understanding, modest, emotional, etc. (i.e., traits typical of the female stereotype). However, this self-stereotyping co-occurred with lower indicated self-esteem, more negative self-directed emotions, more self-concern, and an inferior task performance (Cihangir et al., 2010). This is a variant of a well-known effect, called 'stereotype-threat', in which being confronted with a negative stereotype about one's group leads to hampered performance on a related task. For example: reminding women of the stereotype "women can't do math" can affect their performance on a maths test. While the mechanism behind stereotype threat is itself thought to revolve around a strong focus on preventing mistakes (which, ironically, leads to more mistakes, Seibt & Forster, 2004; Steele & Aronson, 1995), the message here is that being confronted with negative stereotypes or meta-stereotypes can lead to the endorsement of negative self-stereotypes and hampered task performance.

In conclusion, stereotypes can have a profound impact on the way in which people perceive others and themselves. This impact is not limited to people's anticipations of how someone is likely to act, based on the stereotype existing about their group. Stereotypes can also become a normative guideline for how people should act, in which case deviation is punished. Furthermore, based on their knowledge of existing stereotypes about themselves, or stereotypes believed to be held by others, people adjust their behaviour, beliefs, and even their self-image – potentially affecting their career motivation and ability to perform well.

For these reasons, stereotypes may be uniquely situated to understand the professional identity formation of medical students. This is thought to be a socialisation process in which medical students develop a professional identity through coming into contact with the medical educational environment. The identity that they take on includes specific ideas about themselves, significant others such as friends, mentors, and co-workers, and the social group to which they belong or wish to belong (Cruess et al., 2015). Since stereotypes have been shown to have a profound impact on these very ideas, they are well-suited to describe and understand medical students' developing professional identity. Such a description could help us identify which characteristics of being a doctor medical students find important, or deem important based on their perception of other people's needs. This could give us an insight into the aspects of being a doctor that medical students might strive towards, and whether their self-image matches that ideal image. Measuring the content of the medical stereotype as it exists among medical students could thus be key to understanding the professional identity that medical students aspire to or feel obliged to progress toward. Much depends on the content of this medical stereotype, but what do we know about that?

A Positive Medical Stereotype?

While previous research did not investigate the contents of a "medical stereotype" explicitly, there is indirect evidence that a positive medical stereotype might exist about doctors. This stereotype appears to contain the same evaluative components as are usually observed with stereotypes, namely ideas about competence and sociability, in the first place, and, as I will argue, also about morality. Starting with the first two traits, doctors are expected to be competent medical professionals, who are nonetheless also expected to possess good people-skills with patients, and to be of impeccable moral behaviour. Minicuci et al. (2020), for example, let doctors rank values related to their profession, and used factor analysis to classify those values into two dimensions. They labelled these factors 'performance attainment' (containing, e.g., competence, advocacy, and confidentiality) and 'personal involvement' (containing concern and compassion), meaning that the professional behaviour that doctors value relates to their ability to perform as well as to their ability to show personal involvement with patients. Lagro-Janssen and van den Muijsenbergh (2007) let doctors rank a similar set of values, and again found two dimensions of professional behaviour, which they labelled 'curing' and 'caring'. These sets of qualities valued by doctors

agree with the finding that, among the general public, doctors are perceived to be highly competent as well as warm (Nicolas et al., 2022). Other classifications also exist, sometimes containing more than two dimensions of professional conduct, but competence and sociability always appear to be among them (e.g., oncology patients evaluate their doctor on their fidelity, caring, competence, and honesty; Hillen et al., 2012). Importantly, these studies show that doctors, patients and others generally hold positive expectations about medical professionals in terms of their competence and sociability.

Besides technical competence and sociability-related skills such as caring or patient-centredness, morality is likely to be another important aspect of the medical stereotype. The medical profession is, namely, also perceived to be highly moral in nature. Draper and Louw (2007) interviewed medical students studying in South-Africa, who described the work of doctors to be highly significant, "to the point of almost being noble." (p. e105). Tsai et al. (2007) studied beliefs about the medical profession among Taiwanese students, and found that they, too, perceived moral behaviour to be important: accountability to patients, respect for patients and their families, and integrity and prudence were identified as the three most important traits for doctors. Similarly, Losch and Schulze (2016) asked medical students to describe the relationship they planned to have with future patients, who subsequently emphasised trustworthiness and medical expertise as most important for a successful physician—patient relationship. These findings tell us that besides sociability and competence, morality – that is, a belief in the sincerity and good intentions of doctors – may be another relevant aspect of the medical stereotype.

From the medical literature, an image thus emerges of a positive medical stereotype, in which the dimensions sociability, morality, and competence can be clearly recognised. The question that remains is whether medical students all maintain the same medical stereotype, or that students with a migration background maintain a different medical stereotype than students with a native background. To this question, prior research does not appear to have a definitive answer. On the one hand, there are those who argue that the national context in which medical students are educated steers towards the development of a distinct set of ideas and practices among graduate students (Harris, 2011, 2014). According to this view, not migration background, but educational background, then, is responsible for differences between migrant doctors and native doctors. Hence, if medical students are educated in the same place (e.g., the Netherlands), they should come into contact with the same ideas about medical practice, prompting the development of one professional identity shared between students. On the other hand, there are researchers who question the validity of this reasoning, by pointing to the unique, often disadvantaged, position of students with a migration background within the medical education system (Wyatt et al., 2021). This might lead them to develop unique professional identities, even within the same education system.

The scarce literature investigating stereotypes among medical students points in the direction that different stereotypes do exist for students of different ethnicities, and that this may also lead to different outcomes for those students. For black students, for example, negative stereotypes about their competence lead to 'stereotype threat' – undermining

their ability to perform well, whereas for white students, positive stereotypes about their competence lead to 'stereotype lift' – that can elevate their professional motivation and performance (Bandyopadhyay et al., 2022). This prior research, however, only investigated whether stereotypes about specific ethnic groups exist among medical students, while it did not investigate whether those students held different renditions of a more general medical stereotype. As such, the scientific literature is inconclusive about the stereotypical image that medical students hold about the medical profession. That is unfortunate, because descriptive stereotypes, prescriptive stereotypes, meta-stereotypes, and self-stereotypes may represent an important source of information for medical students about professional standards of conduct, the expectations of others, and their own position within medicine. The current study therefore aims to measure these stereotypes among medical students, which we collectively refer to as "the medical stereotype". By mapping these different aspects of the medical stereotype, this study hopes to give a more insightful account of the characteristics that medical students might wish to internalise as part of their professional medical identity.

In doing so, the current study also hopes to shed light on the question whether medical students with a migration background develop a similar professional identity as medical students with a native background. This adds an extra layer to the debate about integration of migrant doctors, which has so far focused mainly on graduated doctors. Interpreting differences between the stereotypes maintained by graduated doctors is difficult, since these doctors have been trained in different places using different methods. By focusing on medical students rather than on graduated doctors, the current study instead recognises that not all migrant doctors will have had the same history leading up to their employment. Some migrant doctors may have lived in the destination country since childhood, followed education there, and see themselves as an integral part of the destination country's population; other migrant doctors may have lived and studied abroad, and only recently have come to the destination country. If following education in the country of destination helps migrant doctors to adopt a similar professional identity as native doctors, then medical education may function as a vehicle towards migrant doctors' integration. Therefore, examining the professional identity of migrant medical students, as it develops during their education in the destination country, helps to determine whether medical education can help towards the integration of migrant doctors.

Method

The current study addressed the following two research questions: 1) What "medical stereotype" do Dutch medical students maintain about the medical profession during their medical education? and 2) Do students with a migration background and students with a native background maintain different renditions of this medical stereotype? To this end, medical students in the Netherlands – some of whom had a migration background and some of whom had a native background – were asked about the descriptive stereotype, prescriptive stereotype, meta-stereotype, and self-stereotype that they perceived in the

medical sector. The dimensions on which these stereotypes were measured were competence, sociability, and morality.

The data analysis consisted of three parts. First, the medical stereotype was mapped for each student, after which statistical analysis was applied to identify significant differences between the competence, sociability, and morality components of the medical stereotype. Second, the stereotype maps of students with a migration background were compared to the maps of students with a native background, to identify whether and where these differed from each other. Third, to control for the possibility that differences in the medical stereotype maintained by students with a migration background versus a native background might be affected by the extent to which students subjectively identified with the Netherlands or an other-than-Dutch nationality, an additional analysis was conducted. In this analysis, an interaction effect between migration background and subjective identification with the Netherlands vs. an other-than-Dutch nationality was plotted against medical students' over all image of the medical profession.

Data collection. Anonymous URLs and QR codes leading to a Qualtrics survey were distributed among medical students studying at several universities in the Netherlands. A variety of distribution channels were used, ranging from e-mail to Whatsapp and Facebook groups. Student organisations of medical students in different cities located in the Netherlands were approached through personal connections of the investigators, if available, or through contact with the contact person of the organisation, after which the survey was further distributed internally. Another investigator used their connection within the student support desk in Utrecht University to distribute the survey among medical students enrolled at Utrecht University. Similarly, the Dutch national student organisation of medical students was contacted by one of the investigators, after which the URL to the survey was e-mailed to all of its members. Finally, one investigator visited one online lecture to first year and second year medical students to promote the survey.

The initial sample consisted of 672 participants. A large portion, however, had not completed the survey. After excluding every participant who completed less than 50% of the survey, there were 470 participants left. In a next step, 22 participants who spent fewer than 150 seconds on completing 50 to 75 percent of the survey, or fewer than 300 seconds on completing 75 to 100 percent of the survey, were excluded, because this amounted to less than half the expected duration to complete the survey. Two participants were excluded for consistently answering the extreme right option on all of the items in the survey, and 12 participants for indicating that they were uncomfortable with answering survey questions in English (< 2 on a 5 point scale). This left us with a sample of 434 participants.

Participants. The migration background of the participants was determined according to the definition used by the Statistics Netherlands, which states that anyone currently living in the Netherlands who was born in a country outside the Netherlands, or who has at least one parent who was born in a country outside the Netherlands, has a "migration background" (CBS, 2021). Hence, we computed the geographic origin of the participant as "Dutch" if the participant *and* both of their parents were born in the Netherlands, but differently if either

the participant or at least one of their parents were born in a country other than the Netherlands. If a participant had a migration background but their geographic origin differed from their parents', or if their parents were born in two different continents outside of the Netherland, the geographic origin was coded as "mixed". While we measured geographic origin at the country level, Table 1 displays only the continent on which those countries were located, in order to reduce the number of categories. Turkey, a country with a sizeable proportion of emigrants to the Netherlands, was categorised under "Asia", while the Dutch Antilles and former Dutch colony of Surinam were categorised under "South America".

Table 1. Sample description.

		n	%	Min.	Max.	*M*	*SD*
Gender	Male	109	25%				
	Female	321	74%				
	Other	4	1%				
	Total	434					
Age				17	36	22.04	2.728
Educational Experience	Study year			1	8	3.47	1.673
	Location						
	Utrecht	248	57%				
	Amsterdam	16	4%				
	Leiden	43	10%				
	Groningen	44	10%				
	Maastricht	28	6%				
	Rotterdam	46	11%				
	Nijmegen	9	2%				
Migration background	No	321	74%				
	Yes	113	26%				
Geographic origin							
	Netherlands	321	74%				
	Europe	37	9%				
	Africa	7	2%				
	Asia	33	8%				
	S. America	14	3%				
	N. America	4	1%				
	Oceania	1	<1%				
	Mixed	17	4%				

Census data indicate that in 2021 a total of 19.131 students were enrolled for the study of medicine at a Dutch university, of whom 30% had a migration background according to the definition used by Statistics Netherlands. Our sample consists of 434 students, or just over 2% of all students studying medicine in the Netherlands. Our sample contains 113 participants with a migration background, or 26% of the total, which is slightly lower than the country average. The proportion of men in our sample is 25%, which is slightly lower than the country average of 32% (CBS, 2023). Looking at the distribution of students' origin, we perceive a relatively high number of students coming from Europe and Asia. The latter category is, however, inflated by a high number of students hailing from Turkey. Similarly,

many students in the South-America category hail from the Dutch Antilles and the former Dutch colony of Surinam.

Scale creation: Competence, sociability, morality. The survey measured three components of stereotypes: competence, sociability, and morality. These components were measured using nine items developed by Leach et al. (2007). Specifically, the items used to measure competence were: competent, intelligent, skilled. To measure sociability, the items were: sociable, friendly, warm. The items used to measure morality were: honest, sincere, trustworthy. These items were used to measure participants' stereotypical beliefs about four different social targets within the medical profession: doctors in general, role-models, patients, and the self. These four targets were, furthermore, included in the items in such a way that they measured a prescriptive stereotype, descriptive stereotype, meta-stereotype, and self-stereotype, respectively. Specifically, participants were asked: 1) *Rate how important you think the following characteristics are for doctors in general. For doctors in general it is important to be ...* 2) *Rate what characteristics medical professionals that you look up to possess. Medical professionals that I look up to are …* 3) *Rate what doctor characteristics you think patients find important. Patients believe it is important that doctors are ...* 4) *Rate how you would describe yourself as a medical student. As a medical student, I find myself to be ...,* which was each time followed by the nine items measuring competence, sociability, and morality.

Simple composite scores were created for each stereotype dimension by summing the three items corresponding to that dimension. This was done separately for each stereotype form. Reliability for the scales thus created ranged from α = .520 to α = .822, which was considered acceptable for scales consisting of only three items each (see Table 2). Four separately run principle component analyses (once for each stereotype form) confirmed that the nine stereotype items loaded on their intended components (competence, sociability, morality) for each of the four stereotype forms (see Table 3, next page). For the prescriptive stereotype, the first competence item cross-loaded on the morality dimension (though the sign is negative). To preserve the theoretical structure, and to facilitate comparing the results of this study to other studies using these measures of morality, sociability, and competence (e.g., Groot & Ellemers, in prep.; Leach et al., 2007) we nevertheless decided to retain all items.

Table 2. Reliability of competence, sociability, and morality measures of the prescriptive stereotype, descriptive stereotype, meta-stereotype, and self-stereotype.

	Competence α =	Sociability	Morality
Prescriptive stereotype	.520	.699	.554
Descriptive stereotype	.726	.822	.769
Meta-stereotype	.612	.761	.620
Self-stereotype	.734	.737	.628

Table 3. Factor loadings (pattern matrix) of items measuring morality, sociability, and competence, per stereotype form.

	Prescriptive St.type			Descriptive St.type			Meta-stereotype			Self-stereotype		
Items	Mor.	Soc.	Com.	Mor.	Soc.	Com.	Mor.	Soc.	Com.	Mor.	Soc.	Com.
Honest	-.778			-.861			.766			.835		
Sincere	-.679			-.766			.675			.680		
Trustworthy	-.581			-.789			.746			.663		
Sociable		.717			.899			-.798			-.762	
Friendly		.809			.832			-.818			-.800	
Warm		.789			.804			-.808			-.820	
Competent	-.518		.348			.750			.609			.822
Intelligent			.809			.815			.650			.677
Skilled			.790			.818			.736			.840
% Variance	12%	28%	17%	11%	38%	20%	30%	22%	12%	13%	17%	35%

Note. Only factor loadings < -.30 or > .30 are displayed. Rotation method: Oblimin.

Identification measures. Besides the demographic variables (see Table 1) that were used to determine participants' migration background, additional items were included to measure the subjective identification of medical students as migrants or Dutch. Our sampling method resulted in students hailing from a range of different countries. Of students with a migration background, some had been born outside the Netherlands, while others were born in the Netherlands of migrant parents. In other words, our sampling method resulted in a varied group of participants with a migration background. To account for some of this variation, we decided also to examine the extent to which participants subjectively considered themselves to be part of the group of students with a migration background. To this end, we measured the extent to which participants *subjectively identified* with the Dutch nationality, as well as the extent to which they identified with an other-than-Dutch nationality. Subjective identification with a group has been shown to correlate with perceptions about the own group and other groups, which makes subjective identification a potentially important moderator of the migration background—medical stereotype relationship (Ellemers et al., 1999, 2004). To measure subjective identification, the following two items were used: *I identify with the Dutch nationality* and *I identify with another nationality than Dutch* (both Likert scales ranging from 1: fully disagree to 7: fully agree).

Analysis. Our statistical analysis aimed to answer the following two research questions: 1) What "medical stereotype" do medical students studying in the Netherlands maintain about the medical profession? and 2) Do students with a migration background and students with a native background maintain different renditions of this medical stereotype? To this end, we performed mixed-method analysis of variance containing two within-participant factors and six between-participants variables.

Within-participant factors. To address the first research question, we included in the mixed-method model two within-participant factors: Stereotype Dimension (competence, sociability, morality), and Stereotype Form (prescriptive stereotype, descriptive stereotype, meta-stereotype, self-stereotype). *Stereotype Dimension* allowed us to examine whether the

medical stereotype – regardless of form – was rated differently by students on the dimensions competence, sociability, and morality (e.g., students give higher scores, on average, on morality than on competence or sociability). *Stereotype Form* allowed us to examine whether the medical stereotype was rated differently – regardless of dimension – between the different stereotype forms. E.g., students may maintain a more positive prescriptive stereotype than a self-stereotype. An interaction term between *Stereotype Dimension* and *Stereotype Form* was also included, to examine whether scores on competence, sociability, and morality differed for different forms of stereotypes. The total model thus contained the following within-subjects design: Dimension (3 levels) + Form (4 levels) + Dimension*Form.

Between-participants variables. To address the second research question, we added *Migration background* as a dichotomous between-participants variable to the model. Since we suspected that the extent to which medical students identified with the Dutch or a non-Dutch nationality might moderate the impact of migration background on the outcome variables, we also included *Identification (Dutch)* and *Identification (non-Dutch)* to the model (both mean-centred), as well as the interaction terms migration background*identification (Dutch) and migration background*identification (non-Dutch). Finally, we added participant gender, study location, and study year (centred) as control variables. The total model thus contained, in addition to the previously mentioned within-participants design, the following between-participants design: Intercept + gender + study location + study year (centred) + migration background + identification (Dutch) (centred) + identification (non-Dutch) (centred) + migration background*identification (Dutch) (centred) + migration background*identification (non-Dutch) (centred).

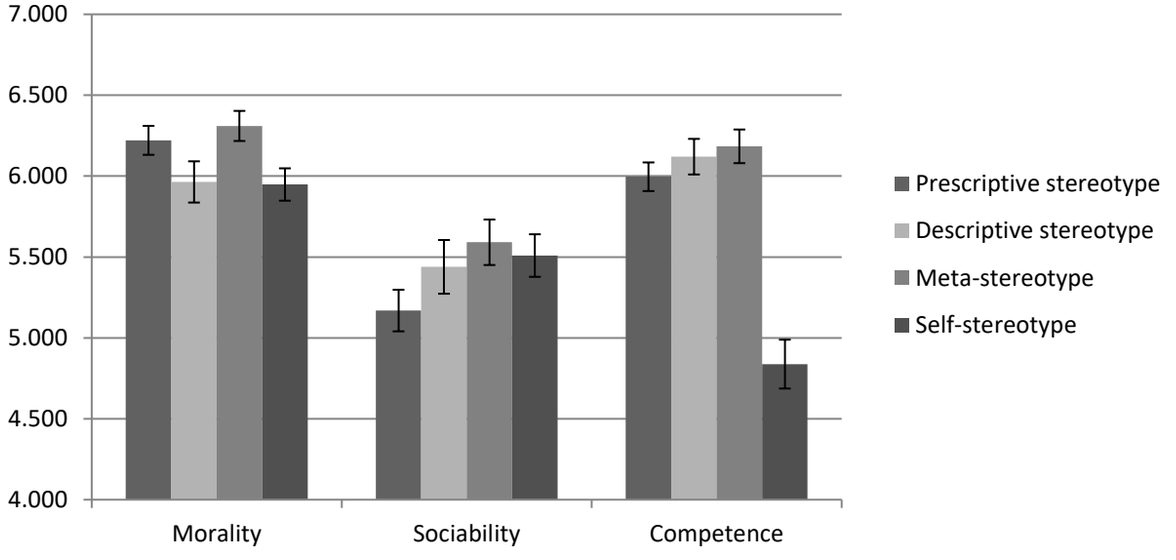
Results

The medical stereotype in terms of competence, sociability, and morality. The repeated measures analysis of variance revealed a significant multivariate effect of Stereotype Dimension, indicating that medical students assigned different scores, regardless of stereotype form, to the dimensions *morality, sociability,* and *competence*, $F(2, 371) = 21.70$, $p < .001$, $\eta_p^2 = .11$. The analysis also revealed a significant multivariate effect of Stereotype Form, meaning that medical students assigned different scores, regardless of dimension, to different forms of stereotypes within the medical profession, $F(3, 371) = 10.49$, $p < .001$, $\eta_p^2 = .08$. Finally, the analysis revealed a multivariate interaction effect between Dimension and Form, indicating that the patterns of scores assigned to *morality, sociability,* and *competence,* differed between the different forms of stereotypes within the medical profession, $F(6, 367) = 10.00$, $p < .001$, $\eta_p^2 = .141$. See Figure 2 (next page) for a graphic representation of these findings.

As can be observed in Figure 2, medical students rated the medical stereotype high in terms of *morality*. Minor but significant differences exist, however, for the different forms of stereotypes that were evaluated: medical students indicated that although it is very important for doctors in general to appear moral (prescriptive stereotype), and that

although patients also expect doctors to be very moral (meta-stereotype), they feel that they themselves do not live up to those expectations (self-stereotype). Rather, medical students indicated that *their own* level of morality is about on par with that of medical role-models (descriptive stereotype), who likewise score somewhat below the scores attributed to how doctors in general should be (prescriptive stereotype) and to patients' expectations (meta-stereotype). Analyses of the univariate effects of medical students' year of study furthermore revealed that expectations about morality remained stable from year to year, all *p*s > .05.

Figure 2. Map of medical students' medical stereotype.



Note. Flags denote the 95% confidence interval around the estimated marginal means. Controls included in the model: gender, study location, study year, migration background, identification (Dutch) and identification (non-Dutch).

Figure 2 furthermore reveals that medical students rated the medical stereotype least high in terms of *sociability*, although it should be noted that scores for sociability were still well above the scale midpoint. The stereotype form seemed to matter in the sense that, this time, medical students perceived that they (self-stereotype) did live up to the level of sociability observed in role-models (descriptive stereotype), and the level of sociability expected by patients (meta-stereotype). They also indicated, however, that for doctors in general it is slightly less important to be sociable (prescriptive stereotype). Analyses of the univariate effects of medical students' year of study furthermore revealed that students in higher years attributed smaller importance for doctors in general to appear sociable, *B* = -.06, *p* = .017. This was not the case for scores attributed to the self, role-models, or the expectations by patients about doctor sociability.

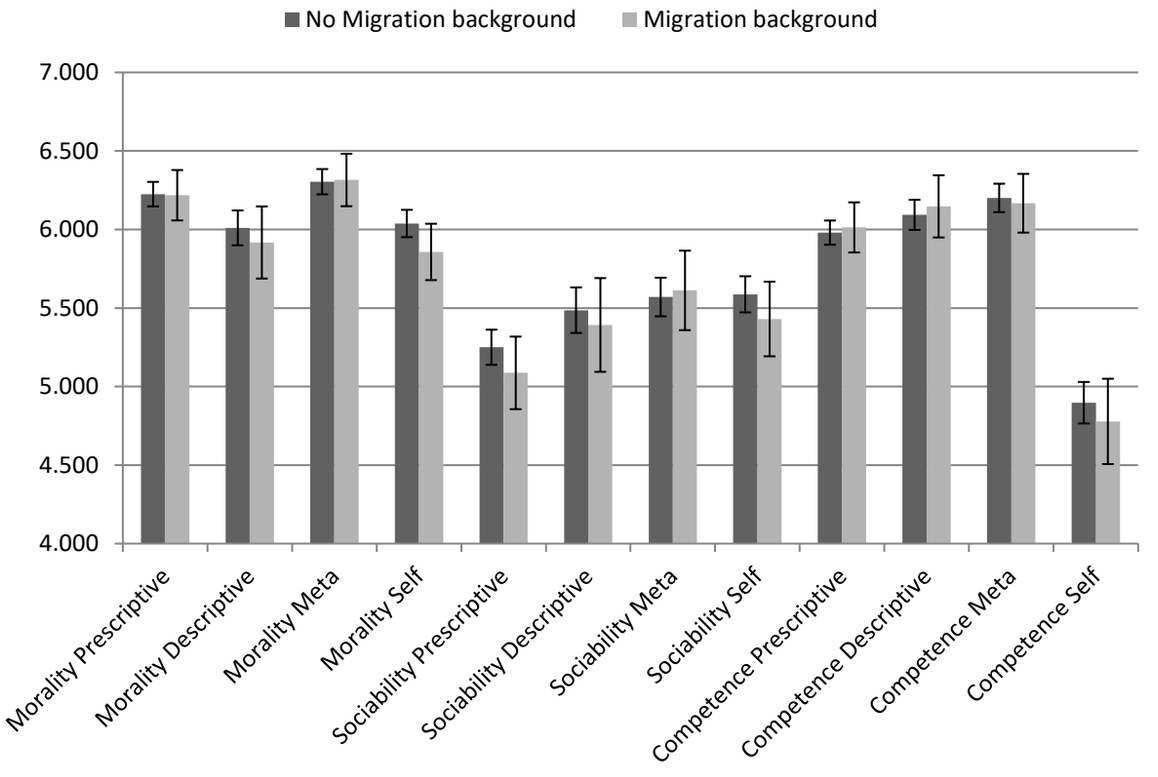
Finally, Figure 2 reveals that medical students strongly felt that their role-models were competent (descriptive stereotype), and that patients likewise expect doctors to be competent (meta-stereotype). Accordingly, they also indicated that it is important for

doctors in general to be competent (prescriptive stereotype). In stark contrast, the scores attributed by medical students to *their own* competence (self-stereotype), lags vastly behind the perceived competence of their role-models, and behind how competent doctors in general should be, and behind the level of competence expected by patients. Furthermore, analyses of univariate effects of medical students' year of study revealed that the students' confidence in their own competence did not depend on their year of study, B = .007, p = .801. Even more interestingly, students in higher years, compared to students in earlier years, were *more negative* about the competence of their role-models, B = -.04, p = .044, and about how important it is for doctors in general to be competent, B = -.05, p = .005, as well as about the level of competence expected by patients, B = -.06, p = .004. Apparently, medical students start out with more exalted image of the level of competence involved with the medical profession than they end up with after some years of studying. And instead of being able to live up to that exalted image as they progress through their studies, they downwardly adjust their image of other medical professionals' competence.

To sum up, looking at students' professional identity through the lens of stereotypes, reveals an image of the medical profession that consists of an expectation that doctors in general should be very moral, followed closely by competent, and, at some distance, sociable. Whereas, according to medical students, there is a strong prescriptive stereotype for doctors to be moral as well as competent, it is of somewhat less importance for doctors to be sociable. The descriptive stereotype of medical role-models generally matches up to the prescriptive stereotype, except in the case of morality (but this effect is only minor). This suggests that students believe that their medical role-models generally embody the qualities that doctors in general ought to possess. They also believe that patients may have even higher expectations of doctors on all three dimensions, sometimes exceeding what role-models, doctors in general, and medical students can offer. The meta-stereotypes about patients are, thus, very positive in terms of competence, sociability, and morality. Looking, lastly, at medical students' perceptions of themselves, they believe to be able to live up to what is expected of them in terms of morality and sociability, but not (or not yet) to what is expected of them in terms of medical competence. Students' self-stereotypes are mostly positive, in line with the positive prescriptive, descriptive, and meta-stereotypes that they discern for other medical targets. This self-stereotype most closely follows the descriptive stereotype of role-models in terms sociability and morality, but not in terms of competence.

The effect of migration background on the medical stereotype. The analysis revealed that there was no direct multivariate effect of student migration background, meaning that the scores attributed by medical students to morality, sociability, and competence for different forms of stereotypes did not differ for students with or without a migration background, $F(1)$ = .910, p = .341, η_p^2 = .002. As can be observed in Figure 3 (next page), controlling for background variables, students with and without a migration background held remarkably similar thoughts about the medical stereotype, across its different dimensions and forms.

Figure 3. The medical stereotype according to students without a migration background versus with a migration background (mean scores).



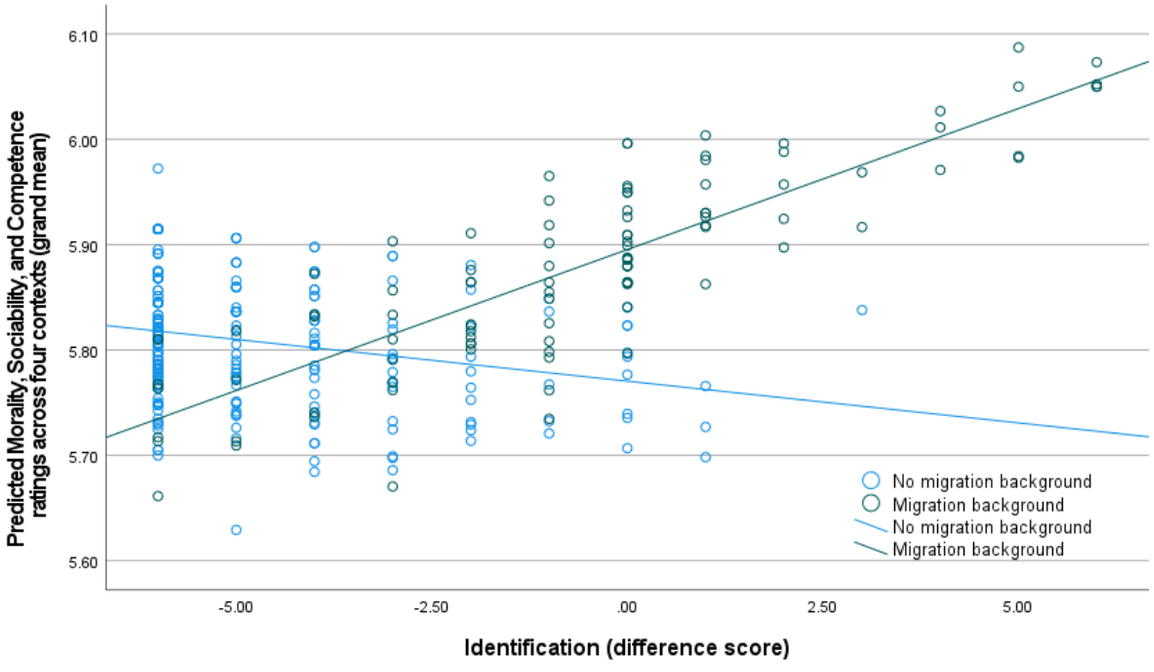
Note. Flags denote the 95% confidence interval around the estimated marginal means. Controls included in the model: gender, study location, study year, identification (Dutch) and identification (non-Dutch).

While the analysis did not reveal a direct effect of migration background on evaluations of the medical profession, it did reveal significant effects of subjective identification with a non-Dutch nationality. First, there was a main effect of the extent to which students identified with a non-Dutch nationality, which impacted the morality, sociability, and competence scores that they assigned to the medical stereotype, $F(1) = 4.902$, $p = .027$, $\eta_p^2 = .013$. This effect was, furthermore, qualified by a multivariate interaction effect between migration background and identification with a non-Dutch nationality, $F(1) = 4.196$, $p = .041$, $\eta_p^2 = .011$. Identifying with a non-Dutch nationality, in other words, led to higher overall ratings of morality, sociability, and competence, but differently so for students with a migration background than for students with a native background. No main effect was found for identification with the Dutch nationality, $F(1) = .679$, $p = .410$, $\eta_p^2 = .002$, nor for the interaction between migration background and identification (Dutch), $F(1) = .201$, $p = .654$, $\eta_p^2 = .001$.

The difference between students with a migration background and students without one becomes most clear if we subtract identification (Dutch) from identification (non-Dutch). This new measure captures identification with the Dutch nationality compared to identification with a non-Dutch nationality. Strong negative scores reflect individuals who

strongly identify as Dutch and weakly identify as non-Dutch, while strong positive scores reflect individuals who strongly identify as non-Dutch and weakly as Dutch. Scores around zero reflect individuals who identify to some extent as Dutch and to some extent as non-Dutch – in other words, dual identifiers. In Figure 4, this identity difference score is plotted against the grand mean of medical students' medical stereotype.[aa]

Figure 4. Migration background contingent on identity difference score.



Note. Circles in Figure 4 represent predicted observations derived from the total model, containing gender, study location, study year, migration background, identification (difference score), and the interaction between migration background and identification (difference score) as predictors. Please note that the Y-axis originally ranged from 1 to 7, and that the figure therefore exaggerates effect sizes.

For students with a migration background, stronger identification with the non-Dutch identity corresponds with a more positive medical stereotype (Figure 4). It is clear that only among the group of students who strongly identify with a non-Dutch identity, and weakly with the Dutch identity, expectations are raised. Students with a migration background who identify strongly as Dutch or who have a dual identity generally have similar expectations as the students with a Dutch background.

[aa] Individual predicted observations on this grand mean were obtained by running a similar model as used previously, but in which the previously used identification (Dutch) and identification (non-Dutch) variables were replaced by the single identity (difference score) variable. In this new model, containing gender, study location, study year, migration background, identification (difference score), and the interaction between migration background and identification (difference score) as predictors, the interaction effect between identity (difference score) and migration background was found to be significant, $F(1) = 4.640$, $p = .032$, $\eta_p^2 = .012$.

Discussion

The current study was undertaken to answer the research questions: 1) What "medical stereotype" do medical students studying in the Netherlands maintain about the medical profession? and 2) Do students with a migration background and students with a native background maintain different renditions of this medical stereotype? The reason for asking these questions was that medical students with a migration background report negative experiences stemming from that background, such as being discriminated against, lacking a sense of belonging, and feeling excluded from existing networks (Waldring et al., 2020). These unique experiences might affect the professional identity of those students, which consists of internalised beliefs about who they are as a medical professional and how they should act accordingly. However, whether and how medical students with a migration background develop a different professional identity than students with a native background has not yet been studied (Fyfe et al., 2022; Wyatt et al., 2021). Most research has instead focused on graduated migrant doctors, which misses the formative influence of locally organised medical education on doctors' interpretation of the profession (Harris, 2014).

To mitigate this, the current study applied social psychological theory about stereotypes to map medical students' "medical stereotype". Stereotypes can be measured through a limited set of central attributes, such as about a group's competence, morality, and sociability (Abele et al., 2021; Landy, 2015; Leach et al., 2007). Perceptions on these attributes have been shown to affect people's behaviour towards others in fields outside and inside medicine (Abele et al., 2021; Cuddy et al., 2007; Ellemers, 2017; Groot & Ellemers, in prep.; Xu et al., 2021). Furthermore, stereotypes come in different forms, which yield unique implications. Specifically, stereotypes do not just inform people about the suspected characteristics of a group (a descriptive stereotype), but also often prescribe how a group of people is supposed to act in accordance to those characteristics (prescriptive stereotype); people may invoke stereotypes also to anticipate how others are likely to perceive them (meta-stereotype), and base their own self-image in part on existing stereotypes about their group (self-stereotype). As such, measuring the stereotype that medical students maintain about the medical profession could inform us in detail about their developing professional identity (see Cruess et al., 2015, for a detailed description of this process, though unrelated to stereotypes).

The results indicate the existence of a positive medical stereotype among medical students. Specifically, medical professionals are seen by students as highly moral and competent, followed by sociable. The prescriptive stereotype, descriptive stereotype, and meta-stereotype strongly resonate with each other on these dimensions, though some significant but small differences exist between them as well. This suggests that students have a fairly uniform idea of how doctors should be ideally, of what patients tend to expect from doctors, and of the ability of medical role-models to live up to these expectations – that is: to be highly moral and competent, and to a lesser extent also sociable.

This has implications for how medical students see themselves as well. In terms of morality and sociability, medical students regard themselves on par with other medical actors, perhaps indicating their belief to be able to live up to the positive expectations in these domains. Regarding competence, however, medical students indicate that they consider themselves to be much less competent than their role-models, and also less competent than how they believe that doctors should be in general, and what they anticipate patients expect from doctors. This may simply be a recognition of the fact that medical students are yet to become full-fledged doctors, whose level of competence by definition lies above that of a student. However, it also resonates with the finding that medical students often feel that expectations of them from others are unrealistic for their level of training (Stubbing et al., 2019). Self-stereotyping as similarly moral and sociable as their more senior peers may, in this regard, serve as a strategy for medical students to maintain a positive self image, despite not living up to expectations of competence (Cambon et al., 2015; Steele, 1988).

In terms of professional identity formation, the medical stereotype appears to present an ideal image that medical students strive towards, but are yet to arrive at (at least in terms of competence). This is in line with an earlier finding that medical students have a positive depiction of doctors, and consequently identify more with doctors than with students (Burford & Rosenthal-Stott, 2017). According to the literature, the resulting pressure to conform to this ideal image may be higher for students with a migration background than for students with a native background. Medical students with a non-western migration background in the Netherlands have been found to have a higher autonomous motivation to perform well than students with a native background (Isik et al., 2017). This higher motivation has been argued to arise from awareness of discrimination, or alternatively from a higher "burden of expectation" for medical students with a migration background (cf. Michalec et al., 2017; Slobodin et al., 2021). Importantly, medical students have also been shown to deal with acts of racism by adopting a professional persona that was resistant to racial slights, or by demonstrating their capability or conform to the majority culture, in attempts to refute stereotypes (Kristoffersson & Hamberg, 2022). In other words, medical students with a migration background may be even more motivated to adopt a positive medical stereotype as part of their professional identity than medical students with a native background. For this assumption, the current study has found mixed evidence.

On the one hand, we found very little difference between the medical stereotype held by students with a migration background and students with a native background. That is, regardless of the form of the stereotype – descriptive stereotype, prescriptive stereotype, meta-stereotype, or self-stereotype – students with a migration background held the same stereotypical beliefs as students with a native background. This is in contrast with earlier findings pointing to differences between doctors with a migration background versus those without, in terms of cultural distance, work-culture, screening practices, and 'care' versus 'cure'-orientation (Alizadeh & Chavan, 2020; Jalal et al., 2019; Koo et al., 2012; Lagro-Janssen

& van den Muijsenbergh, 2007). One explanation for these differences between migrant doctors and native doctors is that medical practice itself subtly differs between countries; doctors thus inherit a set of locally tuned skills and norms through their medical education, which they need to adapt or re-negotiate to the medical practice of the destination country (Dywili et al., 2012; Harris, 2014). The findings of the current study support this theory, by showing that medical students who are being educated in the Netherlands share a similar image of the medical profession, regardless of their migration background. This is an indication that receiving medical education in the Netherlands may lead to a shared professional identity among doctors.

On the other hand, a demonstration that some medical students do maintain a slightly different medical stereotype, comes from the finding that medical students with a migration background *who also strongly subjectively identified* with their non-native background, did maintain a slightly different depiction of the medical stereotype. Specifically, medical students who strongly identified with an 'other-than-Dutch' nationality, but not with the Dutch nationality, maintained a more positive medical stereotype, over all, than other students. Perhaps these students, in lacking a positive connection to the Dutch identity, chose to emphasise another relevant aspect of their identity – namely, their medical identity. This would indeed fit in with other cases in which medical students from minoritised groups have been shown to stress their professional identity in order to deal with racial slights (Kristoffersson & Hamberg, 2022). However, it is also possible that the more positive medical stereotype maintained by these students is a reflection of higher self-imposed standards, or higher perceived expectations by others. This would comply with a high "burden of expectation" found among migrant medical students in other studies (Michalec et al., 2017). In any case, the finding that students who strongly identified with their non-native background maintained a slightly different medical stereotype, is an indication that, for some students at least, having a migration background does impact their professional identity formation, as has been suggested by others (Wyatt et al., 2021).

The findings of this study have some practical implications for the discussion about the integration of migrant doctors. First of all, the current study shows that a positive medical stereotype exists in the Netherlands among medical students. This stereotype implies that doctors should be above all competent and moral, and also to a considerable extent sociable. Migrant doctors coming from a country in which technical competence is praised above social competence should be aware that these two components may be regarded as equally important in the Dutch medical education system (in line with the global trend towards a "humanisation of medicine", Minicuci et al., 2020). Regarding medical students studying in the Netherlands, the existence of a positive medical stereotype implies that they have high expectations about medical professionals. This may put pressure on them, as they perceive their own competence to lag behind what is expected of them. A positive finding, on the other hand, is that students generally perceived that they do live up to expectations in terms of morality and sociability. The small (though significant) differences between the descriptive stereotype, prescriptive stereotype, and meta-

stereotype furthermore suggest that students do not perceive any large conflicts between how their role-models currently act and how they are supposed to act, or how patients expect them to act.

Perhaps the most important implication of the current study comes from the finding that medical students with a migration background maintain the same medical stereotype as students with a native background. This implies that studying medicine in the Netherlands may lead to one medical professional identity among students, and not to distinct professional identities depending on the student's background. In this regard at least, following medical education in the Netherlands may function as a vehicle towards the integration of migrant doctors. Going one step further, these results also suggest that when medical students with a migration background are treated unwelcomingly by their social peers, based on the assumption that they must have a different set of beliefs about what it entails to be a good doctor, then this treatment is unjustified. The assumption that medical students with a migration background hold different ideas about what patients expect, or about what is important for doctors to be like, or about how they are themselves in terms of competence, morality, and sociability, is in any case false. This would make it more likely that the negative experiences of medical students with a migration background during their education and after, are the result of inaccurate stereotypes held by others about migrant doctors, not of any actually existing differences. The only exception to this rule are students who strongly identify with an other than Dutch nationality – but instead of thinking worse of the medical profession, these students actually maintain an even more exalted medical stereotype.

While the data thus seem to suggest that receiving education in the Netherlands leads to the development of a unique professional identity among medical students studying in the Netherlands, there are some limitations to the design that may prevent us from drawing such a strong conclusion. Foremost, the current survey design lacks a reference group outside the Netherlands; as such, it is impossible to compare the medical stereotype of medical students studying in the Netherlands with students studying in some other country. It would be highly informative if future studies could apply this study's method of mapping the medical stereotype to students studying in other countries. If medical students with a migration background studying in, say, France, are found to adopt a medical stereotype that is specific to the French setting, it would offer stronger support for the conclusion that studying in a specific country leads to convergence of stereotypes between medical students with and without a migration background, and hence affects professional identity formation.

In a similar vein, the current data are limited by the fact that they came from a cross-sectional survey. Year of study was included as a control variable, and indeed the students' current year of study impacted parts of their medical stereotype. This is an indication that the medical stereotype amongst students might change over time, as they progress through their studies. However, to study this question properly, a longitudinal approach is needed in which the same students are followed over a period of years. Such an approach would be

able to separate students' individual growth trajectories from other, more-or-less random sources of variation occurring at the level of the study year that may affect medical students' medical stereotype (e.g., at the moment of data collection, there happens to be a very inspiring teacher for 5th year students and a very dull one for 2nd year students). As such, with the current data, it is also impossible to determine whether the medical stereotypes, maintained by students with a migration background and students with a native background, indeed converged over time, or whether they shared a similar image from the start.

Another limitation of the cross-sectional approach is that students who dropped out from their studies are invisible in the current analyses. This might bias the medical stereotype of the remaining sample towards the positive, if the drop-outs had a more negative view on the medical profession than the students who remained. If, furthermore, there are more dropouts among students with a migration background, this could have implications for the finding that students with a migration background share the same medical stereotype as students with a native background.

A different limitation concerns the choice to adopt the three attributes competence, sociability, and morality as central components of the medical stereotype. This decision stems from the fact that these attributes are common in psychological literature about stereotypes, as they have been argued to represent basic dimensions on which people evaluate each other (e.g., Abele et al., 2021). While this decision, in our opinion, strengthens the construct validity of the medical stereotype mapped in the current study, it also makes comparison more challenging to many of the studies within the medical literature that use different labels to characterise the medical profession. These have ranged from 'curing' and 'caring' (Lagro-Janssen & van den Muijsenbergh, 2007) to 'performance attainment' and 'personal involvement' (Minicuci et al., 2020), and other labels. While we argue in this paper that the constructs referred to by those studies reflect the same underlying dimensions – to an extent – as the ones we measured in the current study, the context and items used to measure them differ from the current approach, making a direct comparison more difficult.

A final consideration concerning the decision to create a detailed "map" of the medical stereotype maintained by medical students in the Netherlands, is that although we argue based on existing theories that these stereotypes can have a major impact on, e.g., the motivation and career perspective of medical students, we do not in fact measure any career-related outcome variables. The map of medical students' medical stereotype, presented in the current study, illustrates in detail which expectations students have about doctors and role models, as well as about what is expected of doctors by patients, and about their own ability to live up to these expectations. As such, the medical stereotype mapped in this study could be taken as a detailed description of the professional identity towards which medical students strive. However, to explore how this medical stereotype relates to motivational or career-related outcomes, additional studies are required.

Conclusion

An underlying motivation for the current study was to address an ongoing debate about the integration of migrant doctors. Whereas the debate has focused mostly on differences between doctors, the current study investigated differences between medical students with a migration background and students with a native background. We argue that by focusing on medical students rather than on doctors, we can investigate whether receiving medical education in the country of destination reduces differences between doctors with a migration background and doctors with a native background. If so, it might also be an indication that differences between migrant doctors and native doctors found in previous studies are due to differences in their education rather than in their place of birth or ethnicity.

To investigate differences between students effectively, the current study produced a detailed "map" of the medical stereotype held by medical students in the Netherlands. This map, based on theory about prescriptive stereotypes, descriptive stereotypes, meta-stereotypes, and self-stereotypes, revealed that students with a migration background hold a medical stereotype that is similar to the one held by students with a native background. This stereotype embodies strong positive expectations about the morality, competence, and sociability of different actors in the medical profession, including doctors, role-models, and patients. This complements prior studies, where the main focus was on task (competence) and relational (sociability) aspects of the medical profession. The present research reveals that medical students also anticipate the truthfulness and reliability of their professional activities (morality) to be of primary importance. This is an aspect that has not been highlighted in prior analyses of demands for the medical profession.

Students with a migration background and students with a native background alike felt that their own level of competence lagged behind the level of competence that they perceived in their role-models, doctors in general, and patients' expectations. This pattern was, however, identical between students with a migration background and students with a native background. The only exception to this pattern is that students with a migration background who strongly self-identified as non-Dutch, in comparison to students with a migration background who strongly self-identified as Dutch, did hold a slightly more positive medical stereotype overall. This implies that students who are more aware of their status as relative outsiders hold higher expectations of the qualities associated with the medical profession. This might cause them to hold their own performance to a higher standard, but might also make them more strongly motivated to live up to this positive medical professional identity.

The results thus provide a detailed map of the expectations that medical students have about different actors in the medical profession. They also reveal that medical students with a migration background hold similarly positive, or even more positive, stereotypes about medical actors as do medical students with a Dutch background. This is an argument against the idea that discrimination of medical students and doctors with a migration background springs forth from existing differences in the way they perceive the medical

profession. Instead, the current study suggests that medical education has a formative influence on the professional identity of doctors with a migration background – although limitations stemming from the study design ultimately prevent us from drawing such a strong conclusion. The current study nevertheless hopes to shift the debate away from the present focus on birth place to explain differences between migrant and native doctors, and towards a model where birth place, place of education, and personal factors such as level of identification with the destination country all play a part in explaining the integration of migrant doctors.

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Chapter 5

Migrant doctor, local education: How the place where a migrant doctor received their education affects patients' evaluations and acceptance.

Based on: Groot, P.J. & Ellemers, N. (in prep.). Migrant doctor, local education: How the place where a migrant doctor received their education affects patients' evaluations and acceptance.

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Abstract

Background. In prior work, we found that receiving medical education in the Netherlands appeared to lead to a convergence between the medical stereotypes maintained by medical students with a migration background and those with a native background (Groot et al., in prep.). In the current line of studies, we expand on this finding by investigating how receiving education in the destination country impacts the way in which migrant doctors are perceived by their social surroundings. Specifically, we ask: Will doctors who have been educated in the country of destination be accepted to a higher degree than foreign-educated doctors? *Method*. Five vignette studies measured the response of majority group members (White, UK or NL-born participants), assuming the role of patients, to migrant doctors who were either educated abroad or in the country of destination (total *n* = 1181). *Results.* Both a doctor's birthplace and a doctor's place of education impacted patients' acceptance of that doctor. Changed perceptions about the doctor's level of competence, not of their sociability or morality, explained this increase in acceptance. However, when presented with negative information about the doctor's competence, sociability, and especially morality, patients' acceptance plummeted. This is in line with a recent convergence of evidence within the field of social psychology about the importance of evaluations about competence, sociability, and morality (Abele et al., 2021). *Conclusion.* Concerning migrant doctors, not just where they were born, but also where they were educated determines acceptance by their social surroundings. Evaluations of competence, sociability, and morality may drive this effect.

Introduction

Medical practitioners are highly educated and highly skilled professionals, making them attractive targets for immigration policies. Countries like the United Kingdom, United States, Canada, New Zealand, and Australia, have pursued an active recruitment policy, resulting in a large inflow of migrant doctors. In 2011, 53 per cent of medical practitioners in the Australian work force were born in another country (Negin et al., 2013), while in the UK 29 per cent of doctors currently indicate having received foreign medical education (Baker, 2019; OECD, 2019). To accommodate these migrant doctors, medical institutions have set up procedures to assess migrant doctors' knowledge and skill, and re-educate them where deemed necessary. Despite these efforts, however, migrant doctors face considerable and often enduring challenges in trying to fit in their new work environment (Dywili et al., 2012; Jalal et al., 2019). One of those challenges lies in becoming accepted by patients, who display a preference for doctors who were born in their own country.

This phenomenon, in which patients tend to prefer doctors who share their ethnicity, is known as doctor—patient concordance (Shen et al., 2018). One potential explanation for this effect is that real differences exist between local and migrant doctors (Dywili et al., 2012; Koo et al., 2012). Alternatively, researchers have suggested that perceived differences between doctors exist primarily in the minds of the patients, in the sense that they expect doctors of a different ethnicity also to be culturally distant to themselves (Alizadeh & Chavan,

2020). The focus on real or imagined cultural differences between doctors based on their birthplace, however, obscures an important aspect of migration that, we think, impacts both the real and the perceived cultural differences: the locus of education. In theory, completing a medical education in the country of arrival should allow migrants to learn the many tools of the trade particular to that locality, as well as increase their trustworthiness in the eyes of prospective patients. Acceptance of a doctor by their patients, then, should be understood as resulting from a combination of the doctor's place of birth and their place of education. Research investigating the role of a doctor's place of education seems to support this theory, but remains scarce. This is a missed opportunity, since the place in which a migrant completed their education, in contrast to the place where they were born, is something that they have a certain degree of influence over.

Distinguishing between place of birth and place of education as independent sources for patient—doctor concordance is the first step in determining the mechanism through which a migrant doctor can become accepted by their patients. The next would be to pinpoint which *aspect* of professional performance is affected by being educated locally. Traditionally, to explain why patients come to accept their doctor, medical research has focused on behaviour controlled by the doctor, such as their communication style (Blanch-Hartigan et al., 2019; Hall et al., 2020; Saha & Beach, 2020), or on differences between the patient and the doctor in terms of, for example, culture or personality, as perceived by the patient (Alizadeh & Chavan, 2020; Street et al., 2008). Borrowing from social psychology, the current investigation wishes to study doctor acceptance through an alternative framework, revolving around three central aspects by which a patient might evaluate their doctor: competence, sociability, and morality.

Within social psychology, a consensus is emerging about core dimensions of everyday social evaluation (Abele et al., 2021). These dimensions are robust over a range of social situations, making them reliable constructs to measure patients' perceptions of doctors. By placing these dimensions of social evaluation in the centre of investigation – as variables explaining the impact of a doctor's migration background on the relationship between doctor and patient – we will be able to investigate the psychological *process* that leads to acceptance of migrant doctors. By making explicit the, usually hidden, thoughts that patients have about their doctors, we furthermore provide migrant doctors with knowledge about aspects of their image that they may emphasise in order to become more accepted. The current paper therefore empirically investigates the following two questions in conjunction, with the goal of improving our understanding of migrant doctors' position after migrating: How do a doctor's place of birth and place of education affect a patient's social evaluation of that doctor (in terms of competence, sociability, and morality), and, consequently, how do interventions targeting these social evaluations lead to improved acceptance of migrant doctors?

All migrant doctors were born "over there", but some of them were educated "over here". After migrating to their country of destination, doctors face a series of challenges, as has been identified by medical and social scientific literature. The first set of challenges

pertains to institutional barriers. In the UK, for example, overseas doctors – i.e., doctors coming from the European Economic Area (EEA) as well as of doctors coming from outside the EEA – have to pass a set of examinations testing their professional aptitude and their command of the English language (Jalal et al., 2019). Similarly, in the United States and Australia, comprehension of the English language as well as medical knowledge and skills are tested, besides a credentials check and a check of the other requirements for immigration. Sometimes, the examinations are followed by a period of supervision, or, in some instances, re-education. In the Netherlands, which does not have a strong tradition of importing doctors, some migrant doctors are directly granted the right to work after a check of their credentials and Dutch language capabilities. Most, however, are required to work for one or two years under the supervision of a Dutch practitioner, or even to obtain a medical degree at one of the Dutch universities (Herfs, 2009).

The obligation to pass a set of exams or to undergo additional training in the country of arrival reflects a need to adjust a doctor's skill set to local medical practice. For example, migrant doctors need to be able to communicate with patients, for which an advanced grasp of the destination country's language is required (Herfs, 2022; Herfs & Teunissen, 2017). However, a rich body of medical literature shows that, even after receiving additional training, migrant doctors continue to experience challenges related to becoming accepted by their patients and colleagues. A literature review of doctors immigrating into the UK revealed that some of these challenges are practical in nature: migrant doctors lack, for example, the same access to networks and information that facilitate careers like their native colleagues have. In addition, disease patterns and clinical practice may differ between countries, making it harder for migrant doctors to utilize their tacit knowledge (Jalal et al., 2019). Other challenges are less tangible, however. Some countries maintain a more hierarchical work-culture than the UK, leading to miscommunication between migrant doctors and their colleagues. Miscommunication between doctors and patients can also arise due to subtleties of the English language, or if doctors are used to taking a more formal approach to their patients than what these expect. A study in the Netherlands complements these findings, in showing that explicit criteria for evaluation are often accompanied by implicit norms held by colleagues and evaluators (Leyerzapf et al., 2015).

Migrant doctors are thus facing a double challenge: not only do they need to live up to the explicit standards of their profession, but also to judgments of cultural fit. These can be long-lasting, and may even reflect real cultural differences between ethnic groups. It is known, for example, that the ethnicity of doctors and their patients can influence the doctor—patient relationship. When ethnicities match (otherwise known as doctor—patient concordance), patients are more likely to share information with, and be satisfied about, their doctor (Shen et al., 2018), or describe them as trustworthy, likable, and competent (Saha & Beach, 2020). This preference of patients for concordant doctors may be explained, in part, by patients' more positive perceptions of a concordant doctor's communication style and patient-centred behaviour (Hall et al., 2020; Saha & Beach, 2020). Other explanations include perceived cultural differences between the patient and the doctor, and the

perceived level of personal similarity between the patient and the doctor (Alizadeh & Chavan, 2020; Street et al., 2008). In some instances, the ethnicity of a doctor has indeed been found to affect their medical practice (e.g., Koo et al., 2012), prompting some researchers to suggest that migrant doctors need some time to 'adjust' to the medical practice of the host country (Harris, 2014).

The discussion about real versus imagined differences between doctors of different ethnicities raises the question how important a doctor's place of birth and place of education are for patients' impressions of their doctor. If patients' underlying assumption is that migrant doctors differ in some important respect from native doctors, due to differences in the medical practice between countries, can this perception then be mitigated by knowing that a migrant doctor received education in the host country? The few studies that have taken the location of education into account, suggest that it can. Louis et al. (2010) showed the profiles of several doctors to Australian prospective patients, and found that they preferred Australian doctors over Pakistani doctors. This difference disappeared, however, if the Pakistani doctor had received their education in the UK. The place where a migrant doctor was educated can also affect their success on the labour market. Census data in Canada showed that doctors who had been born abroad were significantly less likely to find an occupation that matched their training, but this effect decreased if they had completed their training in Canada (though not for all medical disciplines; Owusu & Sweetman, 2015). Similarly, outside the medical sector, studies investigating discrimination against migrant job applicants found that having gained experience or having completed part of their education in the host country improves migrants' position on the labour market (Oreopoulos, 2011; Shirmohammadi et al., 2019).

As for the underlying mechanism that leads patients to accept a migrant doctor who has been educated in the host country, there remain some doubts. In a recent study, Groot et al. (in prep.) suggest that receiving medical education in the host country leads to a convergence between the stereotypical perceptions of medical students about the practice of medicine. This would agree with older findings about doctors migrating to rural parts of the UK, Australia, USA, Canada, and New Zealand, who have been found to adapt their practices to the local context after a period of negotiation between themselves and the local community (Dywili et al., 2012). It might thus be the case that migrant doctors' beliefs about the medical profession, and their own medical conduct, do indeed change after receiving education in the host country. Alternatively, patients may make assumptions about migrant doctors that do not accurately reflect those doctors' conduct. To investigate how migrant doctors' place of education affects acceptance by patients, it is necessary to specify these potential assumptions made by patients about migrant doctors. Leaving aside the question of whether patients' assumptions about migrant doctors reflect true characteristics of those doctors, investigating which specific assumptions patients make about migrant doctors' core attributes can help to unravel why receiving education in the host country helps to improve migrant doctors' acceptance by their patients.

Social evaluations as drivers of behaviour. Social psychological research demonstrates that people form impressions of others based, among other things, on the social groups to which they belong. This may involve filling in missing information by resorting to known stereotypes about a group (Yzerbyt, 2016). For migrant doctors this means that patients can make assumptions about their doctor based in part on existing stereotypes about doctors, migrants, men or women, etc. Importantly, mostly negative or mixed stereotypes exist about migrants, while about doctors positive stereotypes appear to exist (cf. Cuddy et al., 2007; Nicolas et al., 2022). The question, then, becomes which characteristics patients will mentally fill in for migrant doctors. Will they resort to information contained by the positive stereotype about doctors, or to the negative stereotype about migrants, or to a mix of both? If receiving education in the host country indeed leads to adaption of the migrant doctor to local medical norms and practices, as some studies suggest (Groot et al., in prep.; Harris, 2014), we may expect to find this also reflected in the way patients form impressions about migrant doctors based on existing stereotypes.

Within social psychology, there is an ongoing debate about the content of the stereotypes by which people form impressions about each other. Although the exact labels are still being contested, a consensus has been reached that any impression, be it about oneself or someone else, a person or a group of people, is composed of evaluations on a limited set of basic attributes, for example about a person's competence, sociability, and morality (Abele et al., 2021; Ellemers et al., 2013; Landy, 2015; Leach et al., 2007). These attributes constitute core dimensions on which people evaluate each other and that make up the content of most known stereotypes. Hence, evaluations about someone's competence, sociability, and morality can have strong implications for how that person will be approached. Of these attributes, sociability and morality are thought to convey information about a person's intentions towards others. However, whereas sociability captures someone's general likability or friendliness, morality specifically conveys information about that person's "goodness". Evaluations of someone's sociability and morality determine people's willingness to trust, help, include, or depend on others (Brambilla et al., 2013; Brambilla & Leach, 2014; Pagliaro et al., 2013). Competence, on the other hand, may be understood as someone's ability to act upon their intentions; evaluations of competence correlate with perceived status, power, skill, and class, among other things (Abele et al., 2021).

Importantly, when a person is evaluated to be very competent, it does not have to imply that the person is also found to be sociable or moral. Evaluations of someone's competence, sociability, and morality are thought to be independent to an extent, leaving room for unique combinations (Abele et al., 2021). These have distinct effects on how a person or group is approached by others. It is true that negative evaluations on competence are sometimes paired with negative evaluations on sociability and morality – this is, for example, the case for poor blacks, Turks, and Arabs living in the USA. When this happens, people often receive scorn and are avoided by others, or even actively harmed (Fiske, 2010).

But other combinations are also possible: Asian Americans are, for example, often evaluated as very competent but not so sociable and moral[bb], which leads to envy, and may come across as threatening (Awale et al., 2019; Fiske, 2010). Vice-versa, some groups, such as the elderly, are considered incompetent but sociable and moral[cc], eliciting pity, which has been linked to helping behaviour (Fiske, 2010). How a person is evaluated on the aspects competence, sociability, and morality, in other words, has unique consequences for how others feel and act towards that person. This makes patients' evaluations of migrant doctors on those dimensions potentially important predictors for their approach towards that doctor, including the possibility that they will accept them as their doctor.

Studies investigating how doctors are typically perceived, found that people rate them as highly competent, sociable, and moral (Groot et al., in prep.; Nicolas et al., 2022). More indirect support for this comes from medical research, which has put much effort into delineating the qualities that make a 'good' doctor. Although labelled differently, the qualities described in those studies also appear to reflect evaluations of competence, sociability, and morality. Researchers have used the distinction *caring* and *curing*, for example, to describe how medical students perceive the ideal physician, suggesting that the ideal doctor is an empathetic listener (caring) and skilled healer (curing) in one (Batenburg & Smal, 1997; Lagro-Janssen & van den Muijsenbergh, 2007). Similarly, Minicuci et al. (2020) let doctors rank values related to their profession, and found that they valued competence, advocacy, and confidentiality on the one hand (labelled performance attainment), and concern and compassion (labelled personal involvement) on the other. In-depth interviews with oncology patients has revealed yet other factors associated with trust placed in doctors: doctor fidelity, caring, competence, and honesty (Hillen et al., 2013; Hillen, Koning, et al., 2012; Hillen, Onderwater, et al., 2012). These are just some of the many classifications used to describe what it entails to be a 'good' doctor, which however all suggest that doctors are likely to be described as competent, sociable, and moral professionals (for more examples, see: Draper & Louw, 2007; Minicuci et al., 2020; Roland et al., 2011; Tsai et al., 2007).

While there thus appear to exist positive expectations about doctors' competence, sociability, and morality in general, predicting how patients will respond to migrant doctors in particular is complicated by the existence of negative stereotypes in terms of those attributes for migrants. If, however, patients value the fact that doctors are educated in the destination country, as we suggested earlier, we may expect that migrant doctors who have received part of their education in the host country will be evaluated more in line with the positive doctor stereotype, i.e., high in terms of morality, competence, and sociability, rather than in line with an existing negative stereotype about migrants. Which of these evaluative dimensions will be affected more is difficult to predict, since the doctor stereotype points to the importance of all three features.

A second difficulty lies in predicting which social evaluations – about competence, morality, or sociability – will in turn lead to more acceptance. Abele et al. (2021) tell us that

[bb] In the original paper, "warmth" is used to describe these attributes.
[cc] Idem.

if people evaluate each other to be sociable and moral, it will inspire them to trust and cooperate with each other. Morality, furthermore, has been shown to weigh more heavily than competence when it comes to the acceptance of new group members (van der Lee et al., 2017). That would make sociability and morality two important characteristics for migrant doctors to display in order to become accepted by patients. Common-sense, however, dictates that patients will likely also value a doctor who is competent, since they depend on the quality of the medical advice given by the doctor after all. In support of both of these statements, recent research in a psychotherapeutic setting has found that when patients perceive their therapist as competent as well as warm (which is thought to include morality and sociability), patients had the most positive expectations about the outcome of the therapy (Seewald & Rief, 2022).

Exploring how patients' evaluations about a migrant doctor's competence, morality, and sociability relate to their acceptance of those migrant doctors, after having received education in the host country, will be the focus of the five studies described in more detail below. All studies utilise experimental designs, in which doctor characteristics (birthplace, place of education, suspected competence, sociability, or morality) are manipulated to investigate what leads to higher doctor acceptance. By focusing on the social evaluations that patients make of their doctors, we can identify which aspect of a migrant doctor's image is affected by their place of education. In doing so, we move beyond identifying demographic-level variables, such as birthplace or ethnicity, as causes for failing integration. Instead, we nuance the debate by pointing out that there exists variation between migrant doctors, for example in where they have been educated. We then tie this to three tangible social evaluations made by patients which may itself be targeted by interventions aimed at improving the acceptance of migrant doctors. In all, the current investigation aims at improving the position of migrant doctors, by elucidating the psychological process that leads to their acceptance after receiving education in the host country.

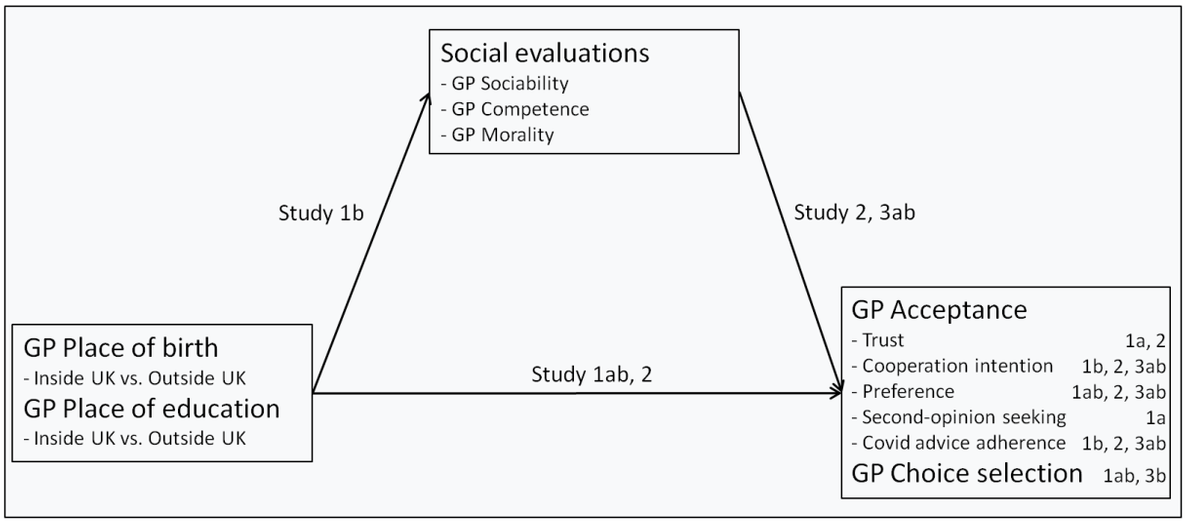
Overview of Experiments

The current investigation employs an experimental design to investigate the relationship between a doctor's birthplace and place of education, their patients' evaluations of that doctor's competence, sociability, and morality, and finally patients' acceptance of the doctor. The investigation thus focuses on three main components. First, there are a doctor's fixed characteristics, such as his place of birth and place of education.[dd] These characteristics were experimentally manipulated (Study 1ab, 2) by presenting different "doctor profiles" to participants in the role of patients. The information about a doctor's birthplace and place of education was expected to influence the second component

[dd] The gender of the doctor is also known to impact patients' impression formation. To keep the design of the experimental studies simple, we however decided not to include gender as a factor. Instead, we chose to target only male doctors in our profiles. To account for potential gender-based concordance effects, we included participant gender in our models as a covariate if gender was found to correlate with any of the outcome variables.

under study, namely the patient's malleable social evaluations of the doctor in question. These social evaluations entertained by the patient were in turn manipulated (Study 2, 3ab) by exposing participants to patient reviews about a doctor. This was expected to affect the final component under study, namely patients' acceptance of the doctor. Put together, these three components form a mediation model, visualised in Figure 1. They address the question of how a doctor's fixed characteristics, such as having a foreign place of birth, influence a patient's acceptance of that doctor, through the process of social evaluation that takes place when a patient perceives the doctor.

Figure 1. Graphic representation of relationships investigated in Studies 1ab, 2, and 3ab.



Note. The arrows represent experimentally manipulated relationships tested in separate studies.

For an overview of hypotheses, see Table 1. Studies 1a and 1b focused on the first part of our research question: Does the place where a medical practitioner completed his medical education (inside the country vs. outside) influence acceptance by potential patients? This was tested by exposing participants to "profiles" (i.e., fictitious personal introductions) of four different general practitioners (GPs), each with a different background in terms of birthplace and place of education. The expectation, expressed in Hypotheses 1 and 2, was that a GP's foreign place of birth and a foreign place of education would both lead to less acceptance by participants in the role of patients. Furthermore, participants in the role of patients were expected to express a preference for a locally born and educated GP, when asked to choose between several GPs (Hypothesis 3). Besides testing whether a GP's birthplace and place of education led to different levels of acceptance, Study 1b also explored how birthplace and place of education affected the perceived sociability, competence, and morality of the GPs.

Table 1. Overview of study designs and hypotheses

Study	Manipulation	Design	Hypotheses and explorations
Study 1ab	Doctor place of birth: UK vs. outside of UK	Within (2)	H1: GP foreign birthplace --> less acceptance H2: GP foreign place of education --> less acceptance
	Doctor place of education: UK vs. outside UK	Within (2)	H3: When asked to choose, participants will pick a UK-born and UK-educated GP E1: We explore how GP birthplace and place of education affect evaluations about their sociability, competence, and morality
	Vignette version: A, B, C - variations to the vignette were randomised between participants to rule out vignette-specific effects	Between (3)	
Study 2	Review type - Good sociability - Good competence - Good morality - No review, GP educated inside UK - No review, GP educated outside UK	Between (5)	H2: GP foreign place of education --> less acceptance H4: Positive review of GP (regardless of type) --> more acceptance E2: We explore which review type (sociability, competence, morality) leads to the largest increase in acceptance, compared to the no review conditions E3: We explore whether a review in one social domain affects only evaluations of that particular domain
Study 3a	Review type - Poor sociability - Poor competence - Poor morality - No review	Between (4)	H5: Negative review of GP (regardless of type) --> less acceptance E2: We explore which review type (sociability, competence, morality) leads to the largest decrease in acceptance, compared to the no review condition E4: We explore whether entitativity moderates the effect of review on acceptance
Study 3b	Review type - Poor sociability - Poor competence - Poor morality	Within (3)	H5: Negative review of GP (regardless of type) --> less acceptance E5: We explore which review type (sociability, competence, morality) leads to the lowest rate of acceptance E6: We explore which review type (sociability, competence, morality) leads to the least GP choice picks
	Review source: fellow patient vs. doctor colleague	Between (2)	E7: We explore whether the source of the review (another doctor vs. another patient) moderates the effect of the review on acceptance

Studies 2, 3a, and 3b investigated whether experimentally manipulating a GP's level of sociability, competence, and morality could lead to increased acceptance. In doing so, Studies 2, 3a, and 3b addressed the second part of this paper's research question, namely: Which of the underlying characteristics that patients ascribe to medical practitioners lead to increased acceptance? The manner in which this was done in Study 2 was to attach a "patient review" to the profile of a GP born and educated abroad, in which either the GP's sociability, competence, or morality was praised. The expectation was that adding a positive review to a profile of a foreign-educated GP would improve patient acceptance of that GP, compared to the same profile without a positive review attached (Hypothesis 4). In addition, by creating two control conditions – one in which the GP profile was of a foreign-educated doctor and one in which the GP profile was of a locally educated doctor – we hoped to replicate the findings of Study 1 (Hypothesis 2). A change compared to Studies 1ab, was that participants saw only one GP profile, while the experimental condition was varied between participants. An advantage of this method is that it may approach the reality of perceiving a doctor better, since patients do not always get to choose between several doctors – they have to make an evaluation based on the one doctor they see in front of them.

To address the potential issue that positive evaluations of a doctor's qualities at baseline leave little room for improvement, Studies 3a and 3b utilized negatively phrased reviews, in which either the GP's sociability, competence, or morality was criticised (instead of praised). The expectation was that such a negative review would decrease participants' acceptance of a GP, regardless of whether the sociability, competence, or morality of the GP was criticised (Hypothesis 5). In Studies 3a and 3b we furthermore explored which type of negative review – being in the domain of sociability, competence, or morality – would lead to the largest decrease in patient acceptance. While Study 3a employed a between-participants design, as in Study 2, Study 3b employed a mixed design in which participants saw three different GP profiles and reviews, while for some participants the review came from another patient and for other participants the reviews came from another doctor. See Table 1 for an overview of all hypotheses and explorations.

The concept of "acceptance" to which the current paper frequently refers, is inspired by a definition of immigrant integration provided by Penninx & Garcés-Mascareñas (2016). They describe integration as "the process of becoming an accepted part of society," whereby people are viewed as more integrated the more accepted they have become by society in general. The *content* of the construct acceptance is intentionally left open, in order to give it the flexibility to be measured at the level of institutions, organisations, or individuals. For the current investigation, we measured acceptance at the interpersonal level, meaning that we study the perceptions of and behaviour towards the integrating party – migrant doctors – by the receiving society, their patients. We conceptualised doctor acceptance as a range of approach-related intentions, containing concepts such as trust, cooperation intention, preference, and the intention to comply with medical advice given by the doctor. These evaluative concepts were varied slightly from study to study, in order to broaden the range of instruments representing acceptance (Figure 1). In addition to these evaluative

components, we also asked participants to make a choice regarding whom out of four potential doctors they would most likely select as their new GP, should they have to make such a choice. This 'forced choice' measure also reflects doctor acceptance, this time as the outcome of unseen forces driving a patient's decision to choose one doctor over the other.

While the definition of integration provided by Penninx & Garcés-Mascareñas (2016) deliberately does not specify the conditions that integrating migrants need to comply with in order to become accepted, the current investigation attempts to elucidate just those conditions, by investigating the social evaluations (i.e., evaluations of sociability, competence, and morality) that lead to acceptance of migrant doctors by their patients.

Studies 1a and 1b

In these first two studies we tested the response of UK-born participants (in the role of patients) to the profiles of doctors, while manipulating the country of birth and the country of education of the doctors presented in the profiles. We hypothesised that a doctor's birthplace outside the UK would lead to less acceptance by UK-born participants, but also that doctors with a UK-based education would receive increased acceptance. We also explored which social evaluations in the domains of competence, morality, and sociability would be most affected by doctor birthplace and place of education.

Pre-registration. Study 1a: https://aspredicted.org/blind.php?x=ft4ph4, Study 1b: https://aspredicted.org/blind.php?x=yp2n8y

Study 1a

Participants. A total of 184 adult participants were recruited through Prolific (69% female). Inclusion criteria were that participants had to have been born in, and currently living in, Wales or England, and considered themselves to be ethnically "White". Additional inclusion criteria consisted of 1) completing at least four out of the total six attention and comprehension checks successfully, and 2) spending at least ten minutes to complete the study. One participant was rejected retroactively on the basis of not meeting those two criteria; this person was not reimbursed, their data were removed, and an additional participant was recruited in their place. All participants – except the one participant that was excluded – were compensated £2.50 for participating in the study, which took on average approximately 15 minutes.

Design. The study used a 2x2x3 mixed within-between design, with doctor birthplace and doctor place of education as within-participant factors, and profile version (A, B, or C) as between-participant factor. Dependent variables in the model, indicating doctor acceptance, were: trust in doctor, second-opinion seeking, and doctor preference. Participant education level was added as a covariate after exploration of correlation patterns.

Within-participant component. Participants were asked to evaluate four fictitious doctors presented to them in profiles that were supposedly written by the GPs, in which they introduced themselves to the patient. The place of birth and place of education of the GP were varied between profiles, creating two fully crossed (2x2) conditions. As a result,

each participant evaluated one profile of a doctor born and educated in the UK, one profile of a doctor born in the UK but educated abroad, one profile of a doctor born abroad but educated in the UK, and one profile of a doctor born and educated abroad.

Between-participant component. We used three different versions of each profile (ABC), which we randomized between participants, to rule out that effects observed could be attributed to a specific profile. Please note, however, that the predictions for this study pertain to the within-participant effects only. In each version of the experiment, the four doctors presented in the profiles were born and/or educated, respectively, in the UK, a Southern European country, an Anglo-Saxon country other than the UK, or a South- or Southeast Asian country. The specific countries from those regions were, however, varied between the experiment versions A, B, and C (see Table 2). In Version A, for example, the doctors were born and/or educated in the UK, India, Australia, or Portugal, while in Version B, the doctors were born and/or educated in the UK, Spain, Pakistan, or the US. The resulting variation between different versions of the same doctor profile allows us to generalise our findings beyond the effect pertaining to one specific country, even if it does not allow us to inspect unique country effects, as would be possible using a more complicated confounded factorial design with a between-participants factor (Steiner et al., 2017).

Table 2. Study 1a and 1b full design.

		Profiles			
		Doctor 1	Doctor 2	Doctor 3	Doctor 4
		Birth: Domestic		Birth: Foreign	
		Education: Domestic	Education: Foreign	Education: Domestic	Education: Foreign
Version	A	UK / UK	UK / India	Australia / UK	Portugal / Port.
	B	UK / UK	UK / Spain	Pakistan / UK	US / US
	C	UK / UK	UK / N. Zealand	Italy / UK	Philippines / Phil.

Note. Profiles (Doctor 1, 2, 3, 4) is within-participant; Version (A, B, C) is between-participant.

Procedure. Participants initiated the experiment by responding to an advertisement on the Prolific web-page or mobile phone app. They were asked to give their informed consent by ticking a box. If they did not give their consent, they were not allowed to continue with the experiment. On the next few pages, participants were asked to consider the possibility that they were visiting a new GP practice for the first time after their old GP practice had closed down. At this new GP practice they are handed a folder containing information about doctors working at the GP practice. It was explained to the participants that in the next part of the experiment they were going to see the "profiles" of four doctors supposedly working at the clinic, and that participants would be asked to evaluate those doctors as if they were going to pick one of them as their usual doctor in the GP practice. After completing two comprehension checks, participants were shown the profile of the first doctor, along with the dependent measures (*trust in oncologist, second opinion seeking,* and *doctor preference*, see 'Measures'). This process was repeated until participants had seen

four doctor profiles. They were then shown the most important information for the four doctors summarised together on one page, and were asked to pick one doctor as "their" doctor (*forced choice* measure). Finally, participants were asked to fill out demographics, were debriefed, and thanked.

Doctor Profiles. Doctor profiles were inspired by vignettes often used in social psychological studies (Aguinis & Bradley, 2014). In such studies, participants usually rate several people profiles (called vignettes) on a variable of interest. On each vignette, one or several characteristics of the person under scrutiny is being manipulated (e.g., age and ethnicity), making it possible to study the causal effect of those characteristics on the dependent variable (e.g., hireability). In the current study we focused on just two within-participants factors – doctor birth place and doctor education place. Additional doctor characteristics that were used to fill the profile and present a coherent storyline introducing each doctor were varied semi-randomly across the three versions (A,B,C) of the profiles. These variations pertained to: doctor name, university of doctor graduation, doctor hobbies, as well as small textual variations. It has been argued that including this kind of distractor information to vignettes will improve their realism, which in turn improves the external validity of the study (Agerström et al., 2012). If the statistical effects of birthplace and education place hold strong despite of this random distractor information, we can be more confident that these variables are robust over a range of other variables that also tend to vary in real life.

Figure 2. Example of a profile used in Studies 1a and 1b: domestic birth, foreign education, Version A.

Hi, my name is James. I'm from the UK. I studied medicine at the University of Otago, New Zealand, where I lived for five years before graduating. Ever since I was young I wanted to be a doctor. It is hard work, but very rewarding. To get my mind off work during the weekend, I like to go swimming, listen to pop music, and make landscape paintings.
Name: James Davies
Age: 29
Nationality: British
Education: Completed medical school at the University of Otago, New Zealand
Experience: Four years of foundational training in hospitals and general practices located in the UK
Language(s): English (native)
Hobby: Swimming, listening to pop music, landscape painting

Figure 2 displays one of the 12 different profiles used in the study. *Country of birth* was signalled in the following ways: the doctor's name was picked from among a list of names that occur commonly within a specific country. Second, the country of birth was mentioned in the written text, and third, after "Nationality" the country of birth was indicated once more. *Country of education* was signalled twice: once in the written text and once after "Education". All universities mentioned in the different doctor profiles were

picked from the Times Higher Education (THE) World University Rankings of 2020. The universities were selected for offering a master's degree in medicine that was ranked within the 125-300 range of the THE rankings for that subject. *Experience* was kept constant for all doctors, and always displayed "Four years of foundational training in hospitals and general practices located in the UK". So even though some doctors were educated abroad, they had at least four years of domestic experience working at as a doctor-in-training. *Language* was set to "English (native)" for UK, US, New Zealand, and Australian born doctors, and to "[country language] (native), English (fluent)" for all other doctors. Finally, each doctor was given three *hobbies*, of which the first was always sports-related, the second music-related, and the third a common relaxation activity.

Measures.

Checks. Two comprehension checks were presented after the instructions, in which participants had to indicate whether they agreed with a written (true) statement about the instructions. In addition to the comprehension checks, four attention checks were included among the list of items following each of the profiles, stating: "This question checks whether you are paying attention. Please click Strongly disagree."

Doctor acceptance. Doctor acceptance was conceptualised as a combination of trust, preference, and the intention to comply with medical advice given by the doctor. These components are described in more detail below. In addition to these evaluative components, we also asked participants to make a choice regarding which out of four potential doctors they would most likely select as their new GP, should they have to make such a choice.

Trust in doctor: Trust in doctor was measured once for each doctor profile, using an adapted version of the 18-item Trust in Oncologist Scale (TiOS). According to the developers of the scale, this scale can be used to measure General Trust by summing all 18 items. In addition, each of the scale's four sub-dimensions (Competence, Honesty, Fidelity, and Caring) can be used by summing the items for those particular subscales (Hillen et al., 2013). Participants read "Please answer the following statements about this doctor presented in the folder", followed by each of the 18 items (e.g., "This doctor is very careful and precise" [competence], "This doctor will always give me honest information about my prospects" [honesty], "This doctor only thinks about what is best for me" [fidelity], and "This doctor listens with care and concern to all the problems I have" [caring]). Items were measured on a 7-point Likert scale (1 = Strongly disagree, 7 = Strongly agree).

Principal component analysis conducted on the 18 Trust items indicated that they did not load consistently on the same components if preceded by different versions of the profile. Furthermore, the sub-components Competence, Honesty, Fidelity, and Caring, which were suggested by the theory, were not found in our data. We therefore decided that for Study 1 we would only consider general trust, and forego exploration of the sub-components Competence, Honesty, Fidelity, and Caring.[ee] Reliability for the 18-item trust scale was good in response to the four doctor profiles, ranging from α = .939 to α = .949.

[ee] See Appendix A for a detailed description.

Second opinion seeking, doctor preference, and doctor forced choice: *Second opinion seeking* was measured following each version of the doctor profile, using a single item adapted from Blanch-Hartigan et al. (2019), stating: "Suppose that this doctor diagnosed you with a potentially serious illness. How likely is it that you would ask your usual doctor for a second opinion?" (1 = Very unlikely, 7 = Very likely). *Doctor preference* was measured after each version of the profile by the single item "How likely is it that you would choose this person as your doctor?" (1 = Very unlikely, 7 = Very likely). Finally, *doctor forced choice* was measured only once, after the participants had seen all four doctor profiles. Summaries of the four profiles were presented simultaneously on a single page, accompanied by the question: "If you had to make a choice, which doctor would you pick?" Participants could then indicate their preference by selecting their most preferred doctor from among the four different doctors presented in the profiles.

Demographics and control measures. The following control variables were included at the end of the study: Race (with responses clustered as: White, Black/African/Caribbean/Black British, Asian/Asian British, Mixed, Other); Region of residence (England, Wales, Northern Ireland, Scotland, Outside the UK); Medical background ("Are you currently working in the medical sector, or did you receive medical education?", Yes, no); Highest achieved education (Less than GCEs or equivalent, GCEs or equivalent, A-levels or equivalent, Some university education, Bachelor's degree, Master's degree, Doctorate); Gender (Male, Female, Other); Annual household income (Less than £10,000, £10,000 to £19,999, ... , £150,000 or more); and Liberalism—Conservatism ("Here is a 7-point scale on which the political views that people might hold are arranged from extremely liberal (left) to extremely conservative (right). Where would you place yourself on this scale?", 0—7 sliding scale).

Results Study 1a

Checks & background variables. Table 3 displays participant characteristics. In accordance with the predetermined inclusion criteria, participants were of White ethnicity and currently living in England or Wales. Additional inspection of attention checks indicated that participants were generally paying attention to the study: attention checks 1-6 were passed by 93% to 97% of participants.

When investigating the correlation patterns of the background variables, we found that education level of the participant correlated significantly with some of our outcome measures, specifically doctor preference and doctor trust of the UK-born, educated abroad doctor, and the foreign-born, UK-educated doctor (correlations ranging from r = .158 to r = .246, p < .05, 2-tailed). We therefore decided to include participant education level as a covariate in subsequent analyses.

Acceptance: Trust in doctor, second-opinion seeking, and doctor preference. To test Hypotheses 1 and 2 – being that a doctor's foreign birthplace and foreign place of education would lead to less acceptance – we performed multivariate analysis of variance. Doctor place of birth and place of education were entered into a General Linear Model in SPSS as

within-participants factors, and profile version as between-participants factor. Dependent variables entered to the model were trust in the doctor, second-opinion seeking, and doctor preference, each measured on four different occasions following the different doctor profiles. Participant education (mean centred) was included as a covariate.

Table 3. Study 1a participant background variables.

	Gender	Region	Race	Medical Background	Education	Household income	Political orientation	Duration in secs.
Male	57							
Female	125							
Other	1							
England		170						
Wales		13						
White			182					
Other			1					
Yes				8				
No				175				
Less than GCSEs					2			
GCSEs					22			
A-levels					52			
Some university					23			
Bachelor's					61			
Master's					19			
Doctorate					4			
<£10.000						18		
£10-£49.999						99		
£50-£100.000						57		
>£100.000						10		
Mean 1-7 (*SD*)							3.05 (1.53)	
Mean (*SD*)								889 (743)

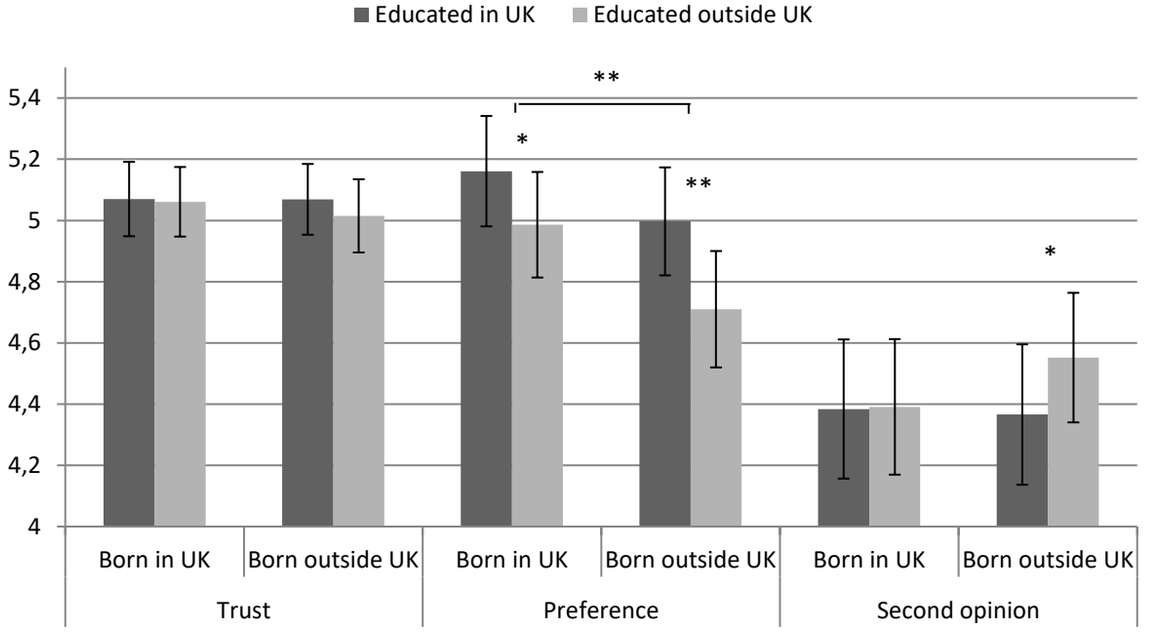
Multivariate tests of our model[ff] indicated that our experimental design worked as intended: The profile version (ABC) did not have an effect on participants' response patterns, meaning that results could be generalised across the different profile versions, $F(6) = 1.602$, $p = .146$, $\eta_p^2 = .026$. In line with Hypothesis 1, a multivariate significant main effect was found for doctor birth place, $F(3) = 5.680$, $p < .001$, $\eta_p^2 = .088$, indicating that – across our three acceptance measures – participants responded differently to doctors born in the UK versus outside the UK. In addition, and in line with Hypothesis 2, a multivariate effect was found for doctor education place, $F(3) = 5.339$, $p = .002$, $\eta_p^2 = .083$.

Univariate tests revealed that the multivariate effect of birthplace was buttressed mainly by a significant univariate effect on preference, $F(1) = 12.216$, $p = .001$, $\eta_p^2 = .064$, while the effect of birthplace on trust and second-opinion seeking remained non-significant.

[ff] While checking the assumptions for the multivariate analysis, we found that there were ten multivariate outliers. See Appendix A for a discussion.

Place of education also only had a significant effect on preference, $F(1) = 14.712$, $p < .001$, $\eta_p^2 = .076$, although an interaction effect between birthplace and education place on second-opinion seeking was present at an alpha = .10 level of significance, $F(1) = 3.313$, $p = .070$, $\eta_p^2 = .018$. Pairwise comparisons (Bonferroni corrected) further illustrate these findings (see Figure 3). Although the general direction of effects displayed in Figure 3 is consistent with Hypotheses 1 and 2 (i.e., more acceptance of doctors born and/or educated in the UK), it should be noted that significant effects on doctor acceptance were found only for the single-item construct of doctor preference, and to a lesser extent also for second-opinion seeking. However, no effects were found for the more reliable 18-item trust measure. This detracts from the support for the hypotheses.

Figure 3. Study 1a: Estimated marginal means for trust in doctor, doctor preference, and intention to ask for a second opinion.



Note. Flags indicate the 95% confidence interval, controlling for participant education level. *$p < .05$, **$p < .01$

Forced doctor choice. As a final measure of doctor acceptance, participants were asked to pick which of the four doctors they would most likely select as their new GP, if they had to choose. The results are displayed in Figure 4. In line with Hypothesis 3, participants displayed a clear preference for GPs that were educated in the UK, and among those more often picked the GP that had been born in the UK as well as educated there. A Chi-squared test confirmed that this pattern of doctor choice was unlikely to be due to chance, $\chi^2(3) = 20.328$, $p < .001$. While Hypotheses 1 and 2 were only partially supported, since effects were found only on two of the three measures of doctor acceptance (i.e., preference and second-opinion seeking), the large effect found in support of Hypothesis 3 indicates that

participants did, in fact, let the information about a doctor's place of birth and place of education influence their decision in picking a new GP.

Study 1b

Design and participants. Study 1b is a direct replication of Study 1a, with adaptations for some of the acceptance measures. A total of 182 participants of UK birth and nationality who self-identified as 'white' were recruited to partake in an online survey. They were randomly allocated to one of three survey versions, after which they were asked to evaluate four profiles of UK-based GPs. The GPs' country of birth and country of education were independently varied, yielding a 3(profile version) x 2(GP birthplace: UK vs. foreign) x 2(GP education place: UK vs. foreign), fully crossed, within-between participants design.

Measures. Doctor preference was again measured using the same single item question as was used in Study 1a. The second-opinion seeking question was adapted to reflect a relevant-at-the-time situation, namely testing for Covid-19 symptoms ("Suppose that this doctor advises you to get tested for symptoms of COVID-19. How likely is it that you would follow up on that advice?") The adapted Trust in Oncologist checklist that we used in Study 1a was replaced by two separate measures. The first of these measures was a seven-item checklist measuring the intention to cooperate ("I would like to..." *cooperate with the target, confront him, oppose him, argue with him, avoid him, have nothing to do with him, keep him at a distance;* Brambilla et al., 2013). Reliability of this seven-item measure in response to the four doctor profiles ranged from α = .821 to α = .877. The second measure that was added was a nine-item checklist measuring sociability ("I think that this doctor is..." *likeable, warm, friendly*), competence (*competent, intelligent, skilful*), and morality (*honest, sincere, trustworthy*). These nine items have been proven to be a reliable measure of sociability, competence, and morality (Leach et al., 2007). Reliability for these 3-item measures of competence, morality, and sociability was good for each doctor profile, ranging from α = .798 to α = .904. As in Study 1a, a 'forced choice' measure was included, in which participants picked one doctor, from among four, as their next GP.

With respect to demographics and control variables, we added participant age, national identification (four items; Postmes et al., 2013; α = .903), and satisfaction with the current state of society (one item; "Overall, to what extent are you dissatisfied or satisfied with the way things are going in the UK today?")

Results Study 1b

Checks and background variables. Study 1b's sample was similar to that of Study 1a, consisting of predominantly female (74%), White-identifying (98%) participants, of which the majority lived in England (88%) and did not have a medical background (93%). Additional background variables are displayed in Table 4 (next page). Participants were slightly left-leaning, and they identified with being a UK citizen. They were also somewhat dissatisfied with the current state of society within the UK. When checking the correlation patterns of these background variables, we did not find that they correlated with many of our

dependent variables, and therefore decided not to include any of these background variables in our subsequent analyses.

Inspection of attention checks revealed that most participants were paying attention, with checks 1-6 being answered correctly by 97% to 99% of participants. No participant reached the pre-registered exclusion criterion of failing more than one attention checks and finishing the study in under five minutes.

As in Study 1a, upon checking the assumptions for the multivariate analyses, we found that there were multivariate outliers. This may be taken as an indication of a deviant response pattern by some participants, but a visual inspection did not reveal any such patterns that we could recognise. Since the participants who were marked as multivariate outliers did pass all pre-registered inclusion criteria, we decided to retain them for subsequent analysis.

Table 4. Study 1b participant background variables.

	Education	Household income	Political orientation	Identification with UK	Satisfaction with UK	Age	Duration in secs.
Less than GCSEs	0						
GCSEs	24						
A-levels	45						
Some university	17						
Bachelor's	74						
Master's	19						
Doctorate	3						
<£10.000		15					
£10-£49.999		120					
£50-£100.000		39					
>£100.000		8					
Mean 1-7 (*SD*)			3.05 (1,63)				
Mean 1-7 (*SD*)				4.98 (1,36)			
Mean 1-7 (*SD*)					2,81 (1,38)		
Mean (*SD*)						35,41 (12,07)	
Mean (*SD*)							737,41 (997,74)

Doctor acceptance: cooperation intention, second-opinion seeking, and doctor preference. Similar to Study 1, we performed multivariate analysis of variance in order to test Hypotheses 1 and 2 – being that a doctor's foreign birthplace and foreign place of education would lead to less acceptance. Doctor place of birth and place of education were entered into a General Linear Model in SPSS as within-participants factors, and profile version as between-participants factor. Dependent variables entered to the model differed in some respects from Study 1. The single-item doctor preference measure was retained.

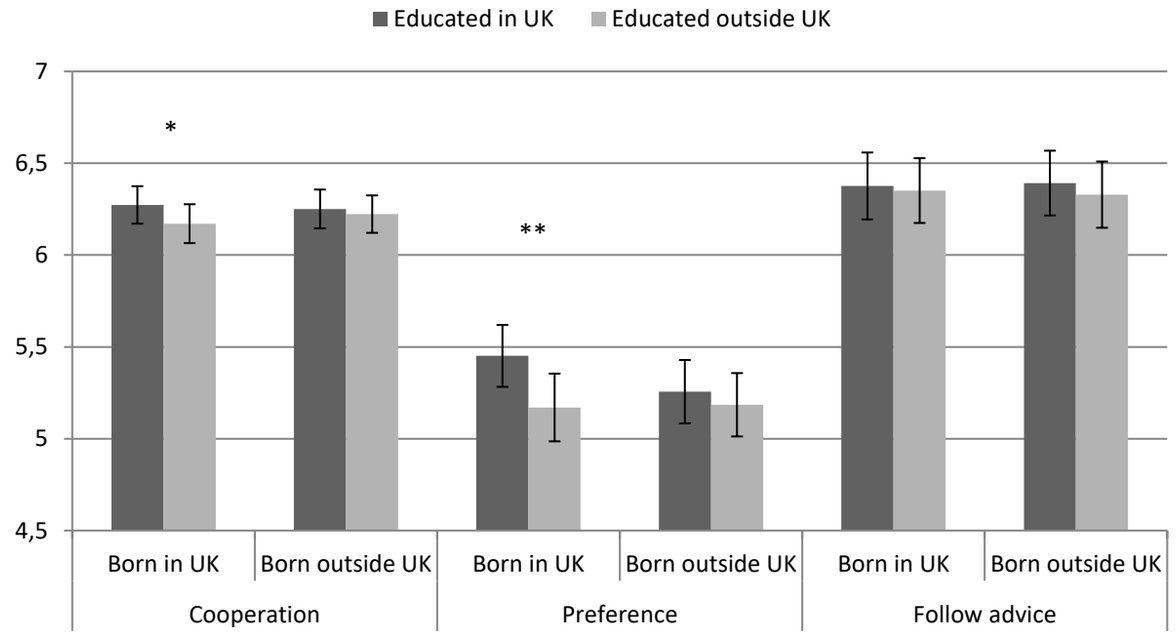
Second-opinion seeking was, however, replaced by a single item measuring compliance with a covid-related doctor's advice. Finally, the generalised trust measure was replaced by a seven-item measure of cooperation intention. All dependent measures were entered simultaneously, in order to study the overall effect of doctor birthplace and place of education on participants' responses on the different constructs conceptually representing acceptance. None of the control variables were included as covariates to the model, as they were not found to correlate with many of the dependent variables.

Like in Study 1a, profile version did not yield a significant effect on the outcome of the multivariate outcome measures, allowing us to focus only on the interpretation of the within-participants effects, $F(6, 356) = 1.476$, p = .185, $\eta_p^2 = .024$. Not in support of Hypothesis 1, a significant multivariate main effect of doctor birth place on cooperation intention, preference, and covid-related advice compliance was not found, $F(3, 177) = 1.843$, $p = .141$, $\eta_p^2 = .030$. Also not in support of Hypothesis 2, a multivariate main effect of doctor education place was not found, $F(3, 177) = 2.566$, $p = .056$, $\eta_p^2 = .042$. This is an indication that the effects of doctor birthplace and place of education are not as strong on the acceptance measures chosen for Study 1b, as they were on the measures chosen for Study 1a.

Although the multivariate effect was itself not significant, the near-significant effect of education place on our three outcome variables suggests that the place of education may have been of influence on a subset of the outcome variables. An inspection of univariate effects revealed that education place did indeed have an overall significant effect on preference, $F(1) = 7.472$, $p = .007$, $\eta_p^2 = .021$, but not on cooperation intention, $F(1) = 3.877$, $p = .051$, $\eta_p^2 = .040$, nor on the intention to follow-up on a covid-related doctor's advice, $F(1) = 1.436$, $p = .232$, $\eta_p^2 = .008$. Pairwise comparisons further specify these findings (see Figure 4 on the next page). The positive effect of receiving a UK education was, somewhat surprisingly, only found for UK-born doctors, although the same direction of effect was also observed for doctors who were born abroad. Keeping also the non-significant multivariate effect in mind, these univariate findings offer, at best, mixed support for Hypothesis 2. No support for Hypothesis 1 (the effect of birthplace) was found.

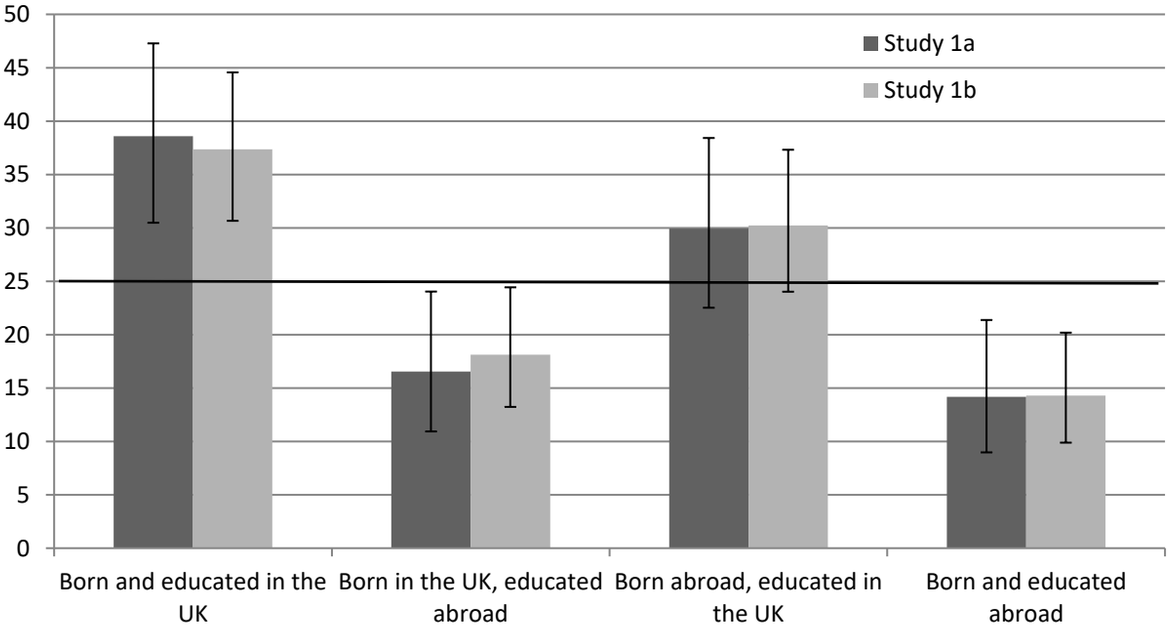
Doctor forced choice. As was the case for Study 1a, participants were also asked to pick one of the four doctor profiles as their preferred GP in a hypothetical scenario where participants were asked to imagine having to choose a new GP. The result of this behavioural choice is displayed in Figure 5 (next page), alongside the result of the choice made by participants in Study 1a. In both studies, participants made strikingly similar choice picks, displaying a clear evidence for doctors educated in the UK. In support of Hypotheses 3, this effect was statistically significant, $\chi^2(3) = 24.901$, $p < .001$.

Figure 4. Study 1b: Estimated marginal means for cooperation intention, doctor preference, and intention to follow the doctor's advice.



Note. Flags indicate the 95% confidence interval. *$p < .05$, **$p < .01$

Figure 5. Studies 1a and 1b: Doctors picked by participants when asked to make a choice.

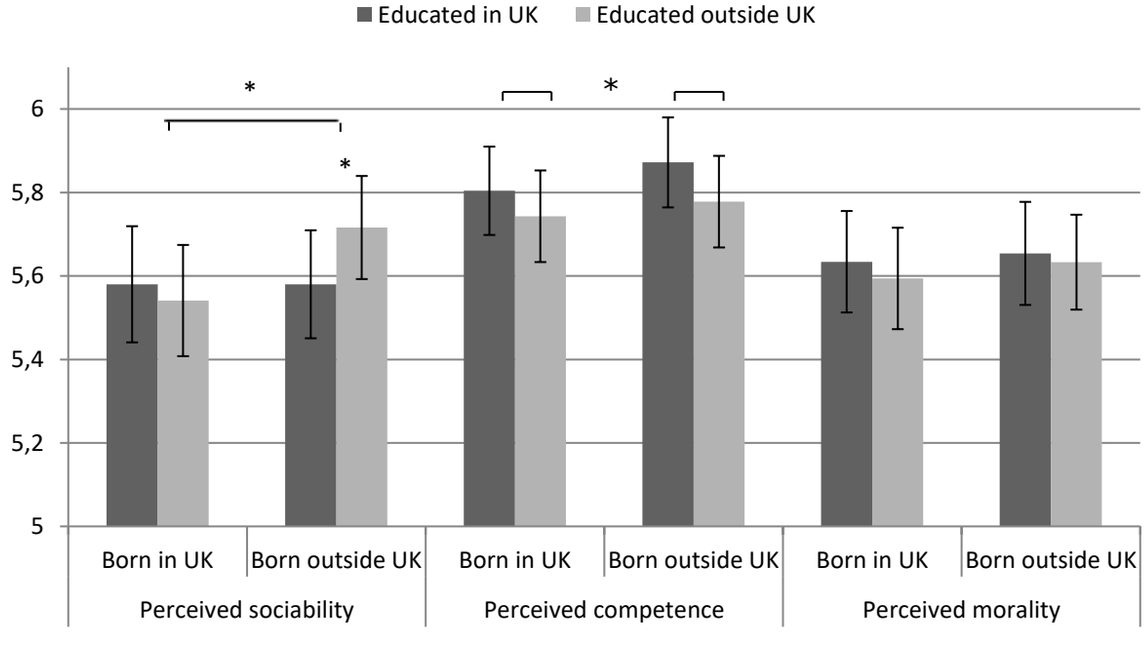


Note. Bars display the % of participants in the total sample who picked a certain doctor. Flags indicate 95% confidence intervals obtained through Agresti-Coull estimation for one-sample proportion intervals. The solid black line marks the expected distribution based on chance, i.e., 25%. Study 1 and 2 show similar results.

Sociability, competence, and morality. In addition to testing the effect of doctor birthplace and place of education on our three measures of doctor acceptance (i.e., cooperation intention, preference, and willingness to follow advice) we also explored whether doctor birthplace and place of education affected three common dimensions of interpersonal evaluation: sociability, competence, and morality. To this end, another multivariate analysis of variance was performed, using doctor birthplace and place of education as two within-participant factors, and profile version (ABC) as between-participants factor. For the outcome variables, sociability, competence, and morality evaluations for each of the four doctor profiles were used.

The multivariate effect of birthplace on sociability, competence, and morality proved to be non-significant, $F(3, 177) = 2.397$, $p = .070$, $\eta_p^2 = .039$. However, place of education did have a multivariate effect, $F(3, 177) = 3.011$, $p = .032$, $\eta_p^2 = .049$. Univariate effects were found for birthplace on perceived sociability, $F(1) = 5.371$, $p = .022$, $\eta_p^2 = .029$, which, however, was qualified by a significant birthplace x place of education interaction effect, $F(1) = 5.857$, $p = .017$, $\eta_p^2 = .032$. Education place had a univariate effect on perceived competence, $F(1) = 5.148$, $p = .024$, $\eta_p^2 = .028$. The estimated marginal means are displayed in Figure 6. From this exploration of univariate effects, we can conclude that doctors who were educated in the UK were generally perceived to be more competent than doctors educated abroad, regardless of where that doctor was born. Doctors who were educated abroad were, furthermore, expected to be more sociable than doctors educated in the UK, but only if they were also born abroad (as can be seen in Figure 6). There were no effects of a doctor's place of birth and place of education on perceived morality.

Figure 6. Study 1b: Estimated marginal means for perceived sociability, competence, and morality.



Note. Flags indicate the 95% confidence interval. *$p < .05$.

Discussion Studies 1a and 1b

In conclusion, Studies 1a and 1b offer mixed support for the effect of a doctor's UK birth or education on acceptance by UK-born patients. When participants were asked to rate each of the four doctor profiles separately, they displayed a minor preference for UK-born or UK-educated doctors on a subset of the acceptance measures used in the two studies. Specifically, in Study 1a, participants gave the profiles of UK-born doctors higher scores on the 'preference' measure, though this effect was not replicated in Study 1b. Concerning place of education, participants rated the profiles of doctors educated in the UK as more 'preferable' in Study 1a, regardless of where that doctor was born. Also in Study 1a, the participants were more inclined to ask for a second opinion if they received a diagnosis from a foreign-born doctor, but this effect disappeared if that doctor was educated in the UK. In Study 1b, however, only the UK-born doctors received any benefit (in terms of preference ratings and cooperation ratings) from being educated in the UK versus abroad.

In contrast to the mixed effects of doctor birthplace and place of education on our measures of doctor acceptance (Hypotheses 1 and 2), Studies 1a and 1b found strong and consistent support for the hypothesis that participants would pick UK-born and UK-educated doctors if they were to be confronted with the decision to pick one of the four doctors to be their next GP (Hypothesis 3).

The different degrees of support for Hypotheses 1, 2, and 3 may have emerged from the fact that, to test Hypotheses 1 and 2, participants saw and evaluated several doctor profiles in succession, whereas to test Hypothesis 3, they saw all four profiles simultaneously. Simultaneous presentation of vignettes has been suggested as a solution to error effects arising from the order in which vignettes are presented, leaving more statistical power to detect the effect of interest (Su & Steiner, 2020). Another argument for why simultaneous presentation of the doctor profiles may have led to stronger support for our hypotheses, is that simultaneous presentation may help to improve the accuracy of participants' estimation of their own internal preference for a certain doctor. In vignette research, there is a known phenomenon where participants may come to inaccurate estimations of a numerical value described in the vignette, if they cannot compare that vignette to other vignettes acting as reference points (Atzmüller & Steiner, 2010; Birnbaum, 1999). Our behavioural choice measure, in which participants had to pick one doctor from among four profiles, may therefore be a more accurate estimation of participants' true feelings towards the four doctors than the acceptance measures we used to measure participants' feelings towards each of the sequentially presented profiles. Finally, we would like to argue, that simultaneous presentation of doctor profiles may also have increased the salience of the differences between the four profiles, making it more likely that participants based their final decision on those differences – in this case, doctor birthplace and place of education – if they indeed felt that those differences were important.

One could question whether participants, had they not been able to make such a clear comparison between different doctor profiles as they did in Studies 1a and 1b, would still have indicated a preference for a UK-born or UK-educated doctor. We argue that this is

a relevant question, since, in real-life situations, people do not always have the opportunity to compare different doctors: they have to decide whether to accept the person in front of them, there and then. If no comparison between different doctors is possible, will patients still be more accepting of UK-born and UK-educated doctors, based on their gut feeling or some unconscious stereotype? To test this, participants' acceptance of doctors born and/or educated inside the UK versus outside the UK needs to be examined in a setting where participants view just one doctor profile. Study 2 will therefore utilise a between-participants design, in which participants see just one doctor profile, while the profiles themselves differ between conditions.

In addition to testing whether participants will indicate their preference for a UK-educated doctor over a foreign-educated doctor in a single-profile scenario, Study 2 will also further specify the mediating role that social evaluations of the doctor may have in the relationship between place of education and acceptance by the patient. In Study 1b we found that participants evaluated UK-educated doctors to be more competent, but less sociable, than foreign-educated doctors. This finding is consistent with the literature about social evaluations, which describes how migrants are often regarded as warm (i.e., scoring high on the sociability and morality) but incompetent (Abele et al., 2021; Fiske et al., 2002). For migrant doctors, it is of interest to find out whether these social evaluations that patients make about them can also be experimentally manipulated. Not only practically, because this finding could provide migrant doctors with a practical tool to improve their own position, but also theoretically: Proving that social evaluations can be manipulated, and that this leads to higher acceptance, would support the idea that there exists a causal mechanism between social evaluations and acceptance. Study 2 will, therefore, attempt to experimentally manipulate social evaluations that participants make about doctor profiles, in order to find out whether this is leads to improved acceptance.

Study 2

Studies 1a and 1b used within-participants designs, in which varying degrees of comparability between profiles led to varying strengths of the effect of doctor birthplace and place of education on patient acceptance. In Study 2, we examined if Hypothesis 2 (i.e., UK-educated doctors will be accepted to a higher extent than foreign-educated doctors) held true if no comparison between profiles could be made at all, by providing some participants with the profile of a foreign-educated doctor, and other participants with the profile of a UK-educated doctor.

In addition to attempting to replicate the findings of Studies 1a and 1b utilising a between-participants scenario, we also attempted to find support for the causal mechanism that may explain why a doctor's place of birth or education impacts doctor acceptance. To that end, in Study 2, we manipulated social evaluations of foreign-educated doctors directly, by attaching a positive patient review of the doctor's sociability, competence, or morality, to their profile. If doctor acceptance is indeed contingent on social evaluations of that doctor, as has been suggested by recent attempts to place social evaluations at the core of social

interaction (Abele et al., 2021), then increasing those social perceptions should also increase acceptance. We hypothesised, therefore, that a positive recommendation of a doctor's sociability, competence, or morality would increase the doctor's acceptance compared to no-review control conditions (Hypothesis 4). We left the question which type of social evaluation would yield the largest effect on acceptance open to exploration.

Pre-registration. https://aspredicted.org/blind.php?x=v66zg5

Method

Design and participants. A total of 240 participants were recruited through Prolific. In order to participate, one needed to be at least 18 years old, currently be living in the UK, have English or Welsh nationality, and have self-indicated as having "white" ethnicity. Participants were randomly assigned to one of five conditions: in the three experimental conditions, participants saw a profile of a doctor born and educated abroad, followed by a patient recommendation praising either the doctor's sociability (condition 1), competence (condition 2), or morality (condition 3). In the two control conditions, participants either saw the profile of a doctor born and educated abroad (condition 4) or of a doctor born abroad but educated in the UK (condition 5), in both instances not followed by a recommendation.

Profiles and recommendations. For conditions 1 through 4 we used the same profile as we used in Study 1 and 2 for the foreign-born, foreign educated doctor (see Appendix B, João profile). For condition 5 we adapted the profile to reflect foreign birth and a UK education.

The doctor profile was presented simultaneously with a short review by another patient of the doctor. This review gave a positive impression of the doctor, focusing on his sociability (keywords: warmly, friendly, likeable), competence (intelligently, skilful, competent), or morality (honestly, sincere, trustworthy). See Figure 7.

Figure 7. Patient recommendation, sociability condition.

I am happy with having doctor Silva as my GP. Whenever I consult him, he always treats me very warmly. I recall one specific occasion when I came to doctor Silva with a physical complaint, which he treated in a friendly manner. Overall, I'd say that João Silva is a likeable doctor.

Note. Underlined words varied between conditions.

Measures. The same indicators of doctor acceptance as were used in Study 1b were also used in Study 2: intention to cooperate, doctor preference, and covid-related advice compliance. Dimensions of social evaluation were measured with the same nine items as used in Study 1b, encapsulating sociability, competence, and morality. Reliability of the scales was good, ranging from α = .863 to α = .881. Also returning to Study 2 are seven items measuring trust in the doctor. The seven items are a subset of items from the Trust in Oncologist scale used in Study 1a (Hillen et al., 2013), for which, in an earlier attempt, we failed to find the expected sub-components. The seven items selected showed the most

promise in loading on their respective components, which is why we selected them for Study 2. However, after inspecting the components structure of these seven items, we again found that they loaded only on one component, signifying general trust in the doctor. Since the reliability for these seven items was good (α = .908), we again decided to include general trust as a measure of doctor acceptance, without its sub-components. The items selected were: "I think this doctor would be available for me whenever I need him"; "I think this doctor would only think about what is best for me"; "I think this doctor would explain everything so that I can consent to medical decisions"; "I think this doctor would always give me honest information about my prospects"; "I think this doctor would be totally honest in telling me about the different treatment options available for my condition"; "I think this doctor would be able to handle any medical situation, even a very serious one"; "I would be confident that this doctor's medical decisions are right".

Control measures included in Study 2 were the same as in Study 1b.

Results Study 2

Checks and background variables. 63% female, 10% had a medical background, 217 came from England, 9 from Scotland and 14 from Wales (see also Table 5 on the next page). Of the 240 participants 7 did not pass the one attention check, and were excluded from subsequent analyses.

There were again some multivariate outliers, but, as in Studies 1a and 1b, we decided to retain these for further analyses as we could not come up with a good reason to exclude these participants. The single-item Covid advice compliance measure was very skewed, as most people indicated complete compliance, while there was a subset of 'outliers' who indicated very little compliance.

Exploring the correlation structure of the variables and control variables yielded that participant age, gender, identification with the UK, education, political orientation, and discontent with society correlated with some of the outcome measures. As such, these variables were mean centred and included in subsequent analyses as covariates.

Effect of review. Two separate multivariate analyses of variance were conducted. The first one was to test the effect of the experimental manipulation on the cluster of social evaluation variables sociability, competence, and morality. We did not pre-register a hypothesis about this analysis, since we conducted it mainly to check whether our experimental manipulation was successful. Experimental version was entered as the between-participants factor, and perceived sociability, competence, and morality as the dependent variables. Participant gender and mean centred participant age, identification with the UK, education, political orientation, and discontent with society were entered as covariates.

From this first analysis, it appeared that our experimental manipulation was not successful. Estimated marginal means of sociability, competence, and morality did not differ between the five conditions, $F(12, 687) = 1.31$, $p = .205$, $\eta_p^2 = .02$ (see Table 6, next page).

Table 5. Study 2 participant background variables.

	Education	Household income	Political orientation	Identification with UK	Satisfaction with UK	Age	Duration in secs.
Less than GCSEs	8						
GCSEs	31						
A-levels	49						
Some university	31						
Bachelor's	85						
Master's	29						
Doctorate	7						
<£10.000		26					
£10-£49.999		138					
£50-£100.000		66					
>£100.000		10					
Mean 1-7 (*SD*)			2.65 (1.54)				
Mean 1-7 (*SD*)				4.89 (1.43)			
Mean 1-7 (*SD*)					2.84 (1.35)		
Mean (*SD*)						35.63 (13.80)	
Mean (*SD*)							405.37 (222.94)

Table 6. Estimated marginal means of social evaluation measures per experimental condition.

	Sociability score	Competence score	Morality score
Sociability recommendation	5.7 (.13)	5.8 (.13)	5.5 (.13)
Competence recommendation	5.7 (.13)	6.0 (.13)	5.6 (.13)
Morality recommendation	5.8 (.13)	5.8 (.13)	5.9 (.13)
No recommendation, UK-educated	5.8 (.14)	5.8 (.13)	5.6 (.14)
No recommendation, foreign-educated	5.7 (.13)	5.8 (.13)	5.5 (.13)

Note. All differences between conditions *n.s.* after Bonferroni correction.

Despite the fact that the manipulation had failed to influence participants' perceptions of the doctor's sociability, competence, and morality, we conducted our second multivariate analysis of variance, in order to test Hypothesis 2 and 4. Experimental version was entered as the factor predicting a cluster of acceptance-related variables, specifically preference, covid advice compliance, cooperation intention, and trust. Unsurprisingly, no significant effect of experimental version on these variables was found, $F(20, 912) = .919$, $p = .563$, $\eta_p^2 = .02$. This disconfirms Hypothesis 2, which stated that doctors who received a UK education (condition 4) would be accepted to a higher degree than doctors who received a foreign education (condition 5). Hypothesis 4 was also disconfirmed, since participants who read a review in which the doctor's sociability, competence, or morality was praised (conditions 1-3) did not accept that doctor to a higher degree than participants who read no such review (conditions 4-5).

Effect of covariates and social evaluations. While the experimental manipulation did not yield the hypothesised effects, some of the participant characteristics that were added as covariates to the second analysis turned out to be significant predictors of doctor acceptance. A series of ad-hoc regression analyses illustrates these effects (Table 7). For simplicity's sake, experimental version is not included in the analysis. Younger participants were more accepting of doctors in general, and politically right-leaning participants were less likely to cooperate with the doctor described in the profile.

Table 7. Regression coefficients (b) of participant characteristics predicting doctor acceptance (Step 1) and of social evaluations predicting doctor acceptance (Step 2).

	Step 1			Step 2		
Predictors	Preference	Cooperation	Trust	Preference	Cooperation	Trust
Gender	-.364*	-.012	-.100	-.372**	-.013	-.049
Age	-.017**	.000	-.013**	-.009	.005	-.008**
Identification	.152*	.048	.109*	.109*	.018	.048
Discontent	-.029	.022	.055	-.135*	-.041	-.035
Education	-.034	-.030	-.077*	-.018	-.021	-.059**
Pol. orient.	-.099	-.105**	-.073	-.010	-.050	.015
Sociability				.342**	.199**	.032
Competence				.599***	.330***	.384***
Morality				-.013	.042	.416***
Adjusted R^2	.060**	.010	.073**	.398***	.358***	.690***

Note. *p < .05 **p < .01 ***p < .001. Unstandardised regression coefficients were reported; all constructs were measured on a 7-point scale except age and gender.

In a second step, sociability, competence, and morality ratings were added as predictors of preference, cooperation, and trust. Since no effect of our experimental manipulation was found (i.e., a positive review of sociability, competence, or morality), this analysis serves as an alternative method to explore the relationship between social evaluations and acceptance. As can be observed in Table 7, competence ratings were positively related to doctor preference, cooperation, and trust. Participants were, in other words, more likely to accept a doctor if they thought that he was competent. Higher sociability scores corresponded to higher preference and intention to cooperate with the doctor, but did not affect trust. Morality ratings, on the other hand, had no effect on preference or the desire to cooperate, but contributed positively towards doctor trust.

Discussion Study 2

Study 2 attempted to replicate the finding of Studies 1a and 1b that a foreign doctor who received UK education were accepted to a higher degree than a foreign doctor who had received foreign education (i.e., Hypothesis 2). New to Study 2 was, however, that we tested this effect using a between-participants setting, where no comparison between doctors could be made, and that participants therefore had to base their judgment on a single

observation. Contrary to expectations, no support for Hypothesis 2 was found in such a setting. The fact that no support for Hypothesis 2 could be found, points to the potential importance of the ease with which participants can make a comparison between doctors. In Studies 1a and 1b, participants first viewed four doctor profiles in succession, leading to mixed support for the effect of doctor place of education. Only when the four profiles were summarised on one page, and participants were asked to make their pick, did the preference for a UK-educated doctor clearly emerge. It seems, now, that when participants are presented with just one doctor profile, their acceptance of that doctor is not influenced by whether that doctor was educated inside or outside the UK. In conclusion, where a doctor was born and where a doctor was educated both seem to impact patients' acceptance of that doctor, pointing to the value of receiving a local education to getting accepted. This effect, however, only appears when several doctors can be directly compared, which is an important boundary condition for the positive effect that receiving a local education has on doctor acceptance.

Besides attempting to replicate the effect of place of education on acceptance, Study 2 also wanted to elucidate the causal mechanism underlying doctor acceptance, by experimentally manipulating social evaluations associated with the doctor. By attaching a patient review to the profile of a foreign-born doctor in which either his sociability, competence, or morality was praised, we expected to increase acceptance. However, no effect of adding a patient review was found (disconfirming Hypothesis 4). The most likely explanation for why our experimental manipulation in the form of a positive review did not lead to higher acceptance of a foreign born and foreign educated doctor, is that they failed to elevate the social evaluations at which they were targeted: sociability, competence, and morality. An analysis of the mean scores on those constructs revealed that participants who read, for example, a positive review of a doctor's competence, did not perceive that doctor to be more competent than participants who did not read any review. This was true for sociability reviews and morality reviews as well. This may be the result of the between-participants design that was used in Study 2, making it harder for participants to compare doctors with a review versus a doctor without a review. Another likely explanation is that participants already perceived the doctor presented in the profile to be highly sociable, competent, and moral, and that the addition of a positive review on those aspects did not elevate their evaluations further. High average scores for these constructs in the two control conditions seem to suggest that this may indeed have been the case.

A final consideration is that, even if the experimental manipulation had been successful, elevated social evaluations would not have elevated acceptance. Ad hoc regression analyses performed after the main analyses had been completed, however, revealed there to be fairly strong and significant relationships between social evaluations of sociability, competence, and morality, and acceptance measures such as preference, cooperation intention, and trust. While this analysis should not be viewed as a substitute for our failed hypothesis test, it does point in the direction that the hypothesised relationship between social evaluations and doctor acceptance would have been found, had our

experimental manipulation been successful. To explore the possibility that the causal relationship between social evaluations and doctor acceptance can in fact be found if a different experimental manipulation is used, additional studies need to be conducted.

Studies 3a and 3b

For the final two studies we wanted to establish whether a negative patient review of a doctor's competence, sociability, or morality attached to a doctor profile would affect the doctor's acceptance. In Study 2 we found no evidence for the effect of a positive review, but since evaluations were generally on the higher end of the scale, it is possible that there was a ceiling effect. Studies 3a and 3b will therefore employ an adapted version of the patient reviews used in Study 2, in which the targeted social evaluation is described negatively instead of positively.

In Study 3a, we utilized a between-participants design, similar to Study 2, where participants read a doctor profile followed by either a negative review of that doctor's sociability, competence, morality, or by no review (control condition). Another change compared to Studies 1ab and 2 is that we recruited a Dutch sample, instead of a UK sample, and altered the doctor profile to represent a doctor born and educated in Syria, with additional schooling in the Netherlands. Syrians form a relatively recent group of immigrants to the Netherlands, many of them arriving after the onset of the Syrian civil war in 2011. This group of Syrian refugees has received a mixed response in Dutch media: while a lot of attention was paid to the Netherlands' struggle to house the sudden surge of refugees resulting from the war, prominent figures in the Dutch mediascape also pointed from the start to the potential benefit the country could gain, given that many Syrian refugees were assumed to be well-educated and capable of filling vacancies in, for example, the medical sector. Measuring the acceptance of Syrian doctors in the Netherlands expands the scope of our investigation beyond the UK, to a group of migrants that has been associated with the medical profession, but of whom the acceptance by the local population is not yet well known.

Our expectation that negative reviews of a Syrian doctor cause decreased acceptance of that doctor predicate on the assumption that participants perceive themselves and the Syrian doctor to belong to different groups. People have been shown to accept critical information about people if they do not belong to their own group, while criticism directed at a person who is perceived to belong to the same group as oneself is often downplayed (Ellemers et al., 2013). To control for the potentiality that participants responded differently to the experimental manipulation depending on their perceived belonging to the same group as the Syrian doctor, Study 3a included a measure of entitativity, or belonging to the same group, and investigated whether this influenced the effectiveness of the experimental manipulation (see Blanchard et al., 2020).

In Study 3b, we returned to the UK setting. Instead of employing a between-participants design, we presented participants several doctor profiles, as in Studies 1a and 1b. Participants saw three doctor profiles, followed by reviews critical of the doctor's

sociability, competence, or morality, and were then asked to pick one doctor as their new GP. For this study we also varied the source of the review: in one half of the sample the reviews came from another doctor, while in the other half they came from another patient. This variation in the source of the review was added to see whether reviews provided by doctors (i.e., experts) had more weight to them than reviews given by patients (i.e., peers), which may be useful information for future interventions targeting social evaluations. Since in the literature conflicting support has been found for the precedence of either peer reviews or expert reviews on impression formation (e.g., Wang et al., 2020), we make no prediction about whether expert reviews or peer reviews have the larger impact.

In Study 3a we expected to find that a negatively phrased patient review, in which a doctor's sociability, competence, or morality was criticised, would lead to lower acceptance of that doctor, compared to no review (Hypothesis 5). In both Study 3a and Study 3b, we explored which type of social evaluation (i.e., sociability, competence, morality) would have the strongest impact on measures of acceptance. The hypotheses for Studies 3a and 3b were not pre-registered.

Study 3a

Participants and design. We recruited 296 participants through Prolific, who self-identified as "white" and had Dutch nationality. Participants were aged between 18 and 69 (M = 29, SD = 9.76), n = 133 were male, n = 160 were female, and n = 3 identified as non-binary. Participants had to register through Prolific and were awarded €0.80 upon completion of the questionnaire, which was written in Dutch. After giving informed consent, participants were randomly assigned to one of four conditions. All participants were asked to imagine going to a new GP practice, upon which they read a profile depicting the Syrian GP working there (see Appendix B). In conditions 1-3 the profile was immediately followed by a review by another patient in which two traits of the Syrian GP were praised, while a third trait was reviewed critically (see Figure 8). Depending on the condition, the trait being criticised was either the doctor's sociability, competence, or morality. In the fourth condition, the doctor profile was not followed by a review.

Figure 8. Patient review of the Syrian doctor, incompetence condition.

One of Amir Al Sahili's patients writes about him: "I am mostly happy with my doctor Amir Al Sahili. When I come to him, he treats me *fairly*. I do, however, remember one specific time when I went to Amir with a physical complaint, and he treated me *<u>incompetently</u>*. All in all, I find Amir to be a *friendly* doctor."

Note. Translated from Dutch. *Italic* words varied between conditions. The <u>underlined</u> word is the negatively phrased target word (in this condition: incompetently; in other conditions unfriendly or unfairly).

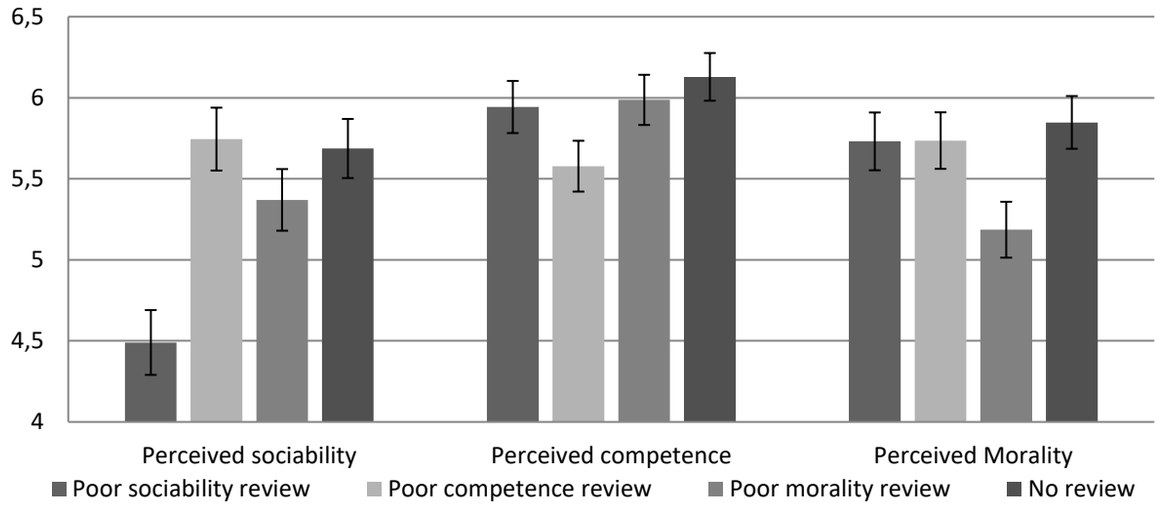
Measures. Similar to Study 2, participants rated several aspects of doctor acceptance after reading the doctor profile, i.e., doctor preference, cooperation intention, and the intention to follow up on a covid-related doctor's advice. In addition to these measures, we included a measure of entitativity, or the perceived belonging to the same group, in order to explore whether the impact of the negative review might depend on the extent to which the Syrian doctor is perceived to belong to the same group as the participant. The entitativity construct was measured using four of the total six subscales measuring group membership, developed by Blanchard et al. (2020). The included subscales were titled entitativity, interactivity, similarity, and common goals, while the boundaries and history of interaction subscales were excluded due to small loadings onto the CFA (Blanchard et al., 2020) and inapplicability to the current study. Example items were: "We are a group", "we have the same values", "we see things the same way", and "we have the same goals". Reliability analysis showed good internal consistency of the scale, α = .915.

Results Study 3a

Of the 296 participants in the sample, 31 (10%) did not pass the comprehension check. This group spent significantly less time to complete the study (316 seconds vs. 378 after removing two outliers who spent over 1500 seconds to complete the study), p = .022. Since this may be an indication that these participants did not pay attention while completing the study, we ran all our analyses again, without participants who failed the comprehension check, but this did not change the outcome of the analyses. As in the previous studies, the single-item Covid compliance item was extremely skewed, with a noticeable peak at point 6 on the 7-point Likert scale.

To check whether the manipulation worked as intended, we performed multivariate analysis of variance, using perceived sociability, competence, and morality as the outcome variables. An interaction term between entitativity (mean centred) and experimental version was added to the model as well, to account for the fact that the extent to which the experimental manipulation was successful may depend on participants' perceived similarity between themselves and the doctor. A significant multivariate effect of experimental version indicated that, this time around, our experimental manipulation had been successful, F(9, 864) = 23.53, p < .001, η_p^2 = .197. Figure 9 displays the estimated marginal means per experimental condition. As intended, participants rated the doctor significantly lower in the domain for which they had read a negative review. Hence, participants who read that the doctor was incompetent, gave that doctor a lower competence score, but not a lower score on the other domains. Entitativity had a significant effect on the social evaluation measures, F(3, 286) = 20.86, p < .001, η_p^2 = .18, however, the interaction term remained non-significant, F(9, 864) = 1.107, p = .355, η_p^2 = .011. In conclusion, the experimental manipulation was successful in changing the participants' opinion of the doctor in terms of sociability, competence, and morality. This did not depend on the perceived similarity between the participant and the doctor.

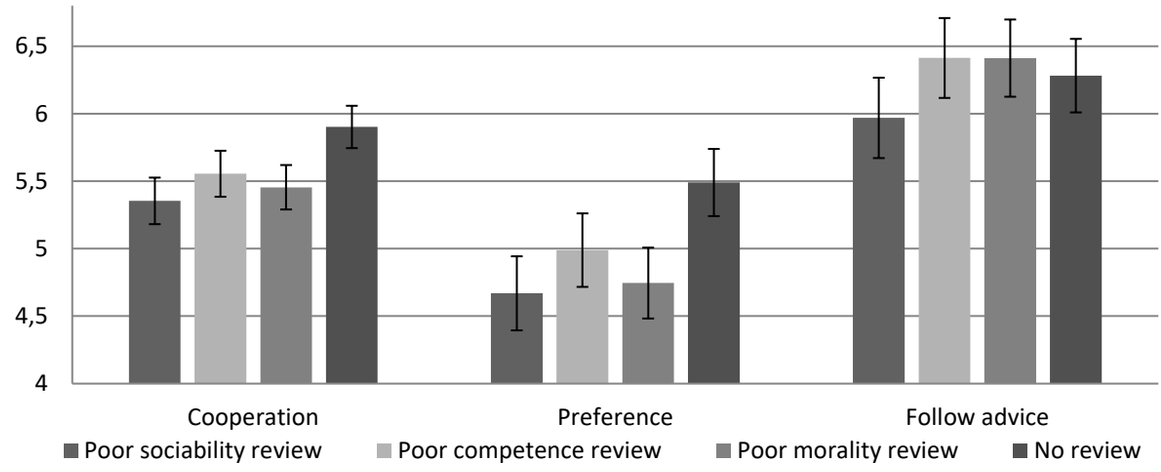
Figure 9. Study 3a: Estimated marginal means for perceived sociability, competence, and morality



Note. Flags indicate the 95% confidence interval, controlling for entitativity.

Next, we examined whether the experimental manipulation also succeeded in changing the participants' acceptance of the doctor, as measured by the intention to cooperate with that doctor, as well as expressed preference for the doctor and the intention to follow the doctor's advice. Performing multivariate analysis of variance with those indicators as the dependent variables, and again controlling for entitativity, yielded a significant multivariate effect for the experimental condition, $F(9, 864) = 4.342$, $p < .001$, $\eta_p^2 = .043$. From inspecting the estimated marginal means (Figure 10) it can be seen that a poor review of the doctor's sociability, competence, or morality affected the willingness to cooperate with this doctor, as well as the expressed preference for the doctor, compared to the control condition. The one domain on which negative reviews did not appear to have an impact, is the patient's willingness to follow the doctor's advice. In conclusion, and in line with Hypothesis 5, attaching a negative review of a doctor's sociability, competence, or morality to the profile of a Syrian doctor working in the Netherlands, negatively impacted the acceptance of that doctor, compared to a situation where participants saw only the profile without a review. Exploration of the magnitude of the effects of the three different reviews revealed that they all had similarly negative impacts on acceptance. That is, negative reviews in the domain of sociability, competence, and morality had an equally large effect on doctor acceptance.

Figure 10. Study 3a: Estimated marginal means for cooperation intention, doctor preference, and intention to follow the doctor's advice.



Note. Flags indicate the 95% confidence interval, controlling for entitativity.

Study 3b

Participants and design. We recruited 279 participants through Prolific, of at least 18 years old and of UK nationality. Participants were aged between 18 and 76 (*M* = 37, *SD* = 13.68), *n* = 107 were male, *n* = 167 were female, and *n* = 5 identified otherwise. Participants had to register through Prolific and were awarded £1 upon completion of the questionnaire, which was written in English. After giving informed consent, participants were randomly assigned to one of two conditions. All participants were asked to imagine going to a new GP practice, upon which they read profiles of three different GPs (see Appendix B). While the doctor profiles were themselves kept very similar, they were immediately followed by a review in which either the sociability, competence, or warmth of the doctor received a critical remark (in randomized order). In addition to this within-participant component, the reviews came from another doctor in one half of the sample (*expert* condition), while they came from another patient in the other half of the sample (*peer* condition; see Appendix B).

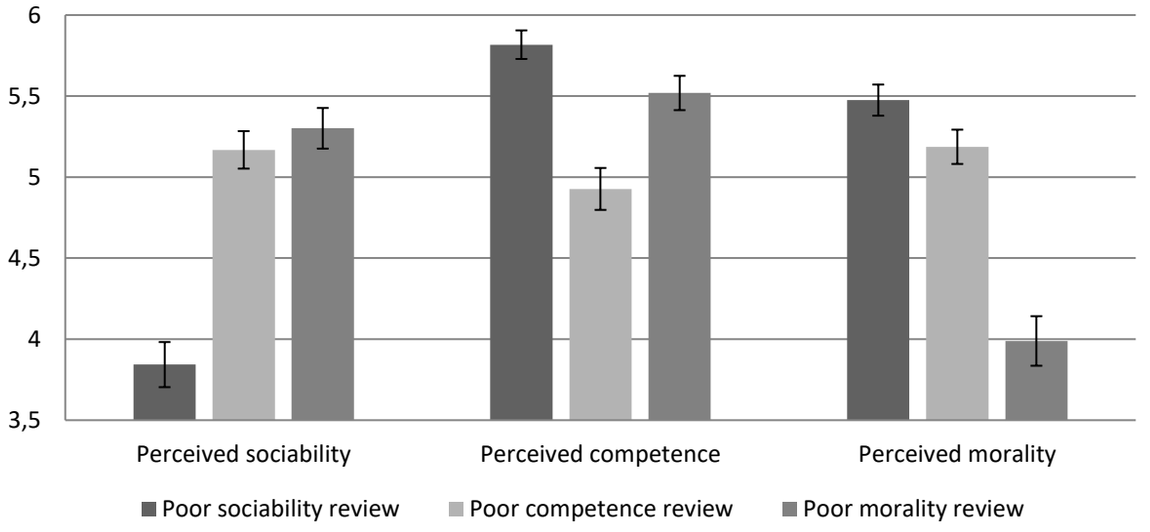
Measures. Similar to Study 1b. Participants rated two aspects of doctor acceptance, i.e., doctor preference and cooperation intention. In addition to responding to the three separate profiles, participants also made one 'forced choice' following the simultaneous presentation of the three doctor profiles, in which they picked the doctor they were most likely to pick as their new GP.

Results Study 3b

To check whether the doctor reviews affected the domain that was targeted in the review (i.e., sociability, competence, or morality), we conducted multivariate analysis of variance using review type as the within-participant factor, and review source (doctor or patient) as the between-participant factor. The multivariate main effect of review type was significant, $F(6, 272) = 96.879$, $p < .001$, $\eta_p^2 = .681$. An inspection of the estimated marginal

means revealed that the reviews indeed affected targeted domains (see Figure 11). Whether the review came from another patient (peer) or from a doctor (expert), did not influence the outcome, $F(3, 275) = .076$, $p = .973$, $\eta_p^2 = .001$.

Figure 11. Study 3b: Estimated marginal means for perceived sociability, competence, and morality



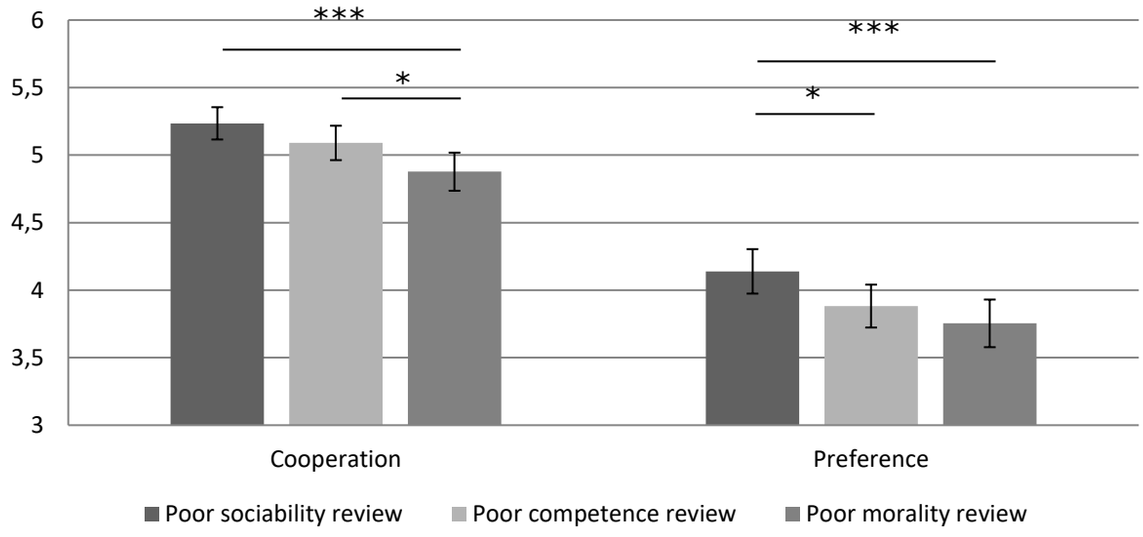
Note. Flags indicate the 95% confidence interval.

To examine whether the type of review (poor sociability, poor competence, or poor morality) and the source of the review (doctor or patient) impacted acceptance of the doctor presented in the profile, we conducted another multivariate analysis of variance, using cooperation intention and doctor preference rating as dependent variables. A significant multivariate effect of review type was found, $F(4, 274) = 6.520$, $p < .001$, $\eta_p^2 = .087$, meaning that participants differentiated between the reviews in terms of how much it let them influence their acceptance. Whether the review came from another patient (peer) or from a doctor (expert) did not influence the outcome, $F(3, 276) = 2.93$, $p = .055$, $\eta_p^2 = .021$. Figure 12 displays the estimated marginal means for the two acceptance measures following the three different reviews. For intention to cooperate as well as for doctor preference, a negative review of the doctor's morality led to lower scores, compared to a negative competence review and a negative sociability review, respectively.

As an ultimate measure of patients' preference for a doctor receiving a poor review of either his sociability, competence, or morality, we employed a 'forced choice' measure, similar to the measure of forced doctor choice employed in Studies 1a and 1b. From this measure it became clear that participants were least likely to pick a doctor who had received a negative review of his morality, followed by a doctor who had received a negative review of his sociability. A doctor who had received a negative review of his competence, was most often picked (see Figure 13), $\chi^2(2) = 28.90$, $p < .001$. This is, surprisingly, a different order than we found when we asked participants to rate the three profiles sequentially. While

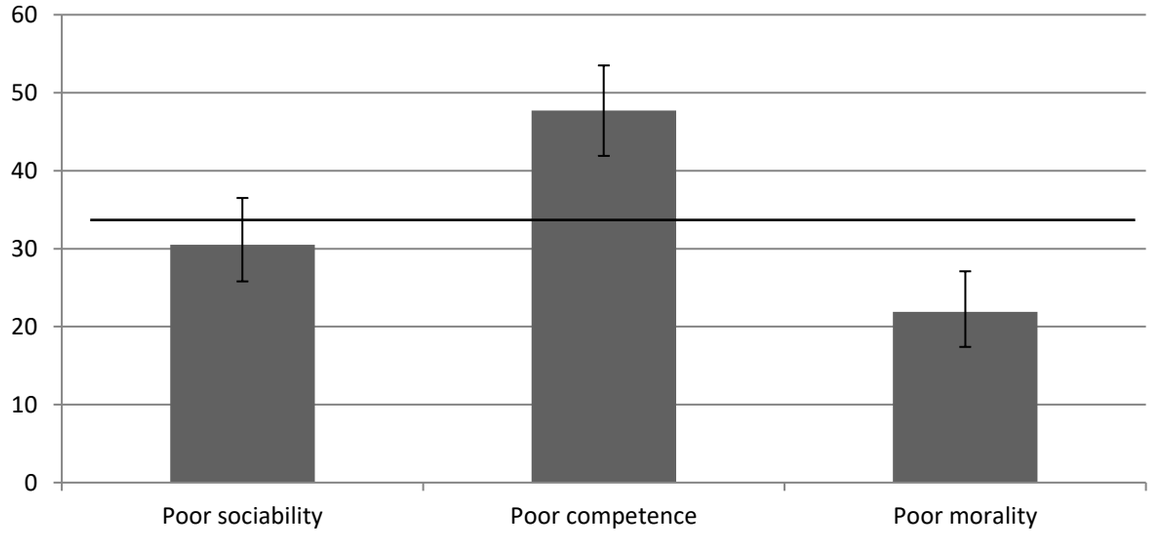
morality was, in both instances, the social evaluation leading to the largest decrease in acceptance, competence and sociability switched positions in the order of magnitude if doctor profiles and reviews were presented simultaneously versus sequentially.

Figure 12. Study 3b: Estimated marginal means for cooperation intention and doctor preference



Note. Flags indicate the 95% confidence interval. *$p < .05$ ***$p < .001$.

Figure 13. Study 3b: Percentage of the total sample who opted for a doctor who was reviewed negatively in terms of sociability, competence, or morality.



Note. The bars add up to 100%. Flags indicate 95% confidence intervals obtained through Agresti-Coull estimation for one-sample proportion intervals. The solid black line marks the expected distribution based on chance, i.e., 33%.

Discussion Studies 3a and 3b

In Studies 3a and 3b we set out to examine the effect of a review in which one of three social aspects (i.e., sociability, competence, or morality) of a foreign-born, foreign-educated doctor was criticised. The goal was to determine whether such a review would deteriorate acceptance, and if so, what type of social evaluation would have the largest impact. From this investigation, support was found for the effectiveness of reviews targeting specific domains of social evaluation, proving that the acceptance of a migrant doctor depends in part on social evaluations of that doctor. Reviews targeting the morality and sociability appeared to have the largest effect on acceptance.

Study 3a supported the hypothesis that providing a foreign-born, foreign educated doctor with a patient review criticising either his sociability, competence, or morality, decreased acceptance of that doctor, compared to a condition were the doctor was not given a review (Hypothesis 5). Importantly, this statistically significant effect was found using a fully between-participants design, in which participants saw just one doctor profile accompanied by a review. This means that a review targeting social evaluations in the domain of sociability, competence, or morality can effectively influence patients' acceptance of a doctor, even when that doctor cannot be directly compared to another doctor. This also supports the theory that competence, sociability, and morality dimensions of social evaluation all play a role in patients' stance towards doctors, which is in line with medical literature that plots aspects of the medical profession approximately along those dimensions (e.g., Draper & Louw, 2007; Hillen et al., 2013; Tsai et al., 2007).

Study 3a provides no evidence that patients value social evaluations of a doctor's competence, sociability, or morality stronger than the others, when it comes to doctor acceptance. It may surprise some readers that patients apparently find it just as objectionable to be treated by an unfriendly doctor as they find it to be treated by an incompetent or even an immoral doctor. We should consider, however, that this was in a between-participants design, where participants saw only one doctor profile, accompanied by a review, making comparison difficult.

To address this, Study 3b utilised a design in which participants saw three similar doctor profiles, each accompanied by a review targeting a different social domain. As has been argued in the discussion of Studies 1a and 1b, presenting several doctor profiles to participants at once should allow them to make more accurate judgments. Indeed we found that, this time, and in contrast to Study 3a, when participants viewed three different doctor profiles that were accompanied by reviews, they attached more weight to some social domains than to others. Specifically, participants who read that a doctor had poor morals were less accepting of that doctor than they were of doctors who were described as incompetent or unsociable. Participants were, accordingly, least likely to pick a doctor who had been described as immoral as their next GP. For sociability and competence, the two measures conflicted: if rated in succession, participants were more accepting of an unsociable doctor than an incompetent one, but if they were asked to make a pick, they less often picked the unsociable doctor. The relative dismissal of an unsociable or immoral

doctor, compared to an incompetent one, points to the importance of social evaluations of morality when deciding whether or not to accept a migrant doctor as one's doctor. This agrees with research arguing that perceived morality, rather than competence, is the most important predictor of people's approach behaviour towards a group or company (Ellemers, 2017; Ellmers & de Gilder, 2022).

One might argue that the negative effect of the reviews on doctor acceptance could have been due to overall negative valence associated with the review, rather than the effect of lowered social evaluations in the domain specifically targeted by the review. To control for this possibility, we included in each review two positive comments (e.g., about the doctor's sociability and competence) and one critical comment (e.g., about the doctor's morality), keeping the overall valence of the review positive. Manipulation checks, performed in Studies 3a and 3b, revealed that the reviews indeed only affected the targeted social evaluation domains, and not the evaluations of the non-targeted domains. Another potential issue with the study design concerns the possibility that reviews targeting social domains only affected the social evaluations of participants if they perceived the doctor described in the profile to belong to a different group than oneself. To account for this possibility, only participants native to the Netherlands (Study 3a) or the UK (Study 3b) who self-identified as "white" were recruited, while the doctor described in the profile differed from the participants both in terms of nationality and in terms of ethnicity. As an additional check, Study 3a included a measure of entitativity, or the perceived belongingness to the same group as the doctor described in the profile. While entitativity was indeed positively related to acceptance measures, it did not interact with the experimental condition, indicating that the review had an effect on acceptance regardless of the level of perceived similarity with the doctor. Finally, Study 3b included a between-participants condition in which the source of the review was varied: some participants read that the review came from another patient, while others read that the review came from colleague doctor of the doctor described in the profile. No effect of review source was found, indicating that reviews targeting social domains had an effect on social evaluations and doctor acceptance regardless of whether the review came from another patient or from a doctor.

Migrant Doctor, Local Education: General Discussion

In this investigation we set out to elucidate how migrant doctors are perceived by potential patients in the country to which they immigrated. We did this in order to understand better what medical institutions and migrant doctors themselves can do in order to become more accepted – and, by extension, integrated into the labour market of their host country. While medical institutions in Western countries recognise the need to subjugate migrant doctors to entry examinations and re-schooling, in order to prepare them for local norms and practices, the effects of receiving a local education on patients' acceptance are little understood. The goal of the current paper was, therefore, to open the "black box" containing the social evaluations that patients make of their doctors, after receiving an education in the country of arrival. To that end, we investigated the following

two research questions in conjunction: How do a doctor's place of birth and place of education affect a patient's social evaluations of that doctor (in terms of competence, sociability, and morality), and, consequently, how do interventions targeting these social evaluations lead to improved acceptance of migrant doctors?

We find that how a doctor is perceived by patients depends on a combination of their birthplace, place of education, and additional information provided about that doctor's competence, sociability, and morality. First, we show that the extent to which a doctor is accepted by prospective patients depends on where the doctor was born, but also on where they were educated: receiving a local education improved acceptance. We also find that doctors who are educated in the host country are perceived to be more competent, yet less sociable, than foreign-educated doctors. Despite these slightly different social evaluations, however, doctors are generally perceived to be highly competent, social, and moral. While it is difficult to improve patients' evaluations on these domains even further, achieving the opposite is easy. If prospective patients perceive any signal that a migrant doctor may lack in either sociability, competence, or morality – e.g. through a critical review left by another patient – their acceptance of that doctor drops. Questionable morality, more so than competence or sociability, is most detrimental for patients' acceptance of a migrant doctor. This makes the position of migrant doctors precarious: although they benefit from receiving a local education, in terms of patients' social evaluations and acceptance, any signal that they might lack in the domain of sociability, competence, or, especially, morality, can make that acceptance go away. As a well-known Dutch proverb would have it: *Acceptance comes with a slow strut, but flees the scene galloping.*[gg]

By providing this somewhat complicated answer, we move beyond finger-pointing to demographic-level variables, such as birthplace or ethnicity, as causes for the poor reception of migrant doctors, and instead highlight the process of acceptance over which institutions and doctors have a certain degree of agency. The first contribution of the current investigation is that, in line with the hypotheses, the place where a doctor was educated impacted the social evaluations of that doctor as well as the extent to which they were accepted, by participants who put themselves in the role of patients. This effect of doctor place of education occurred mostly independently from the effect of doctor birthplace, indicating that prospective patients take more than just a migrant doctor's birthplace into account when deciding to accept that doctor. This may seem like an open door, but, apart from a few exceptions, whether or not a migrant doctor was educated in the same country or in a different country than their patients, has hardly ever been considered in research studying the response of host society's natives towards migrant doctors (but see Louis et al., 2010; Owusu & Sweetman, 2015). The finding that location of education matters adds an important qualification to the question of what it means to be an immigrant, as it points to the fact that although all immigrants were born abroad, not all were raised there, and that this impacts people's acceptance of them. Doctor birthplace and their place of education both contribute towards the way they were perceived by their prospective patients.

[gg] *Vertrouwen komt te voet en gaat te paard.* Lit.: Trust comes on foot and leaves on horseback.

In addition to improving acceptance, having a local place of birth and a local place of education both also influenced the social evaluations that migrant doctors received from prospective patients. Regardless of where they were born, doctors educated in the destination country (in this case: the UK) were rated as more competent than doctors educated abroad at similarly reputable universities. Doctors who were born abroad, however, were evaluated to be more sociable – but not if they were educated in the UK. This adds a layer to the discussion about how groups of immigrants are perceived in terms of fundamental dimensions of social evaluation (e.g., Abele et al., 2021; Fiske et al., 2002; Leach et al., 2007). Whereas previous research has pointed out that immigrants are often perceived to be less competent but warmer than natives, the current results implicate that this observation may need to be attenuated. Immigrants who were educated in the host country are, in fact, evaluated to be more competent than immigrants who were educated in their country of birth, while they are also evaluated to be less sociable. This is an indication that well-known stereotypes about immigrants decrease or even disappear if place of education is taken into consideration.

The second major contribution of the current investigation was that the social evaluations – which were found to differ between doctors of different place of birth and place of education – could also be experimentally manipulated, and that this affected the level of acceptance displayed by participants towards migrant doctors. The extent to which these social evaluations could be manipulated depended on whether the target was praised or criticised. While reviews praising specific social evaluation domains (i.e., competence, morality, or sociability) bore little to no effect, reviews *criticising* those domains significantly impacted doctor acceptance. This may have been due to a ceiling effect – the doctors presented in the profiles were already perceived to be highly sociable, competent, and moral, making further elevation difficult. Another explanation for this finding is that when people form impressions of others, negative information tends to weigh more heavily than positive information (Nicolas et al., 2022; Rozin & Royzman, 2001). That also fits with a recent paper finding no positive effect of signalling warmth on the CVs of immigrants on call-back rates (although signalling competence did yield a small positive effect, Veit et al., 2021). It may explain why the reviews in which one social domain was criticised led to a decrease in acceptance, despite the fact that the review also contained positive remarks about the other two domains. While our manipulation checks indicated that the review was successful at affecting only the targeted domain, and not the others, the combination of positive and critical remarks contained within the review may still have led to an overall negative evaluation of the doctor. The current investigation confirms that, when it comes to accepting migrant doctors, negative social evaluations have a larger impact than positive evaluations.

Which specific social domain was targeted also mattered: the largest decrease in acceptance was found for reviews targeting the doctor's morality, followed by reviews targeting sociability or competence. This agrees with earlier findings in social psychology that people respond more strongly to negative information about a prospective group member's morality than about their competence (van der Lee et al., 2017). An emerging

consensus within the field of social psychology states that any human evaluation – be it of oneself, someone else, or of a group of people – can be measured along two or three central dimensions, such as competence, sociability, and morality (Abele et al., 2021; Leach et al., 2007). The priority of the one dimension over the other has long been debated, as has their relationship. Evaluations about sociability and morality are currently agreed to weigh the heaviest when it comes to impression formation of an unknown person, and the resulting willingness to approach that person. The question was whether this would also hold true for prospective patients and doctors – a patient's health depends, after all, not just on the warmth of the doctor, but also their medical competence. The findings of the current investigation support the notion that evaluations about a doctor's sociability and morality weigh just as heavy as evaluations of their competence. This is in line with much medical research, which does not use the labels competence, sociability, and morality to define professional values, but nevertheless identified components that appear to fit well with such a categorisation (e.g., care vs. cure, Lagro-Janssen & van den Muijsenbergh, 2007; Tsai et al., 2007; competent vs. 'human', Draper & Louw, 2007; maintaining confidentiality and being truthful, Roland et al., 2011). The current investigation shows that evaluations of migrant doctors' sociability, morality, and competence together shape prospective patients' acceptance.

One factor that was not foreseen, but appeared to moderate the effect of a doctor's birthplace and place of education on patient acceptance, was whether or not patients had the opportunity to compare several doctors before evaluating them. In a setting where participants saw only one doctor profile, in the absence of reference profiles, participants did not indicate a stronger acceptance of locally trained doctors over doctors who were trained abroad. When participants saw several profiles in succession, however, they started to indicate slightly yet significantly higher preferences for locally educated doctor. The effect was largest when the four profiles were displayed simultaneously to the participant, and they were required to indicate which doctor they would actually like to pick as their next GP. In such a "forced choice" scenario, participants picked locally educated doctors much more often than foreign-educated doctors. In the past, some methodological considerations have been put forward for why a simultaneous comparison would lead to the most accurate measurement (Atzmüller & Steiner, 2010; Su & Steiner, 2020). Another consideration is that participants had the intention to treat doctors equally, but that this intention was overcome in the scenario where participants were forced to pick one doctor out of four viable candidates. Under these forced-choice conditions, small differences in personal preference may have been amplified to lead to an unequally distributed choice pick by participants. By investigating doctor acceptance in these three different settings – in which a comparison between doctors was increasingly easy to make – we account for the possibility that the ease with which a comparison could be made, as well as the forced nature of some choices in real life, can lead to different outcomes. Our findings indicate that where a doctor was educated only affects prospective patients' acceptance in settings where they are allowed to

compare several doctors – and that this effect becomes strongest when the prospective patient is forced to make a decision between them.

Limitations and practical applicability. The current investigation has a number of strengths and weaknesses that affect its applicability of its findings to theory and practice. Starting with a strength, the current investigation employed five conceptually similar studies, differing on details, to investigate its main research questions. This approach allowed us to examine, first of all, under which conditions the effect of doctor place of education on patient acceptance would replicate. This pointed us to the importance of ease of comparability between different doctors, but it also allowed us to rule out other potential moderators, such as the effect that entitativity (i.e., perceived shared group membership between doctor and patient) or review source (i.e., a patient or a doctor) might have on the effectiveness of the doctor review employed in our studies.

Second, by including multiple experimental studies, we were able to determine the causal relationships between the different constructs under consideration: doctor place of birth and place of education, social evaluations (i.e., sociability, competence, and morality) and acceptance. The hypothetical relationship between these constructs is displayed in Figure 1. The five studies together test all the hypothesised relationships presented in the model, and, thanks to the experimental design of each study, these relationships were proven to exist not just as correlations, but causally. This allows us to conclude that receiving a local education does really lead to more acceptance, and that lowered social evaluations do really lead to lowered acceptance, instead of just being correlated with it. A weakness to this approach, however, is that the hypothesised pathways were never tested simultaneously. In other words, although we know that a doctor's place of education affects social evaluations, and social evaluations affect acceptance, we do not know the weights of these effects relative to each other. We found, for example, that locally educated doctors were evaluated to be less sociable than foreign-educated doctors, and we also found that lower perceived sociability led to lower acceptance. This summation of results might suggest that doctors who received local education would be accepted to a lesser extent than doctors who were educated abroad, but that is contradicted by the evidence. Perhaps the negative effect of being perceived as less sociable is offset by the positive effect of also being perceived as more competent, but since the relative weights of these effects are unknown, we cannot say whether this is indeed the case.

Another design aspect that could be considered as either a strength or a limitation, is how the concept of acceptance was measured between the different studies. We borrowed the acceptance concept from a definition of integration as "the process of becoming an accepted part of society" (Penninx & Garcés-Mascareñas, 2016). How acceptance should be measured was explicitly left open by the authors of this definition, so that researchers could study integration at different levels of society, such as the organisational or the personal. We selected a range of measures that we thought would be relevant for the patient—doctor setting, which represent the process of acceptance. An advantage of this approach is that the effects of doctor birthplace and place of education is measured on a range of outcomes,

such as trust, the willingness to follow advice, and the behavioural choice pick for one doctor over another. A weakness is that, since we also varied the measurement instruments slightly between studies, the study results become more difficult to compare. In Study 1a, for example, we found some support for our hypotheses, which were not replicated in Study 1b. This may be due, in part, to the different measurement instruments used in Study 1b compared to 1a.

Keeping in mind the various strengths and weaknesses of the current investigation's study design, we can make an estimation of how our results would translate to practice. Medical institutions that recruit foreign-born doctors assess and sometimes re-school these doctors in order to prepare them for their entry into the local labour market. The problem is, however, that migrant doctors continue to experience difficulties even after certification or re-schooling (Jalal et al., 2019; Leyerzapf et al., 2015; Shen et al., 2018). The current investigation sheds new light on what institutions and doctors can do to influence the process of acceptance that constitutes their integration into the new work environment. Starting with institutions, they should be aware that their efforts to re-school migrant doctors, as they enter the country, pay off: patients will, on average, be more inclined to accept a migrant doctor if that doctor was educated in the host country. This is good news, since higher social acceptance of newcomers (in our case: doctors with a foreign background) has been found to correlate with positive work-related outcomes such as better job performance, greater job satisfaction, and lower turnover (Bauer et al., 2007).

There are, however, also some boundary conditions to this positive 'locality of education' effect. We found that receiving a local education mainly boosted perceptions of the doctor's competence, while perceptions of competence were in turn least likely to affect doctor acceptance. Communicating that the education has a focus on sociability and morality may therefore have an even better effect at improving immigrated doctors' acceptance rates. In addition, in situations where prospective patients cannot make an easy comparison between different doctors, their default behaviour is to accept doctors, regardless of the doctor's birthplace or place of education. This suggests that a problem only occurs when patients are confronted with more than one doctors, after which the doctor's birthplace suddenly becomes a factor of importance. Our study results suggest that in those situations doctors would do well to emphasise their local experience.

With regard to the mechanism driving the process of acceptance, the current investigation examined three social domains on which people are commonly evaluated: sociability, competence, and morality. The good news is that doctors, regardless of birthplace or place of education, are evaluated highly on those three domains, although small difference exist between doctors educated abroad versus locally. More important is the finding that although these evaluations are difficult to improve even further, they can easily suffer from signals that a doctor might be wanting in any of those three domains. Especially violations of the expectation that a doctor is moral resulted in a decrease in acceptance, suggesting that it is important to educate migrant doctors, not just in the right skills, but also in the morals of the host country. A limitation to this finding is that we only

investigated the effect of criticism for migrant doctors, so that we do not know if the same process also applies to non-migrant doctors.

In conclusion, though the road leading to full integration may be long, there are some practical things that medical institutions and migrant doctors can do to become more accepted by patients, and, by extension, more integrated into their destination country. The current investigation identified receiving education in the destination country to be one of those things, and furthermore points out that morality and sociability, besides competence, are domains that migrant doctors should be mindful of, not to disregard in front of their patients.

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Appendix to Chapter 5

Appendix A:

Study 1a principal component analysis

In order to evaluate the factor structure underlying the 18 trust items at T1 through T4 simultaneously, we first summed each trust item across the four time points and then conducted principal component analysis on the resulting sum scores. This yielded a two-factor solution (oblique rotation), with factor 1 containing 15 positively phrased items and factor 2 containing three negatively phrased items (after reverse-coding).[hh] We decided that a one-factor solution better fitted the exposed pattern, in line with Hillen et al. (2013), interpreting this factor to reflect a sense of general trust toward the doctor under revision. Sum scores were created at each time point by adding all items and dividing by 18.[ii] The scales so created proved to be a reliable measure of general trust, α_{T1} = .948, α_{T2} = .931, α_{T3} = .947, α_{T4} = .944. The four sub-components of trust could not be discovered in our data, even after different attempts to exclude certain items from the scale that might disturb the expected factor structure (like the three negatively phrased items).

Study 1a multivariate outliers

In Study 1a, we found ten multivariate outliers, indicated by Mahalanobis scores that exceeded a certain cut-off score. Upon inspecting these participants' responses, we found that they had a higher preference for a UK-born, educated abroad doctor than the average sample, and were also more inclined to seek second-opinion for the foreign-born, UK-educated doctor. Since we do not know how to interpret these deviations, and had not included any criteria regarding individual response patterns in our ad-ante exclusion criteria, we decided not to exclude these participants. In addition to the multivariate outliers, Levene's test for homogeneity of error variances revealed that the error variance of some of our dependent variables was not equal across groups; specifically the error variance of *trust* differed between the two UK-born doctors, and the error variance of *second-opinion seeking* differed between doctor profiles 1, 3, and 4.

Appendix B: Study 1a, 1b, 2, 3a, and 3b Doctor profiles and reviews

Study 1ab doctor profiles

Version A

UK/UK_A

Hello, my name is Thomas. I was born in the UK. I studied medicine at St George's University of London, where I lived for five years before graduating. It has always been my dream to become a doctor. It is hard work, but very rewarding. To set my mind off of work during the weekend, I like to play football, listen to classical music, and read light novels.
Name: Thomas Smith

[hh] Factor 1 (15 positively phrased items): eigenvalue = 12.1, explained variance = 67.3%; Factor 2 (three negatively phrased items): eigenvalue = 1.5, explained variance = 8.4%.
[ii] Due to a technical error one item was missing at T1. For this item, trust scores were calculated by adding the 17 remaining items and dividing by 17.

Chapter 5 – Migrant doctor, local education

Age: 28
Nationality: British
Education: Completed medical school at St George's University of London
Experience: Two years of foundational training in hospitals and general practices located in the UK
Language(s): English (native)
Hobby: Football, listening to classical music, reading light novels

UK/For_A

Hello, my name is Matthew. I'm from the UK. I studied medicine at JSS Academy of Higher Education and Research in Mysore, India, where I lived for five years before graduating. Ever since I was young I wanted to be a doctor. It is hard work, but very rewarding. To set my mind off of work during the weekend, I like to play tennis, listen to jazz music, and read whodunits.
Name: Matthew Taylor
Age: 29
Nationality: British
Education: Completed medical school at JSS Academy of Higher Education and Research in Mysore, India
Experience: Two years of foundational training in hospitals and general practices located in the UK
Language(s): English (native)
Hobby: Tennis, listening to jazz, reading whodunits

For/UK_A

Nice to meet you, my name is Oliver. I was born in Australia. I've lived in Cambridge for five years, where I did my studies in medicine at Anglia Ruskin University. I am passionate about being a doctor. It is tough but pleasant work. On the weekend, I like to go rowing, listen to blues music, and do wood carving.
Name: Oliver Wilson
Age: 28
Nationality: Australian
Education: Completed medical school at Anglia Ruskin University, Cambridge
Experience: Two years of foundational training in hospitals and general practices located in the UK
Language(s): English (native)
Hobby: Rowing, listening to blues, wood carving

For/For_A

Hello I'm João, pleased to meet you. I'm from Portugal. I lived in Porto while studying medicine at Porto University for five years. I grew up as a kid dreaming to become a doctor. The work can be difficult at times, but it is worth it. To relax, I like to go sailing, play the violin, and go bird watching on the weekends.
Name: João Silva
Age: 29
Nationality: Portuguese
Education: Completed medical school at University of Porto, Portugal

Experience: Two years of foundational training in hospitals and general practices located in the UK
Language(s): Portuguese (native), English (fluent)
Hobby: Sailing, playing the violin, bird watching

Version B

UK/UK_B

Hello, I'm Daniel. I was born in the UK. I studied medicine at Queen's University in Belfast, where I lived for five years before graduating. It has always been my dream to become a doctor. It is hard work, but very rewarding. To get my mind off work during the weekend, I like to play volleyball, listen to rock music, and do some gardening.
Name: Daniel Jones
Age: 28
Nationality: British
Education: Completed medical school at Queen's University Belfast
Experience: Four years of foundational training in hospitals and general practices located in the UK
Language(s): English (native)
Hobby: Volleyball, listening to rock, gardening

UK/For_B

Hi, my name is Joshua. I'm from the UK. I lived in Spain while studying medicine at the University of Barcelona for five years. Ever since I was young I wanted to be a doctor. It is hard work, but very rewarding. To get my mind off work during the weekend, I like to play golf, play the saxophone, and sculpt clay figures.
Name: Joshua Brown
Age: 28
Nationality: British
Education: Completed medical school at the University of Barcelona, Spain
Experience: Four years of foundational training in hospitals and general practices located in the UK
Language(s): English (native)
Hobby: Golf, playing the saxophone, sculpting

For/UK_B

Hi there, my name is Abdul. I was born in Pakistan. I lived in Newcastle upon Tyne for five years, where I did my studies in medicine at Newcastle University. I am passionate about being a doctor. It is tough but pleasant work. On the weekend, I like to do judo, listen to opera music, and read magazines.
Name: Abdul ben Habib
Age: 29
Nationality: Pakistani
Education: Completed medical school at Newcastle University, Newcastle upon Tyne
Experience: Four years of foundational training in hospitals and general practices located in the UK
Language(s): Urdu (native) English (fluent)

Chapter 5 – Migrant doctor, local education

Hobby: Judo, listening to operas, reading magazines

For/For_B

Hello I'm Michael, pleased to meet you. I'm from the United States. I lived in Miami while studying medicine at Miami University for five years. I grew up as a kid dreaming to become a doctor. The work can be difficult at times, but it is worth it. To relax, I like to play baseball, listen to R&B music, and write some poetry on the weekends.
Name: Michael Miller
Age: 29
Nationality: Northern American (United States)
Education: Completed medical school at Miami University, USA
Experience: Four years of foundational training in hospitals and general practices located in the UK
Language(s): English (native)
Hobby: Baseball, listening to R&B, writing poetry

Version C

UK/UK_C

Hello, I'm Jack. I was born in the UK. I studied medicine at Cardiff University, where I lived for five years before graduating. It has always been my dream to become a doctor. It is hard work, but very rewarding. To get my mind off work during the weekend, I like to do short-track running, play the guitar, and listen to the radio.
Name: Jack Williams
Age: 29
Nationality: British
Education: Completed medical school at Cardiff University
Experience: Four years of foundational training in hospitals and general practices located in the UK
Language(s): English (native)
Hobby: Short-track running, playing guitar, listening to the radio

UK/For_C

Hi, my name is James. I'm from the UK. I studied medicine at the University of Otago, New Zealand, where I lived for five years before graduating. Ever since I was young I wanted to be a doctor. It is hard work, but very rewarding. To get my mind off work during the weekend, I like to go swimming, listen to pop music, and make landscape paintings.
Name: James Davies
Age: 29
Nationality: British
Education: Completed medical school at the University of Otago, New Zealand
Experience: Four years of foundational training in hospitals and general practices located in the UK
Language(s): English (native)
Hobby: Swimming, listening to pop music, landscape painting

For/UK_C

Hi there, my name is Francesco. I was born in Italy. I lived in Leeds for five years, where I did my studies in medicine at the University of Leeds. I am passionate about being a doctor. It is tough but pleasant work. On the weekend, I like to do some badminton, play the piano, and write short stories.
Name: Francesco Rossi
Age: 28
Nationality: Italian
Education: Completed medical school at the University of Leeds
Experience: Four years of foundational training in hospitals and general practices located in the UK
Language(s): Italian (native) English (fluent)
Hobby: Badminton, playing piano, writing short stories

For/For_C

Hello I'm Jayson, pleased to meet you. I'm from the Philippines. I lived in Manila while studying medicine at the University of the Philippines for five years. I grew up as a kid dreaming to become a doctor. The work can be difficult at times, but it is worth it. To relax, I like to play water polo, listen to rock 'n roll music, and read science fiction novels.
Name: Jayson Santos
Age: 28
Nationality: Filipino
Education: Completed medical school at the University of the Philippines
Experience: Four years of foundational training in hospitals and general practices located in the UK
Language(s): Filipino (native), English (fluent)
Hobby: Water polo, listening to rock 'n roll, reading science fiction

Study 2 reviews

Positive review condition Version A: Sociability (keywords: warm, friendly, likeable)

I am happy with having doctor Silva as my GP. Whenever I consult him, he always treats me very warmly. I recall one specific occasion when I came to doctor Silva with a physical complaint, which he treated in a friendly manner. Overall, I'd say that João Silva is a likeable doctor.

Positive review condition Version B: Competence (keywords: intelligent, skilful, competent)

I am happy with having doctor Silva as my GP. Whenever I consult him, he always treats me very intelligently. I recall one specific occasion when I came to doctor Silva with a physical complaint, which he treated in a skilful manner. Overall, I'd say that João Silva is a competent doctor.

Positive review condition Version C: Morality (keywords: honest, sincere, trustworthy)

I am happy with having doctor Silva as my GP. Whenever I consult him, he always treats me very honestly. I recall one specific occasion when I came to doctor Silva with a physical complaint, which he treated in a sincere manner. Overall, I'd say that João Silva is a trustworthy doctor.

Study 3a doctor profile

Welkom bij onze huisartspraktijk, wij hebben een nieuwe collega die zich graag aan u voorstelt.
“Hoi, ik ben Amir Al Salihi, leuk om kennis te maken. Ik ben afkomstig uit Syrië waar ik vijf jaar geneeskunde heb gestudeerd aan de Universiteit van Damascus. Ik heb er altijd al van gedroomd om arts te worden. Na mijn vlucht uit Syrië heb ik twee jaar bijscholing ontvangen en ben ik daarna geaccrediteerd (officieel aangesteld) als Nederlandse arts. De werkzaamheden van een arts kunnen soms uitdagend zijn, maar het geeft mij veel voldoening. Ter ontspanning ga ik graag zeilen, viool spelen of tuinieren in het weekend.”

Naam: Amir Al Salihi
Leeftijd: 35
Nationaliteit: Syrisch
Educatie: Gestudeerd aan Universiteit van Damascus, Syrië
Ervaring: Vier jaar gewerkt als basisarts in ziekenhuizen en huisartsenpraktijken in Nederland.
Taal: Arabisch (moedertaal), Nederlands (vloeiend)
Hobby’s: Zeilen, viool spelen, tuinieren

Study 3a reviews

Negative review condition Version A (incompetence)

Een van Amir Al Salihi’s patiënten schrijft over hem:
“Ik ben overwegend blij met mijn arts Amir Al Salihi. Wanneer ik hem ontmoet, behandelt hij mij eerlijk. Ik herinner mij wel een specifiek geval dat ik naar Amir toe ging met een fysieke klacht en hij mij incompetent behandelde. Over het algemeen vind ik Amir een vriendelijke arts.”

Negative review condition Version B (immorality)

Een van Amir Al Salihi’s patiënten schrijft over hem:

“Ik ben overwegend blij met mijn arts Amir Al Salihi. Wanneer ik hem ontmoet, behandelt hij mij vriendelijk. Ik herinner mij wel een specifiek geval dat ik naar Amir toe ging met een fysieke klacht en hij mij oneerlijk behandelde. Over het algemeen vind ik Amir een competente arts.”

Negative review condition Version C (unsociability)

Een van Amir Al Salihi’s patiënten schrijft over hem:

“Ik ben overwegend blij met mijn arts Amir Al Salihi. Wanneer ik hem ontmoet, behandelt hij mij competent. Ik herinner me een specifiek geval dat ik naar Amir toe ging met een fysieke klacht en hij mij onvriendelijk behandelde. Over het algemeen vind ik Amir een eerlijke arts.”

Study 3b doctor profiles

Version A

Hello, I’m Muhammad. I was born in India. I studied medicine at JSS Academy of Higher Education and Research in Mysore, India. It has always been my dream to become a doctor. It is hard work, but very rewarding. To get my mind off work during the weekend, I like to do short-track running, play the guitar, and listen to the radio.

Name: Muhammad Kumar
Age: 29
Nationality: Indian
Education: Completed medical school at JSS Academy of Higher Education and Research in Mysore, India
Experience: Four years of foundational training in hospitals and general practices located in the UK
Languages: Indian (native), English (fluent)
Hobby: Short-track running, playing guitar, listening to the radio

Version B

Hi there, my name is Shivansh. I was born in India. I studied medicine at JSS Academy of Higher Education and Research in Mysore, India. I am passionate about being a doctor. It is tough but pleasant work. On the weekend, I like to do some badminton, play the piano, and write short stories.

Name: Shivansh Sharma
Age: 29
Nationality: Indian
Education: Completed medical school at JSS Academy of Higher Education and Research in Mysore, India
Experience: Four years of foundational training in hospitals and general practices located in the UK
Languages: Indian (native), English (fluent)
Hobby: Badminton, playing piano, writing short stories

Version C

Hi, my name is Advik. I was born in India. I studied medicine at JSS Academy of Higher Education and Research in Mysore, India. Ever since I was young I wanted to be a doctor. To relax, I like to play golf, play the saxophone, and sculpt clay figures.

Name: Advik Ramesh
Age: 29
Nationality: Indian
Education: Completed medical school at JSS Academy of Higher Education and Research in Mysore, India
Experience: Four years of foundational training in hospitals and general practices located in the UK
Languages: Indian (native), English (fluent)
Hobby: Golf, playing the saxophone, sculpting

Study 3b reviews

Peer condition (A)

Version A-1: 2 positive aspects (sociability & competence) 1 negative aspect (morality)

I am happy with having doctor *[Name GP]* as my GP. Whenever I consult him, he always treats me very warmly and he is always friendly towards me. Next to that, he always treats me very intelligently.

I can recall one specific occasion when I came to doctor Silva with a physical complaint, which he treated in a skilful manner. However, he doesn't always treat me very honestly. I remember one time when I also came to doctor Silva with a physical complaint, which he treated in an insincere manner.

Version A-2: 2 positive aspects (sociability & morality) 1 negative aspect (competence)

I am happy with having doctor *[Name GP]* as my GP. Whenever I consult him, he always treats me very warmly and he is always friendly towards me. Next to that, he always treats me very honestly. I recall one specific occasion when I came to doctor Silva with a physical complaint, which he treated in a sincere manner. However, he doesn't always treat me very intelligently. I remember one time when I also came to doctor Silva with a physical complaint, which he treated in a not so skilful manner.

Version A-3: 2 positive aspects (competence & morality) 1 negative aspect (sociability)

I am happy with having doctor *[Name GP]* as my GP. Whenever I consult him, he always treats me intelligently. I recall one specific occasion when I came to doctor Silva with a physical complaint, which he treated in a skilful manner. Next to that, he always treats me very honestly. I remember one specific occasion when I came to doctor Silva with a physical complaint, which he treated in a sincere manner. However, he doesn't always treat me very warmly. I recall one time when I also came to doctor Silva with a physical complaint, which he treated in an unfriendly manner.

Expert condition (B)

Version B-1: 2 positive aspects (sociability & competence) 1 negative aspect (morality)

Hi, I'm doctor Brown and have 20 years of experience working as a GP. I am happy with having doctor *[Name GP]* as my colleague. During consults, he always treats his patients very warmly and he is always friendly towards them. Next to that, he always treats his patients very intelligently. I can recall one specific occasion when a patient came to doctor Silva with a health related question, which he treated in a skilful manner. However, he doesn't always treat his patients very honestly. I remember another time when a patient came to doctor Silva with a health related question, which he treated in an insincere manner.

Version B-2 : 2 positive aspects (sociability & morality) 1 negative aspect (competence)

Hi, I'm doctor Brown and have 20 years of experience working as a GP. I am happy with having doctor *[Name GP]* as my colleague. During consults, he always treats his patients very warmly and he is always friendly towards them. Next to that, he always treats his patients very honestly. I recall one specific occasion when a patient came to doctor Silva with a health related question, which he treated in a sincere manner. However, he doesn't always treat his patients very intelligently. I remember another time when a patient came to doctor Silva with a health related question, which he treated in a not so skilful manner.

Version B-3: 2 positive aspects (competence & morality) 1 negative aspect (sociability)

Hi, I'm doctor Brown and have 20 years of experience working as a GP. I am happy with having doctor *[Name GP]* as my colleague. During consults, he always treats his patients very intelligently and he always handles cases skillfully. Next to that, he always treats his patients very honestly. I

recall one specific occasion when a patient came to doctor Silva with a health related question, which he treated sincerely. However, he doesn't always treat his patients very warmly. I remember another time when I also came to doctor Silva with a health related question, which he treated in an unfriendly manner.


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Chapter 6

General discussion: Education as a vehicle towards migrant integration?

Findings and Conclusion

In this dissertation, I addressed the question: *What are the institutional-, group-, and individual-level aspects of the process leading to mutual acceptance between migrant doctors and their social surroundings?* The occasion for this question was the observation that, due to immigration, the Netherlands is projected to become more diverse in the future in terms of its citizens' origins (Jennissen et al., 2018). This comes with challenges for migrants, who report not feeling at home in the Netherlands despite scoring well on measures of structural integration such as education and employment (Dagevos et al., 2022). Understanding how migrants integrate into their social and professional surroundings may mitigate this, through revealing the conditions under which migrants and their social surroundings may come to accept each other. Integration is a layered process involving not just institutional-level factors such as organisations' official stance towards migrants, but also group-level and individual-level factors such as how migrants perceive themselves and are perceived by their social surroundings. By combining theory and methods from social history and social psychology, I aimed to explore these three levels in tandem, and thus provide a holistic description of the integration phenomenon.

To narrow the scope, I focused on the group of highly skilled labour migrants known as migrant doctors. Doctors are generally respected professionals (Nicolas et al., 2022), and migrant doctors are actively recruited by many Western countries (Baker, 2019; Negin et al., 2013). Despite these facts, migrant doctors and migrant medical students often face challenges in fitting in with their work environment (Dywili et al., 2012; Jalal et al., 2019; Waldring et al., 2020). In other words, migrant doctors are facing problems with their integration despite their relatively strong position on the labour market compared to other migrants. Studying how migrant doctors integrate into their professional and social surroundings might reveal institutional conditions unique to the medical profession, as well as some of the more "hidden" group-level and individual-level processes behind migrant integration.

First, I showed in two historical studies that certain institutional configurations impacted structural outcomes for migrants in 18th-century Holland. Specifically, cities could implement legislation that made it easier or more difficult for migrants to obtain certain rights, such as the right to obtain citizenship, the right to settle, or the right to receive charity. Cities that were relatively welcoming towards migrants, like Amsterdam and The Hague, attracted more migrants than cities that were relatively closed to migrants, like Haarlem. Another factor that influenced the migration of workers from one city to another was the type of vocation of the migrant, and its associated level of skill, showing that group-level factors (i.e., type of occupation) interacted with institutional-level factors (i.e., city policy) to produce unique migration patterns.

An in-depth investigation of the Amsterdam Surgeons' Guild further revealed how institutional conditions could impact individual career outcomes of migrant surgeons. Specifically, the Amsterdam Surgeons' Guild was welcoming towards migrants who wanted to become an apprentice surgeon or journeyman surgeon. At neither of these stages did the

Amsterdam Surgeons' Guild disadvantage migrants to a great extent, and sometimes even lowered the entry requirements for migrants. This resulted in a large influx of migrant surgeon's apprentices and journeyman surgeons. However, although the guild's entry criteria may not have disadvantaged migrants, other institutional conditions affected migrants' career perspectives within the guild. The Amsterdam Surgeons' Guild placed an emphasis on proper surgical education before being allowed to become a master surgeon – which was the final step on the career ladder within the guild. Migrants were exempt from lessons in Amsterdam if they could prove that they had accrued surgical experience outside Amsterdam. Nevertheless, migrants without experience accrued in Amsterdam were much less likely to meet the strict conditions to become a master surgeon in Amsterdam, which involved passing difficult exams and paying a large sum of money. In other words, the welcoming stance of the guild towards migrants was accompanied by an emphasis on local education, leading to the outcome that migrants had a good chance of making career within the Amsterdam Surgeons' Guild, but only if they also received their training there.

In the two psychological chapters, I zoom in on the importance of education, by exploring the individual- and group-level processes that contribute to the integration of migrant doctors after receiving education in the country of destination. This process includes altered images that migrant doctors develop about themselves as medical professionals, but also altered images that their social surroundings develop about them. First, a survey among medical students in the Netherlands revealed that students with a migration background and students with a native background developed a similar image of the medical profession. Both groups maintained a positive medical stereotype, in terms of their expectations about doctors' competence, morality, and sociability. More specifically, a detailed map of medical students' medical stereotype revealed that there were no differences in how they perceived their medical role models, in what attributes they thought doctors in general would have, in what they thought patients expected from doctors, and in how they perceived themselves in terms of competence, sociability, and morality. This implies that receiving medical education in the Netherlands contributes towards the development of a shared professional medical identity among medical students (although there were some methodological limitations that caution against drawing a firm conclusion in this respect). The only difference found between medical students with a migration background and students with a native background, was that among students with a migration background who also subjectively identified as foreign – as opposed to students with a migration background who subjectively identified as Dutch – a slightly more positive medical stereotype existed. If anything, this points in the direction that medical students with a migration background may compare themselves to slightly higher standards than medical students with a Dutch background, possibly due to a high "burden of expectations" for migrant students (Michalec et al., 2017).

Another finding was that medical students, regardless of their background, felt that they did not live up to the high level of competence that they perceived in other medical professionals, while they did indicate living up to the high standards of sociability and morality. This resonates with the theory that people are generally motivated to protect their

self-image as moral beings, while self-evaluations of competence are more flexible (Ellemers, 2017). Medical students often feel that expectations of them from others are unrealistic for their level of training (Stubbing et al., 2019). Self-stereotyping as similarly moral and sociable as their more senior peers may, in this regard, serve as a strategy for medical students to maintain a positive self image, despite not living up to expectations of competence (Cambon et al., 2015; Steele, 1988). Alternatively, for medical students, self-stereotyping as less competent than their senior peers may also be a recognition of the fact that medical students are yet to become full-fledged doctors, whose level of competence by definition lies above that of a student. In that sense, the high levels of competence associated by medical students with doctors in the Netherlands, in combination with high levels of morality and sociability, might represent an ideal image that medical students receiving medical education in the Netherlands are striving towards.

If receiving medical education in the country of destination (e.g., the Netherlands) contributes towards the professional identity development of migrant doctors (while keeping in mind the methodological limitations that caution against drawing too strong a conclusion in this regard), then how does this affect the image that migrant doctors' social surroundings have of them? When online participants in the UK were asked to imagine having to select a general practitioner as their new doctor, they expressed a preference for doctors who had been educated in the destination country. This implies that receiving medical education in the country of destination is valued by migrant doctors' social surroundings – in this case, people in the role of patients. As an underlying mechanism, we explored participants' evaluations of migrant doctors in terms of competence, morality, and sociability. Doctors who had been educated in the destination country were evaluated as more competent than doctors educated in their country of origin. This suggests that, as in our study among medical students in the Netherlands, UK participants in the role of patients have positive expectations about a migrant doctor's gain in competence resulting from receiving medical education in the country of destination. Among medical students studying in the Netherlands, this expected gain in competence became visible when students compared their own level of competence to that of a full-fledged doctor. Similarly, UK participants in the role of patients believed that migrant doctors would gain competence from receiving education in the destination country. Evaluations about a doctor's morality were unaffected, indicating that patients did not expect the location where a migrant doctor received their education (i.e., in their native country versus in the country of destination) to affect a doctor's moral conduct.

This latter finding did not mean, however, that a doctor's presumed morality or sociability did not matter in the eyes of patients. In general, the ratings of doctors' competence, morality, and sociability were very high. In an attempt to uncover which of these three characteristics was more important for patients' acceptance of migrant doctors, we added contrasting information about the doctor's morality, friendliness, or competence. In a review, supposedly left by another patient, about the doctor in question, participants could read that this doctor was either immoral, unsociable, or incompetent (while two other

attributes were each time kept positive). When patients read such a mixed review about a doctor, their acceptance of that doctor plummeted. This happened most sharply, however, when the negative information presented in the review was about the doctor's morality. This is a strong indication that if positive expectations about a doctor's competence, sociability, or – especially – their morality are violated by contrasting information, patients will be less likely to accept their migrant doctor. In conclusion, receiving medical education in the destination country leads to higher acceptance of migrant doctors by the local social surroundings, through higher expectations about the doctor's competence. However, appearing moral and sociable remains important for migrant doctors as well, as signals that a doctor is immoral or unsociable can seriously harm their acceptance.

Conclusion. If we combine these separate findings, the following conclusion in response to this dissertation's research question can be drawn:

1. The process leading to mutual acceptance between migrant doctors and their social surroundings starts with educational institutions. The official conditions of entry that medical educational institutions impose on migrant doctors have affected in the past, and are likely still affecting, the ease with which migrants may gain access to the educational system and, ultimately, the labour market of the destination country. Through setting the conditions for entry, institutions thus play an important part in the selection process determining which migrant doctors get to have a chance at integrating.

2. Gaining access to an educational institution in the country of destination is the first step towards achieving mutual acceptance between migrant doctors and their social surroundings. The second step is mutual investment by the migrant and the institution, over a sustained period of time, in the education of the migrant doctor. Through sustained and repeated interactions between the migrant and their peers and educators, migrant doctors learn the norms and practices of the local setting, and become socialised into the medical system that is specific to the country of destination.

3. The socialisation process, instigated by the education of the migrant doctor in the country of destination, affects psychological processes occurring at the level of the individual and the group through two routes. Route a: Medical students receiving education in the Netherlands develop a professional identity that is particular to the country of destination, as expressed by the existence of a shared 'medical stereotype' among students. This medical stereotype represents an ideal image of the kind of doctor that medical students wish to become: a highly competent, moral, and sociable professional. Route b: Migrant doctors' social environment – e.g., patients – also recognise this professional identity, by indicating that migrant doctors who have received education in the destination country are competent, sociable, and moral. This recognition of migrant doctors comes in spite of the fact that less positive stereotypes exist about migrants in general.

4. The socialisation of new doctors thus appears to be bound by location. That is: it matters for migrant doctors whether they have received their medical education in their country of origin or in the country of destination. Medical practice differs per country, making it likely that doctors develop a professional identity that is attuned to the local

norms and practices of the country in which they received their education. This fact is, in turn, recognised by the social environment, which is more likely to rate a migrant doctor as competent, and more willing to accept a migrant doctor, if they have received education in the destination country. These positive judgments are, however, conditional on the fact that no contradicting information about a migrant doctor's incompetence, immorality, or unsociability is provided.

In other words, the integration of migrant doctors is promoted by receiving medical education in the country of destination. Institutional openness towards migrants, the development of a positive group-level medical stereotype and professional identity among migrant doctors, and personal acceptance by patients due to improved judgments of a doctor's competence, are the institutional-, group-, and individual level factors that drive this process of integration.

Contribution of This Dissertation – Benefits of the Transdisciplinary Approach

This dissertation attempted to investigate a real-world phenomenon – the integration of migrant doctors – through a transdisciplinary lens. To that end, it combined historical studies about 18th-century surgeons with modern-day psychological studies about medical students and migrant doctors. A question posed at the start of this dissertation was whether this "experiment" of combining history and psychology would yield new insights, and whether the whole answer to the research question would be greater than the sum of its – disciplinary – parts.

Over all, I contend that the combination of social history and social psychology was successful in generating novel insights, although the approach – like any other – had some limitations as well. To start with perhaps its most important quality: the combination of social history and social psychology allowed me to investigate integration from a broad point of view. According to transdisciplinary scholars (e.g., Borkert, 2018; Jahn et al., 2012), complex societal problems, like the integration of migrant doctors, are better understood through combining theories and methods from several academic disciplines. This is because complex societal problems tend to supersede the theoretical and methodological boundaries inherently present in any separate discipline. In the case of migrant integration, the superseding of disciplinary boundaries is exemplified by the different dimensions in which migrants may become integrated. Penninx & Garcés-Mascareñas (2016) refer to these dimensions as the legal-political, the socio-economic, and the cultural-religious dimensions, although they are known under different labels as well (Heath & Schneider, 2021). Naturally, social psychology focuses more on the cultural-religious dimension of integration, which encompasses people's self-views, views of others, and interpersonal behaviour. Social history, on the other hand, tends to focus more on the legal-political and socio-economic dimensions of integration, which encompass people's legal rights, formal citizenship, access to institutional facilities, and their resulting education and employment. By utilising a transdisciplinary approach, more of these different dimensions of integration came into view. Similarly, integration in these dimensions also takes place at different analytical levels, that

is: at the level of the institution, group, and individual. Whereas social history focuses mainly on the relationship between institutions and individuals, social psychology focuses on individuals in relation to groups. Again, by utilising a transdisciplinary approach more of these aspects were identified, resulting in a broader, more holistic, approach towards integration.

This broader, transdisciplinary approach towards integration, which combined social history with social psychology, resulted in an important insight that would likely not have been generated using a mono-disciplinary approach. This insight consists of the finding that the place where a migrant doctor has received their medical education, not just where they were born, influences their eventual acceptance by their social surroundings. This is a novel finding within the disciplines of social history and of social psychology, though for different reasons.

Within social history, there is an ongoing debate about guild openness towards newcomers (cf. Ogilvie, 2019; Prak et al., 2019). One of the points of contention is about the motivation behind guilds' attempts to regulate the inflow of newcomers: was this motivated by the desire to restrict newcomers' access to the *rents* of the guild (i.e., economic benefits resulting from being a guild member), or was it motivated by the desire to protect the continued existence of the guild and the well-being of its members, by making sure that new members had received the proper training and were socially and economically invested in the guild? The finding that obtaining education in the place of destination improves acceptance of migrant doctors by their social surroundings sheds new light on this discussion, by suggesting that the training that the local guild provided to newcomers was likely to have been valued by the townspeople making use of the guild's services. Receiving local training leads to local acceptance. This lends credit to the view that guilds' attempts to regulate the inflow and training of newcomers may have indeed been motivated, at least in part, by concerns about the townspeople's appreciation of guild members, and the guild's reputation as a whole resulting from that appreciation. If not for modern-day psychological insights about migrant integration, it would not have been possible to draw such a conclusion about a historical setting.

Within social psychology, the finding that the place where a migrant received their education impacts how they see themselves as a professional, and how their social surroundings see them, is also novel. Migrant education level is, admittedly, included as a variable in a subset of studies focusing on the integration of migrants (e.g., de Vroome et al., 2014; Heath & Schneider, 2021; Smith & Khawaja, 2011). However, it is often taken as an outcome of the integration process, i.e. as an indicator of migrant integration in the structural or socio-economic dimension, rather than as an explanatory variable for their further integration process. In this dissertation, migrant education was used as a predictor of other indicators of migrant integration, like their professional identity formation and evaluation by their social surroundings.

Furthermore, this dissertation adds the distinction that it is not just education level that determines the acceptance of migrants, but rather the place where they have received

their education. This is, as far as I could determine, a novel insight in social psychological research.[jj] It resonates, however, with recent attempts by institutions such as the OECD and The Netherlands Scientific Council for Government Policy (WRR) to introduce a further distinction between different groups of migrants. Specifically, these institutions warn against grouping all individuals by their migration background, as this does not do justice to the large heterogeneity within this group of people with a migration background (Bovens et al., 2016; Engbersen et al., 2020; OECD, 2019). By including the place where migrants have received their education (in their country of origin or in the country of destination), the current dissertation recognises that not all migrants share the same background, and that personal characteristics such as where one received their education can have an impact on their integration process. If not for the historical finding that local education impacted guild member integration, there would have been few clues to motivate the inclusion of migrant place of education as a predictor variable in psychological studies.

Besides the advantage that the combination of social history and social psychology allowed a focus on structural as well as psychological aspects of integration, one other unique advantage of this combination of disciplines lies in the fact that a process, like migrant integration, could be studied in two quite distinct historical periods, with distinct institutional arrangements. The fact that education was found to diminish the negative effects of migration in both settings, is a testament to the importance of education in the integration process of migrants. Specifically, the historical finding that, in 1762, migrant surgeons profited from guild training in the town of destination adds weight to psychological finding that, in 2022, a migrant doctor's place of education affected the way in which they developed a professional identity, and the way in which they were perceived by their social surroundings. Vice versa, the contemporary psychological findings offer an explanatory mechanism for newcomer integration into the guild of surgeons that could not have been investigated using historical data alone.

To also name some of the disadvantages of the transdisciplinary approach, I should mention that it took a considerable amount of time to become familiar with a second academic discipline, besides the one in which I was originally trained. This came from having to invest in two distinct bodies of literature, which each use their own terminology and offer unique explanations for the phenomenon that is integration. This also makes combining findings from social history and social psychology challenging, as researchers need to gain a certain degree of comfort with the literature in one discipline, then in the other, before being able to look for the commonalities between the two. A unique challenge related to the combination of social history and social psychology in particular, lies in finding the bridge between historical findings and subsequent psychological studies. In the current dissertation, this bridge was achieved by using the institutional-level factor identified in the historical

[jj] The following Web of Science search query: [(WC=psychology, social) AND ALL=((migrant* OR immigrant* OR migrat*) AND "place of education")], conducted on January 16, 2023, returned just a single paper in which migrant place of education was suggested as a factor impacting some other migrant attribute, in this case, a health-related outcome (Walsemann et al., 2013).

studies (i.e., place of education) as input for the psychological studies seeking an explanatory mechanism at the individual- and group levels. This requires that the researcher takes analytical levels (institutional, group, individual) into account as an additional factor in their research.

Balancing the advantages and disadvantages of the transdisciplinary approach utilised in this dissertation, I conclude that the transdisciplinary whole is greater than the sum of its disciplinary parts. This mostly comes from challenging the researcher to adopt a broader view of their research topic, leading to a better understanding of the societal problem under investigation. The unique synergy between social history and social psychology in particular, comes from novel vantage points that can be discovered in a historical setting, with its unique institutional and social configuration, which may inspire psychological research. Vice versa, psychological research may offer explanatory mechanisms that can be applied retroactively to understand a historical situation better. In the current dissertation, this has led to the insight that where a migrant doctor has received their education – in their country of origin or in the country of destination – impacts the way in which they develop a professional identity and become accepted by their social surroundings.

Implications of This Dissertation

The finding that, in two quite distinct historical periods, with distinct institutional arrangements, education could diminish some of the negative effects of immigration, has theoretical and practical implications. The most important, positive implication is perhaps that the current medical education system can help to promote integration of migrant doctors, as following medical education in the country of destination leads to a positive professional identity amongst students with a migration background, as well as to increased acceptance by their social surroundings. Before concluding that the Dutch medical education system is therefore a good vehicle for the integration of migrants, there are, however, two caveats to consider.

Caveat one: Maintaining one's cultural identity. Although I show in this dissertation that receiving medical education in the country of destination can lead to several positive outcomes for migrant doctors, I do not make any claims about how this process is *experienced* by migrant doctors. Investing in an education in the country of destination might come at a personal cost, which may subtract from the positive outcome of becoming more accepted. The question, therefore, is not just whether following education in the country of destination leads to integration of migrant doctors, but also whether it does so under acceptable conditions for migrants.

Perhaps the greatest personal cost anyone can experience is the necessity to renounce part of who they are in order to get accepted by others. This dilemma, of remaining true to one's own ethnic identity on the one hand, and adopting the identity of the host culture on the other, is illustrated by the acculturation model of Berry (1980). According to this model, the dilemma of choosing between one's own ethnic identity and

the identity of the host culture can be resolved in four ways. A person either 1) adopts the host culture's identity while retaining their ethnic identity ('integration'), 2) adopts the host culture's identity while renouncing their ethnic identity ('assimilation'), 3) renounces the host culture's identity while retaining their ethnic identity ('separation') or 4) renounces both the host culture's identity and their ethnic identity ('marginalisation'). Of these four different strategies, 'integration'[kk] has been associated with the highest levels of wellbeing among migrants (Berry & Hou, 2017). Determining which identities medical students with a migration background adopt during their education in the destination country, therefore becomes a relevant question.

In Chapter 3, I show that medical students with a migration background generally adopted the same medical professional identity as students with a native background. There was one small exception to this rule, however, for students who strongly identified with an other-than-Dutch identity, while lacking identification with the Dutch identity. This group of students, opting for the 'separation' strategy according to the model of Berry (1980), maintained a slightly more positive medical stereotype than other students. This could be an indication that, in lacking a positive connection to the Dutch identity, these students compensated by instead stressing the importance of their medical professional identity. This would indeed fit with other cases in which medical students from minoritised groups have been shown to stress their professional identity in situations where they perceived that they did not fit in with the host culture (Kristoffersson & Hamberg, 2022). However, it is also possible that the more positive medical stereotype maintained by these students is a reflection of higher self-imposed standards, or higher perceived expectations by others. This would comply with a high "burden of expectation" found among migrant medical students in other studies (Michalec et al., 2017).

Ideally, medical students with a migration background studying in the destination country should opt for the 'integration' strategy, as this is most beneficial to their well-being (Berry & Hou, 2017). An ad hoc cluster analysis, performed for the purpose of this discussion section, using identification with the Dutch nationality and identification with an other-than-Dutch nationality as clustering variables (see Appendix) revealed that the majority of the students with a migration background indeed opted for the 'integration' strategy (52%), i.e., they identified simultaneously with the Dutch nationality and with an other-than-Dutch nationality. This group was followed in size by students opting for 'assimilation' (22%), 'separation' (21%), and 'marginalisation' (5%). In other words, the majority of students with a migration background retained some subjective identification with their ethnic identity. This confirms earlier studies that found that the 'integration' strategy predominates among migrants over time and that, coincidentally, also found no effect of receiving adult education in the destination country on migrant acculturation strategy (Berry & Hou, 2017; Granderath et al., 2021).

[kk] This word, when placed within parentheses, is used in the sense of Berry's acculturation model, not as it has been defined in the General Introduction to this dissertation.

In conclusion, receiving medical education in the destination country does not have to come at the cost of renouncing one's cultural identity, although there is also a sizeable minority opting for the 'assimilation' strategy. This latter finding might be the result of the recruitment strategy employed in Chapter 3, in which 1st and 2nd generation migrant students were recruited (and then grouped together under the label 'students with a migration background'). It is unclear whether the Dutch medical education system itself encouraged students to adopt an 'integration', 'assimilation', or 'separation' strategy, although at least one other study suggests that there is no connection between education and acculturation strategy (Granderath et al., 2021). In contrast, there is more evidence that all students, regardless of their background, adopt a positive medical professional identity throughout their studies. Whether this professional identity is in competition with existing cultural identities, or instead functions as a welcome addition, remains unclear. In any case, students with a migration background adopt a professional identity that is similar to students with a native Dutch background, which does not only contain a positive medical stereotype, but is also recognised by migrant doctors' social surroundings after they have graduated in the country of destination.

Caveat two: Equity or inclusion? This second caveat revolves around the approach of medical institution towards migrants. Simply said, equal outcomes between native and migrant doctors can either be achieved through assimilation of the migrant to the norms and practices of the organisation (equity approach), or by attuning the organisation to the specific needs of migrants (inclusion approach). I will outline both approaches briefly.

Equity refers to "the absence of systematic disparities (...) between groups with different levels of underlying social advantage/disadvantage – that is, wealth, power, or prestige" (Braveman & Gruskin, 2003, p. 254). This approach focuses on reducing systematic differences between groups of people, by changing institutional conditions. In an educational setting, this involves structural decisions about resource allocation, assessment, evaluation, and the organisation and governance of education systems (OECD, 2019, p. 137). Although equal outcomes for all groups seems like a noble goal, the OECD warns against adopting a pure equity-based approach. Focusing purely on equity namely often leads organisations to disregard personal differences, and promote the assimilation and homogenisation of people who differ from the majority. This includes convergence to the majority's language, cultural references, and educational standards and objectives, which may come at the loss of people's identity and sense of self-worth. The equity approach therefore "implicitly views diversity as a problem to be eliminated rather than an asset that can lead to positive outcomes with the right levels of recognition and investments" (OECD, 2019, p. 137).

The better solution, according to the OECD (2019), is also to promote inclusion, Ih hinges on making "individuals feel a part of critical organizational processes such as access to information and resources, involvement in work groups, and ability to influence the decision-making process" (Mor-Barak & Cherin, 1998, p. 48). The thought here is that by making individuals feel included, they become more satisfied with their position, and

consequently more capable and willing to respond to the organisation's needs. To achieve such a positive outcome, it is not only necessary to ensure equal outcomes between migrant and native doctors in the medical education system of the destination country – i.e., the equity approach – but also to shape that educational system in such a way that it is accessible, acceptable, and adaptable to learners' needs (Osler & Starkey, 2005).

The inclusion approach – which does not just recognise the need for migrants to adapt to the country of destination's medical system, but also of adapting the medical education system to migrant doctors' needs – fits with the definition of integration provided at the start of this dissertation, which views integration as a two-way street. However, admittedly, most of the research presented in this dissertation focuses on how migrant newcomers adapt to the institutional conditions imposed on them – how does guild policy affect migrant career making, how does following medical education affect the professional identity of migrant doctors – not the other way around. It is difficult, therefore, to determine with the current studies whether the positive effects of following medical education in the country of destination on migrant doctors' integration is thanks to medical educational institutions' focus on equity, or inclusion, or a combination of both. Since this may seriously affect migrant doctor's experiences within the education system, this is something to consider before drawing conclusions about the suitability of the medical education system as a vehicle towards migrant integration. Yet, despite these considerations, the fact remains that medical students did not only adopt a medical professional identity in the country of destination – which may be a sign of assimilation taking place through an equity-based approach – but that they also became more accepted by their social surroundings after completing their education. The latter finding is a strong signal that migrant doctors, after receiving education in the host country, became in fact more included.

Recommendations. Despite these two caveats, there are some recommendations to be made regarding the scientific study of migrant integration, and regarding policy aimed at migrant integration.

1. Social scientists and policy makers should recognise that a migrant's place of education plays a part in their integration process. I therefore suggest that social scientists who study migrant integration add 'education background' to their list of variables aiming to describe a migrant's background. Currently, demographic variables about a person's country of birth and their parents' country of birth are usually included, sometimes in combination with subjective measures of a person's ethnicity or ancestry (e.g., Heath & Schneider, 2021). When such demographic or subjective measures of a person's background are related to psychological outcomes for migrants, like their endorsement of certain stereotypes about their group, or others' response towards them, education background may be included as a variable moderating those outcomes.

For policy makers, and institutions such as Statistics Netherlands, reporting education background of migrants, in addition to information about their country of birth or their parents' country of birth, does better justice to the variability existing between individual migrants. Much of this information is readily available on Statistics Netherlands's Statline

(https://opendata.cbs.nl/). In doing so, policy makers would comply with recent calls by the The Netherlands Scientific Council for Government Policy (WRR) and OECD to make a more detailed distinction between migrants, instead of the currently common practice to make a dichotomous distinction between 'people with a native background' and 'people with a migration background' (Bovens et al., 2016; Engbersen et al., 2020; OECD, 2019).

2. Receiving medical education in the country of destination appears to promote the integration of migrant doctors. While there are some caveats to consider that may influence the personal experience of migrant doctors, this finding is generally hopeful. Policy makers should consider lowering the entry barriers for citizens with a migration background, or even actively stimulating these groups to participate in medical education. The policy with which this can be achieved was not investigated in this dissertation, but suggestions for improving the accessibility of education for migrants may be found elsewhere (de Winter-Koçak & Badou, 2020; European Commission, 2016; OECD, 2010; Onderwijsraad, 2017).

3. In addition to structural interventions and policy, this dissertation also opens the door for psychological interventions aimed at improving the acceptance of migrants. These interventions may provide a less costly addition to the more structural policy measures. These interventions may involve stressing the professional identity of migrant doctors, which I have shown to contain the positive image of a competent, sociable, and morally operating individual. Reminding migrant doctors and medical students of their professional identity may protect them against some of the more negative experiences associated with their migration background (Cambon et al., 2015; Kristoffersson & Hamberg, 2022; Steele, 1988). Alternatively, reminding migrant doctors' social surroundings (e.g., patients) of those doctors' credentials – especially if some of those credentials have been obtained in the country of destination – could improve the acceptance of migrant doctors.

Limitations and Suggestions for Further Research

While this dissertation has resulted in recommendations for social scientists and policy makers regarding the approach towards migrants and their integration, there are, finally, some methodological limitations to consider before concluding this discussion. These are not meant to detract from the recommendations, but they do provide an indication of the academic degree of certainty with which those recommendations can be trusted or generalised to other countries and sectors. In addition, suggestions for further academic research spring from these limitations that may be of help to other researchers.

Limitations. Perhaps the chief limitation of the current dissertation, is that it only contains data about migrant doctors and patients in the Netherlands and the United Kingdom. The data about migrant surgeons is, furthermore, constrained to the specific setting of 18th-century Amsterdam. This suggests that we cannot automatically generalise the findings of this dissertation to other countries.

Previous research has found that a number of education-related outcomes among young migrants, such as attaining baseline academic proficiency and sharing a sense of belonging at school, depend, in part, on the country to which they migrate to (OECD, 2018).

In other words, there are specific country of destination effects that influence how much a migrant benefits from receiving education in the destination country. This makes it plausible that the specific effects found in this dissertation – that receiving medical education in the country of destination affects migrants' professional identities and their acceptance by their social surroundings – will differ if the same studies were to be repeated in different countries. This may be especially relevant if in a different country a less positive medical stereotype exists, for example because citizens and doctors have less faith in the quality of the medical education of their country. If that is the case, it may also affect the extent to which receiving education in the destination country will be considered a bonus, as it was for doctors studying in the UK.

A related limitation comes not from country of destination effects, but from country of origin effects. How well a young migrant performs in school also depends on which country they were originally from (OECD, 2018; see also Heath & Schneider, 2021). In the current dissertation, we tried to compensate for country of origin effects, by studying migrants from different countries. In Chapter 3, medical students with a range of different geographic origins were included, although we did not study differences between those origins due to insufficient statistical power. Similarly, in Chapter 4, we presented UK participants with doctor profiles of doctors originating from a number of different geographic regions and countries. The aim was again not to make a comparison between migrants with different geographic origins, but to increase the generalisability of our findings by presenting a mixed group of doctors. This makes it more plausible that the effects found in this dissertation apply to migrants in general, although it remains possible that differences between migrants depending on their country of origin exist that were not studied in the current dissertation.

For the historical studies presented in Chapter 1 and Chapter 2, similar considerations must be made. Chapter 1 studied surgeons working in Amsterdam, but hailing from a range of different towns – though most of those towns lie within the current borders of the Netherlands and Germany. Chapter 2 compared three destination towns: The Hague, Haarlem, and Amsterdam, and included migrants with a wide variety of origins across Europe. The focus of especially that latter chapter on the interplay between town of destination and town of origin effects, makes the historical part of this dissertation robust against the country of origin and country of destination considerations discussed above, and this should indeed be considered as one of its strengths.

An additional consideration about the historical studies, is their setting in the 18th century. This could be seen as a unique strength, allowing us to examine the same integration process in two distinct time periods, but also as a limitation. Generalisation of the historical findings to the here-and-now namely depends on assumptions about the extent to which medical education and the broader societal context have progressed since then. As a solution to this problem, the current dissertation conducted psychological studies to find out whether the institutional conditions for integration observed in the 18th century could be replicated in a modern-day setting. While it thus remains difficult to say how the

integration of migrants in 18th century guilds compares to integration through modern-day medical education, we can at least conclude that the process must have remained somewhat consistent over the centuries.

Finally, a word about generalising the findings of this dissertation outside the medical sector. Becoming a doctor is a lengthy and often costly endeavour, and comes with important benefits once it has been achieved, like a good salary and a high social status. It should come as no surprise, then, that people generally have high expectations about doctors, for example about the level of competence that they should possess, and about the moral and friendly behaviour that they should display. This makes the medical profession one in which a high investment on the part of the migrant comes with potentially high rewards. It is possible that other occupations that do not require a similarly steep investment from migrants may not lead to a convergence of beliefs as we observed among medical students. Likewise, if the stereotypes associated with a given occupation are not very positive, as they are about doctors, migrants may not benefit as much from completing their211ducationn, even if that education was completed in the country of destination.

Suggestions for further research. In Chapter 3, people expected migrant doctors' competence to be higher if they had received education in the destination country. This finding could be contingent on the general impression that the research participants had of the quality of medical education in their country. To control for such country of destination effects, future studies could include perceived quality of medical education as a control variable. Better yet would be to repeat the studies presented in Chapter 3 in a number of different countries. A comparison between different countries of destination could elucidate whether the positive effect of receiving education in the country of destination on patient acceptance depends on country-specific beliefs about the quality of the medical education system in that country, or whether it is rather a more general reflection of people's appreciation of the socialisation process taking place through education.

In a similar vein, it would be interesting to repeat the study presented in Chapter 3 in different countries, to measure whether a) a unique medical stereotype exists for each different country, which we would expect based on medical literature (Harris, 2011), and b) whether the same convergence of this image occurs in those countries between medical students with a migration background and with a native background. A cross-countries approach would yield the most definitive answers, as the maps of the medical stereotype can then be compared directly between countries.

A final suggestion springs from what is known as the 'integration paradox' (de Vroome et al., 2014). A study among migrants in the Netherlands revealed the paradoxical finding that higher educated migrants, compared to lower-educated migrants, had more negative opinions about the native majority and the host society. The explanation for this, was that education level also negatively corresponded to perceived acceptance by the host country, through increased encounters of racism and perceived disrespect for minorities. Instead of recognising that the host society accepts them after receiving higher education in the host country, migrants thus perceive *less* acceptance after completing higher education.

Since this dissertation argues that completing medical education in the country of destination can in fact *improve* acceptance among the members of the social environment, researchers could investigate whether informing migrants about their social surrounding's improved acceptance of them can reduce the integration paradox.

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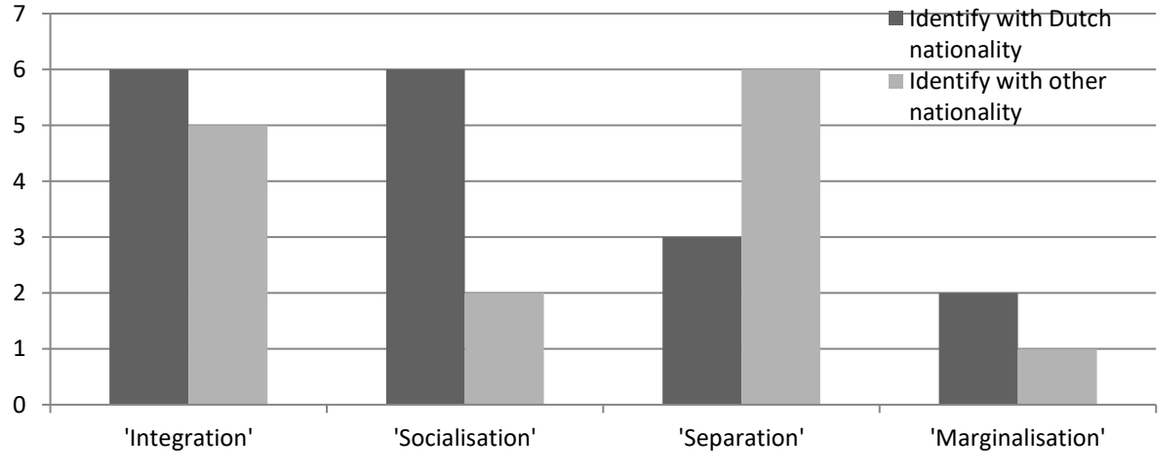
Appendix to Chapter 6

Cluster Analysis

A K-means cluster analysis was performed in SPSS on the subset of medical students in Chapter 3 who had a migration background and of whom we had complete data (*n* = 107). The clustering variables were 'Identify with Dutch nationality' and 'Identify with other nationality', which were two single-item Likert-type measures of participants' subjective identification with the Dutch nationality (ranging from 1 = not at all, to 7 = very much), and an other-than-Dutch nationality, respectively.

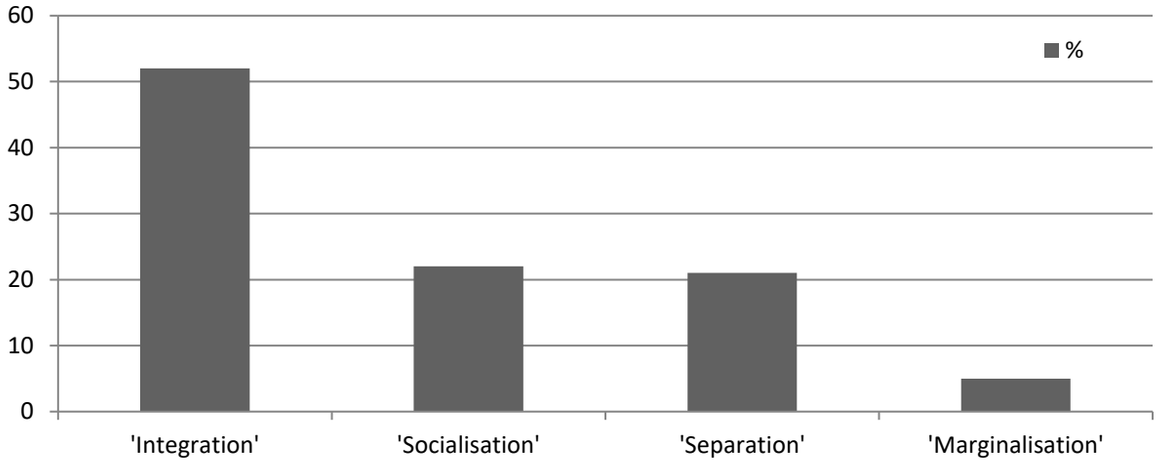
We asked SPSS to return four clusters, which we labelled 'integration', 'socialisation', 'separation', and 'marginalisation'. In line with the acculturation model (Berry, 1980; Berry & Hou, 2017), participants in the 'integration' cluster identified strongly with the Dutch nationality while also identifying strongly with an other-than-Dutch nationality (see Figure 1). Accordingly, participants in the 'socialisation' cluster identified strongly with the Dutch nationality but not with an other-than-Dutch nationality, while participants in the 'separation' cluster only identified strongly with an other-than-Dutch nationality, and participants in the 'marginalisation' cluster did not identify strongly with either nationality.

Figure 1. Cluster centres of K-means cluster analysis on 'Identify with Dutch nationality' and 'Identify with other nationality'.



As for participants' distribution over the four clusters, see Figure 2. Most participants fell in the 'integration' category, followed by 'socialisation', 'separation', and 'marginalisation'.

Figure 2. Distribution of participants over clusters.


60
50
40
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10
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'Integration'
'Socialisation'
'Separation'
'Marginalisation'


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Post scriptum

Nederlandse samenvatting (summary in Dutch)

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About the author

KLI dissertation series

Nederlandse samenvatting (summary in Dutch)

Achtergrond

In dit proefschrift staat de integratie van hoogopgeleide migranten (in het bijzonder: artsen) centraal. Integratie wordt daarbij als succesvol beschouwd wanneer beide partijen (migranten en de hen omringende samenleving) elkaar *accepteren*. Omdat integratie een gelaagd proces is, maakt deze dissertatie onderscheid tussen de *institutionele-*, *groeps-,* en *individuele* aspecten van het integratieproces die tot de wederzijdse acceptatie van migranten en hun sociale omgeving kunnen leiden. Door niet op één, maar drie niveaus integratie te bestuderen, hoopt deze dissertatie een completer beeld te geven van hoe integratie van hoogopgeleide migranten in zijn werk gaat, en zo tot nieuwe inzichten te komen.

Nederland wordt steeds diverser: steeds meer mensen komen naar Nederland, en ook komen zij uit een groeiend aantal verschillende landen. Ook hun motief kan verschillen: waar sommigen vluchten voor oorlog in hun land van herkomst, komen anderen omdat ze in Nederland een baan hebben gevonden of omdat zij hier familie hebben wonen (Jennissen et al., 2018). Hoewel het als goed nieuws kan worden beschouwd dat er graag mensen naar Nederland willen komen, brengt de resulterende diversiteit ook complicaties met zich mee. Zo voelen bewoners van buurten met een hoge mate van diversiteit zich in hun buurt vaak minder thuis. Dit geldt ook voor migranten, die zich vaak niet thuis voelen in de Nederlandse samenleving, zelfs al hebben ze hier werk gevonden of een opleiding afgerond (Dagevos et al., 2022). Het is dus noodzakelijk om te onderzoeken waar het integratieproces lijkt spaak te lopen, niet alleen onder migranten die tot groepen behoren die het traditioneel zwaar hebben (denk aan vluchtelingen) maar ook juist onder migranten voor wie eigenlijk alle seinen op groen zouden moeten staan.

Om deze reden, en om de scope van het onderzoek te beperken, focust deze dissertatie op een groep hoogopgeleide en over het algemeen goed gepositioneerde migranten: artsen. Artsen worden doorgaans hoog in achting genomen door hun sociale omgeving (Nicolas et al., 2022). Tevens worden artsen door een aantal Westerse landen actief voor de arbeidsmarkt gerekruteerd (denk bijvoorbeeld aan het Verenigd Koninkrijk en Australie; Baker, 2019; Negin et al., 2013. Nederland blijft vooralsnog achter, met slechts 2,2% in het buitenland opgeleide artsen; Avontuur & Otten, 2021). Ondanks deze positieve signalen ervaren gemigreerde artsen en geneeskundestudenten dikwijls dat hun migratieachtergrond hen in de weg zit bij het geaccepteerd worden door hun sociale omgeving (Dywili et al., 2012; Jalal et al., 2019; Waldring et al., 2020). Met andere woorden, hoewel gemigreerde artsen een relatief gunstige positie op de arbeidsmarkt innemen vergeleken met andere groepen migranten, ervaren zij toch hinder bij hun integratie. Om dit probleem aan te pakken, wordt in deze dissertatie daarom de integratie van migrant-artsen in hun professionele en sociale omgeving bestudeerd. Het doel is om de institutionele aspecten die de integratie van artsen kunnen bevorderen bloot te leggen, alsmede de doorgaans meer verborgen psychologische processen die zich op groepsniveau en individueel niveau afspelen.

Om zowel de institutionele, als de groeps- en individuele aspecten bloot te leggen die tot de integratie van gemigreerde artsen kunnen leiden, hanteert deze dissertatie een *trans-disciplinaire* benadering. Dit houdt in dat er meerdere academische disciplines worden ingezet om de onderzoeksvraag te bestuderen. Dit levert, volgens de voorstanders van deze benadering, doorgaans een meer gedetailleerd en completer beeld op van een complex onderwerp – zoals de integratie van artsen (Borkert, 2018; Jahn et al., 2012). De disciplines die in deze dissertatie worden gebruikt om integratie van migrant-artsen te benaderen, zijn sociale geschiedenis en sociale psychologie. Dit lijkt voor wetenschappers die zijn opgeleid in een van deze twee vakgebieden wellicht niet een heel voor de hand liggende keuze, maar het idee is dan ook dat deze combinatie wellicht verrassende inzichten oplevert. Omdat geschiedenis en psychologie doorgaans niet in trans-disciplinair onderzoek worden gecombineerd op deze manier, kan dit proefschrift ook als een soort experiment worden beschouwd of deze combinatie überhaupt zou gaan lúkken.

Bevindingen

De eerste twee hoofdstukken van deze dissertatie bestuderen de integratie van migrant-artsen vanuit de sociale geschiedenis. Hoofdstuk 1 behandelt een groep artsen uit de vroegmoderne periode, die, mede dankzij Rembrandts[II] fenomenale afbeelding van deze groep, mogelijk enige bekendheid geniet: het Amsterdamse Chirurgijnsgilde. Van dit gilde onderzocht ik hoe zij in de 18de eeuw omgingen met nieuwkomers, in het bijzonder nieuwkomers met een migratieachtergrond. Hiervoor gebruikte ik documenten die in de archieven van dit gilde bewaard zijn gebleven (en die zich thans bevinden in het Stadsarchief Amsterdam). Deze archieven bevatten de officiële regels (ook wel 'statuten' genoemd) die het gilde opstelde met betrekking tot de rekrutering en opleiding van nieuwe leden. Daarnaast bevat het archief ook informatie over nieuwe leden die het gilde binnenstroomden. Door deze twee gegevens aan elkaar te koppelen, kon ik zien hoe de institutionele regels van het Chirurgijnsgilde effect hadden op de in- en doorstroom van nieuwkomers met een migratieachtergrond.

De belangrijkste bevinding van dit hoofdstuk is dat het Amsterdams Chirurgijnsgilde het nieuwkomers met een migratieachtergrond niet moeilijk maakte om binnen het gilde te beginnen. Hierdoor (en wellicht ook door andere factoren die niet zijn onderzocht) kwamen er veel migranten naar het gilde toe. Echter, en hierin zit hem de crux, het Chirurgijnsgilde hechtte in hun statuten ook een groot belang aan het volgen van voldoende lessen en training binnen het gilde. Een opleiding gevolgd buiten Amsterdam werd ook wel erkend, althans op papier, maar in de praktijk groeiden vooral chirurgijns door binnen de organisatie (tot de trede van 'meesterchirurgijn') die binnen het Amsterdamse Chirurgijnsgilde voldoende ervaring hadden opgedaan. Een Amsterdamse opleiding, zo lijkt het, werd dus anders gewaardeerd dan een opleiding buiten Amsterdam. Hoewel het Chirurgijnsgilde dus open was voor nieuwkomers met een migratieachtergrond, moesten die nieuwkomers wel

[II] Zie Rembrandt van Rijn's *De anatomische les van dr. Nicolaes Tulp,* 1632 (Den Haag, Mauritshuis).

binnen Amsterdam hun opleiding tot chirurgijn volgen, als zij een goede kans wilden maken om op te klimmen tot meesterchirurgijn.

Waarom een opleiding gevolgd op de plek van bestemming een migrant helpt om carrière te maken, onderzoek ik in hoofdstukken 3 en 4. Eerst ga ik in Hoofdstuk 2 echter nog wat dieper in op de institutionele voorwaarden die migratie en integratie kunnen simuleren, dan wel afremmen. Door mijn Amsterdamse data te combineren met data die mijn collega Ruben Schalk had verzameld over Den Haag en Haarlem, waren wij in staat om een vrij gedetailleerd beeld te vormen van migratiestromen tussen verschillende steden in het 18de-eeuwse Holland. Uit deze analyse bleek dat, naast gilden, ook steden er verschillende beleidsstrategieën op nahielden wanneer het aankwam op het binnenlaten en vestigen van migranten. Amsterdam, en in mindere mate ook Den Haag, hielden traditioneel een liberaal migratiebeleid aan, dat in de praktijk de migratie stimuleerde. Tekenend is dat Amsterdam in de 18de eeuw de enige stad was in de Republiek der Zeven Verenigde Nederlanden (zoals ons land toen heette) die in bevolking constant wist te blijven, terwijl andere Hollandse steden er in deze eeuw op achteruit gingen. Amsterdam kende echter een relatief uitgeklede armenzorg vergeleken met andere steden. Steden zoals Haarlem besteedden meer geld aan armenzorg, maar waren ook selectiever in het toelaten van migranten; dit was onder andere terug te zien in het geringe aantal migranten binnen het Haarlemse banketbakkersgilde. Wij concluderen dat het een combinatie was van factoren – zoals de officiële houding van stedelijke instituties naar migranten, maar ook de beroepsgroep van een migrant en de hoeveelheid kunde die daarbij kwam kijken – die bepaalden waar en voor hoe lang een migrant zich ergens kon vestigen.

In hoofdstukken 3 en 4 willen wij verder uitdiepen waarom het ertoe doet waar een migrant zijn of haar opleiding gevolgd heeft. Om hierachter te komen, zetten wij de psychologische methode in, waarmee wij kunnen analyseren welke processen er binnen de hoofden van migranten en hun sociale omgeving plaatsvinden tijdens en na het volgen van een opleiding in het land van bestemming. In hoofdstuk 3 wordt een vragenlijst behandeld die is rondgestuurd onder geneeskundestudenten studerend aan verschillende universiteiten binnen Nederland. Het doel was om erachter te komen wat voor een beeld deze geneeskundestudenten hebben bij het artsenberoep, en of dit beeld wellicht verschilt tussen studenten met een Nederlandse achtergrond en studenten met een migratieachtergrond. Over personen met een migratieachtergrond bestaan immers negatieve stereotypen, en het is mogelijk dat dit ook hun zelfbeeld beïnvloedt, alsmede hun beeld van hoe een medisch professional zou moeten zijn en handelen. Om dit te onderzoeken brachten wij gedetailleerd de stereotype beelden van geneeskundestudenten in beeld, in het bijzonder de manier waarop zij tegen medische rolmodellen aankeken, en hun verwachtingen over hoe artsen zich zouden moeten gedragen, alsmede hun inschattingen van wat patiënten zoal verwachten van een arts.

In eerste instantie vonden wij niet dat geneeskundestudenten met een migratieachtergrond er een ander stereotype beeld van het medische beroep op nahielden dan studenten met een Nederlandse achtergrond. Zowel studenten met een

migratieachtergrond als studenten met een Nederlandse achtergrond hadden namelijk sterk positieve verwachtingen over hoe moreel, vriendelijk, en competent artsen dienden te zijn en ook in werkelijkheid waren. Geneeskundestudenten vonden zichzelf overigens evenzogoed morele en vriendelijke personen, al gaven zij ook aan dat zij op het gebied van competentie nog niet voldeden aan het stereotype beeld van een arts. Dit kan te maken hebben met de hoge druk die geneeskundestudenten vaak zeggen te ervaren vanuit hun omgeving (Stubbing et al., 2019). Anderzijds kan het ook simpelweg een erkenning zijn dat zijzelf nog niet klaar zijn met hun studie, en dus minder competent zijn dan een volleerd arts. In die zin vormen de hoge mate van competentie, maar ook moraliteit en vriendelijkheid, die geneeskundestudenten associëren met het medische beroep wellicht wel een soort ideaalbeeld waarnaar zij graag willen streven.

Dat het stereotype beeld van medische studenten met een migratieachtergrond op het eerste gezicht niet afwijkt van het stereotype beeld van studenten met een Nederlandse achtergrond vatten wij op als een indicatie dat geneeskundestudenten via hun opleiding eenzelfde professionele identiteit ontwikkelen. Een opleiding volgen in een bepaald land – in dit geval Nederland – kan er dus toe leiden dat migranten een professionele identiteit aannemen die lijkt op de professionele identiteit van de andere artsen die in dat land geboren zijn. Een kanttekening dient hier gemaakt te worden voor geneeskundestudenten met een migratieachtergrond die zichzelf ook sterk identificeerden met hun niet-Nederlandse identiteit. Deze groep had gemiddeld gezien een nog net iets positiever stereotype beeld van het artsenberoep dan geneeskundestudenten die zichzelf niet zozeer identificeerden met een niet-Nederlandse nationaliteit. Dit zou kunnen betekenen dat sommige geneeskundestudenten met een migratieachtergrond zichzelf aan nog iets hogere standaarden houden dan andere geneeskundestudenten, overeenkomend met een hogere “burden of expectations” die weleens vaker gevonden wordt onder studenten met een migratieachtergrond (Michalec et al., 2017).

Geneeskundestudenten met een migratieachtergrond ontwikkelen dus min of meer dezelfde professionele identiteit als studenten zonder migratieachtergrond, na het volgen van een opleiding in het land van bestemming. Betekent dit dan vervolgens ook dat de sociale omgeving van gemigreerde artsen die artsen meer gaan waarderen, wetende dat die in het land van bestemming hun opleiding hebben voltooid? Of zorgen hardnekkige stereotypes over migranten ervoor dat migrant-artsen door hun omgeving niet geaccepteerd worden, ongeacht waar zij zijn opgeleid? Deze vragen werden onderzocht in het laatste hoofdstuk van deze dissertatie, Hoofdstuk 4. In een serie experimenten legden wij telkens inwoners van het Verenigd Koninkrijk – en in één geval inwoners van Nederland – de vraag voor wat zij zouden doen wanneer ze een nieuwe huisarts moesten kiezen. Telkens zagen zij de ‘profielen’ van enkele artsen, zogenaamd van de website van een huisartsenpraktijk geplukt. In die profielen stelden de artsen zich voor, en lieten daarbij blijken dat zij ófwel in het buitenland waren geboren ófwel niet, en dat zij ófwel in het buitenland waren opgeleid ófwel in het land van bestemming. De deelnemers aan het onderzoek – zelf dus in de rol van patiënt – werden vervolgens gevraagd de artsen te beoordelen op moraliteit, competentie,

en vriendelijkheid, en om aan te geven welke van deze artsen ze het liefst zouden nemen als hun nieuwe huisarts.

Uit deze experimenten bleek dat mensen uit het VK een voorkeur hadden voor artsen (of die nu in het VK waren geboren of daarbuiten) die in het VK waren opgeleid. Vergeleken met artsen die in het buitenland waren opgeleid, schatten deelnemers de in het VK opgeleide artsen in als competenter, hoewel niet als moreler of vriendelijker. Dit suggereert dat mensen uit het VK positieve verwachtingen hebben over de hoeveelheid competentie die een buitenlandse arts opdoet dankzij een studie in – in dit geval – het VK. Dat lijkt overeen te komen met de bevinding uit Hoofdstuk 3, waarbij in Nederland studerende geneeskundestudenten de onuitgesproken verwachting leken te hebben dat zij tijdens hun studie vooral op het gebied van competentie nog veel moesten groeien om aan de hoge verwachtingen bestaand over het artsenberoep te voldoen.

Het feit dat de meeste winst voor migrant-artsen ogenschijnlijk op het gebied van competentie te behalen valt, wil nog niet zeggen dat moraliteit en vriendelijkheid er niet toe doen. In Hoofdstuk 3 gaven geneeskundestudenten al aan dat zowel competentie als moraliteit en vriendelijkheid in hoge mate aanwezig dienden te zijn bij een volleerd arts. Overeenkomend met dit onder geneeskundestudenten gangbare stereotype beeld van artsen, gaven deelnemers in de rol van patiënt in Hoofdstuk 4 aan dat de artsen waarvan zij een profiel te zien kregen waarschijnlijk over een grote mate van moraliteit, vriendelijkheid en competentie beschikten. Om erachter te komen of, en in welke mate, een oordeel over de moraliteit, vriendelijkheid, of competentie van een arts van invloed was op de keuze voor desbetreffende arts, gaven wij een aantal van onze fictieve artsen een ‘patiëntenreview’ mee. In deze review lazen de deelnemers aan het experiment dat de desbetreffende arts bijvoorbeeld goed scoorde op het gebied van competentie, en ook erg vriendelijk was, maar soms immoreel gedrag vertoonde; of, vice versa, dat hij zich erg moreel en vriendelijk gedroeg, maar op competentievlak weleens een steekje liet vallen. Eigenlijk hadden we gehoopt dat we middels een positieve review het imago van een arts nog een beetje konden opkrikken, maar dat bleek nauwelijks mogelijk omdat artsen al als erg moreel, vriendelijk, en competent werden beschouwd. Het lezen van een negatieve review daarentegen, waarin een van deze drie aspecten juist bekritiseerd werd, gaf zoals verwacht de voorkeur voor de betreffende arts een flinke knauw. Een negatieve review van een arts’ moraliteit bleek daarbij het grootste negatieve effect te hebben. Hoewel een migrant-arts er in de ogen van zijn patiënten er op moreel vlak dus weinig op vooruit gaat door het volgen van een opleiding in het land van bestemming, is het weldegelijk belangrijk dat hij moreel gedrag blijft uitstralen, wil hij het vertrouwen van zijn patiënten niet verliezen. Hetzelfde geldt, in mindere mate, voor competentie en vriendelijkheid.

Conclusie

Uit de geschiedkundige en psychologische onderzoeken naar de integratie van migrant-artsen kunnen we de volgende conclusies trekken. Ten eerste dat het proces dat leidt tot de wederzijdse acceptatie tussen migrant-artsen en hun sociale omgeving begint bij

de opleidende instituties. De formele toelatingseisen die deze instituties opleggen aan migrant-artsen hebben in het verleden het gemak bepaald waarmee migrant-artsen toegang tot een opleiding – en daaraan aansluitend: de arbeidsmarkt – in het land van bestemming konden verkrijgen. Ongetwijfeld spelen deze formele toegangseisen ook vandaag de dag nog een grote rol, waardoor opleidende instituties een belangrijke rol spelen in het bepalen welke migrant-artsen een kans krijgen om te integreren in het land van bestemming.

Ten tweede kunnen we concluderen dat toegang verkrijgen tot een opleidende institutie in het land van bestemming slechts een eerste stap is naar wederzijdse acceptatie tussen migrant-artsen en hun sociale omgeving. De tweede stap bestaat uit een investering, zowel door de migrant als door de opleidende institutie, gedurende een langere periode, in de opleiding van de migrant-arts. Door de herhaaldelijke interacties tussen migranten en hun studiegenoten en leraren, leren migrant-artsen de normen en gebruiken aan van het artsenberoep zoals dat uitgeoefend wordt in het land van bestemming, en verkrijgen zij een professionele identiteit die afgestemd is op de medische praktijk aldaar.

Ten derde kunnen we concluderen dat dit socialisatieproces, dat in gang wordt gezet tijdens de opleiding van een migrant-arts in het land van bestemming, plaatsvindt via twee complementaire psychologische processen. Via het eerste proces ontwikkelen geneeskundestudenten tijdens hun studie in het land van bestemming een professionele identiteit die uniek is voor dat land. Geneeskundestudenten delen een, in vele opzichten, identiek stereotype beeld over het artsenberoep en de hoeveelheid competentie, moraliteit, en vriendelijkheid die daarbij komen kijken of behoren te komen kijken. Onder Nederlandse studenten neemt dit stereotype beeld de vorm aan van een in hoge mate competente, morele, en vriendelijke arts, die staat voor het ideale type arts waarnaar studenten graag streven. Het tweede proces vindt niet plaats onder migrant-artsen zelf, maar in hun sociale omgeving. Patiënten, bijvoorbeeld, erkennen dat een opleiding gevolgd binnen het land van bestemming van invloed is op de competentie van een in het buitenland geboren arts. Zij schatten migrant-artsen overigens ook hoog in op het gebied van moraliteit en competentie, maar dit staat los van de plek waar een arts is opgeleid. Het positieve beeld dat bestaat over artsen helpt daarbij wellicht om bestaande negatieve stereotypen over migranten deels op te heffen.

Ten slotte kunnen we dus concluderen dat het niet alleen uitmaakt dát een migrant tot arts is opgeleid, maar ook wáár dat is gebeurd: in het buitenland of in het land van bestemming. De medische praktijk verschilt immers per land, waardoor het waarschijnlijker is dat artsen opgeleid in het land van bestemming ook een professionele identiteit ontwikkelen die is afgestemd op de aldaar geldende normen en gebruiken. Deze identiteit wordt, op zijn beurt, erkend door de sociale omgeving van de migrant-arts, o.a. door patiënten, die de migrant-arts als competenter inschatten, en eerder bereid zijn om als hun arts te accepteren, wanneer die arts in het land van bestemming is opgeleid.

Aanbevelingen

Uit deze conclusie vloeien een aantal aanbevelingen voort. Om te beginnen moeten sociale wetenschappers en beleidsmakers zich realiseren dat de plek waar een migrant is opgeleid van invloed kan zijn op zijn of haar mate van integratie. Nog te vaak gebruiken sociale wetenschappers alleen demografische gegevens – zoals waar een persoon of waar zijn/haar ouders zijn geboren – om te verklaren hoe mensen op elkaar reageren (al komt in dat laatste gebruik langzaam verandering: zie bijvoorbeeld Heath & Schneider, 2021, die naast demografische gegevens ook de persoonlijk ervaren verbondenheid met een bepaalde etniciteit meten). Omdat deze dissertatie aantoont dat de plek waar een persoon is opgeleid eveneens van invloed kan zijn op de manier waarop die persoon zichzelf en zijn beroep waarneemt, en tevens op de manier waarop iemands sociale omgeving die persoon waarneemt, beveel ik aan dat sociale wetenschappers de plek waar een migrant is opgeleid meenemen als verklarende variabele voor processen gelieerd aan de waarneming van en door migranten.

Beleidsmakers en rapporterende instanties, zoals bijvoorbeeld het Centraal Bureau voor de Statistiek (CBS), doen beter recht aan de grote variatie die er tussen migranten bestaat door ook eens over hun opleidingsniveau te rapporteren, of over waar die heeft plaatsgevonden. Deze informatie is met enig speurwerk reeds op Staline van het CBS te vinden (https://opendata.cbs.nl/). Door naast iemands geboorteplaats (of die van zijn of haar ouders) ook iemands plaats van opleiding te rapporteren, komen beleidsmakers bovendien tegemoet aan recente oproepen van o.a. de Wetenschappelijke Raad voor het Regeringsbeleid (WRR) en de OECD om in meer detail te rapporteren over mensen dan alleen dat zij over ‘een migratieachtergrond’ beschikken (Bovens et al., 2016; Engbersen et al., 2020; OECD, 2019). Dit doet beter recht aan de variëteit die er tussen mensen bestaat, die eveneens van invloed kan zijn op de positie die een persoon bekleedt in de maatschappij.

Een hoopvolle bevinding van deze dissertatie is dat het ontvangen van een medische opleiding in het land van bestemming bij kan dragen aan de acceptatie van – en integratie van – migrant-artsen. Een aanbeveling die hieruit voortvloeit is dat beleidsmakers moeten overwegen of de toegang tot het volgen van onderwijs in het land van bestemming (in dit geval Nederland) kan worden vergemakkelijkt voor mensen met een migratieachtergrond. Wellicht kan deze groep zelfs actief gestimuleerd worden om een medische of andere (universitaire) opleiding te volgen. Welk beleid hiervoor het beste kan worden ingezet is niet onderzocht in deze dissertatie, maar hiervoor kan men rapporten raadplegen waarin enkele goede aanbevelingen worden gedaan (de Winter-Koçak & Badou, 2020; European Commission, 2016; OECD, 2010; Onderwijsraad, 2017).

Naast de mogelijkheid tot structurele interventies en beleidsmaatregelen opent deze dissertatie ook de deur naar enkele psychologische interventies gericht op het vergroten van de acceptatie van mensen met een migratieachtergrond. Zulke interventies bieden wellicht een goede en goedkopere manier om integratie te bevorderen naast de vaak kostbare beleidsinterventies. In zulke psychologische interventies zou bijvoorbeeld de professionele identiteit van een migrant aan zijn of haar omgeving kunnen worden benadrukt, omdat deze

professionele identiteit door mensen geassocieerd wordt met een zekere mate van moraliteit, competentie, en vriendelijkheid (al hangt de kracht van deze associatie waarschijnlijk wel af van het type beroep dat de migrant uitvoert). Anderzijds zou het ook mensen met een migratieachtergrond kunnen helpen om actiever bewust te worden gemaakt van hun professionele identiteit, indien dit een positieve identiteit betreft, omdat zulk een bewustwording ze kan beschermen tegen de vaak negatieve ervaringen die zij associëren met hun eigen migratieachtergrond (zie bijvoorbeeld Cambon et al., 2015; Kristoffersson & Hamberg, 2022; Steele, 1988). Ten slotte kunnen mogelijk bepaalde aspecten uit het medische beroep – zoals het belang van moreel verantwoord handelen, vriendelijk omgaan met patiënten, en competent handelen – ook in andere beroepen sterker worden benadrukt, aangezien dit de aspecten zijn die mensen in het algemeen lijken te waarderen (zie Abele et al., 2021).

Beperkingen

Aan deze aanbevelingen kleven wel een aantal beperkingen en andere overwegingen. Zo gaat deze dissertatie bijvoorbeeld niet in op de manier waarop artsen of geneeskundestudenten met een migratieachtergrond hun (her)scholing binnen Nederland of een ander land van bestemming ervaren. Het gevaar ligt hierbij op de loer dat door te veel op het belang van opleiding te hameren – en het aanleren van lokaal geldende normen en gebruiken – we impliciet van de persoon met een migratieachtergrond vragen om zich te conformeren aan de cultuur in het land van bestemming. Wanneer een persoon de hechting met zijn of haar migratieachtergrond volledig opgeeft ten gunste van een identiteit die aansluit bij het land van bestemming, dan spreken wij volgens sommige modellen echter niet meer over ‘integratie’, maar over ‘assimilatie’. Dit kan negatieve gevolgen hebben voor de geassimileerde persoon, omdat die een belangrijk deel van zijn of haar persoonlijke identiteit opgeeft (Berry, 1980; Berry & Hou, 2017). Wij vonden aanwijzingen dat dit wellicht op kleine schaal gebeurt onder geneeskundestudenten met een migratieachtergrond, hoewel een grotere groep naast de Nederlandse identiteit ook binding met het land van herkomst behoudt. In hoeverre het ontwikkelen van een professionele medische identiteit samengaat of conflicteert met het behoud van de Nederlandse of een buitenlandse identiteit, is op dit moment nog een open vraag.

Gerelateerd aan deze kwestie van het behoud van een positieve culturele identiteit, is de vraag of medische opleidingsinstituties in moeten zetten op ‘equity’ dan wel ‘inclusion’. Beleid gericht op het stimuleren van gelijke uitkomsten voor verschillende groepen (de ‘equity’ aanpak) is nuttig in de zin dat het barrières weg kan nemen voor artsen of studenten met een migratieachtergrond om toegang tot medisch onderwijs te krijgen. Hiervoor moeten structurele beslissingen worden genomen over het toewijzen van middelen, de toetsing en beoordeling van studenten, en over de organisatie van het medisch onderwijs in zijn geheel (OECD, 2019, p. 137). Hoewel het bevorderen van gelijke uitkomsten alleen maar kan worden toegejuicht, dient ook hier goed worden nagedacht over de manier waaróp die gelijke uitkomsten worden bereikt. De OECD (2019) waarschuwt dat een te sterke focus op

uitkomsten weleens kan leiden tot het uit het oog verliezen van persoonlijke verschillen tussen studenten. Dit kan vervolgens weer leiden tot een grotere druk om te 'assimileren', waarvan wij eerder zagen dat dit ongewenst kan zijn, omdat het ten koste gaat van de culturele identiteit van studenten. Een betere aanpak is dan ook, volgens de OECD, om 'equity' te combineren met 'inclusion', waarbij er zorg wordt gedragen dat studenten zich ook daadwerkelijk thuis voelen in het onderwijssysteem. Om het onderwijssysteem 'inclusief' te maken, moet het zo worden vormgegeven dat het toegankelijk is voor verschillende soorten individuen, op een volgens hen acceptabele manier is opgezet, en is afgestemd op hun behoeftes (Osler & Starkey, 2005). Op deze manier voelen studenten zich meer gezien en gehoord, wat tot betere onderwijsprestaties kan leiden.

Deze dissertatie beschouwt integratie als een proces dat van twee kanten komt, wat zou betekenen dat de migrant-arts zich niet alleen aanpast aan het onderwijssysteem in het land van bestemming, maar dat het onderwijssysteem zich ook aanpast aan de behoeften van de migrant-arts. Echter, ik moet hier toegeven dat het onderzoek in deze dissertatie zich voornamelijk richt op hoe onderwijs van invloed is op de ontwikkeling en acceptatie van migrant-artsen, en minder op het omgekeerde proces (dat wil zeggen: hoe past het onderwijssysteem zich aan de migrant-artsen aan). Hierdoor is het moeilijk te zeggen of het, in deze dissertatie gevonden, positieve effect van het ontvangen van een medische opleiding in het land van bestemming te danken is aan het feit dat het onderwijssysteem in dat land van bestemming 'equity' dan wel 'inclusion' voorstaat. Misschien is het onderwijssysteem zelfs wel onevenredig zwaar voor migrant-artsen of studenten met een migratieachtergrond; deze vraag is in dit proefschrift echter niet onderzocht. Dit is een belangrijke overweging voordat men kan concluderen of het huidige medische opleidingssysteem voor migranten dan ook het meest gewénste systeem is; dit hangt immers ook samen met de persoonlijke ervaring van de migrant-arts of student met een migratieachtergrond. Wat wel blijft staan is dat het volgen van een medische opleiding in het land van bestemming (in dit geval Nederland) leidt tot een positieve professionele identiteit onder medische studenten met of zonder migratieachtergrond, en dat deze professionele identiteit ook door de sociale omgeving (dat wil zeggen, patiënten) wordt erkend. Daarmee lijkt het volgen van een medische opleiding in het land van bestemming dus bij te dragen aan de integratie van migrant-artsen.

Tot Slot: Experiment Geslaagd?

Aan het begin van deze samenvatting werd de vraag opgeworpen of het combineren van sociale geschiedenis en sociale psychologie tot nuttige en nieuwe inzichten zou leiden. Terugkijkend op dit 'experiment', kunnen wij concluderen dat beide vragen met een 'ja' beantwoord kunnen worden. Wanneer het aankomt op een complex onderwerp, zoals de integratie van artsen, dan loont het om dit van meerdere standpunten te bekijken. Plots blijkt dan dat integratie van migrant-artsen niet enkel afhangt van hoe instituties de instroom van nieuwkomers door de eeuwen heen reguleren, of van de manier waarop mensen elkaar in groepen classificeren, of van de manier waarop mensen over zichzelf en

over anderen nadenken. Integendeel, integratie bestaat uit een combinatie van al deze factoren. Daar waar de sociale geschiedenis echter uitblinkt in het beschrijven van de manier waarop institutionele structuren op de lange termijn effect kunnen hebben op migratie- en integratiepatronen, hebben we de sociale psychologie nodig om te begrijpen hoe diezelfde institutionele structuren de gedachten en gedragingen van mensen beïnvloeden. Uit de combinatie van deze twee disciplines kwam dan ook het inzicht naar voren dat de manier waarop medische instituten onderwijs vormgeven weleens van invloed zou kunnen zijn op de manier waarop migrant-artsen of studenten met een migratieachtergrond tegen het artsenberoep aankijken, en op de manier waarop de sociale omgeving tegen die migrant-artsen of studenten met een migratieachtergrond aankijkt.

Dit is een nieuw inzicht binnen de sociale geschiedenis, waar tot op heden een debat gevoerd wordt over de intenties van gilden naar nieuwkomers. Probeerden gilden zoveel mogelijk mensen buiten te houden, om zo de privileges van een kleine club gelukkigen te beschermen (Ogilvie, 2008, 2019)? Of waren gilden vooral bezorgd om de kwaliteit van hun diensten, in het belang hun goede naam en het welvaren van de publieke zaak (Prak, 2018; Prak et al., 2019)? Het inzicht dat de sociale omgeving een opleiding gevolgd op de plek van bestemming waardeert, leert ons dat de gilden er waarschijnlijk belang bij hadden om een goede opleiding te verzorgen. Dit maakt het waarschijnlijker dat gilden daadwerkelijk gemotiveerd waren om hun leden van een kwalitatief hoogstaande opleiding te voorzien.

Ook binnen de sociale psychologie is het inzicht nieuw dat de plek waar een migrant zijn of haar opleiding heeft gevolgd van invloed kan zijn op de manier waarop die persoon zichzelf ziet en door anderen gezien wordt. Opleidingsniveau wordt vaak wel als maatstaaf gebruikt voor hoeveel een migrant geïntegreerd is, maar minder vaak wordt er gekeken hoe opleidingsniveau zelf het integratieproces bevordert. Daarnaast brengt deze dissertatie dus het inzicht dat het niet alleen draait om welk opleidingsniveau een migrant heeft behaald, maar ook wáár hij zijn opleiding heeft gevolgd. Dit geldt als een nieuw inzicht, en resoneert met de al eerder genoemde oproep van de OECD (2019) en de WRR (Bovens et al., 2016; Engbersen et al., 2020) om een nauwkeuriger onderscheid te maken tussen migranten, bijvoorbeeld op het gebied van opleiding.

Dat de combinatie van sociale geschiedenis en sociale psychologie naast nieuwe inzichten ook daadwerkelijk núttige inzichten heeft opgeleverd, mag blijken uit het feit dat er in deze dissertatie een aantal aanbevelingen worden gedaan over de integratie van migrant-artsen. Die aanbevelingen gaan niet alleen over het beleid dat beleidsmakers kunnen voeren om integratie op een structureel niveau te bevorderen, maar geven ook enkele handvaten voor psychologische interventies die zulk een beleid kunnen ondersteunen. Zodoende is er een breder pallet aan mogelijkheden om uit te kiezen om de integratie van migrant-artsen te bevorderen. Hoewel er ook nadelen aan de in dit proefschrift gehanteerde trans-disciplinaire methode hangen (denk aan de extra belasting voor de promovendus, die zich in twee verschillende vakgebieden moet verdiepen alvorens een betekenisvolle conclusie te kunnen trekken), moeten we concluderen dat het ‘experiment’ geslaagd is.

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*

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About the author

Piet Groot was born on April 24, 1992, and grew up in the town of Beverwijk in the Netherlands. During his high school years at Gymnasium Felisenum in Velsen he was a member of the students' council, which he headed for a period, and briefly involved himself with local politics. After completing high school he moved to Leiden, where he obtained a bachelor's degree in Psychology in 2013 and a research master's degree in Social and Organisational Psychology (cum laude) in 2016. During his university years he developed a keen interest for current societal affairs, which he intensively discussed with friends during weekly "Open Deur" Discussion Club meetings that he organised at his house. During this period his interest was first sparked by the topics of migration, integration, and the broader question how different people living in the same organised society may come to accept each other.

This latter question never completely left him alone, and so when the opportunity arose to do a PhD on the topic of integration Piet grabbed it with both arms. At Utrecht University Piet started his PhD on the integration of migrant doctors in 2018 under the dual supervision of Prof. Naomi Ellemers of the Social, Health, and Organisational Psychology department and Prof. Maarten Prak of the History and Art History department. During his PhD he was enrolled in Kurt Lewin Institute's social psychological training programme, and also in the Sustainable Cooperation – Roadmaps to Resilient Societies (SCOOP) transdisciplinary training programme. As part of the latter programme, he attended several conferences where the findings of his dissertation were synthesised with findings of other SCOOP PhD candidates in order to fulfil the goal of building a framework that promotes sustainable cooperation. Also as part of his PhD, Piet supervised bachelor and master students on their theses, attended national and international conferences, and published two peer-reviewed papers in international journals. The defence ceremony for his PhD is scheduled to take place on June 14, 2023.

In the photo, Piet can be seen enjoying a Thai sunset, which he was happy to gift himself after handing in his dissertation to the dissertation committee, and watch all his worries about completing his PhD dissolve together with the sun in the ocean. When he gets back to the Netherlands Piet will pursue his ambition to apply the knowledge and skills gained during his PhD in a position where academic research may be combined with policy making.

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Integration of newcomers into existing communities has been an ongoing process throughout the ages. And yet, migrant newcomers in the current day and age often find their path towards integration littered with a variety of obstacles. To understand better what the integration process for migrant newcomers looks like, the current dissertation utilises a new approach: combining historical studies with contemporary psychological experiments. The focal group of newcomers studied in this dissertation is doctors, whose integration process is studied in 18th century Amsterdam and 21st century Europe. It turns out that migrant doctors do not only have to deal with novel and specific institutional arrangements when moving to a new city or country, but also with specific and often hidden psychological responses of patients towards them as doctors. Importantly, the place where a doctor was educated influences the extent to which patients accept them, and therefore has consequences for their integration. This insight opens the door to policy aimed at making medical educational institutions more accessible for migrant doctors, and also for psychological interventions targeting patients' perceptions of migrant doctors.

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