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**Factors that affect the decisions made by skilled professionals to migrate
to the UK: A qualitative study of Cypriot migrant and returning
physicians.**

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ABSTRACT

Background: Migration theorists have been slow to consider international mobility of physicians as well as the feminisation of medicine and physicians' migration and identify the key characteristics for efficient physicians' migration management. This study therefore explored the factors affecting physicians' migration decision-making processes within the Cypriot and UK context. In doing so it identified the role of gender in this process to facilitate the appropriate development of the local healthcare system, medical education and physicians' density management.

Methods: This qualitative study combined an analysis of international migration literature and Cyprus' migration history and relationship with the UK, along with the lived experiences and views of active health care managers and two gender balanced groups of migrant and returning Cypriot physicians; providing a contextualised understanding of Cypriot physicians' migration.

Findings: As identified through the literature and empirical evidence, the main issues faced by the Cypriot healthcare system were the: absence of a full coverage national health scheme; limited educational and training capacity of the system; lack of proper cooperation between the public and private sectors and the lack of patients' trust with the system. In addition proper recording and documentation mechanisms were absent, whereas physicians' migration and health human resources management policies were inefficient. Furthermore, the analysis of physicians' migration at the level of the individual physician confirmed the complexity of the migration decision-making process and identified that the process could be affected by 'push-pull' and 'retain-return' factors, the gender of the individual and the positive and negative impact of physicians' migration on the individual, as well as the home and host country's context.

Conclusions: This study identified the need for proper monitoring and management of physicians' density, skill-mix and physicians' migration flows and the need for efficient partnerships between public and private healthcare sectors. In addition, this study identified that the development of Cypriot medical schools and potential physicians' migration management policies and improvements in local conditions, should fit the needs of the local healthcare system and the individual physician to facilitate the alleviation of any issues associated with gender inequality.

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List of Abbreviations

BSc: Bachelors in Science

CIMT: Committee on the International Migration of Talent

Dr. Med: Doctor of Medicine

EEA: European Economic Area

EU-10: The following ten countries that accessed the European Union in 2004, Cyprus, Czech Republic, Estonia, Hungary, Latvia, Lithuania, Malta, Poland, Slovak Republic, Slovenia

EU-15: Includes the traditional member countries of the European Union prior to 2004 Austria, Belgium, Denmark, Germany, Greece, France, Finland, Ireland, Italy, Luxemburg, Netherlands, Portugal, Spain, Sweden, United Kingdom.

EU-27: Includes all the EU-25 with two countries that accessed the European Union in 2007, Romania and Bulgaria

EU: European Union

GMC: General Medical Council

HSMP: Highly Skilled Migrant Programme

JCAHO: Joint Commission on Accreditation of Healthcare Organisations

MCN: Multinational Corporation

MIF: Migration Impact Fund

MS: Member States

MSc: Masters in Science

NAFTA: North American Free Trade Agreement

NGO: Non-Governmental Organisation

NHS: National Health Service

NRES: National Research Ethics Service

PhD: Doctor of Philosophy

S&T: Science and Technology

UK: United Kingdom

UKBA: United Kingdom Border Agency

UN: United Nations

USA: United States of America

WHO: World Health Organisation

WWII: World War Two

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Chapter 1 Introduction

1.1 The International Migration of Skilled Professionals

This thesis aimed to explore the migration decision-making processes of international skilled healthcare workers and, specifically, Cypriot physicians who migrate with the intention to study, work or train in the UK. Using available literature resources and primary data analysis, a study was undertaken concerning individual physician's motivations for migration, the options considered when selecting the desired destination and the effects of gender in the decision-making process. This discussion also draws upon the broader socioeconomic context of skilled migration. Utilising a study focused on the migratory movements and lived experiences of Cypriot physicians between Cyprus and the UK, contribution to knowledge is made in relation to understanding the decision-making processes in the international movement of skilled healthcare workers. Furthermore, the thesis provides the empirical evidence base for policy makers to act appropriately for the efficient management of the migration of physicians.¹

Even though there is a need for some degree of skilled migration for the promotion of a country's development and competitive advantage in a global market of goods, labour and services, the loss of skilled professionals may lead to 'brain drain' which might have the opposite effect on the further development of the sending country (Castles & Miller, 1993; 1994; 1998). Over time within the available literature, skilled migration has been described through many terms such as: 'brain drain', 'brain circulation' 'migration of expertise' and 'skilled international labour circulation'. Much of the available literature on skilled migration up to 2016 described the functioning of the labour market and the redistribution of workers, as being stimulated by the disequilibrium between the demand for skilled

¹ The terms skilled healthcare workers; gender; migration (including local, temporary, permanent, skilled and gendered migration); physicians (including physicians in training and medical students) are defined and explained in detail in Chapter Four of this thesis through their use in the available empirical and theoretical literature.

labour and the supply of it. However, in another part of the available literature and specifically among supporters of economic maximization theory, there is argument that skilled migration is a result of real wage differentials, since demand and supply are always at equilibrium and only real wages are fluctuating to keep this equilibrium fixed (Greenwood, 1975; Anarfi et al., 2010).

Furthermore, the term 'brain drain' appears to be the most widely used definition; a term first coined by the Royal Society of London in 1963 to describe the occupational exodus of scientists from the UK to the USA (Aluwihare & Mchir, 2005). Brain drain therefore refers to the loss of skilled workers from a source to a destination country that offers greater social and economic opportunities (Iredale, 2001). Prior to the 1990s the main sources of potential migrants were developing countries such as sub-Saharan African countries and India, whereas 'host' countries used to be developed countries such as the UK, USA and Australia. However, since the 1990s it seems that skilled individuals migrating to seek opportunities and career development to improve their personal prospects have only been partly influenced by their country's general development conditions (Iredale, 2001). Due to the transnational nature of skilled professionals' and healthcare workers' migration from 2000 and onwards, in a globalised environment, and the inability of the term 'brain drain' to incorporate this trend of skilled individuals' migration movements the term 'skilled migration' was used throughout this current study.

1.2 Key Concepts

Key terms and definitions relating to skilled and physicians' migration are examined in this section. Combined with analysis of the theoretical models presented in Chapter 3, the analysis of these concepts will promote better understanding of the findings identified in the empirical literature and will enhance the overall understanding of the aim and objectives of this current study. Thus, this section provides a detailed account of the

concept of ‘skilled’ and ‘gender migration’ the term ‘physicians’ and their importance in healthcare and society, and the concept of ‘physicians’ migration facilitating factors’.

1.2.1 Skilled migration

Migration describes the movement of individuals, and/or families from one place to another, further divided into two main categories: internal migration involving movement within a country; and international migration, which describes the process where individuals move across national boundaries (Castles & Miller, 2003). In addition, Castles and Miller (2003) described the process of an individual moving back to their home country for resettlement as return migration. Furthermore, the term migration may refer to the emigration of individuals and their outward movement from their country of origin or the inward movement of individuals to a specific country, referred to as immigration (Keeley, 2009). These movements might be temporary, with the typical length of stay being less than a year (Keeley, 2009), whereas for migration movements to be considered as permanent depends on the regulations of each host country. In accordance with this study context the UK government considers four years of continuous employment as a prerequisite for an application of an “indefinite leave to remain” and permanent residence (Ruhs, 2005).

The Organisation for Economic Cooperation and Development classifies skilled individuals as those who have either completed or are in the process of completing tertiary education (Asabir, 2009), whereas skilled migration refers to the movement of skilled individuals from one place to another both within a country or internationally (Castles & Miller, 2003; Asabir, 2009). Iredale (2001), through an extensive examination of the available migration literature, suggested an efficient and practical mechanism for the identification and analysis of skilled professionals’ migration flow by classifying skilled migration into categories. Therefore Iredale’s (2001) categorisation included: migration by

motivation; migration according to the source and destination of the migrant; migration by channel; migration defined by duration of stay; migration defined by the mode of incorporation; and migration defined by type (national/international) or profession.

According to the World Health Organisation (WHO, 2006), a skilled healthcare worker is ‘an individual who concentrates on activities that have as an objective to satisfy and enhance health’ and it is estimated that there are more than 60 million skilled healthcare workers globally. Skilled healthcare workers’ migration is an international phenomenon that describes the redistribution of professionals such as physicians, nurses, pharmacists, radiologists and lab technicians (Connell, 2008; Anarfi et al., 2010). Since the 1980s there was a rise in the international migration of skilled healthcare workers, usually from less developed countries with weak healthcare systems such as India, the Philippines, and sub-Saharan African countries, to more developed countries such as the USA, Canada, Australia and West European countries such as the UK (Connell, 2008). Another term frequently used by migration scholars was brain circulation. This term outlined the exchange of skilled professionals and healthcare workers between countries and the return of nationals back to their country of origin, as well as the transformation of traditional destinations and sending countries into both (Hamilton & Yau, 2004).

1.2.2 Gendered skilled migration

The term gender according to WHO (2013), describes the socially constructed characteristics, behaviour, activities and roles that are considered appropriate for men and women in a given society, whereas sex refers only to the biological characteristics and differences between men and women. Female professionalism increased during the 1970s when women started to actively pursue professional work opportunities in previously male dominated fields such as law, engineering and medicine, as a result of improved working conditions for female workers and greater educational and social opportunities (Gjerberg,

2001; Riska, 2001b). During the 2000s and the decade that followed, there was almost equal participation of female and male skilled professionals in international occupational migration (Boyd, 2006; Badkar et al., 2007), leading to the increasing feminisation of migration internationally (Castles & Miller, 2003).

Despite a rise in international migration studies, up to the late 1990s; the majority of skilled migration studies examined gender and migration separately (Callister et al., 2008), with limited discussion and analysis on gendered skilled migration and the place of female skilled professionals in migration flows (Kofman, 2000). Furthermore, skilled migration literature was biased towards studying male migrants. The majority of available research studies explored the migration of male skilled professionals within companies and organisations (Salt, 1992; Mahroum, 2001; OECD, 2002; Liversage, 2009). Female skilled migrants therefore were invisible in the majority of research studies as they were identified as spouses accompanying their migrating husbands, or as daughters reuniting with their migrant family (Purkayastha, 2005). Even feminist scholars, who had long argued that labour migration was gendered, failed to explore the place and role of female skilled professionals in international skilled migration, mainly focusing on unskilled female workers and related economic considerations (Boucher, 2007). Consequently, most skilled migration literature was based on male skilled professionals moving within specific institutional contexts and failed to incorporate the professional female migrant, who migrated either as a spouse ready to work in the host country's skilled labour market or as a single skilled migrant seeking better social and professional prospects (Purkayastha, 2005).

Despite the increased feminisation of medicine during the last two decades, gender bias and gendered norms were still present during the late 2000s, consequently sustaining imbalances between male and female physicians, and restricting female physicians from

realizing their full potential. Gender bias in medicine describes all the factors such as behaviours, policies or other actions and trends that influence the medical career of either male or female physicians due to gender dissimilar treatment (Serrano, 2007). A stereotypical role was assigned to male and female physicians and a gendered attitude from patients internationally that consequently led to discriminatory behaviour towards female physicians and physicians in training (Antoniou et al., 2008). The problem of gender inequality in the medical profession was further exacerbated by the inability of the available literature to provide justification for the reasons sustaining gender disparities (Sexton, 2012).

Nevertheless, since the 1990s there has been greater awareness of female skilled migration via migration scholars and other key players in the healthcare sector. This enhanced awareness can be ascribed to several factors such as: the declining demand for skilled professionals in male-dominated sectors; increased recruitment of skilled professionals in feminised professions; international economic development; increased gender-selective demand for skilled professionals; and major international gender relation changes (Kofamn & Raghuram, 2006; Badkar et al., 2007). Consequently a great number of migration scholars have placed importance on recognising the gendered nature of migration (Hartman & Hartman, 1983; Pedraza, 1991; Zlotnik, 1995; Hawthorne, 1996; 2001; Docquier et al., 2009; Docquier et al., 2012). Specific attention has therefore been assigned to the significance of female skilled migration flows; gender specific push-pull migration factors and impact; and the different responses of male and female migrants to specific stimuli and work-related obstacles (Birrell, 1996; Man, 1995; Kofman, 2000; Liversage, 2009). Even though both male and female migrants move and behave in response to certain stimuli or needs, their responses and related behaviour in relation to push and pull migration factors and different socioeconomic conditions differs substantially as a result of personal traits and characteristics (Docquier et al., 2012).

1.2.3 Definition of “physician”

In this thesis the term “physicians” is used to denote the professional group of skilled healthcare workers under study. However, the term “physician” is subject to diverse meanings and requires further analysis. Several empirical studies on physicians’ migration use different wording to describe the group of skilled healthcare workers investigated such as: skilled healthcare professionals; doctors; surgeons; physicians; or they refer clearly to the specialty of the group such as cardiologists or psychiatrists. A number of migration scholars such as Williams and Balaz (2008) in studying return mobility and knowledge transfer, referred to health workers’ migration to identify a range of migrant individuals working in the healthcare sector and used the term doctor to describe the specific group of health professionals that their study focused on. In another study by Klein et al. (2009) exploring the personal side of physicians’ emigration, the term physician was used to describe international medical graduates who were at the practising stage. Whereas Joudrey and Robson (2010) used the term physician in their study that examined the working experiences of South-African qualified and trained physicians working in Canada. Furthermore, Oberoi and Lin (2006) in their study on the experiences of Southern Africa doctors in Australia using the term doctor ignored participants’ specialties and clearly referred to qualified doctors who had been working in the secondary and tertiary health sectors. Lastly, Harrison (1998) in her study on female migrant physicians in Mexico used the term physician to incorporate individuals who were practising in some form of medical work despite their specialty or post including physicians working with patients or in administrative posts.

The Joint Commission on Accreditation of Healthcare Organizations (JCAHO) has defined the term “physician” as a doctor of medicine who is legally authorized to practice medicine and/or surgery and who provides diagnosis and/or treatment (JCP, 2009). This definition is inclusive and not limited to specialty, including surgeons and doctors of every specialty. In

this current thesis the term ‘physician’ is used to denote the range of medical staff designated by JCAHO including individuals who have completed their medical education and were either at the practising stage or had been qualified and working in a specific specialty field. Nevertheless, in order to focus on specific points and raise particular issues throughout this thesis the term ‘physicians in training’ was used. The term ‘physicians in training’ as used throughout this current study refers to medical graduates who have completed their medical education in a recognised University in the UK, enrolled in the Cypriot Ministry of Health, and at the point of interview were at their practising stage. In addition the term ‘medical students’ has also been used to denote individuals who have the intention to study medicine and individuals who were either accepted to study or commenced medical studies at a recognised university.

Even though Clemens’ (2007) study correlates the malfunctioning of the health system to the outflow of physicians, he also argues that it is difficult to enumerate the effect of physicians’ absence on the healthcare system. Nevertheless countries facing severe outflows of physicians experienced significant problems in the provision of healthcare (Brush & Sochalski, 2007; Connell, 2008). The impact of physicians’ migration has been identified in several studies. Palmer’s (2006) study on healthcare human resource management in Malawi referred to the closing down or merging of departments due to the departure of a large number of physicians and nurses. Similarly in Jamaica a great number of wards closed down or merged in the absence of adequate healthcare human resources, causing problems with immunization coverage and training (Chikanda, 2004). Furthermore, Gerein et al.’s (2006) study on the impact of skilled healthcare workers migration outlined that shortages in skilled healthcare workers and physicians in a number of sub-Saharan countries increased workloads, as well as waiting and consultation times. Moreover, Connell’s (2008) review on the international migration of health workers identified that in Zimbabwe a great number of patients were diverted away from inefficient

and understaffed public hospitals to the private sector, resulting in decreased patient equity and increased healthcare spending and out of pocket costs. In another case, inadequate staffing of physicians and other skilled healthcare workers in Malawi led to questionable practices where some of the remaining staff accepted 'gifts' as an incentive to perform their tasks properly (Muula & Maseko, 2006). A multinational report by Awases et al. (2004) on the effects of skilled healthcare workers' emigration away from Cameroon; Ghana; Senegal; South Africa; Uganda; and Zimbabwe identified several problems caused by inadequate staffing of physicians. Amongst these problems were diminished respect and communication amongst remaining physicians and patients; poor health indicators; inadequate healthcare coverage; less attention to patients; migration of patients to receive treatment abroad; and reductions in patients' equity.

1.3 The Migration of Skilled Healthcare Workers

Healthcare has become highly commercialised since 2000 and so has the migration of healthcare workers (Connell, 2008). This was the result of the growing globalization of services' flows, the continuous restructuring in national health systems, and the increasing needs of developed economies (Connell, 2008). Consequentially, these developments have enhanced the demand for migrant skilled healthcare workers as a potential solution to minimise health related costs generated from training indigenous human resources to cover this demand (Iredale, 2001; Findlay & Stewart, 2002; Lowell & Findlay, 2002; Connell, 2008).

In the past, the majority of migrating skilled healthcare workers were male physicians. However, since the 1990s there were great changes in the gender structure and diversity within skilled healthcare workers' migration, with an overall increase in the opportunities offered to female healthcare workers and a greater number of these skilled female workers migrating abroad. The migration flows of skilled healthcare workers have also changed as

a result of shifts in international demographics as well as socio-economic and healthcare restructuring (Connell, 2008). The examples of Ireland and Poland depict these changes and the increased complexity of skilled healthcare workers' migration flows in the two decades since the 1990s. Since 2000, Ireland, which used to be a great exporter of migrant labour, became a major recruiter of skilled migrants. Additionally, Poland during the same period became as much a sending country as well as a host country. Poland, therefore, has experienced the emigration of its local skilled healthcare workers to the English speaking countries of the West. Consequently, Poland has been recruiting workers from other less developed Eastern European countries to cover the resulting vacancies in the country (Buchan et al., 2004).

1.3.1 Factors explaining the migration of skilled healthcare workers

International migration flows of skilled healthcare workers since the 1990s mimicked the migration trends seen among other skilled professionals such as IT specialists, professors and engineers (Lanfranchi & Taylor, 2001; Millar & Salt, 2007; Xiang, 2007). The majority of skilled healthcare workers migrated primarily to enhance their economic prospects and to improve their skills and knowledge in order to subsequently develop their professional careers (Connell, 2008). In addition, other factors that drove the migration of skilled healthcare workers during this period included poor working and social conditions, lack of professional opportunities and promotion, poor technological and research infrastructure and heavy workloads (Luck et al., 2000, Bach, 2003; Buchan et al., 2004; Kingma, 2006). Furthermore, according to these studies, ignorance and marginalisation from peers, management and policy makers, as well as low healthcare spending and its subsequent effects on the development of the local healthcare systems, also facilitated the migration of skilled healthcare workers abroad.

1.3.2 The main factors affecting physicians' migration

According to Mejia (1978) physicians and other skilled healthcare workers migrated abroad in search of a better intellectual milieu that would permit them to exploit their full potential and talents and potentially improve their economic and social status. Nevertheless, push-pull and retention-return factors differ for every individual as well as the importance allocated to each one of these factors by people from different cultures and backgrounds. Therefore different contexts, and different individual or household needs contribute to the complexity of understanding migration decision-making processes and limit the ability to generalize conclusions and migration patterns between individuals and countries (Kelo, 2004; Ross et al., 2005; Wiskow, 2006; Buchan, 2007).

A number of researchers (Harrison, 1998; Marchal & Kegels, 2003; Norzini & Mazmanian, 2005; Boulet et al., 2007; Hallock et al., 2007; Kaushik et al., 2008a; Arah et al., 2008) argued that even though major push-pull factors could influence the migration process, the capacity of a country to provide high quality medical education and training could determine potential physicians' migration flows, size and direction. Therefore, the establishment of the first medical schools in Cyprus might prove decisive in future migration movements of Cypriot physicians, physicians in training and medical students. Nevertheless, as Pond and McPake (2006) suggested, any conclusions on the effects of these medical schools on physicians' migration could only be drawn typically five to ten years after their establishment and following graduation of the first medical students. Even in countries with existing medical schools, physicians' migration could also be triggered through other educational factors; such as the opportunity to attend cheaper medical schools or those schools that require a lower entrance requirement (Hallock et al., 2007). Additionally, another factor could be the opportunity to attend a higher quality and prestigious medical school that could potentially facilitate higher earnings, or the opportunity to re-migrate to a destination with even higher medical and economic

development (Hallock et al., 2007; Arah et al., 2008; Kaushik, 2008b). In their studies Kaushik et al. (2008a; 2008b) and Arah et al. (2008) further argued that the higher the ranking of the medical school that an individual physician graduates from, the higher the probability for this physician to migrate. Kaushik et al. (2008a) and Astor et al. (2005) also stated that those more likely to migrate are the highest-ranking students and graduates from elite medical schools.

Additionally, the enlargement of the EU and the mutual recognition of medical qualifications between member states facilitated the unrestricted movement of physicians seeking employment within the majority of the EU-27 countries. Therefore, despite the difficulties in the implementation of the associated EU directives, physicians' migration flows between EU member states increased in the last decade following the two major EU enlargements in 2004 and 2007 (Gerlinger & Schmucker, 2007). In addition to EU policies; national policies and international market forces are able to affect demand and supply for physicians, and subsequently affect physicians' migration flows internationally as they alter the socioeconomic and professional conditions locally and within the EU. Political decisions in the UK in 1996 to increase healthcare spending without improving physicians' wages and Germany's decision to contain physicians' wages following its unification illustrate the potential effects of national policies on physicians' migration. In both cases the Governments' political decisions on healthcare planning and funding generated disequilibrium in physicians' labour markets that facilitated an increased inflow of foreign physicians to these countries (Pond & McPake, 2006).

Joudrey and Robson (2010) argued that another major factor affecting physicians' migration flows is the degree of professional freedom and autonomy. A number of researchers (Scabler, 2002; Bury, 2008; Feredi, 2008; Joudrey & Robson 2010) concluded that medical autonomy has been declining as a consequent of higher patient awareness; evidence-based medicine (Bury, 2008); and increased corporate control, regulation and

auditing of the profession (McKinley & Stoeckle, 1988; Turner, 2004). Medical autonomy can therefore change the way an individual physician appreciates the profession, and depending on the individual's perspective it may well act as a potential driver for migration.

Lastly, a number of studies (Koser & Salt, 1997; Norcini & Mazmanian, 2005; Adkoli, 2006; Icuare, 2011) depicted the importance of advancements in technology such as telemedicine and virtual medical schools, as well as communication and transport in the migration flows of physicians and other skilled healthcare workers. According to the same migration scholars, technological advancements have limited the need for physical movement whereas advancements in communication and transport have decreased the financial and social costs of migration.

1.3.3 The feminisation of medicine and migration of female physicians

Since approximately 2000, there has been a change in the character of the medical workforce in many industrialised societies. Medicine has become highly regulated, moving from a male dominated profession to one in which there are more equal numbers of males and females. The number of female physicians has increased and there are almost equal numbers of male and female medical students, serving to minimise the gender gap in the medical workforce. Nevertheless, despite increasing numbers of females entering the medical profession, gender inequality is still present in physicians' migration (Riska, 2001b).

Furthermore, the migration of female physicians has increased following the tendency of migrating physicians to seek greater career prospects and destinations where there is a low density of physicians (Connell, 2008). This significant increase in the flow of female migrant physicians over the last two decades can be ascribed to several factors such as family and societal expectations, professional development and professional freedom

(Rickets & Randolph, 2008). Moreover, increased parity in the numbers of female and male physicians migrating further complicated the identification and study of the main factors that initiate and sustain the phenomenon of physician migration (Rickets & Randolph, 2008). The feminisation of medicine, and consequently the feminisation of physicians' migration, has therefore initiated an updated approach from scholars examining the migration of physicians. This updated approach incorporated: the effects of gender; the distinct qualities of female physicians; different socioeconomic contexts in home and host countries; and the circumstances of dual-physician/dual-professional couples on physicians' migration flows and the decision-making processes (Kofman et al., 2000; Purkayastha, 2005; Kofman & Raghuram, 2006).

1.3.4 The main impact of skilled healthcare workers migration

The migration of skilled healthcare workers is a multifaceted issue and it has been difficult to estimate its possible impact on the healthcare systems in sending and host countries, as well as the health professionals involved. Nevertheless, through examples depicted in the available literature since the 1990s in several countries it has been suggested that the migration of skilled healthcare workers had both a positive and negative impact. Initially the sending countries may have experienced a depletion of their available human resources, affecting the delivery of healthcare services and the education of other potential skilled healthcare workers. In addition, sending countries may have faced economic losses from the sponsored training of their local skilled healthcare professionals (Connell, 2008), as well as other complicated socioeconomic and political consequences that are reviewed in greater detail in the following chapters. On the contrary, host countries may have benefited from the inward migration of skilled healthcare workers through the 'filling up' of recruitment vacancies in their local health systems in a cost efficient manner, as no or limited financial resources would have been invested in the training of these staff. Furthermore, individual skilled healthcare workers may have been the key beneficiaries

through the migration process if the set objectives that initiated the migration movement in the first place were fulfilled (Connell, 2008).

It can thus be argued that the migration of physicians can affect individual migrants as well as their home and host countries in a negative or positive manner, depending on the perspectives of the researcher or the individuals and institutions affected by the migration. Through the migration literature identified in this current study the negative or positive impact of physicians' migration were found to be dependent upon several interrelated factors. A number of scholars (Barrel et al., 2007; Young et al., 2010) identified these factors as: the skill mix of individual physicians who decided to migrate and physicians who decided to stay; working environments and conditions; accessibility of the health and research infrastructures of home and host countries; as well as the existing demand and supply of physicians. Furthermore, assessing the impact of physicians' migration becomes even more complex due to: the different context of each country involved; the unavailability of comparable data; and the inability to account for the effect of unexpected events such as the enlargement of the European Union (EU), financial crises and wars (Barrel et al., 2007). Nevertheless, reviewing the available theoretical and empirical literature up to 2016 (as discussed in Chapter 4) facilitated a more precise identification of the major impact, both positive and negative, of physicians' migration within the last two decades.

1.4 The Management of Skilled Healthcare Workers' Migration

The majority of developed EU countries face challenges with supply and aging populations of their local skilled healthcare workers. A number of different approaches and policies were taken by these countries in an attempt to minimise staffing problems and counteract problems of the aging workforce (WHO, 2006). According to Ruhs (2005), in order to achieve effective migration management that is capable of addressing specific circumstances, such as supply and aging of skilled healthcare workers as well as the

specific needs of skilled healthcare workers' and the individual country's context, a balanced trade-off is required. This trade-off should be made between the personal and professional rights of skilled healthcare workers and the appropriate restrictions, regulations, and policies based on solid empirical evidence, (Hamilton & Yau, 2004; BCC, 2009).

The majority of skilled migration management policies seem to have focused on the 'six Rs' principle. This approach suggested that any policy introduced should focus on: Return of migrants; Restriction of mobility; Recruitment and Retention; Resourcing of expatriate; and Reparation (compensation) for lost human capital (Lowell, 2001). On the contrary, Ogilvie et al. (2007) suggested the idea of 'transnational migration policies', emphasising the need to focus on four main areas. These four areas are: the development of ethical recruitment guidelines; the source of skilled healthcare workers shortages; rethinking transnational aid priorities; and the development of potential agreements and collaborative partnerships between countries that can minimize the negative impact of skilled healthcare workers' migration.

The available literature drawn on in this current study identified a number of proposed approaches or approaches that have already been used for the effective management of skilled healthcare workers and specifically physicians' migration. These management approaches included: the provision of financial incentives; bilateral agreements between host and home countries; housing and reduced tax incentives; increased professional autonomy; improvements in professional status and working conditions; and shorter medical curriculums (Lowell, 2001; Forcier, 2004; Zivotofsky, 2009). As Dobson (2008) argued, properly incorporating the specific context of each country in the management of skilled healthcare workers' migration could potentially reduce staffing problems and unemployment through increasing the GDP and decreasing inflation. Chapter 4 identifies

and presents the main policy approaches and strategies used internationally for the efficient management of skilled migration flows.

1.4.1 A new approach in physicians' migration management

Skilled migration has changed since the 1990s following the globalization of labour markets and the forces of demand and supply. Nevertheless, the traditional reality of skilled migrants moving from less developed countries to countries in the West changed, as people moved despite the socioeconomic state of their country. Following a more individualistic approach, they looked at opportunities for economic and professional development. Skilled healthcare workers' migration followed a similar trend as healthcare services became commercialised, and healthcare systems around the world changed, aiming to cover their human resource needs with the minimum expense. As identified through the literature, national healthcare policies applied internationally aimed to achieve cost efficiency through the reduction of training costs and the recruitment of available and already trained skilled healthcare workers from the international market pool. In addition, great changes in international migration trends and healthcare delivery services, combined with the feminization of medicine in the last two decades altered the gender structure of skilled healthcare workers' migration. Consequently, female physicians were offered enhanced opportunities to develop, leading to increased gender parity in migration flows as opposed to earlier trends where male physicians and other skilled professionals dominated migration flows. Therefore, within the last two decades since the 1990s the main factors affecting the migration decision-making process of skilled healthcare workers and the impact that these flows might have on the parties involved were studied in detail in a number of empirical studies. However, the context dependent nature of physicians' migration, major changes in the gender structure of medicine along with the complexity of factors that initiate and sustain physicians' migration, led to an awareness among scholars

that a new updated approach of migration management policies capable of compensating these challenges needed to be developed.

1.4.2 International skilled healthcare workers migration policies

Various programs and policies are implemented worldwide for the efficient management of skilled professionals' migration. As observed in the available literature, some countries that had a demand for skilled healthcare workers developed policies that facilitated higher immigration flows of skilled healthcare workers, whereas other countries attempted to improve local conditions and restrict immigration. These identified migration management approaches aimed to attract immigrant skilled healthcare workers to satisfy their healthcare requirements and provided incentives to local skilled healthcare workers to return or stay in their country of origin, while protecting the indigenous skilled healthcare workforce. Another part of the policy literature examined the development of compensation policies to sending countries and the development of ethical recruitment strategies by major destination countries. These migration management strategies therefore aimed to achieve an efficient and equally advantageous distribution of skilled healthcare workers for both sending and host countries. An outline of this range of policy approaches is presented below.

The USA, a country in high demand for foreign skilled healthcare workers, issued specific visas (H-1A, H-1b) to facilitate the extended stay and employment of foreign trained nurses and physicians for a period of five years, with simultaneous completion of the five-year compulsory period for permanent residence status (Iredale, 2001; Cooper, 2005). Canada used a similar visa that facilitated easier access to employment for a range of skilled healthcare workers in demand (Iredale, 2001). In addition, the OECD, a major player in international skilled healthcare workers' migration, aimed to facilitate efficient distribution of skilled healthcare workers. The OECD promoted the implementation of less

restrictive immigration requirements, shared learning between different health systems and the use of transparent, ethical and targeted recruitment campaigns (Adkoli, 2006).

In contrast, other countries focused on the improvement of local working conditions in order to retain already available skilled healthcare workers and discourage them from migrating abroad (Pena et al., 2010). According to Hamilton and Yau (2004) and Pena et al. (2009), improvements in local working conditions included: increased wages; opportunities for further and higher quality training; improvements in facilities and the provision of incentives such as free accommodation or higher salaries in underserved areas. Furthermore, other countries provided special grants supplementary to the ones regularly provided to other students in order to incentivize indigenous medical students to enrol in local medical schools and satisfy national physicians' requirements (Forcier et al., 2004).

As identified in Forcier et al.'s (2004) study, some countries aimed to discourage foreign physicians from extending their stay in the country they had studied by providing incentives to immigrants to return to their home country. Therefore, a number of countries implemented a compulsory five-year work placement outside the country of study prior to the issuing of a work permit (Forcier et al., 2004). In a number of countries in the Gulf such as Kuwait, local governments attempted to control immigration through the implementation of direct and indirect taxes to immigrants that increased their overall migration costs. Additionally, a number of these countries incentivised local employers to employ indigenous skilled healthcare workers through the provision of subsidies for vocational training or monetary benefits for these employers (Shah, 2006).

Several South American countries such as Argentina and Uruguay attempted to re-recruit migrant skilled healthcare workers who had studied in these countries to satisfy local demand by offering tax concessions and loan deletions to returning skilled healthcare

workers and students respectively (Lowell, 2001). In addition, Lowell (2001) and Castles (2006) suggested that improvements in local infrastructure and the establishment of active expatriate organisations could improve and promote the status and working conditions of specific professions such as medicine and nursing. According to these studies improved conditions and active expatriate organizations could facilitate higher return flows of migrant skilled healthcare workers and satisfy local demand.

1.5 The Study Approach

The aim of this current research is to offer better understanding of Cypriot physicians' migration through studying migrant and returning physicians' personal experiences and their decision-making processes whether or not to migrate, as well as the selection of their destinations. Due to the ageing of physicians and the general population, the feminization of medicine (inactivity as a result of maternity leave), as well as rapid increases in technological advancements and the enhanced specialisation in medicine, the demand for physicians within the EU and internationally has grown faster than supply (Julia, 2016). Furthermore, the globalisation and commercialisation of healthcare and physicians' migration since the 2000s (Connell, 2008) has enhanced the demand for physicians in medically developed countries and the active recruitment for foreign physicians as a cost efficient solution to cover their needs (Findlay & Stewart, 2002; Lowell & Findlay, 2002). Consequently, according to the European commission the EU will face a shortage of 230,000 physicians by 2020 (European Commission, 2012).

Triggered mainly by scarcity of data in relation to Cypriot physicians' migration, this current study aimed to provide an initial evidence base on which more research can be added to aid policy makers to identify the needs of the local educational and healthcare systems, as well as individual physician's professional and personal aspirations to develop an efficient migration management strategy. This study therefore identified the 'push and

pull' factors affecting the decision-making processes through the lens of a transnational approach to incorporate contemporary developments in medicine and transportation, as well as the contemporary approach of physicians toward migration. In addition, through the use of a gender balanced sample this current study identified any differences amongst Cypriot male and female physicians concerning the main factors that initiate or sustain migration, as well as any differences in the overall approach towards migration abroad. This approach therefore incorporated the role of gender in the migration process and enhanced the applicability of this study's findings. The outcomes of this study were to develop a conceptual framework to be used as a policy development tool based on the empirical data and incorporating the results from previous studies and theoretical literature. It also aimed to identify areas for further research to enhance this conceptual framework, as well triggering international research. Lastly, the findings from this study identified factors that might be specific to closed societies and countries with a colonial past. Therefore, this study can be used as a stimulus and evidence base for migration scholars and further research on physicians' migration in low populated countries (i.e. Malta, Luxemburg) or countries sharing close historical and social links similarly to Cyprus and the UK.

The majority of EU-10 countries, including Cyprus are less competitive in terms of remuneration, infrastructure and professional development and so are losing physicians; mainly to the EU-15 and other more developed countries in the West (Bidwell et al., 2013; Scharer-Freitag, 2015; Filippidis, 2016). The migration of physicians could therefore create or enhance the shortage of physicians in small island countries such as Cyprus with all the associated effects. There is a lack of available, reliable and comparable data on physicians' migration or return migration (Jinks et al., 2000; Vujicic and Zurn, 2006; Dussault et al., 2009; Costigliola, 2011; Wismar et al., 2011; Buchan et al., 2014). This lack of available data is further exacerbated for small European countries, such as Cyprus or Malta, which

are not included in major migration literature and statistical data due to small population sizes.

Having in mind both the negative and positive effects of physicians' migration identified in the literature, this study aimed to respond to this gap by producing data on Cypriot physicians' migration and the main factors that initiate or sustain physicians' migration. To achieve this aim, and having identified through the available literature the effects of context on both the sending and receiving countries, as well as the historical and socioeconomic links between countries on the migration process, this study examined Cypriot and UK's educational and healthcare contexts as well as any links between the two countries.

1.6 Roadmap for the Thesis Chapters

This thesis was organised into chapters based on the stated study aim, including the Cypriot context needed for the background information, as well as a detailed review of the available theoretical and empirical literature up to 2015 and the study's specific objectives. There is a detailed review of the methodology used in the thesis, a presentation and discussion of the findings and lastly, a conclusion that summarises the major study findings. The outline of each chapter is as follows.

In Chapter 2, an introduction to the health and educational systems in Cyprus is provided, as well as an outline of the migration history and migration behaviour of Cypriots and the migratory and historical links between Cyprus and the UK. This chapter therefore, provides the necessary context and background needed to explore the research questions and findings in this current thesis.

In Chapter 3, the theoretical context of this study is set out through reviewing the available theoretical approaches and models used in the study of international migration. The chapter is separated into two sections, initially reviewing migration initiation theories followed by

an extensive review of theories on the continuation of international migration; focusing mainly on transnational migration theory and the 'push and pull' model on which the theoretical framework of this thesis was developed.

In Chapter 4, a synopsis of identified empirical literature on the migration of international skilled healthcare workers and specifically physicians is provided within the time limits of this study. In order to depict in detail each issue that is examined, this chapter is divided further into two main sections. A detailed review of the empirical literature is provided in section one; identifying the major factors that affected migration and the impact of such migratory movements on individuals and countries while identifying the potential role of gender in the migration of skilled healthcare workers and physicians. A review of the empirical literature on the main policies used to manage physicians' migration in the EU and internationally is provided in the final section of this chapter.

A review of the research methods and techniques that were used from the initiation to the completion of this study are outlined in Chapter 5. Following the presentation of the relevant methodological and theoretical concepts, there is further discussion of the reasons underpinning the methodological approach taken in this study in relation to the research questions, and the considerations for the selection of the appropriate methods of data collection.

The results obtained through the semi-structured interviews are presented in Chapter 6. Initially there is an outline of the main characteristics of the participants. This is followed by a presentation of the results obtained on: the main impact of the migration of Cypriot physicians the major 'push-pull' and retention-return migration factors; the factors affecting destination selection; the role of gender and family on the decision-making processes. For the purpose of clarity of Cypriot migrants' responses, those returning

physicians, as well as the responses of Cypriot health care managers, were subdivided according to identified themes.

A critical analysis of the findings is provided in Chapter 7. This discussion is therefore guided by the study's objectives and research questions as these were set out in Chapters 4 & 5 respectively. Through this analysis the contemporary behaviour of Cypriot physicians is identified and suggestions are provided through an operational framework developed for the efficient management of the migration of Cypriot physicians.

Lastly, a summary of the study's key findings and contributions to knowledge is provided in Chapter 8. Furthermore, potential implications and applications of this study's findings are discussed while providing suggestions for local policy responses.

Chapter 2: Cyprus and Migration

2.1 Summary

In this chapter background information on Cyprus, the healthcare, educational and training system of Cyprus is provided, as well as the role of women and the migrant profile and recent migration history of Cypriots.

This chapter is divided into six sections. In the first section, general information is provided about Cyprus' geography, demographics as well as the economy and its governance structure. The second section of the chapter outlines the role of women since the establishment of the Cypriot republic in 1960 along with demographics and statistical data on Cypriot women. In the third section there is a detailed analysis of the current Cypriot healthcare system, its current and suggested operating model and an outline of the key healthcare indicators. The next section of this chapter elaborates on Cyprus medical education capacity. It further emphasizes the process for the establishment of the first three medical schools in Cyprus and the debate on their role and efficiency is also discussed as this is significant for appreciating the importance of this study on physicians' migration management. The fifth section provides general information on Cypriots' migrant profile and their migration trajectories. The sixth and final section provides a detailed description of the connection between Cyprus and the UK presenting a historical outline and focusing on the migration links between the two countries. Further significant historical information and landmarks that might have affected the migration process are presented in sequence in Cyprus' Chronology 1920 to 2013 in Appendix 1, for more in depth background information on Cyprus.

2.2 Cyprus: The Background

Cyprus is the third biggest island in the Mediterranean and its geographical position provides a link between Europe, Asia and Africa, forming the Southern 'border' of the EU.

Cyprus is divided into six main districts namely: Nicosia (capital), Kerynia, Famagusta, Larnaka, Limassol and Paphos, covering an area of 9,251 square kilometres (Teerling, 2011), 240 Km from its East to its west end and 100 Km at its widest point from North to South (CyStat, 2016). Its geographical position (33° E, 35° N) is of strategic importance since it lies to the far end of the Mediterranean and it has a close proximity to Africa, Europe and Asia.

2.2.1 Population

The population of the island was last estimated in 2015 at 848,300 people comprised of 412,700 males and 435,600 females (CyStat, 2016). According to the last census available in the National Statistics Service to the area governed by the Republic (the north, occupied part of the island is not included as is not controlled by the Republic) this population comprised of 98% Greek-Cypriots; and 2% from other smaller ethnic groups such as Turkish- Cypriots, Armenians and Maronites (Cystat 2017). The majority of the population (98%) is literate and even though the official languages on the island are Greek and Turkish the majority of Cypriots (76%) have a high level of proficiency in English (Eurobarometer, 2006; CyStat, 2016) Therefore following the 2004 EU accession of Cyprus, Cypriots had no restrictions on moving or working within the EU, in contrast to other EU-10 nationals. Similarly, the Cypriot government allowed for the free movement of individuals from all EU-27 member countries² into its territory in an attempt to substitute the existing third country national workers with EU nationals (Thomson, 2006). In 2012 it was officially estimated that there were around 168,000 immigrants on the island (20% of the population), with 105,000 of them originating from other EU-27 member countries (Vasileva, 2012). Considering the size of the overall population in Cyprus, these numbers were of significant importance and enhanced the need for immediate action on

² Croatia was not included in this study as it accessed the EU in January 2014 and following the completion of this study's literature review, therefore no related data were collected and analysed.

migration management policies to respond to any socioeconomic alterations that might have been caused by these demographic changes.

2.2.2 Governance and Politics

The control of Cyprus was transferred from the Ottomans to UK rule in 1878 (Papadakis et al., 2006), and Cyprus acquired a formal status as a UK colony in 1925, mainly due to its useful geographical position and therefore its strategic importance rather than for economic considerations (Oakley, 1979). Cyprus gained independence from the UK in August 1960 and established its own constitution where the executive power is vested to the President. The president in Cyprus serves for a five-year term following election by universal suffrage. The administration is implemented through a Ministers' council who are chosen from each president at the beginning of the term. The House of Representatives exercise Cyprus' legislation whereas Justice administration is exercised through the Judiciary. (CyStat, 2016). Following the implementation of the constitution in 1960 a number of serious differences on the implementation and interpretation of the constitution arose between the Greek and the Turkish Cypriots, the two main ethnic groups in Cyprus leading to intercommunal violence mainly between 1963 and 1968. A coup in 1974 against the Cypriot president led to the military invasion of Turkey in Cyprus, with Turkey citing the 1960 Treaty of Guarantee to protect the interests of the Turkish Cypriots. The invasion resulted in Turkey occupying 38% of the Cypriot territory to the North. Even though the Republic of Cyprus is the only recognised government in Cyprus internationally, its authorities extend only within the Greek Cypriot part of the Island since the Turkish Cypriots established their own administration (recognised only by Turkey) in the Turkish occupied part (Ioannides & Apostolopoulos, 1999).

2.2.3 Economy

In the last 60 years, the Cypriot economy has achieved great progress and gradually transformed from a traditionally agricultural economy to a services hub offering competitive tourist, financial, legal, healthcare and educational services (Orphanides & Syrighas, 2012). Following the Turkish invasion Cyprus utilised its geographical position, cheap labour (as a result of the invasion), favourable tax legislature and its Mediterranean climate and managed to recover at a fast pace shifting from agriculture to service provision. Indicative is the change in the annual per capita income in just 50 years from 290 Euro in 1960 to 21,700 Euro in 2010 (Orphanides & Syrighas, 2012).

In addition, following the application of Cyprus for EU membership in 1990, the financial system reformed to abide to the EU criteria. This led to an expansion of the financial sector in Cyprus, leading during the 2000s to the liberalisation of financial controls, enhancing competition amongst institutions and therefore driving expansion in the range of financial products and services (Georgiadou 2002). Following the official accession of Cyprus in the EU in 2004 the liberalization of financial controls was completed along with the liberalization in the movement of human capital (Orphanides & Syrighas, 2012). The prosperity of the island at the time of its accession to the EU and its small size in terms of area and population, led to established EU-15 member states allowing Cypriots immediate open access to their labour and services markets. Cyprus went on to join and officially introduced the Euro as its local currency in 2008. A movement that, due to the confidence in the currency, further enhanced foreign and local investments (Orphanides & Syrighas, 2012; CyStat 2016). The great expansion of the economy and specifically of the financial system nevertheless led to the Cyprus financial crisis reaching its peak in 2013 when the IMF implemented a bail in for the second biggest bank on the island and agreed to provide a bailout plan for Cyprus. Cyprus managed to exit the three-year bailout plan in March

2016, being nevertheless monitored by IMF to maintain the economy's proper functioning (Chen & Lu, 2016).

2.3 Cyprus: The Role of Women

The 2015 census found that 51% of the Cypriot population are women. The majority (68.5%) of women belong to the 15-64 age groups and life expectancy at birth is 83.5 years. The literacy rate for women in Cyprus was 99% in 2011. Fifty-seven per cent of women receive tertiary education and women form 48.7% of the labour force (CyStat, 2016).

The position of women in Cypriot society as well as their role in history and society is under researched (Vassiliadou, 1997; Hadjipavlou & Mertan, 2010). Upon the establishment of the Cypriot republic, women in Cyprus had the right to education and the right to vote (GOED, 2006). They therefore participate in the country's social and political life in a way. However, in the years that followed its establishment after 1960, Cypriot society has been identified as male dominated and patriarchal in nature, propagating gender prejudice in terms of civic participation employment, education and politics (Hadjipavlou & Mertan, 2010). In addition, Cypriot women's views and needs have been ignored due to the focus of public discourse on the national problems that followed the armed conflicts on the island between 1963 and 1974 as well as the years that followed (Anthias, 1989, 1992; Cockburn, 2004; Hadjipavlou & Mertan, 2010). Cypriot women in the next 50 years were therefore engaged in a transitional phase where they were trying to utilize modernization of western societies while trying to establish a stronger position in the patriarchal Cypriot society (Hadjipavlou & Mertan, 2010).

Following the modernization of the Cypriot society, the stabilization of the Cypriot socioeconomic and political conditions in Cyprus, women engaged more actively in education, employment and politics enhancing therefore their position in society. Taking as

an example the participation of women in tertiary education during the 1960s the percentage of women of higher than 20 years of age was 0% and there was a gradual increase from 13% during the 1990s, 24% during the 2000s reaching a substantial 38% in 2014 (CyStat, 2016). Furthermore, women's' percentage of the employment force increased from 40% in 2000 to 49% in 2015. The overall gender earnings gap has also decreased from 43.9% in 2002 to 26.9% in 2014 (CyStat, 2016). Nevertheless, besides the increased participation of women in education and employment it seems that there is more work to be done in their participation in key positions such as legislation and senior positions (Hadjipavlou & Mertan, 2010). As Meuleman et al. (2017) report in their study, Cyprus is the lowest ranking state in the 27 EU countries with regard to the participation of women in senior or managerial positions.

2.4 Cyprus: The Healthcare System

The healthcare system in Cyprus consists of both private and public health services. The public health sector is publicly financed through income tax with service users either paying a small amount of money or not at all, whereas the private health sector is financed both through the government as well as private initiatives with service users paying either the total amount either on an out of pocket mode, either through private insurance or through a combined payment.

Public health care services are offered to everyone through eight major hospitals and 23 district health centres. Public health services are nevertheless offered with different charges based on whether the patient is a holder of a medical card or not. Medical cards can be issued to any Cypriot and EU citizen residing permanently in Cyprus under specific criteria mainly focused on annual income. Even though Accident and Emergency services are open to anyone, whether the patient is a medical card holder or not there is a standard fee of 10 Euros regardless of the cost of the treatment. Furthermore, other services

provided by the public health sector such as a visit to a general practitioner, a visit to a specialist, pharmaceutical products and laboratory tests contain a charge based on whether the patient is a holder of a medical card and fees range from 0.50 Euros to 10.00 Euros for card holders and 0.50 Euros to 30.00 Euros for non card holders. (CyMoH, 2016)

Private health care services are again offered to everyone through private hospitals, clinics and health centres. In 2017 there were 40 private healthcare providers enrolled on the Cyprus Association of Private Hospitals, the official registry for private health providers. Any treatment cost incurred through private healthcare providers is paid directly and in full in an out of pocket approach or indirectly and either partly or full through private insurance depending on the policy scheme of each patient (CAPH, 2017).

2.4.1 Cyprus key healthcare indicators

Between 2010 and 2014 (the last year available through official statistics), Cyprus had an enviable health profile amongst the EU-27 and internationally in terms of general health indicators and EU standards (Pericleous, 2011; CyStat, 2016). Infant mortality was amongst the lowest internationally (1.4 per 1000 population) and the average life expectancy was quite high at 80.7 and 84.5 years for men and women respectively, a rate higher than the majority of developed countries (Pericleous, 2011; CyStat, 2016). There was a low average length of stay in hospitals (4.9 days) and there were also a high number of acute care hospital beds available (3.4 per 1000 population) (CyStat, 2016). Furthermore, the percentage of bed occupancy rate seems to have improved in the last few years. It is notable that even though the number of In-patients annually increased from 75,442 in 2011 to 78,573 in 2014, bed occupancy rate has been lowered from 92.4% to 77.4% respectively (CyMoH, 2016), identifying a higher efficiency in the provision of healthcare services in Cyprus.

According to the latest records of the Cypriot Ministry of Health in 2014 there were a total of 2907 physicians in Cyprus, out of which 956 were working in the public and 1951 in the private sector. The case with the nursing officers seems to be reversed since out of a total of 4208 registered nurses 3148 were working in the public sector and only 1060 in the private sector (CyStat, 2016). In terms of key health indicators, Cyprus is ranked amongst the top within the EU countries with 3.4 per 1000 population (CyMoH, 2016) Health Expenditure to GDP was estimated at 6.5% or €1,133,600 in the latest available statistical report in 2014, corresponding to an almost equal distribution between the public and the private health sector (CyMoH, 2016; CyStat, 2016).

2.4.2 Cypriot healthcare system's challenges

Despite the enviable profile in terms of the main healthcare indicators, Cyprus healthcare expenditure is ranked amongst the lowest in the EU with Estonia (5.9%) and Romania (5.6%) being the only countries in the EU with lower health expenditure as a percentage of their GDP (CyMoH, 2016). According to Andreou et al., (2010) the low healthcare expenditure is a result of the low average age of the population, the absence of a unified healthcare system combined with a national insurance scheme as well as the low spending on research and development and specifically in medical research.

According to the EU Commission health expenditure is expected to be reduced further and will continue to be below the EU average following the current economic crisis in Cyprus and lenders instructions for budget constraints (Cyprus News Association, 2012). Despite the low healthcare spending what is notable therefore is the constant increase in life expectancy of Cypriots (both male and female) as well as the number of doctors, nurse and acute beds per population.

The Cypriot healthcare system inherited from the time of the UK colonial rule, used an outdated and inefficient management approach and bureaucratic strategies. These old-

fashioned management and planning approaches established a healthcare system that was inconvenient for patients, incapable of offering an organised primary care system and inefficient in the control and regulation of the private healthcare sector (Antoniadou, 2005). All of the above consequently led to the unequal provision of healthcare services with doubtful clinical services being allowed to propagate, consequently facilitating the formation of a patient approach that was hesitant of the public healthcare sector's capacity to offer high quality of health care (Antoniadou, 2005). Moreover, as the Cypriot government divided healthcare spending almost equally between the public and private sector, the use of two similar size health systems and their inability to offer continuation of care through proper cooperation led to duplication and waste of human and other health resources (Golna et al., 2004; Antoniadou, 2005).

2.4.3 Cyprus' suggested general health scheme

Until 2016 Cyprus did not have a general health scheme and population coverage reached only 80-85% of the total population of Cyprus. Nevertheless a national health scheme is due to be established in the next three years following some amendments to the strategy decided in 2016. Nevertheless not all involved parties are in agreement with the strategy, transition and implementation plan as it was published in 2016 and relevant discussion are still taking place possibly affecting its implementation road map. These negotiations are mainly focused on the establishment of the Family and Specialist doctors' concept, which currently is unavailable as well as on the reimbursement of health workers and insurance structure that will have to be established. Therefore according to the strategy currently in place, published by the end of 2016 (CyMoH, 2016; HIO, 2017) the Cypriot national health systems' main characteristics will be:

- Universal or 100% coverage (currently at around 85%)

- Contributions from employees, employers and self employed to provide the financial resources
- Establishment of public Health Insurance Fund (to manage the contributions and distribute them according to service provided)
- Patient ability to freely select health services provider (no cost considerations)
- Public hospitals autonomy (to enable more efficient resources through competition)
- Procurement from public and private health service providers
- Establishment of Gatekeepers for the system through the introduction of the Family and the Specialist doctor concept

2.5 Cyprus: Medical Education

When Cyprus gained independence in 1960, both private and public colleges and technical institutes provided tertiary education. However, until 1992 when the University of Cyprus accepted its first students following its establishment in 1989, individuals seeking university level education had to study abroad. During the years that followed a number of other colleges were established, offering private funded college level education up until 2007. In 2007 a number of these colleges were accredited with university status and offered private funded tertiary education, meaning that fewer Cypriots travelled abroad to complete their education (Pericleous, 2011). Cyprus, therefore, has seen a tremendous improvement and growth in the field of education in the last few decades. By the year 2008 more than 37.5% of the population aged 25-64 received tertiary education, which was rated as the second highest percentage within the EU-27 (Pericleous, 2011; CYMoF, 2012). Despite the fact that the majority of Cypriots have been educated at a university level, for the most part they have been studying abroad (55%), in other EU countries, the USA and countries from the former East Bloc (CyMoF, 2012).

The first medical school in Cyprus was opened in September 2011 when the University of Nicosia opened a medical school (University of Nicosia 2011). Prior to that date a wide

range of degrees in a cognate disciplines including allied health professions and nursing, has been available. The inability to offer any kind of medical education prior to 2011 entailed that every student wishing to study medicine had to do so abroad. In September 2011 the first private medical school in Cyprus was established at the University of Nicosia in partnership with St. George's University of London, and marketed itself primarily as a medical school for international students offering a 4-year course through a graduate-only entry scheme (University of Nicosia 2011, Pericleous, 2011). Nevertheless since the second year of operation it opened up its admission policy to both Cypriot and international students offering a 4-year course through a graduate-only entry scheme as well as a 6-year undergraduate entry medical degree (University of Nicosia 2016). This course offered a maximum of 90 places for medical students per year. The second private medical school was established in September 2013 at the European University of Cyprus and offered a six-year undergraduate degree in medicine (EUC, 2013). The first publicly funded medical school at the University of Cyprus established and accepted its first students in September 2013, again offering a 6-year standard undergraduate medical course (CNA, 2013).

Postgraduate medical training in Cyprus again was limited to just a small number of specialties and always in collaboration with and under supervision by the Greek Health Ministry. This might have been one of the reasons why the majority of Cypriot medical students selected Greece for their medical education. Residency (physicians' placement) programmes for specialties such as general medicine, orthopaedics, anaesthetics, cardiology, paediatrics and urology were on offer in the Cyprus' public hospitals. This arrangement was achieved through a bilateral agreement between Greece and Cyprus that both Greek and Cypriot citizen physicians could do part of their specialty internship in one of the recognised hospitals or medical schools in Cyprus and obtain a title of medical specialty from Greece (CyMoH, 2016). Nevertheless, in order to complete their studies,

Cypriot physicians in training had to travel to Greece and were examined on the same specialty curriculum as their Greek counterparts at Greek universities (Pericleous, 2011).

According to the 2012 Cyprus medical register Cypriot medical students migrated for their studies to more than 47 different countries. Through the medical register an identified preference was ascribed to: Greece (47.7%); Russia (7.4%); Germany (5.9%); UK (5.2%); Romania (4.7%); Ukraine (4.1%); Hungary (3.9%); Bulgaria (3.2%); Italy (2.6%); and Turkey (2.6%), (CyMoF, 2012). These preferred destinations for Cypriot medical students reflect the findings of earlier studies (Pericleous, 2011), thus outlining a number of 'traditional destinations' for migrating Cypriot medical students and physicians in training.

The introduction of three medical schools in a country with a population of 838,000 people that had not previously had its own medical school could be considered risky and potentially problematic (Pericleous, 2011). Nevertheless, one could argue that this might be universally beneficial because of the healthy competition this stimulated (Hwang, 2005). Therefore, the establishment of three medical schools and especially a publicly funded undergraduate medical school became a topic of debate amongst policy makers, scholars and political parties, particularly in relation to the large associated costs (Ioannou, 2010). The main reason for this debate was ascribed to the high running costs for the University of Cyprus' medical school, particularly in a time following the international economic crisis and the austerity measures that followed. With estimated running costs of 10 million Euros, some viewed this public investment as unnecessary and costly (Pericleous, 2011).

Cyprus, like the majority of other developed countries within the EU and internationally, required a physicians' density of around 300 physicians per 100,000 people (Simoens & Hurst, 2006). Therefore assuming that physicians are professionally active for thirty years, each year Cyprus needed 80 new physicians to enter its healthcare system to maintain this

ratio. According to Pericleous (2011), the initial project for the formation of the University of Cyprus' medical school aimed at recruiting 70 annual entrants. However, budget cuts for government spending decreased the initial number to 33 with five additional students added to the total number of recruits annually (CNA, 2013). Nevertheless, so far Cyprus had been constantly supplied with Cypriot physicians studying abroad who have maintained the desired supply. Therefore, further research was needed on whether the introduction of a public medical school in Cyprus would stem the desire of Cypriot medical students to study abroad or whether Cyprus would end up in the next few years with an unsustainable surplus of physicians (Pericleous, 2011). Therefore, during the development of the first medical schools, Cypriot policy makers were aware that incorrect recruitment strategies and oversupply of physicians might affect future migration flows. As identified in the literature, if the growth in the physician workforce exceeded the population growth, this could generate unemployment or changes in occupational field that could push Cypriot physicians to emigrate with all the associated impacts (Kassak et al., 2006; Akl et al., 2008b).

Despite the high estimated costs and possible problems associated with the density of physicians linked with the establishment of the first medical schools, Cyprus would probably benefit in several areas from their establishment. First of all Cyprus could enhance its position as an educational hub and regional treatment and research centre through major improvements in medical education as well as in research and development infrastructure. It was also anticipated that the establishment of local medical schools could promote postgraduate training to be undertaken completely in Cyprus, with examinations based on the Cypriot context, needs and disease profile. Most importantly Cyprus in the long run could possibly form a local, context specific health system that could be adjusted according to the needs of the country. In this way returning Cypriot physicians could adapt much easier and faster and 'transport' healthy input of experience and skills from other

more developed health systems rather than leading to confusion and lack of common working ground (Pericleous, 2011).

This study through the analysis of the drivers for Cypriot migrant and returning physicians in selecting the UK for their studies, work, or postgraduate training provides an information basis that policy makers could use in order to act more efficiently on managing physicians' migration and physicians' density in Cyprus. By acknowledging the actual needs of Cypriot medical students the Ministry of Health and all medical schools, especially the publicly run and funded medical school, could develop their curriculum, facilities, and infrastructure appropriately and they could more accurately and efficiently assess recruitment and entry needs.

2.6 Cyprus: Migration From Cyprus

Cypriot migrants prior to the 1990s approached emigration mainly as a medium for moving away from unstable political conditions and as a prospect for enhancing their socioeconomic conditions and work opportunities. Adding to these drivers the possession of an English passport by a great number of Cypriots as a consequence to the UK colonial rule, facilitated an easier access to other countries. Cypriot migrants used to be young, with 80% of them being under the age of 35 and better educated than the national average along with high expectations, seeking better economic and professional prospects (Demetriades, 1992). Even though estimates vary within the available literature, in 2010 it was estimated in other empirical studies that 400,000 Cypriot nationals were living abroad (Trimikliniotis & Demetriou, 2007; Teerling, 2011). As an indicative example of the extent of Cypriots abroad were the findings presented by Docquier and Rapoport (2009) in their study where they recorded that the number of PhD researchers working in the USA in the science and technology field in 2009 was 591, whereas the number of Cypriot PhD researchers living and working in the same sector in Cyprus was 532.

Even though Cyprus has a long migration history, the time period between 1920s and 2013 incorporated a number of major events that occurred in a very short period and had a great impact on Cyprus' history and subsequently on the migration trends of Cypriots. Events such as: the major economic crisis of the 1930s; the abolition of the UK's colonial rule; Cyprus' independence and formation of a solitary independent state; interethnic conflicts, war and partition of the island; and accession into the EU (Constantinou, 1990). Therefore a brief synopsis of the landmark events and major socioeconomic and political changes that occurred within this time period is crucial for understanding Cyprus' migration history and the changes in the direction and size of Cypriot migration flows.

The history of Cypriot migration according to Demetriades (1992) could be divided into five time periods. In Demetriades' (1992) categorization the first period was between 1955 and 1959 when there was an armed struggle for independence from the UK's colonial rule that consequently generated the outflow of a large number of Cypriots. The second time period was between 1960 and 1969 and specifically the time that followed Cyprus' independence in 1960. Within this time period and due to the consequential socioeconomic and political uncertainty that followed Cyprus' independence, emigration reached its peak. The third and minor time period from 1970 to 1973 was characterised by political stability and high economic growth with Cyprus experiencing net immigration at that time. The next time period incorporated the years between 1974 and the partition of the island and the transition period up to 1979. During this time period Cyprus experienced possibly its worst socioeconomic conditions in history. In 1974 and in the years following the Turkish invasion, Cyprus experienced great financial damages and a consequential economic decline that resulted in unemployment rates reaching 30% and a general social chaos (Demetriades, 1992). This drove 8% of Cypriots to long-term migration abroad reaching a new peak in 1977. Ironically though, and due to the availability of cheap domestic labour, by the 200,000 Cypriot refugees moving from the northern to the southern part of the

country, between 1975 and 1980 Cyprus experienced increased economic development. The fifth time period, 1980 to 1991, was characterised by net immigration since people who had already migrated abroad were returning to Cyprus. An outcome mainly ascribed to the economic growth of Cyprus, the improved general standard of living and the more stable political conditions (Demetriades, 1992).

Between 1991 and 2015 a number of important socioeconomic and political alterations affected the migration flows in and out Cyprus. During 1991-2015 the flow of migrants to Cyprus was increased as a result of political and economic events such as: the dissolution of the Soviet Union and Yugoslavia; armed conflicts in the Middle East; Cyprus' increased demand for labour during the 1990s; the opening of the 'green line' borders to Greek and Turkish Cypriots; the EU Enlargements of 2004 and 2007; accession of Cyprus in the Euro zone; and the global economic crisis of 2007.

These socioeconomic and political changes on the migration flows in and out of Cyprus is that for the years 1990 to 2004 Cyprus led to a positive net migration of between 4,000 to 8,000 people annually, whereas following the accession of Cyprus in the EU in 2004, net migration increased gradually every year from 2004 and 7,090 people up to 18,142 in 2011 (CyStat, 2016). Furthermore, another example of the extent of migration flows changes during the 2000s is the number of immigrants recorded living in Cyprus in 2010 equivalent to 17.5% of the population at the time (154,300 immigrants) and the number of Cypriot migrants abroad equivalent to 17% of the population (Teerling & King, 2012). According therefore to a number of studies (Brücker and Damelang, 2009; Brücker et al., 2009; Kahanec, 2009) Cyprus in the first years that followed its EU accession up to 2007 was ranked second between the EU-10 countries on the percentage per working age population that moved to another EU country (3%) (Teerling & King, 2012). Following the increase in positive net migration in the years that followed its accession, migration flows seemed to have altered again during 2011 to 2015 when Cyprus had a negative net migration

gradually increasing reaching its peak in 2014 with -14,826 (CyStat, 2016). Nevertheless due to the small population size of Cyprus the available scholarship seems to exclude it completely or group Cyprus with other EU countries making it very difficult to isolate specific migration data or draw any solid conclusions.

2.6.1 Return migration

Cypriots' return migration is referenced in only a limited number of relevant studies and with the absence of appropriate migration control and documentation mechanisms, or official records it remains an underserved research area (Teerling, 2011). A number of available studies (Bertrand, 2004; Thomson, 2006) emphasized the importance that Cypriots assigned to their social attachment with their homeland. In their studies Bertrand, (2004) and Thomson, (2006) also identified small numbers of returning Cypriot migrants during the late 1970s and 1980s, when the Cypriot economy was booming as a result of the increased inflow of foreign tourists and the further development of the associated industry. Another study (Trimiklinitis & Demetriou, 2005) referred to the return of a number of Cypriot migrants who made an intermediate stop in Cyprus prior to their re-migration, utilising the opportunities and scholarships offered from Eastern Bloc universities such as those of Russia and Romania. Another part of the available literature that identified Cypriot return migration (Christodoulou & Pavlou, 2005; Anthias, 2006) focused on the problems that Cypriot migrants faced during the decision-making process and in the course of their social and occupational integration back in Cyprus.

The majority of Cypriot migrants visit the island regularly for vacations especially during the summer months, maintaining in this way a close link with relatives and friends back on the island. Furthermore, some migrants may split their time by residing in Cyprus and their destination country for different periods of the year. Therefore alterations in Cypriots' migratory behaviour during the last two decades could identify them as transmigrants.

Cypriots tend to return to Cyprus mainly to: retire and settle in a permanent residence; to exploit favourable tax exemptions; for ideological reasons such as ethnicity and culture or to be near relatives and friends; due to the ideal climate and quality of life; and lastly to utilise professional opportunities on offer (Teerling, 2011).

2.7 Cyprus and Migration Relationship with the UK

There have been strong historical ties between the UK and Cyprus with the first recorded migrations between Cyprus and UK dating back to the beginning of the nineteenth century when Cypriot merchants and seamen migrated to the UK seeking work opportunities and better economic conditions (Constantinides, 1979). The migration relationship between the UK and Cyprus according to Oakley (1979) and Constantinides (1979) was deeply rooted in the colonial past of Cyprus. There is evidence that Cypriots migration to the UK commenced prior to WWII, since in 1931 more than 1000 Cypriots were recorded as residing in the UK (Constantinides, 1979). In 1939 there was an official estimate of 8000 Cypriots living in the UK, who managed to establish a network of migrants through which further chain migration was promoted (Oakley, 1979). Cypriots' migration to the UK intensified immediately after WWII ended, and mainly from the 1950s and onwards, reaching its peak during 1960 and 1961, when approximately 12,000 Cypriots migrated to the UK annually, contributing to a total of 100,000 Cypriots in the UK in 1966 (Oakley, 1979). Therefore considering that the population of Cyprus in 1970 was estimated to be 600,000 it can be concluded that one out of six Cypriots migrated to the UK during the Cypriot migration peak.

The first official attempt to regulate migration between Cyprus and the UK was recorded in 1937 in response to the reservations that the Cypriot government had about Cypriot migrants in the UK not being treated equally to UK nationals. Therefore the Cypriot government set three compulsory migratory requirements for Cypriot migrants to be more

suitably prepared, and at the same time to enhance their chances for a successful migratory movement to the UK. The potential Cypriot migrant had: to be able to speak and communicate adequately in the English language; be able to deposit the sum of £30 in case there was a need for a financial aid to support any dependants left behind; the obligation to prove that there was a job waiting in the UK as well as an established relative or a friend able to guarantee the migrant's support. Even though these requirements enhanced the difficulty of migrating, they guaranteed that Cypriots' migration to the UK would have had a higher rate of success. Over the years these requirements set by the Cypriot government further enhanced the establishment of a strong Cypriot migrant network (Oakley, 1979). Other characteristics of Cypriots' migratory behaviour that further enhanced the Cypriot migrant network in the UK included: the large number of migrants moving to the UK in a short amount of time; the gender-balanced ratio of migrants during the migration process; and Cypriots tendency to assign high value to family bonds and the Cypriot culture (Constantinides, 1979; Oakley, 1979).

During the first years of migration Cypriots had the tendency to cluster in the same place to support each other. Even though Cypriot migrants shared similar characteristics with UK nationals, usually they were not treated equally due to the negative perception that Cypriot migrants could increase the already high unemployment in the UK (Constantinides, 1979; Anthias 1990; Koupparis, 1999; Anthias 2006). This negative stance from UK nationals made Cypriot migrants' reluctant in forming a UK-Cypriot community, driving them to establish an 'ethnic economy' and other Cypriot social institutions and relying on the wider UK community only for basics such as health and education (Constantinides, 1979; Anthias, 1990). Consequently Cypriot migrants clustered together for cooperation and support in a Cypriot network, comprising of Cypriot owned restaurants, cafes, butcher and grocery shops, and small clinics that could enhance their chances for migration success while at the same time maintaining minimum relationships

with UK nationals. Therefore this initial clustering of Cypriot migrants in the same areas, and the establishment of a support network led to what Constantinides (1979) referred to as an 'ethnic economic niche'. This Cypriot economic niche facilitated financial support, accommodation as well as vital information to subsequent Cypriot migrants, further enhancing chain migration of Cypriot migrants and clustering to specific locations in the UK (Constantinides, 1979; Oakley, 1979; Anthias 1990; 2006).

The majority of Cypriot migrants moved within the Cypriot network area to boroughs of London, namely Islington, Camden Town and Hackney. Nevertheless, following the first years of migration, and the initial clustering, Cypriot migrants spread to other areas as well, such as Enfield, Barnet, Haringey, Brent, Waltham Forest and other boroughs of London (Constantinides, 1979). This spread of the Cypriot migrant network and the detachment from the ethnic economic niche was because Cypriot migrants were becoming wealthier and moving away from the notion that were faced with hostility. This gradual detachment from old-fashioned beliefs and approaches enabled the establishment of links with other UK nationals forming an 'Anglo-Cypriot culture', and broadened the social and professional circles of Cypriot migrants to incorporate people other than Cypriots (Constantinides, 1979, Anthias, 1990).

The establishment of a strong Cypriot network in the UK therefore allowed for the extension and projection of the Cypriot identity (Constantinides, 1990) and following the revolution of air travelling in the 1960s travel to and from Cyprus to the UK became easier, faster and cheaper enhancing the chain migration effect and increasing the number of Cypriot migrants in the UK (Oakley, 1971; Adamson & Demetriou, 2007). Furthermore following the socioeconomic and political events in Cyprus between the 1970 and 1990s the Cypriot migrant network in the UK was further enhanced through high migration flows of Cypriots to the UK aiming to improve their well being and enhance their social and professional security (Christodoulou-Pipis, 1991). Evident of this enhanced migration is

the expansion of the Cypriot migrant network in London during 1990, estimated to be between 180,000 to 200,000 while the capital of Cyprus, Nicosia had an estimated population of 200,000 to 250,000 at the time (Gardner-Chloros et al., 2005). Globalization, technological advancements and the continues enhancement of the Cypriot migrant network in the UK backed by the Cypriot state through material incentives to migrants in the UK allowed for the establishment of a transnational diaspora rather than a marginalized niche society as it used to be during the 1920s (Adamson & Demetriou, 2007).

2.7.1 The UK's and Cyprus' Migration Policy Approaches

The UK's immigration policies generally abided to the Immigration Act of 1971, and its subsequent amendments, such as its major revisions in 2000 and 2002. The UK permitted free access and employment to: every individual who originated from an EU member country; Commonwealth citizens with right of housing; individuals who were holders of UK passports and individuals who acquired finite or indefinite permit to access or stay in the country. Any individual outside that list who wished to acquire employment in the UK was required to have a work permit, which was typically applied for by potential employers. These work permits were issued accordingly depending on the skills on demand and the individual's level of qualifications (Hatton, 2004). Work permits were issued under a variety of schemes including: long-term usually of four years duration with the prospect of renewal; for a fixed duration; permits of permanent status, allowing in some cases specifically restricted family reunification and short-term work permits usually issued to individuals in the business, educational and sports sector. Students who did not fit in a category of free access were granted permission to access the UK via official courses from recognized educational institutions, only for the duration of their course and without being able to work during that period. Furthermore, with regard to skilled professionals and following the revision of the immigration policies under the 2002 Act, the UK government expanded its immigration allowance through a new points based program and

the introduction of special visas to attract foreign skilled professionals (Hatton, 2004).

Through the limited available literature it was noted that Cyprus' migration policies were considered strict as regards to third country nationals and there was a priority system in place on employment procedures. According to Trimikliniotis and Demetriou, (2007) this priority system was addressed to employers who were required to apply a sequence of recruitment initially to Cypriots, followed by EU nationals, and non-EU nationals respectively and under strict criteria set up by the government depending on the occupational sector. Work permits were also issued to asylum seekers or students who could verify their enrolment for three-years programmes of studies in Cyprus and following completion of their first year of studies. Despite the issue of work permits to a number of migrant workers their rights to civic participation were very limited (Trimikliniotis & Demetriou, 2007).

2.7.2 UK policy initiatives related to physicians' migration

The major amendments in the UK's policy approach to physicians' migration occurred within the last two decades, and specifically from 2000 onwards, following the introduction and amendment of policy initiatives relating to the management of physicians' migration (Blacklock, 2012). A more detailed presentation of these initiatives can be found in Appendix 1. The initial modification to the relevant legislation of the UK in 2003 facilitated the implementation and issuing of a new set of work permits and regulations. These amendments in the relevant legislation enhanced requirements for employers such as the NHS for recruiting physicians from outside the EU, assigning higher priority to physicians originating from EU countries (Medical Act, 1983; Blacklock et al., 2012). Since its implementation in 2003, this new act had an actual impact on foreign physicians' immigration in 2005 when medicine was removed from the 1999 UK professions' shortage list (Buchan & McPake, 2007). This development meant that employers had to verify that no physician of EU origin was available for recruitment prior to presenting a vacant post to

an immigrant physician from a non-EU country (Blacklock et al., 2012). A further amendment to the Medical Act in 2006 limited the duration of temporary stay permits for visiting physicians to 26 weeks for any five-year period. Therefore physicians from non-EU countries who migrated to the UK for training purposes were obliged to have a work permit in their possession (Blacklock et al., 2012). These major amendments in the UK immigration policies decreased the number of non-EU physicians' registrations in the General Medical Council. Nevertheless, migration flows of physicians from within the EU to the UK increased and peaked in 2005. This increase seem to follow further immigration policies amendments and the EU enlargements of 2004 and 2007, when the UK experienced an increase in physicians registration coming from the less developed EU-12 countries (Blacklock et al., 2012).

2.8 Concluding Remarks

Following a review of the available literature on Cypriot migration, medical education and the role of women in the Cypriot society combined with a number of key statistical reports from the relevant government bodies this chapter presented all the background information needed to understand the main context for the study. Despite the short time since Cyprus's independence, as identified in this chapter, the country has undergone several developments in its socioeconomic, educational and healthcare status with consequent effects on skilled and physicians' migration flows in and out of Cyprus. In addition to the developments occurred in the last 60 years, the limited availability on empirical studies on Cypriots' migration due to its small population size and Cyprus' specific characteristics such as its colonial past and links with the UK and its strategic geographical position identify Cyprus as an interesting case for further research such as the one conducted for the purpose of this thesis. Following therefore the essential background information that provided the context to the study, the next chapter presents in detail the available theories

on skilled migration and provides an analytical review of the theoretical framework utilized to achieve the main aims and objectives for the study.

Chapter 3: Theories and Models of International Migration

3.1 Introduction

Following identification of the central issues, main aims and objectives, and the background information in both Cypriot and UK contexts, a review of international literature on migration models and theories was undertaken to ascertain the most suitable approach for this current study. This review and analysis showed that a combined theoretical approach, utilizing 'push-pull' and transnational theory, was fit for purpose.

A number of theories and models describe and theorise international migration. These theories and models have been used to explain the size, composition and direction of migration flows and also factors that initiate and maintain international migration flows.

Through a systematic review of the available literature on international migration up to 2016, several migration models and theories were identified that explain how international migration was initiated. Even though all these theories sought to describe the same phenomenon, the way in which each theory approaches international migration differs as they employ different concepts and assumptions.

There are several conditions that serve to initiate international migration. Social conditions that incorporate the individual's or family's desire for better prospects, economic conditions and the establishment of Networks and migration institutions can all be reasons for the initiation of migration flows from home to destination countries. A number of theories aimed to predict migration behaviour during these conditions, while other models aimed to theorize the continuance of migration flows. These were dependent on a number of additional migration determinants. Other factors mainly created from the migration process itself cause migration flows to be sustained or enhanced.

Alongside factors such as wage and employment differentials, risk aversion ‘tactics’, and better prospects for the individual migrant and associated dependants, the existence of migrant networks and migrant supporting institutions has sustained and perpetuated migrants’ flows internationally. Both initiation and continuance theories of migration suggest specific assumptions and approaches for predicting international migration flows using different concepts. Therefore, in the first section of this chapter a detailed review of these theories and their associated assumptions is provided to understand each approach in isolation.

These main migration theories and models have developed from each other over time and have led to particular conceptualisations, which in turn have led to the latest model of transnational migration theory. However, to really understand the development of these migration theories there is a need to present them in terms of their logic, their core elements and assumptions that guide them.

By taking into account each of the theories in isolation and analysing their strengths and weaknesses, a comprehensive theoretical model of skilled healthcare workers’ migration will be set. This chapter is therefore divided into four main sections. The first three sections identify the three main categories of migration theory models based on their approaches, specifically: Economic Theories; Social Theories; and Network and Institutions Theories. These three sections are therefore grouped together based on their focus of the theories identified in the literature. The main components are presented below together with a critical appraisal of how they explain migration.

Finally, in the third section of this chapter a critical appraisal and discussion is provided of the key aspects of previous debates that underpin the approach taken in this current study and the conceptual framework used for the data analysis. This chapter concludes with a discussion on the approach used in this current study.

3.2 Social Theories

Social migration theories revolve around the assumption that the decision to migrate is based on the rational thinking of the individual migrant and in some cases the migrants family and associated community. Emphasis is also placed on the effects of migration on the home country and the indirect effects of remittances and migration benefits for the maintenance of migration flows. Regardless of the inability of initial migration theories, as explained below, to describe the contemporary nature of migration they all played a crucial role in the development of the 'push pull' and the transnational migration theory models used in this current study. Thus, there is a need to present their conceptualisation and development.

3.2.1 Explanatory power

Neoclassical theory was the first model to focus on the individual's needs and desires rather than the overall economic conditions as determinants of migration (Sjaastad, 1962; Todaro, 1976, 1989; Todaro & Maruszko, 1987; Assabir, 2009). In this micro-theory model, rational individual workers make a cost-benefit calculation before taking the decision to migrate. A cost-benefit calculation described by Massey (2002) can be done by taking the expected earnings that the individual would be able to earn in the destination, according to their acquired skills, and the probability for employment according to factors such as local conditions, age, marital status and gender. This cost-benefit calculation would give the individual an indication of the earnings they could expect at the potential destination, which could then be compared with the potential earnings that could be made at origin to estimate the net benefit of migration (Massey, 2002).

The new economics of migration theory that followed, according to Stark and Bloom (1985), challenged what was assumed and proposed by previous neoclassical theories described above and provided new ideas and perspectives regarding the determinants of

migration decision-making. One of the main arguments of this theory was that the decision to migrate was not taken completely by the rational individual; instead it was a more collective process including larger units of related people such as families or communities (Massey, 2002). According to the new economics of migration theory, people acted collectively in order to be able to increase their chances for a better standard of living, by increasing expected earnings, minimizing any risks associated with migration or the failure of markets other than labour, by loosening any constraints within these markets and working in a collective manner. In addition, these units were also utilising other labour markets with a shared objective to maximize their expected income (Stark & Levhari, 1982; Stark, 1984; Katz & Stark, 1986; Lauby & Stark, 1988; Taylor & Harvard University, 1984; Stark, 1991).

These units of related people included families or households in general. However, in the case of an individual it was very difficult to minimise the risks of economic welfare. Proponents of this theory therefore noted that belonging in a household and working collectively could increase their chances for a higher standard of living. This was possible in view of the allocation of resources, such as labour being more diversified. This diversification could enable a member of the household to gain employment in another labour market, generate remittances for the family, and then use these remittances to sponsor the education of another member of the household (Massey, 2002; Assabir, 2009). The ability of the household to diversify its resources in order to gain higher income and minimise risks could continue to exist as long as the economic conditions at the destination were negatively correlated with the home country's conditions. In a case where the household was not functioning efficiently through income generated from local activities, migration could provide a solution to generate more income (Massey, 2002). Additionally, Massey (1993) stated that international migration could continue despite economic

development in the home country, since remittances offered opportunities for successful investments.

Building on previous theories and migration decision-making focused on social conditions, cumulative causation migration theory revolved around the assumption that once migration commenced, it transformed the conditions both in the receiving and the sending country, usually by increasing the probability for higher future migration flows (Massey, 1990). According to cumulative causation theory, every individual who decides to migrate to another country changes the social context in the country of origin. They do so by altering the distribution of income primarily through sending remittances to the region they previously resided in, and through increasing the feelings of deprivation among those individuals left behind in the community of origin. This is a consequence of increased income inequalities related to incoming remittances. These alterations to the social context of a community have a cumulative effect on migration flows, since more and more individuals are willing to migrate to balance the increasing income inequalities. This cumulative process usually continues up to the point where the majority of the community are able to participate in the migration process (Taylor, 1992; Massey, 2002).

Another way that migrants can increase migration flows according to this cumulative causation model is through investing in their countries of origin. Migrants working abroad might save money with the intention of investing in land, instead of using land for agricultural production, decreasing therefore the demand for local labour. Returning migrants can also create a culture of migration, since their lifestyle and objectives are altered following a working period abroad, which might have an effect on the motivations of other members of their community, thus continuously pushing individuals to migration to satisfy their new targets. The cumulative causation process can also affect destination countries. Due to the continuous flow of migrants to the destination country seeking employment in specific jobs with low wages, locals place a low status on these jobs,

consider them as immigrants' jobs and refuse to accept them; a process defined as social labelling. Therefore, these conditions can generate further migration in the search of higher status jobs in other destinations and at the same time sustain quite high demand for labour in specific occupational fields despite unemployment rates (Massey, 2002; Assabir, 2009). In addition to the migration culture, social labelling and the land and income distribution factors identified above, the expansion of networks and the distribution of human capital can also affect migration in a cumulative way. Social networks can actively increase migration flows in a cumulative way because every additional migrant can lower migration related costs and risks for relatives and friends in the home country willing to migrate. By lowering migration related costs, movement abroad for people with low socioeconomic status became easier; therefore more people have the capacity to migrate to the same destination as the established social network of community migrants (Massey, 2002).

Highly skilled workers have more chances to migrate since receiving countries are actively seeking and recruiting highly skilled and motivated professionals who are able to enhance their economic growth. According to Massey (2002), the out-migration of highly skilled workers can cause a decrease in the available human capital in the origin country. Consequently, this can result in recession and stagnation while at the same time receiving countries enjoy enhanced productivity and increased economic growth. While receiving countries benefit from higher economic growth, out-migration is further enhanced in the sending countries, since stagnation and limited growth lead to limited professional opportunities. Therefore, more highly skilled workers are willing to migrate in search of better prospects (Massey, 2002).

The migration 'push-pull' model used in this current study focused on the individual and more specifically on the motives and causes of migration. According to this model, there are some pull or positive factors that can attract potential migrants to a specific destination. Alternatively, push or negative factors might promote migration away from a particular

country of origin (Ravenstein, 1885; 1889; Lee, 1966; Bilsborrow, 1984; Kelo, 2004). Routinely, pull factors in a destination county offer the individual migrant certain advantages when compared to their country of origin, whereas push factors usually consist of challenging social, economic and political conditions in the country of origin (Ross, 2005). Migration flows are therefore dependent on the comparative advantage between a potential destination and the country of origin (Buchan, 2007).

Lastly, the transnational migration theory has been identified as the most up-to-date approach for understanding the migration process in this current study. It integrates components and theoretical assumptions from the previously described theories into a model that focuses on the migrant's experiences and movements internationally (Assabir, 2009). According to this theory, ways of living in the last two decades since the 1990s as well as the experiences of individuals cannot be fully realized by examining them on a national scale. Instead, it is suggested by supporters of this model that a broader and deepen analytical lens should be used to examine an individual's experiences in an international context (Assabir, 2009).

3.2.2 Assumptions

Social migration theories as described above focus on the needs of the individual and the ability of either the migrant or their family to base their decision to migrate on a rational decision that would enhance their prospects in terms of quality of life. The individual and their family members would therefore make a rational decision and migrate to the country with the highest net benefits and lowest material and psychological costs. Therefore, based on all the models presented above the composition of migration flows, size and direction according to a great number of studies (Ojo, 1990; Papademetriou, 1991; Stark, 1991; Logan, 1999; Massey, 2002; Dzvimbo, 2003; Dovlo, 2003; El-Khawas, 2004; Kelo, 2004; Buchan, 2007; Assabir, 2009) is dependent on specific conditions as depicted below:

1. Differentials in both wages and employment rates, which determine the expected migration earnings. Since there were imbalances between the income that different households received and a difference in income between different communities, a household with a high position on the income scale would have a different probability to migrate and vice versa.
2. Disequilibrium in markets other than the labour market.
3. Level of education, experience, training, languages additional to the migrant's native language that could either minimize or enhance employability in host country making the probability for migration a success.
4. Available technologies are able to increase or decrease the costs associated with the migration process and therefore alter the net returns to migration and accordingly regulate migration flows internationally.
5. The degree of comparative advantage between home and host country, the higher the comparative advantage of another country, the higher the pulling force it exerts, and the more enhanced the disadvantage of a place the more likely it is to push individuals to migrate.
6. Any comparative advantage in terms of economic, social or professional advancement that could have been potentially achieved though migration should have been significant enough to outweigh the strong natural desire of the individual to remain in their country of origin.
7. The importance assigned by the individual or household to specific push factors.
8. Demographic characteristics such as age, sex, presence of dependents and marital status of the individual migrant.
9. Governmental schemes/programmes and migration management policies.
10. Ability of the migrating professional to be incorporated simultaneously into the nation-state and into transnational connections and social networks.

11. Ability of the migrating professional to be engaged in the host country with activities and routines performed in the home country as well as transnational.
12. Social labelling of specific jobs as ‘immigrants jobs’.

3.2.3 Critical appraisal

As mentioned at the beginning of this chapter, to identify the most appropriate theoretical approach for this current study there was a need to study all the main available migration theories and models in isolation. Therefore, I have conducted an analysis of the strengths and weaknesses as well as the applicability of these migration theories and models in relation to the main aims and objectives of this current study. Considering social theory models, in particular neoclassical economics micro theory and the new economics of migration, it was identified that their approach on the initiation of migration revolved around the individual and the family respectively. However, by focusing on the needs of migrants and their families to enhance their income these two models fail to incorporate other factors that might have initiated migration such as professional development, social experiences and factors that might have assisted migration, such as social and economic networks.

The next theoretical model that approached migration from a social perspective was the cumulative causation model. Similar to the models described above, this model focused on the effect of wage differentials and the desire of the individual migrant to balance it. However, unlike the neoclassical economics and new economics of migration models this model identified the effect of networks in the migration process but again failed to consider non-monetary motives for the individual migrant in the migration decision-making process.

The next two models have a more social approach, placing the individual migrant as the centre of attention in the migration ‘push and pull’ and the transnational migration theory

models. Both were used for the purpose of this current study, as they were considered fit for the study's aims and objectives, up-to-date with contemporary professional migration and complementary to one another to counteract any weaknesses that might have arisen while using them in isolation.

A number of migration scholars argued that push factors are the main driver for migration, since what drives people to migrate is the desire to improve their economic and social status. This further supports the argument that pull factors are of less significance to the migration decision-making process (Odunsi, 1996; Mayer, 2001; 2003; Ballard et al., 2004; Assabir, 2009). Other researchers (Ojo, 1990; Matsukawa, 1991; Kline, 2003) have argued that even though the 'push and pull' balance is unstable and continuously shifting; migration is primarily initiated and perpetuated through increasing demand. This has been the case especially in the last two decades with the expansion of the services industries. However, critics of this model suggest that it is individualistic and a-historical, assigning great emphasis on the individual and their ability to make a rational decision to migrate or not through a comparative cost – benefit analysis of a potential migratory move. According to Castles and Miller (2003), this model did not account for factors such as government control, emigration laws or international migration policies, referring to them only as distortions that need to be removed, without elaborating on how this might affect the migration process. Additionally, critics state that even though the 'push and pull' model can explain the factors that initiate migration, it cannot explain why migrants might select a specific destination over another, which was one of the aims of this current study. Therefore, combining the 'push-pull' model with the transnational migration model described below, some of the potential weaknesses of the 'push pull model' described above can be alleviated (Assabir, 2009); hence approaching the study's aims with a more appropriate theoretical approach.

Levit & Glick-Schiller (2004) emphasized the need to concentrate on the individual at an international level, since migrants are deep-seated in multi-layered and multi-faced multinational 'social fields', which include both migrants and non-migrants. According to Basch et al. (1994), 'social fields' can be defined as a group of interrelated relationship networks that facilitate the exchange, organization and transformation of ideas, practises and resources. Social fields exist at the national level, as well as the transnational level where the actors involved are inter-connected and able to communicate across national borders. The theoretical framework of transnational migration theory facilitates the opportunity to analyse these social fields to appraise the experiences of people who have already migrated abroad and those who have stayed in their home country. In addition, it allows for the simultaneous evaluation of the migration impact at an individual and national level (Glick-Schiller, 2003; Assabir, 2009).

Another aspect included in transnational theory is the repeated or circulatory movement of people at regular time intervals between a number of countries or places where they are socially or economically linked. This movement has become much easier for some in the last two decades following the removal of borders through the establishment of cooperating multinational communities such as the EU, and the decreased transportation and communication costs that consequently led to a better life described as "transnationalism" (Castles & Miller, 2003). Transnational migrants or "transmigrants" are not people who reside in another host country permanently, neither are they people who are temporary labour migrants who send remittances and visit family in their home country occasionally (Castles & Miller, 2003). The exact definition of a transmigrant was suggested by Glick-Schiller (1999, p.344) as: "persons who migrated and yet maintained or established familial, economic, religious, political or social relations in the state from which they moved even as they also forged such relationships in the new state or states in which they settled". Individuals therefore could be characterised as "transmigrants" when

transnational activities are a major part of their lives and their existence is shaped through their participation in transnational communities.

3.3 Economic Theories

Economic theories identified through the relevant literature revolved around the assumption that international migration was mainly initiated through the existence of geographical differences in the supply and demand for labour and migration composition and directions of migration flows were determined by the markets and the demand for labour in major industrial and more developed countries. Regardless of the exclusion of the individual migrant's needs and desires in the economic theories identified below, some of their assumptions and contributions to migration theories were further examined and adjusted to establish more contemporary theories. Therefore, the transnational migration theory model described in the previous section incorporates parts of these theories, thus it is important to identify their conceptual approach and assumptions, as well as time and conditions during their initial establishment.

3.3.1 Explanatory power

Neoclassical economics macro-theory was developed to define and explain the reasons why individuals may migrate from one part of a country to another following their country's economic development (Lewis, 1954; Ranis & Fei, 1961, Harris & Todaro, 1970; Todaro, 1976; Todaro & Maruszko, 1987). Furthermore, this was the original theory that aimed to define and explain the main reasons for the initiation of international migration (Massey, 2002).

According to neoclassical theory, countries were divided into two categories. The first category included countries where there was a large endowment of labour (workers) in relation to the available capital; therefore equilibrium market wages in these countries were low since there was surplus labour (Lewis, 1954; Massey, 2002). On the contrary, countries belonging to the second category had a low or limited endowment of labour

compared to the available capital. Therefore in countries in the second category, market wages were quite high. In both cases according to neoclassical economists, wages followed the rules and interactions of demand and supply. The differences between the two categories resulted in workers moving from the first category of countries with low wages to the second category of countries where higher wages were available. Following this trend of labour migration in conjunction with the rules of demand and supply, the supply of labour decreased in the low-wage countries leading to a rise in wages; whereas in the countries belonging to the second category, wages decreased following the increase in labour supply. Consequentially according to this theory, migration would have led to an equilibrium in wage differentials internationally given that imbalances between the two categories would have been minimised (Assabir, 2009; Massey, 2002).

Segmented labour market migration theory emerged during the early 1960s and developed through the years to accommodate the development, further segmentation and altered demographic characteristics of the labour market. In segmented labour market theory it was argued that it was not the individual or the household that determined migration flows. This theory moved away from previous theories centred on rational choice to suggest that migration was initiated and enhanced through continuous demand generated by industrialised societies and economic growth (Massey, 2002). In this theory, it was also argued that migration was dependent on certain institutional factors as well as the ethnicity and gender of the migrant (Castles, 2003).

Piore (1979) further argued that in every modern society and in every developed nation at the time, the economic structure demanded a permanent inflow of workers, mainly situated at the lowest level of the social hierarchy. This demand could only be met through the inflow of migrant workers willing to work for low wages and at low social positions in the new destination country. The willingness of these workers to work in these conditions was mainly driven by their desire to send remittances back home and their intention to upgrade

their social status upon return to their home country rather than in the destination (Massey, 2002; Assabir, 2009).

There were, however, some additional demographic and social characteristics that could possibly affect the demand for both skilled and unskilled labour. These included the aging population along with a decreasing birth rate, which as a result decreased the number of available workers, consequently increasing demand. Additionally, according to Massey (1993) through his contribution to the development of the theory during the 1990s, women during that period were becoming better educated and therefore seeking better paid jobs or jobs that could give them higher social status. This could have possibly led to higher migration flows, subsequently decreasing the number of available workers in their home country. Extended formal education again could have been a major reason for shortages. Following the 1990s, people were investing more time in their education, consequently staying out of employment for a longer period, leading to labour shortages and subsequently increasing the demand for migrant workers to fill the vacant posts. Demand could have also been driven by the low status that people assigned to low wage jobs in their home country, providing the opportunity for migrant workers to fill these unwanted posts (Massey, 1993; Assabir, 2009).

Massey (1993; 2002), described several other factors and processes included in the segmented labour market theory that could affect international migration such as: Ethnic enclaves; Social Networks; Economic dualism; Structural inflation; Occupational hierarchies. Nevertheless, considering the outdated nature of this migration model and the intention to not use it for the purpose of this current study, these factors were not elaborated further.

Historical-structural theory emerged as a further theory seeking to explain migration. This theory was developed during the 1950s and reached its peak during the 1960s and 1970s.

An alternative name given to historical-structural theory was dependency theory. Following the emergence of capitalism and in the aftermath of WWII, nations lacking capital and wealth along with developing countries were highly dependent on the rich and developed countries of the West.

The historical-structural theory was based on dependency theory and more modern ideas proposed by Wallerstein (1974), to incorporate the expansion of capitalism and global trade. Drawing on historical-structural theory, Wallerstein (1974) stated that politics and economic structures formed throughout history, affected the position of each country on the capitalistic map and their degree of dependency. According to his classification, countries with political and capitalistic power were classified as core countries, whereas peripheral countries were dependent on core nations to survive and further develop. There was also an intermediate category of semi-peripheral nations, which according to Wallerstein (1974), were slightly wealthier and less reliant than peripheral nations, but still had a high degree of dependency, mainly on the core nations of the West. This expansion on dependency theory and the concentration of its ideas around global capitalism led to the formation of a theory more commonly known as the world systems theory.

According to world systems theorists, the expansion and penetration of capitalism into developing nations, along with: the political and power domination of one country over another; the division of labour between core and peripheral countries and the socioeconomic relations between them provided incentives to the available working population to become mobile in search of better prospects (Massey, 2002; Assabir, 2009). These arguments contrast with ideas put forward by economists such as Todaro (1969; 1976) who stated that migration was a process following the cost-benefit calculations conducted by individual migrants to enhance their potential for a higher standard of living (Massey, 2002).

Multinational organizations were able to move from a core nation and establish themselves in a peripheral nation in order to take advantage of cheaper labour, land and raw materials and to access new markets (Assabir, 2009). A reverse scenario took place in the case of labour. Workers seeking better employment were able to move from peripheral nations to capitalistic and more developed nations. The reasons for these migration flows were ascribed to the transition of the power to control markets from governments and communities to the capitalistic market system, as well as to the dislocations and disruptions that occurred as a result of this transition (Massey 1989, 2002; Assabir, 2009).

3.3.2 Assumptions

Economic migration theories presented above focused on the effects of economic and labour markets, the effects of the two major World Wars in migration between different countries and the effect of globalization on migration flows, composition and direction. According to a number of researchers (Lewis, 1954; Ranis & Fei, 1961; Harris & Todaro, 1970; Todaro, 1976; Massey, 1993; 2002; Assabir, 2009) the below specific conditions formed the assumptions for the development of the economic theories that aimed to define and explain migration flows:

1. The migration of international workers was mainly caused by wage and labour demand differentials as well as active recruitment between countries with different levels of economic development.
2. Globalization and the establishment of capitalist markets in previously pre-capitalist and developing countries were amongst the major drivers for International migration of labour.
3. Unregulated labour markets.
4. Different “stimuli” exist between skilled and unskilled workers, since highly skilled workers might have migrated in response to a better rate of return rather than wage differentials, which were the main incentive for unskilled workers.

5. Colonial ties established specific transnational markets, therefore affecting migration flows and direction.
6. Labour migration has an opposite direction to that of goods and capital.
7. Political and military interventions could affect migration flows and directions.

3.3.3 Critical appraisal

As mentioned at the beginning of this chapter, in order to identify the most appropriate theoretical approach for this current study there was a need to study all the main available migration theories and models in isolation. As identified in the previous section, the purpose for conducting a detailed examination of the main available migration theory models was to identify the model that could best fit the aims and objectives of this current study. Therefore, a detailed analysis was conducted to identify the main approach of each theory, its assumptions and applicability for this current study. It was concluded that all the economic theories examined were inappropriate for investigating the contemporary nature of migration and the experiences of the individual migrant. In contrast to the previous group of theories which focused on the individual migrant, neoclassical economic macro theory, segmented labour market theory and structural or world systems theory all seemed to focus on the role of the labour markets in the migration process. Even though they formed the basis for subsequent more developed theories, all were identified as out-of-date; focusing on the effects of the two World Wars and the economic and social imbalances established between the countries of the West and other Colonial nations and underdeveloped countries. They therefore failed to incorporate both the socio-demographic characteristics of the individual migrant and the effects of established international communities and agreements and the contemporary nature of economic and labour markets even though they briefly focused on the effects of globalization.

3.4 Networks and Institutions

Network and institution theories revolved around the effect of migrant networks on the host country and their role in decreasing the social and financial costs of migration for the individual migrant, as well as allowing for an easier transition and adaptation to a new country. Furthermore, they identified migrant networks as the main factor sustaining migration flows giving less emphasis to the needs and desires of the individual and other factors identified in earlier theories, such as wage differentials, labour and financial market forces.

3.4.1 Explanatory power

Migration systems theory used a more wide-ranging approach, encompassing disciplines from a variety of other theories explaining migration. According to this theory when two countries exchange migrants this can be considered a migration system. When the exchange is between a whole region, such as West Africa or Latin America, the system is called a regional migration system (Kritz et al., 1992). Even though most migration systems function between neighbouring countries or regions, migration systems could be established between countries that are thousands of miles away from one another. Examples of such migration systems include the case of Western Europe and North America, or the migration system established between West Africa and France (Castles & Miller, 2003).

According to the migration systems approach, migration flows are initiated and perpetuated by two interacting structures at the individual and the country level: the microstructure and the macro-structure. Micro-structure refers to the social networks or bonds created between individual migrants, decreasing the economic and social costs of migration by increasing their cultural and social capital, through exchange of information, and assistance for accommodation, travelling and employment. Therefore, the migration

process could be self-sustained through the expansion of these networks (Bourdieu & Wacquant, 1992; Castles & Miller, 2003). The second structure was defined as the macro-structure and is on a larger scale. It referred to institutional factors such as the economy, labour and world markets, as well as laws and regulations. Sending and receiving countries tend to regulate the migration process to a large degree, consequently managing the macro-structure of migration flows (Castles & Miller, 2003).

Going a step further to describe the migration process as effectively as possible, Hugo (1981) and Massey (1993; 1994; 2002) established the migrant networks theory and defined migrant networks as sets of social and personal links established between people that had already migrated to a destination country and non-migrants in the home country. These links were usually formed between individuals or relatives who shared similar interests, kinship and community origin. The importance of migrants' networks in the promotion of migration was highlighted as early as the 1920s. During that period migrant relatives and friends supported their non-migrant relatives to move abroad by providing assistance in accessing information, seeking employment and initial accommodation, increasing the probability that new migrants would find a secure and reliable job (Massey, 2002). Therefore, migrant networks decreased migration related costs as well as a number of associated risks providing more incentives for potential migrants to move (Assabir, 2009).

It was logical to assume that as long as migrant networks were expanding, the migration process would expand as well (Massey, 2002; Assabir, 2009). More migrants meant larger numbers of related people involved in the country of origin, providing them with the essentials to migrate such as initial accommodation, financial support while trying to find a job and employment information, averting much of the associated risks. Therefore, migration became easier and less costly and consequently migration flows increased. However, several researchers (Hugo, 1981; Taylor & Harvard University, 1986; Hatton &

Williamson, 2005) noted that the effectiveness of these networks decreased after a peak point was reached. The diminished effectiveness of these networks was consequent to the decreased willingness of individuals and relatives abroad to provide further assistance to an increasing number of relatives and friends migrating to the same destination.

As migration commenced and steadily increased it generated a simultaneous demand for migrant visas and demand for entry into several core or rich countries (Massey 1993; 2002). There was generally a limited supply of employment visas internationally that did not meet the much higher demand for visas; creating an imbalance between the demand and supply of visas. This imbalance provided the incentives for private institutions and voluntary organisations to attempt to satisfy demand, hence the emergence of the migrant institutions theory. The imbalance established by excess demand, and the barriers to migration implemented from the receiving countries, facilitated an opportunity for these migration related institutions to acquire high profits from undocumented migration and the parties involved (Massey, 2002; Aaronson, 2005). The rise of these profit-making institutions that took advantage of the situation and expanded the undocumented migration market, initiated the establishment of humanitarian institutions. These humanitarian institutions had as their major objective the protection of the rights of the individual and the facilitation of the establishment of a properly documented migration market (Massey, 2002).

Profit maximising institutions were exploiting the establishment of an undocumented migration market, offering illegal services to potential migrants such as smuggling across borders, illegitimate labour contracts and visas, all for a specified fee. On the other hand, humanitarian organisations were set up to protect individual migrants by providing: advice on legal and labour related issues; shelter to individuals who were left with nothing in a foreign country seeking employment; assistance for seeking legal employment, stay and

employment visas, as well as assistance with any other support needs they had (Massey, 2002).

Furthermore, during the 1980s a new theory emerged to describe the migration process emphasising the effect of networks and their ability to sustain migration called social capital theory. Bourdieu was the first scholar to give social capital theory a place in society (Bourdieu, 1986; Massey, 2002). According to Bourdieu and Wacquant (1992) in Massey (2002, p.42) social capital comprises the accumulation of resources, which are either virtual or actual in nature, by either an individual or a group, with the intention of establishing a network or institutionalised relationship of similar interests and objectives that last over time. Portes (1998, p.6), using a more simplistic definition, described social capital as “the ability of actors to secure benefits by virtue of membership in social networks or other social structures.” Social capital therefore could be of significant use to an individual who intends to migrate, since it can be converted into other forms of capital such as financial capital. An individual can utilise social capital by becoming a member of a migrant network, or a member in a migrant-related institution established in a destination country, and use the links they are provided with, in order to achieve and preserve their position in society (Massey, 2002).

3.4.2 Assumptions

As described above network and institution theories focused on the ability of migrant networks and migrant institutions to sustain and enhance migration flows and directions. Besides the migrant institution theory that focused primarily on undocumented migration the entire network theories described above seemed to be dependent on specific conditions that were grouped together and are depicted below (Massey, 2002):

1. The first assumption was that; wage and employment differentials have only a limited effect on the migration process. Migration flows would continue to increase until the

point was reached where migrant networks would not be able to provide the opportunity to all willing migrants in the sending region to migrate with ease and with minimum costs. Once this point was reached migration flows would start to decrease.

2. The expansion of networks causes migration to become institutionalised and become progressively detached from its initial causes.
3. The expansion of migrants' networks and the decrease in migration related costs and risks leads to a more representative flow of migrants from sending countries, loosely related to socio-economic terms, in contrast with the initiation of the process.

Furthermore, Castles and Miller (2003) have identified a set of questions that need to be asked in order to understand the migration process in terms of the main migration networks theoretical approach, as well as micro and macro structures and their interactions:

1. What are the factors (economic, social, political) that changed to such a degree as to cause migration movement away from the home country?
2. What are the opportunities present in the country that migrants intend to move to?
3. How do several social networks and other contacts formed between individual migrants in the destination and origin countries make migration a safer and beneficial process?
4. What are the available or emerging legal and economic structures that regulate the migration process?
5. How are migrants becoming permanent movers? Why do migrants in some countries face discriminatory behaviour while other countries developed multicultural societies?
6. What are the positive and negative effects on the host country in terms of culture, ethnic identity and social structure?
7. What is the impact and what are the changes occurring in the home country?
8. To what degree does migration between two or more countries lead to the development of links between them?

3.4.3 Critical appraisal

In the migration systems approach the aim was to study the two ends of migration flows, both sending and receiving, and to examine the relationships between the countries involved in the process. According to Fawcett and Arnold (1987) the types of probable links could be; mass culture connection, state-to-state relations and family or social networks. Following these identified relationships, proponents of the migration systems theory argued that people were migrating due to previous links between the country of origin and the potential migration country. These links could have been past colonization, political links, similar cultures and trade agreements. Castles and Miller (2003) identified a number of cases of this type of migration such as: the workers migration from Dominican republic to the USA due to previous occupation of Dominican territory by the USA back in the 1960s; the migration of Algerians to France following their colonization by the French; and the migration of Pakistani or Indian workers to the UK following their previous colonization.

Migrant networks can be considered as a self-sustaining process promoting international migration flows. Moreover, the migrant networks theoretical approach seemed to be connected with other theories, accepting earlier arguments that individual migrants or 'households' were the ones defining the migration decision-making process. Adams (2007) asserted that the decision of an individual or family to migrate at a specific point in time and towards specific destinations could increase future migrations intentions and guide future migrants to specific destinations.

Even though migrations systems and migration networks theories seemed to address matters such as the importance of networks and historical links between the host and home country, as well as the importance of international or bilateral agreements, it failed to identify the desire of individual migrants to enhance their social status or professional career regardless of the presence of established networks in the host country. Furthermore,

this theory brought together a number of other theories and identified the existence of both 'push and pull' factors in the home and host country respectively, that drove the individual to migrate permanently abroad. Nevertheless, this theory compared to what was previously used to describe the migration process, failed to incorporate the contemporary nature of international migration. In contemporary migration individual migrants might move to one destination country that might have no links and thus they cannot depend on networks to minimize the social and financial cost of migration. This may be due to the non-permanent nature of their move and their ability to maintain links with their home country through developments in communications and travelling, as well as the transnational nature of skilled professions.

The next migrant institutions theory focused on undocumented migration, refugees and unskilled migration and the role of humanitarian NGOs and other illegal institutions or actions that supported the flow of migrants, mainly from underdeveloped or countries in war to more developed or safer countries. Therefore, regardless of the importance of analysing the role of such institutions in international migration, this theory was not fit for purpose for examining skilled migration, this current study's main aim and objectives.

The social capital theory model aimed to identify the role of networks in migration both skilled and unskilled. Nevertheless, social capital theory focused primarily on how individual migrants could accumulate other forms of capital through links with institutions and networks (Coleman, 1988; Massey, 2002). Even though this tactic seemed to have been used by Cypriot migrants during the first waves of migration to the UK, contemporary Cypriot professional migrants even though assigning high value in the presence of networks seemed to rely on other parameters. These parameters included the recognition of their qualifications in both the home and host country, the promotion of their professional career and the ability to maintain contact with Cyprus while abroad.

In summary, even though this current study aimed to examine both the effect of migrant networks and previous links between Cyprus and the UK on the migration of Cypriots, the inability of the models identified above to incorporate the effect of other major migration factors, both ‘push and pull’ as well as their inability to examine the lived experiences of the individual migrant, disqualified them.

3.5 Critical Appraisal of Existing Migration Theory Models

Globalization in the twenty-first-century has brought about several social transformations. Therefore, understanding the processes that resulted in these changes is crucial for understanding skilled and other forms of migration. Migration networks, flows and direction that constitute globalization and contemporary migration since the 2000s take on specific forms at the local, national or international level. Thus, it needs to be understood that forces such as the international demand and supply of human resources, as well as international policies and socioeconomic conditions might have various impact on these constituents. Nevertheless, any potential impact relies on specific cultural and structural factors as well as the political and social responses at each level and context (Held et al., 1999). Therefore, the impact of these international forces depends upon several specific factors including religion, history, social values and relevant institutions such as governments, NGOs and recruitment agencies. These major factors might have significantly altered the flow and direction of skilled migration as well as the establishment of socioeconomic and migrant networks depending on the resistance in different communities or countries (Vargas-Silva, 2012). As noted above, there are three levels where skilled, as well as other forms of migration, should be considered. Initially, migration should be considered at the local level and the current conditions at the time of study. Therefore, depending on local social transformations and development, skilled migration might be discouraged or promoted. Indeed, processes such as local economic and educational developments, gender imbalances and unemployment or even migration

itself can potentially transform local conditions directly or indirectly affecting migration flows and direction. Furthermore, international forces are significant at the national level, as the nation-state determines the implementation of migration management policies and can alter the development of local conditions such as health, education, and the national economy (Vargas-Silva, 2012). Nevertheless, in the twenty-first-century any national migration management policies should also consider the effect of international or regional developments and social transformations. This is especially the case with the growing importance assigned to international or regional cooperation and established bodies such as the North American Free Trade Agreement (NAFTA), the EU and the Organisation for the Economic Cooperation and Development (OECD). Therefore, during this current study of skilled migration the researcher will consider the complex and dynamic relationships between the migration-related processes and social transformations at different social and spatial levels (Pries, 2007; Vargas-Silva, 2012).

Furthermore, any migration theory model needs to be able to identify the potential social consequences for all relevant parties from the transnational movement of individuals. In addition, it should be possible to analyse these transnational movements in relation to the different levels described above, as well as in terms of the international connectivity of those movements. Thus any economic, geopolitical macro-trends and other affairs such as military and energy related developments, in addition to any social and cultural patterns identified should be incorporated in the study of skilled and other forms of migration. Moreover, some migration researchers argued that skilled and other forms of migration might shift from a top-down power hierarchy towards a networks and transnational cooperation pattern (REF). On the contrary, researchers have argued that the differentiation of migrants between advantaged individuals possessing the necessary capital and those who lack the economic or educational resources to enhance their potential through migration, still remains after two decades (Vargas-Silva, 2012). Therefore, any migration

study should be able to link the migration hierarchies identified at the time and context of the study to the relevant economic and political parties involved in the migration process. Such an approach would be able to contribute to the identification and analysis of contemporary and context specific social developments (Vargas-Silva, 2012). Thus, as argued by a number of migration scholars (Kritz et al., 1981; 1992; Massey et al., 1993; Portes, 1999; Massey et al., 2002; Asabir, 2009), there is no single theory able to describe the migration process in detail and in a way that social scientists and other researchers would accept.

3.6 Theoretical Conceptual Framework Underpinning this Current Study

This section sets out the key aspects of previous debates that underpin the approach taken for this current study. In the last two decades, the course of migration has changed substantially as a result of the capitalist world system and the advancement of technology and communications. The high migration flows and their complex composition; the growth of transnational organisations; the shifting nature of capitalist economies; and the reshaping of citizenship in an era of limited national boundaries has facilitated the need for a new conceptual tool to account for contemporary migration management requirements. The transnational theory model emerged during the 1990s as a new conceptual construct that could explain the characteristics of contemporary migration and facilitate better understanding of its effects on home and host countries, as well as the individual migrant (Kivisto, 2001). According to Glick-Schiller (1997), the introduction and support of this new concept, by a range of migration scholars, suggested that previous theoretical models were unable to offer adequate understanding of contemporary migration and transnational migrants' experiences. In addition, migration scholars in support of the transnational theory model argued that by embracing this new concept old-fashioned categorization of return, circulatory or permanent migration were discarded. Glick-Schiller (1997) further argued that 'old-fashioned' migration theories operated as closed systems, having the

national state at the centre of attention, failing therefore to incorporate the new and transformed phenomenon of transnational migration during the 1990s and onwards within the context of the new world system.

The aim of this current study was to explore and analyse contemporary migration. In order to fulfil this aim, this study examined Cypriot physicians who migrated in the last two decades following the current trends of globalization, professional and medical feminization, as well as professional and technological advancements.

This current study therefore combined the most widely used ‘push-pull’ theory model along with the latest transnational migration approach, hence avoiding the criticisms met primarily on the ‘push-pull’ model while satisfying the objectives and predetermined aim of this study. Initially, the ‘push-pull’ theoretical model facilitated the focus on the main factors affecting migration movement of Cypriot migrant physicians. In addition, the transnational migration model approach focused on both sending and destination countries and incorporated the socioeconomic, political and demographic context of Cyprus and the UK. This approach therefore enabled the moderated generalisation and comparison of these migrants’ experiences across different countries and contexts (Glick-Schiller, 2003). This collective approach of migration theory models thus facilitated the examination of combined and interrelated migration elements, since contemporary migration in the last two decades consisted of a sequence of interrelated events that could have affected each other in a dynamic process (Assabir, 2009).

Additionally, the use of the transnational migration approach facilitated the focus on the role of migrant networks and institutions that sustain migration movements. Furthermore, the transnational migration approach facilitated the broader study of national and international migration policies while incorporating feedback mechanisms and other parameters such as historical and colonial links, which other migration theory models

would not have been able to sufficiently assess (Assabir, 2009). Considering the specific characteristics of this current study such as: previous colonization of Cyprus by the UK; the prolonged interrelated history of Cyprus with the UK; the presence of a strong Cypriot migrant network in the UK since the 1930s; and that both countries were members of the EU and share common policies and regulations; the transnational migration theory model was considered the best possible fit for purpose approach to examine Cypriot physicians' migration.

Moreover, transnational migration theory detaches itself from the old belief that society equates with the national boundaries of each single country. Instead, using a broader perspective it focuses on international rather than national migration policies, as well as the conflicts and cooperation between different countries at the time of study. This alternative focus therefore facilitated the examination of the forces that shaped contemporary migration flows, as well as the effectiveness of implementing specific policies in different contexts. Therefore, the transnational migration approach reformulated the concept of society to incorporate the effect of globalization and the dismissal of national boundaries in terms of labour movement.

According to Polit & Hungler (1995, p.101) a conceptual framework is “an efficient mechanism for drawing together and summarizing accumulated facts”. Therefore, a conceptual framework should be able to explain the main areas of study, the key factors and different variables and the alleged relationships between them (Miles & Huberman, 1994). Hence, this specific framework depicted below in Figure 1 aimed to satisfy a group of predetermined aims presented in Chapter 1 based on the transnational migration theoretical approach in combination with the ‘push-pull’ model as defined and explained above.

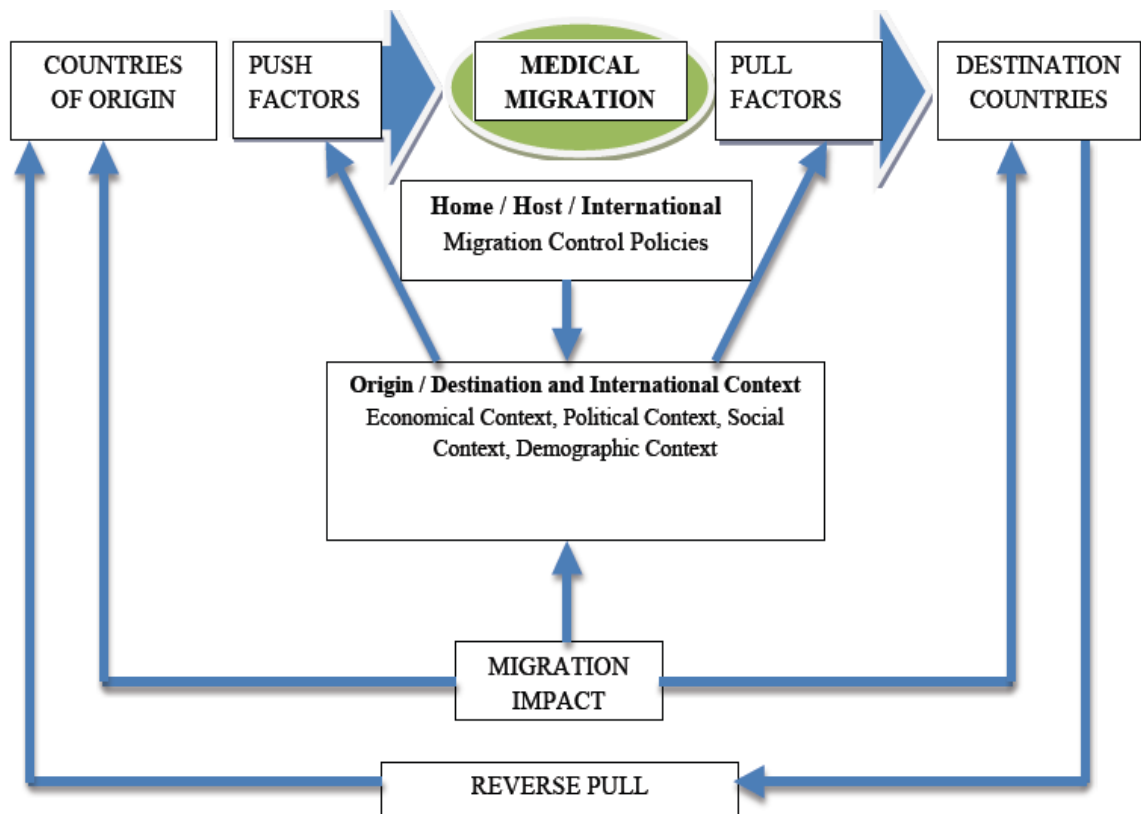


Figure 1: Conceptual Framework

Source: Modified and adjusted from Assabir (2009)

As can be seen in Figure 1 above, physicians' migration was mainly driven by a complex combination of 'push-pull' factor forces, which were in turn were 'shaped' by the political, social, economic and demographic context of the countries involved. The arrows connecting the 'push-pull' factors with the context box indicate that changes in any of the contexts described could affect migration forces, therefore affecting migration flows and direction. Furthermore, migration impact could affect the different contexts/conditions of home and host countries, as well as the socioeconomic condition of the individual migrant. The connection between migration control policies and context suggested that through modifying national or international contexts/conditions governments could regulate physicians' migration through indirect control of identified 'push-pull' factor forces. The last part of this conceptual framework consists of the reverse pull acting on migrants to

return to their country of origin, as well as the forces preventing people from returning or re-migrating.

3.5.1 Approach adopted in this current study

The constructs presented above were used to inform the reader about the dynamic nature of the migration process and the interconnected micro and macro level processes that can take place between two or more countries, therefore affecting migration flows and direction. In order to understand what causes, sustains or inhibits migration flow these micro and macro level processes need to be understood and analysed in depth. Hence, this research is based on the 'push and pull' migration model and focused on the behaviour, motivation and perceptions of the individual Cypriot migrant physician, as well as Cypriot physicians' general migratory behaviour. In addition, attention was given to the socioeconomic context, as well as the environmental and political circumstances present in UK and Cyprus, as well as internationally at the time that this study was performed. In the context of globalization of skills and medicine in particular, migration flows in the last two decades since the 1990s appeared to occur within a transnational context. Within this transnational environment; migration policies, economic context, technology as well as social dimensions were continuously changing, partly as a response to stimulus generated by the migration flows. Therefore, guided by this proposed conceptual framework this current study focused on exploring the experiences and perspectives of Cypriot migrants and returning physicians and Cypriot health care managers in a transnational context by examining physicians' migration in two different contexts, their home and host countries.

The next chapter examines the available empirical literature on the international migration of healthcare professional focusing primarily on physicians aiming to identify the main themes emerging and signposts the study's objectives. Regardless of the absence of previous empirical studies about Cypriot physicians' migration, pre-existing migration

theories and previous empirical studies that focused on migration in other countries were examined in order to formulate the research approach (Gray, 2014). In order to facilitate the analysis of both the micro and macro level processes that might have affected Cypriot physicians' migration in a transnational environment, this current study adopted a specific methodology guided by the conceptual framework. Chapter 5 thus presents in detail the methodological approach including sampling, data collection and analytical techniques in relation to the research questions and the conceptual framework.

Chapter 4: Review of Key Concepts and Empirical Literature

4.1 Introduction

Upon establishment of the theoretical approach and conceptual framework, this current study thoroughly examined the available literature to identify the main concepts around physicians' migration, factors that trigger and sustain physicians' migration internationally and the role of gender in the migration process. In turn, this helped with the identification of the study's specific objectives and served as comparison with this current study's results.

The first three chapters of the thesis explored the available theoretical literature to provide background information to enable a full understanding of the aim of this current study. In Chapter 1, an introduction to the study was provided, outlining the phenomenon under study as well as the key concepts and terms used both in the available literature as well within this thesis. Chapter 2 provided background information on the Cypriot historical, educational and healthcare context and migration history and presented the relationship between Cyprus and the UK, including the effects of colonization and networking. Chapter 3 contained a systematic review of the available theoretical migration literature, provided the necessary background on migration theories, a critical appraisal of these theories and finally, justified the conceptual framework underpinning this current study.

This chapter provides a detailed systematic review of the empirical literature around the international migration of skilled healthcare workers; the primary focus of this review was physician's migration. It is divided into three sections. The first section analyses the literature search approach and methodology for the identification of empirical studies suitable for this current study. Section two evaluates the major themes identified in the available empirical literature and is further divided into four thematic sections including; patterns of migration, factors that affect migration; the role of gender in physicians

migration and the impact of such migration on individuals and countries. The third and last section of this chapter identifies the specific objectives of this current study based on the overarching aim to explore the factors affecting Cypriot Physicians' migration decision-making processes.

4.2 Literature Search

A literature search was conducted to identify published materials relevant to the current study. The initial search was conducted in 2013; subsequent searches using the search strategies were conducted to ensure that the materials identified were current (most recent search was 2017). This literature review therefore presents a critical analysis of the empirical migration literature published from 1990 to 2016. The systematic search was conducted through appropriate databases including ISI Web of Knowledge, Pub med, Science Direct and Google scholar using the key words: 'doctor migration', 'physician migration', 'medical migration', 'brain drain', 'profession* migration', 'Cyprus migration', 'European migration' and 'skill* migration'. Following reading of the abstracts and conclusions of the identified hits, 108 articles were deemed suitable for full text review and were included in this empirical studies review. Subsequently, the systematic search identified that there were no pre-existing case studies on Cypriot physicians' migration. The information from the identified empirical studies was qualitatively synthesized through critical review of their strengths and weaknesses, as presented below.

A review of these studies revealed four major themes in the literature, which were relevant to this current study. These were patterns of migration; explanations of the reasons why individuals migrate; the impact of migration and issues that relate to gender and migration. In the following sections, the findings from the literature search were presented under these four themes. In each section, in respect of each of these themes, a descriptive account of the dominant strands is presented, with commentary on the nature of the

material. For example, whether or not there were any key issues that had not been addressed and also the significance of the material identified for this current study.

4.3 Patterns of Migration: Key Themes Identified

A number of studies identified the extent of international migration, some focused on migration in respect of population movements between particular countries, whereas others focused on particular types of migration, for example skilled occupational groups such as medical migrants. The rest of these studies provided an assessment of the economic and demographic impact of these migratory flows. In a study midway in the period under review (1990 – 2016) Hatton and Williamson (2002) mainly through the use of secondary sources, identified evidence from the UN database that demonstrated that people living in a country other than their country of birth had risen from 75 million in 1965 to 120 million in 1990. According to the same UN reports, in Europe the flow of migrants increased the total EU population to 7.6% in 1990, whereas the increase in the EU population in 1965 was 4.9% (Hatton & Williamson, 2002).

Furthermore, updated reports obtained from the UN database (UN, 2005; 2006) identified that the number of female migrants participating in international labour migration between 1960-2005 increased from 46.8% to 49.6% out of the total number of migrants recorded internationally. In addition, within the same time period female migrants outnumbered male migrants in the majority of developed and developing countries, including Europe and North America (Docquier et al., 2012). In a later study, Muenz (2006) through the analysis of demographic data published by Eurostat, identified that Cyprus was sited first on the net migration table, relative to its population size with +27.2 per 1000 people, well ahead of Spain which was sited second on the relevant table with a net migration rate of +15.0 per 1000 people.

The exodus of skilled professionals from Europe was not significant in terms of real numbers. In 2000 merely 0.3% of the available skilled professionals migrated away from the EU-15, and in contrast the EU increased its skilled labour force by 12.5% from skilled professionals migrating from countries such as Australia, USA and Canada. Despite the fact that in absolute numbers the EU avoided associated problems from skilled professionals outflows, it failed to retain specific skilled professionals capable of promoting research and development, who could subsequently facilitate a better position for the EU in the global economic leadership (Docquier & Rapoport, 2009). Notwithstanding the higher number of PhD holders graduating within the EU, the EU had a lower number of people working in research and development compared to the USA and Japan (5.3 PhD graduates per 1000, 8.6:1000, and 9.2:1000 respectively). It was therefore suggested that the EU suffered from the exodus of major contributors to research and development such as physicians, academics and IT specialists (Docquier & Rapoport, 2009). The loss of these professionals subsequently resulted in constrained innovation, and decline of the EU competitive advantage over the USA, Japan and other OECD countries (Blau, 2004). Cyprus, a EU member state since 2004, faced similar problems with the outflow of its skilled professionals. Initially Cyprus had the highest percentage of PhD holders that migrated outside the EU, compared to the rest of the EU-27 countries. Almost one in two Cypriot PhD holders, and one in two researchers in the science and technology field were working in the USA, with Cyprus sited again amongst the highest rankings on the relevant table with 52.6%, second only to Malta with 55.7% (Docquier & Rapoport, 2009).

Following the coining of the term “brain drain” by the Royal Society in the UK to describe the impact of medical graduates’ migration, trained in the UK, who subsequently moved to the USA (Wright et al., 2008), a number of studies were conducted to identify the size, nature and direction of skilled medical migration flows. The earliest identified study was

conducted by Abel-Smith and Gale (1964), which examined the migration of physicians from the UK to the USA. The most recent empirical study used in this current thesis was conducted by Hossain et al. (2016) and examined the perceptions of Pakistani final year medical students and physicians in training in relation to the 'push and pull' factors affecting their migration decision-making processes. The extent of international physicians' migration has been studied since the 1960s, followed by an increased awareness between 1970 and 1980 and from 1990s onwards in correspondence with the internationally increased physicians' demand within the same time periods. International physicians' migration flows reached a peak during the 1970s, more specifically in 1972, with 140,000 physicians working in a foreign country and more than 105,000 of these physicians working in the UK, USA, Canada, Australia and the Federal Republic of Germany (WHO, 1973). Between 1966 and 1975 the UK NHS provided licence to practise for more than 12,640 physicians that had trained abroad (excluding Irish physicians).

A number of studies placed the patterns of medical migration within a framework of shortage; specifically the failure of certain countries to train sufficient numbers of medical practitioners. This failure to train sufficient medical practitioners was evident in the UK (Wright et al., 2008). In addition, during the 1960s the majority of Western, English speaking countries faced difficulties through an inadequate supply of physicians. Other English speaking countries experienced similar problems to the UK. For example, the USA granted permission to practise to more than 60,000 foreign physicians between 1963 and 1979, and Canada granted 12,000 additional physicians work permits, between 1961 and 1975. Despite that physicians' migration had increased in absolute numbers; physicians' migration flows began to decrease after 1979. This peak in migration flows was possibly related to the great demand for physicians in the UK, the USA and Canada and the socio-economic policies of countries such as Cuba, India, Ireland and the Philippines during the 1970s, which promoted higher physicians' migration flows through increased supply.

These four developing countries trained a much greater number of physicians than they could possibly absorb, investing in physicians' migration as a source of incoming currencies through migrating physicians' remittances (Astor et al., 2005; Wright et al., 2008). The peak in physicians' migration came to an end during the 1980s when the licensing for physicians became stricter internationally, preventing some physicians from migrating and working abroad. Even though stricter licensing limited migration flows of physicians internationally, this lasted up to the late 1990s, when a shortage of physicians in the traditional destination countries such as the USA, UK, Australia and Canada triggered the interest of the public, who were concerned about the lack of human health resources and the associated problems in the delivery of healthcare services. Therefore, the most effective and immediate solution was the recruitment of foreign physicians and nurses to satisfy the increasing vacancies in their national health systems and calm worrying people down; consequently initiating higher migration flows internationally (Wright et al., 2008).

In some countries such as Australia, the USA, the UK and Canada 24% of the available physicians were foreign trained (Hamilton & Yau, 2004). Moreover, in the majority of the Anglo-Saxon countries worldwide, foreign physicians comprised more than 20% of the available medical workforce (Forcier et al., 2004). These numbers identified the reliance of developed healthcare systems internationally on migrant physicians to maintain their services and satisfy local requirements. Furthermore, in a number of countries, physicians' outward migration necessitated the recruitment of foreign personnel to cover for the vacant posts left in the countries of origin. The case of Switzerland depicts the above conditions when in 2001, 555 physicians migrated for training purposes and 629 migrated to practice elsewhere creating a number of vacant posts in the country's healthcare system and an immediate requirement for the recruitment of physicians (Forcier et al., 2004). Furthermore, a shortage of physicians in a number of countries outside the EEA prevailed. For example, in India there was one Indian physician for every 2400 Indians, while in the

USA there was one Indian physician for every 1325 Americans; whereas in the UK 30% of the foreign physicians who worked in the NHS originated from India (Adkoli, 2006).

When physicians' migration in the EU-10 was considered, the extent of migration flows was even higher. In the case of Cyprus and the exodus of Cypriot physicians, despite the low actual numbers, Cyprus had the most dramatic increase amongst the EU-10 and the EU-27 when adjusting for size and population (Docquier & Rapoport, 2009). Therefore, the situation in Cyprus was comparable to non-EU and less developed countries facing chronic problems with medical emigration such as Lebanon, Cuba and the Philippines (Docquier & Rapoport, 2009). Similar to Cyprus, other EU-10 countries faced analogous problems with physicians' migration. A study by Cooper (2005) on the migration intentions of EU physicians identified that 33% of physicians living in Lithuania, Poland and Hungary and 58% of physicians living in the Czech Republic were willing to migrate to other EU countries. Examining the situation in the Czech Republic in more detail it was noted that even though in 2003 the country faced a shortage of 550 physicians, 400 Czech physicians were working in Germany. In another case, Slovakia also faced a critical shortage of physicians due to major outflows as a result of low remuneration, poor working conditions and diminished opportunities for professional development for physicians in Slovakia (Krosnar, 2003). Lastly, in Poland during 2004 and immediately after its accession with the EU, nearly 500 physicians emigrated and registered for practise in the UK, with the number of physicians being thirty times the number of Polish physicians who migrated to the UK in 2003 (Bala & Lesniak, 2005).

4.3.1 Commentary: patterns of migration

Despite the differences in context and population of each country, the empirical evidence presented above demonstrates the extent of skilled migration flows both within the EU and internationally. Indeed, a great number of studies focused on identifying the degree of

skilled migration in terms of actual numbers, the countries with the highest demand, as well as the countries with the highest outflow of skilled healthcare workers. It was therefore identified that the majority of well-developed countries such as the USA, UK, Australia and Canada face a higher need for skilled healthcare workers and physicians in particular they because fail to cover the demand for additional healthcare workers through indigenous human resources. Subsequently, it was identified that these highly developed countries seek to cover their needs through the recruitment of foreign professionals through applying specific migration management policies to recruit additional healthcare workforces. Evidence of this reliance on foreign healthcare workers was depicted in Hamilton and Yau's (2004) study where they identified that 24% of the physicians working in these major receiving countries were foreign trained. Furthermore, the data presented above depicted substantial losses in terms of healthcare human resources in sending countries as a consequence of the inability of major receiving countries to cover their healthcare service requirements. Evidence of this trend was the higher number of Indian physicians per population in the USA compared to the physicians-population ration in India (Adkoli, 2006). Nevertheless, the number of foreign healthcare workers abroad seems to be the result not only of active recruitment from major receiving countries but also a consequence of the migration management policies of sending countries, such as India investing in the migration of these professionals as a major source of currency through remitting (Astor et al., 2005; Wright et al., 2008). Furthermore, when focusing on Europe it was identified that even though the outflow of healthcare workers was low, EU countries were losing human capital such as physicians and workers in the research and development sector being able to promote innovation and development. In turn, this diminished the competitive advantage of the EU in relation to the USA. This also seems to be the case in Cyprus. Cyprus was identified amongst the highest ranks within the EU in physicians outflow compared to its population but for the same reason it seems to be

neglected from major studies. This may possibly be due to its small size and the small effect it might have on overall migration flows within the EU or internationally.

Even though the number of studies examining the phenomenon of migration has increased since the 1990s and there is greater awareness of the major receiving countries covering their healthcare needs, no relevant study was identified in Cyprus. Even though Cyprus is included in a number of studies examining secondary data and statistical reports, it seems to be neglected in the available migration literature. Therefore, the enhanced outflow of Cypriot skilled professionals, specifically physicians, and the absence of similar empirical studies, drove this current study's focus on examining the migration experience of Cypriot physicians, specifically their migration decision making processes in relation to factors affecting migration and destination selection. Furthermore, this current study aimed to examine the UK because it was identified as one of the major recruiting countries with social and historical links with Cyprus (see Chapter 2).

4.4 Explanations of Migration: Review of the Empirical Literature

Following Abel-Smith and Gale's (1964) study of physicians' migration from the UK to the USA, Van Hoek (1970) examined in further detail the migration of skilled professionals. Van Hoek (1970) argued that any developed or undeveloped nation is required to have the appropriate educational policy and capacity to facilitate the requisite education of an adequate number of skilled healthcare workers to cover national requirements. Additionally, in 1970 the 'Committee on the International Migration of Talent' (CIMT, 1970) proposed a more positive approach to physicians' migration. The CIMT explained that countries such as India or the Philippines trained a number of skilled healthcare professionals that exceeded their local requirements and were therefore able to export these professionals to other countries/destinations who had a demand for physicians, benefiting both the sending and receiving country (Wright et al., 2008). In

1971 Oscar Gish, a health economist (Gish 1971a; 1971b; 1977) attempted to analyse physicians' migration through the individual migrant's perspective. He incorporated the motivational factors behind the decision of the individual to migrate and simultaneously analysed the economic impact that physicians' migration could have primarily on sending countries (Gish 1971a; 1971b; 1977).

Gish's first two studies (Gish 1971a; 1971b) along with the studies performed by Abel-Smith and Gales (1964) and Van Hoek (1970) formed the basis for the first international study on physician and nurse migration by WHO in 1973 (WHO, 1973). Therefore, between 1970 and 1980 there was a series of landmark studies by WHO (WHO, 1973; 1975; 1976; Mejia, 1978; Mejia et al., 1979), which focused on understanding the multifaceted nature of skilled healthcare workers' migration. All the studies conducted by WHO (1973; 1975; 1976) were brought together in one piece of work by Mejia et al. (1979), who managed to form the first, and most commonly cited study, on physicians' migration that examined its main patterns and social and economic implications (Bach, 2003; Wright et al., 2008).

Awareness amongst scholars in the last two decades was enhanced following an increase in demand driven migration flows and public concern with regards to potential problems of understaffed healthcare systems in the four major recipient countries (UK, Canada, USA and Australia) between 1970 and 1990. Therefore, international requirements for efficient physicians' migration management strategies initiated scholars' responsiveness to the topic in a great number of studies (Hagopian et al., 2004; Vujicic et al., 2004; Astor et al., 2005; Mullan, 2005; Oberoi & Lin, 2006; Williams & Balaz, 2008; Joudrey & Robson, 2010). A part of the available literature therefore focused on the impact of physicians' migration on home and host countries and the individual physician (Loefler, 2001; Aluwihare, 2005; Rutten, 2009). Moreover, another group of studies examined the individual physician's motives and main factors affecting migration (Robinson & Carey, 2000; Ballard et al.,

2004; Vujicic et al., 2004; Astor et al., 2005; Syed et al., 2008). Nevertheless, there were a limited number of empirical studies on the migration of physicians; these are thematically categorised and critically reviewed in the following sections.

4.4.1 Triggers to migration movements

In their qualitative study on the reasons why French physicians chose to work in London, Ballard et al. (2004) separated triggers for migration into two categories: personal and professional factors. This categorization of migration factors was also utilised in this current study to assist in the analysis of Cypriot physicians' migration. According to Ballard et al. (2004) personal factors may include: the desire of the individual physician to experience different health systems and cultures; learn a new language; travel; and establish or maintain social bonds. Whereas professional factors may include the individual physician's desire to: improve financial earnings; further develop in terms of educational background, professional skills and knowledge; and improve personal and family socioeconomic status (Ballard et al., 2004). These triggers were further explored using the 'push-pull' and transnational migration theoretical approach as described below.

4.4.1.1 Factors pushing physicians to migrate

Migration push factors, such as poor working conditions, are commonly cited internationally. Nevertheless, depending on the conditions in each country, as well as the cultural and socioeconomic background of the individual under study, migration push factors can be more specific and context related and therefore difficult to compare or generalize. According to Syed et al. (2008) who examined the factors affecting the migration decision-making process of medical students in Karachi Pakistan, amongst the most commonly cited factors pushing physicians away from their home country were limited educational capacity and oversupply of physicians. Greece also provided a good example of a country with a surplus of physicians, as despite national requirements for

30,000 physicians the number of available physicians was more than 70,000 (Giannarou, 2009). According to a range of studies, other major drivers for individual physicians moving abroad included: poor working premises/facilities (Loefler, 2001; Ballard et al., 2004; Kirigia et al., 2006); poor working conditions (Loefler, 2001; Brown & Connell, 2004; Malik et al., 2010; Humphries et al., 2015a; Al-Khalisi 2013); low wages (Brown & Connell, 2004; Syed et al., 2008; Hossain et al., 2016; Sohail & Habib, 2016); unstable socio-economic conditions promoting social and professional insecurity (Robinson & Carey, 2000; Brown & Connell, 2004; Malik et al., 2010; Al-Khalisi 2013; Humphries et al., 2014); nepotism and favouritism (Brown & Connell, 2004); and lack of professional opportunities (Brown & Connell, 2004; Sohail & Habib, 2016). Additionally, physicians in a number of cases were pushed to migrate by the inability of a country to accept changes from young physicians who had both the skills and willingness for change but were restricted by a lack of available resources or due to a country's conservatism and 'red tape' (Robinson & Carey, 2000; Loefler, 2001; Kirigia et al., 2006). According to a case study by Robinson and Carey (2000) on the migration of Indian physicians to the UK, the inability to change the home country's health and political system might cause frustration and disappointment for the local or returning physician who might be pushed to move abroad or re-migrate respectively. Similar conditions seem to be identified in other more developed EU countries such as Ireland. According to Gouda et al. (2015), Irish policy makers fail to address problems with local working conditions and inefficiencies in their healthcare system pushing Irish physicians abroad and consequently positioning Ireland at the top of the list amongst EU countries in physicians' emigration and second in the world.

Furthermore, Malik et al. (2010) in their study on the migration motives of physicians in Lahore, Pakistan suggested that similar to other skilled professions, low wages and poor working conditions were identified as the major push factors mediating the decision of an individual physician to migrate. Moreover, Gerlinger and Schmucker (2007) in their

review of the migration of skilled healthcare workers in the EU argued that even German physicians with moderately higher remuneration compared to their colleagues in the majority of EU-27 countries, decided to migrate to the UK. According to Gerlinger and Schmucker (2007), German physicians were pushed to migrate to the UK as a result of high work-related strain present in the German healthcare system in comparison to the higher wage/working hour ratio present in the UK. Similarly, in their study Ballard et al. (2004) identified that a number of French physicians decided to migrate and seek employment in the UK to avoid additional duties required by the French healthcare system such as resource management, consequently increasing their levels of stress and frustration. Moreover, high costs of living and high taxation were also identified in the same study as potential push factors, driving physicians to migrate to a country offering greater value for their earnings (Ballard et al., 2004).

4.4.1.2 Factors pulling physicians to destinations abroad

As Jenkins et al. (2010) identified in their literature review on the availability of psychiatrists in low and middle income countries, improved educational capacity and training opportunities were amongst the major factors motivating physicians to migrate to a destination abroad. Furthermore, higher wages were also cited amongst the major drivers for migration (Ballard et al., 2004), as were better working environments and facilities and improved opportunities to gain valuable experience (Robinson & Carey, 2000; Syed et al., 2008). These were the major and most commonly cited factors attracting physicians to more economically and professionally developed countries. Other secondary and additionally important factors included: opportunities to travel and work abroad in interesting cities (Syed et al., 2008); fair and more accepting societies towards minorities; better medical literature and prestige; team work ability and opportunities to dedicate to the medical profession; avoiding payments from patients (Ballard et al., 2004); active and aggressive recruitment (Jenkins et al., 2010).

4.4.1.3 Factors retaining physicians from migrating abroad

Even though potential migrants might be pushed to move abroad due to unfavourable conditions in their home country or pulled by improved opportunities available in destinations abroad, a range of retention factors were identified that could keep an individual physician from migrating. These factors included: the physician's ability to serve people of their own nationality and community; bonding with patients; the ability to be near family and friends; empowerment; degree of professional autonomy; respect from peers and supervisors (Loefer, 2001; Syed et al., 2008; Malik et al., 2010); and lack of necessary resources to migrate (Syed et al., 2008). Additionally, through their study on the migration of physicians from south pacific island nations, Brown and Connell (2004) found that property ownership might be considered as a major factor retaining physicians in their home country.

4.4.1.4 Barriers and inhibitors to migration

Despite the internationalisation of medicine, EU enlargements and the mutual recognition of medical qualifications, potential migrant physicians in a number of cases faced problems with the strict national rules and regulations and the context specific training present in a number of countries. These restrictions and differences in training and educational context restricted physicians of particular nationalities or training backgrounds from selecting their desired destination primarily as a result of the unwillingness of local authorities in the destination countries to acknowledge their qualifications and experience (Bourgeault, 2009; Jirovsky et al., 2015; Wojczewski et al., 2015). Failure to acknowledge medical qualifications and context specific medical education and training offered in specific countries could result in assimilation problems upon return for foreign trained physicians in their home countries (Bach, 2003; Efthymios, 2006; Wojczewski et al., 2015). Even within the EU, medical education is context specific in several countries such

as Germany, Denmark, Italy and Sweden. Despite physicians from these countries being able to migrate and work anywhere within the EU without any restrictions, differences in curricula and context specific training proved problematic. In Germany and Denmark an individual physician could acquire a postgraduate medical qualification after completing five years of postgraduate studies, whereas in Sweden and Italy for the same medical qualification the duration of postgraduate training was limited to two years (Gerlinger & Schmucker, 2007). Furthermore, France had a very distinct and context specific process for particular medical specialty training that caused adaptation problems during specialisation for foreign physicians and restricted local and foreign physicians who were trained in France from seeking employment in another EU country (Efthymios, 2006).

As identified in the empirical literature, language is a major factor in the migration process as it can determine the success of the migration movement for the individual physician. Despite English being considered as the international language and the language most frequently used in the EU, direct communication with the patient or colleagues might not be always possible. In cases when the migrant physician is unable to communicate in English or in the native language, this could negatively affect a physician's professional development and success in the host country, given that good communication is crucial for learning new skills and practises in a foreign working environment (Williams & Balaz, 2008). Additionally, Bach (2003) and Williams and Balaz (2008) argued that for a successful career in a foreign country an individual physician is also required to overcome potential cultural differences and attitudes of both patients and peers in the host country, in addition to potential professional discrimination. According to Ballard et al. (2004), the migrating physician might be faced with professional discrimination in the form of limited professional opportunities and inferior remuneration, as well as placements in less advantageous posts compared to indigenous physicians of the same specialty, qualifications and experience. Additionally, 'red tape' practices in specific countries might

prove complicated and time consuming. As a result, potential migrant physicians might be discouraged from residing and working in a specific host country and in particular cases this might negatively affect their intended course of migration and professional development (Ballard et al., 2004).

4.4.1.5 Selection of migration destination

According to Akl et al.'s (2008a) study on Lebanese medical graduates, selection of destination primarily depends on the socioeconomic background of the potential migrant. Additionally, in selecting their potential destination migrants assign great importance to factors such as language in the host country and place of medical education. Therefore as Akl et al. (2008a) identified, physicians tend to migrate to destinations where they studied and to destinations with a similar or shared language, as these parameters could facilitate an easier and faster adjustment to a new country. Additionally, Mullan's (2005) study on international medical graduates practicing in the USA, UK, Canada, and Australia found that historical bonds such as similar customs, previous colonization or similar educational and training systems amongst the host and home country could be of central importance in destination selection. However, Connell (2010a) suggested that migrants' destination selection might also depend on the climate at destination, the political and economic background of the potential host country, as well as its geographical position and proximity to the home country.

Cooper's (2005) study compared the number of physicians emigrating against the number of medical students graduating annually in several EU and non-EU countries. Cooper (2005) concluded that destination selection for migrating physicians seemed to have a pyramid like structure with the USA being at the top, other developed countries such as New Zealand, the UK, France and Australia being in the middle and underdeveloped, usually African countries, being at the base of this pyramid. Physicians therefore tend to

move from the pyramid's ground level to the top citing the USA as the leading international destination for migrating physicians (Cooper, 2005). Other highly desired destinations included Australia and Canada whereas amongst the EU countries, the UK was cited as the leading destination for the majority of migrating physicians (Akl et al., 2008a). The UK seemed to be amongst the top destinations for non-EU physicians in addition to physicians originating from highly developed economies such as Italy, Germany and France, as was noted in Martin et al.'s (2004) editorial on the role of foreign physicians in UK NHS leadership. Physicians from Italy, Germany and France seemed to have an impression that the NHS rewards the merits and skills of the individual physician, and facilitates higher responsibilities and opportunities for promotion for more junior physicians. Additionally, potential migrating physicians were attracted to the UK because of the perception that there was more funding for healthcare and research and development, which facilitated better opportunities for a career in medical research and academia, as well as the prospect to improve their proficiency in the English language (Martin et al., 2004). Through a systematic study of secondary databases on the presence of European physicians employed abroad, Garcia-Perez, (2007) identified the most popular destinations. In addition to the UK, Garcia-Perez, (2007) cited other popular EU destinations, included here in order of selection: Germany; Austria; France; Belgium; Luxemburg and Switzerland. Cypriot migrant physicians on the other hand seemed to demonstrate a higher preference for different countries, including, and again in order of selection: Greece; Russia; Germany; the UK and Romania (Pericleous, 2011).

According to Cooper (2005), previous colonization and historical links played a central role in physicians' decisions to migrate to specific destinations. Cooper (2005) identified this relationship in his study of Portugal. Portugal primarily recruited physicians from its former colonies such as Angola and Cape Verde, with 70% of physicians originating from former colonies either studying or working in Portugal. In addition, 46% of the practicing

physicians born in Angola were practicing in Portugal, with the majority having completed their medical education in Portugal (Cooper, 2005), supporting Akl et al.'s (2008a) argument that physicians tend to remain at the place where they studied.

Potential barriers, described in the previous section, can also be a major factor for a migrating physician in selecting a potential destination country. Therefore as identified in Humphries et al.'s (2013) study, in some cases physicians might migrate initially to a potential destination and re-migrate upon failure to realize their migration objectives as a result of migration barriers. In addition, even though qualifications in all member countries following the associated EU directives were supposed to be mutually recognized, in reality this was not the case. In the case of a number of Spanish medical students who failed to qualify in Spain and migrated to other countries such as the UK to complete their studies, it was found that upon returning to Spain it was impossible for them to find employment as their UK qualifications were not officially recognized. Consequently, the majority of these physicians returned to the place they had studied in the UK to seek employment (Cooper, 2005). This example of national policies therefore illustrates some of the problems in establishing a functioning mutual recognition of qualifications between the EU-27 and demonstrates the effect of national politics and bureaucracy on migration and selection of desired destinations.

4.4.2 Commentary: explanation of migration

Physicians' migration attracted the attention of migration scholars and the WHO during the 1970s mainly as a response to increased demand at the time from the USA, Australia, Canada and the UK for physicians and the inability of these countries to satisfy demand through indigenous staff. Furthermore, the awareness of both sending and receiving countries for better physicians' migration management policies maintained the focus of migration scholars on physicians' migration during 1970 to 1990s. Studies during that period aimed to examine the impact of migration on individual physicians and their home

and host country, as well as the motives for migration and the factors that may facilitate or inhibit it. Migration scholars continued to focus on physicians' migration up to the present day, adapting to changes in communication and technological advancements in medicine as well as the expansion of international communities and agreements such as the EU. Nevertheless, only a few studies examined the contemporary nature of migration through a transnational approach and even less studies examined in depth the migration decision-making processes of physicians in small but developed countries such as Cyprus and Malta. In addition, following the 1990s a number of traditional sending countries have been actively recruiting foreign physicians to cover their increasing needs, altering the direction of migration flows compared to the 1970s and 1980s. Adding to that, the assumption during the 1970s and 1980s that physicians moved from underdeveloped countries to the countries of the West seemed to neglect that physicians might move from well-developed countries such as Germany, Italy and France to other developed countries such as the UK or the USA. Therefore, in the absence of any study on Cypriot physicians migration this current study aimed to examine this phenomenon through the migration experiences of individual Cypriot physicians that graduated after the 1990s, through a transnational theoretical approach to incorporate the contemporary nature of the phenomenon and adjust for the socioeconomic changes and alterations in migration patterns that occurred after the 1990s.

As identified in the available literature, migration flows were mainly driven by: 'push and pull' factors; the individual's perceptions and socioeconomic status; and the host and home countries' socioeconomic context at the specific time. In addition, the absence of medical education and training, as in the case of Cyprus, formed an unyielding factor that left no option for the sample of physicians identified for this current study (medical school graduates between 1990 and 2013) to stay in Cyprus. This unyielding factor seemed to be identified in other empirical studies as well, even though most focused on the absence of

specialised training rather than the absence of medical schools. The individual physician or team (including the partner or family) will therefore evaluate and prioritise these factors and depending on the result of this personal cost-benefit equation will decide whether to migrate or not and decide the preferred destination. Nevertheless, the cost-benefit analysis of the potential migrant needs to consider any additional barriers to migration or subsequent return to their home country that is out of their control. Despite the efforts from key players such as the EU, the OECD and the majority of medical schools for the internationalisation of medicine, migrant physicians face major difficulties in their professional development and incorporation following their migration. These difficulties will therefore have to be included in potential migrants' cost-benefit equation as they might affect the fulfilment of the objectives set during the migration decision-making process.

Following a similar approach to the identified empirical studies, this current study in order to examine the phenomenon of Cypriot physicians' migration in depth needed to identify and examine the factors that determined the migration decision-making process for Cypriot physicians to migrate abroad to practice. In addition, considering the absence of a medical school and the limited medical training in Cyprus, this current study needed to explore the factors affecting the migration decision-making process for physicians that migrated to train as well.

Following the triggers to migration identified through the available literature, it was clear that they fall within two categories; professional and social factors. This current study therefore followed a similar strategy to Ballard et al.'s (2004) study investigating the migration decision-making process of French physicians migrating to the UK and categorized the identification and analysis of participant responses into these two categories. Considering the approach utilized by a number of similar empirical studies to identify the triggers to migration and in the absence of previous empirical studies on the

triggers to migration for Cypriot physicians, this current study utilized a combined theoretical approach using the 'push-pull' migration model in conjunction with the transnational model. Using this combined approach allowed this current study to examine the context specific factors related to Cyprus, as well as the personal factors that affected the migration decision-making process for Cypriot physicians through a contemporary approach.

Moreover, it was found that the selection of destinations by migrant physicians was dependent upon the individual's preferences, available opportunities in specific countries for professional and economic development and migration management policies mainly in host and home countries. Additionally, the general socioeconomic context of host and home countries, as well as the social, historical and other similar links between them were cited in the relevant literature as major factors in the destination selection process. Furthermore, migrant physicians who mainly originated from other medically developed countries cited a number of secondary factors affecting the destination selection process such as; climate, travelling opportunities and geographical proximity between home and destination. Therefore, considering that the UK was identified amongst the major receiving countries and a member of the EU as is Cyprus without any restrictions in labour movement and mutual recognition of qualifications between the two countries, it was decided to focus on the UK to examine the Cypriot physicians perspective on the migration decision-making process, including destination selection and the main pull factors present in a specific country's context. Furthermore, considering that Cyprus and the UK shared historical links and the great number of Cypriots living in the UK, focusing on Cyprus' and the UK's context allowed examination of the effects of major migration factors that determined both the decision to migrate to a specific country for study and training, as well as the decision to migrate and remain in a specific country to work. Therefore, focusing on Cypriot and UK contexts facilitated a better understanding of the role of: networks;

English proficiency; geographical proximity; historical, colonial and social links on the migration decision-making process.

4.5 Gender and Physicians' Migration

It should be noted that all the factors discussed above may be mediated by gender. Much of the mainstream literature and empirical studies on skilled healthcare workers' migration have neglected to consider gender as an important dimension that may impact on migratory decisions and movements. However, gender has been acknowledged as an important factor for general migration studies by a number of migration scholars (Birrell, 1996; Man, 1995; Kofman, 2000; Liversage, 2009). Additionally, a number of studies conducted in the last two decades and presented below examined physicians' migration issues and the ways gender may mediate migratory decisions and experiences.

For example, a number of researchers (Davis & Winters, 2001; Curran & Rivero-Fuentes, 2003; Faggian et al., 2007; Docquier, 2009) observed gender related characteristics of female skilled migrants that affect their flows and selection of destination. In particular, they argued that depending on the sending country's context and individual preferences, female migrants had the tendency to: assign higher importance and to and be more dependent on social networks abroad; move to shorter distance destinations; and remit more money over longer time periods compared to male migrants. Rickets and Randolph (2008) through examining secondary data on international movements of physicians in training between 1981 and 2001 identified a general tendency for female physicians to move between countries in search of better prospects. More specifically, they noted that female physicians tended to migrate in search of greater career opportunities in countries with lower physician density and competition, lower unemployment and higher remuneration.

In addition, they found that female physicians were less likely to migrate compared to their male counterparts. Boulis and Jacobs (2008) and Poppas et al. (2008), in their studies in the USA on female physicians' experiences and female cardiologists' career choices respectively, argued that this could probably be assigned to female physicians' specific traits. Specifically, they noted that female physicians were less likely to migrate than male physicians due to their tendency to construct their career progression plans by assigning higher priority to family needs and expectations. On the contrary, male physicians defined high salary and career progression as the major factors in career and migration planning (Boulis & Jacobs, 2008; Poppas et al., 2008). Differences between male and female physicians were also identified in Carr et al.'s (1998) study on how responsibilities towards dependents might affect career targets and aspirations for female physicians and also in Jonasson's (2002) study on the leadership role of female physicians in American surgery. Both these studies noted that female physicians with families modified their plans to enable them to devote more time to their families rather than to go for leadership roles and advanced career progression as the majority of their male counterparts (Carr et al., 1998; Jonasson, 2002). Despite the differences identified above, Ricketts and Randolph (2008) argued that female physicians' migration flows had increased substantially in the last two decades. The most likely reasons for the increase in the migration of female physicians could have been ascribed to: their relative younger age compared to male physicians; pressure from family; more professional freedom to move and practice; and situations that allowed easier movement due to their less permanent nature (Ricketts & Randolph, 2008). However, the increased migration flows of female physicians was not universal internationally, as different country specific contexts had a direct effect on female physicians' migration intentions. As depicted in studies by Akl et al. (2007; 2008) on Lebanese medical students, there was an inverse relationship between female

physicians and migration intentions despite more than 40% of medical students being female.

Even though female professionals and physicians were increasingly migrating to highly developed countries, the percentage of those who integrated into the host country's labour market was quite low. Badkar et al. (2007), in their study on female skilled migrants of Asian Ethnicity moving to New Zealand between 1998 and 2006, examined the main difficulties for the integration of female skilled professionals in the host country. Badkar et al. (2007) elaborated further and used Germany as an example to note that even in one of the most developed economies only 60% of female highly skilled immigrants including physicians were employed, in comparison with more than 80% of indigenous female skilled professionals possessing analogous occupational and educational characteristics. This example was therefore used to emphasize the difficulties that female skilled professionals face integrating into several professional fields. According to the same study by Badkar et al. (2007) the employability of female skilled migrants in most OECD countries followed similar patterns to Germany. This phenomenon according to the OECD annual 2006 report had been ascribed to: language and communication difficulties; racism; difficulties in professional qualification/experience recognition; and the individual migrant's attitude and behaviour (SOPEMI, 2006). Irrespective of the initial difficulties, the integration of female professionals into a foreign country's labour market and society was not always problematic and in many cases the integration of female professionals proved faster than their male counterparts. In their studies on the political participation of Latin American women in the USA, Hardy-Fanta (1993) and Jones-Corea (1998) argued that female immigrants might have experienced faster integration than male counterparts. Faster integration was therefore ascribed to female immigrants' tendency to connect with local authorities such as schools and social services, and their tendency for immediate involvement in the politics of the host country (Hardy-Fanta, 1993; Jones-Corea, 1998).

Returning male and female physicians had to face the challenge of re-integrating into their home country's social network and socioeconomic conditions. Hence, depending on the context of each country and the gender bias present, integration might differ amongst male and female physicians. Despite the degree of gender bias present, both male and female physicians would have to adjust their knowledge and skills in such a way to be able to utilise their full potential (Kaneto et al., 2009; Kodama et al., 2011). Kaneto et al. (2009) and Kodama et al. (2011) in their studies on female physicians' participation in medicine, working status and career paths in Japan between 1980 and 2002 and 1984-2004 respectively, noted several difficulties that returning migrants might have faced on return to their home country. Returning migrant physicians during their professional re-integration would therefore have to overcome potential differences in the functioning of the host and home countries' healthcare system; social circumstances; patients' approach; available technology as well as facilities and resources (Kaneto et al., 2009; Kodama et al., 2011). In addition, female physicians who were on maternity leave, worked part time or abroad for a significant period might have faced difficulties re-integrating into the same labour market due to rapid medical advancements in the approach to treatments and technology used (Kaneto et al., 2009).

4.5.1 Commentary: gender and migration

Through the systematic review of the identified literature it was evident that female physicians' needs, migration patterns and behaviour differed compared to their male counterparts. As was observed, female physicians had the tendency to construct their career plans by assigning higher importance to personal rather than professional factors. Additionally, it was identified that migration scholars should enhance their awareness of the effects of gender on the migration decision-making process due to the different conditions present in the process of male and female skilled and physicians' migration, developments in the medical profession and changes in gender patterns over time. This

necessity for enhanced awareness could be specifically ascribed to: the increase in female physicians migration flows; similarities with their male counterparts on migration difficulties; presence of gender bias in medicine; dependence of migration flows and direction on the context and gender bias present in each country; and different responses to specific stimuli between male and female migrant physicians.

Thus in relation to Cypriot female physicians, their role in the healthcare system as well as their migratory behaviour, has been neglected similar to their male counterparts, since no single study was identified that focused specifically on Cypriot physicians and female physicians. This was in line with the general lack of available studies on the position of Cypriot professional women in specific occupations and society in general (Vassiliadou, 1997; Hadjipavlou & Mertan, 2010). Adding to this under researched area, Cypriot society has been identified as patriarchal and gender prejudiced by ignoring women's professional needs and perspectives (Hadjipavlou & Mertan, 2010). Therefore, the lack of previous research on female professionals in general and the identified gender biased in Cypriot society identified the need for this current study to focus on the role of gender in the migration decision-making process through examining the lived experience and perspectives of female physicians and compare their responses with male participants. Furthermore, examining the available empirical literature where female physicians may have a different approach than their male counterparts to specific migration stimuli should also be examined in the case of Cypriot female physicians through a comparison of responses to the same research questions and objectives. On similar lines, part of the empirical studies reviewed identified specific female traits in migration patterns and the focus of female physicians on family establishment rather career progression with consequent decisions in the migration decision-making process. This focus identified an objective to examine whether or not this was the case for Cypriot female physicians. Additionally, through examining official statistical reports it was identified that the

position of women in Cyprus in terms of participation in education and employment has shifted to a great degree in the last two decades. Specifically, the participation of Cypriot women in tertiary education increased from 13% in 1990 to 38% in 2014, whereas the percentage of women in employment increased from 40% in 2000 to almost 50% in 2015 while the gender earning gap within the same period decreased from 43.9% to 26.9% respectively (CyStat, 2016). Nevertheless, regardless of the increase in educational and occupation participation of Cypriot women their participation in key and decision-making positions was not proportionate as they ranked Cyprus last in this particular indicator amongst the EU-27 (Meuleman et al., 2017). Therefore, the contemporary nature of migration and changes that occurred following the 1990s on the position of women in professional and social fields in Cyprus, should be examined in depth to identify Cypriot physicians perspectives on the effects of gender in contemporary migration, as well as why some discrepancies in migration flows and medicine in general might still exist.

4.6 Impact of Transnational Physicians' Migration: Home and Host Countries and the Individual Physician

Transnational migration is a process that involves complex dynamics that require an active analysis of potential impacts in a variety of different contexts, such as macro and micro levels, including host and home countries as well as the individual migrant. Therefore, the traditional approach to the impact of skilled and physicians' migration in terms of 'brain drain' and 'brain gain' were replaced following the 1990s by the focus on transnational and more temporary migration or 'brain circulation' (Glick-Schiller, 2003; Stark, 2004; Skeldon, 2005; Dodani & LaPorte, 2005; Asabir, 2009). Indeed, migration scholars argued that the process of transnational migration involves the exchange and transfer of skills and ideas internationally and that this could have a range of positive effects for key healthcare players. Despite the tendency of some researchers to focus on the positive side of skilled healthcare workers' migration (Dodani & Laporte, 2005; Assabir, 2009), another part of

the available literature presented the argument for ‘medical exceptionalism’ (Alkire & Chen, 2006). Therefore, scholars in support of ‘medical exceptionalism’ focused on the negative impact of physicians’ migration on a macro level scale as well as on the individual migrant. Hence, the following section in this chapter reviews the empirical literature that identified the positive and negative impact of medical and skilled healthcare workers migration by considering a range of factors and key players. Initially, there is a review of the positive and negative impact of migration on the individual physician as well as on the home and host country. Following this is a presentation of the findings from other empirical studies on the impact of medical knowledge transfer through physicians’ migration. Lastly, the final part of this section presents the impact that could result from the general waste of human resources through the inefficient management of physicians’ migration.

4.6.1 Impact on the individual physician

Buchan et al. (2008) in their study on international migration trends of nurses and other skilled healthcare workers identified that one of the most prevailing effects of migration on the individual migrant physician is the absence of family and everyday life back in their home country. Moreover, in their literature review on the human perspective of skilled healthcare workers’ emigration from sub-Saharan Africa, Ogilvie et al. (2007) found that migrants could take the risk of facing unfavourable conditions (cf. Robinson & Carey, 2000, Buchan, 2008). According to these studies, such conditions may have included difficulties in adjusting to a new health system, unfriendly environments, as well as professional and personal discrimination. Bernstein and Shuval (1998) and Bourgeault (2009) in their studies on physicians’ migration from USSR to Israel in 1990 and physicians’ migration in and out of Canada respectively, also observed that migrating physicians might face the risk of de-skilling by not receiving equal opportunities and professional autonomy. Furthermore, Robinson and Carey (2000) and Brown and Connell

(2004) identified that migrant physicians might have to be employed in less desired rural posts in the host country. According to these studies, employment in a less desirable post or underemployment might inhibit migrant physicians from working to their full potential possibly resulting in “brain-waste” and failure to fulfil their migration objectives for professional development. On the other hand, and according to Buchan et al. (2008), physicians who stay in their home country might face difficulties due to potential extra workloads and diminished professional satisfaction through the loss of tutors, trainers or in some cases their role models. However, migrating physicians could potentially increase their earnings and improve their medical knowledge as Astor et al. (2005) argued in their study on physicians’ experiences in several countries. In addition, migrating physicians might be able to: improve their technical skills and use more advanced technologies (Lowell & Findlay, 2001; Forcier et al., 2004); establish networks with medical centres and peers (Mullan, 2005); and improve their approach to healthcare delivery through exposure to new health systems and cultures (Ogilvie et al., 2007; Buchan, 2008).

4.6.2 Impact on home country

Generally, the impact of physicians’ migration on their home country is dependent upon its socioeconomic situation, as well as the demand and supply for physicians to cover the healthcare system’s requirements at specific times. According to Krieger’s (2004) study on the potential extent and structure of migration from EU-10 to the old EU member countries, when the home country faces an oversupply of physicians their migration could possibly reduce medical unemployment. Furthermore, Krieger (2004) argued that immigration or return migration might augment physicians’ unemployment and possibly result in task shifting and brain waste. Furthermore, Malik et al. (2010) noted that when the home country is in short supply of physicians their migration might cause frustration to the remaining physicians; deprived work motivation and inability to work to their full potential. Consequently, the quality and efficiency of the home country’s healthcare

services might be negatively affected (Malik et al., 2010). Therefore, in cases of short supply of physicians their migration might lead to decreased rates of economic development due to the lack of available human capital and underutilisation of available resources (Mackay, 1969). Another issue for some sending countries was the departure of the most talented amongst their available physicians and the loss of physicians in specific posts who would be able to promote the development of medical education, such as medical professors and trainers (Akl et al., 2008a; Kaushik et al., 2008; Syed et al., 2008; Jenkins et al., 2010). Furthermore, sending countries might experience financial costs accrued through investment in the education of migrating physicians and the loss of earnings through potential revenue taxes (Mackay, 1969; Astor et al., 2005; Giannarou, 2009). Nevertheless, remittances could counteract to some extent the negative impact of physicians' migration as Barrel et al. (2007) and Hartmann and Langthaler (2009) argued in their studies on the effects of migration within the EU following the major European enlargement. Additionally, Astor et al. (2005), Akl et al. (2008a) and Forcier et al.'s (2004) studies on the impact of physicians' migration between OECD countries demonstrated that physicians' return migration following a temporary stay abroad could promote the transfer of new skills, knowledge, technologies and experiences back to the home country.

4.6.3 Impact on host country

Forcier et al. (2004) and Dobson (2009) argued in their studies on the impact of migration on OECD countries and the EU respectively that the most significant benefit for the host country is the staffing of its vacant posts for upgrading the country's healthcare system and making it more efficient. However, as suggested by Young et al. (2010) in their study on the effects of recruitment of foreign workers in the UK NHS, increased medical immigration can cause unemployment if there is already adequate numbers of physicians or in cases where physicians from different specialities than the ones required enter the host country. Additionally, potential differences in training and educational background of

migrating physicians might generate problems in the quality and universal delivery of health services in the host country's healthcare system (Forcier et al., 2004; Young et al., 2010). Other researchers such as Krieger (2004) suggested that an increased inflow of migrant physicians might decrease wages and create unemployment amongst indigenous physicians, as migrating physicians might be willing to work in undesired areas and possibly with lower wages. In contrast, Forcier et al. (2004) stated that this might benefit patients and the healthcare system as a whole since it could stabilise or even reduce prices, therefore enhancing motivation for the development of available physicians' skills through enhanced healthy competition (Forcier et al., 2004).

4.6.4 Transfer of medical knowledge

The high flows of physicians' migration faced by the EU in the last decade provided opportunity for beneficial transfer of medical knowledge within the Union. Indeed, Williams and Balaz (2008) noted in their case study that the return of Slovak physicians to their home country facilitated the transfer of knowledge and skills. Furthermore, a number of skilled migration scholars such as Martineau et al. (2002) studied the impact of physicians' migration on health services through the use of an extensive literature review and interviews in Ghana, South Africa and England. Martineau et al. (2002) concluded that benefits from physicians' migration such as knowledge and skill transfer depend on each national healthcare system's willingness to accept and accommodate new approaches, learning and skills based on available resources and infrastructure. Furthermore, Williams and Balaz (2008), based on other researchers' earlier work (Blackler, 2002; Zubof, 1988; Berger & Lackmann 1966; Brown & Duguid, 1991) provided a synopsis of the benefits of knowledge transfer through physicians' migration. The brief analysis below describes and categorizes the knowledge transfer process and the type of technical and management skills, as well as the academic and cultural knowledge that could be attained through physicians' migration (Williams & Balaz, 2008).

The first category *Embrained knowledge* was based on the skills that could be acquired by recognition and reflection on concepts and patterns. Migrant physicians might be able to acquire this type of knowledge through studying in classrooms or through library-based learning in health systems that are more advanced compared to the place or country of education. *Embodied knowledge* described the process where the migrant physician could develop their knowledge through observation, practical thinking and hands-on actions, either in surgical procedures, consultations and other similar events. *Encultured knowledge* suggested that migrating physicians would be able, through everyday ‘friction’ and socialisation with peers and patients in different healthcare systems, to gain an understanding of different values and approaches in healthcare services. Lastly, *Embedded knowledge*, could be acquired by learning the background and approaches used in different healthcare systems through shared knowledge with different work groups and other different organizational cultures that may work in contrast to what the migrating physician had been taught up to that point.

4.6.5 General waste of healthcare services’ human resources

As illustrated in Saravia and Miranda’s (2004) study on the use of efficient migration management policies, another major issue in the physicians’ migration process worthy of further attention was the ways in which human health resources were utilised. In a number of cases, physicians were filling vacant posts with the obvious benefit of performing tasks that were not previously performed, either in their home country or abroad. Sometimes though, human health resources were inadequately utilised, usually due to limitations and restrictions placed by host and home countries in the recognition of physicians’ qualifications and experience. Consequently, this political approach by a number of sending or receiving countries decreased job satisfaction and efficiency and might have caused unnecessary increase in the demand for additional human resources (Saravia & Miranda, 2004; Joudrey & Robson, 2010). Additionally, as Joudrey and Robson (2010)

noted, already acquired skills might become redundant through a lack of practice, either by regulations in the host country or poor infrastructure in the home country upon return. Therefore, this inefficient use of acquired skills might cause frustration to the potential migrant or returning physicians (Joudrey & Robson, 2010). Consequently, according to Kaushik et al. (2008a; 2008b) a great number of physicians who wished to deploy their full potential were forced to stay in their country of training.

4.6.6 Commentary: impact of transnational physicians' migration

The impact of physicians' migration might be positive or negative depending on the perspective under study because as it frequently depends on the socioeconomic and health context of each country, as well as fluctuations in the demand and supply for physicians. Nevertheless, the differences in training, qualifications, infrastructure and ability of each country to accept and accommodate different approaches determines whether the outcome of inward or outward physicians' migration flows would have a positive or negative effect on the key players involved. With reference to the individual physician, despite the benefits from physicians' migration in terms of professional and economic development, the loss from migration might be detrimental. Therefore, the potential impact of physicians' migration is dependent on the available context in host and home countries upon migration and return respectively and on the individual's abilities to retain social bonds and enhance social and professional networking.

In the absence of any empirical study on the impact of Cypriot physicians' migration on the individual migrant or Cyprus healthcare system, as well as the absence of any official statistics on Cypriot physicians' migration flows, it was timely to seek contextual information through other sources. It was therefore decided to include in this current study key informants that could provide their perspective and insightful information on the impact of Cypriot physicians' migration on the Cypriot healthcare system through their

experience in the sector. This approach was supported by Williams and Balaz (2008) who argued that interviews with experienced and appropriately positioned key informants could potentially provide important contextual information. Therefore, considering the objectives identified in the previous sections of this chapter, enhanced contextual information both for the reader and the researcher in relation to the impact of Cypriot physicians' migration on the healthcare system facilitated a more inclusive examination of the migration decision-making process of Cypriot physicians. In addition, the set objectives and the decision to include the lived experiences of Cypriot migrant physicians also facilitated the examination of the migration impact on the individual. Neglecting only the effect of Cypriot physicians' migration to the host country, which was not the intention of this study, yet may have identified a need for further research based on the results obtained from this current study.

4.7 The Objectives of this Current Study

The central aim of this current study was to explore the migratory movements and experiences of Cypriot physicians moving between the UK and Cyprus. Conducting a thorough examination and critical analysis of the theoretical and empirical literature around skilled professionals, particularly physicians' migration, the literature gaps were identified and the main themes that emerged into this study's aim was addressed through focusing on three key objectives:

- 1.** Identify and explore the factors that led Cypriot physicians (including physicians in training) to migrate to the UK in order to practice medicine or acquire medical training; and why some Cypriot physicians have relocated permanently to the UK following their medical education or training, whilst others have chosen to return to Cyprus.
- 2.** Consider the ways in which gender might have mediated these factors: differences in migration for men and women.

3. Explore how these factors that lead to Cypriot migration contribute to understandings about theories of migration.

This investigation therefore constructs a study about the migration of professionals from Cyprus, and as such, explores a range of issues of interest to policy makers and those involved in managing and delivering healthcare services and healthcare education. Therefore, the findings from this current study could aid key players and policy makers to appropriately structure medical education in Cyprus according to the needs of the local population and physicians and could offer guidance for a more efficient control of physician density. Finally, through exploring and analysing the migration experiences of male and female migrant physicians, this current study could facilitate the incorporation of gender and gender specific needs into national migration management and educational policies.

4.8 Concluding Remarks

Following critical analysis of theoretical and empirical literature up to 2016, gaps were identified as well as the main research themes to forge the main objectives for this current study. In relation to the case of Cyprus, in particular essential background information provided the context to the current study, a review of available theories on skilled migration and identification of the main reasons for selecting this particular field for research. In addition, analysis of the development of skilled and physicians' migration in the last decades showed that the majority of migration scholars focused on the triggers and barriers to migration movement, the main factors affecting destination selection, migration impacts and to a lesser degree the role of gender in the migration process.

Therefore, the main objectives of this current study were set through identifying relevant gaps in the available literature. Furthermore, this study employed the most 'fit for purpose' methodological approach to collect all relevant primary data that could satisfy the research

objectives. Prior to conducting any fieldwork all the main methodological approaches were identified and reviewed in addition to previous empirical studies with similar objectives. Therefore, considering the research aim and context, time constraints and population sample for this current study, a qualitative approach was employed. The next chapter therefore addressed the main methodological considerations to provide clear justification for the methodological approach employed in this current study.

Chapter 5: Methodology

5.1 Introduction

In the first two chapters the overarching aim, as well as the contextual background for this current study was presented in detail. Chapter 3 offered a detailed presentation and critical analysis of the available theories and models that underpin the process of skilled and physicians' migration, setting the conceptual framework utilised in this current study. The previous chapter offered a detailed and systematic review of the available empirical literature, emerging themes were identified and the current study's objectives were drawn from this review. Therefore, drawing on the knowledge acquired from previous chapters, this chapter describes the study's design, methods of data collection and analysis used to achieve the aim and objectives stated in Chapter 1 (Blaikie, 1993; Silverman, 2005). The first section identifies the study's research philosophy and approach and discusses the epistemology and theoretical perspective used in this current study. Section two of this chapter describes the study's methodological approach and justifies the methods utilised in this current study including sampling, recruitment, data collection and analytical technique. The next section of the chapter examines the ethical considerations of this current study, whereas section four provides a brief review on the study's limitations. The following section provides detail in relation to the researcher's positionality and reflects on the relationship between the researcher and the study participants. Finally, the last section provides a chapter summary and introduces the next chapter.

5.2 Theoretical Approach

After careful examination of available theoretical approaches, the research design was grounded in constructivist epistemology. While there are a number of ways in which constructivism can be understood; in broad terms constructivism can be considered as a research approach that is embedded in the recognition of reality being constructed through the interactions between human intelligence and human experience in the real world

(Elkind, 2005). As such, the researcher is part of the world under investigation (Cresswell, 1998). Therefore, the essence of constructivism is that social reality is subjective, as each individual human constructs the social world differently. For this current study exploring the perceptions of Cypriot physicians on migration and the associated decision-making processes, constructivism offers specific advantages. Initially, this approach allowed the researcher to form part of the study and focus on how participants interpret their experiences and how these experiences affected their behaviour and migration decision-making processes (Andrew et al., 2011). Secondly, utilizing a constructivist approach facilitated a more in depth analysis on the effects of participants' social characteristics and specific context on their migration decision-making processes.

Approaching this study from a constructivist perspective therefore allowed the examination of Cypriot physicians' specific behaviour based on the individual Cypriot physician's understanding and evaluation of different lived experiences and objectives, as well as the examination of the effects of specific social characteristics, mostly focusing on the role of gender (Ivanovna et al., 2015). This approach seemed to be supported by other similar studies as well. In their study on the experiences of international migrants in Ireland, Migge and Gilmartin (2013) identified that individuals have a performative social behaviour that can be affected by a number of social factors. This further supports the notion that individuals 'design' their behaviour based on their lived experiences as well as their perception of different social characteristics and available personae and the personae they wish to display.

Approaching Cypriot physicians' migration through constructivism facilitated a more in-depth analysis of the phenomenon and the incorporation of participants' social characteristics and beliefs and the Cypriot contemporary context, compared to an alternative of collecting numerical data and verification of predetermined hypotheses that could have led to inaccurate and out-dated conclusions (Cresswell, 1998; Vargas-Silva,

2012). Participants might share some social characteristics (nationality, class, education level), nevertheless their histories, objectives and perceptions in relation to migration and the micro processes involved in their experience might differ. These micro processes were examined in this current study (Vargas-Silva, 2012; Migge & Gilmartin, 2013; Ivanovna et al., 2015).

The advantages of the constructivist epistemological approach depicted above would not have been apparent in positivist epistemology. This is because a positivist philosophical approach is grounded in the notion that 'truth' is objective and exists independently of the researcher. Furthermore, the positivistic statistical or hypothesis testing model is unable to examine all the potential factors and micro processes involved in the individual's decision-making processes (Easterby-Smith et al., 1991; Creswell, 2003; Silverman, 2005; Assabir, 2009; Vargas-Silva, 2012).

A study grounded in constructivist epistemology leads naturally into an interpretivist methodological approach. Interpretivism's main principle suggests that research is subjective and reality is socially constructed (Husserl, 1965). Thus, reality should be observed through the direct experience of the researcher and the research participants, in order to provide better understanding of a specific phenomenon through the individual interpretation of participants (Cohen et al., 2007). The underlying assumption is that examining participants' specific experiences facilitates better understanding of their perceptions of their actions and decision-making processes (Hussey & Hussey, 1997).

Interpretivism aims to provide contextual depth in relation to a unique phenomenon or situation (Myers, 1997) and thus endorses the use of qualitative research for the generation of knowledge (Kaplan and Maxwell, 1994). Consequently, for a study examining the perceptions of physicians in relation to their individual migratory experience and their migration decision-making processes, a qualitative approach based on qualitative research methods for data collection offers a number of advantages (Blaikie, 1993).

Qualitative research is an approach that can be considered broad, inclined towards interpretivism it considers reality as socially constructed, dynamic and complex; it usually generates data from observations, discussions and conversations (Patton, 1990; Babbie, 1995; Silverman, 2010). The most frequent data collection tools used include; semi-structured or unstructured interviews, observations and the collection of specific secondary and other data (Cresswell, 2003; Assabir, 2009). Qualitative studies are therefore characterised by an in-depth approach, offering comprehensive understanding to a research question, in conjunction with close interaction between the researcher and the study's participants and focus on specific time periods and site(s) (Glesne & Peshkin, 1992; Creswell, 1998).

According to Punch (1998), the basic idea of a qualitative approach, in relation to the set objectives in this current study, is to facilitate the development of a study that could explore in detail the case of migrants and returning Cypriot physicians. This can be achieved by using appropriate methods to satisfy the research questions to develop a complete understanding of the phenomenon of Cypriot physicians' migration. Therefore, utilising a qualitative approach allowed the current study to offer a holistic analysis of Cypriot physicians' migration (Merriam, 1998).

According to Castles (2012), the use of a qualitative approach can provide deeper understanding of social actions at both the individual and the community level, as well as the interconnected effects of history and culture in the sending and receiving countries involved in a study. Consequently, the adoption of a qualitative approach focusing specifically on migrants and returning Cypriot physicians within the Cypriot and UK context, allowed deeper understanding of the role of historical links, social networks and language on participants' migration experience and their migration decision-making processes.

Following selection criteria, the research population was defined at 100 potential participants. Considering the small population, the use of a qualitative approach enabled the researcher's close involvement with the study, subsequently facilitating the recording of the interpretation and meanings that individual Cypriot physicians assigned to the phenomenon under study (Asabir, 2009; Silverman, 2005; 2010). This would not have been possible through a quantitative approach and collection of numerical data obtained mainly through close-ended questionnaires (Easterby-Smith et al., 1991; Babbie, 1995), analysed using mathematical and statistical methods with the aim of verifying specific hypotheses (Aliaga & Gunderson, 2000). Such an approach would have limited the researcher's contact with participants and defining and explaining social phenomena through the use of 'hard' data might have neglected the desires, needs and sense-making of Cypriot physicians leading to an inconclusive or misrepresentation of the phenomenon of Cypriot physicians' migration (Silverman, 2005). Moreover, the limited availability of previous empirical studies on Cypriot physicians' migration meant that there were no available hypotheses on the migration behaviour of Cypriot physicians to be tested. Therefore, using a qualitative research design allows for the formation of specific hypotheses on Cypriot physicians' migratory behaviour and the effects of gender on migration (Charmaz, 2006; Glaser & Straus, 2008). As Morgan (1998) argued, such hypotheses could be later used for the purpose of developing questionnaires in a longitudinal quantitative study or an extensive ethnographic study to verify these hypotheses.

Despite the advantages stated above, the qualitative approach has some drawbacks. For example, even though the researcher's involvement in the study offers in depth understanding of Cypriot physicians' perceptions in relation to their migration decision-making processes, at the same time this involvement might cause potential problems to the presentation of data and separation between the researcher's beliefs and participants'

experiences. This is identified in the theoretical literature as researcher bias (Sword, 1999). This current study, in order to limit researcher bias used reflexivity as a strategy for identifying and scrutinizing any potential threats to the credibility and trustworthiness of any conclusions generated, thus allowing the reader to better evaluate the study's findings (Scott, 1997; Alvesson & Skoldberg, 2000).

A qualitative research approach further lacks the ability to offer results that can be generalized to other settings and contexts (Assabir, 2009). According to Lincoln and Guba (1985) there are two types of generalization, nomothetic and naturalistic. While the nomothetic paradigm is based on positivism and a law-like stance, naturalistic generalisation is mainly based on empirical, personal and direct experience, offering a more intuitive and ideographic approach (Assabir, 2009; Silverman, 2010). This current study adopted the naturalistic generalization paradigm. Therefore, any generalization made would have to be based on and warranted by the readers' experience and reflections on the similarities between the in-depth analysis and context presentation offered in this current study, compared to other similar studies (Melrose, 2009). In addition, consequent to the study's scale, context specificity and selected sampling approach, any generalizations should be careful in terms of application to other contexts, as well as different points in time.

5.3 Research Design

The majority of existing studies concerning skilled migration and physicians' migration have focused on major "sending" and "receiving" countries, i.e., those with the largest populations. Little attention in the body of research has been given to small countries with modest sized populations such as Cyprus and Malta. Differing from previous work, this study focussed on an exploration of the migratory behaviour of physicians from a small island country, with a population of less than one million, to study the main factors affecting the relevant decision-making processes. Nevertheless, the current study was

guided by research approaches from previous studies, such as the work of Ballard et al. (2004) who studied the motivations and expectations of French physicians migrating to work in the UK. Building on previous work, the research design was developed to address the following questions:

1. Which factors were influential in the migratory decisions of Cypriot physicians?
2. What were the key factors that influenced Cypriot physicians' decisions to undertake international migratory movements and more specifically to the UK?
3. What factors influenced decisions by migrant Cypriot physicians to remain in the UK, subsequently returning to Cyprus or further migrating to other destination countries?
4. What influence does gender have on the migratory decisions and movements of Cypriot physicians?
5. What were migrant and returning Cypriot physicians' current and future migration social and career plans?
6. What were migrant and returning Cypriot physicians' overall migration experiences?

These questions were addressed through a research design that used a qualitative methodological approach to extract primary data through semi-structured interviews with specific groups of physicians and healthcare managers. Full details of the research design are provided below.

5.3.1 Recruitment of participants

The Cypriot health sector comprises a varied workforce, which includes skilled healthcare professionals, semi-skilled and unskilled workers. Nevertheless, the majority of these skilled and unskilled healthcare workers did not form part of this research, which focussed on migration of physicians. Two different samples were recruited; a sample of one element of the health care workforce, physicians and a sample of health care managers. The procedures for sampling the healthcare workforce are described initially, followed by the procedures used to recruit the sample of health care managers. The sample of the

healthcare workforce comprised physicians that had studied in the UK between 1990 and 2012 and were enrolled on the Cypriot Ministry of Health official register. The sample of Cypriot healthcare managers comprised current managers that had studied in the UK between 1990 and 2012 and were working in the Cypriot healthcare sector as hospital directors during the fieldwork of this study in 2013.

First, the procedures for recruitment of the sample of physicians are described. To meet the requirements for inclusion in this current study, participating physicians had to have graduated from UK medical schools between 1990 and 2012 and be registered as a qualified physician with the Cypriot Ministry of Health prior to the 31st of December 2012. The intention here was to recruit an equal number of male and female participants to explore potential differences between male and female experiences of migration. There was an additional criterion for inclusion in the sample, participants had to be either Cypriot migrant physicians working in the UK or Cypriot physicians who had returned to Cyprus following their training and/or work in the UK for a period of at least five years.

According to Greenfield (1996), there are two types of sampling techniques: random and non-random. Considering the objectives of this current study a non-randomised purposive sampling technique was employed (Black, 2003). Hence, the identification of a suitable sample of physicians comprised the following stages.

In the first stage, the total population of Cypriot physicians was identified. An estimate of the size of the population of Cypriot physicians was made using data extracted from the Cypriot Ministry of Health official register. In the second stage, once the size of this population was identified, purposive sampling was used to ensure selection of a sufficient number of participants with predetermined characteristics such as occupation, gender and study location, by using the official register of the Cypriot Ministry of Health (Black, 2003; Creswell, 2003; Assabir, 2009). Participants were therefore selected from Cypriot physicians enrolled on the Ministry of Health Register who had returned to Cyprus after a

period of work overseas, working in the four largest cities in Cyprus by population size, namely: Nicosia, Larnaca, Limasol and Paphos between 1st of June 2013 and 15th of July 2013. A similar approach, using centres of high population density, was used to recruit a sample of physicians being trained or working in the UK between 1st of June 2013 and 15th of July 2013. Participants were selected from Cypriot physicians working in the most popular cities chosen by Cypriot physicians to pursue their medical education namely: London, Manchester, Leicester, Birmingham, Nottingham and Edinburgh. According to the Cypriot Ministry of Health official register 70% of the 1990-2012 UK medical graduates were enrolled on medical education programmes at one of these centres. Furthermore, the total number of Cypriot physicians that studied in the UK between 1990 and 2012 was 100 (76 male and 24 female physicians); see Table 1 p. 127

In the third stage, following the initial purposive selection of the sample, a snowball sampling (Berg, 1988; Thomson, 1997; Vogt, 1999; Black, 2003) techniques was used to ensure that an adequate number of participants were recruited. Snowball sampling located additional potential research participants through the social networks of physicians already identified within the sample population. Snowball sampling has been used, as in this case, where research populations are not easily visible to researchers and policy makers (Atkinson & Flint, 2001). Using a snowball sampling approach had additional benefits, for example participants' trust in the research process was enhanced through peer referrals instead of using formal direct requests to participate in the study (Atkinson & Flint, 2001). Other similar empirical studies in this field have adopted a snowball sampling approach. For example, in their qualitative study on the factors affecting the decision-making processes of South African physicians immigrating to Australia, Oberoi and Lin (2006) purposely selected a small number of physicians (10 in total) with specific characteristics, enhancing their sample through snowballing. Furthermore, Oberoi and Lin (2006) similar

to this current study, aimed to examine contemporary migration by purposely selecting participants that had emigrated up to 10 years before the commencement of their study.

While there were advantages to using a snowball sampling approach, there were also certain disadvantages. Even though snowball sampling offered a simple, fast and inexpensive way of increasing the number of potential participants in this current study, it was difficult to ensure that the required number of potential participants with the desired characteristics was recruited. Furthermore, snowball sampling, as an approach, has been criticised as having high selection bias due to selection of participants being based on the first respondents (Kaplan et al., 1987; Van Meter, 1990). Consequently, as Van Meter (1990) and Griffiths et al. (1993) have argued the use of snowball sampling might exclude 'isolates' not being referred by initial participants, therefore affecting the generality of any conclusions made.

Once potential participants were identified they were contacted by email and were given information about the aim of this study, the researcher's background and were invited to participate in the study (see Appendix 3: Invitation letter & Appendix 4: Information Sheet). The first 12 physicians that agreed to participate in the study were invited, on two occasions (on accepting the invitation to participate and following the end of the interview), to identify any other Cypriot physicians of whom they knew and may be interested in participating in the study. The initial 12 participants identified were all willing to assist in the study and from their suggestions the researcher collected an additional 20 contacts after removing duplications. Of these additional 20 contacts, two did not satisfy the criteria for inclusion in the study. All potential participants that satisfied the criteria for inclusion accepted the invitation to participate. Combining the initial 12 contacts and the 18 referrals the total number of participants reached was 30.

Table 1 below presents in detail the number and gender of physicians that studied in six major UK cities compared with the sample frame used in this current study. It can be

clearly identified that female physicians were represented much more accurately than their male counterparts, mainly due to the smaller number of Cypriot female physicians that migrated to the UK for their studies between 1990 and 2012 and the size of the sample needed for gender balance. Nevertheless, the percentage sample for both male and female participants was quite high featuring almost 43% of the physicians that studied in the six major sites in the UK and 30% of the total population that registered as qualified physicians in the Cypriot Ministry of Health between 1990 and 2012.

Table 1: The Distribution of Participants (physicians) in the Major Study Sites

| Major study sites | Total population of Cypriot Physicians | | | Cypriot Physicians participating in the Study (n) | | |
|-------------------|--|--------|-------|---|--------|-------|
| | Male | Female | Total | Male | Female | Total |
| London | 19 | 7 | 26 | 7 | 7 | 14 |
| Manchester | 18 | 2 | 20 | 2 | 2 | 4 |
| Leicester | 10 | 1 | 11 | 3 | 1 | 4 |
| Birmingham | 1 | 2 | 3 | 1 | 2 | 3 |
| Nottingham | 5 | 1 | 6 | 3 | 0 | 3 |
| Edinburgh | 1 | 3 | 4 | 0 | 2 | 2 |
| Total | 54 | 16 | 70 | 16 | 14 | 30 |

The original research design, guided by previous studies (Ballard et al., 2004), was to identify a balanced sample (half male, half female) of 32 Cypriot physicians all of whom would have studied, trained and/or worked in the UK for at least five years, half of whom would have returned to Cyprus, while the other half would have been still working or training in the UK at the time of the interviews. Even though all participants identified accepted the invitation to participate in the study, due to practical constraints and difficulties the researcher was only able to collect responses from 16 returning physicians (eight male and eight female) and 14 migrant physicians (eight male and six female), limiting the total number of semi-structured interviews to 30 instead of 32.

A sample of health care managers' was also recruited to provide an overview of the impact of physicians' migration on Cyprus and relevant contextual information on the scale, scope

and issues associated with Cypriot physicians' migration (Williams & Balaz, 2008). Recruitment of the sample of healthcare managers is described below. To meet the requirements for inclusion in the current study participants had to be graduates of a UK university between 1990 and 2012 and working for a year at least as directors (Chief Executive/Financial Officers) in a major hospital, either in the public or private sector in Cyprus. The initial intention was to recruit both male and female healthcare managers to allow exploration of potential gender specific differences in participants' perspectives. Again, following the objectives of this current study a non-randomised sampling technique was utilised (Greenfield, 1996), identifying participating healthcare managers through the following stages.

Initially, the total number of healthcare centres/hospitals had to be identified. According to official governmental data (moh.gov.cy) the Cypriot public health sector at the time of the interviews in 2013 comprised of five main hospitals in each city and one paediatric/gynaecological hospital in the capital (Nicosia). There were another three small rural hospitals and 268 health centres, scattered in different locations throughout Cyprus. Nevertheless, when it comes to private health centres/hospitals there was no governmental or other official registry, hence affecting identification of the total number of health centres/hospitals and thus the total population of healthcare managers in charge of each available health centre/hospital was impossible to determine.

Consequently, in order to satisfy the current study's pre-determined criteria, healthcare managers were recruited using non-randomised, purposive sampling (Greenfield, 1996; Black, 2003), based on work location, gender, educational and occupational criteria. In the absence of official registers the sampling of healthcare managers for the current study comprised the following steps.

Firstly, through the use of publicly available data on the Internet and using the number of hospital beds as a major criterion, the Directors of the major private and public hospitals

were identified in the four largest cities in Cyprus by population size, namely: Nicosia, Larnaca, Limasol and Paphos. According to the Cypriot Official Statistical service (CyStat, 2016) 95% of Cypriots reside in these four cities.

Secondly, once the population of the healthcare managers had been identified, purposive sampling was used to ensure selection of a sufficient number of participants with predetermined characteristics such as: study location, place of work; occupational experience and gender (Black, 2003; Creswell, 2003; Assabir, 2009). Participants were therefore selected from the identified population based on whether they studied in the UK between 1990 and 2012 for their degree, had at least one year of experience as hospital managers/directors and worked in the four largest cities in Cyprus during the fieldwork of this current study between 1st of June 2013 and 15th of July 2013. At this point it is worth noting that eight healthcare managers were identified as the total population. Nevertheless, for identity protection purposes no reference is made to the population and participants' specific occupational background (public/private; city of work; health centre/hospital; specific post).

Out of the eight healthcare managers identified all studied in the UK and had more than one-year experience as healthcare managers/hospital directors at the time of the study, meeting the predetermined criteria. In light of the objectives of this current study and guided by other previously conducted research in this field (Ballard et al., 2004) the original intention was to recruit a gender-balanced sample of healthcare managers. Nevertheless, out of the eight healthcare managers identified none were female, which made the aim of achieving a gender-balanced sample impossible.

All eight healthcare managers were contacted through email inviting them to participate in the study (see Appendix 3 & 4), which included all relevant information, such as the aim and objectives of this current study, as well as the researcher's background. Due to time constraints, a time frame of one month was set for accepting the invitation for inclusion in

the study. Subsequently, four healthcare managers responded positively to participate in the study.

5.3.2 Procedure

Semi-structured interviews were used to gather data from both physicians and health care managers. The rationale for this approach was well articulated by King (1994) who argued that semi-structured interviews were most appropriate in studies where personal perceptions and experiences were to be recorded and analysed. Therefore, in the absence of previous empirical studies or established hypotheses, semi-structured interviews were the most appropriate vehicle to provide deeper understanding of both Cypriot physicians' experiences of migration and also health care managers' opinions. These interviews provided a forum for close interaction between the participants and the researcher, constructed through open-ended questions that enabled deep exploration of issues of importance to physicians and health care managers (Glesne & Peshkin, 1992; Creswell, 1998; Fylan, 2005; Assabir, 2009). Three interview guides were developed. Even though they were similar, one guide included questions specifically addressed to healthcare managers; another had specific questions for returning physicians and the other contained questions specific for the migrant physicians. For each guide, a brief summary of the themes included is provided below (for the full guides see Appendix 5: Physicians' Interview Guide & Appendix 6: Healthcare Managers' Interview Guide).

The guides used for the interviews with physicians contained open-ended questions that were developed from the empirical literature review. These guides included questions about participants' migration history and overall experience, factors that influenced their decision-making in relation to their migratory moves, as well as questions designed to explore the role of gender in these processes. The guides for returning and migrant physicians were divided into six main sections. In the first section, personal and professional characteristics and details about each participant's unique migration history

were identified. Sections two and three were used to collect information on the ‘push and pull’ migration factors that affected physicians’ decisions to migrate and/or return to Cyprus, as well as the factors affecting destination selection. Section three was divided into distinct questions depending on whether the participant was a returnee or migrant physician. The next set of questions in section four was used to explore the role of gender in each participant’s migration decision-making process, while the last section aimed to collect information about physicians’ future plans in addition to their thoughts and conclusions about their migration and/or return experiences at the time.

Following the development of the interview guides for participating physicians and in order to establish consistency and trustworthiness of the data collection instrument, both guides were piloted with the help of a migrant and a returning Cypriot physician. The pilot study was conducted in Nicosia, Cyprus between 1st of June 2013 and 15th of July 2013.

The piloting of the interview guides for physicians revealed a number of issues. There was a problem with the first question in the guides in which participants were asked: ‘Starting from the present can you think back to the time you first left Cyprus and tell me about your initial move to the UK and/or your subsequent return to Cyprus?’ Due to the phrasing of the question, participants found it difficult to understand what they had to describe and asked for further clarification of the question. This problem was eliminated in subsequent interviews by using appropriate prompts such as: ‘When did you first arrive?’ or ‘Have you migrated anywhere else in between?’, which were designed to help the generation of appropriate responses with full description of physicians’ migration history. In addition, two questions in section three seemed to be very similar and confusing. More specifically participants were asked: ‘Why have you chosen to remain in the UK, long-term, following completion of your medical training?’ and ‘Why have you chosen to stay and live/work in the UK rather than return to Cyprus or move elsewhere?’ Incorporating and rephrasing the two questions into a single question addressed this issue. For instance, participants were

asked: ‘Why have you chosen to remain in the UK to train/work following completion of your medical education rather than return to Cyprus or move elsewhere?’

Once the University Research Ethics committee and the relevant bodies in the UK and Cyprus had given approval for the study to proceed, participating physicians were contacted by email asking to arrange a meeting with them at their office or a public place (migrant physicians) during office hours, to request them to complete a consent form prior to the interview (see Appendix 7) Physicians who agreed to participate in this study were given an information sheet that contained: details of the main aim and objectives of this current study, which included confirmation of Research Ethics Committee approval (see Appendix 8), and details of the researcher’s background. Furthermore, participants were asked to complete a consent form that confirmed their agreement to the recording of the interviews and that at any given point they could withdraw from the study without providing a reason.

All semi-structured interviews with participating physicians were conducted face-to-face in Cyprus between July and October 2013. Interviews lasted 45-75 minutes and were all conducted in English. Interviews were recorded using an audio tape-recorder in conjunction with written field notes that facilitated the recording of non-verbal cues and researcher notes for subsequent comprehensive analysis.

Interviews were intended to take place at the work environment of each individual physician as per Table 2 below. This was achieved for returning physicians as they were interviewed in the city where they worked. Nevertheless, following time and resource constraints, as well as the efficiency of snowball sampling and the time period of data collection, migrant physicians were also interviewed in Cyprus at their summer holiday destinations.

Table 2: Participants' City of Work at the Time of the Interview

| Cities of Current Work | Male | Female | Total |
|-------------------------------|-------------|---------------|--------------|
| London | 1 | 3 | 4 |
| Birmingham | 2 | 2 | 4 |
| Manchester | 2 | 1 | 3 |
| Nottingham | 2 | 0 | 2 |
| Leicester | 1 | 0 | 1 |
| Total | 8 | 6 | 14 |
| Cities of Current Work | Male | Female | Total |
| Nicosia | 5 | 4 | 9 |
| Limassol | 1 | 3 | 4 |
| Paphos | 2 | 0 | 2 |
| Larnaca | 0 | 1 | 1 |
| Total | 8 | 8 | 16 |

The guide for interviews with health care managers contained open-ended questions developed from the empirical literature. The aim of the guide was to conduct interviews that would enable the collection of the personal views and experiences of Cypriot physicians' migration and the associated decision-making processes. The health care managers' interview guide was divided into four main sections. Initially brief biographical details were collected, whereas the first section of the guide comprised questions and prompts that enabled the generation of healthcare managers' perspectives in relation to: the main factors that affected physicians' decision-making processes to migrate to the UK or another country, or return to Cyprus. The next section contained questions and prompts about the potential impact of migration of Cypriots on the local health system and the delivery of health services and also on the migration process. Section three of the guide included questions aimed to identify any potential effects of physicians' gender on migratory flows and the direction of migration. The fourth and last section of the interview guide aimed to explore healthcare managers' views about how the newly established medical schools at the time of the interviews could affect the decision-making processes of Cypriot physicians.

Once the interview guide for healthcare managers was completed it was piloted with one Cypriot healthcare manager in Nicosia, Cyprus between 1st of June 2013 and 15th of July 2013. During the pilot no issues were identified as the questions were clear to participants and the guide generated the desired depth in responses.

Similar to participating physicians, approval needed to be granted prior to conducting the interviews with the healthcare managers. Since all participating healthcare managers were located in Cyprus, approval was requested only from the Cypriot Ministry of Health. Once approval was granted participating healthcare managers were contacted through their publicly available emails to invite them to participate in this study. An email was sent to all eight potential participants, which included all the relevant information such as: the main aim and objectives of this study, Research Ethics Committee approval and details of the researcher's background (see Appendices 3-4 & 8). Health care managers who had agreed to participate in the study were asked to complete a consent form (see Appendix 7) and meetings were scheduled during office hours, in their respective city of work, either in a public place or their office.

All these semi-structured interviews were conducted face-to-face in Cyprus in the respective city of work of each participating healthcare manager between July and October 2013 and lasted between 60–90 minutes. Furthermore, all interviews were conducted in English and recorded using an audio tape-recorder in conjunction with written field notes.

5.3.3 Data analysis: preliminary organisation

Following the completion of each recorded interview and in order to summarize data collected from each participant, the researcher transcribed the interview content and established a content summary sheet. The content summary sheet was edited appropriately to contain any additional notes that were made during the interviews, as well as the researcher's thoughts, ideas and preconceptions. This allowed for the juxtaposition of participants' migratory experiences and the researcher's thoughts and preliminary

conclusions (Smith & Firth, 2011). This ensured that no content or important information was lost (Miles and Huberman 1984; Silverman, 2010) and also enabled reflection on possible researcher bias (Murphy-Shigematsy, 1999). The researcher then transcribed verbatim each recorded interview and double-checked each transcription through a second listening of the recordings updating the content summary sheet each time by writing down any thoughts that emerged. In addition to the researcher's thoughts, each contact summary sheet contained information on the interview place, professional and migration background of each participant, a note on the questions that each participant emphasized, the main themes that emerged from the interview and any new themes or prompts identified compared with previous participants' interviews.

5.3.4 Data analysis: reduction

To analyse the data generated from the interviews, the approach advocated by Miles and Huberman (1984) was adopted. This approach comprises three simultaneous activities namely; data condensation (reduction), data display and conclusion drawing (verification) as shown below in Figure 2. Each of these three processes and the application to the study are described below.

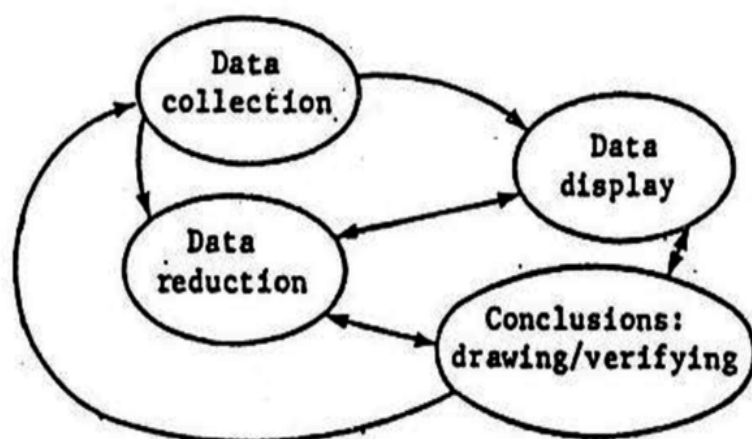


Figure 2: Components of Data Analysis: Interactive Model (Miles & Huberman, 1994, p.12)

The first of Miles and Huberman's activities data reduction, can be understood as a continuous process that takes place during the analysis of data through which collected data are condensed or reduced in such a way as to maintain the context and avoid losing important information shared by participants. To achieve this Miles & Huberman (1994) suggest that data reduction should occur in three stages through: editing and summarising collected data; coding and identifying themes emerging from the data; and lastly conceptualizing and explaining emerging themes and concepts.

This approach was applied in the following way. First, all data collected through interviews and field notes were reconfigured into detailed transcripts thus allowing for their reduction and selection. The transcripts and content summary sheets described in the previous section were further edited to remove any information that was not of use, to select and focus on the data that related to the objectives of the study.

The interview data was then transferred onto Excel® spreadsheets, to facilitate analysis, reduction and categorisation at what was identified as the first coding level. As Miles and Huberman (1994) suggest coding is used to assign particular meaning to raw data collected during fieldwork. Codes in this current study were therefore 'attached' to the transcribed data based on content to organize and categorize data appropriately, thus facilitating analysis. Using the conceptual framework embedded within the study and previous empirical literature, the researcher developed an initial list of main codes as depicted below in Table 3.

Table 3: Initial Data Analysis Framework

| Healthcare manager | MIGRANT physician | RETURNING Physician |
|--|--------------------------------|--------------------------------|
| Participant's Personal Profile | Participant's Personal Profile | Participant's Personal Profile |
| Pull Factors | Push Factors | Push Factors |
| Retain Factors | Pull Factors | Pull Factors |
| Return Factors | Retain Factors | Return Factors |
| Migration Impact | Destination Selection | Destination Selection |
| The Role of Gender | The Role of Gender | The Role of Gender / Family |
| Looking Forward - Cypriot Medical School | Future Plans and Conclusion | Future Plans and Conclusion |
| N/A | Overall Experience | Overall Experience |
| General comments | General comments | General comments |

Proceeding to the next level of coding, transcripts were read and re-read through an immersive interpretive process to understand interviewees' versions of how they made sense of Cypriot physicians' migration and other related social phenomena (Mason, 2002). This immersive process enabled the search for material in the data that fitted within the first coding level (Miles & Huberman, 1994). Since data analysis was performed simultaneously with the collection of data, the second level of coding and categorization of data was developed in an inductive manner from the data collected. This entailed going back and forth and comparing the codes developed and the data collected at each stage, making continuous adjustments by adding or removing sub-codes depending on the emerging themes. Every time a new sub-code was added or removed, interview transcripts were re-read and marginal notes or memos were assigned on the transcripts' text using the proper sub-code and the researcher's preliminary conclusions for either new sub codes or potential links with either the literature or between participants' responses. Assigning

tentative or preliminary conclusions about each transcript allowed the researcher to keep track of them and the opportunity to return to specific elements of the data during subsequent stages of analysis to facilitate the drawing of preliminary conclusions. This approach maintained the integrity of the descriptive nature of data. There can be reasonable confidence that no data were excluded or misplaced under a broader code, which might have led to the loss of important content from participants' responses.

This form of data analysis, or clustering was suggested by Miles & Huberman (1994) and utilised in another similar study by Ballard et al., (2004). In their study, they initially categorised migration factors into instigating, activating and facilitating factors then further enhanced their coding process by subdividing participants' responses into personal and professional. Similarly, the researcher in this current study grouped the coded data into similar categories or clusters. This current study and Ballard et al.'s (2004) study about the migration of French physicians to the UK had similar objectives. As both studies focused on exploring the factors affecting the migration decision-making processes of physicians moving from one particular country to another, it was decided to use a similar coding approach in this current study. Taking the main coding approach on migration factors as a comparative example, the researcher included the following categories: Push; Pull and Retain/Return factors respectively. Participants' responses were therefore identified accordingly through each interview transcript and subdivided based on more specific sub codes (i.e., Push Factor - secondary education effect; Pull Factors - networking; Retain/Return Factors - family status). Again, similarly to Ballard et al.'s (2004) study, each sub code was then categorised into two broader groups based on whether it reflected a migration factor based on personal or professional considerations.

5.3.5 Data analysis: display

The second of Miles & Huberman's (1994) activities is data display. This can be understood as the process that takes place through all the stages of data analysis where data

are summarised, organized and displayed repeatedly and in an iterative way to facilitate the best possible analysis, while at the same time keeping a research audit trail. To achieve a proper display of data the researcher used a series of matrices to identify and reflect upon the ‘direction of travel’ in relation to data analysis. In this current study, the matrices used were developed using Excel® computer software with defined rows and columns that allowed for a detailed presentation to facilitate analysis of data in relation to the main research questions. Therefore for the best possible display, the researcher established a separate matrix for each major theme based on the first level of coding and the Initial Data Analysis Framework as presented in Table 3 (see p.137). Each matrix included the following information:

- Group of participants (i.e., Healthcare manager; migrant physician; returning physician)
- Type of factor being examined (i.e., Push factors)
- Sub factor being examined (i.e., Personal/professional)
- Participants’ gender
- Coded participants responses
- Participants’ verbatim extracts next to each code
- Frequency of repeated codes
- Preliminary conclusions and hypotheses (memos)

Upon the completion of the detailed data display matrix, a secondary, reduced and more comprehensive matrix for each major theme was also constructed to allow for the consistent and coherent synthesis and presentation of findings and to allow the reader to draw their own conclusions. Table 4 below presents the level of synthesis and presentation of each matrix constructed for each major theme, in this case the push factors for migrant physicians.

Table 4: Example of Data Display Matrix – Push Factor Theme

| Type of Migration Factors | Migrant Physicians (14) | | |
|----------------------------------|--|------------------|------------------|
| | Migration Specific Factors | Male | Female |
| | | No. of Responses | No. of Responses |
| Personal Push Factors | <i>i.e., Secondary education effect</i> | | |
| Professional Push Factors | <i>i.e., No medical school at the time</i> | | |
| Total No. of Responses | | | |

This type of matrix data display facilitated the identification of emerging patterns and/or links through comparing and contrasting participants’ responses; within the same group, between the three different groups, as well as between the responses of participating physicians of different gender. In addition, this data analysis framework allowed for the identification of the most frequent responses, as well as the inclusion of any individualistic responses ensuring that no valuable data was lost through data condensation. All participants’ responses were considered during presentation and analysis, both the most common ones as well as other more rare experiences, to ensure that no content was lost (Krane et al., 1997).

5.3.6 Data analysis: conclusions

Miles & Huberman’s (1994) third activity is conclusion drawing. This can be understood as the process through which the researcher draws conclusions based on the collected data and personal experience. Even though there should be a logical order to the processes of data reduction, data display and conclusion drawing, any relationships or patterns may be identified throughout the data analysis process in a tentative form, and be verified once data are organized and displayed using a specific approach based on the study’s objectives. This approach was applied in the following way. During the analytical stage of this study, all participants’ responses were included in the reduction, presentation and analysis of data

to allow for the extraction of more inclusive conclusions based on rare experiences, as well as commonalities and patterns or links between participants' responses or between data and previous empirical studies (Krane et al., 1997). This approach therefore allowed for the identification of specific patterns.

Data display in this format facilitated the move from description to interpretation of data through a constant review of previous empirical studies' findings in comparison with the findings in this current study (Miles et al., 2014). Therefore, to probe critical thinking as suggested by Frankfort-Nachimas & Nachimas (1996), the researcher examined participants' responses to formulate conclusions in relation to: the type of migratory behaviour, the causes and structure of this behaviour, the frequency of specific behaviour amongst participants; the consequences of their specific migratory behaviour and how they dealt with the consequences of their actions in relation to migration. Using matrices in such a way allowed the researcher to organize the initial hypotheses before finalizing the conclusions. This also facilitated the identification of vivid examples of participants' responses which: clearly described the migration decision making processes; accurately presented individualistic or unusual approaches and identified unexpected approaches in relation to the identified literature (Ritchie & Lewis, 2003).

5.4 Research ethics

The University of Salford's ethics committee prior to the commencement of the fieldwork gave ethical approval for the study. Further approval was granted by Keele University during transfer for the continuation of this current study in 2013.

According to NRES, this study did not require review by an NHS Research Ethics Committee as it only involved NHS staff and not patients; therefore there was no additional ethical approval required. In addition, the Cypriot data protection office required a document informing the Ministry of Health and the data protection office about the research study and the researcher's intention to gather and handle data under the

appropriate regulations (Personal Data Handling Protection Act: N.138 (I)/2001 and N.37 (I)/2003). The response from the Ministry of Health was forwarded to the appropriate Ethics Committee of the University, which provided the final approval for commencement of this current study (see Appendix 8).

This qualitative study involved prolonged contact with Cypriot physicians and healthcare managers in different social and professional situations. Consequently, research related ethical challenges were inevitable; therefore it was very important to identify and respond to these challenges appropriately.

Hence, the researcher followed the available data protection guidelines according to UK and Cyprus laws in order for this research to comply with the principles of good practice contained in the UK Data Protection Act of 1998 and the Cypriot Personal Data Management and Personal Protection Act of 2001:

- Participants provided their consent to be interviewed (thus “fairly processed”).
- It was made clear to participants that they could choose to withdraw at any time during the research process and that any data relating to them would be destroyed immediately.
- Transcripts were kept on the researcher’s personal computer protected with a password. This computer was in the researcher’s office in Cyprus, which was locked and it could only be accessed by a code system.
- Consent forms and audiotapes were kept in separate locked cupboards in the researcher’s office in Cyprus, accessed only by the researcher, using a single key.
- Participants were given pseudonyms to protect their identity.
- Any identifying details were removed in the transcription process.
- Consent forms, audiotapes and transcripts were kept separately from each other so that no links could be made between individuals, thus maintaining anonymity.
- Data were not transferred outside the EEA.

- Original data collected from participants were handled and analysed for the specific purposes of this research only and without being used in an unconventional and illegal way.
- Irrelevant data not intended for use within the aims and objectives of this study were not collected.
- Original data collected were kept only for the duration of the study as a part fulfilment of this PhD program. Once the program was completed and the PhD title granted the person responsible for collecting and analysing the data was also responsible for destroying them, except in the case where the data were of statistical nature and it was not possible in any way to determine the participants.

Lastly, while conducting the fieldwork for this current study an issue arose in relation to additional protection needed for participating healthcare managers. There was a limited number of major hospitals in Cyprus, therefore in order to enhance identity protection for participating healthcare managers, besides the use of pseudonyms, no reference was made in this thesis on the sector, city of work or their exact roles.

5.5 Limitations

As with all research studies, there are limitations to the present work, these arise from the size and time restrictions of the current study, the potential for the introduction of bias in the sampling methods and other procedural issues. These limitations will now be considered in turn.

First the size of the study, due to a combination of the small-scale of this current study and the very specific context, understandings generated from the data can only with considerable caution be used to inform discussions about other similar contexts. Generalization through results obtained in similar studies has been commonly described as *moderatum* generalization. According to Payne and Williams (2005), *moderatum* generalization is dependent on the nature and scope of the study and its range is restricted

in terms of comparing results with different cultures and over long periods its scope becomes restricted. According to Payne and Williams (2005), the use of purposive and snowball sampling techniques implies that any generalizations about a study's conclusions should be moderate in nature.

The sampling methods utilised in this current study led to the second major limitation. The Cypriot Ministry of Health register provided data on the number of Cypriot physicians abroad and the country/city of study. This information could not be crosschecked for accuracy as no other similar study or official record was identified, thus it was difficult to defend the representativeness of the sample in respect of the whole population of Cypriot migrant physicians.

Furthermore, the use of snowball sampling may have had an effect on the results obtained due the possibility of missing any "isolates" that might have produced different responses. Moreover, no healthcare managers' registry was available for use in the selection of participants. Additionally, no female healthcare managers were included in the study as intended. Thus participating healthcare managers' responses do not provide female perspectives on Cypriot physicians' migration impact on the health system.

The third procedural issue was that Cypriot physicians were interviewed during their summer holidays; this may have had an effect on their responses. According to Elwood & Martin (2000), the location of the interview and more specifically the relationship of the participant to the sociocultural context of the location may affect the nature and content of collected data. Cypriot migrant physicians being interviewed in Cyprus rather than the UK may have also affected their responses in relation to their future intentions and views on their overall migration experience. On the positive side, interviews with participants which were conducted in Cyprus and especially during their holidays may have produced richer data (Evans & Jones, 2011) and may have contributed to more in-depth examination of participants' experiences. In addition, regardless the researcher's role in this current study,

their background and sociocultural characteristics might have had an effect on the researcher-researched relationship and consequently an effect on collected data.

5.6 Reflective Comments

For the best possible understanding of the epistemological approach utilised in this current study, it is important to clearly identify the researcher's positionality and its effect on the research (Berger, 2013). For example, the researcher–researched relationship, as well as the criteria set to recognise knowledge rather than beliefs and therefore define what was to be included in the study and why (Blaikie, 1993; Creswell, 1998; Gray, 2006).

Even though the involvement of the researcher in a qualitative study such as this one is inevitable (Drake, 2010), reflexivity is utilised to enhance the research study's rigor by allowing the reader to evaluate how the researcher's background might have affected the process and findings of the study (Horsburgh 2003; Pillow, 2003; Bradbury-Jones, 2007; Gemignani, 2011). Positionality and the researcher–researched relationship can have an effect in relation to access to the field, information sharing by participants and interpretation of the collected data (De Tona, 2006; Kacen & Chaitin, 2006; Berger, 2013). To this point, I therefore reflect on the history behind the study, my background and beliefs as a professional and researcher and lastly on my involvement as a researcher with participants. This reflection provides the necessary information that will help the reader identify any potential bias or impact on the approach utilized and the results obtained in this research study.

As a context for reflecting on the study, my personal biography may have impacted on the approach that I have taken. I was born in London to Cypriot parents but raised in Cyprus where I still live and work. My secondary education was in a Cypriot private English school and I studied in the UK between 2006 and 2010 for my bachelor and master degrees. Between 2011 and 2016 I worked professionally in a medical insurance company in Cyprus. During my Masters degree, I completed a thesis about Cypriot Skilled Healthcare Workers (SHWs) migration, in which I realized that there was a gap in the

available literature in relation to the migration patterns of Cypriot SHWs. This gap seemed to be more prominent when researching the migration of physicians rather than other healthcare professionals. Identifying this gap as part of my previous degree triggered my interest to further my studies about skilled migration within the healthcare sector in Cyprus through examining the migration of a specific group of SHWs.

In addition, the researcher's positioning in respect of gender, professional and socioeconomic background, educational and professional experience, linguistics, ethnicity and beliefs and political or ideological stance (Berger, 2013) may affect the outcome of an empirical study (Pillow, 2003; Guillemin & Gillam, 2004; Bradbury-Jones, 2007; Stronach et al., 2007). In relation to this current study, the key issues were: impact on participants' recruitment and willingness to be interviewed; generation of interview rapport; the effect of interview language on data generation; the differentiation between the researcher's beliefs and study's findings and lastly the crosschecking of data resources.

In respect of recruitment, the first point of contact with participants was with healthcare managers. As Groger et al. (1999) comment, where the research population is 'hidden' people in specific positions with close proximity to the research subjects, might facilitate an easier route to the sample population. This was the case in this current study as my position working in an insurance company allowed me to identify appropriate participants (De Tona, 2006). Even though all participants' contact details were publicly available, my position facilitated and expedited the process of making contact.

Being a Cypriot may have positively affected participants' willingness to be interviewed as compared to a researcher with a different ethnicity (Murphy-Shigematsu, 1999). Furthermore, sharing my educational background with the interviewees and letting them know that I had migrated to study in the UK, may have facilitated their engagement and helped to establish rapport, knowing that I had a similar migratory experience (Berger, 2013; De Tona, 2006). Adding to my educational background, my professional

involvement in the Cypriot health sector might have created a feeling of comfort for participants to engage with me on the assumption of shared understanding and familiarity with the healthcare sector and “healthcare language” (De Tona, 2006). Thus, my familiarity with the sector enhanced my ability to probe more efficiently and tease out information that might have otherwise been missed by another researcher with a different background not related to healthcare (Pillow, 2003; Kacem & Chaitin, 2006).

I decided to conduct all interviews in English since this is the language of choice for the majority of recognised medical journals and conferences, and since English is used for communication amongst physicians internationally (Wulff, 2004). Nevertheless, because English was not my mother tongue or that of the participants, this allowed for a relaxed conversation, facilitated a more in-depth discussion (Berger, 2013) and allowed for more authentic responses (Welch & Piekkari, 2006). However, conducting interviews in a language other than the participants’ mother tongue might affect the accuracy of some responses making them less descriptive (Welch & Piekkari, 2006).

Even though in every qualitative empirical study there is a degree of unavoidable researcher bias due to the researcher’s active involvement in all the research processes (Sword, 1999), there is a need for the development and implementation of an effective strategy to address the impact of this bias on the study (Horsburgh, 2003; Berger, 2013). I therefore used reflexivity and contact summaries to disclose my thoughts, ideas and preconceptions, constantly reflecting upon my thoughts and participants’ original responses in an effort to identify and scrutinize any potential threats to the credibility and trustworthiness of any conclusions generated in this study (Scott, 1997; Alvesson & Skoldberg, 2000). Using reflexivity and contact summaries allowed me to bracket off my beliefs (Pillow, 2003; Bradbury-Jones, 2007; Gemignani, 2011) and provide an accurate representation of participants’ views and experiences, thus reducing researcher bias and the possibility of misinterpreting the study’s results (Murphy-Shigematsy, 1999; Smith &

Firth, 2011). Therefore, as part of my reflective strategy I maintained a high level of reflexivity during the interviewing process through analysing data simultaneously in a systematic step-by-step process. During this process, I identified ideas and experiences that were acknowledged as important by participants and constantly reflected on my comments to ensure that participant's views were clearly presented within my analytical framework (matrix data display). This systematic approach therefore allowed for an in-depth examination of retrieved data and facilitated an audit trail indicating how specific hypotheses and preliminary conclusions were drawn, enhancing the rigidity of my analysis and transparency of this study's conclusions (Ritchie & Lewis, 2003; Smith & Firth, 2011; Berger, 2013). In addition, interpretation of retrieved data remained directly linked to participants' words, as depicted by the use of their verbatim responses in Chapters 6 and 7, used to support any identified hypotheses and conclusions drawn respectively.

Lastly, for the collection of primary data in this study, I used different data sources (healthcare managers, physicians) and a predetermined and piloted framework (interview guides) developed in accordance with the aim and objectives of this current study. I also adhered to the strategies suggested in previous empirical studies examining the decision-making processes in migration such as that of Ballard et al. (2004). This approach allowed for: the triangulation of data sources, the crosschecking of retrieved data and the identification of any similarities and/or irregularities between them, as well as between the identified literature. This facilitated the validation of the study's findings (Denzin, 1970; Gray, 2000; Guion, 2002; Yin, 2003; Farmer et al., 2006).

5.7 Chapter Summary

The researcher approached the study of Cypriot physicians' migration through constructivist philosophy, grounded in interpretivist methodology using a qualitative research orientation and semi-structured interviews for the primary data collection. The sample in this study included participants from three specific groups: Migrant Cypriot

physicians that studied in the UK and were either working or trained in the UK; Cypriot physicians that studied, worked or trained in the UK and returned to work in Cyprus; and health care managers that studied in the UK and were working in Cyprus at the time of the interviews. Participants' selection was performed through purposive sampling to satisfy pre-selected criteria and in the case of participating physicians, snowball sampling was also used to increase the number of participants.

Semi-structured interviews were designed to examine the factors affecting the decision-making processes of Cypriot physicians in relation to occupational migration and to explore whether gender mediates this process, and in what ways. Data coding and analysis was undertaken utilising Miles and Huberman's (1984) approach. Here data were initially recorded in full, and subsequently condensed and displayed in a matrix for data presentation and analysis. Any ethical considerations emerging from the methods or the participants involved, as well as the approach utilised, were identified and presented in detail along with any procedural limitations of the study. Lastly, the researcher's position in the study was clearly reflected, setting clear indications of potential threats to the outcome of this study. Chapter 6 now follows and presents the findings of this current study according to the main themes identified such as: migration impact, the factors affecting the migration decision-making processes and the overall migration experience of participants.

Chapter 6: Findings from the Interviews

6.1 Introduction

In the previous chapter, the theoretical approach and methodology used for the collection of primary data for this study were discussed. This chapter presents the findings from this study.

Participating physicians were either living and working abroad or had previously migrated abroad and returned to Cyprus during this study. To be able to examine Cypriot physicians' migration in depth, participating physicians were asked to provide the different destination countries considered throughout the process. Almost one third of the Cypriot migrant physicians considered the UK as their only option for their migration destination, whereas the remaining two thirds provided one or more alternative destination countries. A number of the returning physicians considered the UK as their only realistic option for their migration, whereas the majority of returning physicians had considered one or more alternative countries as a possible destination during their decision to migrate. This indicates a similar trend to that identified by migrant physicians participating in this study. From the entire migrant physicians' responses, a total of 11 different alternative destination countries were identified. However, when reviewing the returning physicians' responses, ten different alternative destination countries were identified. Amongst migrant participants the top alternative destination cited was the USA for both male and female migrants. Nevertheless, male migrants assigned Germany as their second most preferred alternate destination, whereas female migrants cited Greece as their second most preferred alternate destination. Less than one third of both male and female migrants cited a destination such as Australia and countries of the Eastern Bloc (e.g. Romania and Czech Republic) as preferred destinations. Half of returning physicians considered the UK as their only option; the most popular alternate destination cited by both male and female returnees was Greece.

Participating physicians were further probed during the interview process to provide their thoughts in relation to their migratory plans for the future. The majority of female and a quarter of male migrant physicians said that their future plans in terms of remigration, prolonged stay or return to Cyprus were dependent upon the fulfilment of their professional aims. In relation to the intention to migrate in the near future, the majority of participating migrant physicians stated that they intended to return to Cyprus at some point in the future, whereas the majority of both male and female returning physicians said that they intended to stay in Cyprus permanently. On the other hand, three migrant physicians stated that they intended to re-migrate to other countries such as Switzerland and the USA. In addition, two of the returning physicians stated that they intended to locate permanently to the UK, as it could offer a life-style that they found congenial. Amongst the returning physicians one male and one female participant stated that they intended to return to the UK for further specialisation. No returning physician intended to re-migrate to any other destination than the UK. Lastly, half of female and a quarter of male returning physicians stated that they considered their professional aims had been fulfilled through the migratory process and there were no additional professional objectives to pursue through re-migration abroad.

Age and other commitments were also identified as other potential factors of major importance in the migration process, particularly in relation to participants' migratory plans for the future. For example, one male returning physician stated that age was a major aspect, further elaborating that the older the physician the lower the propensity to consider re-migration. On another note, a quarter of female returning physicians stated that financial commitments in Cyprus restricted their potential to migrate in the foreseeable future. Whereas another female returning physician commented that she would not consider re-migration as she had established her own private practise and owned property in Cyprus. A number of participants, including both physicians and healthcare managers seemed to

consider the opportunity to acquire or utilise property in Cyprus as of great importance in their overall migration process. One participant explained:

“I don’t intend to re-migrate as I have too many financial commitments in terms of business mortgages that I cannot leave behind.” (RF2)

Once participants identified the destinations considered during the migration process and their future plans they were probed to provide their perspectives and thoughts on factors affecting the migration process. Thus, justifying country selection and identifying the reasons for rejecting others. Through the analysis of participants’ responses from all three categories of participants the following general themes emerged:

- i) Education and migration;
- ii) Career aspirations and professional development;
- iii) Family, networks and experiences;
- iv) Conditions affecting migration;
- v) The impact of migration.

The rest of this chapter has therefore been divided accordingly, participants’ coded responses are synoptically presented in the following sections and in tabular form in equivalent tables presented in detail in Appendix 9. In addition, each of the sections below provides verbatim participants’ quotations that were selected to represent the majority positions articulated, and in a number of cases to illustrate striking differences from the majority of responses. Where necessary each section was subdivided into smaller subsections to allow presentation and focus in specific areas emphasized by participants’ responses. The chapter concludes with a brief summary of the main points raised and introduces what will follow in the next chapter.

6.2 Education and Migration

Education and migration were entangled throughout participants' experiences and perspectives. Evidence of this entanglement was found in a number of ways: the perceived lack of educational opportunity in Cyprus; the quality and cost of professional education elsewhere; and the ways in which the educational system in Cyprus facilitated subsequent migration.

The physicians in this study were in agreement that there was a lack of educational opportunity in Cyprus, either to become a doctor or to develop further medical skills through advanced medical education. The reason for this lack of opportunity was that at the time they decided to study there, there were no medical schools. One participant succinctly stated that once the decision was made to become a physician one had to move away from Cyprus in order to study medicine, a view confirmed by one of the healthcare managers:

“First of all, the inability of Cyprus to offer undergraduate medical training up until 2011 left physicians and mostly medical students with no alternative than to migrate abroad at least for medical studies.” (HM4)

If the lack of suitable medical education in Cyprus made a period of study overseas necessary for those wanting to pursue a medical career, the decision about where to study was more open and offered many different possibilities. Amongst the participants there was high regard for the quality of medical education in the UK as a preferred destination to pursue their medical education. First, the perceived quality of medical education and the exceptional social experience were both key factors that participants provided as reasons to prioritise the UK as a destination. The majority of male and female participants assigned great importance to the capacity of UK Universities and teaching hospitals to offer excellence in education and training. They emphasized the high quality and standard of medical education that was available in the UK. Two male and two female participants

commented that the UK offered the opportunity for cheap international travel and thus the opportunity for new social experiences. The majority of physicians participating in this study also stated that migration, specifically migration to the UK, provided the opportunity to experience a different lifestyle and meet new people in a more multicultural environment than they would have found in Cyprus. Even though this attitude was stronger amongst male participants, a comment by a female migrant physician exemplified this view:

“I was driven to the UK since as I told you before its a country that offers world-class education and training while offering a multicultural and interesting social experience”.

(MF4)

Another participant added their experience of moving to the UK:

“I would describe my experience as definitely positive. I would have done it again. Not only did I get good quality of training, I also feel that I got a lot of life experiences I wouldn't have got had if I never left Cyprus.” (MM1)

Second, was the reputation of the UK as a provider of medical education. The participants shared an established perception prevalent in Cyprus and internationally, that the UK offered a superior educational and training system as compared to other potential EU destination countries. This view was even more prominent amongst the responses of returning physicians, these participants expressed the view, most strongly, that other potential destinations lacked the standard and quality of education and training that could be offered in the UK. Third, was the cost of medical education in the UK, in comparison with other destinations this was a factor for some participants' preferences. As one participant said, migration offered the opportunity for a high-quality education. He further added that migration to the UK was more beneficial in comparison to other destinations, such as the USA. Particularly in respect of value for money, when calculating the cost of

living and fees paid and taking into account the high-quality education and training offered. Similarly, one male returning physician identified the opportunity to study in the UK through scholarships as a significant factor that influenced their decision about where to pursue their medical education. In short, medical education in the UK was more affordable than in some other destinations.

Third, according to the participants there were aspects of the secondary educational system in Cyprus that, whether by design or not, provided good preparation for further study in an English-speaking country. Participants commented on the high level of English language proficiency that they had acquired through secondary education in Cyprus, which was reported to be of crucial importance to be able to consider migration to an English-speaking country. All male and female migrant physicians and a quarter of female returning physicians commented on the importance attached to the compulsory teaching of the English language in both public primary and also secondary education schools and, in addition, the large number of private schools that taught all modules exclusively in English. The majority of migrant physicians elaborated on this issue, stating that they would have faced potential language difficulties if they had migrated to a non-English speaking destination. While the majority of returning physicians considered that the acquisition of proficiency in another language to be able to relocate to a non-English speaking country as a waste of time and resources, given that they already possessed proficiency in English. For example, one participant stated:

“Even though I was accepted at the University of Prague, due to language difficulties and the inferior health and educational system compared to the UK I decided not to go. On the other hand, Greece was also in my “options list” due to similar language and lifestyle as well as due to its proximity to Cyprus but due to Greece's falling educational system, in the end Greece was not an option for me”. (MF2)

One returning physician agreed:

“Yes. I considered studying in Germany or Greece but I decided to move to the UK as in Germany I had to learn the language whereas Greece had an inferior educational and training system.” (RF5)

Similarly, another participant added:

“Cypriot physicians tend to migrate to the UK due to the range of available training options and the superior quality in comparison with Greece, which is an easier option in terms of adjustment and cost. In addition, the majority of Cypriot physicians and medical students are fluent in English as is the language taught in every school from elementary level.” (HM4)

Proficiency with the English language was not the only factor within the secondary educational system in Cyprus that facilitated the development among participants for a preference or an inclination for further study in an English-speaking country, specifically the UK. The majority of both male and female migrant physicians and one healthcare manager commented that the similarities in the curriculum and teaching approaches between the UK and Cyprus' private schools (i.e., GCE O' and A' level exams) combined with encouragement from teachers for tertiary education studies to the UK, prompted medical students to move, particularly to the UK. Participants also identified a number of drawbacks if they selected a different educational system, other than that of the UK. As an example, three migrant physicians considered the need for a pre-med³ in destinations such as the USA as a drawback in their educational and migration planning, as it would have unnecessarily consumed time and financial resources. Two of the participating migrant

³ Pre-med is the educational track pursued in the USA by potential medical students prior to commencing their medical studies. The usual duration of pre-med is one year, which consists of introductory courses in medicine, in addition to relevant courses in research and opportunities to develop clinical experience.

physicians further elaborated and identified the higher entry requirements in USA schools compared to the UK as another major drawback while considering alternative potential destinations to the UK.

As one male participant illustrated:

“Having been through a private English secondary school which gave me the opportunity to complete my A-Levels, the move to the UK was the more natural choice.” (MM8)

6.3 Career Aspirations and Professional Development

Participants’ perspectives about their career aspirations and professional development were intertwined with their views about migration. The majority of both male and female returning physicians felt migration to the UK had improved their potential for realisation of their career plans. This opportunity to advance their careers had been achieved through the opportunity to study through exceptional training and gain valuable professional experience to the highest level. The fulfilment of career aspirations was a key criterion for physicians’ judgment about the extent to which the overall migration experience had been successful. There were three main elements that seemed to advance participants’ career aspirations.

Firstly, the exceptional and continuous training achieved and the training in specialties non-existent in Cyprus at the time. A quarter of male migrant physicians claimed that their decision to prolong their stay in the UK was to continue to enjoy professional training and high levels of professionalism. Similarly, one healthcare manager explained that Cypriot physicians would be likely to consider extending their stay in an overseas country such as the UK to benefit from superior training, especially in specialties that were not available in Cyprus. In addition, the majority of participants in this study stated that because the Cypriot healthcare and educational system, at the time, did not offer the full range of

specialist medical training or because training and supervision was poor, they considered migrating abroad to advance their careers as doctors.

As one participant explained:

Furthermore, a number of specific training specialties are not available in Cyprus and specialties that are offered in Cyprus have limited spaces available.” (HM4)

The majority of both male and female migrant physicians felt that the availability of superior training abroad, specifically the UK, and the inability of the Cypriot healthcare and educational system at the time to offer the full range of specialist medical training, were factors of major importance in their migration experience. In addition, one quarter of both male and female returning physicians identified the inability of the Cypriot healthcare system to offer high quality postgraduate training that encompassed relevant supervision and guidance, as an important factor in their decision-making processes. As one participant indicated:

“I migrated to be able to seize the opportunity of being trained in a world-class healthcare system that includes teaching hospitals and offers great supervision and guidance which training in Cyprus is lacking even in nowadays.” (RM6)

Another participant added:

“There is no training in ENT surgery in Cyprus apart from the last three years in the speciality and in the UK there are much better training opportunities next to people who are professors in their field.” (MF2)

Furthermore, one male returning physician commented that amongst the major reasons for migrating to the UK was to participate in the continuous medical training offered by the NHS in the UK. More specifically he said:

“Regardless of the formation of the Cypriot medical schools, due to the absence of continuous updating of medical training in Cyprus doctors will continue to go abroad”. (RM4)

In addition to the exceptional and continuous training, participants commented on the opportunities available through migration to become involved in medical research, especially as there were no teaching hospitals or adequate medical research infrastructure available to them in Cyprus. A quarter of male migrant physicians emphasized that their decision to prolong their stay in the UK was to enjoy the superior research infrastructure. Furthermore, one health care manager stated that Cypriot migrant physicians might prolong their stay in the UK to utilise research opportunities available through teaching hospitals and other research centres. Another healthcare manager participating in the study claimed that the opportunity to work in medical academia or a teaching hospital, an option not available in Cyprus up to 2011, was another major factor to be considered during the decision-making process. As one healthcare manager elucidated:

“Some Cypriot doctors that remain in the UK have chosen to do so, because they have developed an academic career and a placement in Cyprus may not fulfil their career potentials. Some of them for instance might rise into high academic qualifications and since clinical research is very limited in Cyprus they do not wish to return.” (HM1)

Secondly, better prospects for career opportunities and professional experience seemed major factors in participants’ migration experience. All healthcare managers said that the main factor that would impact on Cypriot physicians’ decision to remain in the UK would be the existence of better professional opportunities and the potential opportunity to establish a successful career in a world-renowned healthcare system such as the UK NHS. Half of the male and female migrant physicians shared a similar approach in that better

career opportunity and professional prospects were amongst the major determinants that influenced their decision to move to the UK. Half of the healthcare managers elaborated further that Cypriot migrant physicians would possibly remain in the UK because there are fewer doctors per head in the UK than in Cyprus, enhancing their career progression and averting any chance for deskilling.

The opportunity to acquire professional experience seemed to be a major factor in migration for five out of six migrant female participants and one third of their male counterparts. For example one participant commented that:

“There are more opportunities to gain valuable experience through a bigger and more diverse population, something that Cyprus being a small island with only 800,000 people is not able to offer.” (MF5)

Similarly, almost half of female returning physicians said that they migrated to the UK to enhance their career prospects through utilizing better professional opportunities. As one participant illustrated:

“I had the chance to work in a very organised healthcare system and gain valuable professional experience and master my medical skills.” (RF4)

Likewise, three of the four healthcare managers backed this approach, adding that Cypriot physicians would be inclined to extend their stay in the UK in order to acquire professional experience through working in a country with a larger and more diverse population than Cyprus. As one healthcare manager stated:

‘Due to the size of the country the number of patients is not high; therefore, doctors do not get exposed to a high number of patients.’ (HM1)

Another healthcare manager added:

“A Cypriot doctor already in the UK that just finished medical school will find it easier to get a training position in a well-known hospital, bettering their professional chances as a licensed practitioner.” (HM3)

However, one male migrant physician commented that the experience was not entirely beneficial. He felt that the education and training acquired while in the UK was based on the UK context, raising therefore potential difficulties to adjust or utilise his full potential back in Cyprus. More specifically he felt that:

“Nevertheless studying and training in the UK made me feel like I am trained to be a doctor in the UK rather than in Cyprus and this will probably keep me here for the following years to further enhance my career.” (MM2)

Thirdly, was the enhanced professional status and professional experience achieved through migration. According to a quarter of both male and female returning physicians, migration to an overseas destination and thus studies, training and experience acquired in a renowned healthcare system enabled differentiation from the competition upon their return, compared with physicians who studied or trained in less medically developed countries than the UK, thus enhancing their career prospects. Moreover, a quarter of males and one female migrant physician identified that their decision to migrate to the UK for their education and training offered them a higher professional status that could boost their careers upon return, than had they remained in Cyprus. Similarly, one healthcare manager and a quarter of both male and female returning physicians backed this approach. One third of the female migrant physicians that participated in this study identified the following factors as important in their decision to migrate to the UK: the world-class UK healthcare system; the out of syllabus support offered within the UK educational system and the alternative approach to training compared to Cyprus that could offer the opportunity to excel amongst competition upon return.

Elaborating further on this aspect, a quarter of the male returning physicians added that the high density of physicians in Cyprus at the time required physicians to be able to differentiate themselves from the competition. Migration to the UK for the purpose of study, training or work seemed a potential solution. As one participant illustrated:

“High competition is forcing therefore doctors to gain abroad, high quality experience in order to be able to differentiate and be more competitive.” (RM7)

Similarly, another participating physician added:

“The experience of a different approach in the delivery of healthcare services placed the UK at the top of my list and it also gave me the ability to distinguish from competition upon return in Cyprus as UK Universities are considered top quality by Cypriots.” (RM8)

6.4 Family, Networks and Experiences

The importance of family and social relationships to participants was evident in a number of ways, as were tensions of combining a medical career with family life. Participants identified several social and family related elements of their experiences, such as: intentions to focus on career over family or vice versa; plans for establishing a family of their own; and commitments to a partner or responsibilities to the extended family. The majority of both male and female migrants and returning physicians stated that decisions to assign priority, either commitment to family or to individual professional development, are of utmost importance, a significant tension for many, and one that impacts on their migration experience. Similarly, all healthcare managers expressed recognition of the significance of these issues. As one participating health care manager noted:

“Most female physicians in Cyprus wish to spend a lot of time with their family and want to raise their children in a healthy family environment. Devoting more time for

their family rather than their career could probably be a result of Cyprus' closed society that promotes the role of the mother as crucial for a healthy childhood and places a diminished role on careers.” (HM4)

Another participating physician added:

“My intention at this point is to stay here in the UK to complete my training and acquire a bit of working experience, therefore I don't see myself migrating anywhere else but at some point I will return to Cyprus for permanent establishment where I can start my own family and work in private practice.” (MM4)

Participants also identified the importance of personal bonds formed while in the UK. For example, one third of the female migrant physicians reported that the change in marital status from being single to married had an effect on their own migration experience. One female migrant physician felt that her migration experience was also affected by social bonding developed while in the UK during studies and training. As one migrant physician explained:

“In addition, being married to a non-Cypriot partner and having two children in school is holding me back from returning to Cyprus at this point.” (MF3)

How the tension between the pursuit of a medical career and participation in family life played out depended on different perspectives: participants' responses indicated a variety of views about priority given to families and careers. First, these tensions are explored below against the backdrop of societal norms. In particular, how the tension between family establishment and career progression affects the migration process and the individual's experience. Second, a similar related issue was explored concerning participants' views about the interaction between their wider social networks and careers.

The majority of participants referred to the existence of societal norms in Cyprus and commented on their effect on the individual's migration process and experiences. All the

health care managers and one male and one female migrant physician supported the view that there are still strong societal norms about family life in Cyprus and these social norms were likely to impact on the behavior of physicians. Almost half of the males and one female returning physician also expressed the view that their perception of societal norms in Cypriot society affected their migration decision-making processes and specifically their decision about whether to return to Cyprus. For example, a female physician stated:

“Family pressures for females to stay closer to parents and grandparents and the Cypriot traditional view that females are usually the ones looking after young children may jeopardise their career”. (MF2)

There were two distinct perspectives about how to manage the tensions between family and career. Indeed, a number of participants prioritized family over work and others postponed the choice about whether or not to have a family.

All the healthcare managers expressed the view that female physicians, in contrast to their male counterparts, tended to assign higher priority to their societal and family responsibilities rather than their careers in medicine. These views of the health care managers echoed physicians’ responses. A quarter of male and one third of female migrant physicians felt that the conservative nature of the Cypriot family usually pressured female professionals and physicians to avoid long-term movements abroad. Participants also commented that there is social pressure for female professionals to establish a family in Cyprus whilst they are young and also once they have completed their studies and acquired a permanent job in Cyprus. Half the male and female returning physicians and all the healthcare managers shared this perspective.

Almost half of male and female returning physicians stated that having children while overseas had a great impact on their migratory experiences; as they had to consider not only their own career prospects and professional development but also the future of their

children. Half of the male and female migrant physicians shared a similar viewpoint. For example, some migrant participants referred to their concerns about disrupting the social bonds that had been established by their children whilst living in the UK if they decided to return to Cyprus. Other participants referred to their concerns about ensuring a good education for their children; their perception was that this was more likely to be found in the UK based on their perception of the lower quality of the Cypriot educational system. For example, one participant commented:

“Now in terms of migration the decision to return back to Cyprus becomes more difficult as our children have become attached to the country and regardless of their young age they have developed their own social bonds and attachment to their birthplace.” (MF6)

Two thirds of female and one third of male migrant physicians said that their migration experience and associated decision-making processes were greatly affected by caring responsibilities, both for elderly parents or relatives and from a lack of formal or informal support in the caretaking of their children. A number of female returning physicians and one healthcare manager also emphasized the need for informal support from relatives and its importance during the migration process. To give an example, a female physician stated:

“In fact things became much more difficult in terms of staying in the UK where there is no family support with regards to grandparents and other informal carers for the children. If we have ever entertained the idea of returning to Cyprus, it would be for family reasons.” (MF3)

Another participant added:

“Another reason for returning to Cyprus was my parents, who could offer all the help needed for professional establishment (my father is a doctor) and more importantly to look after my son” (RF5)

A similar view was shared by both male and female returning physicians and one healthcare manager who attributed great importance to social responsibilities in Cyprus, such as caring for elderly parents or other relatives. Caring responsibilities were an important reason for the return of a quarter of the males and one female returning physician. As one returning physician explained:

“Care responsibilities back home such as my newly formed family as well as my parents’ old age made my decision to return.” (RM5)

Elaborating on the impact of societal pressure, one female returning physician considered that migration offered an opportunity to avoid social pressure for early establishment of a family, which could hinder career potentials:

“Cypriot society pushes individuals once they complete their studies or training to find a job and start a family when they are quite young. Being a physician this could limit your potential for personal and especially professional development, as social responsibilities could hold you back from that extra effort that you can make to improve yourself.” (RF4)

Half the females and one male migrant physician considered any kind of migration related decision as a joint decision that had to take into account both partners’ needs and desires, career aspirations and family plans. Similarly, more than half the females and one male returning physician shared this viewpoint. As a female physician explained:

“Nevertheless my partner and I agree that at some point we want to return to Cyprus but I don’t think this will happen soon enough as the whole family is happy here and we enjoy a respectable standard of living.” (MF6)

Another participant re-iterated:

“As I told you before, I started my family in the UK but with mutual understanding, and through splitting social responsibilities we were both able to succeed in our careers and raise our family with minimum compromises no matter the difficulties. We decided with my partner that we are going to stay until our children grew enough to return to Cyprus without aiming at a specific timeframe.” (RF4)

The majority of both male and female returning physicians cited that they wanted to establish a family as a major reason for taking the decision to return to Cyprus. Similarly, all participating health care managers seemed to agree with this viewpoint as a factor in decisions about migration. One participating physician reflected that:

“Even though I considered the UK’s training system as superior to any other European destination I planned in my head that once I completed my studies and placement I would return back to Cyprus to start my family and continue training and work in my home country.” (RF7)

Another healthcare manager added:

“Once a Cypriot doctor decides that the time has come to make their own family or if that happens while abroad this most probably will be the reason for a migrant doctor to return”. (HM2)

One healthcare manager exemplified the views of half the males and a quarter of the female returning physicians that Cyprus offered them a safe, family friendly environment,

which linked the decision to return with the establishment of a family. This viewpoint was captured in this comment by one participant:

“The acquisition of a house in Cyprus, their family and friends and the very good weather climate in Cyprus are amongst the main reasons why a Cypriot migrant physician might decide to return.” (HM2)

6.5 Conditions Affecting Migration

The importance of socioeconomic and professional factors was evident in a number of ways. Participants identified that the degree of economic and social stability in the home and host country was of major importance in their migration decision-making processes. Furthermore, participants identified the importance of working conditions and professional norms, again in both the home and host country as being of crucial importance when considering their migration options. Also evident from participants’ responses was a constant comparison of working conditions and professional opportunities between the host and home country that affected the decision-making process and overall migration experience of each individual physician.

Lastly, it was evident from participants’ responses that the work-life balance and maintenance of social bonds was of major importance in any migration related decision-making process, as well as in their overall experience. Aspects such as the geographical proximity of the home and host country, as well as the working schedule of each specialty in different healthcare systems and cultures, seemed of major importance to a number of participating physicians.

6.5.1 Socioeconomic conditions in Cyprus and the UK

Returning physicians seemed to be affected during their decision-making processes by their understanding of conditions prevailing in their home country, both in terms of

economics and social instability. It was evident from returning physicians' responses that the unstable socioeconomic conditions in Cyprus, at the time they were making decisions about their future, was a factor that drove mainly female physicians towards a decision to migrate to the UK for their studies and further training or work. Two healthcare managers also shared this view:

“Furthermore, the situation in Cyprus at the time was not so good as the country was in the process of restructuring following the Turkish invasion in 1974.” (RF7)

“This period, the economic downturn, may also play a significant role as well as the economic situation of the country when the Cypriot student will decide where to study or even at the time that the qualified physician or any other professional studying abroad will start thinking about return.” (HM3)

Elaborating further on this aspect half the male and female returning participants stated that the weak economic situation in Cyprus at the time of the interview would incline them to consider a possible re-migration if conditions worsened. As one participant clarified:

“Currently I am happy but things in Cyprus are worsening with the current economic downturn. Therefore, my plans on re-migration will depend on future conditions.”
(RF1)

One returning male physician commented that the improved socioeconomic conditions in Cyprus in comparison to the conditions at the time he moved to the UK was a key determinant in their decision to return. Half the male migrant physicians and almost the entirety of healthcare managers participating in this study shared a similar opinion about the importance of economic factors and the way in which they would influence their decision-making. For instance, a male migrant physician claimed that:

“The fact that the economic situation in Cyprus is at its worst in the last 20 years acts as a drawback for me to even consider moving back home at this point or in the near future as I intend to stay for at least a few years in the UK.” (MM4)

Half the females and two male returning physicians considered factors such as equal opportunities in terms of education, training and work as of considerable importance in their decision either to move to the UK or whether to return to Cyprus. For example, a participant explained:

“Educational migration is more a matter of choice rather than gender. In terms of work from my experience and according to other Cypriot colleagues that live and work in the UK beforehand I would say that there are equal opportunities for both male and female physicians”. (MF5)

One female returning physician and a quarter of the male migrant physicians indicated that the UK NHS provided equal opportunities to newly qualified physicians based on merit and skills regardless of age, further stating that equal opportunities could affect the overall migration experience of the individual physician.

Nevertheless, both migrant and returning physicians’ expressed similar views about the influence of professional norms in either the home or the host country. As one male and one female returning physician specified, traditional values about the medical profession in Cyprus had an effect on their decision to extend their stay in the UK, prior to a permanent return to Cyprus. Furthermore, more than one third of female migrant physicians felt that male patients’ and colleagues’ traditional perceptions caused professional difficulties. One returning physician expanded on the influence of traditional values:

“In addition, some people both in the UK and Cyprus seemed to have the idea that female physicians place limitations on career choices when it comes to family

planning pregnancy leave etc., hence these employers prefer not to invest in their long-term training; that is rather demanding.” (RM7)

In another example, one female participant stated that:

“As a female doctor it is always challenging as many elderly patients still have the misunderstanding that all females are nurses especially since we have no uniforms or white coats in the UK.” (MF2)

A male participant supported this view:

“From my experience so far, being male and studying or working in the UK did not really better or worsen my experience. The only issue that I had to face was limited opportunities to examine female patients during training.” (MM2)

All the health care managers observed that the medical profession in Cyprus used to be male dominated, especially in surgical specialties and specialties such as cardiology or orthopaedics. Nevertheless, all took the view that traditional values were on the wane. They noticed changes over the last decade, during which there were a number of initiatives to promote better gender balance in medical posts. For example, one health care manager stated:

“Medicine in Cyprus is a male dominated profession as most professional jobs in Cyprus. Especially in surgical specialties it’s difficult or impossible to find any women, as they tend to follow less demanding specialties such as paediatrics and general medicine.” (HM2)

Another participating health care manager elaborated on this:

“Even though the majority of physicians are still male the current trend shows that more females are entering medicine all the time and soon enough the gender balance

in the Cypriot healthcare system will balance or even favour female physicians.”

(HM4)

Furthermore, one third of female participants supported the view that female physicians might benefit from migration to countries that promote the involvement of female physicians in specific specialties and posts. As one female physician claimed:

“Now concerning my professional experience I find it easier for a female physician to establish in the UK, as female physicians are given many more opportunities than male physicians in specific, already male dominated specialties such as surgery.”

(MF6)

Almost half the male and female migrant physicians seemed to have assigned importance to the absence of professional discrimination in the UK towards young and newly qualified physicians. Lastly, another female migrant physician explained that the unconventional and improved surgical approaches in the UK, compared to Cyprus, affected her decision to prolong her stay in the UK, rather than return to Cyprus.

6.5.2 Working conditions in Cyprus and the UK

Participants in this study seemed to value working conditions in the UK more than Cyprus. Three main aspects were of great importance in participants' migratory experience in particular: the working conditions, the financial aspect of migration and equal opportunities.

First, the working conditions present in the host and home country seemed of crucial importance for the overall migration experience and migration decision-making processes. Initially, almost half of male and female returning physicians stated that their decision to return to Cyprus was influenced, amongst other factors, by improvements in working conditions and the opportunity to establish their own private practice in Cyprus, or the

opportunity to obtain a professional post either in the private or public sector. Similarly, two healthcare managers were of the opinion that migrant physicians would return to Cyprus only if they were offered an ideal job. In addition, a quarter of the female and male returning physicians raised another important factor that affected their overall migration experience, in that upon their return to Cyprus they had to overcome an unprofessional medical culture and deal with the absence of proper organization and support from colleagues. Furthermore, a quarter of the female physicians identified that their return to Cyprus could lead to deskilling in their medical skills on account of the limited opportunities to work with a large and diverse population and the limited opportunities for continuing professional development through training to update their skills and knowledge. As one participant explained in detail:

“Nevertheless, the busy schedule and the lack of informal support left me no choice for returning to Cyprus. Returning to Cyprus though was not as I expected it to be. Even though Cyprus offers a great family environment and weather climate, career wise Cyprus is far from ideal. Work is very different here. They don't really have GPs. The government system is chaotic and doesn't work and the private sector is very expensive. In addition, I think it is very easy to get deskilled, as the population is too small.” (RF6)

Furthermore, two healthcare managers and a quarter of the male migrant physicians focused on the importance of job security and emphasized how the absence of a national healthcare system in Cyprus affects the overall migration experience and migration intentions of an individual physician. Lastly, two female participants focused on the presence of a medical ethics code and its importance on their overall migration experience. In particular, one female participant complained that the:

“Code of medical ethics in Cyprus is deprived if non absent and this is something that I didn’t want to experience especially during my career development and establishment as a physician.” (RF4)

Second, the financial aspect was also identified by a number of participants as of major importance in their decision-making and overall migration experience. Specifically, two male migrant participants commented that the low levels of public sector remuneration in Cyprus offered during training also affected their decision-making processes. Almost half the females and one male returning physician shared this view that working in the UK NHS could offer higher remuneration in comparison to Cyprus or other European destinations. Similarly, two of the four participating healthcare managers identified better remuneration acquired in the UK as another possible reason that inclined physicians to migrate. As one female participants said:

“The salary as an orthopaedic registrar (trainee) was much higher than at home.”
(RF5)

One male physician further added:

“Salaries during training in the UK were far superior to other options I had in mind.” (MM4)

Another participating physician stated:

“I decided to remain in the UK once I completed my medical studies since I had much better job offers than I could get in Cyprus and while in the University, and also the remuneration offered was quite high and much better than an equivalent position in Cyprus.” (MF1)

A quarter of male participants and one female participant considered that making a financial gain was a very positive factor in how they viewed their overall migration

experience. Moreover, a male returnee also commented that financial gains acquired through working in the UK were fundamental for the success of his migratory experience.

On another point, one returning physician said that improved physicians' remuneration in Cyprus compared with when they moved to the UK, was a significant factor in their decision to return. One healthcare manager also shared this approach and said that financials remuneration for physicians in Cyprus had improved compared to the previous decade, and this could subsequently pull a number of Cypriot migrant physicians back to Cyprus. As one participant specified:

“As the time passed the situation in Cyprus became better and there were new opportunities and better pay compared to the time I got qualified. So I decided that it was time for me to move on and become established in my home country having already gained the experience of education and training in the UK, and after working in a high quality healthcare system such as the NHS.” (RM4)

Third, participants' overall migration experience and decision-making processes seemed to be greatly affected by the presence or absence of equal opportunities in either the home or host country. For example, one healthcare manager felt that the bureaucratic nature of governmental and healthcare systems in Cyprus did not allow for the desired career development. Therefore, it drove Cypriot physicians to pursue equal opportunities and the reward of merit and skills through migration abroad to a country such as the UK. Two male participating physicians similarly expressed the view that bureaucracy and corruption in the governmental system in Cyprus drove them to migrate abroad.

In addition, through participants' responses it was identified that developments in medicine and society affected the career paths of physicians. Half the female migrant physicians expressed the view that in the last two decades there was a tendency for increased access

of females in the medical profession internationally, leading to the dominance of female physicians over their male counterparts. Half the female migrant physicians expressed the view that since the 2000s there has been evidence of increased opportunities for female physicians to advance their career. One migrant physician re-iterated:

“As I told you before, medicine is becoming feminised and even though in the UK medicine and specific specialties are male dominated this will change and in my opinion this will also change in Cyprus as well where female surgeons are even more scarce than in the UK.” (MF2)

Additionally, a quarter of females and one male returning physician expressed the view that the medical profession was becoming ‘dominated’ by female physicians. In particular, a greater number of female physicians seemed to now be able to pursue identical career and life paths as their male colleagues. The majority of the health care managers interviewed supported a similar view.

6.5.3 Quality of life and networking

Both physicians and healthcare managers participating in this study considered the opportunity to enjoy an ideal climate, a good work - social life balance and an overall high quality of life amongst the major aspects of physicians’ migration experience and migration decision-making processes. Quality of life through participants’ responses was identified in two major areas, the work and life balance and the presence or absence of social networks.

First, the work life balance seemed of major importance in the overall migration experience and it was further broken down in different factors, such working hours vs. family time and overall lifestyle. Half the males and a quarter of the female returning physicians and half the female migrant physicians considered the work schedule of the medical profession in the UK as highly demanding and therefore constrained their

available social time, especially when compared to other countries such as Cyprus or Greece. This proved to be a major constraint for the establishment of a family while in the UK. Elaborating on similar lines, half the healthcare managers participating in this study said that even though this is currently changing, female physicians have previously tended to follow different, less demanding career paths than their male counterparts. According to the same healthcare managers', paediatrics was one example that could facilitate a successful career in Cyprus. As one female migrant physician suggested:

“It could be the working hours, as during the week I work a maximum of 92 hours and a minimum of 55, therefore demanding work schedules could be a possible reason. Therefore I would go with the idea that Cypriot female physicians prefer a less demanding work schedule that will allow them more social time and the ability for family formation and care taking.” (MF4)

One healthcare manager further added:

“In my opinion this discrepancy is possibly a result of the ‘obligations’ that Cypriot female physicians have to face once they are married and especially once they have their own children. In addition, female physicians are more attached to their families than their male counterparts and are less willing to stay abroad for a very long time.” (HM2)

In addition, half the males and one female physician felt that their decision about whether to return to Cyprus was based mainly on the lifestyle that they were experiencing at the time of the interview and the lifestyle they would like to enjoy in the future. Almost half of male and female returning participants stated that they enjoyed a satisfying lifestyle in Cyprus that made them happy. This reduced the need to contemplate the idea of re-migrating:

“Being settled in Cyprus so long ago I have my family and friends here and I can say that I have been established as a doctor, therefore I can’t say that I seek anything else at this point that can be offered through re-migrating abroad.” (RM4)

Second, the overall migration experience of participants seemed to be affected by the preservation of social bonds and networks. Thus, participants referred to the effects of migration on social bonds, as well as the role of geographical distance between home and host country and networking, the effect on their overall migration process and the associated decision-making processes.

Initially, a quarter of both male and female migrant participants seemed to consider their future migration decision-making as based on the absence of friends and relatives while in the UK. A quarter of males and almost half of female returnees cited similar factors. The majority of both male and female migrant physicians reported that the greatest cost of their migration to the UK was the loss of their social relations and being far away from family and loved ones. In addition, they commented that they were less able to enjoy their habitual activities and hobbies. Similarly, a quarter of female and male returning physicians felt that their movement to the UK resulted in a largely negative loss of social bonds with a number of friends and family members. This forced them to alter their lifestyle and habits they had previously enjoyed in Cyprus. One male physician reported that he experienced difficulties adjusting in the new foreign environment, whereas another male participant said that he faced difficulties in establishing any serious relationships. As one returning physician stated:

“Being in the UK for almost 10 years was holding me apart from my friends and relatives back in Cyprus and I was feeling home sick, missing all of my own people as well as my habits and hobbies back in Cyprus.” (RM7)

Another participant added:

“The only negative is being away from family and close friends as well as experiencing difficulties with relationships although I believe that this is also due to the nature of the profession and not only a by-product of migration as such.” (MM6)

From the responses collected, a quarter of males and one female migrant in their decision to prolong their stay in the UK considered factors such as the proximity of the UK to Cyprus and the familiarity acquired with the country. Half the females and a quarter of male migrant physicians stated that proximity of the UK to Cyprus was of major importance as it facilitated the opportunity for frequent visits back to Cyprus, thus maintaining links with friends and relatives back home. For example, one male migrant physician felt that:

“Even though many of my classmates applied for a place in the USA I did not consider that option as I would have had to complete a pre-med, and besides that the USA is almost a one day trip by plane from Cyprus, so Christmas holidays back home seemed impossible and expensive.” (MM8)

As another physician explained:

“I rejected other English speaking countries such as Australia, New Zealand, USA and Canada due to the long distance from Cyprus.” (RF2)

Almost half of male and one third of female migrant physicians supported the view that Cypriot female physicians were more reluctant to move to destinations that were distant from Cyprus compared to their male counterparts. Further, they elaborated that the reluctance of female physicians to migrate over long distances could be more pronounced when the proposed move was for a long-term stay, showing a preference for neighbouring destinations such as Greece that allowed: similar lifestyle; more frequent visits by relatives and friends, and frequent visits back to Cyprus, compared to destinations such as the UK or

USA. Almost all healthcare managers, as well as half of female and two male returning physicians had a similar view. In addition, according to half the male migrant physicians, the younger age of female medical students compared to their male counterparts at the time of studies had a major role in the migration process and the relevant decision-making processes of the individual. The reason for this is simple and straightforward: females commence their studies at the age of 18 whereas at this age males have to enrol in the Cypriot National Guard. They then enrol after two years of service and would be at least 20 years of age. As one participant clarified:

“Perhaps it’s because females have to go at a younger age, as men have compulsory two year enrolment in the army once they complete their secondary education, and females are less ready to move abroad so far from home for a long time.” (MM1)

Over more than half of male migrant participants said that they considered their move and their overall experience as successful and as a result of the professional and social networks they developed. Whereas, one third of female migrant participants considered the development of new social and professional networks as major positive factor in their overall migration experience. Moreover, nearly a quarter of both male and female returning participants felt their move to the UK provided the opportunity to develop rewarding social and valuable professional networks. Half of female migrant physicians expressed the view that the strength of their established professional and social networks in the UK made the decision about whether to migrate again or return back to Cyprus even more complicated. As one migrant physician noted:

“No plans to return as in the UK I have found what I was looking for in terms of work and lifestyle and besides that I don’t want to start from zero.” (MM3)

Another migrant physician commented on the same issue:

“The professional establishment of both of us in the UK, the high standard of living that we are able to enjoy here as well as the social network that our children and we have developed is keeping us for the moment in London.” (MF5)

Migrant physicians gave similar priority to the development of their social and professional networks: a quarter of males and half of female returning physicians said that they were attracted to the UK by the presence of an already established network of relatives and friends and other personal links with the UK. Two health care managers also shared this viewpoint; one participant notably stated that:

“As I told you before the presence of close relatives in London and the opportunity I had to live and experience the country I was born in and the country my parents spent many years of their life pulled me to the UK.” (RF6)

Indeed, one male participant commented on this at length:

“The opportunity I had to get information from relatives and friends in the UK made my choice easier. With my parents being divorced and my father living in the UK for 20 years I was given all the information and insight I needed to have a more complete idea of the environment in the UK. Another link that pushed me to select the UK and especially Birmingham for my studies was the presence of a close friend of mine at the University of Birmingham also studying medicine. He supported my decision to move there and gave me a lot of valuable information that made me feel comfortable that I would enjoy my stay and that I would manage to complete the degree in the UK.” (MM4)

6.6 The Impact of Migration

This section presents health care managers' views about the positive and negative impact of Cypriot physicians' migration on the healthcare system in Cyprus. In discussing the impact of physicians' migration they refer to the impact of migration and the establishment

of the first public medical school on: the Cypriot healthcare system, the individual Cypriot physician and the phenomenon of Cypriot physicians' migration, as described in more detail below using participants' responses.

First, the impact of Cypriot physicians' migration on the healthcare system, the individual physician and the migration process will be discussed. Two healthcare managers argued that the return of Cypriot physicians, with their overseas experience, could facilitate further development of the Cypriot healthcare system both in terms of quality of healthcare delivery through up-to-date and innovative medical approaches, as well as through improved healthcare and patient management. This overseas experience could raise standards in other areas. One healthcare manager added that returning physicians could improve the research capacity of the Cypriot healthcare system through accumulation of skills and knowledge acquired abroad. One healthcare manager expressed the view that the return of established physicians with experience abroad could enhance the confidence of patients about the quality of local treatment, consequently decreasing expenses for the Cypriot Ministry of Health incurred through sending Cypriot patients for treatment abroad. For instance, one participant suggested that:

“Physicians’ migration may benefit Cyprus’ healthcare system with new ideas and approaches once these migrating physicians return. Especially if returning physicians are of specific specialties that Cyprus is short of, such as invasive cardiology, maxillofacial surgery and microsurgery.” (HM4)

Nevertheless, one participant observed that Cypriot physicians' migration would not have such an impact on the delivery of healthcare services noting that:

“Personally I believe that the current trend of Cypriot physicians’ migration will not have such a great impact on the delivery of healthcare services in Cyprus as there is

a plethora of doctors working both in the private as well in the public sector (almost 1500 in the private sector and 700 in the public sector).” (HM2)

On the contrary, two healthcare managers argued that through the loss of Cypriot specialists abroad, Cyprus could lose money and status as Cypriot patients in the absence of specialists would be forced to travel abroad to receive proper treatment. All of which may result in these patients losing their trust in the capacity of the Cypriot health care system to provide adequate medical care. In addition, half the healthcare managers commented that the absence of well-established physicians and specialists in Cyprus could limit the degree of healthy competition for job posts and promotion and this may inhibit further innovation and development in the system of medical care in Cyprus. One participant in particular expressed the view that the loss of qualified Cypriot physicians abroad could be an economic loss for Cyprus:

“When good Cypriot professionals migrate, they inadvertently “feed” the notion patients have that “the health care abroad is better than the care I could receive in Cyprus”. Apart from the economic issue; export of currency, tax income loss, loss of jobs of local professionals etc., this negatively impacts the growth possibilities and the expandability of the local health care system, as well as the quality of the services offered.” (HM3)

Raising another point, one healthcare manager complained that migration of established Cypriot physicians abroad could diminish the quality of the local healthcare system. In addition, another participant expressed the view that Cypriot physicians’ migration could further limit the potential of Cyprus for high quality medical research due to the absence of well-trained physicians and medical researchers.

Second is the impact of the establishment of a new medical school on the healthcare system, the migration process and the Cypriot physician and medical student. Three

participating healthcare managers expressed the view that the formation of the first public medical school alongside the newly established private medical schools would improve the delivery of healthcare services, research infrastructure and local research capabilities. On another note, two healthcare managers felt that local medical schools could attract Cypriot physicians with established careers abroad to return to their home country. This was because Cyprus would be able to offer an attractive ‘package’ for physicians not previously available and would probably lead to a decreased need for migration away from Cyprus. Expanding further on these effects, two healthcare managers commented that the establishment of the Cypriot medical schools could offer a high quality training option for those Cypriot medical students who might not be willing to migrate, or seek medical education at a lower cost. As one participant explained:

‘In my opinion the medical schools in Cyprus will aid many people who wished to study medicine but it was impossible to do that due to high costs of migrating abroad and due to unwillingness to leave Cyprus. If properly managed, Cypriot medical schools could aid the improvement of the healthcare system in general as they could offer better research facilities not only for medical students but for qualified physicians as well who wish to do research.’ (HM4)

Another participant was in agreement:

“The establishment of the medical schools gradually will attract more doctors to return to Cyprus particularly those that have academic training. Indeed we have seen recently through the establishment of the medical school at the University of Cyprus, that very high-ranking doctors have chosen to return to Cyprus since the University is offering a good package, but also these doctors have access to substantial clinical material to perform medical research.” (HM1)

On the other hand, two health care managers argued that the establishment of the new medical schools in Cyprus could have a detrimental effect on the Cypriot health system through an increase in the number of trained physicians who were resident in Cyprus, which may lead to oversupply and medical unemployment or deskilling. The same participants elaborated these views and suggested that with a potential increase in the number of physicians, as a consequence of the establishment of the Cypriot medical schools a greater number of young Cypriot physicians might seek better professional prospects abroad. This could increase the number of physicians' migration. As one participant pointed out:

“Even though Cyprus was lacking a medical school, physicians’ density is at high levels especially in specific specialties therefore in terms of medical staffing medical schools in Cyprus will not make much of a difference.” (HM4)

6.7 Chapter Summary

This chapter presented the findings from the semi-structured interviews performed with the three distinct categories of participants: migrant and returning Cypriot physicians and health care managers. Primary data collected throughout the fieldwork indicated the main aspects affecting the migration process and the lived experiences of Cypriot physicians. A number of participants' verbatim responses were synoptically presented to better depict the most common positions articulated, or any striking differences from the general body of responses.

Initially, this chapter presented the diversity of countries identified by participants as potential destinations and listed the most common destinations considered by both male and female participants during the migration process. The next section presented the importance of education in the migration process, emphasizing also the availability and quality of medical education and training, as well as costs and other indirect effects, such as similarities between educational systems and language proficiency. Then, participants'

responses were presented in relation to the importance they assigned to career potentials and the opportunities provided for enhanced professional experiences and how these aspects potentially determined their future professional career and migration course.

Following this was the effects of family, as well as the effects of social and professional networks on the migration process. Participants' responses were presented in relation to the tensions between career and family and in relation to their desire for a different social experience and the role of relatives and children in their overall migration experience and decision-making processes. This section further provided a synoptic presentation of participants' responses associated with the role of professional and social networks, whether available or established before or after migration. Then, this chapter depicted participants' responses in relation to how socioeconomic conditions in the home and host country affected their overall migration process. Further emphasis was provided through participants' perspectives on their quality of life and how their perspective affected the way they approached the migration process and their professional decision-making processes, such as which specialty to follow. The last section of this chapter presented the potential effects of Cypriot physicians' migration and the establishment of medical schools in Cyprus on the migration process itself and the Cypriot healthcare system through participants' perspectives.

The primary data presented in this chapter will be further organised based on emerging themes and patterns. These will be discussed in greater detail in the next chapter in order to provide in depth understanding of Cypriot physicians' migration through further analysis and comparison with the existing migration literature.

Chapter 7 Discussion: Understanding the Migration Experience

7.1 Introduction

The overall aim that underpins this current thesis was to explore the migratory experience of Cypriot physicians. To achieve this, the voices of Cypriot physicians and health care managers were revealed through interviews about physicians' migratory experiences; these were presented in Chapter 6. In this current chapter, to understand the significance and meaning of these voices, these experiences have been critically analysed and have been subject to a process of reflection. This critical analysis was conducted through juxtaposition with findings from similar studies and also by location of these findings in relation to theoretical frameworks and discussion found in the published literature that was reviewed in Chapter 4. Once this reflection, analysis and situating of the findings was complete it was possible, in the final section of this chapter, to explore the contribution made by this current study to theory about migration from professionals and physicians.

This chapter has been divided into three main sections, each of which addresses one of the three primary research objectives in this current thesis, these were:

- 4.** Identify and explore the factors that led Cypriot physicians (including physicians in training) to migrate to the UK in order to practice medicine or acquire medical training; and why some Cypriot physicians have relocated permanently to the UK following their medical education or training, whilst others have chosen to return to Cyprus.
- 5.** Consider the ways in which gender might have mediated these factors: differences in migration for men and women.
- 6.** Explore how these factors that lead to Cypriot migration contribute to understandings about theories of migration.

The first section of this chapter focuses on participants' experiences and the main tensions that affected their migration in relation to destination selection, duration of migration and the decision to return to Cyprus. This section also provides an analysis of the impact of migration on the individual physician, as well as on the home and host country, and provides a detailed discussion about the potential effects of the establishment of medical schools in Cyprus. The second section of this chapter focuses on the contemporary feminization of medicine and how this may have affected and impacted on the migratory experience. The final section of this chapter presents a theoretical approach to the migration of physicians, which was devised through understandings developed through the process of conducting this current study in combination with an investigation of published literature.

7.2 The Experience of Cypriot Physicians: the Impact of Migration for the Individual and the Health Care System

The accounts of the physicians and health care managers in this current study, suggest three main points at which decisions about migration impact forcefully on the individual experience of physicians, these were the decision: (i) to leave Cyprus (ii) about the desired destination; (iii) to return to the home country (Cyprus) and the extent of their stay overseas. The cumulative effect of these individual decisions about migration had an impact on the health care system. The three elements of the migratory experience and impact on the health care system were analysed in the separate subsections that follow.

7.2.1 Leaving Cyprus

At the time the physicians, who participated in this current study, undertook their medical training, there was no option for them but to complete their medical education in a country other than in Cyprus. Therefore, if the ambition to train to become a physician was strong enough there was no choice for those opting for this type of career to seek medical education overseas. In all probability, there were a number of individuals that would have

liked to pursue a career in medicine but who were dissuaded from doing so because to follow this career choice would have required migration. We know nothing of these individuals from the present study, interesting though their views would have been.

The responses from participants were clear and unequivocal about the reasons for considering migration to another country to pursue their medical education; they recognised that they had no option if they wished to pursue their career. In addition, Cyprus lacked the necessary resources to offer the required postgraduate training in a range of specialties. Physicians who completed their medical education were pushed to migrate abroad in order to train in their desired specialty. The lack of suitable medical education was a strong driver for migration. Syed et al. (2008) identified that amongst the most commonly cited factors for a physician to migrate abroad was the limited training capacity in their home country. This view coincided with the findings of other researchers such as Loeffler (2001); Kirrigia et al. (2006) and Brown and Connell, (2012), who noted that physicians may migrate to improve their professional prospects and excel professionally in a destination country where the healthcare system offers more professional opportunities, as compared to their home country. Participating physicians identified that oversupply of physicians in the individual's desired specialty acted as another factor affecting their decision to migrate. This oversupply was viewed as a potential career inhibitor, which pushed Cypriot physicians abroad. This finding echoes a number of studies, such as those by Syed et al. (2008) and Giannarou (2009). The study by Giannarou (2009) of the migration of young, Greek physicians and mechanics, found that oversupply of physicians and misallocation of human resources, as was the case in a range of specialties of Cyprus, may push an individual physician to migrate or extend their stay in another country. This perception of oversupply was evident in responses by some participating physicians, compounded by views about overburdening bureaucracy and favouritism present in the local healthcare system. They looked to migrate to seek both better professional prospects

and take advantage of meritocratic systems evident in other healthcare systems such as the NHS. There is evidence of the importance of these factors which disproportionately impact on early career physicians; for example, in their study of the key determinants on the decision-making about migration of physicians and nurses from South Pacific Island Nations, Brown and Connell (2012) found that physicians were pushed to emigrate away from countries where nepotism and favouritism were present in the health care system.

It was not just a sense of oversupply or lack of opportunity in Cyprus that encouraged physicians to consider migration. They were attracted to the idea of migrating abroad to gain experience in a world-class healthcare system and enjoy better working conditions and improved research facilities as compared to Cyprus. Other studies have found evidence of similar positive features of health care systems that attract migrants. Robinson and Carey (2000), Loeffler (2001), Ballard et al. (2004), Kirigia (2006), and Syed et al. (2008) in their studies identified that individual physicians might be encouraged to migrate to destinations that offered: greater professional experience; ideal working environments and facilities; and higher quality research infrastructure and resources, as compared to the physician's home country.

However, understanding the decisions of physicians to migrate cannot be framed solely by factors that are specific to the medical profession. Through participating physicians' responses it was clear that a sense of unstable socioeconomic conditions in Cyprus might push an individual to migrate abroad to increase their current earnings and maximize their income potential. From the responses of physicians in this current study it was evident that some were driven to migrate abroad as a result of the low remuneration offered in Cyprus, especially during training. Indeed, individual Cypriot physicians were driven by the desire for better financial gains compared with the rewards available when remaining in Cyprus. Similarly, the study by Ogilvie et al. (2007) about the migration of health professionals from sub Saharan Africa aligned with this current study, in that skilled healthcare workers,

including physicians, were forced to migrate due to poor remuneration. This finding resonated with another empirical study by Robinson and Carey (2000), which supported the idea that Indian doctors moved to the UK to better themselves financially compared to staying in India.

Lastly, it seems that it was not only financial pressure that encouraged Cypriot physicians to migrate, but to a lesser degree social pressure exerted from within the family and Cypriot society seems to have impacted in such a way as to push a number of physicians to migrate abroad. It can therefore be assumed that Cypriot physicians might have been pushed to migrate abroad with the aim of accomplishing specific career and/or financial objectives that could possibly justify a more delayed social establishment in Cyprus, consequently easing the relevant family pressure. Similarly, this finding seems to be echoed in Malik et al.'s (2010) study about the motivational determinants driving physicians from Lahore, Pakistan to study and work abroad.

7.2.2 The choice of destination

There were a number of reasons that the physicians in this current study favoured the UK as a preferred destination. These were the perception of: superiority in terms of educational excellence; ease of educational access; lower educational and living costs as compared to destinations such as the USA. Among the physicians in this current study, there was a clear sense that, in general, they regarded the UK as a location for excellent medical education. As such, they assigned higher value and professional status both to medical schools in the UK, and also the healthcare and training systems as compared to other destinations identified, such as the USA and Germany.

These perceptions of the superiority of the UK medical education and health care systems over those of other medically developed countries may, in part, be attributed to the existence long historical and social bonds between Cyprus and the UK, which have

positively influenced opinions. That is not to state that the physicians in this current study were 'prisoners' of tradition; the effects of such historical ties are subtle and nuanced. The physicians were able to give strong reasons for their preference for the UK as a place to train and work. Their responses indicated that they were attracted to the UK as a migration destination on account of the quality of working conditions and professional environment. A component of the professional environment valued by the physicians was the high-quality research infrastructure, which provided opportunities for a career in medical research and academia. These views echo findings in a previous study by Martin et al. (2004), which supported the existence of the perception of the superiority of the UK in terms of funding in research and development and found that these perceptions of superiority in respect of research infrastructure attracted migrants.

However, it was not only professional factors that attracted Cypriot physicians to migrate to the UK. The geographical proximity of the UK to Cyprus and the ease of travel between the two countries were of high importance in the decision about where to pursue their medical career. Other similar studies, such as that by Connell et al. (2010), reported that the geographical proximity of the host country to the migrant's home country might be of great importance for migrating physicians. Cypriot physicians appear to have taken the opportunity to divide their professional and social time between two or more countries by exploiting low cost travel and communication. In this current study, the physicians stated that opportunity to enjoy a different social experience and cheaper travel while living and working in the UK was an important determinant in their decision to migrate. This finding is not unique, Syed et al. (2008) found that physicians migrate to take opportunities for travel, as well as to live and work in interesting multicultural countries or cities.

Nevertheless, it should not be assumed that because the migrant physicians chose the UK that this country was their only option. The Cypriot physicians considered other alternatives that were more medically developed than Cyprus. This range of choice reflects

the findings of Garcia-Perez's (2007) statistical study about the presence of European doctors that were working abroad. He identified a number of medically developed countries that act as "poles of attraction" for the majority of migrating physicians, with the UK being at the top of the list, followed by the Nordic countries, Germany and Austria. Nevertheless, from the results obtained Cypriot physicians seemed to have identified alternatives such as Greece or countries of the former Eastern Bloc, a trend that was supported in previous studies such as that of Pericleous (2011). It might be assumed that Cypriot physicians would have selected countries such as Romania and Bulgaria with closer geographical proximity, lower costs and easier educational access than the UK, or countries with similar language and customs like Greece. This presumption was supported by a number of other studies (Jolly, 2005; Hallock et al., 2007; Kaushik, 2008b) which found that following the rising costs in medical education from 2000, migrating physicians tended to seek destination countries with low cost studies and standards of living, or they tended to migrate to destination countries with lower entry requirements. In contrast, the Cypriot physicians in this current study took a different view as they did not prioritise low cost education or living costs as the primary determinants for their choice of migration destination.

If, as was the case, for the migrant physicians in this current study, the UK was their destination of choice, there were several factors that made that preference a realisable option. First, the NHS in the UK has a reliance on externally trained doctors, as it cannot meet its staffing needs from UK trained doctors alone. This approach by the NHS can be regarded either as a health service that is open to attract the best and most talented doctors from around the world or as a cynical policy to shift the cost of training NHS doctors to other countries. There may, of course, be some merit in either perspective. Whichever approach underpins the NHS policy on staffing and recruitment, as Stark (2004), Jenkins et al. (2010) and Joudrey & Robson (2010) found, there are a number of countries, such as

the UK that aim to cover their local healthcare staffing needs through recruitment campaigns to attract foreign labour. This openness facilitates the recruitment of physicians from less medically developed countries such as Cyprus and helps these physicians achieve their aspirations but in turn deprive their home country of their medical skills. Second, a number of factors draw Cypriot physicians to the UK, these are: similarities between the Cypriot and UK educational systems; a level of high English proficiency among Cypriots generally; long established Cypriot networks in the UK, following earlier waves of migration. Some empirical studies such as those by Cooper (2005), Mulan (2005) and Akl et al. (2008a) noted similar types of links and connections that could influence the decision of a physician to migrate to a specific destination country, for example when countries share similar training systems or other social or historical bonds, such as previous colonization or social networks. According to Akl et al. (2008a), Lebanese medical migrants considered the language of the host country as a very important determinant for the choice of migration destination. As for the migrant, linguistic competence in the host country's language promoted easier adjustment while allowing the physician to maximize educational and training benefits. The same study suggested that migrating physicians and physicians in training would, unsurprisingly, prefer to move to countries where language would not be problematic and where they could train without additional obstacles. For some Cypriot physicians and medical students in this current study, even if they had high English proficiency the opportunity to be educated, trained and to live in a country with the same language as Cyprus, such as Greece, was an attractive option. Although ultimately, other factors such as the potential for better professional experiences, higher remuneration and the opportunity to become involved with academia and medical research in a world-renowned health system, such as the NHS, were stronger determinants of migration destination.

7.2.3 Returning to Cyprus

The length of stay in a particular migratory destination, in this case the UK, was determined in this current study by similar factors that determined the initial decisions about whether to migrate and the migration destination. The similarities between participants' initial and subsequent migration decision-making processes were identified in a similar empirical study by Buchan (2007). Regardless of the similarities identified, there were nevertheless, differences in the weighting of these factors amongst participating physicians. Cypriot physicians identified two major reasons for their decision to return to Cyprus; the fulfilment of their migration objectives and the improvement of conditions in Cyprus.

On the completion, or not, of their initial migration objectives, participants would compare the professional and socioeconomic conditions in the home and host country and decide whether to extend their stay abroad or return back to Cyprus. Robinson and Carey's (2000) and Long's (2007) studies of foreign healthcare workers placement in South Africa and the migration of Indian doctors to the UK respectively, showed they adopted a similar approach to Cypriot participants in this current study. They noted that individual physicians might decide to remain in a specific destination due to the home country's disadvantaged position in relation to professional conditions. Also, through the responses obtained it seems that Cypriot physicians decided to extend their stay in the UK rather than returning to Cyprus as they felt settled and comfortable with their social and professional life in the host country. The view identified in this current study was thus in line with the findings from Akl's (2008a) study in that migrating physicians would prefer to extend their stay for training and work purposes in their place of study for easier and faster socioeconomic adjustment. However, from a number of empirical studies it was evident that some physicians were unwilling to return to their home country due the fear of losing: their bonds with patients; connections with the local community; the respect gained from

their colleagues in the host country (Loefler, 2001; Syed et al., 2008; Malik, 2010). Nevertheless, none of the participants identified such factors as a major determinant in their decision to return. Cypriot physicians highly valued the possibility of acquiring respect from peers upon return to Cyprus.

Findings in this current study confirmed that Cypriot migrant physicians assigned great importance to family bonds. Once they had acquired the desired economic resources, status and professional experience, the drive to return to Cyprus to establish a family and acquire property in the home country was strong. These key drivers fit closely with the profile of the Cypriot migrants described in previous studies by Constantinides (1979), Koupparis (1999) and Teerling (2010) on Cypriot migration trends. The importance of the desire to own property was strong among Cypriot physicians, both as a home for the family but also as an indicator of success. Through property ownership, they could demonstrate to others that their time abroad had been fruitful and had increased their economic resources. The importance of property for returning migrants was demonstrated in other studies, for example Brown and Connell (2004) found that property ownership was a major determinant in decisions made about migration and the decision to return to the home country.

Several empirical studies identified a number of country specific factors for the main host countries in the EU (UK, Germany and France) that can act as major determinants in a physician's decision to either stay in a host country or return to their home country. These factors include: high work related strain compared to remuneration identified in Germany (Gerlinger & Schmucker, 2007); restricted medical autonomy in the USA and UK (Bury, 2008; Joudrey & Robson, 2010); additional management duties assigned to physicians in France; and the high taxation present in all three major EU host countries Germany, France and the UK (Ballard et al., 2004). However, in this current study of Cypriot physicians there was an absence of any reference to such factors. From this absence, it is possible to

infer that the high regulation of the profession, work related strain, high taxation or any additional management tasks, to the extent that they were present in the work-life of the physicians in this current study, are considered to be part of the consequences of following the profession of physician. As factors in the decision to return to their home country or remain in the host country they do not appear to be important for the physicians in this current study. Yet there is indirect evidence here that the physicians did consider these factors to be important. As they considered Cyprus, as a country that is able to offer an ideal work/social life balance, a great family environment and high overall quality of life and affirmed that this was the environment they wanted or intended to return to.

The decision to return to Cyprus was also highly dependent upon the presence of a partner and or dependant while abroad. The physicians in this current study, in making their decision about whether or not to return to Cyprus took into account: both their own as well as their partner's career aspirations; any dependants, educational or social needs; and availability of formal and informal support or care for any dependants. Participating physicians also identified care responsibilities of usually elderly relatives in their home country as a major determinant in their decision to return to Cyprus. Nevertheless, from the responses obtained and the differences in approaches between migrants and returning physicians it can be assumed that age; incomplete professional establishment and prioritisation of career and family establishment acted as additional variables in the decision-making processes of individual physicians to return to Cyprus.

7.3 Gender in Medicine and Migration

Significant opportunities have opened up for women in the health care professions in recent years. According to the study by Wojczewski et al. (2015), almost three quarters of the professionals working in healthcare in Europe were female. Since around 2010, females have comprised almost half of transnational migrants (Wojczewski et al., 2015). Similarly, since 1990 there was an increase in volume of discussions in various academic

journals about the growing number of female entrants to medical schools (more than 50% in the majority of high income countries) and the medical profession (Mohamed et al., 2018). This growth in the number of women entering the medical profession has given rise to the term “feminization of medicine” (Jefferson et al., 2015). This term has been used to denote the ways in which the medical profession has adapted to or been challenged by an increased number of women entering the profession. The feminization of medicine provides a backdrop to the experiences of Cypriot physicians explored in this current study. Prior to engaging in discussion about these experiences, it was necessary to explore some aspects of the feminization of medicine.

The feminization of medicine and thus female participation in the medical profession could affect health resource planning in each country since, for example, male and female medical students and qualified physicians may differ in terms of specialty selection preferences, career duration, mode of employment preferences and approach towards migration (Mohamed et al., 2018). Such variations could affect supply, distribution and efficiency of the available health workforce in a healthcare system with difficult to assess consequences, such as short supply in specific specialties. (Du Moulin et al., 2000; Alers et al., 2014; Mohamed et al., 2018). Thus, scholars and health decision-makers need to examine these variations to plan and adjust, where necessary, their strategy for health human resource management and for the medical education and training curriculum.

The importance assigned to the role of gender in the migration process was exemplified by a number of empirical studies examining: the lived experiences of female skilled migrants (Man, 1995; Liversage, 2009) the participation of females in medicine and medical academia and the participation and trends of females in the international migration of physicians (Carr et al., 1998; Jonasson, 2002; Badkar et al., 2007; Boulis & Jacobs, 2008; Poppas et al., 2008; Ricketts & Randolph, 2008; Kaneto et al., 2009; Kodama et al., 2011). Furthermore, a number of studies have identified differences in the attitudes of male and

female physicians in respect of: career motivation, the weighting given to careers as opposed to family commitments; choice of type of medical education or training, and choice of different career paths early in their careers (Alers et al., 2014). Specifically Borges et al. (2009); Kusurkar et al., (2010) and Alers et al. (2014) identified that female medical students tend to be more intrinsically motivated than male medical students and more inclined to select those person-oriented specialties (i.e., paediatrics) with a high degree of patient contact as compared to male medical students who may be more inclined to follow more technical and better paid specialties (i.e., surgical specialties). While Alers et al. (2014), identified that male and female medical students tend to have a different approach to work–life balance. This finding lends support to the notion that such differences could be the result of normative values associated with the role of females in a given society or of an improperly structured medical or training curriculum. Another segment of the empirical literature examined the potential role conflicts experienced by female physicians, as compared to their male counterparts, in the pursuit of medical careers. These conflicts focussed on the challenges for women in meeting the often-idealised expectations of being a physician and mother (Potee et al., 1999; Doorne-Huiskes et al., 2005; Mobilos et al., 2008; Pepper’s, 2011; Pouwels, 2011). Nevertheless, despite the increased number of empirical studies on the role of Cypriot female physicians in the healthcare system, there are few studies on their migratory behaviour and this aspect of their experience has thus been neglected (Vassiliadou, 1997; Hadjipavlou & Mertan, 2010) This gap in the literature was one reason for the focus of this current study on the role of gender in the decision-making processes of Cypriot physicians about migration.

7.3.1 Gender in medicine and migration: views from past experiences

A number of empirical studies in the USA, UK and Japan (Serrano, 2007; Boulis & Jacobs, 2008; McEwan, 2010; Kodama et al., 2011) identified that the international feminization of medicine had a localised effect and caused an increase in the participation

of females in the medical profession. Similarly, participants in this current study, mostly female physicians and healthcare managers, felt that the international feminization of medicine caused an increase in the number of Cypriot women deciding to enter medical education to become doctors. Nevertheless, even though one in three of the total physicians' workforce in 2013 was female, the proportion of Cypriot female qualified physicians migrating or working abroad was substantially lower than their male counterparts. A similar situation was identified in Lebanon. Specifically, Akl et al.'s (2007; 2008) studies found that even though indigenous female physicians in Lebanon accounted for more than 40% of the total physicians' workforce, the number of Lebanese female migrant physicians was substantially lower than their male counterpart migrant physicians; showing an inverse relationship between Lebanese female physicians and migration intentions. Participants in this current study were therefore asked for their views about the discrepancies between the number of Cypriot males and females entering medical education and the number of male and female Cypriot physicians migrating specifically to the UK.

A number of both male and female participants attributed these discrepancies to the existence of different approaches between male and female physicians with regards to the emphasis assigned to the balance between work and family life. Furthermore, this difference may, for female physicians, have led to the selection of working environments in nearby countries as preferred migration destinations, when compared to the UK. This reluctance to migrate appeared to be more marked if the proposed period of migration was for a lengthy period, such as would be the case when studying medicine or training in a specific specialty. The views expressed in this current study mirror those in Ricketts and Randolph's (2008) study in which they found female physicians were usually less likely to migrate for long periods of time as compared to their male counterparts. A small number of participants in this current study gave a different explanation for the discrepancies in the

number of Cypriot male and female physicians migrating to the UK, suggesting that this may be a result of the desire of Cypriot female physicians to avoid the demanding nature of the medical profession in the UK. Therefore, they selected destinations that allowed for a more relaxed working schedule, such as Greece. Again, this view echoes other similar studies (Wolfe, 2005; Poppas et al., 2008; Butler & Mason, 2010). All these studies concluded that some female physicians demonstrated the tendency to follow less demanding career paths, when compared to their male counterparts. There could be a number of possible explanations to account for why some Cypriot female physicians in past migration waves appeared to prefer to migrate to destinations that offer “a more relaxed working schedule”. Among these explanations is that a more relaxed working schedule provides opportunity for more frequent visits back to Cyprus or the availability of more free time for recreational activities. However, there may be deeper structural explanations for this behaviour and the identified discrepancies that go beyond personal preference; some female physicians may have been constrained by social norms that prevented them from feeling free to compete with male physicians at the time. Furthermore, participating physicians in this current study identified that gender and age at the time of decision-making for a Cypriot medical student were interconnected and thus identified discrepancies could be the result of age differences between male and female medical students and/or physicians. More specifically, some participants commented that the younger age of female medical students upon commencement of studies was a disadvantage in comparison to their male counterparts. This view contrasts with Ricketts and Randolph’s (2008) study that noted the relative younger age of female physicians in training could possibly increase their migration flows. This contrast could be assigned to the notion that male medical students who were compulsory enrolled for two years in the Cypriot National Guard were more mature and better prepared to move abroad to a distant destination at the age of 19-20 years for a long period to complete their medical education

and training as compared to their female counterparts who would need to migrate at the age of 17-18 years.

This current study explored participants' views about the extent to which gender impacted on their ability to pursue a career in medicine. The majority of male and female physicians expressed the view that they were not personally disadvantaged during their training and career because of their gender. Despite holding these views about their experiences, both male and female physicians were of the view that, regardless of the feminization of medicine and the enhanced opportunities given to female physicians and medical students, a degree of professional gender bias was still present in medicine both in the UK and Cyprus. This form of bias was, according to a number of participants, found in the existence of stereotypical roles assigned to male and female physicians that could have a negative effect on career development, depending on the gender of the individual physician. This apparent contradiction in the views of participants that they were not disadvantaged by their gender and yet they found instances of gender bias in the profession can be explained through cognitive dissonance (Festinger, 1962) between participants' understanding of the social construction of gender in the medical profession and their personal experience. They were able to recognise the existence of gender bias that favoured men in the social structures of the medical profession but did not believe that they had been personally hindered by this bias in the pursuit of their medical career.

The existence of stereotypical views of male and female professional roles is entrenched in Cypriot society as Antoniou et al. (2008) found in their study on the potential gender differences in relation to work stressors and job satisfaction for young Greek physicians. These findings were echoed by a number of physicians in this current study who suggested that traditional perceptions, cultivated by the family-oriented society of Cyprus, have contributed to a normative social climate where female professionals are seen as the ones who should assign greater importance to providing care responsibilities rather than

prioritising career development. These norms about female roles can be constructed as an expression of the tension between the ‘ideal mother versus the ideal physician’; a dilemma, the existence of which was identified in Pepper’s (2011) study and confirmed in both Babaria et al. (2012) and Aler’s et al. (2014). These studies all found evidence of normative views that female physicians should be primarily responsible for childcare in the family and are expected to prioritise the provision of care for others over their own career aspirations. As an example, Aler et al.’s (2014) study revealed that a substantial number of male medical students in the Netherlands expected their partners’ careers to be more heavily and negatively affected than theirs would be when they established a family and had childcare responsibilities. The existence of these social norms in Cyprus can be connected with the persistence of patriarchy in Cypriot society; as Hadjipavlou and Mertan (2010) identified, Cypriot society is in certain respects still patriarchal and gender prejudiced allowing female professionals’ needs and perspectives to be downgraded in importance or ignored. The impact of restricted career development for female physicians has been documented by Potee et al. (1999), Van Doorne-Huiskes et al. (2005), Mobilos et al. (2008) and Pouwels (2011) who all found that such restriction led to personal distress, a decline in motivation and reduced contribution to the profession.

There are factors other than the existence of social norms grounded in patriarchy that may impact on the opportunity for female physicians to pursue a career on equal terms with their male counterparts. A number of studies (see for example Serrano, 2007; Butler & Mason, 2010; McEwan, 2010) found that professional conservatism, as well as training, succession planning and reward models may be traditional in approach and tailored around the needs of male physicians and trainees to the possible exclusion of female physicians. One source of evidence about female medical careers can be found by exploring the extent of female participation in leadership bodies in the medical profession. For example, Meuleman et al. (2017) found that Cyprus was ranked last amongst the EU-28 for female

professionals' participation in key and decision-making positions regardless of the enhanced participation of females in employment. Studies conducted by Wolfe (2005), Poppas et al. (2008), Butler and Mason (2010), Dacre and Shepherd (2010), and Sexton et al. (2012) confirmed that in many cases female physicians were underrepresented in leadership positions within the medical profession and the associated decision-making bodies in high income countries such as the USA and UK. Similar views were expressed in previous empirical studies (Gjerberg, 2001; Mobilos et al., 2008; Goldacre et al., 2009; Elston, 2009) that old professional perceptions and societal norms were still present even in high-income countries and could affect the representation of each gender in decision-making bodies. Regardless of the feminization of medicine, there is good evidence for the persistence of gender bias in medicine, even though bias may have declined since the 1990s professional barriers still exist in the career development of the individual female physician. This view was shared by Arrizabalaga (2015) whose study about the career trajectory of Spanish physicians' in the 21st century suggested gender bias restricts female physicians from fulfilling their full career potential and advancing in higher positions within the medical profession.

7.3.2 Gender in medicine and migration: views on contemporary conditions

Following the 1990s and the globalization of medicine, female Cypriots engaged more extensively in education and employment as compared with Cypriot males and previous generations of females. Specifically, the percentage of Cypriot women in tertiary education increased from 13% of the total population in 1990 to 38% in 2014. Similarly, the percentage of Cypriot women in employment increased from 40% of the labour force in 2000 to almost 50% in 2015; while the gender-earnings gap between male and female workers decreased from 43.9% in 2000 to 26.9% in 2015 (CyStat, 2016). These significant changes have impacted on Cypriot society. These changes led both to an increase in the number of Cypriot women engaged in seeking to combine the dual roles of mother and

professional and also to Cypriot women gaining professional and economic independence, which has enabled them to become more involved in politics and decision-making bodies. Such changes have and are prompting a change in the norms that previously existed in Cyprus in relation to the role of women in society (Stavrou, 1997; Hadjipavlou, 2010). Medicine has been a significant sector of the workforce where the feminization of the profession has promoted the role of females in a previously male dominated area and led to improved gender equality, both in medicine as well as facilitated opportunities for female physicians to migrate. Despite these trends, findings in this current study suggest that social stereotypes and prejudice remain in Cypriot medicine and are evident in specific specialties and decision-making bodies (Hadjipavlou, 2010). Nevertheless, what can be concluded from participants' responses is that both male and female Cypriot physicians and medical students seem to have similar professional and social aims.

Overall, participants' responses indicated that the career path of contemporary Cypriot physicians was mainly determined by personal preferences of individual physicians and not so much by the presence of professional gender bias. The evidence for professional and cultural change towards greater social and professional gender equality seems to be supported by participants' responses, and by local statistics (CyStat, 2016), and the available literature (More, 1999; Jonasson, 2002; Hadjipavlou, 2004, 2010).

7.3.3 Gender in medicine and migration: family and career

The increased participation of women in the medical workforce raises a number of questions about the ways in which physicians combine the requirements of family (having children; caring for children; having an effective partnership; caring for other dependents) and the pursuit of a medical career, in the context of contemporary social norms and role expectations. How they meet the expectations of career and family and to what extent these expectations are different for men and women are of concern here. According to participants in this current study, the way contemporary Cypriot male and female

physicians prioritise their career and family establishment has altered since the 1990s. While there were some differences between the views of male and female physicians in this current study, both male and female physicians felt that they assigned a similar value to the importance of establishing a family and undertaking caring responsibilities. Furthermore, both male and female physicians noted that their career plan was to complete their medical education and training, satisfy their initial professional objectives and eventually return to Cyprus with an established and developing professional career, as well as to establish their own family. These views contrast with the findings in a number of previous studies. For example, Arrizabalaga (2015) found female physicians tended to assign a higher value to the importance of providing family care than male physicians and female physicians gave greater emphasis than their male counterparts to the selection of a career route that would allow for balance between career and family. However, these findings also resonate with a number of other studies. For example, Martinez et al. (2007); Boulis & Jacobs (2008); Poppas et al. (2008) all found that female physicians tended to construct their career progression plan by assigning higher priority to family needs and expectations, as compared to male physicians who defined career advancement as the primary determinant in career planning. As Johansson (2002) and Carr et al. (1998) found, female professionals with families preferred to scale back their career plans so that they were able to devote time to their family rather than seek career advancement. In addition, a number of studies found that female physicians chose a specific specialty or destination with a less demanding nature to allow for more time and more frequent visits to care for their dependents (Wolfe, 2005; Poppas et al., 2008; Butler & Mason, 2010). In this area, the findings of this current study were somewhat at odds with the dominant findings in the literature. In this current study, both male and female physicians said that they assigned equal weight to the ability to be able to pursue a medical career and at the same time be able to establish a family. A plausible explanation for the difference between this current

study and the dominant findings in previous literature may lie in the nature of Cypriot culture and family-oriented society. There are strong social norms that generate expectations for Cypriot physicians, both male and female, to care for their family as well as their elderly parents. They have to reach a compromise with these norms and their desire to combine career with a better future for their children. This finding in this current study seems to parallel that of Teerling's (2010) study, in which she argued that Cypriots, upon successful completion of their migration aims, tend to return to their home country to establish their permanent residence to support relatives and enjoy the lifestyle of their home country. In this way they reach a compromise with the different demands of career and family. Another possible explanation for the similar views of male and female Cypriot physicians could be the contemporary developments in communication and travel, the mutual recognition of medical qualifications within the EU (Gerlinger & Schmucker, 2007), and the existence of more flexible working schedules (Van Doorne-Huiskes et al., 2005). All of which allow any individual, regardless of gender, to follow their desired specialty and their desired destination for studies. These developments potentially allow contemporary Cypriot physicians and medical students to migrate for study, training or work without worrying about the distance between the home and host country or duration of absence. Daily communication and frequent visits to the home country are both possible now in ways that were not conceivable a few years ago. These changes may explain some of the concerns identified by migrating physicians in previous empirical studies such as that of Ricketts and Randolph (2008), who did not have such opportunities for easy communication and travel. Furthermore, since the professional requirements for the individual physician are parallel in the majority of high-income countries, the demanding nature of a particular specialty or healthcare system and thus work-life balance possibly ceased to act as major criteria in the migration decision-making processes of the contemporary Cypriot physician. This view seems to be in contrast to what was identified

in previous studies (Wolfe, 2005; Poppas et al., 2008; Butler & Mason, 2010) and the approach adopted by Cypriot physicians during the 1990s or prior to that.

Following the 1990s, part of the available literature focused on the partner's effect on the migration decision-making process. In their studies, Woodward (2005); Kaneto et al. (2009) and McEwan (2010) identified that dependent on whether both or just one of the two is a professional worker and whether one or both are professionally established, has its own effects on the migration decision-making process, such as the decision to migrate, migration timing and destination selection. The findings in this current study showed that participants considered decision-making as a collective process, as well considering the needs and wants of the 'team' rather than the individual, and mutual adjustments were made depending on the context and better prospects for the team. This view was echoed in other empirical studies. Specifically, Goodyear-Smith and Jane (2006), and Callister et al. (2008) supported the view that contemporary couples, where both partners are working, should be considered as part of 'teams', since they share similar interests and needs. Therefore, migration decisions should be taken collectively according to the needs of the 'team' rather than the needs of the individual. Similarly, the 'team' decision-making concept was shared by participants concerning the presence and care of dependants. Indeed, a number of previous empirical studies emphasized the role of dependants and care responsibilities in the career progression and migration decision-making process of the individual physician (Du Moulin et al., 2000; Alers et al., 2014). Likewise, from the responses obtained, it was evident that care responsibilities and the presence of dependants greatly affected participants' decision-making processes in relation to career choices and migration routes and timing. Nevertheless, participants' responses were common between male and female physicians, consequently contradicting the majority of the available literature (Allen, 1988; 1994; Longo & Straehley, 2008). These empirical studies identified that female physicians' approach to child rearing differed from that of their male

counterparts. These same empirical studies identified that female physicians thought that having children restricted their career progression and in many cases, reported that they tried to delay or avoid motherhood to enhance their career progression opportunities. Another survey conducted in the USA by Alers et al. (2014) found that female physicians had an increased tendency to undertake the role of primary childcare provider compared to their male counterparts. Furthermore, Du Moulin et al. (2000) noted that when male physicians had a partner with the primary responsibility for childcare they pursued a career without any breaks, whereas female physicians who tended to be primary childcare providers engaged initially in full-time work but gradually moved to part-time employment. Nevertheless, in contrast to previous empirical studies the majority of male and female physicians participating in this current study supported the view that the decision-making process with regards to returning to Cyprus or extending their stay in the UK was a collective decision for the 'team'. Any decision was dependent upon better prospects, not only for their partner but also for the dependent(s), as well as the educational potential and better prospects for quality of life. This approach coincided with Askari et al.'s (2010) study supporting the view that male physicians are prepared and willing to share equal responsibilities with their female partners for child rearing, while both partners pursue their professional objectives.

From the findings in this current study, it can be assumed that following the 1990s gender dynamics in Cypriots' skilled and physicians' migration changed. Through participants' responses it can be assumed that contemporary Cypriot male physicians are becoming supportive to their partner. In addition, through the responses obtained, Cypriot female physicians seemed less willing to compromise to the long-standing, pre 1990 socially constructed roles. This follows an international trend for gender equality and mutual support amongst professional couples (Askari et al., 2010; Wojczewski et al., 2015). Furthermore, through the findings of this current study it can be suggested that both male

and female participants aim to combine their professional role and their role as a partner as part of the 'team'. This view was echoed in another study by Gjerberg (2003), suggesting that following the 1990s female professionals and physicians engaged in a dual role aiming to combine career and social responsibilities with similar success rather than aiming to succeed in either the role of the ideal mother or the ideal physician, as expressed in Pepper's (2011) study.

The feminization of medicine is thus proceeding at a slow pace. Evident of this slow-paced change is the low participation of female physicians in decision-making bodies in Cypriot medicine (Meuleman et al., 2017). Nevertheless, the role of gender in the medical profession and the implications of gender specific preferences in the process of Cypriot physicians' migration should become a priority for decision-makers and policy planners in Cyprus to ensure equal rights and opportunities for both genders to participate in the medical profession and physicians' migration.

7.4 Theorizing Migration: Empirical Framework

The findings in this current study indicated that the main reason for Cypriot physicians to move abroad was the desire for training, to achieve professional excellence and maximise their career potential. They prioritised career progression through better education and training over their desire for financial gain. This view was mirrored in Jenkins et al.'s (2010) theoretical study on the migration of psychiatrists from low and middle-income countries to the UK, USA, New Zealand and Australia, and Hagopian et al.'s (2004) theoretical study on the migration of physicians from sub-Saharan countries. Furthermore, participating physicians identified the main factors that affected the overall success of their migration move. Their responses mimicked previous empirical studies (Mejia, 1979; Lowell & Findlay, 2001; Ballard et al., 2004; Forcier et al., 2004; Astor et al., 2005; Mullan, 2005 Ogilvie et al., 2007; Buchan, 2008) and identified the following migration success determinants: educational and training excellence in a more advance system

compared to the home country; more opportunities for professional and academic development and the opportunity to combine professional with social experiences development. Thus, based on the evidence of this and other empirical studies it can be assumed that the overall migration outcome for Cypriot physicians is determined by the fulfilment of pre-migration objectives; the personal socioeconomic conditions of the individual; host-home country socioeconomic conditions; the flexibility given for proper prioritisation according to the career progression plan selected by each individual physician, and the ability to balance this career plan with social responsibilities. This approach therefore corresponds with what other researchers (Carr et al., 1998; Boulis & Jacobs, 2008; Poppas et al., 2008) found; that the success of the migrant physician's experience depends on socioeconomic conditions; the 'career progression plan' and proper prioritisation of social responsibilities and professional objectives.

7.4.1 Theoretical and conceptual insights drawn from this study of Cypriot physicians' migration

This current study of Cypriot physicians was grounded conceptually and theoretically on two constructs, "a push pull model" and a "transnational model" of migration. There are a number of variants of these models but the central question is how and to what extent they can be combined to provide new insight on professional migration in general and the migratory experiences of physicians in particular. In this section, the extent to which these models can be combined is discussed.

The key elements found in 'push pull' models are:

- The focus on the individual migrant and more specifically on the motives and causes of migration.

- The assumption that the presence of pull or positive factors that offer the individual migrant certain advantages when compared to their home country and thus attracting potential migrants to a specific destination (Lee, 1966; Ross, 2005).
- The assumption that the presence of push or negative factors in the home country promote migration to another country (Bilsborrow, 1984; Kelo, 2004).
- The assumption that migration flows are dependent on the comparative advantage between a potential destination and the country of origin (Buchan, 2007).
- The assumption that migration flows are dependent on the importance assigned by the individual or household to specific push factors (Dzvimbo, 2003; Dovlo, 2003; El-Khawas, 2004; Kelo, 2004; Buchan, 2007).
- The assumption that migration flows are dependent on specific demographic characteristics of potential migrants such as age, sex, presence of dependents and marital status (Dzvimbo, 2003; Dovlo, 2003; El-Khawas, 2004; Kelo, 2004; Buchan, 2007).
- The assumption that any comparative advantage should have been significant enough to outweigh the strong natural desire of the individual to remain in their home country (Ojo, 1990).

The key elements in transnational migration models are:

- The focus on the migrant's experiences and movement in an international context.
- The assumption that activities and routines performed by the individual migrant are not based permanently in one country and that following the decreased costs in transportation and communication, the mutual recognition of qualifications and the 'dismissal' of national borders (i.e., EU), the migrant is able to maintain social and economic links in both the host and home country (Gerlinger & Schmucker, 2007).

- The assumption that individual migrants can be incorporated into the host country, sustaining at the same time transnational connections to the home country (Glick-Shiller, 1999).
- The assumption that professionals, including physicians from the 1990s, tend to move frequently, in a circulatory manner, between a number of countries or places where they have social or economic ties (Castles & Miller, 2003).

The combined use of the ‘push and pull’ model with the transnational migration model facilitated the examination of the migratory experience of Cypriot physicians using a contemporary lens. Drawing on the analysis of participants’ responses in this current study and the constant comparison of these responses with findings from other empirical studies, a theoretical framework to understand the migration experience of Cypriot physicians was constructed. This framework comprised six broad elements, these were: push factors; pull factors; retention factors; return factors; gender role; and migration impact role on the process. These various elements were combined to produce a model of the factors that affect the decision-making processes for Cypriot physicians’ migration. This model is presented in diagrammatic form in Figure 3 below.

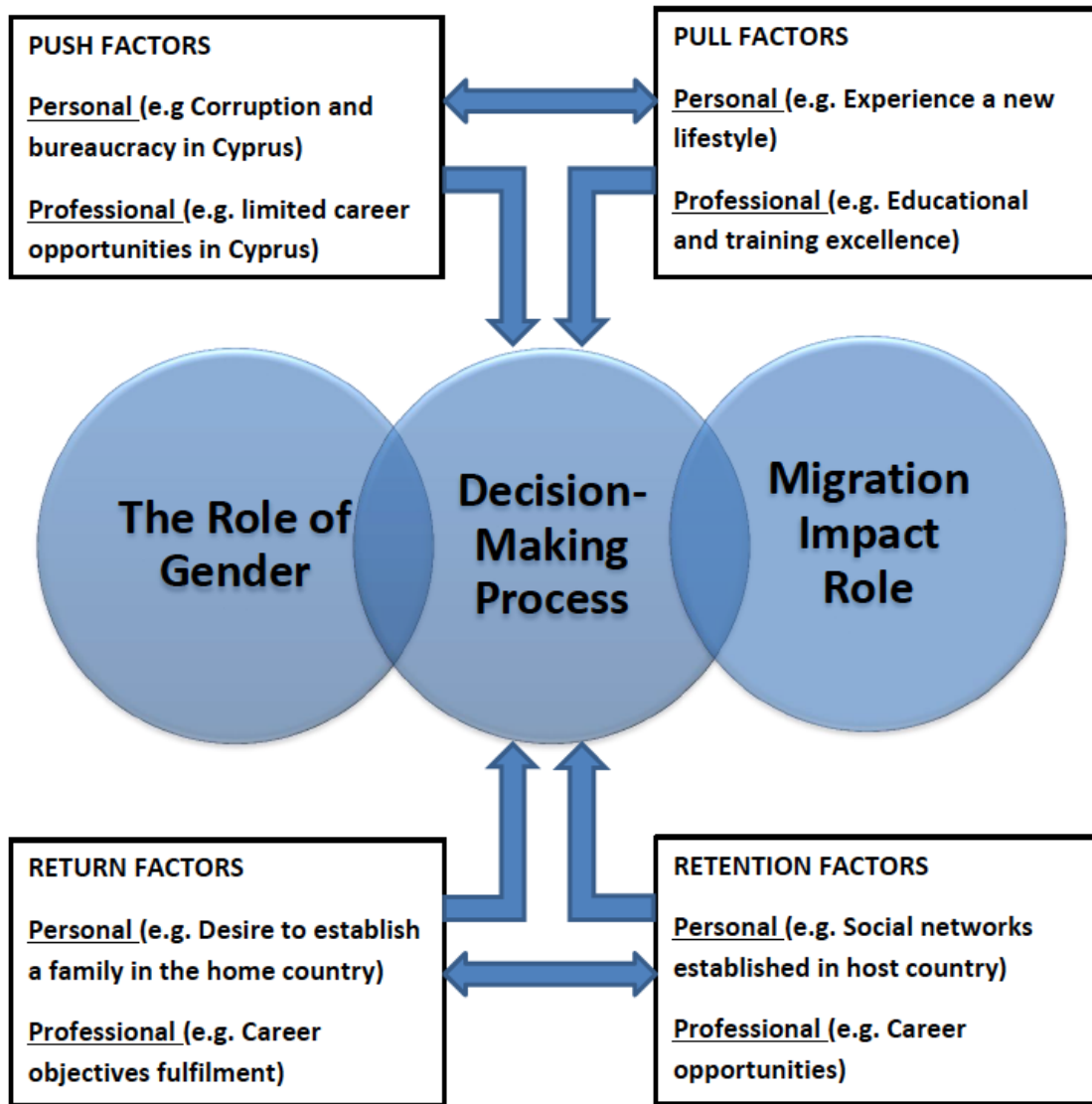


Figure 3: Empirical Model of the Factors Affecting the Decision-Making Processes of Physicians Migration

As can be seen in Figure 3 above, the ‘push and pull’ elements of this model represent contrasting forces. Push factors refer to the negative conditions present in the home country that promote migration to another country with more favourable conditions; whereas pull factors refer to the positive conditions present at a particular destination that may attract migration. Similarly, ‘retain and return’ elements refer to two contrasting conditions. Specifically retain factors refer to the factors promoting a prolonged stay of a migrant in the host country, whereas return factors refer to factors that may attract an individual migrant to return to their home country.

The inclusion of gender in the model was recognition that whether a physician was male or female will potentially affect the selection of destination and the duration of the move for the individual migrant. In addition, the presence of, to a greater or lesser extent, gender bias in the profession and specific gender constructions in either the home or the host country, will impact on the individual's response to specific migration stimuli (i.e., push-pull and retain-return factors).

Lastly, the migration impact element recognises how previous migration might have impacted in a way that altered the flows and direction of contemporary migration. For example, the presence of a Cypriot network in the UK resulted from earlier migration flows might act as an additional attraction point and thus act as a pulling factor for contemporary Cypriot migrants drawn to the potential for an easier adjustment in a foreign country with Cypriot presence.

Each of these elements in the model contributed to an understanding of physicians' migration. The importance for, or effect of, each element on a migrant or potential migrant cannot be isolated easily from the others as the elements combine dynamically. The challenge here is understand to what extent these six elements can be weighed and combined.

7.4.2 Understanding the empirical model developed based on the migration experience of Cypriot physicians

First, there was a need to identify the major factors affecting the migration decision-making processes of Cypriot physicians, which comprise of the individual elements of the empirical framework. The analysis of the responses by participating physicians supports the explanatory force behind the 'push-pull' model in so far as these two groups of factors, the push factors and the pull factors help to understand the decision-making processes adopted by individual Cypriot physicians about whether to migrate abroad for study,

training or work. As the individual physician facing unfavourable conditions in their home country is 'pushed' to migrate abroad; whereas a potential destination country, offering more advantageous socioeconomic and professional conditions, could 'pull' an individual physician to migrate. Therefore, the first step in understanding the mechanisms that initiate and sustain migration flows and direction is to identify and examine the major push factors that drive an individual away from their home country and the main objectives and conditions that the individual physician seeks to fulfil through migration. Through the responses of this study's participants the most frequent factors in relation to the promotion of migration of Cypriot physicians abroad were identified. These factors included:

- the availability and status of medical education and associated infrastructure;
- entry requirements and educational/training costs;
- the availability and excellence of post graduate and specialty training;
- the availability and access in training posts;
- the structure of secondary education in Cyprus promoting studies abroad;
- social experience and travelling; potential career opportunities and prospects;
- the availability and access to research opportunities and appropriate research infrastructure;
- degree of remuneration during placement or work;
- the opportunity given to averse undesired socioeconomic conditions and
- the impact of the close society and social pressure in Cyprus.

The decision made by an individual Cypriot physician to extend their stay abroad or return to Cyprus was found to be dependent upon the conditions they developed and changed in both their home and host countries throughout the migration process. Therefore, the reference to retention and return factors signifies the importance of the conditions in the home and host countries, as well as the degree of fulfilment of specific objectives set prior

to migration in relation to the decision-making process of the individual and the course and outcome of the migration process. The most frequent and unique factors in relation to the promotion of return or extended migration identified by the majority of participants were: the presence of a partner and/or dependants while in the UK; informal support; care responsibilities; family establishment; career objectives fulfilment; homesickness; better quality of life; acquisition of personal property in Cyprus; opportunities for volunteer work; context of training and professional or educational barriers.

Furthermore, the individual's migration decision-making process was found to be dependent on their gender and the degree of gender bias in the medical profession, as well as in the society of their home and/or host country. More specifically, this current study's participants identified that the individual's migration decision-making process was highly dependent upon: personal orientation towards career development and family establishment; the feminization of medicine in the home/host country; the presence of gender specific societal norms; the capacity for male and female physicians to select a similar career path; the presence of equal opportunities for male and female physicians for studies, training and work at the desired destination and in their home country.

In addition, through participants' responses it was also identified that the impact of earlier migration on the healthcare system potentially affected their decision-making processes. More specifically, Cypriot physicians identified that their decision to migrate abroad was mediated mainly by the further deprivation of local conditions caused by the negative consequences of migration on the healthcare system, such as the loss of distinguished physicians able to promote research and development or mentorship to other physicians. The opposite seemed to be the case with the positive impact of migration, where for example new skills and knowledge 'transferred' to Cyprus by returning physicians improved local conditions.

Second, there was a need to identify particular trends or emerging patterns in relation to the main elements of the empirical framework. Through the responses obtained it was identified that participants seemed to assign different weight to different 'push-pull' and 'retention-return' factors based on: individual traits; different objectives; socioeconomic and family status. In addition, through participants' responses these migration factors seemed to fall in two broad categories; professional and social factors. The decision-making process of the individual Cypriot physician seemed to be affected by personal push factors such as: predisposition for studies abroad through the local secondary education structure; the drive to experience new cultures and the opportunity to avoid unfavourable social conditions in Cyprus (e.g., pressure from family; bureaucracy). In addition, Cypriot physicians' migration decision-making processes seemed to be affected by a number of professional push factors. Amongst the most important professional push factors were the absence of specialty training and limited opportunities for career development. Other professional push factors such as: low remuneration during training; high physicians density and poor professional governance were also identified but seemed of less importance as only a few of participants mentioned. Nevertheless, pull factors seemed to be the major driving force for the individual physician's decision to migrate abroad. More specifically, the majority of participants considered professional pull factors such as the opportunity for education, training and professional experiences in a world-renowned system as the major factors for migrating abroad and specifically to the UK. Other factors were also identified in a much lower frequency. For example, participants identified personal pull factors such as the opportunity for travel and gaining social experiences and networking as factors affecting their decision-making processes. From the total range of responses it was apparent that the majority of participating physicians assigned greater weight to professional pull rather than personal push factors in their decision-making processes to move abroad.

Similar to the push-pull elements, the weight assigned to each factor differs between each participant based on the specific characteristics and conditions at the time they were examined. The decision of Cypriot physicians to return to Cyprus was mainly dependent on the improvement of conditions in their home country and in most cases it was dependent on the fulfilment of the initial migration objectives. Besides the fulfilment of participants' migration objectives, it was also identified that the factors given the most emphasis in the decision to return were particularly the establishment of a family while living in their own country and close to family and friends to ensure a better quality of life for themselves and their dependents. These personal factors were given more importance than professional factors in Cypriot physicians' decisions to return.

Third, through participants' responses in relation to the factors affecting their decision-making processes, it was identified that there was a connection and interaction between different migration elements. Thus, the other objective of this empirical model was to identify how the two decision points, to migrate or return, were affected by the other elements identified in this model; gender and migration impact.

Even though migration stimuli were examined in isolation, the migration decision-making process was a more complex matter that can be affected by factors specific to each individual such as: the individual's orientation towards career and family; the presence of a partner in the home or host country; the presence of dependants or family in either the home or the host country as well as factors such as age and marital status. For example, the presence of a partner living and working in the UK might have affected the way that the individual physician reacted in the retention-return factor. Consequently, the fifth element in the model integrates gender as a dynamic force that can mediate the operation of other elements in the model. From the empirical evidence of this current study and the published literature, it was evident that although male and female physicians may respond in a similar manner to 'push-pull' and 'retain-return' factors, the physician's gender could

affect the migration decision-making process in relation to: destination selection; return to the home country; re-migration, or extended stay abroad.

In addition, the final element of the model recognizes the role of migration impact on the migration decision-making process. As identified through the literature and the empirical evidence in this current study, physicians' migration could have a great impact both on the host and home countries, as well as the individual migrant and non-migrant physician. As noted in detail in previous chapters, physicians' migration depending on the time and context of each country examined could have positive or negative effects on the financial, human resources' and health system's efficiency in both host and home countries, as well as on the socioeconomic status and professional development of the individual physician. Therefore, it can be concluded here that the resulting impact of physicians' migration could alter conditions in the home and host country and thus the migration stimuli that initiated migration in the first place (i.e., push-pull and retain-return factors) as well as the objectives and prioritisation of the individual physician.

Consequently, the empirical model that emerged can be utilised for the better understanding of the 'push-pull' and 'retain-return' factors that initiate and sustain contemporary migration in a transnational society based on 'push-pull' and transnational migration models and their particular assumptions as identified above.

In addition, the researcher aimed to analyse the dynamic relationship between the migration-related processes and international or local developments (e.g., EU enlargement, economic crisis in Cyprus) and social transformations (e.g., feminization of medicine). Specifically, the researcher attempted to offer a better understanding of the decision-making processes of Cypriot physicians with regards to the factors that pushed them away from Cyprus and the factors that pulled them towards a particular destination and vice versa. In addition through this current study the researcher examined how gender mediated

the decision-making process at its different stages, including the initial decision to migrate as well as the subsequent decision of the individual to remain abroad or return to Cyprus. Furthermore, the responses obtained in this current study and the empirical model developed allowed for identification of the impact of migration and its interactions in the individual's migration decision-making process and thus contributed the required empirical evidence to evaluate the outcome of Cypriot physicians' migration flows. Consequently, the analysis of physicians' migration at the level of the individual Cypriot physician allowed this study to examine Cypriot physicians' migration decision-making process, its constituents and their interactions beyond the theoretical level. This thus allowed for a better understanding of Cypriot physicians' migration flows and direction. As a result, this current study identified that local authorities and relevant bodies in Cyprus will need to proceed with improvements in:

- Working conditions with emphasis on education and training.
- Management of health human resources (i.e., monitoring of migration flows, identification of gender specific traits and trends).
- Elimination of gender bias in the medical profession.
- Infrastructure (i.e., research infrastructure, facilities).

Addressing these matters combined with empirical evidence similar to the findings in this current study could provide a better professional environment for Cypriot physicians, as well as the potential for evidence based and efficient migration management policies.

The next chapter presents the potential positive and negative impact of migration on the host and home country, as well as the individual physician as identified through this current study's findings and other empirical studies with the aim of examining ways to maximise the positive outcomes of migration. Once the migration impact is discussed, a model is presented for the efficient management of Cypriot physicians migration developed through this current study's findings and through an analytical review of the

available empirical studies. Furthermore, the next chapter provides suggestions to policy makers for achieving improvements in the aspects identified above, again based on the findings from this current study and the available literature.

Chapter 8: Cypriot Migration, Policy Impact and Conclusions

8.1 Introduction

In retrospect, the realisation of the initial aim of this current study has raised a larger question: How can decision-makers and relevant responsible bodies evaluate the results of this study for the proper monitoring and management of Cypriot physicians' migration? Through the analysis of data obtained from participants' responses, this current study identified the role of 'push-pull', 'retain-return' factors and gender in the migration decision-making processes. Findings here therefore confirm that migration in its transnational form shaped following the 1990s can be influenced by the 'push and pull' factors that form the personal cost benefit equation of each individual physician, always according to the socioeconomic and political context at a specific time point.

What was extracted from the theoretical and empirical literature was that the main target of any migration management policy should be to properly manage physicians' flows in and out of the home country. Thus, the main objective of any migration management policy should be to realize all those positive outcomes of migration (e.g., transfer of knowledge; research development) in the delivery of healthcare services, while averting any negative consequences caused by physicians' migration (e.g., physicians' surplus, absence of specific specialties). As Skeldon and Saskia (2007) observed, appropriate physicians' migration management should not focus on restricting physicians' movement across countries. Instead they argued, physicians' migration management should focus on the upgrade of local conditions in such a way to aid domestic physicians to utilise their skills and potential so they can thrive professionally, subsequently improving the capacity for development of the local healthcare system. As was identified through the views and experiences of participants in this current study, Cypriot physicians and health care managers had a similar approach to the one depicted in Skeldon and Saksia's (2007) study.

Thus for the best possible evaluation of the local conditions and the development of the most appropriate migration management policy, there is a need to fully comprehend the potential positive and negative impact of physicians migration on the healthcare system and the role of local medical schools in the process.

This chapter therefore was divided into four sections. The first section explores the impact of physicians' migration on the Cypriot healthcare system and how the establishment of medical schools in Cyprus could affect the migration flows. The next section offers a framework for the analysis of the challenges and parameters affecting contemporary physicians' migration for its efficient management, developed on the empirical and theoretical findings from this current study. Section three presents a number of recommended adjustments and policy responses derived through this current study's theoretical and empirical literature review and empirical findings. The last section of this chapter provides the limitations along with further research suggested and a closing remark on this current study.

8.2 Impact of Migration

The impact of Cypriot physicians' migration on the Cypriot healthcare system could be entirely positive or negative or perhaps more probably mixed with negative and positive features. What can be ascertained here is the complexity of trying to accurately represent the impact of physicians' migration due to interplay between a range of factors that affect both the host and also home countries. This view is shared by a number of contemporary migration scholars (Glick-Schiller, 2003; Stark, 2004; Skeldon, 2005; Dodani & LaPorte, 2005; Asabir, 2009). The factors identified were: host and home countries socioeconomic conditions (Krieger, 2004); the overall density of physicians per unit of population and density in specific specialties (Malik et al., 2010; Young et al., 2010), health resources management and distribution (Mackay, 1969; Forcier et al., 2004; Dobson, 2009) and home and host countries ability in terms of infrastructure and willingness in terms of

management and policies to accept changes and accommodate new approaches, skills and technology (Martineau et al., 2002; Kaneto et al., 2009; Kodama et al., 2011).

In this current study, the positive impacts of physicians' migration were identified. Through participants' responses it can be argued that the transnational movement of physicians provided the opportunity for the transfer of new ideas and approaches in their home country's healthcare system upon return. Hence participants' views seemed to follow a similar approach to other studies (Dodani & Laporte, 2005; Assabir, 2009) focusing on the positive nature of physicians' transnational migration and supporting the view that migration can assist skills and knowledge transfer to the home country. Therefore, through the responses obtained it can be further argued that the positive impact of physicians' migration lies on: local conditions and healthcare needs at the time; the developments of the local healthcare system's infrastructure to accommodate returnees and allow them to reach their full potential; and the introduction of new approaches, skills and knowledge carried by returning physicians. This approach therefore seemed to be in accordance with other similar studies (Forcier et al., 2004; Astor et al., 2005; Akl et al., 2008a) supporting the view that migrant physicians' return or frequent circulatory movements in the home country could benefit from the transfer of knowledge, skills and technologies, as well as professional experience.

What can also be concluded from participants' responses and observations is the opportunity for local authorities to decrease their expenses and increase their earnings through the permanent return or circulatory movements of Cypriot physicians specialised in specific areas that Cyprus might need at particular points in time. More specifically, public healthcare expenses could be decreased through treatments conducted by Cypriot specialists as opposed to sending the patient abroad, and be combined with increased public earnings from the relevant taxation on the physicians' and healthcare facilities' earnings on these treatments. A similar approach was identified in a number of other

empirical studies. For instance Mackay (1969), Astor et al. (2005) and Giannarou (2009) supported the claim that the return of migrant physicians could provide opportunity for the home country to utilise the investment made through governmental financial support of physicians' education and increase public earnings through the enhanced collection of associated taxes i.e., income tax.

To counter these positive impacts negative impacts were also identified. Through participants' responses it can be argued that the negative effect of migration represents the exact opposite outcome from the return or circulatory movements of migrant physicians and the improvements they could bring about. It can thus be concluded that the loss of distinguished and already established physicians abroad, or the unwillingness of others to return to Cyprus, can lead to deprived healthcare delivery services and great economic loss. More specifically, it can be argued that long-term absence of Cypriot physicians abroad can constrain healthy competition and restrict the capabilities for innovation and local medical research, thus limiting further development prospects for the Cypriot healthcare system. What can also be concluded through participants' responses is that the long-term absence of distinguished Cypriot physicians can contain government earnings mainly from income taxes (from treatments made locally) further leading to the export of currency through treatments for Cypriot patients conducted abroad. Furthermore, consequent to this export of Cypriot patients abroad, allied health professionals can face unemployment. Thus as expected, this view is in direct contrast with the positive aspect of migration identified in a number of responses and in contrast with what was found in Mackay (1969), Astor et al. (2005) and Giannarou (2009). Furthermore, and according to Malik et al.'s (2010) study, it can be argued that the long-term absence of distinguished Cypriot physicians abroad can lead to frustration from patients and remaining physicians and other skilled healthcare workers mainly due to the consequent absence of desired specialties and work overload. Indeed, Malik et al. (2010) added that frustration amongst

remaining healthcare professionals can lead to a lack of motivation and restrained potentials, consequently leading to diminished quality and efficiency of the local healthcare delivery system. In addition, Mackay (1969) took this approach a step further and noted that the effect of deprived quality of healthcare services can lead to decreased overall economic development, as resources and human capital might be improperly distributed or underutilised. The approach of participants in this current study was reflected in a number of other studies. More specifically (Astor, 2005; Akl et al., 2008a; Kaushik et al., 2008; Syed et al., 2008; Giannarou, 2009; Jenkins et al., 2010), noted that physicians who decided to leave the home country or decided to stay abroad for long intervals were usually the most distinguished. Thus Cyprus' potential to improve the local healthcare system's capacity could be restricted, consequently limiting the system's expandability and development.

Another conclusion made through participants' responses was that the potential benefits that return migration could bring to the Cypriot healthcare system could not be fully realised as a consequence of the bureaucracy and unprofessionalism still present in Cyprus making it difficult to incorporate new knowledge, skills and technology. In support of this view, Brown & Connell (2012) argued that young physicians with newly acquired skills and up-to-date knowledge were unable to transfer those skills as a result of red tape and nepotism in their home country.

While it is difficult to weigh the respective merits of the positive and negative impact of Cypriot physician's migration, it is beyond doubt that the extent of migration has prompted discussion about the need for medical schools in Cyprus. Participants in this current study expressed strong support in favour of the establishment of medical schools in Cyprus. The reasons for this support were articulated in relation to a range of benefits that the establishment of these schools could bring, such as: the enhancement of medical research; the development of teaching hospitals; the opportunity for local training in a number of

specialties absent at the time of study and the availability of a lower cost option for potential medical students compared to studies abroad. As Hwang (2005) commented, the formation of a medical school in any country would in all probability lead to universal benefits both to the healthcare delivery system as well as benefits to society. Pericleous (2011) expressed a similar view stating that the establishment of a Cypriot public medical school could improve research as well as educational and healthcare services' development capacity and facilitate context specific training and specialisation in a greater number of specialties. Given that physicians in this current study had little choice about whether or not to migrate if they wished to pursue their medical careers; the establishment of medical schools of sufficient quality in Cyprus could lead to an expectation that outbound migrant flows would be reduced. There is strong support for this presumption in several empirical and theoretical studies (Harrison, 1998; Marchal & Kegels, 2003; Norzini & Mazmanian; 2005; Hallock et al., 2007; Kaushik et al., 2008a; Arah et al., 2008), which identified that the capacity of a country to offer high quality medical education through an established medical school will influence physicians' migration flows and direction.

One possible assumption could therefore be that the establishment of a medical school would have attracted migrant Cypriot physicians to visit Cyprus more frequently or to encourage the return of Cypriot migrant physicians to train Cypriot medical students and physicians. Another assumption could be that the presence of a medical school and teaching hospitals would act as inducement for migrant Cypriot physicians to return to Cyprus to become involved with local medical research. An option not previously available, that could enhance the quality of the Cypriot healthcare system while increasing the inflow of Cypriot physicians and moderating medical students' migration flows. Additionally, some participants supported the establishment of local medical schools because they could offer an additional lower cost option compared to alternatives abroad for the potential medical student to study in Cyprus. Hallock et al. (2007) shared these

participants' views and noted that one of the major factors affecting the migration decision-making process of an individual medical student or physician was the availability of low cost medical education and training. Furthermore, the establishment of these medical schools, as participants argued, could offer the opportunity to keep locally qualified physicians in their home countries and attract an even greater number of students to medicine. Therefore, potential Cypriot physicians that could complete their undergraduate medical education in Cyprus would possibly stay to train and work in Cyprus with all the associated benefits. For example, further development and increased capacity of the local healthcare system and the subsequent increase in government earnings through direct and indirect taxation of these physicians. In support of this current study's findings Akl et al. (2008a) argued that a physician will most probably stay in the country of study to train and work as this will allow for an easier professional and social adjustment. Therefore, what can be argued here is that the introduction of Cypriot public medical schools can decrease physicians' migration out-flows while increasing the number of Cypriot and foreign physicians in Cyprus overall.

Nevertheless, participants identified that the establishment of medical schools in Cyprus can also lead to a surplus of physicians with complex consequences. The approach of participants' is therefore in line with what Ioannou (2010) and Pericleous (2011) described as a risky and costly decision to form a public medical school in a country with a small population such as Cyprus, which for the last 50 years has covered its requirements from returning Cypriot physicians that studied and/or trained abroad. Therefore, the positive or negative impact of these developments will be dependent on the needs of the Cypriot system at the given time and the availability of physicians in particular specialties. Thus according to these participants, a potential surplus of physicians could lead to: medical unemployment; frustration in remaining physicians and in some cases deskilling or even

extended physicians' migration. This view was echoed in Kassak et al.'s (2006) and Akl et al.'s (2008a) studies.

It can therefore be concluded that following the establishment of these medical schools and the transnational nature of contemporary migration there will be a need for proper management of physicians' demand and supply through constant monitoring of the flows of inward and outward physicians' migration and the number of applicants and graduates of Cypriot medical schools. Thus, these flows will need to be balanced with the available resources and requirements of the local healthcare system in relation to patients' needs and the number of physicians and specific specialties in demand. To achieve this there is a need for the establishment of context specific mechanisms for the proper monitoring and management of physicians' flows and direction, as well as a need for the participation of all parties involved in the physicians' migration or affected by it.

8.3 Migration Management: Introduction and Suggested Model

Following the analysis of the migration impact in the previous sections it is worth noting that implementation of efficient and evidence-based policies could improve the socioeconomic and professional conditions for the individual physician, therefore enhancing the national healthcare system's capacity and development. For this purpose this section provides a suggested model for the analysis and efficient management of physicians' migration as depicted in Figure 4 p.233. Using the suggested empirical model for the analysis of the empirical data collected through fieldwork in this current study, combined with the analysis of the available empirical and theoretical literature, this study led to a range of recommendations for the development of proper physicians' migration management policies. This current study can therefore facilitate the construction of a roadmap for Cypriot policy makers for appropriate policy implementation and

modifications to the healthcare system to create the desired conditions for the maximisation of physicians' migration benefits offsetting any potential negative impact.

Initially, this current study's findings suggested that in the absence of adequate data on migration flows of physicians, an efficient mechanism should be implemented for the proper documentation of potential flows of human health resources and the efficient control of physicians' density according to national healthcare requirements. Allied with this mechanism, the findings identified the need for efficient recording and management of financial and human resources' distribution. This was especially important in an unstable socioeconomic environment following the Cyprus financial crisis, which reached its peak in 2013 and the fiscal regulations and restrictions implemented by the Troika (European Commission, European Central Bank and the International Monetary Fund) (Chen & Lu, 2016). Moreover, the empirical evidence in this current suggested that the Cypriot Ministry of Health should incorporate the positive and negative impact of physicians' migration on the healthcare system and the individual physician in the evaluation and development of physicians' migration management policies.

Another suggestion generated from the findings in this current study is the need to make the most of the latest establishment of medical schools in Cyprus. Therefore, having in mind the weaknesses identified in the educational and training system of Cyprus, the Ministry of Health and appropriate decision-making bodies should: appropriately develop a context based curriculum; consider and adjust accordingly the number of educational and training posts available, and evaluate and promote the proper development of the necessary medical research and specialty training infrastructure. Furthermore, with the comprehensive establishment of the national healthcare scheme in three phases commencing in 2017, evidence suggested that the Ministry of Health should utilise available resources offered through the private sector for optimising the delivery of services, training and research. Simultaneously, the Ministry of Health should establish a

policy approach that will promote equal professional opportunities for males and females, as well as young and established physicians, for the most efficient allocation and least possible waste of human resources and duplication of services.

Therefore, the development and implementation of appropriate migration management policies should be based on empirical evidence as well as the specific context and needs of the Cypriot healthcare system. To accomplish this, the main decision-making body in Cyprus, the Ministry of Health, should incorporate the data collected by the available and proposed regulatory and recording mechanisms, as well as constructive feedback on the local needs provided by: education and training institutions; context related empirical research and the appropriate health indicators of the local healthcare system.

Furthermore, and following the implementation and development of any migration management policy, there should be proper monitoring of its impact and the need for any further development or adjustments. Therefore, feedback mechanisms and regulatory bodies should be in place for the proper communication of policy outcomes back to the decision-making body. These empirical findings and suggestions are depicted below in Figure 4, which presents the different variables and their connections in the migration management process that can be used for the analysis of local needs and challenges and thus the implementation of custom policies at particular points in time.

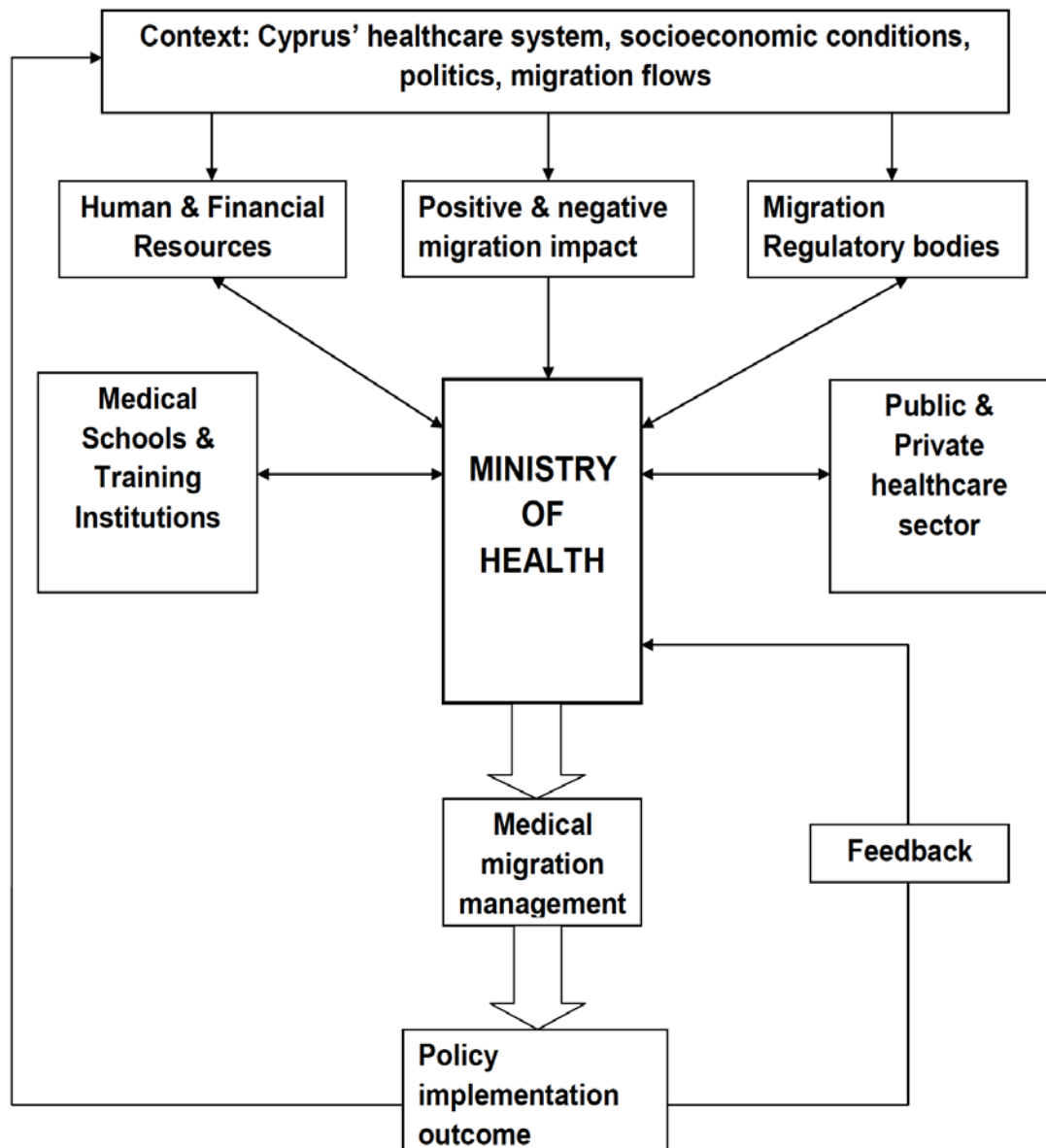


Figure 4: Suggested Model for the Analysis and Efficient Management of Physicians' Migration

8.3.1 Migration management: suggested policy responses on Cypriot physicians' migration management

The analysis of physicians' migration at the level of the individual physician identified that the migration decision-making process could be affected by: 'push-pull' and 'retain-return' factors; the gender of the individual; and the positive and negative impact of physicians' migration on the individual, as well as the home and host country's context. Therefore, what was suggested here was the need for proper monitoring of physicians' density, skill-mix and physicians' migration flows; the improvement of local conditions to fit the needs

of the local healthcare system and the individual physician, and the need for proper management of physicians' migration through evidence based policies. As a conclusion, this current study, based on the findings and the available empirical literature, suggested that Cypriot physicians' migration management strategies should reflect the analytical model depicted in Figure 4 above. Therefore, the formation of proper migration management policies should be based on empirical evidence as well as the context and needs of the Cypriot healthcare system and the individual physician. To do this, the Cypriot Ministry of Health, acting as the main decision-making body, should first of all be able to evaluate at any time and in light of the socioeconomic conditions present, the actual needs and deficiencies of both the private and public healthcare sector, as well as any deficiencies in medical education and training institutions. Furthermore, it needs to acknowledge the needs of the individual physician and potential professional or gender related restrictions, as well as the financial resources available. In doing so, the Ministry of Health should be able to analyse primary data in relation to job satisfaction, as well as the number of physicians available and how these numbers match local needs. Furthermore, it should be able to evaluate, through the use of data collected by the regulatory and recording mechanisms, whether and how the number of physicians or the local working conditions and the systems' healthcare delivery have been affected within a set period by inward or outward migration. Moreover, the Ministry of Health should be able to evaluate data derived by medical education institutions in relation to the number of new graduates and new entries in the local medical schools. Furthermore it should be able to evaluate data derived by the local training institutions on the number of physicians entering or completing their training in a specific speciality and whether this specialty is in need or in surplus. The availability of these data would facilitate the formulation of proper migration management policy according to the Cypriot healthcare system's context and needs, while considering parameters such as: the required total number of physicians; the skill-mix of

available and migrant Cypriot physicians; the number of foreign or transnational i.e., visiting physicians in Cyprus; the specific specialties in need, and the number of medical students allowed to access local medical schools. Following the implementation and development of any migration management policy there should be proper monitoring of its impact and the need for any further development or alterations that should follow. Consequently, feedback mechanisms i.e., work related/satisfaction indicators, should be put in place for the proper communication of policy outcomes to the decision-making body, which in turn would have to proceed to the necessary adjustments in the local conditions in a cyclical process of checks and balances. Thus, in light of the model depicted in Figure 4 p. 233 above, a number of potential policy responses were suggested for the proper management of the phenomenon.

According to Iredale's (1999) and Mahroum's (2001) studies, migration flows could be facilitated by national, European and international policies and agreements. Nevertheless, they argued that the main responsibility for the management of migration flows is assigned to the national government of each country due to its capacity to modify the migration initiation factors. Furthermore, skilled migration management policies should always focus on demand and supply as well as: proper monitoring and documentation; the placement of specifically targeted barriers to restrict unwanted inflows of migrants, and the attraction of foreign and migrant skilled healthcare workers through special incentives such as special visas and tax exceptions (Hamilton & Yau, 2004; Dobson, 2008; BCC, 2009; Humphries et al., 2015b).

As identified in this current study, Cyprus lacked the proper monitoring and recording mechanisms for the efficient management of physicians' migration. Therefore, Cyprus could promote the establishment of a control and feedback mechanism similar to the UK Border Agency (replaced by UK Visas and Immigration) and the Highly Skilled Migrant Programme, responsible for the efficient data collection, documentation and in most cases

the control of illegal and skilled migration flows respectively (UKVB, 2013; UKVI, 2017). Such recording and control mechanisms would enable the Cypriot government to adjust its overall migration policies more efficiently having access to primary data on the number of foreign skilled migrants entering the country and Cypriot skilled individuals and physicians leaving or returning to Cyprus. Therefore, the establishment of such mechanisms could facilitate the identification of emigrant and immigrant workforce characteristics and facilitate the formulation of accurately targeted migration control policies and continue policy development depending on demand and supply. Such policies could involve the formation of expatriate organisations in specific host countries for the promotion of return migration or local support, monetary and training compensation as well as indirect taxation policies through bilateral agreements between Cyprus and host countries. The establishment of these or other similar policies could therefore enhance physicians' migration benefits to Cyprus in terms of financial gains as well as knowledge and skills transfer.

In addition, as identified in the findings from this current study and the empirical literature, Cyprus faced a high physician density in particular fields and a low physician to patient ratio overall. Therefore, as in the case of the UK and the recruitment of physicians from other countries, to cover local needs as described in Ballard et al.'s (2004) study, the Cypriot Ministry of Health could promote the recruitment of Cypriot migrant physicians in specific specialties through direct agreements with other countries. This approach could be implemented through publishing the specialties in need while providing guaranteed employment and opportunities to potential applicants that could consequently attract migrant Cypriot physicians back to Cyprus. In addition, through the use of an application process the Cypriot Ministry of Health would have the opportunity to select the top candidates amongst potential returnees. Furthermore, every country differs in terms of healthcare context and requirements, and as Forcier (2004) suggested, returning or foreign

physicians could be asked to adapt to the local curriculum in order to be able to work in Cyprus. Therefore, depending on the demand for physicians, and following proper monitoring of physician density, the Cypriot Ministry of Health could assign an adaptation period for physicians coming from the EU or other countries. This approach could facilitate the management of the number of foreign physicians and offer greater opportunities to local and returning physicians depending on the needs of the system at specific points in time while maintaining the consistency of healthcare service delivery. This policy approach, again depending on the available demand and the capacity of local medical schools, could be adapted and applied for Cypriot physicians that studied abroad in order to incentivise study in local medical schools with all the associated benefits depicted in previous sections of this chapter. Nevertheless, an adaptation period should be carefully and appropriately customised as it may discourage Cypriot migrant physicians from returning and depending on local demand it could lead to financial losses and failure to utilise new knowledge and skills. Nevertheless as suggested before, the presence of proper monitoring mechanisms could offset such miscalculations and provide the necessary indicators for policy adjustments. An alternative way to incentivise study in local medical schools could be to increase educational grants offered to Cypriot medical students compared to the grants provided to Cypriot students studying abroad.

Additionally, in an effort to improve the capacity and development of the Cypriot healthcare system, the Cypriot Ministry of Health could aim to attract migrant Cypriot physicians who are able to incorporate new knowledge and skills and alternative approaches to medicine. One way to do this could be through examining empirical evidence similar to this current study, to identify the factors that pull physicians to other destinations and consequently improve local conditions accordingly. In their empirical study on the characteristics and performance of medical students and graduates from Arab countries, Tekian and Bulet (2015) proposed a similar approach to be utilised by policy

makers and again emphasized the need for continuous research through empirical studies and application of their findings to improve the local health and educational system. As an example, returnees could be attracted back to Cyprus through: tax exceptions; improved working and research infrastructure; high remuneration packages; opportunities to work in medical academia, and opportunities for extended free or low cost training in a great range of specialties and sub-specialties. Such policy approaches were echoed in other empirical studies, such as those of Lowell (2001), Castles (2006) and Pena et al. (2010).

In addition, the findings here identified the absence of the required research infrastructure for local medical research, high quality specialty training and training in specific specialties not available in Cyprus at the time of this current study, as primary factors promoting migration as well as extended stays abroad. Thus, in line with the planned establishment of the national healthcare scheme and the establishment of local medical schools, the Cypriot Ministry of Health should concentrate on an efficient public-private partnership and the provision of incentives to the private sector, such as tax exemptions, training subsidies and leasing of public property. An efficient and properly organised public-private partnership could subsequently promote the efficient utilisation of available facilities and resources for the improvement of local education and training, as well as increase the number of qualified local physicians in desired specialties. Similar policy approaches were also identified in other empirical studies such as Gouda et al. (2015) who supported the view that enhancement of local medical education and the availability of specialty pathways could assist in managing the emigration of physicians abroad while enhancing the availability of specialists to cover local needs. Furthermore, through the empirical literature it was identified that there were duplication of services and waste of available resources, consequently leading to unnecessary expenditure and lack of patients' trust in the system. Therefore, a competent public-private partnership could improve the allocation of services and facilitate the maximum utilisation of available financial and

human resources for the highest possible quality of healthcare services, thus increasing the capacity of the system in terms of healthcare services' delivery. As such, a well-managed public-private partnership could: increase the number of available training posts; enhance the quality of services and subsequently recover the patients' trust to the system; minimize public expenditure on patients' treatment abroad in the presence of locally trained specialists, and maximize public earnings from the collection of taxes from physicians during local training and further work in Cyprus.

8.3.2 Migration management: suggested policy responses for gender equality in medicine and migration

Even though both male and female migrants move and behave as a response to certain stimuli or needs, the way they respond and behave to migration 'push-pull', 'retain-return' factors and different socioeconomic conditions differs substantially as a result of personal traits and characteristics (Docquier et al., 2012). Therefore, for efficient analysis and management of female skilled healthcare workers' migration flows, policy development should focus on their needs, personal and professional characteristics and migratory behaviour in a country's specific context (Kofman et al., 2000; Purkayastha, 2005). According to Boyd (2006), female migration is more likely to occur during the intermediate stages of a country's economic development. According to the same study, while the economic restructuring is in progress the education levels amongst female labour increases, consequentially leading to improved opportunities for women, improved gender equality as well as higher professional aspirations and increased capacity to act. Migration outflows therefore decline once the home country achieves high levels of gender equality and economic development that deteriorate the motives that promoted initial migration movement (Boyd, 2006). Therefore, the available literature on migration management policies has observed the importance assigned to the promotion of gender equality in education and training, and women's increased representation in professional bodies and leadership positions.

According to Riska (2001b), despite the increasing number of women in medicine and physicians' migration, the presence of gender inequality in medicine could potentially limit career progression for female physicians. According to Longo and Straehley (2008), in order to achieve gender equity there is a need to pursue specific policies that are easy to implement, avoid attitudes and imagery that devalue female physicians, and promote equal opportunities and treatment for female physicians. Several researchers (Bickel et al., 2002; Hansen, 2003; Longo & Straehley, 2008; Butler & Mason, 2010; Sexton et al., 2012) suggested that the easiest way to achieve gender equality in medicine is through straightforward amendments. According to these researchers such amendments could include the revision of medical curriculums, the adjustment of several courses that promote gender bias and the promotion of courses and teaching that engulf gender sensitivity and gender equality. Jonasson (2002) argues that proper development of medical schools could establish the essential foundations that could promote gender equality and diversity in medical academia and provide equal opportunities for female physicians. Moreover, institutions offering medical education and training could impose clear recruitment procedures and evaluations through the establishment of procedural norms that promote equal treatment and opportunities for professional development in spite of gender (Longo & Straehley, 2008).

As identified in the available literature, policy makers have struggled to decide the appropriate form of compensation for the potential problematic re-integration of female physicians in the medical labour market following maternity leave (Serrano, 2007; Mobilos et al., 2008; Kaneto et al., 2009). According to several studies in the USA and Canada (Lyon, 2002; Levinson & Lurie, 2004; Whitcomb, 2004) concerning the effects of medical feminization on the medical profession, healthcare systems and medical education, health policy planners should implement appropriate strategies to eliminate re-integration issues. Therefore, policy makers should offer higher flexibility in working time/schedules

as well as greater incentives and support for female physicians' career development. Such improvements could potentially improve female physicians' career success and experiences in the field of medicine (Lyon, 2002; Levinson & Lurie, 2004; Whitcomb, 2004). Moreover, a number of similar studies (Young-Shumate et al., 1998; Kane-Berman & Hickman, 2003; Borman, 2007; McPhillips et al., 2007) identified additional measures that could further minimize reintegration problems. According to these studies, health policy planners should be able to provide: appropriate maternity and paternity leave; training of female physicians on networking techniques; an open discussion between program directors and directly related physicians; flexible training/curriculum and on-site childcare and support groups. In addition, health policy planners could offer more immediate solutions similar to the example of Japan. The Japanese government, in an attempt to improve the working conditions for female physicians, initiated a scheme where female physicians on leave were recruited to form a human resource bank and part-time female physicians were employed to provide outpatient services only. The implementation of this scheme thus allowed additional time for the required female physicians' social responsibilities (Kodama et al., 2011).

Poppas et al. (2008) suggested that the way to alleviate gender inequalities in medicine and avoid the diversion of female physicians away from specific specialties and towards migration is to assign greater emphasis on the proper utilisation of empirical data by policy makers and health institutions. Therefore, several researchers (Kofman et al., 2000; Purkayastha, 2005; Kofman & Raghuram, 2006) argued that policy makers and future migration research should focus on analysing and incorporating female skilled migrants' needs and experiences. This modernised skilled migration management model could therefore offer better understanding of skilled migration trends for both genders.

8.4 Limitations of this Current Study

Following the design and development of this current study a number of practical limitations were identified. This section therefore reviews the limitations of this current study as well as a number of ways to alleviate them in future research. Initially, responses in this current study were obtained from three distinct groups: Cypriot migrant physicians in the UK that were either training or working in the UK; Cypriot returning physicians that studied in the UK and were working in Cyprus; and health care managers that studied in the UK and were working in Cyprus. However, the range and quality of data could have been enhanced if the study had included and compared the experiences of a sample of migrant and returning physicians that had studied or trained in other countries other than the UK.

Furthermore, this current study utilised qualitative research methods and semi-structured interviews with participants within the context of the UK and Cyprus at a single point in time on the factors affecting migration decision-making and the role of gender in the process. While this approach facilitated an in-depth examination of the migration factors and the role of gender in the absence of previous empirical studies, other critical issues such as the impact of migration, the effects of specific established migration policies and Cyprus' accession in the EU were not thoroughly investigated mainly due to time restrictions. Therefore, this current study could have been enhanced if it incorporated official statistical and empirical data on the impact of Cypriot physicians' migration on the: Cypriot healthcare system's health indicators; number of specialties affected the most, as well as the impact on non-migrant physicians and allied health professionals consequent to the migration of their colleagues. Furthermore, the range of data could have been enhanced through comparing potential alterations in the migration flows and direction of Cypriot

physicians prior to and after Cyprus' accession in the EU. This could have proved beneficial for the proper assessment of contemporary migration, including the need for improvements in local conditions in relation to other EU countries. Additionally, in light of the main migration drivers identified in this current study, there could have been more extensive assessment of the economic and other requirements of the context related migration management policies suggested here, as well as any potential barriers to their implementation. Furthermore, based on the Cypriot healthcare system's and Cypriot physicians identified needs, the suitability and effect of these proposed policies could be further validated through a more extensive empirical study assessing paradigms and data from countries that had already established similar policies. Lastly, the specific time-period of this current study's fieldwork restricted the ability to accurately include the effects on the migration flows and direction of Cypriot physicians following the establishment of the first medical schools; the upcoming establishment of the national health system and the downturn of the local economy following the EU financing program implementation.

Lastly, the selection of participants was based on purposive sampling according to specific pre-set criteria suitable for this current study, with snowball sampling used to enhance the number of participants. Therefore, and according to Black (2003), this did not allow for equal chance to be selected for each member of the study's population. As such, the selection of this specific sampling technique even though it offered unique insights was based on the pre-set criteria and facilitated a degree of moderate generalization, which limits the ability for generalising the study's findings to other populations and professional groups or other countries. Nevertheless this type of generalization used in this current study did not intend to produce statements that could hold over time, over a range of cultures but to generate a number of testable hypotheses. Therefore, any generalization in this study produced "testable propositions that might be confirmed or refuted through further evidence" (Payne and Williams, 2005, p.297).

Furthermore according to Payne and Williams (2005), this type of moderatum generalization is limited on generalizing these “testable propositions” dependent on the study’s nature and scope; in this case the context of Cyprus and the UK as well as a specific group of Cypriot physicians who studied, trained and/or worked in the UK. Therefore, in order to confirm or refute the hypotheses produced in this current study there is a need for further expansion of the sample through less limitation in the sampling approach. Hence, fewer selection criteria during sampling and the use of standard questionnaires could facilitate the inclusion of a greater number of participating physicians as well as participants of different age, socioeconomic and educational background who can confirm or refute the hypotheses produced in this current study respectively.

8.5 Further Research Suggested

Overall, this current study contributed to an identified gap in the available literature about Cypriot physicians’ migration. It has provided in-depth investigation and new insight on the factors that affected the migration decision-making processes of Cypriot physicians as well as the role of gender in this process. Nevertheless, it was identified through here that in addition to the perspective of the individual physician there is also the need to include political, institutional and economic perspectives. Furthermore and in line with the identified limitations of this current study there is a need for a cross-country, longitudinal study that will include participants that migrated, studied and worked in other countries besides the UK. This type of study could facilitate enhanced analysis of migration factors, especially factors ‘pulling’ physicians to other destinations that may differ from the ones identified in the UK. Furthermore, a cross-country longitudinal study could examine any potential deviation in responses through a greater period of time, as well as wider comparison and crosschecking of responses as this current study was limited to four months of data collection and 30 participating physicians. In addition, a quantitative study based on random sampling could offer the opportunity for a more extensive and

representative sample with the opportunity for testing the hypotheses and concepts formulated through this current study. Lastly, in the absence of previous experience or other empirical studies, further research should focus in depth on the effects and challenges from the establishment of the first three medical schools in Cyprus in 2011 and 2013, and the upcoming establishment of the national healthcare scheme in 2016. At this point, it is important to note that the full effect of the establishment of a public medical school would not be completely unfolded up to the qualification of the first graduates, taking a minimum of five to ten years (Pond & McPake, 2006). Thus for any accurate conclusions on the actual effects and subsequent political actions, there is a specific time that is outside the study's timeframe that would have to be investigated in future studies.

8.6 Concluding Remarks

As identified through the literature and empirical evidence, the main issues faced by the Cypriot healthcare system were the: absence of a full coverage national health scheme; limited educational and training capacity of the system; lack of proper public-private sectors' cooperation; lack of patients' trust to the system; inefficient distribution of health human resources; and absence of proper recording and documentation mechanisms and physicians' migration management policies. This current study focused primarily on the management of physicians' migration, as it could directly and indirectly affect all the issues identified above and could provide relevant empirical data in an under researched phenomenon in the available literature. Therefore, this current study aimed through the presentation and analysis of its findings to offer empirical evidence to policy-makers for the proper management of Cypriot physicians' migration and provide guidance on the indirect management of the identified issues depicted above.

Thus, against the backdrop of this study's findings, policy-makers within the healthcare and political sector should recognize the importance of physicians' migration management,

as well as the main factors that affect this phenomenon. As such, the development of this evidence base from the primary data of this current study could enable policy-makers to implement efficient policies for the maximization of related benefits while averting any negative impact. Throughout this current study it was identified that: there is a need to set up mechanisms for the proper monitoring of skilled and physicians' migration; local conditions should be improved; there should be proper and efficient public-private healthcare sectors and careful design and development of the recently established medical schools.

Initially, up to the completion of this current study there were no mechanisms available for the collection of data on the outward or inward migration of skilled healthcare workers and physicians. The absence of such mechanisms made it impossible to estimate the potential impact of migration and thus assign proper priority in the political and healthcare agenda for the management of this phenomenon. Therefore, proper mechanisms should be imposed for the collection and recording of relevant data on the flows of skilled healthcare workers in and out of Cyprus and fed back accordingly to the relevant bodies, such as the Ministry of Health and the Ministry of Labour. Furthermore, it was identified that local conditions such as available post graduating training, research infrastructure, remuneration and employment procedures need to be improved because poor local conditions could motivate the individual physician to seek better professional conditions in more developed destinations. The Ministry of Health should thus be focused on the improvement of these local conditions through the enhancement of the training capacity of the system and the introduction of new training programmes in new specialties, as well as through the provision financial and professional motives for local training. Such improvements could provide incentives to local physicians to remain in Cyprus and established migrant physicians to return with all the associated benefits. In addition, the Ministry of Health should improve the research infrastructure through higher investment in facilities and

through offering motives to individual migrants or local physicians focused on research, to return or remain for work in Cyprus; consequently enhancing the development of the local healthcare systems. Moreover, there should be proper mechanisms for ensuring meritocracy and promotion according to qualifications in the public as well as in the private sector, as the noted bureaucratic and advantageous nature of the Cypriot healthcare system was identified as disincentive for migrant physicians to return. Nevertheless, these improvements should be developed through efficient partnerships between private and public health sectors. Therefore, in line with the establishment and implementation of the national healthcare scheme, the Ministry of Health should manage these partnerships in such a way as to improve the allocation of human and financial resources in turn improving local conditions such as postgraduate training, research infrastructure and healthcare service delivery. A successful and efficient cooperation between the two sectors could restrict the migration of available physicians and other skilled healthcare workers abroad and reclaim the patients' trust to the local delivery of healthcare services. Furthermore, the Ministry of Health should aim to enhance this public-private sector cooperation through involving other private research institutions and relevant NGOs. Finally, the Ministry of Health and the universities involved in medical education in Cyprus should develop their promotion process, curriculum and training programmes in such a way as to: alleviate any issues associated with gender inequality; promote clear admission procedures; facilitate the introduction of female physicians and trainers in leadership positions in medical academia, as well as in decision-making bodies, and previously male-dominated fields in medicine. From the aforementioned, it is worth noting that the ability to efficiently manage physicians' migration and subsequently the ability of the Cypriot Ministry of Health to retain or attract back qualified Cypriot physicians as well as to regulate their overall flows is dependent on demand and supply, the available socioeconomic conditions and the political environment at a specific point in time.

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Appendices

Appendix 1. Cyprus' Chronology 1920 to 2013

Time period 1920-1954

- The first migration movements of Cypriots commenced during 1920 were directly related to the economic crisis that was initiated right after the First World War. Between 1920 and 1924 around 6650 Cypriot houses were sold due to the inability of their Cypriot owners to pay taxes, as their income was limited consequential to the economic crisis (Katsiaounis, 1990).
- Migration flows were usually directed to destinations such as Greece, Egypt, Australia, and Belgian Congo and to countries of Central Africa such as Nigeria. At a later stage the U.S became another ideal destination (1000 passports were issued to Cypriots for travelling to the US in 1930) (Constantinou, 1990; Katsiaounis, 1990).
- The first official reports on Cypriot migrants which decided to travel to the UK were issued during 1930 by the “Great Britain Colonial Office” which referred to 200 Cypriot migrants being employed as waiters and caterers in the UK during 1930 (Constantinou, 1990, P: 154). Cypriot migrants were travelling in the UK prior to 1930 but due to their small number they were not included in official reports (Katsiaounis, 1990). Anthias (1990) in her study revealed that Cypriots not only migrated to the UK prior to 1930, but they also clustered in areas such as Holborn (17%) and St. Pancras (35%).
- The great economic crisis was initiated in October of 1929 (Katsiaounis, 1990). This event according to the Great Britain Colony Office decreased the rates of migration from Cyprus to the UK, and Cypriots' migration flows in general. This decrease in the migration flows from Cyprus ceased during 1934. During 1935 a great number of Cypriots migrated to the UK as economic migrants (Constantinou, 1990; Katsiaounis, 1990).
- In October 1931 there was an uprising of Cypriots against the UK colonial rule that created tensions and altered the socioeconomic situation in Cyprus possibly generating a minor wave of emigration (Constantinou, 1990).
- In 1932 and 1933 there was a great drought in Cyprus. In an agricultural society such as that of Cyprus at that point, a drought deprived the production of agricultural products, therefore Cypriots were unable to pay taxes to the UK government. Hence migration was one possible getaway solution; therefore this

climatic change may have altered the migration flows of that period (Constantinou, 1990).

- Between 1939 and 1945 there was the Second World War. Within that time period migration from Cyprus continued with decreased flows with a total sum of 2000 people migrated away from Cyprus, averaging around 290 Cypriot migrants each year (Constantinou, 1990)
- Between 1947 and 1954 according to the British Colonial Office report there was an increase in the emigration flows from Cyprus with averaging 2100 Cypriots migrating each year (Constantinou, 1990)
- In 1947 the UK proposed a solution plan for limited sovereignty to Cypriots that was rejected by Greek-Cypriots (O'Malley and Craig, 2008).
- Between 1949 and 1950 a great drought drove a great number of Cypriots working in the agricultural sector to migration, as they were unable to sustain their production making it therefore impossible to pay their taxes and sustain the essential needs for their families (Constantinou, 1990).
- The then Bishop of Kitium, Makarios, who in 1960 became the first Cypriot president, was elected as an Archbishop in 1950 (O'Malley and Craig, 2008).

Time period 1955-1959

- The struggle for independence from the UK colonial rule, and the attempts to unite Cyprus with Greece ("Enosis") took place in Cyprus between 1955 (01/04/1955) and 1959 (09/03/1959). This armed struggle led a great number of Cypriots in search of a more stable environment and better economic conditions to migrate abroad (Teerling, 2011).
- The economic booming in the UK between 1950 and 1960, the so-called "long boom" in conjunction to the unstable socioeconomic state of Cyprus during that period, could possibly driven a great number of Cypriot migrants to seek better prospects in the UK (Anthias, 1990; Teerling, 2011).
- In 1955 The Bank of Cyprus established its first branch in the UK (London) providing Cypriot migrants with banking services such as loans and savings accounts, something that at first UK banks did not easily allowed (Koupparis, 1999).
- The 'affidavit' (prove for support) system which dated from back in 1930, ceased in 1954 (Anthias, 1990). Cypriots therefore were able to migrate without the need for official proves of support by relatives or friends. The removal of the 'affidavit'

could have increased migration flows of Cypriots to the UK (Oakley, 1979; Anthias, 1990).

- In February 1959 the London agreement and Zurich agreement were signed by; Archbishop Makarios representing the Greek Cypriots, Dr. Fazil Küçük representing the Turkish Cypriots and the 'guarantor forces' UK, Turkey and Greece. These agreements set in place the foundation for the formation of the Republic of Cyprus.

Time period 1960-1969

- On the 16th of August 1960 Cyprus was declared an independent state under the name Republic of Cyprus, with the official date sited as the 1st of October 1960 (Oakley, 1979).
- In 1961 the newly formed Republic of Cyprus joined the Council of Europe taking the very first steps towards its Europeanization (Trimikliniotis, 2001).
- In 1962 the UK government initiated the Commonwealth Immigration Act enforcing tighter control of immigrants consequently leading to a constant decrease in the migration flows of Cypriots to the UK. This Act was amended in 1968 leading to even stricter measures, superseded later by the Immigration Act in 1971; further decreasing Cypriots' migration flows to the UK (Oakley, 1979). By 1966 and according to Anthias (1990) the annual number of Cypriots migrating to the UK was limited to 200 compared to 12,000 in 1961. In contrast another study by Oakley, (1979) argued that the annual number of Cypriots migrating to the UK in 1966 fell but it was close to 2000. Such differences between migration scholars identify the difficulty to obtain reliable data on Cypriot migration, as there was no accurate mechanism in place able to record data on inward or outward Cypriot migration.
- During the Christmas of 1963 an internal conflict outbreak lasting up to 1967 between nationalists Greek-Cypriots and nationalists Turkish-Cypriots (Papadakis et al, 2006).
- Between 1964 and 1974 they were Internal conflicts between left wing and right wing party supporters. This unstable state of the country altered the socioeconomic situation in Cyprus possibly 'pushing' a great number of Cypriots to migration (Constantinou, 1990).
- In 1964 the UN arrived in Cyprus to safeguard the peace (Papadakis et al, 2006)

- Between 1965 and 1975 there was a great number of Cypriots that were granted scholarships in countries of the East Bloc such as Romania and Russia migrating to these destinations for their tertiary education studies. Additionally a 'wave' of return migration was reported in the available literature during the 1970s. During that period Cypriots who completed their tertiary education in these East Bloc countries were getting married at destination (either with other Cypriots or locals) and returned for permanent settlement back to Cyprus (Teerling, 2011).
- In 1967 the Six Day War between Israel, Egypt, Jordan and Syria commenced (O'Malley, and Craig, 2008), possibly driving a small number of immigrants from these countries to Cyprus as asylum seekers and economic migrants.
- In 1967 the Greek Junta came to power in Greece and had a major role in post 1974 status quo. In the same year the Republic of Cyprus moved away from the initial thoughts of becoming part of Greece. The Greek Junta was the 'mind' behind the actions of EOKA B', which had as its major aim to overthrow Archbishop Makarios from the Presidency through a military coup to facilitate union with Greece. (Koupparis, 1999; Papadakis et al, 2006).

Time period 1970-1973

- On the 21st of October 1971 the Organisation of Educational Groups of Greeks and Cypriots of England (OESEKA) was established. Its main objectives were: The organisation and cooperation of the educational groups in the UK; the continued teaching of the Greek language; and lastly the maintenance of the Cypriot national identity to existing and future generation migrants (Koupparis, 1999). This is an example of how Cypriot migrants enhanced their established networks in the UK promoting a 'chain migration' effect.
- In December 1972 Cyprus signed the Association Agreement (AA) with the then called European Economic Community (EEC). This agreement officially linked Cyprus with the EC and promoted the gradual abolition of customs and restrictions between Cyprus and the EEC regarding certain products etc (Trimikliniotis, 2001).
- During the 1970s and 1980s there was an economic booming of Cyprus that might have decreased migration rates and probably increased return migration flows back to Cyprus (Teerling, 2011).
- On the 30th of September 1972 AKEL (left wing party) was the first branch of Cypriot political party that established in the UK aiming to involve migrant Cypriots in the Cypriot politics. Other political parties followed with EDEK

(socialists) establishing its own branch on 01/08/1974, followed by DHSY (right wing party) on 06/12/1981 and DHKO (democrats) on 05/06/1983.

- During the 1970s Australia attracted the majority of Cypriot migrants and in 1983 it became the leading destination for almost two thirds of all Cypriot migrants while in 1984 only 1% of Cypriot migrants were moving to the UK (Constantinou, 1990).

Time period 1974-1979

- On the 15th of July 1974 there was the coup against Archbishop (and President) Makarios From EOKA B' and the Greek Junta (Papadakis et al, 2006)
- On the 20th of July 1974 the Turkish military forces invaded Cyprus from the coast of Kerynia leading the en mass movement of Greek Cypriots living in the Northern part of Cyprus towards the south part of the country where they still reside. The amount of Cypriots that moved was around 200,000 and more than one third (37%) of Cyprus territory was captured and during the writing of this thesis is still under the Turkish military and political forces. (Papadakis et al, 2006)
- During the beginning of 1974 and also right after the partition of the island an internal conflict was taking place between far right and far left Greek Cypriots. (Papadakis et al, 2006)
- Between 1974-1975 and right after the Turkish invasion there was a 18% decrease in the GNP, 86% decrease of real per capita income, and 30% unemployment increase compared to 1973 (Koupparis, 1999; Trimikliniotis and Demetriou 2007).
- In 1974 following the partition of the island, in a rough calculation presented by Koupparis, (1999, p: 201) it was estimated that the island lost more than 75% of the total agricultural products, 50% of the raw materials, 30% of the industry and 82% of the tourist development.
- Following the partition of the island in 1974 and due to the availability of cheap local labour (supplied by the 200,000 refugees that moved to the south of the island) the Cypriot economy started developing in a fast pace, crucial for its future economic development (Trimikliniontis, 2001; Papadakis et al, 2006).
- Following the partition of the island in 1974 for the first time according to Constantinou, (1990), Greece became amongst the leading destination of Cypriot migrants.
- In 1974 The National Federation of Cypriots in Great Britain was established (Koupparis, 1999).

- During 1975-1979 Cyprus had an average annual growth of around 10% with the construction and manufacturing sectors booming consequential to the reconstruction of the island and the influence of the Arab markets (Trimikliniotis, 2001)
- During 1974-1979 almost 40,000 Cypriots migrated abroad according to official documents (Koupparis, 1999, p: 200):
 - In 1974, 15,408 Cypriot migrants; in 1975, 11,542; in 1976, 5,648; in 1977, 4,184; in 1978, 1,909; and in 1979, 1,168
- In 1977 the Migrants Service was founded (Koupparis, 1999).
- In august of 1977 the first president of the republic of Cyprus, Archbishop Makarios dies (O'Malley and Craig, 2008).
- In 1979 it was officially estimated by Cyprus Tourism Organisation (KOT) that remittances from the UK were around £2.5 millions (Cypriot pounds). Whereas remittances from the rest of the migrants in countries like Australia, South Africa Canada and other destination countries reached £1.5 millions. Similar trends followed in 1980 with £2.5 millions in remittances coming from the UK and £2 millions coming from the rest of the destination countries (Koupparis, 1999, p:212). These official statistics therefore depict the great number of Cypriot migrants living in the UK, as well as their success in their migration movement, by becoming employed and able to remittance back to Cyprus.

Time period 1980-1990

- The 31st of December 1982 was the last day that Cypriots born in the UK acquired the British Citizenship automatically. This opportunity given to Cypriots to naturalize their children prior to 1983 may had a direct effect on increased migration flows prior to 1983 (refereeing to adults that gained naturalisation in this way), since there were fewer bureaucratic difficulties once a Cypriot migrant was a naturalised British citizen.
- In 1983 the Turkish Cypriots and Turkey self-declared the Turkish Republic of Northern Cyprus (Papadakis et al, 2006).
- In the early 1980s the Cypriot Community Centre was opened by the Haringey Council in London to be used by the Cypriot migrants in the UK. This was the stepping stone for the establishment of a strong pressure group comprising of Cypriots working in social service offices as social workers enhancing further the Cypriot migrant network in the UK (Anthias, 2006).

- During the mid-1980s a great number of affluent Lebanese, Kuwaitis, Palestinians and people from the Arab countries migrated to Cyprus following the collapse of Beirut and the general unrest in the Middle East. The majority of these migrants were not workers but instead they were businessmen and other affluent people (Trimikliniotis and Demetriou, 2007)
- The decrease in the economic growth of the country (6% between 1981-1986; 5% between 89-93; 3% following 1993) lead to the increased demand for labour, and this was the main reason for reconsidering the strict immigration policies (Trimikliniotis, 2001). Cyprus therefore abandoned the restrictive immigration policy followed until 1990s in an effort to meet low skilled labour shortages generated by an economic development model based on mass tourism and services.
- Another reason for abandoning the restrictive policies of the 90s was the effort to tackle the rise of inflation and the slowing down of the economic growth in Cyprus. Furthermore as an EU candidate country Cyprus had to abide and adjust on the EU directives by opening a greater labour market (Papadakis et al, 2006).
- In 1988 Cyprus government signed the Customs Union Treaty (Trimikliniotis, 2001)
- In 1990, Cyprus completed all the necessary procedures and officially applied for access in the EU.

Time period 1991-2003

- In 1991 The Republic of Cyprus signed the application to join the EU (Trimikliniotis, 2001).
- The end of the Gulf war in February 1991) motivated a great number of people to migrate to Cyprus either as asylum seekers or economic migrants seeking employment (Trimikliniotis, 2001; Trimikliniotis and Demetriou 2007).
- The abolishment of the USSR in December of 1991 lead a great number of foreign national such as Romanians and Ukrainians to move to Cyprus seeking employment. In addition there was a great number of offshore companies from these Eastern European countries that considered Cyprus as a good opportunity to invest. Furthermore a great number of Pontic Greeks originating from the Caucasus area moved to Cyprus taking advantage of their newly granted Greek nationality and the special conditions applied to Greek nationals by the Cypriot government (Trimiklinitis, 2001; Trimikliniotis and Demetriou 2007).

- Koupparis (1999) in his study depicted another strong link between Cyprus and the UK possibly affecting the decision-making of Cypriot migrants to select the UK as their destination. According therefore to official data from the Cypriot Ministry of Tourism, in 1995 the Cypriot government received £103 million (Cypriot pounds) from exports to the UK (27% of all Cyprus exports), and received another £454 million from tourists coming to Cyprus from UK (40% of total tourists arrivals). Between 1961 -1980, tourists from the UK fluctuated to a minimum of 22% - 57% of the total tourists inflow in Cyprus, reaching around one million visits between 1994-96 (Koupparis, 1999). Through tourism therefore the UK offered economic aid to Cyprus by providing foreign currency. The economic and touristic relationship according to Koupparis, (1999) possibly became stronger due to: the large presence of Cypriot migrants in the UK acting as promoters for Cyprus as a tourist destination; the high English proficiency of Cypriots; as well by the warm Cyprus climate (Koupparis, 1999).
- In August of 1996 the stable political situation in Cyprus was disturbed following the killing of two Cypriots at Derynia borders during a protest against the illegal partition of the island causing political and socioeconomic instability that may have pushed a number of Cypriots to move abroad.
- In 1997 there was a direct Turkish threat for a possible air strike in case the Cypriots installed a Russian missile system (S-300) in Cyprus (O'Malley and Craig, 2008), creating further political instability raising fears for conflict following the events of 1996 altering the socioeconomic stability in Cyprus.
- The war in Yugoslavia in 1999 brought a significant number of Serbs to Cyprus, adding to the rest of the migrants coming from the former Eastern Bloc (Russia, Romania) to Cyprus mainly due to the common religion (Greek Orthodox) and available work opportunities.
- In 2001 the service sector in Cyprus (and mainly tourism) employed 60% of the population and accounted for almost 70% of the GNP.
- In April of 2003 the green line borders opened allowing for the first time access to Greek Cypriots to the Turkish occupied site.

Time period 2004-2011

- The Annan plan was up for a referendum (for federal, Bizonal republic of Cyprus) in April 2004 which 76% of Greek Cypriots rejected and 66% of Turkish Cypriots approved (Trimikliniotis and Demetriou, 2007)

- In 1st of May 2004 The Republic of Cyprus officially accessed the EU along with 9 other countries namely: [Czech Republic](#), [Estonia](#), [Hungary](#), [Latvia](#), [Lithuania](#), [Malta](#), [Poland](#), [Slovakia](#) and [Slovenia](#)
- Higher restrictions and stricter policies towards Russian nationals were implemented following the accession of Cyprus in the EU. (Russian nationals enjoyed a visa free entry to Cyprus due to a bilateral agreement of the Cypriot and the Russian government, a policy which needed to change after the EU accession due to the compliance with the politics of the Union) (Trimikliniotis and Demetriou 2007).
- During 2005 there was a mass movement of Polish and Slovaks to Cyprus seeking employment in the construction and tourist industry (Thomson, 2006).
- In March 2005 the Cypriot government decided to change the duration of work permits to third countries nationals from six to four years (Trimikliniotis and Demetriou 2007).
- In 2006 a great number of people (11,500) of Lebanon, Philippines, [Sri Lanka](#), Ukraine, [Russia](#), [Mexico](#) and [India](#) nationals residing in Lebanon migrated to Cyprus as a result of the conflict between Israelis and Hezbollah. This action may had an effect on the applications of asylum or on the number of illegal migrants, therefore could possibly have affected the number of third country nationals on the island (<http://english.peopledaily.com.cn>)
- On the 1st of January 2007 Bulgaria and Romania joined the EU forming a community of 27 member countries.
- In January of 2008 Cyprus joined the Euro zone sharing a common currency with another 16 countries namely: [Austria](#), [Belgium](#), [Estonia](#), [Finland](#), [France](#), [Germany](#), [Greece](#), [Ireland](#), [Italy](#), [Luxembourg](#), [Malta](#), [Netherlands](#), [Portugal](#), [Slovakia](#), [Slovenia](#), and [Spain](#).
- In February of 2008 Cyprus underwent presidential elections and for the first time in history a left wing president was elected.
- The Economic crisis of 2008 (late 2007) (Lehman brothers etc).
- In April of 2008 Ledra Street borders opened.
- In September 2011 the first private medical school in Cyprus (University of Nicosia) accepted its first students.
- In July 2012 Cyprus applied for an economic support programme through the EU, European Bank and the IMF.

- In February 2013 Cyprus underwent presidential elections with a simultaneous signing of the economic support programme.
- In September 2013 the new European University of Cyprus private medical school and the University of Cyprus medical school accepted its first students.
- On the 1st of January 2014 Croatia joined the EU (Data for Croatia are not included in this study)

Appendix 2. UK Physicians' Migration Management Policy Initiatives

| YEAR | TITLE | SOURCE |
|---|--|----------------------|
| Recruitment targets set | | |
| 2000 (Jul.) | The NHS Plan. A plan for investment. A plan for reform | UKDoH 2000 |
| 2002 (Jan.) | International recruitment of consultants and General Practitioners for the NHS in England | UKDoH 2002 |
| Ethical guidance issued | | |
| 1999 (Nov.) | Guidance on International Nursing Recruitment | UKDoH 2000 |
| 2001 (Oct.) | Code of Practice for NHS employers involved in the international recruitment of healthcare professionals | UKDoH 2001 |
| 2003 | List of countries published from which active recruitment was prohibited | UKDoH 2000 |
| 2004 (Dec.) | Code of Practice for the international recruitment of healthcare professionals | UKDoH 2004 |
| Immigration law revised | | |
| 1999 (Nov.) | List of shortage specialties made available | UKDoH 2000 |
| 2002/2003 | Medical Act 1983 Amendment Order | MEDICAL ACT 1983 |
| 2004 (Oct.) | New member states admitted European Union | Blacklock et al 2012 |
| 2005 | List of shortage specialties removed | Blacklock et al 2012 |
| 2006 | Medical Act 1983 Amendment Order (draft legislation) | Blacklock et al 2012 |
| 2006 | Work permit changes | Blacklock et al 2012 |
| 2007 (Jan.) | New member states admitted European Union | Blacklock et al 2012 |
| 2008 | Change in immigration law | UKBA 2012 |
| 2010 (Nov.) | Change to immigration laws | UKBA 2012 |
| Bilateral agreement signed between United Kingdom and South Africa | | |
| 2003 (May) | Memorandum of Understanding between the Government of the United Kingdom of Great Britain and Northern Ireland and the Government of the Republic of South Africa on the reciprocal educational exchange of health care concepts and personnel | Blacklock et al 2012 |

Modified from Blacklock et al, (2012)

Appendix 3. Invitation Letter

Dear Dr/Mr./Miss. xxxxxxxxxxx xxxxxxxx

My name is Constantinos Constantinou and I am a PhD student at the University of Keele England, UK. The subject of doctoral thesis is an exploration of the factors that affect the decisions of skilled professionals to migrate to the UK. The study has a specific and detailed focus on Cypriot migrant and returning physicians that have studied and/or worked in the UK. Using publicly available archives you have been identified as a potential respondent as your individual occupational and professional characteristics are consistent with the linked objectives of this study. I would therefore like to ask you whether you would be willing to be interviewed for approximately one hour and about your experience as a migrating physician and your views and ideas on Cypriot medical migration? If you are interested in taking part in this study you can find further information regarding the research objectives, data collection techniques and data protection measures - on the attached information sheet.

Researcher's Contact Details

If you are able and willing to participate in this study or in case you want to ask some further questions or require more information please contact:

Constantinos Constantinou,

University of Keele, England, UK

Tel +35799511066

Email:

c.constantinou@keele.ac.uk

I would like to thank you in advance for your time and help

Regards

Constantinos Constantinou

Appendix 4. Information Sheet

Factors that affect the decisions made by skilled professionals to migrate to the UK. A qualitative study of Cypriot migrant and returning physicians

Study Importance

Following a review of literature, a knowledge gap has been identified concerning the topic of skilled migration by Cypriots and especially Cypriot physicians. Additionally, the ongoing processes of globalization, the 2004 EU accession of Cyprus and the recent economic crisis have all altered the factors affecting Cypriot physicians' international migratory movements. Against the backdrop of internationalization of the medical profession, this study therefore explores Cypriot physicians' perceptions, experiences and expectations about medical migration through a qualitative research study, utilizing in-depth semi-structured interviews. The project has three linked objectives:

1. To identify and explore the factors that underpins Cypriot physicians' (including physicians in training) decisions to migrate to the UK in order to practice or train.
2. To understand the reasons why some Cypriot physicians relocate permanently in the UK (i.e. over 5 years residence) following their training, whilst others choose to return to Cyprus.
3. To consider the ways in which gender may mediate these decisions.

The Researcher

My name is Konstantinos Konstantinou, I am 27 years old, I was born in London and raised in Cyprus. I have been enrolled on a full-time PhD program since the 26th of October 2010 at the University of Salford and transferred to Keele University in 2013. I am currently based in Cyprus, performing regular trips to the UK as part of the degree requirements. This research study is part of my dissertation thesis as a part fulfilment of my PhD degree.

Data Collection

Data will be gathered from three main sources:

- **Semi-structured interviews will be conducted** with key informants of healthcare management background to provide an overview / broad contextual information about the general situation of Cypriot medical migration. These will include hospital managers/directors from each Cypriot major city.
- **Semi-structured interviews will be conducted** with 16 'Migrant Cypriot Physicians' (i.e. physicians who have migrated to the UK to study/train and have subsequently remained in the UK for work and/ or training purposes),
- **Semi-structured interviews will be conducted** with 16 'Returnee Cypriot Physicians' (i.e. Cypriot physicians who initially migrated to the UK for training and graduation purposes but who subsequently returned to practice in Cyprus).

The semi-structured interview's transcriptions will be read and analysed in an interpretive fashion that will allow assessing the interviewee's version of how participants make sense of Cypriot medical migration and other related social phenomena.

Your Contribution

As mentioned above this study aims to explore Cypriot physicians' perceptions, experiences and expectations about medical migration. As a result a specific group of physicians/key informants were identified as the most appropriate to present their views and experiences. You have been identified as a potential respondent since your individual

occupational and professional characteristics are able to satisfy the linked objectives of this study. Would you be willing to take part in a semi-structured interview lasting approximately one hour and provide some evidence from your experience and your view and ideas on Cypriot medical migration? The interview will be audio recorded using a tape-recorder and transcribed verbatim using computer software. In order to ensure anonymity participating physician's transcripts will be assigned a code number and/or an agreed pseudonym that will be used as part of the analysis.

Study's Contribution

- Provide a better understanding for Cypriot physician's explicit needs and expectation that they seek through migration contributing in the development of targeted and more efficient health policy planning.
- By investigating medical migration thoroughly key policy makers and health planners will be able to assess strengths and weaknesses of national healthcare policies and help develop a country-specific healthcare planning especially in the next few years with the formation of the Cyprus NHS
- Since the number of studies focused on physicians' motives to migrate is limited, an in-depth investigation on the intentions and needs of Cypriot physicians will provide migration researchers in general and Cypriot policy makers more specific, vital information that will bridge a knowledge gap that has been identified.
- The data generated in the interviews will be used for various other academic outputs such as conference papers and academic journal articles in Cyprus and the UK. All data will be anonymised before publication.

Participation

- Participation in the study is completely voluntary and non-participation will have no negative or adverse effect on you or your organization
- If you decide to participate in this study we will agree a mutually convenient date time and location for the interview to take place at your workplace during your free time within working hours. The interview will last a maximum of 1 hour. If you agree I will audio record the interview and also take additional written notes.
- In you decide to withdraw at any point during the interview process or during the study there would be no negative effect either on you or your organization. In addition any information given will not be used at any point and any recorded data including personal data and information collected will be deleted/destroyed.
- The research has been approved by: the Cypriot Ministry of Health, the Cypriot data protection office, the NHS research committee and the Research, Innovation and Academic Engagement Ethical Approval Panel.
- If you wish to make a complaint arising from the interview in the first instance you should contact the project's lead supervisor:

Professor Steven M Shardlow PhD, Doc. Soc. Sci. (h.c.), AcSS
Professor of Social Work,
University of Keele, Keele. UK
t: +44 (0) 7808779101
Email address s.m.shardlow@keele.ac.uk

I would like to inform you that there is no risk associated with this project neither for the

participant / organization, nor for the associated University and researcher.

Researcher's Contact Details

If you are able and willing to participate in this study or in case you want to ask some further questions or require more information please contact:

Constantinos |Constantinou,

University of Keele,

Tel +35799511066

Email: c.constantinou@keele.ac.uk

I would like to thank you in advance for your time and help

Regards

Constantinos Constantinou

Appendix 5. Semi-Structured Interview Guide Used for Cypriot Physicians and Physicians in Training

Semi-Structured Interview: Physicians

1. Migration history

1.1 Starting from the present can you think back to the time you first left Cyprus and tell me about your initial move to the UK and/ or your subsequent return to Cyprus? (As appropriate)

Prompts

- How long have you been here?
- When did you first arrive?
- When did you return?
- Have you migrated anywhere else in between?

2. Influential factors in initial migratory decisions

2.1 What were the key reasons underpinning your (initial) decision to move to the UK?

Prompts

- Lack of available medical training options/positions (e.g. in specific specialties) in Cyprus
- Possibility to train/work in the UK
- International social experience
- Lack of appropriate work in Cyprus
- The situation in Cyprus (socioeconomic / health infrastructure)
- Better working conditions or pay in UK/Cyprus
- Established links to the UK through previous migration of friends/family colleagues
- Suggested by/recruited by an agency

2.2 Why did you choose to move to the UK in particular?

2.3 Did you consider any other options as alternative destinations?

Prompts

- Quality of the work / training on offer
- Availability of work opportunities in the healthcare sector in the UK
- Language i.e. taught in English (why not other English speaking country e.g. US, Australia etc)
- Networks / links in the UK
- Financial issues e.g. better pay, rewards, opportunities

3. Subsequent decisions to return to Cyprus or remain in the UK

Only for those who have chosen to remain in UK rather than return to Cyprus

3.1 *Why have you chosen to remain in the UK long term following completion of your medical training (where applicable)?*

3.2 *Why have you chosen to stay and live and work in the UK rather than return to Cyprus or move elsewhere?*

Prompts:

- Availability of appropriate work in the UK healthcare sector
- Lack of work opportunities in Cyprus
- Personal reasons: e.g. partnered with someone in UK, children established in schools etc

Only for returnees who subsequently returned to Cyprus?

3.3 *What underpinned your decision to subsequently return to Cyprus following a period in the UK?*

Prompts:

- Lack of work opportunities in the UK?
- New opportunities / better pay and conditions in Cyprus?
- Homesick
- Care responsibilities back home (e.g. family, older or other relatives, property)

4. Gender

4.1 *To what extent has the fact that you are male / female impacted on your decisions in respect of migration and working as a doctor?*

4.2 *How did things change for you once you started a family in respect of migration and work?*

Prompts:

- Does the career of one partner or another, take precedence? If so whose?
- Does informal care of children or older relatives feature in your decisions re work and migration?
- To what extent are equal opportunities/lack of discrimination/fairer opportunities for women and men a feature of your migratory decisions?

4.3 *Even though one in every three physicians (33%) in Cyprus is female the percentage of female physicians migrating to the UK is only 24%. Drawing on your personal experience why do you think this is the case?*

5. Looking forward

5.1 *Do you plan to migrate again in the future?*

5.2 *Where to, when, why might you relocate again?*

5.3 *If not, why not, what is stopping you from returning home or holding you here (UK)?*

Prompts:

- Pay and conditions
- Family reasons
- Lack of available continues / updating medical training in UK/Cyprus
- Possibility to extend training / experience abroad / Cyprus
- Further international experience (social / travelling)
- Offer of new contracts/opportunities to develop your medical career abroad
-

6. Interview closing

6.1 Overall, would you see your decision(s) to migrate as a positive or negative experience? Why?

Prompts:

Opportunity cost of migration

Social (family / friends / habits)

Personal economics

Training / education

Career

6.2 Is there anything else that you would like to add or discuss further?

Appendix 6. Semi-Structured Interview Guide Used for Cypriot Healthcare Managers

Semi-Structured Interview with Healthcare Managers

1) Influential factors in initial migratory decisions

1.1 Why might Cypriot doctors, or doctors in training, choose to leave Cyprus for the UK?

Prompts:

- Studies
- Train/retrain
- Work
- Economic crisis (pay)
- EU accession effect

2) Subsequent decisions to return to Cyprus or remain in the UK

2.1 What are the main factors that may affect the decision of Cypriot physicians to remain in the UK following their postgraduate training?

2.2 What are the possible factors underpinning Cypriot Physician's decision to return to Cyprus?

Prompts:

- (Re) Induction in the Cypriot labour market
- Cypriot socioeconomic situation effect on migration / return?
- Health infrastructure / Health Policies had an effect?
- Family / care reasons?

3) Impact

3.1 How does the migration of Cypriot doctors impact on medical provision in Cyprus?

Prompts:

- The Cypriot context (Public and Private Health System)
- Society (patients, general health infrastructure / indicators, remaining physicians etc)
-

4) Gender

4.1 Would you consider the medical profession in Cyprus as a gendered profession?

4.2 Given that one in every three physicians (33%) in Cyprus is female the percentage of female physicians migrating to the UK is only 24%. why do you think this is the case?

Prompts:

- Equal professional opportunities / treatment
- Professional or sexual discrimination / harassment
- Family reasons
- Gendered norms re roles in respect of care of children or ascendant relatives

5) Looking forward

5.1 How will the formation of the first independent medical school in Cyprus change the present situation in the Healthcare system or/and Cypriot Medical migration?

6) Interview closing

- Is there anything else that you would like to add or discuss further?
- Do you know anyone else that I can approach to interview?
- Do you have any questions that you would like to ask me?

Thank you very much for your time and help

Appendix 7. Consent Form

Factors that affect the decisions made by skilled professionals to migrate to the UK. A qualitative study of Cypriot migrant and returning physicians

Please read the information sheet and confirm that you give your consent to take part in this interview by ticking the appropriate boxes and signing and dating this form

- I confirm that the purpose and objectives of the study have been clearly explained to me, that I have been given all necessary information in a written form, and that I have had the opportunity to ask any questions about the study
- I understand that my participation is voluntary and that I am able to withdraw at any time I wish
- I give permission for the interview to be audio recorded on the understanding that all research data collected will be anonymised, and the tape recording and any notes taken will be destroyed once the contents have been analysed.
- I agree to take part in this research study

Name of respondent

Date

Signature

Name of researcher

Date

Signature

Assigned key informant code number

If you would like to participate in this study please complete this form and email me on: c.constantinou@keele.ac.uk

within 15 days of receipt.

Appendix 8. Participation Document: Ethics Committee Research Study Approval



Research, Innovation and Academic
Engagement Ethical Approval Panel

College of Health & Social Care
AD 101 Allerton Building
University of Salford
M6 6PU

T +44(0)161 295 7016
r.shuttleworth@salford.ac.uk

www.salford.ac.uk/

14 March 2013

Dear Constantinos,

RE: ETHICS APPLICATION HSCR12/80 – Factors that affect the decisions made by skilled professionals to migrate to the UK: a qualitative case study of Cypriot migrant and returning physicians

Following your responses to the Panel's queries, based on the information you provided, I am pleased to inform you that application HSCR12/80 has now been approved.

If there are any changes to the project and/ or its methodology, please inform the Panel as soon as possible.

Yours sincerely,

Rachel Shuttleworth

Rachel Shuttleworth
College Support Officer (R&I)

Appendix 7. Synoptic tables of participants' coded responses

Participants' coded responses are presented in a series of tables below according to theme, main category and participants' group. Each table related to chapter six presents participants' coded responses according to theme, main category and participants' group, as well as the frequency of responses. Where applicable, participants' responses are presented according to the gender of each participant to assist in the identification and analysis of potential gender differences in the factors that affected the migration decision-making process. Lastly at the end of each table the total number of different responses is summed up, which when compared to the number of participants provides an overall idea on the diversity of factors that may have mediated the decision-making process of participants.

Table 1: Positive and Negative Impact of Cypriot Physicians' Migration on the Healthcare System and the Medical Profession in Cyprus

| Type of Migration Impact | Healthcare Managers (4) | No. of Responses |
|-------------------------------|---|------------------|
| Positive | Returning specialists bringing new improved approaches | 2 |
| | Returning specialists improving Cypriot healthcare system | 2 |
| | Returning specialists improving research capabilities / collegial collaboration | 1 |
| | Lower cost for MoH from abroad Cypriot patients treatments | 1 |
| Neutral | No impact on healthcare system / healthcare delivery | 1 |
| Negative | Loss of Cypriot patients abroad form specialists' absence | 2 |
| | Absence of healthy competition | 2 |
| | Loss of income tax | 1 |
| | Export of currency | 1 |
| | Unemployment in allied health professions in the local healthcare system | 1 |
| | Limited growth and expandability of the local healthcare system | 1 |
| | Deprived healthcare delivery | 1 |
| | Limited local medical research | 1 |
| Total No. of Responses | | 17 |

Table 2: Positive and Negative Effects from the Establishment of the First Cypriot Public Medical School

| Type of effect | Healthcare managers (4) | No. of Responses |
|-------------------------------|--|------------------|
| Positive | Improvements in the local healthcare system / healthcare delivery | 3 |
| | Improvement of Cyprus' research infrastructure / capabilities | 3 |
| | Attract high-ranking medical migrants back to Cyprus | 2 |
| | Offer great job package to physicians (Work / Research / Remuneration) | 2 |
| | An option for Cypriots for a lower cost of Medical education | 2 |
| Negative | Further increase in local physicians' density | 2 |
| | Further increase Cypriot physicians' migration abroad | 2 |
| Total No. of Responses | | 16 |

Table 3: Personal/Social and Professional Push Factors for Cypriot Migrant Physicians

| Type of Migration Factors | Migrant Physicians (14) | | |
|----------------------------------|---|------------------|------------------|
| | Migration Specific Factors | Male (8) | Female (6) |
| | | No. of Responses | No. of Responses |
| Personal Push Factors | <i>Secondary education effect</i> | 4 | 5 |
| | <i>Experience a multicultural country without limiting within the Cypriot "closed" society</i> | N/A | 3 |
| Professional Push Factors | <i>No medical school at the time</i> | 8 | 6 |
| | <i>Limited professional / career opportunities / prospects</i> | 5 | N/A |
| | <i>Unavailability of specific specialties / sub-specialties training</i> | 4 | 1 |
| | <i>Low remuneration during training / work</i> | 2 | N/A |
| | <i>Cyprus' bureaucracy / corruption</i> | 1 | N/A |
| | <i>Poor post graduating training</i> | 1 | N/A |
| | <i>Unavailability of research infrastructure (Teaching hospitals / research facilities / funding)</i> | N/A | 1 |
| Total No. of Responses | | 25 | 16 |

Table 4: Personal/Social and Professional Push Factors for Cypriot Returning Physicians

| Type of Migration Factors | Returnee Physicians (16) | | |
|----------------------------------|--|------------------|------------------|
| | Migration Specific Factors | Male (8) | Female (8) |
| | | No. of Responses | No. of Responses |
| Personal Push Factors | Secondary education structure effects | N/A | 2 |
| | To avoid social pressure | N/A | 1 |
| | Experience a new multicultural country | 1 | N/A |
| Professional Push Factors | No medical school at the time | 8 | 8 |
| | Socioeconomic situation in Cyprus at the time | N/A | 2 |
| | Unavailability of specific specialties / sub-specialties training | 4 | 3 |
| | Unavailability of research infrastructure (Teaching hospitals / research facilities / funding) | 3 | N/A |
| | Poor healthcare infrastructure (organisation / professionalism / governance) | 2 | 2 |
| | Poor post graduating training | 2 | 3 |
| | High physicians density & competition / differentiation | 2 | N/A |
| Total No. of Responses | | 22 | 21 |

Table 5: Personal/Social and Professional Push Factors for Cypriot Medical Students and Physicians According to Healthcare Managers

| Type of Migration Factors | Healthcare Managers (4) | |
|----------------------------------|--|------------------|
| | Migration Specific Factors | No. of Responses |
| Personal Push Factors | <i>Socioeconomic conditions in Cyprus</i> | 2 |
| Professional Push Factors | <i>No medical school at the time</i> | 4 |
| | <i>Unavailability of specific specialties / sub-specialties training</i> | 4 |
| | <i>Poor post graduating training</i> | 4 |
| | <i>Limited professional / career opportunities / prospects</i> | 2 |
| | <i>Cyprus' bureaucracy / corruption</i> | 1 |
| Total No. of Responses | | 17 |

Table 6: Personal/Social and Professional Pull Factors for Cypriot Migrant Physicians

| Type of Migration Factors | Migrant Physicians (14) | | |
|----------------------------------|---|------------------|------------------|
| | Migration Specific Factors | Male (8) | Female (6) |
| | | No. of Responses | No. of Responses |
| <u>Personal Pull Factors</u> | <i>Network (Friends & Relatives abroad)</i> | 5 | N/A |
| | <i>Experiences in a multicultural country</i> | 4 | 1 |
| | <i>Opportunities to travel UK / EU</i> | 2 | N/A |
| | <i>Attractive country / lifestyle</i> | 1 | N/A |
| <u>Professional Pull Factors</u> | <i>Educational and training excellence</i> | 8 | 6 |
| | <i>Language proficiency</i> | 4 | 3 |

Table 7: Personal/Social and Professional Pull Factors for Cypriot Returning Physicians

| Type of Migration Factors | Returnee Physicians (16) | | |
|----------------------------------|---|------------------|------------------|
| | Migration Specific Factors | Male (8) | Female (8) |
| | | No. of Responses | No. of Responses |
| <u>Personal Pull Factors</u> | <i>Experiences in a multicultural country</i> | 4 | 3 |
| | <i>Network (Links, Friends & Relatives abroad)</i> | 2 | 4 |
| | <i>Opportunities to travel UK / EU</i> | N/A | 1 |
| | <i>Code of ethics present</i> | N/A | 1 |
| <u>Professional Pull Factors</u> | <i>Educational and training excellence</i> | 8 | 8 |
| | <i>World - renowned Healthcare system</i> | 4 | 1 |
| | <i>Renowned research infrastructure / facilities</i> | 4 | 1 |
| | <i>Language proficiency</i> | 3 | 2 |
| | <i>Great professional / career opportunities / prospects</i> | 3 | 3 |
| | <i>Higher professional status earned when educated / trained in UK universities</i> | 2 | 2 |
| | <i>High remuneration during training / work</i> | 1 | 3 |
| | <i>Ideal working environment</i> | 1 | 1 |
| | <i>Scholarships</i> | 1 | 1 |
| | <i>Continues medical update / training offered (not happening in Cyprus)</i> | 1 | N/A |
| | <i>Cheap fares compared to other equally medically developed countries</i> | N/A | 1 |
| <i>Meritocracy</i> | N/A | 1 | |
| Total No. of Responses | | 34 | 33 |

Table 8: Personal/Social and Professional Pull Factors for Cypriot Medical Students and Physicians According to Healthcare Managers

| Type of Migration Factors | Healthcare Managers (4) | |
|----------------------------------|---|------------------|
| | Migration Specific Factors | No. of Responses |
| Personal Pull Factors | <i>Network (Friends & Relatives abroad)</i> | 2 |
| Professional Pull Factors | <i>Educational and training excellence</i> | 4 |
| | <i>Great professional / career opportunities / prospects</i> | 2 |
| | <i>Better overall working environment</i> | 2 |
| | <i>Higher professional status earned when educated / trained in UK universities</i> | 1 |
| | <i>Renowned research infrastructure / facilities</i> | 1 |
| | <i>Language proficiency</i> | 1 |
| | <i>World - renowned Healthcare system</i> | 1 |
| Total No. of Responses | | 14 |

Table 9: Alternative Destinations Considered by Cypriot Migrant Physicians During their Decision-Making Process

| Sample | Country | No. of Responses |
|--|----------------------------|------------------|
| Male migrants | <i>USA *(1)</i> | 4 |
| | <i>Germany *(4)</i> | 4 |
| | <i>Greece *(2)</i> | 2 |
| | <i>Australia *(5)</i> | 2 |
| | <i>Romania *(3)</i> | 1 |
| | <i>Only UK *(8)</i> | 0 |
| Total No. of Group Responses | | 13 |
| Female migrants | <i>USA</i> | 3 |
| | <i>Greece</i> | 2 |
| | <i>Only UK</i> | 2 |
| | <i>Australia</i> | 1 |
| | <i>Czech Republic *(9)</i> | 1 |
| | <i>Germany</i> | 1 |
| Total No. of Group Responses | | 10 |
| Total No. of Responses | | 23 |
| *No. in Bracket next to each country denotes the alternative destinations in order of frequency in total responses of migrants and returnees | | |

Table 10: Alternative Destinations Considered by Cypriot Returning Physicians During their Decision-Making Process

| Sample | Country | No. of responses |
|---|-------------------|------------------|
| Male returnees | Greece | 4 |
| | USA | 2 |
| | Only UK | 2 |
| | Germany | 1 |
| | Sweden *(11) | 1 |
| | Ukraine *(12) | 1 |
| Total No. of Group Responses | | 11 |
| Female returnees | Only UK | 4 |
| | Greece | 2 |
| | USA | 2 |
| | Romania *(6) | 2 |
| | Australia | 1 |
| | Bulgaria *(7) | 1 |
| | Canada *(8) | 1 |
| | Germany | 1 |
| | New Zealand *(10) | 1 |
| Total No. of Group Responses | | 15 |
| Total No. of Responses | | 26 |
| No in bracket next to each country denotes the alternative destinations in order of frequency in total responses of migrants and returnees. | | |

Table 11: Main Reasons Provided by Cypriot Migrant Physicians for not selecting an Alternative Destination to the UK

| Reason | No. of Responses |
|--|------------------|
| <i>Inferior Education / Training / Placement</i> | 6 |
| <i>Language</i> | 6 |
| <i>Need for Pre-Med</i> | 3 |
| <i>Higher Entry Requirements</i> | 2 |
| <i>Geographical Distance From Home Country</i> | 2 |
| <i>Inferior professional Status Gained</i> | 1 |
| <i>High Cost of Living or/and Training</i> | 1 |
| Total No. of Responses | 21 |

Table 12: The Main Reasons Provided by Cypriot Returning Physicians for not Selecting an Alternative Destination to the UK

| Reason | Returnees |
|--|------------------|
| | No. Of Responses |
| <i>Inferior Education / Training / Placement</i> | 9 |
| <i>Language</i> | 5 |
| <i>High Cost of Living or/and Training</i> | 5 |
| <i>Geographical Distance From Home Country</i> | 3 |
| <i>Need for Pre-Med</i> | 1 |
| Total No. of Responses | 23 |

Table 13: Personal/Social and Professional Factors for the Extended Stay of Cypriot Migrant Physicians in the UK

| Type of Migration Factors | Migrant Physicians (14) | | |
|--|---|------------------|------------------|
| | Migration Specific Factors | Male (8) | Female (6) |
| | | No. of Responses | No. of Responses |
| <u>Personal Factors promoting extended stay in the UK</u> | Deprived socioeconomic situation in Cyprus | 3 | 3 |
| | Exceptional living experience / High standard of living | 3 | 1 |
| | Dependants effect (e.g. education) | 2 | 1 |
| | Proximity to Cyprus | 2 | 1 |
| | Familiarity with country / place of studies | 2 | N/A |
| | Less corruption / bureaucracy | 2 | N/A |
| | Social networks formed | 1 | 1 |
| | Opportunities for volunteer work | 1 | N/A |
| | Marital status | 1 | 2 |
| | Career over family priority | 1 | N/A |
| | Travel opportunities | N/A | 1 |
| <u>Professional Factors promoting extended stay in the UK</u> | High remuneration during training / work | 7 | 5 |
| | Better training / availability of specialty options | 5 | 4 |
| | Superior quality healthcare system | 4 | N/A |
| | Job offers / opportunities prior to graduation | 3 | 3 |
| | Better career progression / prospects | 3 | 2 |
| | Better working conditions / facilities | 3 | N/A |
| | Job security | 2 | 1 |
| | Superior research infrastructure (Teaching hospitals / research facilities / funding) | 2 | 4 |
| | Professionalism | 2 | N/A |
| | Continues training / update | 2 | N/A |
| | Meritocracy / no professional discrimination | 2 | 3 |
| | UK context / application training | 1 | N/A |
| | Experience | N/A | 5 |
| | Professional / political / educational barriers in Cyprus | N/A | 1 |
| Availability of alternative approach to medicine / training | N/A | 1 | |
| Total No. of Responses | 54 | 39 | |

Table 14: Personal/Social and Professional Factors for the Extended Stay of Cypriot Physicians in the UK According to Healthcare Managers

| Type of Migration Factors | Healthcare Managers (4) | |
|---|---|------------------|
| | Migration Specific Factors | No. of Responses |
| Personal Factors promoting extended stay in the UK | Deprived socioeconomic situation in Cyprus | 3 |
| Professional Factors promoting extended stay in the UK | Better career progression / prospects | 4 |
| | Experience | 3 |
| | Better working conditions / facilities | 1 |
| | Better training / availability of specialty options | 1 |
| | Research opportunities | 1 |
| | Opportunities to work in medical academia | 1 |
| | High physicians density in Cyprus | 1 |
| Total No. of Responses | | 15 |

Table 15: Personal/Social and Professional Factors for the Return of Cypriot Returning Physicians

| Type of Migration Factors | Returnee Physicians (16) | | |
|--|---|------------------|------------------|
| | Migration Specific Factors | Male (8) | Female (8) |
| | | No. of Responses | No. of Responses |
| Personal Factors promoting Return to Cyprus | <i>Family Formation</i> | 6 | 5 |
| | <i>Desired Environment for children</i> | 4 | 1 |
| | <i>Family / team decision</i> | 3 | 4 |
| | <i>Homesickness</i> | 2 | 3 |
| | <i>Care responsibilities</i> | 2 | 1 |
| | <i>To acquire / Utilise property in home country</i> | 1 | 2 |
| | <i>Improved socioeconomic conditions</i> | 1 | 1 |
| | <i>Better quality of life</i> | 1 | 2 |
| Professional Factors promoting Return to Cyprus | <i>Informal support</i> | 1 | 1 |
| | <i>Work / training opportunities</i> | 3 | 3 |
| | <i>Improved Healthcare system / professional conditions</i> | 1 | 1 |
| | <i>Fulfilment of career objectives</i> | 1 | 1 |
| | <i>Initial Career / life plan</i> | 1 | 1 |
| | <i>Professional / political / educational barrier</i> | N/A | 1 |
| Total No. of Responses | | 27 | 27 |

Table 16: Personal/Social and Professional factors for the Return of Cypriot Physicians Back to Cyprus According to Healthcare Managers

| Type of Migration Factors | Healthcare Managers (4) | |
|--|---|------------------|
| | Migration Specific Factors | No. of Responses |
| Personal Factors promoting Return to Cyprus | <i>Family Formation</i> | 4 |
| | <i>Homesickness</i> | 4 |
| | <i>Better quality of life</i> | 3 |
| | <i>To acquire / Utilise property in home country</i> | 2 |
| | <i>Informal support</i> | 1 |
| Professional Factors promoting Return to Cyprus | <i>Work / training opportunities</i> | 2 |
| | <i>Improved Healthcare system / professional conditions</i> | 1 |
| | <i>Formation of Cypriot medical school</i> | 1 |
| Total No. of Responses | | 18 |

Table 17: The Role of Gender for Cypriot Migrant Physicians in their Decision to Migrate

| Migrant Physicians (14) | Male (8) | Female (6) |
|--|------------------|------------------|
| | No. of Responses | No. of Responses |
| <i>No effect on initial decision making to move</i> | 7 | 5 |
| <i>Equal opportunities during Education / Training</i> | 4 | 3 |
| <i>Equal opportunities during Placement / Work</i> | 3 | 4 |
| <i>Effect of Societal norms</i> | 1 | 1 |
| <i>Limited Opportunities to examine patients of the other gender</i> | 1 | N/A |
| <i>Increased opportunities for female physicians in previously dominated Specialties / Posts</i> | N/A | 2 |
| <i>Old perceptions raising professional difficulties</i> | N/A | 2 |
| Total No. of Responses | 16 | 17 |

Table 18: The Role of Family/Social Life in Migration and Decision-Making Process According to Cypriot Migrant Physicians

| Migrant Physicians (14) | Male (8) | Female (6) |
|---|------------------|------------------|
| | No. of Responses | No. of Responses |
| <i>Career Vs Family Orientation</i> | 7 | 4 |
| <i>Dependants Effect</i> | 4 | 3 |
| <i>Care responsibilities / Informal support</i> | 2 | 4 |
| <i>Partner Effect</i> | 1 | 3 |
| Total No. of Responses | 14 | 14 |

Table 19: The Role of Gender for Cypriot Returning Physicians in their Decision-Making Process

| Returning Physicians (16) | Male (8) | Female (8) |
|--|------------------|------------------|
| | No. of Responses | No. of Responses |
| <i>No effect on initial decision making to move</i> | 8 | 8 |
| <i>Effect of Societal norms</i> | 3 | 1 |
| <i>Equal opportunities during Education / Training</i> | 1 | 4 |
| <i>Equal opportunities during Placement / Work</i> | 1 | 4 |
| <i>Old perceptions raising professional difficulties</i> | 1 | 1 |
| Total No. of Responses | 14 | 18 |

Table 20: The Role of Family/Social Life in Migration and the Decision-Making Process According to Cypriot Returning Physicians

| Returning Physicians (16) | Male (8) | Female (8) |
|---|------------------|------------------|
| | No. of Responses | No. of Responses |
| <i>Career Vs Family Orientation</i> | 8 | 6 |
| <i>Dependants Effect</i> | 3 | 3 |
| <i>Care responsibilities / Informal support</i> | 2 | 3 |
| <i>Partner Effect</i> | 1 | 5 |
| Total No. of Responses | 14 | 17 |

Table 21: The Main Positive and Negative Factors Affecting the Overall Migration Experience of Cypriot Migrant Physicians

| Approach | Migrant Physicians (14) | Male (8) | Female (6) |
|-------------------------------|---|------------------|------------------|
| | | No. of Responses | No. of Responses |
| <u>Positive</u> | <i>Social experience</i> | 6 | 2 |
| | <i>Training excellence</i> | 5 | 2 |
| | <i>Social networks developed</i> | 5 | 2 |
| | <i>Professional experience</i> | 2 | 5 |
| | <i>Financial gains</i> | 2 | 1 |
| | <i>Positive cost of Living / education & training ratio</i> | 1 | N/A |
| | <i>International travel opportunities</i> | 1 | 2 |
| | <i>Research opportunities</i> | 1 | 1 |
| <u>Negative</u> | <i>Homesick / Loss of social bonds</i> | 6 | 3 |
| | <i>Difficulties in adjustment in a foreign environment</i> | 1 | N/A |
| | <i>Context specific training</i> | 1 | N/A |
| | <i>Difficulties in relationships</i> | 1 | N/A |
| | <i>Demanding work schedule</i> | N/A | 2 |
| Total No. of Responses | | 32 | 20 |

Table 22: The Main Positive and Negative Factors that Affected the Overall Migration Experience of Cypriot Returning Physicians

| Approach | Returning Physicians (16) | | |
|-------------------------------|--|------------------|------------------|
| | Overall Migration Experience | Male (8) | Female (8) |
| | | No. of Responses | No. of Responses |
| Positive | <i>Training excellence</i> | 5 | 6 |
| | <i>Professional experience</i> | 5 | 6 |
| | <i>Family formation upon return to Cyprus</i> | 4 | 2 |
| | <i>Social experience</i> | 3 | 2 |
| | <i>Excel amongst competition upon return to Cyprus</i> | 2 | 2 |
| | <i>Social networks developed</i> | 2 | 1 |
| | <i>Financial gains</i> | 1 | N/A |
| | <i>Informal support upon return to Cyprus</i> | N/A | 2 |
| | <i>Better social life / work ratio upon return to Cyprus</i> | N/A | 1 |
| | <i>Research opportunities</i> | N/A | 1 |
| Negative | <i>Homesick / Loss of social bonds</i> | 2 | 2 |
| | <i>Lack of professionalism in Cyprus</i> | 2 | 2 |
| | <i>Demanding work schedule</i> | N/A | 2 |
| | <i>Deskilling</i> | N/A | 2 |
| Total No. of Responses | | 26 | 31 |

Table 23: Future Plans of Cypriot Migrant Physicians in Terms of Re-Migrating or/and Returning to Cyprus

| Migrant Physicians (14) | Male (8) | Female (6) |
|--|------------------|------------------|
| | No. of Responses | No. of Responses |
| <i>Re-migration to another destination beside Cyprus</i> | 1 | 2 |
| <i>Return to Cyprus</i> | 5 | 4 |
| <i>Remain In the UK</i> | 2 | N/A |
| Total No. of Responses | 8 | 6 |

Table 24: Future Plans of Cypriot Returning Physicians in terms of Re-Migrating or/and Returning to the UK

| Returning Physicians (16) | Male (8) | Female (8) |
|--|------------------|------------------|
| | No. of Responses | No. of Responses |
| <i>Remain in Cyprus permanently</i> | 7 | 7 |
| <i>Re-migration to another destination beside the UK</i> | N/A | N/A |
| <i>Return to the UK</i> | 1 | 1 |
| Total No. of Responses | 8 | 8 |

Table 25: The Main Factors Affecting Future Plans of Cypriot Migrant Physicians in Terms of Re-Migrating or/and Returning to Cyprus

| Migrant Physicians (14) | Male (8) | Female (6) |
|---|------------------|------------------|
| | No. of Responses | No. of Responses |
| <i>Lifestyle / Standard of living</i> | 4 | 1 |
| <i>Fulfilment of career / professional targets</i> | 2 | 5 |
| <i>Family Formation</i> | 2 | N/A |
| <i>Job Opportunities</i> | 2 | 1 |
| <i>Marital Status / Dependants</i> | 2 | 1 |
| <i>Socioeconomic condition in host/home country</i> | 1 | 1 |
| <i>Established bonds / networks</i> | N/A | 3 |
| <i>Family and friends at home country</i> | N/A | 1 |
| Total No. of Responses | 13 | 13 |

Table 26: The Main Factors Affecting Future Plans of Cypriot Returning Physicians in Terms of Re-Migrating or/and Returning to the UK

| Returning Physicians (16) | Male (8) | Female (8) |
|--|------------------|------------------|
| | No. of Responses | No. of Responses |
| <i>Establishment of family / dependants</i> | 4 | 4 |
| <i>Socioeconomic condition in Cyprus</i> | 3 | 4 |
| <i>Lifestyle / Standard of living</i> | 3 | 3 |
| <i>Fulfilment of career / professional targets</i> | 2 | 4 |
| <i>Age</i> | 1 | N/A |
| <i>Property</i> | N/A | 1 |
| <i>Financial commitments</i> | N/A | 2 |
| Total No. of Responses | 13 | 18 |

Table 27: Reasons for the Male and Female Discrepancies in Cypriot Physicians' Migration to the UK and Future Trends According to Cypriot Migrant Physicians

| Migrant Physicians (14) | Male (8) | Female (6) |
|--|-------------------------|-------------------------|
| | No. of Responses | No. of Responses |
| <i>Gender biased reluctance to long term / distant moves</i> | 3 | 2 |
| <i>Army / Age effect</i> | 3 | 1 |
| <i>Effect of Societal norms / Family Pressure</i> | 2 | 2 |
| <i>Demanding profession</i> | 1 | 3 |
| <i>Feminization of Medical Education / medicine</i> | N/A | 3 |
| <i>Increased opportunities for female physicians in previously gender biased Specialties / Posts</i> | N/A | 3 |
| Total No. of Responses | 9 | 14 |

Table 28 Reasons for the Male and Female Discrepancies in Cypriot Physicians' Migration to the UK and Future Trends According to Cypriot Returning Physicians

| Returning Physicians (16) | Male (8) | Female (8) |
|--|-------------------------|-------------------------|
| | No. of Responses | No. of Responses |
| <i>Effect of Societal norms / Family Pressure</i> | 3 | 4 |
| <i>Demanding profession</i> | 3 | 2 |
| <i>Gender biased reluctance to long term / distant moves</i> | 2 | 5 |
| <i>No obvious reasons</i> | 2 | N/A |
| <i>Feminization of Medical Education / medicine</i> | 1 | 2 |
| <i>Personal choice of career path</i> | N/A | 4 |
| Total No. of Responses | 11 | 17 |

Table 29: Reasons for the Male and Female Discrepancies in Cypriot Physicians' Migration to the UK and Future Trends According to Healthcare Managers

| Healthcare Managers (4) | No. of Responses |
|--|-------------------------|
| <i>Effect of Societal norms / Family Pressure</i> | 4 |
| <i>Gender biased reluctance to long term / distant moves</i> | 3 |
| <i>Feminization of Medical Education / medicine</i> | 3 |
| <i>Personal choice of career path</i> | 2 |
| Total No. of Responses | 12 |