‘We have families to feed’: Exploring the push and pull factors for South African medical doctors migrating to other countries.

By

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Declaration of authenticity

I Sandla Sakhe Sikho Nomvete declare that this dissertation is my original work. Where secondary material has been used (either from printed sources or the internet), this has been carefully acknowledged and referenced in accordance with the requirements of the Department of Sociology, Faculty of Humanities, University of Pretoria.

Signature.....

Date.....

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Summary/ Abstract

The globalisation of labour markets is at hand. After re-joining global markets post-apartheid, South Africa was faced with different forms of labour market flexibility. This flexibility allowed workers to seek working opportunities wherever they could be found. Also, it further allowed countries to explore international borders, recruiting people of the desired skills in their respective countries. Consequently, South Africa has seen lots of movements within and to outside of the country. These movements are by skilled professionals, semi-skilled and the unskilled. Over the past two decades, there has been rapid growth in migration by health workers. In particular, these have been mostly nurses and doctors. When these professionals migrate, it is usually based on their social, geographical, political, economic needs or otherwise.

This study therefore, explores the pull and push factors that influence South African medical doctors in migrating to other countries. This study was done in three cities in South African namely, Durban, Johannesburg and Pretoria. In explaining data obtained from the doctors interviewed three theorists were used, Bourdieu on forms of capital, Marx on class and Weber on status.

The results indicate there are various factors that influence migration by South African medical doctors. They further indicate that, because doctors are of different life trajectories, their influences for migrating may differ.

Ultimately, this study explored but did not conclude that, doctors are professionals that migrate concerned with the primary goal of restoring an element of status. This element I assert has been eroded by the changing nature of work. Therefore, I have argued that, prestige, social honour and economic means make up a medical doctor status in society and that migration is a move towards sustaining this status.

Acronyms and Abbreviations

CDE	Centre for Development and Enterprise
CT SCAN	Computed Tomography scans
DENOSA	Democratic Nursing Organisation of South Africa
DoL	Department of Labour
DoH	Department of Health
DPSA	Department of Public Service and Administration
GP	General Practitioner
HPCSA	Health Professions Council of South Africa
HSRC	Human Sciences Research Council
KZN	Kwa- Zulu Natal
MBChB	*Medicinae Baccalaureus, Baccalaureus Chirurgiae* (Bachelor of Medicine and Surgery)
MO	Medical Officer
NEHAWU	National Education Health and Allied Workers Union
NSFAS	National Student Financial Aid Scheme
OBE	Outcomes Based Education
OECD	Organization for Economic Co-operation and Development
OSD	Occupation Specific Dispensation
SACE	South African Council of Educators
SAMA	South African Medical Association
STATS SA	Statistics South Africa
UK	United Kingdom
UN	United Nations
USA	United States of America
WHO	World Health Organization

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Chapter One

South African medical doctors: History, race, gender and migration

1. Introduction

This study focuses on medical doctor migration by South African doctors. In this study, I argue that although issues of economics have always been identified as a central factor for migration, there are various other social factors that can be attributed to migration such as culture, race and gender. As a starting point, however, a detailed historical background of the history of South African medical schools is provided. This is informed by the belief that the history will allow the reader to understand the genesis of medical doctor migration particular to South Africa and therefore, to make the necessary connections with the rest of the emerging themes.

The South African medical service is unique, particularly on issues of racial and gender composition. Owing to a historically racially divided South Africa before the first democratic elected government, the university and schooling system was also divided. Race in schools and universities was used as a category of acceptance and in this process some schools and universities had a better standard of education than others (Price 2012; Buchanan & West 2012). Also, some fields of study were open to others, mainly white people, while limited to the rest, namely, blacks, coloureds and Indians. This was rife in medical training schools and its consequences continue to be prevalent to this day.

Established at different times in South African history, South Africa has eight medical schools located in different provinces in the country. These institutions are as follows: Stellenbosch University Medical School and the University of Cape Town Medical School which are based in the Western Cape province; the Medical University of South Africa (Medunsa) which is now part of the University of Limpopo, the University of Pretoria Medical School and the University of the Witwatersrand Medical School, all of which are in the Gauteng province; the Nelson R Mandela Medical School, part of the University of Kwa-(formerly the University of Natal) in the Kwa-Zulu Natal province; and Walter Sisulu University Medical School, formerly known as the University of Transkei and the University

of Free State Medical School which are found in the Eastern Cape and Free State provinces respectively (Health Systems Trust 2000).

As briefly stated above, these institutions admitted students of different races. Walter Sisulu University and Medunsa only trained black students exclusively and the University of Kwa-Zulu Natal (Nelson R. Mandela Medical School) trained both Indian and black students. The rest of the other universities were exclusively for white students and later began to admit black students in the early 1980s (Health Systems Trust 2000).

Amongst the previously white medical schools is the University of Cape Town Medical School. This school was established in 1912 and now 101 years later in 2013, is the oldest medical school in the country. Arguably, the University of Cape Town Medical School has produced more doctors than any other medical institution in the country (University of Cape Town 2013). This may be attributed to the length of time since its establishment and the consistency of medical doctor graduates which is discussed later in the chapter. Contrary to the inception of the medical school 101 years ago, the institution began to integrate other races into the institution on the eve of democracy in South Africa and in 2012, a total number of 184 doctors of different races graduated from the medical school.

Also a previously a white institution, located four kilometres from the Johannesburg central business district, the University of the Witwatersrand Medical School was established in 1919. The institution, now 94 years old, is amongst the oldest medical institutions in the country. Like other previously white medical schools, the University of the Witwatersrand Medical School moved towards racial transformation through the integration of black, Indian and coloured students on the eve of South African democracy. Since 1919, the University of the Witwatersrand Medical School has produced more than 10 000 doctors of different races and has also trained other medical health professionals such as physiotherapists and pharmacists (Wits University 2013).

The University of Pretoria Medical School is located approximately two kilometres north of the Pretoria central business district. Also a previously white institution, it was established at a much later stage in comparison to those discussed above. The medical school was established in 1943 with a student body of 57. Following the establishment of South Africa's first democratically elected government, the University of Pretoria Medical School also moved towards racial integration and as at 2013, has an MBChB class of 300 students with representation from all racial groups (University of Pretoria 2013).

Although there is limited information on the historical background of Stellenbosch University Medical School and the University of Free State Medical School, these two institutions are also amongst the oldest medical schools in the country. As previously white institutions racial transformation has taken place. This will be discussed later in the chapter.

The Nelson R Mandela Medical School, in contrast, was established as the University of Natal Medical School in 1951 under the patronage of two missionary doctors, Dr John McCord and Dr Alan Taylor. Upon its inception, the institution only enrolled 35 students. The institution was started for a specific purpose. Its inception came after the realisation that there was a growth in the black population in areas surrounding the university and that there was a growing need for public health. Therefore, at the outset this medical school was concerned with providing medical training to black, Indian and coloured students who would then provide health care to the surrounding communities (University of Kwa-Zulu Natal 2000).

It is important to note that the University of Natal was the first institution to offer medical training to black students in South Africa. Paradoxically, in an all-white institution the medical faculty's comprised of black, coloured and Indian students with white teaching staff. Owing to the government policies of the time, there were several attempts by the government to separate the medical campus from the University of Natal; however, with no success. The medical faculty became a target of the government because of its racial composition. Furthermore, the medical school residence based in Wentworth, south of Durban became home to student and political activism from the mid-1960s to the late 1970s (University of Kwa-Zulu Natal 2000). This, however, began to subside in later years.

Since its inception, the former University of Natal Medical School has produced more than 4000 black medical doctors and for the first time in 1995, the institution accepted their first white undergraduates as a movement away from racial based admissions. The former University of Natal Medical School is now amongst the best medical schools in the African continent (University of Kwa- Zulu Natal 2000).

The Medical University of South Africa was formed at a very critical point in the history of South African education, in 1976. During this time, South Africa saw the Soweto uprising where hundreds of students died, having been shot by apartheid police as they protested against the Bantu Education System. Based in a semi-rural area north of Pretoria, Medunsa was the first institution to stand alone that offered an MBChB degree to black students. Like

the University of Natal, Medunsa also became home to political activism; this was also seen years after the end of apartheid in South Africa through constant student protests. Following a merger with the University of Limpopo in 2005, Medunsa faced significant resource constraints that led to internal conflict within the university; hence, the student protests. To its credit, Medunsa had a student population of 3800 in 2011 and has contributed more black health professionals than any other institution in South Africa (South African Medical Journal 2011).

Lastly, the University of Transkei Medical School, now Walter Sisulu University Medical School, located south of the Umtata central business district is the youngest medical school having been established in 1985 (Iputo & Kwizera 2005). This institution was established to serve the specific purpose of filling a gap in the shortage of medical doctors in the Transkei region, now part of the Eastern Cape. The institution specifically aimed at producing black medical doctors who would serve the largely rural Transkei region. As a result, the former University of Transkei Medical School employed a unique curriculum, namely, Problem Based Learning and Community Based Education that challenged rural pathology (Iputo & Kwizera 2005).

After its inception, the University of Transkei Medical School struggled to attract black students. Iputa and Kwenzera (2005) argue that this inability to attract black students was reflective of the poor science and mathematical literacy in the rural areas surrounding the institution. To improve the numbers of students getting into medical school, the university decided to lower the standards for students that came from previously disadvantaged backgrounds so that they would be able to access the MBChB course.

Walter Sisulu University is a previously black institution and consequently, it was one of the few institutions that produced black doctors at the time. To date, the Walter Sisulu University Medical School continues to be amongst the best producers of black doctors in the country. However, like all other universities it has been transformed in a sense that it has been able to admit students of different races.

A consideration of the deliberations discussed above shows that the racial composition in the medical service still leaves much to be desired if it is to be viewed in the eyes of the racial demographics of the country.

Table 1: Medical practitioners on PERSAL and HPCSA, by race, 2005-2007

Year	Sector	Category	African Number	%	Colourd Number	%	Indian Number	%	White Number	%	Total	%
2005	**Public (Persal)**	**MPs**	3295	37.7	386	4.4	1651	18.9	3415	39.0	8747	100
		Specialists	617	17.6	110	3.1	618	17.7	2154	61.6	3499	100
		Total	3912	32.0	496	4.1	2269	18.5	5569	45.5	12246	100
2006	**Public (Persal**	**MPs)**	3759	39.5	455	4.78	1854	19.5	3459	36.3	9527	100
		Specialists	675	18.3	127	3.4	665	18.0	2228	60.3	3695	100
		Total	4434	33.5	582	4.4	2519	19.1	5687	43.0	13222	100
2007	**Public (PERSAL)**	**MPs**	4103	41.2	453	4.5	1961	18.7	3542	35.6	9959	100
		Specialists	794	19.8	172	4.3	745	18.6	2289	57.2	4000	100
		Total	4897	35.1	625	4.5	2606	18.7	5831	41.8	13959	100
2007	**All (HPCSA)**	**Total**	5143	15.0	481	1.4	4269	12.4	15367	44.8	34324	
2007	**All (HPCSA)**	**Total**	5143	20.4	481	1.9	4269	16.9	15367	60.8	25260	

Source: Department of Labour (2008)

The above table shows consistent signs of growth in the practice of medicine by people of different races. A significant growth is seen amongst Africans; however, there is still a huge gap between African and white doctors, and it does not reflect the country's population. Also interesting to observe is the inconsistency and slow increase in medical practitioners amongst coloured people. Furthermore, they have fewer medical practitioners than the other population groups; namely, black, Indian and white. It is difficult to find an explanation for this as the number of coloured doctors does not reflect the coloured population in the country. I am of the opinion that the number of Indian doctors is closest to reflecting its population.

Parallel to racial laws in apartheid South Africa was the oppression of women in a sense that by law they were limited to certain types of work. Seldom did one find a female doctor during the apartheid regime. In post-apartheid South Africa, however, there has been an increase in labour market participation by women and the medical practice is no exception. Table 2 reflects the registration of doctors by gender.

Table 2: Registered medical practitioners, by gender, 2002-2006

Year	Male No	%	Female No	%	Total No	%
2002	21881	73	8022	27	29903	100
2003	22066	72	8512	28	30578	100
2004	22305	71.50	8909	28.50	31214	100
2005	22750	71	9447	29	32198	100
2006	23250	70	9966	30	33220	100
% change 2002-2006	6%		24%		11%	
Av Annual growth	1.5 %		5.6%		2.7%	

Source: Department of Labour (2008)

In this table one can observe a gradual growth in participation by both genders in the medical practice. Notably is the rapid growth of 24% amongst women in a space of four years as opposed to the 6% growth by their male counterparts. However, demographically, there are more women than men and therefore, this growth does not reflect the overall population.

Even though the above history of medicine and the demographical information about registered medical practitioners in post-apartheid South Africa reflects the precariousness of the country in this regard, it has not made the global market immune to exploring her borders.

The close of the twentieth century and the early twenty-first century marked an escalation in international migration by highly skilled workers. This has negatively affected many struggling economies. Many scholars of migration and related disciplines have attributed this to the globalisation of markets. The globalisation of markets has weakened national borders; it has come to allow for easier flow and movement of people with highly specialised skills across national boundaries. In this regard, the United Nations (UN) has estimated that about 200 million people or 3 % of the world's population live outside their countries of origin. Consequently, the most active category of the skilled has been the health workers. The twenty-first century has seen great mobility amongst health professionals and this is due to the high demand of these professionals across the globe. These movements involve nurses

and doctors moving from poor/ developing countries in the southern hemisphere to richer/ developed countries in the northern hemisphere.

In 2005, approximately 35 000 nurses sold their labour outside South Africa. The role of globalisation in the movement of professionals is something mentioned in literature; for example, Oosthuizen and Ehlers (2007) argue that it is the characteristics of globalisation such as growth in the need of human capital that has caused many South African nurses to migrate. They further attribute reasons for migration, particularly amongst the nurses to various factors. Amongst these factors are threats of safety. Between April 2005 and March 2006 a total number of 18 545 people were murdered in South Africa. Furthermore, within the same period, 54 926 cases of rape were reported. It is also argued that nurses experience both murder and rape in two ways: in their personal capacity and in their capacity as professional nurses (Raubenheimer, Magus & Delange 2006:1).

Amongst other frequent factors involved in migration, Van Rooyen (2000) puts forward the lure of a good quality of life outside the country, and issues of high income tax and a low currency in the home country. On the other hand, DENOSA (2001: addendum 1) states that there are multiple factors that have to be considered; these include inadequate salaries, limited career opportunities and the poor public image of nursing amongst other factors. For further engagement in this literature, please refer to Steger (2010), Maharaj (2007), Rogerson and Crush (2007), Ozden (2000) and the Centre for Development and Enterprise (CDE) (1997).

Notwithstanding the high migration rate seen amongst South African nurses, there has been observable mobility amongst South African medical doctors. Van der Vyver and De Villiers (2008), for example, state that in 1996, 14,8 % of doctors in Saskatchewan, a Canadian province were from South Africa. They further state that speculations and opinions have attributed the cause of such rapid and frequent migration by doctors to non-conducive working environments, dissatisfaction with remuneration, political instability, violence and crime. These factors appear to be consistent with some of the factors which have been identified above in relation to nurses.

In light of the above, this study is undertaken so as to identify what the core factors of international migration by South African medical doctors are. This is based on the assumption that some causes of migration by doctors may be specific to certain countries; hence, the focus on South Africa. This study argues that different doctors migrate for

different reasons. However, even though this may be the case, more emphasis is put on some factors than on others by doctors who migrate.

1.1. Problem Statement

The South African health care system faces the challenge that a large number of South African medical doctors migrate to other countries. It has emerged through various forms of reports such as academic and media articles that there is a shortage of doctors in the South African health sector. Therefore, migration in numbers by medical doctors does not aid the situation of shortage within which the country finds itself. Studies have been conducted on the migration of medical doctors from as far back as the 1970s. Bezuidenhout *et al* (2009: 12) state that in a study conducted for the University of the Witwatersrand, "approximately 45% of physicians who graduated in 1978 were located abroad".

In 2006, South Africa had a population of 48 million people, however; there were only 33 220 doctors to serve a population of this size. The Department of Labour's (DoL) report on the shortage of medical doctors in South Africa suggests that this number reflects a 7.7 doctor to 10 000 patients ratio. Table 3 reflects the dynamics of the shortage of medical doctors in South Africa.

Table 3: Medical practitioners, 1999– 2006 (Some may be out of the country)

Year	Total no	Growth no	% Change 1999- 2006	Av annual Growth
1999	29108			
2000	29788	680		
2001	29927	139		
2002	30271	344		
2003	30578	307		
2004	31214	636		
2005	32198	984		
2006	33220	1022	14%	1.91 %

Source: HPCSA (2006)

A study of Table 3 shows the steady progress in the growth of medical practitioners in the country. However, the growth in the number of practitioners is still not proportionate to the country's population. Moreover, even though these numbers show signs of growth, some of the doctors are no longer active in practice, others are outside the country and possibly others may be involved full-time private practice. These statistics by the Health Professional Council of South Africa (HPCSA) only reflect registered doctors for the years, 1999 - 2006 and do not suggest that all of those who are registered are active. This, therefore, suggests that the number of doctors in relation to the population maybe a lot less.

Bezuidenhout *et al* (2009) also highlight that between 1996 and 2006, South African doctors working in Canada increased by 60%. The above statistics are one of many signs that indicate the kind of challenge South Africa faces.

Some of the Commonwealth countries namely, Australia, Canada, New Zealand and the United Kingdom as well as the United States of America are amongst the receiving countries of migrating medical doctors. The source countries, South Africa being the case in hand, experience major shortages of medical doctors while the above mentioned countries boast the best health care systems in the world (Hathout 2002).

Through academic and public discourse, I gathered information, but did not conclude that in South Africa there is a shortage of medical doctors as a result of the culture of migration by medical doctors amongst other things. The aggregated data provided by the World Health Organization (WHO) on their website shows that there are great disparities between South Africa and other countries on a ratio of doctor to patient per thousand as opposed to the 10 000 put forward by DoL. The doctor to patient ratio in South Africa stands at 0.77: 1000 whereas Canada has a ratio of 1.98: 1000, New Zealand 2.74: 1000 and the United Kingdom 2.74: 1000 (WHO 2011).

1.2. Research question

This research question serves as a guide for this study and is in line with the social problems identified in the problem statement:

- What are the social explanations associated with the push and pull factors for migration by South African medical doctors to other countries?

This research question also has the following sub-questions:

- Are there cultural dynamics involved in South African doctors migrating?
- What are the race and class dynamics, if any, that can be associated with South African medical doctor migration?

1.3. Rationale

While migrating doctors of different race groups and gender are likely to understand the consequences of their actions (migration) in their home country, patriotism and possible isolation in the receiving country does not seem to prevent their outflow. The latter suggests push factors from the home country and pull factors from the receiving country.

The above has been subject to lengthy academic debates. Scholars of migration, economics, geography, history and demography have engaged this topic (Collins *et al* 2003; Posel 2004; Stilwel *et al* 2004; Kevin 2005; Manik 2007; Koser 2007). However, no consensus has been reached on what influences these movements. The multiplicity of disciplines concerned with the topic of migration makes it subject to a wide range of theorising and hypothesising with regards to push and pull factors.

The debates referred to above are largely economic in nature and thus, this may mean that medical doctor migrate primarily for economic reasons. These debates, moreover, are intricate on the negative effects of medical doctor migration in the home country and the impact of the migrated medical doctor in the receiving country. What these debates ignore, however, are the possible demographic and socio-political explanations that possibly inform the migration process.

This study, therefore, is motivated to fill the gap left by other scholars by examining social characteristics and how they influence the decision to migrate. Some of these social characteristics are specifically gender and race related. Gender is an important category as it will inform the study on who between males and females is more mobile and under what socio-economic conditions.

Taking into consideration that South Africa is a racially diverse country the responses are likely to be different given the historical differences in political and socio-economic

conditions. Historically, in South Africa some racial groups such as Indians and whites acquired more wealth than others such as blacks and coloureds. Therefore, and because of these historical imprints, it is safe to believe that there may be different motivations to migration amongst the different race groups and gender. It is a motivation of the study, therefore, to establish if whether or not there is a relationship between race, gender and the decision to migrate.

1.4 Scope of the study

This study employs the use of a qualitative approach. The data that informs this study was obtained from a sampled number of South African medical doctors (see Chapter 4 for further information) based in Durban, Pretoria and Johannesburg by means of interviews. The background information for this study was obtained through the process of a literature review that is inductive in its approach. The literature covers local migration by unskilled workers and concludes with literature that covers international migration by highly skilled workers. The study encompasses a total of eight chapters and seven of these are outlined below. It is important to note that, because of the sample size, the findings in this study cannot be generalised.

1.5. Chapter outline

Chapter 2 of this study is the literature review and it outlines the research that has already been done by other scholars on the subject matter. It concisely covers the history of migration in South Africa as far as its initial recording to date. Moreover, the chapter also examines international migration since the phenomenon of migration is not unique to South Africa. In this chapter, key concepts and prominent theories of migration are discussed.

In Chapter 3, I critically engage my work using three theorists, one contemporary theorist and two classical theorists: Pierre Bourdieu on taste and distinction, Max Weber on prestige and Karl Marx on class. In Chapter 4, the research methodology of the study is discussed. In this chapter, the areas where the research was conducted and the reasons for the choice thereof are discussed at length. The sample size which comprises the gender and racial composition is also discussed. Furthermore, the method of data collection and data analysis are examined. Chapter 5 highlights the key pull and push factors for South African medical doctors. At the same time, it raises other key issues that contribute to these movements.

In Chapter 6, migrant cultures of medical doctors are discussed. Furthermore, the habits, actions and behavioural patterns that are consistent with South African medical doctors are studied. Topics such as the way their movements are initiated in the home country and how they negotiate their everyday lives in the host countries are discussed.

Chapter 7 is the conclusion of this study. It summarises and discusses the link shown between the findings, theory and literature. Furthermore, gaps in literature and contributions of this study to literature and theory are clearly outlined.

Chapter 2

From local to international, unskilled to skilled international labour migration: a literature review

2.1. Introduction

This chapter reviews existing literature on local and mostly international labour migration. Firstly, there is a brief discussion on the history of migration, mainly by unskilled workers in the South African and the Southern African context. Later in the chapter, the transition from migration at local level to migration at international is examined while also observing the change in skills or the lack thereof of people that migrate. Amongst other things the gender patterns in migration are explored. Finally, prominent theories of migration are outlined.

2.2. Migration, family and gender

A study of the literature of both local and international migration reveals that migration as a subject of study has always focused on the individual, that is the principal migrant and not the family. Families have been seen as adjunct entities to the principal migrant (Carlos & Alarcon 2012). This means that families are seen as subordinate structures and the person of essence, the principal migrant, is the actual person selling the labour. What these studies of migration do not do, however, is to pay attention to the working results of the persons that migrate with families and those that do so as individuals.

The nature of migrant policies is that they are structured in a way that only accommodates the principal migrant and not the rest of the family. It is a common thing, nevertheless, that the principal migrant may want to bring the family with. The success of this, however, in most cases, depends on the importance of the principal migrant in their specialty of work. It is further stated by Carlos and Alarcon (2012) that even though migration with families is viewed positively by many, often it has far reaching financial ramifications on the principal migrant. These financial ramifications are usually as a result of travel expenses and living standards that may be higher than the country of origin. This is stated with the full understanding that the principal migrant will not have made his/her first earnings in the host country (Carlos & Alarcon 2012).

Notwithstanding the sometimes negative ramifications of migrating with family, there are also a lot of positives that are developmentally inclined. Carlos and Alarcon (2012) state that migrant workers that have access to their families tend to perform better at work than their counterparts who do not enjoy the privilege. They also assert that the former adjusts better and quicker to the foreign country, and that the latter enjoys better health because of reduced stress levels.

On the other hand, there are negative consequences on families of principal migrants in traditional families where males are often the heads of households. It is usually a daunting experience for the women left behind to assume social and family responsibilities. Carlos and Alarcon (2012) further state that this pressure of responsibilities often results in social stress as they face the challenge of having to negotiate their way around household related chores and responsibilities. These chores often include paying for children's education while awaiting remittances, cooking and taking care of children, to mention but a few. Other social stresses may also arise from extended family members that may pressurise the wife of the migrant on how she ought to spend and or invest the remittances (*ibid*).

Carlos and Alarcon (2012) moreover, assert that migration is a phenomenon consistent with males; this means that the act of migration is something that is more popular amongst males than it is with females. However, Pogge (2012) argues that in recent years there has been a shift in that there are a growing number of women that engage in the process of migration. This can also be seen in Fakier's (2009) PhD thesis, *The Impact on Emnambithi Households: A Class and Gender analysis*. In this study, amongst other things, she looks at how migrant and resident women negotiate their everyday lives in an attempt to support the broader household. Historically, the role of provision and the act of migrating were phenomena consistent with men. Responses to the questions posed to women in the study and studies in this area can be seen as supportive of Pogge's argument that suggests an increase of women migrants.

This increase, however, is also seen to have far reaching consequences on the traditional family unit. It triggers changes in gender relations and challenges patriarchy. This means that when women are the principal migrants, men often assume duties that are traditionally assumed by women. Boeh (2008) states that upon return of the mother or upon return to the home country the gender roles are often redefined; in other words, traditional roles are resumed. The mother goes back to assume the traditional motherly chores and the man

assumes his respectively. In cases where during the absence of the mother, the man experiences challenges with children or otherwise in relation to household chores, they are often assisted by extended family members.

This section has provided insight into how migration has an impact on the household and how the household influences the principal migrant in their presence or absence in the host country. Furthermore, the section also gives the reader insight into how trends of migration have evolved over time in as far as gender based migration is concerned.

Although the above authors have suggested that there has been an increase in migration by women, there has not been a suggestion that there has been a drop in male migration either. In the following sections of this chapter, various patterns of migration ranging from unskilled labour migration to highly skilled labour migration are discussed at length.

2.3. The concept of migration

The term migration has similar terms that if not clearly defined and or understood could be incorrectly used interchangeably. These terms are immigration and emigration. One must, therefore, acknowledge that there is a fine line between them and that the term, migration is no exception. These terms are thus discussed.

Immigration is a process whereby one enters and becomes established in a country, especially in a country where one is not a citizen (Whithers 2010). This process of immigration may occur for many reasons such as economic, academic opportunity or family reunification. Whithers further states that this process is usually on a permanent basis. On the contrary, emigration is the direct opposite of immigration; it refers to the process whereby a person leaves one country and settles in another. This process may be influenced, amongst other social phenomena, by economic or political unrests in their country of origin and family reunification *(ibid).*

The key term in this study, however, is migration. Migration refers to the process whereby one crosses political boundaries or administrative unit for a certain period with intentions of returning (Boyle *et al* 2008). This process of migration happens temporarily with intentions of returning to the original place of residence or place of birth; for example, when someone leaves their country or locality for reasons of accumulating financial resources or remittances, this is referred to as migration.

In as much as the research topic suggests that one must engage the topic of migration at an international level, it is important that other levels from within which lie at the roots of international migration are acknowledged; that is, the migration process at local level.

2.3.1 The Genesis

The history of migration began long before the arrival of white settlers under the leadership of Jan van Riebeek in 1652. Peberdy (2009) states that wars, particularly during the times of Shaka Zulu, pushed people northwards. This phenomenon on its own facilitated movements even though they were not yet motivated by the markets.

Consequent to the discovery of gold in the year 1886, migrant labour in South Africa was accelerated. Wilson (1972) states that one hundred years before the birth of the Witwatersrand gold mining industry, men had begun to migrate between their rural homes and their areas of work which were mainly based on agricultural work. This meant that the process of labour migration had dawned as a result of one of South Africa's biggest sectors at the time.

In literature, we learn that not much has been documented about the early agricultural economy. Nevertheless, Wilson (1972) writes that it is the industrial economy that accelerated the migration process. Years after the inception of the agricultural sector, because of its growth in the 1870s, it was faced with a problem of labour supply. This problem of labour supply had been previously addressed through systems of slavery that were later abolished. This meant that alternative forms of addressing the problem at hand had to be identified. Workers were recruited wherever they could be found in order to address the problem (Wilson 1972). Ciskei and Transkei which now form the Eastern Cape Province are some of the places where agents were sent in order to recruit workers as an attempt to solve the problem of labour supply.

As was the case in the 1800s, agriculture continues to be an important sector of the South African economy. Even though this might be the case, the discovery of gold in 1886 caused the agricultural sector to trail the mining industry which was soon to take South Africa to greater economic heights. It is the mining economy that accelerated the migration process. Consequently, by 1910, merely 24 years after the discovery of gold, 200 000 workers were taken to the Witwatersrand annually from different parts of the country and the continent (Jeeves 1985).

It is important to note that most, if not all the workers that arrived in the Witwatersrand were unskilled labourers. In other words, none of them had received prior training for the kind of the jobs that they were soon to perform. The absence of skill, Wilson (1972) suggests, was a common phenomenon amongst all race groups, both black and white migrant labourers. However, it was other white workers, expatriates that had been recruited from other countries who possessed certain skills necessary for the labour process.

Coming from the former Bantustans, these workers had no housing in their city of destination. In 1923, the government of the time saw the need to establish same-sex hostels (mainly for men) where these men would dwell. Their design and location was to ensure that the government would be able to control labour. Overpopulation, squalor, loneliness, alienation from the rest of society and social dislocation amongst other things were the order of the day (Xulu, 2012; Jeeves 1985; Wilson 1972).

Even though there has been such fascinating sociological data that has been interpreted and analysed for these periods, internal labour migration remains amongst the most under researched topics in South Africa (Kok *et al*. 2003). Although scholars such as Ramphele (1993) have covered areas of internal migration, particularly the work on compounds in Western Cape townships, there is not much literature on this topic. What one often encounters is literature based on migrant labour into South Africa by migrants in the Southern African region. Furthermore, many of the studies on labour migration in South Africa have always been centred on the mining sector and little on the health, education and the domestic sectors, just to mention a few. However, Ramphele (1993) looked at compound dwellers in the Cape that were, unlike the above, workers spread across places of work in the Cape and not only concentrated on the mines. However, from the status quo of the South African labour market and its labour supply, it is safe to assume that the movement of people within provinces in South Africa to different sectors other than the mining sectors has always been prevalent. Nevertheless, these movements through provinces were limited by apartheid laws in South Africa before 1994 that did not allow for the free movement of black South Africans to some parts of the country.

Little research has been conducted on internal labour migration; Kok *et al*(2006*)* state that before 1996 the only available data on labour migration in South Africa were those of the period, 1975-1980, emanating from the 1980 census. Furthermore, Kok *et al* (2006) state that this information of the latter period on its own was flawed because it excluded data on the

former homelands areas. This phenomenon of limited literature of internal labour migration challenges scholars to start questioning the new patterns of labour migration in post-apartheid South Africa. On the other hand, Standing (1996: 61) differs in views with Kok (2006). He argues that, "there has been a great deal of excellent research on the issue". Moreover, Standing asserts that, even though there topic of internal migration in South Africa is well studied the worrying factor is illegality of immigrant from the surrounding states.

Despite the scarcity of literature that exists on internal labour migration, Rogan (2008) suggests that between the years 1993 and 1999, there was a noticeable increase in the number of labour migrants throughout the country. Posel (2003) supports this suggestion, but associates the increase in labour migration with the feminisation of work in South Africa. Khan *et al* (2006: 113) corroborates these assertions by saying, "The overall rise in labour migration is likely to be explained, in part, by a significant rise in female migrants relocating to work in or search for work." It is argued that in the 1990s labour migration was at 30 %and by 1999 it had increased to approximately 34 % (Posel 2003).

Migrant labour for men in South Africa has often been associated with the mining sector. This was because of the belief by the employer that the nature of mine work is something that could be best done by men. On the contrary, a third of migrant women which has influenced an increase in labour migration by women have been associated with the domestic service sector. This may be associated with the choice of work (domestic service) by migrant women with the South African trend of the work force that has largely in the past been male dominated and thus, limiting women to sectors such as the domestic service sector.

The labour market is and always has been responsive to the laws of supply and demand. In the above paragraphs, one may deduce that much of the labour migration that has been discussed involves largely unskilled rural migrant labourers as a result of labour market demands. The contribution of this chapter in the dissertation, therefore, is to show how migration in the South African context has evolved. This will allow the reader to make sense of the dynamics of migration, if any, between the early migration days to the present in the country. These dynamics include how the labour market has now stretched to a demand for semi-skilled and skilled workers which had not previously been the case. In the following section, skilled and semi-skilled internal labour migration is discussed

2.4. Skilled and Semi-skilled internal labour migration

The democratic South Africa presents an opportunity for all. With a constitution said to be amongst the best in the world, everyone since 1994 has a right to education. With the democratic South Africa came a new legislative frame work that abolished acts that were oppressive in nature while adopting ones that are racially and gender inclusive. One of the abolished acts was one that limited the free movement of people across provinces (Bantu Authorities Act and Group Areas Act). The opportunity afforded by the right to education has allowed people to participate in schooling and post-schooling education that enables people to be active economic participants in the South African labour market in various sectors.

Post-apartheid South Africa was and still is faced with the task of rectifying the ills of the apartheid government; therefore, this meant training people in large numbers so as to better equip the South African labour force. Professional teachers are an example of people who even under the apartheid government were trained, but were limited to certain geographical locations. For various reasons, post 1994 teachers began to migrate into other parts of the country that they previously could not migrate to. A South African Council of Education (SACE) report (2011) suggests that teachers often leave government rural schools for urban and private schools. The report suggests that teachers often refer to under-resourced school facilities and limited access to development programmes as their primary reason for migration.

As mentioned above, "the constitutional and the political developments post 1994 in South Africa created opportunities for middle class professionals in relation to career pursuits" (Wamla 2001: 111). The removal of movement restricting acts and the development of a state divided into nine administrative provinces and new government structures at national and provincial spheres brought about a major transition. Workers who had worked in the previously homeland areas were migrating to new geographical areas of work (*ibid).*

It is safe to assume from the previous paragraph that this process of internal labour migration by skilled workers is not limited to teachers and public servants only. Although literature on internal migration by professionals is more limited than that of unskilled workers, from social action one is able to learn of migrant labourers around their settings. Across all sectors in our country, whether private or government property, we encounter people of different ethnic groups that speak different languages predominantly spoken in provinces that are not the ones in which they currently live. Often we discover that these workers are either migrant workers

or sons and daughters of migrant workers. These workers occupy different professional sectors of the economy such as the private health sector, public health sector, education sector and business sector.

When the South African labour market demanded mostly unskilled labourers, most labourers from rural areas moved urban areas as they viewed the latter as a land of promise and plenty. (Wamla 2001) states that often students and writers of migrant labour associate migrant labour with unskilled labour. However, the current South African labour market shows that there has been since a shift from a need for a large number of unskilled to skilled workers. This need for skilled workers, on the contrary, requires recruitment in a wide range of places, local and internationally.

Similar to the previous discussion on the unskilled, this section also places focus on establishing connections in order to sensitise the dynamic processes of migration; in other words, the evolution from the need of unskilled labour to semi-skilled and skilled labour. The limitation in both these sections, however, is the paucity of research done in South Africa in relation to broader internal migration in the 1970s and 1980s. The following section, therefore, looks at literature on South African's semi-skilled and unskilled international migrants.

2.5. International Migration by semi- skilled and unskilled workers

While international migration by skilled personnel continues to take precedence consequent to its demand, unskilled labour demand has not necessarily disappeared. In relation to this, use of domestic workers as a case study of the "unskilled" labour force is employed.

In the early years after the discovery of the Witwatersrand, South Africa saw an influx of migrant workers to the mines in the Rand to sell their labour. These migrant workers came from various areas in the Southern African region. However, the degree of their demand in later years has subsided. On the contrary, demands for unskilled labour in a different sector have become rife.

Over the past years there has been a noticeable increase in the need for domestic services. Through an understanding of the country's history one could attribute this increase to the lifting of the apartheid laws that prevented the free movement of people across the country and to the growth in feminisation of work. Peberdy & Denat (2005) also state that domestic

work provides significant employment for migrant women in Johannesburg from both in and outside the country. The latter can be corroborated with the 2001 census that indicated that 31 percent of South Africa's women and migrant women in general constitute the domestic sector.

While these women engage in international labour trade, the majority of them keep contact with their families while sending money as frequently as possible to their families (Peberdy & Denat 2005).

The process of migration in the unskilled labour force is not unique to Southern Africa. The largest group of migrant workers in the world are found in the Philippines; this has been the case for over four decades. Seventy two percent of migrant Filipino workers are women. Most of the Filipino women sell their trade to households as domestic servants and their services to countries like Italy have been in use for over three decades (Marchetti 2012).

The commonality between the Filipino migrant domestic workers and those in the Southern African region is that there is common motivation in their quest. The Filipino and the Southern African region are areas that struggle with absorbing their citizens in employment. Therefore, policies of migration in these areas allow for migrants to seek economic greener pastures while bringing back remittances to their respective countries of origin.

Countries such as Italy have citizens that are not keen on activity in the domestic sector. One may be tempted to align the lack of interest in the domestic sector by Italian citizens to the country's economic stability. This, therefore, makes the demand for migrant workers in such countries relatively high; thus, leading to willing Filipino migrants taking up the economic opportunity.

Most migrant domestic workers in the Southern African region tend to migrate to Johannesburg, South Africa. Their actions are a consequence of the scarcity of feminine jobs in the countries of origin. Another possible contributing factor may be the economic stability in their country of origin. On the contrary, their visibility in the South African market is also influenced by their alleged will to work for a minimal wage as opposed to their local counterparts.

This section in this literature review shows the dynamic nature of the labour market. It shows that the labour market responds differently to different economic circumstances and the nature of the globalised labour market. Earlier in the literature review, cases of demand in

unskilled internal labour migrations were discussed in contrast to internal and international skilled labour migration in order to show the labour market's reaction to issues of supply and demand.

2.6. International labour migration by South African professionals

"Globalisation can be defined as the intensification of worldwide social relations which links distant localities in a such a way that local happenings are shaped by events occurring many miles away vice versa" (Giddens 2010: 49). The latter definition may not necessarily be the best definition for explaining the phenomenon of international labour migration. However, from the definition one can arrive at the idea of the homogeneity of skills and expertise around the world as a result of globalisation that exists in the global labour market.

The global labour market has over a number of years had difficulties producing a proportional number of professionals in certain sectors of the world economy. There have never been enough health professionals such as doctors, nurses and midwives as well as engineers and teachers in other sectors to satisfy or fulfil the needs of the globalised world. This has caused South African professionals or professionals in other developing countries to be susceptible to international labour migration so as to fill gaps in the developed world (Manik 2007).

Across the globe there is the challenge of producing an adequate number of professionals such as the ones mentioned above. Competition across the globe, therefore, has become intense. Developed countries may have a competitive advantage over their developing country counterparts because they possess economic resources that are yet to be seen amongst some of their competitors if at all. Moreover, the infrastructure in general surpasses that of developing countries.

Amongst the professions discussed is teaching. In developed countries, particularly the United Kingdom (UK) there is a high demand for teachers. However, the demand for teachers in the UK is not met by the supply coming through from local colleges and universities. The alternative in this case becomes recruiting teachers from wherever they can be found in order to meet the demand and thus, maintain the standard of decent education. Since South Africa is part of the global labour market she is not immune to losing her teachers, thus, causing the "brain drain" (Manik 2007).

While South Africa has her fair share of education problems that include a shortage of teachers across the country, Manik (2009) states that at least 4 000 teachers leave the Republic of South Africa annually. On the other hand, she further argues that if South African teachers were not "poached" there would likely be a satisfactory number of teachers within the country.

When figures of the brain drain appear this big, one may be tempted to make an ethical or moral judgment of what some writers and commentators refer as "brutal recruitment" by developed countries. Nevertheless, teachers that migrate to these countries state clearly the reasons for their actions. Experienced migrant teachers cite the absence of upward mobility and being unhappy with their careers in South Africa as a reason. Furthermore, they also cite frustrations with educational policies governing the profession. Manik (2007), for example, argues that experienced teachers have increasingly been frustrated with outcomes based education (OBE). OBE, she argues, has converted subjects to learning areas; for example, Geography was changed to Human and Social Sciences which, in turn, encompasses both History and Geography. This, therefore, has affected issues of pedagogy and alienated them from their work.

However, novice teachers, namely, the relatively young and the least experienced teachers cite slightly different reasons. They argue that what motivates migration the most is financial gains in the developed world. Furthermore, they are also critical of South Africa stating that they do not think that the teaching profession in South Africa is appreciated as it should be in terms of incentives. Lastly, novice teachers also said that part of the reasons why they migrated was to afford them an opportunity to travel while they still can.

The literature above contends that migration by professionals in South Africa is not limited to teachers only. This process affects all the sectors that are in high demand by developing countries yet are disproportionally supplied by their necessary institutions.

While a lot of literature on migration in South Africa is about migrant labour to the Witwatersrand mines by largely unskilled workers in the 1900s, a lot has transpired since then. Rogerson and Crush (2007) state that, the early 21stcentury has brought about a significant increase in international migration by highly skilled professionals as a result of globalisation. Amongst the highly skilled professionals that migrate, a large percentage of these are health workers, particularly doctors and nurses.

There is no doubt that South Africa faces major challenges in terms of healthcare despite her quality of training and research in the health field. The country has internationally renowned personnel yet her health problems remain unresolved and furthermore, she keeps losing these personnel at a rapid pace (OECD 2004).

A fascinating sociological observation that emerges in the literature is that the typical countries of destination for these health workers can be counted on one hand regardless of the dates of migration. These countries include Australia, Canada, New Zealand, United Kingdom (UK), and the United States of America (USA). These countries in different bodies of literature are referred to either as the "OECD countries" or "The Big Five". Establishing what these five countries have in common is of prime importance as it will definitely help answer the research question of this study.

A good number of South African nurses sell their trade in the above mentioned countries. Another percentage of these nurses sell their trade in other countries. There are, however, no accurate statistics known to reflect specific percentages. However, the OECD (2007) states that there are approximately 35 000 nurses working outside South Africa.

The literature provides evidence that there has been a tremendous growth in destination countries for nurses and other health professionals. It has been argued previously that migration took place from a wide range of developing countries to a few developed countries (Mejial, Pizuk & Royston 1979). To generalize, migration by nurses and other health workers was generally from the northern hemisphere to the southern hemisphere. Bach (2003) argues that workers now move from poor countries to less poor and then richer. Bach (2003) further points out that destinations for these health workers are now the Gulf States, Europe and North America. The Gulf States include countries such as Bahrain, Iraq, Kuwait, Saudi Arabia and the United Emirates where most South African nurses have shifted to as migration homes (Brush and Sochalski 2007).

While this migration by nurses is an on-going process daily in South Africa there are news reports of understaffing in public hospitals, negligence, overworking of available nurses and a high rate of infant mortality (Mail & Guardian 2012). These problems which may be viewed as ethical and moral obligations are not enough to curb this process of migration. Thus, the immediate consequence of nurse migration becomes the shortage of nurses to fill the gap of the aging generation of nurses.

This problem of the shortage of nurses is not a case unique to South Africa only. Wealthy countries such as Canada, Ireland, Germany and the USA, just to mention a few, are experiencing the same dilemma. The fundamental difference, however, between the above countries and South Africa are the causes of the shortages in nursing staff and them being the receiving countries as opposed to being the source countries.

Problems of public health have become rife in this day and age with wealthy countries not being exceptions to such. Part of the problem is the shortage that has been discussed. While the demand for nursing personnel rises in the above mentioned countries, supply on the contrary has been very minimal. According to Staiger and Auerbach (2000), with nursing being a previously feminine profession, females in recent days enjoy a wider variety of career choices than what was previously an obvious choice. Furthermore, in the above mentioned countries there is lack of interest from the youth of pursuing nursing as a profession (Staiger and Auerbach 2000).

The preceding paragraphs highlight not only the reasoning behind the shortages of nurses, but also the reasons for the fast paced recruitment of nursing personnel from developing countries. Furthermore, there is peculiarity in the sense that countries that enjoy overall recourses are incapable of attracting their own citizens to the demand of the health sector.

South Africa is faced with a lot more challenges than her counterparts. Shortages of nurses add to the problem of supply versus a large demand. However, another larger portion of her nurses are migrant labourers in the OECD countries owing to pull and push factors of migration.

In a study by the Human Social Research Council (HSRC) (2005) on migration of South African nurses, nurses gave some interesting perspectives into the reasons why they migrate. They state amongst other things that South Africa is a violent country and therefore, their safety is compromised. Moreover, they argue that constantly they are faced with dealing with violent victims such as rape and patients who have been physically assaulted which can prove to be traumatic.

This section in the chapter offers the reader a transition: local based migration which was largely based on unskilled workers to skilled professional has been discussed. The section provides the reader further insight into which of the South African professionals is susceptible to migration. Furthermore, the shift in countries of destinations for these

professionals and what the influences behind their decision to migrate are is discussed. In the following section international migration by semi-skilled and unskilled workers is discussed.

2.7. International Migration by Health Workers

Rogerson & Crush (2007) recognise that international migration is not a new phenomenon. They argue that it is a debate that dates back to the 1950s and early 1960s in the industrialised world. The debates in literature around the merits of health worker migration and its disadvantages are something that has been discussed before in the Edinburg Commonwealth Medical Conference and conferences that followed.

It is has been further stated that international migration of health workers specifically became a major topic in the early years of the 21st century. This migration by health workers is not a situation or problem unique to South Africa. Ghana, for example, had a doctor and nurse to patient ratio of one doctor for every 10 641 and one nurse for every 1 636 citizens in 2006 owing to migration (Asiedu 2010).

This phenomenon of migration amongst other things is also seen to be a product of the globalised world (Rogerson & Crush 2007). It is, however, a very limited researched topic. Studies suggest that health worker migration had not been studied extensively and that the last studies were in the 1970s by the World Health Organisation (WHO) (Stilwell *et al*2004).

The 1970s study by the WHO showed that of the overall health workers in the world, six percent of nurses and five percent of physicians (doctors) were practising outside their countries of origin. Thirty-five to 40years later the possibility of growth in the above percentages has probably been experienced. Out of the migrating health workers the trend in literature suggests that amongst them it is doctors and nurses that engage most in the migration process. This does not in any way suggest other health professionals do not migrate, but asserts that they do not as much as their counterparts (Ramurmuthy 2003; Stilwell *et al*, 2004; Rogerson & Crush 2007).

Much of the international mobility of health worker tends to be from developing countries in Africa, Latin America and Asia to North America and Europe (Ray *et al*2006). The mobility of health workers is said to have a history of one sidedness. In other words, often health worker migration involves health workers from poor countries going to richer countries.

Seldom is the opposite the case (Ramurmuthy 2003; Stilwell *et al*; 2004 Ray *et al* 2006; Rogerson & Crush 2007).

What causes health worker migration is subject to debate as shown in the above paragraphs relating to doctors specifically. On a basic level, international health worker mobility is attributed to the role played by recruitment agencies. There are international recruitment agencies across the globe. These specialise in recruiting health workers for their parent countries, offering better overall remuneration as opposed to the home country.

Stilwell *et al* (2007) says that causes of health worker migration can also be personal at a basic level. However, she acknowledges that these causes may be due to political atmospheres and socio-economic influences. Flexible visas and work permits, she argues, could be amongst the contributing factors of increased international health worker mobility. Countries like India and Philippines which have an oversupply of workers are instrumental in encouraging migration

At present, it has also become easier to secure employment in other parts of the world and this is due to modern day technology that exposes people to vacancies across the globe. Furthermore, it is stated that it becomes hard for health workers in the developing world to resist these temptations especially when they are a mouse click away (Rogerson & Crush 2007).

Socio-economic conditions continue to dominate the pull and push factors of health worker migration. One could argue, therefore, that if disparities between developing and developed countries were to be minimised so would international health worker migration. This would mean that wages and working conditions in the developing world have to be improved.

The most outstanding phenomena from the literature on migrant labour are the transition in the markets over time. Although in this dissertation the case of South Africa is used to a large extent, it can be deduced at some point in time that migrant labour was limited to national boundaries and later to regions. It was a matter of time before the latter became a global practice that now is said to cause harm in some countries while emancipating others. Debates rage about what has caused this transition from national and regional to the international absence of boundaries. However, as mentioned before no consensus has been reached.

Furthermore, the transition on the kind of labour sold is something worth noting. Early in the literature we noticed that much of what is sold by migrant labourers both from a national and

an international perspective is labour power. On the contrary, later in the chapter a transition that suggests selling of human capital as opposed to the latter was noted: how the globalisation of the labour markets and the change in the nature of demanded labour power/ human capital has influenced these transitions.

2.8. Migration by South African Medical Doctors

By virtue of being medical personnel, doctors qualify as health workers. From the above paragraphs we gather that human capital in the health sector is in high global demand yet the supply is minimal due to various shortcomings. From the preceding paragraphs it can also be established that countries that have the financial muscle tend to be aggressive in their recruiting in attempts to consolidate their health care system.

The South African health system as it has been noted above is in a state of disarray. The migration by medical doctors as a result of global labour market demands is a continuous process. Literature dates this phenomenon of doctor migration to over seven decades ago. Bezuidenhout *et al* (2009) state that in a study conducted for the University of the Witwatersrand (Wits) in the year 1975 about its graduates between 1925 and 1972, it was found that 83.6 % of those graduates practised their medicine in South Africa. However in a follow up study it was discovered in that in the class of 1975, 45% of graduates had migrated mainly to the Commonwealth countries.

Notable in the literature of migration is that regardless of what kind of skill that is being discussed in relation to its scarcity and migration, the same countries keep appearing as the receiving countries. These countries' ability to provide adequate skills for themselves as developed countries may be questioned, especially with the knowledge that countries have the autonomy to enhance their economies by every means necessary. It is important that the sustainability of their dependability on other countries is questioned.

It appears, first and foremost, that there are very few countries that produce enough medical doctors for their populations. This, therefore, means in as much as there already is a shortage in the supply of medical doctors, the situation could be worse. Squalid conditions exist in places full of bacteria and germs such as public hospitals when patients are not treated adequately as a result of shortages. The number of patients needing services is exacerbated. The increase in the number of patients means an increase in demand for doctors. The future

of the source countries' health systems and the ability to sustain them amid the "fierce" recruiting also leaves much to be desired.

While migration by South African medical doctors has far reaching consequences for the health sector, the same can be said about its financial implications. It takes R1 million to train a medical doctor in South Africa and so much of it ends up out of the country. It is further argued that such financial implications can also both harm education and the health sector with so much investment in people that results in minimal outcomes (Bezuidenhout *et al* 2009; Grant 2004). .

Bezuidenhout *et al* (2009) justify the migration by stating that the rate at which South African medical doctors migrate can be attributed to the good standard of the country's medical schools. It can, however, also be argued that as long as South Africa produces graduates with excellent skills and training, they will continue being sought after by developed countries.

It has become typical that most migration cases have an economic base of reasoning. Grant (2004) states that overall there is dissatisfaction with conditions of employment amongst medical practitioners. Remuneration and concerns of safety in the country are recurring themes. DENOSA (2007) supports the economical pull factor when they say most of what causes health workers to leave the country are the relatively low wages they receive. On a scale of one to five in Bezuidenhout's work, 86 % of people who migrated to other countries left for financial reasons.

This section has identified South African doctors as part of a global labour market. South Africa as a country has also been identified as one of the key source countries in the market for doctors. Furthermore, reasons for migration by these doctors and to which countries they frequently migrate to have also been identified. The health sector in each country is always amongst the highly prioritized. Therefore, citizens and authorities of countries often assume a moral and ethical stand in as far as health worker migration is concerned. The following section focuses on the contested topic of ethics in health worker migration.

2.8. Ethics in health worker migration

"Globalisation and prospects of international migration bring both opportunities and challenges" (Shah 2010: 106). What Shah means here is that globalisation and international migration loosened national borders and boundaries. This allows for much easier flow and

movement of people, culture and commodities across these national boundaries. This however, she argues, also carries its own negatives in a capacity as it does its merits. Globalisation, nonetheless, has become an internationally accepted phenomenon even though there is still the ethically debated topic of international migration by health workers.

The core of the debate on migration by health workers is a moral one. Morality emerges when health workers from developing or poor states migrate to the rich states where their skills are less needed. Emerging arguments are that the source countries face much larger patient populations and that the state of their health care is disadvantaged. In contrast, the host or country of destination often has the direct opposite as there are fewer patients and improved patient health conditions. This movement of skilled people from poor to rich countries has been termed a brain drain (Lesser, Sager, & Shah 2010).

Furthermore, advocates against this brain drain argue that a lot of money is spent in the source developing countries for educating and subsidising education for health students and yet they are "poached" or they decide to sell their labour elsewhere. As a result, Sager (2010) argues that politicians, pundits and policy papers have suggested that there should be much more rigid policies of migration to control this outflow.

Other scholars have highlighted the inconsistency of this moral and ethical debate on health worker international migration. If one, for example, is to argue ethically for migration one would argue that it is unethical for one to question one's right and decision to migrate. According to human rights, every one reserves the right to sell their labour to whoever is willing to buy it for a price agreed upon and therefore, the moral and ethical debate becomes rather questionable.

Although migration by health workers is a subject looked down upon by health authorities and other interested parties of the source countries, those who are in favour of this action do not find much fault in it. They argue that source countries are often under-resourced from financial to equipment resources and further argue that these shortcomings make the prospective countries of destination even much more attractive (Shah 2010).

Sager (2010) asserts that the brain drain is not about the movement of the people. Rather, vast inequalities and human misery are the root causes. Developing states, therefore, it seems, need to move away from the moral and ethical debate and begin to think in terms of supply and demand and how these are to be satisfied. It has also emerged that each country should

look into its own root causes and find solutions that are workable in their context. There are various theories of migration that attempt to explain various forms of root causes; this is discussed in the next section.

2.9. Theories of migration

There are a considerable number of theoretical models and frameworks designed to explain and interpret the logic of migration and international labour migration. These logically connected sets of ideas employ different radical approaches and concepts, assumptions and frames of reference (Massey *et al* 2011). This means that even though these theories have one objective which is to explain and interpret migration, how they go about in doing so is different.

Neoclassical economics is one of the many theories used in the interpretation and explanation of the migration process. In interpreting migration, this micro theory narrows down its logic to explanations of differentials (Massey *et al* 2011). This means a comparative is drawn in terms of wages and employment conditions between the source countries and the receiving countries. In a case, for instance, where South Africa is a source country and Canada is the receiving country, comparatives are drawn between the two countries based on conditions of employment to explain why a South African would view Canada as preferred country of destination. It can be concluded that this theory views migration as an individual decision based on economic benefits. I am of the view that the theory disregards issues related to the world labour market and the influence of globalisation in the markets which makes it unsuitable for interpreting a sociological study.

The new economics of migration, on the contrary, seeks to explain migration not only in terms of the different labour markets, but on a broader scale. It considers migration not to be an individual decision, but one that has been influenced by family so as to keep the family incomes intact and minimise the risks surrounding the income (Massey *et al* 2011). It is an undeniable fact that, this theory as well as the former do to an extent, interpret migration, but one may argue that they do not do so adequately. The theory of new economics of migration does not engage in it the influence that society at large and the globalisation of the labour markets has on migration.

Lastly there is the Dual Labour Market Theory and the World Systems theory. These two theories ignore such micro levels of decision process, focusing instead on forces operating on much higher levels of aggregations (Massey *et al*, 2011).

The former Massey *et al* (2011) argue links migration to structural requirements of modern industrial economies while the latter sees migration as a natural consequence of economic globalisation and market penetration across national boundaries.

"Many sociologists have linked the theory of international migration to the structure of the world market within particular national economies" (Massey *et al* 2011). This interpretation may mean that they do not narrow their understanding of international migration from the perspective of an individual market, but the world market since markets have been globalised to an extent of homogeneity.

In relation to international migration the World Systems theory states that the penetration of peripheral economies by largely capitalistic nations and societies creates a moving population, prone to migrate abroad. At present one could interpret this by stating relations between countries through their markets exposes populations to other countries, thus, creating interests that may be either socially or economically motivated.

Bezuidenhout *et al* (2009) argues that what makes South African health workers to be vulnerable to migration is also the due to their exposure to other world labour markets courtesy of globalisation.

According to the World Systems Theory, migration is a consequence, a natural one, of disruptions and dislocations that come with capitalist development (Massey *et al* 2011). Certain economies nowadays find themselves in situations where they are faced with an economy short of crucial human capital after having produced much. In the case of South Africa, for instance, she produces a good number of health workers which are then recruited by economies that hold the capitalist upper hand. This, therefore, creates challenging health conditions in home countries, thus leading to non-migrant workers joining their counterparts in economies that promise better conditions; hence, the cycle of migration.

The World Systems Theory goes on to argue that international migration is consequent to the political and economic organisation of an expanding global market. An expanding global market knows no boundaries, but rather uses a neoliberal approach that focuses on

maximisation. This, therefore, means that anything necessary to emancipate will be done through the most extreme measures regardless of who loses or benefits at that point.

It is also argued in the World Systems Theory that international migration is likely to happen between post-colonial powers and their former colonies. It is further argued that this is motivated by the fact that culturally, linguistically and in terms of transport there is a possibility of similar culture (Massey 2011). From literature we learn that it is the Commonwealth countries, the former British colonies, that take part in the international migration of health workers. What is common about these countries are the transports systems, administration and the use of the English language. We can, therefore, conclude that this assumption complements the known literature on the subject.

Furthermore, this theory also argues that migration has little to do with wage rates in source and destination countries. Instead the theory argues for the dynamics of market creation and the structure of the global economy. The latter argument remains to be tested through research because what literature at this stage suggests is that most movements are monetary motivated.

By and large, this theory shows that the process of migration does not happen in a vacuum; in other words, there is more than one way of giving an interpretation to migration than economics, political violence, geographical irregularities and so forth. Instead the World Systems theory accounts for the general reconfiguration of the global economy that comes with the globalisation of the world.

These theories of migration in this chapter have been used not in their traditional sense, but as a form of literature review. They offer diverse explanations to the phenomenon of migration, ranging from issues of the labour market, globalization and socio-political relations amongst other things

2.10. Conclusion

This chapter offered a comprehensive insight into the trends of migration by outlining chronologically the history of migration in South Africa. Moreover, the chapter also covered existing literature on the logic of migrating, that is, who migrates and why they do. In doing so, the chapter engaged issues of migration relative to family and gender, the highly contested ethics of migration and the theories thereof.

South Africa has done very well in capturing the genesis of migration, particularly to the Witwatersrand by mainly unskilled workers. There is also comprehensive information on migration to South Africa by mine workers and workers from the Southern African region into the Witwatersrand (Listen to Hugh Masekela's song '*ISTIMELA'* for a narrative). While this area of mine work has been the focal point for many historians, sociologists and other interested parties, other areas such as the domestic service sector and the agricultural sector which are equally important to understand migration in South Africa have not been covered to the same degree.

Internal labour migration of moving south of the country has suffered immensely in literature because of the biased attention paid to the north. Early internal migration by the early South African professionals in the dawn of democracy is also not clearly captured and this makes it much more challenging to understand dynamics peculiar to certain kinds of work. Furthermore, there is a scarcity of literature on health worker internal migration.

There is, however, ground-breaking research and extensive coverage on international health worker migration, particularly on doctors and nurses post 1994. Issues of supply and demand, strong currencies in host countries and weak currencies in home countries have been discussed. Low wages and unbearable working conditions, amongst other things, have been all identified as factors of migration.

Following a democratic South Africa very few have asked how much has changed in the health sector 20 years hence. There is little attention paid to social influences that might be associated with migration; in other words, family responsibilities, race and gender issues and cultural differences amongst other factors. This is the contribution that this study seeks to contribute to the existing literature on the subject.

This chapter has served as a point of departure for this study. It has enlightened me about what is already known about the subject. The theoretical guide of the study is examined in the following chapter.

Chapter 3

The theoretical discussion: Marx, Weber and Bourdieu

3. Introduction

This study focuses on medical doctor migration by South African medical doctors. It is concerned with establishing which social factors result in the decision to migrate by South African medical doctors. In order to do so, I interviewed medical doctors from different socio-economic and historical backgrounds. This is discussed further in Chapter 4. I conducted these interviews with the understanding and knowledge that these respondents might offer different perspectives that may need various theoretical explanations.

Consequently, I decided to make use of three theorists: two classical theorists of sociology, Karl Marx and Max Weber, and a contemporary theorist, Pierre Bourdieu. These three theorists were chosen specifically because their respective theories explain different aspects of the present study. Marx's concept of class, Weber's concepts of status and prestige, Bourdieu's forms of capital are employed in the present study. The manner in which these concepts are used in the study is established later in the chapter.

There is not much literature on the theories of Marx and Weber in relation to migration. However, scholars such as Oliver and O'Reilly (2010) have used some of Bourdieu's work to explain the lifestyles of British migrants in Spain. Their use of Bourdieu, however, is projected differently from how I make use of him in this study. In contrast, to the concepts of Bourdieu that I have adopted, they used the concept of habitus in particular to explain issues of class and migration. These scholars argue that migrants' choice to often relocate away from family and work is often in quest of self-realisation. They further argue that this process of self-realisation gives the migrants an opportunity to alter some of life's trajectories and redefine their class positions in a different field. In this chapter, Marx as he is widely known and how I have, in unconventional terms, related to him in the present study is explained. Furthermore, Weber and Bourdieu and their contributions to this study are discussed respectively.

3.1. Marx and his notion of class: a theoretical discussion

The theory of social class is probably one that Marx is widely known for (Jordan 1971). Some scholars remain critical of his work while many believe that in an attempt to make sense of class and class relations his works remain most relevant. In one of his attempts to explain class relations and categories in society Marx and Engels wrote:

> In the earlier epochs of history we find almost a very complicated arrangement of society into various orders, a manifold gradation of social rank. In ancient Rome we have patricians, knights, plebeians; in the middle ages, feudal lords, vassals, guild masters, journeymen, apprentices, serfs; in almost all of these classes, again, subordinate gradations. The modern bourgeois that has sprouted from the ruins of feudal society has not done away with class antagonism. It has but established new classes, new conditions of exploitation, and new forms of struggle in place of the old ones (Marx & Engels 1848: 1).

The above quotation by Marx and Engels is found in the Manifesto of the Communist Party. Its relevance in this case is that it offers a very brief historical background on class relations and class ranks. Furthermore, the quotation also offers the reader a transition to the paradigm in which Marx viewed and made sense of class.

Contrary to class categories that existed in ancient Rome and possibly in many other parts of the world, Karl Marx viewed society in positions of class which for him related to two things: production and the exercise of control over property. In his view, society was a phenomenon that only has two existing classes. These two classes he called the bourgeoisie and the proletariat. By bourgeoisie, Marx meant the class of modern capitalists and owners of the means of production. By the proletariat, he referred to those that sell their labour to the owners of the means of production. He asserted that the existence of class and these two classes in particular is bound up with certain societal developments particularly in relation to production (Marx & Engels 1848; Engels 1888; Lever 1982).

Marx referred to the relationship between the two classes as one of class struggle. This means that the relationship involves one class actively exploiting the other and the other trying to overcome their state of exploitation. Exploitation in this case occurs when “surplus labour is appropriated by someone other than the one performing the labour” (Lever 1982: 13). This means that exploitation occurs when the profits of labour are enjoyed by a person that

performed the labour. The exploiting class are the bourgeoisie who attempt to get the best labour out of the exploited, the proletariat, for a minimal wage. These two classes are referred to as having "simplified class antagonism"; a natural dislike and hatred for one another (Marx and Engels, 1848:1). Furthermore, this class situation is one that does not consist of complex categories of class.

As briefly noted above, in the 18th century a series of developments in the modes of production gave birth to an industrial society (period of industrialisation) and thus, the birth of the bourgeoisie class. This was the period of economic and social change that saw the transition from agrarian societies (Giddens 1994).The period of change resulted in the demise of the feudal, patriarchy and idyllic relations which then resulted in the birth of the proletariat.

This relationship of class struggles between the bourgeoisie and the proletariat means the proletariat plays the role of having to sell his labour to the owner of the means of production. His ability to work, his possession of a skill and love for his work all becomes a commodity. In this relationship, the proletariat lives only so as to find work and through his hard labour increases the volumes of capital. Consequent to improved industrialisation, his love for his work is replaced by a machine; his work becomes a monotonous and boring phenomenon from which he derives no pleasure. At the far end of the relationship, the bourgeoisie improves modes of production by introducing machinery, dehumanising the modes of work and introducing improved division of labour, all in an attempt to improve profit margins (Marx & Engels1848).

Marx and Engel stressed that class struggles have a generational trend. They maintained that sons of the owners of the means of production would not perform manual labour. This means that they would not typically form part of the working class. However, they were of the view that the sons of those who perform manual labour, the working class, would do manual labour throughout most of their working lives (Lever 1982)

Marx and Engels (1848), however, also argued that the rapid development of industries in society has also increased growth in the number of the proletariat. They further believed that growth in the numbers of the proletariat would equal strength in the working class (proletariat). They argued that workers would form "combinations", namely, trade unions against the ruling class (bourgeoisie) and eventually overthrow the ruling class. Moreover, the "dangerous class" (lumpen proletariat) that has been relegated to the lowest levels of

society by the growth of capitalism would join forces with the proletariat revolution, giving it strength to overthrow the ruling class (Marx & Engels 1848).

Marx made an important assertion about the sons of the owners of the means of production with regards to continuing with their father's legacy. Although Marx put forth important arguments about the nature of class in society, he overlooked a few important things about class. These are evident in the study and are subject to observation in the South African society and the global community at large.

3.1.1. The relevance of Marx in this study

As indicated above, Marx's theory only makes provision for two principal class categories, the bourgeoisie and the proletariat. What Marx's theory disregards, however, is arguably the fastest growing, most crucial and operative class in society today: the middle-class. When one takes a look at society today, it will be noted that economies and every day white collar operations are done by the middle class. Most economists, for instance, who make sense of the profits for the owners of the means of production, are middle-class. I further argue that the middle class that Marx disregards, this operative class, are custodians of the means of production. I refer to them as such because they have been given power by the owners of the means of production to run production and also to some degree, manage and control the proletariat. Some of these people are the senior managers of big companies, managers, teachers, doctors, nurses, lawyers and other people in certain professions that give society a horizontal structure.

Equally, the theory of Marx on class also disregards the fluidity of class. Nowhere in his interpretations does he make note of possible class mobility. He argues instead that these two classes, the bourgeoisie and the proletariat will reproduce themselves. This exposes a limitation in Marx's theory of class in a sense that it does not envisage growth of what is arguably the most operative and useful class today. On the contrary, some writers such as Goldthorpe *et al* (1968) have acknowledged class fluidity; he states that where worker solidarity is strong, workers are not ambitious about prospects of promotions because it may be viewed as a sign of class disloyalty. Although not overt, Goldthorpe *et al* (1968) acknowledge class fluidity in a sense that in his analysis he recognises that if workers accepted promotions they would be upwardly mobile. Ultimately, this would qualify them to improve their positions of class.

In accordance with what has been stated above, I have used Marx's concept of class struggle, but not in the classical sense that suggests conflict between the proletariat and bourgeoisie. Instead, I have employed this concept in terms of avenues of mobility. I am of the opinion that South African medical doctors that migrate are engaged in a class struggle. In other words, these doctors are actively involved in an activity that will better their socio-economic standing. In their quest to be self-sufficient after graduating and to be content with the class in which they are classified, they see it necessary to engage in international migration. This engagement makes it possible for the attainment of certain assets and financial possessions that will place them in the desired class. In the home country these prospects are minimal and this can be seen as a push factor. On the contrary, these prospects are prevalent in the country of destination and can be viewed as a pull factors.

I am also of the opinion that these medical doctors are also indirectly involved as agents in a class struggle. My assertion is that the country of destination is often in a better economic position than the home country. Therefore, in this case, the country of destination reflects bourgeoisie qualities. These qualities are monetary, thus, giving them financial advantages in the form of excellent salary packages. Furthermore, the countries of destination boast forms of state of the art machinery that allow for the effective and modern day practice of medicine. In contrast, the home country is in a less advantageous economic position than the country of destination. The home country often depends on out-dated yet scarce machinery and does not enjoy many financial resources to encourage their doctors to stay.

In conclusion, I believe that Marx's theory is useful in this study in the sense that he places the subject matter into categories of class. Moreover, his concept of class struggle helps the present study explain the action of migration; why medical doctors engage in this action. However, one of Marx's shortcomings in relation to class is that he wrote about it in early days of capitalism. Therefore, he was not able to envisage some of the results that would come with capitalism. This is evident in his omitting the rise of the middle class to prominence as the operative class as well as the importance of the middle class in neutralising the working relations between the bourgeoisie and the proletariat. Lastly, Marx made no provision for class flexibility that is witnessed quite often in the present under the system of capitalism.

3.2 Max Weber, status and prestige

Max Weber is arguably the most influential theorist of class after Karl Marx. While Marx defines class in terms of property and the means of production, Weber argues class in terms of market relations and economic distribution (Cox 2012). In an attempt to give interpretation to class, Weber puts forward various sub-topics to explore; these include: economically determined power, determination of class situation by market situation, status and honour; and status privileges (Gerth & Mills 1948).

Referring to economically determined power, Weber (1948) states that power that is gained through economic means is not the same as power gained through other means such as social means. He, however, acknowledges that economically existing power may be a result of power existing at a social level. He further states that striving for power and power in itself is often conditioned by power existing at a social level. It is further stated that although there exists a positive relationship between power and social honour, not all power entails social honour (Gerth & Mills 1948). Weber, cited in Gerth and Mills, further notes that "mere economic power" or naked money is by no means consequent to social honour. This means that being in possession of access or surplus money does not grant one social honour; for example, a mafia in the city of Johannesburg may have all kinds of money from his untaxed businesses dealings, but no social honour and power as he is considered a criminal by the larger society. With regards to power, his may be limited only to the world of the mafia.

Gerth and Mills (1948) further assert that Weber explains class according to ones' access to the markets and the relationship to the market; this they refer to as "Determination of Class by market situation." Elaborating on this component of class, Weber, cited in Gerth and Mills, pronounces that "classes are not communities." Weber means that assuming residence in a particular area with a particular group of people does not necessarily put them in the same class. He argues instead that class can only be spoken about if only a particular group finds itself in the same class situation; in other words, if only a group of people find themselves having equal life chances such as access to equal opportunities economically, in the labour market, in commodities, as well as income chances (Gerth& Mills 1948).

Weber is also of the opinion that the existence of a market allows for class determination: the ability of some to compete for goods in the market and the inability of others to compete allows for classes and classification (Gerth & Mills 1948). This can be thus explained: those that have monopoly over all available goods in the market constitute the higher class while

those that can compete for a little or none constitute the middle class and the lower class respectively. Ownership of property and the lack thereof is also seen by Weber as the basis of class. In other words, in identifying one's class, property possession or the absence of it can be used as basis for class categorisation (Gerth & Mills 1948).

Weber also explains his theory on class using the dimension of status. In this regard, Weber states that status groups are normally communities that are not of a definite kind. Status groups, he argues, are not economically or property determined. This means that possession of money and property ownerships are not the only determinants of one's status. In other words, one who has property and one who does not have property both enjoy the possibility of being classified under the same status (Gerth & Mills 1948). In pre-modern societies, for instance, where aristocracy existed, a king or queen could grant their loyal servants estates which would automatically improve their status and thus, expose them to wider status privileges that not everyone enjoys.

Weber also uses status privileges in his analysis of class. In this regard, Weber says this privilege is enjoyed by a particular status group with regards to given material goods or opportunities. Status privileges are connected to an element of exclusivity and particular association; in other words, people of certain status groups enjoy, for example, the use of materials and association with particular people and or things that are not afforded to the majority, (Gerth & Mills 1948).

Cox (2012) further elaborates on the theory of class as set out by Weber by using three typologies of class. He refers to the first typology as the as the *property class* and he asserts that the class situation in this case is determined by property holding and differentiation. In other words, what one has as possession and what they have access to, and the absence thereof is what categorises classes. The second typology is the *acquisition class*, and it is further asserted that this class is based on opportunity, chance and access into the exploitation of existing services in the markets. The last typology is the *social class*. This particular class, it is argued, is based on plurality of people in different class situations. Therefore, this class is constituted by persons that have no particular property or employment to show Cox (2012).

Marx also spoke of class struggles; in particular, the struggle of the proletariat in their quest to affirm themselves into a better class. Similarly, Weber cited in Cox (2012) deliberates on class action; he argues that class action is something that is consistent with people of the same class situation. Thus, if medical doctors earn approximately the same salaries because

of inflation rates, they will begin to feel the financial recession simultaneously and consequently, they will belong to the same class situation by virtue of earning the same salaries that expose them to similar chances in the market. It is, however, argued that in as much as class action is consistent with people of the class situation, it is not something that can be generalised across all existing classes. For instance, it is very normal to see employers engaging in class action. Concurring with Marx's argument that the proletariat would topple the bourgeoisie and claim their spots, Cox says that Weber suggests that class action is consequent to prevalent possibilities of class mobility (Cox 1950).

3.2.1 A conversation with Weber: Status and Prestige

In the present study I have identified three elements of status: social honour, prestige and economic means. I argue that the combination of the three elements give a medical doctor a particular status in society. For many years a degree in medicine has been held in high regard; for generations it has been seen as one of the most prestigious degrees to hold. Consequently, one may enjoy a high status in society owing to a number of things that are in line with the above factors. These include the difficulty of the degree, the sensitivity of its curriculum and the lengthy amount of time spent in university before one actually obtains an MBChB. This, in turn, also presupposes high levels of intelligence of those that are able to complete it, ultimately linking it to prestige. Furthermore, historically, doctors have been known to be amongst the highest paid professionals in the world and hence, enjoy the economic means attached to their status. It is also important to take note of the nature of the job that includes assisting people in improving their health and recommending to them many other necessary avenues of good health. Contrary to the traditional forms of obtaining status highlighted above, I hold the view that the above perceptions and noble nature of medical practice afford doctors high levels of appreciation and respect from the communities they serve. This in many ways translates to what Weber refers to as social honour.

In the years preceding the integration of South Africa into globalised markets, these elements of status coexisted. However, because of the changing nature of markets and privatisation of work, there has been a reduction in the element of economic means that completes the concept of status in relation to doctors, (See Buhlungu 2010 & Standing 1997 on the changing nature of work and the markets). Consequently, I argue that this reduced economic means also affects the material conditions owned by medical doctors. Therefore, this creates a lot of pressure amongst medical doctors. In an attempt to improve and or retain the element

of economic means that is connected to the envisaged status of medical doctors, it may become necessary for medical doctors to migrate. I am of the opinion that some who have migrated did so in the quest to achieve the status bestowed upon them.

In my analysis of Weber and the concept of status, I pointed out that traditional societies did not link economic means to one's status. However, presently one's economic means affords them the possibility of enjoying a particular status in society. Failure to own property in a prestigious area because of a lack of economic means may dent one's status. In this regard, I question the absolute sufficiency of status in the traditional sense of interpreting society. One may challenge nonetheless that status as discussed by Weber is a phenomenon that must be redefined in contemporary terms as opposed to assuming traditional explanations and examples. It is commendable that with regards to the concept of status, Weber anticipated fluidity. However, it is not certain whether Weber envisaged that a lessening of one element of status would affect the overall status of an individual as it appears to be the case with medical doctors. Furthermore, there are people that hold positions of high prestige and social honour in society such as teachers, religious and traditional leaders, and nurses. They in, contrast to doctors, are of very modest economic means, but still enjoy high status in society.

3.3. Bourdieu and his forms of capital as means to explain the study.

Unlike the classical theorists discussed above, Bourdieu is a contemporary theorist. He became prominent in the second half of the 20th century and unlike many theorists he believed that both theory and practice should co-exist. Similar to Marx and Weber, Bourdieu was also interested in questions of class. He, however, unlike Marx but more in line with Weber believed that the study of class is not a phenomenon that can be reduced to economic relations. He argued instead that class entails an analysis of symbolic relations (Bourdieu 1986; Harker, Maharaj & Wiles 1990).

In his book, *Distinction: a Social Critique Judgment of Taste* which was published in 1979 Bourdieu discusses what he means by symbolic relations. For purposes of this discussion, I will discuss his widely known concepts that are in line with symbolic relations. These are the forms of capital, field, habitus and symbolic violence. These are essential in understanding how Bourdieu breaks down and interprets the question of class. However, as concepts that directly interpret this study, I will use his forms of capital, economic capital, social capital and cultural capital. The choice of these concepts comes from the understanding that the

medical doctors being studied come from different trajectories, that is, different walks of life, historically, economically, socially and otherwise. Therefore, each form of capital may directly explain trajectories particular to certain groups and not others.

By economic capital, Bourdieu refers to the command that an individual possesses over economic resources. These resources may include money and assets (Haker, Mahar & Wilkes 1990). Access to excess resources of this nature assumes one a certain class position that is not common to lay persons. For instance, symbolically, a person that enjoys a surplus in cash consequent to business or has ownership is placed in a particular class in as far as economics is concerned. It is important to note that this is one of only a few times where Bourdieu predisposes economic capital. In his forms of capital, Bourdieu further talks of cultural capital.

By cultural capital he refers to any form of knowledge, experience or connections that have the ability to improve one's life chances; that is, cultural resources that could help one succeed in life (Bourdieu 1986). Cultural capital, Bourdieu argues, can come from institutions and/or values. In order to discuss this explanation, I will refer to the leading institutions of higher learning in South Africa. Arguably, the University of Cape Town, the University of the Witwatersrand, Stellenbosch University and the University of Pretoria are the four leading universities in the country. Therefore, it is contested and factually stated that people that have graduated from these institutions have better chances in the labour market than those in institutions of a lower rank. Furthermore, the value placed on things such as books of character which contain certain contents and particular knowledge also locate people into certain positions of class.

Social capital refers to resources that are based on network connections and group memberships that are associated with influence and support. Belonging to an association of academics, for example, may improve one's chances of collaborating with renowned academics in writing for publications, improved chances of being recruited into institutions of high prestige for employment and this places one in a particular rank in the social class order (Bourdieu 1979).

Bourdieu (1986) also talks of symbolic capital. This form of capital refers to resources that are available on the basis of honour, prestige and recognition. Accolades in academia that observe people that have contributed in knowledge production through teaching and publishing include the award of professorship. Bourdieu states that all these forms of capital

are used in the field by agents in order to enjoy power relations and monopoly. The award of professorship, for example, affords one the opportunity to belong to many committees and boards of decision- making where the title of professor enhances the credibility of one's contribution. The field within which agents use forms of capital is discussed below (Haker, Mahar & Wilkes 1990).

Bourdieu (1979) talks of the field as a visible network of historical and current relations between objectives that are encored in capital. These objectives he argues are taken by agents that have a stake in the field. I will use the academic field to illustrate this. The academic field consists of administrators and academics as agents. The positions they hold is reflective of the amounts of capital they enjoy in the field and vice versa. The field, it is argued, is a competitive terrain or space where agents fight to have monopoly of over capital (Haker, Mahar & Wilkes 1990).

The habitus is a system of mental structure within which we make sure of our surroundings over a period of a lifetime. It is an internalised embodiment of how we view and perceive the social structure. Furthermore, it is a structure upon which we produce our thoughts and actions. Bourdieu nonetheless has been critical of the universal view of the habitus as an autonomous entity. He argues that people or rather human beings are not stupid, they can reason and therefore, the habitus does not have absolute control over human beings because they have a sense of reason and this he refers to as practical sense (Bourdieu 1979, Haker, Mahar, & Wilkes 1990).

Symbolic violence, on the contrary, is an action towards a social agent; it can be practised directly, but mostly indirectly through the use of language, picture or symbols. It is a tool for the dominating to dominate and for the dominated to accept their position (Bourdieu 1979).

3.3.1 Talking to Bourdieu's forms of capital in relation to the study

The above outlined concepts are but a brief introduction to the work of Bourdieu. These concepts do, however, lay a foundation for the concepts of Bourdieu that are most relevant in the interpretation and explanation of this study. I will use the four forms of capital as conceptualized by Bourdieu as means to explain and interpret.

Firstly, I will use of the concept of social and cultural capital from Bourdieu's work that was done amongst the people of different economic and educational backgrounds in France. In his

study, he examined whether or not preferences in phenomena would translate to social stratification. In this study, Bourdieu concluded that "scientific observation shows that cultural needs are the product of upbringing and education. Surveys established that all cultural practices and preferences in literature, painting and music are closely linked to educational level and secondarily to cultural origin"(Bourdieu 1979: 139).

Children are born into families and through the process of socialization they learn about certain cultures in society and especially about those that are in line with their own families. In line with the theory of Bourdieu, I have looked at culture as a learned phenomenon and its applicability to medical doctors. Furthermore, I have also examined the assumption that careers in medicine are attached to prestige and status across the globe. I am of the opinion that this assumption is something that may have been learned directly or indirectly through family culture. This does not end only in the choice of a career, but can also be seen in the choice of reputable institutions in the field. In South Africa, for example, the University of Kwa-Zulu Natal and the University of the Witwatersrand are very reputable in the medical field and the majority of respondents in this study, had studied, had worked or were currently working in either of the institutions. These are very good medical institutions and people that have degrees from these universities hold a high degree of prestige. Consequently, children that have seen graduation photos and certificates from these institutions are influenced to study at those institutions and have enjoyed social and cultural capital.

Not all the respondents in this study enjoyed being a part of a legitimate or dominant culture. Rather some are products of two things which Bourdieu refers to as social origin and social capital. These are the doctors in this study that I refer to as upwardly/ or socially mobile. I argue that since human beings do not exist as entities but in society, young men and women learn from their surroundings about what is legitimate, dominant or otherwise. This, in turn, informs their judgment of taste. For example, choices of career and university from those respondents are consequent to social origin and to a limited extent social capital.

Having been socialised into the field of the dominating group, members of the dominated group, the socially mobile group begin to learn legitimate tastes and preferences. If they come from modest or humble backgrounds, they begin to adopt legitimate lifestyles from their counterparts. They begin to assume residence in suburban areas; something that is not consistent with their backgrounds, but has been learned through social capital. Assuming residence in suburban areas is also attached to an element of status, one that is above a person

that lives in a township or rural parts of the country. This action then directly reveals class as a flexible and fluid concept

3.4. Conclusion

Typically, theories of migration which were discussed in the previous chapter dwell extensively on the economics of migration, the influence of globalization in migration, the expansion of markets world markets and such. What these theories do not do elaborate upon is to engage the "covert" sociology manifested in this chapter.

As mentioned earlier in the chapter, these theories are different, and their contributions and meanings for the study are also different.

I have made use of Marx's concept of class, in particular the concept of class struggle. In the present study, the concept of class struggle enabled me to give meaning to the action of doctors leaving their country in the quest for self-sufficiency and an improved socio-economic standing. Also, the concept of bourgeoisie is used to explain the qualities of the first world countries. I argue that the first world countries exhibit bourgeois qualities in a sense that they are concerned with expropriating resources in other countries which in turn, have much more to lose than to gain.

I have employed Bourdieu as his concepts of class give meaning to the career choice of medicine which is a prestigious degree. I argue that through social and cultural capital my respondents may have been born in families where parents and other family members are also involved in the health profession and they as offspring have adopted the culture. Furthermore, the choice of institution of education may be reflective of family culture. Bourdieu's views further explain the standing of those that do not enjoy this form of capital. Using the concept of social capital, I argue that people do not exist in a vacuum, but are part of a larger society. From these societies they learn through networks what is legitimate and what is not. It is from that capital that they begin to emulate what is not part of their history of cultural capital.

The two theorists outlined above have helped me to interpret some of the complexities of the study. However, their concepts do not capture completely the dynamic action of migration by the South African doctor. Doctors are of the middle-class, an operative class, yet the theory of Marx rejects their presence. This, therefore, makes it impossible for me to adopt the whole theory for this given study. Although more flexible, Bourdieu's theory in this study and, in

particular, the concept of taste, social and cultural capital speaks to the medical doctors in the study before the action of migration.

Although I do not refute the above theories, this study adopts largely the use of Weber's theory, and specifically, his concept of status. Here, I argue that there are three important concepts to consider if we are to make sense of status in relation to medical doctors. These are social honour, prestige and economic means. I argue that doctors form part of a historically prestigious discipline of medicine. Furthermore, because of the noble kind of job they do which is helping people, they enjoy a lot of respect from society which then translates to social honour. I also argue that with time the element of economic means has been lessened and this puts doctor under pressure in the attempt to live up to their status which is also manifested very much by their material conditions. I, therefore, argue this may make it necessary for them to migrate in order to keep up with what they and society expects of them. The following chapter looks at the methodologies applied in the process of this research.

Chapter 4

Methodology

4. Introduction

This section of the dissertation discusses the methods that were used in the present study. The subject of the study is discussed, that is, whom or what the study focuses on. The respondents that made the study possible are also identified. In this section, the question of how the accessibility of respondents was achieved is also addressed. Moreover, the ways in which the study would or would not affect the respondents is discussed at length (Babbie & Mouton 2008).

Data is of importance in the process of social scientific enquiry and in the methodology, data collection is also discussed. Data collection in this section is discussed in a manner that answers questions such as what instruments were used in collecting data. There is also a discussion on data analysis in this section. In other words, data analysis tools and instruments of analysis and how they were used in the fields are captured explained. I further discuss and substantiate the use of the qualitative methods approach in this study. Lastly, research ethics adherence is also subject to discussion. In this section, how the research endeavoured to uphold the ethical code during the research process is outlined.

4.1. Research design

When conducting research, researchers are always faced with a choice of either using a quantitative or qualitative research approach. Neuman (2000) argues that the two research approaches differ in numerous ways; nevertheless, they are complementary to each other in many ways as well.

The fundamental difference between quantitative research and qualitative research is that quantitative research pays more attention to issues of measurement, design and quantifying. Qualitative research focuses on robustness, texture and feeling of raw data. It allows for an inductive approach that paves the way for developing insights and generalisations (Neuman 2000). Although the two methods are complementary, the use of the quantitative approach as means to conduct the study was not employed. There is a very minimal, if any, need for quantifying and placing numerical value on the findings in this study. This study is concerned with developing insights that allow for the describing of the phenomena being studied.

Therefore, a qualitative approach was adopted for the purposes of this study. This choice is motivated by the overall characteristics of the qualitative approach. Qualitative research can be described or referred to as a "generic research approach in social research according to which research takes as its departure point the insider perspective of social action" (Babbie & Mouton 2008: 296). Babbie and Mouton further suggest that it is people concerned with describing, understanding and explaining social events that employ the use of this approach. This study, as pointed out above, is concerned with understanding the pull and push factors that result in doctors migrating out of the country. In other words, the study seeks to understand the action of movement by doctors to other countries as well as the reasons thereof.

As part of the quest to understanding the pull and push factors on the South African medical doctors, I decided to make use of life histories as a method. Questions that would mirror vividly the history of each respondent so as to give the study context beyond what is visible to the naked eye, but to also identify what some of the pull and push factors in the study could be were designed. Classically, Marshall and Rossman (1995: 151) define life history as a "deliberate attempt to define the growth of a person in a cultural milieu and to make cultural sense of it". Marshall and Bogdan (1995) state that Taylor and Bogdan (1984) described life history as a description of important events and experiences in a person's life, told in many ways that captures the person's views and perspectives.

The essence of life history is further highlighted in numerous ways; for example, in the social sciences it assists researchers with imagining themselves in the context of the interviewee. It gives the researcher an understanding of the social development of the interviewee. It also offers a view of how culture evolves and how one links or is linked to some of the cultural patterns around his or her culture. Lastly, and of essence in this study is that life histories are helpful in defining a problem and in studying aspects of certain professions (Marshall & Bogdan 1995).

In light of the fact that this study sought to find out what the social reasons for migrating are using life history methods was very instrumental. General questions about each respondent's family background were asked. This offered me an understanding of some of the things that form the family pattern namely, family culture. For instance, one may find that migration by some families of the respondents is a pattern, a family trend that has been done by at least a few family members in a given year. Therefore, migration by the respondent could be seen as

something consistent with family culture. In some instances, on the contrary, one may find that migration is a foreign concept; hence, the decision against migration. Life histories in this study, therefore, allowed one to link respondents, their social reality and their reasons for migrating.

In as much as the qualitative research approach which involves life histories allows for understanding of research participant's actions, it is also interested with describing the action by the participant. This becomes possible through collection of profound data by means of the employment of other qualitative methods of data collection.

The choice of the qualitative approach in this study has also been influenced in a broad sense by the methodological approach to the study of social action. As a result, Babbie and Mouton (2008) use the term 'qualitative' to refer to a collection of techniques. Qualitative studies, therefore, have their own way within which they use to gain access to research subjects such as snowball sampling, purposive sampling or quota sampling. There are also qualitative methods of data collection that include participant observation, semi structured/ open-ended interviews and collection of documents to write life histories and such. Within the umbrella of qualitative studies, there are also qualitative methods of data analysis such as the grounded theory approach and narrative or discourse analysis (Babbie & Mouton 2008).

As mentioned above, there are certain data collection and sampling techniques that are used in the qualitative research approach. In the following section, the data collecting technique is discussed.

4.2. Data collection Methods

Experience has allowed me to arrive at the conclusion that the data collection stage is the most delicate stage in the research process as it involves the approach or direct interaction with the subject of study. Appearance, approach and the manner in which the interview is conducted influences the success of an interview and the amount of information obtained during the interview.

In the present study, face-to-face interviews were conducted. There are a number of things that motivated the choice to conduct face-to-face interviews. Firstly, face-to-face interviews allow one to explain his or her questions if not clearly understood by the research respondent. Secondly, in some interviews respondents give responses that they are not sure about and

thus, the presence of a researcher allows for studying non-verbal cues. Thirdly, the researcher has the opportunity to give interpretations where a language is not understood and reads for respondents that are not able to read.

In conducting the interviews open-ended questions were used. Even though the use of open-ended questions is substantiated it is important to note for a number of years there have been lengthy debates on open versus closed questions. Open-ended questions are also known as unstructured or free response questions (Neuman 2008). They are known as such because of the autonomy that they provide respondents in the study in responding to questions. An example of an open- ended question is: how would you define good music? Questions such as the latter give room for thought, expression and explanation.

On the other hand, closed-ended questions are also known as structured or fixed questions (Neuman 2008). Close-ended questions do not allow the respondents to answer outside of the scope of answers provided. This means that they are limited to a number of certain answers that they may not necessarily agree with. An example of a close-ended question is: how would you explain Bafana Bafana's performance against the Brazilian soccer team? Fair, good or excellent?

As briefly outlined above, both these types of questions have their advantages and disadvantages. A number of factors motivated the choice of open-ended questions for this study. One such factor is that open-ended questions permit for a number of unlimited answers. Furthermore, respondents can answer in detail and clarify some of their answers (Neuman 2008). The strength of these questions lies in the fact that since they allow for unlimited answers, respondents may introduce themes through their answers that were not thought of prior to the commencement of the interview. Such developments are advantageous for purposes of research continuity. Since open-ended questions allow for the clarification of answers by the respondent, the researcher escapes coding or analysing false or irrelevant information that would later be subject to academic consumption. These substantiations do not in any way suggest that open-ended questions are the ideal form of questions, but suggest in every way that they are relevant for use in this study.

4.3. Research Instruments

In this study, open-ended face-to-face interviews were conducted. A certain number of themes and a set of questions were also used by the interviewer or researcher as a guideline to open-ended questions. Their purpose, however, was limited to being a guideline for the researcher and not presented as a questionnaire to the subjects. The questions also served as a contingency plan where the researcher would not be able to conduct an interview and there had been a request for written questions from a prospective respondent. However, the contingency plan did not become necessary as most of the respondents honoured their respective interviews.

An audio recorder was also used as the primary instrument for the research. An audio recorder is designed to capture conversations audibly. This allows for effective transcribing through listening, writing and or alternatively linking the audio recorder to machines programmed for voice recognition for transcribing. The researcher acknowledged audio recorders as technological objects that are prone to technical complications. Therefore, as a secondary tool of data collection, a note pad was used and served as back-up in case technical problems were experienced.

In research, audio recorders are notorious for causing discomfort to the subjects of study. Prior to the actual interview the researcher first asked for consent. None of respondents refused to be recorded.

By means of e-mail, some respondents overseas agreed that they would be interviewed using Skype; an internet video calling service. Challenges that could come with using such technological methods were anticipated and also by interviewing people outside of one's time zone were anticipated. Alternatively, through the use of the internet an online open-ended questionnaire could also be designed for the convenience of the subject. However, all of the above did not materialise as prospective respondents based outside the country proved very problematic to solicit.

4.4. Participants of the study

The primary sources of the data required for the study were South African medical doctors; in other words, doctors who were born, and medically trained in South Africa and graduated at South African universities. The research focused on no particular specialty in the medical field. Anyone who is a medical doctor was eligible to participate in the study.

Taking into consideration the diversity of the South African racial groups, blacks, coloureds, Indians and whites, I wished to ensure a maximum representation of the races mentioned above for the sample. This was important because an understanding of South Africa will reveal that there seems be a different interpretation and understanding of the South African economic and socio-political landscape that may be the cause for the migration of doctors. As a result of the latter, certain themes emerged, thus, helping the study to answer some sociological questions around issues of race. However, of the three racial groups, the coloured racial group was not represented. This could be due to a number of reasons: the under-representation of coloureds in the medical profession; the fairly minimal representation of coloured people in the cities used for sampling; or the sampling technique, snowball sampling may have directed me to a certain group of people due to its nature. The snowball sampling technique is designed in a manner that it directs you to people of more or a less the same quality and this could have been the case in this study.

In terms of the doctors within the country, I interviewed doctors from three cities: Durban, Johannesburg and Pretoria. There were no complex sociological explanations that led to the choice of these cities. Rather it was because of easy access to doctors in these particular areas. I enjoyed the advantage of networking and/or social capital amongst medical doctors because one my relatives is also a medical doctor. My relative and other respondents in the study trained at the University of Kwa-Zulu Natal's Nelson R. Mandela Medical School. Upon returning from their terms overseas some returned to Durban where they had been trained as doctors. Those that had not migrated had remained there since graduating.

Using social capital, I employed my relative as a key informant and this meant he was to assist me to locate prospective respondents for the study. After he had agreed to assist, I drafted a concept paper which my relative later disseminated amongst his colleagues and friends through the use of e-mail. I was introduced and the contents of the study outlined in the e-mail which further requested my relative's colleagues to participate in the study. Within a week of this proposal all the doctors had agreed to be part of the study. These prospective respondents were contacted telephonically in order to set up a schedule of interviews.

My relative did not enjoy a wide range of networks in Johannesburg as was the case in Durban. A Wits Medical School graduate, Dr Ross having met him during his community service year was also very willing to form part of the study. In the process, Dr Ross identified three other doctors namely, Drs Tiffany and John Ogle, and Dr Johnson.

On the contrary, it was easy to get respondents in Pretoria. My personal doctor, Dr Van der Merwe agreed to be part of this study and then recommended her colleague, Dr Kwetshube.

The research also hoped to extend the study to doctors who had migrated to other countries. For reasons stated previously, interviews at an international level were not achieved.

4.5. Sampling

"Sampling is a portion or a subset of a large group called a population" (May 2011: 98). This means that in a case where one has a total population of 15 000 doctors in a country and then extracts a population of 500 as subjects for the study, that 500 constitutes what is referred to as a sample. There are two types of sampling methods, the probability method of sampling and the non-probability sampling method.

An important principle of probability sampling is that everyone stands an equal chance of being a part of the sample (May 2011). This means that each individual who is accessible and is willing to participate in the study can do so.

On the contrary, non- probability sampling refers to a sampling where not everyone stands a chance of being selected as a unit of analysis (Babbie & Mouton 2011). Babbie and Mouton (2008) suggest researchers usually employ this method when they are looking for specific characteristics from their respondents; for example, this study focuses on medical doctors and hence, the choice of this sampling method.

Within non-probability sampling there is a sampling technique that many people consider to be a form of accident sampling; it is popularly known as "snowball sampling". This is the sampling technique that this research sought to employ. Babbie and Mouton (2008) argue that snowball sampling is appropriate when members of a certain population are difficult to locate; for instance, homeless individuals, migrant workers and undocumented migrant workers.

The study focused mainly on migrant doctors namely, doctors from South Africa who have migrated to other countries and those that have since returned. The study hoped to expand its scope of respondents not only to doctors that have migrated and returned, but to the community of doctors in foreign countries as well. However, this was not achieved owing to logistical constraints.

The sample for this study was limited to 13 respondents. The respondents can be broken into two categories. There were 8 respondents in the sample of returnee doctors and there five respondents who had not migrated.

At the beginning of the study, I believed that responses from returnee doctors would yield different and comprehensive data. This is because I knew that the content of questions were different to the questions structured for the doctors who had not migrated. Furthermore, the experience of working in a first world country was envisaged to offer a different outlook and perspective to the study. I had believed that this group of respondents would offer much more substance to the question of why medical doctors in South Africa migrate. On the contrary, I was of the opinion that interviewing doctors who had not migrated would offer unique data. The purpose of interviewing this group of doctors was mainly to find out their general perspective of the South African working environment and health system, their view on migration by other doctors and where they stand with regards to migrating. Probing such questions may in some respect map the future of migration by doctors in South Africa.

4.6. Data Analysis Method

Because almost all the information is verbatim for in-depth interviews, it is easy to be overcome by words and not be able to make sense of answers (Babbie & Mouton 2008). Therefore, in order to make sense of the data, I summarized each interview at the completion of the interview. Data was analysed through the development of themes that emerged from the literature and the findings. When themes were gathered, they were grouped together into a meaningful way such as by the type of participants.

4.7. Ethical Considerations

"Ethical issues always arise out of our interaction with other people, other beings such as animals and the environment, especially where there is potential for or is a conflict of interests" (Babbie & Mouton 2008: 519). In many cases in the social sciences including Philosophy, Psychology, Sociology, History and Anthropology, there has been constant debate about ethics. People argue that what may be ethical for one may not necessarily be for the other.

However, the ethical standards within research were adhered to in this study. I adhered to the ethical issue of voluntary participation and this was done by a consent form that had to be

signed by the researcher and all the respondents. Respondents were not compelled to participate in the study.

No harm was caused to participants as there was no physical contact or participation involved in the study. Confidentiality and anonymity were of prime importance and were adhered to. In the presentation of this study's findings people's names have been replaced with pseudo names that have been randomly allocated.

4.8. Reflection: Interviewing elite professionals.

Interviewing is an important part of collecting data across social sciences (McEvoy 2006). Even though it is one of the most used methods in the social sciences, when interviewing the elite this method is a different experience altogether as opposed to interviewing the lay person. Smigel (1958) and McEvoy (2006) conducted studies amongst the elite respectively at contrasting times over the years. Smigel (1958) focused on interviewing Wall Street lawyers from different law firms in New York in the USA. He argued that when interviewing the elite and in particular lawyers one ought to be careful while working with this group lest they be interviewed. He further argued that the researcher ought to observe all the research ethics as he or she is dealing with a knowledgeable group of people. It is further asserted that this group of elites is very observant of time and keeping to time agreed upon by the researcher is of essence.

The above views are echoed by McEvoy (2006). She interviewed a group of politicians of a power sharing executive in Northern Ireland. She asserts that the basic strength approaching this group is preparation beyond the norm as one is dealing with a group who are knowledgeable about their line of work and who are familiar with how research and interviewing is done. Amongst other things she identifies as a precaution, is having a very detailed interview schedule outlining times and inductive questions that touch the sensitive at a much later stage of the interview. McEvoy (2006) argues that by the nature of their work politicians are evasive in response and one ought to be careful how one raises sensitive questions. She also argues that the question of identity is prevalent: being a female and interviewing elite, older males.

As discussed earlier in the chapter, the elite professional in the present study were South African medical doctors. There are considerable similarities that may be drawn from Smigel (1958) and McEvoy (2006). However, differences in professions assert themselves

vigorously to set the three apart. Important to note first and foremost in the present study and reflective of an elite, professional status are the areas within which most of the interviews were held.

The interviews began with a group of the Johannesburg based doctors; the first doctor was Dr Ross. On his suggestion, we agreed to meet at a coffee shop in Sandton City Mall, an upmarket area in the northern suburbs of Johannesburg. As I was the host and researcher, and in order to achieve control and confidence, I felt the need to buy the coffee. However, the respondent insisted he understood a student budget and therefore, he would pay. Later in the same area, I met with Drs John and Tiffany Ogle, though at a different coffee shop. In this case I also hoped to flag a "researcher in control attitude". This too was not to be as the social norm of older takes care of the young was waved against me. The choice of the area of meeting was based on the fact that they were residents of the Sandton area.

The last interview in Johannesburg was with Dr Johnson whom I met in his rooms, in a paediatric private hospital in Alberton, south of Johannesburg. The hospital appeared to be organised and not full of patients. Upon arrival I was escorted by the secretary to the doctor's consulting room where the interview took place.

The following series of interviews took place in Umhlanga Rocks, an upmarket suburb north of Durban with both of the Zakarias; however, separately. The initial plan was to interview Mr Zakaria and not his wife, but Mr Zakaria recommended that I also talk to his wife who was more than happy to oblige. I met with the Pillays in an upmarket area west of Durban. When the interview was finished, I interviewed Mrs Pillay who had been preparing dinner for her family and friends who were due to visit that evening. The other person whom I met at his modest house was Dr Zulu who stays in the Bluff near Brighton Beach, south of Durban.

I met the last group of doctors, Drs Cele and Ntsikana at their offices at the Nelson R. Mandela Medical School where they work. Lastly, I interviewed Dr Lethlodi over a cup of coffee at Musgrave mall.

In Pretoria I met Dr Kwetshube and Dr Mathebula during their hectic hours of work at a private hospital in Pretoria. I met with Dr Van der merwe in a surgery on a Saturday morning that was not that busy, unlike her counterparts.

4.8.1. How do the professionals respond at interviews?

Out of the sample of twelve doctors interviewed, eleven were specialist doctors and ten of these worked in academic hospitals. The nature of their work subjects them to a lot of academic work as they supervise and mentor registrars. Therefore, this had far-reaching positive effects on my work. The first thing to note about these professional elites is that they were more than happy to form part of the sample and this is possibly because of their understanding of the importance of research. Secondly, their impressive understanding of the subject matter was notable. Their responses offered a robust texture of raw information. Lastly, they went beyond the questions asked and began to talk about issues surrounding the subject matter; the researcher might not have otherwise noted these issues as important.

The disadvantage nevertheless is that these elite professionals are extremely busy and finalising dates for an interview is not an easy task. Furthermore, even upon securing an interview with them, their time was limited which makes it very hard for the researcher to probe. Another disadvantage is the evasiveness about questions in which most people would want to be politically correct for example, a controversial question of race.

4.9. Conclusion

In conclusion, this chapter mapped out in detail the manner in which the study was conducted. In the chapter the choice of a qualitative approach to the study was discussed. The manner in which the data was collected, namely, the interview approach and use of an audio recorder and note pads as tool was accounted for. The locations within which the interviews were conducted, the sample size, the subjects of the study and ethical considerations were discussed. The findings of the study are discussed in the next chapters.

Chapter 5

Contesting motives of migration

5. Introduction

This chapter is concerned with outlining various social, economic, and demographic factors that can be attributed to the act of migration. It begins by discussing paying off of student loans as one of the primary factors for migrating. This is followed by various other push and pull factors that are social, demographic and economically inclined. This chapter also attempts to give a direct response to the research question posed in the study.

As it has been noted in the literature review chapter, there are various motives for migrating by South African medical doctors and their counterparts around the world. In this chapter, I further explore factors such as better economic conditions and family reunion as motives just to mention a few. However, what the existing literature has fully disregarded are questions such as who of the medical doctors in South Africa migrates? Also, another question that has not been explored in South Africa is that of the kind of family backgrounds from which these doctors come.

5.1. Paying of student loans as a push factor

Emerging from this research study is that a large number of South African medical doctors are children of working and middle class families. This information on the kinds of jobs the respondents' parents are and were doing emerged during the interviews. This suggests, therefore, that working and middle class families face many challenges and to such an extent that it is an impossible task to afford education at a university medical school in South Africa without being subsidised. Quoted by Business Day Live (2011), the current Health Minister, Dr Aron Motsoaledi said, "It costs R750 000 to train a South African medical doctor in Cuba, but double that to train them here." The figure of R750000 stated by the minister provides insight into a medical student's tuition fee. Evidently, after a government subsidy, these amounts are still difficult to pay; hence, the plausible thing to do is for students to apply for student loans. These are obtained through various firms such as Eduloan, National Student Financial Aid Scheme (NSFAS) and various banks that offer student loans.

A number of respondents in the study with various demographical data, namely, age, gender, race and marital status used study loans in order to pay for their seven years of education. The table below from the University of Pretoria gives an example of the amounts charged by this institution at the different levels of a medical degree:

Table 4: MBChB tuition fees

Level of study	**Fee (ZAR)**
Level 1	39 170
Level 2	42450
Level 3	38660
Level 4	42000
Level 5	39550
Level 6	39550

(Source, University of Pretoria financial handbook, 2012)

The above amounts are needed to complete a Bachelor of Medicine and Surgery (MBChB). The monies total R242 020. Furthermore, university residences cost an average of R30000 per annum; over a period of six years this will total R180 000. Thus, a medical student who wishes to stay in residence will pay R422 020 (UP Financial handbook, 2012). In addition to these figures, students will be required to pay annual interest rates on their loans, and thus, their education could cost them R 500 000.

Many amongst those respondents that migrated attributed their migration to the large amounts of student loans that they had to pay back. They argued that working in South Africa in the year 2002 and earlier would not have allowed them to pay off their student loans and then live comfortable lives, especially before Occupational Specific Dispensation (OSD). By OSD we refer to an "Occupation specific dispensation which recognizes that some the

working conditions of workers, especially wages have been generally neglected in policy of government to improve service delivery" (NEHAWU 2007: 1). The OSD aimed to look into the wages and salaries of certain professions such as teachers, doctors, and nurses with an aim to improve them.

While it makes sense that some of these medical doctors migrate because they have to pay off significant amounts of student loans, it is important to note this cannot be generalised. Other factors which contribute to a doctor's decision to migrate are discussed later in the chapter.

> John has ancestry Visas to the UK, his parents were born there, we wanted to do a bit of travelling and most importantly pay off two massive student loans which we did much quicker than we would have, if we would have been here. We paid over 400 000 in just 3 months, so we had to kill ourselves (Dr Tiffany Ogle, age 36).

Another crucial point to note of in one of the above quotes is that of Dr Tiffany Olge. She points out that John, her husband, has an ancestry visa to the UK; this on its own may have been a factor for migration. When one holds an ancestry visa to another country it suggests an endorsement of one as a citizen of that particular country. Therefore, they are treated as citizens of the country and also enjoy perks that come with such. Securing employment is easier as one competes equally with other citizens. Familiarity with the culture of the country that may have been passed on to them by previous generations as well as knowledge thereof are some of the factors that may have influenced their decision to migrate.

During my interview with Dr Ogle (John), I noticed that he had a British accent. This portrayed him as a person who still identified very much with his family roots. Consequently, I concluded that his reason for migrating and for many others in a similar position might be a cultural curiosity or getting in touch with their roots.

Dr Tiffany Ogle was interviewed together with her spouse, Dr John Ogle. She migrated to England together with her spouse in 2002 for a period of three years and returned for family reasons which will be highlighted later in the chapter.

This section in the chapter shows that a large majority of my respondents migrated with the primary reason of paying off student loans. Furthermore, two factors emerged in this section. Firstly, not all doctors who migrate have to pay off student loans. Secondly, those with

multiple visas may find it attractive to work in their country of lineage because of cultural curiosity and attachment to family culture. In the next section, I will discuss other significant factors in the decision to migrate: finances and the working environment.

5.2. Finances: motive enough for migrating?

In the first section of this chapter, paying of student loans was viewed as the primary factor involved in the decision to migrate. However, I place equal weight on the fact that financial accumulation is as much a primary factor for migrating as paying off student loans. It is important to note that although these factors may appear to contradict one another, paying off student loans is in itself a financial exercise.

Ceretis paribus, the table below illustrates salaries of doctors of the same level in the UK (main host country in the study) and South Africa.

Table 5: Medical officer (MO) or General Practitioner (GP)

Countries	**Salary by currency**	**Currency converted (£)**
South Africa	R 423, 864 P.A	_____
		X 15.8
United Kingdom		= R 558, 0876 P.A

Sources: Department of Public Service and Administration (DPSA) and National Health Service (UK) (DPSA and NSH).

At the time of migrating, the respondents were at the levels of MO (Medical Officer) or GP (General Practitioner) as it is referred in South Africa. They were mainly in their third year of medical practice. The above table gives one an idea of salaries earned by medical practitioners as well as the disparity in medical salaries between South Africa and the United Kingdom.

In Africa and in some other parts of the world that are affected by a shortage of health workers migration outside of these countries is an action frowned upon. Words that have negative connotations such as brain drain are used to describe this action. Moreover, health professionals who part take in migration are often seen as money chasers by their fellow countrymen and other anti-migration forces. Therefore, migration is highly stigmatised by fellow countrymen and other interested parties such as health authorities. Because of the stigma attached to migration, a large percentage of the respondents were very evasive and defensive about discussing finances as the major influencing factor that leads to migration during their interviews. In cases where they were not being evasive, they mentioned finances as a minor motive for migrating. Contrary to their evasive responses, all the other motives they mentioned before finance are all possible because of good financial conditions. Paying off loans and accumulating enough to buy a house and a car, for example, require a healthy financial situation.

> The migration by South African medical doctors is a multi-facet problem and obviously, there are many different aspects. There is that work environment to it, social environment and all kinds of things and the financial aspects. The truth is that doctors study a long time to be where they want to be, even if it's being a General Practitioner (GP), a lot of money is put into university training. We do not necessarily get paid terribly but if you look at the equivalence of a person who did accounting the same number of years etc, the amount of money we make is actually poor (Dr Ross, age 37)

The above quote from Dr Ross is a good example of many other responses that emanated from the discussions and interviews with the respondents. This is in corroboration with an earlier statement that, more often than not, doctors put forward other factors for migrating and yet in these responses emphasis is placed on the financial aspect of things.

An analysis of the contents of Dr Ross's answer reveals that he begins his responses by highlighting other factors, but ultimately delves deeper into finances. This form of responding is consistent across the sample amongst the returnee doctors. It is not very clear, however, why doctors are reluctant to discuss the issue of finance as the primary or crucial factor in their decision to migrate. I believe that this may be attributed to the assertions that migration is frowned upon and that the doctors that do migrate are perceived as money chasers by anti-migration forces.

Some doctors credited South Africa, specifically on job satisfaction. Job satisfaction is referred to as the ability of being able to do the desired work, at all times, and the ability to find joy and satisfaction in the kind of job that one is trained to do as a doctor. Notwithstanding the above, the respondents were also very quick to discredit South Africa for considerably lower salaries, especially in comparison to their former host countries (Refer to Table 5). Dr Shinwell Pillay is amongst the doctors that spent a year in the UK and he mentioned that "the work we did there (UK) is probably one fifth of the work I do here at home for three or four times the salary, but the work was fairly mundane." On the other hand, it is also important that we note the opinions of the doctors who did not migrate because they are likely to have had discussions about the subject, as to what they think the primary factor of migration is.

Without much hesitation the doctors who had not migrated stated that if they were to migrate it would be based purely on issues of finance. Also, they argued that their counterparts migrate for primarily those reasons while not overlooking other minor contributing factors. Dr Van Der Merwe (54) has never migrated and has no intentions of doing so. She articulates with utmost confidence that, there are no other reasons for South African doctors to migrate, but financial ambitions: "It is money my friend, it is money nothing else makes these guys migrate but money. My former classmates that are in Vancouver earn six times more than we do my friend".

While returnee doctors proved defensive about financial ambitions and the decision to migrate, many of their motives required the realisation a good financial position in order to be achieved. This then manifests contradictions between responses and actions. Furthermore, counterparts who had not migrated concurred that migration is a move towards improved financial realisations and further stated that if they decided to migrate, their decision would be driven by financial motives.

This section outlines financial realisation as a very important factor of migration and other factors as being secondary. Another important point consistent with respondents in this section is that doctors do not necessarily view themselves as being underpaid. Instead, they view themselves as being underpaid in comparison to their colleagues in first world countries, and other public and private sector workers that studied for the same length of time as they did. The factors of family responsibilities and issues of security as motives for migrating are discussed in the following sections.

5.3. Family and personal responsibility as key factors for migrating

Most of the doctors that were interviewed for this study entered medical school in 1996 and therefore, assuming that they all passed without having to repeat, they would have graduated in 2002. Most of them were born in 1976 and 1977; thus, they were 36 and 37 respectively when the study was conducted in 2013. Another consistent feature about these doctors is that almost all the respondents were married persons at the time of the interview. They had their own nuclear families and others also had extended families. Therefore, much of their decision-making did not rest with the self, but the family at large.

Amongst the returnee doctors, the doctors who had intentions of migrating and those with no intentions of doing so, it became evident that the decision to migrate was influenced by family responsibilities.

> And another thing is education I mean many people want their kids to grow up in an area where there is good schooling and that is part of why people in South Africa don't want to work in rural areas because schooling in those areas is not quite good but at least in the big cities you can still get good schooling and education, but obviously there are people who want to go to the extreme and leave South Africa completely just for the education of their children" (Dr Ross, age 37).

> Initially the thought was money and this was before our salaries were reviewed a couple of years back. By the time we came out of universities we had bills like nobody could believe it, you got family responsibility, people are saying take this person and that one to school and this was in 2003. There are also pressures that come with being a doctor, there are expectations of a certain life style, you cannot take a taxi and the money is not there and people are expecting to see stuff and that was the primary reason I wanted to migrate then (Dr Cele, age 34).

There are a lot of things that influence one's decision to migrate or not to do so. Many doctors see this phenomenon of migration as a phenomenon that is both family and personal responsibility bound. In terms of family, some doctors are of the opinion that migrating with their children would assist in continuing with the already existing culture of education in their families. It emerged during the interviews and it is also public discourse that many middle class South Africans such as doctors have lost faith in the country's public schooling system. This then leaves them not much of a choice, but to explore further educational avenues outside South Africa. Their responsibility, they argue, therefore is that one of creating a legacy of education by ensuring that their children attend better schooling elsewhere in the world.

Some are of the opinion that South Africa does not boast the best public education system. The private schooling system, however, is of a better standard than the latter and most doctors and other middle class citizens often send their children to private schooling to ensure that they get a good education. It is rather unconventional for people to migrate for opportunities for a good education and thus, there may be an ulterior motive. This does not in any way suggest that the education of children is not a driving motive, but it serves to highlight inconsistencies.

Personal responsibility on the one hand includes migrating to a place that will allow one to be self-sufficient in order to achieve one's youthful aspirations. These aspirations include things such as living a certain kind of envisaged lifestyle, in a particular area of choice and earning a particularly satisfying salary amongst other things.

Those doctors who did not migrate did so because of family responsibility. Dr Cele, for example, is the oldest of her four siblings in a working class household. She stated that she could have migrated, but did not do so because of family responsibilities that included educating her younger siblings and some of her extended family members. Dr Cele was one of the representatives of black doctors within my sample and it is the norm amongst black people that they assume this "normative social responsibility" for their siblings on finding a job. Many other black respondents in the study shared this view on responsibility. Dr Kwetshube, for example, also stated that he supported the wife and children of his late brother. Thus, for some family responsibility necessitates migration and conversely, could

make migrating impossible as one may need to be present to offer responsibility beyond finances. This is further discussed in Chapter 6.

It is normal that bread winners or family leaders such as parents want to take care of their offspring. This is often expressed by sending their children to the best schools and taking care of them emotionally and physically. Taking children to good schools and ensuring that they enjoy a good life is highlighted in this section. However, this context it is possible that children are being used as scapegoats. This is based on the fact that in a country like South Africa, one who has the financial resources has the ability to ensure a good quality life for their children. This I state with the knowledge that in South Africa world standard schooling is offered in the private sector which a doctor can possibly afford. Consequently, I assert that there is probably a movement towards social mobility by the parents that comes with living in a first world country.

5.4. "Crime is everywhere, they mug you but they won't stab you whilst at it": personal security an issue

Another important factor to note that was consistent with the respondents in this study is the issue of personal security. Statistics South Africa (Stats SA) in 2012 conducted a "victims of crimes survey" where amongst many things the survey looked at perceptions of crime and safety. In the survey, they found that six to ten (59 %) households perceived housebreaking/ burglary to be one of the most common types of crime, followed by home robbery (46, 2 %), street robbery (41,4 %) and pick-pocketing (32,1%). The study further revealed that the most crimes in these households were housebreaking/ burglary (57, 4 %), home robbery (49, 8 %), street robbery (39, %6) and murder (38, 8%) (Stats SA, 2012).

Media reports and reports such as this one by stats SA have always earmarked South Africa to be amongst the most dangerous countries in the world. Evidently, the latter perception was noted by half of respondents in the study. While some claimed victimhood, some expressed fear for their lives. Even though the issue of personal safety does not take precedence as a push factor, doctors certainly view safety threats as a good reason for one to migrate outside of their country and or to possibly emigrate.

> The only thing that is major really is our personal safety. If something were to happen to us, if an incident were to happen or our lives were to be in threat! I know myself we would definitely leave but hopefully is doesn't come to that (Dr Tiffany Ogle, age 36)

> I am sure there is crime everywhere but the kind of crime you experience here is very different from the one you experience overseas. And I mean people with young children and family think that they do not want to stay in such unsecure place, they rather go live in a much secure place overseas (Dr Ross, age 37).

While the issue of personal security has proved to be a push factor and enough of a threat to migrate, the same can be said about improved personal security in prospective host countries as a pull factor. Countries like the UK, USA and Canada are said to have better personal security than South Africa. The latter factor on its own becomes a pull factor for threatened doctors who want to leave the country.

In relation to personal security, it is interesting to note was the demographic dynamics; race in particular. I sampled three racial groups: black, Indian and white doctors. It emerged that it was only the sample of white doctors that had major crime and security concerns. Indian doctors sampled for this study made no significant mention of crime and security problems that would make them leave as such. Their black counterparts, however, made mention of crime and security threats as a factor, but also more of as a phenomenon synonymous with their white counterparts who perceived it as reason enough to migrate and not them.

> People talk of crime; I have never had a black South African leaving because of crime. Our Caucasian colleagues the core reason for them is safety and their kids. Believe you me having been outside and back crime is everywhere it is just the reporting of media. I mean in London you get 16 year olds carrying knives and this is stuff that used to happen in Soweto years back. It is issues of hijacking that are a problem, I had an incident of a 9mm on my head but believe me that was not reason enough for me to leave the country even though it happened six months after I had come back. There are really different dynamics of why people leave, but for us blacks I really think it is for academic reasons and financial ones (Dr Lethlodi, age 37).

The merging question of interest here is: why do white medical doctors consider crime to be a good enough reason to inform their decision to migrate? Consequently, it also raises the question of why their black counterparts do not consider it a good enough reason to leave.

There are various possible answers to this phenomenon. One could be that, historically, white South Africans have enjoyed better social and economic amenities whereas Indian, coloureds and black South Africans enjoyed much less. This possession of socio-economic amenities could have made the white population susceptible to crimes by the economically disadvantaged and criminals. As a result of the knowledge about the latter, the white respondents may feel that they are more at risk than their black counterparts and hence, the decision to migrate. Media reports and social movements against the killing of white people that are very prevalent these days may also exacerbate or encourage distrust of the country's ability to protect its people; hence, the threatened see migration as an option.

Furthermore, after the abolition of apartheid in 1994 and the first democratically elected government in South Africa, there were a lot of sceptics about the country's ability to sustain itself. Therefore, after 1994 there was a lot of migration and emigration witnessed in South Africa, particularly amongst white people (Bezuidenhout *et al* 2009). This proneness to migrating by South African white doctors could be a reflection of a now subsided migration phenomenon. On the other hand, this could be merely because of the availability of an alternative country to stay in since some of the respondents in the study enjoyed lineage in some of the typical countries of destination.

There are a multitude of possible reasons black doctors do not migrate because of crime. The first is a very controversial one. It is a known fact that black South Africans in townships and rural areas experience more crimes than people in suburban areas. Furthermore, although I do not have scientific proof of this, these offenders are often from these areas where black people in general and these doctors in particular were born and bred. My argument, therefore, is that it is highly likely that because these black doctors grew up in those areas, they are not disturbed by these crimes. This is based on the assumption that in a place where you experience a particular phenomenon, like crime, it becomes a social reality for you, albeit, a socially unacceptable one.

It is also important to note that there are significant cultural differences between the above mentioned racial groups. The concept of the nuclear family is something that is not common in traditional black families because in the latter, people are part of a larger extended family for which, in various circumstances, they may have to assume responsibility. Most black doctors who participated in this study were from such backgrounds. This suggests that one's decision to migrate with his nuclear family or as an individual is not a decision to make

independently, but with the consent of many other extended family members. This is done because one may carry extended family responsibilities that may place a burden on others upon his/her departure. This is one amongst many other things that tie black doctors firmly to the country.

Lastly, unlike some of their white counterparts, black doctors do not enjoy lineage in the countries of destination. Therefore, there are no attractive cultural similarities or ancestry visas for them. This will be further discussed in Chapter 6.

This section in the chapter mapped out key factors why white doctors are likely to migrate for reasons of crime and why their black colleagues are not likely to do so. These factors are stated in such a way that proposes that they are absolute, but also challenges future researchers to explore them.

5.5. Better quality of life: a pull factor?

Coupled with other pull factors mentioned earlier in the chapter, medical doctors in South Africa, particularly the returnee doctors, gave credit to the quality of life in their former host countries. The majority of returnee doctors were white and Indian.

Not at any point did the race groups that constituted the larger percentage above discredit the quality of life in South Africa. However, in comparison with their home country, they considered their former host countries as offering a more promising quality of life. By quality of life they referred to various factors such as schooling or education systems for their children, improved security, and better and more effective public transport systems; these they viewed as pull factors should they make the decision to migrate again.

> Living there is also a lot more different, the public transport for one is so much more organised than here, their whole environment, and there personal security is awesome. I used to catch a train in a place that was considered to be a dodgy place in London, guys never used to believe me but I told them that for me it was a great pleasure than the kind of environment that we are used to working in and live in (Dr Johnson, age 37).

In contrast to the general view that the host countries offer a better quality of life, the same doctors complained mainly about logistical issues. They argued that the efficiency of public transport served as a disadvantage as it influenced them against buying cars. In cases of an emergency during night hours, they were not able to attend to those matters. Moreover, they also complained about little things such as the absence of petrol attendants in petrol stations; something that is found across their home country. Teller assistants in grocery stores that help with putting groceries in plastic bags were also absent in host countries; they also complained about this. I imagine the examples above contribute to what constitutes a good quality of life. Thus, the absence of them in the host country questions the completeness of quality in those countries.

This paradigm of viewing host countries as places with a good quality of life is consistent with particular race groups, namely, whites and Indians. The other minority constituted by the black doctor confessed to a number of things that they did not enjoy such as limited space; namely, that is one has to live in controlled and limited spaces. Two of the black doctors that migrated complained that there is no space in areas of residence as opposed to home. As people are used to gardens in the home country, they also complained about not having a chance of doing gardening because of small yards.

This section has offered insight into one of the recurring themes in the study which highlight that host countries enjoy a better quality of life. On the contrary, I have also questioned the quality of life in the absence of certain important amenities that may well constitute a quality lifestyle. The following section considers whether one's imagined class position plays a role in migration.

5.6. Class envisaged and imagined class position: an influence in the decision to migrate?

The general perception about doctors in South Africa is that they constitute part of the upper middle class. I am inclined to attribute this perception by the South African society to the "imagined" salaries of medical doctors. I use the word 'imagined' consciously because even people that do not have the slightest idea of medical doctor earnings tend to view them as big earners and wealthy people. Furthermore, I hold this perception because of the observations that I made when I conducted the interviews. Of the doctors whose houses I visited, they

were up-market houses that contained high quality and potentially costly material possessions such as furniture and motor vehicles. These houses were also found in the up-market suburbs of the two cities within which the interviews were held in Durban and Johannesburg.

It must be said that this perceived class position does play a role in one's decision to migrate or the thought thereof.

> There are also pressures that come with being a medical doctor, there are expectations of a certain lifestyle, you cannot take a taxi and yet the money is not there and people are expecting to see stuff, that is the primary reason I wanted to migrate (Dr Cele, age 34).

What we gather from the above quote is the general perception of an ordinary South African about a medical doctor. Doctors are perceived to be high earners regardless of the length of time they have been in medical practice. Dr Cele, for example, stated that soon after her graduation her first salary in 2003 was R6000; a relatively small salary in relation to that imagined. Yet there are pressures from both family and society to acquire possessions that reflect one's imagined socio-economic class.

In order to achieve societal expectations and imagined class position, certain doctors end up migrating. Dr Shinwell Pillay admitted that "at home we are faced with a lot of pressures. I think a lot of guys when I went over there were there just to work for a year or two so that they could pay their student loans, get a house and a car." He also alluded to the fact that had he not spent the two years that he did in the UK then he would not have been able to pay off his student loans as fast as he did and live the lifestyle that expected of and envisaged for him.

Outside of the societal pressures contributing to a few doctors migrating there are other contributing factors such as one's actual socio-economic class. The majority of doctors that participated in this study were born into middle class families. They were sons and daughters of teachers, medical doctors, lawyers and engineers. People that come from professional families tend to have much more international exposure than others. As a result, a certain number of doctors enjoyed information possession about the countries to which they migrated by virtue of having family members in those countries. Such social capital allows them to inform their decision-making better than their counterparts who do not enjoy such capital.

Some other respondents also alluded that they were not migrating as such, but were visiting siblings who had migrated and ended up working in those countries by coincidence. Dr Pillay and Dr Johnson said the following:

> I went to England (U.K) for about 18 month to 2 years, just to break away from things. I think for me it was more of a personal thing when I finished I didn't know what's I wanted to and didn't want to get into something for the sake of specializing, so I wanted a time away to just clear my mind or to make a clear decision as to what I liked/ wanted and also at the time my brother was also overseas for like 5 years, that was kind of a secondary factor for me because my niece was just about to be ready to be born and I wanted to be along when she is born to be involved, I wanted to see her, and wanted the option to see her like regularly, I think that's the big factor why I decided to go (Dr Shervon Pillay, age 36).

> I haven't really migrated out of South Africa, I just spent a year out in England in 2005 and that wasn't really migrating it was really more like a year out type of thing, you know travelling, makes some money overseas and have a total different kind of experience (Dr Johnson, age 37).

Both Dr Johnson and Dr Pillay were both born into middle-class families. Dr Johnson's father was the owner of an engineering company, his mother a housewife and his siblings were also medical practitioners. Dr Pillay's father was a company manager, her mother a school teacher and her brother an accountant. They both had no commitments at the time of migrating since they were both single and had no other financial dependents to prevent them from migrating. The international world was not a foreign concept to their families.

This section offered a direct response to the core research question. This section further contributed to literature by offering different views with regards to the known and overt factors of migration.

5.8. Conclusion

As suggested by many respondents in the study, international labour migration by South African is a multi-faceted problem. The various themes in the chapter that outlined each factor involved in migration supports this. The respondents attributed their decisions to migrate to the following factors: financial accumulation in order to pay student loans; to

enjoy a better quality of life; to give their children better opportunities; and personal safety. It is rather complicated to assign an ordinal value or rather place these factors in order of importance because there is not a homogenous value placed on each motive. Issues of compensation, class position and safety, though relative, are also contributory factors in the decision to migrate. Migration cultures of South African medical doctors are discussed in Chapter 6.

Chapter 6

Migration cultures of South African medical doctors

6. Introduction and background

Many scholars, sociologists, anthropologists and historians have written about migrant cultures. In particular, they have written about the early days of migrant labour by unskilled workers from the Southern African region. These scholars include Wilson (1972), van Onselen (1976), Ramphele (1993), Moodie (1994) and Maloka (2004).

Moodie (1994) writes about South African migrant workers that leave their homes in the rural parts of the country to go and mine gold in the Witwatersrand. In the section on migrant cultures, he focuses on issues of recruitment at home and livelihoods at the mines, specifically in their areas of residence. Contrary to the ways in which doctors are recruited, it is stated that these workers signed up in recruiting stations typically for a year. They in contrast to the doctors used in this study worked for low wages and lived in single sex compounds that housed between 15 and 50 men per dormitory (Moodie1994). Van Onselen (1976) stated that the compound system for mine workers in Rhodesia (now Zimbabwe) was inadequate. As a result, men that came to work at the mines had to construct their own huts and grass shelters.

Moodie (1994) further states that it was the tradition at the mines that upon arrival to be stripped naked as a matter of routine and humiliation as it was perceived by the mine workers. As compensation for the loss social companionship, these workers would also take younger men as their lovers. Teamwork amongst miners to ensure safety was prioritised. Men at the mines made use of recruitment agencies and their close friends to send money and letters home to their families. As part of social interaction and social rank at the mines, men often called *Amampondo,* used the same categories of rank as they were back home for social relations. These categories referred to the uneducated as *Amaqaba* and the partially educated as the Gentleman or *Amanene* (Moodie 1994).

The social culture of migrant workers was very important as they spent much of their time away from families because of work. Maloka (2004) states that because they spent so much time at work, Basotho migrant workers picked Sunday as the day for relaxation. On this day, they would sit around the fire on their brown blankets and enjoy communal smoking while

also enjoying a game of *morabaraba* (a board game). They would also sing and dance while also enjoying other recreational activities (Maloka 2004).

This culture was not only unique to the Basotho migrant workers. Ramphele (1993) referred to this sort of culture in her book, *"A bed called home: Life in the migrant labour hostels of Cape Town."*Similarly, people would use nicotine and alcohol in their leisure time. Churches were also places where people would go passively so as to get involved. Burial clubs *(oomasingcwabane)* and credit clubs *(imigalelo)* were some of the activities that marked migrant culture (Ramphele 1993).

This section serves as an introduction and background to the chapter on migrant cultures. I have decided to have an in-depth discussion on migrant culture history because first and foremost, there is very little documented on migrant cultures by white collar workers, let alone medical doctors. The next section reflects on what medical doctors do upon returning home and further explores other medical doctor migrant cultures.

6.1. Homecoming and repatriate experiences: what does this mean?

I was born and bred in a small town in the Eastern Cape called Flagstaff. It forms a part of the area known as Emampondweni which in South Africa is popularly known for supplying labour force to the mining areas of the country. Growing up, I would watch men in the neighbourhood of e Ntlenzi/ Ndakeni leave their families behind for periods over six months to two years. In cases where there had been a death in the family, they would perhaps return earlier. They would leave their wives and children behind with all sorts of promises that e Goli (any mining town away from home) promised them. The absence of the father figure would be very visible as from time to time these families would knock on doors borrowing money and asking for food relying on the promise of their father's return.

Indeed, these fathers would return on some early morning, typically in December from Goli. Some of the promises made would be easily observable on the day of return and some days later. These would possibly include a bigger radio player, new fencing for the yard, a bicycle for the young man and many black plastic bags which the contents thereof were uncertain. The point I am making is that they had something to show for their migration.

In the present, these things are prevalent though in a different fashion. Upon returning, men usually take their women into town the day after arriving and buy all the necessities for the household and family. They can be seen with second hand cars that have number plates from the province in which they have been working. In local pubs and shebeens, they drink expensive brandy for at least the first week of arrival before their money is depleted. Moodie (1994) refers to these men as "men of two worlds", one at the mine and one at home where he is building *umzi* (a home).

In this section, I also wish to highlight the difference between white collar South African medical doctors and blue collar migrant mine workers and how they display their acquisitions following a spell of work away from home.

The average age of the respondents, men and women, in the present study, was 28 years at the time of migrating. None of them had nuclear families of their own and consequently, they had no nuclear family responsibilities. The absence of the nuclear family made it an easy decision for the large majority of them to migrate. However, those that did not migrate did not do so because of family and cultural differences dues to race. This is discussed later in the chapter.

The results of coming home after spending a short spell in the host country are clear, this mean that they can be witnessed in naked eye. Firstly, they shared an expatriate experience; namely, the experience the returnee doctors gained in the host countries. The returnee doctors stated that the way in which medicine in practised in their former host countries is significantly different from the home country. Therefore, upon returning, these doctors contributed significantly to South African medicine by applying methods of used in their former host countries. They stated that medicine in their former host countries is based on diagnosis and prevention whereas here at home it is based on curing. Therefore, coming back to the home country forms part of their contribution as they claim to transfer the skills of diagnosis and prevention when resources are available. However, resource constraints do not allow this to be done to an optimal level.

Spending a year, two or more in a foreign country means that one gets to emulate and adapt to certain norms and work cultures that may be vastly different to the ones in the home country. This mentioned in the above paragraph about their contributions becomes the first reflection of their status as repatriates.

Economically, returnee doctors suggested that they accumulated enough money such that they were able to achieve their financial needs much more rapidly than they otherwise would have with a salary at home. Unlike their some of their counterparts who did not migrate, returnee doctors were able to pay off their student loans in a twelve month period; some of those who did not migrate are still paying those loans. Moreover, they suggested that they were able to purchase property in areas of choice and were not bound by limited financial resources. This is depicted by the description of their houses in Chapter 4. This does not in any way suggest that doctors who have not migrated stay in houses of less value.

In a conversation with my relative who is a senior medical doctor he said, "I can tell you one thing for sure, when those guys returned two years later they were able to things that I could not do. And I can assure you, had I migrated with them in 2004 I would not be in the kind of debt I find myself in today''. From this quotation one may deduce that, financially, returnee doctors are in a better position than those who have not migrated.

Upon returning home these returnee doctors were faced with both work-related and social transitions. Doctors return to a much faster paced working environment in the sense that there are a lot of demands made on doctors because of medical personnel shortages in comparison to their former host countries. Since most of my respondents were public sector workers they mentioned being faced with difficulties in terms of resources within their working environment; something that they had to adjust to. They also joined academic hospitals so as to further their education while working.

After obtaining a medical degree, medical doctors are faced with the choice of either practising as general practitioners of medicine or specialising in a particular field. During the time doctors are studying to be specialists they are referred to as registrars. They do not attend classes, but are supervised by specialists at hospitals who then credit their readiness after a period of three years and consequently, recommend them for examination. All the respondents who had migrated in the study, registered as registrars on returning to the home country. They opted not to continue training as registrars in the former host countries, arguing that the best training for a medical doctor is found in South Africa.

Socially, the major transition is that during the first year of returning, the majority of the respondents got married and started their own families. As they had not been married before they migrated, this social transition may be attributed to their acquired financial means and the socially "correct" age where one is expected to marry. Those who had not migrated also

got married at the so-called "correct" age and thus, those who had migrated may have also got married when they did regardless of whether they had been able to afford to start families and whether they had migrated or not.

This section in the study gives one an idea of what happens when doctors return from their host countries; it suggests how repatriates make use of their acquisitions, be it in monetary form, experience or otherwise. I laid a foundation for this discussion by including migrant mining workers in South Africa. This section also explores nuances of class dynamics between white collar and blue collar workers. Most importantly, this section indirectly reveals the factors that are involved in the migration of medical doctors. In the following section, the act of migration as a culture amongst doctors is discussed.

6.2. Migration, a culture of graduate medical doctors?

There is adequate literature on international labour migration by South African doctors and about doctors within the African continent at large. Some of the literature is discussed in Chapter 2 of this study. However, not much has been discussed about whom of the differently ranked doctors actually migrates; in other words, speciality in the medical field, period of time spent in medical practice and so forth with regards to the decision to migrate remain unanswered. This section attempts to make sense of these unanswered questions, specifically focusing on the two examples above.

A large majority of the medical doctors that participated in this study were specialist doctors such as paediatric surgeons, physicians and gynaecologists. Only one doctor who had not and had no intention of migrating was a GP. This composition of specialist doctors in the sample was influenced by the fact that my sampling technique, snowball sampling, typically identifies people with similar characteristics. In the case of my respondents, many of them were friends and in cases where they were not they were introduced by a common friend. This may suggest that specialising in their various fields could have been a result of peer influence.

It is important to note that at the time of migrating, these doctors were not specialists. The majority of them graduated in 2002, did their community service and internship year in 2003 and migrated immediately the following year, 2004.

> During those times it had become more like a tradition that when you finish your community service you go abroad for about a year or two then come back and then decide on what you want to do for a specialty or otherwise (Dr Shinwell Pillay, age 37).

At the time of migrating most of the doctors were 28 years old and single. Literature has suggested that most of the doctors that migrate are often single doctors that not do have much family responsibility to tie them to their home countries. The findings of the present study are in line with the literature. Asked what makes it easier for most doctors to migrate, quite a number of the doctors alluded to the fact that their decision to migrate was made easy by the absence of nuclear family and extended family responsibilities. The findings of the present study suggest that GPs are more likely to migrate than medical specialists.

This study also reveals that people with no more than five years of experience in the medical service migrate. While that is the case, I also acknowledge that my sample was biased towards a certain age group because of the nature of the snowball sampling technique. Furthermore, the few respondents in the study who were older than 28 years with less than five years of experience migrated. One may question why the younger generation of doctors migrate at a rapid pace and yet the older generation in the present study are not likely to migrate. Reponses to such a question vary: some have claimed loyalty to family units and others, particularly black doctors, dismissed the thought of migrating as being a phenomenon of their white counterparts.

The black doctor's view of migration that it is a white doctor phenomenon is a notion worth considering. Bezuidenhout *et al* (2009) assert that migration by medical doctors in the late 1990s was actively a phenomenon done by white workers. I am inclined to attribute this to the fact that in the late 1990s, the majority of doctors were white doctors because the apartheid system had resisted educating black doctors in big numbers. However, it is also important to note that this phenomenon is prevalent in this study which shows that white graduates are much more likely to migrate than their black counterparts.

> The thought of migration is something that has always been removed from me because during my time the perception was that white doctors were the only ones migrating mainly to the US and a few to the UK. Also it was mainly Wits graduates who did and I don't know the reasons for this, it was not for us African doctors (Dr Ntsikana, age 45).

Dr Ntsikana's quote is reflective of two things. Firstly, there has been a shift in "racial based migration" because even though not many black doctors migrate, a group of Indian doctors migrated. Secondly, in this study a large majority of doctors who migrated went to the UK as opposed to the USA. This, therefore, could suggest that there has also been change in the preferred country of destination, contrary to Doctor Ntsikana's notion

Based on the findings, it is not very easy to give a sociological explanation for the shift in the country of destination. One can assert, however, that the sample chosen for this study could have gone to the UK because they were of the same network group. During the interviews, it appeared that the UK has become a popular choice across the board and the "in thing" as Dr Johnson called it. Moreover, it is possible that because the USA has much more stringent visa policies as stated by one of the respondents, doctors have found the UK much more attractive.

On the one hand, the shift in racial based migration could be attributed to the political transformation in post-apartheid South Africa. During apartheid, career choices in South Africa were race specific and some races, particularly the black race were confined to a few in careers in medicine. Furthermore, they were also confined to within the borders of the country and found it difficult to migrate for any reasons, political or otherwise. In post-apartheid South Africa things changed and racial based laws were abolished and people of different races were able to move freely and hence, the shift.

This opening section of Chapter 6 discusses the 'who' in the chapter; namely, who of the medical doctors migrate and to where. The following section introduces the question of how these doctors reach their decision to migrate.

6.3. Medical doctor migration: a collective action?

In the sample used for this study, none of those that migrated did so as individuals. This means that each time South Africa produces doctors, it has to fill the gap of medical doctor shortages. Ultimately that achievement is short-lived since many doctors stay for a year or two after their community service. Dr Zakaria, 37, a graduate of the University of the Witwatersrand mentioned that of his 220 class mates he had at medical school, 200 migrated. This large number of graduates that migrate as a unit has major implications on how medical

students view medical practice. This act also implies that this action of migration is not a haphazard one by medical doctors, but a long premeditated action.

It is evident from my findings that prior to this collective action of migration by these doctors, they were engaged in discussions amongst themselves when they were still students. It is not very clear what makes them engage in discussions about migration. My argument is that they could well be following a trend or a culture that happened before them. Furthermore, the frequent media reports against doctors leaving the country could be counterproductive as it may make students aware of the realities that surround the profession they undertook. It could be caused by the tough practical experiences these doctors have during their years of training, internship and community service.

There are also a number of sociological accounts that I want to attribute this collective action by doctors to. Firstly, these doctors spend a lot of time together at medical school: a period of seven years on the same campus, same classes and same laboratory, and doing practicals in possibly the same hospital. After so much time spent together it is inevitable that they may develop strong bonds as colleagues and friends as well as emotional bonds amongst different groups in the class. Moreover when these doctors graduate, they do so as one class of 100 to 200 students. During the graduation ceremony they together recite an oath that binds them to their service. One, therefore, cannot be oblivious to the fact that this unique practice by medical doctors may bind them together. Together with the other above mentioned factors, this oath may unite them to a point that they will do other things as a unit beyond medical school; hence, migrating collectively.

Returnee doctors mentioned positives that emanate from having migrated as a group while attaching negatives to migrating as individuals. Amongst the negatives, consistent features across the sample of migrated doctors were that of loneliness and the difficulty to assimilate to a new environment. My respondents argued that if one has migrated with somebody or a group they may teach each other about the local cultures and learn their ways in and around the host city together.

> I think it really becomes hard when you go on your own, it takes a lot more time to adjust , hence when we went there we went as a group. When you go with a group it becomes easier to adjust, we used to meet at least once every two weeks (Dr Zakaria, age 37).

Another consistent feature was that one of language. I mentioned earlier in the chapter that my sample was composed of doctors that had only migrated to the UK. Therefore, the use of English as a professional language in South Africa and a mother tongue to some made it easy for them to adjust in an English speaking country such as the UK.

> When we went overseas to the UK in particular, at the time UK was the easiest to get into and also it is English speaking country with ok, weather conditions. Another thing is that we tended to go in groups and worked for the same employer (Dr Seshan Pillay, 37).

An interesting phenomenon about this collective action of migration is that it does not end with a group of graduates leaving together. It also means establishing or creating a new network, a "home network" in a foreign country. As mentioned above, these doctors would often meet once every two weeks. Similar to the migrant workers referred to earlier in the chapter, they met at braais (barbeques) which reminded them of their home country. Those who shared a particular language communicated as such; for example, some of my respondents were first language speakers of Afrikaans and they shared that they communicated as such.

Since all of the migrated doctors were based in the cosmopolitan city of London, UK they said that they would identify South African restaurants where traditional South African dishes were served. This is how they kept in touch with their home countries. These actions created unity in the host county and suggest the temporality of the act of migration. Furthermore, it may be viewed as a form of survival or a coping strategy for the migrated doctors. Moreover, it is also reflective of the unity amongst doctors as graduates that I alluded to early in the chapter

While migration outside the country is a collective action, migrating back into the country is no different. Asked about her reasons for returning home Dr Tiffany Ogle said, "For me returning home was about following John Ogle (now husband) who had gotten a post back home but I was also very happy to come back to Cape Town (CPT). Cape Town is my home town and a lot of friends we had left with had also returned home at that time so it was a lot easier, about 30 of them had returned".

Back home, these networks become manifest in a different manner; for example, these doctors, if of the same specialty, form teams and work for the same unit in a particular hospital. Alternatively, those that are in dual practice collaborate in the running of private rooms. These networks are further manifested through patient referrals where one who is not a specialist in a certain field may refer to the patient other colleagues. Therefore, these networks become important for growth in the home country.

This section has discussed the livelihoods of South African doctors in the host country and further explored the way in which they negotiate their lives back in the home country. The experiences of these doctors in the work place and in the society within which they lived in the host country is discussed in the next section.

6.4. Experiences of SA medical doctors in former host countries

In this section, the South African medical doctors who participated in this study reflect on their former host countries. These experiences have been placed into two categories: working and social experiences. Often scholars that are interested in migration are concerned with the question of why people migrate, to which places they migrate and the benefits of migration. Little is documented on their actual experiences, both in the social and working environment.

This comes with the understanding that other health workers, particularly female nurses, who migrate to the gulf countries often have to emulate the way women live in those countries for reasons of acceptance. Owing to the fact that some of these communities are largely patriarchal, women are not allowed to drive and some nurses have to wear the *niqab* (face veil for Muslims) as a sign of respect and conformity. These are two examples that make it important that we reflect on the leaving experiences of doctors. This may also shed light on whether or not their imminent returns could have been cause by these experiences.

Furthermore, a reflection on these experiences will help us understand the fundamental difference between doing medicine in a developed country as opposed to a developing country.

6.4.1. Work experiences in the host country

With regards to working experiences, the majority of the respondents were appreciative and impressed with the nature of work and the standard of infrastructure in their host countries. They asserted that the availability of infrastructure and the support of staff and colleagues

who had the same qualifications was overwhelming and allowed them to work effectively. The pace of work, manageable patient populations and availability of machinery that was scare in the home country (South Africa) were among the few things that they mentioned. These aspects made it enjoyable and they derived pleasure out of the work. Reflecting on the above, Dr Ross said:

> Another thing is that the whole infrastructure is a lot more organised there, I mean the computers there and CT-scanners, medication and everything that you need is basically there. Access to data captured is much better there as opposed to here. So the whole organising of infrastructure there makes your day to day work a lot easier and less challenging. For example to book an X-ray here I would just log in and request an X-ray to be done whereas here I would have to fill in a form and walk to the X-ray and drop it off. So there it would take me 30 seconds to do it and here it could take possibly over 10 minutes just walking on the corridors (Dr Ross, age 37).

Thus, it may be deduced from the above quotation is that what these doctors encounter in these host countries is improved administration from the side of the hospital. This allows for the availability of the necessary working machinery, availability of medicinal equipment, support staff, contemporary forms of practising medicine and so forth. This leads to efficiency and the doctors find enjoyment in their work. While some doctors such as Dr Ross were impressed with the kind of work environment, some other doctors were critical of a number of things and expressed this;

> The working environment there was excellent, the working staff was nice, the work wasn't as demanding as here. The work there was probably like one 5th of the work I do here for three or four times the salary, the only difference the job was very well paying, very light and fairly mundane unless I ended up doing an accident or an emergency or anything else as added work but that too was much quiet than any other South African hospital (Dr Shinwell Pillay, 37).

The above alludes to the topic of patient populations in hospitals which was a constant theme during the interviews with my respondents. They projected that in their former host countries there are far fewer patients to see in one day. They also said that although there were only a few patients, they were divided amongst many other doctors. Some stated that this meant that

they did not have to work long hours as is often the case in South Africa. However, some like Dr Pillay viewed this as something that creates boredom and minimal excitement in their work. This view of mundane work is reflective of the nature of work that South African doctors are used to, namely, higher patient populations, working under pressure and multi-tasking.

6.4.2. Social experiences

Social experiences refer to experiences outside of the working environment; in other words, how the respondents related to the society that surrounds them. As in the case of their working environments, there were contrasting views about the social experiences in the host country. Firstly, these workers lived in either hospital or private accommodation. This depended on one's choice as the hospitals that they worked for made provisions for accommodation. Therefore, socially, some were surrounded by a community of doctors and others not. Furthermore, as mentioned previously in the chapter, their social life was also highly dependent on one another as a network of friends and colleagues.

The cost of living in the UK is significantly higher than that of South Africa; however, none of the respondents complained about this. I am of the opinion that this is because in the UK doctors are held in high prestige by both authorities and citizens. Therefore, the amount of money they earn is such that they do not feel the pinch of a high cost of living. What is not quite clear is that as migrants living in an expensive country does one get to save as much as intended? However, those respondents that migrated were able to accumulate enough to take care of their financial needs more rapidly than their colleagues who did not migrate.

Furthermore, some respondents praised the country of destination and specifically, London for being a great cosmopolitan city. They argued that one never really feels out of place as the place is densely populated by foreigners that could possibly out number UK nationals. Hence, they were no issues of race whatsoever experienced by any of my respondents.

They defined it as a crime free area where one was able to commute between places free of common worries that are commonly experienced in South Africa such as robbery.

In contrast, a few respondents dismissed the host country as being a friendly country. They referred to weather patterns as unfriendly and too cold and this is as something that they as South Africans are not used to. They also referred to locals as being mechanical and

unfriendly people that would never invite them into their circle of friends. The latter can be linked to the reasons why upon arriving in the host countries medical doctors create home networks. This has been discussed in-depth earlier in the chapter.

When doctors migrate they often do so with the choice of either joining the private or the public sector. In this study it emerged that the all of the respondents who migrated went into public service. The question may be asked why they join the public sector. Some of the answers that emerged include that the private sector in developed countries has more doctors that the public service does. Another reason is that the medical doctors in South Africa are often recruited by government agencies and not private agencies. This process often occurs after doctors have been registered with HPCSA where contact details and qualifications of an individual can be obtained. Although these doctors often work in government in their host countries, they said that it feels as though they were working in a private hospital if they are to liken the working situation to that found in their mother country.

6.4.3. Returning home = Dual practice

The HPCSA (2008) handbook and guidelines makes provision for doctors to practise dually, that is, in both the public and the private sector. However, this phenomenon is viewed negatively by governmental health authorities because they are of the view that doing so is acting outside of the acceptable code of ethics. Section 27 of the regulatory guidelines of the HPCSA caters for dual practice. Nonetheless, negative opinions on the subject abound. This negative view of dual practice is not a situation unique to South African authorities. Many others outside South Africa have expressed their concerns and regulatory frameworks have been established as a result (Gonzalez & Stander 2012). Within South Africa, the Kwa-Zulu Natal (KZN) provincial government has abolished dual practice basing their argument on grounds of ethics and loyalty.

Gonzalez and Stander (2012) state that in countries with mixed health care systems, namely, private and public health care, it is common to witness dual practice. Furthermore, they cite certain European countries such as Austria, Ireland and the UK where 100 %, 90% and 60% of their senior specialist doctors respectively work in both sectors.

Despite the negativity that surrounds the topic of dual practice, it remains dominant. In the present study, of the Gauteng based returnee doctors, only one respondent was not involved in dual practice. Their Kwa-Zulu Natal based counterparts expressed frustration and

unhappiness with being limited to one sector. Consequently, many of the Kwa-Zulu Natal respondents said a lot of their colleagues have opted to join the private sector because it financially it was more lucrative. There are a number of doctors from this province who have opted to migrate to provinces that permit dual practice.

> I work in a public hospital, Johannesburg hospital but I also work in two other hospitals around Johannesburg. The reason I work in the government sector I feel there is a huge shortage of paediatric surgeons in South Africa, so there is a huge social demand and we have a huge patient load that needs to be looked after so you know, I enjoy working with the community, serve the community and also being involved at the university through research and teaching I really enjoy that kind of stuff. I also work in the private sector just to feed up my finances, I mean the truth is I don't make a lot of money in government but you know working in private gives me more money you know (Dr Michael Ross, age 37).

The above quote places emphasis on two major things that makes doctors to take up the option of dual practice and these include, wanting to contribute academically and wanting to improve the financial situation at home. Similarly the below doctor says:

> I am serving in the public sector the majority of the time and I do also a little bit of private on the side but 90% of my time is in the state. I think the two sectors are a different kind of medicine; it is also nice to get a little bit of a break from the madness of Baragwaneth everything there is just chaos there. And also financial you got to supplement your income a little bit, especially if you want a family and you have education intentions. Especially with us paediatric surgeons there aren't too many of us so we are actually forced to do both state and private (Dr John Ogle, age 40).

Doctors want to be involved in dual practice because of finance, in European countries, doctors earn £ 395 982 per annum (doctorsalaries.com). Therefore, it is difficult for returnee doctors to earn less in order to maintain the standard of living they had enjoyed in the host country. However, one could argue that in as much as medical doctors get fairly high salaries, it is not sufficient enough for their standard of living and the cost of living. Of the respondents, the returnee doctors claimed to have been more able to meet their needs at home than their counterparts who did not migrate. Furthermore, discussions with doctors other than

the respondents revealed that they concurred with the assertions made by their colleagues. The ambiguity of the realisation of financial needs as a result of migration requires further research.

It can be deduced from the quotations above that South African medical doctors are not content with the salaries earned in the country's public service. They stated that public service salaries are not adequate to meet their daily needs nor do they afford them a comfortable standard of living.

An important phenomenon to note here is that very few of the many professionals outside of the medical profession that constitute the middle class are involved in dual practice. The latter may lead one to question why medical doctors practise such whereas other professionals outside of the medical field do so minimally. Once again, one may be inclined to attribute this phenomenon to the ascribed societal status given to South African medical doctors. Medical doctors in South Africa are classified by society as being highly prestigious and thus, they see reason to live up to this expectation by supplementing their salaries through dual practice.

While issues of insufficient government salaries are prevalent, other social factors need to be considered; for example, doctors view working conditions in government hospitals as dire. They stated that there is overcrowding and shortage of working material. They argued that the private sector offers them a less emotionally stressful environment as well as a totally different improved pathology while allowing them to also enjoy financial gain. Some doctors have linked this phenomenon of dual practice to an argument of passion. They believe that because there is a general shortage of doctors in the public sector, dual practice is a necessity. They further claimed that both sectors are well deserving of service and that none should be deprived of this at the expense of the other.

These conflicting opinions are important to make reference to if the relevant parties are forbid doctors 'involvement in dual practice. In this section of the chapter, dual practice and what it can be attributed to has been discussed. In the next section, the possible factors that are involved in the reluctance to migrate by black South African medical doctors are explored.

6.6. Black doctors and migration: umbilical cords firmly attached?

International labour migration by SA medical doctors is a frequent phenomenon of discussions amongst medical professionals. The present study reveals that after a certain period of engaging in discussions on migration, more often than not a large number of doctors eventually migrate. However, this study also shows this action of migration as something that is common in particular race groups, namely, Indian and white doctors. Notably, discourse around international labour migration is not a situation that is common amongst all races. "There would need to be a total collapse of the country for me to migrate" (Dr Kwetshube, 51). Like Dr Kwetshube there were many others within the sample of black doctors that felt strongly against migrating to other countries.

Unlike their Indian and white colleagues, black doctors did not mention family networks in other parts of the world. Therefore, it is safe to assume that lack of knowledge about prospects in the host country informs the decision against migration. Other factors such as stereotypes and beliefs also influenced these doctors not to migrate.

> The thought of migration is something that was always very removed from me because during my time the perception was that white doctors were the ones migrating mainly to the US and a few to the UK and it was mainly Wits graduates who did and I don't know the reason for this, it was not something for us African doctors (Dr Ntsikana, age 45).

It is noteworthy that the above quoted doctor was a lot older than the other doctors in the study. This may imply that the time at which this doctors graduated is a phenomenon to take into account. However, there may not be a significant relationship between the time of graduation and the decision to migrate, but rather it suggests that there are historical implications that black people encountered with regards to exposure of the international community. Another important factor to note is that the older doctors in the sample mentioned that they were already tied down by nuclear and family responsibilities and therefore, could not afford to migrate.

The younger generation of black doctors very often engage in discussions of migration, even more than their older counterparts. However, hesitation is always prevalent. In this study,

hesitation can be attributed to "family social responsibilities." This was referred to in Chapter 5. These social responsibilities come with being a black working South African in a black household. In many black households, though unwritten, working persons are faced with a "social responsibility" of financially and emotionally supporting their nuclear and extended families. Therefore, it becomes hard for them to completely leave their mother countries while leaving people that are highly dependent on them. Others, mostly males, are head of the broader extended families and key decision-makers in major cultural decisions and therefore, their absence could have far- reaching effects on household operations.

Also, the possible absence of the culture of migrating or travelling and exposure in black households removes the urgency to wanting to leave the country. Furthermore, as indicated in Chapter 5, no matter how South African black doctors are irritated with the health care system, it may not be as easy for them to migrate as it is for their Indian and white counterparts. This may be due to not wanting to immerse themselves into a totally different culture of doing things

This theme has offered unique ideas and responses of why black South African doctors are reluctant to migrate as opposed to their Indian and white doctor counterparts. A number of answers relative to historical imprints and cultural background have been attempted.

6.7. Conclusion

In this chapter, migration by unskilled workers as discussed by Moodie (1994), Ramphele, (1993), Maloka (2004) and van Onselen (1976) were further discussed. These books offered this chapter a rich background of what is meant by migrant cultures. This was done by identifying how people negotiated their livelihoods in migrant spaces.

Consequently, this background information on migrant cultures by the unskilled workers allowed me to identify what migrant cultures are amongst the skilled, white collar worker. With regards to unskilled migrant workers discussed in literature the migration to the mines was cyclical. Mine workers accumulate enough and later go home. They return to the mining towns once they have exhausted their supply of money.

In contrast, medical doctors appear to only migrate once and do not migrate again. However, they leave this option wide open if things in the country were to become unstable, socially, economically or politically. The type of social networks the two types of workers experience

is also reflected as relatively different because of time and space. The difference in the cultures also displays distinct classes amongst the two.

The last sections in the chapter have contributed to the understanding of what returnee doctors experience when they are back at home as well as their experiences in the host countries, both socially and in terms of work. The chapter also explored the cause for dual practice and the resistance of black doctors to migrate

The next chapter reflects deeply on the findings of the study and what the implications are for literature.

Chapter 7

Conclusion: A reflection, synthesis and implications of findings

7. Introduction

Although it is not documented, it is safe to assume that migration in South Africa began long before the arrival of Jan van Riebeeck in 1652. A study of history could lead to the suggestion that before 1652, South Africa was a place that comprised of hunting and gathering or agrarian societies. The mode of subsistence in these societies included growing and collecting wild plants, fishing, hunting for wild animals, crop and animal farming. From time to time these men migrated to other places because of a limited supply of food. Giddens (1993:44), Post (1952) and Wilson (1972) suggest that movements based on agricultural and pastoral trade became prominent in South Africa and developed into the economy of the country.

Nevertheless, it was the discovery of diamonds in Kimberly and later the discovery of gold in Johannesburg in 1886 that intensified the migration processes. There was an influx of mostly unskilled men from all over the Southern African region to the Johannesburg mines to mine gold (Moodie 1994). A century and a quarter later, dynamics have transformed. Unlike before, South Africans now seek employment throughout the world. Contrary to movements by unskilled labourers from the Southern African region, many more skilled or professional labourers from South Africa and other Southern African regions at large have turned away from South African shores in search of greener pastures in the global northern hemisphere. In the first chapter of the dissertation, this was attributed to the globalisation of markets.

“Globalisation is the catch word of the day. It emerged in the 1990s as the preferred term for encompassing the multiplicity of supernatural forces that have imprinted themselves on the contemporary world, and it seems likely to remain in use, and probably overused for the foreseeable future” (Hopkins 2002: 1). Steger (2010:48) goes on to define globalisation as “the intensification of worldwide social relations that link distant localities in such a way that local happenings are shaped by events occurring many miles away and vice versa”. Although this term globalisation does not appear frequently in this study, its attributes are certainly phenomena to consider in the quest to give an elaborative response to the research question at hand. In the first chapter, the fact that the globalisation of markets has weakened national

borders and has encouraged easier movement of goods, commodities and people with commendable skills was highlighted. As a reflection of the rest of the study, class in relation to medical doctors is highlighted.

7.1. Doctors: a case of class reproduction?

It is importance to note the kind of people that were being studied; beyond themselves as individuals, but as people of broader families and households. This will assist the reader to have a further understanding of the significance of class and status, and the maintenance thereof by these doctors.

The class positions of medical doctors with special reference to the meanings of occupation and perceived class position is discussed; in other words, the way in which certain occupations are associated with a particular class. This is also related to the parents and siblings of the respondents in the study in an attempt to make sense of their current class positions.

As stated in the previous chapter, medical doctors are perceived to be people that occupy the upper middle class of the societal ladder by lay South Africans. However, what influences or informs this perception is not discussed. Their family situations which could well be one of the determinants of their decision to migrate are not elaborated upon.

A large majority of doctors that participated in this study came from typical middle-class families. Of the doctors that were interviewed, they either belonged to a family that had both parents who were professionals or had one parent working, mostly their fathers while their mothers were housewives. These respondents were either sons or daughters of medical doctors, teachers, businessmen and women, engineers and so forth. It is important to highlight that this class reproduction was consistent with particular racial groups, namely, the Indian and white respondents.

> My father is an accountant and my mother was a professional nurse, she stopped working when my brother and I were babies, so when we grew up she was not working (Dr Ross, age 37)

The above quote is an example of what I refer to as class reproduction. Dr Ross is a white doctor who comes from an evidently stable financial background; this can be deduced from the professions of his parents. By virtue of being born into such families, they assume a

particular class position. Growing up, they enjoyed better life chances and thus, had access to things that are not common to people born of families without professionals. These may include things such as a better financial possession, ownership of property and prestigious schooling. When considering the kind of profession that the quoted respondent finds himself in it is safe to assume that Dr Ross is now of the same class as his parents. This is assumed because currently there is a marginal or no difference between his parents and him in terms of income, life chances and degree of prestige.

The Indian respondents like their white counterparts, though to a lesser extent, have assumed class positions of their parents. In the literature, there is no evidence that doctors will be sons of doctors as is the case in this study. It is not very easy to explain this phenomenon of class reproduction, particularly that of doctors. However, the following may be considered. Firstly, historically, doctors' remuneration has been satisfactory and therefore, medical doctors' offspring may have wanted to follow suit because of the prospects of a comfortable life. Furthermore, the prestige, status and social honour enjoyed by parents is something that may influence the offspring to also enrol for a degree that promises these advantages after graduation. Furthermore, in a country with an approximate 25% unemployment rate, a qualification that promises self-employment may seem attractive. Lastly, some parents like to see themselves in their children; therefore, choosing a profession for some of my respondents may have been as a result of family pressure for some of the respondents.

With black doctors there is a minimal chance of class reproduction. What was most visible in the black respondents was class mobility which will be discussed in the next section.

7.2. Black doctors and class mobility

One of the facts in South African history is the racial economic injustices of the past. History suggests that these racial economic injustices ensured that the white minority enjoyed a larger share of economic and social amenities such as better jobs and better schools than the majority; blacks, Indians and coloureds did not have such advantages. These exclusions included certain levels of education. For black people, the highest levels of education meant one could only become a teacher, nurse or administrative clerk, to mention a few. Typical forms of employment were to be found in agriculture as farm workers, mining and domestic service. The more prestigious professions were reserved for the white minority and the Indians.

> My parents were zero, they never studied, and my father worked in the mines and came back. In fact he did his standard 7 when I was already a general practitioner, that is when he decided he should study (Dr Kwetshube, age 51)

Black South African medical doctors could be viewed as a case of class mobility. Obtaining an MBChB degree granted them a professional status that improved their life chances, access to financial security, credit worthiness and so forth, something that they were not used to in families within which they were born. The far-reaching effects of this mobility are likely to give birth to case of generational class reproduction as is the case with their white counterparts. This assertion, however, does not suggest that upward class mobility will not be possible for the next black generation nor does it suggest its absence in the future generations of their white, coloured and Indian counterparts.

7.3. Sibling status and class position

All the racial groups sampled for this study, namely, blacks, Indians and white mirrored class positions of their siblings. This means that these respondents fell under the same class category as their brothers and sisters. The above was gathered after asking a series of questions on the working status of their siblings, respondents shared the following:

> I have got an older sister; she is a house wife, younger sister that is a medical registrar (trainee specialist) and a younger brother who is a neurology registrar. When my sister finishes she will be a physician like me and when my brother finishes he will practice as a neurologist. They both go to the same university that I went to the University of Natal, well now it's called UKZN (Dr Pillay, age 36).

The respondent strengthens my argument of class reproduction in a sense that many white and Indian respondents mirror the class of their parents. The black respondents in the study however, have shown that many of them are a case of class mobility and symbolise growth in black middle class South Africans. That is, they have moved up from the position of working class currently or previously occupied by their own parents.

Lastly, in this study, social factors relating to culture, race, and class relative to migration by South African doctors have been identified. However, health care remains an essential service and by this in this context I mean it falls under a class of occupations that are prioritised by

government. Therefore one cannot run away from the fact that if one is to assess progress in the development of a country, the health sector would be amongst the prioritized. Servants within this sector, in particular medical doctors are essential. It is imperative, therefore, that the relevant authorities pay attention to the problems that have been identified.

7.4. Synthesis and implications for literature

These findings have produced a new dimension away from the conventional known and assumed pull and push factors of migration. As a new contribution to literature, these findings present something that is not only unique to South Africa, but the rest of the other countries in the Southern hemisphere. Consequent to large amounts of tuition paid in South African universities, in particular for the MBChB programme, students find themselves in debt from student loans. As a result, by the time they graduate it seems they have already contemplated how to pay off their student loans. The study indicates that in an attempt to pay off these exorbitant amounts, the common solution is to assume a career in a place that would best assist in quickly paying off their student loans.

Many graduates in the study opted for international migration, mainly to the UK, where better salaries are offered than those in the home country. Linked to this factor are other factors of migration that are related to the prospects of a better quality of life promised by the possibilities of living in a first world country upon as well as on returning home. Secondly, the recurring theme across literature is that one of improved salaries offered in the northern hemisphere.

The attractive salaries paid by host countries allow these doctors to meet their financial needs outside those of paying student loans. Theoretically, and using the work of Weber, this study contributes to literature by putting forward a different argument to what meets the eye. This is mentioned in Chapter 3. I argued that Weber states that status in traditional societies can be bestowed upon one by royalty. I stated further that financial standing or economic means during present times helps one to achieve status and assists in sustaining it thereafter. To enjoy a particular status nowadays, one needs to live in a particular up-market area of residence, listen to particular kinds of music, drive classy cars amongst other things and certainly have a good financial standing.

One could be convinced that the decision to migrate is solely based on an act of ‘money chasing’, that is, financial accumulation. However, from a sociological perspective, I am of

the opinion that medical doctors may be migrate as means to inform and improve their social status.

In line with the latter and as stated in Chapter 3, there are a lot of assumptions about medical doctors' earnings in the South Africa society. These assumptions suggest that there are big pay cheques for doctors, ultimately suggesting that doctors are rich people and hence, there is societal expectation. I further argue, therefore, that some of these doctors may migrate consciously or subconsciously to live up to the societal expectation of 'what should be' their status.

Due to their 'noble' job of saving people's lives, they enjoy social honour and a lot of attention from their communities. Coupled with the above assumptions, they may need to migrate in order to also keep up with class expectations. Whether these doctors are conscious or not about this, migrating may suggest a move towards a certain class and upon return, their acquisitions, financial or otherwise may also place them in certain class positions. After financial accumulation in the host country, perhaps these doctors may belong more to a particular class in which they fit and had been assumed to be in even before they migrated.

Thirdly, a number of respondents had issues with a number of other social situations which I presume they view as ills of the South African society. The education system of the country was a recurring theme during the interviews. Asked about future migration, the respondents did not overrule it. They felt that it would be unwise to raise their children in a country whose education system is in question; therefore, it would probably necessary to migrate. However, this was consistent with a particular race group; this has been previously discussed. Crime was also an area of concern. As head of families or partners within a family unit, some of the respondents stated that it is their responsibility to take care of their families. So it is imperative that they in the future move their children to safer places than South Africa.

These fears of crime and the concern about the South African education system were consistent with the Indian and white respondents. It is difficult to account for why white and Indian doctors view the education sector in this light taking into account that there are private and former model C schools that offer globally compatible education. Black doctors studied under the Bantu Education System and thus, when they reflect on their own education in relation to that of their children whom are mostly in private schools and former model C schools, they do not appear to be concerned about it. Contrary to this assumption, white and

Indian doctor who had the privilege of attending better schools may be noticing a drop in standard.

Another important contribution to literature is the identification of white collar migrant cultures, particularly those of medical doctors. The collective action culture of migrating by graduate doctors is one of the important contributions to literature. I have argued it as a phenomenon that possibly emanates from the structuring of the medical degree and the culture within. Attached to this is the culture of unity and home practices such as braais, socials and the visiting to South African restaurants in the host country.

There are a further two contributions to literature. Firstly, upon returning from the host country medical doctors turn to dual practice, which means working in both the sectors. I am of the opinion that this has more far-reaching effects on one sector than the other. I am of the opinion that the public sector will suffer because the private sector is more lucrative. This dual practice by medical doctors has been attributed to 'unsatisfactory' salaries for medical doctors. However, I also argue that in terms of the market, medical doctor salaries are satisfactory; however, if one compares South African salaries to salaries in Europe, they are unsatisfactory.

It is noteworthy that, there are no racial exceptions in as far as the discourse of and the thought of migrating is concerned. However, execution or exercise of this action has been racialised. In the study, migration appears to be a white person phenomenon. For black doctors it remains an issue of discussion. In Chapter 6, I have delved into issues of exposure, historical racial imbalances, traditional family roles and family social responsibilities to explain this phenomenon.

Finally, it is important to note that this study has contributed to the study of migration in general by significantly introducing the concepts of class and status. Using the theories of Bourdieu, Marx and Weber, this study was able to sway away from the conventional economic argument on causes of migration. Moreover, this study also moved away from the topics of political stability, geographical threats and many other topics relative to and typical of this migration topic. Ultimately, this study has explored, but not concluded that doctors are professionals interested in maintaining their envisaged class and status position.

List of references

Asiedu, A. 2010. 'Perspectives on the Migration of Skilled Professionals from Ghana'. *African studies review*, Vol 53. No 1, pp. 61-78.

Babbie, E. and Mouton, J. 2008. *The Practice of Social Research*. Cape Town: Oxford.

Bezuidenhout, M., Joubert, G., Hiemstra, L., and Striwig. 2009. 'Reasons for Doctormigration in South Africa'. Bloemfontein: *SA fmPract*, Vol. 1, No 53, pp. 211-214.

Bonnin, D &Ruggunan, S. 2013. 'Towards a South African Sociology of Professions', *South African Review of Sociology*, Vol 44, No.2, pp. 1-5.

Bouare, O. 2008. 'Determinants of internal migration in South Africa', *SA Journal of Demography*, Vol. 8, no.1, pp. 23-29.

Bourdieu, P. 1977. 'Cultural Reproduction and Social Reproduction'. *Oxford University Press*, New York, pp. 487-511.

Bourdieu, P. (1984 1979) Distinction: A Social Critique of the Judgment of Taste. Richard Nice (tr.). Harvard University Press.

Bourdieu, P. 1986. The Forms of Capital. In: Richardson, J. G. (ed.) Handbook of Theory and Research for the Sociology of Education. New York, Greenwood Press, pp.241-258.

Boyd, M. 2013. 'Family and Personal Networks in International Migration : Recent Developments and New Agendas'. *The Centre for Migration Studies of New York, Inc.* Vol . 23 , No . 3 , pp. 638–670.

Buchan, J. and West, S. 2012. 'UCT's admission policy demotivates black pupils', *Cape Argus*, 19 January 2012.

Buhlungu, S. 2010. A paradox of victory: COSATU and the Democratic Transition in South Africa. Scotsville: University of KwaZulu-Natal Press.

Burawoy, M &Von Holdt, K. 2012. *Conversations with Bourdieu*. Johannesburg: WitsUniversity Press.

Brush, L &Sochalski, J. 2007. International Nurse Migration: Lessons from the Philippines Policy, Politics & Nursing Paractice SAGE Publishers.

Catesls, S. 2000. 'International Migration at the Beginning of the Twenty-First Century: Global Trends and Issues'. *International Socialcience Journal*, Vol. 52, No 165, pp. 269-281.

Cox, K.R., Hemson, D., & Todes A. 2004. 'Urbanization in South Africa and the Changing Character of Migrant Labor', *South African Geographical Journal* 86:17- 16.

Cox, O. 2013.‘ Max Weber on social stratification: a critique’. *American Sociological Review*, Vol. 15, No 2, pp. 223–227.

Collins, M., Tollman, S. & Kahn, K. Highly prevalent circular migration: Household, Mobility and Economic Status on rural South Africa, paper prepared for Conference on African Migration in Comparative Perspective,Johannesburg, South Africa, 4-7 June.

Department of Pediatrics, University of Pretoria. 2012. Annual Report. Pretoria: University of Pretoria

Digby, A. 2005. ‘Early black doctors in South Africa, *The Journal of African History*, Vol 46. No 3, pp. 427-454

Dolvo, D. 2003. ‘The brain Drain and retention of Health Professionals in Africa: A case Study for a Regional Training Conference on Improving Tertiary Education in Sub-Saharan Africa: Things that work!’, paper prepared for a Regional Conference on Improving Tertiary Education in Sub-Saharan Africa, Accra, Ghana. September 23- 25.

Ellerman, D.2005. Labour migration: A developmental path or a low-level trap? Development in Practice, 15(5), pp.617–630.

Fakier, K. 2009. The Impact of Migration on Emnambithi Households: A Class and Gender Analysis. Unpublished PhD. thesis. University of the Witwatersand.

Favell, A., 1998. Rebooting Migration Theory Interdisciplinarity, Globality, and Post disciplinarity in Migration Studies. , pp.259–278.

Fevre, R., Denney,D&Borland, J. 1997. “Class, Status and Party in the Analysis of Nationalism: Lessons from Max Weber.” *Nations and Nationalism* 3(4):559–577.

Gerth, H & Mills, C.1946 . *From Max Weber: Essays in Sociology*. Oxford University Press: New York.

Glodthorpe, J., Lockwood, D, Bechhofer, F &Platt, J. 1968.*The affluent worker: industrial attitudes and behavior*. London: Cambridge University Press.

González, P. & Macho-Stadler, I., 2013. A theoretical approach to dual practice regulations in the health sector. *Journal of health economics*, 32.No.1, pp.66–87.

Haringgton, J., McGlashan, N. and Chelkowska, E. 2004.‘A century of migrant labour in the gold mine of South Africa’.*The Journal of the South African Institute of Mining and Metallurgy*, pp. 65- 70.

Harker, R., Mahar, C & Wilkes, C. 1990. An introduction to the work of Perrier Bourdieu. London: Macmillan New York.

Health Systems Trust. 2000. Change and Innovation in South African Medical schools: An Investigation of Students Demographics. Durban: Heath Systems Trust- Research.

Hopkins, A. 2002.*Globalization in world history*. London: Pimlico publishers.

Iputo, J &Kwizera, E. 2005. 'Problem based learning improves the academic performance of medical students in South Africa'. *Medical Education,* Vol 39, pp. 388-3939

Jeeves, A. 1985.Migrant Labour in South Africa's Mining Economy: The Struggle for the Gold Mines' Labour Supply 1890- 1920. Montreal: McGill- Queens UniversityPress

Jones, T, 2009. 'Migration Theory in the Domestic Context: North-South Labor Movement in Brazil'*Sociology& Anthropology Faculty Publications.*Paper 14.

Jordan, Z.A, 1971. *The making of Sociology: Karl Marx*. Michael. London: Joseph Ltd.

Kabwe, A.W.& Landau, L.B. 2008.'Migration in post-apartheid South Africa Challenges and questions to policy-makers'.*Agencefrançaise de développement* , (November).

Kincaid, V. 1957.'Interviewing the Business Elite'.*American Sociology Journal,* Vol. 63, No. 3, pp. 304-311.

Kline. S. 2003. 'Push and Pull Factors in International Nurse Migration'. *Journal of Nursing Scholarship*, pp. 107-111.

Kok, P. &Collison, M. 2006.Migration and Urbanisation in South Africa. Report 03-04-02. Pretoria: Statistics South Africa.

Kok, P., Gelderblom, P., Oucho, J. and Van Zyl, J. 2006. *Migration in South and Southern Africa: Dynamics and determinants.* Cape Town: HSRC Press.

Kok, P., O'Donovan, M., Bouare, O. and Van Zyl, J. 2003.*Post-apartheid patterns of migration in South Africa*. Cape Town: HSRC Press.

Kogo, S. 2009. Migration of African trained Physicians abroad: A case study of Saskatchewan, Canada. Masters thesis, Department of geography, University of Saskatchwan.

Koser, K. 2007.*International Migration: A Very Short Introduction*. Newyork: Oxford University Press..

Lee, E. 2007.A Theory of Migration.*Population Association of America,*Vol. 3, No1, pp.47–57.

Lever, J. 1982. *A series of Social science monographs: Some elements of Marx's thought*. Pretoria, Academia.

Maharaj, B. 2010. The African Brain Drain: Causes, Cost, Consequences. *Africa Insight*, Vol 40. No 1, pp.96–108.

Maloka, E. 2004. Basotho and the Mines*: A Social History of Labour Migration in Lesotho and South Africa, c,1890-1940.* Dakar. Council for the Development of Social Science Research in Africa.

Manik, S. 2009. 'Understanding the exit of teachers from South Africa: determinants of trans-national teacher migration'.*Perspective in Education*, Vol 27, No 3, pp. 267-277.

Manik,S. 2009. 'Understanding the exit of teachers from South Africa : determinants of trans-national teacher migration'. *Perspectives in Education*, pp.267–277.

Manik, S. 2007. 'To greener pastures: Transnational migration from South Africa'. *Perspective in Education*.Vol 25 No 2, pp. 55- 65.

Marshall, C & Rossman, G. 1995.*Designing qualitative research*. London: SAGE publications

Marx, K. and Engels, F. 1948. Manifesto of the Communist Party (May 1871).International Publishers CO.

Massey, D., Arango, J., Hugo, G., Kouaouci, A & Taylor, J. 2003. 2011. 'Theories of International: A Review Migration and Appraisal'.*Population and development Review*. Vol, 19. No 3, pp.431–466.

Mattes, R. &Mniki, N. 2007. Restless minds : South African students and the brain drain Restless minds : South African students and the brain drain. *Development Southern Africa*, Vol. 24, No.1, pp.37–41.

May, T. 2011.*Social Research: Issues, Methods and Processes*. New York: Open UniversityPress.

McEvoy, J. 2006. 'Elite Interviewing in a Divided Society: Lessons from Northern Ireland' *The Author. Journal complication*,Vol. 26, No 26. 184-191.

Moodie, D.1994. *Going for gold: men, mines and migration*. Berkeley: University of California Press.

Moomal H, Pick W. 'Production of doctors in South Africa. In': *South African Health Review*.Durban: Health Systems Trust, 1998.

Mulenga, C.2007. Recruitment and Selection of foreign Professionals in the South African Job Market: Procedures and Processses. SA Journal of Human Resources, Vol. 5, No.3, pp. 30-37.

Murray, C. 1981. *Families divided*. London.: Cambridge University Press.

Ncayiyana, D. (ed). 2011. ' Medunsa's rebirth would do well to start with and reconciliation' *South African Medical Journal*, Vol.101, No 8, pp. 489.

NEHAWU. 2007. Occupational Specific Dispensation OSD- Nurses Victory: The Nurses have scored a majority in the OSD agreement. Issued statement. NEHAWU

Nueman, W.2000. *Social Research: Qualitative and Quantitative Approaches*. Boston: Allan and Bacon.

Oosthuzien, M. & Ehlers, V. 2007.'Factors that My Influence African Nurses' Decision to Emigrate'.*Health SA Gesondheid*.Vol, 12.No. 2, pp.14- 26.

Pauw, K., 2009. Understanding the Efficiency and Effectiveness of the Dispute Resolution System in South Africa : An Analysis of CCMA Data

Perberdy, S. 2005. Synthesis Report : Migration and Urbanisation in South Africa Setting the Scene.The Atlantic Philanthropies.

Perberdy,S & Dinat, N. 2005. *Migration and domestic work in South Africa*: Health and Mobilty: Idasa.

Posel, D. 2004. 'Have Migration Patterns in post-Apartheid South Africa Changed'? *Journal ofInterdisciplinary Economics*, pp.4–7.

Posel, D &West. 2004. 'Labour Migration and Households: AReconsideration of the Effects of the Social Pension on Labour Supply in South Africa' African Development and Poverty reduction Forum'. South Africa, pp. 1-25.

Posel, D. & Casale, D., 2003. 'What has been happening to Internal Labour Migration in South Africa, 1993-1999 ?'DPRU. University of Cape Town

Posel, D., Fairburn, J. a. & Lund, F., 2006. Labour migration and households: A reconsideration of the effects of the social pension on labour supply in South Africa. *Economic Modelling*, 23(5), pp. 836–853.

Price, M. 2012. 'In defence of race based policy'. *Mail & Guardian*, 06 January.

Ramamurthy, B. 2003. *International labour migrants: unsung heroes of globalisation*. Stockholm: Sida.

Ramphele, M. 1993. *A Bed Called Home: Life in the Migrant Labour Hostels of Cape Town*. Claremont: David Philip Publishers.

Republic of South Africa Department of Health.2011-2012. Annual Report. Pretoria: Government Printer.

Republic of South Africa Department of Labour. 2007. Labour Migration and South Africa: Towards a fairer deal for migrants in the South African Economy. Pretoria: Government Printer.

Rogerson, C. & Crush, J. 2007.South Africa and the Global Recruitment of Health Professionals. *Africa Institute of South africa*,Vol 37, No.4, pp.1–15.

Rugunnan, S. 2010. 'The role of state institutions in shaping the labour market for seafarers: the cases of South Africa and Philippines. *Politeia,* Vol 29. No 2, pp. 42-63

SACE. 2011. Teacher Migration in South Africa: Advice to the Ministries of Basic and Higher Training. South African Council of Educators.

Naicker.,Rhule, J., Tutt, R & Eastwood.2009. Shortage of Healthcare Workers in Developing Countries- Africa. *Ethnicity & Disease*, Vol 19. pp. 61-64

Sarantakos, S. 2005. *Social research. New York*: Palgrave Macmillan.

Smigel, O. 1958. Interviewing a Legal Elite: The Wall Street Lawyer. *American Journal of Sociology*, Vol. 64. No. 2, pp.159-164

Smith, C. 2006. Reflections of South African Nurses migrating to the Kingdom of Saudi Arabia: A Framework for Support.P.h.D Thesis, Nelson Mandela Metropolitan University.

South African Health Review. 1999. Annual Report. Pretoria: South Africa.

South African Migration Project. 2005. Migration and Domestic Workers: Worlds of Work, Health and Mobility in Johannesburg. Cape Town: Idasa

Standing, G. 2011.*The Precariat: The new dangerous class.*London: Bloomsbury Publishing Plc.

Standing, G, 1997. 'Globalization, labour flexibility and insecurity: The era of market resgulation'. *European Journal of Industrial Relations*, Vol 3. No. 1, pp. 3-37.

Standing, G., Sender, J & Weeks, J. 1996.*Restructuring the labour market: The South African challenge; An ILO Review*. Geneva: International Labour Organisation.

Statistics South Africa. 2012. Documented immigrant in South Africa. Pretoria: Statistics South Africa

Statistics South Africa. 2012. Victims of crime survey. Pretoria: Statistics South Africa.

Statistics South Africa. 2006. Migrtion and Urbanisation in South Africa. Report No. 03-04-02. Pretoria: Statistics South Africa.

Steger, M. 2010. *Globalization: the greatest hits, a global studies reader*. Boulder: Paradigm publishers.

Stellenbosch University. 2012. Annual Report: Stellenbosch University.

Stilwell, B., Dialo, K., Vujicicic, M & Dal Poz.2004. Migration of Health- Care Workers from Developing Countries: strategic Approaches to its Management.Bulletin of the World Health Organization.

University of Limpopo. 2011. Annual Report. Mankweng: University of Limpopo.
University of Pretoria. 2011. Annual Review. Pretoria: University of Pretoria.
University of Pretoria. 2010. Annual Report. Pretoria: University of Pretoria.

Van Onselen, C. 1980. *Chibaro: African Mine Labour in Southern Rhodesia 1900-1933.* London. Pulto Press Limited

Van der Vyer, JD., & De Velliers, P. 2000 'The Migration of South African Graduates to Canada: a Survey of Medical Practitioners in Saskatchewan'. *SA fam*, Vol. 22, No 1. pp. 17-22.

Webster, E. & Von Holdt (eds). 2008. *Beyond the Apartheid Workplace: Studies in Transition*. Scotsville: University of KwaZulu- Natal Press.

Weinber, D. 2002. *Qualitative research methods*. Malden: Blackwell Publishers.

Wilson, F. 1972. *Migrant Labour in South Africa*. Johannesburg: The South African councilChurches.

Xulu, N. 2012.Changing migrating spaces and livelihoods: Hostels as community residentiall units, Kwamashu, Kwa-Zulu Natal. PhD thesis, Department of Sociology, University of Cape Town.

About us

http://www.hpcsa.co.za/ (accessed 7 September 2012)

About SAMA

http://www.samedical.org/about.html (accessed 03 October 2012)

Global Health Observatory Data Repository

www.apps.who.int/gho/data (accessed 23 October 2012)

University of Pretoria Undergraduate Fees and Funding 2013.
https://web.up.ac.za/sitefiles/file/publications/2013/UP_Fees_Funding_2013(Eng).pdf
(accessed 16 July 2013)

Salaries
www.doctorsalaries.com (accessed on10 October 2013).

World Health Workforce Crisis, an Overview

www.gmu.ac.ae/carea/worldwide.html (accessed 11 October 2012

The difference between, immigration, emigration, and, migration

http://suite101.com/article/the-difference-between-immigration-emigration-and-migration-a306560 (accessed 28 August 2012)

Appendix 1

Profile of Participants

Pseudo name	Sex	Age	Race	Migration status	Marital status
Dr Ross	Male	37	White	Migrated	Married
Dr John Ogle	Male	41	White	Migrated	Married
Dr Tiffany Ogle	Female	36	White	Migrated	Married
Dr Johnson	Male	36	White	Migrated	Married
Dr Kwetshube	Male	51	Black	Never migrated	Married
Dr Cele	Female	34	Black	Never migrated	Married
Dr Seshan Zakaria	Male	37	Indian	Migrated	Married
Dr Van der Merwe	Female	54	White	Never migrated	Married
Dr Mathebula	Female	47	Black	Never migrated	Married
Dr Ntsikana	Female	45	Black	Never migrated	Married
Dr Letlhodi	Female	37	Black	Migrated	Married
Dr Shinwell Pillay	Male	37	Indian	Migrated	Married
Dr Shervon Pillay	Female	36	Indian	Migrated	Married

Appendix 2

Informed consent form

Title of research project: '**We have families to feed': Exploring the Pull and Push Factors for South African medical doctors migrating to Other Countries**

2 I …… hereby voluntarily grant my permission for participation in the project as explained to me by Sandla Nomvete

3 The nature, objective, possible safety implications have been explained to me and I understand them.

4 I understand my right to choose whether to participate in the project and that the information furnished will be handled confidentially and that I shall remain anonymous. I am aware that the results of the investigation may be used for the purposes of publication.

5 I am also aware the that an audio recorder will be used for capturing the interview and that I reserve the right to withdraw from the study as and when I feel I deem necessary

6 Upon signature of this form, I will be provided with a copy.

Signed: _____ Date: _____

Researcher: _____ Date: _____

Researcher Contact Details

Email address: snomvete91@webmail.co.za

Cell phone No: 071 551 6359

Appendix 3

Themes as guidelines for unstructured questions

Personal

- Demography (Age, race and gender)
- Socio- economic status
- Reasons for migration
- Implications of migration in relation to race and gender

Social and Political issues

- Political and social environment
- Race and the decision to migrate
- Gender, age and the decision to migrate

Family

- Marital status and the decision to migrate
- Family time
- Sibling Status
- Family Background

Work Life

- Finance and working environment
- Working in public hospitals
- Working in private hospitals
- The meaning of working in a first world country
- Family and Personal Responsibility
- Perspective or position on migration
- Life of a migrant in the host country
- The social in the host country