

## **RESEARCH CHALLENGES**





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# Negotiating Professionalism, Economics and Moral Obligation: An Appeal for Ethnographic Approaches to African Medical Migration

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**Abstract**

This article provides a preliminary framework of useful methodologies and topics for future ethnographic research on medical migration from Africa to North America. We argue that medical professionals' migrations must be understood in terms of their multiple struggles for meaning as they negotiate their professional and personal preferences in light of their desires to help rebuild ailing medical systems in their countries of origin. Our ethnographic interviews suggest that networks and family have been of critical importance to medical mobility, as well as providing a potential means of continued involvement in philanthropic investments in their countries of origin. Ultimately, we argue that economic perspectives on medical migration are insufficient, and leave out the complexities of balancing professionalism, personal goals and moral obligation to the country of origin.

**Keywords**

medical migration, professional networking, social responsibility, ethnographic methods, brain drain

**Résumé**

Cet article offre une première grille d'analyse des méthodologies utiles et des thèmes à aborder pour une future recherche sur l'immigration médicale depuis l'Afrique vers l'Amérique du Nord. Nous avançons une théorie selon laquelle l'immigration des professionnels du secteur médical doit être abordée par le prisme de la recherche de sens de ces derniers lorsqu'ils négocient leurs préférences professionnelles et personnelles à la lumière de leurs désirs d'aider à reconstruire les

systèmes médicaux mal en point existant dans leurs pays d'origine. Nos interviews ethnographiques suggèrent que les réseaux et la famille sont d'une importance cruciale en ce qui concerne la mobilité médicale, et offrent un sens au fait de continuer à s'impliquer dans des investissements philanthropiques dans les pays d'origine. Enfin, nous expliquons que les points de vue économiques de l'immigration médicale sont insuffisants et excluent la complexité d'équilibrer le professionnalisme, les objectifs personnels et les obligations morales à l'égard du pays d'origine.

**Mots-clés**

migration médicale, réseau professionnel, responsabilité sociale, méthodes ethnographiques, fuite des cerveaux

## Introduction

In recent years the growing migration of health professionals from Africa to North America and Europe has attracted the attention of academics, public health experts and policy makers (for example, Astor et al. 2005; Chikanda 2005; Conell et al. 2007; Eastwood et al. 2005; Hagopian et al. 2005; Hagopian et al. 2004; Ogilvie et al. 2007; and Patterson 2007). While it is difficult to measure the exact scope of the 'medical brain drain' from sub-Saharan Africa to the Western hemisphere,<sup>1</sup> a recent study by Hagopian et al. (2005) claims that 12% of *all* physicians from sub-Saharan Africa currently live and work in the United States, the United Kingdom and Canada.

The reasons that health professionals from sub-Saharan Africa migrate to 'greener pastures' abroad appear self-evident. During the last two to three decades, globalisation and structural adjustment have placed heavy strains on health care systems in southern, eastern and western Africa. In South Africa, working conditions for medical professionals have been shaped by sinking incomes and corruption in the health sector, the government's growing focus on primary health care in rural areas (neglected during apartheid), a lack of technologies and resources in state hospitals, and increasing crime rates (Grant 2006). In other regions of sub-Saharan Africa – countries like Tanzania or Nigeria – reduced government spending on health care in the wake of structural adjustment has reinforced problems that 'recovery measures' were meant to solve. Thus, despite involvement of multiple local and international

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<sup>1)</sup> We are well aware that African medical professionals have also migrated to countries in the Middle East (esp. Saudi-Arabia, cf. Raufu, 2002) as well as to countries *within* the African continent. However, it is beyond the scope of this article to address these issues adequately.

(governmental and non-governmental) partners in the health care sector, health systems continue to suffer from understaffed hospitals, overburdened health workers, and the ‘emptying-out’ of clinic spaces in terms of drugs, resources and technologies (cf. Peterson forthcoming).

This article offers a preliminary framework of methodologies and topics for future research on medical migration from Africa to North America. Going beyond the ‘push/pull’ approach articulated by earlier migration studies, we argue that the migratory trajectories of medical personnel from sub-Saharan Africa to ‘the West’ are embedded in complex ‘cultures of migration’ that have shaped processes of mobility and migration in and beyond Africa over the last few decades (cf. De Bruijn et al. 2001; Akl et al. 2007; Hahn and Klute 2007). The mobility of medical personnel from sub-Saharan Africa must be understood with regard to the multiple struggles for meaning and belonging that have characterised migrants’ experiences and practices in trans-national settings (Glick-Schiller and Levitt 2004). Of crucial importance are the networking activities in which medical professionals engage to pursue their professional and personal goals while abroad.

Medical migration has particular characteristics that become increasingly salient when related to Africa. Medical migrants are actors within global biomedical assemblages (Collier and Ong 2005) of knowledge, disseminated through networks of health institutions, transnational and bi-lateral funding institutions, and a variety of state and non-state organisations. This affiliation with global assemblages of biomedicine allows some to travel and join networks that will assist them, while others may be excluded.<sup>2</sup> Yet for some medical migrants from Africa, there is an ethical dilemma attached to participating in the ‘emptying out’ of already compromised health sectors: thus, some become committed to (re)building their home country’s health care systems, engaging in practices of long-distance nationalism as suggested by Glick-Schiller and Fouron (2001). These dynamics cannot be captured by exclusively focusing on socio-economic conditions in the countries of origin and/or the host country of migrants, but rather come to light employing methodologies that are attentive to experience, culture, connection and meaning-making.

<sup>2)</sup> Our focus on medical doctors in this article does not mean that spiritual and traditional healers – as well as representatives of other medical traditions – have not found their way into the globalised markets of healing and health care (Carvalho forthcoming; Kane forthcoming). In this regard, the transnational circuits of health professionals reflect the way in which pluralistic health care systems include and exclude various forms of medical expertise in the context of globalisation (Dilger et al. forthcoming).

Ethnographic methods can provide more nuanced understandings of the motivations and struggles with which medical professionals grapple when they consider migrating. The macro-economic and political processes that have come to structure the scope and shape of medical migration worldwide acquire meaning only in relation to the existing and recently formed professional and personal networks of mobile medical professionals. These networks have considerable influence on the decisions and strategies of prospective and existing migrants to North America and Europe (cf. Akl et al. 2007; for the role of networks in transnational migration, see Glick-Schiller et al. 1995).

Furthermore, the decision of health professionals from sub-Saharan Africa to migrate may be motivated by intellectual curiosity, the quest for specialisation and a longing to apply professional skills under *adequate* conditions (Astor et al. 2005; Chikanda 2005; DeVecchio Good et al. 1999). These opportunities are often not available in the strained health care systems in African countries that have become heavily dependent on outside funding and the priority-setting mechanisms of the international development industry (cf. Booth 2004). Finally, while ideas about professionalism and profit play a role in decisions to emigrate, African medical migrants continue to have a strong sense of social responsibility to help rebuild the ailing health care systems of their country of origin. Medical migrants must navigate between professional, personal and moralistic aspirations, which have important impacts on the decisions they make (cf. Digby 2005). Drawing on themes gleaned from ethnographic interviews with African medical professionals in the United States, we explore how professionalism and personal goals interact with notions of moral responsibility in the eyes of mobile medical professionals.

### *Methodology and 'Sample'*

The original purpose of this study was to determine what an ethnographic approach to the issue of African medical migration could contribute to our understanding of the issue as a whole. We felt that the experiences of and motivations behind medical migration out of Africa were not adequately addressed within existing literature. The project aimed to provide an initial framework of themes to explore more deeply in future research on medical migrants from Africa. Dilger contacted potential participants about participating in qualitative interviews relating to their experiences of medical migration out of Africa. Participants were recruited from within one city in Florida. Ethnographic interviews were conducted between March and April 2006. Dilger was the principal investigator, and Garcia and Sullivan conducted

interviews. The Internal Review Board of the University of Florida approved the project. All participants were informed of the purpose of our research and voluntarily signed informed consent forms.

Our study comprised six participants, originating from three countries: one private practice [physician, two physician specialists, a researcher in dentistry, a graduate student in ethnomusicology, and a medical student born in Africa but raised from a young age in the United States. The latter two participants were excluded from this analysis. The first was excluded because the therapeutic system he practised was not biomedical, and his case did not fit well within the ethical debates surrounding (bio)medical migration. The second was excluded because she was young when she moved to the United States, had little recollection of her life in Africa and had not returned since. The remaining interview participants were middle-aged males. Three of the interviewees were from Nigeria and the fourth was from South Africa. Each participant was interviewed once.

The semi-structured interviews asked questions based on participants' personal histories, motivations to come to the United States, life circumstances in their countries of origin and in the United States, conditions of the medical system in their countries of origin versus the United States, their remaining ties to their country of origin, their connections to other medical migrants in the United States, and their opinions about the medical 'brain drain'.

Our sample is small (4). We make no claims that our study is representative of all African medical migrants to the United States. Rather than attempt a representative sample, we suggest a preliminary framework for future research on African medical migration, particularly regarding ways ethnographic approaches can enhance understandings of this issue. The majority of African immigrants obtaining legal resident status in the United States between 1998 and 2007 came from Nigeria [14.3%] and Ethiopia [12.3%] (US Dept. of Homeland Security 2007), and the majority of medical migrants to the United States are from Nigeria [40.5%] and South Africa [36.4%] (Hagopian et al. 2004). Thus, our sample reflects current migration trends among medical professionals from Africa to the United States.

### *Profiles of Research Participants*

Each of the participants has a unique personal history and trajectory. With one exception, all of the participants came to North America to specialise in their fields and the migration was not initially intended to be permanent.

*Mr. Okoye<sup>3</sup>*

Nigerian dental researcher, Mr. Okoye, was born in 1953. He was the only male child in the family and the only one to go abroad. He completed a Bachelor of Dentistry degree in the mid-1980s in Nigeria, followed by a specialty degree in public health, and a Master's degree in dental public health. The school nurse at his Nigerian university encouraged him to go abroad to specialise in his field. Upon completing his Master's degree, he went to Toronto in 1985 to do a fellowship, which he completed in 1987. He subsequently returned to Nigeria without completing the fellowship exam because he could not afford the fee. Mr. Okoye worked in Nigeria until 1999, when he returned to Canada on a full scholarship for specialty training in dentistry and public health. He finally completed the fellowship exam in Canada in 2003. He moved to Florida in 2004, where he conducts research. Mr. Okoye is unable to practise in the US because his Nigerian dentistry degree is not recognised in North America. He had neither the money nor desire to complete the two years of schooling required in order to practise.

*Dr. Sani*

A Nigerian sub-specialist physician, Dr. Sani, was born in England to Nigerian parents in 1959 and was one of four children. He lived in England until he was five, and then went with his parents to Nigeria, where he was raised and completed medical school. After finishing five years of medical training and a year of internship in Nigeria, he served as a military physician for a year. Afterwards he entered private practice for about 18 months and returned to medical school for a residency in internal medicine. It was his curiosity about how medicine was practised abroad that compelled him to leave his residency in Nigeria to work in the United States. Dr. Sani's first visit to the United States was in 1986, for an interview for a position as a resident in a county hospital in Chicago. He was accepted and moved to Chicago in 1987. He remained at that hospital for four years, and then transferred to another Chicago hospital for a fellowship in a sub-specialty. After the fellowship, he served as a physician in rural Kentucky and moved several times before settling in Florida to practise. He met his wife in Chicago and they have three children.

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<sup>3)</sup> All names used in this paper are pseudonyms and their location in Florida and their medical specialisation has not been identified in order to protect the participants in our study.

*Dr. Muir*

The South African participant, Dr. Muir, was born in 1956 as an only child in a Jewish family (Caucasian). Although they were not wealthy, his parents and grandparents were able to save money to pay for his university education and he lived with his family during medical school. After medical school, he completed one year as an intern and was conscripted into the army for two years. Dr. Muir initially came to the United States to do a residency in a sub-specialty. As far as Dr. Muir was concerned, training, including specialty training, was superior in South Africa in the 1970s and 1980s compared to the United States. He felt it was in areas of sub-specialisation that the American medical education system excelled. He wanted to train in a sub-specialisation in the United States before returning to South Africa to practise. He and his wife arrived in Florida in 1983 so that he could do his residency followed by a fellowship. Although he had intended to return to South Africa, later he decided to stay in the United States, and he and his family have lived in Florida for over 20 years.

*Dr. Alade*

Dr. Alade, a family physician, was born around 1970 in Nigeria, where he remained until his early adolescence. When he was 13, his parents sent him to boarding school in Switzerland, and three years later, he was sent to Michigan, where he completed his undergraduate and master's degrees. He later moved to Ohio for medical school. Upon completion, Dr. Alade moved to Florida for his residency. He met his wife, who was born and raised in Florida, while in residency. Upon completing the residency, he decided to open his own practice and stay there to raise his family. He is now a US citizen, although he hopes eventually to return to Nigeria. Dr. Alade is the youngest of eight children, all of whom were sent abroad for education. Today, five of the siblings live in the United States, one resides in the United Kingdom and two remain in Nigeria.

Despite Dr. Alade not being trained in Nigeria, he grew up in Nigeria and maintained close ties to the country – returning at regular intervals. His case provides interesting insights into the complexities of being an African physician living abroad at a time of controversy regarding the African 'medical brain drain'. He is devoted to helping rebuild health systems in Nigeria, and Africa more broadly, and is both nostalgic about Africa and critical of what he sees as the corruption of African states. Dr. Alade's case provides important insights into the diversity of experiences among African medical professionals in North America.

## **Motivations for Migration and the Role of Networks**

Initially, with the exception of Dr. Alade, the participants came to North America for specialty or sub-specialty training, and the move was seen as temporary. Dr. Muir referred to sub-specialty training abroad as the “cherry on top before going back to South Africa.” For Mr. Okoye, “all I just wanted to do was to increase my skills in terms of educational regard – advancement to make sure that I bring myself up a little bit, and to be able to get a job anywhere I wanted.” Indeed, the mentors and teachers of the participants who trained in Africa also trained abroad and encouraged them to go abroad for specialisation (cf. Hagopian et al. 2005).

Networking with professors or other medical professionals from their country of origin played a major part in how they came to North America. Mr. Okoye had a professor who had moved to Toronto, “so, when I thought I was sick and tired of Nigeria I just wrote a note to him,” and managed to get a scholarship that covered tuition. That professor introduced him to another faculty in Toronto, and he was able to use those initial contacts to secure a full scholarship in the second year. Dr. Sani noted that when it came to applying for programmes abroad, “you can’t just show up in the States and go to residency. It’s easier to kind of know, ‘okay, where am I likely to be able to get a spot, who’s there to maybe put a good word in for me, who has blazed the trail before and will make it easier for me to get into a spot?’” Drs. Sani and Muir acknowledged the role of other physicians from their country of origin in paving the way for their migrations.

Drs. Muir and Sani have been able to help other doctors from their countries of origin to come to the United States. According to Dr. Sani, “at least six or eight doctors who I know got into their residency programs and came to the States because I wrote letters for them or knew people they could get in touch with, and I also benefited from that too.” Dr. Muir helped other South African physicians get positions in the United States. However, except for those he had helped, he did not keep in regular contact with other South African doctors. At physicians’ conferences, South Africans greeted each other, and for Dr. Muir there was ‘a bond’, although not necessarily more than what he felt for other colleagues. For the participants initially trained in African countries, having ties to other medical workers from their country of origin facilitated their entry into North America and they in turn have helped others.

In contrast, Mr. Okoye’s case illustrates the difficulties of migrating and being successful without these kinds of networks. Mr. Okoye was attracted to medicine because he would be part of a profession that was accepted world-

wide. Yet Nigerian migrants within Canada played no role in his entry to the Canadian programme. While his subsequent return to Canada was due to a relationship with a previous Nigerian professor, this connection did not get him as far as he had hoped. His multiple degrees from both Nigeria and Canada are not recognised and he cannot practise dentistry within North America. When other young Nigerians attempt to contact him about moving to Canada, he discourages them. He argues that prospective African migrants need to know exactly what they are looking for before leaving. He attempts to dispel the idea that if one can just get to North America, everything is possible. Indeed, "you go [to] a place like Toronto, you find physicians, surgeons, from India, from so many parts of the world, driving taxis. And they're not prepared to go back [home]. Part of it is also shame."

Due partially to the Internet, such informal networking practices have become more formal. Dr. Sani mentioned that for Nigerian medical associations, "I've never been to meetings or been particularly involved, but I get emails and letters all the time." Dr. Muir knew that there were clubs of South African physicians in the United States, although he did not belong to them. Today, many medical professionals are using more formal networks, many of which have a dynamic internet presence. For instance, the Association of Nigerian Physicians in the Americas (ANPA) organises medical missions to Nigeria and works to influence Nigerian health policy. The organisation has a website (<http://www.anpa.org/>) that provides networking opportunities between prospective migrants and those who are established in the United States, including an online discussion forum and professional development resources. In 2009, the organisation had over 4,000 members throughout the United States, Canada and adjacent territories like the Virgin Islands.

### **Finding a Home for One's Profession**

Of those participants who trained in Africa, all had anticipated returning to and working in their country of origin after studying in North America. However, the difficult political-economic and medical climates in their countries of origin made participants feel that there was no long-term future for their profession back home. Drs. Sani and Muir perceived a difference between the motivating factors behind their migrations, and those of people coming over afterwards. According to them, subsequent waves of migrants came due to the poor socio-economic conditions of the medical systems back home and economic incentives of working abroad:

Sani: It's almost as if the exodus coincided to, after the peak of the [economic crash]. A few years after I left there were a lot of doctors who were a couple of years after me in medical school, who are here in the States who really didn't practice at all in Nigeria, who were so focused on 'I've gotta leave as soon as I get out of [medical school]', who didn't want to practise under the conditions that were prevalent at the time.

NS: Those were the conditions of military rule?

Sani: Military rule, the fact that you really don't have the resources, you can't do things. If you're interested in academic medicine there is very limited work potential there. But also the fact that you could make a better living.

Dr. Muir felt that there was no long-term professional or personal future for those physicians he had helped to emigrate out of South Africa. Crime was high, the medical conditions post-apartheid were deteriorating, and doctors became tired of living and working in such an unstable environment.

Despite thoughts of return after receiving specialty training, for three of the participants, there were limited prospects of practising academic medicine in their country of origin (with which all but Dr. Alade were involved). The political-economic and working conditions in their country of origin, and the establishment of families in North America, made choosing to go back increasingly difficult. For Dr. Muir, the idea of staying in the United States was

not a matter of selfishness, and yes from an altruistic perspective it would have been better to go back and be part of that situation, but from my perspective... from the work that I did,... the cutting-edge work that I really liked, as well as for my children, this was by far the easier choice.

Although he had not trained in Nigeria, Dr. Alade had visited several times since becoming a doctor. He said, "the system that is in Africa is just not conducive... for people to come back there to function." Mr. Okoye felt that in Africa, governments and individuals were unaccountable, and individuals' ability to function was more about who they knew and with whom they aligned themselves.

Drs. Sani and Muir explained how conditions in their countries of origin had changed since the early 1980s when they left. Dr. Sani noted that in the 1970s and 1980s medical schools in Nigeria were productive and had reputable research programmes. He saw the rise of medical emigration from Nigeria as a slow process, and noted that several of his medical school professors had left in the 1970s to go to Saudi Arabia. Part of this early exodus was due to the poor relationship between the government and medical professionals. While Nigeria had had a nationalised medical system, in practice hospitals were understaffed and under-resourced. Dr. Sani described the relationship between medical professionals and the Nigerian government as 'antagonistic',

with several medical workers striking and using work to rule strategies to entice the government to improve conditions, only to have their licences suspended or be put in jail.

Dr. Muir also contrasted health sector conditions in the 1990s with the unique medical training environment that South Africa provided in the 1970s and 1980s. South Africa was exceptional because “there’s... a greater array of patients, more diseases.” If, as a medical student, one was assigned to a ‘white’ hospital, everything was first rate, with full access to the technologies and resources physicians needed in order to practise. Yet in the ‘black’ hospitals (in which he also worked), resources were scarce, and aspiring physicians had to be more creative. Although he felt that the end of Apartheid in 1994 was positive and necessary for South Africa, he felt that restructuring the medical system had had many negative effects.

Dr. Alade, who left Nigeria in his adolescence and never trained there, was the only participant who still thought that he might go back if the conditions in Nigeria were to improve:

I went into medicine to go to practise where needed... my goal is potentially to go back to Africa,... the point being that [if] things are feasible that I can go there and practise and treat people, and, I mean, I would go. That’s my ultimate goal. My next option is, until that happens, is to make trips to Africa, to go back to Nigeria every so often, you know, go back and help.<sup>4</sup>

### **Roots: The Role of Family in Migration**

Similar to other migrants from Africa (cf. Mercer et al. 2008), family played an important role for the participants in their migration decisions. Dr. Alade, who was an American citizen by the time he entered medical school in the United States, stated that while family could be helpful in networking and decision-making, it was

not required. Yeah, most people do come because they have family here as well. But it’s not – people who are in university who are physicians, they have ambition, they’re really, you know, um, they already have high expectations of what they want to accomplish that family or no family, most people find a way to make it out to wherever they want.

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<sup>4)</sup> In 2009, Dr. Alade established a clinic in his grandfather’s home village in Nigeria, and he has since been travelling regularly to supervise the staff there and provide medical care.

This opinion of the role of family in his decisions to become a doctor and where he wanted to train was complex. He was expected, like his siblings, to study abroad. Yet he said, “for me, it was just part of the process of what my parents envisioned for all the kids to go, you know, abroad and study. If you ask me if I agree, I don’t agree, but that was their intent.” While Dr. Alade considered going to Nigeria to be a physician, having his wife and children in Florida made that decision less of a possibility – he had settled in a place with a healthy environment to raise a family.

In contrast, Mr. Okoye had not married nor formed a family. He had experienced a series of bureaucratic constraints that limited his prospects in North America. He said all of his professional pursuits had enabled him to do “nothing.” He was introspective about the importance of family, stating, “because I have no family and I’m trying to do my own things too, I would have thought I would have been able to . . . get here and then dish out money and you know it doesn’t happen that way. I was beginning to feel that what my parents, grandparents have built throughout the years, I just throw it away.” This situation made Mr. Okoye nostalgic about the networks he would have enjoyed had he remained in Nigeria:

[Networking is] something that has happened over generations, you know, your father knows somebody who knew somebody and it constantly grew for generations. Now, one of the things we are using back home again is that we are cutting our roots, and so it’s a little hard to start from wherever.

The formation of nuclear families influenced participants’ choice to remain in North America and contributed to how they negotiated their sense of obligation to their home countries amid their employment opportunities in the United States. With the exception of Mr. Okoye, all of the participants moved to the United States as single people, and formed families in the subsequent years. The presence of families in the United States influenced thoughts about returning to their country of origin. Dr. Sani remains a citizen of Nigeria and is a permanent resident of the United States. Earlier in his career, he felt that had conditions in Nigeria changed, he would go back. However, having a family in the United States changed his mind: “I’d be back home if things were better, but I don’t see them getting any better, and I have a family to take care of and that’s going to have to be my number one priority, rather than what the economic and political climate is like in Nigeria, and I’ll send money home. That’s about all I’m gonna do.” Dr. Muir and his wife have reformulated their ideas about ‘home’ and participation in the home country. Both became American citizens, and have not applied for dual citizenship for their children.

## Negotiating Professionalism, Economics and Moral Obligation

For various reasons, all of the participants separated themselves and their situations from the idea of the 'brain drain', although each of them had perspectives on the matter. Mr. Okoye stated, "I am not sure if I could typically fit into what you would call a migrant, in the sense that, my outlook is to look at the world as a global market and I just would want to be anywhere if I could be of service." For Mr. Okoye, the medical brain drain was about a changing value system, from cooperative and collective to individualistic. Dr. Alade made a similar statement that studying medicine opened opportunities to go where there was a need.

For some of the participants, the medical 'brain drain' out of Africa was a question of economics. Mr. Okoye, Dr. Muir and Dr. Alade all used economic language to describe the scope of the issue. For Dr. Alade, the brain drain was about 'supply and demand' where Western countries have a demand for physicians and African professionals were filling those demands. When asked about his thoughts on proposed policies of limiting immigration of medical personnel from Africa to North America and Europe, Dr. Muir responded:

I think it depends on what the intent is. If the intent is that we have a lot of our own people, or we don't need any more doctors, I think it's understandable. There's a protectionism. If the United States got to the stage that we were flooded with physicians and there were too many I say that we should close the door. On the other hand if there are physicians where there is a need, if they can provide a service that is of quality, and not in any way bring down the quality of the service that they can provide, I think they should be encouraged.

Similarly, Mr. Okoye was attracted to the medical profession because it would allow him to go where he could help. It was interesting that as the only participant who had not trained in Africa, Dr. Alade stated:

The motivation for [the brain drain] is always, you know, economics... Now, is that the right way to think? Absolutely, I think, there are more things that are better than money. Of course, you know, progress. Somebody has to pay a price for things to be better wherever you're from.

Each of the participants was cognizant of the deteriorating impacts of medical migration on health sectors in Africa. Yet for the participants, Africa was not a viable medical 'market'. When asked about the impacts of medical migration, Dr. Muir immediately responded, "South Africa has suffered tremendously." Dr. Muir expounded:

I believe that everyone needs to do what is best for them and what is best for their people. I don't necessarily practise that because if I really truly practised that in terms of the real difference I could make I would be back in Africa. But having said that, I think people should be given the opportunity, if there's a need,... and based on quality, they should be given the opportunity to go wherever they want to.

Dr. Sani said the medical brain drain was "sad but I think that it's inevitable. I think people are going to make decisions not based on what's the greater good, but they'll make decisions based on 'what do I want out of my life' and 'what is best for my family.'" Dr. Alade's view provided an interesting contrast. He argued that even if governments in Africa could slow the exodus of medical personnel, they were not motivated to do so. Governments were corrupt and the only means to maintain power was by keeping people uneducated and unable to challenge their authority: "Governments are not there to make things better. People who rule the countries are there to rob the countries, steal things from the country."

The ANPA website provided further examples of the ways that African medical professionals in North America were conflicted regarding migration and prospects in their countries of origin. At the time of writing, on the ANPA website blog, two of the topics were related to medical migration, both pointing to the urgent need for Nigerian doctors living abroad to go back and provide health care services in their country. One blog post commented: "How long can I carry this guilt. Are we all waisting [*sic*] our time propping up a failed state? How could I be so irrelevant to a place that invested so much materially to get me here. Is there light at the end of this tunnel?"<sup>5)</sup>

ANPA has adopted an interesting approach to emerging conflicts between professionalisation abroad and the desire to contribute to the betterment of the Nigerian health sector. The organisation argues that a better Nigeria is possible through technological advancement, modernisation and development. ANPA envisions itself as a broker that can close the economic and medical gap between where members currently live and in Nigeria. ANPA has organised several medical missions per year since its inception. The importance of these medical missions to the organisation was highlighted in ANPA's eighth annual meeting in Atlanta in 2002, when the president stated that medical missions "continue to define us. It is our Raison D'etre" (ANPA.org). Since ANPA organised the first one in 1997, the number of medical missions has increased

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<sup>5)</sup> <http://anpaorg.blogspot.com/>

each year.<sup>6</sup> In 2007 they had ten medical missions and for 2008, ANPA planned seven of these events – nine in Nigeria and one in Uganda (*ibid.*).<sup>7</sup>

## Conclusion

Our preliminary ethnographic interviews with African physicians in Florida have demonstrated the importance of going beyond a 'push/pull' approach to medical migration. We demonstrate that qualitative methods can provide information about experiences of and influences upon medical migration and emic perspectives on the ethics of policies that contribute to or discourage medical migration. Medical migratory trajectories must be understood not as merely professional and economic decisions, but as mitigated by complex and highly personal negotiations between feelings of responsibility towards country of origin and desires for professional and economic advancement. In addition, the role that family plays in the decisions of medical professionals to remain abroad or return to countries of origin must not be underestimated.

Future research on medical migration out of Africa should use ethnographic methods to provide a more nuanced understanding of motivating factors of mobility, how these are negotiated on a personal and professional level, and how networking contributes to mobility. If structural adjustment and concurrent deterioration of health sectors in Africa are seen as important contributors to medical professionals' exodus out of Africa, they must also be understood in relationship to the struggles for meaning that are of critical importance to the lives and decisions of African medical migrants. Our preliminary analysis suggests that there is a multifaceted terrain of meaning through which medical migrants manoeuvre. Their desires for professional and economic advancement are tempered by goals for their families, feelings of social responsibility to their countries of origin and disappointment at the deteriorating conditions of health care in Africa. In some cases, the latter developments have contributed to a nostalgic view among medical professionals of the 'pre-SAP' era in which working conditions for medical doctors and scientists are represented as

<sup>6)</sup> Except for 2006 when there were only three medical missions.

<sup>7)</sup> Unfortunately, there is limited information about the specific outcomes of ANPA's medical missions on their website. Interesting work has recently hinted at the multiple medical engagements of African migrants (health professionals as well as others) in Senegal (cf. Kane forthcoming, Foley 2006).

being superior to the deteriorating health care conditions in the context of globalisation.

Future research could use ethnographic methodologies to further explore important themes regarding the issue of medical exodus out of Africa. Such approaches could reveal important insights regarding the ways medical migrants think about their social vs. their personal responsibilities and how these responsibilities are mediated. They could also isolate different 'generations' or 'waves' of medical migrants, compare the experiences of medical migrants from different African countries and highlight the motivating factors underlying mobility in both cases. Future research should also consider how gender<sup>8</sup> affects experiences of medical migration. Research regarding professional networking could also be insightful, including participant observation and interviews among members of professional associations to further understand the kinds of benefits such formal networks provide to their members, motivations for participation, and how these networks operate to influence policies and health conditions in Africa.

As government policies that attract medical migrants have recently been seen as an ethical issue (for discussions, see Dauphinee 2005; Eastwood et al. 2005; Iglehart 1996; MacIntosh et al. 2006), ethnographic approaches including interviews, focus groups, participant observation and archival research, could potentially be applied to policy circles where such issues are being debated, focusing on how governments and transnational bodies are attempting to enact policies to circumvent the 'emptying out' of African health systems. Conversely, ethnographic methods could attend to the ways that aspiring or current medical migrants are thinking about, engaging with, maneuvering or even circumventing such structural issues.

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<sup>8)</sup> Gender issues were beyond the scope of our study. Nonetheless, since many medical migrants are female – and the nurse cadre is one of the major professions involved in medical migration – the relationship of gender to professional and personal obligations vs. moral obligations to one's home country are likely to be very significant to coming to an overall understanding of African medical migration more broadly (Böhmig 2010).

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