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# The Concept of the Self in Explaining Post-1989 Bulgarian Physicians' Emigration

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**Abstract.** This article presents the results of the methodological and empirical efforts for exploring and understanding the emigration of Bulgarian physicians, after 1989. The study applies a biographical approach through a conceptual framework, which utilizes concepts from social theory and social anthropology. Using in-depth interviewing as the main research tool, complemented by a secondary data gathering technique, the study offers an explanation of the migration decision as generated in a conflict of the migrant's understanding of his/her self and of the desired relation of the self to society on one hand and the migrant's understanding of his/her society on the other. The concept of the self (self-identity, self-consciousness) proves effective in explaining the migration decision.

**Keywords:** *migration, Bulgarian physicians, biographical approach, self*

## Introduction

The research question of the study to be presented, stated briefly, is 'Why do Bulgarian physicians emigrate?'. The application of qualitative methods would answer it successfully because they present effective tools for understanding unexplored migrations and for studying them in their depth and integrity. The aim of the paper is to give as complete as possible picture of the core findings of the study.

## Approach and Conceptual Framework

Exploring Bulgarian physicians' migration in its depth and integrity could be achieved only through the application of an approach which main characteristics

are perceptive openness and non-selective sensitivity. That is why the biographical approach was chosen as giving good opportunities to grasp the multilayered nature of reality.

With regards to migration research in general the application of the biographical approach in the study would contribute to 'acknowledging the non-economic worlds of migration decision-making'[1] and overcoming the 'economisation of migration'[2].

The migration under study has a concrete positioning in time - after the year of 1989. This is a time of post-traditional order, of modernity. And as Giddens states, 'Modernity opens up the project of the self'[3] understood as 'reflexively developing a coherent self-identity'[4]. In this way the functioning of contemporary social life brings to centre stage the individual's self-identity in understanding and explaining his/her behaviour. It is in this light that we could understand the following idea concerning the application of the biographical approach – to conceptualise migration as an expression of identity rather than behaviour[5].

From the adoption of this perspective followed the formulation of the thesis of the present study – explanation of the migration decision of Bulgarian physicians should be searched for in the self-identity of the migrant in its human totality and not in one or several of its aspects.

In order to concretise the idea of self-identity as a basis of the conceptual framework of the study we deployed the advancements on this issue made by Anthony Cohen[6].

According to Cohen[7] 'any individual must be regarded as a multi-dimensional self' and self-identity is the 'symbolisation' of that self, a 'self-conception'[8]. Through the acquisition of experience the individual constructs

[1] Keith Halfacree, "A Utopian Imagination in Migration's Terra Incognita? Acknowledging the Non – Economic Worlds of Migration Decision – Making," *Population, Space and Place* 10 (2004): 239, doi: 10.1002/psp.326.
[2] Halfacree, "A Utopian Imagination in Migration's Terra Incognita", 247.
[3] Anthony Giddens, *Modernity and Self-Identity. Self and Society in the Late Modern Age.* (Stanford: Stanford University Press, 1991), 196.
[4] Giddens, *Modernity and Self-Identity*, 200.
[5] Paul Boyle, Keith Halfacree and Vaughan Robinson, *Exploring Contemporary Migration* (New York: Longman, 1998).
[6] Anthony Cohen, *Self Consciousness. An Alternative Anthropology of Identity.* (London: Routledge, 1994).
[7] Cohen, *Self Consciousness*, 7.
[8] Cohen, *Self Consciousness*, 29.

his/her world, building it up from his/her perceptions of his/her self, of the society with which he/she interacts and of his/her relationship to that society. And here follows the central to the present study statement of Cohen that the individual's world, imbued with meaning by him/herself, presents a point of departure for his/her behaviour. Or in Cohen's words[9] – 'the self, located in time and space and subject to the subordinate forces of society and culture, constitutes his/her world as meaningful and *behaves accordingly*'.

Addressing this concept, for the purpose of the present study, would mean to search for explanation of the migration decision of Bulgarian physicians in their understanding of their selves, of Bulgarian society and of their relationship to it.

**Data Gathering**

In-depth interviewing was chosen as the appropriate qualitative method. The interview guidelines and the interviewing strategy took their final form with the help of two pilot interviews.

With regards to the format of the study – exploring migration using the data resources of the country of origin – the potential respondents present an 'invisible' group. There are no formal data sets allowing identification, finding and contacting Bulgarian physicians who have emigrated after 1989. That is why, as recommended in such cases, the sampling technique of 'snowballing' was applied. Thus through informal networks ten interviews were conducted. They were undertaken in Bulgaria in the period from March to November 2007 during a visit of the migrants to their home country. In the analysis process we also utilise the empirical material from the two pilot interviews - those aspects of their content that help better explore the problem under study.

The average duration of the interviews is 1.3 hours.

A second data gathering technique was sought in order to complement and elaborate the interview analysis. The chosen technique has a questionnaire format and uses the Internet[10]. The questionnaire form followed closely the interview guidelines and gave respondents as often as possible the opportunity to freely formulate their answer. As a result the questionnaire form could be characterised as quite detailed – its completion required one to two hours. Consequently, the

[9] Cohen, *Self Consciousness*, 191. (*my emphasis*)
[10] The questionnaire format is realised using an Internet site and e-mail.

adequate analysis of the empirical material is principally incompatible with the big number of respondents common to typical questionnaire surveys.

The legitimacy to use the questionnaire format in the context of the present study is partly based on the perspective that 'a biographic approach to the conceptualisation of human migration promotes (although *not exclusively*) a very in-depth qualitative methodological approach towards primary fieldwork'[11]. And also on the fact that the empirical material gathered through the questionnaire format plays in the analysis a secondary, complementary role to the generated through interviewing material.

***Respondents***

All 37 respondents in the study, the two pilot interviewees including, are Bulgarian physicians[12], long-term migrants[13] who have emigrated from Bulgaria in the years after 1989. The 37 migrations under study have a time span determined by the first in chronological order migration in 1991 and the last in 2004. In order to show the distribution of the 37 migrations in this time span, three relatively homogenous periods were determined with regards to political and economic conditions. The number of the studied migrations within each period is as follows: nine (9) for the period 1991-1995; twelve (12) for 1996-1999 and sixteen (16) for 2000-2004.

With regards to country of immigration the majority of respondents migrated to old EU member states and USA; South Africa, Australia, Jamaica, Israel and Turkey are presented by one respondent each. At the moment of taking the interview six of all interviewees are in their 30-ies, two – in their 40-ies, one – in their fifties, and one at the age of 65. Among all interviewees women have a smaller share – the ratio of male to female participants is 7:3. The two pilot interviewees are men in their thirties.

Among the respondents to the questionnaire women slightly prevail, taking 60%-share. With regards to age structure – the leading one is the group of 30-35 years of age (40%), followed by the 36-40 years of age (32%) and the 41-45 years of age (16%). At the last place are the aged below 30 and above 45 – with one representative each.

[11] Halfacree, "A Utopian Imagination in Migration's Terra Incognita", 241. (*my emphasis*)
[12] Bulgarian physicians – Bulgarian citizens who have graduated as MDs from a Bulgarian university and who were practicing their profession in Bulgaria prior to their emigration.
[13] Long-term migrant – a migrant that resides outside his/her country of origin for more than one year.

**Findings**

In this part we are going to see the conceptual framework 'at work'. Due to the writing fallacy the three elements of the conceptual framework may resemble a static constellation but in reality they interact intensively. And it is in this interaction that we should look for the answer to the research question. The analysis revealed that it is the interaction between the element 'migrant's understanding of Bulgarian society' and the other two elements - understanding of one's self and of his/her relation to society - that presents the 'ferment' of migration decision-making because it turned out to be an 'arena' of serious for the migrant's self conflicts. In order to present this interaction in an explicit way given the limited volume of the paper the following presentation strategy is taken. A focus is selected the purpose of which is to give a more elaborate picture of the elements' interaction. This focus falls on the interaction of the element 'understanding of one's relation to society' and an aspect of the element 'understanding of Bulgarian society'. It is specially chosen because of its potential to preserve the other elements of the analysis implicitly present and in this way to allow the whole to be seen through one of its parts.

***'Understanding one's relationship to society' and 'Understanding Bulgarian Society' in interaction***

The picture of the desired relation to society builds on a number of aspects. Each of them is presented on its own as well as in interaction with social reality. Thus the points of conflict or discontinuity for the self with its reality are revealed and their role for the formation of migration decision is brought to light.

A. *Giving meaning to one's path of life.* This aspect revealed itself in two forms which are found independently as well as combined. Very strong is the presence of the first form – giving meaning to one's life through realisation of the inner impulse and need to be of help to people. The second form is striving for perfection of one's self. It is understood by some respondents as an integral development of the self while others understand it as a predominant development of *one* aspect of the self – professional identity. The former case is well illustrated by interviewee №10 for whom self-perfection is directed to acquiring worldly wisdom understood as true knowledge of one's inner and outer world. When acquired it brings emotional

orderliness and clarity and manifests as peacefulness. Interviewee №7 can be an example of the latter case. For him/her 'Life is full when you have aim every day. … the struggle to achieve your goal is what makes your life – this is happiness.' At the same time it is professional goals that emerge as leading and predominant. Thus the understanding of self-development is significantly narrowed. A prerequisite for this narrowing is the understanding Bulgarian society and physicians traditionally hold of the medical profession and of the 'good doctor' – as exceptionally high level intellectual and moral practice. Interviewee №7 also shares this perspective: '[People] have always treated [physicians] with great respect – they treated us as individuals who are great persons.' From here it is very easy to pass on to automatic association and identification of the practicing of the medical profession with the integral and fulfilling development of the self. As a result of this narrowing, professional realisation is overloaded with the role of the main meaning giving activity in life. Thus in the moment of attaining the existing professional aims the potential for self-development is perceived as exhausted and the path of life as empty: 'You reach the top of your profession and from that point on – what?!' What follows is a deep life crisis – emptying and losing the sense for one's self: ' … and you start to lose your individuality'. Feelings of melancholy, indifference and meaninglessness arise: ' … to stay at the top and to feel dumb … we felt depressed.' Making this crisis come faster and run deeper is the need and expectation professional aims to be determined from the outside – to be pointed at and demanded. Thus professional realisation as meaning giving activity is itself limited and dependent on existing formal professional opportunities.

As we can expect in these two different cases migration attains different existential meaning. For interviewee №10 migration provides new, unfamiliar context able to challenge the taken for granted and thus give him/her the opportunity to gain 'rich life experience', to 'better know myself' and to 'grow up faster through life experience'. Interviewee №9 takes a similar stance towards migration – aspiring to refine his/her behaviour and outlook on life. He/she perceives migration as offering the right context for change because 'when a person lives abroad it is common to acquire the qualities of the people that surround him/her.' While for interviewee №7 migration presents access to an elaborate system of formal rules for professional development and career advancement every stage of which leads to another that, even if final, offers an infinite spiral of requirements and opportunities. In this way migration gives

interviewee №7 the opportunity to satisfy his/her perpetual striving for new professional goals even if they differ only in context from those already achieved: 'And we don't let it go this empty way and always search for something new and new, and new … And now I am at the very start [of my career] again.'

*Points of conflict or discontinuity for the self with its reality.* Interviewee №10 needs what he/she has taken for granted in his/her self to be questioned and challenged in order to strengthen his/her self-awareness and self-knowledge which to serve as ground for self-development. Interviewee №9 needs models that with their intensity of experience permeate his/her self and change it. Both of them need an outer trigger for inner change and according to their understandings of Bulgarian society they do not find it there. So what their selves face in Bulgarian society as they understand it is a point of discontinuity for the self that questions the desired way for self-development. And this opens up space for a different place - migration.

The example of interviewee №7 continues in the following way. According to his/her understanding of the functioning of the medical profession in Bulgaria there is no comprehensive system that can satisfy his/her aspirations for professional development and career advancement. There are no formal requirements: 'And nobody tells you "Why don't you write something? Why don't you discover something?" And even if somebody does, it is not in the system – nobody formally demands this from you.' There are insufficient opportunities for professional development: ' … you take your specialty and training ends. From that point on – nothing.' There is poor network of professional positions: 'And there are only two possible positions here – physician and head of clinic. If you are to have an opportunity to become head of clinic, your head of clinic either has to die or to quit.' What becomes evident in this example is that the meaningful way for self-development collides with the self's reality. The result is a crisis in giving meaning to one's life which leads to perceiving one's lifetime as empty and wasted: 'And we felt dumb because our life went in going to work, patients, salary … And you stay and waste your time.' And it is this conflict experienced by the self that generates a significant impetus for taking the decision to migrate: 'I have thought that I would never leave Bulgaria. This thought [for migrating] has never occurred to my mind, unless … there was no light in the tunnel for our professional development.'

B. *Life goals.* Life goals stem from the way the self gives meaning to life and present concrete forms for its realisation. In this sense they reflect in each

respondent a definite idea for life satisfaction. The analysis brought out four groups of life goals which are presented according to their prevalence among respondents.

*Life goals related to professional realisation* among interviewees form a spectrum that starts with the more common aim to specialise in a preferred medical field and to receive good remuneration, goes through acquiring high quality training in a definite specialty and ends with the difficult and ambitious aims for gaining excellent professional reputation, acquiring one of the highest academic ranks and founding a modern centre for treatment of a socially significant disease.

*Points of conflict or discontinuity for the self with its reality.* Interviewee №4 serves as a good illustration of how the problematic status of this aspect can trigger a migration decision. The socialist policy of training physicians for export according to interviewee №4 and other respondents has been still valid in the first years of the transition period in Bulgaria. This overproduction of medical doctors interviewee №4 sees as an important problematic aspect of the functioning of the medical profession and names it as 'the unnecessary graduates'. Logically overproduction leads to unemployment and impossibility for specialization. Here are the words of interviewee №4 that show how such a life situation is lived through. It is interesting to mention that this quote is taken from six consecutive minutes of the interview. Interviewee №4: 'We were unnecessary. We were all unnecessary graduates [1993]. We were unnecessary to Bulgaria. … And here I say again we were unnecessary graduates. We were kicked out almost from everywhere. … We were unnecessary … we were all unnecessary graduates. … The senior physicians insisted to show us that we were unnecessary. … We were unnecessary to Bulgaria.' What is more than evident in these words is the feeling of being unneeded. Its destructive influence on the self is painfully experienced and is clearly present. The feeling of being unneeded and the objective fact of being redundant and unemployed are experienced as cul-de-sac: ' … we were driven to the wall. All of us were driven to the wall.' And a way out is migration: ' … "The absence of alternatives clears the mind marvelously." And this was my case. … I did not have any choice – I had to do it [migrate].'

Among *life goals related to family life* stand out those focused on children – their education, prospects for success in life, way of life. These three aspects emerge as connected – giving good education to children secures them better chances for success in life and for better way of life. Actually, the main aim of these migrant parents is to keep this connection real for their children – they want just

social logic. As interviewee №7 informs us 'I wanted my child to live in a just society. … to be equal to those on her level … get what she deserves.'

*Points of conflict or discontinuity for the self with its reality.* As a result of corruption the child of interviewee №7 studied together with children who have not passed the secondary school entry exams. This fact was known to both parents and children and had destructive effects especially on educational achievements. Such is the messed up social logic from which interviewee №7 wants to take his/her child out through migration and which he/she determines as 'one of our main motives'. The migration of interviewee №4 is also a response to a similar perverse social logic. It imposes itself on the children in their everyday life and weakens the value of the parents' professional choice. Thus, the desired intergenerational professional succession is hindered: 'It was a problem for me to explain to my children why they should become physicians. This is a very good profession. Provided, however, that they saw the children of '*мутрите*'[14] whose needs were satisfied more than enough and whose parents had almost no education. How can I convince a child that the medical profession is good and at the same time tell it that chocolate is bad for health because of calories while I do not have the money to buy it?!' Interviewee №4 reveals another problematic aspect. Of very high significance for him/her is that his/her communication with his/her children is of full value: '… this is the fundamental thing that is important.' And here is the social reality with which interviewee №4 confronts in this respect: [because of insufficient income] ' … I had to work in [city X] while my family was in [city Y]. In this way I lost three years in which I could not watch my children grow. … It was here that the full-value communication with my children was threatened.'

*Material well-being as a life goal* is understood by respondents as independent meeting of one's own and family vital needs excluding superfluity and wastefulness. Material support to close relatives is also present - explicitly for some respondents or implicitly for others. The meaning of migrants' words on material well-being – 'descent income', 'to be able to live normally', 'financial independence', 'to earn one's money without being dependent on somebody' – is undoubtedly relative but it becomes clearer when looked through the social reality of the migration decision.

[14] Read as [mutri] and literally translated as 'mugs'. A social phenomenon of the transition period - usually low educated persons conspicuously consuming income from grey economic activities. (Emiliya Pernishka, Diana Blagoeva and Siya Kolkovska, Dictionary of the New Words and Acceptations in Bulgarian Language. (Sofia: Nauka & izkustvo Ltd., 2003), 178. (in Bulgarian).

*Points of conflict or discontinuity for the self with its reality.* The experience of three of the interviewees serves as good illustration to this aspect. The income they received did not guarantee subsistence for them and their families. It was not sufficient for providing the needed for subsistence food. And here are the words of two of the interviewees in no need of comment: ' … absurd. With what I received as remuneration it was absolutely impossible to do it [provide one's subsistence] … If under subsistence it is understood to have one bread and a yoghourt per day, maybe it was possible. But I do not think that these are the normal living needs.' (interviewee №10); 'It is not about some sort of a standard of living for the family – we are not going to discuss such a thing at all. We are talking simply about food. There were periods [2001 - 2004] when the situation was so tragic that we could not afford to have wholesome food – bread, beans and some other things. Words are failing me …' (interviewee №2).

An example of *life goals related to the perfection of one's self* presents interviewee №10. Through his/her migration decision interviewee №10 sought to bring desired changes to his/her self – 'to become more active' in life – and to gain confidence in the veracity of the understanding he/she holds of his/her self by testing and 'proving' it.

C. *The meaning behind the choice of the medical profession*. A common characteristic for all respondents is the presence of their concept for a meaningfully living self in the idea they hold of the medical profession. As a result of this identification the medical profession is perceived as an opportunity to bring to reality the concept of the self, i.e. as an opportunity to be oneself. This can be seen in the words of interviewee №7 for whom the idea of not being a physician is extremely destructive to the self: ' … the psychological moment of not being a physician anymore … is killing.' The identification takes two directions. The leading one is that of putting into the choice of the medical profession the meaning that fills one's path of life. In this sense some of the respondents perceive the practice of the medical profession as an opportunity to be of help to people and others – to develop one's self through enriching one's understanding of human nature and being. The words of interviewee №9 illustrate this point well. From the meaning that fills his/her life – 'to have the opportunity to be of help to people' – grows his/her choice of the medical profession – ' … and I have always perceived my profession as an opportunity to be of help to people … with my work, with my approach.' The second direction presents the medical profession as an opportunity

to fully realise one's inherent intellectual potential and natural aptitude. Attractive features of the medical profession like its prestige, internationalisation, security and good income have come out as secondary in importance as they were mentioned by few respondents and explicitly criticised and rejected by a considerable share of interviewees.

*Points of conflict or discontinuity for the self with its reality.* The striving of respondents to practice the medical profession as an opportunity to be of help to people takes part in some major collisions with reality. One of them is generated by a structural change in the healthcare system – the introduction of financial incentives in the physician-patient relationship. The core of the conflict is clearly seen in the words of interviewee №1: 'The physician should cure the ill in order to cure them … He/she cannot cure a patient in order to take money from him/her … because compassion and the desire to profit materially are mutually exclusive.' Interviewee №6 reveals the conflict mechanism - the change has led to replacement of the central to the medical profession motivation – to cure: ' … becoming managers of their own enterprises [physicians] have to pursue definite economic interests. … they are more and more forced to put in the centre of their work their own interests and just after that the interests of the patients.' For two of the interviewees the consequences of this conflict have significant effect on the generation of the migration decision.

The second conflicting aspect of reality comes from low incomes and even poverty in the general population. And that means poor patients. From the premise of the treatment process which undoubtedly involves 'material' intervention success requires materially able to cooperate partners. If a patient is not able to provide for him/her-self wholesome food and buy the necessary medications then the efforts of physicians to help are rendered senseless. Quite illustrative are the words of two interviewees (№10, №5): 'It is impossible for a pensioner [this is the population most often in need of healthcare] to live with one hundred leva [a monthly pension of 50 Euros] normally. He/she cannot buy … elementary food to feed him/herself … from this point on there is nothing to be talked about.'; ' … and I am forced to make compromises with the fact that the patient does not have money and I have to treat him/her with a medication that I know is of no help.' The last words of interviewee №5 'is of no help' are clearly in conflict with the migrant physicians striving to be of help, to be physicians. Thus not being able to be of help they have become migrants in order to be physicians. Here it is necessary to

mention that this conflict contributed to the migration decision only after no way was seen to overcome it. An illustrative example is the one-year practice of interviewee №10 in a small town – that physician used a considerable part of his/her own insufficient income to buy the medications for the poor patients. A doomed to failure solution.

D. *Professional aspirations*. If the above aspect shows *what* is sought and achieved through the practice of the medical profession this aspect presents *how* it is preferred to be done. And the answer is by being a 'good doctor'. The ethos of the idea of the 'good doctor' manifests in the high importance attached by almost all respondents to fulfilment and content from the well-performed work, and to professional activity and diligence. The words of two interviewees (№9, №0) serve as examples: ' … to be good … in one's profession to the degree of perfection'; ' … to be proud with one's work and to strive that it is of the best quality possible.' A deeper and more concrete focus reveals professionalism, humaneness, and abiding moral norms as embodying respondents' understanding of the 'good doctor'. This understanding represents on the one hand the attractive image of the medical profession with which the respondent's concept of the self is in resonance. While on the other hand it is the prime professional aspiration from which arise all other aspirations and towards which it acts as a constant corrective. From the three elements of the idea of the 'good doctor' professionalism is essentially important for professional identity. That is why many of the professional aspirations of respondents ensue from their understanding of professionalism. These include: acquiring and practicing quality knowledge from the progress of medical science and for some respondents participating in its generation; knowing and using up-to-date diagnostic and curative technologies. In this sense respondents aspire to active participation in the international exchange of medical knowledge and its application, i.e. to the practice of medicine at good international level.

*Points of conflict or discontinuity for the self with its reality.* Almost none of respondents' professional aspirations find their counterpart in reality. In order to be acquired knowledge should be first handed down. Two interviewees point to this self-evident condition as quite problematic. According to interviewee №4 this barrier to acquiring knowledge stems from 'a serious problem which is not talked about' – the strongly deteriorating inter-colleague relationships. As a root cause for this situation interviewee №4 sees a structural change in the healthcare system – the introduction of privately paid specialisations. It had a very important

consequence - bringing in the medical profession of the idea that ' … medicine is a craft that has to be stolen and is not given … and that everyone whom you teach something is a potential competitor for you' (interviewee №4). The resulting general atmosphere as described by interviewee №4 is: ' … senior physicians are suspicious towards junior physicians, junior physicians hate senior physicians, junior physicians hate each other, which is the same for senior physicians'. And interviewee №9 gives concrete examples through which this atmosphere manifests: senior physicians perceive junior physicians as a threat to their professional position which starts a defensive reaction towards them. Thus junior physicians are not given opportunities for demonstrating and proving their capabilities, their high professional successes are left unnoticed, they are not assigned to positions adequate to their professional level and in some cases confront purposefully erected walls that hamper their professional progress. In this way respondents' aspiration for gaining and practicing quality knowledge collides with serious barriers in reality. For some respondents this conflict has taken part in the formation of the migration decision or in reinforcing it.

Another barrier to this striving presents a formal characteristic of the healthcare system – it has a poorly designed system for professional development and progress that offers 'low horizons' and scarce opportunities. In this way the majority of respondents face a barrier or rather a void in trying to realise a significant professional striving. The words of a number of interviewees illustrate the consequences: ' … at that moment what I missed was an opportunity to achieve something more in my professional development … before migrating … I had the feeling that I had achieved what was there to be achieved … I did not know what followed … I was in a standstill.' (interviewee №6); 'I had the feeling that I mark time. … Nothing happened in life professionally.' (interviewee №9); ' … as if in a standstill and you ask yourself – you have come to here and from this point on?! And you see that there is almost no development. … There was no normal development in healthcare … and you cannot say "yes, I'll be here and learn something new". Everything went down and we stood in a standstill.' (interviewee №2). For most interviewees the described situation took part in migration decision-making in a quite explicit way. Some examples are: 'My aim was to continue my professional development which I did not see as possible here.' (interviewee №7); ' … to see something new … to learn things we'll not learn here.' (interviewee №2); 'Of course, this was exactly why I migrated.' (interviewee №8). Interviewee №6

presents an interesting viewpoint on this barrier – perceiving it as a sign that Bulgarian healthcare does not need the physicians whose potential goes beyond the professional horizons set by it. From this understanding interviewee №6 states: ' … before I migrated I gave eight years to my country to find out whether it needed me or not.'

The poor system for professional development and progress has another not easily seen consequence. It canalises physicians' striving for professional development and career in a wrong direction – towards the space for advancement opened up by the introduced financial incentives. In this way success starts to be measured through the number of patients served and the financial benefit brought by them. Interviewee №7 describes this phenomenon as a struggle for patients in which there are no winners: ' … and you start to compete for patients … You want patients and think about getting them but you do not think about professional development.' As a factor contributing to this situation interviewee №6 sees the general change in values in society during the transition period – turning success and its material dimensions into major criteria for life satisfaction: ' … this whole change in society towards measuring progress through material values and success or failure.' In this way two parallel and contradictory value systems start to function in the medical profession – one in which the central value is satisfaction from well-performed work and respect as its outer measure and another for which work is mainly a means for making money while a well-done job is measured through material gains. And this situation drags respondents into a value conflict. A negative form of materialism is one of the most discussed points of conflict. It is described by interviewee №2 as excessive and violating core human values: 'Materialism not within normal limits – to aim at material well-being, but materialism in its other form – ignoring significant things in human relations just for getting to something totally material.' Its main manifestations are dishonest practices in the professional and inter-colleague relations planes. Interviewee №2 points out some of their frequently visible aspects - irresponsibility, egocentricity, struggle for power at the expense of others. Dishonest practices succeed in supplanting honesty and correctness in inter-colleague relations and in the achievement of professional goals and this presents one of the most painful for respondents point of conflict. Lack of openness, hypocritical and malevolent behaviour, 'embitterment', 'bringing out the brute in oneself' characterise inert-colleague relations.

The described contradiction between the two different systems can be seen as a multilayered value conflict. Each of its layers contributes to the formation of the migration decision. The first layer is that of conscious awareness that there is a value conflict. For a considerable part of respondents being aware of a value conflict and 'witnessing' its manifestations has contributed to migration decision-making. Respondents reveal two mechanisms with regards to influence on migration decision. One is the desire to distance oneself from the environment of the conflict. The other operates through professional satisfaction. The existence and the successes of the conflicting value system lower the satisfaction from the benefits one's own value system brings. Thus a desire is generated to prove the strengths of one's own value system and strengthen the satisfaction its results bring. This is seen as being possible through achievement of new professional aims and horizons in a value friendly context. The second layer is related to the fact that good professional results and progress in general require consonance and medicine is in general a team-based activity. Therefore the presence of value conflicts can have very deteriorating effects on professional development and progression. As the above description suggests the experienced value conflict provokes numerous interpersonal conflicts that not only generate negative working atmosphere but also hinder good professional interaction. The third layer is that of experiencing the conflict. In the words of two interviewees the value conflict brought to the self feelings of embitterment, burden, stress. Here again two mechanisms with regards to influence on migration decision emerge. Interviewee №2 describes one of them as impossibility to overcome the value conflict and free one's self from its negative consequences. The result is a self that incorporates negative aspects from the conflict and starts to spread them through one's own behaviour: 'We are in this social milieu, we worked in this social milieu and there is no way not to get entangled … sometimes even in one's embitterment on the side of the bad ones – you attack someone without a reason.' In this way migration comes out as an opportunity to free the self and thus let it be more authentic: 'And this is a significant factor for our decision to *get away from here*. And not only for my decision – many colleagues from the clinic left for very similar reasons.' (interviewee №2). Interviewee №10 reveals the other mechanism. In trying to overcome the consequences of the conflict – high level of constant stress, danger of being turned into object of dishonest practices or into their accomplice – the self loses much of its inner resources that are necessary for good professional

functioning, i.e. for successful pursuing of one's major life striving. Or in interviewee №10 words: ' … to protect oneself from the immoral [colleagues]. The people that can mislead you … And this pushes out the most important for a professional – you start to think about things that push aside the main purpose of the physician.' Thus migration again comes out as an opportunity for the self to be in an authentic way.

All these points of conflict hamper achieving professionalism as understood by respondents and play significant role in the formation of the migration decision.

Knowing and using up-to-date diagnostic and curative technologies is the other aspect of professional aspirations that has no counterpart in reality. In this respect of central importance are the conditions of the working process, i.e. availability of material professional resources. According to interviewees they are 'inadequate, to put it mildly', 'extremely impeding the working process', 'more than bad', 'heavy', 'misery', 'primitive'. Behind these evaluations stand morally old equipment to the degree of backwardness, a limited range of medicines usually of low effectiveness, physically old equipment that more often than not is out of order, old transport vehicles for patients, low availability of consumables, etc. As becomes clear respondents lack opportunities to perform and develop professionally in the way they understand it. And this plays a significant role in the formation of the migration decision as the words of interviewee №10 well illustrate: 'And this is one of the reasons I have migrated – to develop as a physician in a much better way … While here it is difficult to reach such a level.' The extremeness of the evaluations above suggests the second and more important effect with regards to migration decision. This state of the conditions of the working process, especially the poor availability of medicines, compromises the whole curative process and thus renders professional functioning meaningless. An illustrative example is given by interviewee №2. The availability of medicines at his/her workplace (a university hospital) has been constantly worsening for a number of years reaching a state when key drugs are missing: ' … in the end [year 2004] we were forced to work with one or two drugs, and we lacked the most important medicines which were crucial for our patients. … The hospital pharmacy was simply empty. So!?' This situation according to interviewee №2 confronts the physician with the following dilemma – either to stop taking patients, i.e. stop practicing, or try to help patients breaking a number of legal regulations, i.e. becoming a criminal: 'You have either to break the law … to be a criminal, for which

you are going to be sanctioned any moment, or simply leave the patient in the street.' This is a dilemma that cannot be solved – either 'exit' is destructive to the self: 'The cruellest dilemma.' (interviewee №2). The words of interviewee №10 add some details to this important destructive conflict for the self: ' … here you simply have to forget about morality in order to continue. You cannot keep your eyes shut when your patient is dying and it is not possible for you to prescribe him/her a medicine that exists … And these are the moral obstacles, moral compromises that you have to make as a physician.' The nature of the conflict and the way it is experienced are quite explicit in the words of interviewee №10: 'We as physicians want to help the patient in any way possible and not being able to is the heaviest burden. And you know that these are material things that can be delivered, but you do not have them. And this is a very heavy burden.' For interviewee №2 this conflict creates a feeling of being trapped, caught in a standstill, facing an insurmountable hindrance, impotence. A way out is migration: ' … and when a person confronts so many walls and he/she says to his/herself why should I stay here and wrack my brains!?' In the words of interviewee №10 it is clearly visible that the conflict is not only about being a good professional but it also reaches the central to the self striving to render help to people by being a physician: ' … the social realisation as a physician, because every one of us studies this profession with the idea to give help to people. And you see that for a physician in Bulgaria this is quite difficult to do.' And here again migration comes out as an opportunity for the self to be in a more authentic way.

E. *Professional expectations*. While professional aspirations present that part of the interaction with society in which respondents are active professional expectations put forward the idea of their activity being reflected and coming back to them as sources of satisfaction. At the centre of professional satisfaction stands receiving positive feedback from patients with regards to achieved diagnostic or treatment results. Its contribution to professional satisfaction is first in significance and almost beyond comparison with that of others. It is followed by remuneration in its multiple dimensions – expression of the positive feedback from employer and society, i.e. their appreciation of physicians' work; means for meeting one's own and family vital needs and for maintaining good professional level. Another important expectation is professional development and progression to be based on knowledge, skills and capabilities.

*Points of conflict or discontinuity for the self with its reality.* It is the last two

professional expectations that come into serious conflicts with reality. With regards to remuneration the points of conflict are numerous. As a whole they stem from different kinds of mismatches. The received remuneration does not correspond adequately to the level of qualification and intensity of labour and to growing responsibilities. In this way it rather gives a negative feedback from employer and society. It is also disconnected from the requirements for professional development. This is clearly seen in the words of interviewee №5: 'It is not possible to have to buy a textbook in paediatrics for 150 euros and at the same time to receive a salary that is 150 euros. How can I buy this textbook?! How can I read this textbook?!' A requirement exists that physicians should deliver their labour in a predictable and consistent way with clearly set time limits while their remuneration is characterised with 'absolute uncertainty' (interviewee №2) with regards to formation and time. The expectation that remuneration should allow meeting one's own and family vital needs is also unmet. This is well illustrated by interviewee №2: 'At one moment I had to work in three places and my spouse [also a physician] on two positions in order to roughly succeed in securing an income for subsistence.' Due to taxing policies the result from this attempt to overcome remuneration shortcomings is only physical and mental exhaustion. All these points of conflict feed into the migration decision – migration is seen by respondents as an opportunity to receive an adequate material appraisal for their labour and to escape 'poverty', 'misery', 'dependence', 'financial insecurity'. The most serious for the self consequence from the conflict is revealed by interviewee №5. The difficulty in meeting the basic living needs disrupts adequate professional functioning and does not allow for practicing at a good professional level: 'And when I come back home I think how to get money to repair this or that … or that the school demands money … when my brain is busy in such a way I turn from a physician into a murderer … I cannot deliver even forty percent of my capacity.' As a result of extreme material conditions the self starts to shrink in order to survive. Professional interaction with patients is one of the aspects from which the self begins to withdraw: 'When I am not paid for my labour, it is the patient who suffers. … Because I have my close people … that interest me most and all the others start to fade out, go to the periphery. … but this is a protective reaction. I, too, need to survive.' Experiencing this situation is hardly bearable in intellectual and emotional terms and is defined as 'perversion' that traps the self and brings very deep dissatisfaction. In this way migration emerges as an opportunity for the self to regain integrity and fullness.

The expectation that professional development and progression should be based on knowledge, skills and capabilities also collides with reality. The conflict has multiple layers each of which contributes to the formation of the migration decision. In this respect what respondents find in reality is 'bureaucracy'[15], 'corruption', 'cronyism' which operate at all levels – entry exams to medical universities, university exams, competitions for specialisation and working positions. The first layer of the conflict is the barrier it creates for professional practice. In this respect very illustrative are the words of interviewee №4, one of the three excellent graduates of his/her university: 'And I realised that if I stay in Bulgaria, I'll simply be a loser. And not because I'm incapable, but because the conditions are going to be against me. And much more mediocre people than me are going to be much more successful just for being the children of professors in medicine.' The second layer is a value dimension and relates to 'the way things ought to be done' (interviewee №0) - knowledge, skills and capabilities are the just criteria for access to professional resources. An example in this respect is given by interviewee №0 who wants and tries to advance on his/her professional path by applying this value: ' … when a person wants to do something, he/she wants to be absolutely equal, to accomplish it without patronage, but simply … according to his/her skills and capabilities. But it did not work for me in this way and this contributed very much to making the more cardinal decision [migration].' The mechanism of influence on migration decision in this respect can take another form as the experience of interviewee №4 informs. The values that regulate access to professional resources which are also the values of respondents, are challenged by new and negative ones. Thus professional life is regulated by different and contradictory values which leads to confusion and unpredictability in achieving goals. In this way migration emerges as an opportunity to regain control over professional life – to practice in a context where definite rules bring definite aims and results. Or as interviewee №4 puts it: 'Then I decided that I have to take things in my hands and that I could not let myself be tossed to and fro. And thus I decided to leave.' The third layer is related to the level of professionalism. Put succinctly a corrupt system cannot deliver high levels of professionalism. Interviewee №10 gives details on this point. According to him/her the physicians that take advantage of corrupt practices are holders of corrupted moral and competence which are

[15] Bureaucracy here means lack of effectively working transparent system for competitions that guarantees abiding of formal rules.

incompatible with a high level of professionalism: ' … a person like this in no way can become a good specialist.' As can be expected corrupted physicians quickly succeed in taking leading positions of key importance for the functioning of the medical profession in the respective healthcare facility: 'They took the best positions and one day these people were going to determine what medicines should be used in a definite situation and what medical tests to be performed.' And here comes out an important mechanism for migration decision-making – the perspective that one's professional practice depends on incompetent and morally corrupt colleagues is unacceptable and generates the idea to distance oneself: 'And this thing, too, made me search for solutions for me because I did not want to work with such people … they have no idea of basic things and one day you are going to depend on them. It sounded to me quite illogical. And this was one of the reasons for me to take this step [migration].' The forth layer relates to the experience of the conflict. It gives rise to strongly negative feelings like embitterment, sadness, feeling for being unneeded, insult. These feelings in some cases are aggravated by the openly cynical way of breaking formal rules and acting against accepted values on behalf of senior representatives of the profession. In conclusion it should be noted that it is the less visible layers of the conflict that play the more significant role in migration decision-making. These are the collision of values and the unpredictability it brings, the expected dependence on morally compromised and incompetent colleagues and the strongly negative emotional experience.

F. *Position towards social life.* The majority of respondents consider as important for them the opportunities they have to influence the development of social life through instruments of civic culture. This is clearly expressed in the words of two interviewees: ' … to live in a society in which … you are able to bring positive changes.' (interviewee №10), 'Our voice has to be heard in some way' (interviewee №9).

*Points of conflict or discontinuity for the self with its reality.* In reality respondents do not find effective mechanisms through which they as citizens can contribute to positive change. A number of respondents have reached such conclusions as a result of their own experience. They invested substantial efforts in solving social and professional problems but results did not follow and the experience as a whole was quite disappointing and brought evidence for pessimistic realism. In this way respondents form the attitude that the development of social life is out of their reach as citizens. Illustrative in this respect

are the words of interviewee №10: 'Because you see that you cannot manage in a country in which you can do nothing and you don't expect that anything positive can happen.' As a result a feeling of meaninglessness grows in respondents which points to the two mechanisms of influence of this collision with reality on migration decision-making. The first is that the self is deprived of a number of key opportunities to create the favourable conditions for his/her desirable relation to society and thus its achievement is questioned. The second relates to the fact that an important aspect of the desired relation to society – being an active citizen - cannot be realised and this confines the self leaving it emptier and smaller. In this way migration to a better developed civil society is seen as an opportunity to live as an active citizen and thus free oneself from the feeling of meaninglessness.

G. *Relatedness with close people.* Interviewee №2 reveals a surprising viewpoint in this respect which may sound paradoxical but remains logical – going far away brings you closer. The multiple conflicts experienced by interviewee №2 drained his/her vitality in an extreme way. As a result it becomes impossible for him/her to maintain close relationships and social life narrows and gets poorer: 'We were so tormented … that the bonds grew weaker and thinner.' Relations with parents are also perceived as damaged because of the impossibility to fulfil adequately one's filial duty: 'We could help them [parents] only with presence. We could do almost nothing for them.'

The picture of the formation of the migration decision becomes complete with the discussion of the second element of respondents' understanding of Bulgarian society – functioning of social life. It comprises a number of problematic aspects for respondents which contribute to migration decision-making. These include the understandings respondents hold of the way in which the state is governed and the formal rules of social life are produced, the work of law protecting institutions, civic and political culture of society, the state of values in society, interaction between social agents, negative culture traits, opportunities for civil impact on social life, expectations for the successful ending of the transition period. As can be expected their discussion is not possible here due to limits in volume.

As the analysis suggests the attempts of respondents to relate to Bulgarian society in a meaningful to them way fail. The self fails to integrate truly into social realty and as a result the reciprocal continuity from which both self and reality grow is not established. Thus unable to be in an authentic way the self resides in a

multiple conflict state that depletes its inner vital resources and threatens its existence. It is in this sense that not migrating from Bulgaria would turn respondents into 'suicide' and 'victims' and could even challenge their human nature. In this light the migration decision should be looked at as formed by the serious hindrances or impossibility for the self to be in an authentic way. It is this point of view that reveals the meaning of the spontaneously given by some respondents 'names' to migration: 'salvation', 'deliverance', 'a way out in order to survive', taking back one's life.

**Conclusion**

The answer to the research question formulated concisely is: the migration decision of Bulgarian physicians arose from a conflict between their understanding of their selves and of the desired relation to society on one hand and their understanding of Bulgarian society on the other. Here 'conflict' stands in its wider meaning and embraces the following three nuances 'discrepancy', 'discontinuity', and the strongest one 'collision'.

Every respondent faced serious hindrances in realising the desired relation of his/her self to Bulgarian society. In this light the following picture of respondents' endeavour for self-realisation in Bulgarian society could be reproduced – IMPOSSIBILITY to:

- achieve life goals concerning professional realisation, family life and close people, self-perfection;
- realise professional aspirations for practicing medicine at a good international level and this practice to have humaneness and abiding of moral norms as unthreatened natural characteristics;
- be professionals according to their own conceptualisation of the medical profession – as an opportunity to render help and support to people or to realise in the highest possible extent their inborn intellectual potential and aptitude;
- meet their professional expectations – to be given adequate to their work material and non-material appreciation, professional development and progression based on knowledge, skills and capabilities;
- satisfy their striving to be citizens of their society with constructive and fruitful position and activity;

- fill in the greatest possible extent their life path with meaning in the way they understand it – realisation of the inner striving for and need to render help and support to people, purposeful aspiration for perfection of their selves.

As the findings and conclusions suggest, the study succeeds in answering the research question by applying a biographical approach together with concepts from social theory and social anthropology integrated in a comparatively coherent conceptual framework. The concept of self-identity proved effective and useful in explaining migration decision-making.

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