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Changes in Highly Skilled Migration Policies: Turkish-German Medical Migration since the 1960s

Lisa Peppler [±]

Abstract

Turkish physicians have been migrating to Germany since the 1960s to obtain professional experience. Therefore, this article takes a long-term perspective: How and why did the careers of physicians with medical degrees from Turkish universities change through time? This study is based on 29 semi-structured and three expert interviews. The results show that the migrant physicians can be classified as three generations, whose qualifications have been viewed variably through time: The first generation (migrated 1961-1974) was welcomed because of a lack of doctors. They got special permits to practice medicine, which was usually bound to German citizenship. The second generation (migrated 1979-1990) only got permission to treat Turkish immigrants – because of both an excessive amount on doctors and ethnicization. The third generation (migrated 1999-2012) was affected by Europeanization and the competition with immigrating physicians from Eastern Europe. The findings show how medical migration changes due to migration and healthcare policies, thus highlighting the context-dependent nature of skill valuation processes.

Keywords: medical migration; healthcare system; migration policies; Germany; qualitative research.

Introduction

Given today's global labour market for healthcare professionals, it is important to understand the mechanisms that influence the transnational careers of physicians. This article aims to explore the changing determinants of medical migration through the example of physicians from Turkey who have immigrated to Germany since the 1960s to attain medical knowledge and professional experience abroad. This long-term perspective demonstrates decisive influences changing over time. Indeed, German and European migration policies differentiate between desirable qualified migrants and other migrants, who are considered a burden (Erel, 2009: 3). From a historical perspective we can see, that qualifications do not have a fix, clearly defined value, but their value depends on the specific context. It is the interplay of diverse aspects that cause the changing framework conditions for highly skilled migration. In the following I will present which factors have been influencing migrant physicians' careers since the 1960s. How and why did their career paths

[±] Dr. phil. Lisa Peppler, Charité – University Medicine Berlin, Institute for Medical Sociology and Rehabilitation Science, Charitéplatz 1/ Virchowweg 22, 10117 Berlin, Germany.
E-Mail: lisa.peppler@charite.de.

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change over time, even though all physicians interviewed have medical degrees from Turkish universities?

I will elaborate on the major finding of my dissertation (Peppler, 2016), that there are three generations of migrant physicians, whose professional careers are characterized by remarkably different determinants. This classification is based on a new concept of migration generations to analyse change in long-term migration processes (Peppler 2016). By focusing on collective experiences in both the society of origin and the society of residence, it is possible to identify varying determinants of transnational professional biographies. The three generations of migrant physicians are named after the interviewees' social background in Turkey. The first generation (migrated 1961-1974) is called the *migrant 'old' elite* because they grew up during the 1930s/1940s in the old upper classes. The second generation (migrated 1979-1990) is called the *migrant 'new' elite* because they grew up during the 1950s/1960s in the newly formed middle and upper classes that have been emerging in Turkish society due to demographic changes. The third generation (migrated 1999-2012) is called the *migrant 'global' elite* because they grew up during the 1970s/1980s in middle and upper classes with increasing globalization. Although these terms are based on the physicians' background in Turkey, the following remarks focus on their experiences in Germany. I analyse the effect of changing migration and health policies on the experience of the three generations of Turkish doctors in order to highlight the changing demand for the same occupational group of highly skilled migrants through time.

Some remarks on medical migration: research and legal aspects

International research on medical migration has been increasing significantly since the early 2000s (Rutten, 2009: 319), especially in the USA, where approximately 25% of the healthcare workforce is foreign-educated (Chen et al., 2013). In contrast, Germany has not officially recruited foreign physicians for decades (Adel et al., 2004: 211). Only in the Immigration Act of 2005 and the National Integration Plan of 2007 were highly qualified migrants defined as a target of immigration policy for the first time (Srur, 2010: 167). Therefore, there has been little empirical research on this issue (Henkelmann, 2007; Hoesch, 2009). Given the current lack of medical specialists, research on migrant physicians (Klein, 2016), intercultural opening (Mayer, Vanderheiden, 2014), and diversity management (Bouncken, 2015) is increasing. However, these studies focus on organizational structures and cultural differences in hospitals, while research on resident doctors is lacking. Additionally, research is focusing on current developments, even though migrant physicians have been playing a significant role in healthcare in Germany since the post-war period. Overall, research on physician migration does not systematically analyse

the complex interactions between healthcare and migration policies. This article constitutes an attempt to fill this gap.

Medical professionals are a special group of highly skilled migrants; due to professional law, migrant physicians face extremely high barriers to enter the labour market (Schmidtke, 2010: 252). For example, foreign physicians need both recognition of their diplomas and a license to practice medicine. Both certificates are independent of one another in the legal sense. Furthermore, the medical profession is regulated by the national state, so preconditions for access to the medical field and surrounding conditions of medical activity are determined by law. The Federal Ministry of Health is tasked with regulating the structure and policies of healthcare. For example, according to the Federal Medical Code, the license to practice medicine in Germany was bound to German citizenship until 2012. As in most countries, the German medical profession "is characterized by a history of barriers erected to exclude foreign medical practitioners" (Iredale, 2001: 12). Therefore, migrant physicians are confronted with national policies and profession-specific regulations considerably more than other occupational groups (Adel et al., 2004: 202).

Most international studies are based on quantitative approaches and statistical data in order to analyze and control the professional workforce (Akl et al., 2007; Boulet et al., 2006). Research on migrant medical professionals is lacking qualitative approaches to show the migrants' subjective perception; therefore, this article focuses on the interviewees' views and experiences. This research is based on anonymized semi-structured interviews with 29 (post-) migrant physicians and three expert interviews with presidents of Turkish-German medical associations. The interviewees were born between 1931 and 1981; they came to Germany between 1961 and 2012. While the above-mentioned studies focus on medical migration at a specific historical date, this article takes a long-term, processual perspective. This gives us the chance to compare migrants' career opportunities under changing circumstances.

Wanted as doctors: Turkish physicians of the *migrant 'old' elite*

In 1961, Turkey's new constitution allowed Turkish citizens to leave the country for employment. At the beginning of the 1970s, approximately 18.4% of Turkish doctors lived abroad, most of them in West Germany (Oğuzkan, 1975: 206). At that time, the German healthcare system was benefiting from general economic growth. In particular, huge hospitals with research facilities were built, which increased demand for physicians and medical scientists (Lindner, 2004: 109). These career opportunities attracted numerous physicians from developing countries. The World Health Organization (WHO) noted that in 1976, 140,000 physicians were working abroad – approximately 6% of the total number of physicians worldwide. Germany was one of five main destination countries (Mejia et al., 1979: 399).

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One of these migrant doctors was Dr^{T} Ülger, who earned his doctoral degree at a Turkish University (Dr^{T}). He had applied for a special training in a German hospital in 1974, and he reports on the ease with which foreign physicians could practice at that time:

> "And then [the head of the department] said, 'In two months, you can begin your job here with us.' It was that easy … back then, because when I hear about the difficulties which other colleagues experienced, I am astonished … recognition, and so on. […] And in my case, two months after, I received my identity card, passport and such. I didn't visit the aliens' department or any other authority from the government and simply received my residence permit, my occupation permit, and my work permit. Everything came to my desk." (Ülger 2010)

Dr^{T} Ülger highlights the historically specific circumstances that characterized the physicians' easy access to the German medical field at that time. In this special situation, national and professional opportunities came together. Germany's increasing need for medical personnel simplified access to a field that was nationally determined. This opened up opportunities to non-Germans who traditionally would have found it more difficult to enter the workforce. Moreover, they found jobs that met their formal qualification. Hiring foreign physicians was the only way Germany could grant a supply system tailored to the needs of the people. Moreover, health insurance institutions determined that regular medical care was made possible only with the support of foreign doctors (Groß et al., 1982: 101).

In addition to a lack of clinicians, there were also too few medical practitioners in rural areas (Lindner, 2004: 88). Dr Bilgen, for example, speaks of his father, who took initiative to emigrate from Turkey in 1961:

> "Back then, my father wanted to move to the USA, but he didn't find a job immediately. He applied for a job in Germany as well, and he promptly received an offer, and he then considered moving to Germany for five years, with the possibility of moving on to America afterwards. And … well … we're still here today. [Laughing]" (Bilgen 2008)

Because of the exceptional need for physicians in rural areas, German authorities made special allowances for foreign doctors from outside the European Community to open practices. Thus, Turkish physicians and their families moved to smaller towns, where their medical expertise was needed. Many of the interviewees mention colleagues, friends or parents who possessed this special permit for a so-called deprived area (Peppler, 2016: 141). Dr Baydar, who grew up in Germany as the son of two migrant doctors, explains:

> "At the end of the 1970s, one could gain a license to practice medicine without possessing German citizenship. [...] For later generations of

> physicians, it became a large problem when they didn't have the license to practice medicine; they always needed the one-year occupation permit." (Baydar 2010)

The above-mentioned quotes show that the first generation of migrant physicians filled a critical workforce need. Nevertheless, the situation of these physicians was very precarious because their special permits were temporary and could be retracted at any time (Euwals et al., 2010: 516). This was the case until the mid-1970s, when their position changed remarkably because of restrictive migration policies and processes of change in the medical profession. In 1973, German authorities stopped the recruitment of foreign workers due to economic crisis and the expected increase in national unemployment (*Anwerbestopp*). As with the lack of workers in general, the lack of doctors was considered eliminated. Dr[T] Ülger talks about the authorities' decision:

> "[T]he government said, 'We have overcome the doctor crisis and the medical gap, and […] new recruits are on their way. We should send these foreign doctors back to their home countries.' Yes, and these politics were massively exercised." (Ülger 2010)

As a consequence of these changing policies, temporary occupation permits and special allowances for medical practice would not be renewed at the end of their validity. Additionally, the Primacy of Native Citizens (*Inländerprimat*) came into effect in 1974, under which applicants holding foreign citizenship received subordinate access to the labour market. Authorities then issued new work permits only after a strict testing procedure of the labour market; however, residence permits were directly linked to work permits (Birsl, 2013: 34).

A research study from the Center for International Migration and Development in 1982 describes the considerably high pressure exerted on the German labour market by doctors and medical specialists from developing countries (Groß et al., 1982: 100). Initiatives to send them back to their home countries were matched to state development aid. The argument was: Highly skilled migrants, who have gained advanced knowledge and skills in Germany, should now bring their expertise back to developing countries (Groß et al., 1982: 105). By appealing to their role in international development aid, the argument was specific to push off highly skilled people holding foreign citizenship.

Subject to this repressive migration policy, migrant physicians could no longer participate in the German medical labour market to the same extent. Practising doctors faced particular difficulties. If their special allowance was not renewed, they had to give up their established practice. Dr Fındık-Taylan explains the problem her father experienced:

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> "[He] also had a social responsibility. If he would have had to eventually close his practice, his employees would have been out of work. So at one point he decided [...] to take German citizenship." (Fındık-Taylan 2011)

Like Dr Fındık-Taylan's father, all of the foreign physicians had to decide whether to go back to Turkey or take German citizenship to stay in Germany. This decision was final in a sense, as the permission to practice medicine in Turkey was also bound to Turkish citizenship. This collective experience of exclusion came as quite a shock to physicians who had felt accepted as professionals in German healthcare prior to this legislation. Ultimately, because of restrictive migration policies and profession-specific closure, the *migrant 'old' elite* was divided into returnees and naturalized doctors starting in the mid-1970s.

Wanted as Turkish doctors: the *migrant 'new' elite*

The following generation of Turkish physicians came to Germany shortly after the above-mentioned new repressive migration policy had been introduced. They were forced to leave Turkey because of political unrest since the end of the 1970s. At the beginning of the 1980s, highly qualified Turkish migrants constituted the largest group of all non-EU-academics living in West Germany. Approximately 1,280 of them were doctors (Groß et al., 1982: 114/89). At that time, Germany was characterized by declining economic growth, a stressed labour market, restrictive migration policies and a population that was increasingly sceptical or even hostile towards foreigners (Şen, 1994: 4). The medical labour market was also stressed, and in the 1980s, there was some talk about an upcoming 'glut of physicians' (*Ärzteschwemme*) (Hoesch, 2009: 233). This increased competitive pressure in the medical field, and meanwhile, economic pressure forced the healthcare system into financial reform. Beginning in 1977, the formerly huge costs and expenses in healthcare were lowered by law. The 1980s were characterized by economic measures, culminating in the Healthcare Structure Act of 1993 (*Gesundheitsstrukturgesetz*) (Hoesch, 2003: 106).

Given these changing determinants in social, migration and healthcare policies, the new physicians were confronted with many problems during their migration processes. While the first generation got jobs according to their qualifications, the new migrant physicians had to obtain a student status. Their medical degrees were no longer accepted – even though these physicians had been educated in the same Turkish universities as the first generation. They even needed official support to get a student job. Their medical superior had to affirm that this foreign physician was needed for a concrete job that nobody else could perform. This drew special attention towards the growing group of Turkish patients, as the following example shows.

Dr Paksoy had already completed his medical studies in Turkey, which German authorities did not recognize. As a foreign medical student, he was not allowed to perform a student job in a hospital. His German thesis supervisor negotiated with the authorities, stating that Dr Paksoy's expertise was needed to treat the Turkish patients in this hospital. Ultimately, he got this job to make a living, as he explains here:

> "So I didn't receive an occupation permit, I didn't receive a work permit, and it was very unclear to me what I was supposed to live on. But within a brief time, I found work, and [the professor] heavily supported me. [He] gave me a written confirmation that I would absolutely have to work in a clinic where the patients are usually Turkish." (Paksoy 2010)

The physician's Turkish background became relevant for his professional career in Germany, although his Turkish medical exam was not recognized. The opportunity to practice medicine arose from the idea that doctors of a Turkish background should treat patients of a Turkish background. This ethnic assignment also influenced his further career, as he later became responsible for constructing a clinical department for migrants.

Another interviewee, Dr Canoğlu, was forced into student status as well and had to do both the preliminary examination and the medical exam at a German university. After having finished university successfully, she had a prospective job, which was later cancelled for economic reasons. Authorities told her there would be 13,000 too many doctors in Germany and that she would have "no chance" (Canoğlu 2011) to find a job. Simultaneously, another clinic had an opening for a Turkish-speaking doctor because it was building a ward for Turkish patients. By the time Dr Canoğlu had sent in a resume, another physician already received the job: "But I said, 'If you want to expand the team or if another job comes up, I'm there,' and [...] they wanted to expand the ward, so I began working there after all" (Canoğlu 2011). Interestingly, she got a job that was spontaneously created for her because of her Turkish skills, while the healthcare system in general was characterized by economical pressure and job cuts.

The story of Dr[T] Çelık illustrates another case in which ethnicity played an important role in starting a career in Germany. After arriving in Germany, he got to know an older Turkish colleague, who was a naturalized physician from the first generation. He treated mostly patients of Turkish origin because the growing Turkish population in Germany consulted mainly city doctors with their own practice (Peppler, 2016). Therefore, he preferred Turkish assistance, and Dr[T] Çelık became his junior doctor (Çelık 2010). When the older physician retired, Dr[T] Çelık took over his practice. This example shows how younger migrant physicians could profit from resources that their older colleagues had worked for. The new generation of Turkish migrant doctors came across

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already existing ethnic group structures. Relating thereto, the medical field reproduced itself through ethnicity: Turkish patients consulted Turkish doctors, and older Turkish doctors therefore needed younger Turkish assistants. This was a kind of continual ethnic circle based on the doctor-patient-relationship.

Dr Paksoy, Dr Canoğlu, and Dr[T] Çelık are three examples of doctors from the *migrant 'new' elite* that show a resurrected need for Turkish doctors, which began to emerge in the 1980s. All new-generation physicians' Turkish background became relevant for their professional careers in a different way from the original 1960s/1970s generation. All of them received access to the nationally determined medical field from which foreigners officially should have been excluded, primarily by the ethnicization of their expertise. In all cases, established professionals of German citizenship – of both German and Turkish origin – helped them by articulating an urgent need for Turkish doctors. Being German citizens, and therefore state-approved professionals, these promoters were legally authorized to do so.

This possibility to gain access was based on the Ordinance on Exemptions from the Recruitment Ban (*Anwerbestoppausnahmeverordnung*) of 1990, according to which Turkish citizens could obtain residence permits as skilled workers with a university degree provided that their work was in the interest of the public (Derst et al., 2006: 15). Obviously, healthcare for Turkish patients was accepted as a public interest. This was partly due to the initiative of migrant physicians, who have been demanding cultural sensitive healthcare concepts since the 1970s (Falge, Zimmermann, 2014: 330). Even though medical professionals could not directly influence national migration policy, they could secure occupation-specific policies (Peterson et al., 2014).

The growing popularity of ethnic healthcare was driven by two additional factors: First, a growing number of migrants led to a growing number of potential patients of Turkish background; second, the physicians were increasingly seen as Turks. Furthermore, they attributed the ethnic envisioning to themselves, too. Therefore, the physicians either were seen as competent to address Turkish patients or felt personally responsible for them. An ethnic doctor-patient relationship developed because of complex social processes and changing structures in a stressed healthcare system with different interest groups involved. As a result, a specific segment in the German medical field was defined as 'Turkish'. Therefore, speaking the Turkish language and having the appropriate knowledge of medical culture became useful in gaining symbolic and economic profit as a physician. As opposed to the older migrant professionals, who were needed as *doctors for patients*, the new migrant physicians were only accepted as *Turkish doctors for Turkish patients*. This again changed during the 1990s, when German migration policies turned to European Union (EU) migration policies, as the career paths of the following migrant physicians show.

Hardly wanted at all: the *migrant 'global' elite*

The third generation of migrant physicians is the *migrant 'global' elite*. These doctors had grown up with an "emigration disposition" (Sunata, 2011: 241) in a globalizing world. Nevertheless, they were confronted with the restrictive migration regime of the EU that have influenced German-Turkish migration processes starting at the end of the 1990s. Since the *Treaty of Amsterdam* (1997), new laws and structures have limited the possibilities of professional mobility for Third Country citizens, while they have facilitated them for EU citizens (Iredale, 2001: 11).

The case of Mr. Uçan demonstrates how EU law affects the conditions of living and working in Germany. His German superior told the employment office that he wanted to hire him as a junior doctor, and he therefore needed residence and work permits. German authorities replied: "No, firstly the job vacancy must be published, there must be no application from other EU countries" (Uçan 2010). Due to the labour market examination, Turkish citizens received subordinated access to job positions. They were now considered not only after German citizens, as was the case with the physicians of the *migrant 'new' elite*, but also after citizens from other EU countries (see § 39 AufenthG). In contrast to his colleagues from the *migrant 'new' elite*, Mr. Uçan's superior could not use his Turkish skills as an asset. The legal framework was powerful no longer on a national level but on a supranational level. The European labour market levered the national structures of opportunity that former generations of migrant physicians had. The above-mentioned Ordinance on Exemptions from the Recruitment Ban was no longer relevant. Therefore, residence and work permits were now dependent on neither the medical degree (as for the *migrant 'old' elite*) nor on ethnic medical knowledge (as for the *migrant 'new' elite*).

In 2007, when a new lack of doctors became apparent, authorities introduced an equivalence assessment for medical degrees from Third Countries to examine whether they were equal to German degrees. Since then, passing this examination has been a mandatory requirement in obtaining a license to practice medicine (§ 3 Abs. 3 BÄO). This assessment was implemented because many physicians from Eastern European countries and Russia have been immigrating since the 1990s. Mr. Uçan criticizes this new development because he sees himself as disadvantaged:

> "[A] great many Russian-Germans or German-Russians have come here. Many of them were physicians, and unfortunately, their qualifications weren't that good. Then, suddenly, Germany said, 'Everyone who comes from outside the EU needs an equivalence assessment.'" (Uçan 2010).

Nowadays, the *migrant 'global' elite* has to face a competitive situation with other migrant physicians in Germany. Although this exam was implemented to equalize migrant physicians' access to the German healthcare system, for those

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from Turkey, this was a kind of setback. Currently, Turkish physicians tend to stay in Turkey or move to the USA (Köşer Akçapar, 2006) because the German healthcare system is no longer attractive for them (Peppler 2016). Therefore, medical immigration from Turkey has experienced a steady decline in comparison with the immigration of physicians in general. Statistics of the German Medical Association show that the number of physicians with Turkish citizenship has stayed at nearly the same level since 2006 (2006: 745; 2016: 826), while the number of physicians with non-German citizenship – from European as well as non-European countries – in general has been constantly increasing (2006: 16,080; 2016: 41,658) (Bundesärztekammer, 2007, 2017).

Conclusion

Although the three generations of migrant physicians received their degrees from Turkish medical schools, their institutional qualifications were recognized differently by German authorities over time. Relating thereto, their medical expertise was also valued differently. The valorization depends on a complex interplay of migration and healthcare policies; meanwhile, the medical profession also defines preferences on migrant physicians. It is the interplay of these aspects that causes the changing framework conditions by giving or removing migrant physicians' access to resources. The important thing to remain is that *needed medical expertise* is relevant for the conceptualization of migrant physicians' skills. However, the medical profession itself participates in discussions about what talent is needed in Germany. German as well as naturalized profession members of Turkish origin influence discourses on medical migration. Access to the German healthcare labour market is determined, depending on the issue, whether foreign physicians are needed primarily because of their medical expertise or their cultural expertise.

The year 2012 may mark another turning point for future medical migration to Germany. The Recognition Act (*Anerkennungsgesetz*) of April 1, 2012, unified and simplified the recognition of foreign qualifications to facilitate access to the German labour market for qualified employees, especially those from Third Countries. The reason is a new lack of specialists, especially doctors. In this context, German citizenship is no longer needed to obtain a license to practice medicine. Future research will show how these changing circumstances influence again medical migration to Germany.

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