Understanding doctors' decisions to migrate from the UK

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Background

The UK medical workforce, in common with that in other countries, is highly mobile. In 2021, almost 10,000 doctors left the UK medical workforce (GMC, 2022), and previous analysis indicates that around half of those leaving plan to move overseas (GMC, 2021b). Fostering the talent, commitment and diversity of doctors across the UK is crucial to addressing ongoing shortages of healthcare professionals in the UK.

While there is a great deal of data on medical migration trends, less is known about the details of doctors' migration journeys and decisions. This report presents the findings from a qualitative study of 90 doctors either strongly considering migration or having already migrated. It gives important insights into doctors' journeys to working outside the UK and highlights opportunities for intervention.

Study aims

The study aims to understand in detail the steps between an initial interest in migration and moving abroad. Our work also looks to understand how the associated push and pull factors around migration vary, both for different types of doctors looking to leave the UK and for the different stages in their migration journeys.

To achieve these aims, the study addresses the following research questions:

- What are the common 'trigger points' for first considering migration?
- How are initial options of where to migrate to identified and confirmed?
- What are the practical steps taken?
- When and why are these practical steps taken?
- At what point in the process does the decision become more fixed?
- Which push and pull factors are prominent in different parts of the process?

Methodology

We conducted 90 qualitative interviews each lasting 45 minutes, with fieldwork conducted between February and March 2022. A purposive sampling approach was taken to recruit doctors across two participant groups:

- Those that have left the UK to practise in another country
- Those that are considering leaving the UK to practise in another country

The achieved sample was broadly reflective of all doctors leaving the UK to practise overseas.

The interviews provided a mechanism for understanding decision-making journeys, and we used semi-structured interviews to explore individual decision-making journeys in depth.

What are the common 'trigger points' for first considering migration?

The research identified the 'key trigger moments' – these being defined as the moments that caused the doctor to take their first steps in moving abroad to practise. Triggers were sociopolitical, professional and personal, with the most common triggers across each of these areas as follows:

Sociopolitical

- Brexit referendum
- Political decisions around the NHS and responses to the junior doctors' strike
- Visa issues for them and their family

Professional

- Being headhunted, approached by a recruiter or ex-colleague
- Workplace incidents – change in management, bullying
- Coming to a career crossroads or disappointment, e.g. a break in training, finishing a phase of work, not getting a job or promotion
- The overwork, death or poor health of a colleague

Personal

- Life stages: buying a house, divorce, death of dependents, children leaving home
- Experiencing serious wellbeing issues
- Financial issues such as going into debt, or forecasting this

How are initial options of where to migrate to identified and confirmed?

For many, country choice was fixed from the start, particularly for IMG and EU doctors returning home, or to the country of their spouse. Others had a specific country, or at least a shortlist, in mind from an early stage, usually based on the perceived ease of migrating to these countries and word-of-mouth from ex-colleagues and friends. For UK-born doctors in particular, Australia and New Zealand were popular routes, with these locations perceived as having the simplest visa/work requirements and being most likely to address their present issues with practising in the UK.

What are the practical steps taken?

Many commonalities exist in doctors' journeys from the UK. Though there was variation in the exact steps taken as well as the speed and order, steps could be broadly grouped into the following stages:

- *Research*: Discussing the idea with others or doing independent research.
- *Country selection*: Either fixed from the start or involving weighing up options.
- *Job hunt*: Sourcing jobs through direct contacts/peers, recruiters, being headhunted; then attending interviews and securing a job.
- *Administration*: Confirming employer and visa requirements.

- *Regulation and education*: Medical registration paperwork or language requirements.
- *Preparing to leave*: Logistical aspects such as selling their homes in the UK, and making arrangements abroad.

Speed of the migration journey

Even though some doctors always had the idea of migration in their minds, specific trigger points encouraged them to take practical steps towards doing so. Our research highlights how the speed, order, and number of steps tended to change depending on:

- *The nature of the trigger points*: When the prompt to leave was highly emotional, the overall speed of the journey was quicker, meaning practical steps were completed at pace.
- *Nationality and migration history:* For those returning home or to a familiar country, there were often fewer steps required in the last stages of the journey, e.g. visa applications.
- *Existing networks*: This often quickened the job hunt stage of their journey, and meant several steps here were skipped, e.g. using recruiters.
- *Certainty levels*: Those who were highly certain also tended to have quicker journeys, sometimes as they had no choice, e.g. due to visa issues.

At what point in the process does the decision become more fixed?

The point at which the decision was fixed depended largely on the nature and intensity of the trigger and push/pull factors. Notably for some migrating doctors, the point at which their decision was fixed was often at the same time or very close to the trigger point – when they first considered migrating and started to take steps in their journey. This tended to be the case for situations in which the trigger was highly emotional or traumatic (for example, experiencing the death of a colleague), or when it fundamentally threatened the wellbeing of a doctor.

Otherwise, points in their journey where the decision to leave became fixed tended to focus on when they secured a job abroad or when they agreed it with family, some of whom might also need to find work. However, a decision could also be fixed purely by triggers or push and pull factors experienced, for example, not getting a job they wanted, having a positive experience working in another country or finding their career opportunities limited. While Brexit was a trigger for some, it was a decisive final factor for others.

Which push and pull factors are prominent in different parts of the process?

While many push and pull factors were also triggers, and were specific to different groups of doctors, there were a few key push factors that did not necessarily always act as triggers, but were crucial in decision-making or as a backdrop against which triggers were received and acted upon. These included overwork and work-life balance – a factor in almost all the migration decisions we heard about. These were particular issues for those with young families, but also a push factor for those without them.

Public and media attitudes towards the medical profession also formed a key backdrop to decisions to leave, expressed in some cases via unpleasant experiences with the public.

Once a decision was underway the emotional pull of a better quality of life, and the ability to lead the kind of existence that they thought was more becoming of someone of their age and skill level represented a strong pull factor. Overseas job offers sometimes came with more flexible working conditions, for example, that fit more easily around childcare. While pay was a pull for a minority, for most this was not the key driver.

Push and pull factors varied less by point in journey than they did by type of doctor (or group). They were also significantly different depending on the country to which a doctor was migrating.

After migration, pull factors around work-life balance were often strengthened, particularly in relation to the number of patients seen per day and hours worked per week. However, doctors also detailed a range of factors in which the UK was superior, not least the strength of training, opportunities to use the most up- to-date equipment and methods, the ethos of the NHS, teams and colleagues, friends and family and some aspects of UK culture.

What groups of migrating doctors were identified?

- *Burnt-out GPs:* while many doctors in our study mentioned experiencing burnout, there were some specific issues in primary care driving GPs to migrate.
- *Career-limited doctors:* international mid-career doctors who felt that they had exhausted all possible career opportunities in the UK.
- *Disheartened EU and international doctors:* doctors in their mid-career, often with young families, who recounted negative experiences at work, directly or indirectly, in relation to their identity as a foreign national living and working in the UK.
- *Disillusioned doctors:* mostly UK-trained doctors in their mid to late career who were driven to migrate due to frustrations with the health system in the UK.
- *Internationally mobile doctors:* consultants in their mid-career who had plenty of previous experience abroad, working in different countries whenever the opportunity allowed or when administrative or visa issues determined.
- *Older explorers:* older doctors who had spent most of their career working within the NHS, seeking adventure, a new professional experience or a challenge.
- *Salary seekers:* typically made up of men in their 40s who had come to a point within their career when they realised that their current salary and future salary prospects were not sufficient to sustain the quality of life they desired.
- *Young explorers:* this group was made up of early-career, UK-trained doctors who typically had travel in mind from medical school, seeking fun and adventure.

BACKGROUND TO THE RESEARCH

THE NEED FOR A SUSTAINABLE MEDICAL WORKFORCE

In light of COVID-19 and other societal changes, healthcare in the UK is being delivered in a heavily changed setting. Demand for healthcare is rising, not least due to a backlog of cases accumulated over the course of the pandemic (Willan et al., 2020) and the continuing impact of COVID-19 on the physical and mental health both of the public (DHSC, 2021) and of the medical workforce (BMA, 2020). This is against a longer-term context of growing demands on health services due to the ageing population in the UK, and what historically have been increasing expectations around healthcare (Oliver et al., 2014).

Although the number of licensed doctors rose by 14% between 2016 and 2020[1], the wider context reveals potential supply issues around growing proportions of doctors intending to reduce their working hours – 35% of doctors in 2021 (GMC, 2021b) – and leaving the profession. In 2020, the GMC found that 4% of all doctors said they had taken 'hard steps' towards leaving the profession: this figure was up to 7% in 2021, with doctors reporting rising burnout, declining job satisfaction and increasing workloads (GMC, 2021b).

Protecting the health, safety, and wellbeing of the public alongside an increasing demand for healthcare is very much linked to the GMC's core strategic theme: *developing a sustainable medical workforce*. This strategic aim is focused on the GMC working alongside partners to support the development of a diverse workforce with the right skills to meet future patient needs. The GMC recognises that fostering the talent, commitment, and diversity of doctors across the UK is crucial to addressing ongoing shortages of healthcare professionals in the UK, and that 'better recruitment and retention of doctors' is vital to meet patient needs (GMC, 2020, p. 1).

This research builds on previous work conducted on behalf of the GMC and others, with a particular emphasis on better understanding doctors' migration decisions, and encouraging those in clinical roles to stay in the UK.

EXISTING RESEARCH AND DATA AROUND MEDICAL MIGRATION

There is already great deal of research and data on medical migration. Much of the work in this area to date has focussed either on patterns of medical migration or on the reasons why doctors are leaving the UK.

Through managing the UK medical register, the GMC has an understanding of trends in the UK medical workforce migrating overseas. In 2021, almost 10,000 doctors left the UK medical workforce (GMC, 2022), and previous analysis indicates that around half of those leaving plan to move overseas (GMC, 2021b). The GMC's Barometer survey (GMC, 2021a) found that 13% of doctors say that they are likely to move to practise abroad in the next 12 months. The

[1] Figures from the GMC Data Explorer: https://data.gmc-uk.org/gmcdata/home/#/

majority indicating that this was either because they felt doctors were treated better abroad (71%) or to obtain a higher salary (53%).

Further analysis of GMC data on doctors migrating overseas (Brennan et al., 2021, p. 8) found that:

- A higher proportion of non-UK PMQ doctors leave to move overseas than UK trained doctors, especially doctors with a European Economic Area (EEA) PMQ.
- A similar proportion of male and female doctors leave to move overseas each year.
- The highest proportion of UK PMQ doctors moving overseas are under 30, whereas the highest proportion of non-UK PMQ doctors moving overseas are aged 30-39.
- Doctors who are not on the specialist register, the GP register, and are not in training are more likely to leave to move overseas than doctors on other register types.

In addition to this analysis of migration patterns, there is also a body of research looking at the drivers for medical migration out of the UK. The GMC's Drivers of International Migration report (Brennan et al., 2021) discusses the 'push' factors – those that encourage doctors to want to leave a country – and 'pull' factors – those that make other countries appear attractive. Following a systematic literature review and stakeholder interviews, the research identified the key drivers for migration out of the UK, organised into macro (global and national factors), meso (profession-led factors) and micro-level factors (personal-led factors):

- **Macro-level**: poor working conditions in the UK, attractive working conditions overseas, and employment opportunities.
- **Meso-level**: pushed/desire to leave the National Health Service (NHS), better training and development opportunities, feeling undervalued professionally, and better working conditions (e.g. more work breaks, protected annual leave).
- **Micro-level**: better quality of life, family reasons, desire for a life change, financial gain for self, the sense of migration as 'a rite of passage', and that it results in a better CV.

Similarly an exploration of the reasons why Scottish doctors choose to leave UK medicine after foundation year-2 (FY2) (Smith et al., 2018) found that factors influencing decisions were either 'structural' (countrywide and worldwide), 'organisational' (the NHS and other healthcare providers), 'occupational' (in relation to their specific role and career), 'workgroup' (relating to their relationships with colleagues) or 'personal'.

Other recent studies relevant to our work here look at the experiences of specific groups of doctors, e.g. the experiences of IMGs in the UK (Al-Haddad et al., 2022), the impact of Brexit on EEA doctors' migration decisions (Milner et al., 2021), and doctors' decisions to migrate at specific career transition points such as the end of foundation training (Smith et al., 2018).

RESEARCH AIMS AND QUESTIONS

The aim of this research is to build on this previous work by focusing in detail on doctors' 'decision-making processes' regarding international migration. It seeks to add to the pre-existing body of research by moving beyond setting out the international migration trends that are taking place and describing reasons for migration, to understand how the actual decision-making process to migrate internationally works for doctors in practice.

The research details the steps between an initial interest in migration and moving abroad. Our work also looks to understand how the associated push and pull factors around migration vary, both for different types of doctors looking to leave the UK and for the different stages in their migration journeys.

To achieve these aims, the study addresses the following research questions:

- What are the common 'trigger points' for first considering migration?
- How are initial options of where to migrate to identified and confirmed?
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- When and why are practical steps taken?
- At what point in the process does the decision become more fixed?
- Which push and pull factors are prominent in different parts of the process?

The end goal of this work is to enable organisations to identify potential opportunities for intervention in such decision-making processes (where it is ethical and appropriate to do so), in order to support the sustainability of the UK medical workforce.

METHODOLOGY

SUMMARY

Qualitative methods were utilised to obtain deeper insight and understanding of the diversity of experiences, opinions, and conceptions of doctors leaving the UK to practise medicine elsewhere. The study involved a series of depth interviews (n = 90), with fieldwork conducted between February and March 2022.

As discussed, the key objective of this research was to build on existing research in this area by exploring migration decision journeys and the practical steps and considerations at each stage of the process. As part of this research, groups (types of migrating doctors) were created following a thematic analysis of interview transcripts. These groups were based on common characteristics, contexts and factors influencing migration decisions.

It should be noted that the interviews provided a mechanism for understanding decision-making journeys, and were not intended to produce an exhaustive segmentation. However, the findings detailed here may guide future research activity, for example, quantitative testing

of journeys and groups, or contribute to the design and evaluation of interventions produced with these groups in mind. Considerations here are discussed later in this report.

DATA COLLECTION AND TOPIC GUIDE DEVELOPMENT

Semi-structured interviews were the chosen method, as they allowed time to explore individual decision-making journeys in depth. Interviews lasted around 45 minutes, and were conducted by Microsoft Teams, Zoom or telephone. Two topic guides were produced in collaboration with the GMC: one for those doctors who had already migrated and one for those who were considering a move in the future (available in Appendix B). Each was structured around a chronological timeline or personal journey to help respondent recall and to overcome the challenges of discussing migration experiences retrospectively.

These guides built on past research to ensure maximum utility of findings. A similar methodology has been used successfully in projects with comparable objectives – for example, see Sarpong and Maclean (2019) and Sveinsson (2015). Given our focus on individual migration 'journeys', an adaptation of the 'life history' interviewing method (Jessee, 2019) was used. This is an approach often used in healthcare settings (e.g. see Corbally et al., 2014), and is designed to record personal histories in a participant's own words. Life history interviewing allows researchers to "examine how local, communal, societal, and global changes affect, and are understood and responded to, as meanings are carried as well as shaped, within 'ordinary' lives" (Roberts, 2014, p. 11). This makes this approach well-suited to this complex world and building on knowledge of the macro, meso and micro-level drivers and barriers identified in previous research (Brennan et al., 2021).

Interviews allowed for a thorough exploration of doctors' memories around their decision to migrate. This 'story' began whenever the interviewee first considered the idea of migrating, for example, during medical school or training, and followed different consideration or decision points to when they finally solidified their decision (if they did migrate or had decided to do so). By individually exploring the decision-making journeys of migrating doctors in this way, space and opportunity were provided for the identification of practical steps, when and why these were taken, and when the decision to migrate became fixed. It also brought to the surface non-rational decisions, emotions, drivers, and factors which may not be socially acceptable or related to the behaviour of others. During discussions, researchers made use of screen-sharing to visually outline all of these elements, using diagrams to further aid respondent recall.

SAMPLE

A purposive sampling approach was taken, and invitations were sent to suitable participants from previous GMC studies who had opted-in to take part in future research. We contacted doctors across two participant groups:

- Those that have left UK to practise in another country
- Those that are considering leaving UK to practise in another country

An Expression of Interest form was created and sent to all contacts, in order to collect responses to screening questions, which helped achieve our identified sample.

Table 1 outlines the final sample achieved in the 90 interviews. This provides a breakdown of the sample by different migration subgroups, split by the total number of respondents who had either already migrated (based abroad) or were considering migration (based in the UK) for each subgroup. We also monitored other characteristics, including gender, place of PMQ, migration destination, home country, career stage and specialism. A full profile of respondents is available in the appendix.

Table 1: Sample by PMQ and migration location

Group	Migrated from the UK	Considering migrating from the UK	Total
1: Doctors with UK PMQ going to originating countries	4	1	**5**
2: Doctors with international PMQ going to originating countries	20	1	**21**
3: Doctors with UK PMQ going to Australia, New Zealand, Canada, Ireland or the US	13	15	**28**
4: Doctors with international PMQ going to Australia, New Zealand, Canada, Ireland or the US (not home country)	10	2	**12**
5: Doctors with UK PMQ going to non-English- speaking countries	8	3	**11**
6: Doctors with international PMQ going to non-English-speaking countries (not home country)	12	1	**13**
Total	**67**	**23**	**90**

Evidence from existing GMC research and data was used to inform and validate the ongoing design and shape of the sample: this included the Barometer survey, the Completing the Picture survey and data on doctors leaving the register. The aim of the qualitative research was not to achieve a fully representative sample, but to have a sample that was generally reflective of the types of doctors leaving to practise overseas, so as to ensure there were no significant gaps and that all types of leavers were included in the interviews.

ANALYSIS AND REPORTING

Interviews were recorded and transcribed, then pseudonymised prior to being analysed in Atlas.ti 22, a thematic coding software. An initial deductive thematic code frame was developed, with further inductive codes applied and shared by researchers through the analysis process as new themes emerged. The code frame and analysis were informed by previous research and discussions with the GMC.

Further analysis identified coherent groups based on differences in their decision-making journeys, demography, behaviours and the key push and pull factors. This facilitated the creation of 'groups' of migrating doctors – representations of different types of individuals based on a set of qualities or traits that were specific to that group. These initial groupings were reverified, refined and merged, and a final grid charting the key push and pull factors for each group was produced.

GROUPS OF MIGRATING DOCTORS – AN OVERVIEW

A key aim of this research was to explore how factors around migration vary for different types of doctors looking to leave the UK. Analysis of the interviews led to the emergence of different groups of migrating doctors, which are summarised below. More developed descriptions of each group are given later in the report, as well as a table summarising their triggers, push and pull factors, and journey characteristics.

Given the nature of the study and sample, this is not intended to represent an exhaustive segmentation, but rather to inform the development of interventions by highlighting key common characteristics, journey types, trigger points, push/pull factors and other elements which can potentially be targeted. While efforts have been made to ensure that these 'groups' are as distinct as possible in terms of their definition, decision-making here is complex and often involves a range of factors. As a result, these distinctions should not be thought of as being exact, with some overlap between groups evident.

Note that in addition to these broad groupings of migrating doctors, there were also those who left for purely personal reasons, e.g. the illness of a dependent.

Table 1: Overview of the groups of migrating doctors

Name	Brief description
Burnt-out GPs	While many doctors in our study mentioned experiencing burnout, there were some specific issues mentioned in primary care. This group therefore was comprised of GPs specifically, at various stages in their careers. They were more often women than others in our sample, and many had partners who were also doctors. Most had trained in the UK and had initially not had any intention to migrate, outside perhaps temporarily. These doctors were more likely to have negative drivers, having found working conditions in the UK system taking an increasing toll on their wellbeing. Their decision to migrate was also likely to be influenced by the political and cultural context – for example, changes to the NHS or social care system with which they disagreed with, or media and public attitudes to their profession.
Career-limited doctors	This group was made up of international mid-career doctors with few personal or family ties to the UK and its systems. They were highly ambitious and career motivated, but felt as if they had exhausted all possible career opportunities in the UK, with moving away now being the only logical step for them. Demographically, these doctors originated from, and were often returning to India and Europe, and had achieved their PMQ from the late 1990's onwards. This group were not particularly dissatisfied with the NHS, besides issues with the limited scope for progression, compared with some groups.
Disheartened EU and international doctors	This group consisted of consultants and SAS doctors in mid-career, often with young families, spanning a wide range of UK locations prior to migrating and migration destinations. They recounted negative experiences at work, directly or indirectly, in relation to their identity as a foreign national living and working in the UK – with issues said to have increased post-Brexit.
Disillusioned doctors	Mostly UK-trained GPs and consultants in mid to late career, the journeys of this group were characterised by frustration with the health service in the UK and the way in which it was developing. While their workloads were high, they felt able to cope, however, they were choosing not to continue within a system they felt was heading in the wrong direction and not capable of changing.
Internationally mobile doctors	This group were often highly mobile consultants in mid-career who had plenty of previous experience abroad, working in different countries whenever the opportunity allowed. They were generally in GP or early consultant roles. It wasn't dissatisfaction that led them to move, instead a zest for trying something new and a desire to take up any new

	opportunities that arose. Their chosen destinations were often determined by ease of visa and administrative process, although Canada, Australia and Europe were key destinations. In some cases, they were moving back to a country where they had nationality in order to make administration easier. The migration journey we discussed with them was generally not the first, nor was it sometimes intended to be the last.
Older explorers	This group is made up of older (late 50s upwards), mainly UK-born doctors or doctors born elsewhere who had spent most of their career working within the NHS. Their motivations were wanting a change or an adventure, a new professional experience or challenge. Their chosen destinations were varied depending on their previous experiences and contacts, though Australia was a key destination. The migration was generally planned to be short-term and many in this group planned to retire in the UK. Some had even kept their GMC registration.
Salary seekers	This group was typically made up of men in their 40's who come to a point within their career when they realise that their current salary and future salary prospects are not sufficient to sustain the quality of life they desire. They tended to be consultants in secondary care with an accumulating feeling that the demands of their job were too high in relation to their remuneration. Many in this group were based in London prior to considering migration, partially driven to migrate by high property prices. Some had migrated to places such as the UAE or Singapore, which had advantageous tax systems.
Young explorers	This group is made up of early-career UK-born and trained doctors who typically always had the idea of travel in mind from medical school, seeking fun and adventure. They grasped the opportunity once they approached a natural crossroads in their careers, which was typically after their foundation or core training. Chosen destinations tended to be Australia and New Zealand – accessible for UK trainees and well-trodden paths peers had taken. Although this group primarily moved short-term to experience life abroad, after their expectations were exceeded and they realised the differences between working in the UK and working in countries such as Australia or New Zealand, they typically ended up staying longer than planned or decided to migrate again, either temporarily or permanently.

WHAT ARE THE COMMON 'TRIGGER POINTS' THAT START MIGRATION JOURNEYS?

This research identified the 'key trigger moments' – these being defined as the moments that caused the doctor to take their first steps in moving abroad to practise.

It should be recognised that, for some doctors, migrating abroad had always been a back-of-mind idea, perhaps due to past experiences, or observing the career journeys of their peers. Many doctors often spoke of an accumulation of factors that influenced their decision, which might push or pull them in one direction or another, and a small number could not identify a particular trigger outside these longer-term influences.

Within our analysis, the actual '*trigger point*' is defined solely as the moment when the idea became more solidified, a moment that prompted doctors to take action and practical steps in their journey, perhaps by researching opportunities or telling their peers. What might be a trigger point for one doctor might be a push factor, but not a trigger, for another.

Trigger points could be broken down into three broad categories that map onto the macro, meso and micro-level drivers and barriers identified in previous work in this area (such as Brennan et al., 2021).

1. **Sociopolitical:** Political, social and cultural triggers associated with living in the UK and with their feelings about working as an NHS doctor in this context.
2. **Professional:** Triggers associated with career progression, future professional aspirations, or workplace experiences.
3. **Personal:** Triggers associated with their personal life aspirations, needs or family commitments. This also means personal triggers associated with living a certain quality of life, which often stemmed from professional career factors.

This trigger could sometimes be a highly emotional event in a doctor's life. They also often acted to symbolise more general areas of dissatisfaction that might have been ongoing for some time. While not necessarily any more important than the nature of the push or pull factors preceding the trigger, the nature and intensity of it, as well as the background to it, were important in determining the manner and speed with which they left the UK as well as the likelihood of their return.

We outline key trigger points below, pointing out those that are particularly common in the identified 'groups' or types of migrating doctors. It should be noted that it is not the aim of this research to attempt to quantify the relative strength of these triggers across the whole population of those either migrating or considering migration. Further quantitative work would be required to achieve this as outlined in the conclusion.

SOCIOPOLITICAL TRIGGER POINTS

Some doctors experienced sociopolitical triggers that ultimately meant living in the UK was not as desirable to them. While these triggers were around broad national issues, they often had a highly personal resonance as well as professional impact.

THE BREXIT REFERENDUM

As reported elsewhere in relation to EU-born doctors (Brennan et al., 2021; Milner et al., 2021), the referendum acted as a trigger for medical migration. This was the case for UK-born doctors as well as for EU and international doctors. Respondents in this study did not discuss

Brexit as a potential opportunity to retain more UK doctors or attract more overseas doctors, but this was suggested as possible by some interviewees in the research by Brennan et al. (2021).

For those born outside the UK, the referendum sometimes had the impact of making them feel that they were no longer welcomed or wanted by the UK public. In some cases, this had a profound impact on their sense of identity and this had triggered the decision to leave, as explained by this respondent, originally from Spain:

"It was the day after Brexit that I thought I should leave … It was the first time I thought I never realised I'm a foreigner. Up until that day I never felt as a foreigner or immigrant. I felt it was my home and that was it. There were no complications … I thought it would be a landslide win for staying in the EU, and when I realised oh my goodness, no, right I'm not from here, this is not my country, and I'm a foreigner, and at the beginning it was very upsetting but then I realised it opened some doors."

Consultant, Scotland -> Ireland, Woman, 41-50

For UK-born doctors, the referendum was more likely to have acted as a trigger by making them feel that the culture they were living in was no longer fully in line with their values.

As well as these emotional impacts, in some cases, the referendum was linked to practical changes – for example, uncertainty around visas for them or a spouse, or the potential for more limited access to what was seen as critical EU research funding. Concerns around uncertainty here were also raised by interviewees in the research study by Brennan et al. (2021).

SPECIFIC POLITICAL DECISIONS INVOLVING THE NHS

A trigger for both UK-born and international doctors, specific political decisions prompted some to consider their options. Doctors discussed feeling highly antagonised at what they perceived to be the unfair treatment of doctors, citing the Junior Doctor strikes and changes to doctors' contracts as some of the key events that had brought their anger and frustration to the fore. This reflects the findings from a previous GMC report (Brennan et al., 2021), in which concerns around NHS doctor contracts and the perceptions of doctor employment being low on policy-makers' list of priorities were identified as a driver of doctors leaving the UK to work abroad. Here, one SAS doctor originally from the Middle East, who migrated short-term to Australia and returned to the UK, discussed immediately wanting to migrate again:

"I came back. I was not applying to go back to Australia. However, on my day two they changed the new doctors' contracts. It was Jeremy Hunt, and the new doctor contract working Monday to Saturday as a normal week, and 7am to 10pm as normal hours without being overtime, and you can work every Saturday in acute care without it counting as overtime or an incentive. I felt that was just [the] wrong thing to do, and that was the final decision-maker."

SAS doctor, England -> Australia, Man, 41-50

Others mentioned a decision triggered by seeing increasing levels of private healthcare in their healthcare settings, as a result of political decisions being taken, with which they did not agree.

Seeing what they saw as systemic problems that they could not change was particularly an issue for the 'disillusioned doctors' and 'career-limited' groups.

EVENTS RELATING TO VISA ISSUES AND POLICIES AROUND IMMIGRATION

International doctors, particularly those from outside the EEA, discussed various events related to their visas and immigration status that meant working in the UK was no longer feasible or became overly complex. Visa issues as well as complex and changing UK immigration requirements have been identified as challenges for overseas doctors in previous studies (Brennan et al., 2021; Jalal et al., 2019). Examples included respondents who felt that they might be unable to get a new position before their visa ran out; one that was on a 6-month fixed-term contract who had experienced difficulties in transferring their visa sponsorship from one employer to another; another who found the visa system too complex to navigate in addition to the demands of their job; and another who found it too costly and felt they would have had to go into debt to cover these costs. Family visas were also a trigger as well as a push and pull factor – for example, one Indian-trained doctor was frustrated at not being able to bring his elderly mother with him.

For one respondent, there appeared to be mismatches here between visa requirements and doctors' terms of employment:

"Yes. I think that the way that the system is designed in the UK is designed to force you to stay with a single employer and that is probably because the tier 2 visa is of course not designed just to be for medical trainees or doctors or anything like that. The tier 2 visa is a visa for everyone, and so I think that the government wants to keep people at their same job or keep people stuck to an employer and there are logistics behind that and reasons behind that, I am sure. Specifically, when it comes to doctors and more specifically doctors in training with fixed-term contracts, this doesn't really work."

Specialty trainee, England -> Australia, Man, 31-40

For our internationally mobile doctors in particular, it was seen as administratively simpler and less costly to work in another country than to deal with some of these issues.

PROFESSIONAL TRIGGER POINTS

RECEIVING INFORMATION ABOUT OTHER POSITIONS

Often against a backdrop of pre-existing dissatisfaction or difficulties, being sent information about opportunities elsewhere could act as a trigger. Respondents reported being sent these

by specialist recruiters, peers who were working elsewhere or contacts in other countries they had met during previous time working overseas.

Sometimes the opportunities presented to them seemed too good to pass up, due to higher salaries or good benefit packages being offered.

"Over time I gradually started feeling that I couldn't see myself there in 10, 15 or 20 years … So what happened was I was approached, just one of those things, I was a little bit unsettled, then these people come and say 'Do you want to get paid twice as much to work for half the time' and I thought 'Well why not'."

Consultant, Scotland -> Australia, Man, 41-50

Being approached by recruiters was particularly common amongst our 'internationally mobile' group and others who trained overseas, who commonly had pre-existing relationships from past migration or work experiences. Doctors earlier in their career also sometimes had relationships from earlier experiences of working outside the UK:

"I was going to take at least one year out after foundation training to get some time abroad and during that … I had made friends with quite a few different people in different parts of the healthcare industry, for example, some of the directors of regional hospitals and the ministry of public health. My role there allowed me to network with a lot of different people in different positions and there was a prospect they were offering having a job there and the benefits that the package includes. Having worked there I benefitted from a lot of those benefits and I know that this is what the life would be like."

Core trainee, England -> Singapore, Man, 31-40

DISAPPOINTING CAREER PROGRESSION INCIDENTS

This was a particular problem for our 'career-limited' respondents. Specific incidents included applying for, but not getting, a particular job role that represented a step up from their current position and being passed up for promotion.

"In 2014, I was offered a job, I had an interview, and I didn't get the job. I felt frustrated, and that was the point where the decision was sealed. Part of the frustration of losing this opportunity of a job made me decide to leave. I really wanted a job. It was the last drop in the bucket."

Consultant, England -> Germany, Man, 41-50

There were specific issues here for a number of international doctors. The study by Brennan et al. (2021) found that doctors with a non-UK PMQ found it difficult to progress within the UK. Our study explored this issue further. Some of the international doctors discussed the difficulties of entering the specialist or GP register in the UK due to them having obtained qualifications outside of the UK, which led to limited career prospects here. IMG doctors working in SAS roles in particular discussed struggling to find positions compatible with their qualifications, which they felt were not sufficiently recognised:

"No job progression … if your training hasn't been qualified through Europe or the UK, you find it very difficult to be able to register with the GMC on a sub-specialist register, and if you can't get onto that register, you're stuck in a SAS role, so a middle grade staff grade role, and you aren't able to move from there, so there's no job progression."

SAS doctor, England -> South Africa, Man, 41-50

For 'older explorers', one version of this trigger was that a new manager was brought in to oversee their team who did not appear to appreciate what their expertise or experience could bring. This suggests poor line management experiences can act as triggers. Brennan et al. (2021) suggested that both feeling undervalued professionally and sub-par workplace management can act as barriers to retention of doctors in the UK.

WELLBEING CRISES ARISING FROM WORKLOAD

Having an overwhelming amount of work in their roles prompted respondents to feel as though they had no choice but to make a change. GPs especially discussed dealing with high levels of patient demand and high expectations, meaning they reached a point where they didn't feel they could sustain working in that way. This issue has been highlighted in other literature, with Hewett (2022) pointing out that workload and stress issues should be treated as systemic issues and not personal resilience problems, and (Balendran et al., 2021) describing the risk of burnout as high among doctors overall globally, but dependent on age and specialisation. This is particularly relevant, as previous research identified poor working conditions, and the perception of a better work-life balance in other countries, as primary drivers of migration out of the UK (Brennan et al., 2021). There were sometimes also peaks of stress with new responsibilities, such as becoming a partner in a practice:

"I think we were beginning to feel that, certainly from my perspective in General Practice, things were tough. They were much tougher than they had been. I think at that point as well there were GP strikes happening … again, the government didn't do anything, and the level of discontent was becoming higher and higher. I then got my first partnership post as well, which yeah, that was interesting … well I just made a bad choice … but anyway, it didn't work out. And yeah, it was just getting really, really hard, the hours, the pressure, patient demand, the expectations. And again, we were trying to – secondary care, we just couldn't get people seen, and I think it was just becoming more and more frustrating to bounce back, and yeah, just the lack of – it just seemed to be fracturing."

GP, Scotland -> New Zealand, Woman, 41-50

MISSING MAJOR LIFE EVENTS

As well as being signalled by mental health or broader health issues, an unworkable workload could also be signalled to a doctor by them missing major life events with family and friends, such as weddings or holidays.

The sacrifices that doctors made in this respect were sometimes also brought into focus by particularly intense periods of work:

"I'd had several weeks where I'd been working ten days straight. I hadn't seen my family. We had a son in 2013, and I saw very little of the first years of his life. I mean I spent most of my time at work. I even joked with my secretary that I was going to change my home address to work."

Consultant, England -> Qatar, Man, 41-50

CAREERS CROSSROADS

Reaching a key career milestone could trigger a decision to migrate. For young doctors, this was often the gap between one training stage and another, either at the end of foundation or core training. For older doctors, it might be the point at which a major professional ambition or goal had been achieved, which led them to seek new challenges.

Some older, more experienced, consultants discussed the desire for new adventures with their spouse prior to retirement. Trainees too discussed the desire to try something new before committing to their next stage of medical training, often when they reached a natural crossroads at the end of their foundation or core training. To some degree, these decisions are natural, and it could be argued even beneficial, to ensure the medical workforce gains international experience. However, these trigger moments often coexisted with underlying push factors. Once a career stage was finished, some doctors were unable to justify continuing working in the same conditions or were unlikely to come back once they had tasted life working elsewhere.

EXPOSURE TO THE NEGATIVE EXPERIENCES OF MORE SENIOR COLLEAGUES

A number of doctors we spoke to were tiggered by talking to more senior colleagues and hearing about their experiences of working in the NHS throughout their careers.

"Mainly the experiences of people that you met, more senior people who were all unhappy with the conditions and the work-life balance and the pay."

Core trainee, England -> Australia, Man, 26-31

At the most extreme end of this trigger scale, a number of our respondents, particularly GPs, mentioned quite **traumatic experiences around the death or serious illness of a colleague**, which they associated strongly with their overwork.

NEGATIVE INCIDENTS IN THE WORKPLACE

For some, poor experiences in their workplace provided the nudge for them to consider making a change and migrating abroad. These included:

- A bullying incident at work.
- Not feeling respected or supported by line managers or supervisors.
- Experiences with favouritism in the workplace.

These experiences were somewhat more common in our 'disheartened EU and international doctors' group. Other literature points to discrimination challenges faced by overseas doctors in the UK (Brennan et al., 2021; (Jalal et al., 2019).

One respondent also reported smaller events that appeared to have a highly symbolic value, such as receiving several parking fines for parking at the hospital where they worked.

Interestingly, although increasingly negative experiences with patients were mentioned as a push factor by some respondents, as an element of a wider culture of under-appreciation of healthcare professionals that contributed to many doctors feeling demoralised (Mahase, 2021), this was not mentioned as a specific trigger. Negative experiences with colleagues appeared to be far more impactful as a prompt to leaving the UK, as were experiences where they felt unsupported by their colleagues, institution or the GMC when dealing with complaints and abuse from the public.

BEING SUBJECT TO CLOSE PROFESSIONAL SCRUTINY

Several respondents, particularly our 'burnt-out GPs', had been through recent experiences in which they were placed under intense professional scrutiny – these could include a CQC inspection of their GP practice and being under investigation by the GMC. These incidents could exacerbate other push factors, such as being discriminated against or feeling undervalued, and were likely to affect some groups of doctors more than others. This reflects "the likelihood of a non-UK graduate being referred for malpractice is higher than that of the UK counterpart and white practitioners qualified in the UK are at lower risk of exclusion" (Jalal et al. 2019).

In our interviews, these stressful situations were said to be the '*straw that broke the camel's back*' – the final factor that had made them make the decision to move. This could be the case regardless of the outcome of the inspection or investigation.

PERSONAL TRIGGER POINTS

Existing research identified a host of more personal factors drivers of doctors' decisions to leave UK practice, including: fulfilment, quality of life considerations, family motivations, as well as the desire for a life change (Brennan et al., 2021). Our research provides additional insight here, by showing how personal trigger points were often linked to life-stage transitions.

WANTING TO BUY A HOUSE

This was a key life stage change that appeared to initiate migration journeys. Respondents talked of high housing costs in relation to salaries in the UK, as in the following example of a consultant from our 'salary-seeker' group, who trained in Syria:

"The other reasons are financial. Even though we are both professional, well-paid people, my wife and I, for some reason we couldn't get on the property ladder, we couldn't buy a house, we felt that we were struggling financially, and we thought about starting somewhere else."

Consultant, England -> Germany, Man, 41-50

FACING FINANCIAL ISSUES

For some respondents, particularly our 'salary seekers', a revaluation of their situation had arisen from a discovery that they were living beyond their means. A few respondents felt the salary levels in the UK did not allow them the standard of living they hoped for without going into debt, therefore they sought better remuneration abroad. For these doctors, hearing about the higher salary of a peer working abroad could also be a trigger.

TRANSITION TO THE NEXT STAGE OF LIFE

Our 'older explorer' group in particular was one for whom life stage triggers were key – in particular, older children leaving home, or the death of a family member which left them free of previous caring responsibilities and more able to move. Conversely, other doctors with families earlier in their career mentioned a realisation that their children would not be so easy to move as they became older.

MEETING FAMILY OBLIGATIONS

For some international doctors, being closer to their country of origin was sometimes necessary for personal reasons, for example, the illness of a loved one.

WHAT ARE THE PUSH AND PULL FACTORS THAT INFLUENCE THE DECISION TO MIGRATE?

This research provided an opportunity to explore the push and pull factors, defined here as factors that influenced the decision about whether or not to migrate and where to migrate to.

As already discussed, there are overlaps between these factors and the triggers for migration journeys. A trigger for one doctor might be a push or pull factor for another and vice versa. Often triggers were specific events that acted to crystallise a push or pull factor to the point that a doctor felt compelled to finally act on it. The distinction between the trigger point and a push factor that we make in this report allows us to highlight the situations where push factors become active catalysts of migration decisions.

It was also notable that, within the different groups of migrating doctors identified in the research, some were more driven by push factors and others by pull factors. For example, our 'young explorer' group was largely driven by a positive desire to travel and explore the world. By contrast, our group of 'burnt-out GPs' was driven almost entirely by push factors. They often wanted to continue working in the UK, but just felt unable to continue due to burnout and stress.

Overall, the push and pull factors highlighted throughout this research closely parallel those in the GMC Drivers of International Migration report by Brennan et al. (2021), at the macro, meso and micro levels. An overview is shown in the table below.

Table 2: Overview of key push and pull factors in this research

Broad type of factor	Push factors encouraging doctors to leave the UK	Pull factors attracting doctors to other countries
Sociopolitical: Wider, political and often country-specific factors that were out of doctors' hands	• Brexit • High cost of living • Visa issues • General political landscape	• Better standards of living • Ease of professional registration • Favourable immigration policies
Professional: Factors related to doctors' current roles, career progression or working environments	• Dissatisfaction with working in the NHS • Experiences of heavy workloads and burnout • Poor experiences in training or other issues related to this • Poor experiences in the workplace • Limited career prospects • Feeling undervalued or under-supported in their role • Challenges with entering the specialist register • Poor work-life balance	• Better career development or training opportunities • Better salary • Better work-life balance and flexibility in their role • Attractive working conditions • Headhunted with opportunities
Personal: Elements related to personal aspirations or family commitments	• Absence of family	• Family commitments/ responsibilities • Better quality of life • Experience of working in the country • Peer recommendations • Returning home

KEY UNDERLYING PUSH FACTORS

Many of the factors listed above have already been discussed as triggers. However, there were a few key push factors that didn't seem to act always as triggers, but were crucial in decision-making or as a backdrop against which triggers were received and acted upon. These are outlined below.

OVERWORK AND WORK-LIFE BALANCE

As we have already discussed, events relating to work-life balance were a key trigger for some, particularly our 'burnt-out GPs'. In addition, this issue was an underlying factor in almost all the migration decisions we heard about. This also related to compensation, with a number of doctors having worked out their 'true hourly rate' given overtime worked but not paid for and found it very much lacking.

Despite very long hours of work being a key factor in decisions to leave, it was very unusual for the doctors we interviewed to have asked for a reduction in their hours or request to move to a part-time position. There were two main reasons given for this:

- Even going part-time was seen to still involve long hours in the UK.
- There was seen to be a lack of flexibility in the UK system, making it difficult to reduce working hours, particularly without a 'reason' such as a young child or an illness.

Although this was not mentioned explicitly by respondents, it was apparent that none had lost their desire for a successful career. It may be that this was another reason for seeking work abroad rather than reducing their hours in the UK.

Issues around over-work also strayed onto the difficulties of taking holidays or having time off in general.

"When I was in the NHS, they wouldn't give me a day off for my grandma's funeral, whereas here they gave me two weeks off so I could get back. It's a huge difference. In the NHS, I was told if you want to take that day off, you find someone to swap with. We're not giving it you off. Here they were bending over backwards to make my roster work and they cared that you had a life outside."

Foundation Trainee, England-> Australia, Woman, 31-40

These were particular issues for those with young families, but also a push factor for those without them. We often heard about only fleeting moments spent with partners and children due to constantly working overtime and the difficulties of taking time off to go on holiday. Some felt this was an issue with working culture in the UK more broadly:

"The quality of work-life balance was one thing, and that has got nothing to do with the NHS, in many ways that is the UK versus other countries' lifestyles..."

SAS doctor, England -> India, Woman, 51-60

Consistent with West and Coia (2019), a lack of autonomy was demotivating, for example, around the number of patients seen per day. This linked to West and Coia's other stated core need of 'competence', particularly when doctors were unable to meet the high standards that they had set for themselves around patient care.

ATTITUDES TOWARDS THE MEDICAL PROFESSION

Many interviewees felt that society no longer valued the contribution made by doctors and that their efforts were not appreciated by the public. They felt this expressed in their day-to-day interactions with patients.

"I'd say people have lost respect for the NHS and for doctors. I hardly ever get a thank you card or a chocolate box. I only get complaint letters. It's become uncomfortable. You feel like everybody is against you or ready to complain rather than cooperate..."

Consultant, Scotland -> Ireland, Woman, 41-50

These public attitudes were thought by some to be fuelled by the media and by politicians. This research confirmed the demoralising impact it had on primary care practitioners especially, as discussed by Mahase (2021). Salary levels, particularly when calculated at an hourly rate without overtime pay, also contributed to doctors' sense that they were undervalued by UK society.

International doctors reported experiencing more demonstrations of this lack of respect than their UK-trained counterparts. Given the long hours and sacrifices made for public health as well as the years of training they had amassed, many of these doctors felt that they deserved higher status and recognition.

KEY UNDERLYING PULL FACTORS

FLEXIBILITY, PAY AND WORK-LIFE BALANCE

While a lack of any one of these factors was problematic for many respondents, the pull of a life in a different country where they felt that all three would be addressed was highly alluring. Participants spoke of these issues as being interlinked. The emotional pull of a better quality of life, both materially and emotionally, as well as the ability to lead the kind of existence that they thought was more becoming of someone of their age and skill level, represented a strong pull factor and overseas job offers sometimes came with more flexible working conditions, for example, that fitted more easily around childcare.

There were many cases in which respondents mentioned being able to access more flexible working arrangements, be this part-time working, or even just days off to deal with life administration. This also applied to training arrangements overseas:

"Absolutely. I can work part-time here, and that was overriding. In the UK, the training structure is so inflexible and it's so difficult to work less than full-time. You have to prove how you're going to spend your time. You have to be a parent. You have to be a carer."

Foundation Trainee, England -> Germany, Woman, 31-40

In addition, what was described as the standard working week in the UK of 48 hours was not equivalent to what was expected elsewhere. When this was married with pay that was equivalent or in some cases more, the pull of working overseas became very powerful.

CAREER DEVELOPMENT

As already discussed, particularly for some international doctors having issues around lack of recognition for their previous experience, or feeling limited in their careers for other reasons, the promise of being able to develop their careers without this limitation was a key pull factor. For some other consultants, the ability to teach at higher education institutions, or carry out clinical academic research work, was also an important benefit of having migrated. The ability to do this may not have been a pull factor as such, with them becoming aware of the possibility only after having started practising overseas, but it did meet their wider needs

of wanting to progress in their careers and feel more valued by others, making them less likely to return.

PUSH AND PULL FACTORS RELATING TO SPECIFIC COUNTRIES

Many pull factors were country-specific and respondents expressed a number of pros and cons of each destination. We heard how these experiences were seldom unexpected – in some cases because doctors were going back to countries they had practised or trained in, as citizens or otherwise – but also because of individual research, speaking to peers and recruiter preparation pre-migration.

One area where participants were perhaps a little less well prepared was around cultural 'fit' in the workplace – particularly where systems were very different to the NHS. This is important as perceptions around cultural compatibility with the destination country can act as barriers, or inhibitors, to migration (Brennan et al., 2021). But it is also worth noting, for example, that work culture issues are also faced by overseas doctors coming to the UK (Jalal et al. 2019).

Among our interviewees, cultural differences largely presented themselves in the different kinds of hierarchical structures and levels of management within hospitals, and how these translated into their own responsibilities. It also presented new issues, for example, with rural Australian culture and society being seen as less open and tolerant than the UK.

Table 3 summarises participants' positive and negative experiences and attitudes to living and working in different destination countries. In most cases, their experience of working overseas exceeded their initial expectations. Key areas in which the UK appears less competitive are around working hours, pay and work/life balance.

The findings presented in this table are noteworthy in that they represent the lived experiences of individuals who have migrated to the countries in question, but as they are based on a small number of interviews, they are not necessarily indicative or typical of the wider population. It should be noted that exploration of this area was not a key research objective, and subsequent research may elucidate further detail here.

Table 3: Respondents' experiences practising in other countries

Country	Positive experiences	Negative experiences
Australia	• Better pay • More autonomy • Less bureaucracy and more time to spend on clinical practice • Ability to focus solely on private practice • No requirement to take extra exams for UK doctors	• Need for expats is largely in less desirable locations • Smaller, more rural and less well-equipped hospitals with lower standards • Burdensome visa system • Difficulties with registration, qualifications and regulatory

	• No language barrier • Ability to focus on more highly skilled tasks, e.g. junior registrars are able to cut out skin cancers, which is unheard of in the UK	paperwork for non-citizens, from countries other than the UK • Less open and tolerant society in some places
New Zealand	• Less onerous immigration/ visa system than Australia • A higher likelihood of getting into a good hospital in an urban centre • Good for those looking to retire in the short term • A stronger focus on training	• Pay not as high as Australia • Still the chance of moving to a quiet, rural location • Can feel culturally restricting • Difficult to meet academic/scientific needs • Difficult to find a suitable job for partners in the same region
Qatar	• Said to be better for families than Abu Dhabi/Dubai • Recruiters/state highly supportive of new emigrees • Improved work-life balance • 40 hour per week contract, which is never exceeded • High levels of pay • New, highly modern and technology centred institutions • The chance to work with highly skilled experts from all over the world • Diverse case loads	• Pronounced cultural differences • A lack of job security • Differences in employment law – anecdotes about hospitals simply stopping paying staff to force them out • Modern systems are very different to those within the NHS
UAE	• Feel highly supported and valued by the state and employer • Fairly easy to move there with a firm job offer and the right paperwork	• Some concern with a low standard of nursing
Singapore	• Pay much higher than the UK • A highly valued occupation by the public and state, leading to better working conditions • Domestic government, with significant incentives offered by recruiters, for example, with help in getting settled, finding schools for children, providing insurance and even financial incentives for newlyweds • Welcoming and safe culture and lifestyle	• Promotions 'internally prioritised' and less open to foreign qualified doctors • Expensive • Unable to get a job, training or other funding for some specialist areas domestically • Based on the US system, with constant formal training, which some felt could be draining

	• Location within Asia allowing for travel and secondments in less affluent countries • Recognition of UK medical qualifications • More flexibility in terms of taking leave • Academic opportunities, including the opportunity to contribute to high-level meetings, e.g. with the Ministry of Public Health and the WHO • Small and easy to get around, easy to live close to the hospital	
Canada	• Similar public healthcare system to the NHS • High wages	• Difficult immigration and exam requirements • Small job pool, especially in more desirable areas and cities
US	• Cheaper visa system than the UK • High wages • Opportunities to work in more specialist areas, or with more advanced/ cutting-edge procedures, e.g. within transplantation • Faster progression and opportunities within clinical academia • English-speaking • Many taking this route had already practised there • Limits on the number of patients that can be seen in one day	• Extremely difficult immigration/ visa system, especially for those from the Middle East • Large differences by state/ region, with some felt to be more suitable than others; limited opportunities to move around once migrated • Strong local competition for jobs • Litigious culture, mistakes could cost a career • Cultural differences in the healthcare system make it somewhat difficult to 'bed in' • Public system described as 'third world'
Cyprus	• Equivalent pay to the UK, but with an easier, less intense lifestyle	• Lower standards and more basic procedures • Less opportunity to become skilled in modern technology • Requirement to be highly personally motivated and look towards international societies and meetings in order to remain current
Germany	• Higher wages, easier to get on the property ladder	• Fewer training opportunities

	• Met the needs of EU citizens who felt uncomfortable in a post-Brexit Britain • A sense that colleagues are more supportive and friendly, although it is easy to move hospitals if not • Rare to work more than contracted hours	• Less up-to-date techniques practised in some cases • More hierarchical, with clinical staff also expected to shoulder management responsibilities
India	• As many or more training opportunities and the ability to gain a wider skill set and breadth of clinical knowledge • Felt valued, for example, by being called to lead teams and institutions • No shortage of staff	• Very different health system that requires time to understand and fit into successfully • Large cultural differences, in terms of infrastructure, patient care and support teams • Sense that pandemic experiences and reaction have been different to those in the UK • Wide variety of hospitals and clinics, some of which are less well equipped than a similar NHS facility • Some more junior staff are less well trained than others, requiring training and management • Indian law does not allow dual citizenship • Options limited in some specialties, e.g. psychiatry

WHAT ARE THE PRACTICAL STEPS IN THE DECISION-MAKING JOURNEY?

COMMON STEPS

Using the life history interviewing technique, as highlighted in the methodology section, respondents were asked to describe their decision-making and migration journey, from when they first began considering a move, to when they then migrated. Those who were currently in the process of considering migration were asked to describe steps they had taken so far, and those they anticipated taking in future.

As would be expected, many commonalities exist in doctors' journeys from the UK. Table 3 shows the **common steps** typically taken by migrating doctors. As is later demonstrated, the speed, order and number of these steps tended to change based on a range of factors, including trigger points, demographics, existing networks and certainty levels throughout the journey.

The **steps in the journey have been grouped into stages** as shown in the first column. The second column demonstrates the steps typically undertaken by the majority of respondents regardless of their reasons for leaving. The third column lists the steps taken by fewer respondents. For example, if doctors were hoping to migrate to countries such as the US or Canada and were not nationals of these countries, they often had to take additional exams to demonstrate their knowledge and skills (as seen in the 'regulation and education' stage).

Table 4: Practical steps in the decision-making journey

Stage of journey	Steps that all tended to take	Steps that only some tended to take
Research	• Discuss the idea with family or friends • Discuss the idea with expats	• Explore options online/research opportunities • Explore other options in the UK
Country selection	• Discuss options with family or friends • Weigh up requirements	• Visit the country
Job hunt	• Apply for jobs • Attend interviews • Secure the job	• Recruiters reach out, i.e. headhunted • Contact recruiters directly • Reach out to existing contacts
Administration	• Hand in notice at current job	• Confirm requirements with new employer, e.g. some may need visas for themselves and family members, paperwork
Regulation and education	• Share paperwork/proof of qualifications • Obtain GMC certificate of good standing	• Complete additional required exams • Learn language or complete language checks
Preparing to leave	• Organise accommodation abroad • Organise when to move, e.g. book tickets	• Sell/rent house if homeowner • Arrange requirements for children, e.g. school places • Coordinate arrangements with partner (securing a second job abroad)

STAGE: RESEARCH

This stage involved doctors exploring their migration options and could often be combined with country selection. While most examined options online, particularly looking at potential jobs, exploring systems and requirements abroad, often it was discussions with expats or current colleagues who had previously worked abroad that helped consolidate their interest in migration, and in migrating to particular countries. These stories were regularly the most

powerful, tending to highlight the key benefits of moving abroad in relation to their own experience of working for the NHS.

International Migrating Graduates (IMGs) working as SAS doctors or on short-term contracts in the UK were most likely to be searching for additional options in the UK, in a bid to stay. Unfortunately, visa issues/lack of visa, or what they felt were inadequate opportunities to join the specialty register or get help with visas in order to secure a new post, meant that they generally felt pushed out, and, as a result, while they tried to extend their journey, it was often shortened in reality. Here some felt that they were less in control of their own journeys.

"My colleagues joined the [specialist] training and I saw them moving forwards. They were getting consultant posts and here I was stuck. I couldn't move on. I couldn't get onto the specialist register."

SAS, England -> South Africa, Man, 41-50

STAGE: COUNTRY SELECTION

For many respondents, the country choice was fixed from the start. This was particularly the case for IMG and EU doctors returning home, or to the country of their spouse. For UK doctors, and international doctors not returning home, a specific country or at least a shortlist was typically fixed from the start. This was often based on the perceived ease of migrating to these countries and word-of-mouth from ex-colleagues and friends who had previously worked abroad.

As discussed earlier, for UK-born doctors in particular, Australia and New Zealand were popular routes, with the simplest visa/work requirements, alongside not requiring any additional language qualifications, like non-English-speaking countries. While the sample included only a small number of respondents migrating to the US, it was sometimes cited as an option that had been considered but discounted due to the additional professional exams that would be required. It was notable that those with families had additional considerations here around the ease of obtaining visas for other members of their family.

Considerations around country choice included whether they would be able to practise without having to sit additional exams and doctors took care to avoid places where they would be unable to practise at the same level.

STAGE: JOB HUNT

With the exception of a few respondents, leaving quickly for personal reasons, most respondents successfully secured a job in their destination country before migrating. This stage differed for many, dependent on whether they:

- Contacted prospective employers directly (often when they had personal contacts there).

- Applied individually using websites.
- Used a recruiter.

Some of those using a recruiter described the usefulness of this part of the process. Not only did the recruiter help to secure them a job (including Health Match BC, Global Medics and Medex), they were also useful in preparing the candidate for what they would need, in some cases directly helping them to produce the paperwork they needed.

"I remember one of my friends and colleagues mentioned he had been recommended an agency to arrange his travel and recruitment to a position in New Zealand, and he gave me their details. Within a week, I'd had my meeting with them and was processing paperwork."

Core trainee, Wales -> Australia, Woman, 31-40

Alongside considerations related to country choice, doctors were also taking into account salary, and for consultants and specialty doctors they were seeking interesting opportunities to help them develop in their fields. Consideration was also given to location of specific opportunities within a country, for example, thinking about whether they were prepared to work in some of the more remote areas of Australia where vacancies were more plentiful.

STAGE: ADMINISTRATION

Most likely to hold up the process, and to cause some anxiety and frustration for some doctors, was the administration, whether it was the securing of visas for themselves and family, or getting the professional paperwork arranged and finalised. This stress was also coupled with the expense of securing these visas, which could be very costly for some.

"Then once you've got the job offer, which can happen relatively quickly, actually, it's a lot of trying to sort the administrative side of things, so making sure that you get registered with the Australian Medical Council. To do that, you need a lot of formal identification notarised. You need to get an appointment with a solicitor and notarised bank statements, IDs, passports. You also need to get Fitness-to-Work police check on this side, which depending on which health board you're working in, can be one of two different types, so you probably need to get two different police checks. And there's a big list of all administrative stuff that you need to get signed off that takes months and months and months, because some of these things need to be sent in hard copies rather than virtual. So it's a very arduous process."

Core trainee, Scotland -> Australia, Man, 31-40

However, for many respondents, this stress was lessened by their new employer or an agency taking charge, who supported them during this process. Several mentioned how securing the

job was essential for making the visa application simpler, giving them license to move and work in the country.

STAGE: REGULATION AND EDUCATION

Ease of professional regulation was certainly a large factor in country choice, particularly for our 'internationally mobile' group of doctors. For many, particularly those moving from the UK to Australia, this was generally more administrative in nature – filling in the correct paperwork, registering with the medical body and securing the GMC certificate of good standing. However, for others, this proved far more complex. Regardless, this process was often lengthy, commonly taking over a year from beginning the process to eventually moving.

Some of those moving to non-English-speaking countries were required to take language exams, going through a period of language learning before starting their new roles. For others, professional regulation required taking additional exams, which was a factor that prevented several from considering the US rather than Australia or New Zealand.

"For example, the [US] offer good salaries, but you have to do a 3-stage exam, you have to be pretty sure that you want to go there to engage in the 3 exams. So, that was already ruled out...."

Specialty trainee, London ->Australia, Man, 31-40

STAGE: PREPARING TO LEAVE

At this point, migration was a certainty for all of our respondents, yet it was often one of the toughest parts as they now had to say goodbye to family and friends – one of the factors that encouraged others to stay. Jobs had been secured and it was time to book tickets, sell or rent their homes, consider work arrangements for their partners or spouses, and perform the other personal administrative tasks prior to leaving the country.

THE SPEED OF THE JOURNEY AND THE WINDOW FOR INTERVENTION

Respondents were asked **when their decision to migrate became fixed**.

Notably for some migrating doctors, the point where their decision was fixed was often **at the same time or very close to the trigger point** – when they first considered migrating and started to take steps in their journey. For these doctors, the only window for intervention was prior to the trigger point itself. This tended to be the case for situations in which the trigger was highly emotional or traumatic (for example, experiencing the death of a colleague), or when it fundamentally threatened the wellbeing of a doctor. In such cases, the

trigger event became the straw that broke the camel's back. Many of our 'burnt-out GPs' were examples of this.

Even when the trigger and the decision to leave were not at exactly the same point, **when the trigger to leave was highly emotional the overall journey was generally quicker**, with doctors eager to leave as quickly as possible. This included those who had experienced difficult professional circumstances, such as litigation that had an adverse impact on their confidence and health, as well as those influenced by larger sociopolitical events, such as Brexit, making them feel like they no longer belonged in the country. While they still had several steps to go through, the feeling that they 'must leave' drove them to move through the steps as quickly as possible.

"...the whole thing was coming out of me trying to change the system to improve it, and here I am being investigated. I just felt like I can't do much more than this, what do I do? Well, you know, you've got to take into account you've got a family, you've got children. You've got to look after your mental health and once things get to that point then, you know, it's two ways; either you break down or you move on. And I decided to move on. I didn't decide to stay there and break down."

Consultant, Emergency Medicine, England -> Australia, Man, 41-50

Otherwise, points in their journey where the decision to leave became fixed tended to focus on when they secured a job abroad or when they agreed it with family, some of whom might also need to find work. However, it could also be fixed by similar sorts of factors that for other doctors were triggers or push and pull factors, for example, not getting a job they wanted, having a good experience of working in another country or finding their career opportunities limited. While Brexit was a trigger for some, it was a decisive final factor for others.

The speed of the journey from the trigger to leaving the country was dependent on a range of factors as outlined below. Due to this, the overall speed of the journey could be anywhere between several months to a few years.

- The need for a job search phase and familiarity with the new location.
- The nature of the push to leave.
- Any requirements to leave.
- Country choice.

THE NEED FOR A JOB SEARCH PHASE

Where doctors were presented with an attractive job opportunity, for example, with a past contact, a lengthy job search phase was not required. In these cases, often these contacts had been acquired during past visits to a country, even possibly when working in the same institution, so a country visit might not be necessary, making the process much faster. This meant, for example, that many of our 'older explorers' had quicker journeys, facilitated by contacts.

THE NATURE OF THE DRIVER

Where the push factor was more proactive – for example, seeking a higher salary – then doctors would spend more time to make sure that they were maximising their opportunities. Our 'salary seeker' group generally fitted into this model. In general, those on more 'proactive' journeys took longer, whereas those on more 'reactive' journeys were faster.

PERSONAL CIRCUMSTANCES

Migration was sometimes also performed at pace due to the necessity to return home, or to their partner's home country as soon as possible for personal obligations. In some of these cases, they didn't look for work until they had left the country, which meant the journey away from the UK was performed very speedily. In other cases, particularly with our 'internationally mobile' group, there was a requirement to leave quickly due to visa limitations.

COUNTRY CHOICE

Unsurprisingly, country choice played a significant role in the speed of the journey, based on a range of different elements – either speeding up or slowing down the journey. Those returning to their home country had the 'easiest' journey, requiring little paperwork as visas were not needed. The only exception was for those returning home with a partner from another country, which extended the journey time as they investigated and secured spousal visas.

However, for UK doctors migrating overseas, visa application processes had to be followed, with those receiving help from their new employees often assisted with paperwork here. Additionally, those moving to Canada and the US spoke of the need to sit further professional tests to ensure that they met the expected regulations of their chosen country in order to secure both work and visas. For these respondents, the time was extended, but by this point their decisions were always fixed. Some would also visit the country beforehand on holiday and/or for an interview, to ensure that they were happy with their decision, allowing them to experience the country before they made their final selection.

GROUPS OF MIGRATING DOCTORS

BURNT-OUT GPS

WHO ARE THEY?

This group was made up of GPs exclusively, at various stages in their careers, including a small number in training. There were more women in this group than others in our sample

and many had partners who were also doctors. Most had trained in the UK and had initially not had any intention to permanently migrate.

These individuals were hard-working professionals, highly committed to their careers and patients. Unlike some other groups, where doctors had a positive desire to migrate and try something new, these doctors were more likely to have negative drivers, having found working conditions in the UK system were taking an increasing toll on their wellbeing. Their decision to migrate was also likely to be influenced by the political and cultural context – for example, changes to the NHS or social care system that they disagreed with or media and public attitudes to their profession. This project captured some experiences of how GPs were affected by what Mahase described as 'toxic media stories' (2021).

Australia and New Zealand were the chosen destinations of many of these respondents, who were sometimes recommended these destinations by past colleagues because they offered a good quality of life, high salaries and attractive working conditions.

The migration journeys discussed here were likely to be seen as permanent, with return unlikely unless they saw a huge change in the healthcare system.

WHAT WERE THEIR TRIGGER POINTS FOR FIRST CONSIDERING MIGRATION?

Doctors in this group had often been experiencing extremely heavy workloads for some time, so triggers arrived against a backdrop of long-term dissatisfaction and burnout. Such workload conditions could become toxic and too high to be safe (Hewett 2022). Although workload was an issue for many groups, there were specific triggers here for those working in primary care around the sheer number of patients they had to see in a day. In some cases, this was exacerbated by becoming a **partner in a practice**, which could add extra stress.

Triggers for these groups were highly memorable and specific moments – often a crisis point that might be a mixture of personal, professional and national factors, with workload issues often amplifying events that were already highly emotive. One GP spoke of meeting someone in a similar situation 10 years on in their career who had suffered a heart attack:

"He said I would sincerely recommend you investigate working elsewhere in a different country in a different system because when you have your heart attack they just tell you you're not to come back and they're going to get someone else in. … Naturally I sat and thought about it for about a week and then I booked some flights. I flew to Vancouver and had a look around and went 'can I live here? I think I can'."

GP, England -> Canada, Man, 41-50

Similarly, another respondent had recently experienced the premature death of a friend who was working as a GP. In both cases, this gave our respondents the sense that life was passing them by in their current role.

Being put under **extreme scrutiny professionally** was another common trigger. One doctor shared the anxiety and pain brought on by a coroner's inquest at which she was eventually

found to be without fault; another was the subject of a GMC complaint; and a third was also going through a Care Quality Commission inspection.

"I had a GMC complaint, which eventually came to nothing, but it was extremely stressful, and we had a CQC inspection at the same time, and it all came together over a week, and I just thought … that was the start of it, and I thought I'm not happy anymore … I had 70 patient contacts that day, and probably 40 face-to-face and the rest other things, and I knew I hadn't done a good job. I knew I couldn't have looked after all those people properly, and that was the straw that broke the camel's back. I thought I can't look after people properly, do a decent job, and look after myself and spend time with my family, and that was when I started seriously looking for another job, and looking overseas."

GP, England -> Australia, Woman, 41-50

The final trigger source could be specific events within the political environment, either Brexit and what it signalled to them about UK culture, or specific changes introduced to the NHS brought about by political decisions, such as seeing the introduction of more private companies within the NHS or changes to the structure of social care.

WHAT WERE THE CHARACTERISTICS OF THEIR JOURNEY?

Because this group was often experiencing a highly emotional trigger following a period of extremely high pressure, once the trigger was introduced, they moved quite quickly to a state of certainty about migrating.

"Genuinely there were so many other things that I was unhappy with and fed up with so by this stage I didn't look back. I never, ever considered a change of plan. I think once we both made that decision we didn't look back, just continued."

GP, England -> New Zealand, Woman, 51-60

This steadfastness could continue even in the face of bureaucratic obstacles:

"There were a few times when they'd request some other document that was really difficult to get hold of, and you'd think this isn't going to happen, but I never changed my mind. I wanted to carry on doing it. Sometimes, you think how much more ridiculousness can they ask for, but there was never anything insurmountable."

GP, England -> Australia, Woman, 41-50

This group often had very **short journeys** as it was necessary for them to leave for their wellbeing. They tended to have a shortlist of a small number of countries, with Australia and New Zealand being the most common. They approached recruiters and used specific GP jobsites such as RACGP. Discussions with colleagues took a little while longer perhaps than for some other groups because they felt guilty about leaving those colleagues with a potentially heavier workload. In some cases, where partners were also moving jobs, job hunting occurred after arriving in the country, as they were entering using their partner's visa.

WHAT PUSH AND PULL FACTORS INFLUENCED THEIR JOURNEY?

These doctors were strongly influenced by push factors, as opposed to pull factors. Primary push factors were mostly related to workload and stress (see Hewett 2022), which were attributed to a number of sources:

- Burnout caused by the sheer number of patients they were expected to see in a day alongside home visits, for some that were in the UK during this period this was exacerbated by COVID and the requirement to cover for unfilled vacancies or illness
- A lack of sympathy from practice partners, or if they were partners, from Commissioning Groups.
- High patient expectations, which, in some cases, resulted in abusive behaviour from patients and also stress arising from an increased risk of litigation.
- The perceived inadequacy of related services such as Social Care or NHS Direct, resulting in a heavier workload for GPs.
- Inability to sustainably juggle work and family life.

These factors often led them to feel that they weren't able to give patients the quality of care they hoped to deliver, particularly alongside any personal commitments to children or other dependents. For some, it also led to a sense that they were not in control

"It just became almost like conveyer belt medicine, and it was impossible, I felt, to do a good job. And I felt it was beginning to ... sometimes it was dangerous what we were doing."

GP, Scotland -> New Zealand, Woman, 41-50

These issues were exacerbated by what were perceived to be broadly unsympathetic attitudes towards GPS, emanating from the media and from politicians (see Mahase 2021).

While push factors predominated for this group, the primary pull factor was a better work-life balance, particularly in terms of patient workload. Pulls towards **particular countries** came through having colleagues based there, or past experience during gaps in training.

WHAT WERE THE TRADE-OFFS WHEN MIGRATING?

Although the GPs we spoke to usually felt compelled to leave, they did express a number of trade-offs, mostly related to the nature of the health systems that they had joined when compared to the NHS. In particular, these doctors were generally believers in the principles behind the NHS and there was sometimes dissonance between their values and working in a system where healthcare was not free at the point of access:

"There's a gap fee. I found it difficult asking people to pay for healthcare, coming from the NHS. I found that strange and I didn't like it, and I still find that funny. When I'm prescribing the pill and they have to pay for it, whereas in England they wouldn't have to pay for it ... I fundamentally agree with a free at the point of delivery system. That was tricky, and I still find it difficult. I don't like the money side of it. It doesn't sit so well."

GP, England -> Australia, Woman, 41-50

Some also mentioned the quality of work and the level of teamwork they experienced working in the NHS:

"I do miss the NHS because the quality and the standardisation of work was exceptionally good. I miss my colleagues in the emergency department who could do everything. The competencies are not the same over here, there's not as much team work and so what you find is it's very granular and very fragmented and very silo-based healthcare."

GP, England -> Canada, Woman, 31-40

GPs leaving the NHS in these circumstances had strong ties to their colleagues and often felt guilty about leaving them in what they felt to be a difficult situation. There were also personal trade-offs in terms of proximity to family.

WHAT WERE THEIR POST-MIGRATION EXPERIENCES?

All doctors we spoke to were pleased to have moved and their migration was deemed to have been successful in terms of an improved work-life balance. Partially, this might be explained by the self-selection bias, but it still illuminates the strength and variety of pull factors.

"(We) had more of a chat than an interview, and they offered that to me. That was great because that made me decide because, speaking with the practice manager, and I had primary school age children, and she said 'so we'll put you in just working school hours."

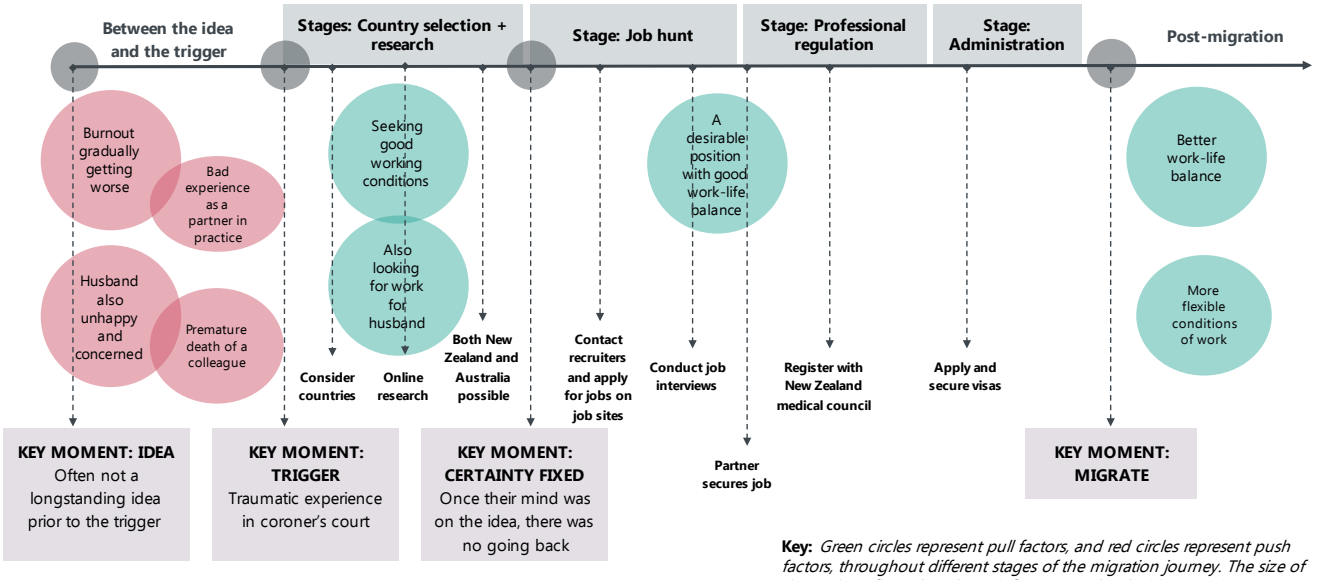
GP, England -> Australia, Woman, 41-50

While they expressed some sadness about not working within the NHS anymore, the sometimes-traumatic events they had experienced prior to leaving made them extremely reluctant to return without there being substantial changes within primary care.

CASE STUDY

Case study 1: Burnt-out GP

The journey below depicts the steps and considerations of a GP based in the UK, who migrated to New Zealand with their partner who was also working as a consultant in the NHS. Please note that some steps have been inferred based on the findings from this group overall.



Key: *Green circles represent pull factors, and red circles represent push factors, throughout different stages of the migration journey. The size of the circles reflects the relative influence on the decision to migrate*

SUMMARY

'Burnt-out GPs' were a group with often highly emotional stories. The difficult experiences they had had in the UK made it very unlikely that they would return. The fact that they were sometimes married to other clinicians meant that often the NHS effectively lost two keyworkers rather than one with their migration. Interventions for this group would need to be made prior to the trigger point in terms of reducing burnout and supporting them in their work, particularly making the transition into partnership, offering mental health support and more flexible working conditions to support their health and wellbeing more widely.

CAREER-LIMITED DOCTORS

WHO ARE THEY?

Individuals in this group tended to be international, ambitious, mid-career specialists, Specialty and Associate Specialist (SAS) and Locally Employed Doctors (LED) with few personal or family ties to the UK and its systems. They felt that they had reached an impasse and **exhausted all career opportunities** – moving overseas was the only way they could achieve their ambitions. This group was often clear on a destination that would meet their needs – with either their country of origin or a location they had tried temporarily and found attractive foremost here. Many had trained outside of the UK, and had stronger ties to other nations.

The core rationale here was largely based on direct career factors, with the UK having stopped working for them professionally. However, this was grounded in a sense that there were systemic issues with a lack of career opportunities. Pressures were particularly keenly felt

by those combining research with clinical work, who felt that team working conditions were worse in the UK than elsewhere in the world.

This was the largest group in our sample. Demographically, these doctors originated from and were often returning to India and Europe, having achieved their PMQ from the late 1990s onwards. Interviews described their UK practice as being in urban centres, with most located in London, the South East and the South West. As noted in the 'Burnt-out GPs' group, it appeared that some of this group were spouses of other healthcare professionals, who were also from the same country, making it relatively straightforward for them both to migrate.

WHAT WERE THEIR TRIGGER POINTS FOR FIRST CONSIDERING MIGRATION?

Doctors in this group were less likely to first consider migration after a traumatic or easily identifiable trigger point than other groups identified in the study, although we did hear recurrent themes of underlying career dissatisfaction and a general sense that they had exhausted job opportunities. Tangible trigger points were focused on progression and included:

- Applying for, but not getting, a particular job that represented a step up from their current position.
- In some cases, having difficulties in getting their past experience recognised by the GMC and getting onto the specialist or GP register.
- Wanting to pursue work within a more specific field and seeing a relevant job opportunity elsewhere.
- Consistently being asked to work above their pay-grade, without the associated increase in salary or promotion.
- Having to wait for what they felt was an unnecessary period of time before being promoted.
- Being unable to get into a training post.

"I just couldn't get a job, and I thought a year and a half waiting is more than enough because if I couldn't get into a training post, what's the point? I don't want to be a GP. I don't want to be a locum SHO forever. I wanted to climb up the ladder."

Specialty trainee, England -> Malaysia, Woman, 41-50

While, in many cases, these triggers were sufficiently strong for doctors to take action, migration decisions were hastened by external events, with the Brexit referendum and result a particular factor for European doctors.

"When I made the decision it was mainly Brexit and the fact that I couldn't accelerate training and not get this sub-specialty module. That was at the point when I made the decision, we thought, if the UK doesn't want the Polish plumber, they don't get the German eye surgeon."

Specialty trainee, England -> Germany, Man, 41-50

WHAT WERE THE CHARACTERISTICS OF THEIR JOURNEY?

This group was highly pragmatic – once it was clear that they had fully exhausted all their progression opportunities in the UK, they began making steps towards moving. **Locations were few and predetermined.** This group tended to have one country in mind, either their country of origin or somewhere they have practised or trained before. They might already be on the register of practice. They also had some existing knowledge around where to go and how to get there.

WHAT PUSH AND PULL FACTORS INFLUENCED THEIR JOURNEY?

'Career-limited' doctors were primarily influenced by the pull factor of **better employment opportunities in terms of role, specialty, seniority and salary**. Prestige and CV building were key to this audience, and factors that supported these were strongly welcomed. Where their expectations were not met, they felt undervalued.

"I could see that I was working as a consultant, my duties involved performing complex surgery, especially in gynae-oncology and all the complex procedures. I was working more than what a regular consultant was doing but my position within the department was still a speciality doctor. That's when I felt I was not being valued enough to stay on in the country."

SAS doctor, England -> India, Woman, 51-60

Having their experience, qualifications and skills recognised was a key pull factor, with many using the experiences of colleagues who they had trained with but had gone elsewhere as a way of evaluating how possible this was.

This dovetailed with returning to their home country at a point in their lives when they felt they had more to give to the profession and their families.

Another pull factor was the fact that they were directly approached and persuaded by those in overseas institutions. A small number of the sample were contacted directly by overseas hospitals, or had maintained links with particular facilities via their family and professional contacts who then reached out to them. This looked to be most pronounced in India. For those who had chosen to move to Australia or New Zealand despite not holding citizenship there, the pull factors of a new international experience and broadening their horizons, again relating to CV building, were important.

Push factors outside feeling limited in their career in the UK were notably less important when it came to decision-making with this group than others, although still present. These often occurred after their decision had been fixed and the move was in progress, simply confirming their course of action. Dissatisfaction with the NHS appeared to be less important than elsewhere, and related more to their own inability to progress rather than the system as a whole. In some cases, participants discussed how they did not feel strongly invested in the NHS, and this could be reflected in the relative ease and speed of their decision-making.

WHAT WERE THE TRADE-OFFS WHEN MIGRATING?

Doctors from this group reported few barriers in their journey and a lack of uncertainty at any point once they had decided to migrate. They were focused on career progression and, so long as they had achieved this, they were satisfied. Interlinked with this desire for progression was a sense that this was the right time, personally and professionally, for them to act.

However, they did have to make trade-offs regarding job security – they were largely in somewhat comfortable and senior positions and moving elsewhere could mean making a lateral career move or having to concentrate on a particular sub-specialty. At the same time, continuing along the same track locked them into a position for the long-term, which they knew they were already unhappy with.

"I had to weigh the risks and benefits about continuing as a consultant – once I make my job permanent there's nothing left, I'll just be working, and that's it, there are no further career options. I thought this is the right age also, if I just missed this opportunity I'll never get it [again], so I thought, it was difficult decision, but yeah, I was certain of that."

Consultant, England -> India, Man, 31-40

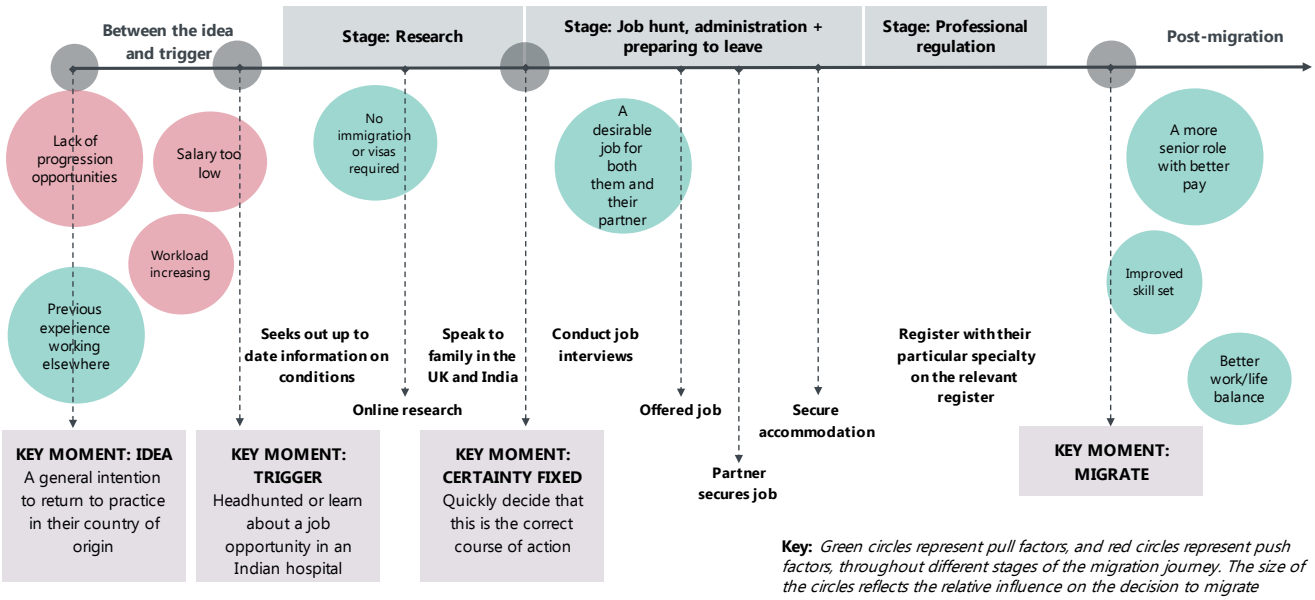
WHAT WERE THEIR POST-MIGRATION EXPERIENCES?

Doctors reported satisfaction with their decision, having met the goals they had set for themselves, in terms of improvements to their skill set, clinical knowledge and experience, as well as position and salary. Access to attractive career progression opportunities should form the basis of any interventions for this group.

CASE STUDY

Case study 2: Career limited doctor

This journey below depicts the steps and considerations of a doctor originally from India, migrating back to home after feeling limited by the career prospects in the UK.



Key: *Green circles represent pull factors, and red circles represent push factors, throughout different stages of the migration journey. The size of the circles reflects the relative influence on the decision to migrate*

SUMMARY

Career-limited doctors may be a difficult group to successfully target with interventions past the initial trigger to go, given their often-close family ties to their country of origin, their lack of doubt in their decision-making, and the speed and determination with which they went on their journey. However, these are a highly skilled set of individuals, with a relative lack of dissatisfaction with the NHS compared to some groups, suggesting that they should still be a high priority for retention. Specific programmes to identify members of this group and facilitate their career goals will help, but action is also needed to address more systemic barriers to career progression.

DISHEARTENED EU AND INTERNATIONAL DOCTORS

WHO ARE THEY?

This was a diverse group of mostly consultants and SAS doctors, spanning a wide range of UK locations prior to migration and varied migration destinations, both international and EU. These individuals were generally in their 40s, and often had families or close personal ties to the UK, but had chosen to migrate anyway despite the difficulties this introduced. They had originally intended to make a new permanent home in the UK, but at the time of leaving believed themselves to be in a 'now or never' situation, particularly those with younger children who felt a move would become difficult once their children were more settled in school.

The main differentiator between this group and others was in the **level of negative experiences reported, which related to their identity as a foreign national living and working in the UK**. They reported significant levels of hostility in their professional lives. This identity had left them feeling exposed in what was described as a challenging climate. Brexit was a key trigger, with the vote, media and public mood re-emphasising an underlying feeling that they did not belong. These feelings around Brexit were especially strong from EU doctors, but it was significant to those originating from elsewhere as a signifier of changes to British culture. Concurrently, they felt that there had been a loss of respect for the profession from the media and general public, reflected in patient interactions and formal investigations, which could affect overseas doctors disproportionately (Jalal et al. 2019).

It should be noted that this was not the only group that reflected the experiences of international doctors, many of whom were also represented in the 'career-limited' group.

WHAT WERE THEIR TRIGGER POINTS FOR FIRST CONSIDERING MIGRATION?

The **Brexit referendum of 2016** was the key trigger point for first considering migration. There were multiple factors for Brexit resounding so negatively with this audience, with healthcare authorities, the government, the public and the media contributing to a highly negative atmosphere. Some EU members of this group had been active in protesting, writing letters and sending petitions to healthcare bodies, including the GMC. However, the response to this was felt to be dispiriting and patronising in content and tone. We often heard how it was a sense of internationalism and workforce diversity that had first drawn them to practise

in the UK. Now this was much diminished, the concept felt naïve, and they were looking for an exit to a country where they felt more at home.

This quote from a doctor from Sierra Leone highlights the link made by some international doctors between Brexit and their experiences:

"It was around the time of Brexit and a time of rising xenophobia in the UK."

Consultant, England -> NZ, Man, 41-50

Some had experienced highly negative interactions that they saw reflecting a much-changed public mood towards those of a different nationality or ethnicity:

*" My Bangladeshi colleague was told, 'P***, when are you going home?' – he has lived here for 35 years. I was seeing this around me. This had changed since 2016."*

Consultant, England -> Germany, Man, 31-40

There were also more specific workplace incidents that precipitated change, including:

- Unprofessional conduct from managers and other colleagues.
- Bullying from colleagues.
- Having to take time off work with stress or anxiety related conditions.

WHAT WERE THE CHARACTERISTICS OF THEIR JOURNEY?

Doctors from this group were highly likely to be bi-lingual, and so found it relatively straightforward to find a job in their country of choice, often with the help of a recruiter.

Visa issues were highly variable depending on destination. Around half of the EU doctors in this group were going back to their country of origin, which meant that there was relatively little research or administration required. International doctors were more likely to be going elsewhere such as New Zealand, Australia and the UAE. There were more administrative hurdles in these cases.

These doctors often had young families and partners who themselves worked within healthcare, and so may have had to either wait for them to find a new position, or themselves follow their lead.

WHAT PUSH AND PULL FACTORS INFLUENCED THEIR JOURNEY?

The migration journeys of this group were predominantly driven by push factors rather than pull factors. The primary push factor was a sense of an unwelcoming professional and sociocultural environment, with UK society seen as increasingly xenophobic. Some identified a perceived lack of support from relevant organisations on any issues that arose, and an unsympathetic working environment. Consultants were singled out as particularly problematic in terms of their interactions with others, making for dysfunctional working environments and leading to what they perceived to be low-level bullying and harassment.

"The context always remains that there is a lot of racism in this country. There's a lot of talk about we will do this, do that, but nothing gets done and I hate to actually think that some of the people are ignorant, because ignorance is not an excuse, and at times, it can cut quite deep. What is even worse is when that is accompanied by, or is explained as a symptom of, one being undermined. Then it just happens quite frequently."

Consultant, England -> Germany, Man, 31-40

Patient interactions had also become difficult. They perceived there to be an undercurrent of xenophobia to some of these interactions and situations, relating specifically to their international status. The negative media attention on medical professionals from some quarters of the media during this period intensified issues here. Many of these factors combined to create difficult and stressful situations and what was felt to be a disproportionate number of complaints.

From EU doctors, we heard concerns about practical issues such as difficulties in accessing EU grants and other funding, as well as uncertainty around new visa and administrative issues for them and their families.

Secondary push factors were clustered around **workload**, both in terms of the number of patients they were expected to see and the level of complexity and skill that was required in order to get through their caseloads. From starting within the NHS, many had found their role to be incredibly demanding, in terms of the amount of time they were expected to work, a situation which had worsened over time and looked set to continue to become ever-more challenging. In contrast to other groups, **this level of intensity seemed unexpected**.

In common with many other doctors, this group reported a lack of autonomy and work-life balance, with inflexible rotas and lengthening shifts further dulling their experience. Some of the international doctors in this group also shared some of the push factors around career limitations that were experienced by our international career-limited doctors.

Attractive working conditions were the primary pull factor, alongside improving their work-life balance. This group had experience or knowledge of other systems, and the working conditions in the UK were felt to be substantially worse than elsewhere.

WHAT WERE THE TRADE-OFFS WHEN MIGRATING?

Despite reports of serious interpersonal issues with both absent or combative senior staff and unresponsive junior roles, **many other colleagues were supportive** and it was a wrench to say goodbye to these teams. We heard about a great deal of variation here, with the workplace culture of some hospitals or other facilities much more difficult to leave behind than others. There was also a wider sense of solidarity with many of their colleagues, particularly in response to changes to the junior doctors' contract. Leaving behind family and friends was more difficult for those migrating to Australia/New Zealand than for those going to Europe.

Some international doctors travelling to EU nations described **post-Brexit administrative hurdles**, for example, around UK training certificates not being valid under EU law. There were also trade-offs and risks in terms of where individuals were in their **training**. We heard one description of a UK norm for senior consultants to front-load their specialty training, leaving them potentially less experienced in terms of role and responsibilities than their overseas counterparts upon migrating.

WHAT WERE THEIR POST-MIGRATION EXPERIENCES?

Participants from this group described largely positive experiences, with few to no regrets about their decision to emigrate. A much-improved working environment, more opportunities for professional development, and the ability to become involved in clinical research and academia were all mentioned. An increased level of autonomy over their day-to-day activities meant that workload looked to be much more manageable across all migration destinations, which meant they were able to spend more time with their family.

"The colleagues are more supportive. I feel more part of the team. I feel that the hours are better, as in people are counting the hours and working. I'm better paid, and we've got a better lifestyle, and if you don't like someone and you really can't work with them, then you don't have to change country, you just go in a different hospital. I've met people that didn't like their colleagues and have moved to different hospitals and that's okay."

Specialty trainee, England -> Germany, Man, 41-50

Nevertheless, the nature of some hospitals, especially where these were smaller or in rural locations, meant that there were **lower standards of equipment and less advanced approaches** than those they were familiar with in the UK. Pension arrangements were sometimes also worse. However, participants were prepared for this. There was also some remorse about leaving the NHS, although this was offset by **a feeling of being valued** – a core need for this group.

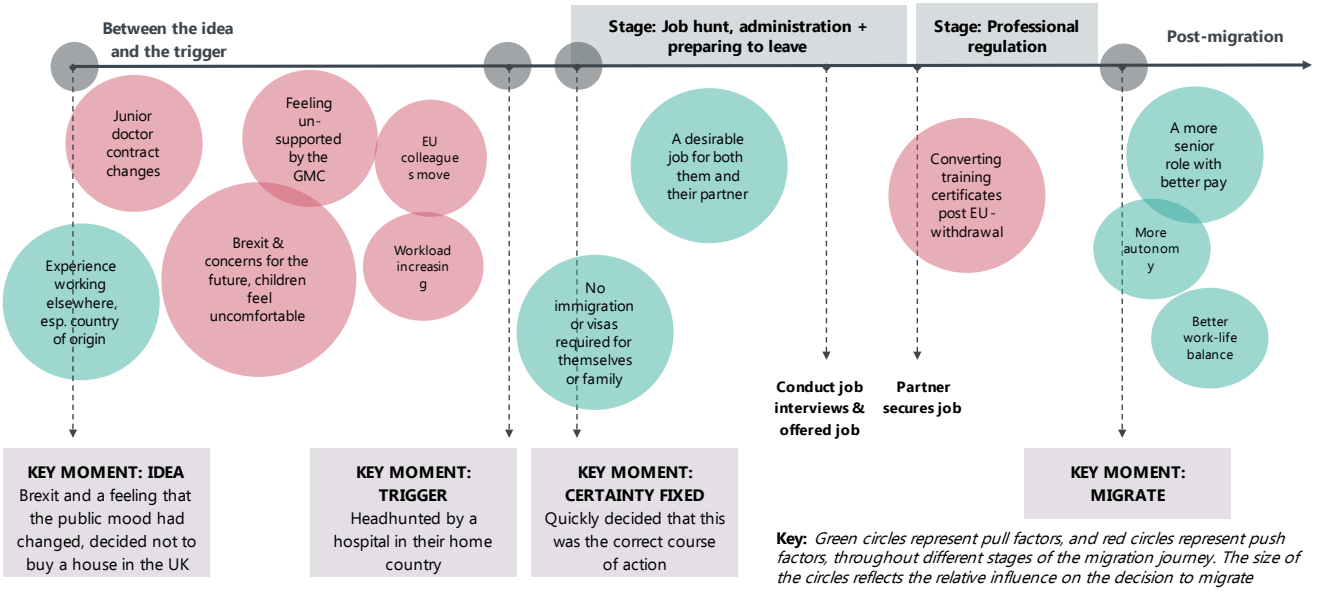
"The pension contributions here, the employer puts in 3%, whereas the NHS pension I have to say was a huge thing. But I'll happily trade that for the feeling of being valued."

Consultant, Scotland -> New Zealand, Man, 41-50

CASE STUDY

Case study 3: Disheartened EU / international doctor

The journey below depicts the steps and considerations of a consultant who had moved to the UK from Germany, along with their partner, with both settled in senior, permanent roles in the UK. Please note that some steps have been inferred based on the findings from this group overall.



Key: *Green circles represent pull factors, and red circles represent push factors, throughout different stages of the migration journey. The size of the circles reflects the relative influence on the decision to migrate*

SUMMARY

On arrival in the UK, this group appeared to have been enthusiastic, with a desire to progress at work and settle down with a family. However, a combination of factors and cumulative negative experiences led them to feel that they had been pushed out of the system. For them, poor treatment by colleagues, patients and the general public had intensified following the Brexit referendum. The importance of socio-political factors external to the NHS make the decisions of this group harder to influence by those involved in the health system than those of some other groups. However, work to make the health system in the UK more hospitable to these doctors would be helpful as well as work to ensure they feel well-supported as they navigate other difficult aspects of their environment.

DISILLUSIONED DOCTORS

WHO ARE THEY?

Mostly UK-trained GPs and consultants in their mid- to late-career, the doctors in this group were defined by the extent to which their journeys were characterised by frustration with the health service in the UK and the way in which it was developing. Key issues here were underfunding, dangerously high caseloads, increased patient expectations and the potential for litigation, a lack of honesty around what it was possible for the NHS to achieve, the reliance of the NHS on goodwill and overworking, the encroachment of private organisations into the health system, issues around the relationship between the NHS and the social care

system, as well as increased bureaucracy and targets undermining clinical practice. While their workloads were heavy, they felt able to cope, it was rather the case that they were choosing not to continue within a system they felt was heading in the wrong direction and incapable of change. They tended to be more vocal about the actions of policy-makers in relation to healthcare.

Mostly trained in the UK, they were migrating to a variety of destinations where they could practice in English, including Australia, New Zealand, Cyprus and the UAE.

WHAT WERE THEIR TRIGGER POINTS FOR FIRST CONSIDERING MIGRATION?

While some in this group shared the triggers of the 'older explorers' group such as around life stage, or had partners significantly impacted by Brexit, some had trigger points that involved **conflict with an authority within the health system**, for example, a meeting with managers about issues with the hospital, which convinced them that change was not possible:

"It was sometime last year when I was in a meeting with one of my bosses, and I realised that they have set up something a couple of years ago, and now we're thinking why isn't it working, and it was clear as day to me why it wasn't, and somehow it hadn't clocked to them ... that was the point when I thought what am I in? This is not going to change."

Consultant, England -> New Zealand, Man, 41-50

Already being approached regularly by recruiters, it was a small step from this feeling to returning one of their calls.

WHAT WERE THE CHARACTERISTICS OF THEIR JOURNEY?

This group had a mixture of different types of journeys following the initial trigger. They often seemed to use a mixture of methods to get a position, including LinkedIn, responding to recruiters and reaching out to contacts. The journey time was not on the whole fast, as the trigger was not as intense or emotional as some of the other groups. They took their time in making the right decision in terms of country and job. Their decision might not be fixed until the appropriate destination was found and, in some cases, they also considered positions in different regions of the UK.

WHAT PUSH AND PULL FACTORS INFLUENCED THEIR JOURNEY?

This was a group driven primarily by push factors. The primary push factors for this group were **dissatisfaction with the direction the NHS was taking** and a **lack of belief that it could change direction**. Areas of particular concern were workload, underfunding and privatisation of services, along with underfunding of Social Care services. They also discussed high levels of workload, but this was seen through the lens of fundamental issues around the way the NHS was run, which they felt to be counter to their values:

"I'm proud of the NHS, but it's being completely run into the ground and they're going to lose its best asset, which is the people that work for it, if they don't look out for them and treat them better."

Foundation trainee, England -> Australia, Woman, 31-40

Other push factors included a feeling that there was a lack of support for them, changes in their jobs that meant they had more administration and the general lack of respect for doctors in UK society.

Pull factors were less prominent than push factors, but centred around **better pay** and the desire to work in a system that was better funded and offered the possibility of serving patients better while maintaining a better work-life balance.

WHAT WERE THE TRADE-OFFS WHEN MIGRATING?

These doctors were not at their limits and were making a decision to leave rather than being forced to, after weighing up the pros and cons. In doing so they were often trading off the potential for training opportunities and missing relatives and friends against a better work-life balance, higher salary and freedom from the frustrations of providing high-quality patient care within what they considered to be a broken system.

WHAT WERE THEIR POST-MIGRATION EXPERIENCES?

Doctors in this group often had positive post-migration experiences around work-life balance in particular, but still some appeared disinclined to say that they would stay working outside the UK. A number indicated that they would be likely to return; in one case, this was so that they would be able to claim a full NHS pension:

"Well, I probably would practise, because I think I've got to do three more years to get a full NHS pension, so yeah, even if I only do a few years, I probably will do that."

Consultant, Wales -> UAE, Man, 51-60

Essentially this group believed strongly in the principle of free access to care on which the NHS was founded. For this reason, there was sometimes some dissonance with their values when they moved abroad to different healthcare systems:

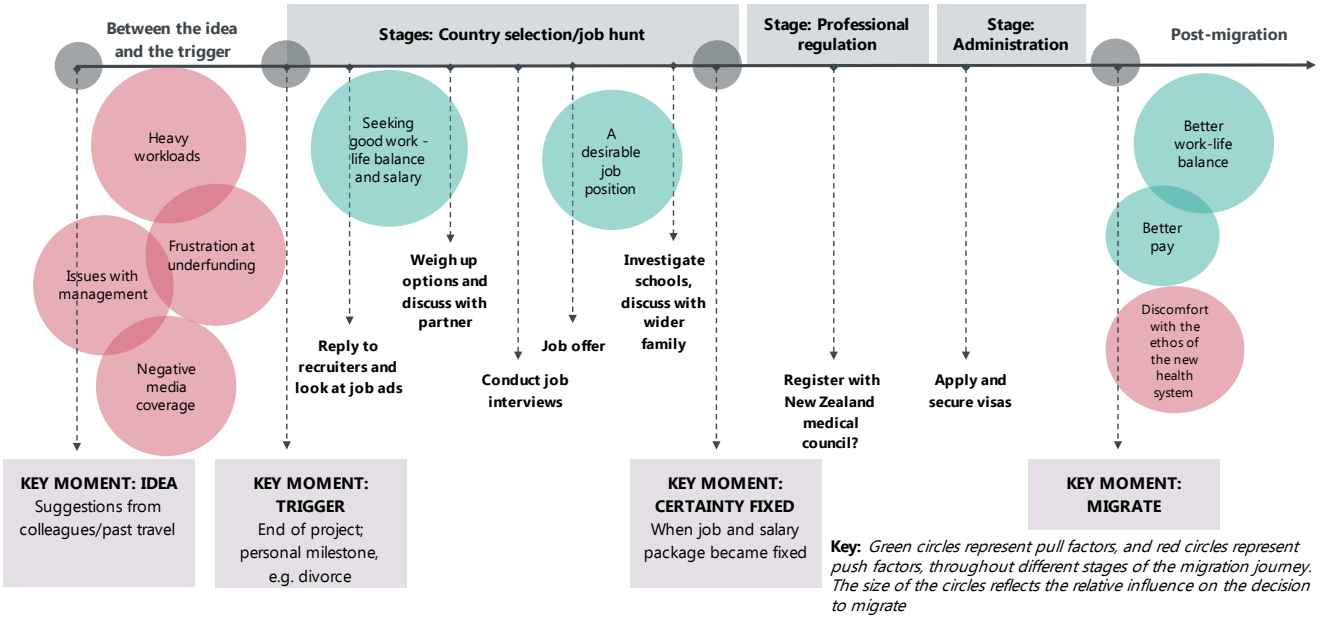
"The NHS philosophy is never mind can you afford it, do you need it? And it's not the same out here, and I miss that."

GP, England -> Australia, Man, 41-50

CASE STUDY

Case study 4: Disillusioned doctor

The journey below depicts the steps and considerations of a consultant, based in the UK, migrating to Australia in mid career. Please note that some steps have been inferred based on the findings from this group overall.



Key: *Green circles represent pull factors, and red circles represent push factors, throughout different stages of the migration journey. The size of the circles reflects the relative influence on the decision to migrate*

SUMMARY

This might be thought of as a key group for potential intervention post-trigger or even post-migration given their commitment to the NHS and the dissonance they experience when working elsewhere. They were also less likely to rule out returning to the UK relative to many other groups. However, to return they would need to feel a sense that there had been some progress in addressing the issues they have with the NHS, rather than just being attracted back to the UK through propositions around salary or progression.

INTERNATIONALLY MOBILE DOCTORS

WHO ARE THEY?

This group often comprised highly mobile consultants in their mid-career who had plenty of previous experience abroad, working in different countries whenever the opportunity allowed. They were generally in GP or early consultant roles. They had trained in a number of different locations, had sometimes moved around as children and/or had partners or parents of different nationalities. These cosmopolitan risk takers **enjoyed moving to new places, and gaining both life and work experience elsewhere**. Therefore, it wasn't primarily dissatisfaction that led them to move, instead a zest for trying something new and a desire to take up any new or better opportunities that arose.

Their chosen destinations were often determined by the ease of the visa and administrative process, although Canada, Australia and Europe were key destinations. The US tended to be avoided as its visa regulations were seen as restrictive. Europe in particular was attractive for EU nationals due to the recognition of credentials across borders.

In some cases, they were moving back to a country where they had nationality, so this made administration easier. The migration journey we discussed with them was not their first, nor was it sometimes intended to be their last.

WHAT WERE THEIR TRIGGER POINTS FOR FIRST CONSIDERING MIGRATION?

Triggers for these doctors often involved some sort of **administrative issue** in the UK, for EU nationals sometimes connected to uncertainty and changes initiated by Brexit. It was interesting that, for this group, it was the administrative burden and uncertainties created by Brexit that were key influences of their decision rather than any perception that the UK was fundamentally unwelcoming.

For example, one international doctor had issues with their visa in relation to their fixed-term contract, which led to frustration and financial issues:

"The first thing was checking the visa requirements if I wanted to stay in the UK. As I said, my job is a fixed term, so the fixed term job means that I have to find another employer 6 months after my joining date. This is part of it. I checked visa requirements for changing jobs in the UK, so going to a different hospital. After checking, I discovered that I have to reapply, there was no way to transfer the sponsor. Maybe I misunderstood, maybe I got the wrong information but that is what I understood when I checked it. I also had to reapply, and if I had to reapply, the process is difficult, and the price is high … Assuming that I didn't get the Canadian job, I would've had to take a loan or borrow from a friend to afford the tier 2 visa in order to stay."

Specialty trainee, England -> Canada, Man, 31-40

Another Syrian-born doctor had an issue with their tier 2 visa where they were given a 10-year period rather than a 5-year period before being able to apply for leave to stay, which remained unexplained and left them feeling uncomfortable. Another respondent was put off by the uncertainty around visa, taxes and the ability to buy a house post-Brexit.

Some were contacted by headhunters. In other cases, triggers were the end of a short-term contract or a period of time that they had set themselves prior to starting work in the UK.

"Again, I had a 13-month contract and so that was the deal from the beginning. Now, so the question is, did we ever consider staying longer. No, not really."

Consultant, England -> Norway, Man, 41-50

This particular doctor was frustrated by not being able to work even as a locum after the contracted period without jumping through a number of administrative hurdles and suggested looser systems of recognition with other European countries should be in place for locums.

These doctors were largely making **highly measured decisions about where to work based on administrative convenience and quality of life**. Some indicated that their identity was

aligned with medicine internationally, not with medicine in the UK. Where the system appeared to be working against them remaining in the UK, they took steps to move.

WHAT WERE THE CHARACTERISTICS OF THEIR JOURNEY?

This group often had a previous experience of moving from one system to another. They could already have been contacted by recruiters or used them for a previous move. However, they did not have quite the depth of contacts and currency in terms of their experience as our older explorer group, so the job application process appeared to take a little longer in some cases.

They were often considering a wide range of options. This group tended to consider many countries in their search and used their existing knowledge of visa systems and regulation, enhanced by recruiters. Discussion with colleagues was very common, in some cases perhaps because they did not really feel it was an option to stay.

Since some had a hard deadline in terms of their visa expiration, the speed of this process was very important. Some highlighted the speed of the process in other countries:

"...deciding to move to Norway and actually doing it took two days and that was it. We decided on Norway. Norway/Denmark, it's so easy. Bureaucracy, you handle, anyone with half a brain would never be in the way of getting more GPs. In the UK, even leaving the UK, they were asking for documents I couldn't procure, so it was obvious that this would never fly."

GP, England -> Norway, Man, 41-50

WHAT PUSH AND PULL FACTORS INFLUENCED THEIR JOURNEY?

As already discussed, internationally mobile doctors typically experienced a **push factor around administration and visa regulations**, with the accompanying career disadvantages, uncertainty and costs that arose as a result of these.

While some respondents were unhappy with working conditions in the UK, these dissatisfactions were a secondary push factor. These respondents had worked under other systems and often saw issues in the UK within the context of issues they had come across working in other countries. In some cases, there were also push factors from partners and close family members who may have travelled with them if they did not feel happy and settled in the UK. Feelings around the culture in the UK post-Brexit could contribute to this.

The primary pull factor was **career opportunity**, with respondents happy to move in order to enhance their careers whilst escaping administrative issues. They were likely to consider career opportunities on a global rather than national basis.

Pulls towards **particular countries** came through having family based there, past experience, language and ease of administration related to visas and licences to practice.

WHAT WERE THE TRADE-OFFS WHEN MIGRATING?

These doctors were used to migration, but still aware that it could be challenging:

"Whenever you migrate to another country, there is a great deal of uncertainty and instability between changing houses, buying new furniture and moving, new banks, new laws, new rules. You have to deal with all of this stuff at the same time. That is very annoying. Many people I think do prefer to stay in the same country if their requirements are available or met. That is probably what was keeping me in the UK, but unfortunately it was not strong enough against the huge bureaucratic hurdle."

Specialty trainee, England -> Canada, Man, 31-40

They often had enjoyed working in the UK and the career advantages they felt it gave them. They often felt they had little option but to leave, but in some cases did feel that this came at the expense of opportunities for training and development in the UK. However, this was variable by specialty, depending on the extent to which the UK was seen to be world-leading.

WHAT WERE THEIR POST-MIGRATION EXPERIENCES?

The post-migration experiences of this group were highly variable. While some were extremely happy in their new positions, particularly in Northern Europe, others were less happy. Despite this, many of these doctors would only return if visa and administrative hurdles were lifted and uncertainties removed, as outlined by this respondent, who trained in Iraq:

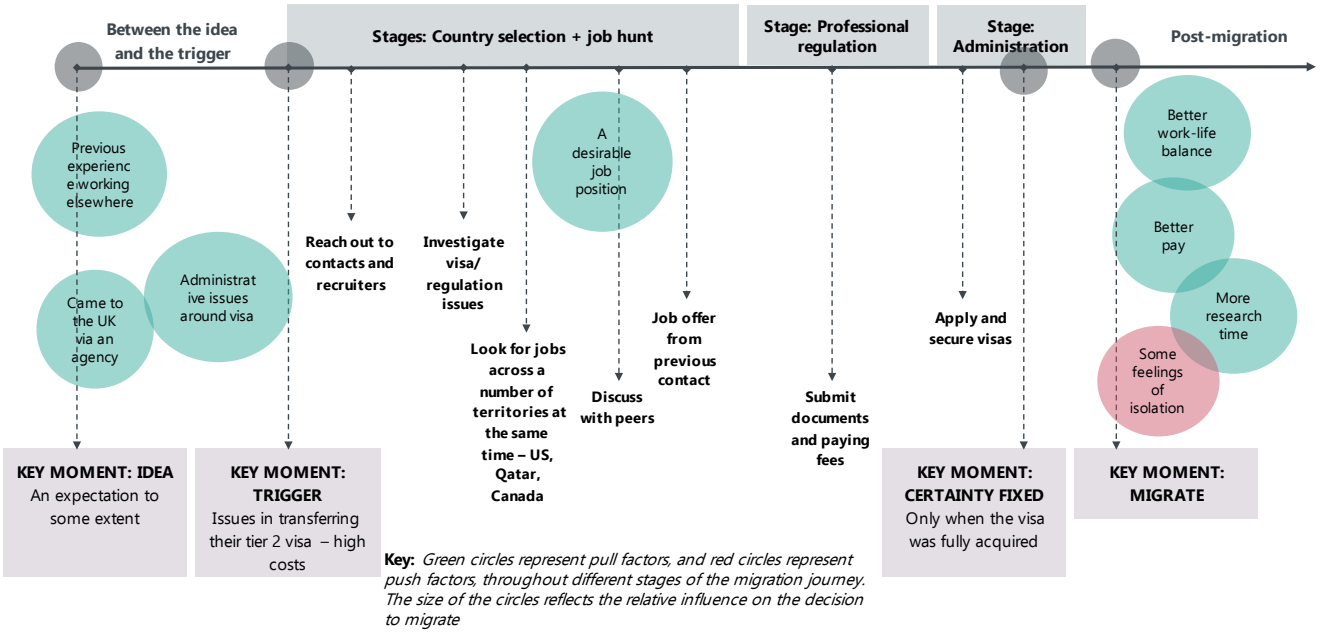
"I asked to get a licence of practice, but there are a lot of complications maybe because of Brexit. That is why I told the agency I wanted to stay here for a while and to look at what happens with the rules and conditions after Brexit. So, it's not that easy to go back again and practice in the UK."

Consultant, England -> Netherlands, Man, 60+

CASE STUDY

Case study 5: Internationally mobile doctor

The journey below depicts the steps and considerations of a doctor in specialty training, originally from Japan, who migrated to Canada after issues around their visa. Please note that some steps have been inferred based on the findings from this group overall.



Key: *Green circles represent pull factors, and red circles represent push factors, throughout different stages of the migration journey. The size of the circles reflects the relative influence on the decision to migrate*

SUMMARY

Internationally mobile doctors are a key group for potential intervention. They are not unhappy with working in the UK and have skills that are valuable globally. More support around administration and visa systems might well enable them to stay working in the UK.

Their experience and contacts allow them to find positions internationally, but they have often not made a completely firm decision to leave until all administrative processes are tied down, thus giving a wider window of opportunity than some groups.

Strategies to ensure they come back to resume their careers in the UK are also key here, reassuring them that the experiences they have had before will not be repeated and supporting them through the administrative hurdles necessary to work in the UK medical system.

OLDER EXPLORERS

WHO ARE THEY?

This group is made up of older (late 50s upwards), mainly UK-born doctors or doctors born elsewhere who had spent most of their career working within the NHS. They perceived themselves typically to have had successful careers and, although they were not positive about all elements of working in the UK, they felt that they had been able to cope with the challenges presented by working within the NHS. Their motivations were usually more positive – wanting a change or an adventure, a new professional experience or challenge, or, in one case, also wanting to top up their pension pot prior to retirement.

Their chosen destinations were varied depending on their previous experiences and contacts, although Australia was a key destination. While some planned to retire abroad, for most in

our sample migration was planned to be short-term and many in this group planned to retire in the UK. Some had even kept their GMC registration.

WHAT WERE THEIR TRIGGER POINTS FOR FIRST CONSIDERING MIGRATION?

This group had often already had some experiences of working in other countries, or had played with the idea quite seriously early in their careers. Triggers therefore were often **personal life-stage changes** that made them more mobile, perhaps a lack of dependents through children getting older, or the death of their parents.

For others, the trigger was the achievement of **long-term professional goals** that left them hungry for new professional challenges:

"I began to think about another move a couple of years ago after achieving a second career goal which was to establish curative treatment through [redacted]. As that's now this year fairly well established, I feel I could move on and take on some new challenges."

Medical academic, England -> Australia, Man, 60+

Although feeling confident about their ability to cope within the NHS, some were also triggered by **unsatisfactory line management situations** – for example, the imposition of a new manager who made them feel disempowered.

As with the young explorers, travel had always been somewhat in mind for this group, in some cases following positive previous experiences. Therefore, the *idea* of migrating came much earlier, and typically occurred a while before they experienced the actual trigger to start their journey or take any concrete steps.

WHAT WERE THE CHARACTERISTICS OF THEIR JOURNEY?

This group was highly experienced, well-connected and much in demand from other health systems. They could already have been contacted frequently by headhunters or have relationships with individuals or institutions in other countries that had already expressed an interest in hiring them. In some cases, they were prepared to do this very quickly with the minimum of fuss. They had often already had experiences of working abroad.

Therefore, after the initial trigger, feeling it was the right time to migrate, an older explorer's journey could move fairly quickly. It was really just a case of choosing between the many opportunities available to them. They tended to migrate to countries where they already had professional connections or approaches, but a family visit to the country in question might be required prior to a decision.

Unlike younger explorers, their level of certainty was often not high, as they were also weighing up the impacts of leaving on their family or other social ties. Often married, their spouses also were key in decision-making. It was these negotiations with family that could slow the process down or make it less certain.

WHAT PUSH AND PULL FACTORS INFLUENCED THEIR JOURNEY?

Older explorers typically experienced several **prominent personal and professional pull factors**:

- The **desire to take on new career challenges**, in some cases to spend more time on research.
- A desire **for a change** after many years of working in the same system and a desire for better work-life balance in a sunny climate.
- Wanting to **travel** and experience new things. For example, Australia was seen by some as a springboard towards travel in Asia.
- Pulls towards **particular countries** came through past experience there, existing contacts in those locations or, in the case of the Gulf States, a desire to augment their pension pot through a few years of tax-free working.

Whilst proactivity and pull factors define this group, there were still some **secondary push factors**, primarily **professional**:

- Difficult managerial situations, new line management or organisational changes that left them feeling unappreciated.
- Changes to conditions of work that made them feel unappreciated.

WHAT WERE THE TRADE-OFFS WHEN MIGRATING?

As many of these doctors had already achieved a great deal in their careers, there were few perceived trade-offs professionally, although some did mention that doctors migrating to Australia were perhaps allocated positions in more distant areas of the country that were hard to fill.

Trade-offs for this group were predominantly personal – moving away from older children, elderly relatives or their social lives and friends. The personal and professional lives of partners also needed to be considered. In the end, those who chose not to migrate had usually done so for these personal reasons. Without really strong reasons to leave, they appeared more open to choosing against leaving:

"Actually, for us it was a very balanced thing. There were almost identical pros and cons. So (my wife) said, well, I'm going to phone my parents and see what happens. As soon as the phone call started, her mum burst into tears and said you're taking the grandchildren away. Broadly, that was it. I think if we'd had a stronger list of pros and a shorter list of cons then probably, we could have worked through that."

Consultant, Wales -> Australia, Man, 51-60

There were also trade-offs in terms of partners' careers, for example, where they might not be able to work due to visa restrictions.

One respondent also mentioned balancing their better work-life balance in Australia against the loss of access to some cultural activities, events and hobbies.

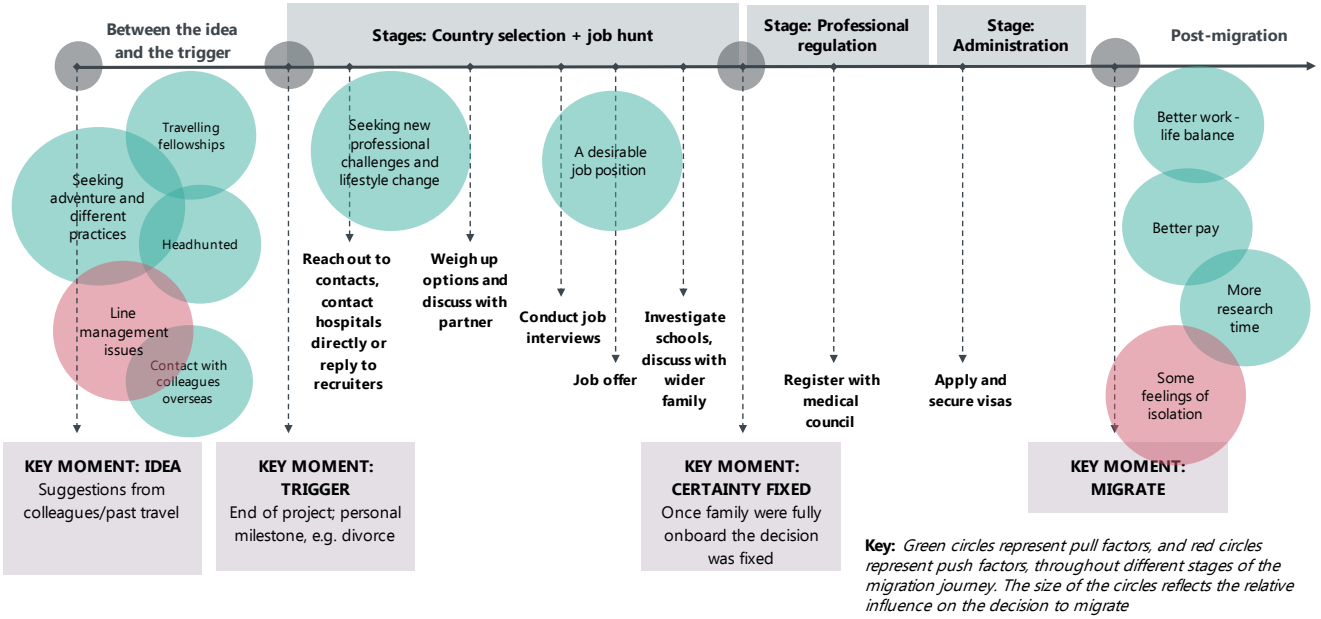
WHAT WERE THEIR POST-MIGRATION EXPERIENCES?

The post-migration experiences of this group were highly positive. Despite this, many were considering retiring in the UK, where they had strong ties to family and friends. Some felt a little isolated where they were or missed cultural aspects of living in the UK, for example, choirs or art.

CASE STUDY

Case study 6: Older explorer

The journey below depicts the steps and considerations of a senior consultant based in the UK, who migrated to Australia late in their career. Please note that some steps have been inferred based on the findings from this group overall.



Key: *Green circles represent pull factors, and red circles represent push factors, throughout different stages of the migration journey. The size of the circles reflects the relative influence on the decision to migrate*

SUMMARY

Older explorers are a sought-after group internationally, with many potential options open to them, depending on their personal circumstances. Their experience and contacts allow them to find positions internationally and they're driven by a desire for new professional challenges and experiences. In many cases, they will have already worked overseas.

As this is a group that may return, strategies to ensure they come back and fulfil their careers in the UK will be key for this group, as well as those to enable them to stay. Key tactics might include offering more flexible working options that allow them to reduce their hours as they lead up to retirement, while others may be more influenced by being offered a set of new challenges in their late career that make them feel fulfilled and valued.

SALARY SEEKERS

WHO ARE THEY?

This group was typically made up of men in their 40s who had come to a point within their career when they realised that their **current salary and future salary prospects were not sufficient to sustain the quality of life they desired**. They tended to be consultants in

secondary care with an accumulating feeling that the demands of their job were too high in relation to their renumeration.

Most people in this group were international citizens with international PMQs who first moved to the UK typically for a training opportunity. The UK was often praised for the quality and prestige of its training. However, it appears that the post-training experience for these doctors gradually deteriorated.

A majority of people in this group were based in London prior to considering migration, partially driven to migrate by high property prices. Some migrated to places such as the UAE or Singapore, which had advantageous tax systems.

WHAT WERE THEIR TRIGGER POINTS FOR FIRST CONSIDERING MIGRATION?

As with other groups, there tended to be an accumulation of push factors that left them open to the idea of migration, followed by a trigger that drove them towards taking action. While the specific triggers varied across the group, they generally served the purpose of highlighting how their salary in the UK was insufficient or how opportunities abroad could be better.

Triggers that highlighted the limitations of salaries in the UK included realising that they were **unable to get on the housing ladder**, or would **soon be in debt** if they were to continue on their current salary, and being unable to meet financial commitments back home.

"Even though we are both professional, well-paid people, my wife and I, for some reason we couldn't get on the property ladder, we couldn't buy a house, we felt that we were struggling financially, and we thought about starting somewhere else."

Consultant, England -> Germany, Man, 41-50

Other triggers brought to light how **salary opportunities in other countries might be better** and varied from being headhunted by a recruiter to hearing about experiences of practising abroad. In most cases, people heard about practising abroad from colleagues who had either already migrated or were in the process of migrating. One person said that they had become open to the idea of migration as they had become increasingly aware of their financial situation and were then convinced that they would eventually be migrating after attending an information session organised by a recruitment agency.

WHAT WERE THE TYPICAL STEPS IN THEIR DECISION-MAKING JOURNEY?

After the initial trigger, the journey of the salary seeker **could move relatively fast or slow based on their financial situation**, as well as on the destination they chose. In some cases, people were close to running into debt or were coming towards the end of a contract, making them propel their journey as fast as possible. When their situation enabled it, salary seekers took their time migrating, often waiting for a job they felt was particularly suitable or for the best opportunity to move their family.

WHAT PUSH AND PULL FACTORS INFLUENCED THEIR JOURNEY?

Salary seekers were primarily driven by the combination of several **sociopolitical and professional factors**, at the core of which was a **salary they felt was insufficient**.

Unsatisfactory salary was a particular issue as they felt it did not enable them to live the kind of life they desired or plan for the future. This was linked to life-stage, with several participants stating how the salary left them struggling to pay for childcare, their children's education or get on the housing ladder. **National policies relating to taxation and pensions** played a part here, with some respondents in fear of what retirement costs looked like.

The salary was often closely associated with other structural issues such as **long working hours and heavy workloads**. Not only did these contribute to the lack of a work-life balance, but doctors in this group had a strong sense of an **imbalance between work and pay**. These factors together left them feeling like their time and skills were not appropriately compensated for.

"Then the other thing was I sat down one day and calculated that for my on call, because of the way you were remunerated in the UK for your on-call system, I was being paid less than minimum wage for the amount of time I spent on call and I thought what's the point? I was literally … of all the people in the hospital, including the cleaners, I was the lowest paid person."

Consultant, England -> Qatar, Man, 41-50

Furthermore, some people in this group also made references to difficulties entering the specialist register via the CESR/CEGPR route (formerly Article 14). The process was described as being extremely difficult, time-consuming and costly. Without going through this process there appeared to be a limit to how far they could progress in their career and how much their pay could increase.

"I had a contract in 2017 and a contract in 2018, 12-month fellowship contracts, and then when that contract was up, I didn't have a job anywhere, and I applied for a few locum consultant positions in the UK but I hadn't got them, and to go to the Article 14 is a long process, and when I looked at the end result in terms of salary, the salary I would make was about a third of what I could make as I was in Australia without undertaking Article 14, so I thought there's no point in me going through all that when I can just get on a plane and find a job."

Consultant, England -> Australia, Woman, 41-50

In addition to this, some people within this group also experienced secondary professional push factors. Some doctors within this group stated experiencing a **growing dissatisfaction with the NHS**. A few doctors referenced the current appraisal system, feeling that it was unnecessarily complicated 'box-ticking' and only served the purpose of adding to their workload without progressing their careers or motivating them.

WHAT WERE THE TRADE-OFFS WHEN MIGRATING?

On a personal level, many of the participants discussed how they had genuinely liked living in the UK. Some international doctors had developed close personal ties, and for EU citizens the physical and cultural distance between the UK and their home country was not too far (particularly in comparison to Australia). This meant that one of the main trade-offs was between a desirable salary and their emotional connections.

"I had very good years in the NHS and the UK, and I was very happy, but my future was better served somewhere else."

Consultant, England -> Germany, Man, 41-50

Some people in this group also experienced professional trade-offs. For a few, even though the job in their destination country was better paying than the one in the UK, the job role was not as senior. In some cases, opportunities for career progression were also limited. This meant that they wrestled with a trade-off between a well-paying job and a more prestigious job.

One participant again made a particular reference to this in regard to the CESR/CEGPR process. They commented that if they were to go through CESR/CEGPR, they would certainly have a more prestigious role, but in the end the stress and cost of actually going through the process tipped them towards migration.

Additionally, some felt the UK did offer more flexibility in progression than some other countries:

"I think [in] the UK there is a variety of different jobs whereas in Singapore it's very fixed, they're trying to follow the American system now where you've got to be in formal structural training to really go anywhere. I don't really like the word progress, it's a dirty word, but I mean I've always been told that if you're not in training in Singapore then you've got no progress. Whereas I don't get that in the UK, I mean I think you can be at any stage in your career, it doesn't matter, as long as you're contributing and doing good work, that's fine. So I miss that."

SAS, England -> Singapore, Man, 41-50

WHAT WERE THEIR POST-MIGRATION EXPERIENCES?

With the exception of the trade-offs mentioned earlier, post-migration experiences were largely positive. The most prominent reason for this was that the expectation of a better salary combined with a better work-life balance was met. In general, people felt they had more money and more time to enjoy their life in the way they wanted.

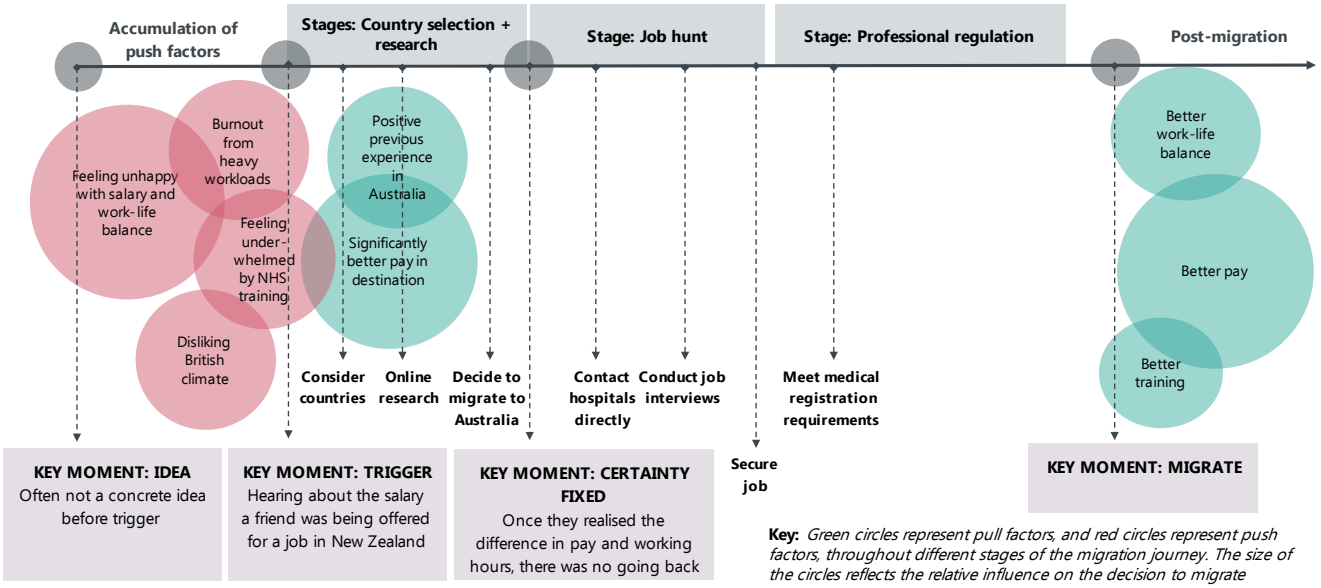
"It is about the work-life balance. You work a lot in the UK. I know it gets better through the years but here I am still a trainee, working 3 days a week. That is my whole hours, and I am getting paid twice. I am working less and getting more money."

Specialty training, England -> Australia, Man, 31-40

CASE STUDY

Case study 7: Salary seeker

The journey below depicts the steps and considerations of a Spanish born and qualified doctor in specialty training, who moved from London to Australia in search of a more secure future. Please note that some steps have been inferred based on the findings from this group overall.



Key: *Green circles represent pull factors, and red circles represent push factors, throughout different stages of the migration journey. The size of the circles reflects the relative influence on the decision to migrate*

SUMMARY

Salary seekers were a group mainly motivated by the desire to provide a good life for themselves and their families.

Interventions for this group should ideally occur before the trigger event as once they get exposed to lucrative and suitable job offers they will be difficult to persuade to stay. While the most obvious intervention for them is increasing the salary of doctors, other interventions like more support with work or more flexibility could also have significant impacts. National changes to tax and pension policies would also be strong motivators for people in this group to remain in the UK.

YOUNG EXPLORERS

WHO ARE THEY?

This group is made up of early-career, UK-born and trained doctors who typically always had the idea of travel in mind from medical school or earlier, seeking fun and adventure, and then, part-way through their medical training, were enticed to do so. They grasped the opportunity once they approached a natural crossroads in their careers, which was typically after their foundation or core training. Their chosen destinations tended to be Australia and New Zealand – attractive and accessible countries for UK trainees and well-trodden paths they'd heard about from their peers. The migration was generally planned to be short-term, ranging from 1 to 3 years.

However, there are two key findings for this group. After experiences abroad exceeded their expectations:

a. Some trainees were encouraged to stay abroad longer than planned, or were considering returning for more short-term experience some day.
b. Those who had returned from their short-term migration abroad and were now in the middle of their specialty training were seeking to make a permanent move in future.

Therefore, although this group primarily moved short-term to experience life abroad, once they realised the differences between working in the UK and working in countries such as Australia or New Zealand, they typically ended up staying longer or planned to migrate again one day.

WHAT WERE THEIR TRIGGER POINTS FOR FIRST CONSIDERING MIGRATION?

Travel had typically always been in mind for this group, who knew that one day they would like to take up the opportunity to experience life abroad. Therefore, the *idea* of migrating came much earlier, and typically occurred a while before they experienced the actual trigger to start their journey or take any concrete steps.

"Travel has always been a big part of my life, so I think even from early doors in working in med school I knew I wanted to explore it a bit more and use work as an opportunity to travel. I was always a keen skier, still am, and the dream job was working at the top of a mountain in New Zealand."

Core trainee, Wales -> Australia, Woman, 31-40

What generally actually *triggered* them to make the first step towards migrating was reaching a natural crossroads in their training. Doctors discussed being unsure, after their foundation or core training, of the medical route they wanted to take or what they wanted to specialise in. This notable space in their training allowed them time to think – the opportunity to gain experience abroad in particular specialties or simply being given the time and space in their career to consider their options. The exciting prospect of finally moving abroad was usually an idea sparked by friends or peers they had known who'd gone down this 'well-trodden' path.

"It was a perfect junction in my life. I didn't have any responsibilities or commitments. I didn't have a mortgage, pet or human, or anyone I had to run my decisions by. I had my friend who was moving over at the same time ... For me it was perfect timing."

Core trainee, Wales -> Australia, Woman, 31-40

WHAT WERE THE CHARACTERISTICS OF THEIR JOURNEY?

After the initial trigger, feeling it was the right time to migrate, a young explorer's journey could move fairly quickly, to make use of the opportunity available to them. This meant that their certainty level tended to stay high throughout the decision-making journey. Decisions tended to be fixed either from when they were first triggered to move, meaning they were keen to pursue the idea, or when they secured a job opportunity, meaning it was now a reality. Country choice was often decided at the start, through peer recommendations.

The pull factors experienced after short-term migration were often what encouraged them to stay longer, or consider migrating again, either temporarily or permanently. To add to this, for those who had returned to the UK after a short-term migration experience abroad and were keen to make a move in future, having had previous experience abroad was a significant variable that would speed up future journeys – as they would have completed a number of the typical migration steps already. There was increased familiarity with the process:

- They knew how to become professionally registered or might have kept their professional registration.
- There might be fewer costs involved.
- Whilst some had used a recruiter for their first time travelling, trainees were less likely to use them again in the future, as they now were likely to have existing connections, making the job search easier.

WHAT PUSH AND PULL FACTORS INFLUENCED THEIR JOURNEY?

Young explorers typically experienced several **primary pull factors** – highly **prominent personal and professional factors**.

- Personally, the **desire to travel** was always the initial major pull, as they're generally adventurous and willing to try something new.
- Later on, when they started to take practical steps, this desire to travel often tied in with the **professional factors of being unsure of their next career steps and wanting to gain medical experience abroad**.
- As discussed, **pulls towards particular countries** were often emphasised through peer recommendations.
- **Peer recommendation** was also the root of a lot of anecdotes of what practising in Australia and New Zealand would be like: better lifestyles, less demanding positions, better salaries.

However, a notable area to discuss with this group was the **pull factors experienced *after* having migrated**. This is what often encouraged them to stay longer, or consider migrating again, either temporarily or permanently. Having had the opportunity to practise elsewhere allowed them to compare the working conditions in the UK to those of Australia or New Zealand; and the UK often came up short. Typical pull factors noted after young explorers had experienced living abroad were around lifestyle and quality of life – access to regular warm weather, a sporting culture and a sense that they had more free time to enjoy them.

Travel and new experiences were initial pull factors for young explorers, although experiences abroad encouraged some to stay longer:

"So mainly it was to travel, experience another country, the sun and the adventure, basically that was it. Also, I wasn't sure what I wanted to do, I wasn't sure if I wanted to specialise or not so I thought I would work in ED and see what I want to do. I was always thinking of going for two years, I didn't plan to stay, so now I've stayed for three and a half years and joined the training programme, but I didn't plan to do that."

Foundation trainee, Northern Ireland -> Australia, Woman, 26-30

Whilst proactivity and pull factors define this group, there were still some **secondary push factors** surrounding wider **political and professional factors**:

- Those just finishing their FY2 noted a **high level of burnout and fatigue** – they felt that they hadn't had access to much unfettered free time over the previous 2 years and they needed a break before they could consider continuing into core and specialty training in the UK.
- For others, **general frustrations with the wider profession and the NHS** further encouraged them to want to experience something different.

For some trainees, there was the sense that the profession was not valued:

"You would go to marches and meet all these people who were like, 'This is what it is like,' and you start to get a very negative view about the job. Then when all the contract stuff came out there was a lot of politicising about the government saying, 'They're getting massive pay rises', when in reality we weren't, so the political nature of what doctors had become."

Foundation trainee, England -> Australia, Man, 31-40

As well as a desire to see if healthcare systems were better abroad:

"It was a general frustration with how the NHS was going. There's been a general feeling that healthcare in the UK is struggling and it has been struggling for a long time, and almost impossible to identify how to change that direction. I wanted to try and see if it was better somewhere else, and whether that can be implemented."

Core trainee, Wales -> Australia, Woman, 31-40

WHAT WERE THE TRADE-OFFS WHEN MIGRATING?

Although not explicitly stated by trainees as a trade-off for migrating abroad in the short-term, the fact that many returned to the UK to complete their specialty training suggests that access to the strong UK training programme and to specialty opportunities in the UK were key factors – and something that many were not willing to give up.

One trainee discussed how it was harder to get onto niche specialties in New Zealand:

"There's less jobs in my field available to me in New Zealand, so that might stop me going. In the UK there's the specialties evolving quite a lot and there will probably be a lot of jobs here in the future, and it might get easier to work in slightly more interesting places, so a bit more niche parts of my specialty. I suppose accessing different types of career opportunities might be a factor in staying here if I could get something I was interested in, and then if I couldn't get something I wanted to do in New Zealand ... but you have to be in the country for a bit with the more niche specialties to get your foot in the door, which is why I've tried to maintain some relationships over there."

Specialty trainee, Wales -> New Zealand/Australia, Woman, 31-40

Trainees discussed being motivated to return home for specialty training:

"I think professional development was the reason we came home, because the training program admittedly is not as good in Australia. And like that was a huge factor in our coming back, was to be the best that we could be and work for the NHS and give something back type thing. But the training over there is not as good, so definitely the move back was for our professional careers and our personal probably took a bit of a hit."

GP trainee, England -> Australia, Woman, 26-30

However, although the training in the UK was a strong pull to return, some were still **considering migrating abroad again in future because of the positive experiences they had**:

"I'm not 100% going to say yes, but I think when I went out there before, I didn't think it was going to be a permanent move at all, and I had a two-year timeframe in my head. And I wasn't expecting it to be as hard to leave. I wasn't expecting to be two-and-a-bit years down the line and still wishing we were there."

GP trainee, England -> Australia, Woman, 26-30

WHAT WERE THEIR POST-MIGRATION EXPERIENCES?

Unlike with the other groups discovered, post-migration experiences have been inherently discussed throughout for this group, as these experiences have such a big impact on this group's future likelihood to migrate. For many, experiences abroad exceeded their expectations to the extent that many developed further pull factors that encouraged them to either stay abroad longer than planned or consider migrating abroad again, often to the same countries experienced already – Australia or New Zealand. Once they had experienced working abroad, they noted factors such as better salaries, having more control over their free time and a more relaxed, less demanding/pressurised work environment. This aspect of their journey is incredibly important to bear in mind, as it affects young explorers' likelihood of staying in the UK medical workforce.

Trainees discussed positive factors coming to light after they had migrated:

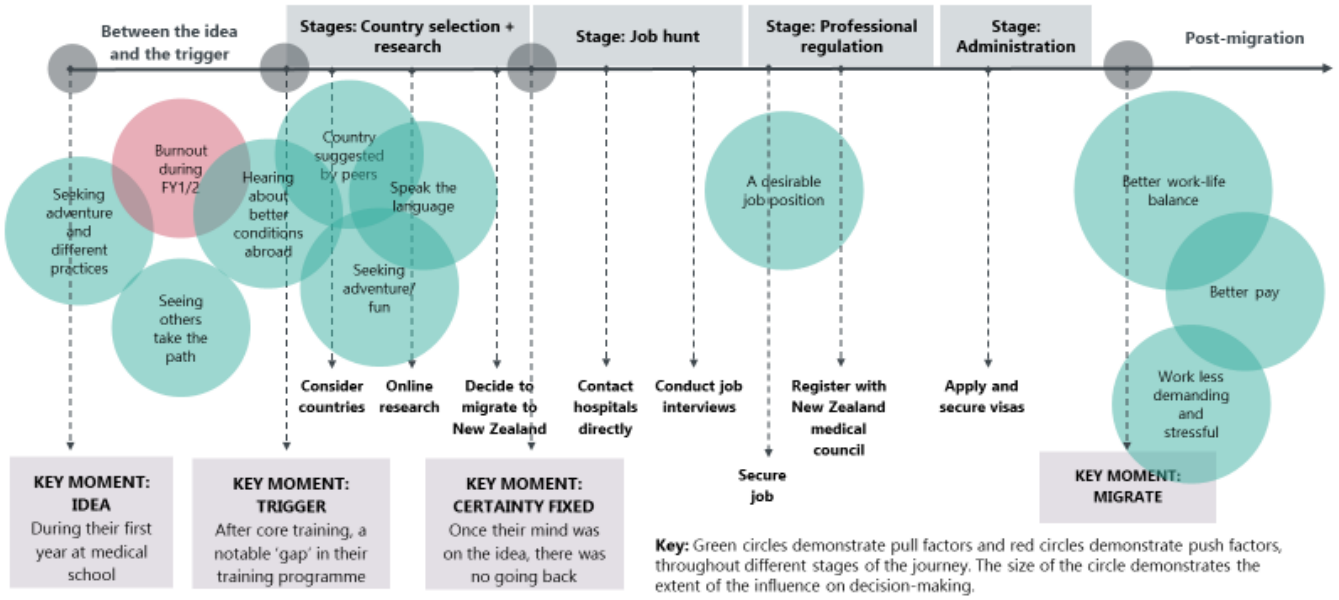
"Now that I am here there are different advantages that I have seen, but I actually didn't know that when I was applying. I didn't know about the salary and I also didn't know about the working conditions, I didn't know at all, I just wanted a different experience and to travel and the sun was a big factor in it all."

Foundation trainee, Northern Ireland -> Australia, Woman, 26-30

CASE STUDY

Case study 8: Young explorer

The journey below depicts the steps and considerations of a specialty trainee based in the UK, who migrated to New Zealand short-term after core training to gain some experience abroad and to have a break before entering specialty training. Prompted to return to the UK to complete specialty training, the experience abroad has encouraged them to consider migrating again in future. Please note that some steps have been inferred based on the findings from this group overall.



Key: Green circles demonstrate pull factors and red circles demonstrate push factors, throughout different stages of the journey. The size of the circle demonstrates the extent of the influence on decision-making.

SUMMARY

Young explorers always had plans to travel, with strong desires to experience new systems and ways of living. Often, the first trip was thought to be a temporary one, but once they experienced working in another system, they might find they preferred it. Those yet to do their specialty training were pulled back to the UK by the prospects of high-quality training and opportunities, but the memories of a less stressful way of working and living might stick with them, prompting them to consider migrating again more permanently in future. Strategies to ensure they come back and fulfil their careers in the UK are key – the strength of the UK's training programme and availability of specialties will be strong levers here.

CONCLUSIONS

This qualitative study builds on previous research on medical migration, by exploring in detail the journeys of different groups of migrating doctors and looking at the triggers, decision points and steps involved.

Our findings support the idea found in the literature that doctors' migration decisions are based on a combination of macro, meso and micro-level push and pull factors, here conceptualised as sociopolitical, professional and personal. We also looked at the ways in which the nature of the initial trigger to leave can have a big impact on the subsequent speed of the migration decision and the actual journey itself, which can have major implications in terms of designing interventions.

It is useful here to think of interventions in terms of those targeted pre- and post-trigger as well as pre- and post-migration. The different groups examined here may require a different type and balance of interventions, some at an individual level, for example, in terms of encouraging an open discussion of career options, and some more systemic. While some groups such as 'burnt-out GPs' are likely to require preventative action around working conditions before they get to the trigger point, others such as the career-limited group are more likely to change their minds post-trigger but prior to leaving if given access to the right development opportunities. Finally, challenges and disappointments in the migration experience also present opportunities. Those in groups such as our young explorer group may be open to return to the UK post-migration, particularly where their destination country doesn't offer equivalent opportunities for training or career development. The table after this conclusion summarises the identified groups and potential intervention opportunities.

While there were different groups of migrating doctors, at the same time there were common themes looking at key push factors, which were present in almost all cases and should be a cause for concern. Heavy workloads and a sense that public support and respect for the medical profession has waned were both important factors for many of those we talked to. When medics face these issues without a sense of support from colleagues, this seems particularly impactful.

A number of future avenues for research are suggested by this project. The largest group of migrating doctors discussed here was those who were career-limited, further quantitative work would be useful to validate and establish the relative size these groupings and test the relative prevalence and importance of both triggers and push and pull factors. In addition, although some work exists here, a closer examination of the experiences of both international doctors and GPs looks vital. Finally, we wonder whether closer examination of families in which both partners are in the medical profession should be explored. In many cases, we talked to migrating doctors in this situation, where the UK health system was not losing just one doctor, but two.

Table 5: Summary of the groups of migrating doctors

Type	Personal characteristics	Triggers	Push factors	Pull factors	Speed of journey	Intervention opportunities
Burnt-out GPs	Exclusively GPs, at various stages in their careers. They were more often women than others in our sample and many had partners who were also doctors. Most had trained in the UK.	Death or poor health of a colleague; professional scrutiny (GMC Complaint, CQC inspection); Brexit - signal around UK culture, seeing more private companies; Responsibilities recently acquired	Burnout due to overwork; a lack of sympathy from practice partners or commissioning groups; covering for unfilled vacancies or illness; high patient expectations, abuse, risk of litigation; the perceived inadequacy of related services.	Better work-life balance.	Fast where serious wellbeing issues were concerned.	Interventions need to be **pre-trigger**, potentially around workload, more opportunities for flexible or part-time working, better support from other services, more effective cover for illness, more mental health support, more support through moments of professional scrutiny. **Post-trigger:** This group is unlikely to change their mind post-trigger, given the highly emotive nature of their triggers.
Career-limited doctors	Individuals in this group tended to be international, ambitious, mid-career specialists/ specialty and associate specialists (SAS)/locally employed doctors (LED) with few personal or family ties to the UK and its systems. Demographically, these doctors originated and were often returning to India and Europe, having achieved their PMQ from the late 1990s onwards.	Applying for but not getting a particular job role, which represented a step up from their current position; not being accepted onto the medical register; wanting to pursue work within a more specific field and seeing a relevant job opportunity elsewhere; consistently being asked to work above their pay-grade, without the associated increase in salary or promotion; having to wait for what they felt was an unnecessary period of time before being promoted.	Personal and perceived systemic issues around career opportunities.	Better employment; opportunities, in terms of role; specialty, seniority and salary; better recognition of experience and qualifications; prestige and CV building.	Fairly quick, though looking for the best opportunities	Mostly **pre-trigger**, ensuring good career planning, particularly for international doctors. Removing systematic barriers to career progression. Support at times of disappointment around career, provision of career advice and guidance. **Post-trigger:** Targeted career opportunities. Keeping in contact to ensure they are informed if rules around the medical register change or if new job opportunities arise.

Disheartened EU and international doctors	Consultants and SAS doctors, spanning a wide range of locations prior to migration and varied migration destinations. Often in their 40s with young families.	Brexit - emotional and practical issues including lack of access to funding and a change in public mood; unpleasant interactions at work, including bullying.	Increasing workload; a sense that UK society has become more xenophobic since Brexit; moving their families while they still could.	Attractive working conditions; a sense that other cultures might be more appreciative of them.	Generally quick, with little admin required for nationals returning to their home country.	**Pre-trigger:** Additional support and taking action to tackle negative experiences for non-UK doctors in the workplace with both colleagues and patients. Reduced workloads. **Post-trigger:** Information which might inform them of any changes to the situation they experienced.
Disillusioned doctors	Mostly though not exclusively consultants and GPs trained in the UK, 40+ men.	GMC investigation; inciting hospital incident, meeting with bosses (clarity over how nothing had changed); Brexit especially for those with partners from EU.	Feeling of hopelessness about the state of the NHS and how it was run and funded; Work load and lack of work-life balance.	Better pay and better work life balance; The sense of a system which was more 'functional'	Fairly slow, they took time to evaluate different opportunities open to them.	**Pre-trigger:** Sensitive handling of key moments such as GMC investigations; changes to the working conditions of doctors particularly in terms of hours worked / bureaucracy / funding; information about initiatives which might improve the current situation and offer hope. **Post-trigger**: Stressing the values on which the NHS is based, this is the main area of dissatisfaction for these doctors when working abroad.
Internationally mobile doctors	International mid-career doctors in GP or consultant roles.	Administrative issues with visas, license to practice; trying to purchase a house; headhunted.	Administrative/ visa issues, career limitations.	Career opportunities, experiences.	Fast when required by visa issues.	**Pre-trigger:** More support with visa issues and other administrative elements of living and working in the UK.

						Post-trigger: Faster processes to encourage them to return. Support with administrative processes. Details of new job opportunities.
Older explorers	This group is made up of older (late 50s upwards), mainly UK-born doctors or doctors born elsewhere who had spent most of their career working within the NHS.	Professional goals achieved; change in management making them feel their expertise wasn't appreciated; personal life stage change, e.g. lack of dependents.	Feeling under-appreciated; lack of challenge.	Wanting change, adventure or new challenges.	Fast as they had contacts offering them jobs in many cases.	**Pre-trigger:** Offering a set of new challenges, finding a place for experienced doctors and using their skills. **Post-trigger:** News about opportunities for new challenges for experienced doctors. More flexible working patterns towards retirement age.
Salary seekers	Mostly men in their 40s, consultants in secondary care, often living in London, often IMGs. Sometimes migrating to UAE and other tax-free areas.	Buying a house; hearing about salary from a peer; going into debt or realising they were living beyond their means; approach from a headhunter.	Salary, particularly in relation to hours worked and comparisons with others.	Higher salary, also advantageous tax or pension arrangements.	Highly dependent on precarious-ness of the individual's finances.	**Pre-trigger:** Higher salaries, financial advice and support around crucial moments such as house purchase. **Post-trigger:** Predominantly salary based, though changes to tax and pension also important.
Young explorers	This group is made up of early-career UK-born and trained doctors who typically always had the idea of travel in mind from medical school or earlier.	Crossroads in training; the idea was always present.	Mainly determined by pull factors, but fatigue and burnout post-training also an issue.	Initially, a desire for new challenges, adventure, experiencing a new system; once there encouraged to stay by lifestyle	Fast as no dependents and certainty high throughout.	**Pre-trigger:** Providing opportunities for travel and adventure within a structure where return after a period of time is to some extent formalised. Reducing trainee workload to avoid burnout and the requirement for a career break.

				and work- life balance.		**Post-trigger:** Strategies to ensure they come back and fulfil their careers in the UK are key – the strength of the UK's training programme and availability of specialties are strong levers here.

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APPENDICES

ADDITIONAL NOTES ON THE STUDY AND METHODOLOGY

PROJECT LIMITATIONS

Limitations to the study include:

- **Selection bias:** all research is likely to suffer from selection bias, often resulting in more responses from those at extreme ends of the spectrum, i.e. individuals who are most and least satisfied. To try to mitigate this, we used multiple channels and methods to encourage participation, and set clear quotas around participation of particular types of respondents.
- **Further biases:** a number of other biases were also considered in our analysis, in particular, a tendency for respondents to over-rationalise decision-making, underemphasising emotional triggers. We sought to reduce this as much as possible during fieldwork through careful question wording and the use of very open questioning, e.g. 'Tell me about how that came about…' rather than more direct questions, e.g. 'What were your reasons for leaving?' We were also cognisant of the potential for social desirability bias, with respondents wanting to say 'the right thing' with regard to their reasons, e.g. underestimating the impact of financial reasons and overplaying those around concerns for family.
- **Timing of the research:** fieldwork was conducted during the COVID-19 pandemic, which may potentially have had an impact on the research findings, therefore questioning was used to decipher the extent to which any influencing factors had been impacted by the pandemic. It also took place during the broadcast of the BBC series 'This is going to hurt' which dramatised the working conditions of doctors on an NHS labour ward. This and accompanying press coverage may also have influenced our interviewees though it was not mentioned specifically by any of our respondents.

RESEARCH ETHICS AND ETHICS APPROVAL

The study raised some ethical questions:

- We recognised that respondents may use the interview to report a patient safety, bullying or undermining concern, or raise something that could be a fitness to practise issue.
- We were mindful that clinicians may have experienced an unusual amount of trauma over the past year and a half.
- Given the subject matter, we were prepared for participants to share insights that were sensitive or highly personal to them.

Risks were mitigated against throughout fieldwork. Interviewers were briefed in what might define a fitness to practise issue and a protocol was developed for sharing these. Communications with respondents stressed the confidential nature of this research and that transcripts would be pseudonymised as far as possible to limit any identification.

Shift Insight is a small company and does not have a formal ethics committee. However, we are committed to promoting high ethical standards and to safeguarding the dignity, rights and welfare of all those involved in research and the implementation of its results, as a fundamental part of our principles of research integrity. We have a research ethics policy and connected policies on whistleblowing and safeguarding. All GMC research, including this study, is developed in line with an in-house research ethics code of conduct.

ADDITIONAL NOTES ON THE SAMPLE

The full breakdown of the overall sample of 90 respondents is shown in the tables below.

Table 7: Sample by respondent job role

Job role	Number
Doctor in foundation training	7
Doctor in core training	8
Doctor in GP training	2
Doctor in specialty training	12
Consultant - medicine	22
Consultant - surgeon	10
GP	10
Specialty and Associate Specialist	10
Locally Employed Doctor	2
Medical Academic	4
Other	3

Table 8: Sample by respondent country of origin

Country of origin	Number
UK	39
EEA	27
South Asia	12
Africa	4
Middle East	2
South America	2
US/Canada	1
Australia/New Zealand	3

Table 9: Sample by respondent gender

Gender	Number
Man	62
Woman	27
Non-binary or gender non-conforming	0
Prefer not to say	1

Table 10: Sample by specialism (if applicable)

Specialism (if applicable)	Number

Anaesthesia	6
Cardiology	1
Dermatology	1
Emergency medicine	3
Endocrinology and diabetes	1
General practice (GP)	12
Gastroenterology	1
Geriatric medicine	3
Intensive care medicine	5
Internal medicine	4
Obstetrics and gynaecology	3
Oncology	1
Ophthalmology	2
Paediatrics	6
Pathology	2
Psychiatry	3
Surgery	15
Other	8

Table 11: Sample by respondent's UK region of current or previous residence

UK region (currently practising/previously practised in)	Number
London	21
South West	19
North West	9
East of England	5
South East	6
South Wales	6
West Midlands	5
North East	4
Northern Scotland	4
Yorkshire	4
Southern Scotland	3
East Midlands	2
North Wales	1
Northern Ireland	1

TOPIC GUIDE

INTERVIEW GUIDE FOR RESPONDENTS WHO HAD MIGRATED

Introduction (3 minutes)	
Question	**Notes or prompts for interviewer**
About you (3-5 minutes)	
1. Interviewer to confirm the following: • Country practising in • Original country of citizenship • PMQ country + year • Year they moved from the UK • UK region moved from • UK role/career stage + specialty when moved	
2. What is your current job role?	
3. (If non-UK PMQ) I understand that you gained your PMQ in [country]. When did you move to the UK?	*Prompt: What was your role at the time?*
4. (If non-UK PMQ) How long did you stay in the UK for?	*Prompt: Was this what you had intended?*
5. (If non-UK PMQ) If you had to summarise in 1 minute, why did you move to the UK?	*Prompt: What encouraged you to move? What were your main reasons for moving?*
6. If you had to summarise in 1 minute why you decided to leave the UK to practise in [country], what would you say?	*Prompt: Can you remember why you decided to do this?*
First considered migrating (2-5 minutes) I'd now like to understand when you first considered leaving the UK to practise in another country and why.	
7. Did you always intend to leave the UK to practise in another country?	*Prompt: Why is that?*
8. (If relevant) Looking back, when would you say you first considered leaving the UK to practise in another country?	*Prompt: What year? What was your job role at the time?*
9. (If not mentioned) What prompted you to consider leaving the UK to practise in another country?	
10. (If relevant) Was moving to practise in another country the only career change you were considering at the time?	*Prompt: For example, were you considering anything else such as a career move/break? Why?*
11. (If not mentioned) How certain were you about your decision at this point?	
The migration journey (25 minutes) I'd now like to understand what stages you went through as part of your migration journey. At each stage, I'd really like to hear about what was influencing your decision, any barriers you came across, and how certain your felt about your decision to leave at that time. I'll share my screen so we can visualise these steps.	
12. I'd like you to talk me through the different stages of your migration journey – so the different steps that you took to help you make your decision to migrate, and then to eventually migrate. It would be great if you	

could also let me know when you carried out those steps (which might be the year or timeframe that you did them, but also your career stage at the time).	
13. I'm going to share my screen with you now, so we can visualise your journey together. So, it sounds like these steps were part of your journey. I've also grouped them into different stages – around the point in time that they happened – does this look right? Were any of the other steps that you can see here, part of your decision-making process and migration journey? (And at what point in your migration journey did they occur?) • Discussing the idea with others • Researching practising abroad • Deciding where to move • Contacting a recruiter • Attending information sessions to prepare for migrating • Taking tests or taking part in qualification checks • Obtaining a certificate of good standing from the GMC • Applying for jobs abroad • Securing a job abroad • Obtaining a visa • Meeting immigration requirements	
14. Are there any steps that you took that are not covered here?	
Questions about the migration journey	
15. [For each stage] At this stage in your journey, what factors were influencing your decision to leave the UK to practise in another country?	*Prompt: What were your main reasons for wanting to migrate at this time? If poor working conditions in the UK mentioned: What aspect of this was influencing you? From your perceptions, what was different about the working conditions in other countries?*
16. Did you interact with any organisations or people at any point in your migration journey? For example, this might be medical bodies or other organisations, recruiters, colleagues or friends. If so, who? In what way did your interaction with x influence your migration journey, if at all?	*Prompt: Could you tell me a bit more about that? What other organisations or people did you interact with throughout the stages you mentioned?*
17. Did you come across any barriers or challenges at any point in your journey? By this I mean anything that made the process more difficult for you at this point. When?	*Prompt: In what way? Was there anything that was preventing you from leaving UK practice?* *If applicable: To what extent was this stage influenced by the COVID-19 pandemic?*
18. How certain were you about your decision at different stages in your journey?	*Prompt: Why is that? Were you close to changing your mind about leaving UK practice at any point?*

	For example, when comparing the UK to other countries, to what extent was there anything that was making you want to stay in the UK? e.g. care being free at the point of delivery. If not certain, were you considering other career options at this point?
Recapping and reflecting on the journey (5-10 minutes) I'd now like to summarise your migration journey back to you, to ensure I've understood it correctly and to see if there is anything you would change or add to your experience of leaving the UK to practise in another country.	
19. After I have finishing recapping, I'd like you to tell me if that sounded right or if you would change or add anything. • Background e.g. when moved to UK if applicable and why • Initial considerations: when + why • Each stage in their journey: when + why + barriers • The point they were certain in their decision	
20. Is there anything else about living in, or opportunities in, the UK or [country] which you feel influenced your decision? If so, what?	*Prompt: At what stage was this influential?*
21. Is there anything else in terms of your work or professional development which you feel influenced your decision? If so, what?	*Prompt: At what stage was this influential?*
22. Is there anything else in terms of your personal aspirations or relationships which you feel influenced your decision? If so, what?	*Prompt: At what stage was this influential?*
23. Reflecting on your journey, what, if anything might have influenced you to stay in the UK (or stay longer in the UK)?	*Prompt: Why is that?*
24. To what extent has your experience of practising in [country] met your initial expectations?	*Prompt: Why or why not? In what way? To what extent has this been influenced by the COVID-19 pandemic?*
25. (If not mentioned) Did you or do you have any plans to return to the UK to practise? If so, when?	*Prompt: Why is that?*
26. (If not mentioned, and no plans to return) Is there anything that might make you consider moving back to the UK to practise? If so, what?	*Prompt: Why is this?*
Conclusion (1 minute)	
In conclusion do you have anything else you'd like to say about what we have spoken about today?	

INTERVIEW GUIDE FOR RESPONDENTS WHO WERE CONSIDERING MIGRATION

Introduction (3 minutes)	
Question	**Notes or prompts for interviewer**
About you (3-5 minutes)	
• Interviewer to confirm the following details:	

• Current job role/career stage + specialty • UK region practising in • Original country of citizenship • When they came to the UK, if relevant • PMQ country + year • Where they might migrate to, if known • When they might move, if known	
1. (If non-UK PMQ) I understand that you gained your PMQ in [country]. When did you move to the UK?	*Prompt: What was your role at the time?*
2. (If non-UK PMQ) How long did you intend to stay in the UK for?	
3. (If non-UK PMQ) Why did you move to the UK?	*Prompt: What encouraged you to move? What were your main reasons for moving?*
4. To what extent has your experiences of practising in the UK met your initial expectations?	*Prompt: Why is that?*
5. If you had to summarise in 1 minute why you are thinking about or have decided to leave the UK to practise [in country/abroad], what would you say?	*Prompt: Can you remember why you decided to look into this?*
First considered migrating (3-5 minutes) I'd now like to understand when you first considered leaving the UK to practise in another country and why.	
6. Did you always intend to leave the UK to practise in another country?	*Prompt: Why is that?*
7. (If relevant) Looking back, when would you say you first considered leaving the UK to practise in another country?	*Prompt: What year? What was your job role at the time?*
8. (If not mentioned) What prompted you to consider leaving the UK to practise in another country?	
9. (If relevant) Is moving to practise in another country the only career change you are considering at the moment, or have previously thought about?	*Prompt: For example, are/were you considering anything else such as a career move/break? Why?*
10. (If not mentioned) On a scale of 1 to 5, where 1 is not at all and 5 is definitely, how certain are you about leaving the UK to practise in another country? Why is that?	*Prompt: How likely is it?*
The migration journey (25 minutes) I'd now like to understand what steps you have taken towards your plans to migrate, and any future steps you might take here. At each stage, I'd really like to hear about what was influencing your decision, any barriers you came across, and how certain your felt about your decision to leave at that time. I'll share my screen so we can visualise these steps.	
11. I'd like you to talk me through the different steps you have taken so far towards migrating, and when these were taken (which might be the year or timeframe that you did them, but also your career stage at the time).	
12. I'm going to share my screen with you now, so we can visualise your journey together. So, it sounds like these steps have been part of your	

journey so far. I've also grouped them into different stages – around the point in time that they happened – does this look right? Have you taken any of the other steps that you can see here? (And when did you do them?) Have you taken any other steps not shown here? (And when did you do them?) • Discussing the idea with others • Researching practising abroad • Deciding where to move • Contacting a recruiter • Attending information sessions to prepare for migrating • Taking tests or taking part in qualification checks • Obtaining a certificate of good standing from the GMC • Applying for jobs abroad • Securing a job abroad • Obtaining a visa • Meeting immigration requirements	
Questions about the steps already taken	
13. [For each stage] At this stage in your journey, what factors were influencing your decision?	*Prompt: What were your main reasons for wanting to migrate at this time? Had they changed at all? If poor working conditions in the UK mentioned: What aspect of this was influencing you? From your perceptions, what is different about the working conditions in other countries?*
14. Did you interact with any organisations or people at any point in your migration journey? For example, this might be medical bodies or other organisations, recruiters, colleagues or friends. If so, who? In what way did your interaction with x influence your migration journey, if at all?	*Prompt: Could you tell me a bit more about that? What other organisations or people did you interact with throughout the stages you mentioned?*
15. Did you come across any barriers or challenges at any point in your journey? By this I mean anything that made the process more difficult for you at this point. When?	*Prompt: In what way? Was there anything that was preventing you from leaving UK practice?* *If applicable: To what extent was this stage influenced by the COVID-19 pandemic?*
16. How certain were you about your decision at different stages in your journey?	*Prompt: Why is that? How close were you to changing your mind about leaving UK practice at any point? For example, when comparing the UK to other countries, to what extent was there anything that was making you want to stay in the UK? E.g. care being free at the point of delivery. If not certain, were you considering other career options at this point?*
Questions about future steps	
17. So, the last thing you did was [last step] / the current stage you are at is [stage]. What would you say your next steps are? When do you plan to do this?	

18. Do you anticipate that you will carry out any of these steps in the near future? And when will you do them? Don't worry if you are not sure yet. Do you plan to take any other steps not shown here? And when will you do them? • Discussing the idea with others • Researching practising abroad • Deciding where to move • Contacting a recruiter • Attending information sessions to prepare for migrating • Taking tests or taking part in qualification checks • Obtaining a certificate of good standing from the GMC • Applying for jobs abroad • Securing a job abroad • Obtaining a visa • Meeting immigration requirements	
19. Do you anticipate coming across any further barriers or challenges? If so, when and what?	*Prompt: In what way? Is there anything that might prevent you from leaving UK practice?* *If applicable: To what extent do you feel your future steps might be influenced by the COVID-19 pandemic?*
20. What factors do you think might influence your decision in the future?	*Prompt: Why is that? In what way? What other organisations or people do you think will be involved? If working conditions in the UK mentioned: What aspect of this might influence you? From your perceptions, what is different about the working conditions in other countries?*
21. Is there anything that might make you change your mind about your decision?	*Prompt: Why is that? What, if anything, might influence you to stay in the UK (or stay longer in the UK?) For example, when comparing the UK to other countries, is there anything that might make you want to stay in the UK? e.g. care being free at the point of delivery. What about other career options?*
Recapping and reflecting on the journey (5-10 minutes) I'd now like to summarise the journey you have taken so far back to you as well as your planned future steps, to ensure I've understood it correctly.	
22. After I have finishing recapping, I'd like you to tell me if that sounded right or if you would change or add anything. • Background e.g. when moved to UK if applicable and why • Initial considerations: when + why • Steps taken so far in their journey: when + why + barriers • Future steps in their journey: when + why + barriers	

• The point they were or might be certain in their decision	
23. Is there anything else about living in, or opportunities in, the UK or [country/abroad] which you feel has influenced or might influence your decision? If so, what?	*Prompt: At what stage was this / could this be influential?*
24. Is there anything else in terms of your work or professional development which you feel has influenced or might influence your decision? If so, what?	*Prompt: At what stage was this / could this be influential?*
25. Is there anything else in terms of your personal aspirations or relationships which you feel has influenced or might influence your decision? If so, what?	*Prompt: At what stage was this / could this be influential?*
26. (If not mentioned) If you were to migrate, do you think this will be a permanent move? Why is that?	*Prompt: Could you see yourself returning to the UK in future? If so, when? Why/why not?*
27. (If not mentioned, and no plans to return) Is there anything that might make you consider moving back to the UK to practise? If so, what?	*Prompt: Why is this?*
Conclusion (1 minute)	
In conclusion do you have anything else you'd like to say about what we have spoken about today?	