New Europe College Yearbook
2017-2018
2018-2019

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This collection contains the papers of the Fellows from the NEC Program, the NEC International Program, and the UEFISCDI Award Program.

The UEFISCDI Award Program was supported by a grant from the Romanian Agency for Higher Education and Research Funding (UEFISCDI)
Project number: PN-III-P3-3.6-H2020-2016-0017
Project number: PN-III-P3-3.6-H2020-2016-0018

ISSN 1584-0298

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RETURN MIGRATION OF HEALTH CARE PROFESSIONALS AND THE TRANSFORMATION OF MEDICAL PRACTICES: BULGARIA AND ROMANIA IN FOCUS

Abstract

This paper analyses the category of returning health professionals in the field of maternal and child health in Bulgaria and Romania. It looks at the motivations, trajectories and experiences of return migrants on one hand, and on the effects their return migration has on the ways they themselves practice medicine at an individual level and the efforts and steps they take for bringing in transformations at a systemic level. The concept of "medical habitus" is used to grasp the reflexive move that medical professionals are compelled to make when shifting between different medical systems. The result of this shift is transfer of knowledge and transformative effects on the medical system that is framed as "professional remittances".

Keywords: high-skilled return migration, medical transformations, maternal and child health, Eastern Europe

Ten years after Romania and Bulgaria became members of the European Union, out-migration of high-skilled medical professionals continues to be high and to trigger public fears of "brain drain". Migration has been blamed as one of the main causes for the growing shortage of health professionals in Eastern Europe (e.g. Karanikolos *et al.* 2013, Rohova 2017, Sechet and Vasilcu 2015, Wismar *et al.* 2011).[1] Indeed, EU accession brought about free labor mobility and open labor markets, synchronizations and recognition of qualifications, simple professional transfers across the EU, all of which facilitated already intensive high-skilled labor mobility and continuing education/specialization mobility in the European Union among Eastern European health professionals (Glinos 2015). Competitive

wages, bigger opportunities for professional development, and the shortage of medical professionals in Western European countries, have been identified as the main factors for Eastern European professional medical migration (Boncea 2014, Séchet and Vasilcu. 2015, Eurofund 2013).

Economic and social conditions as of 2018 have only recently started to improve for health professionals in Romania and have not significantly changed in Bulgaria. Nonetheless, there seems to be a growing niche for returning medical specialists to engage in a variety of activities that create both profitable and professional development opportunities. This small, but influential category, has been overshadowed by the analysis of "brain drain" and their attempts for re-integrating in their home countries' health systems have remained unnoticed. The vectors of this "return migration" are far from simple or unidirectional. Some return after several years of education, others have migrated with the sole purpose of specialization unavailable at home, yet others have worked abroad for a number of years, before deciding to restart practicing at home. A diverse group, return migrants vary from classical examples of long-term settlement in the home country, through educational fixed-term mobility, to novel patterns of mobility which involve circular movements, highly intensive, short-term regular mobilities, and sometimes simultaneous professional incorporation in more than one country, which is transborder in its character (Krasteva 2015, Roman and Goshin 2015, Tjadens *et al.* 2012).

This chapter focuses on the category of returning health professionals in the field of maternal and child health in Bulgaria and Romania. It looks at the motivations, trajectories and experiences of return migrants on one hand, and on the effects their return migration has on the ways they themselves practice medicine at an individual level and the efforts and steps they take for bringing in transformations at a systemic level. These two dimensions are analyzed through looking at:

1. The structural factors that enable and motivate return migration and the individual experience of re-integration of return migrants;

2. The transformative steps taken by returning health professionals to advance medical knowledge and practice in their home countries both at individual and at systemic level.

In what follows I first outline my methodological and conceptual choices. Then I present the conceptual framework of medical habitus and transformation as applied to the medical field and introduce the concept of "professional remittances". I then move on to a discussion of

the regulatory framework and the factors that enable and facilitate return or circular migration. Next, I present the profile of the returning medical professionals, their diverse professional trajectories, as well as their motivation for return. Finally, I discuss two main aspects of how return migratnts engage in transformative practices:

1. Transformation of individual practices of the return medical professionals;

2. The redefinition of relations and redistribution of roles between different medical and non-medical professionals.

My main argument is that by experiencing ruptures in their medical habitus, return migrants have the potential of being drivers of change both in the individual medical practice and at the systemic level of medical standards, hospital regulations, and state policies. By doing this, however, the medical professionals I interviewed face numerous challenges, tensions, and difficulties to practice their profession. The successful strategy most commonly used to overcome these tensions is to build a strong cooperative network of like-minded colleagues and to choose a niche and a workplace which is welcoming such initiatives and mode of practicing. At the same time, working in such a niche, which also most commonly means working in a private setting in a large city, also poses limitations to the potential scope and outreach of the transformations at this moment in time. My respondents provided diverging solutions for solving these tensions, varying from volunteering in disadvantaged areas, organizing free trainings for other medical professionals, organizing public information campaigns, and finally, influencing the development of new standards and protocols.

Methodological and Conceptual Choices

The research has focused on medical professionals working in the field of maternal and child health. The reason to limit it to only one field is founded in the need to understand better the particular practices and standards in this field in order to grasp the transformative efforts of medical professionals in a more in-depth way. Widening the study to all medical fields would provide a bigger sample but would make more difficult to analyze medical practices in various fields. Medical standards and protocols, guidelines, and concrete everyday ways of practicing

and relating to patients, tend to differ between health systems. These divergences manifest themselves sharply in the field of pregnancy, child birth, and neonatal care, when comparing Eastern European countries with countries like Germany, France, or the UK, which are the main destination countries for migration of health professionals from Bulgaria. In terms of maternal and child morbidity and mortality Bulgaria and Romania score higher than the EU average (http://www.europeristat.com/). High numbers of unmonitored high-risk pregnancies, complications, resulting in high numbers of neonatal mortality, almost three times higher than recommended rates of C-sections (above 40 per cent both for Bulgaria in 2014 and for Romania and growing, with WHO recommendations of 10-15 percent),[2] unnecessary and outdated medical interventions during physiological births, insufficient or non-existent postpartum care, and poor neonatal care (data is available in the National Health Strategies for Bulgaria and Romania). The international medical community has repeatedly criticized such medical practices as outdated and out of line from the latest developments of evidence-based medicine (see WHO guidelines, Byrom and Cooper 2016). While the factors leading to this situation are multifarious, there is a clear divergence between medical standards, hospital protocols, standard procedures, and in the roles and responsibilities of the medical staff (doctors, midwives, nurses) as compared to other EU countries scoring above the average (Miteniece 2017).

The empirical material for this paper was collected in four localities in Bulgaria and Romania. I have interviewed returning medical professionals in the two capital cities, Sofia and Bucharest, and in two other large cities in each country. At this stage of the research and in a context of very little secondary literature available, the empirical material is not sufficient for a full-fledged comparative analysis that would explain potential differences and similarities between the two countries. The sample is too small and the analysis of the context and structural conditions in the two countries is yet to be developed to provide a sound comparative framework. Yet, I have decided to analyze the cases from both countries here for two reasons. First, this allows a bigger number of examples of return medical professionals, given the limitations posed by the narrow field I have defined and the small numbers of returnees overall. Second, and more importantly, the study builds on the similar profile of Bulgaria and Romania as the poorest new EU member states with high numbers of out-migration of health professionals and emerging patterns of return migration and

as countries facing similar challenges in the field of maternal and child health. I aim to go beyond the national specificities of each country case, and to lay the foundations for future in-depth comparative analyses of the state of the maternal and child health in the two countries and the role that return migrants play.

For the purposes of this research, the term "return migration" will be used widely to denote a variety of professional mobilities that involve exposure to a different health system and medical practice, that is followed by some form of re-incorporation into the home labor market, be it full time and long-term, circular, or temporary. The sample is relatively small, given that the numbers of returning health professionals are still low. I have interviewed obstetricians, pediatricians, and midwives, who currently practice in two cities in Bulgaria and two cities in Romania. In total, I have interviewed 18 return medical professionals, I have also interviewed other actors active in this field who are not return migrants: other doctors and midwives, doulas, birth educators, a lawyer, and a journalist. The return migrants have professional or educations experience in Belgium, Estonia, France, Germany, Slovenia, Switzerland, and the United Kingdom.

I have also interviewed women who gave birth in Romania or in Bulgaria, some of whom have experience with return medical professionals. While I do not explicitly analyze their experience in this paper, I have used it to confirm stated practices, behavior and approaches. The larger part of the return migrants I interviewed are doctors. In addition, I have interviewed three midwives in Bulgaria and Romania, who have short (up to two months) experience from other countries, which were part of their education or professional development and informed their way of practicing. The question of low numbers of returning midwives can be explained through the structural conditions and will be addressed in the second part of the paper.

The research methods for collecting the empirical material for this paper are qualitative. I have conducted qualitative in-depth semi-structured interviews. My selection of respondents was based on the definition of return migration I have given above. The sample was build using snowball effect, networks, and personal contacts in the field. The sample is not exhaustive, there are other return migrants in this field whom I have not reached. Yet it is representative, as explained above, because the people interviewed work in major hospitals in the two countries, are all well connected in their field, and are influential with their opinions. Many of them also either participate actively in public discussion on social networks

groups and through their profiles, or have their own blogs or facebook pages, where they share their personal opinions on medical development, but also reshare studies and research in their field. In this sense, most of the people I interviewed are also running a public profile as professionals in addition to their strictly medical activities and relations with colleagues. In the empirical examples that I give below, I have chosen to not specify whether the respondent is from Romania or from Bulgaria in order to protect their anonymity, which some of the respondents explicitly asked for. Due to the small sample and the narrow field, specifying the country and the city would make it much easier to identify concrete individuals. For the same reason, I will explicitly avoid mentioning names of hospitals or medical centers where these professionals practice currently.

I have also interviewed other active people, working in this field, like journalists, lawyers, activists, birth educators, doulas, lactation consultants, some of whom have also professional experience outside Bulgaria and Romania, others do not. I have also interviewed women who gave birth recently and were in touch in one way or another with some of the medical professionals discussed here. I will not analyze specifically the material from these interviews here, but I have used the information gathered to better grasp the transformative trends discussed by the medical professionals themselves.

In addition to the interviews, I have also analyzed the policy documents like the National strategies on Maternal and Child health of the two countries, available medical standards, professional qualification standards, the publicly available statistical data, and the regulatory framework for professional mobility, for educational and professional recognition of certificates and qualification, and policies for re-integration.

Medical Habitus and the Transformation of Medical Practices

Medical systems are conservative and hierarchical institutions that follow rigorous protocols, assign strict distribution of tasks and roles, and require from their practitioners the adoption of a certain habitus and establishing of authoritative knowledge through certainty (Luke 2003), of certain modes of being and acting, and of relating to other actors (including patients) (Holmes and Ponte 2011). The concept of medical habitus (Luke 20013) builds on Bourdieu's theorizing (1991) and allows to clarify how the medical profession reproduces itself in the forms of

durable dispositions. Practicing in different systems creates the potential for a rupture and requires more than a simple readjustment, it requires a profound transformation of professional habitus. Through various types of migration (labor or professional specialization) health professionals are exposed to alternative models of medical practice in their field. This could result in a disruption of their professional habitus and requires a reflexive move outside the knowledge and practice system in which they have been professionally socialized and educated. This may trigger crises and ruptures in the individual professional practice of the medical specialist, but it may also transform the system itself. Having gained experience from different medical systems and practices, and/or further medical specialization, the return health professionals bring back not only their labor force, but the potential for advancement in knowledge and innovation and to trigger change in their home health systems.

The transfer of new practices and different ways of doing has been called in another migration context "social remittances" (Levitt 2001). In the case of professional practices, we can describe this phenomenon as "transfer of knowledge" or indeed "professional remittances". I use the concept of "professional remittances" to describe the process of transforming medical practices back in the home country as a result of gaining experience and practicing in a different medical system abroad. Transformation of medical practice in relation to return migration is a highly unexplored field, both theoretically and empirically. Studies of health professionals' mobility almost exclusively examine outmigration and the related labor shortage for the country of origin, or integration in the destination country (e.g. Connel 2007, Ognyanova et al 2012, Schah 2010, Schultz and Rijks 2014, Wismar et al 2011). Return migration of health professionals is rarely addressed and mostly through a policy perspective or through analysis of intentions. Specifically, on Bulgaria and Romania, the main interest has been to identify novel forms of return migration (Krasteva 2015) intentions to return (Roman and Goshin 2014), and a more general analysis of return migration policies (Ivanova 2012). None of these studies is concerned with the effects of return migration on the health systems, the return migrants' experience of different labor regimes and medical practices/medical habitus, or how medical practices are transformed by return migrants. In the field of medical sociology and anthropology that is concerned explicitly with medical transformations in the area of child birth, the focus is primarily on long-term historically oriented studies or on ways of promoting change in areas considered

problematic. (e.g. Browner et al 1997, Davis-Floyd 2001, 2004, Kitzinger 2006). The role of health workers mobility is marginally addressed as having the potential for knowledge transfer, without explicit analysis of the actual effects on the system (Williams and Balaz 2008). In this context, studying in-depth the experiences and the efforts of medical professionals to transform the medical practices, is an attempt to better understand the effects of intensified mobility of high-skilled professionals on the wider society.

In the field of medical sociology and anthropology that is concerned explicitly with medical transformations, the focus is primarily on long-term historically oriented studies or on ways of promoting change in areas considered problematic (e.g. Davis-Floyd 2004, de Vries *et al.* 2002, Duden 1993; Kitzinger 2004; Oakley 1980, 1984, Van Hollen 2003). Surprisingly, the field remains largely unaffected by studies of health workers mobilities. The other empirical field that remains underexplored is the field of maternal and child health, especially prenatal, natal, and neonatal care. In Bulgaria, this field is only examined by a handful of current medical practitioners from a practical point of view and a limited scope. In Romania, while more numerous, the sociological studies have been tackling other aspects of reproductive health, more specifically tracing the effects of the highly restrictive abortion policies of the Romanian socialist state (Anton 2009, Kligman 1998, Pop 2015, Sijpt 2017).

My study aims to shed light on this unexplored interconnection between professional mobility and transformation of medical practices and to set the basis for further research and analysis in other fields, but also with other methods, in order to understand the wider scope of the potential for transformation and positive change.

Structural and Individual Factors for Return and Circular Migration

EU freedom of mobility, high-skilled labor regimes, and recognition of education and professional qualification

Freedom of mobility as one of the principles of the European Union is one of the main factors that allows circulation of medical professionals. Yet, conditions for the out-migration of high-skilled professionals already existed before Bulgaria and Romania EU accession and the restriction to

access to the labor market which some countries applied after 2007, did not affect these categories of skilled and high-skilled migrants. While access to the labor market was not a major barrier, the process of recognition of education and skills required more time and efforts, both in the case of finding employment in another EU country and in the case of returning to Bulgaria and Romania. Until 2007 education and qualification gained abroad had to be recognized through a complex multi-step procedure.

Currently, within the European Union recognition of education and professional qualification for medical professionals like doctors, nurses, and midwives is not fully automatic. These professions fall in the category of regulated professions and they need to follow a certain procedure for recognizing the educational certificates, diploma, specialization and professional position, in order to be granted the right to practice the same profession in another country. The procedures are simplified and there are generally no extra exams (except a local language exam in some cases). Nonetheless, each EU country has different procedures for recognizing professional education and further specializations obtained in another EU country. The documents requested might include diplomas and certificates, programs of study, certificates for good behavior issued by the national professional organization. Mobile medical professionals who are returning to Bulgaria or Romania to practice medicine are required to recognize any diploma or further professional training that they obtained abroad. Compared to the period before 2007 when both countries joined the EU, the procedure are much simplified, faster and straightforward. While there is a need of submitting documentation, the recognition is considered "automatic" in most of the cases. My aim here, however, is not to discuss in detail the different steps of this recognition process, but to see how the returning medical professionals experienced it and thought about it.

All the respondents have returned after the two countries joined the European Union in 2007. Educational and professional recognition has been simplified since the entry in the EU and this has affected the regulated professions (see NACID for Bulgaria, CNRED for Romania). Within the EU, the procedures have been simplified both for qualification acquired in Romania and Bulgaria, and for qualifications acquired in other EU countries and recognized in Bulgaria and Romania. My respondents did not consider qualification recognition as a major barrier. On the contrary, many explicitly mentioned that it was a simple and easy procedure, both for leaving the country to continue their education/specialization or to work,

and for returning back with foreign diplomas and experience. The cases differ widely, ranging from gaining basic medical education in another EU country, through making a specialization, or parts of it, practicing for an extended period abroad, or spending part of the mandatory internship in a hospital in a different EU country.

The private sector in Romanian and Bulgarian healthcare

The emergence and flourishing of private hospitals and the possibilities to register private medical centers is another important structural factor that makes return migration more attractive. Over the last decade private hospitals gained stable grounds in both countries. Arrangements with the National health insurance companies allow some procedures in the private hospitals to be covered by the state health insurance. In addition, private health insurance companies gained momentum and provide additional insurance for extra procedures in private hospitals. The result of these developments is that the number of patients in private hospitals grew steady over the last decade. In all locations studied, the private obstetrical hospitals have a steady flow of patients. Pregnancy monitoring with additional tests and examinations also flourished outside of what is guaranteed under the national health insurance. Fetal morphology is also gaining popularity as a test and is performed by specially trained doctors in private clinics or medical centers. All of these factors contribute to the widening opportunities for successful re-integration of return migrants in settings with better financial conditions, better facilities and more advanced equipment.[3]

Simultaneous professional incorporation

Another factor, contributing to the return mobility of medical professionals, is the opportunity to be professionally engaged in more than one location across the EU. Practicing in more than one country and commuting between locations on a regular basis is an emerging pattern, called "fluid migration", "circular migration" or "pendulum migration" (Gozdziak 2015, Krasteva 2015). Practicing simultaneously in more than one place is made possible by the regulatory framework for medical specialists, but also by the structural context of freedom of mobility within the EU, regular and affordable transport, and flexible hospital regulations on full-time/part-time contracts. The possibility to continue to be professionally engaged in a work place abroad has both

professional and financial implications. On one hand, the financial benefits from sustaining a life in Romania or Bulgaria while also generating income in Western European country are obvious. But in addition to that, there are also professional development aspects that make such divided lives attractive. Finally, the decision to relocate permanently or to keep practicing abroad is bracketed when a professional can be simultaneously incorporated in two sites. In this sense, the structural opportunity that allows simultaneity is a contributing and enabling factor for return, or in this case a type of circular migration of high-skilled professionals.

A good example of such simultaneous professional incorporation is one of my respondents. A well-established doctor with years-long experience in several countries abroad, he came back to Romania[4] about 10 years ago, while keeping his practice in Germany. Every month he spends one week in Germany, and the rest of the time in Romania, where he changed several positions in the meantime. He is actively practicing medicine in both places, but also participates in the management process and organizational decisions in both places. This simultaneous professional engagement in different locations, different countries with different health systems contributed to his continuing reflexive comparison between ways of practicing, ways of organizing healthcare, ways of interacting with patients and colleagues, and distributing tasks among different medical positions. After an extended period of working in Germany, he was reluctant to terminate his practice there and relocate permanently back to Romania. At the same time, he was invited to return by a colleague and help with developing better medical practices in Romania in a prestigious hospital. The regulatory framework of the European Union allowed him to take the decision to return, without giving up his work in Germany. What is more, this simultaneity of practicing affects the ways of doing medicine and will be addressed in detail in the final section.

Motivation and Profile of the Return Migrants

The main category of returning health professionals is doctors. There are hardly any noted cases of returning midwives or nurses. I have managed to identify returning obstetricians and pediatricians in both countries and they were my main scope. The midwives that I have included in this sample, have been professionally abroad either for short exchange trips, or for several months long internships. Nonetheless, I have decided to

include them in the analysis, because first, they are exceptional in their attempts to gain a different kind of professional experience and then apply it back home, and second, because they have established close cooperative working relations with some of the other return doctors and play an important role in the redefinition of relations between professionals, and of redrawing the lines of professional autonomy, as I will discuss below. That said, the majority of the returnees are highly skilled doctors, most of them coming back after a specialization abroad or after having practiced as doctors for an extended period of time (i.e. more than 6 months). With a few exceptions, the returnees got full-time resident positions in large private hospitals, or alternatively, opened their own private practice for consulting, while partnering with a hospital for additional procedures, or for being present during their patients' birth. Those who studied abroad, returned after finishing their specialization or after having practiced for a while abroad. Only two of the doctors I interviewed came back to finish or to do their specialization in Bulgaria or Romania. Two others have acquired their specialization in the country of origin and have practiced as residents abroad, before returning.

The financial factor, while not the first to be mentioned, was something that respondents acknowledged as a base line. The conviction that a doctor can actually make a decent living in Bulgaria or Romania, if working in the private sector, was the necessary condition in order to consider return in the first place, despite the fact that it was not regarded as a sufficient condition. Almost all of the respondent are currently working in the private sector - whether opening their own private practice for monitoring pregnancy and providing special tests, fetal morphology, etc., or working in a private hospital. The financial side of this decision is certainly not the only one, but it is worth mentioning it in view of the discussion on out-migration and brain-drain where one of the major motivations quoted is the financial benefits that medical specialist get in more economically advanced countries in the EU and elsewhere. In addition to working in the private sector, more recently in the case of Romania, the salaries of doctors working in state hospitals have been substantially raised and have become competitive/ comparable to the private sector. While none of my respondents mentioned this aspect, because they have returned before this raise, it is a significant change that might offer more attractive conditions for future return migrants.

The decision to return after a period of studying or practicing out of the home country is usually interpreted as a desire to come back and bring in

something new, to change the system, to contribute to the development of new practices and to improve the health care system as a whole. This is in line with the analysis of motivation for out-migration of Romanian doctors by Irina Boncea (2015), who demonstrates that the financial aspect is only one and not the most important factor for medical professionals to leave. The main reasons behind the decision to emigrate are the undesirable working conditions and the state of the facilities. In this sense, identifying an opening for practicing medicine in a way that will contribute to improving these conditions is of major significance. For all return migrants I have interviewed, identifying a place and a team where they can work in a professional environment that corresponds to their gained experience in other settings, was extremely important. This meant on one hand to be able to work in an establishment which maintains a high level of material and technological basis, which would allow them to use their gained experience fully. In the case of birth giving for example, this means having separate birthing rooms for women, sophisticated birthing chairs/beds, monitoring devices, as well as a number of advanced equipment, most of which is available in some of the private hospitals. At the same time, improving the equipment and the facilities is only one side. Equally important is the team and the relations with colleagues (hierarchies and the skills and approach of their colleagues), the arrangement of work duties (how much administrative work, for example, how are shifts arranged)

This demonstrates two things. One is that raising salaries, while important, needs to go hand in hand with improving facilities, allowing more opportunities for research, encouraging more internal trainings for practicing medical professionals would be an important step for attracting further return migrants. The other point is that return migration is not an individual trajectory, but a move that is conditioned by the networks that medical professionals are able to mobilize upon return for a better re-integration and a way of practicing. In this sense, return migration does not happen in a vacuum and is it not motivated solely by the person's trajectory, individual skills, personal preferences, financial situation. All of my respondents identified at least one other colleague with whom they knew they could partner or turn to upon return, and in most cases, more than one. For most, though, it was more than direct partnering in the form of working together or for someone. It was about identifying the potential of finding a network of like-minded people and the structure to apply their ideas and ways of doing. In the last part of this chapter I will

return to this point by discussing further this establishing of cooperative strategic networks between like-minded professionals.

Two key issues emerged while discussing differences between health systems and the effort to bring in transformation at home: medical practices during labor and delivery, and the redefinitions of roles and relations between medical professionals for building a network of cooperative actors. The rest of the chapter is devoted to these two issues.

Transformation of Individual Medical Practices: Doctors in the Delivery Room

The professional trajectories of returning medical professionals vary. While some obstetricians continued practicing in the labor and delivery wards, others preferred to specialize in pregnancy monitoring, fetal morphology, or new reproductive technologies. Two of the obstetricians changed their track after attempting to work in labor and delivery for a while, while another three only attend births as an exception. I will come back to these cases in the next section. The midwives I interviewed started off as lactation consultants, birth educators and provided monitoring of low-risk pregnancies, before moving to a hospital and attending deliveries. Two of the pediatricians who studied or specialized abroad, also did not start off working in hospitals straight away upon return. I will discuss these winding trajectories and the reasons given in the next section on the redefinition of roles and relations with other actors in the field. In this section, I will focus on those doctors who attend deliveries on a regular basis and the ways in which they assess the system and act as agents of change.

Regarding medical procedures, the respondents chose to address in most details the topics of recommendations for scheduled c-sections, approaches during physiological vaginal birth, and ways of treating the newborn babies during the first hours and days after birth. All doctors agreed that their involvement with a low-risk physiological birth has to be minimal and has to be attended mainly by midwives. This was their experience while practicing abroad in three different countries: Belgium, Germany, and Switzerland. They also discussed relations with other colleagues-obstetricians and how trust and being on the same page is crucial when introducing new ways of practicing. Two out of the three also discussed the relations with neonatologists and the possible tensions that arose in their own practice.

I will illustrate this with the case of Dr. Atanassov.[5] He left Bulgaria in the early 1990's after gaining his specialization in obstetrics and practiced in Germany until his return 9 years ago. He was invited by a former colleague to head the maternity ward in a private hospital. Since then, he changed his position several times, until he found a team and a hospital where he feels he can apply his own methods and practice in a way that he learned in Germany and he thinks is better. In Germany, he worked in an environment where doctors were encouraged to read and apply evidence-based medicine. Sometimes, this means, changing your ways of practicing and learning a new skill, he said. In Germany, he attended annually mandatory trainings organized by the hospital on updating his knowledge and discussing new approaches, he also regularly attended international conferences and went to special trainings to update his skills several times (for example on vacuum extraction). His opinion is that most of his in Bulgaria are not encouraged to develop in their professional knowledge and skills and that this results in using outdated approaches. This is particularly true for low-risk vaginal births, he thinks. In the course of the interview, we discussed different things that he does differently, following what he observed and practiced for many years during his active time in Germany. He is famous among women who are interested in giving birth naturally and without unnecessary interventions. He is also active in public discussions about birth giving being highly critical of the high rates of c-sections in the country, promoting evidence-based medicine as an approach, and arguing about the important of placing women in the center of care.

During our interview Dr. Atanassov explained that he works differently than most of his colleagues-obstetricians in the country. He thinks that many of his colleagues continue to follow recommendations and practices from the 1980s or even earlier. He feels that Bulgarian medicine in the field of birth has frozen since the years when he was a student in the 1970s and has not adjusted to up-to-date research and recommendations. His own experience in Germany has thought him new approaches and the ability to adjust to new recommendations based on on-going research. He emphasized the need of evidence-based medicine:

> Medicine is changing all the time. New things are being discovered all the time, new technologies, new drugs. We need to follow what others develop and apply it in our practice. We have access to research nowadays. We can go to international conferences, read medical journals online…. But what

> is happening in the field of birth giving, is that on one hand there are new techniques, new drugs, new instruments for precise monitoring etc. But .. there is also a move to step back, to relax, to give way to the natural process to evolve. Hands down approach, so to say. So, the progress sometimes means stepping back from interventions for example. And this is difficult to live with, to accept. In Germany this has happened long ago, this move away from medicalizing a natural process, when it is not necessary. Now we need to learn it here as well.

He gave examples with three issues: the rate of c-sections, practices during vaginal birth, and the approach to newborn babies during the hospital stay. He also discussed at length the role of other medical and non-medical specialists during birth and the importance to be able to work well in a team, rather than to feel threatened and think of others as competition. He explicitly referred to the role of midwives and the differences between his experience with midwives in Germany and in Bulgaria. These issues were also key for the other respondents practicing in the delivery room. I will summarize here the main points that were highlighted by Dr. Atanassov and mentioned by my other respondents. The observations made by him have been confirmed by the other interviews I made with midwives, the interviews with women, and the discussions in media, blogs, and social media forums like Facebook. In this sense, this is not an exceptional opinion, but rather describes the wide-spread practices in Bulgarian and Romania hospitals.

First, performing c-sections on a much higher rate than it is recommended by the WHO is common for Bulgaria and Romania (close to 50% as compared to 15%). Dr. Atanassov says that the extremely high rates as compared to other countries in the EU demonstrate a wrong approach from the start. He thinks many of his colleagues find performing a c-section easier, more predictable and easier to control, and less time consuming, than attending a physiological birth which is often unpredictable and certainly longer. However, the benefits for both mother and baby are much higher, he acknowledges, and the risks from unnecessary c-sections are serious. In his practice, he follows recommendations that he followed in Germany and his scheduled c-sections rate is much lower than the average. He makes sure to weigh all the risks of a c-section and present them clearly to the women. His aim is to not downplay the risks, as he thinks is the case often in Bulgaria. In addition, when he does think that the c-section is the safest option for both mother and baby, then he advices

for waiting when possible for the birth to start, before operating, if the case allows it, rather than scheduling it prior the due date, as many other doctors typically do.

Second, Dr. Atanassov discussed at length the concrete practices during vaginal birth that he thinks he does differently compared to most other places. In his view, the reason why so many vaginal births end up often as emergency c-sections or with complications and unnecessary interventions, is lack of understanding of the way the natural process evolves.

> The way natural birth happens in a hospital here is in a very controlled way. The way it used to be done in the 1970's or even the 1960's in other countries. The woman used to enter the hospital with some contractions and the doctors would start procedures on her: a drip with oxytocin to make the contractions regular and stronger, anesthesia to ease the pain from the oxytocin, constant fetal heart tones monitoring, a drip for hydration, a drip for glucoses… then telling the woman how to push, when to push, how to lye down, then - an episiotomy, to make things faster, then pulling the baby, pressing the belly, then pulling the placenta, stitches… The baby is taken for cleaning, for checkups… does not meet the mother for hours… Etc etc.

To this he also added:

> All of this looks like the doctor is in control, regulates the process, even dictates how it will happen. But in fact, it often completely confuses all-natural processes that take place in the body and leads from one intervention to the next, leaving the woman fully exhausted, out of control, in a panic often… We end up with women who are scared, do not know what is happening to them, tired from the effects of all the synthetic drugs that do not allow the body to follow its own rhythm. And often it is the doctor's fault that we end up with an emergency c-section.

As opposed to this practice, he enumerated what happens differently during vaginal births that he supervises: He allows and encourages women to move freely, to change positions often, to drink or eat light food and he only works with anesthesiologists who are comfortable with this approach. He is ready to wait as long as needed for progress as long as the baby's heart-rate tones are good, and the mother is in a good shape. He feels this is a great difference between him and other obstetricians. He also encourages different positions during the second stage. Regarding interventions, Dr. Atanassov thinks that in Bulgaria it is common to use

interventions routinely, without clear indications: routine induction on the 8th day after the due date, routine membrane rupture, routine augmentation of contractions with oxytocin upon hospital admission, routine use of methods that are considered dangerous like the Kristeler maneuver (or fundal pressure), routine episiotomy. He also discussed the common practice to offer epidural anesthesia early and routinely, especially in private hospitals, which he is also against. The active management of the second stage of labor with directed pushes is also a practice that he finds outdated and counterproductive. All of these interventions, he says, might be needed and lifesaving in certain cases, but they should not be used routinely, and the risks of each intervention must be clearly discussed with the women before birth and once more, when they are proposed.

Third, he thinks that the common practices in the immediate period after the birth have to be renegotiated with the neonatologists in the hospitals. He suggests delayed cord clamping, instead of immediate clamping as it is usually done. After the baby is born, he insists that there is "first contact" and the baby stays as long as two hours on the mother's breasts. This means delayed check-up of the new born, or an immediate check-up while the baby is lying on the mother. Something that neonatologists are not easily convinced. He strongly supports breastfeeding and thinks that it is crucial for women to get assistance and advice from a midwife or a lactation consultant in the first days after birth. *"All of this I saw in practice in Germany. This is how things are done there. Here, I have to negotiate and fight with many of my colleagues and even sometimes to convince women that this is better for them."*

This topic intersects with his discussion of the distribution of roles between medical professionals, and the role of midwives in particular. Having practiced in Germany, where midwives are the key actors in low-risk physiological vaginal deliveries, Dr. Atanassov has great trust in the midwife he most often works with.

> When I say I supervise a natural birth, I actually mean I supervise my midwife. She is there, with the woman, she knows what to suggest, what to be attentive to. And I expect her to call me only when there is a problem and I need to intervene. That's what the German midwives were doing, and how things should be. I come every once in a while, to monitor, examine, discuss the progress. But I'm there at all times, ready to intervene immediately if things go wrong, to suggest a different course of action, if there is no progress.

He thinks that there is a shortage of skilled midwives who can attend low-risk vaginal births confidently and skillfully. He himself works with a midwife that he trusts, and he thinks this is crucial for having good outcomes.

The different protocol that Dr. Atanassov follows echoes what the other obstetricians shared. The midwives that I interviewed also try to follow the same recommendations, albeit not always successfully, because of their limited power in certain situations where their decisions or recommendations get overwritten by the doctor on duty. The understanding of what are good practices is shared between these different medical professionals who live in different countries and different cities. In all these cases, the medical professionals were using guidelines, that were also applied in the places where they had the chance to practice. What is important here is the value that respondents place on the opportunity to practice in a different way before returning to their home country. Practicing in a different setting and observing other colleagues following different protocols and medical standards, gave them the confidence to apply these differences upon return. What is more, all these professionals were exposed not only to different protocols and standards but also to a model of adjusting to new recommendations based on evidence-based medicine.

In the next section I continue the discussion of the role of midwives through the lens of relations with other colleagues, distribution of roles between professionals, trust and cooperation – all issues that came up as crucial for future positive transformations of the health care system beyond the individual transformations of medical practices.

Relations with Other Actors in the Field: Obstetricians, Midwives, Doulas, Neonatologists

Good cooperation with other medical and non-medical professionals is a topic that came up in all in the interviews. The role of midwives for monitoring pregnancy and attending physiological uncomplicated births is a theme that both midwives and obstetricians discussed in view of their experience practicing in other countries. Another theme is the relationship with neonatologists and the potential conflicts that arise in Bulgarian and Romanian hospitals between the neonatologists and the obstetricians or midwives. Finally, the issue of cooperation with birth workers without

medical degree like doulas and lactation consultants as crucial support both for women and for the medical professionals was addressed as a contentious point.

The role of the midwives kept coming up in discussions about the distribution of roles among medical professionals. All respondents who practiced or had practiced in a labor and delivery unit, doctors and midwives alike, emphasized the discrepancy between the roles of midwives in Bulgaria and Romania, and the roles of midwives elsewhere. In Bulgaria and Romania midwives and delivery nurses have little autonomy and work under the close supervision of the obstetricians on call. In Romania the midwife profession ceased to exist for a long period since the late 1970s. It was reinstated only in 2004 when under the pressure of EU accession regulations, medical universities re-opened a separate specialization for midwives. In the meantime, the role of the midwife was taken by the delivery nurses, who are still the majority of medical personnel in the delivery wards. Midwives are hired only occasionally. Recently, there have been discussion of closing down the specialization track in the Medical University of Bucharest, I was told in two of the interviews, which, if effective, will leave only to places which offer higher education for midwives: in Galati and in Craiova.

While in Bulgaria, the midwifery profession and education were never interrupted, the actual role of midwives in hospitals is limited to that of nurses. They have auxiliary functions and almost no autonomy in taking decisions. When they do, it is exceptional and depending on the individual arrangements with particular doctors or the shift they end up in (night shifts for example), rather than an institutionally established practice. The education was upgraded in 2004 from vocational training of two years to a BA program of four years with one-year internship included. However, my respondents commented that the academic syllabi, the courses, and the materials used are outdated, in some cases based on textbooks from 1950s, without any access to recent studies, evidence-based approaches, or practical training that involves actual participation of the student or intern. In comparison, the training that the three midwives I interviewed received in other institutional settings was, according to them, much more up-to-date both theoretically and in practice. All this suggests that the skills and the role of midwives are more limited as compared to other countries discussed in this research. When midwives are used in the delivery room as auxiliary personnel, instead of autonomous professionals,

their decision-making capacity and responsibility is often shifted to the obstetrician on call.

These specificities of the education and the status of the midwives in the two countries have resulted in two problems, according to my interviewees. The distribution of roles between doctors and midwives, and the approach to physiological birth. Both midwives with experience in other countries (Estonia and the UK) and obstetricians who worked with midwives in other countries (Belgium, Germany, Slovakia, Switzerland, the UK) confirmed that the role of midwives is more autonomous and that they are the main actors during an uncomplicated physiological birth. They are also the ones monitoring low-risks pregnancies. Midwives have more skills and are allowed to do more interventions than in Bulgaria and Romania. Doctors, on the other hand, step in when there is a need of a higher-level intervention, there is a complication, or a need of surgical skills. Because of this autonomy as medical professionals, midwives in the countries listed above, also learn more skills on how to attend a physiological birth and at the same time also learn how to assess the need of an obstetrician's intervention.

A midwife who works with a doctor, who has practiced for many years in the UK, explained that his approach was to let her attend the birth and only interfere if called by her.

> When I called him, he usually came running, holding an instrument ready for an intervention. That's how he was used to step in the UK. He trusts the midwives fully and knows that he is only needed, if a complication arises. It is not how it work here [in Romania] though. Doctors take the lead in all circumstances and midwives need to follow their suggestions.

Several of the obstetricians interviewed mentioned this discrepancy in the roles of midwives and doctors. They felt, that upon return, practicing in the delivery room meant taking on the job of the midwife, because midwives themselves were not taught how to attend births independently or did not have the authority to negotiate with doctors, being positioned lower in the hierarchy.

This distribution of professional roles in which obstetricians feel they take up the role of the midwife is one of the reasons some of my respondents gave up on practicing in the labor and delivery units. The case of Dr. Mitescu is illustrative. He specialized in Slovenia and took up a job in a big maternity hospital upon return. He was one of the famous doctors

looked after by women who were interested in giving birth naturally with fewer interventions. He was comfortable working with doulas and with student midwives. At the same time, he continued attending international trainings on developing his techniques and knowledge on specific types of interventions. After 4 years of practicing in the labor and delivery unit, he decided to change his professional track to new reproductive technologies. To me, he explained this move with the following words:

> I had enough being a midwife. Not even a midwife, but a security guard who stays at the door of the delivery room and guards it from other colleagues, so that the woman and the midwife can do their job in peace. Most of my practice has to do with waiting and sending colleagues away – the other doctors, the neonatologist, the anesthesiologist who all impatiently kept coming and asking why is it taking so long, why am I not intervening (a Kristeler, an episiotomy, some extra oxytocin)… I was doing something that is not a doctor's job, it is a well-trained midwife's job. I want to sit in my office, do research, read articles, give consultations, and to be called in the delivery room only when there is a need of an intervention. I want to practice my learned skills in complex cases, in high-risk deliveries.

Dr. Mitescu also referred to the tensions with the neonatologists in the hospital, who thought he puts the babies at risk with his approach and often "punished" his patients by keeping the babies longer under observation, administering unnecessary medication, and commenting about his approach. He did not find a team with whom to work in a comfortable way and decided to change his track to a field where he feels more useful as a doctor.

Another obstetrician who is considering returning to Romania but is currently practicing in Germany shared that she does not see how she can practice in Romania unless she finds midwives to trust and work with.

> I have no place in the delivery room during a normally proceeding labor. I am needed when there is a complication. This is my job. The midwives are full-fledged professionals who should know what they are doing and we need to work together.

The role of the midwife, the autonomy, the trust between different medical professionals (obstetricians, neonatologists, midwives) came up in many of the interviews. Not simply as a distribution of tasks, but also as a certain

set of skills that are missing, when the role of midwives is restricted to that of nurses.

The skills that my respondents' midwives gained during their educational exchanges and continuing trainings are not skills that they learned in the university or during their internships in the state teaching hospitals. These are techniques that aim to avoid an interventionalist approach.

One of the midwives who attended an educational exchange in the UK said:

> A lot of what I saw during my internship is a hands-off approach. Waiting. Suggesting different positions. But mostly, being there and making sure everyone is ok. If there is something worrying, then make an assessment and call the doctor. But often the whole birth was only attended by midwives. They even do the stitching at the end, and before that, the episiotomy, if deemed necessary,

She thinks that Romanian midwives and nurses have lost these skills over time. At the same time, doctors learn an interventionalist approach and as the opinion of Dr. Mitescu shows, they prefer not to take up the tasks of the midwives. This is in line with the analysis of the medicalization of birth across the world and the authoritative knowledge which has been shifted in many places from women and midwives to doctors.

In light of the above, the returning medical professionals, midwives and doctors alike, play a crucial role not only in the transformation of their own individual practices, but also in the process of redistribution and redefinition of medical roles. The tensions that often arise between obstetricians or midwives and neonatologists also add to this. In addition, there are other non-medical birth workers who also could play an important role in labor and delivery and the subsequent stage of breastfeeding and caring for a newborn. Far from all obstetricians in Romania and Bulgaria feel comfortable with the presence of a doula during labor. In many hospitals in both countries the access of doulas is restricted. In others, doctors agree reluctantly, but try to convince women not to go with a doula. In contrast, during my interviews, the question of the presence of doulas was regarded in a positive way both by doctors and by midwives. Some of them in fact recommended explicitly to the women to hire a doula if they can, because this facilitates their own work as well. One of the doulas I interviewed told me that the only doctor who

explicitly encourages women to hire a doula in fact has also practiced in Switzerland. While this might be a coincidence, it demonstrates a trend also confirmed by my other respondents. The medical professionals quoted their own positive experience with doulas, but also the most recent studies which demonstrate that the presence of doula improves the outcomes for both mother and baby. IN this sense, there is a collaboration that stretches beyond the categories of medical professionals, to include other birth workers.

The attitude towards lactation consultants was similarly positive. While in certain hospitals, visits from lactation consultants are undesirable, if not forbidden, the medical professionals I interviewed were confident in their usefulness for women in the current distribution of medical roles. In countries like the UK or Germany it is common for the midwife to provide additional consultations on breastfeeding. In Bulgaria and Romania midwives and nurses have contradictory knowledge and skills in this field, some using outdated methods and recommendations. For this reason, the category of lactation consultants is gaining momentum. Some are certified as paid IBLCE (https://iblce.org/) consultants, others work voluntarily and are certified by organizations like La Leche Ligue (https://www.llli.org/). My respondents, the pediatricians more particularly, felt very strong about the importance of lactation consultants and saw how cooperation with them results in better outcomes for breastfeeding mothers.

A good team of an obstetrician, a midwife, a doula, a neonatologist, and a lactation consultant represent a network of professionals that can guarantee a holistic care for women and babies. Such cooperative networks are yet to be developed fully. Currently, in Bulgaria there is an association called Modern Maternity Care Network (https://modernmaternitycarenetwork.wordpress.com/), whose members are actively working in this direction. This is just one example of a formalized network of professionals and activists who aim at triggering a positive change by cooperative efforts. The midwives in this study all work in private settings with certain doctors and doulas who trust each other. Unlike the experience of Dr. Mitescu, these teams manage to support each other in their efforts to practice in a way that is still different than the average in the two countries. Their examples show how the individual changes in the medical practice need to be placed in the context of a network in order to bring about consistent and long-lasting change.

Conclusion and Future Directions

The two issues discussed above – changes in the individual medical practices during labor and delivery and the question of relations between colleagues, more specifically between obstetricians and midwives—emerged as key themes in the interviews with returning medical professionals. They are at the core of organized efforts to transform the model of maternal and child care in Bulgaria and Romania. As I have illustrated medical professionals with practical experience in other medical systems are consciously changing their own way of practicing and making further steps to bring about change at a systemic level. I have argued that the experience in a different medical system bring ruptures to the medical habitus established through education and medical socialization. Switching from one system to another requires a reflexive move. My respondents critically appraise their position of re-entering a system while doing things differently than it is established. All of them are actively and consciously engaged not only in applying different practices, but also in pushing further for changes at a meso and macro level.

The divergent and multi-level efforts made towards transformations of the health system as a whole need further exploration. Three issues came up during my interviews, which I could not address here due to lack of space: the need to change the interactions with patients, the re-definition of hierarchical relations between colleagues, and the involvement in systemic changes at policy and normative framework level.

The first issue is particularly crucial when discussing birth giving women. Whether women are treated as passive patient to whom medical specialists perform intervention, or are treated as active participants in the process, makes a huge difference in the outcome, my respondents maintained. What is more, the autonomy of the patient, the right to be informed in a clear and simple manner and the right to take decisions over one's body and treatment is still a problematic question in both Romania and Bulgaria, and needs to be addressed further. The differences of experience between practicing abroad and practicing in their home countries, were striking for my respondents.

The second, the relations between colleagues and the lack of environment for professional development, was something that several of my informants found problematic as compared to their experience in other places. They are all actively working towards fostering fruitful conditions for further professional growth, for incorporating international standards

and guidelines into their hospital protocols, and for developing a learning environment in their institutions. What is more, some of my respondents have organized free training and continuing education workshop with international lecturers for the wider medical community providing an avenue for learning new skills and for further professional development.

Finally, the active involvement in policy making at the level of re-writing medical standards, guidelines, and protocols, but also at the level of public awareness raising through various campaigns, are steps that some of my respondents are taking towards a systemic change that will affect a wider group of people than just their own patients.

To conclude, medical habitus is not only about concrete medical practices, but also involves a structure of hierarchical and collegial relations, trajectories for professional development, interactions with patients, and position within a network of professionals working together. These different levels of being and becoming a medical professional are informed by being part of a health system. My research has demonstrated that being incorporated in more than one health system and being thus exposed to different ways of doing medicine and relating to colleagues and patients, might lead to transfer of knowledge, to transformations of practices, and ultimately to transformations of the system as a whole. In this way, migration that involves return and circular mobility, contributes to these multiple incorporations and brings about change in the form of "professional remittances".

NOTES

1 This paper builds on a long-going research in Bulgaria and Romania. Besides the generous funding I received as a NEC fellow, I have also used materials from my research conducted during my fellowship at the Centre for Advanced Studies in Sofia in 2018.

2 See https://www.europeristat.com/images/EPHR2015_Euro-Peristat.pdf Data in this report is from 2014 with 43 percent for Bulgaria and 46.9 for Romania. Bulgaria and Romania are both in the section of highest share of c-sections in Europe together with Cyprus and Poland. Since then these numbers keep growing.

3 In some cases, equipment in state hospitals is more sophisticated, especially for critical cases, like premature births etc. In this sense, I do not claim that private setting have better equipment in all spheres. However, private settings do invest in new and advanced technology for pregnancy monitoring on a much higher rate than state hospitals can afford to do, according to my respondents, which is considered a beneficial factor.

4 For the sake of keeping the respondents' anonymity I use interchangeably Bulgaria and Romania as countries of origin, without matching them to the actual examples.

5 All names have been changed for the purpose of anonymity.

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