POLISH MEDICAL MIGRANTS IN THE UNITED KINGDOM: THE COMPLICATED NATURE OF THEIR BELONGING TO A NEW SOCIETY*

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Abstract: ***The paper aims at analyzing the effects induced by processes of migration of Polish medical professionals to the United Kingdom following Poland's accession to the European Union and their situation in the UK. First, a brief note on the methodology and characteristics of the sample is presented. Second, migration of Polish medical professionals is juxtaposed to existing migration theories. Third, belonging and integration are introduced, to be followed by some striking observations related to Polish medical migrants in the UK. Migrants share their opinions of the receiving society and of their lives in Poland and the UK.***

Keywords: ***Migration; international migration; transnationalism; diasporas; social integration; assimilation; conflict***

Introduction

In recent years the extent of the international migration of Poles has been rising. However international migration is not a new phenomenon in the history of the nation (Stola 2007). With the growth of migrations there is also a rising interest in migration among various groups of stakeholders, such as scholars, policy makers, politicians and journalists. The medical professionals stand out among the various socio-professional groups migrating out of Poland. In fact they defy all the statistics, as their mobility all across the continents is high, not only in the case of Polish medical professionals.

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In this paper the author wishes to explore medical professionals who left Poland after EU accession and the nature of their belonging and integration practices. Those migrating professionals scrutinized include mainly doctors, such as surgeons and dentists, as well as pharmacists and qualified nurses, etc., who migrated to the United Kingdom in the period between 2004 and 2011. The paper aims at analyzing the effects induced by migration of Polish medical professionals to the United Kingdom following Poland's accession to the European Union and their situation in the UK. First, a brief note on the methodology and characteristics of the sample is presented. Second, migration of Polish medical professionals is juxtaposed to existing migration theories. Third, belonging and integration are briefly introduced, to be followed by some striking observations related to Polish medical migrants in the UK. The question posed in this paper is as follows: what is the nature of belonging of Polish medical professionals in the new society? Are there any traces of transnationality among Polish medical migrants? What integration practices can be spotted?

1. A few remarks to the methodology and characteristics the group

This paper brings some empirical findings from qualitative research carried out among Polish medical professionals who had left the country after 2004 and migrated to the United Kingdom. The selected professionals (20), who had previously agreed to be interviewed (with semi-structured interviews), shared their experiences, reflections in relationship to their motives, intergenerational relations, integration practices and their plans for the future. The initial group was selected based on initial contact with medical professionals' recruiters and doctors already residing in the UK. Then the snowballing principle was used to extend the sample. The two rounds of interviews were conducted among Polish medical professionals in the UK, i.e., in Plymouth, London and Glasgow. This was complemented by additional interviews conducted with some returning migrants in Poland, in Cracow, Gliwice and Wrocław. The group consisted of doctors, mainly surgeons in various areas and anesthetists, as well as some dentists, pharmacists and qualified nurses. Furthermore, it should be emphasized that the topic related to family and the relationships within the families turned out to be a very sensitive area. Some respondents were rather reluctant to discuss the issues related to their immediate families (partners and children), while others treated the interviews as an opportunity to consider, analyze and share

their observations and reflections with an interviewer who was an outsider. Both males and females taking part in the survey presented different migration forms and stages, from emigration decision and plan through temporary labor migration to circular migration. Also some doctors already returned to Poland after some time spent as migrant health workers in the UK. Based on the analyses of interviews conducted within the study a number of commonalities and patterns can be observed. These are listed and briefly characterized below.

First, migration experiences varied. In the sample two main groups of migrants were seen: those who migrated for good with their spouses and adolescent children and those who chose temporal or circular migration with their families and children left behind in Poland.

Second, within the analyzed group there existed a clear gender gap; the majority of doctors were male, whereas the majority of women were qualified as nurses, dentists, anesthetists or pharmacists. This pattern reflects a certain professional segregation in professional specialization which is observed in Poland. Additionally, the majority of female doctors accompanied their husbands and partners, as the males were the leaders in migration decisions. On the other hand it must be noted that there were cases of female doctors being accompanied by partners or lovers, or traveling every other weekend to Poland to see their husbands and growing and adult children.

Third, almost half of the migrants had had several migration experiences before migrating to the UK in 2004. Also half of the sample were forced to return to Poland, usually due to family obligations or a wife's "demand." There was even a case I called a notorious migrant. This lady used to work in the 1980s in Tunisia, in the 1990s in Malta and for the past seven years in the UK, with short spells of work in Poland.

Fourth, the circular or temporal migrants regarded their migration as a way to maximize their utility and thus maximize their resources and human capital. Some of them presented strong organizational skills and excelled in planning their rounds so that they could even spend three to four months a year in Poland, which is much longer than a regular vacation period. Their visits were regular and frequent, even every fortnight, following some favorable employment conditions which gave them access to additional 30 days of study leave which was used in Poland.

Fifth, some of the respondents expressed solitude and nostalgia for being away from Poland. One of the doctors living in the UK on her own made it very clear that some time ago it was difficult for her, but she got used to living

abroad. Employment as a dentist in the UK gave her and her family a very stable financial situation. She also noticed that relations at work were based on partnership. She visited her family as often as possible, even twice a month, and she enjoyed time spent there. Her husband and she cherished their time together, taking into account that it was something precious so they should not argue.

Finally, whether temporal, circular or quasi-emigrants they did not plan their future too much. They appreciated the very favorable conditions that they lived in and their work for reasonable remuneration. If the favorable conditions prevailed they would wish to stay as long as possible. They said that it was unknown what would happen in the future, what it would bring. As their retirement age and pension were a very distant matter they did not plan, but still expected they would probably spend that time in Poland.

Last but not the least, as the sample may be regarded as not completely representative for the population of medical professionals, the conclusions will refer to the experiences and reflections expressed by the respondents and only those identified effects will be discussed. These conclusions could also be seen as a basis for further study.

2. Theoretical explanations for medical professionals' migration

Before we proceed to integration practices and the nature of belonging, the migration of medical professionals to the UK will be set in a theoretical context (Ślęzak 2012).

Since 2004 the UK has allowed migration of individuals from the new member states and attracted large numbers of migrants, also including medical professionals. The migrants have found attractive the possibility of earning a higher income as well as improving their standard of living and the possibility of professional development. On the other hand, particularly in the early days of EU accession, migration was an obvious reason to escape from low salaries and almost poverty, as well as pay irrelevant to their qualifications and long working hours. Thus, the neoclassical macro theory explains the migrations, showing that the existing wage differential between countries underpins our workers' decisions to move to a country with higher wages. As a result of such decisions the labor supply falls and wages increase in the capital-poor country, while the labor supply rises and wages decrease in the capital-rich country (Massey et al. 2001: 3–4, Arango 2011, Greco 2010).

The micro-perspective neoclassical theory also seems to be present in the behavior the analyzed group of Polish migrants. Rational individuals make migration decisions using a cost-benefit calculation which allows them to look for positive returns (monetary) from migration, which is surely the case of the medical professionals. A peculiar form of individual investment in human capital is observed as every potential migrant analyzes the costs and benefits in a certain time horizon. If the net returns of migration for a given destination prove to be positive, then the rational potential migrant decides to move. This is the case of many Polish doctors and nurses who migrated to the UK. In theory it is clear that individual characteristics like skills, qualifications and experience would positively impact the probability of employment and remuneration in the destination country and increase the probability of international migration levels (ceteris paribus). In fact these elements usually gave certainty of employment prior to arrival in the UK. On the other hand there were also elements that reduced migration costs like technologies, social conditions and individual characteristics. All the above would raise the probability of international migration, having a positive effect on net returns (Massey et al. 2001, Arango 2011, Greco 2010).

The medical professionals just like any other migrants attempted to estimate potential costs and benefits, along with assigning certain values to them. However, as interviews proved, these were not purely individual decisions made in a social vacuum outside the family and the household of potential migrants. That is why new economics of the migration theory can be seen as much more fit to the social reality of the analyzed international migration. In fact, their migration appears to be a rational decision of the household or of the family as an example of a strategy aiming at maximizing income and minimizing risks, inter alia, to loosen constraints related to a variety of market failures apart from those located in the labor market. Surely it may be seen as a household strategy to diversify its livelihood and decrease the risks of market failures, even in the context of absent wage differentials (Greco 2010: 12). This theory is strengthened by the fact that the Polish value their family a lot. Hence, migration decisions of doctors refer to assigning responsibilities to individuals as well as weighing the risks associated with migration to the UK, which was clearly confirmed by the undertaken research.

Interestingly enough, medical professionals who decide to move to the UK would work in high-skilled sectors where they can enjoy the same treatment as that of the local medical personnel in terms of pay, stability, advancement

possibilities and other job characteristics. The most prominent proponent of the dual labor market theory, Michael Piore (1979), argues that international migration stems from the intrinsic labor demands generated by modern societies and economies.[1] Thus immigrant labor is, in fact, inherent to the economic structure of developed countries. Immigration therefore is not caused by push factors of the sending country but rather by pull factors of the receiving country, i.e., the need for the immigrants' labor. The former demand for immigrant labor is seen as structurally built into modern advanced societies and economies, which are often characterized by the bifurcated nature of the labor markets. Furthermore, the health care sector in the UK is a sector where medical professionals from all over the world are employed. There is no social stigma of the "immigrant job" depicted in the cumulative causation theory. The only sign of the labor-market duality occurs in the place where the employment is located. This is often an area distant from London and the southeast of the country where saturation of medical professionals and interests among local doctors and other migrants is lower. In those places Polish work alongside professionals originating from various, distant places. It is worth mentioning here that in the UK, regarded as a main destination for medical migrants, there are more than one third of practicing migrant doctors who had their training outside the country (Greco 2010: 10).

Furthermore, Immanuel Wallerstein's world system theory suggests that what drives migrants to migrate is the demand for labor expressed by capitalist economies. Hence, labor migration is a source of capital accumulation, with poorer countries losing citizens to the benefit of the wealthier ones (Greco 2010: 14–15). Yet, it appears that this theory might be seen as irrelevant to international migration of Polish medical professionals. Although never a colonial state, Poland and its economy, like other new member states and their economies during the change of economic systems and the transformation, had been penetrated in a manner similar to neo-colonial economies. Migration of medical professionals is thus seen as their response to a demand for labor within the health care system, which is expressed by the UK economy.

However, the network theory addresses the important issues related to the migration of Polish medical professionals to the UK. Doctors and other medical

1 In the original, Massey et al. (2011: 11) use the expression of modern industrial society and economy, which does seem to be slightly outdated. As the present phase of economic and social development is seen as post-industrial and/or postmodern/ risk (see Bauman, Giddens, Beck), the phrase modern societies and economies is used instead.

professionals are active members of various professional networks, where various useful information regarding migration is exchanged, discussed and benefited from. Networks may reduce risks and costs associated with migration and increase expected net returns. Migration is seen here as a self-sustaining diffusion; a quasi–perpetual process expanding over time and place aiming at building a quasi-spider-web of connections and relations, so that almost all interested can move with not much difficulty (Massey et al. 2011: 19). On top of the above, doctors do not lose contacts in Poland; they continue to be active in national professional networks as this is seen as a way to ascertain a safe return if needed. Also when abroad they create certain social networks, usually with people of the same nationality from their immediate working medical environment. Such networks serve as a replacement, sometimes stable sometimes temporary, for the community they left in Poland.

Similarly, the institutional theory to some degree serves an interesting explanation. The space is open to various institutions which sustain international migration, e.g., private employment agencies (Massey et al. 2001: 20–21, Arango 2011). Their recruitment procedures are carried out by specialized recruitment agencies of Polish and UK origin. Their services are highly specialized and they provide interesting information for international migrants, e.g., in some cases they organize migrants' lives at a destination. Finally, non-governmental organizations of a professional character like the General Medical Council, rather than fight exploitation and victimization of migrants, serve as consulting bodies in the country of destination.

Furthermore, in a process of cumulative causation, the growth of networks and the development of institutions supporting migrants' international migration sustain themselves in other progressing ways. They are cumulative as every single case of migration changes the social context where migration decisions are made, usually supporting additional mobility. As jobs and positions of doctors and nurses in the UK are not stigmatized, migration leads to a change of migrants' families' positions in the local community. It also creates shortages of highly skilled personnel and their services. On the other hand, the migration experience is associated with a witnessed change of values, beliefs, perceptions and new perspectives introduced.

Finally, the multidimensional framework adopted by G. Greco (2010: 18–19) further explains international migration as a decision starting in the household where other elements join like social and kinship bonds and other informal bonds. The bonds tie the destination and the country of origin and institutions

shaping the global context. The migration process is regarded as a system of identified and stabilized networks that link countries, a system of two or more countries that exchange migrants. These movements can be explained as an effect of interaction between microstructures and macrostructures, i.e., large scale institutions, e.g., global market forces, migration laws and regulatory policies between involved countries. Medical professionals indeed focus on social bonds and create their own web of networks. Here the networks also include mezzo institutions of a legal, formal and informal character. Surely, macrostructures comprising a regulatory framework and cultural aspects are elements that attract and foster migration of medical professionals to the UK. This framework and the case of medical professionals as migrants might be related to Pierre Bourdieu's habitus. The migrants seem to be making very good use of social capital, in the sense that they effectively manage their material and symbolic resources for their own and their families' benefit. Various forms of bonds and contacts of a formal and informal nature might be turned into obligations crucial to realize goals important to a person. In the case of medical professionals this could be migration itself or it could be a higher standard of living, access to various new opportunities or a new experience, to list a few. Surely, the migrants cannot lack elements of cultural capital, i.e., symbolic knowledge allowing them to comprehend the actions of the social system of their new country of residence. This can be further transmitted as a way of socialization of other new-coming migrants via elements of networking (Szendlak 2011: 246).

3. Polish medical professionals in the UK – belonging and integration

Migrants can expect the occurrence of a number of potential problems related to their citizenship status and belonging when they move. This is so as citizenship is used by the receiving country as a tool to sort out the newcomers, to select those wanted and unwanted, more desirable and undesirable (Baubök 2006: 1). The former might become potential full members of the receiving society, whereas the latter will be a subject of exclusion and even expulsion. Yet the array of choices is vast and it is associated with the integration paradigms and procedures existing in a given society, depending upon the given regime of the state and society. This is the reason why at first belonging and citizenship will be briefly discussed to be followed by integration practices and procedures.

However S. Castles and M. J. Miller (2009: 245–247) ask whether and how migrants and their descendants can be incorporated by the receiving societies and nations. Moreover, how should these processes be facilitated by the receiving societies and nation states? These processes are generally seen as integration in a broad sense. Some policy documents argue that "the aim of social integration is to create a society for all in which every individual, each with rights and responsibilities, has an active role to play. Such an inclusive society must be based on respect for all human rights and fundamental freedoms, cultural and religious diversity, social justice and the special needs of vulnerable and disadvantaged groups, democratic participation and the rule of law. The pluralistic nature of most societies has at times resulted in problems for the different groups to achieve and maintain harmony and cooperation and to have equal access to all resources in society. Full recognition of each individual's rights in the context of the rule of law has not always been fully guaranteed. Since the founding of the United Nations, this quest for humane, stable, safe, tolerant and just societies has shown a mixed record at best." (Declaration and Program of the World Summit on Social Development, chapter 4, p. 68, http://www.unesco.org/education/pdf/COPENHAG.PDF).

The transition processes bring considerations related to the depth and specifics of this process. The deepest and most thorough is the incorporation of migrants (in fact, immigrants) into the receiving, dominating society, with the loss of the migrants' identity characteristics such as language and cultural and social characteristics, so that they become impossible to distinguish from the rest of the society. This assimilation process is seen as a one-sided process, where migrants have no other option and have then to adjust. Historically this was the original idea, which with time was replaced with the integration rule. The integration rule is based upon the social integration principle regarding a more gradual process, taking into account mutual adaptation, at least to a certain degree. Hence, it was seen as a process of more subtle and slower assimilation as the complete absorption of migrants into the dominating culture was seen as an ultimate goal. Finally, multiculturalism should be mentioned as a concept which recognized the fact that migrants should have equal rights to belong and participate in all spheres of social life of the receiving country, with no requirement to abandon their own characteristics like culture, religion, or language. Yet conformity to certain crucial values of the dominant culture was expected. The American model allowed for and accepted cultural diversity and the existence of ethnic communities. Yet the state was not seen as a guardian

for the ethnic group or work towards social justice. On the other hand, the Canadian model sees multiculturalism as public policy. The dominating group expresses its willingness to accept cultural differences and the state is obliged to secure equal rights for all the minorities (Castles and Miller 2009: 248–249).

3.1 Belonging – the medical professionals living and working "in between"...

Although medical professionals are in a much better situation than other migrants, their situation is more complex. In general, doctors and other medical personnel in the UK enjoy a high social status and they are appreciated in the receiving society. But there are some indications that they seem to miss out on the fact that they are migrants and some have not learned the specifics of the receiving society and its culture, expecting the same type of relations as they dominate in Poland, in their home society.

"I think that the Polish do not integrate well. But to be honest I think this has to do with the receiving society. The English are not keen on integrating, they are very kind and pleasant, but this is all you can count on. There are no contacts outside the workplace, we do not meet up, and nothing is happening... From time to time we would go to have a pint in a pub after a staff meeting, etc. However, we would not watch or play football or engage in other forms of social activity. The locals would not receive you in their homes as is common in Poland." (anesthetist J)

On the other hand there are accounts of medical professionals who find themselves well integrated and who enjoy the benefits of life in the new country.

"Yes, I would say that we feel well integrated with the society here, not as much with the city, it is rather a big city. But surely there is some advancement here. Now that we are quite certain we know the place and people, we do not feel as lost as we felt at the very beginning... There is quite a number of international staff in the hospital so it is difficult to state whether integration refers to the local community or to the work community (international one). ...To be honest, I think this is normal. When we arrived I was really lost. At present I know the local specifics...but still feel Polish and this identity is still dominant in me in many ways..." (anesthetist A).

The Polish, however, would expect more dense relationships and interactions with the British, whereas this is not the case. Typically the neighbors would engage in some superficial conversations. Anecdotal evidence shows the following:

"In the morning when I meet them (my neighbors) they return smiles and hellos, discuss the weather... and that is it. Do not expect more. They are strange to me. Completely different from us. This is the way that they are raised. This is

their culture... another thing. They are masters of routine. There is lunch break and it must take place, no matter what..." (anesthetist B).

To sum up, those who reside along with their families, whether they lease or buy new houses in new areas complain about the distant kindness expressed by the English. Their neighbors, contrary to the situation in Poland, are kind but not interested in their situation; there is no discussion (anesthetist J). However, some enjoy and appreciate this distance in mutual contact: "*We have fantastic relations with our neighbors. They do not interfere, they are not nosy and they are willing to help when they are asked*" (laparoscopic surgeon). From the theoretical standpoint these accounts point to the fact that migrants focus on constructing various models of identity in relation to different countries, groups and places (either stakes or ties). The ties might be of social, cultural, religious, economic and political character, with less emphasis on identity but instead on relations and practices performed by individuals. If such ties of an individual are transferred to a higher level, i.e., linked with those of another person, group or community, then they are referred to as stakes (Bauböck 2006: 19 after Christiansen and Hedetoft 2004). Clearly stakes relate to communities formed by the Polish, who seem to wish to develop their own pattern of belonging. It is complicated as their belonging, because of their situation, lies in between societies, cultures, regions, cities, religions, political groups, etc., i.e., it is not rooted in a single society, culture, etc. On top of these dimensions nowadays individuals belong to so-called imaginary communities, social movements and social networks. All of these are socially constructed phenomena, with no clear borders pointing out who belongs or who does not, who is in and who is out, and who stays and who leaves (see Tourrain 1991). As a result the very nature of being a migrant forces each one of them to make multiple choices, multiple social ties, multiple economic and political stakes. On the other hand it varies from their sense of belonging, as this must be set on some factual dependency on an individual's professional and private situation, which gives medical migrants more freedom than most of the migrants.

3.2 Integration practices: workplace and external world

The vast majority of the doctors' contacts are set in the hospitals and institutions they work in. *Being a temporal or a circular migrant makes it worse as they are perceived as travelers who are keen on earning better money, not as much involved, always thinking about their family* (anesthetist – intensive therapist J).

Some doctors see migration as a process bonding people, creating ties. Those ties relate to other Polish doctors and their families in their country of origin. "*It forces people to meet, to bring families together if there are no serious problems. But you tend to seek contact with your colleagues... I work less, earn more, my standard of living is higher, I have more time for pleasures and as there are no other options we medical professional migrants stick together and spend time. We have formed some sort of community.*" (anesthetist B). Then of course the question is whether such dense relations needed by the Polish are good for integration at work and outside work within the receiving society.

Outside, Polish medical professionals in the UK try to build their own networks, inviting other doctors from the area to parties at home, where they complain about their "difficult situation." Some even find the British as kind and willing to integrate with the Polish as the Polish medical professionals would have expected. The situation of temporal and circular migrants who had left their families, spouses and children at home in Poland, who even attempted life in the UK is even more complex, characterized by temporality.

"I left for the UK first, then my wife joined me. In fact she did not like it during the period we spent there (more than a year and a half) ... She did not work and perhaps this was one of the reasons she did not like life in the UK. We had to return to Poland for me to take my professional qualification exams (specialization)" (orthopedist P).

Some in a rather blunt way argue that it is almost impossible to integrate with the Brits due to their behavior. "*...There is a lack of integration. It is some sort of deficiency of the English. I used to have many contacts with foreigners in Bentley. It was not friendship but we used to enjoy our company. I became befriended with a Spaniard, an Indian, a German, not a single English person, though.... All of them, my friends, or acquaintances were from outside the UK, they were migrants. The Brits seem to be nice and open, but they are not open deep down, there is an illusion of openness, interest in you, kindness. They keep a distance... never invite you to their homes. Never visit other people. Thy might have some friendships, probably back from school days, but we as migrants are never a part of these networks...friendship is not with us...*" (anesthetist B).

But some manage to have some interaction with the English, even feel integrated. "*We do feel a part of the community. To be a part of the society is perhaps an overstatement. Not a part of the city; the city is such a big unit ... Surely we do feel better than at the very beginning when we arrived. Mind you, there is quite a big group of foreigners at work, so it is difficult to agree whether we*

are integrated with other migrants or with the locals.... On the other hand there are moments that we feel more Polish, when we analyze certain behavior, Polish customs, habits, values are closer to us than those English ones ... It is a matter of national identity." (qualified nurse).

Based on the above one might conclude that most of the migrants analyzed here, particularly temporary or circular migrants, are trapped between societies which they live in. In this sense we might consider them as being marginalized in both societies as every society has its own characteristic social identities, values, norms, symbols, etc., which distinguish it, as well as its groups, including members, from the rest of the world (Grotowska – Leder 2002: 63). Not all migrants are willing to join these particular groups, or not all will be welcomed by these groups. Some migrants will be kept outside or will be regarded as a threat to the group and order existing within the group, or their participation will be limited by existing barriers. Numerous migrants who, in spite of the initial interests of the receiving country to ascertain integration, often suffer from being such "outsiders" trapped at the borders of the new society. Hence, they will not be able to integrate thoroughly. There is always identification with and loyalty towards the society and the group that they come from, which is very strong in the case of circular and temporal migrants. However, if they wish to integrate in the receiving society, such identification and loyalty towards this new group is required. In the case of many migrants the feeling of living between two worlds, two societies and two groups dominates, making it difficult to be a real member of the old society and a real member of the new society, leading to the emergence of frustrations.

As already mentioned the medical personnel enjoy high social status, so such migrants are not placed on the outskirts of the receiving society. But there are some accounts of marginalization of the groups of medical professionals which is visible. Out of the whole list of Tadeusz Kowalak (1998) clearly there are some deficits of participation in the spheres where it is expected, where the Brits participate. Moreover, as they possess Polish citizenship they cannot participate in national elections, hence they lack rights (power) and the possibility to make use of them. Finally, in spite of excellent language skills they experience communication problems, resulting from cultural differences, as shown above. Particularly important from the perspective of migrants, seen as "strangers" is the lack of participation in spheres of life in which is it commonly expected that they will participate in a receiving society. Participation is understood here as playing roles in their broadest sense, including both undertaking actions and

refraining from them, in producing and consuming, giving and taking, finally having duties and rights. The bases for participation are prescribed in norms typical for a given socio-cultural category, by the material status required to engage in participation, by no barriers to participate (lack of impediments), individual eagerness to participate, and educational attainment. The spheres of participation include important areas such as the labor market, consumption, culture (impossibility to perform standard social roles, viewed as essential by the dominating groups), education (access to literature and art), politics, welfare (social benefits), housing, etc.

Additionally, migrants, whether seen as individuals or as a group, even though a very diversified group, experience degradation of their position to a peripheral status in comparison to the dominating status of the core (central) groups. This might also be related to the fact that migrants do occupy a univocal social position, they are in most cases affiliated with one or more social groups, or belong to two different cultures, often of a conflicting character. Such a situation is also witnessed in a migrant's transition process from one culture to another. Surely, marginal groups lack access to power (political, economic, cultural) in comparison to people situated in the center. Groups with double affiliation or in a transition period from one group to another within a hierarchical society experience a change of norms and values, e.g., migrants from the developing countries in the developed ones. Finally, this limited participation of migrants might often be considered as an example of deviant behavior and migrants as deviants accept stigmatization and behave as social labeling expects them to do (Kowalak after Germani 1998: 23).

3.3 Transnationality and families

Finally, one of the most striking observations on migration is the new form of family. Families are often scattered between countries, societies, regions, hence they experience various problems, starting from a shortage of time spent together and devoted to socialization and upbringing of children, to the phenomenon of Euro-orphans left behind by parents busy with working abroad and earning money.

"... Family relations since we have entered the EU have changed... People leave and migrate, leaving children behind, hence the orphans or, as they call them, the Euro-orphans. Once my daughter approached me and asked:

– Dad, do you know that I am a Euro-orphan?

– I said: a half-orphan to be precise, as Euro-orphan refers to a child left alone

or with grandparents, when both parents have migrated." (anesthetist – intensive therapist J).

There is often a case of material compensation at the expense of emotional support and involvement. The breakdown of families living in two or more countries is also seen and there was such a case was among the respondents. Dilip Ratha et al. (2010: 9) points to the emotional costs of migrants and their families associated with the separation from the immediate family, in particular in regard to children growing up without parents or with only one parent and experiencing psychological trauma.

On the social side there were a number of social problems encountered in various configurations. The families residing with their children in the UK observed that their children attending schools there (public ones) tend to lose their national identity. Some Polish children who had left the country as adolescents could not merge with the British and did not appreciate the new country and opted to go study in Poland, e.g., in medical schools.

The migrants obviously notice a lack of regular daily contact with their families, even though they try to cover it with regular Internet or mobile communication, which creates yet another virtual community within the family.

"...It is not the same as being close to your child ... My children have their mobiles and they could call me anytime they had such a need. They were aware that I was away, but they could reach me any time with modern technologies. Of course it is not the same as regular daily contact, but as you know children now spend many hours on Facebook with these cameras on, chatting – then our relations were almost the same as relations with their teenage friends, quite modern, I do not see any traumatic impact. Also they benefited as I earned more and I had more free time I could spend with both of them..." (anesthetist – intensive therapist J).

As a result of feeling a lack of real contact migrants try to visit the family as often as possible and use benefits of their employment contracts and favorable regulations towards doctors' work time. As a result they end up spending ca. three months at home with their families.

"My family lived in Poland during the seven years of my labor migration to the UK ... To be honest the system in the UK is rather simple and predictable. I would know my work plan for six weeks ahead. My colleagues would know the names of patients on whom I would perform anesthesia ... Hence, with proper planning and perhaps some holiday days I would very often have five days off in a row. Just after being on call on a Thursday I would board a plane and fly home on the same day. I would be home in three hours' time. There were 30 days of holidays

plus additional days of study leave that I would spend in Poland ... I traveled home regularly every two-three weeks for a weekend" (anesthetist – intensive therapist J).

"...We (as doctors) had both holidays and study leave... Altogether it was about 64 days a year. The rounds are organized in such a way that after weekend duty you would have two days off. So by taking two additional days off the whole week was free." (orthopedist M).

This is quality time, more entertainment and more time spent with family than prior to their migration. In a sense they are far away, but they are in charge, they know what is going on with their families and they want to know the developments in the family members' lives.

"I have two kids, one is 18 and the other is 15. When I left for the UK the younger one was not even six ... It was a very difficult decision. I am not sure what the impact of my migration will be on their lives and development, whether it would bring more benefits or more problems. As I can see it now, I see it as a way to broaden their horizons, they see the world in a different way, something that is difficult to learn living only in Poland ... The problem I had was related to my personality, my style of being and behaving. A lot of people see me as a dominating person in a sense, somebody who is decisive, this is not the best word, in fact the children were afraid of me most of the time ... Perhaps I am straightforward, I do not beat about the bush, but this is my personality – there were some problems with my older daughter – she would be distant – so I hoped that my migration would help us to solve the problem. Now she is 18 and we are finding a way to each other, slowly we are beginning to understand each other. Life is not either white or black, there are some shades and negotiations need to be conducted. She is learning to live. Migration was also related to opportunities that are here (financial) ... On the other hand what is the use of the 15 minutes chat of the parent with a child when they have nothing to share or talk about ..." (anesthetist – intensive therapist J). *"Also, if there is a family problem in Poland, UK-based bosses support me and help me to go to Poland when there is a need, e.g., health problems of the family members."* (dentist B).

Once migration is a common decision of spouses some common decisions are made, like reduction of employment in the case of a wife who stays at home with the children, while her husband works in the UK. So basically there is a trade-off between costs and benefits, yet the area of family relations seems to be of utmost importance to all individuals.

Finally, there is the question of what would happen if the offspring living at present in Poland moved to the UK. As long as many doctors treat their

stay in the UK as a temporary work–related issue some do not know what they would do in such as hypothetical situation. The anesthetist argues that "*if my daughter decided to live in the UK, to have a family and kids here, I would have to reconsider whether to come back to Poland or to stay here with her. I would have nobody to return to in the home country. I do not return to my ex-husband or to Polish friends really, do you? The only person I care for is my daughter...* " (anesthetist B).

Conclusion

The growth of migration is surely positive in many ways for individuals, but not for all or in all ways. The feelings of entrapment, life between societies and groups, with multiple choices and identities, often with a suitcase ready to travel, make life and daily decisions complex. There is no doubt that this will affect the interest and will of migrants to engage in integration with the locals and the core of the society. As seen and shown by some examples they do not seem to be willing to assimilate on terms and conditions typical for the English society. They do seem to express a certain superiority, expecting the Brits to really accept the values and modes of behavior of the Poles and to follow their patterns and practices. It seems that migrants expect reverse assimilation in the receiving country, i.e., the nationals of the receiving country to adapt to the migrants' behavior. On the other hand the migrants form alternative communities, Polish–Polish and Polish with other migrants. However what is important is that they do not mix with other migrants, only medical professions and acquaintances of their spouses with higher education attainments. Finally, what stands out is the fact that that they do have strong bonds with the homeland via their immediate family. In that sense it is fair to admit that most of the interviewed medical staff have a transnational family, always having in the backs of their minds their Polish identity and a wish to return when they retire at the latest. Then of course there is the question if there is space for real and in-depth integration or assimilation. In my opinion, looking at this sample, I see no space for assimilation at all and not much space for integration either. They do present a case of extra-territorial citizenship based in Poland. In view of the above I would argue that transnationalism appears to be a dominant process stronger than integration, but its interactions require further study and analysis.

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