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The migration of healthcare professionals from Turkey to Germany: Reasons, challenges, and navigating migration

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ABSTRACT

This article examines the growing migration of Turkey-trained healthcare professionals to Germany, arguing that it reflects a fragmented and weakly institutionalized configuration of migration infrastructures in which mobility is sustained not through bilateral agreements or standardized policy frameworks but through individualized coordination, peer networks, and intermediary actors. Drawing on semi-structured interviews with 16 Turkey-trained doctors and nurses based in Germany and four independent consultants, the study analyzes how migration becomes actionable and how regulatory, linguistic, and adaptation-related challenges are navigated under conditions of fragmented governance. The findings show that while deteriorating working conditions in Turkey generate migration readiness, mobility unfolds through layered social, technological, regulatory, and commercial dimensions. Workplace networks first normalize migration as a viable option, but fragmented recognition regimes create uncertainty that is partially compensated by intermediaries. Independent consultants emerge not as formal recruitment agents but as gap-filling coordination actors who provide procedural guidance, information consolidation, and emotional reassurance within a decentralized system. By demonstrating how coordination work is displaced onto migrants and intermediaries in the absence of institutionalized pathways, the study contributes to debates on health workforce mobility, migration governance, and the infrastructural organization of skilled migration.

1. Introduction

The migration of healthcare professionals has become increasingly central in both academic and policy debates. Two global trends drive this visibility: the rising demand for highly skilled workers in high-income countries and persistent healthcare workforce shortages, especially in nursing and elderly care (WHO, 2020; Pillars of Health, 2022). As populations in many OECD countries age and the supply of domestic healthcare labor declines, recruiting foreign-trained professionals has become a key strategy to fill urgent staffing gaps. In response, many governments have turned to international recruitment as a key policy strategy, reinforcing the role of health worker mobility in global social policy (Cerna, 2013; Yeates & Pillinger, 2019; Dhillon et al., 2010; OECD, 2008). This trend has increasingly linked labor migration with broader governance questions about the ethical recruitment of health workers, the distribution of medical resources, and state responsibilities in both sending and receiving countries.

Health policy research -across disciplines-has explored the drivers of healthcare worker mobility using both qualitative and quantitative methods (Bidwell et al., 2014; Ferreira et al., 2020; Walton-Roberts et al., 2017). Commonly cited push factors include poor working conditions, high occupational risks, burnout, and limited career advancement opportunities in sending countries. Pull factors, on the other hand, are often associated with higher wages, safer work environments, and better long-term career prospects in destination countries (Clark et al., 2006). While such explanations identify important structural pressures, they often leave how such pressures are translated into actual migration pathways unexplored. On the other hand, the structural imbalances have led to an increasingly globalized labor market in healthcare, shaped not only by formal policies but also by informal networks, private recruitment channels, and the lived experiences of migrants navigating complex regulatory systems.

These dynamics point to the importance of examining not only why professionals move, but how mobility is organized and mediated in practice. The *migration infrastructures* perspective foregrounds the relational and processual dimensions of migration, examining the interconnected roles of regulatory regimes, commercial intermediaries, technological systems, humanitarian actors, and social networks

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-conceptualized as the regulatory, commercial, technological, humanitarian, and social dimensions of migration infrastructure-in shaping access to mobility (Lin et al., 2017; Xiang & Lindquist, 2014).This approach responds to the call to explore the "middle-space" of migration, the often-overlooked processes that occur between the initial desire to move and the final settlement (Bastide & Yeoh, 2025; Düvell & Preiss, 2022). In this framework, migration is a layered and mediated process in which facilitation and friction coexist. "Infrastructural involution" captures how expanding technologies and intermediaries may ease access to mobility while simultaneously increasing regulatory complexity and dependency (Xiang & Lindquist, 2014). By centering these mediated processes, the migration infrastructures framework enables a better understanding of how healthcare mobility is organized in practice, especially in cases where formal bilateral frameworks are absent and mobility unfolds through fragmented channels.This study situates itself within this broader literature by examining a newly emerging migration flow: Turkish healthcare professionals migrating to Germany. While much of the existing research has focused on well-established flows - particularly from the Global South to English-speaking countries - this case presents a different set of dynamics. Despite the absence of bilateral agreements or formal policy incentives between Turkey and Germany, the number of Turkish-trained physicians and nurses migrating to Germany has increased substantially in recent years. These dynamics raise key questions: (1) How does migration from Turkey to Germany become actionable for healthcare professionals in the absence of institutionalized frameworks? (2) Through which mechanisms do they navigate the migration process?

Through semi-structured interviews, this study explores the structural factors behind migration decisions, the bureaucratic and professional challenges encountered along the way, and the mechanisms used to overcome them. In doing so, it contributes to two key strands of literature: health workforce mobility and migration governance. As one of the first empirical investigations conducted by already-migrated professionals, it provides grounded insights into how migration processes unfold in practice and how governance gaps are navigated at the individual level. The findings have implications not only for academic understandings of skilled migration, but also for policymakers seeking to design more effective and equitable migration frameworks.

The study argues that the migration of Turkish healthcare professionals to Germany exemplifies an fragmented configuration of infrastructures, in which the absence of bilateral frameworks or institutionalized pathways shifts the practical work of migration governance onto individuals, social networks, and intermediaries such as independent consultants. Empirically, the analysis traces how the migration process interact with social, technological, regulatory, and commercial infrastructures at different stages, thereby operationalizing the migration infrastructures framework in the context of skilled healthcare mobility. In this configuration, mobility is sustained not through standardized policy instruments but through informal and relational arrangements and individualized strategies that mediate movement under conditions of fragmented institutional support. By foregrounding these mechanisms, the study highlights both the limitations of existing migration governance and the resilience strategies developed by professionals navigating it.

2. General context and a view of the recent flow

Within the broader global context of healthcare mobility, Germany represents a particularly illustrative case. Policymakers have increasingly emphasized what they refer to as a "bottleneck of skilled workers", with the healthcare sector cited as most affected (DW, 2024; Wiegel, 2023). In 2022, nearly 15% of the German workforce was employed in health and social services (OECD, 2025b), yet staff shortages persist, particularly among nursing personnel. The term "Pflegenotstand" (care crisis) has gained currency in public and political discourse, reflecting the depth of the issue (Pillars of Health, 2022).

To address these shortages, Germany has increasingly relied on the migration of foreign-trained professionals. Among various initiatives, the Triple Win Project, launched in 2013, established recruitment partnerships with non-EU countries such as Bosnia and Herzegovina, the Philippines, Tunisia, Indonesia, Jordan, and India (GIZ, 2025). By 2024, the project had brought 5300 nurses to Germany. However, the broader scale of international recruitment far surpasses this program, showing that informal and non-bilateral pathways now dominate the landscape. Recent statistics from the Federal Employment Agency show that by the end of 2023, approximately 270,000 nurses in Germany were foreign nationals, representing 16% of the total nursing workforce—up from 10% in 2018 and 5% in 2013. Moreover, the proportion of foreign nurses arriving from non-EU countries rose from under 50% in 2018 to 65% in 2023 (Bundesagentur für Arbeit, 2024).

Physicians reflect similar growth: the proportion of foreign-trained doctors increased from 4% in 2000 to 14% in 2022, with Germany increasingly reliant on migration to meet professional demands (OECD, 2025b). However, these figures mask significant variation in migration experiences. Despite new pathways created through the Skilled Immigration Act and the Opportunity Card (Chancenkarte), foreign-trained professionals - especially from non-EU countries - continue to face burdensome, decentralized, and inconsistent bureaucratic requirements. The recognition of medical and nursing qualifications is subject to state-level regulations, case-by-case evaluation, and often opaque standards (Pillars of Health, 2022, p. 11).

These procedural uncertainties generate emotional and professional strain for applicants. Previous studies indicate that uncertainty in credential recognition and long waiting periods often lead to frustration and diminished self-confidence (Skjeggestad et al., 2015). Professionals from outside the EU frequently navigate these challenges without the support of structured bilateral agreements or institutional channels, relying instead on personal networks or formal and informal intermediaries.

2.1. *Turkey as a source country*

Migration from Turkey to Germany has a long history, beginning with the 1961 bilateral labor recruitment agreement that initiated large-scale movements of *Gastarbeiter* (guest workers). In the following decades, family reunification and the settlement of subsequent generations turned Germany into the country hosting the largest Turkish diaspora in Europe. The current wave of healthcare professional migration, however, differs in important ways: it is not driven by bilateral agreements but by individualized initiatives and informal mechanisms. This marks a rupture with earlier flows, underscoring the absence of state-level recruitment frameworks in the healthcare sector today.

Against this historical backdrop, recent trends show Turkey emerging as a notable source country specifically for healthcare professionals. Data from the Turkish Ministry of Health show a 25% increase in the number of doctors between 2014 and 2020, yet Turkey still lags behind Germany in healthcare workforce capacity (OECD, 2025a). While Turkey does not officially report healthcare outmigration, the number of "good standing certificate" requests issued by the Turkish Medical Association (TTB) has surged—from 59 in 2012 to over 3000 in 2023—indicating a marked increase in professionals seeking opportunities abroad (TTB, 2023). Political responses, on the other hand, have been largely dismissive. President Erdoğan's 2022 statement - "If they want to leave, let them go" - reflected an indifference toward the outflow of skilled professionals, despite growing concerns from medical associations and labor unions (Baser et al., 2022). No preventive policies have been adopted to address this trend.

Although Turkey lacks detailed data regarding the exact number of emigrating doctors, statistics from the German Medical Association provide a clearer picture. The migration of Turkish-trained doctors to Germany shows an especially steep increase. From 995 in 2015, the number rose to 3169 by the end of 2024, representing an increase of

approximately 218% over less than a decade (Bundesärztekammer, 2025). In contrast, the UK hosted only 470 Turkish doctors in 2023, underscoring Germany's increasing appeal despite language and bureaucratic challenges (Baker, 2023). As shown in Fig. 1, the number of Turkish-trained physicians working in Germany has increased steadily over the past decade, reflecting the growing significance of this migration corridor.

This upward trend is particularly notable when compared to other major source countries. Austria stands out as the country whose healthcare professionals are expected to face the least challenges during relocation owing to the absence of a language barrier and the streamlined process of diploma equivalency. Greece, on the other hand, presents a unique case, as it has the highest ratio of practicing doctors among OECD countries. Greek doctors, particularly after the 2009 financial crisis, faced an oversupply of medical professionals and a lack of job vacancies in their domestic hospitals. Research indicates that the primary motivations for Greek doctors to migrate include long waiting periods for medical specialist training—often leading to significant periods of unemployment - as well as low salaries in Greek hospitals (Gkolfinopoulos, 2016).

For Romanian healthcare professionals, the increase in migration has been closely tied to Romania's accession to the EU in 2007, which significantly simplified migration procedures and facilitated labor mobility (Rohova, 2011). Syria presents another distinct case, particularly because security concerns have driven highly skilled professionals to leave their country, which in turn affects their legal status when they arrive in Germany and the specific challenges they face in transitioning into the workforce (Abbara et al., 2019; Loss et al., 2020).

The doctors from Turkey, however, exhibited unique characteristics compared with the other groups. Unlike Romanian and Greek doctors, they do not benefit from EU membership and the associated procedural advantages. However, they share similar bureaucratic hurdles with a significant group of foreign doctors from Syria since both are from non-EU countries and face challenges in obtaining work permits and diploma recognition. Turkish healthcare professionals, by contrast, continue to migrate voluntarily in growing numbers, facing complex procedures without political protection or structured facilitation.

Regarding nurses, there are no publicly available figures on how many Turkish nurses have migrated, nor are there comprehensive studies on their experiences. Political discourse in Turkey has largely ignored this issue, and the nursing profession lacks the strong professional advocacy seen among doctors (Baser et al., 2022). Despite this, the outflow of nurses appears to be gaining momentum, visible through the proliferation of German language courses targeting healthcare workers, active online communities, and social media content offering migration advice.

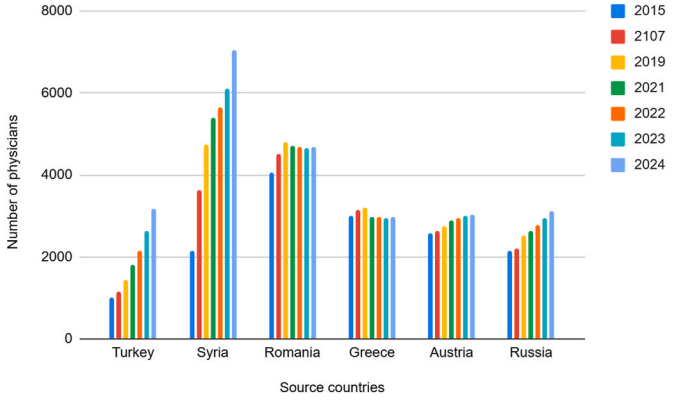

Fig. 1. Changes in the number of foreign physicians working in Germany by year (top 6 groups).
Source: Yearly data retrieved from Bundesärztekammer Statistics, available at: https://www.bundesaerztekammer.de

Recent data show that by 2023, 16% of nurses working in Germany were foreign-born, up from 10% in 2018 and just 5% in 2013 (Bundesagentur für Arbeit, 2024). A significant shift has occurred: in 2023, 65% of all foreign nurses came from non-EU countries. Turkey has become one of the top five source countries, despite being excluded from Germany's official bilateral recruitment agreements.

Beyond these aggregate indicators, a growing body of research points to a growing demand for outward mobility shaped by structural pressures in Turkey's healthcare system. Quantitative studies consistently document high levels of migration intention for doctors and nurses and link these to structurally embedded working conditions, including excessive workloads, diminished professional recognition, exposure to workplace violence, and broader ethical and professional strains (Arslan Yürümezoğlu & Çamveren, 2024; Öncü et al., 2021; Mutlu et al., 2024; Yılmaz and Koyuncu-Aydın, 2023; Önal & Akay, 2024). Large-scale survey studies show that more than half of respondents actively consider working abroad, associating migration with lighter workloads, higher professional prestige, improved safety, and better economic conditions, with Central European countries - followed by North America and Scandinavian countries - emerging as the most frequently preferred destinations (Küçükkendirci & Yücel, 2025; Özşahin & Çağatay, 2025).

While these studies provide important insights into the drivers of migration intentions, they offer more limited empirical understanding of how migration unfolds after the decision to leave has been made. A smaller body of qualitative research has begun to address post-migration experiences, focusing on issues such as language and recognition requirements, cultural barriers, and working conditions. Although based on relatively small samples, these qualitative studies consistently indicate that migrated Turkish health professionals express little or no intention to return, suggesting that migration is increasingly perceived not as a temporary strategy but as a durable exit pathway from Turkey's healthcare system. (Gülşen et al., 2025; Yılmaz Sezer, 2023). The literature to date offers limited country-specific and comparative insights into destination choice. Rather than reducing Germany's prominence to a single causal explanation, it can be conceptualized as emerging from the convergence of sustained healthcare labor demand in Germany, migration infrastructures -including language courses and intermediary services tailored to healthcare workers in Turkey- and historically embedded mobility channels between Turkey and Germany.

Building on but also extending this emerging work, the present study shifts attention from push factors and post-migration experiences alone to the broader processes through which migration is navigated. Rather than treating migration as a linear outcome of individual intentions or structural pressures, it examines the overall process with fragmented institutional arrangements, navigating mechanisms of the professionals and the role of intermediary actors.

3. Methodology

This study is based on qualitative data collected through 20 semi-structured interviews with Turkish healthcare professionals (n = 16) and independent consultants (n = 4) involved in migration to Germany. The aim of the study was to explore motivations for migration, challenges encountered during the process, and the informal support mechanisms used to navigate Germany's complex and highly regulated migration system. Semi-structured interviews were chosen to allow flexibility in probing individual narratives while also enabling the identification of recurring patterns across cases. Interviews were conducted between September 2024 and February 2025, informed by preliminary desk research on legal and bureaucratic requirements. Depending on participants' availability and location, interviews were conducted both online (via secure video-conferencing platforms) and in person in Germany.

The study focused on doctors and nurses, as they represent the largest professional groups within Turkey's healthcare outmigration and

are the most visible in both public debate and policy discussions. Other categories of healthcare workers - such as midwives, physiotherapists, or technicians - were not included due to limited accessibility within the scope of this research. The sample consisted of nine nurses (all women) and seven physicians (four men and three women), reflecting gendered patterns of professional representation commonly observed in the healthcare sector. While three physicians migrated immediately after completing medical school, the remaining participants had at least two years of professional experience in Turkey prior to migration. All nurses had worked for a minimum of one year before migrating. At the time of the interviews, all healthcare professionals had been residing and working in Germany for at least one year and were employed in healthcare institutions across four federal states. Migration pathways varied, including language visas, temporary work permits, and spousal relocation; however, all participants had undergone Germany's multi-step recognition and licensing process.[1]

Recruitment of healthcare professionals followed a snowball sampling strategy. Initial access to participants was facilitated through personal contacts with physicians in Turkey, which enabled the first interviews, followed by snowball sampling. Interviews lasted between 45 and 75 min and were guided by an interview protocol organized around three broad themes: (1) migration decision-making, (2) challenges related to diploma recognition, language acquisition, and employment procedures, and (3) strategies of adaptation, including the role of consultants and social networks. While the semi-structured format allowed participants to elaborate on their individual experiences, these thematic areas provided a consistent analytical framework across interviews, ensuring comparability and methodological transparency.

In addition to healthcare professionals, four independent consultants based in Germany were interviewed. These intermediary actors are referred to as "consultants" here, reflecting both how they describe their own role and the nature of the services they provide. Analytically, these consultants are understood as intermediary actors within the migration process. The small number of consultant interviews reflects the limited and specialized nature of this group, as well as the attainment of theoretical saturation, given the strong thematic repetition observed across interviews. Three of the consultants were themselves former healthcare migrants. Consultants were recruited via email and social media platforms, where they actively disseminate information to Turkish-speaking healthcare professionals. These interviews lasted between 60 and 90 min and covered topics such as consultants' own migration trajectories, demand for consultancy services, and recurring patterns observed among their clients.

All interviews were transcribed manually and analyzed using thematic analysis. The analytical process was iterative, beginning with open coding of the transcripts, followed by the grouping of codes into broader categories reflecting pre-migration experiences, bureaucratic challenges, adaptation strategies, and coordination practices emerging from consultant interviews. These categories were then compared across interviews to identify patterns of convergence and variation. Table 1 below provides an overview of the main analytical categories and subthemes derived from the thematic coding process. The analytical categories were subsequently interpreted through the lens of the regulatory, commercial, technological, and social dimensions of migration infrastructures.

Table 1
Overview of thematic coding structure.

Main analytical category	Subthemes
Structural conditions shaping migration readiness	Working conditions and workload
	Professional autonomy and managerial practices
	Workplace violence
Bureaucratic challenges in the migration process	Language requirements
	Diploma recognition regime
Adaptation in Germany	Workplace level adaptation
	Job satisfaction
	Professional and social networks
Independent consultants facilitating mobility	Navigating recognition process
	Employment-related guidance
	Emotional reassurance and expectation management

The researcher's positionality influenced both access to participants and the conduct of the study. While the researcher had prior experience as a migrant and was temporarily residing in Germany during the research period, but was not embedded in the specific professional or migration networks examined in this study. This positioning facilitated rapport with participants but also carried the potential for shared assumptions, while the lack of professional embeddedness introduced different interpretive distances. Reflexive attention was therefore maintained throughout data collection and analysis.

Formal institutional ethical approval was not sought for this study, as the research involved low-risk qualitative interviews with adult participants. All participants were informed about the aims of the research, the voluntary nature of participation, and the use of anonymized data for academic purposes. Verbal informed consent was obtained prior to each interview, and participants were assured of confidentiality and their right to withdraw at any time. No identifying information was recorded, and all data were handled securely. Ethical considerations were observed throughout the research process.

4. Experiences of Turkey-trained physicians and nurses migrating to Germany

This section examines how the mobility of Turkish healthcare professionals to Germany is produced and mediated through structural pressures, institutional encounters, social networks, and intermediary actors. From a *migration infrastructures* perspective, the analysis here concentrates on interaction of the empirically observable dimensions, which this migration corridor is constituted through: regulatory (recognition, language and work authorization regimes), commercial (independent consultants), technological (digital information available) and social (peer networks). By analyzing these as a 'linked ecology' (Bastide & Yeoh, 2025), we can move beyond seeing these layers in isolation and examine how the limitations or 'frictions' of one dimension, such as the unpredictability of the diploma recognition process, are actively compensated for by the activities of others, such as consultants. Drawing on interviews with healthcare professionals and consultants, the findings explore how migration decisions, bureaucratic challenges, and facilitation practices are experienced and navigated in practice. Organized thematically, the section traces different stages of the migration process -from pre-migration motivations to recognition procedures and intermediary support-highlighting how mobility unfolds under conditions of fragmented institutional coordination and, in doing so, reflects a specific configuration of infrastructures shaping skilled mobility.

[1] This study analytically treated these trajectories as comparable. Regardless of entry route, migration decisions were initiated while actively employed in Turkey, shaped by similar informational sources, and followed by comparable challenges related to language acquisition, credential recognition, and professional re-entry. Differences in entry routes, therefore, constitute variations in legal status rather than analytically distinct migration pathways. In cases of spouse relocation, migration was not framed as the outcome of one spouse's unilateral decision but described as a joint family decision, in which spouse's entry to Germany functioned for the health professionals primarily as an earlier legal entry opportunity.

4.1. Structural conditions shaping migration readiness: workload, managerial arbitrariness, and workplace violence

This section examines the structural pressures that led Turkish healthcare professionals to consider migration and explores how these pressures were translated into actionable pathways. Drawing on interviews with physicians and nurses who had already migrated, three interrelated themes consistently emerged as central to the start of the process: excessive workloads and long working hours, arbitrary and non-meritocratic management practices, and the increasing prevalence of workplace violence.

Excessive workload and working hours were described as the most immediate and pressing concern. Interviewees reported mandatory 24-h shifts, blurred job descriptions, and persistent difficulties in taking legally entitled leave, particularly in public hospitals. Nurses frequently emphasized the expectation of constant availability through workplace WhatsApp groups, which they experienced as intrusive and normalized within the Turkish healthcare system. In contrast, Germany's regulated working hours and respect for personal time were repeatedly cited as a key improvement. As one nurse explained:

> "Here [in Germany], my working hours are fixed, and I was especially surprised that no one contacts me outside of my shift. In Turkey, every hospital or clinic has a WhatsApp group, and you have to check it 24/7 because they can ask for something at any time. Sometimes, there are even arguments in those groups. Here, there isn't even a WhatsApp group. Our shifts are humane; we have rest periods after night shifts, and taking on extra shifts is entirely voluntary. If you don't want to, you don't have to. Every extra shift is paid, and for annual leave, they give us an open schedule, and everyone writes down their preferred dates."

A second major pressure concerned managerial arbitrariness and the lack of transparent career pathways. Both doctors and nurses described rigid workplace hierarchies in which seniority and informal power relations outweighed merit in shaping professional advancement. Interviewees emphasized that the perceived lack of meritocracy extended beyond administrative appointments to include access to specialist training positions and opportunities for career progression. Advancement was often described as contingent on political affiliations, patronage networks, or informal hierarchies rather than clearly defined performance criteria. These dynamics discouraged long-term professional planning and reinforced the perception that professional effort and qualifications alone were insufficient to secure stable career trajectories in Turkey. Many respondents viewed such practices as structural and unlikely to change under the prevailing political conditions.

Rising violence against healthcare workers constituted a third, and particularly destabilizing, pressure. Even among those who had not personally experienced physical attacks, the visibility and frequency of violent incidents contributed to a pervasive sense of vulnerability. Interviewees emphasized that violence had become an anticipated occupational risk rather than an exceptional occurrence. One physician (age 36, three years in Germany) described how institutional responses often compounded this insecurity:

> "In Turkey, when you experience violence, your supervisors try to prevent you from reporting it because they might be held responsible. One of my colleagues experienced this and was pressured, and despite our efforts, we couldn't convince him otherwise. The management of the hospital said that reporting wouldn't change anything and would only harm the hospital's reputation. Private hospitals, in particular, are especially fearful of these incidents becoming public."

Taken together, these accounts suggest that migration decisions were rarely driven by a single grievance. Instead, interviewees described a cumulative process in which excessive workloads, managerial arbitrariness, and the normalization of workplace violence jointly undermined the sustainability of long-term professional careers in Turkey. In this context, remaining in the country was widely perceived as increasingly untenable, regardless of individual economic circumstances. This pattern resonates with existing research on healthcare worker dissatisfaction and mobility in Turkey. Institutional reports document a steady rise in workplace violence over the past decade, with incidents extending beyond emergency departments to outpatient and primary care settings (TTB, 2017; TTB, 2019; TTB, 2024). Survey-based studies similarly identify workload, professional insecurity, and exposure to violence as central sources of discontent among physicians and nurses (Hamzaoğlu & Türk, 2019; Yılmaz & Koyuncu Aydın, 2023). Consistent with these findings, participants in this study emphasized that financial considerations played a secondary role. Although salary differentials and recent financial incentives were acknowledged, they were widely seen as insufficient to offset what interviewees described as structurally unsustainable working conditions.

However, these pressures did not automatically translate into migration. Rather, they became meaningful within peer-based social networks in which workplace frustrations were collectively discussed and compared with perceived conditions abroad. Many participants recalled that conversations in work settings frequently included references to colleagues who had already migrated, particularly to Germany. The idea that there was sustained demand for healthcare professionals in Germany also circulated widely in these informal exchanges.

In this sense, initial information about migration opportunities typically emerged through word-of-mouth and peer networks, where the feasibility of migration was first imagined and normalized. As the idea matured, participants described turning to individual online research to assess procedural and language requirements, concretely. Social networks thus functioned as the primary site where migration became socially thinkable, while available digital information enabled individuals to evaluate its practical viability. Migration, therefore, did not begin as a purely individual decision, but as a mediated and layered process in which first social and then technological infrastructures interacted to transform dissatisfaction into a concrete mobility project.

4.2. Navigating fragmented recognition regimes: language requirements, diploma recognition bureaucratic uncertainty

All participants reported initiating the migration process while still actively employed in Turkey. At this stage, Germany emerged as a particularly salient option, both because of the perceived attractiveness of working conditions and because informal knowledge about migration pathways, recognition procedures, and everyday work experiences had begun to circulate within Turkey. In this context, the structural pressures outlined above became operationalized through perceived opportunities. Participants' transitions from employment in Turkey to relocation in Germany were rarely linear; instead, they unfolded through trial-and-error processes in which information obtained from peers, online forums and video materials, and intermediaries shaped how individuals identified, tested, and adjusted their initial entry routes, such as job applications, language visas or family-based pathways. Thus, rather than relying on a centralized or formalized professional network, participants described situational and often weak-tie connections that played a role in encouraging mobility.

Participants described this phase of migration as long, complex, and emotionally taxing. The most frequently cited challenges were language acquisition and the bureaucratic process of diploma recognition - both of which were seen as significantly more burdensome than for other highly skilled migrant groups. These challenges reflect the highly regulated nature of the healthcare profession, which requires certified language proficiency and formal recognition of educational and practical qualifications. While work authorization constitutes an additional formal requirement -issued either as temporary or permanent work permits- participants consistently emphasized that once language certification and recognition procedures were secured, obtaining work authorization

became largely a matter of time rather than a substantive obstacle.

Language learning was typically described as the earliest tangible step undertaken after deciding to migrate. Most participants reported pursuing language courses while still actively employed in Turkey, which limited their ability to engage in systematic or immersive learning. Instead, they described prioritizing exam-oriented preparation through short-term courses and individual study aimed primarily at obtaining the required certificate. This prerequisite, particularly for those attempting to meet it alongside full-time employment in Turkey, often prolonged the time to take the next steps. Language especially emerged as the most significant initial barrier for nurses, many of whom had to reach B1 level to begin working with a provisional license and continue language training after arrival in Germany. Doctors generally reported fewer difficulties, as many had previously studied in English or had greater exposure to international academic environments.

Participants also emphasized that formal certification did not immediately translate into communicative competence in the workplace. As one nurse (age: 25, 1 year in Germany) explained:

> "Even with a C1 certificate, when you arrive, you speak like you're at A2 level. If you're lucky enough to land in a supportive team, it gets better. But facing the same communication challenge every single day is exhausting."

Participants expressed little doubt regarding the substantive quality of their education in Turkey; instead, the central challenge was described as an institutional mismatch in credential recognition. Although the application can be initiated from Turkey, both countries' bureaucratic limitations contribute to inefficiencies. In Turkey, institutions often lack the documentation systems required by German authorities - particularly records of "practical hours." As one nurse (age 35, 5 years in Germany) shared:

> "Due to long working hours and patient overload in Turkey, we might measure blood pressure 70–80 times a day or draw blood 50 times, but none of this is officially documented. There is no system in place to record these activities. I had been a nurse for eight years, but when I arrived in Germany, I had no official proof that I had ever drawn blood. To obtain full recognition, I had to complete these requirements again here."

Because German authorities do not automatically recognize Turkish diplomas, educational and professional backgrounds are assessed on an individualized basis by state-level authorities. Recognition requirements and processing times vary across federal states and are not fully standardized, making the choice of state a consequential decision. In this context, full recognition at the initial stage was widely understood to be highly unlikely, and none of the participants had obtained full recognition upon first application. Uncertainty regarding the length and complexity of the documentation process, especially for participants with families, was described as a major obstacle to planning the timing and logistics of migration.

Doctors described the recognition process as particularly rigid with respect to medical specializations. Most reported having to complete supervised practical work and pass oral or technical language examinations before becoming eligible for full recognition. Prior to this stage, physicians were typically granted a limited license (*Berufserlaubnis*), the scope and conditions of which varied considerably across hospitals and were often shaped by supervisory discretion. Nurses, in turn, reported the need to complete additional practical hours, during which they could work as assistant nurses. Some physicians also described choosing to re-enter specialty training in Germany rather than attempting to have their Turkish specialization recognized.

In the absence of clear timelines, participants emphasized that navigating the recognition process largely required waiting, gathering as much information as possible from available sources, and exercising patience. Many reported calibrating their expectations by drawing on the experiences of other individuals who had undergone similar procedures, using these shared accounts as informal benchmarks for anticipating delays and outcomes.

Consultants confirmed these accounts and pointed out that even recent reforms have not sufficiently streamlined recognition. Each state interprets federal guidelines differently, and even within the same office, outcomes can vary depending on the clerk assigned. As one consultant put it:

> "Germany can't solve a skilled labor shortage with one English-language website [make-it-in-Germany]. There's too much happening behind the scenes, and we often don't know what to expect either."

These experiences illustrate how language requirements and recognition procedures are not experienced as discrete hurdles but as interconnected elements of a fragmented and individualized recognition regime, placing the burden of navigation largely on migrants themselves. Importantly, many healthcare professionals entered this process with the expectation that their qualifications would not be immediately recognized and that a period of deskilling would be unavoidable. Consultants' accounts further underline that the gap between official narratives of "welcoming skilled migrants" and the realities of bureaucratic navigation is experienced not only by healthcare professionals but also by those supporting them. In this sense, the emergence of prolonged deskilling and reskilling processes within a policy context that actively promotes the recruitment of skilled migrants appears deeply ironic - not because deskilling itself is unexpected, but because its duration and unpredictability repeatedly reassert it as an ongoing condition rather than a temporary phase.

Read through the lens of the "welcoming skilled migrants" discourse, these trajectories underscore the relational and contingent nature of migrant skill itself. As argued in the migrant skills literature, skill is not a fixed attribute carried across borders but is socially constructed through recognition regimes, language requirements, and institutional validation in destination contexts (Nowicka, 2014; Liu-Farrer et al., 2021). The experiences described here therefore cannot be reduced to a straightforward narrative of deskilling. Instead, they point to a prolonged transitional phase in which formal qualifications are temporarily devalued, skills become socially questionable, and professional competence is only gradually re-established through language acquisition, supervised practice, and full recognition. These processes involve overlapping dynamics of de-skilling and re-skilling shaped by temporal and regulatory conditions rather than linear downward or upward mobility (Korzeniewska and Erdal, 2021). Seen in this way, the relevance of this case lies not in the existence of deskilling and reskilling per se, but in how these processes unfold within individualized and fragmented governance contexts.

4.3. From initial disorientation to adaptation: working conditions and social networks

Most interviewees who had completed the migration process and have been working in Germany for at least one year reported a high level of satisfaction with their current working and living conditions, despite the aforementioned challenges. Prior to arrival, they had anticipated a lengthy adjustment period, particularly regarding language proficiency and adapting to a different healthcare system. While daily challenges related to linguistic barriers and unfamiliar procedures persisted, interviewees emphasized that workplace integration became noticeably smoother as their command of German improved. Ultimately, all participants expressed satisfaction with their decision to migrate, as well as with their professional environments and overall living standards.

With regard to workplace adaptation, all but two nurses and one physician reported satisfaction with their initial workplaces. Those who were initially dissatisfied described their experiences not as overt discrimination or racism, but rather as a sense of "social distance" in their work environments. However, upon switching employers, they

found more welcoming workplaces and were able to establish better professional relationships. The ability to change workplaces relatively easily was seen as a significant advantage compared with their experiences in Turkey, where career mobility within the healthcare sector is more constrained. One of the doctors (age: 28, 3 years in Germany) explained:

> "When I first started working in Germany, I was placed in a hospital where the work environment felt quite isolating. It wasn't outright discrimination, but there was a clear sense of social distance. I struggled to integrate into the team. I wasn't sure if it was because I was a foreign doctor or simply because of the different workplace culture. After a few months, I realized that staying there would be mentally exhausting, so I started looking for other opportunities. I reached out to the social network of doctors coming from Turkey here and through these connections, I found a position at another hospital."

Improved working conditions in Germany -particularly regulated working hours, clearer job boundaries, and greater control over personal time-re-emerged in this section as a key factor facilitating adaptation. Several interviewees noted that while emotional challenges related to distance from family and familiar social environments persisted, these were mitigated by the increased time and energy available outside of work. As one nurse (age 26, two years in Germany) explained:

> "There were many times when I felt bad simply because I was in a different country and couldn't see my family and friends whenever I wanted. But then I realized that, due to the workload, I didn't have much of a social life in Turkey either. After overcoming the initial sense of foreignness, I noticed that I actually had more time for myself and, albeit remotely, for my friends here. That realization helped me stop feeling bad."

Notably, most interviewees highlighted the significant role of social networks consisting of fellow doctors or nurses from Turkey in facilitating their adaptation to a new working environment and healthcare system. These networks provided crucial support by helping them navigate unfamiliar surroundings, anticipate potential challenges at each stage of their transition, and develop strategies to overcome them effectively. Beyond workplace-related issues, they also play a vital role in easing integration into daily life by offering guidance on practical matters such as securing housing contracts, enrolling children in daycare, and finding local stores. Many interviewees emphasized that these networks provided not only essential information but also a sense of security and belonging. Consequently, rather than being a linear or purely individual process, workplace adaptation emerges here as a relational outcome shaped by improved working conditions and the support of professional and social networks.

The experiences described here also echo findings from studies on other groups of foreign-trained healthcare professionals in Germany, including research on Syrian doctors, which similarly points to the absence of clearly structured institutional pathways for workplace adaptation (Abbara et al., 2019; Klingler and Marckmann, 2016). In these studies, as in the present case, adaptation is shown to depend less on formal integration mechanisms and more on how individual workplaces operate, how managers respond, and which forms of informal support become available. While some employers facilitate language learning or offer limited forms of guidance, such support remains inconsistent. As a result, healthcare professionals often rely on professional and social networks to identify job opportunities, navigate workplace cultures, and adjust to new professional environments. Seen from this perspective, individualized pathways of adaptation do not appear as exceptional or group-specific outcomes, but rather as a recurring pattern shaped by broader institutional arrangements.

4.4. Independent consultants as intermediary actors under limited institutional support

The preceding sections show that the migration of healthcare professionals from Turkey to Germany unfolds through individualized pathways shaped by limited institutional guidance. Consultants featured in participants' accounts in multiple ways and at different stages of the migration process. Consultants' online materials and publicly available guidance were widely accessible and frequently consulted throughout the migration journey -particularly by those who had migrated more recently- and most participants described turning to consultants at moments of uncertainty or institutional blockage, such as difficulties with recognition procedures, contradictory information, or unsatisfactory encounters with other channels. Importantly, none of the participants in this study initiated their migration through these intermediaries. Rather than functioning as primary recruitment actors, consultants were described as reactive and situational resources, whose involvement intensified when individual migration processes became difficult to navigate. Based on interviews with four such consultants -three of whom were themselves former migrants-this section examines how their work responds to persistent gaps in institutional coordination.

Unlike traditional recruitment agencies that typically focus on job placement and contract signing, these consultants provide personalized, process-oriented support, often becoming the main source of reliable information for healthcare professionals. According to the consultants, many healthcare professionals turned to them after unsatisfactory experiences with recruitment agencies, which were described as offering little assistance beyond facilitating initial employment. Consultants, in contrast, position themselves as ongoing points of reference, particularly in situations where official information is difficult to interpret or inconsistently applied.

The consultants interviewed have gained increased visibility since around 2021 and have played a crucial role in organizing and systematizing the fragmented information circulating within professional social networks, a role they actively acknowledge and emphasize in their own narratives. As of the end of 2024, they reported receiving daily inquiries from dozens of healthcare professionals seeking guidance on various aspects of the migration process. While only a portion of these inquiries result in full consultancy arrangements, the volume of requests underscores the demand for coordinated guidance in an otherwise opaque and decentralized system.

A central area of consultants' expertise concerns the recognition of professional qualifications. Their role involves anticipating documentation requirements across different federal states, advising applicants on how to prepare more complete application files, and reducing delays caused by repeated requests for additional information. By drawing on accumulated experience from multiple cases, consultants offer a more predictable pathway through recognition procedures - something that is not readily available through official channels alone. Importantly, consultants also provide reassurance by framing delays and procedural complexity as systemic features of the process rather than as reflections of individual inadequacy.

Beyond their familiarity with German regulations, consultants are also knowledgeable about navigating documentation practices in Turkey. Given the lack of standardized records in Turkish institutions for practical training and work experience, particularly in healthcare settings, consultants continuously update their strategies through interactions with applicants and institutions. This cross-contextual knowledge enables them to bridge mismatches between Turkish documentation practices and German recognition requirements.

In addition to one-on-one consultancy, two of the consultants interviewed actively disseminate accurate and up-to-date information through social media, where they have thousands of followers. These platforms serve as valuable resources, helping prospective migrants to understand the complexities of the process, anticipate challenges, and access reliable guidance in an otherwise opaque system. Their ability to

break down bureaucratic uncertainties and provide structured information significantly enhances the preparedness and confidence of healthcare professionals in navigating the migration journey.

Consultants also play an important role in mediating access to the healthcare labor market. Drawing on accumulated knowledge of employment conditions, they advise healthcare professionals on contract terms, workplace expectations, and negotiation strategies. This support is particularly valuable for those unfamiliar with German labor law and professional norms. As one consultant explained:

> "Those who come without carefully reviewing their contracts and working conditions often run into problems later. Some are unfairly dismissed, while compensation was required from some other. However, most of the contracts do not require the worker to commit for a certain period of time or to pay any compensation upon leaving the workplace. As part of our consultancy, we also review contracts for our clients after their job interviews. Our legal advisor checks the details, and if there are issues, we help them negotiate necessary corrections before they sign."

Finally, consultants provide forms of psychological and emotional support that extend beyond technical guidance. By normalizing uncertainty, explaining delays, and clarifying workplace expectations, they help mitigate the stress associated with prolonged migration processes. This support is particularly significant given that most healthcare institutions lack dedicated structures to assist foreign-trained professionals with adaptation and integration, as studies on the integration of foreign-trained healthcare professionals have systematically shown (Abbara et al., 2019; Konrad, 2024; Schumann et al., 2022).

These findings suggest that independent consultants are best described within the commercial dimension, as they operate through fee-based service provision. However, their role extends beyond technical coordination. By organizing and redistributing knowledge circulating within peer networks, they shape the informational environment through which migration becomes navigable. While analytically situated within the commercial dimension, their activities also resonate within the social sphere by influencing how experiential knowledge, risk perceptions, and expectations are formed. Their growing prominence thus reflects not only regulatory gaps but also the interdependence of regulatory, commercial, and social processes in sustaining this migration corridor.

5. Concluding discussion

This study has examined the migration of healthcare professionals from Turkey to Germany, a recently accelerating trend, by focusing on the lived experiences and non-institutionalized arrangements through which this movement is practically navigated. The findings show that while Germany has increasingly promoted skilled migration in response to healthcare workforce shortages, the migration process itself remains highly complex, individualized, and weakly supported by formal institutional mechanisms. Despite recent reforms such as the Skilled Immigration Act and fast-track recognition procedures, migration experiences, particularly for healthcare professionals from non-EU countries, continue to be shaped by bureaucratic fragmentation and regional variation.

Taken together, the findings suggest that the Turkey–Germany healthcare corridor operates through a fragmented configuration of migration infrastructures, in which coordination work is largely displaced onto individuals and intermediary actors. As the structural pressures in Turkey generated widespread dissatisfaction, they created a state of migration readiness that became actionable first through social and then technological infrastructures. Workplace conversations and peer networks were often the first sites where Germany emerged as a viable alternative. As these narratives circulated and normalized the idea of departure, individuals turned to online research to assess the feasibility of the regulatory pathways. At this stage, the regulatory dimension (particularly recognition regime) is highly fragmented and unpredictable, failing to provide synchronized pathway for migration. This institutional gap is partially compensated by commercial and social dimensions: independent consultants and peer networks act as vital nodes that centralize and translate official information. Thus, mobility unfolds sequentially yet relationally across social, technological, regulatory, and commercial dimensions. Consequently, migration governance is effectively reconstituted through these mechanisms, which in practice provide greater predictability than the formal regulatory framework itself. This configuration helps explain why intermediary actors, such as independent consultants, become particularly salient: not as substitutes for formal recruitment systems, but as responses to gaps and inconsistencies within existing governance arrangements.

This interpretation also reframes how we understand destination country recruitment strategies. While high-income countries such as Germany increasingly promote skilled migration to address workforce shortages, the case examined here suggests that policy discourse and infrastructural reality may diverge. This resonates with broader scholarship on skilled migration, which highlights how high-income countries often rely on international mobility as a short-term response to workforce shortages without adequately addressing structural inefficiencies in workforce planning (Bach, 2008; Yeates & Pillinger, 2019). The reliance on social networks and intermediary actors therefore illustrates how migration governance reassembled through relational and infrastructural work beyond formal policy design.

From the perspective of the already migrated professionals interviewed in this study, demand for migration from Turkey remains high and shows little sign of slowing despite the absence of comprehensive institutional frameworks. Participants consistently framed their decision to migrate as rooted not in short-term economic considerations, but in deteriorating working conditions, non-meritocratic workplace hierarchies, and a pervasive sense of insecurity in healthcare settings in Turkey. Given the broader political and economic context, there was little expectation among participants that these conditions would improve in the near future, reinforcing migration as a viable exit strategy.

All interviewees expressed satisfaction with their decision to migrate to Germany and reported no intention to return in the near term. However, these accounts represent only part of the broader picture. To date, there is limited empirical research on healthcare professionals who have returned to Turkey, abandoned the migration process, or decided not to migrate after initial attempts. Understanding the factors that might slow, reverse, or reshape this trend requires further research that includes returnees, unsuccessful migrants, and those who remain undecided. Such perspectives would provide a more nuanced understanding of the sustainability and potential limits of this migration flow.

A deeper examination of Turkey's role as a sending country would also contribute to broader debates on migration governance. While this study does not focus on the Turkish government's direct policy stance, there is no clear evidence of policies aimed at retaining healthcare professionals. Public statements such as President Erdoğan's remark -"Let them go"- have been widely interpreted as signaling an indifferent, if not dismissive, approach to healthcare workforce outmigration. At the same time, migration scholarship emphasizes that sending states are rarely passive actors (Cabanda, 2017). Future research could therefore explore how Turkey's policy choices, regulatory omissions, or strategic inaction shape healthcare professionals' migration decisions and whether more implicit governance mechanisms are at play.

At the destination end, the growing role of independent consultants suggests that as long as bureaucratic inefficiencies persist, migration flows are likely not only to continue but also to become increasingly organized through informal coordination mechanisms. Interview data indicate that professionals who initially relied on trial-and-error strategies increasingly turn to consultants who provide procedural guidance, step-by-step assistance, and emotional reassurance. In parallel, social and professional networks play an expanding role in facilitating

adaptation by sharing knowledge on recognition procedures, job searches, and workplace integration. As newcomers benefit from the experiences of earlier migrants, the perceived risks of migration diminish (Clark et al., 2006), making the decision to leave more accessible for future cohorts.

At the same time, the future of this migration corridor remains subject to political uncertainty in Germany. While the country has actively sought to attract skilled healthcare professionals, shifts in the political landscape - particularly the rising influence of right-wing parties and changing migration discourses - may affect the long-term stability of current recruitment and recognition practices. Whether Germany will sustain its current approach or move toward more restrictive policies remains uncertain, adding an additional layer of contingency to the future of healthcare professional migration from Turkey and other non-EU countries.

Several limitations of this study should be acknowledged. First, the qualitative sample is relatively small and not intended to be representative. While the focus on doctors and nurses reflects the most visible groups within Turkey's healthcare outmigration, the experiences of other healthcare workers and broader forms of regional, institutional, and gender diversity remain beyond the scope of this study. Second, the analysis draws exclusively on the perspectives of healthcare professionals who successfully migrated and independent consultants based in Germany, excluding return migrants, unsuccessful migration attempts, policymakers, and recruitment agencies, whose inclusion could further contextualize the governance dynamics discussed here. Finally, the findings reflect a specific temporal moment, as interviews were conducted between 2024 and 2025 during a period of ongoing regulatory and political change in Germany. Future research could build on this study through longitudinal designs and by incorporating a wider range of actors to examine how migration pathways and governance arrangements evolve over time.

In sum, this study highlights a growing yet institutionally fragmented migration flow of healthcare professionals from Turkey to Germany, emphasizing the individualized experiences of migrants and the role of independent consultants in compensating for governance gaps. Taken together, the persistence of structural pressures in Turkey, sustained demand in Germany, and the expansion of informal support mechanisms suggest that this migration trend is likely to continue. However, as long as regulatory frameworks remain fragmented, healthcare professionals will continue to rely on individualized strategies and informal coordination in navigating their migration journeys.

Declaration of Competing Interest

The author declares no conflicts of interest. The research was conducted independently, without any financial or institutional support that could be perceived as influencing the findings or interpretation of the results.

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