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ORIGINAL RESEARCH

The Ethics of Medical Practitioner Migration From Low-Resourced Countries to the Developed World: A Call for Action by Health Systems and Individual Doctors

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Abstract Medical migration appears to be an increasing global phenomenon, with complex contributing factors. Although it is acknowledged that such movements are inevitable, given the current globalized economy, the movement of health professionals from their country of training raises questions about equity of access and quality of care. Concerns arise if migration occurs from low- and middle-income countries (LMICs) to high-income countries (HICs). The actions of HICs receiving medical practitioners from LMICs are examined through the global justice theories of John Rawls and Immanuel Kant. These theories were initially proposed by Pogge (1988) and Tan (1997) and, in this work, are extended to the issue of medical migration. Global justice theories propose that instead of looking at health needs and workforce issues within their national boundaries, HICs should be guided by principles of justice relevant to the needs of health systems on a global scale. Issues of individual justice are also considered within the framework of rights and social responsibilities of individual medical practitioners. Local and international policy changes are suggested based on both global justice theories and the ideals of individual justice.

Keywords Migration · Ethics · International medical graduates · Health workforce · Health systems · Global justice

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Introduction

Globalization has led to an apparent increase in medical migration. The need to view medical workforce adequacy at a global rather than a country level is also becoming clear (Anyangwe and Mtonga 2007; Kaiser et al. 2009). This is partly due to global epidemics such as H1N1 influenza (Wilson et al. 2005) and, most recently, the Ebola epidemic in Western Africa (Briand et al. 2014). The reasons for medical migration are complex and may include the pursuit of postgraduate training, economic opportunity, and religious or political freedom (Bezuidenhout et al. 2009; Jakubowski and Hess 2004; Parsi 2008). To promote effective medical migration, there are calls for both undergraduate and postgraduate medical education to integrate international learning experiences. These include electives and overseas work placements to encourage graduates to think globally about health issues (Law 2013; Macfarlane, Jacobs, and Kaaya 2008).

There are concerns that by happily receiving immigrant medical practitioners to solve their workforce issues, high income countries (HICs) are effectively exploiting low- and middle-income countries (LMICs)

as producers of a relatively inexpensive medical workforce (Dwyer 2007). LMICs tend to have a higher burden of disease than HICs. Consequently, the departure of medical practitioners from LMICs in order to contribute to improving the health of HICs with lesser health burdens has a large negative impact. A "brain drain" is the term used in this regard and encompasses both push and pull factors (Aluttis, Bishaw, and Frank 2014; Hooper 2008; Okeke 2013). This view tends to portray medical practitioners, either intentionally or unintentionally, as merely responding to issues of dissatisfaction with career and life opportunities in LMICs (Huijkkens et al. 2010; Morton, Hider, and Schaab 2008). Such actions have given rise to a number of recommendations, including reviews of medical education in originating countries and monetary compensation and visa processes in destination countries (Lumely 2011; Nair and Webster 2013). These recommendations do not effectively target the health systems that are players in this global economy, nor do they target individual medical practitioners on the grounds of obligations they have to their countries of training. This paper, therefore, seeks to examine the actions of HICs and those of individual medical practitioners in this medical migration scenario.

This work adds to the scholarship of Pogge (1988) and Tan (1997) who discuss the usefulness of the global justice theories of John Rawls and Immanuel Kant when examining issues of social and economic differences between LMICs and HICs. Here, the work is extended in two ways: firstly by applying the theories of both Kant and Rawls to the issue of medical workforces; and secondly, by using a two-pronged approach to examine global justice issues together with individual justice issues in the context of health workforces and medical practitioners. In this way, this work expands and focuses the work of other scholars concerned with health workers in general (e.g. Dwyer 2007; Taché and Schillinger 2009) and specifically the nursing workforce (Kaelin 2011).

We begin by giving examples of medical practitioner migration trends from LMICs to HICs. Although medical practitioners have traditionally migrated to HICs such as France, Switzerland, Norway, and Japan, other countries now include the United States, the United Kingdom, Canada, Australia, and New Zealand (Pond and McPake 2006)—which have, in the past two decades, consistently employed the highest number of international medical graduates. For example, in 2006 the in-country proportions were: New Zealand, 35 per cent, United Kingdom 28 per cent, Australia, 27 per cent, United States 25 per cent and Canada 23 per cent (Dwyer 2007). These proportions are continuing to grow with New Zealand's international medical graduates currently at approximately 41 per cent of the total medical graduate pool (Cullen 2013). Some of the reasons for the high demand in international medical graduates include ageing populations, growing incomes, and feminization and misdistribution of the workforce, especially in rural and remote areas of HICs (Canadian Institute for Health Information 2010; Latham 2010).

Moreover, it was observed that in the early 2000s, LMICs contributed between 40 and 75 per cent of the international medical graduates in HICs (Mullan 2005). Nine of the twenty countries with the highest emigration factors were reported to be in sub-Saharan Africa (Mullan 2005) including South Africa, Zimbabwe, Botswana, Zambia, Ghana, and Nigeria (Mackey and Liang 2012). The reasons for such high immigration factors are manifold. In addition to the push and pull factors, these countries could be losing medical practitioners because of what scholars have termed a "post-colonial legacy," where previous colonial relations act as facilitators to migration (Hagopian et al. 2005). Postcolonial relations are also linked to conformity of medical curricula and the English language medium of instruction with those of former English-speaking colonial powers (Astor et al. 2005).

Main Concerns

The main concerns with these migration scenarios relate to the disproportionate distribution of the medical workforce when compared against the global burden of disease. In this instance, it has been noted that while India, the Philippines, and Pakistan are said to be the leading sources of international medical graduates, the most worrying incidences of medical migration to HICs are from sub-Saharan Africa (Parsi 2008). This is where the World Health Organization has noted severe manpower shortages to cope with the high incidence of disease, especially HIV/AIDS. Infant mortality is also high in these LMICs. For example while infant mortality is four per thousand in the United Kingdom, in Zimbabwe it is fifty-six per thousand (World Health Organization 2009). It has also been reported that the 11 per cent of the world's population in sub-Saharan Africa bears 24 per cent of the global disease burden but only has 3 per cent of the world's healthcare personnel (World Health Organization 2006). On the other hand, the 14 per cent

of the world's population in the Americas has 10 per cent of the disease burden managed by 37 per cent of the world's health workers (Taché and Schillinger 2009; World Health Organization 2006).

Another concern relates to the costs associated with the use of LMICs' human resource investment by HICs. On this note, several examples of net losses have been documented (Hagopian et al. 2005). The financial cost of the six hundred South African medical practitioners who were at one point said to be in New Zealand, was once estimated to be at US$37 million (Eastwood et al. 2005). These costs included losses in investment and the cost of education of medical practitioners. A recent study (Mills et al. 2011) utilized econometric methods of human capital cost analysis of publicly available data to estimate lost investment of medical practitioners migrating from sub-Saharan African countries to Australia, Canada, the United Kingdom, and the United States of America. Costs for each country ranged from US$2.16 million for Malawi to US$1.41 billion for South Africa (Mills et al. 2011). This study found that when taking the lost investment and the gross domestic product into account, Zimbabwe and South Africa had the largest net losses in Sub-Saharan Africa. In terms of financial savings, this study noted the savings in costs of educating medical practitioners for four countries—Australia, Canada, United Kingdom and United States—were US$621 million, US$384 million, US$2.7 billion, and US$846 million respectively (Mills et al. 2011). The calculation of the financial savings included such factors as cost of education from primary school to university level and interests generated from investing immigrants. In view of the above concerns, ethical frameworks are proposed for the analysis of these issues as they concern the global world including individual medical practitioners.

A Framework of Analysis

The exacerbation of the disproportionate global distribution of the medical workforce by HICs reliance on such resources, reveals a potential injustice. It is, therefore, important to frame such a scenario in global justice theories in order to provide an explanation of the injustice as seen at both a global and an individual level. As mentioned earlier, both John Rawls and Immanuel Kant allow us to see the issue as calling for both global and individual action (Pogge 1988; Tan 1997). A global outlook views medical practitioners as participating in a global socio-economic order and brain drain issues as ingrained in global institutions. From this perspective, the systems of which the individuals are a part, are the ones perpetuating such global imbalances and hence the focus on social institutions. We, therefore, specify social institutions as health systems within each country and individuals as; a) recruitment agencies in receiving countries, and b) individual medical practitioners in sending countries.

Insights From John Rawls' Theory of Justice

The tenets of John Rawls' theory that are relevant to the topic of global medical practitioner migration include justice and injustice. In general, scholars have defined justice as fair, equitable, and appropriate treatment of persons and a consideration of what is due or owed to them (Pogge 1988). On the other hand, an injustice involves a wrongful act or omission where persons are denied benefits to which they have rights or situations where burdens are not distributed fairly (Denier 2007). Rawls, therefore, proposes the concept of just institutions and a just world. He states that in a society there can be issues of justice and injustice and these can be at a personal level, as well as the social and institutional level.

For Rawls, the principles of justice that form the basic structure of society are the object of a social contract. Everyone in society will have a different conception of what is good, but they should agree on a concept of justice. This agreement is brought about by means of a constructivist procedure that Rawls calls the "original position" (Rawls 1971), which is hypothetical and non-historical, as is the contract for Kant. The purpose of this device is to provide a fair viewpoint from which principles of justice are to be chosen by representatives of the people in society. It is a fair viewpoint in the sense that it removes the effect of morally arbitrary factors from the choice situation. The conception of justice chosen will, therefore, be fair; hence he calls the conception "justice as fairness" (Rawls 1971).

The choice situation is made fair because the representatives choose principles behind a "veil of ignorance" (Rawls 1971). This hides from the representatives' morally arbitrary contingencies, which, if known, would unfairly bias their choice of principles. It hides from them the knowledge of their place in society, social class, wealth, and the talents and intelligence with which they are endowed. They do not know the relative development of their society, although they do know general facts about human society—principles

of economics, principles of psychology etc., in order to make a choice about the principles of justice possible.

With all this information hidden, Rawls claims that the principles chosen will be fair. He thinks that once a representative has reached a state of "reflective equilibrium," which occurs "after a person has weighed various proposed conceptions and he has either revised his judgements to accord with one of them or held fast to his initial convictions" (Rawls 1971, 48), the following principles will be chosen:

> *First Principle*
> Each person is to have an equal right to the most extensive total system of equal basic liberties compatible with a similar system of liberty for all.
> *Second Principle*
> Social and economic inequalities are to be arranged so that they are both:
>
> a) to the greatest benefit of the least advantaged … and
> b) attached to offices and positions open to all under conditions of fair equality of opportunity (Rawls 1971, 302).

The first principle is about entitlement to basic freedom as one route to a just society. It ascribes rights and liberties to all citizens equally. The second principle is meant to show there can be inequalities in a society and that this is just, as long as they make the least advantaged person better off. On the basis of the second principle—the difference principle—Rawls contends that justice is the first virtue of social institutions and these institutions, at times, have attributes that perpetuate social inequalities and deprivation. In the case of inequalities, instead of simply redistributing to the poor, justice is actually about reforming these institutions through a process Rawls calls moral reflection (Rawls 1971). According to this perspective, individuals who participate and gain from an unjust institutional arrangement are collaborating in perpetuating injustice (Pogge 1988; Rawls 1971) and Rawls therefore calls for individual reflection from those who comprise such institutions.

Implications of Rawls' Global Justice Theory for Medical Practitioner Migration

Arguably, a just system of healthcare is a prerequisite for citizens to be considered as "free and equal" according to a Rawlsian conception. The status of being free and equal, facilitated by the "veil of ignorance," will supposedly guarantee that individuals will make impartial choices and agree on what basic rights and principles of justice (Pogge 1988). It is important to note that under the veil of ignorance, rational decisions are made based on known scientific facts and in the case of the migration of health professionals these facts relate to statistics about global inequalities. Statistics about the global distribution of the medical workforce can also be taken into consideration in this imaginary situation. Indeed, if such statistics are taken into consideration in making decisions under the veil of ignorance, a just society with a fair distribution of the medical workforce may indeed be possible. Although this conception is imaginary, Rawls' theory gives us an idea of how deliberations can be made on global workforce issues.

According to Rawls, a lack of healthcare deprives people of their ability to make use of their liberties and hence to contribute to society. In this application of Rawls' theory to health, he emphasizes the need to restore "our capabilities when by illness and accident we fall below the minimum and are unable to play our part in society" (Kaelin 2011, 38). For example, from a Rawlsian perspective, healthcare recruitment policies that involve recruitment of personnel from other countries could be seen as insensitive and undermine the basic rights of people in LMICs. For Rawls, examining issues of justice is a key attribute of social organization because justice is the first virtue of social institutions and structures. Rawls theory helps us to see the current distribution of medical practitioners as part of the basic structure of global society—a structure that is unjust and needs to be reformed. In terms of institutional reform, Rawls' theory is bottom-up as it proposes that instead of mitigating the effects of unjust institutions, the best solution is to reform those institutions. Accordingly, the focus of this paper is to argue for reform of the health institutions of both the HICs and LMICs.

Another tenet of John Rawls' global justice theory is that all people are of equal moral worth, and therefore this evokes binding moral reasons for everyone to respect the principle of equality. It follows from this that the unequal distribution of medical practitioners between LMICs and HICs is a moral problem (Kaelin 2011) that HICs have an obligation to redress. Following Rawls, global society should take an interventionist approach to this situation by, for example, sending representatives of relevant countries to discuss issues of justice and basic rights

behind the "veil of ignorance" (Kaelin 2011). We would argue that LMICs cannot compete with HICs in such discussions as there is not a level playing field in this scenario. We suggest that HICs need to acknowledge their dominant position and seek to remedy this imbalance in ways we discuss in more detail later. The implication of Rawlsian global justice theory is that those HICs that currently receive medical personnel from LMICs should examine their actions in light of the effect this may have on the citizens of developing countries—what Rawls calls "moral reflection."

Insights From Kantian Ethics

In addition to deliberating on what is just and how to remedy what is not just, the actions of HICs in recruiting, or failing to adopt policies that discourage recruitment, from LMICs should be examined. In this instance, the actions of HICs can be analysed from a global justice perspective within Kantian ethics. The aspects of Kantian ethics that can guide us in our deliberations about global justice include both the first and second formula of the Categorical Imperative as well as Kant's notions of duties of virtue and duties of justice.

For Kant, in order for an action to be morally acceptable, it must accord with the fundamental principle of morality, or the moral law, which he calls the Categorical Imperative (Kant 1964). Kant gives four different formulations of this moral law, all of which are supposed to be equivalent. For our purposes, we shall concentrate on the second formulation.

The second formulation states: "Act in such a way that you always treat humanity, whether in your person or in the person of any other, never simply as a means, but always at the same time as an end" (Kant 1964, 96). By this, Kant means that when we act we should always respect the rationality and autonomy of everyone affected by our actions, because people have value in themselves; we should not treat them as if they only have instrumental value. The formula also shows that it is motives, rather than consequences, that are the key to evaluating an act and thus one needs to look at what the actor actually aims to do. It is obvious from this second formulation of the Categorical Imperative why Kant's moral theory is of extreme importance for issues of international justice—it is a cosmopolitan morality, i.e. one that applies to humanity as a whole and not only to a particular sub-group such as the citizens of an individual nation-state. The international domain might be characterized by the division of humanity into nation-states, but this does not, in itself, have any bearing on the truth or falsity of Kant's Categorical Imperative. Rather, any acceptance of Kantian morality must affect the way nation-states are perceived and the principles which ought to govern their behaviour and the behaviour of individual citizens.

In order to fully understand Kant's global ethics, it is important to acknowledge the difference between duties of virtue and duties of justice (Kant 1964). For Kant, duties of virtue are matters of moral assessment and cannot be enforceable or externally demanded by an agent; whereas duties of justice are enforceable by public legislation (Tan 1997). So, for example, duties of virtue might include duties to intervene in countries faced with epidemics that they cannot handle alone and duties to promote the empowerment of women in patriarchal states. Kant considers duties of virtue to be imperfect, which means they do not specify what actions should be taken for them to be fulfilled. For example, in the case of a military coup in one country, those countries that chose not to send military aid cannot be held accountable unless they belong to a community that makes it a duty of justice that members should do so.

On the other hand, duties of justice are perfect as they can be externally enforced. For Kant, duties of justice arise because the need to assist others results from either institutional injustices of which individuals are part, or previous injustices done by others with whom they are associated. He notes,

> … [t]he most frequent and fertile source of human misery is not misfortune, but the injustice of man [and] if man were scrupulously just there would be no poor to whom we could give alms and think that we have realised the merit of benevolence. (Kant 1931, 236)

There are two important factors when considering duties of justice in terms of issues of global concern. Firstly, Kant calls for the perpetrator to cease violating such duties and, secondly, if they are already violated, compensation should be given. This second point is particularly important for the following discussion as it suggests that we have a perfect duty to return that which is gained in an unjust manner.

Implications of Kant's Moral Theory on Medical Practitioner Migration

Kant's moral theory can help us in our deliberations regarding situations in which HICs justify their use of medical practitioners from LMICs by claiming they are doing it to fulfil their moral obligation of providing adequate care to their own citizens. As we have seen, motives are key to evaluating actions rather than the consequences for HICs. So, if there are policies in HICs that encourage the recruitment of medical practitioners from LMICs, we should look at the intentions and not the consequences of those policies. It may be claimed the HICs are doing good because they have an obligation to meet their workforce needs in order to optimize the health outcomes of their citizens, irrespective of the requirements of other countries. However, we shall argue that in fact, any evaluation of the intentions of HICs in meeting the health needs of their citizens should be done from a global perspective that includes consideration for the needs of LMICs. In this way, distribution of medical practitioners is seen as a global issue and not only in terms of the needs of HICs. A consideration of Kant's second formulation of the Categorical Imperative can provide some insights. When HICs and their medical recruiting agencies are judged as having the primary motive of making money, we can see they are, in Kant's terms, treating others merely as a means to an end—simply a means to achieve profits at the expense of the suffering health systems in low- and middle-income countries.

Another scenario that warrants an analysis using Kantian global justice theory is that of the deliberate poaching or recruitment initiatives employed by HICs. This not only occurs between HICs and LMICs but also happens between HICs themselves. For example, Australian medical recruitment companies are on record as going onshore to New Zealand to advertise medical vacancies in Australia (Toevai and E. Kiong 2007). This has not been debated in depth, probably because Australia and New Zealand are seen as relatively equal players that leave mediation of competition to market conditions. However, concern should be raised in situations where HIC medical vacancies appear in LMIC newspapers such as in South Africa (Ehman and Sullivan 2001; Spurgeon 2001).

With respect to the issue of the deliberate poaching of medical workers, the obligation of HICs to fulfil the duties of virtue has resulted in the mushrooming of ethical recruitment codes. These include the United Kingdom's Department of Health Guidance on International Nursing Recruitment in 1999 (Department of Health 2001), the Commonwealth Code of Practice for International Recruitment of Health Workers in 2002 (Commonwealth Medical Association 2002), and the Melbourne Manifesto Code of Practice for the International Recruitment of Health Care Professionals (WONCA 2002). However, the proliferation of these codes has not resulted in any noticeable decrease in poaching activities in LMICs. The absence of enforcement of duties of virtue has been a major criticism of *voluntary* codes of ethics. The duty to abide by these codes of ethics is left to the discretion of the profession and as a result, poaching of health workers continues untamed (Tan 1997). Indeed, most of these codes do not specify what actions will be taken against those who continue to recruit internationally. This can be seen in the Melbourne Manifesto, which is an ethical Code of Practice for the International Recruitment of Health Care Professionals adopted in May 2002 at the World Rural Health Conference Melbourne, Australia (WONCA 2002). This code only emphasizes virtues such as integrity, transparency, and collaboration in the processes of recruitment of health professionals from LMICs. For example:

> … discourage activities that could harm any country's health care system … Countries considering and benefiting from recruitment from other countries must: a) examine their national circumstances and b) consider the effect that their existing recruitment policies and practices are having on lesser developed countries.

The word "examine" in the above statement points to the need for self-reflection rather than a deterrent imposed in the form of sanctions. Similarly, the phrase "consider the effects" also points to self-reflection on the part of the recruiters.

Another important point to raise is that if some, but not all, HICs follow these ethical codes strictly, then those that do will be in an unfair competitive environment. For example, the United States has strengthened international recruitment by setting up structures and policies that facilitate international medical graduate recruitment. These policies are outlined in the Educational Commission for Foreign Medical Graduates. On the other hand, the United Kingdom's National Health Service is putting more emphasis on ethical recruitment codes. Such measures may give the U.S. market a competitive advantage in the global migration of medical practitioners. Therefore we would argue,that in order to be effective, ethical

recruitment codes need to be adhered to collectively by all nations and not by isolated blocks of countries.

The discussion above suggests that relying entirely on Kant's doctrine of virtue in terms of global justice in the distribution and utilization of the medical workforce may not provide us with adequate rationale for intervention. Indeed, Kant believes that perfect, rather than imperfect, duties may yield more tangible results. Scholars such as Tan (1997) have proposed the need to rely instead on the strength of Kant's doctrine of duties of justice as it acknowledges that assisting the needy is an issue of justice rather than an issue of virtue. In short, these require HICs to fulfil their duties by giving to those countries for whose suffering they are causally responsible, i.e. LMICs.

While Rawls' theory of justice encourages the reform of social systems, Kantian theory sees justice in terms of performing one's duties, which may include compensation, and restraint from actions that lead to the suffering of others. For example, Kant sees the privileged as having both duties of justice and duties of virtue to the less privileged (to be discussed in more detail below).

Issues of Individual Justice

As we argued earlier, medical practitioners are active players in the migration scenario and it is therefore important to examine individual justice issues as well as those at the level of social institutions. Most studies of migration of medical practitioners (Astor et al. 2005; Eyal and Hurst 2008; Hussey 2007) have tended to portray these professionals as only responding to push and pull factors dictated by the dynamics of the global market economy. This has led to more scholarship pursuing issues of push and pull factors (Okeke 2013) with little attention given to the actions of medical practitioners as autonomous agents of change.

Here we examine issues of individual freedom and the social responsibilities of medical practitioners to their societies. These will be conceptualized within the framework of individual rights (freedom) and social responsibility. For the sake of this work, rights will be defined in accordance with the framework of Kantian ethics. Social responsibility, whether enacted by an organization or an individual, is the imperative, without compulsion from an external sanction or authority, to make decisions on the basis of that which will do the most for society at large, even if that means sacrificing the personal wants and/or needs of the decision-maker (Brandão et al. 2013; Semplici 2011; Vallaeys 2014).

In terms of rights, we begin by exploring relevant aspects of Kantian ethics. For Kant, in society "we find a union of many individuals for some common end which they all *share.*" The end that all individuals ought to share, he argues, is "the *right* of men *under coercive public laws* by which each can be given what is due to him and secured against attack from any others" (Kant 1991, 73). Kant claims that *right* is the restriction of each person's freedom so that it is in harmony with the freedom of all, and *public right* is that distinctive quality of the *external laws* which make this harmony possible (Kant 1991). The end in itself which all individuals ought to share could not be happiness, he suggests, for happiness is subjective, and so could not possibly result in shared political principles for society. Laws are not in existence to secure the greatest happiness for the greatest number, but rather to secure the greatest amount of freedom compatible with a similar amount of freedom for all. This is made clear with Kant's universal principle of right or justice: "every action which by itself or by its maxim enables the freedom of each individual's will to co-exist with the freedom of everyone else in accordance with a universal law is *right*" (Kant 1991, 133). Moreover, from this Kant claims that freedom, equality, and independence are "the three rightful attributes which are inseparable from the nature of a citizen as such" (Kant 1991, 139).

In terms of individual freedom in today's world, it has been argued (Bader 2005) that free movement is a principle of great moral weight and therefore, any discussion of ethical issues surrounding the migration of medical practitioners should factor in medical practitioners' basic freedom of movement. Bader (2005) further argues that freedom of movement across state borders implies the legally recognized right to emigration and voluntary expatriation and this is called justice in emigration. This term means situations where restrictions are placed on outgoing freedom of movement need to be just. This basic liberty means that states cannot force medical practitioners to stay in their countries of training. In this regard, it is also important to note that international ethical recruitment codes, such as the Melbourne Manifesto, have upheld individual autonomy rights; for example, principle number three reads:

> The principles of social justice and global equity, the autonomy and freedom of the individual, and

> the rights of nation states, all need to be balanced (WONCA 2002, 1).

Furthermore, it has been claimed (Dwyer 2007) that Article 13 of the Universal Declaration of Human Rights of 1948 indicates that the right to emigrate is itself a human right of healthcare professionals (United Nations Human Rights 1948). However, one important point that is often overlooked is that a right to emigrate does not imply the right to get a particular job in the country to which you emigrate. There is nothing inconsistent in holding that whilst an individual medical practitioner from an LMIC has a right to emigrate to a high-income country, they do not have a right to get a job as a medical practitioner when they arrive. Likewise the HIC does not have a duty to allow them to apply for such jobs.

Discussions about issues of justice also need to be put in the context of social responsibility. One basis for this responsibility is the public investment that society makes in the education and training of healthcare professionals. Low- and middle-income countries invest funds into the education of medical practitioners assuming that, upon graduating, they will contribute to the economy in terms of labour input. For example in Kenya, the public funds subsidizing each medical student for five years of undergraduate training are estimated to be US$65,000 (Kirigia et al. 2006). South Africa, a country that loses most of its medical practitioners to HICs, subsidizes each medical practitioner's education by approximately US$40,000 (Mills et al. 2011). Therefore, medical practitioners' rights to freedom of movement should be weighed against the population's rights to access basic liberties of care.

Similarly, while medical practitioners are exercising an important human right to migrate and help HICs fulfil their obligations of social justice, they are, however, also creating social injustice in the countries they leave. Solving these problems requires the balancing of social needs (social responsibility) against individual rights (Dwyer 2007). In terms of obligations of social justice in this scenario, we argue that individual medical practitioners are causing harm by leaving their countries and contributing to shortages. However, global justice advocates (Taché and Schillinger 2009) argue this harm is caused by asymmetric and unfair incentive structures between HICs and LMICs. As long as these imbalanced incentive structures exist, individual medical practitioners will continue to act rationally within these structures. Efforts to change unfair institutional and governmental incentive structures would require a global justice approach rather than an individual justice approach (Taché and Schillinger 2009).

Examination of medical practitioners' individual actions can be done by focusing on professionalism and integrity-virtue ethics. According to Simpson and McDonald (2011), professionalism and integrity require health professionals to act in ways consistent with the values of their respective professions. In this instance, one needs to ask a question about the intentions of medical practitioners when they chose their profession—whether they do so for reasons related to care of patients or for the sake of associated higher incomes and/or the possibility of migrating abroad. For example, it is known that in countries, such as the Philippines, the nursing and the medical profession are used as vehicles for migrating to HICs (Connell 2010; Kingma 2006). In terms of seeking better remuneration, Simpson and McDonald (2011) remind us that health professionals have a legitimate interest in appropriate levels of remuneration. Therefore, it can be asked to what extent medical practitioners should balance personal interests with both professional and national interests when migrating from one country to another for higher salaries.

The intention of migrating medical practitioners can be examined utilizing Kant's Categorical Imperative. In the case described above the intentions of medical practitioners (to fulfil their own and their families' aspirational desires for higher incomes, education, adventure, self-fulfilment, and esteem etc.) are over and above basic needs for survival. In most societies, medical practitioners are paid well above most members of society who are classed as being in need of basic living necessities (Davison 2010; Okeke 2013). According to the Categorical Imperative, medical practitioners with these personal intentions are using the citizens of the LMICs that have paid for their medical training merely as a means to further their own desires and can therefore be judged as doing injustice to their profession and their state.

Migration theorists such as Massey et al. (1993) may argue that such forms of migration are a national investment—as family remittances that help the country's economy. However, Bader (2005) argues that this is not an effective remedy for poverty because the proportion of the world that might be helped in this way would be very small. Furthermore, the relief provided is imperfectly distributed as those who can afford to migrate are usually not among the worst-off. The actions of individual medical practitioners can also be examined from the perspective of

distributive justice. This perspective claims that while medical practitioners have a free will to choose to migrate, at the same time they are not meeting their social obligations to meet the workforce needs of their own country (Taché and Schillinger 2009). In this instance, justice, according to Seglow (2005) concerns what we can do for others, or what we ought to do for fellow members of our common humanity. The guiding principle of this perspective is that individuals bear special obligations of distributive justice to other members of their nation (Caney 2001; Miller 1995; Tamir 1993). Seen at a nation-state level, this thinking can be useful as it claims that medical practitioners need to consider their social obligations to the nation when making decisions to migrate. However, a criticism of this is the assumption that individuals have special duties to others because they engage in a joint cooperative national system (Miller 1995; Tamir 1993). The main question that follows from this criticism is: are nations really co-operative systems with common goals? The answer is that this is far from true as some individuals are born into a social strata that will predispose them to a propensity for individualism and hence self-sufficiency, while others are born into a strata that makes them dependent on national resources.

Discussion of Possible Global, Health Systems, and Individual Medical Practitioner Action

As can be seen from the arguments outlined above, the justice issues that are specifically relevant to the movement of medical practitioners from LMICs to HICs concern key themes of moral obligation to corrective action and moral obligation to mutual respect. However, such obligations leave individual medical practitioners and LMICs out of the broader picture. The strategies below, therefore, include action by both receiving and sending countries, by medical practitioners themselves, and action by other global players.

Global Action

Global players have a moral obligation to ensure equitable allocation of resources among groups of countries with specific reference to medical workforce needs. The Alma Alta Declaration requires that all governments of different countries act as key players in addition to health and development workers and world community organizations (World Health Organization 1978). These world community organizations—the World Bank and International Monetary Fund, as well as bilateral and multilateral agencies—are key players in ensuring a fair distribution of wealth and resources including human resources for health (Kingma 2006). We argue that the ever increasing phenomena of medical practitioner migration from LMICs to HICs is a sign that there are some loopholes in effective global action by these organizations. These international organizations are well positioned to champion a counter-brain-drain action.

Action by the Receiving HICs

Workforce planning in HICs should be proactive and adequate for the populations' health care needs. Workforce inadequacy in HICs is seen as a factor in recruiting or making the conditions necessary for medical practitioners from LMICs to leave their countries (MacDowell et al. 2010). Within brain-drain scholarship there have been discussions about moral obligations for corrective action addressing inequities that have already been created by unfair recruitment practices. This includes conferring a duty on the part of wealthier nations to compensate those countries whose needs have been eroded (Eyal and Hurst 2008). However, these corrective actions raise other ethical issues as they are linked to pro-colonial provisions—where former colonial masters may indirectly retain their dominance over former colonies through financial provision. Even compensatory and other incentives suggested in policy statements, such as the Melbourne Manifesto, have been looked at with hesitation for these reasons. However, the idea of monetary compensation needs to be considered, including how much and for how long. It will not be surprising if, in some countries, as a result of such compensation medical practitioners come to be seen as foreign currency earners, as is happening in the Philippines.

Action by Both LMICs and HICs

Given the fact that much scholarship (Dwyer 2007; Kaelin 2011) advocates the need for medical practitioners to weigh their individual rights to migrate against their obligations to the countries of training, recommendations focusing on empowering medical practitioners in their reasoning are important. Ethical thinking is a complex intellectual process (Seedhouse 2005). We argue that the ethics curriculum in medical education in LMICs should include a strong emphasis on both individual rights and

obligations to states. Such a balance between knowledge of rights and knowledge of responsibilities might help in ensuring that medical practitioners are not coerced to stay but rather choose to do so. LMICs could also promote loyalty and acknowledge the travel and lifestyle wishes of medical practitioners by promoting international education for undergraduates or work experiences and research trips for residents. Although an argument can be made that this situation promotes expatriation, some workforce experts have adopted this practice and argue that it has proven useful in medical workforce retention (Radio New Zealand 2010; Torjesen et al. 1999).

High-income countries can also promote global health curriculum content which is linked to reflection about the global distribution of the medical workforce. Ethical reasoning about obligations to contribute in any way to global medical workforce disparities could also be built into the curriculum. This is important because medical practitioners in HICs can also be advocates for health systems in LMICs. International experiences in LMICs can also help in this regard (Leather et al. 2010). Such programmes are already being promoted by, for example, the United Kingdom's National Health Service (Leather et al. 2010) but are not widespread in HICs.

Individual Action by Medical Practitioners

In addition to action by LMICs and HICs, wee challenge medical practitioners to reflect on their obligation to ensure that their personal aspirations of migration are balanced against their obligation to provide care where it is most needed. Such a process of reflection could be aided through formal instruction during undergraduate training. Reflection on the part of medical practitioners needs to be considered alongside recommendations for action by states and organizations.

Conclusion

This paper adds new knowledge to the existing scholarship on the ethics of global medical migration by arguing for a two-pronged policy action targeting both global economic players and health systems as well as the individual medical practitioners who migrate. The argument initially postulated by Tan (1997) and Pogge (1988) on how Kantian and Rawlsian theories can be applied to global issues of inequality has being taken a step further. This was done by applying the tenets of these theories to the issue of global medical practitioner migration from low- and middle-income countries to high-income countries. This discussion is intended to challenge HICs to consider and act upon their moral obligation to redress the brain drain from LMICs in two ways. Firstly, by remedying the losses that have already occurred, and secondly, by taking proactive measures to minimize further brain-drain scenarios. Medical practitioners should also realize they are stakeholders in efforts to achieve workforce adequacy and hence should examine their actions alongside the ideals of both social responsibility and global justice. Such a process of self-reflection can be aided by an undergraduate medical curriculum with a strong emphasis on rights of individuals as well as obligations to the local communities. A curriculum with global and international dimensions is recommended. Future studies might extend this work by investigating the contribution of, or lack of ethical reasoning, in decisions to migrate among medical practitioners.

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References

Aluttis, C., T. Bishaw, and M.W. Frank. 2014. The workforce for health in a globalized context—Global shortages and international migration. *Global Health Action* 7: 23611.

Anyangwe, S.C., and C. Mtonga. 2007. Inequities in the global health workforce: The greatest impediment to health in sub-Saharan Africa. *International Journal of Environmental Research and Public Health* 4(2): 93–100.

Astor, A., T. Akhtar, M.A. Matallana, et al. 2005. Physician migration: Views from professionals in Colombia, Nigeria, India, Pakistan and the Philippines. *Social Science & Medicine* 61(12): 2492–2500.

Bader, V. 2005. The ethics of immigration. *Constellations* 12(3): 331–361.

Bezuidenhout, M.M., G. Joubert, L.A. Hiemstra, and M.C. Struwig. 2009. Reasons for doctor migration from South Africa. *South African Family Practice* 51(3): 211–215.

Brandão, C., G. Rego, I. Duarte, and R. Nunes. 2013. Social responsibility: A new paradigm of hospital governance? *Health Care Analysis* 21(4): 390–402.

Briand, S., E. Bertherat, P. Cox, et al. 2014. The international Ebola emergency. *New England Journal of Medicine* 371(13): 1180–1183.

Canadian Institute for Health Information. 2010. *Supply, distribution and migration of Canadian physicians, 2009*. Canadian Institute of Health Information, ISBN 978-1-55465-823-7.

https://secure.cihi.ca/estore/productFamily.htm?locale=en&pf=PFC1567. Accessed January 15, 2016

Caney, S. 2001. International distributive justice. *Political Studies* 49(5): 974–997.

Commonwealth Medical Association. 2002. Commonwealth Code of Practice for International Recruitment of Health Workers. Geneva: Commonwealth Secretariat. http://www.odi.org/sites/odi.org.uk/files/odi-assets/events-documents/2440.pdf. Accessed January 15 2016.

Connell, J. 2010. *Migration and the globalisation of health care: The health worker exodus?* Cheltenham, UK: Edward Elgar Publishing.

Cullen, A. 2013. *Raw data report on foreign trained doctors on register by country of training by year (Information Analysists*, Teamth ed. Wellington, New Zealand: Medical Council of New Zealand.

Davison, I. 2010. Oz offering NZ doctors $6000 a weekend. *The New Zealand Herald*, July 16. http://www.nzherald.co.nz/nz/news/article.cfm?c_id=1&objectid=10659107. Accessed February 24, 2016

Denier, Y. 2007. *Efficiency, justice and care: Philosophical reflections on scarcity in health care*. Dordrecht: Springer.

Department of Health. 2001. *Code of practice for NHS employers involved in the international recruitment of healthcare professionals*. London: Department of Health, England.

Dwyer, J. 2007. What's wrong with the global migration of health care professionals? Individual rights and international justice. *The Hastings Center Report* 37(5): 36–43.

Eastwood, J.B., R.E. Conroy, S. Naicker, P.A. West, R.C. Tutt, and J. Plange-Rhule. 2005. Loss of health professionals from sub-Saharan Africa: The pivotal role of the UK. *The Lancet* 365(9474): 1893–1900.

Ehman, A.J., and P. Sullivan. 2001. South Africa appeals to Canada to stop recruiting its MDs. *Canadian medical association journal* 164(3): 387–388.

Eyal, N., and S.A. Hurst. 2008. Physician brain drain: Can nothing be done? *Public Health Ethics* 1(2): 180–192.

Hagopian, A., A. Ofosu, A. Fatusi, et al. 2005. The flight of physicians from West Africa: Views of African physicians and implications for policy. *Social Science & Medicine* 61(8): 1750–1760.

Hooper, C.R. 2008. Adding insult to injury: The healthcare brain drain. *Journal of Medical Ethics* 34(9): 684–687.

Huijkkens, E.G.W., A. Hooshiaran, A. Scherpbier, and F. Van der Horst. 2010. Barriers and facilitating factors in the professional careers of international medical graduates. *Medical Education* 44(8): 795–804.

Hussey, P.S. 2007. International migration patterns of physicians to the United States: A cross-national panel analysis. *Health Policy* 84(2–3): 298–307.

Jakubowski, E., and R. Hess. 2004. The market for physicians. In *Health Policy and European Union enlargement*, ed. M. McKee, L. MacLehose, and E. Nolte, 131–142. Berkshire: Oxford University Press.

Kaelin, L. 2011. A question of justice: Assessing nurse migration from a philosophical perspective. *Developing World Bioethics* 11(1): 30–39.

Kaiser, H.E., D.J. Barnett, E.B. Hsu, T.D. Kirsch, J.J. James, and I.I. Subbarao. 2009. Perspectives of future physicians on disaster medicine and public health preparedness: Challenges of building a capable and sustainable auxiliary medical workforce. *Disaster Medicine and Public Health Preparedness* 3(4): 210–216.

Kant, I. 1931. *Lectures on ethics*. Century Co: Translated by L. Infield. New York.

Kant, I. 1964. *Groundwork of the metaphysics of morals Translated by H. J. Paton*. New York: Harper & Row.

Kant, I. 1991. *Kant: Political writings*. Cambridge: CambridgeUniversity Press.

Kingma, M. 2006. *Nurses on the move: Migration and the global health care economy*. London: ILR Press.

Kirigia, J.M., A.R. Gbary, L.K. Muthuri, J. Nyoni, and A. Seddoh. 2006. The cost of health professionals' brain drain in Kenya. *BMC Health Services Research* 6(1): 89.

Latham, S.R. 2010. Too few physicians, or too many? *The Hastings Center Report* 40(1): 11–12.

Law, I.R. 2013. International medical electives undertaken by Australian medical students: Current trends and future directions. *Medical Journal of Australia* 198(6): 324–326.

Leather, A.J.M., C. Butterfield, K. Peachey, M. Silverman, and R.S. Sheriff. 2010. International Health Links movement expands in the United Kingdom. *International Health* 2(3): 165–171.

Lumely, L. 2011. *Doctors leaving New Zealand: Analysis of online survey results*. Wellington, New Zealand: Medical Council of New Zealand.

MacDowell, M., M. Glasser, M. Fitts, K. Nielsen, and M. Hunsaker. 2010. A national view of rural health workforce issues in the USA. *Rural and Remote Health* 10(3): 1531.

Macfarlane, S.B., M. Jacobs, and E.E. Kaaya. 2008. In the name of global health: Trends in academic institutions. *Journal of Public Health Policy* 29(4): 383–401.

Mackey, T.K., and B.A. Liang. 2012. Rebalancing brain drain: Exploring resource reallocation to address health worker migration and promote global health. *Health Policy* 107(1): 66–73.

Massey, D.S., J. Arango, G. Hugo, A. Kouaouci, A. Pellegrino, and J.E. Taylor. 1993. Theories of international migration: A review and appraisal. *Population and Development Review* 19(3): 431–466.

Miller, D. 1995. *On nationality*. Oxford, UK: Clarendon Press.

Mills, E.J., S. Kanters, A. Hagopian, et al. 2011. The financial cost of doctors emigrating from sub-Saharan Africa: Human capital analysis. *BMJ* 343: d7031.

Morton, J., P. Hider, and K. Schaab. 2008. Factors influencing the departure of non-consultant hospital doctors from Christchurch, New Zealand. *New Zealand Medical Journal* 121(1273): 13–24.

Mullan, F. 2005. The metrics of the physician brain drain. *New England Journal of Medicine* 353(17): 1810–1818.

Nair, M., and P. Webster. 2013. Health professionals' migration in emerging market economies: Patterns, causes and possible solutions. *Journal of Public Health* 35(1): 157–163.

Okeke, E.N. 2013. Brain drain: Do economic conditions "push" doctors out of developing countries? *Social Science & Medicine* 98: 169–178.

Parsi, K. 2008. International medical graduates and global migration of physicians: Fairness, equity, and justice. *The Medscape Journal of Medicine* 10(12): 284.

Pogge, T. 1988. Rawls and global justice. *Canadian Journal of Philosophy* 18(2): 227–256.

Pond, B., and B. McPake. 2006. The health migration crisis: The role of four Organisation for Economic Cooperation and Development countries. *Lancet* 367(9520): 1448.

Radio New Zealand. 2010. Trainee doctors to do OE on full pay in trial. November, 2010. http://www.radionz.co.nz/news/national/

33418/trainee-doctors-to-do-oe-on-full-pay-in-trial. Accessed November 13, 2010.

Rawls, J. 1971. *A theory of justice*. Cambridge, MA: Belknap Press.

Seedhouse, D. 2005. *Values based decision making for the caring professions*. Chicheste: Wiley.

Seglow, J. 2005. The ethics of immigration. *Political Studies Review* 3(3): 317–334.

Semplici, S. 2011. The importance of 'social responsibility'in the promotion of health. *Medicine, health care and philosophy* 14(4): 355–363.

Simpson, C., and F. McDonald. 2011. 'Any body is better than nobody?' Ethical questions around recruiting and/or retaining health professionals in rural areas. *International Electronic Journal of Rural and Remote Health Research* 11(4): 1867.

Spurgeon, D. 2001. Canada asked to recruit fewer South African doctors. *BMJ: British Medical Journal* 322(7280): 189.

Taché, S., and D. Schillinger. 2009. Health worker migration: Time for the global justice approach. *American Journal of Bioethics* 9(3): 12–14.

Tamir, Y. 1993. *Liberal nationalism*. Princeton, NJ: Princeton University Press.

Tan, K. 1997. Kantian ethics and global justice. *Social Theory and Practice* 23(1): 53–73.

Toevai, S., and E. Kiong. 2007. Kiwis moving to Australia at 19-year high. *The New Zealand Herald*, December 19. http://www.nzherald.co.nz/nz/news/article.cfm?c_id=1&objectid=10483282. Accessed January 21, 2016.

Torjesen, K., A. Mandalakas, R. Kahn, and B. Duncan. 1999. International child health electives for pediatric residents. *Archives of Pediatrics & Adolescent Medicine* 153(12): 1297–1302.

United Nations Human Rights. 1948. Universal declaration of human rights. http://www.ohchr.org/EN/UDHR/Pages/Language.aspx?LangID=eng. Accessed March 01, 2016.

Vallaeys, F. 2014. Defining social responsibility: A matter of philosophical urgency for universities. http://www.guninetwork.org/articles/defining-social-responsibility-matter-philosophical-urgency-universities. Accessed Accessed May 04, 2016.

Wilson, N., M. Baker, P. Crampton, and O. Mansoor. 2005. The potential impact of the next influenza pandemic on a national primary care medical workforce. *Human Resources for Health* 3(1): 7.

WONCA. 2002. A code of practice for the international recruitment of health care professionals: The Melbourne manifesto. https://www.srpc.ca/PDF/MelbourneManifesto.pdf. Accessed Accessed May 04, 2016.

World Health Organization. 1978, 6-12 September. Declaration of Alma Ata. Presented at the meeting of the International Conference on Primary Health Care, September 6-12, in Alma-Ata, USSR. http://www.who.int/publications/almaata_declaration_en.pdf. Accessed May 04, 2016.

World Health Organization. 2006. *The world health report: working together for health*. Geneva: World Health Organization. Publication no.: WA 530.1. http://www.who.int/whr/2006/whr06_en.pdf. Accessed May 04, 2016.

World Health Organization. 2009. *Global health risks: mortality and burden of disease attributable to selected major risks*. Geneva: World Health Organization. Publication no.: WA 105. http://www.who.int/healthinfo/global_burden_disease/GlobalHealthRisks_report_full.pdf. Accessed March 11, 2016.