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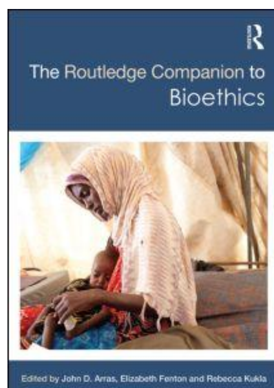

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DO HEALTH WORKERS HAVE A DUTY TO WORK IN UNDERSERVED AREAS?

Nir Eyal and Samia A. Hurst

Background

Health worker shortages are a crucial obstacle to relieving the burden of disease in many countries. Their impact is most concentrated in the remote, rural areas of sub-Saharan Africa and South Asia, where a great number of the world's poorest, sickest, and most vulnerable populations reside. Local health workers are often reluctant to work in these critically underserved areas, preferring instead to work in cities and the private sector. Exacerbating this problem, some of the wealthiest countries allow in, and often actively recruit, health workers from these poorer countries. Large differences in the availability of health workers result. According to the most recent WHO data available, the ratio of physicians per 1,000 population in Malawi is 0.019, whereas in the U.S. it is 2.42, for 2008 and 2009 respectively (WHO 2012a: 14–15). Disparities in the availability of physicians and other health workers inside countries are also extreme.

As a result, basic medical procedures including HIV care, mental health services, and vaccinations are not delivered, setting back infant, child, and maternal survival, and the overall health status of these communities (WHO 2006; but see Clemens 2007). Health worker migration to so-called "destination countries" also translates into loss of potential employers, teachers, and role models in migrants' "source countries" (Aluwihare 2005). Especially when unplanned, such migration can wreak havoc in medical delivery systems (Martineau et al. 2004). Moreover, because in many developing countries medical education is publicly funded, global medical "brain drain" amounts to absurd humanitarian aid by poorer nations to richer ones (Alkire and Chen 2006: 113).

The option to migrate is good for health workers. Many compatriots can only dream of this opportunity. It is also good for patients in rich countries, who can improve their access to care through better-staffed health systems. But the patient populations from whom these doctors are taken often need them much more.

Several options exist for attempting to secure healthcare for underserved populations even when health workers leave. One is to train many physicians and nurses to replace those who leave, hoping that not all replacements will leave. Another is to train different cadres of health workers with cheaper training and employment. Thus far, these workers have proven less likely to leave resource-poor settings (WHO 2012b). With

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WHO backing, African countries already delegate tasks including screening, management of most first-line HIV care, mental health treatment, and Caesarian sections to such non-traditional health workers (WHO 2006, 2008, 2010b, 2012b). Finally, some healthcare services can be provided through telemedicine, which usually involves a highly skilled worker consulting patients over the phone or video from afar, with assistance from a local, less skilled worker (Mars 2010). Each of these options to replace migrating physicians has its limitations, however (Eyal and Hurst 2008). For example, while less-trained health workers can safely perform a range of tasks, physicians currently remain necessary for many referral, supervision, and even clinical tasks (Hirschhorn et al. 2006; WHO 2008; Chu et al. 2009), and less-trained health workers are also increasingly likely to move to well served settings (Dugger 2004).

Several claims have been made about the potential benefits of physician migration. First, it is sometimes claimed that remittances, or money sent home by migrants, offset any loss from professionals' emigration (Clemens 2011). But remittances may be small in the specific case of physicians (our focus in this chapter), whose families are typically middle class and urban; usually such families do not need or feel comfortable asking emigrating relatives for money. Nor do transfers to urban families greatly assist the rural needy. Another potential benefit is that lucrative migration options for physicians create some incentive to study and excel in the profession (Clemens 2011). While this is true, these incentives might be too weak to restore the supply of physicians to their home countries, and may perpetuate the vicious cycle of expensive training and professional flight (Kangasniemi et al. 2007). A third alleged benefit, skill-sharing upon a physician's return to his or her country (Ana 2005), is largely a pipedream: The vast majority of migrants never return to enable such sharing to take place (Mullan 2005).

One proposal for a coordinated political intervention to improve the balance of benefits and harms from physician migration is for source countries to impose a so-called "Bhagwati" tax on migrant workers' foreign incomes (Hannum 1987: 39; Bhagwati 2012; see also Brock and Blake forthcoming). That tax on emigrants would be imposed by the source country and collected for it by the receiving country. Bhagwati originally proposed a progressive tax, or flat 10 percent tax, on emigrant earnings for 10 years (Bhagwati and Dellalfar 1973). Even if such a tax were practically enforceable abroad (Alkire and Chen 2006: 113), tax revenues might fail to reach source countries' underserved and often disenfranchised populations. Nor is it clear that it is the most efficient or ethical solution for migrants to be forced to pay source countries, as opposed to the institutions or countries that recruit and employ them (Ypi 2008: 414; Clemens 2011: 92–3; Dumitru 2012).

The global crisis in human resources for health was the focus of the 2006 World Health Report. This canonical document argues that on balance the domestic or international flight of health personnel from areas of critical shortage vastly undermines public health and welfare in those areas—and this chapter operates on a similar assumption. Furthermore, in 2010 the World Health Assembly unanimously adopted the *Global Code of Practice on the International Recruitment of Health Personnel*. This document strikes a balance between the rights of underserved patients, those of health workers, and the prerogatives of Member States, with a more extensive monitoring process than that of earlier WHO codes and conventions.

The next section of this chapter introduces some of the most important, and often underexplored, ethical questions about the crisis in human resources for health. The

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final section explores one such question in depth: Whether health workers have either a moral duty, or a morally defensible legal duty, to work in underserved areas rather than, for instance, migrate to countries where their services are less critically needed.

Ethical Questions about the Distribution of Human Resources for Health

When we think of resource allocation in health care, we typically think about distributing pills, procedures, or access to facilities among patients. Much less attention has been paid to the skilled health professionals without whom these other resources lie unused or misused. How should these "resources" be "allocated"?

The concepts and methods used in economic, medical, and ethical reflection on the allocation of ordinary health resources do not straightforwardly govern this area. "Human resources for health" are special. Antiretroviral pills do not have a will of their own. They lack rights. We lack responsibilities toward them. We cannot "disadvantage," "coerce," or "exploit" them. Nor do pills have duties toward patients. No pill has ever taken the Hippocratic Oath.

A full theory of the ethical distribution of human resources for health must heed the fact that the "resources" here are persons. It should also clarify what remains constant in comparison with non-human resources like drugs or surgeries.

This section explores some central questions in the ethics of allocating human resources for health, especially in light of the challenges associated with medical migration. Our hope is to elicit more scholarship on these often neglected questions.

Responsibility for the Harm of Insufficient Access to Health Services

According to Norman Daniels, when rich countries lure health workers away from underserved patient populations in poor countries, this is paradigmatic of the active harm perpetuated on the poor at the global level—the sort of harm that Thomas Pogge often argues is such a wrong for rich countries to perpetuate (Pogge 2002; Daniels 2008: 337–9, 353). But this claim faces three challenges. First, when rich country employers recruit doctors from underserved areas, rich country governments may be involved only passively, by failing to meddle with that interaction. How does that count as *active* harm?

Second, even when active harm takes place, when it is the result of market competition, commonsense morality often holds that no wrong was done. For example, market competitors are not wronging me by opening a nearby shop that drives mine out of business—although that actively harms me. And rich universities are not wronging other rich universities and their typically privileged students by actively recruiting their star professors. Even if it is morally wrong for a rich university to recruit professors from struggling public universities that serve the less well-off, what makes it wrong is not simply the fact of active harm—or the same action would have been wrong between rich institutions as well. The wrong consists of something else.

A final challenge is the agency of health workers. Does the fact that workers are persons whose consent and collaboration are necessary for uptake affect the recruiters' moral responsibility for downstream effects on patients from source countries at all? And can we call it "poaching," as many do, although these workers are individuals with free will and not the property of others to poach (Snyder 2009)?

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Source versus Destination Country Patients

Global health worker migration often increases access to services in destination countries while thwarting it in source countries. This casts new light on the universal coverage schemes found in rich countries. Following the 2010 *Patient Protection and Affordable Care Act* (ACA, or "Obamacare"), the U.S., for example, offers coverage and services to many more Americans. This expansion of services is excellent for many uninsured and underinsured Americans, but unless U.S. doctors flock to primary care, which is unlikely (Schwartz 2012), or the U.S. trains enough additional doctors and physician assistants to treat everyone, it may lead to increased demand for foreign-trained health workers. One result could be fewer physicians available in rural India and other developing countries. Broadly stated, when greater health workforce availability in a developed country has a detrimental impact on its availability in source countries, how much is that developed country ethically permitted to prioritize its patients over those in the source country?

This broad question may also play out beyond the borders of the developed country. In the future, the U.S. may send many patients as "medical tourists" to India or Thailand to receive surgeries and other treatments that are much less expensive there than at home (see Chapter 8 in this volume). Such medical tourism may lure Indian health workers to their home country's private hospitals, thereby undermining service availability in rural sectors. Is the U.S. government obligated to prevent these prospects from materializing, even at the expense of Americans' health?

Self-Sufficiency

The World Health Assembly's *Code of Practice on the International Recruitment of Health Personnel* calls on destination countries to take serious measures to be self-sufficient, for example, by training more physicians and nurses of their own. But *shouldn't* some countries focus on producing what they produce best, rather than doctors? Some countries, like the Philippines and India, seem to deliberately train health workers as an "export industry," hoping to benefit from taxed foreign income and remittances. These doctors are then available to supplement the pool of available doctors in other countries that have produced fewer doctors than they require (Alkire and Chen 2006: 113; Dimaya et al. 2012). However, the human cost on migrants' families and on underserved patients in these countries is tremendous. Should these workers be barred from moving, or should their movement persist?

Medical School Intervention

By training physicians, medical schools help their countries address physician shortages. But many other things that medical schools can do to help address these shortages are less clearly legitimate. For example, is it morally permissible for medical school faculty to let students understand that they would greatly disappoint them unless they work with the underserved—which might be considered emotional blackmail or an implicit threat to breach entitlements to future support? Is it permissible for schools intentionally not to teach some essential aspects of care in rich countries precisely in order to delimit graduates' "marketability" abroad (Eyal and Hurst 2011)? Is it permissible for schools to admit preferentially applicants who are relatively likely to choose

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later to work in underserved areas—say, residents of underserved rural areas (WHO 2010a), or applicants with suboptimal academic performance—who are more likely to work in such areas than the academically best (Zimmerman et al. 2012)? Is it permissible for schools to offer applicants scholarships conditional on a very long commitment to later rural service (Eyal and Bärnighausen 2012)?

Intra-societal Wage Inequality

One way to increase health worker retention is to make their salaries at home more competitive with salaries abroad. This strategy is rarely criticized, but for local salaries to be genuinely competitive, they may have to be grossly disproportional to those of other local public workers. Would "overpayment" to health workers not violate social equality? When such competitive salaries follow a bargaining process and raise the specter of threats to emigrate without the guarantee of disproportional salaries, don't the bargaining health workers thereby exploit their patients' desperate needs in order to secure unfair privileges from employers (Cohen 1992)? However, can high salaries really compensate health workers fairly for disadvantages such as stunted professional development ladders, inadequate personal safety, or lack of social respect?

When Is Compensation Enough?

Recently it has become popular to demand that destination countries or workers compensate source countries for lost workers. Such resources could for example facilitate future efforts to train and potentially retain the next generation of health workers. Some authors defend this demand, for example, as a matter of internalizing externalities or reparation (Brock 2009; Brock and Blake forthcoming; Wellman 2010).

This demand, however, raises questions about specification and justification. First, what should determine the scale of compensation? Is it how much the destination country's population benefits from the migration? How much the source country had spent on the migrant's studies, upbringing, and conditions enabling them to become physicians, such as functioning infrastructure (Brock and Blake forthcoming)? How much the source country or its underserved populations stand to lose from the migration (under the ideal assumption that the migrant would work with underserved populations if he or she could not migrate, or under realistic assumptions)? And who should pay that compensation—migrant health workers, destination country employers and recruiters, or destination country governments? Who should receive the money—the source country government, its health ministry, its medical schools, its underserved communities, or charities working for the latter? Questions also arise as to whether such compensation is in fact appropriate. In normal market transactions, when one employer lures workers from another company, usually we do not think that compensation is due absent special contractual arrangements that make that the case. And aren't remittances from individual migrant workers to their families compensation enough?

Doctors' Liberties versus Patients' Health

After this necessarily brief survey of the central ethical issues raised by physician migration, let us focus on one set of these questions. Some policies to draw health workers to work in underserved areas seem coercive. Consider several cases:

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1. In Ghana, physicians are in short supply in rural areas, and temporary district hospital and rural clinic postings and training are often compulsory preconditions for obtaining medical degrees or entering residency and specialization programs (Appiah-Denkyira et al. 2012).
2. Many countries and schools expect medical graduates who received a special stipend to stay and work in underserved areas in return. The current expectation is typically that they would stay for the same number of years that they received funding, but in principle, commitment periods could last much longer (Eyal and Bärnighausen 2012).
3. Since 2008, the UK has almost completely stopped issuing work visas to doctors and nurses from countries outside the European Union, including ones with critical shortages (Travis 2008). If and when many more Western countries adopt similar policies, international employment options for health workers from countries with critical shortages would be severely curtailed.
4. Until recently, Norway determined by lottery which newly minted physicians would do their residency in which areas (Skinningsrud 2011). In spring 2011, the European Union banned this practice. Now the best students pick residency locations first, the second-best, second, and so forth. The new arrangement offers the best graduates greater autonomy and liberty; but it might saddle underserved remote populations with less well qualified physicians.

These cases highlight the potential tension between underserved populations' health needs and physicians' liberties. To what extent, if any, do physicians and other health workers have a moral duty to work for patients in underserved (home country) areas? And if this moral duty exists, is it a legitimately enforceable legal duty?

Traditional liberals devoted to both liberty and equality tend to give two responses to this question: Health workers have a moral responsibility to prioritize the underserved, but it remains morally illegitimate to force them to do so. Their moral duty, in other words, is non-enforceable.

This twin message figures in related codes of practice. The *WHO Global Code of Practice on the International Recruitment of Health Personnel* says, on the one hand, "The health of all people is fundamental to the attainment of peace and security and is dependent upon the fullest cooperation of individuals and states." But it also states, "nothing in this Code should be interpreted as limiting the freedom of health personnel, in accordance with applicable laws, to migrate to countries that wish to admit and employ them" (WHO 2010c). Similar duality is present in the American Medical Association's *Code of Medical Ethics*. One of the Code's opening principles reads, "A physician shall recognize a responsibility to participate in activities contributing to the improvement of the community and the betterment of public health . . . A physician shall support access to medical care for all people." But another principle warns, "A physician shall, in the provision of appropriate patient care, except in emergencies, be free to choose whom to serve, with whom to associate, and the environment in which to provide medical care" (American Medical Association 2012). Political theorists have shared this dual stance (Carens 1992: 33, 34; Cohen 2011: 129–30; Brock and Blake forthcoming; and others). Kieran Oberman, for example, agrees that "a skilled worker has a [moral] duty to assist her poor compatriots," but "finds that justifying immigration restrictions on brain drain grounds is far from straightforward" (Oberman 2013: 430).

Most policy proposals to decrease migration likewise consider access to health for all people very important, and recognize its dependence on individual practitioners, but

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remain emphatically non-compulsory. Formal limits on doctors' immigration and emigration, for example, are rejected outright on grounds of doctors' basic freedoms of movement, occupation, and education (Hannum 1987: 34–40; Physicians for Human Rights 2004; Hunt 2005, par. 46–49, 60ff.). The following statement, backed by no further argument, is typical:

> Protective strategies cannot be coercive. Slowing the pace of emigration cannot be done through prohibition of the human right to movement . . . Potential source country policies must address directly the disincentives to health personnel in the form of remuneration, working environments, and security concerns.
>
> (Alkire and Chen 2006: 112)

In the next two sections we argue a rather different position. It is far from clear that choosing not to work for the underserved is necessarily wrong for physicians. Nevertheless, when other interventions fail, compelling physicians to work for the underserved can remain perfectly legitimate.

The Moral Permissibility of Failure to Work in Underserved Areas

Do health workers, and especially physicians, have a moral duty to work in severely or critically underserved areas? Accepting offers to work in cities, in the private sector, or abroad is not illegal, but many writers believe that it is morally wrong.

Assistance?

It is clear that patients in critically underserved areas would benefit from medical assistance, often far more so than patients in well served areas. It is also clear that physicians are often best placed and best qualified to provide this assistance. On this basis physicians can be said to have general moral reasons to respond to the needs of the underserved. Moreover, many patients in critically underserved areas are disadvantaged in terms of socio-economic *and* health status; they are often far worse off than either typical physicians or well served patients. Many come from the world's poorest and sickest populations. From a utilitarian standpoint, but also from an egalitarian, prioritarian, and sufficientarian standpoint (that is, one that minds inequalities, failure to prioritize the worse off, or failure to bring everyone above some minimum threshold), physicians typically have very good reasons to dedicate their finite ability to helping them. This implicates physicians' duty of beneficence and, at least for compatriot physicians, it is also a matter of distributive and social justice (Dwyer 2007: 39).

General duties to promote basic needs, utility, and distributive justice are not usually viewed as limitless. Common sense morality grants individuals moral "prerogatives" to prioritize their own basic commitments over optimizing good (Slote 1977; Scheffler 1992). While some thinkers insist that these duties admit of no limits (Kagan 1989; Unger 1996; Ashford 2003), their position would equally suggest that intelligent non-physicians must sacrifice whatever life plans *they* might have, study medicine, and treat underserved patients whenever that would help the underserved. Indeed, because all physicians tend to have reasonable salaries, for many non-physicians, the opportunity cost of becoming a physician for the underserved is economically *smaller* than for a high-earning physician for

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the well served. But no existing legal or political system endorses such a suggestion. Usually we assume that the stringency of general duties of assistance or beneficence depends *inter alia* on the size of burden one would incur in meeting them—we have duties of assistance, but only if they can be discharged without being "too burdensome"—and that this remains the case even when the assistance is needed for medical reasons (Beauchamp and Childress 2009: 202, note condition 4; Akabayashi et al. 2012). This, at least, is what the political and legal *status quo* recognizes. Work in medically underserved areas will often limit physicians' life choices, comfort, professional development options, safety, and access to quality health care and education, for themselves and for their families. Such burdens would appear to preclude (*status quo* recognition of) any limitless duty to assist the underserved.

Reciprocity?

Do physicians have special duties, then, to work in underserved areas? Several authors cite reciprocity as the kernel of such special duties (Oberman 2013: 435; Brock and Blake forthcoming; de Lora and Ferracioli fortcoming). For one thing, physicians have benefited from elite education, often fully state funded, and bear a special obligation to "give back," or simply "repay" (Oberman 2013: 430), rather than "free ride" (Ypi 2008). The point here is that physicians have enjoyed benefits that the state made available through the cooperative work of their fellow citizens. Physicians who then refuse to share their efforts with them in return unfairly exploit the work of others for their unilateral advantage (Ypi 2008: 408). Former Tanzanian President Julius Nyerere dubbed such physicians "traitors" (quoted in Dumitru 2012).

In fact, a special duty of reciprocity should not be narrowly construed around financial investment in students. For one thing, "If social responsibility is merely a matter of paying off debts incurred by individuals, those receiving private training are morally off the hook to their communities" (Snyder 2009; de Lora and Ferracioli forthcoming). Physicians will also have benefited from earlier public education, from public safety that facilitates studies, from mentors' good advice, from patients who undertook risks during physicians' training, from later exclusive license to practice medicine, and so forth (Ypi 2008; Brock and Blake forthcoming; de Lora and Ferracioli forthcoming).

Put generally, medicine is a collective endeavor, which none of us could sustain on our own. Every step of it, from basic research to the development of clinical strategies, training of health professionals and delivery of care, requires not only many different people but also some form of coordination of their efforts and collective support. To become a health professional is to benefit from the assistance of many, usually on the understanding that one would thereby become able to contribute to a collective good.

This reciprocity account only works to a limited extent. One complication is that health workers will rarely be needed for the specific individuals who had benefited them—most clearly, the taxpayers who funded medical education, public safety and so forth. Health workers are needed for impoverished patient populations, and they only rarely contribute to their education. While advocates of the reciprocity account have responded that their model of reciprocity is "transitive"—because I received good mentoring from my teachers, I should be a good mentor to my *students* (de Lora and Ferracioli forthcoming)—it remains difficult to see how even transitive duties of reciprocity would call on medical graduates to work in underserved areas. When the underserved are unpopular, disenfranchised minorities, they are rarely taxpayers' or mentors' first priority, and it is hard to see how helping the underserved does anything for taxpayers or for

aloof mentors. Student training may place some underserved urban patients who receive care in academic hospitals at risk, but how can that account for graduates' duties to remote rural populations?

Any duty of reciprocity must count just as much against a South African doctor moving to richer New Zealand without helping South Africans, and also against her moving to poorer Malawi without helping South Africans. Either way she fails to reciprocate for her South African training. It even counts against New Zealand doctors who leave upon graduation to volunteer in Malawi (except perhaps if their volunteering pleases Kiwi taxpayers and professors). Indeed, several sub-Saharan countries have no medical school, and on this logic of reciprocity, they might have ended up with no graduates who owe "their" patients care. All that seems absurd. For most doctors there are no significant moral reasons against moving to less-served countries—whether they be reasons of reciprocity or any other moral reasons.

Similar responses threaten attempts to ground obligations to assist the medically underserved as a matter of special duty toward compatriots. They also threaten Jeremy Snyder's relational theory of the duty of health workers to serve the underserved. For Snyder, that duty comes from encountering (coming into contact with) people in great need, which medical students do during externships in their country of study (Snyder 2009). Despite Snyder's account, however, medical students do not come into contact with more vulnerable populations elsewhere. So a Snyderian obligation would also—absurdly—count against fresh medical graduates moving from South Africa to Malawi.

A Professional Obligation?

Physicians are also thought to have special or role-based obligations to treat the sick simply because they are physicians. As for firefighters and lifeguards, becoming a health professional involves accepting a duty to provide services even at significant personal risk (Emanuel 2003). At least some health workers must show up for work during Ebola or severe acute respiratory syndrome (SARS) outbreaks and treat patients who might give them a fatal infection. Or so, at least, we shall assume here. If so, one may argue that physicians are also obligated to forego some options and remain working in the communities that need them the most, at least once it becomes clear that their colleagues will not go there. Whether or not we have the political power to force them to stay in the profession, in the country, and in such communities, we can agree that morally, they should do so.

Or so the argument goes. This rationale cannot fully ground moral duties to find jobs and remain in underserved communities. No one would say that a lifeguard has a special professional duty to find a job in an understaffed beach. As we shall put it, highly demanding *internal* professional duties (to enter tumultuous waters to rescue the drowning child once you work there, *or* to show up and work at your ward during a SARS outbreak) do not always give rise to equally demanding *external* professional duties (to seek work in an understaffed beach *or* clinic). We can therefore accept that duties to treat one's patients are very stringent while denying that the duty to make them into one's patients is remotely as stringent.

Admittedly this is not the case for all professions. Priests, for example, may have not *only* internal professional duties toward their flock (to show up at their church every Sunday), but also external professional duties (to seek a community in need of pastoral guidance, assigning little weight to compensation). Still, their external duties remain far

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weaker and less clear than the simple duty to be in church for their own sermon on Sunday. And it is not clear—not without an argument—that physicians are more like priests than they are like lifeguards.

We are not making the extreme and to our minds implausible claim that (assuming that professional obligations exist) physicians have unique obligations only to their own active patients. That extreme claim was recently made in defense of physicians who might have dreaded radiation and refused to serve in nuclear disaster zones following the accident in Fukushima, Japan (Akabayashi et al. 2012). In our view, physicians have special obligations not only once they meet, obtain consent, and establish an *active* doctor–patient relationship with determinate patients (call the latter obligations "super-internal" because they are even more closely linked to a clinical encounter than the obligations that above we call "internal"). In our middle-of-the-road approach, physicians may encounter special obligations to remain in workplaces and develop new therapeutic relationships at some personal sacrifice even earlier than the establishment of these active relationships. What we question are the moral obligations physicians allegedly have to seek work in such workplaces in the first instance. In the terms just introduced, we question physicians' external special obligations while recognizing both their super-internal and internal special obligations.

America's *Emergency Medical Treatment and Active Labor Act* (EMTALA) might be seen as a counter-example to this argument: As proof that health providers have external obligations to help even people who are not their patients as yet, when they lack other sources of care. EMTALA allows hospitals to reject patients in emergent conditions only after having stabilized them or transferred them elsewhere (42 U.S.C. § 1395dd 1986). However, even if health providers have a moral obligation not to abandon patients, this obligation might not apply outside strict medical emergencies and to each individual practitioner (as opposed to hospitals). Consider again the case of lifeguards. Are chronically overworked and underpaid individual lifeguards morally prohibited, absent any active emergency, from leaving their jobs when their contract ends but the replacement is not there? At least when no identified patient has an emergent need of a doctor, it is hard to argue that the doctor cannot move to another job.

Our analogy between physicians' external duties and those of lifeguards might be questioned on grounds of a difference in terms of service-seekers' personal responsibility for their need of service. When a lifeguard leaves a job and the beach is unguarded, a black flag is flying. People who later come to need a lifeguard there could have simply chosen to swim in a guarded beach instead. Patients usually have no parallel way to avoid disease. While we have reservations about applying considerations of personal responsibility to health practice (Eyal 2011), some readers may take this difference to show that physicians' external duties are somewhat stronger than those of lifeguards. Even so, it would not show that physicians' external duties are limitless.

Avoiding Harm

As discussed above, for Daniels physician migration is a case of developed nations *causing* harm, and not merely one of allowing harm to take place. He argues that international institutions like the World Bank and the International Monetary Fund have in fact forced many poor countries to trim their public sectors, drying up potential budgets for health worker positions. Given these austerity-inducing interventions, international institutions bear responsibility for the absence of health workers in these countries. As

Daniels puts it, this is an instance in which Thomas Pogge's concerns about causing harm in the international sphere hold strong (Daniels 2008).

Similarly, James Dwyer highlights the responsibility of migrants' receiving countries for ensuing medical harm in source countries:

> The problem of medical migration [arises] because the destination countries are . . . restricting immigration in a highly selective way. They seem only too willing to accept highly qualified health care workers while trying to keep out less skilled workers. It is this approach to immigration that raises issues of justice.
> (Dwyer 2007: 39)

If the wrongful active harm and injustice that Daniels and Dwyer stress were always the reason behind critical physician shortages, that might have made it physicians' moral duty to stay, or destination countries' duty to stop luring them over. Why? Because if harmful shortages stemmed entirely from wrongful agency by international monetary institutions, recruiting agencies, destination countries, or physicians themselves, that would cancel out any moral prerogatives on the parts of physicians or destination countries to prioritize their own plans. They would be under a moral duty to address critically unmet needs that they have caused. As Thomas Pogge writes, we have no prerogative to do harm to others, not even if the cost to us of refraining is steep (Pogge 2002).

But what Daniels and Dwyer describe are only contingent phenomena, not general characteristics of all physician shortages and migration in the world. Not all physician failure to help the critically underserved stems from wrongful active or selective agency. Some of it does not. Critical scarcity in health workers also arises in countries that have not seen devastating structural reforms. Some physicians don't need agencies' coaxing in order to want to move. Physicians' own *failure* to help the neediest patients is not an action but a failure to act in a certain way. Even if what precipitates and forces it is action on the part of the physician (moving abroad), the failure to help remains inaction.

Moreover, recall the case of one rich university luring workers from another. Free market transactions that selectively do harm are not always wrongful. They do not always encounter special prophylactic or reparatory obligations. So even if Daniels and Dwyer captured a universal characteristic of critical physician shortages, it would remain unclear that it is morally wrong for physicians to leave. The case against physicians who leave critically underserved areas rests then on something else—perhaps on the especially devastating nature of the resulting harm to vulnerable populations, as opposed to the sheer fact that harm takes place. Dwyer himself notes that the wrongness of medical migration does not depend solely on the fact that migration has taken place, but on the health status of the relevant communities:

> I am troubled by the emigration of 30 percent of Ghana's physicians because life expectancy in Ghana is about fifty-seven years. I am less troubled by medical migration out of Ireland. About 40 percent of Irish physicians have emigrated, yet in spite of this high rate, life expectancy in Ireland is about seventy-six years. Of course, the high rate of Irish medical emigration still raises questions about international fairness, postcolonial exploitation, and national policies, but the questions lack the moral salience and urgency that they have when we think about Ghana.
> (Dwyer 2007: 40)

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Let us recapitulate our discussions of assistance, reciprocity, professional obligations, and avoiding active harm. Despite the arguments of several authors, it is *not* clear, and contemporary political, legal, and professional institutions cannot consistently assume, that it is the moral duty of all physicians, all things considered, to work for critically underserved patient populations or to compensate them, either as a matter of general duty, or as a matter of special duty.

The Moral Permissibility of Forcing Physicians to Work in Underserved Areas

Despite serious doubts about a moral duty to work in underserved areas, might forcing health workers, and especially physicians, to work in underserved areas remain legitimate, under certain conditions and in certain forms? This section defends an affirmative answer to this question, a position further developed elsewhere (Eyal and Hurst 2010).

Although restricting medical migration carries some costs for physicians—namely, being barred from working (or living) where they please—the stakes are much higher for underserved patients. As one author explained, "To be prevented from entering a foreign state is one thing; to die from an easily curable disease for lack of medical attention is quite another" (Oberman 2013: 429). Given these high stakes for patients, there are humanitarian and distributive justice reasons for compulsory measures to keep physicians working for the underserved—whether or not it is their personal moral duty to do so.

Obviously that does not settle the debate about compulsory measures, because there are also considerations pushing in the other direction, against coercion. For example, forcing health workers to work in specific underserved areas for life would surely be wrong; indeed, it would constitute outright enslavement. It would grossly violate any freedoms of movement and occupation of these workers, exposing them to exploitation and arbitrary power in their workplaces. It would defeat virtually any personal project that these health workers might have formed earlier in life, and would probably alienate them both from the health care system and their own identities, further decreasing already low workforce morale.

And yet, in other areas of life, some policies that seem compulsory at first glance can be decisively morally justified. For example, forcing doctors who harbor prejudices against patients with HIV to treat them is legitimate. Inserting fluoride into communal drinking water despite the opposition of some is legitimate. Forcing the rich to pay redistributive taxes is legitimate. Forcing medical residents to work more hours than is necessary for their professional training to help care for local patients is legitimate. The fact that a policy seems compulsory or coercive is far from a conclusive reason against it. Some seemingly coercive policies are morally justifiable, either because they are not really coercive, or because the coercion they involve is not problematic, or because overriding factors make that policy legitimate on balance (Eyal and Hurst 2010).

The level of coercion or compulsion that a policy to reduce the brain drain involves affects its overall justification. Coercing doctors to work in rural areas for one or two years post-graduation may be legitimate, even if coercing them to work there for 25 years would not be morally permissible. Issuing migrant doctors only temporary work visas (Kupfer et al. 2004) may be legitimate, even if denying them entry visas and asylum is not. To treat *any* seemingly compulsive measure as a categorically forbidden encroachment of self-ownership is highly implausible for all but the staunchest libertarians (Tesón 2008; Dumitru 2012).

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These intrusions into physicians' option sets are small relative to the stakes for patients. Many medical students have acceptable alternatives to studying medicine; for example, they can study biology or engineering, which also lead to comfortable lives. Furthermore, any coercion against them typically affects social elites with relatively robust social and economic standing, whose option sets remain on balance far better than those of the patient populations who need them. What coercion *not* to take up lucrative jobs abroad forces them to give up is a privilege that is (unfairly) unavailable for their poor patients and for most other compatriots. There is no injustice to speak of when the price of substantially more universal access to basic care is blocking access to a lucrative job that is itself an unfair privilege (Eyal and Hurst 2010).

For some writers, the notions of coercion and involuntary measures conjure up images of arbitrary border officers or even work camps. But far from defending any of these draconian measures, we support fairly benign ways to encourage or even compel physicians to work for the underserved: Measures such as short compulsory service, or somewhat longer service in return for prior funding of physicians' education (Eyal and Bärnighausen 2012); deliberately *not* starting or funding "concierge" medical services and training targeted at the needs of the wealthy; focusing medical training on skills that are relevant in underserved settings and less relevant elsewhere, which can make physicians' skills less portable (Eyal and Hurst 2008).

We shall now address several potential responses to this defense of apparently compulsory measures to counteract physician shortages.

Inefficiency?

Coercion and compulsion are often counterproductive. Do physicians working under duress make for good caretakers? Physicians' many judgment calls are notoriously difficult to monitor. Making them work for the needy *or else* could increase burn-out and absenteeism that already exacerbate shortages (Dovlo 2005).

The question whether coercive or compulsive measures actually work is empirical. The answer may vary for different measures and different settings. But recent reviews of compulsory service and conditional scholarship programs are telling (Bärnighausen and Bloom 2009; Frehywot et al. 2010). Compulsory service and conditional scholarship programs, at least, are rather compulsory measures but they usually work when done properly and promote health worker availability in underserved areas.

Disrespect?

Even if coercion increases net utility, Kantians and many other thinkers may oppose it. According to legal thinker Fernando Tesón, for example, coercive measures assume that physicians are "mere resources" of the state, and that assumption "fails to treat persons as autonomous agents." Most fundamentally, "For the state to decide what I am supposed to do with my talents is to debase my humanity" (Tesón 2008: 906, 917; see also Dumitru 2012: 14–15).

Tesón probably assumes that, no matter how worthy the cause, to promote it through coercion is to treat people wrongfully as mere resources (at least when it is not their independent duty to do so). Coercion violates at least Lockean self-ownership, which Tesón, following Robert Nozick, associates with Kantian rights (Tesón 2008: 908–11).

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Tesón's Nozickian libertarianism is, however, a minority position. Not only has it been philosophically refuted (Cohen 1979, 1995; Murphy and Nagel 2002), but states use coercion all the time, and most people rightly think nothing of it. The examples of distributive taxation and medical residency remain telling. Generous welfare states legitimately coerce the rich to pay more in redistributive tax than it would have been their moral duty to donate to the poor, absent a generous welfare state, and most people think that is highly justified. Medical residency programs put pressure on physicians to use their bodies and minds to perform actions that help others, and they remain legitimate (even libertarians do not object to them), so long as the actions expected and the coercive means being used remain limited. The same could be true of measures to address critical health worker shortages.

Violation of Basic Rights?

How can these measures be defended in the face of fundamental rights to free association and free movement that some coercive or compulsive measures might violate (Dumitru 2012)?

These rights, while fundamental, are not absolute. Lucas Stanczyk explains that liberal rights such as the right to free movement, employment, or association cannot be seen as fundamental constraints that apply in every environment, regardless of any devastating impact on social welfare and on proper positive rights to healthcare. Instead, we should view all rights as derivative from society's proper goals. And on that view, any rights to emigrate or to work in an area of one's choosing are likely to give way when what is at stake is the fundamental health interests of some of the world's worst-off populations—a very important social goal (Stanczyk 2012). In Dwyer's succinct summary,

> the right to emigrate is . . . certainly an important right. Still, like all rights, it needs to be specified, qualified, and balanced against other rights and concerns . . . The right to emigrate should be qualified by and balanced against the social responsibility of health care professionals.
>
> (Dwyer 2007: 38)

Does our approach lead to extreme violation of the person's moral agency? Some theories ascribe to people rights to conscientious objection to perfectly legitimate social goals, when complicity in promoting these goals would violate deep personal commitments, misguided though these commitments may be. Nevertheless, several years of communal work rarely violates anyone's deep moral commitments (Fabre 2006: ch. 3), especially not those of physicians, whose prevailing ethos valorizes helping the needy (Eyal and Hurst 2010). Further, a physician's claim to conscientious objection would be questionable when she cannot be easily replaced (Brock 2008). Part of the reason why is that physicians had the liberty to pick another profession in the first instance (Eyal and Gosseries 2013).

Inequality?

Carens' rationale for the freedom of movement is not only that such freedom is good in itself, but also that it is "essential for equality of opportunity," and that it "contributes to reduction of political, social, and economic inequalities" (Carens 1992: 26; see also Dumitru 2012).

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However, surely physician shortages pose a major threat to global equality—in health resources and in every real opportunity that depends on living and remaining healthy and independent. Fully free movement for health workers maximizes protection of opportunities for them, but it comes at a major cost to the protection of opportunities for patient populations with far fewer opportunities. Restrictions of that movement would then seem typically to increase equality of opportunity (Caney 2012). And limited restrictions upon free movement would seem easy to justify.

Even Carens admits that "restrictions may sometimes be justified because they promote liberty and equality in the long run" (Carens 1992: 25). When it comes to restrictions of medical migration from certain settings and against certain background conditions, promoting long-term liberty and equality might be the rule, not the exception.

Hypocrisy?

Oberman reasons that sometimes physicians might have a duty to stay and assist their poor compatriots, but this is not a duty that the rich state "has the legitimacy to enforce." Such cases arise because the hypocrisy involved is particularly strong—for example, when "skilled workers only have a secondary duty to stay and assist their poor compatriots because a rich state has failed in its own primary duties towards people in that country." Here, Oberman holds, "in the absence of reparative steps, rich states do not have the legitimacy to enforce counter-brain-drain immigration restrictions." Non-enforcement may lead to worse consequences but, he answers, "why should we think that it is the consequences alone which matter?" (Oberman 2013: 450–1).

On Oberman's implicit approach to hypocrisy, it may follow that just because an agent has wronged someone, that agent must, to avoid hypocrisy, continue to wrong her. That can't be true. It may also follow on his implicit approach that when an agent's only way to right a wrong to a population would involve placing pressure on a third party to treat them right—in our case, placing pressure on physicians to work with underserved compatriots—the agent mustn't do so. And she mustn't do so even if placing that pressure would have otherwise been perfectly legitimate. Oberman, recall, agrees that treating the underserved could be an *otherwise* enforceable duty of these physicians.

It is especially remarkable that Oberman presses his point regardless of consequences, catastrophic as they might be—in absolutist fashion. Whatever stance one may take on the moral import of hypocrisy, absolutism seems implausible. Reassuringly, on the practical matter of barriers to health worker migration, Oberman concedes that "Perhaps in most ordinary cases rich states will retain the right to enforce restrictions despite their own failures" (Oberman 2013: 450).

Carens also warns about what he calls "hypocrisy." We would surely oppose barriers to workers' movement as ways to reduce intra-country regional inequalities. We would insist that workers have a basic freedom of movement. Therefore, we should not stop workers from moving across national borders simply in order to reduce international inequalities. Their freedom of movement is no less basic in the international context (Carens 1992: 27–8, 33).

Carens' warning about hypocrisy is unwarranted. The regional inequalities inside (developed) countries that fuel his argument rarely create critical worker shortages. Health worker shortages in sub-Saharan Africa and South Asia are critical. It is true that existing border controls provide the opportunity to implement these legitimate restrictions and protect public health. But is it evil to use arrangements (bound to remain in

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place in the foreseeable future) to address the critical health needs of some of the world's most vulnerable populations?

Leah Ypi, who is friendly to some migration restrictions, decries what she nevertheless sees as inconsistency. For her, "if R provides a valid reason for restricting incoming freedom of movement, R also provides a valid reason for restricting outgoing freedom of movement." She complains that those who worry about the public health consequences of medical brain drain typically approve of limitations on immigration while opposing limitations on emigration (Ypi 2008: 391, 402–5).

But there is at least one big difference between typical restrictions of immigration and restrictions against emigration. That difference may make the former more palatable in the fight against critical health worker shortages. When physicians are completely denied entry to a given developed country, or even to all *developed* countries, they retain their ability to flee persecution in a hostile home country. That is not so when physicians are completely denied exit rights from their home country. As we have already mentioned, to say that some coercive or compulsive-looking measures (in this case, denial of entry rights) are permissible vehicles of health promotion, is not to prejudge any and all such measures.

In conclusion, then, despite continuing doubt about a moral duty to work in critically underserved areas, some policies that compel physicians to work in such areas could be legitimate and morally justifiable. Leaders and policy-makers should not rule out seemingly coercive responses to critical physician shortages in underserved areas. They could complement existing policies in the fight to provide access to basic care for all people.

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Related Topics

Chapter 8, "Medical Tourism," I. Glenn Cohen
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