A global affair

doi:10.1136/medethics-2013-101809

Michael Dunn, *Associate Editor*

The *Journal of Medical Ethics* has always had a global outlook. International in its authorship, readership and editorship, the journal recognises the value of exploring how ethical issues in healthcare and scientific research manifest themselves in different geographical settings, of examining ethical issues that cross national boundaries and of ensuring that the analysis and promotion of ethically defensible care is responsive to local practices in all parts of the world.

A number of the papers in this issue of the journal exemplify the value of this global approach towards medical ethics scholarship. This month's feature article by Javier Hidalgo (***see page 603***, Editor's choice) focuses on the increasing trend for the recruitment of health workers in low-income countries by organisations within high-income countries. Hidalgo's message is clear; that an ethical analysis that carefully attends to the harms and benefits of such a practice should lead us to conclude that it is, in most cases, morally permissible.

Five commentators take issue with Hidalgo's analysis in various ways, seeking to isolate and explain the common intuition that this global flow of health workers is ethically problematic. A couple of significant difficulties in conducting ethical analyses across national boundaries emerge from these exchanges, and are considered at length by Hidalgo in his response to the commentators (***see page 618***).

First, the challenges in adequately identifying, and measuring, the varied consequences —both positive and negative—of such practices are illuminated, with Hidalgo himself recognising that 'it is hard to accurately estimate the causal effects of medical emigration'. Iain Brassington (***see page 610***), Carwyn Rhys Hooper (***see page 611***), Gillian Brock (***see page 612***) and Alok Bhargava (***see page 616*** and a further comment in an accompanying e-letter: http://jme.bmj.com/content/early/2013/05/30/medethics-2013-101409.full/reply#medethics_el_16607) question the ways in which Hidalgo accounts for, and explains, the harms and benefits within his ethical analysis. It will always be difficult to capture fully the 'ripple effect' from a practice of this kind, and, like other ethical issues that cut across local, national and international scales, it will be particularly difficult to navigate between different kinds of data in explaining any observed effects. In contrast to consequentialist analyses of ethical issues arising in very local practices, the analysis of these population-level phenomena requires the integration of complex epidemiological datasets with smaller scale micro-sociological and demographic data to capture an isolated, snapshot account of the multiple consequences of this type of emigration. As the disagreements between Hidalgo and Bhargava show, care must be taken to ensure that the relevant data are handled correctly when conducting such an analysis. There is clearly much more work to be done to explain the full range of harms and benefits that accrue from this movement of health workers before drawing any definitive ethical conclusions about this growing phenomenon.

The second difficulty in analysing transnational ethical issues is the presence of background injustices that cannot be disentangled from the ethical analyses of healthcare phenomena that look, at first glance, to be quite distinct from questions of fairness. Such injustices are likely to be a significant part of the intuition that people in low-income countries (or, perhaps, the countries themselves) are being unfairly treated by powerful and wealthy institutions in other parts of the world. Both Hooper and Sigrid Sterckx (***see page 614***) highlight such injustices, and criticise Hidalgo for his narrow focus on harms and benefits.

Background injustices should always be accounted for in the analysis of practices that involve nations, communities or people with contrasting power, wealth and status. Such injustices, which have complex social, cultural, geopolitical and historical features and explanations, mean that medical ethicists will need to delve into political philosophy when examining these global issues. Exactly how such injustices should be responded to within the normative analysis of ethical issues must be determined, and responsibilities accounted for appropriately. One way of dealing with such background inequalities is apparent in Hidalgo's recommendation that immigration restrictions within high-income countries should be removed in order to increase people's freedoms, to reduce global poverty and to improve income equality between countries. Again, however, such a proposal raises the first concern about adequately predicting and accounting for the likely consequences of such an action.

Ramin Asgary and Emily Junck (***see page 625***) analyse a different kind of movement of health workers between countries: volunteer doctors and trainees travelling from high-income countries to low-income countries to provide short-term humanitarian assistance. They identify a range of ethical issues in this practice, many of which arise because of the differences in resources, medical practices and patients' expectations between the two countries. Here, it is the negative consequences associated with the short-term nature of this pattern of health migration that raise concern. In particular, the authors identify the burden placed upon local practitioners to maintain the healthcare infrastructure and manage the follow-up of care once the volunteers have returned home, and emphasise the volunteers' inability to develop the necessary long-term relationships with patients and the community that are conducive to high-quality service delivery.

Again, the background injustices that form part of this practice need to be accounted for. For Asgary and Junck, justice here can be advanced by individuals 'on the ground', rather than by endorsing the more radical policy changes proposed by Hidalgo. Asgary and Junck claim that the appropriate way to deal with background injustices is for medical volunteers to recognise their responsibilities as global citizens rather than as charity workers. Reflecting concerns raised within the philosophy of humanitarianism, performing one's role as a global citizen requires upholding patients' human rights, addressing broader social justice concerns locally, and equalising power relations between the provider and recipient of care. In so doing, the volunteers avoid legitimating lower standards of care and undermining the dignity of people in the communities the volunteers are assisting, which the authors see as being validated by acts of charity.

Another common thread in ethical analyses of healthcare issues in international contexts is the management of social norms or cultural practices within medical encounters that conflict with universally held duties within healthcare practice.

Tensions here can arise in different ways. As Asgary and Junck discuss, established standards for—or an individual practitioner's views about—bedside rationing and the triaging of patients requiring emergency care may clash with local conventions about who should be prioritised for medical assistance. Elsewhere in the issue, Suzanne Booij and colleagues (***see page 621***) show how doctors in the Netherlands are hesitant to start conversations about patients' end-of-life wishes until the patient him/herself raises the topic for discussion. Interestingly, whilst professional guidance in the Netherlands encourages an open and dialogical approach to planning patients' end-of-life care (supported by a legal framework that allows for euthanasia and physician-assisted suicide), doctors look to endorse a culture of practice that places the responsibility on patients to take the lead with care planning.

To tackle the conflict between the norms and duties identified in the Netherlands, one proposal offered by Booij and colleagues is to instigate a referral process for those doctors who have a conscientious objection to euthanasia when this option is raised by the patient in a conversation that the doctor instigates. In their analysis of conscientious objection policy in England and Ireland, Cathal Gallagher and colleagues (***see page 638***) disagree with such a proposal. Discussing access to emergency hormonal contraception, the authors heavily criticise policy guidance that introduces a 'conscience clause' allowing pharmacists to opt out of prescribing such contraception, but that requires them to refer patients to other prescribers. Arguing that (i) there is 'no ethical difference between dispensing the medication and enabling another willing pharmacist to do so', and that (ii) referral will, in some cases, act against a patient's best interests because of the narrow window in which the contraception is effective, Gallagher and colleagues conclude that the status quo is ethically unjustified.

As people increasingly move between countries and localities to provide and receive healthcare, the tension between doctors' duties and disparate social, cultural and religious attitudes and practices is likely to intensify. As the paper by Booij and colleagues illustrates, it is important that any such tensions are exposed, explained and managed as they are pertinent to ensuring that good healthcare is underpinned by careful reasoning about different values. However, reflecting Gallagher and colleagues' pertinent analysis, care must also be taken that any policy or practice that is established to deal with one or more of these tensions tackles the underlying ethical conflict between values, rather than sidestepping this conflict to endorse an approach that can command consensus.

Changing global trends in healthcare practice and policy pose new challenges to the provision of good care around the world. However, these trends also pose new opportunities for medical ethicists to broaden their horizons, expand their analytical range and develop new disciplinary perspectives. The journal is proud of its global reach and outlook, and remains keen to receive submissions from all parts of the world. Papers that shed new empirical light on how ethical problems arise in one or more geographical settings, and that consider how such problems should be dealt with in light of the relevant ethical and practical considerations, are always encouraged.

Competing interests None.

Provenance and peer review Commissioned; internally peer reviewed.