

We want to help: ethical challenges of medical migration and brain waste during a pandemic

Elizabeth Fenton,¹ Kata Chillag²

¹Bioethics Centre, University of Otago, Dunedin, New Zealand
²Department of Public Health, Davidson College, Davidson, North Carolina, USA

Correspondence to

Dr Elizabeth Fenton, Bioethics Centre, University of Otago, Dunedin, New Zealand; elizabeth.fenton@otago.ac.nz

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ABSTRACT

Health worker shortages in many countries are reaching crisis levels, exacerbated by factors associated with the COVID-19 pandemic. In New Zealand, the medical specialists union has called for a health workforce emergency to be declared, yet at the same time, many foreign-trained healthcare workers are unable to stay in the country or unable to work. While their health systems differ, countries such as New Zealand, the USA and the UK at least partially rely on international medical graduates (IMGs) to ensure access to health services, particularly in underserved communities. This paper focuses on the challenges faced by many IMGs, particularly those that constrain their capacity to live and work in the countries that rely on their skills. These challenges give rise to two ethical problems. First, they represent a failure of reciprocity towards IMGs; second, they represent a source of harm, both to IMGs themselves and to communities whose healthcare service depends on contributions made by IMGs. We argue that brain waste and devaluing the contributions of IMGs and other foreign-trained health professionals have significant costs for maintaining a functional healthcare system, costs which must be adequately recognised and counted.

INTRODUCTION

Longstanding clinician shortage in New Zealand has reached crisis levels during the COVID-19 pandemic, impacting a range of medical services. In late January 2022, the Association of Salaried Medical Specialists, a union representing physicians and dentists, called for the declaration of a health workforce emergency and urgent action to recruit and retain healthcare workers.¹

The severity of the recent, acute health professional shortage can in part be attributed to the COVID-19 pandemic, taking into consideration workforce depletion as healthcare workers become infected, and the impact of border and immigration restrictions on the pipeline of workers coming from overseas.² Though COVID-related factors have likely exacerbated the impacts of shortage, the current health workforce crisis reflects structural problems in the New Zealand healthcare system present long before the COVID-19 pandemic.³

New Zealand is highly reliant on foreign-trained physicians and nurses. This reliance is catalysed by high rates of healthcare worker emigration, driven in part by higher wages overseas, and that New Zealand trains fewer healthcare workers than many comparable countries.^{4 5} With this reliance comes negative impacts to the health system overall and the healthcare professionals who work in it, including vulnerability to acute shocks to the healthcare

system as has occurred during the COVID-19 pandemic, and persistent scarcity of healthcare workers in rural areas and serving vulnerable populations. In addition to stressors affecting all health professionals working in a system with inadequate human resources, the foreign-trained clinicians who help (or aspire to) address that shortage, including physicians (referred to as international medical graduates or IMGs), may confront additional challenges. These relate in particular to immigration policy and processes, credentialing, sociocultural and professional adaptation and other challenges related to the underserved areas in which they often practice.^{6 7}

Despite the recognised need more effectively to recruit and retain healthcare workers, IMGs and other foreign-trained medical staff eager to stay in New Zealand and work in the health sector report being unable to secure permanent working visas or jobs. The unemployment or underemployment of these healthcare workers represents a source of ‘brain waste’—the underutilisation of highly skilled workers.⁸ Added to this brain waste is the impact of immigration policies on retention of IMGs already working in the country. Difficulty obtaining residency status for themselves and their family members is among the most pressing challenges experienced by IMGs and influencing their decisions to leave New Zealand for countries offering higher pay and more accommodating immigration policies.⁹ Given that IMGs make up just under 43% of the physician workforce in New Zealand, retention of their skills and contributions is critical to maintaining healthcare services.¹⁰ This is especially important in rural areas, where IMGs make up 52% of doctors, compared with 38% in urban areas.¹⁰

New Zealand is far from unique either in its dependence on foreign-trained health workers or its current health workforce crisis. In the USA, for example, IMGs comprise approximately one quarter of all practicing physicians, but in some regions and specialities proportions of IMGs are significantly higher.¹¹ As in New Zealand, rural and underserved areas are particularly dependent on IMGs and are already suffering from physician shortages, contributing to disparities in health outcomes and higher all-cause mortality rates.¹² Overall physician shortages in the US are predicted to reach up to 139 000 by 2033.¹³ It seems clear that without IMGs, many already vulnerable groups would, for all intents and purposes, lose access to healthcare, and many healthcare institutions would likely functionally collapse.¹⁴

Recent research on the experiences of IMGs highlights the complex interplay between health workforce shortages, immigration policy and brain



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waste, especially during a public health crisis (Chillag K, Freij M, Sirbu C, et al. International Medical Graduates at the Crossroads. Unpublished data 2022).^{15 16} In spite of the significant contributions IMGs make to the availability of healthcare services in the countries where they work, their lives are often made precarious and difficult through a range of challenges, many related to immigration processes and status and the complexities of credentialing requirements. These challenges give rise to two ethical problems. First, they represent a failure of reciprocity towards IMGs, where reciprocity requires proportional or fair return for services rendered to those who supply the services.¹⁷ This is a problem of justice. Second, these challenges are a source of harm both to the IMGs themselves, in terms of the professional and personal stressors they create and to communities whose healthcare service is in large part dependent on contributions made by IMGs. We argue that obligations of reciprocity provide reasons to address the burdens imposed on IMGs, and the moral responsibility of governments to provide access to healthcare services provides a reason to address the potential harm to communities served by IMGs.

IMGS AND RECIPROCITY

Ethical analyses of the role of foreign-trained, expatriate health workers, particularly in relation to migration from countries with fewer resources and healthcare worker shortage to countries with more resources, often focus on so-called 'brain-drain'. This focus has gained additional attention during the COVID-19 pandemic.¹⁸ While these considerations are important, complex dynamics in medical migration and the experiences of IMGs, across different healthcare systems and social contexts, challenge this as the only or primary ethical framing meriting consideration.

Health is essential to human well-being, so is promoted and protected as a central concern of social justice.¹⁹ Its relationship to well-being gives everyone a morally urgent claim often codified in the language of rights. Like other entitlements of social justice, government institutions assume at least some moral responsibility for ensuring that everyone has equitable access to essential healthcare services.²⁰ Part of this responsibility is to create the conditions under which people will be willing to train and work in the health sector and provide those services. Meeting this responsibility sometimes justifies imposing on medical graduates service obligations that they are required to meet as a condition of emigration. These can be described as obligations of reciprocity: where healthcare workers benefit from publicly funded education and training programmes, they have obligations of reciprocity to contribute their skills and knowledge back to those who have benefited them.²¹ Such compulsory programmes can also be justified when they help to ensure that the government meets its obligations to secure urgently needed basic goods, including healthcare.²²

But compulsory programmes are only one side of the reciprocity coin. These programmes do not address the obligations of reciprocity governments hold towards healthcare workers in return for the critical role those workers play in meeting the government's moral responsibility to provide healthcare. As a norm by which good is given for good received, reciprocity is deeply rooted in both private and public morality.¹⁷ The notion of responding in kind applies not only to individual exchanges (eg, when someone has done us a favour) but also to the receipt of public or collective goods from which we all benefit. All beneficiaries incur an obligation to contribute in some way to sustaining the institutions that provide those goods.¹⁷ In the

context of public goods, reciprocity is underpinned by a principle of fairness or fair return for benefits received, and it has been invoked throughout the COVID-19 pandemic to demand appropriate returns (such as personal protective equipment or PPE) for healthcare and other essential workers who have taken on additional risks to sustain critical public services.²³ Even outside of pandemic times we all, as potential beneficiaries of a functioning health system, owe healthcare workers fair return for their contribution to that system, via the governmental institutions that control and operate it.²³

The reciprocity demanded of healthcare workers by compulsory programmes must be preceded, or at least accompanied, by every effort on the part of governments to secure the conditions under which trained medical professionals are able and willing to serve the health system of their own accord. Securing these conditions is both one part of the government's obligation to sustain its health system and provide healthcare as well as an obligation owed directly to healthcare workers to reciprocate for their contribution to providing an essential public good. Like PPE during an infectious disease pandemic, conditions that support the life and work of healthcare workers are fair return for the services they provide, and from which we all benefit. Efforts to secure these conditions are more likely to result in longer term retention of healthcare workers, promoting continuity of care and establishing relationships of trust, particularly with vulnerable communities. The conditions include salary, workload, working conditions and access to professional opportunities and advancement. For IMGs and other foreign-trained medical professionals, favourable conditions related to immigration and credentialing policies and processes are especially critical. To the extent that IMGs contribute directly to the government's capacity to meet its obligation to provide healthcare as a basic social good, it is under a reciprocal obligation to IMGs to offer secure immigration and training pathways as a key component of their working conditions.

HARM, IMGS AND PROVISION OF HEALTHCARE SERVICES

The COVID-19 pandemic has exacerbated hardships experienced by IMGs and other foreign-trained health professionals. During the pandemic, like all healthcare workers, IMGs have often accepted significantly increased risks and burdens to provide healthcare to communities in need. Unlike healthcare workers who are citizens or permanent residents, however, IMGs have experienced additional burdens during the pandemic. In the USA, potential job losses have threatened IMGs' immigration status and that of their families, as have delays in processing immigration applications and visa extensions due to office closures during lockdowns. IMGs whose families are dependent on them for their own immigration status worry about the consequences if they contract COVID-19: death can mean deportation for their family members.¹⁵ Complexities related to international travel during the pandemic, such as quarantine policies or less frequent flights, presented additional challenges for some IMGs, such as being unable to visit family for extended periods.²⁴ These stressors are compounded by years-long backlogs in obtaining permanent residency.²⁵ Similar problems have been experienced by IMGs elsewhere, including in the UK, where IMGs faced increased risk of COVID-19 death alongside lower levels of social and professional support.²⁶

In New Zealand, a lack of secure pathways to residency and appropriate training positions mean IMGs and foreign-trained nurses can be either unemployed or unable to stay, even in the midst of a workforce crisis and the increased demands of

a pandemic.^{8 27 28} These constraints on practice contribute to a perception on the part of foreign-trained healthcare workers that their skills are undervalued.^{5 9 28} Feelings of being undervalued are common to the IMG experience, alongside other sources of stress, including bias and discrimination, communication, limited understanding of the health system and the challenges of working in rural areas.^{6 7}

As argued above, obligations of reciprocity, grounded in fairness, provide reasons of justice to address these harms directly experienced by IMGs. Since ensuring access to healthcare services is a core moral responsibility of governments, and IMGs help meet that responsibility, governments owe IMGs appropriate living and working conditions in return for their contribution.

But there is another reason why governments have an obligation to provide the conditions necessary to retain IMGs and other foreign-trained health professionals, which also stems from its core moral responsibility to provide access to healthcare services. Policies that constrain the contributions IMGs can make to the availability of healthcare services, or exclude them from the workforce, are a source of indirect harm to the communities IMGs serve. Brain waste can be costly for health systems that are heavily dependent on immigrant health workers.⁸ During the COVID-19 pandemic in the USA, IMGs were often required to turn down urgent requests to assist in pandemic hotspots due to their visa status, which permits them to work only in one specific location. This waste of skill is a source of harm for patients and communities in need of care as well as a source of stress for IMGs.^{15 25} IMGs fill many gaps in rural and underserved areas, where health services are already under considerable strain.^{14 29} Backlogs in patients waiting for surgery have reached such high levels in New Zealand the government has appointed a special taskforce to address the issue, noting the impact of COVID-19 on waiting times; critics argue that entrenched workforce shortages are the real problem.³⁰ To the extent that these shortages, both short-term and long-term, contribute to reduced access to healthcare services, wasting or foregoing the contributions made by IMGs and other foreign-trained health professionals is a significant source of potential harm to the communities they serve.

CONCLUSION

Government institutions have a moral responsibility to ensure equitable access to essential healthcare services. This responsibility has several implications. First, in countries that have evolved a structural reliance on foreign-trained healthcare workers and IMGs, particularly in underserved areas, governments assume an obligation to ensure that IMGs are enabled to live, practice their skills and deliver healthcare services. This is a reciprocal obligation owed to IMGs in return for their contribution to meeting the government's responsibility to provide healthcare. Second, constraints on IMGs' capacity to live and work in receiving countries are a source of harm both to them and to the communities they serve. To the extent that these constraints, including immigration and credentialing policies, deprive communities of needed healthcare services, they undermine governments' ability to meet their responsibility to provide healthcare. Agile immigration and credentialing policies that can appropriately match surges in need with available skills are especially critical to provision of adequate healthcare services, both during a public health crisis and for routine care.

While brain drain of skilled healthcare workers from weak health systems remains a pressing problem of justice for global health policy, ethical failures must also be recognised in policies

and processes that result in brain waste and disvaluing of the contributions of IMGs and other foreign-trained health professionals. The cost of these failures for maintaining a functioning healthcare system must be adequately counted.

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