Special Section: Bioethics Beyond Borders

A Closer Look at the Junior Doctor Crisis in the United Kingdom's National Health Services

Is Emigration Justifiable?

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Abstract: This article attempts to tackle the ethically and morally troubling issue of emigration of physicians from the United Kingdom, and whether it can be justified. Unlike most research that has already been undertaken in this field, which looks at migration from developing countries to developed countries, this article takes an in-depth look at the migration of physicians between developed countries, in particular from the United Kingdom (UK) to other developed countries such as Canada, Australia, New Zealand, and the United States (US). This examination was written in response to a current and critical crisis in the National Health Service (NHS), where impending contract changes may bring about a potential exodus of junior doctors.

Keywords: National Health Service; NIH; junior doctors; immigration of physicians; United Kingdom

The National Health Service (NHS) is a public healthcare entity of the United Kingdom (UK) and is the sole employer for all medical school graduates, who are classified as junior doctors while they receive their postgraduate training for 5–15 years, until they qualify as consultants. There has been a steady flow of physicians leaving the NHS in the UK in recent years, but this problem will be greatly intensified in the upcoming years.[1, 2]

On September 15, 2015, the UK Department of Health announced that it would be imposing a new contract for junior doctors in England starting in August 2016.[3] Jeremy Hunt, England's Health Secretary, has stated that these changes are being driven by a desire to improve provision of care on weekends, based on a recent study in the *British Medical Journal* that shows that patients are more likely to die if they were admitted on a weekend. However, it is unclear if those deaths are avoidable or preventable by increased staffing, as patients admitted during weekends tend to be sicker.[4]

There are 53,000 junior doctors working in the NHS as of September 2015, and they have rallied together to resist the pending new contract.[5] Under the new contract, although basic pay will increase by 13.5 percent on average, the definition of what constitutes "unsociable hours" has signficantly narrowed, such that day hours on Saturday are paid at a normal rate and extra premiums that were being offered for night shifts and the rest of weekends are reduced under the new contract.[6] The old system of pegging pay increases to time in the job will be removed, which means that junior doctors will be penalized for taking time out from work for sabbaticals, research, or paternity or maternity leave, and that the "standard" normal

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working hours will be significantly extended.[7,8,9,10]The proposal also entails a removal of safeguards that would prevent physicians from working excessively long shifts, and makes no mention of putting in place an alternative solution to prevent physicians from suffering from unsafe working schedules that indirectly endanger patient care.[11] In fact, presidents of the medical royal colleges have written to Health Secretary Hunt to express their overwhelming concern for the damaging effects of the proposed changes.[12,13]

Numerous protests with massive turnouts of up to 20,000 physicians occurred in October 2015, and in a ballot of more than 37,000 junior doctors organized by the British Medical Association, an overwhelming 98 percent voted in favor of a full strike action.[14,15,16,17] Junior doctors first went on strike on January 12, 2016, cancelling all elective care and providing only emergency care, making it the first strike by physicians in four decades.[18] They went on to carry out another strike on Feburary 10, 2016 which led 3000 elective operations to be cancelled, and again on April 26, 2016 where both routine and emergency cover were withdrawn.[19, 20, 21]

More importantly, there are telling signs that junior doctors are looking to leave the NHS in search of better job prospects elsewhere in the world. Physicians who are interested in working abroad have to apply for Certificates of Current Professional Status (CCPS) from the General Medical Council (GMC) in the UK and in just 3 days after the September 15, 2015 announcement, the GMC received 1,644 requests for CCPS documents, an alarming and irrefutable increase from the typical 20–25 requests the GMC receives each day.[22] A poll done by *The Guardian* in October 2015 of more than 4,000 physicians revealed that more than 70 percent of junior doctors plan to move abroad, change careers, or become a locum if the contract changes are to be implemented.[23] Another poll of 1,000 physicians by the *Independent* revealed that 90 percent of physicians would resign if the new contract were imposed; and, on the day the government imposed the contract (February 11, 2016), the number of physicians who applied to work abroad surged by 1000 percent.[24,25] An Organization for Economic Co-operation and Development survey in December 2015 revealed that the United Kingdom was already the 2nd highest exporter of doctors (second only to Germany), although it must be noted that these figures refer to all doctors working in the NHS and not merely junior doctors.

The possible mass exodus of junior doctors in response to the imposition is a highly pertinent and timely issue, given the potential for its far-reaching and devastating impact on the already overstretched and understaffed NHS in the UK.[26,27,28] This article aims to explore whether their choice to emigrate can be justified.

Looking at a New Issue with an Old Lens

There is a wealth of research on the issue of migration of physicians from developing countries to developed countries, as this is a problem that is long-standing and has been hotly debated for its ethical implications. However, there is a scarce amount of literature on the migration of physicians between developed countries, likely because of the milder moral impact this has on the source countries and the smaller scale on which such migration happens. Using current available research on the migration of physicians from developing to developed countries as a framework, this article explores, from the perspectives of physicians and source countries, the ethical implications involving the migration of physicians between developed countries.

Perspective of Physicians

From Developing to Developed Countries

There are four overarching reasons why physicians have a duty to remain: every citizen in developing countries has a right to health; there is a reciprocity-based reason to serve the citizens after imposing risks on them during training; physicians have a social responsibility to the community; and physicians have an obligation to refrain from overburdening fellow physician colleagues who stay behind.

Everyone has a right to health, and this includes citizens of all developing countries. The right to health can be found in international treatises such as Article 25(1) of the Universal Declaration of Human Rights, which states that "everyone has the right to a standard of living adequate for the health and wellbeing of himself and his family including food, clothing, housing and medical care," and Article 12 of the International Covenant on Economic, Social and Cultural Rights defines the right to health as "the right of everyone to the enjoyment of the highest attainable standard of physical and mental health."

Having an adequate number of physicians plays a crucial role in ensuring that citizens in developing countries have a "right to health." Although the "right to health" involves increasing access to healthcare and tackling pertinent issues such as good healthcare infrastructure, reducing financial barriers, and ensuring availability of drugs, a fundamental facet is having sufficient qualified physicians to administer much-needed medical care to the citizens.

Unlike other professionals, physicians impose high risks on fellow citizens when they undergo training, as they have to practice on them in order to learn new procedures and skills. This in turn gives rise to a reciprocity-based reason to prioritize the needs of fellow citizens.[29] It can also be said that physicians owe a form of social responsibility to the community or as Anne Raustol puts it, "duties towards compatriots."[30] Viewed from another perspective, people, including physicians, acquire social responsibilities when they opt to acquire professional skills at the expense of public resources and institutions; hence there is a duty to repay the social resources that have been invested in the workers' education by working for the community.[31] This does not necessarily imply that physicians who pay their financial bill should be free to leave, it merely imposes a social and moral duty to stay to repay the moral debt that was incurred during their training.

The departure of physicians from developing countries also has the unintended effect of increasing the workload for the physicians who do remain behind, especially in the absence of adequate replacements.[32]This may be deemed to be morally troubling, as this rewards physicians who leave to seek better opportunities and punishes those who choose to stay behind to serve the community, and it exacerbates the migration of physicians, which results in a vicious cycle.

On the other hand, physicians have a right to leave their country should they wish to choose to do so, in order to seek a better life for themselves: Article 13(2) of the Universal Declaration of Human Right states that individuals have a moral right to leave any country, including their own. Michael Blake points out that according to Article 15(2) of the Universal Declaration of Human Rights, no individuals shall be arbitrarily deprived of the right to change their nationality; and it follows that they, therefore, have a right to renounce their moral duties toward the people of the country whose citizenship they are relinquishing.[33]

From a virtue ethics perspective, the reason for leaving matters, and there are numerous valid and understandable push factors that drive physicians toward migration. Physicians may find that their personal rights are not being fulfilled in a myriad of ways. In their workplace, they may have to suffer intolerable working conditions, such as long shifts with poor health infrastructure and resources to support their work, or they may receive inadequate remuneration for their efforts. In their personal life, they may face political and social threats to both themselves and their families, harsh living conditions such as unsanitary housing and poor nutrition, as well as limited education opportunities for themselves and their children.[34] Unsurprisingly, better personal and professional opportunities in developed countries make it highly attractive and rewarding for physicians to take the risks involved in uprooting themselves and leaving their home country. Besides, physicians who face resistance when attempting to migrate and are pressured into stay against their will are more likely to suffer from reduced morale, lower productivity, and increased inefficiency.[35, 36]

The right to health is also not a binary; that is, it is not "all or nothing." The preamble to the World Health Organization (WHO) constitution defines "health" very broadly as "a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity."[37]A right to health is more than just a right to healthcare or access to care, and is influenced by a wide range of social, economic, and political factors, including safe environments, access to nutritious food, education, and fair work with income.[38, 39, 40] The migration of physicians cannot be held solely responsible for the declining and insufficient healthcare systems in impoverished countries or the failure to provide a right to health for people in developing countries. In other words, it is unjust and unfair for the burden of the right of health to rest on the shoulders of a small group of individuals rather than the state.[41] Having said that, given the broad definition of health, the state may arguably still satisfy its obligation to guarantee to right to health even if physicians leave.

It also does not follow that simply because citizens have a right to health and that the state has the responsibility to guarantee it, that therefore, physicians *personally* have an obligation to provide it because they were trained in the country. The state could devote a much larger share of its tax revenue to health, pay higher wages, and thus incentivize physicians to stay.

Between Developed Countries

With regard to physicians having a duty to stay, the arguments for reciprocity and social- based responsibility also apply to the case of emigration of junior doctors between developed countries. In the best seller *Complications,* Atul Gawande discusses his experience as a first year surgical resident. Using his personal experience of learning to insert a central line—from the first few failed attempts to eventually being skilled enough to teach another resident—he notes that physicians always have the unspoken "moral burden of practicing on people." [42]

Apart from reciprocity and social-based responsibility arguments, there is also an argument to be made on financial grounds as to why junior doctors should stay. It seems reasonable to think that junior doctors in the UK have a duty to serve and pay back the financial debt owed to the public if they have made specific use of public resources, namely subsidized medical education. However, this train

of thought necessarily favors the migration of junior doctors who come from a financially privileged background, as they would be in a better position to be able to pay back.

Also, like physicians in developing countries, junior doctors in the UK also have a right to freedom of movement and choice of employment, as spelled out in Articles 13, 23, and 25 of the Universal Declaration of Human Rights.[43]

It is also important to note that unlike in developing countries, most physicians who are trained in the UK have a strong desire to remain in the country. From a virtue ethics perspective, the motivation and the character of an individual matters more than that person's actions, and most skilled emigration is likely to be the result of extreme unhappiness and dissatisfaction with the current situation, rather than a mere desire to explore greener pastures elsewhere.[44] The contract changes can also be said to be affecting the morale of current junior doctors: the eleven royal medical colleges that are responsible for the training and development of junior doctors have written to the health secretary to criticize the contract changes on the grounds of severely lowering morale of current physicians.[45]

Unlike developing countries, the UK has a well-developed healthcare infrastructure, the NHS; therefore, the traditional argument that it is unethical for junior doctors to leave their home countries, as it will jeopardize the survival of their home healthcare systems, is less pronounced as when physicians leave developing countries. Admittedly, the fact that the threatened survival of the home health system is more of a problem in the developing world than in developed countries does not necessarily mean that this is not a problem in the developed world.

An important distinguishing issue in this situation is that the change of working conditions that have been imposed on the junior doctors was one that was given suddenly and without notice. An argument can be given that changes to working conditions have always been implicit: medicine and work are always changing. The bar examination for lawyers has been changed on occasions, but no one can claim that they were entitled to be tested under the old system because the change was unforeseen. Although that may be true, the extent and impact of change in the situation with junior doctors is hugely amplified. For them, changes that were imposed strike at the core of their working conditions: they involved an overhaul in not only the working shift patterns (junior doctors are likely to find themselves working more weekends) but also their overall pay.[46] Some hospitals had even considered refusing to impose the new contract with its controversial working hours. [47]

The changes that are being discussed are not trivial measures that may impact one's working life in minor ways; for example, dental or childcare benefits, but, instead, are changes that drastically affect a person's livelihood. This rings especially true for female physicians: the Department of Health's Equality Impact Assessment of the contract reached the astonishing conclusion that although the contract would "impact disproportionately on women," especially single mothers, the adverse effects could be "comfortably justified" as "any indirect adverse effect on women is a proportionate means of achieving a legitimate aim."[48] The Medical Women's Federation (MWF), which represents female physicians, is concerned that the new contract could breach junior doctors' right to a family life under the Human Rights Act.[49] Under such circumstances, attempting to resist adverse changes being forced upon one's life by emigrating is surely an understandable move.

It might be suggested that if the timing and lack of notice of the changes were to be addressed, the issue could be resolved, and junior doctors would have a diminished right to leave. In fact, the pay of existing physicians are protected for a few years after the changes are implemented to ease the changes, although it can be argued that the proposed changes could be phased in over a longer period of time instead of being implemented over a 1-year period, as was the case. [50, 51] With regard to the lack of notice of possible change, the notice given to current physicians can be given to prospective medical students, thus averting a future crisis. In other words, prospective junior doctors would have a choice from the beginning to choose a different career path if they do not want to stay on to serve the public or if they want to leave the country after graduation. In countries such as Singapore and Israel, people are given the choice of giving up citizenship or leaving the country before compulsory military service requirements kick in.

However, I argue that, based on grounds of coercion, even with measures such as phasing in and giving advance notice of changing work conditions, based on grounds of coercion, it is still insufficient justification to deny junior doctors the right to leave the country in search of better working conditions.

Alan Wertheimer provides a two-pronged test to determine if a proposal is coercive. The first prong is the "choice prong," and it looks at whether "A's proposal creates a choice situation for B such that B has no reasonable alternative but to do X," whereas the second prong is the "proposal prong," which looks at whether the proposal is one that A has a right to make.[52]

In this case, the proposal in question is the proposal to change the contracts of junior doctors. Given that the government is the sole employer of junior doctors and that junior doctors have to accept the contract if they wish to continue their medical training (even if notice is given and the changes are to be phased in), it is safe to say that junior doctors do not have a "reasonable alternative" other than to accept the contract changes. The second prong poses a trickier question: whether the proposal is one that the government has the right to make. Mitchell Berman suggested that the existing law could help determine whether one has a right to make such a proposal, whereas Wertheimer himself suggested a "moral" test to help in the determination.[53]

In a lawsuit brought forth by Justice for Health (a company set up by a group of physicians) against the Health Secretary Jeremy Hunt, the High Court decided that the latter had acted within the scope of his statutory powers. In other words, the government is deemed to have a *legal* right to approve the new contract.[54] However, it does not necessarily follow that it is *morally* right for the government to impose the contracts in a unilateral fashion with little regard to the views of the lives of those whom the contract will come to affect. This is especially pertinent for female physicians for whom, as mentioned earlier, the fundamental basic right to a family life is being outrightly and irrefutably threatened in the name of an alleged "legitimate aim." Under the threat of a coercive proposal imposed on them, junior doctors should have the right to leave the country in pursuit of better working conditions.

Perspective of Source Countries

Developing Countries

From the perspectives of developing countries, should they be allowed to restrict the emigration of physicians? We need to first examine the negative impact that

emigration would have on a country. As Gillian Brock pointed out, the emigration of physicians can have a detrimental impact on a country in three main ways: pure financial loss, loss of skills and services, and loss of institution-building assets.[55]

It is inevitable that the source country will incur a financial loss, in part because of the vast amounts of money and resources invested in a physician's medical training, and in part because of the loss of a future source of tax revenue for the country. It follows that countries are entitled to expect a return on their investments by placing restrictions on the emigration of physicians, and that taxpayers are also entitled to make the same claim. There is an obvious outflow of vital skills and services that accompany the emigration of physicians, which is nearly impossible to replace. Last but not least, the country also suffers a loss of institution-building assets, as talented citizens provide an impetus for and often contribute to a country's institutional reform. In view of these detrimental impacts, it is not surprising that source countries would want to put up barriers that restrict the emigration of physicians.

There are, however, two ways in which the emigration of physicians can benefit the source country: remittances and transfer of knowledge and skills. However, these two benefits are likely to be inadequate and disproportionate with losses sustained by source countries resulting from the loss of physicians. [56]

Nonetheless, there are reasons why a source country should not be allowed to put a blanket ban on the emigration of physicians. Developing countries invest heavily in the education of not just physicians, but of all its citizens. If a duty to repay the state exists for physicians, then surely all other citizens should be obliged to remain to provide services for the state and fellow citizens, such as lawyers who are educated using state funds. Asking physicians to stay may be justifiable in limited situations; for example, asking them to provide public service in an epidemic. But if we impose a heavier duty on physicians only, such as requiring them to stay in the country of origin to serve the citizens, we run the risk of coercion and restricting the right to freedom of movement and opportunity, especially if it is an obligation that not all citizens share.[57]

The varying lengths and absolute costs of investment in education do not constitute a valid objection. The period of time that a citizen has to remain in the state can be pegged to the cost of the state's investment in his or her education, reflecting a proportional obligation to remain.[58] If restricting all forms of emigration for all graduates until they repay their debt to the state were a preposterous idea, then an alternative would be to consider allowing physicians to fulfil their obligation in other ways. Perhaps physicians can pay back and buy themselves out of what they borrowed from the country for medical school, in excess of the debt incurred by an average student. Or physicians can have a proportional obligation to stay based on the extra debt incurred as compared with that of an average student.

Moreover, it is unfair for the burden of the right of health to rest on a few individuals rather than the state. The state, in this case in developing countries, is obliged to train sufficient numbers of health workers to meet the needs of the community (and to take into account the numbers of health workers who might migrate).[59] Individual health workers may be partly responsible for meeting their obligations to respect the right to health, but they bear no personal responsibility to fulfill human rights such as rights to health.[60]

Looking at the issue from another angle, physicians learn skills from medical training from the state, but the skills ultimately belong to the physicians themselves.

It is one thing to say that physicians have a moral duty to repay the debt incurred from their training and that developing countries may harbor legitimate moral expectations for them to stay; but it is another thing to pressurize people via political means, as physicians are under no contractual or legal obligation to fulfill their expectations. Such compulsion, however subtle, runs the risk of treating human lives like property.[61] This concern is even more pronounced the lengthier the compulsory service contracts are after graduation, especially if it comes to a point where these inevitably undermine an individual's capacity to alter his or her life plans at the end of the service contract.[62]

Restricting emigration only for physicians would also violate the freedom of occupation in developing countries.[63] Additionally, imposing arduous working restrictions on physicians may dissuade the brightest students from pursuing medicine as a career in developing countries.[64] Given that medicine is a field that places the utmost emphasis on intelligence and diligence, having a significantly narrower field of applicants can indirectly result in "brain waste."

Developed Countries (in Particular the UK)

All the arguments for restricting emigration from developing countries apply in the context of developed countries too. Developed countries suffer from pure financial loss, and loss of skills and services, as well as loss of institutional-building assets when physicians emigrate. In the context of the UK as source country, that country is already facing a shortage of physicians, and the proposed plans by the government to extend services to a 7 day NHS requires at least 4,000 more physicians.[65] The potential exodus of home-trained physicians out of the UK in response to the contract imposition is expected to aggravate the situation. The current shortage, the proposed expansion of services, and potential emigration of UK-trained physicians will likely exacerbate the emigration of physicians from developing countries as a result of the increase in recruitment by the UK to make up for shortfall.[66]

On the other hand, the aforementioned arguments for supporting emigration in relation to developing countries fully apply to the UK too. In particular, the concept of tying graduate doctors to working in NHS for a minimum number of years or asking them to repay the cost of their training has recently been discussed in public, and has been greeted with much outrage from junior doctors, with aforementioned reasons including lowering morale and encouraging "brain waste" being similarly cited in this discussion.[67] In addition, there are three arguments of note that are applicable from the perspective of developed countries.

First, the burden of fulfilling the right to health should not lie solely on the junior doctors' shoulders. The state also has a role to play. Unlike the governments in developing countries, the UK government has been introducing budget cuts for healthcare despite escalating costs, causing a financial crisis among hospitals.[68]

Second and more problematically, in addition to issues with coercion, there are antitrust concerns. To better elucidate the complication pertaining to a possible antitrust issue, a brief explanation of the term "monopsony" is needed. A monopsony exists when there is a single buyer in a market with many sellers and in the case of a labor market, it refers to the case of a single employer dominating the labor market for employees with a certain skill set. The single employer has the market power in setting wages and choosing how many employees to employ.

By adopting a policy of limiting the number of workers hired, it can depress employees' wages. The term "rate of exploitation" refers to the gap between the value of the workers' contribution to the employer's output and the workers' wages, and the existence of competition among employers drives the rate of exploitation down. Monopsony can lead to two main problems: lower wages and less incentive to improve the working conditions of workers in the absence of competition.

In this case, the government is the sole employer for all junior doctors who wish to continue their medical training, and it in effect exerts monopsony power in the market. Is it ethical for a single employer to impose harsh working conditions and reduced wages on junior doctors who have no other viable alternative for employment? Not only does this potentially lead to antitrust infringement, it also brings us back to the possibility of coercion. As mentioned in the previous section, the lack of a reasonable alternative for employment means the first prong of Wertheimer's two-pronged test is easily satisfied. In light of the possible antitrust infringement, it makes for a more persuasive argument that the second prong is also satisfied: that the proposal to impose new contract changes is one that the government has no right to make.

Even if one argues that the terms in the old contract and the new proposal are not coercive when examined in isolation, Glenn Cohen rightly argues that such terms "could become coercive if the offeror insisted on changing them mid-way through the exchange." [69] Using an example of a ship captain who initially offers to take a passenger home for free, but decides midway to leave her stranded on an iceberg in the Arctic Ocean if she does not agree to pay him $4,000 for the voyage, Cohen illustrates that changing terms can be perceived as being coercive. Under the threat of a coercive proposal imposed on them in the midst of their careers, junior doctors should have the right to leave the country in pursuit of better working conditions.

If prospective students are given notice (prior to choosing medicine) of their postgraduate obligation to accept terms set by the government and of their duty to stay, it is still debatable that the obligations later imposed by the government would be entirely free from coercion. Having advance notice may preempt and ameliorate to a small degree the dissatisfaction medical graduates feel about their obligation; but it does not change the fact that the government is still the sole employer postgraduation, and that incoming medical students have little or no choice but to accept the obligation being imposed on them if they want to pursue medicine as a career in the UK. When faced with coercive proposals from a single employer, I argue that it is wholly understandable and forgivable that prospective medical students and junior doctors would choose to avoid working under duress, and would prefer to leave the country to seek more reasonable working conditions.

Third, I argue that junior doctors should have a right to leave based on a contractual analysis of the situation. Given that the government is the sole employer for junior doctors who wish to continue their medical training, there is an obvious imbalance of bargaining power between both parties. Unless junior doctors opt to take time off from their medical training and do locum work, they are left with no viable option but to accept the contract offered by the government. The same applies for prospective students interested in pursuing medicine as a career in the UK. The clear discrepancy in bargaining power is reflected in the fact that the government has decided to proceed with imposing the contract unilaterally despite

failed negotiations with the British Medical Association (a union that represents junior doctors).[70] The junior doctors' lack of bargaining power and the "take it or leave it" stance of the government brings to mind the possibility of the contract being a contract of adhesion. It remains to be seen whether the imposition of contract will be illegal; but even if it is not, one cannot discount the likelihood that the contract is unconscionable, particularly because the contract terms are one sided and are being imposed on junior doctors unilaterally by the government despite obvious resistance. Based on a contractual analysis of the situation, I propose that junior doctors should have a right to "walk away" and leave the country.

Conclusion

The potential exodus of junior doctors from the UK in an act of resisting impending contract changes brings to the forefront the controversial issue of emigration of physicians. However, the issue of emigration of physicians between developed countries is one that is relatively unexplored and has not garnered much academic attention. Looking from the perspectives of physicians and source countries, I find the arguments for and against emigration of physicians from developing countries to developed countries to be applicable and as compelling in the context of emigration of physicians between developed countries. Additionally, new arguments relating to antitrust law, coercion philosophy, and contractual analysis are also relevant in the latter situation. In exploring these arguments, I reach the conclusion that it is morally justifiable for junior doctors to resist the unilateral imposition of contract changes and choose to leave the country.

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