Jason O'Neale Roach examines the ethics of international recruitment

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Stealing Doctors

Countries benefiting most from globalisation of the medical workforce have an ethical responsibility to frame their workforce policy in a manner that reflects global, not merely domestic, need

Staff recruitment and retention in the National Health Service (NHS) has dominated the media health agenda in the past few months. The latest NHS saga reveals a morally questionable twist in the story. Overseas recruitment of health care workers has emerged as a key strategy in the government's attempts to fulfil its promises in the NHS Plan. However, while active recruitment overseas may benefit developed nations, it may be detrimental to global health.

Examining the workforce

The medical profession is experiencing severe workforce shortages as part of a wider recruitment and retention problem that also affects NHS services as diverse as dentistry and physiotherapy. In 2000 there were 1,214 general practice vacancies in England and Wales; deprived urban areas were experiencing the most difficulty attracting applicants. As the number of qualifying GPs drops, the amount of doctors leaving rises. In 1998, the number of newly qualified GPs reached an all-time low of 1,636.[1]

Drop out rates are high among junior staff as well. Cohort studies reveal that in 1993, only 75.7 percent (1969 out of 2600) of newly qualified doctors definitely or probably intended to practise in the United Kingdom, compared with 89.2 percent (2812 out of 3154) of those qualifying in 1983.[2] Similarly, a postal questionnaire survey of doctors 18 years after their 1977 graduation revealed that only 80 percent were working in the NHS and nearly half of the female doctors were working part time.[3]

Almost a quarter of those persevering in the NHS plan to retire early.[4] For example, the NHS will also lose thousands of Asian GPs who will reach retirement age en masse during the next decade.[5] One in six GPs (4,192 out of 25,333) currently practising in the NHS qualified in a South Asian medical school and two-thirds of these doctors are likely to have retired by 2007.

There is controversy over whether so many doctors actually leave or in fact just take time out. The lack of accurate NHS workforce statistics is striking.[6] However, the fact that there is a shortage is beyond doubt. In July 2000 the government's promises to deal with this problem were laid out in the NHS Plan. It promised to recruit 2,000 more GPs and 7,500 more consultants by 2004.[7] Some of these additional staff are already in training, but others are being recruited from abroad as a stop-gap.

At present, about 76 percent of doctors in the NHS are from the UK. This proportion has decreased in recent years and the government's own analysis suggests that this trend is set to continue[8] (see also Table 1).[9] Two main factors are responsible for this trend, the first one being huge financial incentives for many overseas doctors, particularly those from developing nations, to work in the UK.

TABLE 1: 1995 NHS statistics on the origins of the surgical workforce in England and Wales

1995	Total number	European Economic Area (%)	Overseas (%)
Consultant	18400	310 (1.7)	2700 (14.7)
Staff Grade	1760	50 (2.8)	1130 (64.2)
Senior Registrar	4240	180 (4.2)	610 (14.4)
Registrar	6580	290 (4.4)	2430 (36.9)
Senior House Officer	12930	1120 (8.7)	3430 (26.5)

Analysing international recruitment

The second factor influencing the rise in numbers of overseas doctors is active international recruitment. This approach has recently become more aggressive in view of NHS Plan promises. The International Fellowship Scheme, a campaign spearheaded by heart surgeon Professor Sir Magdi Yacoub, allows overseas consultants to work in the NHS for up to two years, initially in four key specialities that have significant staff shortages: cardiothoracic surgery, histopathology, radiology and psychiatry. Alan Milburn, the health secretary, announced in July that about 500 doctors had been shortlisted to work in Britain.[10]

In January another scheme became available to overseas doctors - the Highly Skilled Migrant Programme (HSMP).[11] Applications from various professions are assessed on a points-based system of qualifications and experience. Under the HSMP applicants will initially be given twelve months' stay in the UK. Towards the end of that period, applicants can apply to remain in the same capacity for a further period of up to three years. After four years as a highly skilled migrant, applicants can apply for settlement.

The governments of developing countries simply cannot compete. The Zambian public health service has only managed to retain about 50 of more than 600 doctors that have been trained in the country since independence. The doctor:population ratio in Uganda is 1:24,700.[12] Employment conditions and general living conditions may not be conducive to retaining professionals but Zambian and Ugandan doctors have still been actively recruited to work in a number of richer countries including South Africa.

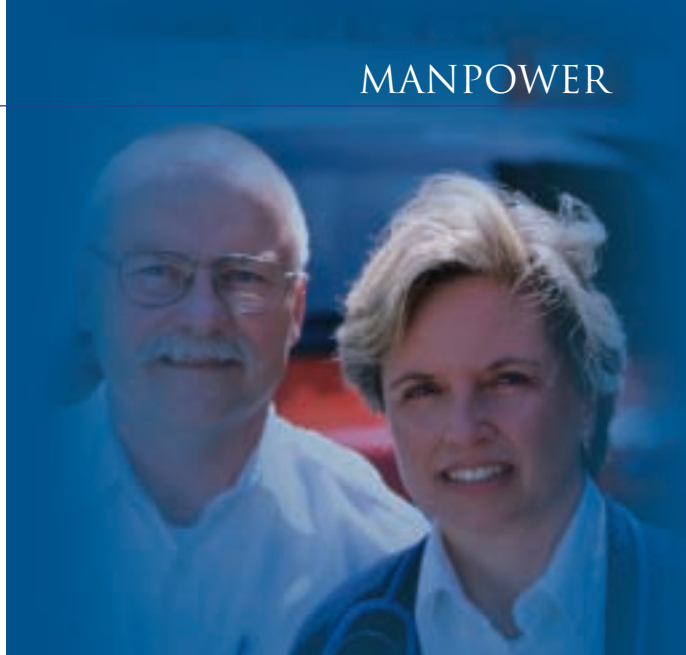
Alternative solutions

The government is already pursuing other ways of tackling the recruitment problem. The European Union produces surplus doctors and could replace those retiring. For example, Spain has more doctors and nurses than it needs and the UK has an official agreement that allows it to recruit Spanish staff.[13] Mr Milburn has also confirmed that he is in active discussions with private healthcare providers from France, Germany and Sweden to encourage them to carry out routine operations for the NHS, to reduce demand.[14]

It is estimated that some 2,000 refugee doctors live in the UK but are denied the opportunity to practise medicine here.[15] Allowing these doctors to work in the system would not only help avert disaster but allow us to learn from their valuable skills while allowing them to begin to rebuild their lives and support their families.

In 1997 the government proposed a substantial increase of about 1,000 in annual medical school intake, to be fully implemented by 2005.[16,17] However, it is unlikely that the new intake of medical students would be ready to enter general practice in large enough numbers within the next ten years to deal with the shortage completely.[18] In addition those health authorities with the greatest shortage of doctors are in some of the most deprived areas in the United Kingdom and have experienced the most difficulty in filling vacancies.[19]

In February 1999, the government published *Agenda for Change*, outlining new proposals for a radical overhaul of NHS pay, career



A Christian Doctor's Covenant

With gratitude to God, faith in Jesus Christ, and dependence on the Holy Spirit, I publicly profess my intent to practise medicine for the glory of God.

- With humility, I will seek to increase my skills, I will respect those that teach me and will broaden my knowledge. In turn, I will freely impart my knowledge and wisdom to others.
- With God's help, I will love those who come to me for healing and comfort. I will honour and care for each patient as a person made in the image of God, putting aside selfish interests.
- With God's guidance, I will endeavour to be a good steward of my skills and society's resources. I will convey God's love in my relationships with family, friends and community. I will aspire to reflect God's mercy in caring for the lonely, the poor, the suffering and the dying.
- With God's blessing, I will respect the sanctity of human life. I will care for all my patients, rejecting those interventions that either intentionally destroy or actively end the lives of the unborn, the infirm and the terminally ill.

Stevens D. In The Doctor's Life Support 2, ICMDA, 2002.

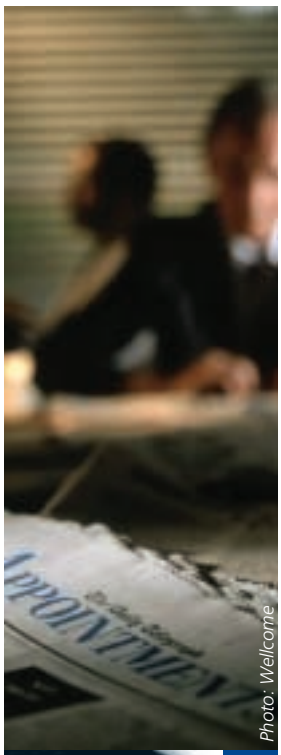


Photo: Wellcome

KEY POINTS

The government is actively recruiting doctors from developing countries in an attempt to make up for inadequate training numbers, part-time working and early retirement. While it is natural for skilled doctors in developing countries to be attracted by the better lifestyle and security offered in the UK, the needs in their own countries are far greater, and their loss is seriously compromising global health. Alternative solutions include recruiting European surplus doctors, training refugee doctors already resident here, improving links with developing world medical schools and increasing UK medical school intakes further. This may be more challenging and costly, but it is ethically essential.

structures and employment conditions; negotiations with staff organisations are proceeding slowly. However, as attempts at increasing numbers begin to offset required reductions in working hours, staff retention will become increasingly important in the short term.[20]

Conclusions

Struggling economies that cannot afford to offer better deals for their doctors lose out to richer nations. It is much cheaper to take a doctor from another country than it is to train one yourself, so the rich save money at the expense of the poor.[21] Developing countries need their doctors the most. Kenya pays its doctors less than US$256 per month and simply cannot compete with the salaries on offer in more affluent nations. Currently, the South African government will not issue work visas to doctors from developing countries. This change in policy may have been influenced by the fact that South Africa now loses more of its own doctors to other continents than it recruits from its northern neighbours.

One cannot blame doctors for seeking a better lifestyle with better remuneration and better working conditions. Concern for personal safety rather than monetary issues now underpins many doctors' wishes to emigrate. The question is whether it is ethical for developed countries to recruit actively in developing countries, deliberately enticing doctors and other health professionals.

IT IS MUCH CHEAPER TO TAKE A DOCTOR FROM ANOTHER COUNTRY THAN IT IS TO TRAIN ONE YOURSELF, SO THE RICH SAVE MONEY AT THE EXPENSE OF THE POOR

Jesus emphasised to his disciples a duty of care for the poor.[22] He also insisted that we love our neighbours as ourselves; this implies generosity to those in need.[23,24] Active recruitment of overseas doctors from poorer countries goes against these gospel principles.

There are potential solutions to this problem other than those currently being tried by the UK government. Active linkages between medical schools across the economic divide could be encouraged, allowing exchange without financial penalty.[25] Developed countries that recruit doctors from developing nations could pay compensation for each doctor lost. The government could simply try harder to learn from other countries about making the NHS more efficient.[26]

Countries benefiting most from globalisation of the medical workforce have an ethical responsibility to frame their own workforce policy in a manner that reflects global, not merely domestic, need. Implementation might be technically challenging but is ethically essential.

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