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FORUM

Medical Migration

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The issue of professional migration, however emotional it may have become, ought not to be regarded in moralizing terms. The history of western medicine is the history of migrating physicians. A doctor who moves from a locality to another to take up a new assignment there cannot be said to have "abandoned his patients". This emotional bond has become the victim of specialization and of depersonalization of medical services and not of medical migration, brain drain or otherwise. The primary reason for medical migration is not financial; the desire to migrate usually begins with the desire to learn. Professionals crave in the first line for professional satisfaction. The migration of medical manpower cannot be stopped with administrative measures and will not be stopped by exhortations and appeals, moralization and condemnations. Brain drain is a global phenomenon and has always been so. A country which loses its professionals, its doctors, should examine the social relationships within the profession and should investigate whether the opportunities for deriving professional satisfaction from everyday work exist – or whether these have been thwarted by the hierarchy, conservatism, cronyism and the general lack of comprehension of what good medical care is about.

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There are three reasons for doctors to migrate: one is to learn, the other to seek professional satisfaction combined with the opportunity to make a decent living, and the third one is to escape political oppression and professional stagnation.

The motivation of a given migrant may be difficult to determine and on occasions may not be clear even to the individual concerned, since the motivation is often a combination of two or all three factors. The distinction between refugee status and search for greener pastures is particularly delicate, for it is frequently altogether in the realm of individual perception. The expression "economic refugee" has a patronizing, if not derogatory, connotation, implying that the reason for "escaping" was solely a matter of living standards. A suggestion of moral failing is attached to the individual as well as to the host country. Indeed, the term "brain drain" has implications of poaching, of improperness, if not illegality. In the language of the third world ideologist and politician as well as in the imagery of the political correctness movement, rich societies exploit the poor by attracting and capturing talent that has been born to the poor and belongs to the poor. Consequently, for this school of thinking, the poached professional is regarded as a traitor, someone who has cheated his countrymen, and has not returned the investment that his brothers and sisters could hardly spare in the first place.

From time to time attempts are made to curb the brain drain, to declare it illegal, even to penalize it. Sometimes it is suggested that the rich countries benefiting from the phenomenon ought to reimburse the poor countries.

The issue of professional migration, however emotional it may have become, ought not to be regarded in moralizing terms. A doctor who moves from one locality to another to take up a new assignment cannot be accused of having "abandoned his patients". The ethical responsibility of physician is not toward a village, a tribe, a nation, or a political unit of one kind or another, but toward humanity, patients, whoever they are, wherever they live, and however poor or well off they are. In any case, doctors who actually have strong emotional bonds to their patients, say general practitioners, particularly village doctors, rarely migrate. This emotional bond has become the victim of specialization and depersonalization of medical services and not of medical migration, brain drain or something else. It is simply not true that a citizen of a country is bound by any moral obligation or international law to serve his countrymen, unless, of course, the individual is bonded by certain bursary schemes or educational training contracts.

Neither is it true that the primary reason for medical migration is financial. In the first line professionals crave for professional satisfaction. For professional satisfaction sake they put up with considerable hardships, whether economic or political. This is true even today, when professions, especially medical, are so highly commercialized. (It should be said that

this commercialization is driven by consumerism, a rightly questionable and certainly rather gullible behavior which doctors may duly exploit, even promote, yet dislike and certainly not regard as a long term solution for society's medical needs).

The fact is that in many countries, and not necessarily the poorest ones, doctors find it difficult to partake of professional satisfaction. There are many reasons for this, not only the unavailability of drugs and the quality of equipment, or, for that mater, uncongenial professional environment and the like.

A peculiar but nevertheless ambiguous reason for the dearth of professional satisfaction in many countries arises from the circumstance that medical care is mistaken for technology and that technological advancement is the most urgent priority in upgrading medical care. The desire to achieve "Golden Standard" in technological preparedness is shared by both societies and governments. These "Golden Standard" and "State of the Art" practices are mistaken for techniques that could be purchased and at the same time are thought to be the very essence of good medical practice.

The history of western medicine is the history of migrating physicians. Only artists move about more than doctors. The desire to migrate usually begins with the desire to learn. Learning in the realm of medicine has always been associated with "Centers", the island of Kos, Rome, Alexandria, The Islamic Universities of Southern Spain, Salerno, Montpellier, the numerous centers of medical excellence in 19th century Europe and latter-day centers in America, following each other in the great tradition of Western medicine.

The desire to learn is very often the first motive of the medical traveler. This has always been so and will remain so.

Most traveling apprentices return home upon completion of the desired training and try to find a niche in the medical care system in their home country. Many become frustrated at that time. The reasons for frustrations vary, some are objective, some are subjective. The former usually arises from the conditions at home, material as well as social, whereby the stale, traditional system of decision making and doing things is often the chief source of annoyance. Perceived rather than real reasons are often associated with the misconceptions acquired in the prosperous and advanced host country where the impressionable trainee could not see the wood because of his fascination with the trees.

The departure of the returnee is the critical phenomenon. This is the time when the "brain push" operates and when the most regrettable losses occur. These young, mostly well trained professionals are frustrated because they would be the natural agents of change, and change is resisted and subverted by the establishment. For every lure pulling towards the West there is a chief at home pushing...

The migration of medical manpower cannot be stopped with administrative measures and will not be stopped by exhortations and appeals, moralization and condemnations. Brain drain is a global phenomenon and has been so in the antique times, the middle ages and the renaissance. Only the national state was hostile to migration of professionals and hampered the free movement of doctors by bureaucratic means: papers of one kind or other.

A country which loses its professionals, its doctors, should examine the social relationships within the profession and should investigate whether the opportunities for deriving professional satisfaction from everyday work exist – or whether these have been thwarted by the hierarchy, conservatism, cronyism, and the general lack of comprehension of what good medical care is about.

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