Viewpoint

Do physicians and other health care personnel have ethical obligations towards mirgrants?

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Abstract

Given the present migration crisis, health care personnel working in developed countries encounter patients with a history of migration even more frequently than in the past. From the 8.4 million persons living in Switzerland, 2.1 million persons (25%) are of foreign origin, and thus are deemed to be immigrants (includes both economic migrants and refugees). Differences exist concerning legal protections and degrees of vulnerability among different subgroups of migrants. A number of ethical issues arise including access to health care. This article explores necessary definitions, in particular the difference between migrants and refugees, and illustrates facts health care personnel should know when facing migrant patients. After a brief summary of the international legal framework, an analysis and recommendations are presented as regards ethical obligations of health care personnel towards migrant populations in hospitals and outpatient care.

Introduction

Given the present migration crisis, health care personnel working in developed countries encounter patients with a history of migration even more frequently than in the past. A number of ethical issues arise including access to health care. Such concerns have been pointed out by physicians in the past. For example, in Switzerland H. Stalder, former head of Policlinic in Geneva [1], clearly stated that physicians have the obligation to care for illegal immigrants ("[l]es médecins ont le devoir de soigner les illégaux"). Similar statements have been made by Canadian physicians: "Physicians have professional responsibilities to provide medically necessary care to uninsured residents regardless of the residents' ability to pay or their politically determined insured status. Policy makers have an equal responsibility to ensure providers are afforded the means and compensation to provide this care to expected standards. Otherwise, Canada risks an apartheid health care system" [2]. In the following article, we will first explain necessary definitions, in particular the difference between migrants and refugees; second, illustrate facts health care personnel should know when facing migrant patients; and third, after a brief summary of the international legal framework, analyze ethical obligations of health care personnel towards these populations in hospitals and outpatient care.

Migrants versus refugees: definitions, numbers and health care needs

The terms *migrants* and *refugees* are sometimes used in a similar manner although their legal definition is distinct. A refugee is defined by Article 1 of the UN Convention Related to the Status of Refugees [3] as any person who "owing to well-founded fear of being persecuted for reasons of race, religion, nationality, membership of a particular social group or political opinion, is outside the country of his nationality and is unable or, owing to such fear, is unwilling to avail himself of the protection of that country; or who, not having a nationality and being outside the country of his former habitual residence as a result of such events, is unable or, owing to such fear, is unwilling to return to it."

Unlike refugees who are forced to leave their country of origin in fear of persecution, a migrant is a person who chooses to leave his country of origin in search of (mostly) better economic opportunities. The International Convention on the Protection of the Rights of All Migrant Workers and Members of their Families [4] (hereafter "UN Convention on Migrant Workers") defines a migrant worker as "a person who is to be engaged, is engaged or has been engaged in a remunerated activity in a State of which he or she is not a national" (Art. 2; definitions are also provided for migrants workers who are seasonal workers, frontier workers, etc.). Among migrants, one can distinguish immigrants and emigrants, according to whether a person leaves or enters a country. In the following, we will use the terms *migrant* and *immigrant* synonymously.

The UNHCR [5] estimates that there are currently 22.5 million refugees worldwide. In 2015, more than 1 million refugees sought asylum in Europe, with Germany being the country to receive the most of them. Concerning international migrants, the International Organization of Migration [6] estimates that in 2015 there were 244 million persons living in another country than the country they were born in. The proportion of migrant population in developed countries varies considerably. For instance, 14.5% of the US population consists of immigrants, 22% in Canada, 15% in Germany, 12% in France, and 10% in Italy.

From the 8.4 million persons living in Switzerland, 2.1 million persons (25%) are of foreign origin, and thus are deemed to be immigrants (includes both eco-

nomic migrants and refugees) [7]. Italians, Germans, and Portuguese constitute little less than half of the total immigrant population. A quarter of the immigrant population stems from Kosovo, Serbia, Turkey, Asia, Oceania, and Africa. Of the non-Western European immigrants in Switzerland, one in ten have entered the country as a refugee [8]. The number of individuals in asylum process amounted to 39 388 persons at the end of 2015 (defined as persons with identity cards F and N).[1]

Studies on *immigrant health* underline the poorer health of the migrant when compared to the nationals. In the case of refugees, studies highlight the prevalence of mental health conditions due not only to the trauma associated with the flight from the home nation but also challenges faced in the host nation [9, 10]. Irrespective of the reason for migration, these immigrants face several challenges when accessing health care in their host nation. Empirical evidence is available from many countries and regions, including among others Australia, Canada, the United States, and Europe [2, 11–15]. Access to health care depends on legal situation of the migrant. However, common barriers evident from the studies can be categorized into two main issues: (a) structural barriers that include lack of health insurance and thereby insufficient access, the complex health care system, and lack of interpreters. (b) Individual level barriers of the patient comprise inability to speak the native language, lacking knowledge of how to access health care, logistic concerns such as finances and transportation, mistrust of the system, and perceived discrimination. Related to the individual barriers, a Swiss study concluded that general practitioners ration health care based on the legal status, nationality, and economic status of their patients [16]. Other studies from Switzerland also illustrate language as a major barrier to provision of health care to immigrants [17–19], lack of knowledge about health care support available [20, 21] (as well as how to access the health care system [21]). Migrants and refugees seeking asylum in Switzerland are likely to have basic health insurance coverage. But the situations of those who are undocumented (these so-called "Sans-papiers" are estimated to amount to more than 70 000 persons) are different. They not only face the above-mentioned challenges but may also fear accessing health care for fears related to being reported to migration authorities [22]. A study from Lausanne on children has captured their precarious health care situation [23].

1 In 2015, a total of 39 523 applications for asylum were registered with the Office of Migration. This number was 27 207 in 2016. www.sem.admin.ch/dam/data/sem/publiservice/statistik/asyl-statistik/2016/faktenblatt-asylstatistik-2016-d.pdf (accessed 21/11/2017).

International legal provisions regarding access to health care

Refugees and non-refugee migrants are not protected equally by legal provisions. The UNHCR convention of 1951 [3] stipulates that refugees' human rights should be fully respected. "Economic and social rights are equally applicable. Refugees should have access to medical care, schooling and the right to work" [24]. Art. 24b of the UNHCR convention [3] notes legal rights in accordance with social security laws to "occupational diseases, maternity, sickness, disability, old age, and death" (among others). The UN Convention on Migrant Workers (1990) Art. 28 underlines that migrant workers and their families "shall have the right to receive any medical care that is urgently required for the preservation of their life or the avoidance of irreparable harm to their health". In addition, Art. 43e of the same Convention stipulates that migrant workers have right to the same treatment as nationals with respect to "access to social and health services, provided that the requirements for participation in the respective schemes are met". What remains unclear is the rights of those migrants who are undocumented.

Ethical obligations for health care personnel treating immigrants in Switzerland

It is important for health care personnel to be aware of the concerns that act as barriers for immigrants to seek health care and know about existing general recommendations developed based on international expert opinions and, among others, as part of the Swiss project on migrant-friendly hospitals [18, 19, 25]. From these recommendations follow a number of agreed-on good practice obligations.

First of all, health care personnel should invest time to develop a trusting relationship with their immigrant patients. During the first visitation, they need to take time to provide basic education on the organization of the health care system, how to access health care, and what resources are available so that they can avail to lighten their concerns related to linguistic and knowledge barriers. Such general education will be particularly important for migrants with lower socio-economic levels, refugees, and those who are undocumented. They should also clearly assure the immigrant patient that the role of the health care professional is to provide medical care and that medical confidentiality will be ensured. Although doing so may seem a huge time burden on already stressed health care personnel, this will be a critical step for all medical interventions in the future.

Second, in order to ensure that the immigrant patient does not feel discriminated or neglected, it is critical that information about their health, medical procedures, and when to further seek health care be pro-

vided in clear and understandable fashion. This would mean some planning and management from the part of health care personnel (or institution) in organizing interpreters when needed.

Third, migrant's gender and cultural origin should not be used to either discriminate or conclude "expected" results. Such actions further raise doubts and distrust in the health care system. Hence, the quality of care provided to a migrant should be similar to what would be provided to someone else who comes with similar complains.

Fourth, when referring the patient for further specialized care, it is the responsibility of the primary care provider to identify care providers and hospitals that are best suited to provide this patient with the best care based on linguistic, cultural, or other specific competences.

Finally, in the hospital setting, the primary physician should ensure that his patients receive continuity of care securing designated nurses who are the constant persons that remain in contact with the patient. These health care providers should be "immigrant"-friendly and competent to communicate with the patient.

Respecting these general obligations should not be controversial and should always be put in practice for immigrant patients since most of them are likely to have the mandatory health insurance in Switzerland, allowing them access to equal care (at least at the financial level). However, how should health care personnel react to more than 70 000 undocumented migrants in Switzerland who lack health insurance? This group is clearly the most vulnerable among all migrants in terms of legal protections and access to health care resources (unless, ironically, they are imprisoned where the principle of equivalence of health care applies to inmates).

Indeed, while Switzerland finances regular health insurance policies for recognized asylum seekers as well as those in the asylum procedure, this does not apply to asylum applicants whose request have been denied, those for whom the authorities refuse to open an asylum procedure, the so-called NEM (non-entrée en matière), as well as persons who live in Switzerland without legal permission. Cantonal resources to finance health care for this latter vulnerable group are limited and this has fueled ethical debate in Switzerland and other countries [1, 2, 26]. The right to health care in Switzerland is overall programmatic. Based on Art. 12 of the Swiss Constitution, only a very limited right to health care has been enforceable [27]. Art. 12 stipulates the obligation to obtain help in situations of distress [or need]. Persons in a situation of distress and unable to provide for themselves have the right to assistance and care, and to the financial means required for a decent standard of living[2] (le "[d]roit d'obtenir de l'aide dans des situations de détresse. Quiconque est dans une situation de détresse et n'est pas en mesure de subvenir à son entretien a le droit d'être aidé et assisté et de recevoir les moyens indispensables pour mener une existence conforme à la dignité humaine", see www.admin.ch/opc/fr/classified-compilation/19995395/index.html). This has been interpreted as a limited right, e.g. mostly access to basic health care to avoid death in emergency situations [27].

Such limitations are in conflict with medical ethics. Health care personnel worldwide are expected to treat patients independently of legal status, ethnicity, religion, race, country of origin or the fact that they have a history of migration [1, 2, 11, 28]. In Switzerland, the National Ethics Commission stipulated this obligation [26]: "Health care personnel has the obligation to treat all patients independently of their legal status … It is unthinkable to deprive a person of medical care based on the argument that he or she is living illegally in Switzerland. More generally, the moral obligation to provide care which is incumbent upon all physicians and other health personnel will not be repealed by the fact that the patient does not have valid legal papers to stay in a country. Health care personnel should not be instrumentalized by public authorities on the basis of asylum legislation. The obligation to provide care, the fundament of medical ethics, is also a right: the right of persons suffering from health problems to access health care. Moreover, ethical requirements demand that authorities mobilise the necessary resources to accomplish this mission[3]" [26].

In Germany, medical students and physicians have joined at the University of Erlangen to find a mechanism to provide free care as part of a solidary network. They have created the "AG Medizin und Menschenrechte" [29] where medical students offer consultations to migrants and refer them to a network of collaborating physicians who agree to provide council and treat a certain number of uninsured migrants per month as a token of solidarity.

It is the obligation of all health care personnel in Switzerland to continue similar to H. Stalder [1] and the *Plate-forme nationale pour les soins de santé aux sans-papiers* [30] to respect fully their medical obligations towards all migrants, to continually remind these

2 Translation of French original text by the authors. It is important to note that the language nuances in the German and French original text are already not exactly the same. The English translation on the Swiss federal website translates "détresse" with need (in the German version "Notlagen").

3 "Les professionnels de la santé ont l'obligation de traiter toutes les personnes indépendamment de leur statut légal. […] Il est impensable de priver une personne de soins médicaux de base au motif qu'elle séjourne illégalement en Suisse. Plus généralement, l'obligation morale de soigner qui incombe à tout médecin et tout soignant ne saurait être abrogée dès lors que la personne nécessitant des soins n'a pas de titre légal de séjour. Les professions soignantes n'ont pas à être instrumentalisées par la puissance publique sur la base de la législation sur l'asile. L'obligation de prodiguer des soins, fondement de l'éthique médicale, est aussi un droit: le droit d'accès aux personnes atteintes dans leur santé. De plus, ces exigences éthiques requièrent que les autorités mobilisent les ressources nécessaires à l'accomplissement de ces missions" [26].

obligations to authorities and the public, and to search for sustainable ethical and legal solutions in Switzerland.

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