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Medical Cosmopolitanism: The global extension of justice in healthcare practice

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Abstract

While there is a shortage of healthcare workers in virtually all countries, there currently exists a pronounced inequality in the distribution of healthcare workers, with a high concentration of healthcare workers in high income countries (HIC) and low concentrations in low- and middle- income countries (LMIC). This inequality in the distribution of healthcare workers persists, in spite of the fact that HICs enjoy a much lower disease burden than LMICs This inequality raises medical ethical issues related to what obligations health workers from HICs have to correct these imbalances by working in LMICs. While the biomedical principle of Justice, first formulated by Beauchamp and Childress, advocates for healthcare workers to conduct themselves in a manner that is fair and equitable in light of what is due or owed, it does not elaborate on what sort of obligation this places on healthcare workers from HICs to work in LMICs in a bid fairly distribute the availability of healthcare workers. As such, this paper gives a normative argument for why healthcare workers from HICs have a moral obligation to work in LMICs, a concept we call Medical Cosmopolitanism. Following our positive argument, we debunk prominent objections to the concept of Medical Cosmopolitanism and consider ethical, educational and governmental implications of our findings.

KEYWORDS

Medical Cosmopolitanism, distributive justice, medical ethics, moral obligation, developing world

1 | INTRODUCTION

There is worldwide concern regarding the global shortage of healthcare workers in both high-income countries (HIC) and low- and middle-income countries (LMIC), which represents a real challenge in reducing the overall burden of disease.[1] Although the healthcare worker shortage is a problem for virtually all countries, it is a more severe problem in the poorer countries of the world. For example, Sub-Saharan Africa only has 4% of the world's healthcare workers but 25% of world's disease burden, while the Americas have 37% of the world's healthcare workers and only 10% of the world's disease burden.[2]

This extensive inequality raises a significant moral question regarding the obligations of people in richer countries towards those in LMICs. In this regard, cosmopolitans claim that moral obligations to relieve suffering and prevent injustice are not reduced by distance alone, entailing strong obligations to relieve the plight of people in LMICs.

[1]Castillo-Laborde, C. (2011). Human resources for health and burden of disease: An econometric approach. *Human Resources for Health*. 2–3. https://doi.org/10.1186/1478-4491-9-4.

[2]Ibid.

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While the claims and implications of cosmopolitan political philosophy have been extensively dissected,[3] the implications of cosmopolitanism regarding the unequal distribution of healthcare workers, and healthcare workers' resultant obligations, have received little attention. This paper engages the question of whether healthcare workers from HICs have an obligation to render care to people in LMICs. We argue that healthcare workers from HICs have such an obligation. We refer to this idea as 'Medical Cosmopolitanism'.[4] At the outset, it is important to be clear that we will not argue that HIC healthcare workers ought to be compelled to work in other nations. Instead, we claim that there is a moral duty to do so, which ought to be included alongside a healthcare worker's other obligations.

In section 1, we outline the positive case for Medical Cosmopolitanism, drawing on key cosmopolitan arguments and the bioethical principle of Justice. In subsequent sections we address objections to this claim. In section 2, we discuss the objection that healthcare workers ought to serve their nations out of reciprocity, and claim that because of HICs' exploitative relations with LMICs, healthcare workers also have reciprocal duties to LMICs. Thereafter, in section 3, we argue against the objection that rendering care in LMICs is too demanding an obligation, making the case that the demandingness of the obligation is easily overstated. In section 4, we address an objection based on deep-seated moral intuitions towards partiality (which stand in stark opposition to cosmopolitan impartiality). Following Singer, we claim that intuitions concerning partiality are rooted in amoral evolutionary processes and ought to be rejected in favour of non-evolutionary intuitions towards impartiality. In section 5, we address the objection that Medical Cosmopolitanism is inappropriate because cosmopolitan ends may be better achieved through donating part of a healthcare worker's HIC salary. While we concede that it is possible that the aims of Medical Cosmopolitanism may be achieved through donation, we argue that this is far from certain, and in any event would not undermine medical cosmopolitan duties altogether. Ultimately, we claim that healthcare workers have strong obligations to render care to people in LMICs.

2 | COSMOPOLITANISM AND MEDICAL COSMOPOLITANISM

Moral Cosmopolitanism – etymologically meaning citizenship of the cosmos or world – is the normative theory that asserts that all humans are a part of a singular community, irrespective of any other defining characteristic such as religion, race or nationality. Moral Cosmopolitans advocate for impartiality and equal moral concern for all on the basis of shared humanity and moral understanding.[5]

Cosmopolitan theorists argue from a variety of normative grounds including Utilitarian,[6] Kantian,[7] and Virtue Ethical.[8,9] A significant implication of impartial cosmopolitan ideas is that our duty to help others who may be geographically or temporally distant is not diluted by a countervailing duty to help locals. In particular, our duty to help others does not increase in strength when locals or compatriots are in question.[10]

In practical terms, Cosmopolitanism entails that our duties to those geographically near are equivalent to those that are distant. While we might accept that there are some efficiency factors that make it more difficult or costly to aid those who are distant, at base the obligation is the same. Cosmopolitan arguments have been extensively employed to argue for far stronger obligations toward poorer nations and their citizens.[11]

While Cosmopolitan claims are widely discussed, there has been little examination of their implications for workers in particular fields. In this section, we present an argument in favour of Medical Cosmopolitanism, the claim that healthcare workers ought to preferentially work in low- and middle-income countries with insufficient numbers of healthcare workers, wherein the length of time that a health worker commits to working in a LMIC should be determined within the context of other morally relevant considerations, such as income or the lack thereof.

While there are many possible routes to presenting this positive case, given that Beauchamp's and Childress's Principlism is an influential basis for decision-making in medical ethics, it makes sense to hinge our case on this framework, and more specifically on the principle of Justice. Below, we briefly outline Principlism and the Justice-based argument for Medical Cosmopolitanism. In subsequent sections, we address potential objections to Medical Cosmopolitanism.

Beauchamp's and Childress's *Principles of Biomedical ethics* holds that there are four principles that are a source of prima facie duties, and which form the moral foundation for healthcare practice: Autonomy, Beneficence, Non-Maleficence and Justice. The authors argue that

[3]Kleingeld, P. (2013). Cosmopolitanism. In International encyclopedia of ethics. Wiley Online Library.

[4]The term 'medical cosmopolitanism' is also used by Broadbent (2019). While there are affinities between medical cosmopolitanism as we define it, and the 'moral stance' described by Broadbent, we use it in a way that is more strongly tied to notions of impartiality in cosmopolitan conceptions of justice; Broadbent, A. *Philosophy of Medicine. New York: Oxford University Press, 2019.*

[5]Kleingeld, P. (1999). Six varieties of cosmopolitanism in late eighteenth-century Germany. *Journal of the History of Ideas*. 506. https://doi.org/10.2307/3654016.

[6]Singer, P. (2004). One world: The ethics of globalization. One World: The Ethics of Globalization. https://doi.org/10.2307/4614534Kamm, F.M., & Unger, P. (1999). Living High and Letting Die: Our Illusion of Innocence. *The Philosophical Review*. https://doi.org/10.2307/2998310.

[7]O'Neill, O. (2009). Kant's justice and Kantian justice. In Bounds of Justice. https://doi.org/10.1017/cbo9780511605734.006.

[8]Nussbaum, M C. (2006). Frontiers of Justice: Disability, Nationality, Species Membership. Cambridge: Belknap Press.

[9]Nussbaum, M C., et al. (1996). For Love of Country: In J. Cohen (Ed.), Debating the Limits of Patriotism. Boston: Beacon Press.

[10]Kleingeld, P & Brown, E. (2019). Cosmopolitanism. In E.N. Zalta (Ed.), *The Stanford Encyclopedia of Philosophy*. https://plato.stanford.edu/archives/win2019/entries/cosmopolitanism/.

[11]Pogge, T. (2005). World Poverty and Human Rights. *Ethics and International Affairs*. https://doi.org/10.1111/j.1747-7093.2005.tb00484; Singer, op. cit. note 6.

these four central tenets are part of a 'common morality', that is, a premise that derives its normative authority from universally held moral attitudes.[12] The Principlist approach is, according to the authors, drawn from Duty-based (deontological) as well as Outcome based (consequentialist) moral theories of Jeremy Bentham and John Stuart Mill.[13]

Of the four principles, our primary interest here is Justice, defined as the "fair, equitable and appropriate treatment in light of what is due or owed".[14] The duty of justice relates specifically to how medical professionals ought to conduct themselves in their line of work. As such, healthcare workers ought to do what they can to ensure that costs and benefits are distributed fairly, they ought to use their skills to correct unfair distributions.

It is still worth mentioning that the literature on various perspectives of justice as they relate to duties to correct healthcare imbalances is rich, and on any of these accounts a justification for why healthcare workers ought to correct unjust distributions can be made. 'Luck Egalitarianism' argues that justice requires correcting disadvantages resulting from brute luck.[15] With Albertsen and Knight[16] arguing "that luck egalitarians should address distributions of health rather than healthcare," that people are duty bound to correct global health imbalances. The concept of egalitarian 'Sufficiency' holds that it is morally valuable that as many possible of all who shall ever live should enjoy conditions of life that place them above the threshold that marks the minimum required for a decent (good enough/sufficient) quality of life.[17] Fourie and Rid[18] apply this notion of sufficiency in the global healthcare context in determining a basic minimum of accessible healthcare. Prioritarianism is the aggregative utilitarian view that worse off people experience more utility from any particular good than better off people; on this account It can argued that healthcare workers working in LMICs would maximize utility due to LMICs scant health resources.[19]

The principle of Justice has widely accepted implications at local and national levels, creating obligations for healthcare workers to attempt to transcend access barriers, and, for instance, deliver healthcare services to under-served rural areas.[20] However, a wider obligation to deliver such services internationally is yet to be recognised. As mentioned, there is gross inequality in the global distribution of health workers, with LMICs experiencing severe shortages in the availability of healthcare personal and HICs possessing a disproportionately high share of healthcare workers.[21] If Cosmopolitan ideas in general are justified, then it is also justified to extend the sphere of concerns about Justice in the provision of healthcare services. The argument for Medical Cosmopolitanism holds that healthcare workers as a discipline are bound by the principle of Justice, and so have duties to contribute their skills to remedying the unjust distribution of healthcare workers. Taking into consideration the diversity of different healthcare infrastructural landscapes that LMICs may find themselves; it is worth noting that not all LMICs have a shortage of healthcare workers. For instance, countries such as Cuba and (to a slightly lesser extent) the People's Democratic Republic of Korea are LMICs who arguably are 'oversupplied' with healthcare workers.[22] Medical Cosmopolitanism is primary concerned with the correction of global distributions in healthcare workers and not in giving aid to LMICs *per se*. Therefore, under extenuating circumstances, the duty to work in a LMIC can be negated in cases where a LMIC has a sufficient number of healthcare workers already or even reversed (all things considered) in cases where LMICs have an oversupply of healthcare workers.

To see the force of cosmopolitan claims, it is worth quoting at length the thought experiment of the drowning child employed by Peter Singer to argue for strong duties of international aid.

> To challenge my students to think about the ethics of what we owe to people in need, I ask them to imagine that their route to the university takes them past a shallow pond. One morning, I say to them, you notice a child has fallen in and appears to be drowning. To wade in and pull the child out would be easy but it will mean that you get your clothes wet and muddy, and by the time you go home and change you will have missed your first class.
>
> I then ask the students: do you have any obligation to rescue the child? Unanimously, the students say they do. The importance of saving a child so far outweighs the cost of getting one's clothes muddy and missing a class, that they refuse to consider it any kind of excuse for not saving the child. Does it make a difference, I ask, that there are other people walking past the pond who would equally be able to rescue the child but are not doing so? No, the students reply, the fact that others are not doing what they

[12]Beauchamp, T.L., & Childress, J.F. (1994). Principles of Biomedical Ethics. Emergency Medicine Clinics Of North America. 4th ed. https://doi.org/10.1016/S0033-3182(95)71674-7.

[13]Beauchamp, T.L., & Childress, J.F. (2001). Principles of Biomedical Ethics, fifth edition. *Oxford University Press*.

[14]Beauchamp, T.L., & Childress, T.J. (2009). Principles of Medical Ethics. 7th edition. *Oxford University Press*. 250.

[15]Segall, S. (2009). Health, luck, and justice. Health, Luck, and Justice. https://doi.org/10.1163/174552411x589035.

[16]Albertsen, A., & Carl, K. (2015). "A Framework for Luck Egalitarianism in Health and Healthcare." *Journal of Medical Ethics 41* (2): 165–169. https://doi.org/10.1136/medethics-2013-101666.

[17]Arneson, R. (2013). Egalitarianism. In E.N. Zalta (Ed.), *The Stanford Encyclopedia of Philosophy*. https://plato.stanford.edu/archives/sum2013/entries/egalitarianism/.

[18]Fourie, C., & Annete, R. (2016). What is enough?: Sufficiency, Justice and Health. Oxford University Press.

[19]Segall, S. (2010). "Luck Prioritarian Justice in Health." In Responsibility and Distributive Justice, edited by Carl Knight and Zofia Stemplowska, 246–65. Oxford; New York: Oxford University Press.

[20]Eyal, N., & Bärnighausen, T. (2012). Precommitting to Serve the Underserved. *American Journal of Bioethics*. https://doi.org/10.1080/15265161.2012.665134; Matsumoto, M., & Kajii, E. (2009). Medical education program with obligatory rural service: Analysis of factors associated with obligation compliance. *Health Policy*. https://doi.org/10.1016/j.healthpol.2008.09.004.

[21]Castillo-Laborde, op. cit. note 1: pp. 2–3.

[22]WHO. (2016). WHO | World Health Statistics 2015. *WHO*.

ought to do is no reason why I should not do what I ought to do.

> Once we are all clear about our obligations to rescue the drowning child in front of us, I ask: would it make any difference if the child were far away, in another country perhaps, but similarly in danger of death, and equally within your means to save, at no great cost – and absolutely no danger – to yourself? Virtually all agree that distance and nationality make no moral difference to the situation.[23]

Singer's thought experiment presents a powerful case for Cosmopolitanism in general, which can be extended to Medical Cosmopolitanism in particular. Extending this analogy means that healthcare workers have strong obligations to sick people both near and abroad, even at substantial cost and inconvenience. Indeed, two points of disanalogy strengthen the case for Medical Cosmopolitanism. The first is that in Singers' thought experiment all the people around the pond are equally able to save the child. Medical care, by contrast is a far scarcer good. In LMICs like Liberia or Niger, which have some of the most unfavourable ratios of physicians to patients, there are far fewer people with the requisite skills and resources to do the saving.[24] This places a heavier burden of obligation on healthcare workers to help to rectify imbalances. The second significant point of disanalogy is that in LMICs there are more children 'drowning' in the pond, and far fewer resources to save them.

The case for Medical Cosmopolitanism thus holds that because healthcare workers have Cosmopolitan duties to treat all people everywhere, and because the principle of Justice demands that health workers use their skills to correct unjust distributions, then healthcare workers must employ their skills to correct globally unjust distributions in healthcare resources and workers. On this view, Justice that is exclusively exercised purely within the confines of HICs is at best sub-optimally just. Healthcare workers from HICs that do not serve in LMICs fail to fulfil Justice-based duties to provide care in a manner that is fair, equitable and appropriate in light of what is due or owed to the sick.

In the following sections we address a number of objections to this claim, including that we have stronger duties of reciprocity to those in our own nations, that Medical Cosmopolitanism is too demanding, that foundational 'partialist' intuitions justify preference for local people, and that obligations towards others can be better fulfilled in ways other than working in under-served nations. We argue that these objections fail to undermine Medical Cosmopolitanism.

[23]Singer, P. (1972). Famine, affluence, and morality. *Philosophy & public affairs*. 231.

[24]https://www.statista.com/statistics/280151/countries-with-the-lowest-physicians-density-worldwide/.

3 | THE RECIPROCITY OBJECTION

In this section, we address the 'Reciprocity Objection' to Medical Cosmopolitanism. This objection rests on the claim that healthcare workers from HICs benefit from their home nations, and that people have special duties to serve the nations from which they derive benefits. Healthcare workers from HICs therefore have special duties to treat the sick in their home nations, which may outweigh any cosmopolitan duties they may have to the sick in LMICs.

This objection challenges the impartiality that Medical Cosmopolitanism requires by highlighting the countervailing normative axiom of reciprocity, according to which we have special obligations to do right by people and institutions that have done right by us. In this instance, these 'special obligations' appear to necessitate partiality, so that healthcare workers in HICs must reciprocate the benefits they have received from their home nations by working in their home nations.

While it is true that healthcare workers derive many benefits from their home countries, this objection ignores the fact that HICs also derive substantial benefits from LMICs. According to Thomas Pogge[25] inequalities that are visible today are due, in large part, to the wealth that HICs have accumulated through colonialism, slavery and the subjection of women. These inequalities are perpetuated by global arrangements that systematically benefit wealthier nations at the expense of poorer ones. According to the United Nations Conference on Trade and Development, market distortions intentionally made by HICs cost the developing world over 700 billion dollars per year.[26] Moreover, as a consequence of 'brain drain' many healthcare workers in HICs received training in lower income nations and provide substantial benefits to their adopted nations at the expense of their home nations;[27] expenses that, amongst other things, tend to include an exacerbation of child and maternal mortality and a tendency to hinder treatment of HIV/AIDS.[28] A broad consensus exists that, where medical brain drain exacerbates healthcare shortage in LMICs, it is unethical[29] with some authors arguing for immigration restrictions in a bid to restrict brain drain.[30] While precise measures of who owes what are probably impossible, it should nonetheless be clear that HICs derive immense benefits from LMICs. Thus, *if* reciprocity grounds a healthcare worker's duty to care, far from being an objection to Medical Cosmopolitanism, it may provide an additional justification.

[25]Pogge, op. cit. note 11.

[26]Ibid. : 17.

[27]Cometto, G., Tulenko, K., Muula, A.S., & Krech, R. (2013). Health workforce brain drain: from denouncing the challenge to solving the problem. *PLoS Medicine*. *10*(9).

[28]Eyal, N., & Hurst, S.A. (2008). Physician Brain Drain: Can Nothing Be Done? *Public Health Ethics*. 180–92. https://doi.org/10.1093/phe/phn026.

[29]Kollar, E., & Buyx, A. (2013). Ethics and policy of medical brain drain: A review. *Swiss Medical Weekly*. https://doi.org/10.4414/smw.2013.13845.

[30]Oberman, K. (2013). Can brain drain justify immigration restrictions? *Ethics*. 427–55. https://doi.org/10.1086/669567.

Against this, it could be claimed that leaders and statesmen are responsible for past and present injustices, while ordinary citizens have no control over the benefits they receive. In this case, perhaps the only relevant relationship of reciprocity is between the healthcare worker citizen and her state. If so, wider networks of inter-state reciprocity are not morally relevant in the decisions of individual healthcare workers.

However, this response neglects two features that link individuals into global networks of reciprocity. First, at least in democratic nations, citizens participate in the elections of leaders, and therefore arguably share responsibility for government decisions. If so, citizens also share responsibilities for unequal arrangements between states. Second, consumer behaviour contributes to the exploitation of LMICs and links citizens more directly into relations of reciprocity with LMICs. As one example, consider that minerals such as coltan, cassiterite, wolframite and gold are mined in conflict zones in the eastern Democratic Republic of the Congo, they are sold by local warlords to multinational corporations that make consumer electronics such as mobile phones, laptops, and MP3 players that people in HICs choose to purchase, and the proceeds from the sale of these minerals are used by these warlords to perpetuate armed conflict.[31] There are countless other instances of how consumer behaviour fuels global injustices in a similar manner, arguably generating debts of reciprocity towards LMICs.

International, democratic, and consumer relations between individuals in LMICs and HICs generate relations of reciprocity. This means that people in HICs have obligations to people in LMICs because they derive benefits from LMICs. Reciprocity cannot be used to justify medical parochialism, and so the Reciprocity objection fails.

4 | THE DEMANDINGNESS OBJECTION

In this section, we evaluate the 'Demandingness Objection.' It might be claimed that it takes time and resources for a healthcare worker to work in LMICs, and doing so may also pose a risk to the lives of healthcare workers. Given this, the duty of Medical Cosmopolitanism appears too demanding. The demandingness objection holds that we ought to reject Moral Cosmopolitanism because there are theoretical and practical reasons for rejecting overly demanding moral claims.

Objections to the demandingness of moral obligations are of course not unique to our claim. Demandingness is often a raised complaint against accounts that appear to extend the boundary of what should be morally obligatory, to including actions that are ordinarily considered supererogatory.[32] For instance, Utilitarianism is often seen as too demanding since it implies obligations to entirely neglect any kinds of self-interested concerns when they conflict with the greater good. Such accounts are seen as theoretically problematic because they contradict more deep-seated moral views. They are also practically problematic, since they run counter to what can be expected of humans.

While we are arguing for an obligation to perform actions that would often be considered supererogatory, three considerations point to Medical Cosmopolitanism being less extreme than the expectations of Utilitarianism. First, we are not arguing on the basis of the radical Utilitarianism that suggests that almost no actions can be supererogatory.[33] Instead, we claim that Medical Cosmopolitanism is a logical extension of an existing, generally accepted obligation towards Justice. Contra extreme versions of Utilitarianism, many sorts of beneficial behaviour will, unless further argument is provided, remain supererogatory.

Second, as we discuss later, while we suggest that the duty is strong, we are nonetheless claiming that it is a pro tanto duty, not an 'all things considered' duty. That is, it is a potentially defeasible duty that ought to be considered in the context of other moral duties. Other duties might also warrant pro tanto moral consideration, and in some cases, these may, all things considered, override duties towards Medical Cosmopolitanism.

Third, it is plausible that the idea that Medical Cosmopolitanism is overly demanding is generated by unsound generalisations and stereotypes about LMICs. In particular, that working in a LMIC takes excessive time and resources to do, and that LMICs pose a grave threat to healthcare workers' health and security. There are convenient and safe places for healthcare workers to practise, and programs that assist in doing so.[34] It should also be clear that there are rewards to this kind of activity. Notably, altruistic behaviour tends to increase happiness,[35] and healthcare workers would also gain greatly in experience and in less measurable and tangible aspects such as a widened worldview.

Additionally, it is worth acknowledging that accounts have been submitted that defend healthcare worker's claim of Justice to medical attention even when they choose to treat the sick during infectious pandemics: from luck egalitarian perspectives,[36] and on conditions that healthcare workers expressly consent to working in pandemic zones.[37] Moreover, it has been argued that healthcare workers ought to receive preferential treatment in the allocation of scarce medications during ensuing pandemics. This literature review highlights ethical perspectives that seek to

[31]Raj, S. (2011). Blood electronics: Congo's conflict minerals and the legislation that could cleanse the trade. *Southern California Law Review*.

[32]Chappell, T. (2009). The problem of moral demandingness: New philosophical essays. Palgrave Macmillan.

[33]McKay, A.C. (2002). Supererogation and the profession of medicine. *Journal of Medical Ethics*. *28*(2), 70–73.

[34]Fox, R.C. (1995). Medical humanitarianism and human rights: reflections on doctors without borders and doctors of the world. *Social Science & Medicine*. *41*(12), 1607–1616.

[35]Post, S.G. (2005). Altruism, happiness, and health: It's good to be good. *International Journal of Behavioral Medicine*. *12*(2), 66–77.

[36]Albertsen, A., Thaysen, J.D., & Albertsen, A. (2017). Distributive justice and the harm to medical professionals fighting epidemics. *Journal of Medical Ethics*. 861–64. https://doi.org/10.1136/medethics-2017-104196.

[37]Malm, H., May, T., Francis, L.P., Omer, S.B., Salmon, D.A., & Hood, R. (2008). Ethics, pandemics, and the duty to treat. *American Journal of Bioethics*. 4–19. https://doi.org/10.1080/15265 16080 2317974.

protect healthcare workers who choose to work in pandemic zones. As such these accounts also serve to protect Medical Cosmopolitans from moral liability in light of the fact that they would be choosing to face higher pandemic disease burdens while working in LMICs , thereby negating some of the demandingness associated with the risk of disease that Medical Cosmopolitanism inevitably poses.

Nevertheless, there are doubtless inconveniences and costs to carrying out Medical Cosmopolitan duties. However, the objection from demandingness only works if the demands conflict with reasonable moral convictions or what is realistic to expect in terms of human nature or psychology. It does not hold that we only have moral duties insofar as they are convenient to execute. The fact that many healthcare workers already provide assistance in lower income countries, do not suffer unduly, and in many cases gain and provide substantial benefit[38] is evidence that Medical Cosmopolitanism is not excessively demanding.

5 | THE INTUITIONS OBJECTION

Medical Cosmopolitanism rests on the idea that duties of justice require us, other things equal, to be impartial between the hardships of people, regardless of their geographic proximity. While this kind of impartiality is common in moral theory, it is not universally accepted. Some theorists cite deep and perhaps foundational *intuitions* that we have partial moral duties to favour ourselves, our families, friends, and cultural groupings. In partialist moral theories, these may override the stronger needs of others.

The claim that our intuitive ability at moral evaluation forms the basis of ethical knowledge draws from the moral theory of ethical intuitionism, which holds that some basic moral propositions are self-evident—that is, evident in and of themselves—and so can be accepted without any argumentation.[39] The Intuitions Objection rests on the idea that our commonly held intuitions with respect to moral partiality, towards friends, family or compatriots, are self-evident moral truths of this kind.

This kind of partiality, if justified, appears to provide a reason for rejecting Medical Cosmopolitanism. If healthcare workers in wealthier nations ought to be partial, perhaps they ought to favour provision of healthcare to people in their own nations. The Intuitions Objection thus holds that Medical Cosmopolitanism is wrong, on the basis that it is antithetic to more deeply held intuitions concerning partiality. Like the Reciprocity Objection, the Intuitions Objection suggests we have special duties towards people in our nation. However, unlike the Reciprocity Objection, this claim is based on appeal to a foundational intuition about the partiality of morality, rather than to reciprocity. We respond to this objection in two ways.

The first response is to point out that even partialist theories do not generally *dissolve* obligations to distant others. Instead, they tend to weaken such obligations relative to obligations to those who are geographically or relationally near. Expounding a partialist African moral theory, for instance, Thaddeus Metz holds that although we have stronger duties to those with whom we are in existing relationships, we nonetheless have duties to others as the potential subjects of moral relationships.[40] In this case, some Medical Cosmopolitan duties remain, albeit in weakened form.

A second response points to a complex debate in metaethics and holds that we ought to resolve debates between foundational partial and impartial intuitions in favour of impartial ones. Singer and De Lazari-Radek, for instance, employ an evolutionary debunking argument against partialist theories.[41] The debunking argument holds that

> we should be suspicious of intuitions that are likely to have been caused by evolution. This is because natural selection favours beliefs that further survival, rather than truth. Thus, in the absence of some further explanation relating survival and moral truth, it would be a strange coincidence if a moral belief or intuition caused by evolution turned out to be reflective of moral truth.[42]

According to this debunking strategy, impartial beliefs are unlikely to be have been caused by evolution, because they require us not to give preference to people that share genetic material with us. Impartial beliefs thus appear less likely to be 'selected.' By contrast, partial beliefs are highly likely to be selected, since they encourage us to favour individuals with whom we are likely to share genetic material. The upshot is that we should prefer moral theories and beliefs that are impartial since they are less likely to be distorted by amoral processes that do not track moral truth.

This is certainly not the place to resolve the clash between partial and impartial intuitions. However, if the above is correct, then there are reasons to favour impartial intuitions where they conflict with partial ones. This would restore the strength of obligations of health workers towards Medical Cosmopolitanism. Either way, though, it should be clear that the Intuitions objection fails to undermine Medical Cosmopolitanism. Even if debunking fails, the objection at most weakens, but does not dissolve, the health workers' obligation to share skills with less wealthy nations.

[38]See for instance Doctors without Borders for some claimed benefits of Medical Cosmopolitanism https://www.doctorswithoutborders.org/careers/work-field/pay-benefits.

[39]Stratton-Lake, P. (2016). Intuition, Self-Evidence, and Understanding. In Oxford Studies in Metaethics (pp. 28–44). https://doi.org/10.1093/acprof:oso/9780198784647.003.0002.

[40]Metz, T. (2010). African and western moral theories in a bioethical context. *Developing World Bioethics*. *10*(1), 49–58. https://doi.org/10.1111/j.1471-8847.2009.00273.x.

[41]De Lazari-Radek, K., & Singer, P. (2012). The Objectivity of Ethics and the Unity of Practical Reason. *Ethics*. *123*, 9–31.Singer, P. (2005). Ethics and intuitions. *Journal of Ethics*. *9*(3–4), 331–352. https://doi.org/10.1007/s10892-005-3508-y.

[42]Wareham, C.S. (2017). Partiality and distributive justice in African bioethics. *Theoretical Medicine and Bioethics*. https://doi.org/10.1007/s11017-017-9401-4.

6 | EFFECTIVE ALTRUISM OBJECTION

The objection of this section differs from those previously discussed, in that it accepts impartiality and does not dispute that healthcare workers in HICs have strong obligations towards people in LMICs. Instead, it holds that providing their skills and labour is an ineffective means to fulfil this obligation. It could be argued that healthcare workers can make significantly more money by working in HICs than they could by working in LMICs. Donating an appropriate amount of that money to some reputable charity or organization will help more people in LMICs than by working in those places directly. If so, the most effective way to fulfil obligations of justice is *not* to work in LMICs, but instead to work in richer countries and donate part of one's earnings.[43] There cannot be a duty to work in LMICs if there is always a better way to fulfil that duty.

The above objection is grounded in the concept of 'counterfactual consequences'. That is

> [The consequences] of an action are the differences between what happened because of that action and what would have happened otherwise.[44]

The morality of an action depends on the difference that the action makes as compared to other possible actions. In this case, the suggestion is that the counterfactual in which one works in a HIC and donates (which we will refer to as the 'professional altruism counterfactual'), is better than the counterfactual in which one works in a LMIC (the 'medical cosmopolitan counterfactual').

This is probably the strongest objection to Medical Cosmopolitanism. At the outset, we concede that if it were the case that monetary donations provided by HIC health workers would fulfil the need for resources in LMICs, then this would over-ride Medical Cosmopolitan obligations. Nonetheless, four responses cast doubt on this possibility, and also serve to clarify our claim. The first response is that, if successful, the effective altruism objection would nonetheless require the fulfilment of the professional altruism counterfactual, which would itself need to respond to the objections we have discussed. In other words, Medical Cosmopolitanism is defeated only if another, potentially more demanding obligation is defended, which would require further argument.

Second, it is important to point out that there are a number of unfathomables and context-dependencies in the claim that the professional altruism counterfactual would be better than the medical cosmopolitan counterfactual. For one thing, it is not certain that a healthcare worker in an LMIC will be paid less, all things considered. Medical Cosmopolitanism is a response to unjust distributions of healthcare workers. It will not always be the case that this shortage is due to lower salaries. Moreover, in LMICs, other costs, such as rental and buying are often reduced, and experiences gained in LMICs may lead to higher salaries more quickly. If medical cosmopolitans are not substantially disadvantaged, it remains possible that they could donate some of their salaries. The positive elements of *both* sets of counterfactuals might be fulfilled. These costs and benefits are difficult to calculate, so that it is difficult to say whether the professional altruism counterfactual will result in more benefits.

Third, Medical Cosmopolitanism is driven by the need to correct unjust distributions of healthcare workers. It is not obvious that donated money will always translate to the provision of healthcare workers, or the skills that they provide. Money will be useful in most contexts, provided it can be used efficiently, but it will not necessarily remedy the distributions that Medical Cosmopolitanism aims to remedy. For instance, merely providing money is less likely to help where healthcare worker shortages are not due to economic, but instead due to past bad health prioritisation policies. To adapt Singer's analogy in section 1, paying someone else to jump in to the pond to save the drowning child would only fulfil my obligation if there was someone else who could swim. Similarly, scarcity of healthcare worker skills is a problem whose solution does not always correlate directly to provision of funds. The problem may be that there are no healthcare workers, not that there is insufficient money to pay them. In such cases, the professional altruism counterfactual will not always deliver equivalent benefits to the medical cosmopolitan counterfactual.

The fourth response is to point out again that medical cosmopolitan duties are proposed as pro tanto duties, not all things considered duties. Properly understood, the Effective Altruism Objection does not hold that there is no duty to work in LMICs. Instead, it proposes a new obligation (again, one that requires independent defence that we have not provided). This new obligation to work and donate may operate as a defeater for the proposed pro tanto obligation.[45] In this case it is not correct to say that Medical Cosmopolitanism fails if the Effective Altruism objection is successful. Instead, the obligation is better understood as applying, unless other justified and more pressing obligations override it.

In short, while effective altruism is an important consideration, it does not undermine Medical Cosmopolitanism. Instead, it raises a new obligation that must be clarified and defended and then compared to the effects of Medical Cosmopolitanism. The claim that the professional altruism counterfactual would do better at remedying unjust disparities rests on empirical claims that are uncertain and difficult to prove. In addition, it is worth noting the fact that effective altruism is not uniquely reserved for healthcare workers, but reflects a duty that all people who earn sufficiently large incomes have; HIC

[43]This objection is suggested, though not directly made, by McAskill's Effective Altruism movement. See MacAskill, W. (2015). Doing good better: Effective altruism and a radical new way to make a difference. Guardian Faber Publishing.

[44]Todd, B. (2012) Which ethical careers make a difference?: The Replaceability Issue in the Ethics of Career Choice. [Graduate Thesis]. University of Oxford. Retrieved June 29, 2020 from https://www.academia.edu/1807196/Which_Ethical_Careers_Make_a_Difference_The_Replaceability_Issue_in_the_Ethics_of_Career_Choice.

[45]Interestingly, this obligation may in turn potentially be defeated by an obligation to work in an even wealthier profession, so that one can donate more to resolve health problems in LMICs; MacAskill, op. cit. note 45.

or otherwise. As such, people in other professions are similarly obligated to either engage in their own form of professional cosmopolitanism or to donate a commensurate amount of money. All things considered duties will vary based on context dependencies unique to each profession, but cosmopolitanism in this context still requires extension of moral consideration to all people.

7 | CONCLUSION

There is massive global inequality in the distribution of healthcare workers and healthcare resources. High-income countries possess a disproportionate share of these healthcare resources in spite of their lower burden of disease, while LMICs must make do with fewer healthcare workers and higher disease burdens.

In this context, we have argued that healthcare workers from high-income countries have a moral duty to work in LMICs, an idea we referred to as Medical Cosmopolitanism. We based this claim upon the biomedical principle of Justice, which requires that healthcare workers must use their skills to address unjust distributions. We also advanced the cosmopolitan claim that people's moral obligations extend to all people everywhere in the world, irrespective of their nationalities. The conjunction of cosmopolitanism and justice requires that healthcare workers have a moral obligation to exercise justice globally, and that healthcare workers from high-income countries ought to use their skills to address unjust distributions in healthcare resources by working in LMICs. Following the argument in favour of Medical Cosmopolitanism, we addressed objections to it. These objections were made on the basis of national reciprocity, demandingness, countervailing moral intuitions, and effective altruism. Given that these objections fail, Medical Cosmopolitanism generates important obligations for health workers in an unjust global landscape.

Given the obligations raised by Medical Cosmopolitanism, we recommend that healthcare workers from HICs recognize and act upon their duty to work in LMICs. Secondly, we recommend that healthcare education should emphasize medical cosmopolitanism as a duty that logically flows from the biomedical principle of Justice, that Justice demands that healthcare workers from HICs have an obligation to work in LMICs. Thirdly, we encourage further research into the possible obligations that HIC governments have in facilitating and mandating Medical Cosmopolitanism through the precommital of their healthcare students to work in LMICs.

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