Article

A Future for Migrants with Acute Heart Problems Seeking Asylum?

GÖRAN HERMERÉN

Abstract: This paper discusses the future of migrants with acute heart problems and without permanent permission to remain in the country where they are seeking asylum. What does the country they have traveled to owe them? Specifically, what healthcare services are they entitled to? This may seem a niche problem, but numbers of migrants with acute heart problems could increase in the future. Besides, similar problems could be raised by, for instance, traumatized migrants with acute needs for healthcare services for other serious conditions. The paper identifies the issues and some positions on them. Arguments for and against these positions are explored. This particular set of problems in healthcare ethics creates several challenges, at both national and international levels, concerning access to transplantation, public willingness to donate organs, optimal use of organs, justice and fairness, and potential conflicts of law, politics and ethics, as well as issues revolving around interaction and communication (or lack of it) between agencies and professions.

Keywords: migrants; heart transplantation; ethics; politics; cross-border healthcare; rights of asylum seekers; Istanbul declaration; Geneva declaration; healthcare need

Setting the Stage

The use of the indefinite article in the title of this paper needs to be stressed. Bioethics, including medical ethics, has many futures. Hopefully this is also true for migrants with acute heart problems. So what I want to call attention to here is the future of a small group of the population, and also of medical ethics. My aim is to keep the political and legal context of medical ethics in particular focus.

As an illustration, I will discuss a problem that has surfaced recently in some EU member states. It is, I think, of general interest, even though healthcare legislation varies somewhat in the different member states of the EU. Instead of writing about particular countries like Sweden, the Netherlands, Croatia, or Serbia, we can discuss two countries, X and Y, and make certain assumptions about them. This will facilitate discussion of a problem which may have some general interest now, and perhaps more so in the future.

So, let us assume that X is a country with excellent healthcare, particularly when it comes to the transplantation of organs like hearts and kidneys—as well as the necessary follow-up, which is required if the transplanted organs are not to be wasted. Let us assume that Y is a country which differs from X in precisely these respects. Besides this, life in Y is dangerous; various groups in this country are fighting with each other; there is in effect a civil war going on, with other countries as interested players in the background.

Acknowledgment: I want to thank my colleague Nils-Eric Sahlin for helpful comments on an earlier version and cardiologist Björn Kornhall for information about some patient cases involving migrants in acute need of heart transplantation. The paper was originally to be presented at a symposium honoring Professor Inez de Beaufort in connection with her farewell lecture at the Erasmus Medical Center, Rotterdam. However, owing to the Covid-19 pandemic the symposium was cancelled.

Cambridge Quarterly of Healthcare Ethics (2021), **30**, 297–311.
© The Author(s), 2021. Published by Cambridge University Press.
doi:10.1017/S0963180120000857

https://doi.org/10.1017/S0963180120000857 Published online by Cambridge University Press

People may leave their country for many different reasons. Some do so because their lives are endangered by an on-going civil war. Others may do so for medical reasons. Combinations of reasons are also possible, and the need for a heart transplant may arise unexpectedly during travel to a new country. But let us assume that young migrants with acute heart problems escape from their country Y to country X hoping to get a heart transplant. They move in order to access what they cannot obtain at home. In this situation, the healthcare regulations of the national states and the EU become relevant. Ethical issues are also raised. What does the country the young people arrive in owe them? What healthcare services are they entitled to? This may seem a small problem, but numbers of migrants with acute heart problems could rise in the future. Equally, similar problems could occur in other areas—for example, there may be traumatized migrants with acute needs for healthcare because they suffer from a number of serious diseases other than heart conditions.

There are many studies of cardiac rehabilitation and readmissions after heart transplantation,[1] as well as analyses of public discourse on heart transplantation.[2] Extensive studies of the need for lifelong follow-up after heart transplantation have been published, for example, by the French Intensive Care Society.[3] We have several studies of outcomes after heart transplantation, and of ways of optimizing these outcomes.[4]

These and similar studies are relevant to the empirical aspects of this paper. But I am not aware of any studies focusing directly on the precise problem I wish to discuss: the ethical and legal issues raised by transplantation of hearts to migrants without permanent permission to remain in the country where the transplantation will take place.

Values at Stake

The goals of healthcare are stated in various regulatory documents in force in EU member states. They are referred to in Sweden, for instance, in a healthcare act, a patient data act, and a patient security act. In other countries, there are similar documents. There are also European and international documents of varying force with implications for healthcare and medical research, including the General Data Protection Regulation (GDPR) and the Advanced Therapy Medicinal Products (ATMP) regulation of the EC, as well as the UN declaration on human rights, the Oviedo convention,[5] and the UN convention on the rights of children.

The basic goals in the documents helping to state the mission of healthcare include: to promote good health, prevent ill health, further patient safety, respect the autonomy and integrity of patients, safeguard human dignity and the equal rights of everyone, promote equal access to healthcare, and prioritize those who are most in need of help. Who is entitled to the healthcare services in a country? The scope of these benefits will be discussed in more detail below.

This is a long list of good and worthy goals, containing both vague and value-loaded terms. The goals, and the values underpinning and motivating them, are often abstract, and they are generally not supported by argument in guidelines and regulatory texts. This is likely to create difficulties when they come to be implemented. It may lead to interpretative disputes, especially if those involved in the implementation are unfamiliar with the origin and standard understanding of the values in the relevant ethical traditions.

https://doi.org/10.1017/S0963180120000857 Published online by Cambridge University Press

As is well known, there is free movement of persons, goods, and services within the EU. It is possible to seek healthcare services that you cannot get access to at all, or as quickly, in one country in another member state, although the conditions for reimbursement vary somewhat between member states. This is obviously very good for those who are citizens of EU member states. But it does not help migrants from outside EU. It should perhaps be mentioned at this point that, according to the basic EU treatises, the commission has no legal competence concerning healthcare and medical research. This is for member states to decide on.

Already here, some interesting value conflicts arise. In the EU, an explicit exception is made for the transplantation of organs.[6] Here, the principle of free movement does not apply. But suppose there is a law, or a principle, in hard or soft law in an EU member state (as is in fact the case in Sweden) stating that healthcare resources should be distributed according to need. Who is entitled to enjoy these healthcare services? The exact scope of the benefits is obviously crucial in this context, and this issue will be addressed below. Again, suppose (as is also the case in Sweden) that anyone, even migrants from outside the EU, is entitled to healthcare services that "cannot be postponed"—a phrase which presumably means that if the requested healthcare service is delayed, or not provided at all, this will cause serious harm to the patient requesting help.

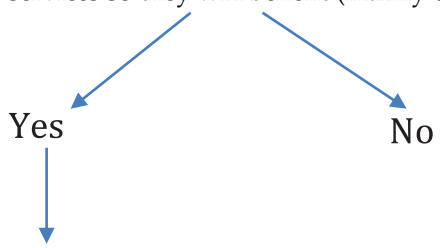
In both cases, there seems to be a conflict between these principles and the exception for organ transplantation, since the care of a person with acute heart problems cannot be postponed without risking the life of that person. There are other conflicts as well, as will be seen shortly.

Some Problems

With the stage set in this way, let us now approach the issues somewhat more systematically. We can begin by distinguishing between some problems and possible positions related to a series of decisions that can be taken during the handling of requests from migrants with acute heart problems.

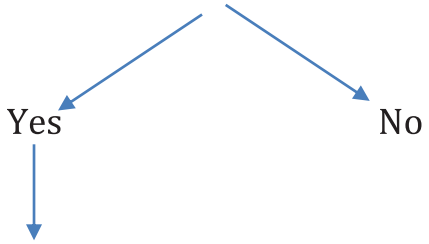
I will first indicate some problems and arrange them, tentatively and sequentially, in a decision tree. Variants of the questions as well as possible answers—to be discussed more fully in what follows—are indicated in the parentheses in the questions below. The questions can be answered by Yes or No. Assuming that the answers in each situation are "Yes," the decision tree might look as follows:

1) Is it a basic health policy responsibility of a state to arrange its healthcare services so they will benefit (mainly or only) its own citizens?

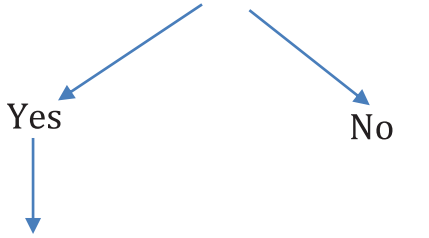


https://doi.org/10.1017/S0963180120000857 Published online by Cambridge University Press

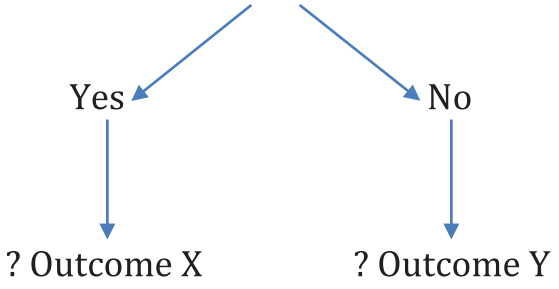
2) Ought there to be exceptions granted by hard or soft law?



3) Should migrants be put on waiting lists for transplantation if (or only if) this is medically justified?



4) Should migrants receive a new heart if (or only if) they have permanent permission to remain?



In what follows some positions, that is, possible answers to these questions, will be discussed, and arguments for and against these positions will be indicated and commented on. In concluding the discussion, I will bring in the political context.

The focus on this particular set of problems in healthcare ethics raises several challenges at both national and international levels. They have to do with access to transplantation (donated hearts are a limited resource, and there are waiting lists), with factors influencing people's willingness to donate organs, and conditions for the optimal use of transplanted organs. They also connect with justice and fairness, potential conflicts between law, politics, and ethics, and various issues revolving around the interaction and communication (or lack of it) between different agencies and professions.

Three Positions

The problems above can be addressed in several ways. In what follows, I will indicate some possible answers and identify and comment on arguments for and against them.

I propose to single out three positions—to be further clarified in the subsequent sections—as possible perspectives on the problems above. The first position is

https://doi.org/10.1017/S0963180120000857 Published online by Cambridge University Press

taking a stand on the obligations of a state to provide healthcare services to those other than its own citizens. The second position is taking a stand on the conditions under which a migrant without permanent permission to remain should be put on the waiting list for a transplantation. The third position is taking a stand on the relations between receiving a new heart and being granted permanent permission to remain in the country where the transplantation is carried out. The list of positions is not meant to be exhaustive. Others could also have been highlighted.

Arguments For and Against the First Position

As already indicated, the first position concerns the obligations of a state to provide healthcare services for the benefit of those other than its own citizens, and the conditions under which this may be the case.

At this point there is a choice. We can (1) stay within the context of existing regulatory frameworks or (2) question these frameworks, and then proceed to discuss hypothetical examples and changes in rules and regulations. But those who make decisions in healthcare systems usually stick to the regulatory framework in their own country to avoid criticism. Since the purpose of the article is to call attention to possible conflicts between—and also within—hard law, soft law and ethical principles, as well as tensions between politics and ethics, I adopt the first point of departure (1).

The conditions will then depend to an extent on current regulations and how they are interpreted. It may make a difference whether or not the patient is a citizen of an EU member state, and (if he or she is an EU citizen) which member state is in question. It may also be relevant whether the patient has tried to obtain permission to remain, and whether his or her request has been turned down and the patient is now waiting to be sent home to the country where he or she came from.

One possible answer to the first problem above can be stated as follows:

Position (P 1)

(P 1) It is a basic health policy responsibility of the state to organize its healthcare services so that they benefit its own citizens.

Different versions of this position can be obtained by replacing "benefit" with "benefit mainly" or "benefit only." The latter gives a strict position that may be softened by saying instead: "benefit only … unless there is legal provision for exceptions."

Thus, we may distinguish between the following three versions of this position:

(P 1.1) It is a basic health policy responsibility of a state to organize healthcare services so that they benefit *mainly* its own citizens.

(P 1.2) It is a basic health policy responsibility of a state to organize healthcare services so that they benefit *only* its own citizens.

(P 1.3) It is a basic health policy responsibility of a state to organize healthcare services so that they only benefit its own citizens *unless* legal provision is made for exceptions.

The relevance of some of the arguments for and against these positions will depend on the particular position being examined, and how that position is understood. Hence, a few comments on the wording may not be out of place.

https://doi.org/10.1017/S0963180120000857 Published online by Cambridge University Press

Obviously "mainly" is vague. There is a difference between a general, vague position and a position that distinguishes between different kinds of specific exception which may be combined: for example, exceptions granted by hard law, by soft law, by common praxis, or when certain economic requirements are met ("pay the full costs").

Other versions can be obtained by adding after "citizens" a clause like: "or those who have permanent permission to remain in the country, or have lived in the country for a specified number of years, … and who have also paid taxes." The term "basic" also opens up the possibility of exceptions. Finally, several further versions can be obtained by specifying different exceptions in addition to the one mentioned in (P 1.3). For example: "unless there is no displacement effect," or "unless those who are not citizens pay the full costs of the healthcare services they receive."

Arguments Against Versions of the First Position

Arguments *against* versions (P 1.2) and possibly (P 1.3) of the first position include the following.

(A 1) *The dignity argument.* All persons have the same human dignity, and the same entitlement to have their rights respected. Thus, they should be judged by the same criteria. Healthcare resources should be distributed on the basis of the treatment needs of the patient and the efficacy of the proposed medical intervention. Ethnic classification, birthplace, political views, the color of the patient's skin, and the patient's economic or social position are irrelevant.

(A 2) *The safety argument.* The health and safety of patients may be jeopardized if they do not receive the healthcare services—including heart transplantation—they need. That may happen, in particular, if they suffer from acute heart problems, or where, after having received a new heart, they are sent to a country where adequate follow-up is not available.

These two arguments are obviously different in kind. (A 1) is based on a principle established in the Kantian tradition where human dignity ("Menschenwürde") provides the basis of human rights. Human dignity is an ambiguous concept that has been both criticized and defended. The particular understanding of it applied here centers on nondiscrimination. Persons have equal rights, and the same entitlement to have their rights respected, regardless of their political views, ethnic origin, political or religious convictions, age, and social or economic position. The literature on this topic is vast and cannot be discussed here.[7] But one particular problem needs to be addressed.

What does (A 1) entail in its most radical form? Does it mean that anyone from anywhere is entitled to healthcare in any given country? If the argument is interpreted as implying a universal right, this certainly seems to be the implication. Article 1 in the Oviedo Convention mentioned earlier ("Parties to this Convention shall protect the dignity and identity of all human beings and guarantee everyone, without discrimination, respect for their integrity and other rights and fundamental freedoms with regard to the application of biology and medicine") can be interpreted as a basis for universal rights and duties concerning healthcare and medical research. It can be taken to support a universalist interpretation. Incidentally, the Convention is also legally binding within states that have signed and ratified it.

Perhaps the dignity argument and its underlying moral principle should be understood more modestly, so that they apply only to people within a certain

https://doi.org/10.1017/S0963180120000857 Published online by Cambridge University Press

geographical area, holding certain passports, or having contacts and resources that make it possible for them to travel to other countries. The objection to this, however, is obvious: it cannot be excluded that those who do not have these qualifications may suffer more, and have stronger needs for healthcare. Hence, the scope of the argument is obviously important.

If (A 1) is viewed, not as soft law, but as a moral principle, its scope can be limited in various ways—for example, to cultures or countries where the majority of the population is inclined to accept the principle. However, the much-discussed naturalistic fallacy is a problem for those who define the scope of the principle in this way.[8]

Unlike (A1), (A 2) is an empirical argument. As such it raises the question: What evidence is there for this argument?

Evidence?

Good intentions can do a lot of harm if they are not well-informed. So the question about the strength of the evidence is important. As to (A 2), cases have been reported in Swedish media which illustrate the fatal risks of not transplanting a heart to someone suffering acute heart problems, or of sending transplanted patients to countries where adequate follow-up is not available.

Key questions here include: What standards should the evidence meet, and what criteria should be used in assessing the evidence available? The answers will not be ethically neutral. A central starting point in this context is evaluation and judgment of the harm that will be done if the evidence contains false statements or turns out to be misleading. The more serious the harm would be, the more important it is that the evidence is correct and not misleading.

Relevance?

The relevance of the arguments above will depend on the version of (P 1) we have in mind. (A 1) and (A 2) are both relevant against (P 1.2) and (P 1.3). The vague "mainly" in (P 1.1) weakens the force of these two arguments against (P 1.1).

Another argument, particularly against versions (P 1.2) and (P 1.3), is this:

(A 3) *The confidence argument.* The confidence of citizens in their healthcare system is likely to be undermined if heart transplants for migrants without permanent permission to remain displace domestic citizens who then find it harder to access adequate healthcare, including heart transplantations if and when they need them. The problem will be intensified if, by paying their taxes, the domestic citizens have funded and maintained the healthcare system in their country—or if they have relatives who have donated organs and/or have declared that they themselves are willing to make such donations.

This is an empirical argument. It has a ring of plausibility. But is there any evidence supporting it? More research is needed to shed light on this issue. The same can perhaps be said for the following argument intended to undermine (A 3):

(contra A 3) *The contra-confidence argument.* So far the problem raised by migrants with acute heart problems seeking asylum is not a big one in terms of numbers. Only a few cases have been discussed in the media, and only in a small number of the relevant countries. So there is little risk of displacement of the sort envisaged. The likelihood that the healthcare system of the country receiving migrants will be

https://doi.org/10.1017/S0963180120000857 Published online by Cambridge University Press

drained of organs and other healthcare resources, such as operating rooms and the time of transplantation surgeons, is actually rather small.

Evidence?

There is some evidence supporting this argument. At present only a few cases have been reported and discussed in the media. Whether this means that there is no displacement effect, however, is open to question. It seems difficult to draw any specific and general conclusions from the media reports alluded to in argument (contra A 3) above. Besides, even a limited number of cases can raise difficult ethical challenges.

Another argument against the focus on the country of origin of the patients that can be seen in all versions of position (P 1) is based on common medical practice. It is this:

(A 4) *The individual assessment argument.* Individual assessments should be made, in each case, of all of the potential effects of the transplantation. They should involve more than a check on whether the patient has the right kind of permission to remain or is in danger of being sent to a country that is unwilling, or unable, to give the patient the necessary lifelong follow-up after a heart transplantation.

Evidence?

The view expressed in (A 4) is consistent with the Geneva Declaration,[9] which historically has its origins in the Hippocratic oath ("The health of my patient will be my first consideration"). Many would argue that this is still a cornerstone of professional healthcare ethics.

The commitment in the Geneva Declaration to the principle that "The health of my patient will be my first consideration" makes it difficult to carry out priority setting fairly in accordance with the principles that guide these difficult choices in many countries, including Sweden. As a matter of fact, this is one of the conflicts I want to highlight—a conflict between, in this case, the ethics of a profession and hard law, since, in at least one country (Sweden), the principles of priority setting have become part of healthcare law.

Relevance?

The force of the argument depends on the way we view clashes between legal regulations and the professional ethics of doctors and nurses. Those taking a strictly legalistic position may not be impressed by the reasoning. But the argument will be relevant, and worthy of consideration, if the laws in question presuppose (or are based on) a moral underpinning, or ethical framework, specifying the mission of the healthcare system and the obligations of healthcare staff.

Arguments for Versions of the First Position

But there are also arguments for the first position. The main arguments *for* all versions of position (P 1) include:

(F 1) *The shortage argument.* In all countries there are shortages of organs. Waiting lists affect every kind of organ transplantation, and patients die as a result of them.

https://doi.org/10.1017/S0963180120000857 Published online by Cambridge University Press

There are also waiting lists for many other kinds of healthcare intervention. According to national law and basic EU treatises, it is up to each country and its parliament to decide how its healthcare services are to be organized and who will have access to them.

(F 2*) The erosion of willingness to donate argument.* Public willingness to donate organs for transplantation may be undermined if it becomes known that donated organs are not being deployed optimally—that is, are not always transplanted into patients who can receive the lifelong follow-up that is necessary to avoid wastage of the organ.

Evidence?

The evidence for (F 1) is strong and easily accessed via the Internet. (F 2) appears plausible, but the evidence supporting it is not strong, to the best of my knowledge. I have been unable to find studies in PubMed presenting evidence supporting this argument. More research is needed on the factors positively and negatively influencing public willingness to donate organs if we are to assess the argument properly.

Relevance?

The relevance of argument (F 2), in particular, assuming that argument is sound, will depend on the frequency of heart transplantations involving migrants without permanent permission to remain in the country where the transplantation takes place. The more common such transplantations are, the more relevant it will be to consider (F 2).

Howsoever that may be, exceptions, or explicit limits, in legal and quasi-legal documents can be used as an argument supporting all versions of (P 1), at least where the transplantation of organs within EU is concerned:

(F 3) *The cross-border exception argument.* In the EU directive on cross-border healthcare an exception is made precisely to cover the distribution of organs for transplantation.[10] EU citizens are not permitted to move to other member states to receive transplanted organs or join the waiting lists for such treatment.

But what if the patient is not an EU citizen? Then the following argument may be considered:

(F 4) *The organ trafficking argument.* There are international agreements such as the Istanbul Declaration[11] to the effect that all efforts should be made to prevent "organ trafficking." This includes situations where persons with acute heart problems have to pay individuals or organizations to smuggle them into countries where they can receive a transplantation (including the necessary follow-up) and any other healthcare intervention that the migrants cannot receive in the country from where they come.

This argument is relevant only if there are reasons to believe that the patient has paid somebody, or an organization, to be smuggled into the country where the transplantation is to take place. It goes without saying that it is difficult to find reliable evidence for claims of this kind. The job of finding such evidence is certainly not one of the responsibilities of the healthcare professions.

Arguments For and Against the Second Position

There are two main versions of the second position:

https://doi.org/10.1017/S0963180120000857 Published online by Cambridge University Press

(P 2.1) A migrant without permanent permission to remain, suffering from acute heart problems, and at risk of dying if he or she does not receive a transplant, should be put on the waiting list for a transplant *if* this is medically justified.

(P 2.2) A migrant without permanent permission to remain, suffering from acute heart problems, and at risk of dying if he or she does not receive a transplant, should be put on the waiting list for a transplant *only if* this is medically justified.

Further variants of these positions can be obtained—for example, through clarification of what is meant by "medically justified."

Arguments Against Versions of the Second Position

The confidence argument against (P 1.2) and (P 1.3) mentioned earlier can also be harnessed to challenge (P 2.1):

(A 1) *The confidence argument.* The confidence of citizens in their healthcare system is likely to be undermined if heart transplants for migrants without permanent permission to remain displace domestic citizens who then find it harder to access adequate healthcare, including heart transplantations if and when they need them. The problem will be intensified if, by paying their taxes, the domestic citizens have funded and maintained the healthcare system in their country—or if they have relatives who have donated organs and/or have declared that they themselves are willing to make such donations.

Another argument against this position is the following one:

(A 2) *The optimal use argument.* If the patient's need and the efficacy of the proposed intervention are considered together, the use of the organ is not optimized if it is transplanted to a migrant without permanent permission to remain, or who will be, or is in danger of being, sent to country that is unable or unwilling to provide the lifelong follow-up without which the transplanted organ will be wasted. The organ would be better used—that is, serve its recipient longer—if it were transplanted to an alternative patient with access to adequate follow-up, other things being equal.

Evidence?

(A 1) seems plausible. Obviously, there will always be an alternative way of using a donated heart, since there are waiting lists for transplants of this organ; it could always be transplanted to someone else on the list, provided that size and human leukocyte antigen (HLA) typing allow this. However, I am not aware of any studies devoted specifically to the question addressed by (A 1). On the other hand, there is evidence supporting (A 2), according to personal information provided by transplant surgeons.

Relevance?

The "if" version of (P 2) opens up the possibility of adding other sufficient conditions and is easier to criticize than the "only if" version, given the current state of regulations in the EU. The confidence argument (A 1) and the optimal use argument (A 2) are relevant to the consideration of both versions, but they seem more relevant and forceful against the "if" version.

A comment:

https://doi.org/10.1017/S0963180120000857 Published online by Cambridge University Press

(A 1) and (A 2) are to some extent both empirical and normative. The empirical aspects concern assumptions about the consequences of certain actions or events. As for the normative foundations, the values underpinning (A 1) are related to some conception of justice or fairness. The values underpinning (A 2) are directly related to the promotion of optimal use of resources, including organs. They relate less directly to health, quality of life, utility, and patient safety.

The legal or quasi-legal cross-border exception argument against (P 1.2) and (P 1.3) mentioned earlier can also be used against (P 2.1), at least in the context of transplantation:

(A 3) *The cross-border exception argument.* In the EU directive on conditions of cross-border healthcare (2011/24/EU, chap. 1, article 1) an exception is made precisely to cover the distribution of organs for transplantation. EU citizens are not entitled to move to other member states to receive transplanted organs or join the waiting lists for such treatment.

Arguments For Versions of the Second Position

But there are also arguments *for* both versions of position (P 2). The ethics-based dignity and safety arguments against (P 1.2) and (P 1.3) referred to above can be used for this purpose. So we may add:

(F 1) *The dignity argument.* All persons have the same human dignity, and the same entitlement to have their rights respected. Thus they should be judged by the same criteria. Healthcare resources should be distributed on the basis of the treatment needs of the patient and the efficacy of the proposed medical intervention. Ethnic classification, birthplace, political views, the color of the patient's skin, and the patient's economic or social position are irrelevant.

(F 2) *The safety argument.* The health and safety of patients may be jeopardized if they do not receive the healthcare services—including heart transplantation—they need. That may happen, in particular, if they suffer from acute heart problems, or where, after having received a new heart, they are sent to a country where adequate follow-up is not available.

Evidence?

(F 1) is essentially normative, based on values enshrined in international declarations and conventions (including the Oviedo Convention[12]) that have been signed by many countries. (F 2) is based on assumptions for which there appears to be empirical evidence, but I am not aware of any studies presenting evidence supporting it. I have checked PubMed without success.

Arguments For and Against the Third Position

Two possible answers to problem (4) can be indicated as follows, defining a third position:

(P 3.1) If a migrant receives a new heart in a particular country, he or she should be granted permanent permission to remain in that country, or at least not be sent to a country that cannot, or will not, provide the patient with the follow-up that is necessary to avoid his or her premature death and waste of the transplanted organ.

https://doi.org/10.1017/S0963180120000857 Published online by Cambridge University Press

(P 3.2) A migrant should receive a new heart only if he or she already has, or will be granted, permanent permission to remain in the country, or at least will not be sent back to a country that cannot, or will not, provide the patient with the follow-up that is necessary to avoid his or her premature death and waste of the transplanted organ.

Needless to say, it is important to distinguish between these positions when we are considering the relevance and cogency of arguments for and against the third position.

It may not always be easy to obtain solid evidence that is relevant, in particular, to assessment of the last clause of both versions of (P 3). Besides, suppose the competence and the necessary resources are in fact available in the country to which a migrant with a transplanted new heart may be sent. We must still ask: What is the likelihood that the migrant will have access to them, and thus will benefit from them? This may not always be easy to assess.

The uncertainties and knowledge gaps indicated above should not be dismissed out of hand. They complicate the decision-making and make it difficult to arrive at robust decisions.

Arguments Against Versions of the Third Position

There are several arguments specifically against (P 3.1):

(A 1) *The undermining of regulations argument.* Position (P 3.1) implies that a medical doctor's judgment can trump the regulations governing the work of those agencies which, according to their instructions, have to decide whether migrants seeking asylum should be granted permission to remain permanently. This introduces a conflict with the current regulations in countries with such agencies.

Relevance?

The relevance of (A 1) depends on the way clashes between legal and ethical principles are viewed. Specifically, it depends on the way these principles are interpreted, and on the assumptions on which they are (taken to be) based.

Evidence?

Not much is currently available, to the best of my knowledge. Such evidence may exist, but I have not been able to find any studies in PubMed presenting evidence supporting the argument above.

Another argument against (P 3.1) runs as follows:

(A 2) *The unfair displacement argument.* For countries granting permanent permission to remain only to a fixed number of persons per year, (P 3.1) will, as a side-effect, introduce a new means of obtaining permission to remain in that country that could lead to unfair displacement of others.

Relevance?

The argument is relevant. It relies on underlying conceptions of fair procedure and due process that are widely shared.

https://doi.org/10.1017/S0963180120000857 Published online by Cambridge University Press

A Future for Migrants with Acute Heart Problems Seeking Asylum?

Evidence?

My search on PubMed for articles pertaining to this issue returned no results. This suggests that more research is needed on various aspects of this argument.

Arguments for Versions of the Third Position

But there are also arguments *for* versions of the third position. One supporting position (P3.2) is this:

(F 1) *The concern for the wishes of donors' argument.* It can safely be assumed that those donating organs (and their families) will want their donated organs to be used optimally to prolong the life and quality of life of the recipients. These wishes are best respected when the donated organs are reserved for recipients who will benefit from them for as long as possible; thus organs should not be given to patients where there is no possibility of adequate follow-up.

Comments

Argument (F 1) is relevant to all versions of the third position. It combines empirical and normative considerations. If interpreted empirically, it has a ring of plausibility, but I am not aware of any research or studies supporting it. Its normative underpinning involves values directly related to the promotion of optimal use of organs and other healthcare resources, and values relating less directly to, among other things, utility, health and quality of life.

Concluding Remarks: The Future of Medical Ethics

It is difficult to generalize about the relevance and tenability of the arguments for and against each of the three positions discussed here—and in particular the strength of the evidence to which they appeal. The reason is simple. There are variations between EU member states, and between these states and states outside of the EU, both in the regulation of the healthcare, the rules governing access to it, and other matters such as healthcare insurance, and demographic, political and economic conditions. Accordingly, a particular argument for or against one of the positions may be cogent and relevant in one country, but not—or not to the same extent—in another.

One lesson to be drawn from the discussion above, relevant to the future of medical ethics, is that discussions in ethics, medical ethics, and bioethics often take place in a political and legal context. This presents us with challenges at the national as well as international level. At the national level, the challenge is to maintain some sort of distinction, vital for academic respectability and trust, between politics and ethics. This is not always easy, since in many countries today political parties are divided on issues connected with immigration, on precisely what rights asylum seekers have, and on what, exactly, is the mission of healthcare where persons lacking permanent permission to remain in the country are concerned. Tension can also arise between the ethical principles of some healthcare professions and regulations in the countries in question, and between soft law (professional guidelines, recommendations) and hard law (binding legal instruments and laws).

https://doi.org/10.1017/S0963180120000857 Published online by Cambridge University Press

To be sure, the distinction between ethics and politics is not crystal clear, since many political programs for care of the elderly, the educational system, and also healthcare, are based on general value premises. Ethical considerations are relevant, and they play an important role in shaping the policies in these areas. But obviously it is possible to be normative without being involved in party politics, given a general ethics framework.

Politics is about getting things done—about promoting changes, or preventing proposed changes. It is essential for a political party to ensure that the bills it proposes are accepted by the national parliament—and that bills proposed by other parties with contrary views on the subject are rejected. To achieve this, coalitions have to be formed, and compromises need to be made. In order to succeed, economic and strategic desiderata may limit the space for ethical input.

One way to deal with this challenge might be to promote legal certainty and the rule of law. If there are no relevant differences between two cases or situations, they should be dealt with in the same way. Sticking to this principle could help to limit variations in decisions from clinic to clinic, or from hospital to hospital. Another approach is also possible but more cumbersome. The idea here would be to focus on the moral underpinnings of current regulations and, if necessary, argue that they need to be changed—because the situation, the available evidence, or the values of society, have changed.

At the international level, a corresponding challenge arises from the fact that healthcare and medical research fall outside the legal competence of the EC: nation states determine their own healthcare and medical research. On the one hand, harmonization of regulations is desirable, in view of the cooperation between hospitals and medical researchers across national borders, and given that disease spreads without respect for national borders—as the recent coronavirus disease 2019 (Covid-19) pandemic has demonstrated. On the other, harmonization is difficult in view of the differing historical, political and religious traditions in many countries, and as a result, also, of differences between states in terms of economic and technical development. This applies as well to states within the EU.

The obvious need for harmonization is dealt with somewhat indirectly by the European Commission via EU directives (on cell and tissues, patents, data protection, clinical trials, and so forth) and EU regulations covering areas that are relevant to healthcare and have an impact on medical practice and research. Examples are: GDPR and the ATMP regulation. Different member states have chosen somewhat different ways of organizing and regulating their healthcare systems, but there is also collaboration in the area of transplantation via Eurotransplant and Scandiatransplant.

One way to deal with this challenge is through dialogue between the various stakeholders on means and ends—in both the short and the long term. The process is sometimes slow, but my experience as chair both of the EGE, the European group on ethics, and of the permanent working group on science and ethics of ALLEA (All European Academies) has convinced me that progress can be made in this way.

To resolve many of the conflicts touched upon in this article a global ethics would be needed, and ideally also global regulations. It will not be enough to harmonize the regulatory framework within the EU, as many migrants come from countries outside of EU. But the problems go deeper than that. Even if the ethical and regulatory frameworks were global, differences in economic and technical development between countries around the globe would still make the future of migrants

https://doi.org/10.1017/S0963180120000857 Published online by Cambridge University Press

with acute heart problems somewhat insecure. Here again we are reminded of the political context of the discussion.

Notes

1. Justin M Bachmann, Ashish S Shah, Meredith S Duncan, Robert A Greevy Jr, Amy J Graves, Shenghua Ni, *et al*. Freiberg Cardiac rehabilitation and readmissions after heart transplantation. *Journal of Heart and Lung Transplantation* 2018;37(4):467–76. doi:10.1016/j.healun.2017.05.017.
2. N Nawa, H Ishida, H Suginobe, S Katsuragi, H Baden, K Takahashi, *et al*. Analysis of public discourse on heart transplantation in Japan using social network service data**.** *American Journal of Transplantation* 2018;18(1):232–7. doi:10.1111/ajt.14527.
3. French Intensive Care Society, International congress—Réanimation 2016. *Annals of Intensive Care* 2016;6(Suppl 1):50. doi:10.1186/s13613-016-0114-z.
4. Ángela López-Sainz, Eduardo Barge-Caballero, Gonzalo Barge-Caballero, David Couto-Mallón, María J Paniagua-Martin, Leticia Seoane-Quiroga, *et al*. Late graft failure in heart transplant recipients: Incidence, risk factors and clinical outcomes. *European Journal of Heart Failure* 2018;20 (2):385–94. doi:10.1002/ejhf.886.
   Lund HM. Optimizing outcomes after heart transplatation. *European Journal of Heart Failure* 2018;20 (2):395–7. doi:10.1002/ejhf.1026.
5. Council of Europe. *The Convention for the Protection of Human Rights and Dignity of the Human Being with regard to the Application of Biology and Medicine: Convention on Human Rights and Biomedicine.* Strasbourg; 1997 (ETS No 164).
6. European Union. *Directive* 2011/24/EU *on patients' rights in cross-border healthcare.*
7. See e. g., Beyleveld D, Brownsword R. *Human Dignity in Bioethics and Biolaw.* Oxford: Oxford University Press; 2001.; Macklin R. Dignity is a useless concept. *British Medical Journal* 2003;327:1419.; Killmister S. Dignity: Not such a useless concept. *Journal of Medical Ethics* 2010;36:160–4.; McCrudden C, ed. *Understanding Human Dignity.* Oxford: Oxford University Press; 2013.; Foster C. Human dignity: Be philosophical and European, but not Scottish. *Cambridge Quarterly of Health Care Ethics* 2019;28(3):534–41.
8. The *locus classicus* of this fallacy is Moore GE. *Principia Ethica.* Cambridge University Press; 1903. For later discussion of it, see e.g., the contributions of Frankena, Paton, Edel, McKeon, as well as Moore's replies, in *The Philosophy of G. E. Moore*, Schilpp PA, ed. New York: Tudor; 1952.
9. WMA *Declaration of Geneva.* Adopted by the 2nd General Assembly of the World Medical Association, Geneva, Switzerland, September 1948, amended and revised several times subsequently.
10. European Union. *Directive* 2011/24/EU *on patients' rights in cross-border healthcare.* chap 1, article 1.
11. The declaration of Istanbul on organ trafficking and transplant tourism. *Clinical Journal of the American Society of Nephrology* 2008;3(5):1227–31. doi:10.2215/CJN.03320708.
12. Council of Europe. *The Convention for the Protection of Human Rights and Dignity of the Human Being with regard to the Application of Biology and Medicine: Convention on Human Rights and Biomedicine* (ETS No 164).

https://doi.org/10.1017/S0963180120000857 Published online by Cambridge University Press