Healthcare, migrations and everyday bioethics: Weighing the difference

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ABSTRACT: This work uses the lens provided by the everyday bioethics perspective to assess the weight of the difference, which currently overwhelms migrants in both maintaining psychophysical wellbeing and accessing adequate healthcare services in host countries. I will start by outlining the main risks for migrants' health during their transit, as well as the main obstacles usually preventing them from accessing adequate healthcare services in receiving countries. I will elaborate by trying to shed light on the association between people movement and the spread of infectious diseases, which arguably represents the core of current political debate and tensions over international migration flows. Thereafter, I will continue by looking at the interplay of detention, migration and healthcare, in which both illegal and legal migrants are often entrapped because of their intrinsic precarious conditions. I will then highlight the main challenges associated with socio-cultural misconceptions in health and healthcare that exacerbate health inequalities to the detriment of migrant people. In the conclusions, I will try to build on the everyday bioethics approach of Giovanni Berlinguer by speculating what its contribution may be to both bioethics and the attempt to enhance the protection of migrants' health.

1. Introduction

In the Encyclopaedia of Bioethics, Warren Thomas Reich defines bioethics as the "systematic study of the moral dimensions – including moral vision, decisions, conduct, and policies – of the life sciences and health care, employing a variety of ethical methodologies in an interdisciplinary setting" (Reich, 1995: xxi). Metaphorically speaking, bioethics arose in the midst of the 20th century as a means of 'putting out fires', such as reacting to the atrocities of Nazi medical experimentation, or to the outrage provoked by the US Tuskegee Syphilis study (1932-1972). In the following decades, bioethics has evolved extraordinarily and contributed to enhancing patients' dignity and other fundamental rights, such as the right to

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be informed about one's health conditions, as well as to choose the care or treatments one must undergo. Nonetheless, when considering the elements included in that definition – life sciences, health care, moral visions, decisions, conducts and policies – it is possible to observe that each of them assumes a different weight within contemporary bioethics debates. Indeed, bioethics scholars show a clear preference for discussion and research over cutting-edge topics and dilemmas arising from technological advancements in health sciences and healthcare. Nevertheless, as highlighted by the Italian physician and bioethicist Giovanni Berlinguer (1924-2015) these topics represent only a part of bioethics that he defined as 'frontier bioethics'. Besides frontier bioethics, Berlinguer describes (claims for?) an 'everyday bioethics', which includes matters that concern the majority of the population in contemporary societies, such as health access and equity, health inequalities and discrimination, public health and primary care services. Far from underestimating the relevance of societal challenges posed by cutting-edge discoveries and technological developments, Berlinguer advocates an alternative role for bioethics aimed at enhancing the impact of this discipline in the individuals' everyday life (Berlinguer, 2003; 2000). Although it has been suggested that the approach of everyday bioethics lacks a proper theoretical basis (Biller-Andorno, 2003), it has nonetheless been welcomed especially in Italy, where the National Bioethics Committee (CNB) has referred to it in several circumstances. The CNB states that:

> Frontier bioethics focuses on the most problematic and controversial matters involving public policies and personal choices, especially for what concerns classic boundaries (i.e. birth and death); the troublesome character of these matters often depends from its being radically new, resulting from the continuous development of biomedical sciences, as well as from new technological advancements. Conversely, everyday bioethics originates from a dimension that is much closer to individuals' common experience; rather than the exceptionality of extreme cases, it instead looks at situations of normalcy (CNB, 2010: 5)

Therefore, it is possible to assert that the approach of everyday bioethics is primarily concerned with health justice, which entails taking into account the moral visions and needs of the entire population, and not only parts of it (Lecaldano, 1999). If all individuals are equal

in the eyes of the law – so to speak – yet they are not likewise equal in the face of disease and suffering. Indeed, when talking about health justice and healthcare organization, it is necessary to consider the weight of cultural, social, and economic factors such as employment, income, education, gender, and discrimination. Although these factors are external to healthcare organization, they are, to a significant extent, able to influence the effectiveness of health protection, especially when considering access to healthcare by the most vulnerable groups (Botrugno, 2014a). Over the last decades, the analysis of these factors has assumed a renewed relevance due to the work of the WHO Commission on Social Determinants of Health (WHO, 1998; 2003). Additionally, empirical research conducted in the last few years regarding the correlations between socio-economic conditions and health inequalities has shown that each of these factors has its own impact on individuals' health conditions and often negatively affects health protection, being largely responsible for a social gradient in health and healthcare access (e.g. Fox, 1989; Kunst & Mackenback, 1992; Costa & Faggiano, 1994; Kawachi, 1999; Subramanian *et al*., 2002; Padovani, 2008; Marmot, 2017). This body of evidence has made it possible to show that migrant status in industrialized societies represents a cause of multi-dimensional vulnerability, the seriousness of which is such to undermine health protection more than any other factor (Costa *et al*., 1998; Hayward & Heron, 1999; EU FRA, 2011; Reyneri, 2011; Tognetti Bordogna, 2013).

Migrant people are today estimated to number 244 million worldwide, corresponding to 3.3% of the global population (UN, 2016). While international migrations increase at a constant pace – being today 41% higher than in the year 2000 –, the utopian dream of a world without borders, envisaged the day after the collapse of the Berlin Wall, has rapidly made way for a strengthening of border control, and an exacerbation of political tensions and national ambitions imbued with xenophobia and racism. Therefore, the main objective of this work is to use the lens provided by everyday bioethics to assess the 'weight of the difference', which currently overwhelms migrants in both maintaining psychophysical wellbeing and accessing adequate healthcare services in host countries. Though mostly referring to the situation in the EU and the Mediterranean area, many of these considerations also apply to the overall migration phenomenon. I will start by outlining the main risks for migrants' health during their transit, as well as the main obstacles usually preventing them from accessing adequate healthcare services in receiving countries. I will elaborate by trying

to shed light on the association between people movement and the spread of infectious diseases, which arguably represents the core of current political debate and tensions over international migration flows. Thereafter, I will continue by looking at the interplay of detention, migration and healthcare, in which both illegal and legal migrants are often entrapped because of their intrinsic precarious conditions. I will then highlight the main challenges associated with socio-cultural misconceptions in health and healthcare that exacerbate health inequalities to the detriment of migrant people. In the conclusions, I will try to build on the everyday bioethics approach of Giovanni Berlinguer by speculating what its contribution may be to both bioethics and the attempt to enhance the protection of migrants' health.

2. International migrations and health risks

To define what migration is, I mostly refer to the work developed by the French-Algerian anthropologist Abdelmalek Sayad (1933-1998), who applied to migration the perspective of social phenomena as 'total social facts', developed by Marcell Mauss (Sayad, 2006). Following Sayad, migration should be seen as an 'epistemological itinerary', since its analysis involves the whole spectrum of social sciences: law, economy, history, geography, demography, sociology, anthropology, linguistics, and socio-linguistics, etc. Nevertheless, despite the great appeal of Sayad's thought, the epistemological complexity that should characterize the analysis of migration issues has been largely disregarded within political discourses and official orientations adopted by the EU and Member States. Conversely, simplifications have been useful to both policy-makers and mass media to legitimize the distinction between 'economic migrants' and asylum seekers, which has become a central point of the 'flows' management strategy' pursued by the EU over the last few decades (Botrugno, 2014b). Indeed, since turning back asylum-seekers is explicitly forbidden by the 1951 UN Geneva Convention Relating to the Status of Refugees – see the so-called *non refoulement* principle at Art. 33 – the distinction between asylum-seekers and economic migrants[1] has enabled national authorities to overlook their obligations toward the protection

[1] As highlighted by the 2016 UN International Migrations Report, a migrant is an individual who is living in a country other than where he/she was born (UN, 2016). Therefore, in this work, the term 'migrant' is used to

of foreign individuals intercepted at land borders, or those rescued in international waters. By contrast, when it comes to weighing the incidence of push-and-pull factors, it should be acknowledged that the majority of these flows shall be framed into the category of 'forced migrations'. A forced migration entails that individuals have little or no choice of leaving their origin countries. As a matter of fact, escaping from famine, serious unemployment, political, cultural, ethnic, or religious persecution, physical or psychological violence, or threat of violence means being forced to leave. On this note, it's worth to recall a well-known classification of the health risks faced by migrants – pre-migration factors, migration factors, and stay factors (Bhugra & Gupta, 2010; Loue & Sajatovic, 2012) – which provides a significant insight into the epistemological complexity of contemporary migrations, seen as 'a total social fact'.

Among the most common pre-migration threats to migrants' health are the exposure to infectious diseases (e.g. HIV, cholera, diphtheria, ebola, hepatitis, malaria, gastroenteritis, measles, pertussis, tuberculosis, tetanus, pneumonia, and typhus), and the risk of developing diseases caused by malnutrition and scarce hygienic conditions (e.g. marasmus, kwashiorkor, anaemia, ariboflavinosis, beriberi, goitre, pellagra, rickets, scurvy, and xerophtalmia). Furthermore, it is necessary to consider parasitic diseases and neglected tropical diseases (NTDs). In particular, the persistence of NTDs has been recently reported in 149 low- and middle-income countries of tropical and subtropical regions, especially in Africa, Asia and Latin America (WHO, 2017a). NTDs include disorders such as dracunculiasis (also known as Guinea-worm disease), trachoma, lymphatic filariasis, schistosomiasis, soil-transmitted helminths, onchocerciasis, buruli ulcer, chagas, cysticercosis, dengue fever, echinococcosis, fascioliasis, human African trypanosomiasis (also known as African sleeping sickness), leishmaniasis, leprosy, rabies, and yaws[2]. Lastly, among pre-migration risk factors, some of the above-mentioned push factors should also be included (e.g. exposure to war, torture, terrorism, famine, and violence). Indeed, beyond acting as push factors for migration, they can also act as social determinants of health, leading to the emergence of diseases or other relevant conditions such as psychological distress or physical injuries.

encompass any kind of human movement, including economic migrants, refugees, asylum-seekers, and undocumented migrants.

[2] The first six of these have also been defined as "tool ready diseases", since they can be controlled or eradicated through massive drug administration or other ordinary interventions (US-CDC, 2017).

When it comes to consider the repercussions of migration on an individual's health (i.e. migration factors), it is necessary to take into account not only those events and conditions that are strictly related to the journey, but also any other events that precede its beginning. This is especially necessary when considering the criminal gangs of people smugglers and traffickers[3] on which migrants rely in the attempt to reach EU soil. In particular, this is the case of migrants coming from the sub-Saharan African region, who are forced to pay considerable sums of money to smugglers, and deal with long and dangerous journeys before reaching the embark points at the Mediterranean coast. As reported by many NGOs operating in the Mediterranean Sea area, besides the psychological distress and physical suffering related to traveling in very precarious conditions, smugglers often leverage the migrants' condition of subjection to abuse them and rob their savings. Additionally, migrants are frequently subjected to violence, rapes, and torture. Not least, they may also be sold, executed, abandoned in the middle of the desert or in the open sea. According to data collected by initiative of the International Migration Organization's "Missing Migrants Project", 2961 migrants have been found dead in 2017 alone (IOM, 2017). Thus, it is clear that during migration routes, migrants' health and lives are threatened by a countless series of factors, including injuries, hypothermia, burns, gastrointestinal illnesses, cardiovascular events, pregnancy complications, diabetes, hypertension, and psychological distress.

As for stay factors, once migrants have survived the smugglers and the dangerous journeys, they then have to deal with a series of issues related to their adaptation and integration in receiving countries. As shown dramatically by recent clashes between border authorities of the EU Mediterranean countries and NGOs active in migrants' rescue operations, welcoming undocumented migrants and refugees to the EU soil is getting complicated. Countries such as Italy, Spain, Greece and Malta are reacting to the (assumed) excessive exposure to migration flows, and claim for a 'fair relocation' of migrants, which

[3] Although the distinction between smuggling and trafficking is very subtle, it may be useful to recall the UN Protocols on smuggling and trafficking of people, both adopted in 2000. The "Protocol Against the Smuggling of Migrants by Land, Sea and Air" defines smuggling as "the procurement, in order to obtain, directly or indirectly, a financial or other material benefit, of the illegal entry of a person into a State Party of which the person is not a national or a permanent resident" (UN, 2000a: Art. 3). Meanwhile, the "Protocol to Prevent, Suppress and Punish Trafficking in Persons, especially Women and Children" defines trafficking as "the recruitment, transportation, transfer, harbouring or receipt of persons, by means of the threat or use of force or other forms of coercion, of abduction, of fraud, of deception, of the abuse of power or of a position of vulnerability or of the giving or receiving of payments or benefits to achieve the consent of a person having control over another person, for the purpose of exploitation" (UN, 2000b: Art. 3).

involves sharing the 'migration burden' with the other EU Member States. Additionally, subsequent international tensions are heightened by some right-wing political parties that leverage the fear of an 'invasion of strangers' – in particular by Muslim people – to exacerbate nationalist and xenophobic attitudes among autochthones.

Upon arrival, illegal migrants face two main difficulties: getting a job and achieving legal status. These difficulties are tightly correlated since both the EU and Member States' national policies in the field of immigration have mostly associated foreigners' right to stay with the obtainment of a job. Therefore, getting a job and obtaining legal status may represent a problem not only for illegally entered migrants, but also for the so-called 'overstayers', which refers to those foreign national citizens who entered the EU through a temporary visa – for work, tourism, or study – and remained after the period they were allowed to stay Despite the common perception that migrants are invading the EU through illegal disembarkations, the majority of illegal immigrants in the EU are currently represented by overstayers (Cuttitta, 2007). Nonetheless, since it is very difficult to obtain a job without first holding a legal status, many migrants are forced to accept illegal, precarious, dangerous, and underpaid jobs on the black labour market (Reyneri, 2011).

The overall state of subjection lived by migrants in receiving countries has a direct incidence on their state of health, increasing exposure to psychosocial disorders, reproductive problems, infant mortality, nutritional disorders, noncommunicable diseases, and drug and alcohol abuse (WHO, 2017b). Furthermore, the condition of illegality in which many of these individuals are forced, prevents them from gaining adequate access to healthcare services, except for emergency treatments. Moreover, the persistent economic crisis that industrialized societies have experienced in the last decade has legitimized attempts of introducing 'zero tolerance' policies in what concerns undocumented migrants' access to healthcare. For instance, in Italy in 2009, the approval of Law no. 94/2009 by the Italian Parliament has, for the first time, introduced the crime of 'illegal stay' into the Italian legal system. Additionally, this law detailed an obligation for healthcare professionals to report any illegal migrants they receive for care reasons. This quite controversial obligation has been largely disregarded and strongly contested by Italian healthcare professionals, as well as by many NGOs that have promoted 'I do not report' campaigns.

Nonetheless, the introduction of this obligation has turned into a significant deterrent for undocumented migrants who have avoided – more than ever before – to seek access to healthcare services.

An even worse situation has occurred in Spain with the introduction of Royal Decree no. 16/2012, that has excluded undocumented migrants from having access to healthcare services unless for emergency treatments. Even in this case, the introduction of such a provision has been openly contested for its inhuman effects by citizens, healthcare professionals, and NGO activists. Additionally, several Spanish Regions have *de facto* eluded its application and continued to provide healthcare to migrants regardless of their legal status. Nonetheless, the Decree's approval has achieved dramatic effects over time, with at least 873 000 health books withdrawn since 2012, and approximately 3340 migrants excluded from healthcare services since 2014 (Red Acoge, 2015; Reder, 2017).

3. People on the move and infectious diseases: a threat to public health?

The association between human movements and the risk of infectious disease arguably represents the core of current debate and political tensions over international migration flows. But are migrants' health conditions a threat to public health in receiving countries? Before answering this question, it should be made clear that a growing body of literature has recently highlighted the seemingly paradoxical 'healthy immigrant effect' (HIE). This expression has increasingly been used by scholars to describe the fact that migrants arriving to industrialized countries are on average healthier than native-born populations, although the firsts usually live in worse conditions, have lower socio-economic resources, and sub-optimal access to healthcare services (Kennedy *et al*., 2015; Domnich *et al*., 2012). More research is needed in order to fully understand the main features of the HIE, especially when considering that several explanations are possible, and many factors may be involved. Nonetheless, available evidence shows that the HIE results from 'multiple filters', among which is the combination of migration with employable age:

> it is well known that workers are generally healthier than other members of society (the healthy worker effect) and that employment is one of the most important reasons for immigration, it is possible to affirm that the healthy worker effect selects healthy immigrants. (Domnich *et al*., 2012: e7532)

A further filter invoked to explain the HIE is 'cultural buffering'. This expression describes the protective effect played by lifestyles and behaviours typical of non-industrialized societies and cultures, many of which appear to be healthier than those adopted by native-born populations in receiving countries. However, it has been also reported that the HIE tends to dissolve during migrants' stay in receiving countries. Indeed, after a first period of adaptation, in many cases most indicators of migrants' health worsen until they reach levels comparable to those of native-born populations. This induced the literature to speak of an 'exhausted migrant effect' (e.g. Tognetti Bordogna, 2013; Constant *et al*. 2015). Besides the adoption of new unhealthy lifestyles, the good state of health enjoyed by migrants upon their arrival may be undermined by the difficulties encountered to stabilizing their presence within receiving countries – e.g. poor housing and working conditions, discrimination and marginalization (EU FRA, 2017), and last but not least, inadequate access to healthcare and prevention services (Mondo *et al*., 2017).

Going back to the central question – do migrants' health conditions represent a threat to public health in receiving countries? – it should be considered that in recent times, the assumed association between migration flows and the spread of infectious diseases, especially HIV, has been used at a political level to legitimize right-wing orientations and politics directed to strengthen border control, and prevent undocumented migrants' entry[4]. On one hand, it is undeniable that infectious diseases may represent a threat to public health, as shown by the spread of syndromes such as severe acute respiratory syndrome (SARS), Middle East respiratory syndrome (MERS), and more recently, West African Ebola (see also Blumberg *et al*., 2010). Nonetheless, it should be made clear that the relevance of these threats has always been controversial and deemed to be highly variable, depending on the specific features of the concerned diseases, as well as on the conditions that fostered their

[4] HIV infection risk has been a fundamental part of anti-immigrant rhetoric conducted by Donald Trump both before and after the 2016 US presidential election, especially against Mexican migrants. With regard to the EU, similar arguments have been repeatedly used by political parties such as the Polish *Prawo i Sprawiedliwość*, the Italian *Lega Nord*, and the UK's Independence Party during the 2016 Brexit campaign.

spread. Additionally, both political claims and mass-media representations leave often unclear that infectious diseases do not arise from genetic or ethnic factors, but are rather provoked by extremely poor hygienic and living conditions. Therefore, infectious diseases are not at all a peculiarity of African, Asian or South-American countries. Over time, industrialized countries have significantly downscaled the incidence of infectious disease among the native population thanks to improved living conditions, access to clean water, adequate sanitation, more efficient health systems, vaccination programmes, and the availability of antibiotics. Indeed, a huge body of literature agrees in rejecting the link between migration flows and the importation of infectious diseases, an association which has been deemed epidemiologically unfounded (e.g. CNB, 2017; Castelli & Sulis, 2017; Pfortmueller *et al*., 2016; Arnold *et al*., 2015; ISS, 2015). In spite of the common perception that exaggerates the risk of infections upon migrants' arrival, available evidence shows that infectious diseases among migrants have a 'negligible impact' on the epidemiology of destination countries: "infectious diseases are not at all a health priority at hotspots and first arrival sites, where traumatic, obstetrical and psychological disorders are most prevalent" (Castelli & Sulis, 2017: 4). In this regard, the Italian Superior Health Institute (ISS) has reported that infectious diseases detected in groups of illegal migrants upon their disembarkation in Italy – which is one of the countries most exposed to illegal migration flows – are mostly limited to dermatological infections like scabies and other controllable diseases such as measles and varicella (ISS, 2015). Furthermore, the association between migration and the importation of infectious diseases has been explicitly rejected by the WHO:

> Communicable diseases are associated primarily with poverty. Migrants often come from communities affected by war, conflict or economic crisis and undertake long, exhausting journeys that increase their risks for diseases that include communicable diseases, particularly measles, and food- and waterborne diseases. [...] The risk for importation of exotic and rare infectious agents into Europe, such as Ebola, Marburg and Lassa viruses or Middle East respiratory syndrome (MERS), is extremely low. Experience has shown that, when importation occurs, it involves regular travellers, tourists or health care workers rather than refugees or migrants. (WHO, 2017b)

Notwithstanding these data, as reported within the UNAIDS report "Outcome Framework 2009-2011", several countries correlate migrants' admittance, stay and residence with HIV testing results. These politics are not only discriminatory to migrants and totally contrary to the most basic ethical principle of taking care for the sick, but they are also not justified by an effective risk of infection, in that a chance of physical contact with HIV-affected individuals is not enough to propagate infection, nor is the physical presence of nearby affected individuals. Paradoxically, these politics may achieve the opposite effect (thus endangering public health), because they induce infected individuals to hide their conditions in the attempt of eluding border controls. For the purposes of this work, it is also worth remembering that Recommendation no. 200 issued by the International Labour Organization (ILO) forbids considering HIV infection as a means of discrimination, and explicitly inhibits employers from requiring HIV testing or other forms of HIV screening (ILO, 2010: 25). Following the Recommendation, workers should not be required to disclose HIV-related information about themselves, and their access to employment should not be endangered by HIV testing. Concerning migrant people, the Recommendation explicitly states: "Migrant workers, or those seeking to migrate for employment, should not be excluded from migration by the countries of origin, of transit or of destination on the basis of their real or perceived HIV status" (ILO, 2010: 26).

As suggested by a huge body of literature in this field, the key to ensuring safety against the spread of infectious diseases is the implementation of adequate surveillance systems and specific screening programs aimed to detect and neutralize major threats to public health (e.g. Soto, 2009; IOM, 2010; WHO, 2013). Nonetheless, in this regard, it has been reported that only a few of EU Member States have adopted specific immunization programmes to the benefit of migrants and refugees (WHO, 2017c), which means that migrants still face significant obstacles in accessing vaccination services in destination countries.

4. Migrants, detention and healthcare

Since the 1999 Council of Tampere, the EU institutions have been committed to elaborating and implementing a complex strategy of 'migration flows' management'. This

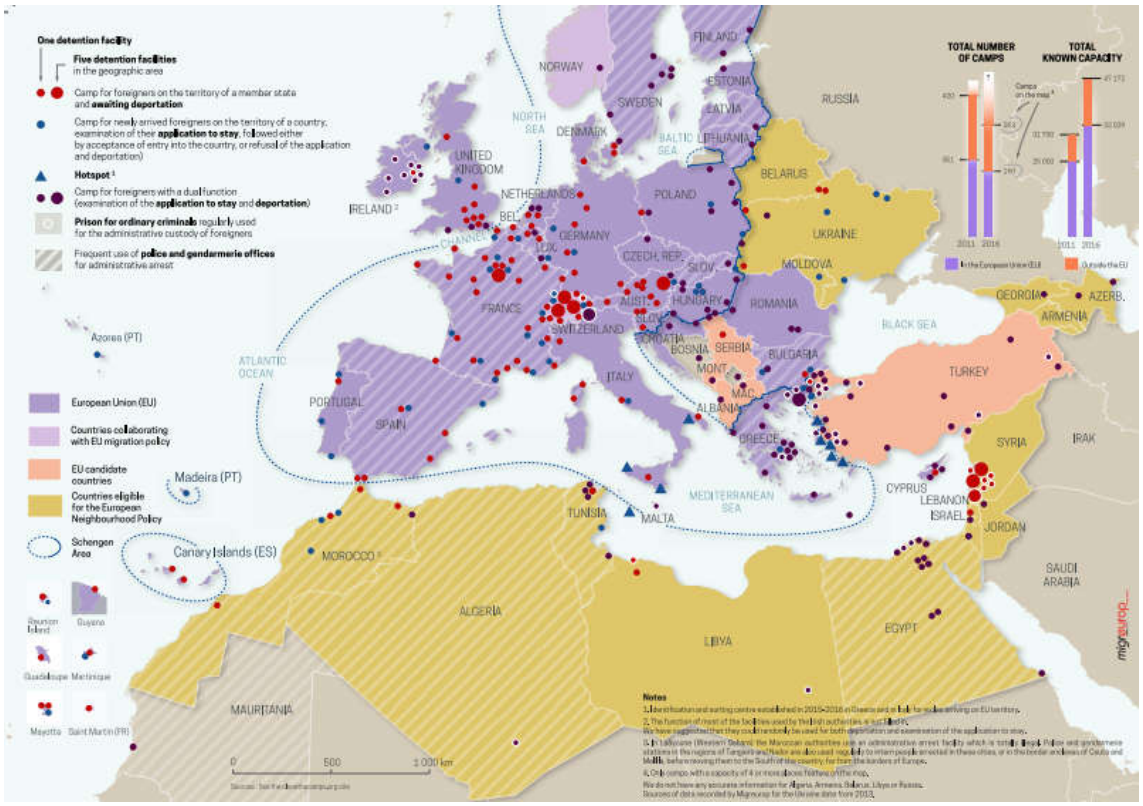
strategy has lead to the integration of the Schengen Convention into EU treaties, and it has been mostly concerned with the involvement of third countries' local authorities in strengthening border controls, as well as with the physical containment of illegal migrants and asylum-seekers intercepted at the borders (Botrugno, 2014b). Meanwhile, in the majority of EU countries, intolerance towards the presence of migrants has proliferated. This has led the EU Member States to adopt:

> [a] set of seemingly disparate developments concerning the constant reinforcement of border controls, tightening of conditions of entry, expanding capacities for detention and deportation, and the proliferation of criminal sanctions for migration offences, accompanied by an anxiety on the part of the press, public and political establishment regarding migrant criminality can now be seen to form a definitive shift in the European Union towards the so-called 'criminalisation of migration' (Parkin, 2013: 1)

As a main corollary of adopting policies that limited the legal entry of migrants, illegal migration routes have developed further, and criminal gangs leveraging migrants' desperation have flourished. As mentioned previously, over time this has contributed to a dramatic increase in the number of deaths both in the Mediterranean Sea and on the way to reach the embark points.

When intercepted at land borders, or rescued in the Mediterranean Sea, migrants are brought to 'identification centres' or 'temporary centres', and held there for a period of time that may vary (from 6 up to 18 months), depending on Member States' national policies. On paper, the stay of migrants in these centres should not go beyond the necessary time for their reception, identification, and eventual repatriation. However, in reality these centres represent today the main instrument of physical containment adopted by the EU over the last three decades, under the label of 'managing the flows'. Not least, the bilateral agreements signed by the EU with third countries' governments under the *aegis* of the European Neighbourhood Policy have made way for an 'externalization' of the borders. This means that third countries' national authorities have been urged by the EU to prevent illegal migrants' departure, with a view to reduce incoming flows. As also highlighted by reports from NGOs (Del Grande, 2007), many of the countries with which the EU has signed a partnership completely

disregard fundamental rights, which explains why local authorities are often charged of inflicting, on migrants in transit, abuses and violence that do not differ from those inflicted on them by traffickers and smugglers.



Migreurope Detentions Camps Map 2016.
Available at http://www.migreurop.org/IMG/pdf/migreurop_carte_en_hd-compressed.pdf.

Migrants are usually detained in identification centres for much more than the maximum allowed time, and in conditions that have been often reported as comparable to those of concentration camps. In this regard, the European Committee for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment (CPT) has repeatedly highlighted that most of the EU detention centres are overcrowded and lacking the most basic hygienic conditions (CPT, 2017). Moreover, the centres often host rival ethnic groups in the same space, which increases episodes of fights and violence among detainees. Consequently, disease and trauma easily proliferate among the detainees, with a worrying escalation of self-harm episodes and suicides (Fekete, 2011; MSF, 2016; MEDU, 2017). Additionally, most of

the centres lack adequate care professionals and services, and abuse of drugs has been reported as a means to control detainees and prevent agitations. For instance, a research conducted by the Italian Association MEDU in 2013 has shown that prolonged stays in detention centres are often associated with starting or increasing use of benzodiazepines (MEDU, 2013).

These drugs are often administered without the due psychiatric assessment and with higher dosages than recommended – up to seven times higher – after which, individuals fall into a state of confusion for a prolonged time. The use of psychiatric drugs has been also reported as a way of punishing detainees that try to escape, manifest dissent, or show attitudes that are considered as inadequate by professionals working for the centres (MEDU, 2013). For the purposes of this work, it is worth to recall the Principles of Medical Ethics adopted by the UN General Assembly in 1982, according to which, the restraining of prisoners or detainees is an open contravention to medical ethics, unless carried out in accordance "with purely medical criteria as being necessary for the protection of the physical or mental health or the safety of the prisoner or detainee himself, of his fellow prisoners or detainees, or of his guardians, and it presents no hazard to his physical or mental health" (UN, 1982: art. V).

Regarding the situation of the identification centres, the Italian National Bioethics Committee (CNB) has recently claimed the introduction of a torture crime in the Italian legal order, as a way to prevent "dramatic experiences like those suffered by migrants, and especially women, such as arbitrary detention, inhuman treatments, sexual harassment and rape, slavery for purpose of prostitution" (CNB, 2017: 4).

Undocumented migrants who survive the adversities of the trip and/or escape from the control of border authorities are forced to live in a condition of uncertainty and precariousness, which often leads them to resort to the black labour market, or to fall into the trap of criminality. As shown by Santoro (2006), when considering the situation in EU penitentiaries, it is possible to observe a clear disproportion between the incidence of foreign people in the general population, and the incidence of foreign people detained in penitentiaries. Unless resuscitating Lombrosian nightmares of ethnic- or morphological-inspired criminal instincts, this leads to the conclusion that denying migrants the opportunity to gain a legal status arguably represents the waiting room of criminalization processes. The analysis of Santoro also provides an interpretation through which framing the over-

representation of detained migrants within the wider economic and political context of the EU. As he argues, the deliberate exclusion of migrants from citizenship and enjoyment of social rights has been used as a means to cover the "perception of the inevitable scarcity of resources at the disposal of the State for welfare purposes" (Santoro, 2006: 69). In other words, while migrants are largely denied civil and social rights, they are also massively exploited by the productive systems of the EU countries and used at a political level as a scapegoat for justifying the progressive loss of financial sovereignty by national governments. From a slightly different viewpoint, the over-representation of migrants in EU penitentiaries confers a renewed relevance to the work of Sayad, who coined the expression of the *double peine* of the migrant – signifying their being guilty and being a migrant – to describe the burden overwhelming migrants in contemporary societies, where each of their gestures, behaviours or attitudes seems to be reproachable and prosecutable.

5. How much does the difference weigh? Socio-cultural misconceptions and inequalities in health and healthcare

In "The Foundation of Bioethics", T.H. Engelhardt coined the definition of the 'stranger in a strange land' to describe the asymmetrical position in which a non-professional stands when facing the bureaucratic-based organization of contemporary healthcare systems (Engelhardt, 1996: 295). Though Engelhardt was not specifically concerned about migrants, it would be impossible to find a better expression to explain the exceptionally asymmetrical position in which most migrants to industrialized societies stand when trying to get access to healthcare services in receiving countries. Beyond the lack of legal status – which, as seen above, is in itself a significant obstacle – many other factors may hinder an effective access to healthcare by migrant people. As easily imaginable, an initial main obstacle is the language barrier. Unfriendly care services expose migrants to linguistic difficulties and incomprehension, thus amplifying the perception of strangeness and unfamiliarity experienced in approaching the healthcare system. A huge body of literature – not only from bioethics and medical ethics, but also from sociology of health and medical anthropology – has contributed to shedding a light on the distance separating the technical perspective of

healthcare professionals from the lay vision of patients. In particular, Clark & Mishler (1992) have described this distance as a conflict between two different voices:

> the 'voice of medicine', expressing a technical, biomedical frame of reference, and the 'voice of the lifeworld', reflecting the patient's personal, 'contextually-grounded experiences of events and problems', expressed in familiar terms. Usually, the voice of medicine dominates the discourse, but the conflict tends to recur throughout the encounter at various levels of intensity (Clark & Mishler, 1992: 346)

Following this interpretation, the efforts made by patients to tell their own stories shall not be seen as a mere complaint accompanying the experienced suffering, but an attempt to make sense of technical facts such as symptoms and medical prescriptions. If healthcare professionals do not strive to mediate the distance, it is highly probable that patients will have a negative experience, which may lead to a failure of the 'therapeutic alliance'. Therefore, it is clear that language barriers can have a terrible impact on interaction between migrants and healthcare professionals, thus increasing sensations of fear, discomfort, and inadequacy, which may deter migrants to seek access to healthcare.

To stay on the topic of language(s) and voice(s), a second factor to be considered here is what kind of meaning lies behind the patients' voice. Language is a conventionally established system of communication and significance, which depends on social and cultural practices, values, beliefs, and norms. But when considering the features of communication in medicine and healthcare from the patients' viewpoint, language turns into a system of reference that often hides more than it expresses. Considering both language barriers and the restriction of verbal expression induced by the asymmetry and reverence towards healthcare professionals, a significant part of patients' expression shifts to nonverbal communication, which is arguably the most socially and culturally grounded mode of expression known to date. Indeed, expressing feelings as pain, embarrassment, approval, disagreement, (dis)satisfaction, sadness, happiness, subjection, and engagement is highly dependent on the cultural variables that contribute to shape individual and collective identities. Correlatively, the multiple forms of expressing these feelings call on likewise different ways of conceptualising the body, as well as its relation with practices, values, beliefs, and norms. In

this regard, bioethics is already facing severe challenges arising from socio-cultural misconceptions, especially when it comes to establishing what belongs to the moral spectrum of individuals and social groups, what the individual's hierarchy of values is, and how to balance dominant hierarchies with those of minorities[5]. Disregarding the incidence of socio-cultural factors in healthcare may lead to 'pathologizing diversity', which could thus be considered as a deviation from the standard biomedical parameters, social practices, and behaviours involved in the relationship between health, disease, and the body (Botrugno, 2014c).

To summarize, migrants in industrialized societies are often caught in a pathological circle of discrimination, criminalization, language barriers, poor living conditions, and socio-cultural misconceptions (McGuire & Martin, 2007; Fassin, 2001). In this circle, migrants are often reduced to invisible beings because they are to a large extent discriminated, which means that they end up having much less agency than autochthones, as well as much less ability of moving into the meanderings of the healthcare system. Moreover, they have less time and economic resources, which shall be coupled with the fear of being discriminated and blamed. This affects their agency and, again, condemns them to being invisible in the hosting societies. To understand the weight of these differences, and how invisible migrants may be to healthcare services, it is possible to look at inequalities in health and healthcare. A considerable body of evidence shows indeed that the migrant status represents a significant disadvantage to both maintaining a good state of health and accessing adequate healthcare services. The countless inequalities reported to the detriment of migrants include but are not limited to: a higher rate of complications in pregnancy and birth, and lower access to gynaecological public services than autochthones (Tognetti Bordogna, 2011); more difficulties in expressing individual needs and understanding physicians than autochthones (ISTAT, 2013); higher exposure to on-the-job injuries and job-related diseases than autochthones – up to two times higher – while migrants' employment levels remain lower (EU-OSHA, 2007; Reyneri, 2011); higher incidence of post-traumatic stress disorders among refugees – around ten times higher – than in the general population (Fazel *et al*., 2005); and higher depression and anxiety disorders rates among refugees – around two times higher –

[5] For instance, consider the controversial cases in which a blood transfusion shall be performed on a Jehovah's Witnesses, or the refusal of Muslim patients to be treated by professionals who are not of the same sex.

than in general population (Lindert *et al*., 2009). In this regard, it is also worth considering that the European Parliament has adopted a clear position with the Resolution on "Reducing Health Inequalities" (EU Parliament, 2010), in which EU Member States are called on:

> to ensure that the most vulnerable groups, including undocumented migrants, are entitled to and are provided with equitable access to healthcare [and] to assess the feasibility of supporting healthcare for irregular migrants by providing a definition based on common principles for basic elements of healthcare as defined in their national legislation (EU Parliament, 2011: 5)

Moreover, a specific consideration is given to the health protection needs of immigrant women and the correlated necessity of developing "training initiatives enabling doctors and other professionals to adopt an intercultural approach based on recognition of, and respect for, diversity and the sensitivities of people from different geographical regions" (EU Parliament, 2011: 6).

6. Conclusions: What can everyday bioethics do for bioethics (and for migrants)?

The medical anthropologist Paul Farmer has used the expression 'materiality of the social' to qualify the perspective he claims as necessary to seize the embodiment of structural violence that generates a socially-informed distribution of diseases (Farmer, 2004). As Farmer argues, "the adverse outcomes associated with structural violence – death, injury, illness, subjugation, stigmatization, and even psychological terror – come to have their 'final common pathway' in the material" (Farmer, 2004: 308). The materiality of the social has much to share with the approach of everyday bioethics, especially when considering that the latter pursues social justice and aims to give value, protect, and respect diversity, as well as to consider differences in health and healthcare. Nonetheless, as argued by Wild (2012), what is missing in bioethics today is a wider debate:

> on moral responsibilities that explicitly addresses the different groups of migrants, whether differential treatment for citizens can ever be morally

> justified, and how these moral evaluations should find their way into public and institutional policies (Wild, 2012: 12)

An attempt to bridge this gap is currently represented by the work of Mocellin Raymundo (2011), who traces a noteworthy connection between bioethics and interculturality, finding that both converge on the common ground of respecting diversity and crossing disciplines. Indeed, as reminded by Raymundo, appreciating the difference(s) arguably represents one of the most important inspiring principles of bioethics, as also predicted by Van Rensselaer Potter (recalled by Raymundo, 2011: 495). On this basis, Raymundo claims for a Bioethics that is able to recognize and protect the plurality of epistemologies and cultural perspectives in healthcare, avoiding the dominance of any particular one – usually the western biomedical perspective – upon the others. Here, it is worth adding that this kind of orientation is compliant with the 2001 UNESCO "Declaration on Cultural Diversity", according to which, defending cultural diversity shall be considered as:

> an ethical imperative, inseparable from respect for human dignity. It implies a commitment to human rights and fundamental freedoms, in particular the rights of persons belonging to minorities and those of indigenous peoples. No one may invoke cultural diversity to infringe upon human rights guaranteed by international law, nor to limit their scope (UNESCO, 2001: art. 4)

From a partially different viewpoint, everyday bioethics may also take inspiration from the well-known reflection developed by Juan Carlos Tealdi in the attempt to enhance a 'bioethics of human rights'. In his work, Tealdi claims that there is a need to restore the moral universalism that inspired the emergence of bioethics at an international level after the end of World War II. According to Tealdi, the bioethics of human rights shall serve as a meta-theory through which to react to the extremism of ethical principles, as well as to the correlated moral imperialism that proceeds from neo-pragmatism and neoliberalism (Tealdi, 2008: 177). The bioethics of human rights is relevant to the everyday bioethics' approach in so far as it pursues justice as an unavoidable obligation, which also entails recognizing the unconditioned value of human dignity (Tealdi, 2008: 178).

Undoubtedly, interculturality and human rights are fundamental pieces – among others – to complete the puzzle of everyday bioethics. In this regard, it is worth clarifying that the approach of everyday bioethics was not conceived by Giovanni Berlinguer as a new or alternative bioethics theory. It was rather proposed as a perspective through which conferring a renewed value to some elements that have always belonged to bioethics, although *de facto* set aside by the prevalence of individual-based theories, approaches, and questions. Metaphorically speaking, therefore, it is possible to argue that enhancing everyday bioethics may be seen as an attempt to enhance equity in bioethics debate. In practical terms, this would entail working towards a set of tools through which to help individuals reacting to the hierarchies of values, interests, and practices resulting from established relations of power in healthcare (Carapinheiro, 1993). By disregarding the application of the newly introduced obligation to report illegal migrants, the above-mentioned Spanish and Italian healthcare professionals have reacted to inhuman and unfair rules, which they felt as not grounded in the common – or maybe, the universal, so to recall Tealdi – moral vision that defends everybody's right to access healthcare. Additionally, by acting in this way, those professionals have *de facto* opened the black box of legal order(s), showing the (material) gaps, conflicts, and negotiations that separate the 'law in the books' from the 'law in action'. Therefore, let's consider everyday bioethics as a 'bioethics in action'.

Enhancing everyday bioethics also requires further research and further education based on this perspective. Applied to migrants, this entails educating healthcare professionals on how to receive foreign patients and how to establish good (intercultural) care relationships. It may also involve making it known to population in receiving societies that migration flows are not a 'disease' of the contemporary era, nor does the migrants' arrival represent a crisis or a threat to our stability. Rather, migration flows are the final outcome of combining poverty, war, persecution, and social exclusion, to which extent industrialized countries have enormous responsibilities (Buxo i Rey, 2004). Additionally, receiving societies should be aware that migrants are usually healthier than native-born populations in industrialized countries, and that their health problems are mostly due to malnutrition, poor education, and poor living conditions. Furthermore, migrants represent a significant resource for the economic development of receiving countries, as also explicitly recognized by EU policy-makers (European Commission, 2005).

To summarize, from an everyday bioethics' perspective, there are several reasons why we should not hesitate in taking care of migrants' health:

- it's a matter of public health: an effective prevention requires the implementation of surveillance systems and immunization programmes to neutralize potential threats of spreading diseases;

- it's a matter of economy: primary care services and prevention activities are much less expensive and much more efficacious than treating acute episodes, dealing with emergencies, or managing chronic diseases;

- it's a matter of justice: migration flows shall be seen as a global movement for social justice, and healthcare access is a fundamental right to be protected regardless of citizenship or legal status;

- it's a matter of professional deontology: healthcare professionals have an ethical obligation to care for the sick, which implies not to 'close one's eyes' in the face of human suffering, but rather to develop a proactive attitude to meet the needs of the most vulnerable and underserved populations.

Therefore, in order to ensure that migrants have full access to healthcare, it is indispensable to adopt policies directed to compensate health inequalities and eliminate discrimination in healthcare, which may be achieved through:

- promoting of migrant-friendly care services, not only in English but also in migrants' native languages;

- developing a systemic approach to migrants' health protection to be shared among the EU Member States;

- educating healthcare professionals in order to enable the recognition and protection of cultural diversity and the development of linguistic competency, and to contrast 'policies of deterrence' and anti-immigrant rhetoric.

In conclusion, the everyday bioethics' approach may contribute to raising awareness and enhancing bioethics as an active discipline through which to contrast inequalities, defend equity, and protect fundamental rights of all populations, especially those of the most vulnerable.

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