Public Health Doctors’ Ancillary-Care Obligations

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This comment on the case presented in ‘Cholera and Nothing More’ argues that the physicians at this public-health centre did not have an ordinary clinician’s obligations to promote the health of the people who came to them for care, as they were instead set up to serve a laudable and urgent public-health goal, namely, controlling a cholera outbreak. It argues that, nonetheless, these physicians did have some limited moral duties to care for other diseases they encountered—some ancillary-care duties—arising from their voluntarily entering into a kind of intimate relationship with the patients they took in, one in which those patients effectively waive certain rights to bodily and medical privacy.

The case described in ‘Cholera and Nothing More’ raises difficult and delicate issues regarding physicians’ ancillary-care duties. I have previously addressed these issues in the context of medical research (Richardson and Belsky, 2004; Belsky and Richardson, 2004; Richardson, 2007, 2008). In the case of the Cholera Treatment Centre, similar issues arise in the context of public health efforts. In general, ancillary-care duties are duties that one person owes to another that arise from transactions between them but are conceptually subordinate to, and supplement, the duties of care grounded in the principal purpose of their interaction. While the principal purpose of an interaction between two persons can be open to negotiation and dispute, often the institutional settings establish a salient interpretation. In the case of the Cholera Treatment Centre in Juba, this purpose was carried by the Centre’s name. Certainly, the NGO that established it—as its ‘memorandum of understanding’ spelled out—had the principal purpose of addressing a cholera outbreak; and because of the Centre’s name, the Sudanese who came to it at least had a reason to recognize that this was the principal purpose of the Centre’s interaction with them. Although, in certain public-health contexts, physicians might be expected to deal fairly comprehensively with the health of people who present themselves for treatment, that was not so in this case: The policies of the Centre explicitly discouraged such a comprehensive approach. Against this backdrop, Dr. Devakumar’s case raises poignant questions about whether the physicians at the Centre had duties of care ancillary to those connected with this purpose—duties to care, say, for the meningitis, measles, malaria, or pneumonia, with which they were presented.

Briefly considering the parallel issue of ancillary-care obligations in medical research will help establish that these are serious questions. In particular, they are not settled by the fact that the Centre was staffed with physicians. Like physicians serving public-health goals, physicians who do medical research involving human subjects have other responsibilities that may override or limit researchers’ duties to provide medical care for their subjects.

To fix ideas, let us consider an actual case—one that, like the Cholera Treatment Centre, was situated in the context of extreme hardship and poverty. In the late 1990s, researchers in Zambia conducted a randomized, placebo-controlled trial of the effectiveness of nitazoxinide in treating cryptosporidial diarrhea in children (Amadi et al., 2002; discussed further in Richardson, 2007). The trial divided the children into those who were HIV-positive and those who were not and yielded the result that the drug was effective in children who were not HIV-positive but ineffective in those who were. Despite focusing, in this way, on these children’s HIV status, these researchers did not take on a responsibility to provide these children with a full range of HIV care. HIV care was ancillary to the research in that, given the local conditions, a sound and important scientific question could be safely addressed without providing the full range of care to all of the children with HIV. Antiretrovirals are still difficult to come by in Zambia and were all the more expensive when the trial was conducted than they are now. Although these researchers surely had some obligation to provide the HIV-positive children in the study with HIV care, this obligation was limited by their commitment to their scientific mission, which was...
important from a public point of view. Although this trial was conducted by physicians, their interaction with the trial subjects was controlled by the trial’s scientific objective,\(^2\) which was plain to the research team and at least should, via the informed-consent process, have been made plain to the participating children and their families. If these researchers had had to divert their budget and their personnel to providing HIV care, it is doubtful that they would have been able to carry out their research on the vital issue of treating cryptosporidiosis.

In general, because of their responsibilities to their scientific mission, physicians acting as medical researchers bear somewhat different obligations to the human participants in the research than physicians acting as clinicians bear to their patients. As Miller and Rosenstein argue, ‘randomized clinical trials differ fundamentally from standard care in their purpose, characteristic methods, and justification of risks’ (Miller and Rosenstein, 2003: 1383). Because the scientific purpose of clinical trials and other medical studies involving human subjects is important in itself, it stands to reason that physicians on a research team would have duties of care towards their research subjects that are less extensive than clinical physicians would towards their patients.

The physicians at the Cholera Treatment Centre also had an important and specific mission of public importance, namely, getting control of a cholera epidemic. As Dr. Devankumar remarks, ‘We also had a duty to protect the population who did not have the disease’ (1). This public purpose is, if anything, more focused and urgent than the kind of increment to scientific knowledge at which a medical research study aims. In fact, controlling a cholera epidemic is a sufficiently urgent public-health goal that it makes this case a little bit too easy: it opens up a broad zone of permissible discretion, such that any reasonable way of proceeding seems readily defensible. That being so, I will sometimes abstract from the particular public-health challenge addressed here, as I want to discuss the ancillary-care obligations of public-health doctors more generally.

In one important way, the rhetoric of the two contexts differs: medical researchers relate to ‘trial subjects’ or ‘research participants’, whereas, I gather from the case, doctors on a public-health mission, at least operating one-on-one as they were at the Cholera Treatment Centre, still speak of interacting with ‘patients’. This rhetorical difference may lead some to resist my analogy to medical research and to hold that in the case of the Cholera Treatment Centre, unlike in cases of medical research, we are talking about clinicians’ core duties of care towards their patients. That would be to invest too much importance in these words. To be sure, these words do have some importance. As the persistence of what is often called ‘the therapeutic misconception’ in the context of clinical trials shows, individuals in need of medical care are apt not to make fine distinctions and are apt, when they see someone with a white coat and a stethoscope, to see in that person a source of the care they need (cf. Appelbaum et al., 2004). The lack of a distinct term for the individuals with whom they were relating (‘infectee’?) may have made the distinctness of the Centre’s mission less transparent to the physicians at the Cholera Treatment Centre and to the individuals seeking care there. The Centre was offering individualized medical care, but care tailored to a specific purpose, one not equivalent to promoting the health of the individuals who presented themselves at the intake tent. Where one has, knowingly or unknowingly, contributed to false expectations, one perhaps sometimes has some obligation not to disappoint too brusquely; but this obligation will here still fall short of the obligations these physicians would have if they were operating simply as ordinary clinicians.

The mission of public-health interventions, like the mission of medical research, is directed towards benefiting a collective—a local community, if not humanity as a whole. This focus generates truly difficult ethical quandaries regarding whether and when promoting the public good can justify restrictions on individuals’ basic liberties, such as forcibly quarantining people with dangerous infectious diseases (cf. Corrado, 1996). Whether to use triage and other priority procedures to sort among individuals in allocating resources in a public-health effort is not one of these difficult quandaries. For instance, when authorities are faced with an incipient flu epidemic, if supplies of flu vaccine or anti-virals are limited, it is presumably not only permissible but also morally required for the authorities to ration the supply in some reasonable way. What particular principles should apply to their allocation will be a more controversial question (cf. Persad et al., 2009); but that they may be denied to some and offered to others on some basis reasonably related to public health is beyond question.

On the basis of these considerations, I conclude that the physicians at the Cholera Treatment Centre did not have a professional duty grounded in their being physicians to provide care for anything besides cholera. They were physicians permissibly pursuing a well-defined and urgent public-health mission, which required them to allocate their resources carefully and to keep their focus on cholera. In this case, their obligations as physicians were permissibly narrowed to doing what was necessary to prevent the further spread of cholera.

This conclusion about their obligations as physicians is not the end of the story, however. As Dr. Devakumar
says, there is a human difficulty in saying to someone, “I don’t care about your cough, I just want to know how much diarrhea and vomiting you have.”’ (1). As in the case of medical researchers, these public-health physicians may have ancillary-care duties that are not grounded in their professional standing as physicians but that are nonetheless grounded in their interactions with the individuals who have come to them for care.

In my writings on medical researchers’ ancillary-care obligations, I have argued that researchers have obligations to provide ancillary care that, while not as broad in scope or as demanding as a clinician’s duties of care, are nonetheless significant. A number of others have come to agree with me on this general point: that medical researchers have ancillary-care obligations to participants in their studies, obligations that, while significant, do not cover all aspects of their health needs (Participants, 2008). I want to suggest that the same holds for public-health physicians, though for slightly different reasons.

In focusing on public-health physicians’ ancillary-care duties—which, as I indicated at the outset, are duties that one person (perhaps as a member of a team, say as a physician at the Cholera Treatment Centre) owes to particular other people—I am leaving aside some general duties that may be important for the case but that do not concern the transactions between the individuals in question. For instance, it may be that, as citizens of wealthy nations, or former colonizing nations, the physicians at the Centre have a duty of justice to the poor of Sudan, just as their fellow citizens back home may have. The general duty of rescue will also apply, requiring all to take easy steps to save individuals from dire ills if they can easily do so. Hence, the physicians should clearly stabilize someone who has a heart attack while visiting the Centre. Since they would also have a similar duty to help someone having a heart attack while they were out for their lunch break in Juba, however, the duty of rescue, like the duty of justice, is not grounded in the relationship between these public-health physicians and the locals who come to the Centre seeking care.

How can the transactions between one of these public-health physicians and an individual Sudanese give rise to special, ancillary-care obligations? I have already ruled out the possibility that these arise from the former’s role obligations as a physician. Some moral difference seems to be made by the inception of a relationship between doctor and infectee, but how and why? ‘If only they get to our Admissions tent,’ Dr. Devakumar asks, ‘were we obliged . . . to treat them?’ (1). Not quite. The special ancillary-care obligations kick in, I would argue, not from the moment they are in the tent, but from the moment at which the treatment team begins to examine them or take their medical histories. It is at that point that the team effectively agrees to begin processing otherwise confidential medical information about an individual. Once that step is taken, the team becomes morally entangled in that individual’s medical affairs. A sign of this is the hard-heartedness Dr. Devakumar rightly sensed in simply saying to someone being examined in the intake tent, ‘I don’t care about your cough, I just want to know how much diarrhea and vomiting you have.’ To say this in word or deed is to express an unacceptable level of callousness in the face of another’s clear need.

Adequately explaining how accepting individuals’ waivers of medical privacy morally entangles someone—even someone otherwise offering help—more deeply in someone’s affairs would be a long story (cf. Richardson, unpublished). Notice, though, that obtaining waivers of privacy rights is typically a necessary step in medical transactions with patients, research subjects, and likely infectees. That this is so is not always obvious. In the context of medical research—because of the way in which the regulation of medical research arose from past scandals and abuses, I take it—analysis of the function of informed consent has understandably focused on protecting against a repeat of those horrors. Requiring informed consent does this by seeing to it that the relevant information about the study is brought to light and, relatedly, by making sure that people sign up autonomously. An even more basic function of obtaining informed consent, however, is to gain individuals’ permissions to do things—take medical histories, obtain samples, make specialized images of the body, and so on—that would be morally wrong (and perhaps even amount to criminal battery) to do without permission. The reason that these things would be wrong to do without permission is generally that they would thus violate individuals’ rights to informational privacy. Informed consent thus has this third function, of waiving those rights to informational privacy. Ordinary clinicians and public-health doctors need similar permissions if they are going to do these things, even if they do not need them in writing.

It can be unacceptably callous to refuse to deal with an individual’s ancillary-care needs in the public-health context as much as in the medical-research context, though for slightly different reasons. In the case of medical research, what gives rise to a heightened moral concern with expressing a callous disregard for need is that if the researchers ignored—that is, did nothing to act on—the needs or diagnoses they discover by carrying out study procedures on an individual, they would be using that individual as a mere means in an obvious and objectionable way. Having initiated a relationship
for their own, research purposes—in part by soliciting privacy waivers—medical researchers thereby become morally entangled in their subjects’ medical affairs. Public-health physicians who are offering primary care, by contrast—such as the physicians at the Cholera Treatment Centre—do have as a central purpose helping the individuals with whom they are interacting. It is just that the help that is offered is not comprehensive, but targeted to the disease that has raised the public-health concern. As helpers, they are not in danger of using these people as mere means; but helpers, too, can get morally entangled. In the context of helping relationships in which one has accepted an individual’s tacit or explicit waiver of privacy rights, what gives rise to heightened concern with expressive cruelty is, not the concern about using persons as mere means but, instead, the objectionable ungenerosity of interpreting the helping relationship exceedingly narrowly.

On these grounds, I conclude that within certain limits the physicians at the Cholera Treatment Centre had ancillary-care duties that, were they not defeated by other duties, would have called upon them to treat the meningitis, measles, malaria and pneumonia they encountered in the people who came to them.

I have argued, however, that these public-health physicians do have a countervailing duty, namely, to keep their focus on addressing the cholera outbreak. Which of these competing duties should prevail is a matter that should be addressed case by case, or at least on a highly contextualized basis. That does not mean, however, that one should not try to articulate why, in each sort of case, one or the other type of consideration should prevail. In the case at hand, according to Dr. Devakumar’s account, many of these judgments seem to have been made on pragmatic grounds. For instance, treating complicated malaria cases, I take it, would have seriously distracted the staff from their cholera work, whereas treating simple malaria cases would not. This kind of consideration is perfectly appropriate in light of their public-health mission. My analysis of these public-health physicians’ ancillary-care obligations, however, suggests specifically moral considerations that should also be taken into account. For instance, when one diagnoses an illness by doing tests and performing examinations, one is more entangled in that person’s needs and affairs, morally, than if the person had simply presented at the admissions tent saying that they had that illness and needed care. Further, when one has generated these diagnoses from a somewhat extended interaction with an individual, the entanglement is much greater and the callousness of refusing to respond to the discovered need is all the more marked. Keeping children as inpatients long enough to determine whether their diarrhea was caused by cholera and then discharging them if it was not but merely, say, cryptosporidiosis, runs this danger. If the local hospital would have effectively treated the cryptosporidiosis, fine; but if not, these public-health physicians’ ancillary-care obligations should probably have led them to compromise their pursuit of their laudable and urgent public-health aim.

Although these factors that affect the strength of ancillary-care claims vary from context to context and cannot meaningfully be boiled down to a single index, they can nonetheless be deployed fairly systematically (cf. Richardson, 2007). In the context of medical research, likely ancillary-care claims and their likely strength can to some extent be foreseen at the stage of protocol review, making Institutional Review Boards or Research Ethics Committees a natural venue for these issues to be considered. In the case of a public-health effort like that of the Cholera Treatment Centre, such issues are perhaps better dealt with by the sponsoring governmental authorities or NGOs.

Notes

1. The term ‘ancillary’ appears with a similar meaning in the phrase ‘ancillary services’, which, in the context of a hospital, supplement the principal health-supporting efforts of the hospital and are subordinate to them, not in a moral sense, but in the conceptual sense that the definition of the ancillary services presupposes what the hospital’s core services are. In the text, however, I am focusing on ancillary duties of care, not ancillary services.

2. To be pedantically precise, it is the researchers’ interaction with the subjects quià research subjects that was controlled by the scientific purpose. Since the children were recruited from among those who had presented with cryptosporidial diarrhea at any of a number of Zambian hospitals or health centers, it seems likely that these children initially were simply patients of some of the research physicians. In this brief comment, I do not attempt to characterize the duties of care incumbent on an individual who has both an ordinary physician’s relation to a patient and a public-health or research relationship to that same individual.

References