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Health Electives in Africa and the Duty to Care in the Age of HIV/AIDS

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Destinations on the African continent—where three-quarters of the world’s HIV-infected people live, and where the complications of HIV are overrepresented in hospitals and clinics—have become sought-after sites for medical students and residents seeking experience in global health. Motivations vary: some travelers are pursuing scientific opportunities or building resumes; others are curious about tropical diseases or about practice unencumbered by American bureaucracy. Many (perhaps most) of the medical trainees who make such journeys, however, are compelled by an awareness of the suffering engendered by HIV and other health problems. They feel a moral obligation to help where help is so clearly needed; in other words, they are motivated by what bioethicists have come to refer to as a “duty to care.”

Some physicians and ethicists understand the duty to care as the single most important commandment of medicine [1]. Others see it as a dangerous idea that should be discarded, lest health care personnel feel coerced into working in situations that put them at undue risk (psychological or physical) [2]. For the purposes of this discussion, I will table the question of whether such a duty actually exists, and whether the belief that it does has benevolent or pernicious effects. In practice, whether the duty is a “real” ethical command or not, its consequences are real when we act upon it.

Many student doctors describe a strong sense of duty to assist those in the parts of the world that bear the heaviest burdens of disease and poverty. Others do not. Rather than goading the latter group into a sense of obligation, I want to explore what the implications of the duty to care *that they already feel* might be for the former group. I will assume that students who seek out situations in which they have contacts with patients take on a moral obligation to those patients. Those who choose to engage in short-term medical outreach in a setting of epidemic disease, in other words, through that choice accept a duty to care for the people with whom they interact during the course of the program. But what might that duty actually mean? As one ethicist who teaches about global health puts it, “the real issue is not about whether there is a duty to assist, but about the nature, extent, aim, and fulfillment of this duty” [3]. If we embrace a duty to care in an epidemic, what does “caring” entail? Is it a duty to feel somehow, to act in some way, to think about something—or all three?

Context: HIV/AIDS on Two Continents

Epidemic transmission of the HIV virus probably began almost simultaneously in North America and Africa, but, as is well known, the epidemiologic picture of the disease looked very different in the two regions. Clinicians' responses to the epidemic were also different. In the early 1980s in the United States, HIV hit a country that had not faced a lethal and untreatable epidemic in some time. It also first seriously affected populations that were already highly stigmatized: gay men, and, soon after, intravenous drug users. The HIV-infected became pariahs. Many avoided them, and some clinicians refused to treat them, while others took on HIV research and care as not just an intellectual opportunity but a moral mission. Debates over the duty to care raged: did doctors or nurses, dentists or students, have an obligation to provide medical care, even to those of whom they disapproved, even when doing so might put them, and possibly their family members, at risk [4]?

The burgeoning African epidemic, essentially off the radar for most American clinicians in the 1980s and early '90s, was all too visible to African doctors and nurses. For them the impact of HIV was different and greater. An opportunistic virus hit communities made vulnerable by a long history of chronic disruption and population movements, not to mention other illnesses and malnutrition [5]. Epidemic disease was no novelty, nor—alas—was widespread death at early ages, although there was a notable shift from a concentration of deaths among children to its concentration among young adults. Stigma was different too. In some places HIV became associated with “promiscuous women,” but overall it did not disproportionately afflict already stigmatized groups. The disease's toll was felt across social classes and religious affiliations and ethnicities, among men and women, in rural and urban areas.

By the mid-1990s, the situation had changed in both settings. With the advent of protease inhibitors, HIV infection in North America became a manageable if serious chronic disease, and the epidemic stabilized at low levels without a large-scale impact on most of the communities that doctors and nurses call home. Most clinicians could feel themselves to be safely separate from the groups at greatest risk. Among Americans, attention turned belatedly to the problem of African AIDS. Meanwhile, in much of sub-Saharan Africa, the magnitude of death among young adults reached a level never seen before. Hard-won gains in life expectancy were lost across much of the continent. Teachers, nurses, doctors, the highly educated, and the upwardly mobile were overrepresented among the casualties; clinicians saw their colleagues, friends, and family members sicken and die [6]. Where patient loads were high, equipment old and not always sterile, and post-exposure prophylaxis nonexistent, the fear of contracting AIDS in the course of patient care was widespread [7] and justified; many observers believe that the impact of unsafe medical practices on the African epidemic has been underestimated and under-investigated [8, 9]. AIDS often gave rise to feelings of immense frustration and medical impotence, as demoralized health care workers watched their patients die, knowing full well that effective treatment was available to people in wealthy parts of the world [10, 11].

Many of these stresses and strains remain in the African clinical venues where students on short-term outreach projects learn today. It is true that steady pressure from HIV/AIDS activists, including physicians, has ensured that basic antiretroviral drugs (ARVs) are now prolonging the lives of African patients (including clinicians) in a wide range of settings. In most places, however, ARVs are not yet available on the scale necessary to treat the numbers of those infected. Clinicians are often forced to triage, deciding who will get lifesaving drugs and who will not [11, 12]. Across most of the continent, in outpatient or inpatient contexts, one cannot work or learn without extensive contact with HIV-infected patients. In some settings, estimated seropositivity of patients on medical and surgical wards is in the 80-90 percent range, even when HIV infection rates in the adult general population are much lower. Clinical work in these venues is often difficult. Regional poverty, transnational economic forces, and the loss of personnel to migration, premature death, or better-paid jobs with non-governmental organizations continue to strip the public hospitals and clinics that provide the most care, leaving a thin line of beleaguered staff facing staggering patient loads [13].

What might a “duty to care” mean, abstractly and concretely, for medical students and residents who enter these wards during a global health elective or short-term outreach project?

Three Components of the Duty to Care

It is useful to consider the ordinary ways in which clinicians use the word care—to care deeply about a problem, to provide patient care, to be careful. These everyday meanings can illuminate the practical and conceptual issues at stake.

- *Care as emotion: a feeling of concern*
Medical students and doctors are often drawn to Africa by a deep feeling of concern and empathy, the first meaning of “care.” We care about the suffering of those affected by HIV and other apparently intractable health problems, and that caring prompts a desire to help where help is desperately needed.
- *Care as action: provision of medical services*
The second meaning of “care” is one with which clinicians are well acquainted: care as our everyday work providing medical services. “Patient care” covers a range of actions, from changing bandages to counseling to surgery, whether those actions are in a district hospital in Botswana or an outpatient clinic in Minnesota.
- *Care as cognition: preparation, caution, reflection*
Care can also mean caution, and taking care can require deliberate thought, preparation, and reflection. This third meaning of “care” is the one most often overlooked in global health ethics—and as students prepare for global health experiences.

Propelled by feelings of concern (caring) and a desire to assist (by giving care), we are sometimes at risk of forgetting another ethical principle: first do no harm (take

care). In this sense, the duty to take care requires us to make every prospective attempt to minimize harm, and to learn retrospectively from mistakes and failures as well as from successes.

Limited opportunities for follow-up, time constraints due to heavy patient loads, abundant cultural and linguistic barriers, and the high status often afforded to foreigners in white coats can add up to plenty of opportunities to harm. Students on global health clerkships often encounter situations in which they can exceed their capabilities—prescribing unfamiliar medications or performing half-learned procedures—with impunity. (Indeed, this is part of the draw for some. It is also an area that is beginning to draw attention and debate in global health ethics [14, 15].) For instance, students in an HIV clinic could overlook signs and symptoms of a worsening cough if they were unaware that patients in the first stages of response to ARVs may suffer acute, potentially even fatal, reactivation of tuberculosis [16]. The duty to care requires that we recognize our limitations, strive to educate ourselves as much as possible, and seek assistance from those—nurses, midlevel clinicians, doctors—who are experienced and knowledgeable.

Doing harm can take subtler forms, and care requires us to think about these too. I have worked at a medical school in Malawi through which many European, American, and Australian medical students circulate. These students understand themselves as motivated by altruism and perceive themselves as both caring and providing care. But some of them choose not to perform—and others are forbidden by their schools from participating in—procedures that might entail a risk of contracting HIV. Their Malawian student colleagues place intravenous catheters, catch babies, scrub in on surgery cases while expatriate students watch. Refusal to care for the HIV-infected sends troubling messages to our African colleagues and patients. Like exceeding the limits of our training, refusing to implement our training when it might put us at risk does harm. It exploits African patients as learning material. It also says plainly to our African colleagues that we consider our lives more valuable than theirs. A duty to care means that students and residents who plan global health electives in epidemic-affected areas must prepare themselves to accept the small risks associated with giving care to the HIV-infected.

Conclusion

This discussion sidesteps several important topics. Do health care professionals—and would-be professionals—indeed have a duty to care for others? If we do not, how else can we think about our moral obligations to patients? If we do, how is that duty circumscribed, geographically or otherwise? Does it lessen or disappear as we move farther away from our families, our communities, our states, our nations? In a world with enormous and growing health disparities, do our obligations as health care professionals somehow extend to everyone around the globe? Instead of tackling these difficult questions, I have focused closely on what the concept of care might mean for students who are already concerned about global health and who are planning electives in Africa.

Many students have found short-term global health outreach electives to be times of personal transformation and intellectual growth. Such experiences can be powerful motivators for continued involvement in global health or for other kinds of efforts to make the world a better place. Converting empathy to action, embracing a duty to care, feels good and can result in good work. If not carried out with due care, it can also do real harm. A version of “care” that does not incorporate all three aspects—concern, intervention, and caution—is ethically inadequate.

If reflection and preparation as well as empathy are understood as ethical tasks central to the provision of care, students will consider carefully what their impact in Africa’s outpatient clinics and hospital wards may be. They will learn as much as they can about medical care for the afflicted and seek to understand the upstream factors—the social, economic, and political determinants—that are so much more crucial to health than medical care alone. They will also do some honest introspection about their own motivations and limitations [17]. Some may ultimately decide not to do a global health elective, instead donating the funds they would have spent on travel to support African institutions that help the HIV-infected—a practical expression of solidarity that does not put them at physical risk. Others may choose to travel abroad to study and work with African colleagues side-by-side, and with those colleagues work out ways to maximize the long-term impact of their visit. Still others may choose to channel their altruistic impulses into clinical and educational experiences closer to home, among poor or HIV-infected members of their own communities. All of these choices harness empathy to both action and reflection. An understanding of care that incorporates its emotional, practical and cognitive aspects can be a powerful motivator for ethical responses to the devastation of epidemic disease.

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