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Ancillary care obligations in light of an African bioethic: from entrustment to communion

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Abstract Henry Richardson recently published the first book ever devoted to ancillary care obligations, which roughly concern what medical researchers are morally required to provide to participants beyond what safety requires. In it, Richardson notes that he is presenting the ‘only fully elaborated view out there’ on this topic, which he calls the ‘partial-entrustment model’. In this article, I provide a new theory of ancillary care obligations, one that is grounded on ideals of communion salient in the African philosophical tradition and that is intended to rival and surpass Richardson’s model, which is a function of Western considerations of autonomy. I argue that the relational approach of the former has several virtues in comparison to the basic individualism of the latter.

Keywords African bioethic · Ancillary care · Autonomy · Clinical trials · Communion · Partial-entrustment model · Relationality · Research ethics

The underexplored controversy about ancillary care obligations

What does a medical researcher (or, more carefully, her team, which includes sponsors and fieldworkers) morally owe participants in her study when it comes to resources and not matters such as informed consent and privacy? Virtually no one doubts that the researcher owes participants information and materials that would prevent them from being harmed by the study, at least if the cost of providing them would be reasonable and the avoidance of harm would be consistent with obtaining the information sought. In addition, there is no debate that if the study does end up harming participants, the researcher normally must compensate them for it. That

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applies not merely to the time taken and inconvenience caused, but also for any unforeseen physical or psychological injury produced by the study.

Now, is there any additional respect in which a medical researcher has a moral obligation to provide resources to participants in her study? Debate about how to answer this question is underdeveloped. There is a lack of consensus in the field, intuitions pull in opposite directions, and little theory has been applied to the matter. The debate concerns what is sometimes called ‘ancillary care obligations’ or ‘ancillary standards of care’, with the ‘ancillary’ indicating what in addition to harm caused by the study might warrant the provision of aid to participants.

In this article, I do not really try to argue for the existence of ancillary care obligations, but, instead, mainly seek out a theory that would make the best sense of them, supposing they exist. If the theory is independently attractive, then there would in effect be an argument for their existence. However, my main aim is not to establish that they exist, but rather to identify which moral principle would entail and best explain their existence.

As Henry Richardson has recently pointed out in the first and only book-length discussion of ancillary care obligations, his is the ‘only fully elaborated view out there’ on this topic [1, p. xi]. Richardson calls his theory the ‘partial-entrustment model’. Ultimately grounded on the value of autonomy, it is roughly the view that, upon waiving privacy rights and providing information to the researcher, the latter becomes obligated to support participants’ health in light of the information acquired from them, even if their need for medical assistance has not been caused by the study.

I argue here that the partial-entrustment model is vulnerable to criticism, and that a new theory is attractive for being able to avoid and to explain the objections facing the former. This novel approach is grounded on some ideas salient in the African philosophical tradition, which are fundamentally relational and, more specifically, communal. Very roughly, it is community, construed as an end in itself, that explains ancillary care obligations better than autonomy.

I start by clarifying what the debate is about, providing a more thorough account of what ancillary care obligations are, or, more carefully, would be if they existed. Then, I expound an African bioethic, a principle grounded on a characteristically sub-Saharan value of communion (initially advanced in [2, 3]), and show how it does a *prima facie* strong job of entailing and explaining ancillary care obligations. I next briefly expound Richardson’s partial-entrustment model, note some of its weaknesses, which are largely a function of its individualism, and contend that the African relational approach is much less vulnerable to these weaknesses. Finally, I respond to some criticisms of the communal approach to ancillary care obligations, which Richardson himself has raised, and close by noting some issues that need to be addressed elsewhere to continue the debate between us.

Ancillary care obligations: what the debate is about

Ancillary care obligations, supposing they are real, are moral duties binding on a medical researcher (and her team) to provide information, treatment, funds, or other resources to study participants for reasons other than scientific soundness,

participant safety, or compensation for study-caused harm. More roughly, they are responsibilities of those conducting medical research to aid study participants for diseases or injuries that were not caused by the study.

There are two familiar illustrations of ancillary standards of care (found in [1, 4, 5]). First, someone conducting research on malaria might encounter evidence of long-standing schistosomiasis in a given participant. Must the researcher disclose to a participant that he has this disease and even provide treatment, supposing she could do so at little cost to herself?

Second, consider a scholar researching an HIV vaccine who finds out that some study participants have acquired HIV during the course of the study. Suppose, though, that she did everything she could have in order to help them avoid becoming HIV+, providing information about how to avoid it, offering free condoms, and the like. Even though her study did not cause the harm of acquired HIV, should the researcher provide ARVs or other relevant treatments, again, if she could do so at little cost to herself?

Although some answer 'no' to both questions, friends of ancillary care obligations answer 'yes'. Most of the latter believe that there are often obligations between a researcher and her participants that are *positive* rather than negative (i.e., are not merely to avoid doing harm or interfering), *special* rather than general (i.e., are owed to particular individuals¹), and *unassumed* rather than intentionally acquired (say, by having made a promise either explicitly or implicitly²). Even if not all ancillary care obligations take this form, for most in the debate these days, they do on many occasions.

This kind of obligation would be unusual, given a background of characteristically Western moral categories. Quite often, positive obligations to particular others are assumed, e.g., by having made a promise, and unassumed positive duties are general, e.g., one can have a duty of beneficence to help anyone facing an emergency or who is amongst the worst off. Can one really have an obligation to provide aid to a specific person that one did not elect to take on?

Remember that I do not seek to answer this question definitively in this article. Instead, I aim to explore two theoretical explanations of how one might plausibly make sense of such ancillary care obligations and to argue that a new one, grounded on African mores, is particularly promising.

An African bioethic

Elsewhere, I have expounded an approach to medical ethics that is relational, somewhat like the ethic of care, but that is theoretical, in the manner of the four principles, Kantianism, and utilitarianism. In contrast to all these Western

¹ Hence, this account of the nature of ancillary care obligations assumes from the start, with Richardson, that they are not merely obligations of general beneficence, the approach that had been deemed most promising by some in early discussions more than ten years ago [4].

² Hence, this account of the nature of ancillary care obligations assumes from the start, with Richardson, that they do not merely 'arise from implicit and explicit commitments, such as promises and roles' that have been taken on with the expectation of providing aid, as per some others in the recent debate [5, p. 153].

approaches, my approach is grounded on a characteristically African value of communing, which is not reducible to caring, promoting wellbeing, and so on.

As one is obliged to point out when discussing sub-Saharan Africa, it does not manifest a uniform culture, with more than 50 countries, thousands of different ethnic and linguistic groups, and cultural influences from Euro-America, the Middle East, and the Indian subcontinent. Even so, most anthropologists and historians note *salient* (present neither everywhere in Africa, nor only there) patterns amongst indigenous ways of life below the Sahara, that is, norms that are not a function of what has come to it from other regions. In particular, most readers beyond Africa will likely have heard that its moral belief systems are characteristically communitarian, focused on relational values such as harmony or cohesion. In the following, I expound a moral theory that specifies the nature of this relationship and that roughly takes it to be something that merits pursuit for its own sake.³

For some rough expressions of this perspective, consider the claim by Peter Kasenene, a Ugandan-based scholar of sub-Saharan religious and moral thought: ‘in African societies, immorality is the word or deed which undermines fellowship’ [8, p. 21]. Consider also the remarks about indigenous Africans made by Desmond Tutu, ‘Social harmony is for us the *summum bonum*—the greatest good. Anything that subverts or undermines this sought-after good is to be avoided like the plague’ [9, p. 35].

With these terse statements, which I unpack below, Kasenene and Tutu are seeking to provide an accurate description of African beliefs about ethics, whereas I draw on one major sub-Saharan approach to morality in order to advance a normative theory, one that is particularly revealing with respect to bioethics. According to this prescriptive ethic, *an act is right insofar as it honours (people's natural capacity for) communal relationships, ones of identity and solidarity.*

To begin to spell out what I mean by ‘communal’ relationships, or ones of ‘fellowship’ or ‘harmony’ as per the quotations above, consider some representative comments about it from sub-Saharan African intellectuals. According to the Ghanaian Kwame Gyekye, the most influential African political philosopher of the past 20 years, ‘The fundamental meaning of community is the sharing of an overall way of life, inspired by the notion of the common good’ [10, p. 16]. Pantaleon Iroegbu, a Nigerian theologian, maintains that ‘the purpose of our life is community-service and community-belongingness’ [11, p. 442]. Former South African Constitutional Court Justice Yvonne Mokgoro remarks, ‘Harmony is achieved through close and sympathetic social relations within the group’ [12, p. 17]. Finally, the Kenyan historian of African philosophy Dismas Masolo highlights what he calls the ‘communitarian values’ of ‘living a life of mutual concern for the welfare of others, such as in a cooperative creation and distribution of wealth ... [of] feeling integrated with as well as willing to integrate others into a web of relations free of friction and conflict’ [13, p. 240].

The above characterizations of communion suggest two distinguishable properties (first reconstructed in [14]). On the one hand, there is what I call ‘identity’, a

³ Some other African philosophers consider communion merely to be a means towards the realization of other values such as wellbeing [6] or vitality [7], particularly (but not solely) that in one's society.

matter of sharing a way of life, belonging, being close, and feeling integrated. On the other hand, one finds reference to promoting the common good, engaging in service, being sympathetic, and living a life of mutual concern for others' welfare, which I call 'solidarity'.

More carefully, it is revealing to understand identifying with another (or being close, belonging, etc.) to be the combination of exhibiting certain psychological attitudes of 'we-ness' and cooperative behaviour. The attitudes include a tendency to think of oneself as a member of a group with the other and to refer to oneself as a 'we' (and not merely as an 'I'), a disposition to feel pride or shame in what another member does, and, at a higher level of intensity, an emotional appreciation of the other's nature and value. The cooperative behaviours include being transparent about the terms of interaction, allowing others to make voluntary choices, acting on the basis of trust, adopting common goals, and, at the extreme end, choosing for the reason that 'this is who we are'.

Exhibiting solidarity with another (or acting for others' good, exhibiting concern for their welfare, etc.) is also usefully construed as the combination of exhibiting certain psychological attitudes and engaging in helpful behaviour. Here, the attitudes are ones positively oriented towards the other's wellbeing, and include a belief that the other merits aid for her own sake, an empathetic awareness of the other's condition, and a sympathetic emotional reaction to the empathy. And the actions are not merely those likely to be beneficial, that is, to improve the other's state, but also, in the ideal case, are ones done for that reason and for the sake of making the other a better person or for the sake of communal relationship itself.

These specifications of what it is to commune with others, schematically presented in Fig. 1, ground a fairly rich and promising normative ethic with a sub-Saharan pedigree. A prescription to honour communion (or, more carefully, people in virtue of their ability to commune) means, in part, respecting actual relationships of identity and solidarity. To honour a relationship means producing, sustaining, and enriching it, but not in whatever way one can, as consequentialism would prescribe.

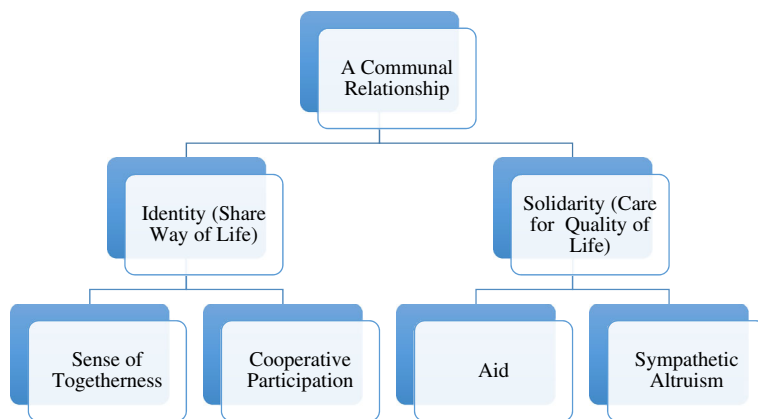


Fig. 1 Schematic representation of communion (slightly modified and reprinted with permission from [15])

For example, honouring the value of communion would normally mean not seeking to advance it by means of discord, the opposite of communion comprised of division ('me vs. you' and subordination) and ill will (harmful behaviour consequent to indifference or cruelty), at least when it comes to those who have not been discordant.

To begin to appreciate the explanatory power of this moral principle, consider its implications for the nature of wrongdoing. The relationship of identifying with other people in combination with that of exhibiting solidarity with them is basically what English-speakers mean by 'friendliness', or even a broad sense of 'love'. Hence, this African moral theory implies that wrong actions are, very roughly, those that are not friendly. What makes acts such as killing, coercing, deceiving, exploiting, cheating, breaking promises, and the like typically impermissible is that they are (extremely) unfriendly, indeed, ways of prizing division and ill will (discordance).

It is not merely that these actions are uncaring but also that they typically involve subordination done out of a divisive attitude. This Afro-communal ethic includes everything that care ethicists prize, as it prescribes acting to improve others' quality of life consequent to certain attitudes of sympathy and altruism. However, it also includes a certain kind of relationship that care ethicists typically do not prize, or at least not in the way they normally expound their view. African moralists tend to value both caring for others' quality of life and sharing a way of life with others, where the latter is more or less the combination of enjoying a sense of togetherness and participating in cooperative projects. Elsewhere, I have argued that this latter condition must be brought into a relational morality in order to avoid concerns about paternalism, exploitation, and similar objections that plague the ethic of care because of its exclusive focus on welfare [16]. For example, considerations of informed consent are plausibly captured by the idea that conducting research on or treating someone without his consent would essentially be to degrade his capacity to genuinely *share* a way of life, and not so much a failure to care for him.

Note that the present normative interpretation of African morality is not vulnerable to one of the most frequent criticisms of sub-Saharan ethics, namely, a demand for uniformity or an inability to account for the value of the liberty to be different from others. For one way to see that it avoids this problem, recall what I have said about the meaning of the phrase 'identify with others' or 'share a way of life', namely, that it by definition includes coordinating behaviour, such that honouring this value *prima facie* means not subordinating others. Forcing others to be like oneself or a group is not to *share* a way of life, which in this context implies voluntariness, at least on the part of adults. For another, consider what it means to prize friendliness, which I suggested above is a rough equivalent of my Afro-communalism. To be friendly with someone hardly means pressuring him to become like someone else. Instead, part of the value of friendship (an intense form of friendliness) is that two adults have elected to come together, and to stay together, of their own accord. Another part of its value is that friends help one another to 'do their own thing', not to become the same. What goes for the good of friendship goes for a normative ethic of friendliness.

For a last clarification, I point out that as a relational approach (and like the ethic of care), there is a clearly partial dimension to African ethical thought. Traditionally

speaking, in sub-Saharan societies, blood ties were deemed grounds for having a greater claim to aid than those lacking such relationship [17]. However, a more attractive reconstruction would imply that those who are already in communal relationship with one have a somewhat greater claim to one's aid than others who are not in such a relationship with one. Such a principle plausibly explains why a patient already being treated by a medical professional is entitled to continued attention, relative to someone not yet in treatment, even in the absence of a promise to provide it. It also explains why a medical professional can be obligated to cover for a colleague with whom he works, but not for one at another hospital whom he does not know, again, even without any explicit agreement.

I lack the space to spell out and defend this principle any more, or to bring out its African pedigree. Although the quotations above indicate that this ethic is founded largely on ideas from the sub-Saharan region, it is not meant to be only for people with such a cultural background. Although friendliness has not served as a salient principled ground of moral thought in the West (or in the East), I presume readers from a variety of traditions can appreciate its *prima facie* appeal. If one were sympathetic to the idea that there are ancillary care obligations of the form adumbrated above, and if the Afro-communal principle did turn out to account for them well, then that would serve as some additional evidence in its favour.

Ancillary care obligations as ways of honouring communion

In this section, I apply the Afro-communal ethic to ancillary care obligations, indicating that it entails and plausibly explains them. It is only in the following section that I argue that it does a better job than the partial-entrustment model at doing so.

Here is the basic rationale for thinking that a medical researcher can have obligations to aid her patients beyond what safety or a promise requires.⁴ Upon sharing a way of life with participants, a researcher has established part of a morally significant relationship that demands respect and hence full-blown realization in the form of caring for their quality of life as well. Once a researcher and a participant have begun to think of themselves as a 'we' engaged in the joint project of a study, they have formed a tie that imposes special obligations to care for one another's quality of life that can go beyond those listed in a participant agreement form (with the one in a greater position to aid naturally having more of a duty to do so). Just as extant patients are normally entitled to treatment from a given medical professional and with some priority relative to strangers, extant participants have a claim to receive aid from a medical researcher, such that it would be *pro tanto* wrong for her to allocate it to strangers with whom she has not related communally.

In addition to providing an explanation for who it is that a medical researcher must aid, an appeal to communion can account for how to aid. Basically, the form

⁴ I first briefly suggested this reasoning in [2, pp. 55–57], but do much more to spell it out and defend it here. It would be interesting to compare my approach with another relational account that Nate Olson has recently advanced [18], according to which the concept of respect for meaning in people's lives as it inheres in their relationships is key.

that caring should take is determined by considerations of the way of life that has been shared.⁵ That is, the proper way for one person to seek to benefit another is in large part a function of the nature of the relationship of which they have both been a part. Since a medical researcher and participants have been involved in a joint project of discovering information about health, health-related care is the appropriate sort.⁶ When a medical professional owes a colleague aid, it is for help with such matters as taking over her shift when she has family obligations, and not, say, assistance with cleaning her garage. By analogy, if indeed a medical researcher owes participants aid, it is a matter of informing them about unknown diseases and treating them.

Finally, consider the question of how much a medical researcher is required to aid participants. Researchers are already often concerned about the costs of their studies, and they might reasonably be worried about being deemed to have obligations to aid participants beyond what research ethics committees currently tend to expect. There are two respects in which researcher obligations would be limited by the present bioethic.

For one, the Afro-communal ethic plausibly entails that researchers are more obligated, the more good they are able to do without imposing great costs on themselves. Honouring communion does not mean maximally promoting it; it is not utilitarian, demanding that a moral agent sacrifice up to the point that he would be as badly off as the worst off he is seeking to help (as per Peter Singer's view advanced in [19]). Instead, honouring the capacity to commune means giving all of one's extant relationships their due, which, for a medical researcher, include ties to his employer and the scientific community. It also means protecting one's own *capacity* to commune, which has value, a dignity, apart from the way it has been actualized. Given, then, that one is not to treat oneself merely as a means to the ends solely of one's participants, or indeed to those of anyone with whom one is communing, there are limits to what can be expected of a researcher and her team.

Of course, speaking of 'no great cost' or of 'little cost' is vague. To say a bit more, the thought is that a given agent has trivial, moderate, and urgent interests, and that she can be required to sacrifice at least her trivial interests when the urgent ones of others are at stake. What counts as a trivial interest will depend on the agent. Spending a million dollars would not be trivial for most human beings, but it could well be trivial for a pharmaceutical company with profits in the billions.⁷

A second principle that follows from the basic one advanced here is this: the closer the relationship between two parties, the greater the obligation to aid. The moral reason why one is required to give one's family the lion's share of one's resources is plausibly that one is closest to them, not that one has promised or that one could do the most good by helping them rather than others. Even if one had not

⁵ It need not take the form of a *role*, the strategy largely employed in [5, p. 153; 18].

⁶ I first advanced this rationale in [2, pp. 56–57], and it has recently been echoed in [18, pp. 7–8].

⁷ A fuller account would require a theory of what is good for a human being, which I lack the space to provide here. However, I note that in the African tradition, the human good is usually conceived objectively, i.e., in terms of needs and not so much pleasant experiences or satisfied desires. A need-based theory of the human good would provide the ultimate basis for evaluating an agent's claim that a certain degree of sacrifice is too great.

promised to do so, and even if one would not maximize good outcomes by doing so, one would still have some weighty duty to help one's family before non-family. And an appeal to communion makes good sense of that.

By extension, the closer a researcher becomes to participants, e.g., by virtue of having engaged in a longitudinal study with the latter, the more that is owed to them in comparison to, say, those subjected to a once-off drawing of blood. Of course, often times, it is not literally the researcher who develops ties with participants, but rather those acting under her direction, such as fieldworkers and nurses. However, insofar as the latter's agency is a function of those who have conceived and funded the study, the ties they form with participants are also plausibly considered to be those of the principal investigator and her sponsors.

In sum, the appeal to communion provides powerful explanations of an array of positive, special, and unassumed obligations in a medical context, not merely those between a researcher and participants. It explains why a researcher can be obligated to aid participants apart from any agreement to do so, but not, say, those who work at a shop till. It accounts for the intuition that a researcher can be obligated to aid participants with regard to their health, but not for everything they might need in life. And it also makes good sense of how much a researcher owes different participants. It therefore merits being paired up against the dominant theory of ancillary care obligations.

Communion versus entrustment

Here, I briefly expound the partial-entrustment account of standards of ancillary care, most often associated with Richardson's book [1], but also advanced by others [5, pp. 155–157; 20], and I provide some reasons to favour communion as their ground. I maintain that Richardson's individualist foundation, viz., his appeal to autonomy, is not as powerful as a relational dimension of communion at accounting for the intuitive contours of ancillary care obligations. I also respond to objections to my approach, some of which have recently come from Richardson himself [21].

According to Richardson, ancillary care obligations arise when patients' autonomy is reduced or threatened by virtue of disclosing intimate information about themselves with a researcher. 'The central claim of the partial-entrustment model is that, simply by providing researchers with these special permissions (to conduct research on them), participants effectively entrust the researchers with special responsibilities to look after needs they discover by acting on those permissions' [1, p. 35]. The entrustment is only partial, as participants naturally retain significant responsibility for looking after their own needs. However, upon receiving private information from participants, which places them in a vulnerable position, according to Richardson, the researcher becomes obligated to help participants, even if their need for help was not caused by the study.

Self-governance is the value at the bottom of Richardson's explanation of ancillary care obligations. Roughly, since the researcher has compromised the participants' autonomy, she has a duty to protect them in other ways. As Richardson

says, ‘The basis of the special ancillary-care obligation, then, lies in the special responsibility for protecting participants’ autonomy that falls to researchers when they accept the participants’ waivers of their privacy rights’ [1, pp. 96f.]. Upon giving informed consent to participate in a study, participants waive their right to retain certain kinds of information about themselves (e.g., about their body and intimate behaviours as they pertain to the object of study) and thereby put themselves in a compromised position, which, for Richardson, means that the researcher incurs an obligation to protect them from harm discovered by means of that information. The obligation is all the weightier if the researcher (or her team) asked participants to become a part of the study.

Rather than point out the advantages of this model, which Richardson has done quite ably [1], I focus on what I think are new and important weaknesses,⁸ so as to motivate the communal alternative. One of these problems is that there are places in Richardson’s complete theoretical account where autonomy does not do the sole—or even the main—justificatory work, as it is supposed to do according to the official line of argument adumbrated above; autonomy is supplemented by an ad hoc appeal to an altogether different, relational value.

For one, according to Richardson, a researcher has a duty to offer treatment or funds to participants only after, and because, she has warned them of harm that she discovered in the course of the study about them. Once she notifies them of a sensitive matter, *the relationship becomes more intimate*, which is what obligates the researcher to offer aid as well. As the point is important, I quote several passages from Richardson to this effect:

The warning or, more generally, the broaching of the sensitive issue deepens the relationship between these two parties.... Insofar as the demandingness of beneficence obligations varies directly with the depth of relationships, this deepening of the relationship is itself a basis for firmer obligations of beneficence [than merely warning]. [1, p. 92]

[T]he morally required warning ... has transformed this situation from one in which the best and most apt way of promoting these autonomy concerns would likely have been to back off and keep one’s distance into one in which one is instead called upon to be supportive.... While we would typically prefer that such support come from our close intimates, broaching the issue *makes* the acceptor an intimate. [1, pp. 93–94]

⁸ A weaker objection is that Richardson overemphasizes the role of free and informed consent to conduct the study. Suppose researchers did not seek out such consent, or suppose they sought it out but actually failed to obtain it (unbeknownst to them). Even so, ancillary care obligations would still obtain. This is not a deep problem for Richardson, I believe, since he could say that the violation of autonomy imposes all the more responsibility on the researcher to make up for it. What really does the work in Richardson’s theory is not the *giving* of informed consent or a waiver of privacy, *contra* his phrasing [1, pp. 34–37, 65], but the *taking* of private information, whether consensually or not.

A stronger objection, but one already made in the literature, is that the partial-entrustment model is too narrow when it comes to ‘scope’, i.e., the range of aid that a researcher should be expected to provide. In particular, several have suggested that participant conditions known to the researcher prior to the study can warrant being treated no less than those discovered in the course of the study (e.g., [18]).

Once one has warned the other about a new problem that one discovers on the basis of private information ... the morally best way to address these underlying concerns becomes not to duck out, but rather to help.... [T]he duty to warn (or its cognates) further deepens the incipient relationship begun by the initial intimacy, providing a clear locus for a special obligation of beneficence. The upshot is a special ancillary-care obligation. [1, pp. 95–96]

My point is this: it is *not* so much the fact of reduced privacy or compromised autonomy that, by Richardson's full account, generates the duty to aid beyond providing a warning of a discovered illness, but rather the intensity of the relationship between the parties. Richardson's appeal to intensity of relationship in order to ground obligation fits naturally in a communal ethic, but not in an autonomy-based one that makes no essential reference to other persons.

Continuing the dialectical move against Richardson, notice that he also appeals to the depth or intensity of the relationship, e.g., how close the parties are and how long the relationship has lasted, in order to determine how much a researcher is obligated to aid participants (while also including a 'little cost' rider) [1, pp. 42, 48–49, 188]. However, this factor again has nothing inherently to do with the participant's autonomy, and rather fits best within a fundamentally relational ethical framework.

In reply, Richardson could seek to give up the appeal to intimacy as a factor determining the ground and content of obligations. He might instead maintain that it is indeed a reduction of autonomy, or threat of such, that creates the obligation for a researcher to aid a participant. Sometimes, for example, he contends that when a researcher warns a participant of a disease revealed in the course of the study, 'the gaze of another threatens to inhibit how one deals with particularly sensitive matters' [1, p. 93], or that the participant 'will likely feel temporarily at a loss when suddenly confronted with the issue' [1, p. 94]. Imposing these autonomy-related risks on participants, the researcher incurs a duty to make up for them, by offering treatment for the disease.

This approach would be more coherent for Richardson, but, I maintain, less plausible. The obligation to offer treatment to participants, it seems to me, existed *before* such threats to autonomy obtained. My intuition is that if the researcher has a duty to warn participants of a disease they are revealed to have in the course of the study, then she also has a duty to offer more than that *at the same time, prior to having actually warned them* and thereby having negatively affected their autonomy. And if the duty to offer treatment existed prior to the participants being warned, then it of course was not the warning that created the duty. It must have been something else that created it, plausibly the fact that the researcher and the participant shared a way of life or came to identify with one another with respect to medicine.

Finally, I suggest that autonomy is a *prima facie* poor explanation of a special, positive, and unassumed obligation. If a person makes a fully free and informed choice to give something to a party, then, *in light of autonomy*, he is responsible for any foreseeable vulnerability that doing so may entail, and the one who now has the information is not liable to aid *on that basis*. Consider that when I provide money to

a seller on the internet, I freely reduce my autonomy to some degree, as I no longer have the money and hence cannot make a wide array of other purchases. My range of choice is now limited merely to using that purchased object; I am unable now to acquire any number of other objects to use. Yet, the seller normally incurs *no* liability as a result, with respect to any autonomy-related issues.

Similar remarks seem to apply to someone who makes a free and informed choice to give information to a researcher. So long as the participant was not exploited, i.e., had little or no choice but to become a participant, and so long as the participant was neither deceived nor otherwise ignorant of key facts, autonomy-based factors mean that it is his responsibility to bear the cost of having disclosed the information about himself. When thinking from the perspective of autonomy, there is no difference between deciding to put personal information about oneself on the internet and giving the same information to a researcher. In both cases, others do not become obligated to help one because one's autonomy has been compromised. If a researcher has some liability towards participants, it is probably not because their autonomy has been reduced in the course of making a free and informed decision, but rather, more promisingly, the fact of having related in a certain way.

I agree that contractual exchanges can sometimes give rise to supra-contractual obligations, as Alan Wertheimer has argued [22, pp. 255–320]. My claim is that *autonomy* provides a poor account of when such exchanges do so, and that, on the face of it, relational considerations do a better job of explaining them. For example, communion is a plausible reason why an internet seller incurs no liability to provide aid to a purchaser who loses some autonomy in making a purchase, and why one might plausibly owe the kid who mows one's lawn over time more than one could get away with by paying him (cf. [22, p. 256]).

To sum up this section so far, I have more or less argued that where the partial-entrustment model appears strong in accounting for ancillary care obligations, it is so by illegitimately invoking relational values that are distinct from autonomy, and that where it is weak, it is so because of its appeal to autonomy as the ground of ancillary care obligations. Before closing, I address three important objections that *prima facie* apply to my appeal to communion as a way to account for ancillary care obligations. The first two have been suggested by Richardson [21].

Richardson's two worries concern who, precisely, is owed aid from a researcher and under what conditions. One of the criticisms is that my appeal to a relational value is too narrow, unable to account for cases in which there is interaction, but not relationship, between a researcher and participants. For example, imagine a case in which researchers have merely asked some demographic questions of a person and then taken a cheek swab to collect a DNA sample. Suppose that analysis of the sample has revealed a fatal condition, and that the researcher has a duty to warn the patient of that. Partial-entrustment appears to make good sense of this duty, since the disease was revealed in the course of the researcher having obtained health-related information from the patient, whereas an appeal to communion has more difficulty, on the face of it, since there is no real relationship yet between the parties.

In reply, the first thing to note is that, even if there is a duty to warn the participant, there is probably no duty to treat her, at least if there is some real cost to doing so. The brevity of the length, and the weakness of the intensity, of the

relationship (if there is one at all, of course), plausibly explain why. But partial-entrustment cannot appeal to these relational factors, at least if seeking to ground considerations on the individualist value of autonomy. Indeed, considerations of autonomy (at least as Richardson is inclined to understand them) likely are counterintuitively to entail a duty to provide treatment, supposing that revelation of a fatal illness were foreseeable to the researcher, and especially if conveyed to the participant prior to taking the swab.

Secondly, note that, strictly speaking, the appeal to communion does not require a full-blown relationship in order to ground a duty to aid. It is one thing to relate in a certain way, and another to be party to a certain kind of relationship. To be sure, the African ethic instructs moral agents to form communal relationships (amongst other things), but that does not mean that relationships alone obligate within a relational ethical framework (*contra* the view advanced in [18]); weaker ways of relating can also obligate.

Suppose, for example, that the crossing-guard at my son's school cannot afford the fees to send his own son there. I see the guard most days, obeying his instructions and exchanging a nod and a smile, but not much beyond that. Despite our lack of relationship, we enjoy a sense of togetherness and we cooperate in the shared aim of protecting school-bound pedestrians. That, I submit, is enough to obligate me to help if he were to ask parents at the school to each contribute a small amount to enable his son to attend, at least more than if he were a stranger. This obligation is one that partial-entrustment cannot capture, given the lack of intimate information disclosed. And the case is similar to the putative counterexample of the cheek swab participant with whom there is a lack of relationship but with whom there is a sense of togetherness and coordination in pursuit of shared ends.⁹

The second criticism of the communal theory of ancillary care obligations is the converse of the first one; namely, the approach is too broad, such that it cannot avoid entailing that a medical researcher has duties towards her local bartender, with whom she might well have a relationship. Even if a full-blown relationship is not necessary to have a special duty to care for another, by the African ethic, it is surely sufficient. So, it appears that a researcher could be obligated to aid her local bartender just as much as, if not more than, a participant in her study, which is counterintuitive.

Or is it? Recall my proposal that the nature of caring is properly determined by the nature of the sharing, i.e., that the ends sought out by the parties are what largely fix the content of the kind of aid that they must provide each other, such that a medical colleague can be obligated to cover another's shift, but not to clean his garage. It follows that if the researcher did have an obligation to help her bartender, it would not be to provide him healthcare. Instead, at most, it would be to assist in tending bar. Is that such an odd idea? Suppose the researcher has indeed formed a trusting, somewhat intimate relationship with the bartender, sharing stories about their lives over some years. Then, if the bartender needs to take an urgent call, and the researcher can help to keep things running for 20 minutes, I find it plausible to think that she would be wrong to refuse to do so (even if not the sort of wrong that would call for the use of force or punishment).

⁹ A third possible reply is to suggest that the duty to aid in the present case is not a special one, but rather, an instance of a duty to rescue.

A third objection to the communal account of ancillary care obligations is that its rationale is too weak to ground an actual obligation on the part of a researcher. Aid to participants is never to be too costly, and it is only in the case of having intense ties with them that providing aid would really ‘pinch’ a researcher and her team. Perhaps, then, providing ancillary care is not really a duty, but something beyond the call of duty.

I make two replies, here. First, one should distinguish between what a duty calls an agent to do and how strong the duty is. A duty might be strong in the sense of not being easily overridden by other moral considerations, but not in the sense of requiring all that great a sacrifice. The objection presumes that if one need not provide much aid, then one lacks a duty (or a strong duty) to provide it, but that either conflates two issues or supposes a closer tie between them than intuitively obtains. After all, I might well have an actual (strong) duty merely to return a book that I borrowed from you.

Second, my aim in this article is to weigh Richardson’s partial-entrustment model of ancillary care obligations against a new, Afro-communal alternative. Insofar as both of these theories include similar accounts of how much aid is required, the present objection cannot provide grounds for choosing between them.

Conclusion: further topics to be addressed

In this article, I have sought to mine the African philosophical tradition for ideas that can make sense of ancillary care obligations, giving the dominant view of them a run for its money. Relational values are known for their salience in sub-Saharan philosophy, and I have argued that they account well for the existence of special, positive, and unassumed duties that a researcher has with respect to participants in her study. Specifically, I have articulated an ethic according to which a moral agent must honour communion (or, more carefully, treat people as special in virtue of their capacity to relate communally), which means identifying with others and exhibiting solidarity towards them. I have also provided reasons to think that the ethic not only provides a plausible ground for ancillary care obligations, but also is in several ways more promising than Richardson’s influential partial-entrustment model, which is grounded on the value of autonomy.

I close by pointing out some ways in which the debate between communion and entrustment can be furthered, supposing that the former is indeed promising. One way would be to consider which approach best handles additional cases in which there are intuitively positive, special, and unassumed obligations. In this article, I have mentioned some, for instance, the duty to aid a medical colleague, a crossing-guard, and a bartender. Are there indeed duties to aid particular individuals that are not a function of promise-keeping in these and a variety of other cases? If so, which theory does better at capturing them? On the face of it, the appeal to communion is going to have a much broader reach than entrustment, for which the duty to aid is triggered by the disclosure of intimate information.

Another issue worth discussing, and which I did not address here, is who, precisely, can be the proper object of aid in a medical research context. For

example, suppose a woman brings her sick child to a study. Can a researcher be obligated to treat the child? If so, why? Is it because the researcher has threatened the autonomy of the mother or the child? Or is it because the researcher has related communally with her or the child?

Finally, there needs to be more analysis of the limits to aid. I briefly addressed them, suggesting that respect for oneself as a being capable of communing can ground a distinction between what is dutiful, which can require sacrificing trivial interests, and what is beyond the call of duty, which would involve giving up urgent ones. However, I accept that the analysis merits further consideration, particularly in relation to the idea that it might be, in fact, the researcher's autonomy that deserves self-respect.

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References

- Richardson, H. 2012. *Moral entanglements: The ancillary-care obligations of medical researchers*. Oxford: Oxford University Press.
- Metz, T. 2010. African and western moral theories in a bioethical context. *Developing World Bioethics* 10 (1): 49–58.
- Metz, T. 2010. An African theory of bioethics: Reply to Macpherson and Macklin. *Developing World Bioethics* 10 (3): 158–163.
- Slack, C., et al. 2005. Provision of HIV treatment in HIV preventive vaccine trials: A developing country perspective. *Social Science and Medicine* 60 (6): 1197–1208.
- Stobie, M., and C. Slack. 2010. Treatment needs in HIV prevention trials: Using beneficence to clarify sponsor-investigator responsibilities. *Developing World Bioethics* 10 (3): 150–157.
- Gyekye, K. 2010. African ethics. *Stanford Encyclopedia of Philosophy*, ed. E. Zalta. <https://plato.stanford.edu/entries/african-ethics/>. Accessed March 1, 2017.
- Bujo, B. 1997. *The ethical dimension of community*. Trans. C.N. Nganda. Nairobi: Paulines Publications.
- Kasenene, P. 1998. *Religious ethics in Africa*. Kampala: Fountain Publishers.
- Tutu, D. 1999. *No future without forgiveness*. New York: Random House.
- Gyekye, K. 2004. *Beyond cultures: Ghanaian philosophical studies, III*. Washington, D.C.: The Council for Research in Values and Philosophy.
- Iroegbu, P. 2005. Beginning, purpose and end of life. In *Kpim of morality ethics*, ed. P. Iroegbu and A. Echekwube, 440–445. Ibadan: Heinemann Educational Books.
- Mokgoro, Y. 1998. Ubuntu and the law in South Africa. *Potchefstroom Electronic Law Journal* 1 (1):15–26. <http://www.nwu.ac.za/p-per/volume-1-1998-no-1-1-Articles>. Accessed March 1, 2017.
- Masolo, D.A. 2010. *Self and community in a changing world*. Bloomington: Indiana University Press.
- Metz, T. 2007. Toward an African moral theory. *Journal of Political Philosophy* 15 (3): 321–341. Revised version in 2017. *Themes, issues and problems in African philosophy*, ed. I. Ukpokolo, 97–119. London: Palgrave Macmillan.
- Metz, T. 2016. An African theory of social justice: Relationship as the ground of rights, resources and recognition. In *Distributive justice debates in political and social thought: Perspectives on finding a fair share*, ed. C. Boisen and M.C. Murray, 171–190. New York: Routledge.
- Metz, T. 2013. The Western ethic of care or an Afro-communitarian ethic? Finding the right relational morality. *Journal of Global Ethics* 9 (1): 77–92.

17. Appiah, A. 1998. Ethical systems, African. In *Routledge encyclopedia of philosophy*, ed. E. Craig. London: Routledge.
18. Olson, N. 2016. Medical researchers' ancillary care obligations: The relationship-based approach. *Bioethics* 30 (5): 317–324.
19. Singer, P. 1972. Famine, affluence, and morality. *Philosophy & Public Affairs* 1 (3): 229–243.
20. Richardson, H., and L. Belsky. 2004. The ancillary-care responsibilities of medical researchers. *Hastings Center Report* 34 (1): 25–33.
21. Richardson, H. 2015. Correspondence with the author, December 6.
22. Wertheimer, A. 2010. *Rethinking the ethics of clinical research*. Oxford: Oxford University Press.