

CASE STUDIES

Isolation of an individual already treated for Ebola: Has India gone too far?

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Abstract

A 26-year-old Indian male travelling from Liberia to India after being treated for Ebola Virus Disease (EVD) was isolated at Delhi airport, even though he was symptom-free, because his semen was positive for Ebola virus. His blood, saliva and urine samples had tested negative for Ebola. There is no conclusive evidence of sexual transmission of EVD and the World Health Organisation does not recommend the isolation of convalescent patients whose blood is negative for Ebola virus. The decision of the Indian health authorities to isolate this individual is not only unscientific and excessively precautionary, but also raises various ethical and legal issues related to the potential violation of individual rights. The decision to impose individual restrictions during public health emergencies should be a transparent one that is guided by science, and should follow consultations among the various stakeholders. Further, such restrictions should be imposed only when alternative approaches are not sufficient or effective.

Ebola Virus Disease (EVD) has never been reported in India. In view of the experts' warning that the disease will have devastating effects if it arrives in India, the Government of India (GoI) is taking several measures to prevent its entry. These include screening people coming and/or travelling from West African countries, designating certain hospitals in major cities as Ebola management centres, training healthcare workers and deploying rapid response teams in every state (1). So when a 26-year-old Indian male travelling from Liberia to India landed at Delhi's Indira Gandhi International airport on November 10, 2014 and informed the Indian health authorities that he had been admitted in a health facility in Liberia from September 11–30, 2014, they decided to isolate him for further evaluation. This was in spite of the fact that he was asymptomatic and carried a certificate of medical clearance from the Ministry of Health and Social Welfare, Government of Liberia, stating that "he has successfully undergone care and treatment related to EVD and after post-treatment assessment, he has

been declared free of any clinical signs and symptoms and confirmed negative by laboratory analysis" (2).

His three blood samples tested in India between November 10–13, 2014 were found to be negative for the Ebola virus. By now, the health authorities should have terminated his isolation. However, they decided to test his semen, probably because a few studies in the past have reported the presence of the Ebola virus in the semen of convalescent patients, with one such study reporting live Ebola virus in the semen of a convalescent man even 82 days after the onset of the disease (2–4). Two samples of this Indian traveller's semen were sent to two different laboratories and these tested positive for the virus on November 17, 2014. After this, the Indian health authorities decided to keep him in isolation until all his body fluids tested negative, something which could take as long as three months (2). His urine and saliva samples, tested on November 21, 2014, were negative for the virus. However, it was decided that he would continue to remain in isolation till his semen tested negative (5). Meanwhile, the GoI imposed travel restrictions on individuals who had been treated for Ebola: they are not to enter India until 90 days after the date of discharge from hospital unless they produce a certificate stating that the Ebola virus is not present in their body fluids, including the blood, urine, vaginal fluid and semen, as well as stool (6).

A GoI press statement released on November 18, 2014 states that the testing of the Indian traveller's semen and his subsequent isolation were done as a "matter of abundant caution" which would rule out even the remote possibility of the spread of EVD by the sexual route (2). Till date, there is no evidence of sexual transmission of EVD. One study that followed four men recovering from EVD and their sexual partners found that no sexual partner developed symptoms (7). The World Health Organisation (WHO) does not recommend the isolation of male convalescent patients whose blood has tested negative for EVD, as in case of this traveller. WHO advises that men who have recovered from EVD should maintain good personal hygiene after masturbation, and either abstain from sex (including oral sex) for three months after the onset of the symptoms, or use condoms if abstinence is not possible (8).

In the absence of any evidence of sexual transmission of EVD, isolation of a person for a period which could last as long as three months is not only an unscientific overreaction, but also raises serious ethical and legal issues related to the potential violation of individual rights (9). It is evident that the Indian

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health authorities have not made enough efforts to let the public know about the decision-making process, and the rationale behind imposing restrictions on the individual is arbitrary. There is no mention of the stakeholders involved in decision-making and if at all the ethical ramifications of such an extreme measure were deliberated upon while making a decision. The decision-making process is obscure and it seems that the decision was taken in haste, without consulting experts in law and bioethics. Due to the obscure decision-making process and the paucity of communication (eg few press releases), there is very little information on the alternative measures (if any) that were considered and found insufficient or ineffective before restrictive measures were imposed on the individual. There is no discussion of ethics and this person's individual rights, and whether isolation is the best strategy for balancing the interests of the community and the rights of the individual in this particular instance. Experience with previous public health emergencies has shown that in the absence of a clear ethical framework and an understanding of the decision-making process, decisions may not be readily accepted and there may be long-term repercussions (10–11).

During a public health emergency, a government has the legal right to take appropriate measures, in a transparent and ethical manner, to protect its citizens. However, while doing so, it must ensure that the decisions are evidence-based and that the interests of the community and the rights of the individual are well balanced. The rights of groups are important, but those of the individual are equally, if not more, important. According to Human Rights Watch, "International human rights law requires that restrictions on human rights in the name of public health or public emergency meet requirements of legality, evidence-based necessity, and proportionality. Restrictions such as quarantine or isolation of symptomatic individuals must, at a minimum, be provided for and carried out in accordance with the law. They must be strictly necessary to achieve a legitimate objective, the least intrusive and restrictive available to reach the objective, based on scientific evidence, neither arbitrary nor discriminatory in application, of limited duration, respectful of human dignity, and subject to review" (12). The Siracusa Principles also recommend that the restrictions imposed should be based on sound scientific evidence. In a democratic society, the restrictions should be strictly necessary to achieve the objective, and should be imposed only when no less intrusive and restrictive means are available to achieve the objective. The Siracusa Principles also say that such measures should be taken with due regard to the international health regulations of WHO (13).

Isolation and quarantine are extreme measures that require rigorous safeguards, including scientific assessment of the risk posed by the patient and the effectiveness of the measure. The process of taking a decision on such restrictions should be well thought out and communicated to all concerned in advance (14–15). The stakeholders involved in the decision-making process should be representative of the society, and should include experts in public health, bioethics, law and

human rights. They should disclose any conflict of interests. Researchers have proposed ethical frameworks for restricting personal freedom when managing such situations. Kass has suggested a six-step framework to guide health authorities in deciding upon an ethically sound course of action. The emphasis of this framework is on evaluating the various options available to them (16). According to Kinlaw and colleagues, restrictive interventions and procedures should be in the form of recommendations for voluntary action. Mandatory liberty-limiting interventions should be imposed only in cases in which voluntary actions seem unlikely to be effective (17).

What is more surprising in the present case is that there is not much national discourse in the scientific community and media on the ethical issues arising out of this decision. In contrast, the decision of the state of New Jersey in the United States to quarantine a symptom-free nurse returning from Sierra Leone gave rise to a huge debate and the matter was taken to court (18). In the present case, if the matter were taken to court, it would be very difficult for the Gol to justify its measures to curb individual rights for the larger good of society as (i) it lacks scientific evidence, (ii) such measures are not recommended by various international organisations, such as WHO and the Centers for Disease Control and Prevention, and (iii) no other democratic country in the world has taken such a drastic step to isolate convalescent patients who are coming from West African countries, having been cured of Ebola, on the basis of positive semen samples.

In conclusion, keeping a symptom-free person who is convalescing from Ebola in isolation, even though his/her blood, saliva and urine samples are negative, is not only unscientific and excessively precautionary, but also constitutes a clear violation of individual rights as there is no evidence that the person is a threat to the community. Unscientific and arbitrary "abundance of caution" cannot be a justification for the suspension of individual rights. Individual restrictions should be imposed with the utmost care and only when alternative approaches are not sufficient or effective. Such decisions should be guided by science and taken transparently, after prior consultations among the various stakeholders (community, providers and recipients), so as to balance the community's interests and the individual's rights.

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Domestic abuse and the duties of physicians: a case report

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Introduction

Domestic violence against women is a global issue. An earlier report from the Centers for Disease Control and Prevention (CDC), USA, reported that injury caused by domestic violence was the second most common cause of death during pregnancy and in the postpartum period (1). The pregnancy-associated homicide ratio was found to be 1.7 per 100,000 deliveries and firearms were identified as the main source of injury. Domestic violence is more common in developing countries than in the developed world, and rural areas are worse affected than urban ones. The risk factors associated with intimate partner violence include husbands being unemployed, belonging to a lower socioeconomic group, poor educational status, and alcohol and substance abuse. In a hospital-based study of 500 women, around 12.6% reported physical abuse by their spouses in index pregnancy (2). In another hospital-based study in which women were interviewed during the postpartum period, 23% reported physical abuse during index pregnancy (3). Death as a result of violence is not a new phenomenon. In 1994 the Human

Rights Commission of Pakistan reported 372 cases of domestic violence, due to which around 274 women died during an 8-month period. According to a report for the year 2012-13 around 389 cases of domestic violence were reported in the Pakistani media that year. The same report states that in 2013, more than 800 women committed suicide due to domestic violence. In 2013, the Provincial Assembly of Sindh, Pakistan, passed The Domestic Violence (Prevention and Protection) Bill, 2013, which imposes a fine of Rs 20,000 for violent offences against women. Such bills have not been passed in other provincial assemblies of the country. Other countries in South Asia (India, Nepal, Bangladesh, the Maldives, Sri Lanka and Afghanistan) have national laws which make provision for extending medical assistance to women who have suffered domestic violence (4). However, a lot remains to be done to translate these laws into actual practice. In Nepal, special cells have been set up in police stations to offer services to women reporting domestic violence. Among those responsible for the implementation of these services, only a few were found to be aware of the fact that such services were supposed to be provided (5). Only 8% of women knew that such services were available (6). In Bangladesh, crisis centres have been established in tertiary care hospitals to deal with domestic abuse. Manuals have been designed for the attending doctors on how to provide assistance to the women and on the reporting of such events(6). In India, providers of medical care do not consider it their duty to report domestic violence(4). There is a need to sensitise the medical fraternity

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