# *Ethics and Semantics of Managing an Infectious Epidemic*

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Awhile ago, a friend asked me, what makes an epidemic take off? Mendacity, I replied, among other things.

In early 1999, shortly after the Nipah epidemic spread to Bukit Pelanduk and its nearby villages, Seremban Hospital clinicians who began treating Nipah patients (at the time, presumptively managed as atypical Japanese encephalitis cases) were instructed to refrain from discussing their cases with their Seremban Hospital colleagues who were not treating Nipah patients.

In June 1999, I received the preliminary program for the 33rd Congress of the Academies of Medicine of Malaysia and Singapore. Looking over the scheduled presentations, I was astonished to see that it did not feature a single speaker, let alone a panel to address the clinical, epidemiological, or virological aspects of the Nipah outbreak.

Here was the biggest event in tropical medicine in the world in 1998-1999, medical history in the making which had foreign researchers stampeding to this country, and which prompted the Massachusetts General Hospital to invite Dr Adeeba Kamarulzaman, University Hospital infectious disease specialist for a specially scheduled seminar on her clinical experience in treating Nipah encephalitic patients.

In Kuala Lumpur, barely an hour's drive from the southern epicenter of this momentous event, our local clinicians (and biomedical researchers) were being obliged to bury their heads in sand.

I wrote to the chairman of the conference scientific committee, enquiring about this glaring omission, and volunteered to convene such a panel on behalf of his committee. An infectious disease specialist himself, he weakly replied that the organizing chairman was a high official of the Health Ministry, and that this was still a sensitive topic (in late 1999!).

This was outrageous, I decided, curbs even within the confines of medical academe, completely at odds with the institution's goals of professional exchange and continuing medical education.

I hinted that I might lodge a complaint with the Malaysian Medical Association's professional ethics committee, for an unwarranted obstruction of information flow, collegial exchange and professional discourse which was vital to clinical and public health practice, and hence an unconscionable threat to the public interest. Eventually a panel was constituted, under spin control, to peddle the discredited theory of a "dual JE/Nipah" epidemic which continues to circulate to this day.

Evidently, the same mindset persists. In July 2000, the Minister of Science, Technology & Environment decreed that Air Pollution Index (API) readings would henceforth no longer be released to the public, hoping that Malaysian residents (and CNN) would obligingly see "no smoke without API" during our seasonal smogs.

In 2002/2003, a markedly accentuated outbreak of dengue fever was denied along with outright refusals to divulge figures on dengue incident cases and fatalities to the press.

And now, in April 2003, we have a nationally televised hairsplitting over whether we have "probable" and/or "suspected" cases of Severe Acute Respiratory Syndrome (SARS) in Malaysia.

We can speculate as to whether this is the legal mind at work, or the Health Ministry's sudden conversion to scientific rigor. By the criterion of isolated and definitively identified etiological agent (pathogen), there have been no confirmed cases of SARS anywhere in the world to date, since the World Health Organisation is still evaluating the evidence implicating a novel coronavirus, and the possible, independent or simultaneous involvement of a metapneumovirus, and possibly even other as yet unidentified pathogens. (http://www.promedmail.org April 3, 2003, SARS etiology)

By these semantic devices, the Health Minister may try to avoid Malaysia's listing as a country where "probable" SARS cases have been "confirmed" (overriding consideration for the tourism and related industries), but public health responses to epidemic emergencies operate on the basis of the precautionary principle, i.e. you cannot wait for the *i's* to be dotted and the *t's* to be crossed, before you take action on a presumptive basis, i.e. on the basis of best available and rapidly evolving knowledge. No competent health professional seriously doubts at this point that we have probable SARS cases in Malaysia.

Sadly, the Malaysian Medical Association, instead of stepping into the breach with its professional expertise to display some medical statesmanship, seems more concerned with pursuing its turf battles with traditional healers (Star, April 4, 2003 *"MMA: No Proof Folk Medicine Will Cure the Illness"*), when not dueling with pharmacists.

This is in contrast to the courage and dedication of individual doctors (and nurses and other healthcare staff) whose steadfast service in the face of mortal risks deserve our highest accolades and sincere appreciation.

Among the eighteen designated hospitals nonetheless with special isolation wards for SARS patients, not a single private hospital is to be found. Indeed, when two foreigners insisted on being admitted into a private hospital for SARS observation, the Association of Private Hospitals of Malaysia (APHM) responded by persuading the Health Ministry to invoke emergency quarantine powers *"if a patient refused to be admitted into a public hospital…. the district health officer concerned can issue a quarantine order making it compulsory for a patient to be admitted into a dedicated [i.e. government] hospital…The*

*[private] hospital had to admit them [at the time] because there were no guidelines outlining what private hospitals could do if they had to handle such a case. Now they know what to do,"* according to APHM president Dr Ridzwan Bakar *(Star April 7, 2003).*

Weighing on their minds, evidently, beyond the expense of maintaining a SARS isolation ward, was the further worry that a hospital's fee-paying clientele would avoid a "SARS-tainted" hospital. One wonders what squabbles might break out between (for-profit) private hospitals if the hospital sector in Malaysia were ever to be completely privatized.

Three years ago, I ended a commentary on the Nipah epidemic with these paragraphs:

> *"Responsible Malaysians understand and accept that in an emergency situation of outbreak investigation and control, the government in principle should have the discretion for timely and responsible release of information. Having said that, CHI (Citizens' Health Initiative) would add that the government must sustain the confidence of the public that it is doing a competent, just and credible job in the broader interests of the entire community.*
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> *In confronting national emergencies, we expect the government to exercise accountable, exemplary leadership in implementing well-considered and firm but necessary measures in a difficult situation, and in ensuring that these are equitably borne as a national, social compact. There is no other way to sustain confidence, broad-based support and unity in facing such challenges.*
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> *Gag orders on public and professional discourse, and media blackouts fail miserably in averting disquiet and panic -- this can only be achieved by accurate, timely information from a credible, competent and responsible source.*
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> *In its handling of information dissemination in two disastrous epidemic outbreaks (Sarawak 1997 and Ipoh/Negri Sembilan 1999), and in these recurrent seasonal smogs, the government has repeatedly transgressed the reasonable limits of responsible information management. Its mindset of obsessive, unwarranted secrecy and its unwillingness to divulge legitimate information to the Malaysian public, is reprehensible and totally unacceptable".*

Nothing has changed in the interim to make me revise this opinion.

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