Shutting Up Infected Houses: Infectious Disease Control, Past and Present

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At the time of writing this article (March 2010), the world remains in the highest phase of pandemic alert. Fortunately, it looks as though the influenza A H1N1 pandemic has been relatively mild. Except for certain risk groups (e.g., those with pre-existing morbidity, pregnant women, marginalised communities), this pandemic has not had the devastating impact on public health and societal life that many feared. However, despite the feeling of having had a lucky escape this time, the general view amongst public health professionals, planners and scientists is that it is just a matter of time before we are hit by a much more deadly influenza pandemic. Part of this ongoing concern is based upon historical accounts of past influenza outbreaks, most notably the 1918 Spanish Flu (Crosby, 1989).

Historical studies are not only illuminating in the sense that they result in better understanding of the epidemiology of past epidemics, but they also offer vivid lessons as to how infectious diseases may impact upon all aspects of the lives of individuals and communities. One of the salient features of infectious diseases is that they may result in certain aspects of our everyday social lives becoming the source of an increased threat of harm: talking to one's neighbours, going to work or to school, children playing together, congregating in public places to protest or enjoying music or sporting events. All such routine activities become the focus of concerns about potential modes of disease transmission, and in the face of dramatic risks this is likely to affect everyone's attitudes to strangers, friends and to themselves.

One outstanding work in the social history of epidemics is Moote and Moote's (2004) *The Great Plague: The Story of London's Most Deadly Year*. The 1665 plague killed, by rough estimation, one fifth of all inhabitants in London. Moote and Moote explore how Londoners coped with the threatened and the actual ravages of the disease. Their book is based upon numerous personal and official documents, such as the diaries of Samuel Pepys (Pepys and Braybrooke, 1887), letters of inhabitants and the registries of London parishes. It tells stories of people fleeing to the countryside, of uncertainty

and panic amongst those staying in the city, of the rumours about possible cures and wonder drugs and the competition and struggles between Galenic and 'chemical' physicians and apothecaries peddling their potions and 'cures'. Quarantine measures such as those governing travellers arriving on ships from certain European harbours were in place, but it seems as though they could be easily bypassed. One of the measures used, particularly in the early stages of the plague's arrival in London, was the traditional method of social distancing used in previous plagues in London. Persons showing symptoms were locked up with their families in their own houses, as a means of both isolating those infected and quarantining those presumed to have been exposed to infection. Such houses were then in turn supported by local church parishes: given the role of supplying food, guarding the properties and employing nurses to care for the families that were locked up.

During the outbreak of 1665, an anonymous author wrote a pamphlet about the policy of 'shutting up' infected houses. This paper, printed and published during the plague, can be considered not only as a contribution to the contemporary debates about the legitimacy of such measures, but also to public health ethics *avant la lettre*. We are pleased to republish it here in the first issue of 2010, which is almost entirely devoted to discussion of ethical issues relating to infectious disease control. The author of the pamphlet argues passionately against the shutting up of people within their houses. The arguments are clearly based upon first-hand experience and the introduction to the pamphlet even suggests that the author was struck by illness during this time. In the seventeenth century, the pamphlet was a vitally important means of debate and discussion of topical, political and religious issues. Here, the author uses rhetorical devices, religious and political arguments, historical and statistical evidence, and medical knowledge to try and press for the primary end of writing: as a means of changing policy. However, in retrospect it is interesting to see that the seven arguments that are advanced against compulsory isolation are, mostly, as relevant today as they

were in 1665. It might be tempting to think that it will be consequentialist approaches, still often key influences upon contemporary public health policies, that will be used to justify dramatic policies, like quarantine and isolation even if they are imposed on people, whereas human rights arguments would support respecting people's freedom and autonomy. Although our anonymous author appeals in the introduction for considerations that could nowadays be rephrased in terms of human dignity, most of the arguments employed have a distinctly consequentialist flavour.

The first argument appeals to benevolence. The charitable practices within Christian communities in the early times of Christianity are set as an example: even during plague outbreaks, sick people were not abandoned but cared for by other members of the community, and when they died they were given a decent burial. Many Christians lost their lives as a result of taking part in such compassionate work. After these remarks on heroic benevolence, the author suggests that such a consideration may not persuade people any longer and so the author continues with arguments that appeal more to each individual's own interests. Those arguments can be categorised into three groups.

The second, fourth and fifth arguments are concerned with potentially counterproductive effects of the practice of shutting up houses. The author argues that the policy gives persons who experience the first symptoms of the disease a reason to flee, and hence avoid the fate of being locked up, rather than seeking isolation. This could only foster further spread of the plague. In addition, it is argued that shutting up families, which then had to survive in appalling circumstances, would ensure that conditions existed to 'breed a plague if there was none'. Indeed, it is argued, as a result infection would be likely to gain in strength, given the state of the locked-up homes, which would make it only more likely that the pestilence would escape, infecting whole streets and neighbourhoods.

Another group of arguments (the third and sixth) basically hold that 'freedom of converse' would help to control the epidemic. The author presents data from the plague of 1625, and claims that the number of cases of illness only declined after houses were no longer shut up. Another argument emphasises the need for advancement of medical science and the need to learn from cases of plague. By shutting up infected families, no systematic study was possible of how disease may have been transmitted and in what circumstances patients recovered from the plague. Apparently, the author had been able to register quite a number of cases himself as the

(sixth) argument also contains, to our eyes, two rather amusing lists from the 1665 plague: one of conditions believed to have been responsible for caused illness, and the other of circumstances in which patients had allegedly been cured.

A third group of arguments is discussed in the final section: shutting up infected families would have other dreadful consequences, including domestic violence, but it would, also, it is claimed, provide a reason for employers to flee, and thus rob people of the possibility to earn income (which, again, might further facilitate the plague).

All three types of arguments fit well into a consequential mode of reasoning about isolation and quarantine, and clearly some are as relevant today as in 1665; for example, in discussions of mandatory isolation or detention of XDR-tuberculosis patients in a country like South Africa. Critics of such policies will often appeal to human rights as grounds for condemning such an approach. But even within a rights-based perspective, detention may be justified if it is necessary as a means to protect the public health (Singh *et al.*, 2007). A decisive factor in any justification, however, will be the evidence for the effectiveness of such policies. In the context of tuberculosis in South Africa, Eric Goemaere and others argue that detention will often have little effect given the long diagnostic delay. Individuals will have been able to spread XDR-TB for months before they are diagnosed and isolated (Goemaere *et al.*, 2007). Moreover, it is essential to TB and HIV control that patients comply with treatment. Médecins Sans Frontières (MSF) promotes drug adherence by offering HIV and tuberculosis care close to where patients and their families live, with the aim of fostering relationships of trust and promoting HIV and TB awareness (Médecins Sans Frontières, 2009). If regular examinations within such a health care relationship lead to a diagnosis of XDR-TB followed by involuntary detention, this may impact negatively upon the reputation of caregivers and hence undermine the effectiveness of the patient-centred approach to infectious disease control. Moreover, forced hospitalisation may discourage people from seeking diagnosis and thus contribute to transmission in the community—precisely the danger envisioned by the anonymous author of *The Shutting Up Infected Houses*.

Infectious disease control faces many different ethical issues: the possibility of involuntary quarantine is only one major controversy. This issue of *Public Health Ethics* is devoted to the ethics of protection against contagion and contamination. Of the various excellent contributions, we highlight only two here. Terrance McConnell's

paper might be as ‘unexpected’ a paper in our journal as a pamphlet from 1665, because he discusses the arguments that feature in Ibsen’s play *An Enemy of the People* (1882). In the play, Ibsen portrays the conflict over the possible contamination of the new spa baths in a Norwegian town. Which concerns are to be given priority: protection of public health, or protection of the economic benefits that the baths are capable of bringing to the town? Such a conflict of important values is of course timeless. The second contribution we would particularly like to highlight is a case presented by Delan Devakumar, outlining a dilemma in a Cholera Treatment Centre in Juba, in southern Sudan. If the aim of the hospital is to protect public health by treating cholera, how are employees to deal with the many patients who do not have cholera but come to the Centre for treatment of other diseases? The case is followed by five different commentaries from different perspectives. These are followed by a brief discussion of how the case and commentaries might be used in a teaching context. As editors, we hope to be able to publish similar case discussions regularly in the future.

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