the coronary and peripheral arteries may be retarded and that in some situations the blockages may even be reversed upon near-normalization of blood cholesterol levels. This may be due to recent therapeutic advances allowing a much greater lowering of plasma cholesterol levels and, by extrapolation, the risk of coronary heart disease.

The report also ignores the recommendations of the CCCC[2] while advocating discrimination in medical practice on the basis of sex, age, lifestyle, knowledge and a physician's ability to speculate accurately about patients' potential compliance. Although this is not the forum for a rebuttal of the false logic behind the recommendations (a report is now being prepared by physicians who are experts in cholesterol levels and coronary heart disease) a simple analogy might be enlightening: Each risk factor might be compared to the tire of an automobile. Applying the same logic used by the task force one should only start inspecting the tires for possible defects when one of them has worn down to a dangerous degree.

The Ministry of Health, seconded by the OMA, is rightly concerned about the additional resources needed in this era of spiralling health care costs. However, this attempt at health care rationing makes a shambles of preventive medicine, a concept much promoted by both the ministry and the OMA. Why not be "up front" about it to the citizens of Ontario and invite them to pay privately for serum cholesterol testing? The statement that, as opposed to population screening, "instead, the weight of opinion and evidence supports a [selective] case-finding approach" ignores the therapeutic incentive of knowing that one has a modifiable risk factor and, paradoxically, gives a break to patients who indulge in such self-destructive habits as overeating and smoking while penalizing those who have adopted a health-promoting lifestyle. Such reasoning tempts one to have patients smoke a cigarette as part of their annual health examination, which would qualify them to have their cholesterol level tested!

The recommendations of the report should be withdrawn.

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Potential traps for the allergic

The list of potential traps for people with known severe food allergy seems to be endless. Among the traps for peanut-allergic people have been a chocolate chip cookie in which peanut butter was not known to be an ingredient, wedding cake with icing in which peanut paste had been mixed with almond paste, a small Easter egg removed from a wrapper with no label (it was later determined that an outer wrapper had had a label that listed peanut as an ingredient), "walnut" donuts at a donut shop that were loaded with peanuts but contained no walnuts and a cracker with peanut butter given by one child to another at nursery school.

A nut-allergic child who routinely ate apple desserts in fast-food restaurants reacted to an apple dessert in a new fast-food restaurant that used hazelnut powder in its dessert. In another restaurant almond slivers were sprinkled on the salad during Christmas season as a "bonus".

A chicken-allergic person reacted to a vegetable soup in a restaurant after being assured by the chef that there was no chicken in it. Later it was learned that a different chef had cooked the soup.

Since prior knowledge of potential traps may reduce the risk of dangerous allergic reactions, it might be useful to provide affected patients with lists of experiences such as these.

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The case against HIV antibody testing of refugees and immigrants

As a practising physician with some background in public health I disagree with the substance and logic of Dr. Margaret A. Somerville's article (*Can Med Assoc J* 1989; 141: 889-894).

Somerville confuses discrimination against people with discrimination against disease (and a lethal one at that).

Under "Public health and safety" all the arguments that the author applies to HIV infection can equally be applied to another lethal sexually transmitted disease — the "great imitator", syphilis, which before the discovery of penicillin was held at bay by appropriate public health measures preceded by testing.

Somerville makes a very

broad presumption when she states that an HIV-positive person may contribute at least the cost of treatment ($100 000 plus) to Canadian society before demise.

The author compares HIV infection with Huntington's chorea, diabetes and other inherited conditions. These are not infectious. Two paragraphs later she states that AIDS is unique and should not be compared with other diseases.

Under "Choice" and "Right not to know" Somerville suggests we should never test when a bad prognosis might arise. The endorsement of the principle of denial as a suggestion in a medical journal I find particularly disturbing since at present it is very much to the patient's health advantage and long-term prognosis to know his or her HIV status. The avoidance of immunosuppressive events and treatment with zidovudine have been shown to have a positive effect.

Under "The case against testing" the author cites Meyer and Pauker's hypothesis regarding false-positive results.[1] This paper has been superseded by more recent studies,[2,3] of which Somerville appears to be unaware. Referring to such studies is an editorial entitled "HIV testing is the answer — What is the question?"[4]

I feel that the benefits accruing to Canada from Somerville's article may contribute to severe strains on the taxpayer-funded health care system. To remove any screening procedures between Canada and the pool of infection south of the border or elsewhere (e.g., central Africa) is folly of the highest order and in nobody's best interests.

Montreal (the venue for the 5th International Conference on AIDS) has recently been demonstrated, through anonymous testing by Dr. Catherine Hankins, to have an HIV prevalence rate of 1:400 in the obstetric population (*Globe and Mail*, Toronto, Nov. 17, 1989). This is behind New York but ahead of San Francisco! Is it possible that this may have some relation to the misguided philosophy that places individual civil rights ahead of community rights? Can we expect Vancouver, Winnipeg, Toronto etc. to follow suit?

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[Dr. Somerville responds:]

The first point made by Dr. Parker is pure semantics. If one discriminates against a disease, one necessarily discriminates against people with that disease. The issue is whether such discrimination is wrongful. It is when there is no valid justification for it. Protection of public health is not a valid justification for excluding people with HIV from Canada.

I query the accuracy of Parker's statements concerning the effectiveness of approaches for dealing with syphilis[1] and, even if accurate, that these provide a model that should be followed in relation to HIV. Much of our conduct in dealing with syphilis, especially before a cure was available, would almost certainly not be acceptable today. For instance, it would invade rights protected by the Canadian Charter of Rights and Freedoms.

Parker appears to have completely failed to appreciate my arguments; consequently, it is difficult to reply to the points he raises. In brief, I argue that because prospective immigrants with HIV are not per se a threat to public health they are comparable to persons with Huntington's chorea and other inherited conditions (which are also "transmissible") in that the sole issue under the Immigration Act of 1976 with respect to their inadmissibility on medical grounds is whether they will be an excessive burden on the Canadian health care system.

With respect to uniqueness, again Parker fails to appreciate the points made. AIDS is not unique in terms of many of the issues it raises; it is unique in terms of being the scapegoat disease of our era.

The point about choice and the right not to know is that one should respect a person's autonomy and right to self-determination unless there is clear justification for not doing so. Parker's point is well taken that it might be an advantage to people to know their HIV status now that early treatment has been shown to be helpful. However, people have a right to be told of this advantage and then to choose whether to accept it, which includes deciding whether to know their HIV antibody status. We are not, as Parker implies, justified in imposing either knowledge or treatment on people who do not want it. This is accepted in relation to other illnesses, with very few exceptions — when testing or treatment is specifically authorized by legislation. HIV infection should not be governed by such an exception for many reasons, including that at present there is no cure for AIDS and there can be serious side effects of treatment for HIV-related illness, even treatment that promises substantial benefit.

The articles to which Parker refers are either neutral with respect to or support the stance proposed in my article. In particu-