Should immigrants be screened?

The numbers in the article "Economic impact of HIV [human immunodeficiency virus] infection and coronary heart disease [CHD] in immigrants to Canada," by Hanna Zowall and associates (*Can Med Assoc J* 1992; 147: 1163–1172), are interesting, but I note that the authors felt the need to insert some personal opinions unrelated to their figures: apparently "most cases of HIV transmission occur through unprotected intercourse, for which the individual is solely responsible"; thus, the infecting individual is absolved. It is implied, though not explicitly stated, that to treat HIV infection and CHD differently for immigration purposes is "arbitrary at best and discriminatory at worst."

In Canada and the United States excluding as immigrants those people with serious health problems was a policy that lasted for many generations with general approval. Chest radiography and serologic testing for syphilis in prospective immigrants continues as a legacy of that policy. Currently applicants rightly pay for the screening tests themselves, so that this need not be a consideration in calculations of the economic impact on Canada. I believe there continues to be widespread support for the rejection of candidates with serious or chronic diseases and that this is not discriminatory or immoral.

On the other hand, infectious diseases require special consideration. Surely no reasonable person would countenance the admission as an immigrant or refugee of someone with active tuberculosis or cholera. HIV infection is, of course, much less likely to be transmitted to innocent bystanders, but the potential exists. We have an obligation to protect the weaker people in our society who are not sufficiently prudent or conscientious to follow guidelines to protect themselves. At present we do not have the legal means to constrain HIV-positive people from exposing others to risk.[1] If we have not screened them we cannot even counsel them about appropriate behaviour.

In short, I believe that screening prospective immigrants and refugees for potentially costly and debilitating diseases of all kinds is perfectly appropriate. Furthermore, screening for infectious diseases that pose a threat to Canadians is also fully justified and is a special case in which more than simple economic issues need to be considered.

I have a feeling that the CMA may promulgate an official position on this subject. I respectfully but strongly urge that in this, as in other public policy matters, the CMA make a concerted effort to poll its members on their views before doing so.

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Reference

1. Johnston C: AIDS and the law: Do courts have a place in the bedrooms of the nation? *Can Med Assoc J* 1992; 146: 2065–2066, 2068–2070

The endorsement of the study by Zowall and associates in "Can we afford to screen immigrants for HIV infection?," by Douglas E. Angus (*ibid:* 1132), stretches the credibility of *CMAJ* as a vehicle for expressing scientific method.

From one hard fact (the number of immigrants entering Canada in 1988) a case is made to equate the economic impact of HIV infection in immigrants with that of CHD, and this is offered as an argument against screening! There is confusion between a chronic infectious disease occurring in young people and a noninfectious condition in older people (a comparison of apples and oranges). The word "assumed" is presented 21 times in different contexts.

This admixture of mathematics and assumption creates convolution. If the study's conclusions are founded on known rather than assumed rates of HIV infection in the immigrants of 1988 and also known rather than assumed rates of CHD in the same population, then the figures may have some validity. The use of assumed data, however, is a somewhat transparent attempt to confer a degree of legitimacy on an extremely dangerous immigration policy, which has been advocated and adopted and represents continuing cause for concern to an unsuspecting Canadian public.

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Although there are many problems with our Canadian health care system it is widely recognized here and abroad as having many admirable features, including the lack of financial barriers to access. Because of this it is surprising that Zowall and associates assume "that only people who were free of clinically detectable CHD (e.g., angina and previous myocardial

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