# The case against HIV antibody testing of refugees and immigrants

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Physicians are role models for the general public with respect to how medical issues should be handled, especially in situations that are perceived as threatening or dangerous to health. Likewise, governments listen when physicians speak out on medical matters. Therefore, it is particularly important that physicians make an informed decision on whether they are for or against HIV (human immunodeficiency virus) antibody testing of refugees and immigrants to Canada. The argument against such testing of prospective immigrants who are asymptomatic for HIV infection is presented here. The issue of admission to Canada of visitors who either are or are suspected of being HIV antibody positive is addressed briefly, mainly to compare the similarities and dissimilarities with admission of immigrants and to provide insights in the latter respect.

## Rationale

Canada provides entry to refugees and immigrants for two fundamental reasons: humanitarian concerns and benefit to Canada. Humanitarian concerns govern our decisions about refugees, who by definition are threatened with serious harm, even death, if forced to return to their country. Could we even imagine agreeing that a person was a genuine refugee, testing him or her for HIV antibodies and then, if the results were positive, forcing the person to return home? Benefit to Canada is the basis for our decision in the case of many immigrants, especially those who enter on the basis of professional, trade or economic qualifications. In yet other cases both reasons can be present — for instance, when reuniting a family.

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## Discrimination

All communities are concerned with the entry of "outsiders". The entry of immigrants has often been opposed on the basis of race, colour, national or ethnic origin, or religion. Such discrimination is now prohibited by both federal law[1] and provincial law (e.g., in Ontario[2] and Quebec[3]), and probably as a result it has become unacceptable to articulate prejudices or fears (reactions that are often closely connected) in terms of these traditional prejudices. Discrimination on the basis of mental or physical disability is also prohibited by provincial[1,3] and federal[4] law but is allowed (it becomes "non-wrongful") when it relates to a "bona fide qualification".[5] The Immigration Act of 1976[6] makes it clear that passing a medical examination is an acceptable bona fide qualification for admission to Canada as an immigrant.

## Medical fitness

The provisions in the Immigration Act governing medical examinations of immigrants were adopted in response to a plea by the World Health Organization (WHO) for more humanitarian immigration policies. Many countries, including Canada, had used a list of specified diseases that precluded immigration. The new legislation was intended to provide discretion to examining medical officers in deciding whether people were medically fit to enter Canada.[7] In other words, prospective immigrants were not to be excluded solely

because they had a designated condition or disease.

The act states that a medical examination is required,[8] but it does not specify what tests, apart from "a mental examination, a physical examination and a medical assessment of records respecting a person",[9] this examination may or must include. The act gives discretion to the examining medical officer, provided his or her opinion is "concurred in by at least one other medical officer", to declare a person inadmissible to Canada on medical grounds if the person is likely to be "a danger to public health or to public safety" or if "admission would cause or might reasonably be expected to cause excessive demands on health or social services".[10]

If a person has overt symptoms of HIV-related disease these can, may and probably will be taken into account. However, they should be considered only in the same manner as overt symptoms of any other disease would be. That is, reactions based on involvement of HIV must be carefully guarded against. The issues are whether we should screen asymptomatic people for HIV antibodies and, if they are found to be positive, whether they should be excluded as immigrants to Canada.

## Public health and safety

It is totally irrational to exclude HIV-antibody-positive immigrants on the grounds that they constitute a danger to public health or safety. They are not introducing a new disease to Canada, and, indeed, if we were thinking about potential transmission hours (the total number of hours during which conduct that could result in HIV transmission is engaged in) and opportunities, such people would constitute a minuscule proportion of the risk presented by the total number of people entering Canada each year. In 1987, 152 000 immigrants entered Canada, as compared with approximately 40 million visitors. If one considers one of the modes of transmission of HIV, sexual intercourse — especially casual sexual encounters — and looks at the likelihood of an infected person spreading HIV to other members of the population, this would appear to be far more likely with tourists and business travellers than with immigrants, many of whom have families with young children and are seeking a new life, a home and work. In short, if our concern was with public health and safety and we decided that immigrants must be screened on this basis, it would be illogical not to screen all visitors as well. But considering the numbers involved this would be impossible in practical terms.

One possible response, which is contemplated by the Immigration Act, is to test only some visitors. Section 11(2) of the act allows an immigration officer to require a person seeking entry into Canada to undergo a medical examination if the officer is of the opinion that the person may be inadmissible on medical grounds, even though the person may be entering Canada only as a tourist or business traveller. Those tested would most likely be perceived (often for some reason that would found a claim for wrongful discrimination) to be at risk of HIV infection. Such an approach would be arbitrary, fortuitous in its impact and results, and open to abuse, especially in the form of wrongful discrimination. Visitors who are known to be or suspected of being infected with HIV have been refused entry to the United States. The same can happen in Canada, and in fact some visitors have allegedly been seriously harassed by Canadian immigration officers.[11]

Visitors have been identified as possibly being infected with HIV because they were carrying medications for HIV-related illness. It is shocking to think of establishing, and surely no physician would encourage deliberately setting up, a process that would force sick people treated with life-prolonging medication such as zidovudine (AZT) to choose between, on the one hand, visiting their families for such occasions as funerals, weddings and holidays, attending conferences on AIDS or travelling for business purposes and, on the other hand, continuing to take their medication. The US system has presented visitors with exactly this dilemma. Some people who have had AZT with them and declared it to, or it was found by, US customs officials, and others who were known to be HIV antibody positive, have been refused entry or even jailed. The following actions were taken as a result of the harm and suffering caused by this approach.

Members of [the United States] Congress moved April 18 to pressure the administration to modify an Immigration and Naturalization Service regulation prohibiting HIV-positive persons from entering the U.S., saying the regulation not only is not "civilized" but jeopardizes the hosting by the U.S. of the Sixth International AIDS Conference next year in San Francisco.

Sen. Edward Kennedy, chairman of the Senate Judiciary Immigration Subcommittee, was preparing a letter April 18 to be circulated to colleagues for signature saying the regulation was "an international embarrassment" and urging the administration to liberalize a waiver policy to allow seropositive tourists to enter the U.S.[12]

On May 25, 1989, the US Department of Justice issued a news release containing instructions regarding the exercise of "waiver authority", under the federal Immigration and Nationality Act, "with respect to the admission of HIV-infected aliens into the United States as short-term visitors". This enunciates a presumption that infected people are ineligible for entry visas because HIV infection is "a dangerous, contagious disease". HIV-antibody-positive visitors can be admitted for 30 days or less if they establish the following.

That their entry into the United States would confer a public benefit which outweighs any risk to the public health. A sufficient public benefit can include a showing that the short term nonimmigrant will be attending academic or health related activities (including seeking medical treatment), or conducting temporary business in the U.S. A sufficient public benefit can also include the applicant establishing that he or she will visit close family members in the United States. Entry into the United States essentially for tourism reasons alone does not constitute the requisite public benefit to overcome the risk.

Before the Vth International Conference on AIDS, held June 4 to 9, 1989, in Montreal, the Canadian government issued an internal memorandum stating that for the duration of the conference people with HIV infection and AIDS should not be deemed inadmissible for short-term visits (Mr. Joel Finlay, Federal Centre for AIDS: personal communication, 1989). Although this directive was clearly based on humanitarian concerns, it implies that such people would, or even should, in general, be deemed to be inadmissible as visitors to Canada.

HIV is transmitted only through exchange of body fluids in sexual or parenteral contact and perinatally. In this respect HIV infection can be distinguished from other diseases, such as tuberculosis, that manifest a broader range of modes of transmission. Further, the rate of transmission is on the whole lower for HIV than for many other infectious agents, such as hepatitis B virus, that can also cause disease that has a fatal outcome. This is not meant to be falsely reassuring or complacent about HIV, but such facts are relevant to deciding whether HIV-infected people should be excluded from Canada on the basis of being a risk to public health and safety. HIV and AIDS must not be treated in isolation; comparison with analogous situations is mandatory.

There are broader implications. The belief that prospective immigrants infected with HIV are a danger to public health and safety would necessarily set a precedent that all HIV-infected people in Canada could be similarly characterized. One result would be that irrespective of their behaviour they would *automatically*, by virtue *only* of their HIV status, fall within legal provisions in provincial public health acts, which depend for their operation on a person's being a danger to public health and safety. These provisions are highly invasive of people's rights and restrictive of their liberties. Even if these provisions were not applied to responsible people, creation of a potential for their automatic application is highly likely to be counterproductive in reducing transmission of HIV. First, if people are potentially subject to highly coercive interventions *whether or not* they act responsibly to avoid transmission of HIV there is far less incentive to act responsibly. Second, interpreting such provisions to include automatically all HIV-infected people is likely to have an alienating and hostility-producing effect that can be expressed in conduct that is risk-producing. That is, such an approach could in fact augment transmission of HIV by causing people who would otherwise act responsibly to act irresponsibly. There is an obligation on all parties whose actions are relevant to HIV transmission and AIDS, including HIV-infected people and those involved in interventions (e.g., legislators), not only to act responsibly but also not to act in ways that, although they can be *prima facie* characterized as responsible, are highly likely to elicit irresponsible responses. This latter consideration has not yet been fully explored.

## Demands on health services

The second basis in the Immigration Act for excluding immigrants who are HIV antibody positive — that they would or might reasonably be expected to cause excessive demands on Canadian health or social services — is more complex.

It is difficult to determine what excessive means. First, all of us, including immigrants, will at one time or another probably place some demand on the Canadian health care system. Whether the cost of that demand is excessive, assuming the cost of the demand is the relevant criterion, is a value judgement. For instance, would an immigrant whose net contribution to the gross national product has outweighed any health care cost that that person engendered constitute an excessive cost to the Canadian health care system? An immigrant, who may be more productive than the average person, could contribute more in 5 years of work within Canada than that person could cost, even if he or she were to become ill and die of HIV-related disease.[13] Would this net benefit to the Canadian economy mean that such a person should not be considered an excessive cost to the health care system? Therefore, should people with at least a 5-year life expectancy not be regarded as inadmissible as immigrants on medical grounds?

Second, we do not yet have sufficient data on the cost of *not* screening all immigrants who are asymptomatic for HIV infection. This means that we must decide whether we should presume that they will not constitute an excessive cost and, consequently, not screen, or vice versa. The former is the preferable approach for two reasons. First, it gives the benefit of the doubt to prospective immigrants. Vulnerable people, a description applicable to many immigrants, deserve this benefit. Second, to the greatest extent possible we should avoid "reification" — turning people into things or products. Assessing prospective immigrants in purely monetary terms carries a very high risk of such an outcome; indeed, it constitutes such an outcome in itself (*Montreal Gazette*, June 25, 1989: B2). Further, to assume without any evidence that immigrants who are HIV antibody positive would necessarily constitute an excessive burden on Ca-

nadian health care services is also dangerously close to treating people only as monetary resources.

## Precedent setting

Our decision about testing immigrants for HIV antibodies will not be isolated with respect to either the use of that test or the testing of only immigrants. There are tests being developed, in particular genetic screening tools, that will enable us, if we wish to use them, to predict with greater or lesser accuracy when and from which disease a given person will most likely die. For instance, there are genetic screening tests for Huntington's chorea, diabetes and other inherited conditions for which we know the average life span. Should we also use such tests on immigrants? When should we use them on ourselves or, for instance, allow or even require their use for employment screening purposes?

## Choice

Having a test for a given condition does not necessarily mean that we should use it. In the past there has been what now can be considered a "knee-jerk" reaction — if we have a new test and in the past we tested for everything possible why would we now not do the same? The answer is because there is enormous harm in some cases in using the available technology and because we now must make conscious, ethical and acceptable decisions as to when we will or will not use such technology.

It is worth focusing here on which tests should and may be used on prospective immigrants and which ought not to be. Under the Immigration Act this decision lies within the discretion of the examining medical officers.[7] But all discretions, especially those statutorily conferred, must be exercised reasonably. This means that the tests ordered must be reasonably necessary and that their benefits and potential benefits must outweigh their harms and risks. Most would probably agree that it would be unacceptable, considering the risk, harm and cost involved, to order cardiac catheterization in asymptomatic immigrants to try to reduce the cost to Canada of those in whom heart disease would later develop. HIV antibody testing makes an interesting comparison in this respect. The procedure for carrying out the test — taking a blood sample — is relatively harmless, but the effects of the test can constitute very serious harm. We must take such harm into account in deciding whether to perform mandatory HIV antibody testing. It has usually been assumed that tests done for the purposes of a medical examination were justified unless shown to be unjustified. HIV antibody testing will cause a reappraisal of this presumption. Such tests should be considered unjustified unless shown to be justified — which they will be when their benefits outweigh their harms and any harm to an individual is clearly justified.

## Rights not to know

All people who wish to know their HIV antibody status have a right to do so. Further, the conditions in which this right is exercised must include a requirement for informed consent and should include the availability of anonymous testing, if the person concerned desires this, or a guarantee of confidentiality, as well as an offer of counselling before and after testing.[14] Difficult questions, which cannot be discussed here, are raised by third parties' claims to their rights to know the HIV antibody status of a person who could place them at risk of HIV infection.[15] However, do we have any right to force knowledge on people who prefer to live their lives not knowing that they are members of a high-risk group or, if they know this, that they are affected (e.g., they are carrying some deleterious gene) when this information could be determined by testing? In other words, do people have a right not to know (indeed, a right not to have generated) information about themselves that could only be known by subjecting them to certain tests?

The rights of personal autonomy and self-determination would require that, as a general principle, people be given information about themselves that they seek and not be given information that they choose not to have. In the context of HIV the strongest argument against a right not to know is that this could result in failure to prevent transmission of HIV in situations where this is preventable. However, *all* people must adopt safe practices to prevent transmission of HIV: those who are infected, to avoid infecting others; and those who are not infected, to avoid becoming infected. That is, the conduct required is the same whether or not people have knowledge of their HIV status. But it can be argued that knowledge of positive HIV antibody status can lead to counselling and behaviour modification and, therefore, benefit others, if not the patient. However, to force such knowledge on an unwilling recipient could also exacerbate risk-producing conduct. Consequently, there would not appear to be a justification for forcing people to know their HIV antibody status.

Often there is little sympathy toward people's claims of rights not to know their HIV antibody status. However, like most issues related to HIV and AIDS, this must be viewed in a larger context and compared with analogous situations for which our response in the case of HIV could set wide-ranging precedents. The most pertinent example is genetic screening, especially mapping of the human genome; we may all soon have to decide how much we want to know about what our future holds, including illness and death.

## Scapegoat disease

We also need to recognize that not all illnesses are created or at least treated as equal. HIV infection and HIV-related illness are not the same as other infections and illnesses. They constitute the stigmatized "scapegoat" disease of our era. As a result, those affected are often subject to wrongful discrimination. We need to be particularly careful of acting on the basis of and in relation to HIV and HIV-related disease; certainly we should not be so naive as to equate it with all the other infections and illnesses to which we are susceptible.

## The case against testing

I believe that we should choose not to test prospective immigrants for HIV antibodies who are asymptomatic for HIV-related disease for many reasons. In adopting this position I am prepared to accept that we could save money for the Canadian health care system by testing all prospective immigrants for HIV antibodies and prohibiting the entry of those who are HIV antibody positive. Even then, the case against testing asymptomatic prospective immigrants could be established.

The arguments against HIV antibody testing of asymptomatic prospective immigrants are, first, that just because a test is available does not mean that its use is acceptable or even more so that it should be used. Many tests that will become available probably should not be used for screening immigrants, or people in many other circumstances, because the harm involved, whether to those tested or to the values of our society, is not outweighed by compensating benefits. Second, to institute such testing could appeal to and confirm the deepest prejudices of people who are opposed to anyone they perceive as unlike themselves, of whom immigrants are often considered to be a prime example. Sweden's ombudsman on ethnic discrimination[16] found that citizens opposed to immigrants in general usually cloaked their prejudice by expressing it as a fear that immigrants might have some terrible, unknown disease that would be passed on to the citizens' children. AIDS has given an identifiable substance to these fears, but such prejudices should not be encouraged or given symbolic confirmation through implementation of mandatory HIV antibody testing.

Third, in an era when many countries are closing their borders to both immigrants and visitors on the basis of their HIV antibody status, Canada could stand out as an enlightened example to the contrary. Over 30 countries have already closed their borders to HIV-infected people, despite strong pleas from the WHO not to do so.[17] A world that has been linked by the aeroplane, tourism and extraordinary developments in international communications technology is threatened with unlinking by a virus. Instead of using HIV to build symbolic walls we could use our battle against it as a bridge to link the world, especially to foster closer ties between developed countries and the Third World. HIV transmission and AIDS are a shared problem threatening us all. This is unusual and provides an unusual opportunity for powerful, personal identification by people in countries such as Canada with their neighbours in developing countries.

Fourth, there are technical–humanitarian concerns that support the argument against mandatory HIV testing of asymptomatic prospective immigrants. Tests for HIV antibodies can give false-positive results. High rates of false-positive results are particularly likely in populations with a low prevalence of HIV infection,[18-20] which is true of some populations from which immigrants come. Further, the rate of false-positive results when only one test is used can be very high. Of samples found to be positive for HIV antibody through enzyme-linked immunosorbent assay (ELISA) 50% to 60% are negative when tested again with ELISA or the Western blot technique.[21] Confirmatory tests in instances of positive results of an initial screening test are unavailable in some countries. Consequently, after having been tested some people may live their lives believing that they have a life-threatening infection when this is not the case. We would not want to add to the numbers of such people; therefore, if Canada were to require HIV antibody testing of prospective immigrants it would have an ethical obligation to make available confirmatory testing facilities. The cost of this would be relevant. But a much more important issue would be the effect on people identified as being HIV antibody positive who lived in countries with coercive legislation or policies for dealing with such people. In these cases, people who wish to immigrate to Canada would be forced to choose between losing any opportunity to do this and taking a risk of what could happen to them in their country of origin if they were rejected as immigrants on the basis of HIV antibody positivity.

Canada has a strong commitment to human rights, but for most of us this is a commitment in theory rather than one that is regularly tested in practice. HIV transmission and AIDS present a test in practice of our real commitment to human rights, and how we meet the challenge in relation to immigration will provide a particular and important example in this respect.

Immigrants, like prisoners, are particularly vulnerable. They are people from whom, for various reasons, it is often easy to disidentify; indeed, when we disidentify from particular immigrants, unlike even most prisoners, we will never have to identify with them, because they will never belong to our country. Further, they are a convenient group on which politicians can demonstrate that they are willing to take "hard-line" approaches (for instance, pass highly intrusive or invasive laws in relation to HIV transmission and AIDS) without fear of losing votes, because by definition the

people affected by those laws will never be voters in Canada. That is, politicians can finesse a "no-win" situation of necessarily losing one or another group of voters by being seen as either too lenient or too strict in relation to dealing with HIV transmission and AIDS. They can be strict on prospective immigrants, who will be nonvoters if they are found to be HIV antibody positive, and thereby appease hard-line voters, as well as be lenient on voters who would be personally affected and feel themselves disenfranchised by a hard-line approach.

Even if it costs Canada some money for additional health care because some HIV-infected immigrants are admitted, what Canada could achieve by not requiring mandatory testing for HIV antibodies among asymptomatic prospective immigrants would far outweigh any losses that such testing involves. Some of the countries that have shut their borders to HIV-antibody-positive people, whether visitors or immigrants, are also the countries that are considering or have even started to institute compulsory testing for HIV antibodies and isolation or quarantine of people found to be infected.[22] Such breaches of human rights, which are likely to cause increased transmission of HIV by sending infected people underground and causing them to try to avoid testing, must be decried. To some degree there is a "slippery slope": the first step on the part of a government (which is all of us) that invades individual rights is often the most difficult one to take, but once taken it can lead to another.

## Conclusion

Canada could provide an important, indeed critical, example to the rest of the world if it is prepared to state that the potential costs, in economic terms, to care for people admitted as immigrants who later develop HIV-related illness are more than compensated for by the values — humaneness, humanitarian concern and respect for human rights — that we wish to uphold in *choosing* not to test asymptomatic prospective immigrants for HIV antibodies. This is not a benighted, "bleeding-heart" approach. Rather, the benefits accruing to Canada from this approach and the example that Canada would set to the rest of the world in adopting this position (particularly because it would be in contrast to the approach taken by the United States) far outweigh any cost to Canada in terms of the economic burden that asymptomatic HIV-antibody-positive immigrants would impose on our health care system.

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### Experimental medicine

*Only by passing through the fire of experiment will medicine as a whole become what it should be, namely, a conscious and, hence, always purposefully acting science.*

*— Ivan Pavlov (1849-1936)*