

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.<sup>1</sup> This paper has been superseded by more recent studies,<sup>2,3</sup> of which Somerville appears to be unaware. Referring to such studies is an editorial entitled "HIV testing is the answer — What is the question?"<sup>4</sup>

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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## References

1. Meyer KB, Pauker SG: Screening for HIV: Can we afford the false positive rate? *N Engl J Med* 1987; 317: 238-241
2. Mortimer PP: Tests for infection with HIV: slandered goods. *Br Med J* 1988; 296: 1615-1616
3. Burke DS, Brundage JF, Redfield RR et al: Measurement of the false positive rate in a screening program for human immunodeficiency virus infections. *N Engl J Med* 1988; 319: 961-964
4. Weiss R, Thier SO: HIV testing is the answer — What is the question [E]? *Ibid*: 1010-1012

[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<sup>1</sup> 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-

lar, the excellent editorial in the *New England Journal of Medicine* suggests, after reviewing the other articles to which he refers, that we should not rely on the possibility of false-positive results as an argument against mandatory HIV antibody testing, because even if the rate were acceptably low such testing is not justified. The editorial concludes: "At present . . . voluntary testing, accompanied by counselling . . . is the approach most consistent with the information at hand". Parker has either not read or misconstrued the arguments in this editorial — and, indeed, in my article. One can only hazard a guess as to why this would occur, and I do not wish to attribute motives to Parker. However, it is not uncommon for us to allow personal values, attitudes and beliefs to colour our responses to AIDS and, for example, to read an article as stating what we would like it to state rather than what it does state. It is not enough that we act in "good faith" in entering the debate surrounding AIDS: we must also act non-negligently. But, most importantly, we must enter with open-mindedness and a spirit and approach of active tolerance.

Parker is correct that some of my propositions (for example, the suggestion that HIV-antibody-positive immigrants could contribute more to the economy than they would cost in terms of health care) cannot be ascertained with any accuracy. But neither can propositions to the contrary. When faced with such uncertainty we must choose which of the two alternative propositions should form the basic presumption from which we work. This proposition will then govern until displaced by proof that it is not accurate. Parker proposes a presumption against allowing the entry of HIV-antibody-positive people. I propose the opposite presumption, on the basis that it does not appear to involve undue harms, risks or

costs and, most importantly, best promotes a position of humanity and respect for human rights.

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## Resuscitation of the terminally ill

In her recent article<sup>1</sup> Dr. Françoise E. Baylis takes issue with Drs. Robert Buckman and John Senn's recommendations on eligibility for cardiopulmonary resuscitation (CPR).<sup>2</sup>

Buckman and Senn argued that if no benefit is expected from therapies such as CPR in a specific group of patients, such as those with terminal irreversible illnesses, then the treatment should not be provided or offered. They suggested that patients suffering from irreversible, fatal conditions who are receiving palliative care and in whom no curative intervention is being carried out or planned fit into this category. Baylis challenges this concept and argues that even if the chance of CPR's being successful is infinitesimally small, and even if death may be postponed only for a very short period, the decision to have CPR belongs to the competent patient, regardless of whether the patient is receiving palliative care.

Although Baylis raises the issue of allocation of scarce resources, she appears to feel that physicians should have no say in this but must blindly follow the wishes of the patient. It is of interest that she agrees that a physician is not required to provide therapy contraindicated on

medical grounds. However, the only contraindications she appears to accept for CPR are "a seriously ruptured myocardium, a pulmonary artery completely filled by embolic material or a seriously ruptured abdominal or thoracic aortic aneurysm". She ignores the fact that CPR was introduced as an emergency treatment for acute cardiac insults, and she does not seem to accept the very real distinction between a cardiac arrest that can respond to CPR and death occurring in terminal progressive illnesses with multiorgan failure.

Of most concern is her lack of understanding of palliative care. Palliative care consists of a multidisciplinary approach to the provision of care, with comfort and support provided through excellent symptom control. It avoids injudicious invasive investigations or treatments that will have no measurable benefit for the patient. In discussion of the prognosis of a terminal illness with patients and families the goals of such palliative treatment can be clearly outlined and acceptance of these goals obtained. However, Baylis insists on discussion of inappropriate treatment in all cases, which, as Buckman and Senn rightly said, is both inhumane and unconscionable.

Baylis seems to feel that physicians, nurses and other health care professionals have no rights in these matters but must perform interventions at a patient's request even when they regard these as inappropriate both medically and ethically. She also does not seem to understand that physicians have to make decisions regarding allocation of resources on a daily basis. If these resources are used inappropriately, patients with reversible and remedial conditions will die.

The real issue is the appropriateness of "Do not resuscitate" (DNR) orders, which are as much for the medicolegal protection of