

# Disease, Disparities and Decision Making: Mandatory HIV Testing of Prospective Immigrants to Canada

## ÉTUDE DE CAS / CASE STUDY

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Reçu/Received: 1 May 2013

Publié/Published: 5 Jul 2013

Éditeurs/Editors: Zubin Master & Ali Okhowat

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### Résumé

Cette étude de cas examine les enjeux éthiques associés à la politique d'immigration du Canada et à la nécessité du dépistage obligatoire du VIH chez les futurs immigrants. L'attention est portée à l'examen médical de l'immigration officielle (EMI) parce qu'il s'agit d'un site clé au sein du système d'immigration. Les quatre enjeux suivants sont soulevés: les différences dans les demandes de connaissances officielles et l'expérience sur les activités qui se produisent (ou non) dans l'EMI lorsque le demandeur est diagnostiqué avec le VIH, le traitement exceptionnel du VIH au sein du programme d'immigration du Canada, l'organisation discursive de la politique de dépistage du VIH et les insuffisances dans la façon dont les pratiques spécifiques sont adoptées dans le traitement des demandes d'immigration faites par des personnes vivants avec le VIH.

### Mots clés

exclusion, l'examen médical d'immigration, la politique d'immigration, dépistage obligatoire du VIH, le droit, médecin du panneau, l'organisation sociale de la connaissance

### Summary

This case study explores ethical issues with Canada's immigration policy and the requirement of mandatory HIV testing of prospective immigrants. Attention is directed to the official immigration medical examination (IME) because it is a key site within the immigration system. The following four issues are raised: the differences in official and experiential knowledge claims about what activities occur (or not) in the IME when an applicant is diagnosed with HIV; the exceptional treatment of HIV within the Canadian immigration program; the discursive organization of the HIV testing policy; and, the inadequacies with how specific practices are enacted in the processing of immigration applications made by people living with HIV.

### Keywords

exclusion, immigration medical examination, immigration policy, mandatory HIV testing, law, panel physician, social organization of knowledge

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### Remerciements

Manuscrit préparé pendant le mandat de Laura Bisailon comme chercheur postdoctoral aux [Montreal Health Equity Research consortium](#) du Biomedical Ethics Unit à l'Université McGill. Laura Bisailon a reçu le soutien financier suivant pour la recherche qui a informé cette étude de cas: Instituts de recherche en santé [numéro de subvention 200810IDR-198192-172991], les Fonds de la recherche en santé du Québec [numéro de subvention 16588], et Ontario Metropolis Centre [2009 Graduate Student Award].

### Conflit d'intérêts

L'auteur déclare aucun conflit d'intérêt.

### Acknowledgements

Manuscript prepared during Laura Bisailon's tenure as Postdoctoral Research Fellow with the [Montreal Health Equity Research consortium](#) at McGill University's Biomedical Ethics Unit. Laura Bisailon received the following financial support for the research that informed this case study: Canadian Institutes of Health Research [grant number 200810IDR-198192-172991]; les Fonds de la recherche en santé du Québec [grant number 16588]; and, Ontario Metropolis Centre [2009 Graduate Student Award].

### Conflicts of Interest

The author reports no conflicts of interest.

## Background

Canada has required HIV testing of all persons aged 15 years and older who request Canadian permanent resident status (immigrants and refugees) and temporary resident status (migrant workers, students, and long-term visitors from designated countries) since 2002.<sup>1</sup> Citizenship and Immigration Canada (CIC) manages the testing program and contracts general practitioners to carry out HIV testing as part of the immigration medical examination (IME). About 1,200 such doctors, called “Panel Physicians” (formerly “Designated Medical Practitioners”), are mandated to conduct approximately 550,000 IMEs per year in domestic and foreign settings. Tuberculosis, syphilis and HIV are the three conditions for which testing is required. Canada, along with Australia and New Zealand, distinguish themselves as a small minority of Organisation for Economic Co-operation and Development (OECD) countries that impose HIV testing on applicant immigrants as a pre-condition for being considered for immigration.

Prior to 2002, there was no blanket immigration testing for HIV in Canada, and it remains unclear why the HIV test was singled out as the only addition to the IME in over fifty years. The rationale for mandatory immigration HIV testing is not made explicit in the HIV policy text, though we know that immigration law and policy are organized within logics of exclusion. (1) As with all public policy, Canada’s mandatory HIV testing policy is neither value neutral nor without intended effect. How and why the absence of a clearly articulated policy purpose is problematic has been argued elsewhere and met with civil society contest. (2, 3)

The number of HIV-positive applicants admitted to Canada relative to the population increase through immigration and the resident population living with HIV is small. 4,374 persons tested HIV-positive through the IME between January 2002 and March 2010. (4) CIC agents found 453 of these people inadmissible for a Canadian visa based on a hypothetical estimate of costs for their care over a ten-year period. For the person living with HIV, the cost matrix is based on anticipated future participation in pharmaceutical insurance, which means the likelihood of taking antiretroviral medication. (5) Most immigrants with HIV who acquire a visa to remain in Canada, however, are persons who cannot, according to the law, be excluded on the basis of their health status: people applying as refugee or family class applicants. In 2006 and 2007, 1,050 HIV-positive applicants sought permanent residence, of which 994 persons were refugee or family class applicants. (6)

This case study is a composite of experiences that were reported during fieldwork carried out in 2009 and 2010. Institutional ethnographic research spanned eighteen months in various locations in Montreal, Ottawa and Toronto. (7) Findings from this theoretically informed fieldwork show that the state’s immigration HIV testing and decision making about medical admissibility ushers in a set of institutional practices and produces troubling ethical dilemmas. Findings also shine light on the ways in which health status shapes and limits the possibilities for settlement and citizenship in the Canadian context. These issues are revealed to be highly problematic for immigrants with HIV, Panel Physicians and other state agents, and the Canadian immigration program more broadly.

## Anna’s Case

Anna is a 38-year-old woman born in Chad who applied to immigrate to Canada as a skilled worker.<sup>2</sup> Having earned a doctoral scholarship to study in Russia, she completed the required immigration related administrative procedures, including medical examination by a Panel Physician, in that country. Her efforts spanned three years and involved considerable personal expense. Anna’s initial

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<sup>1</sup> The list of countries that Canada designates is found here: <http://www.cic.gc.ca/english/information/medical/dcl.asp>

<sup>2</sup> ‘Anna’ is a pseudonym. Names have been altered to shield identity.

visit with the Panel Physician was brief, and the interaction consisted mainly of questions asked of her from a checklist. While the doctor did not inform her that an HIV test was among the diagnostics performed, she was not surprised when she later learned that an HIV antibody test had been done. This is because in Russia, foreign students are obliged to submit to HIV tests prior to the start of each academic year. Where the result is positive, the person faces deportation.

A week before her doctoral defense, and four weeks after her medical examination, Anna received a telephone call during which she was asked to report to the Panel Physician's office. She did so, and during this visit, she learned that she was living with HIV. "I knew that I would have to go back home because in Russia, they would repatriate me. Foreigners with HIV are expelled. I thought going home to Chad just meant that I was going to die and that's the end of it. I started *really* wondering what was going to happen to me."

Anna was heavily burdened by the discovery that she was living with HIV. She was troubled by the interaction with the Panel Physician at her diagnosis, not least of all because the doctor speculated that successful immigration was closed to her because of her health condition. Anna was also disturbed by activities that happened, and did not happen, at the time of her diagnosis. "The doctor gave me a piece of paper that I had to sign that stated that I acknowledged that I was HIV-positive; that I am aware that I am HIV-positive; and that I had been educated about the means of transmission. I had not been educated through this doctor. Probably he was going to give me that talk. I read through his paper, and agreed with everything it said. It said, 'You cannot donate blood; protect yourself when engaging in sex; cannot give organs.' That was the attempt at counselling. I eased his job. Or, maybe I made it more difficult."

For prospective immigrants such as Anna and others like her, an HIV-positive result can heighten a person's vulnerability in significant ways. Applicants speculate about what place HIV holds within their Canadian immigration application process. They talk about chronic uncertainty with how their health condition is perceived by CIC decision makers. 'Will I be barred or deported because of my HIV as happens in other countries? Will I be treated differently by the state? Will I be able to sponsor family?' (8) In fact, the Canadian immigration program imposes on prospective immigrants a test that would be unlawful to impose on Canadian citizens and permanent residents except by court order. HIV testing of the latter is generally voluntary, perhaps anonymous, and within specific public health relations such as partner notification.

Within Anna's case there are explicit and implicit ethical issues that invite our exploration. The discussion that follows is organized around four of these issues.

## Discussion

### **1. There is a disjuncture between immigrants' reports with the practices associated with HIV testing in the IME and the states' reports about the same practices.**

An article appearing in the *International Journal of STD and AIDS* four years after the introduction of the HIV testing policy reported on the functioning of the screening program in its first two years. (9) The authors claim that all HIV-positive applicants consent to HIV testing, receive pre- and post-test counselling, and are referred to specialty facilities. The problem with these claims is that they are inconsistent with reports about the material conditions of the IME and diagnosis, as per Anna's and other people's experience. Applicants to Canada do not have a choice to opt out of HIV testing if they desire to immigrate, which calls into question the authenticity or meaningfulness of the informed consent process. Consent is not necessary. What is more, an applicant might not know that s/he is being tested for HIV, which was Anna's experience. Anna was neither the recipient of counselling before or after diagnostic screening, nor was she referred on to facilities with expertise in care to people living with HIV. The dissonance between official and experiential forms of knowledge is

problematic because left unchallenged, the former become accepted forms of evidence despite that they are divorced from embodied accounts, and that they elide empirical circumstances.

## **2. No other medical condition is subject to comparable scrutiny within the Canadian immigration program as is HIV.**

This claim is evidenced and measured by the quality and quantity of institutional documents and practices developed to govern and track immigrants with HIV in the post-2002 period. A diagnosis with HIV during immigration procedures is a strong institutional marker around which there are particular forms of state surveillance directed at immigrants. Diagnosis triggers condition-specific institutional practices, attention, and interactions that seronegative applicants do not experience. A positive diagnosis catalyzes the state's collection of medical data in the form of a medical file based on lab results, which is the basis for the decision making about the person's admissibility. The activities in which government employees including Panel Physicians engage in relation to HIV show that distinct understandings of contagion, infection, disease transmission, and 'risk' inform their work. In this way, the mandatory HIV test is found to be more than just a medical test because it organizes social and ruling relations and interactions that stretch well beyond the IME. As a result of testing, Anna, for example, is rendered vulnerable in ways that are very serious: she faces probable deportation from Russia; insecure and uncertain social conditions in Chad, including lack of access to antiretroviral medication without which she will not live; and, the prospect of blocked immigration to Canada as a skilled worker despite three years of focused investment of her resources. We see that Anna is made more vulnerable because of Canada's imposition of a test than would have been the case had she not been tested.

## **3. When the HIV testing policy text is examined for what it projects into the work practices of state agents including Panel Physicians, various forms of exclusions and stratifications are evident.**

These exclusions include the following: whether the applicant is already taking antiretroviral medication, in which case s/he is inadmissible to immigrate to Canada; narrow understandings of HIV and AIDS as strictly medical conditions though evidence shows that these strongly reflect the social conditions of peoples' habitat; dubious associations linking sexual offense and positive HIV status, with the suggestion that Panel Physicians report to CIC suspicions about deliberate infection of HIV from one person to another; and, finally, an inequity related to the country from which a prospective applicant files an immigration application. For while Anna needed to make numerous trips to Moscow to undergo the expensive and advanced diagnostic tests that the Canadian government requires when an applicant is HIV-positive and located outside of Canada, she nevertheless had the opportunity to access these tests in Russia. These tests are CD4 and viral load counts; measurements of immune system health and HIV blood levels, respectively. In her native Chad, however, it is unlikely that Anna would have had access to a CD4 test. Where an applicant does not produce results of these tests, her/his immigration application is incomplete and unable to be processed.

## **4. The medical examination of prospective immigrants and the work of Panel Physicians in the IME have little to do with medicine per se.**

The Panel Physician's IME work is organized in the interests of the state and its regulation of the immigration program and medical admissibility decision making; both of which are based on exclusion. In the IME, the Panel Physician is engaged as a textual fact-finder and her/his clinical reasoning is displaced by administrative form-filling obligations. (10) Contradictions arise out of the state's claims to provide counselling when this occurs as part of fact-finding and accountability practices. The requirement of mandatory immigration HIV testing, coupled within an application process that is focused on detecting biomedical evidence that might disqualify an applicant, creates serious challenges to the delivery of meaningful HIV post-test counselling. We see that at the very least, there is a distinct cleavage between how Panel Physicians and applicants such as Anna understand what activities should be involved in HIV test counselling. The particular interaction of the

IME is neither a clinical encounter, nor is it organized in the subjective best interests of applicant immigrants. In the IME, counselling does not occur because the organization and intent of the examination is exclusion rather than therapy; a finding that troubles taken-for-granted assumptions about physician responsibility towards patients. This disturbing issue shows that the particular form of 'doctoring' carried out in the IME has Panel Physicians working in ways that are squarely at odds with professional ethics principles guiding medical practice.

## Questions

1. Findings discussed in this case study could be used to inform a principle-based bioethics or ethics critique of mandatory HIV testing of immigrant applicants to Canada.
  - What form could this critique take?
  - What ethical issues arise through this case study?
  - What other critiques could be formulated based on issues explored?
2. Is it ethically justifiable to oblige foreign citizens to submit to HIV testing as a pre-condition for being considered for possible immigration to a foreign country? Discuss.
3. What ethical issues arise when we use a hypothetically derived dollar value to understand what a prospective immigrant living with HIV might extract from Canada, while ignoring consideration of the potential contributions the person might make?
4. In view of the findings about the social organization of the IME discussed in section four of this case study, can the encounter actually be transformed in ways that Panel Physicians import their clinical reasoning in post HIV test interactions (which might include delivering counselling to persons with HIV)?
  - Will still more physician training achieve valuable, relevant outcomes?
  - How are explanations of how the IME is organized useful for various audiences? Policy makers and state officials involved in immigration medical programming; Panel Physicians; immigrants with HIV; and, civil society advocates, among others?
5. How does the role and function of the Panel Physician relate to and differ from the institutionally initiated health work that takes place in shadowed, hard-to-reach locations inside and outside the formal health care system? Prisons, immigration detention centres, worker's compensation boards, military settings, or public health offices, for example.
  - How are doctors' divided or dual loyalties problematic for themselves and others (and who are the possible others)?
  - What does what happens in such hard-to-reach locations tell us about the ethical tensions, contractions and dilemmas faced by people who receive care there?

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