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## AIDS and United States Immigration Policy: Historical Stigmatization Continues With the Latest "Loathsome" Disease

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# AIDS AND UNITED STATES IMMIGRATION POLICY: HISTORICAL STIGMATIZATION CONTINUES WITH THE LATEST "LOATHSOME" DISEASE

Acquired immunodeficiency syndrome ("AIDS") is a group of diseases caused by a collapse of the immune system.<sup>1</sup> The human immunodeficiency virus ("HIV"),<sup>2</sup> the cause of AIDS,<sup>3</sup> continues

<sup>1</sup> See MIRKO D. GRMEK, HISTORY OF AIDS: EMERGENCE AND ORIGIN OF A MODERN PANDEMIC 33 (Russell C. Maulitz & Jacalyn Duffin trans., 1990). AIDS is a clinical consideration or a pathological state resulting from infection with the human immunodeficiency virus ("HIV"). *Id.*: Abe M. Macher, *HIV Disease/AIDS: Medical Background*, in AIDS AND THE LAW 1, 1 (Wiley Law Publications Editorial Staff eds., 2d ed. 1992) ("Acquired immune deficiency syndrome (AIDS) is a specific group of diseases or conditions that indicate severe immunosuppression related to infection with the human immunodeficiency virus (HIV)."); *Id.* at 8-11 (Centers for Disease Control defines AIDS as illness characterized by certain "indicator" diseases or positive laboratory evidence).

AIDS was originally categorized as Gay Related Immune Deficiency ("GRID"), a classification that has been proven inaccurate since the disease has reached pandemic proportions spreading far beyond the gay community. See Thomas B. Stoddard & Walter Reiman, *AIDS and the Rights of the Individual*, in A DISEASE OF SOCIETY 241, 256 (Dorothy Nelkin et al. eds., 1991). Although at first AIDS was known as GRID, gay advocates worked to change the name in fear "that the new illness would exacerbate the stigmatization already accorded gay people in the United States." *Id.*; see also GRMEK, *supra*, at 10 (newspapers referred to disease as "gay cancer," "gay pneumonia" or "gay plague," and "some started to use an acronym that had a more scholarly ring: GRID (Gay-Related Immune Deficiency)"); Dennis Altman, *The Politics of AIDS*, in AIDS PUBLIC POLICY DIMENSIONS 23, 23-24 (John Griggs ed., 1987) (discussing conceptualization of AIDS as homosexual disease). See generally Stoddard & Reiman, *supra*, at 241-269 (discussing discrimination arising from AIDS and epidemic's effect on concept of "equal protection").

<sup>2</sup> See June E. Osborn, M.D., *The AIDS Epidemic: Discovery of a New Disease*, in AIDS AND THE LAW 17, 21-22 (Harlon L. Dalton et al. eds., 1987). During the early 1980s, medical institutions reported the detection of various retroviruses, and after detailed comparisons, it was obvious that they were fundamentally alike. *Id.* Subsequently, the virus was named Human Immunodeficiency Virus (HIV). *Id.*; see also Harold Jaffe, *The Medical Facts About AIDS*, in AIDS AND THE COURTS 7, 8-9 (Clark C. Abt & Kathleen M. Hardy eds., 1990). HIV is a virus that infects white blood cells by transcribing its genetic material from RNA form into DNA form, which allows it to integrate and become part of the white blood cell, thereby establishing a latent infection. *Id.* at 8. A few months after this initial infection, the infected individual's immune system produces antibodies in reaction to the virus, which can then be detected by a blood test. *Id.* The time from infection to antibody presence is known as the "window period." *Id.*

It should be noted that the term "HIV" is used throughout this article chiefly in discussing the HIV-1 epidemic, which is more widely dispersed throughout the world than the HIV-2 epidemic (minor AIDS). See *Update: HIV-2 Infection—United States*, 38 MORBIDITY & MORTALITY WKLY. REP. 572, 572-74 (1989). HIV-2, the other virulent strain of AIDS, was first discovered in 1985 and predominantly centered in Western Africa, particularly in asymptomatic prostitutes. *Id.* at 572. It has since turned up sporadically in other countries.

to spread at an unprecedented rate within the United States<sup>4</sup> and throughout the world,<sup>5</sup> and shows no sign of abatement.<sup>6</sup> AIDS

*Id.* at 574. The seven HIV-2 infected individuals in the United States (four more under examination) have all been heterosexual West Africans. *Id.* Canada, Central Africa, Western Europe, and Brazil have also reported cases of HIV-2 infected persons. *Id.* Although HIV-1 and HIV-2 are distinct viruses, they are still closely related and may crossreact each other during testing. *Id.*; see also GRMEK, *supra* note 1, at 141 (distinguishing HIV-1 from HIV-2).

<sup>3</sup> See National Academy of Sciences, *HIV Infection and Its Epidemiology*, in THE AIDS READER 74, 74 (Nancy F. McKenzie ed., 1991) (scientifically analyzing HIV as causative agent of AIDS); see also Richard Green, M.D., *The Transmission of AIDS*, in AIDS AND THE LAW, *supra* note 2, at 28, 29-30. The three distinct conditions following infection with the HIV virus are the seropositive state, AIDS-related complex (ARC), and AIDS, with AIDS being the most serious of the three conditions caused by HIV. *Id.*

<sup>4</sup> Telephone Recording of the Centers for Disease Control ("CDC"), *AIDS Quarterly Surveillance Report*, read by Kay Gallan, CDC Public Affairs Office (July 2, 1992) [hereinafter Telephone Recording]. Current statistics as of March 31, 1992 report 214,609 adult AIDS cases (Caucasians, 116,542; African-Americans, 63,941; Hispanics, 35,582; Asians, 1,365; unknown, 519). *Id.*; see *The HIV/AIDS Epidemic: The First 10 Years*, 40 MORBIDITY & MORTALITY WKLY. REP. 357, 357 (1991) [hereinafter *The First 10 Years*]. At the end of 1991, AIDS was projected to be the second leading cause of death among men ages 25-54 (second to unintentional injuries), and one of the five leading causes of death among women ages 15-44. *Id.*; see also AMERICA LIVING WITH AIDS. REPORT OF THE NATIONAL COMMISSION ON AIDS 3 (1991) [hereinafter 1991 NATIONAL COMMISSION ON AIDS]. Current estimates indicate that at least one million Americans are HIV-positive, and that over 350,000 people will have died from AIDS by 1993 (more than doubling the 120,000 deaths reported in first ten years of documentation in this country). *Id.*

<sup>5</sup> See *The First 10 Years*, *supra* note 4, at 357. The World Health Organization ("WHO") estimates that 8-10 million adults and 1 million children in the world are HIV-positive. *Id.* Furthermore, 40 million persons worldwide are expected to be HIV-infected by the year 2000. *Id.*; Anthony S. Fauci, *The Human Immunodeficiency Virus: Infectivity and Mechanisms of Pathogenesis*, 239 SCIENCE 617, 617 (1988) (referring to AIDS as worldwide epidemic even though most cases are in United States); see also Catherine Arnst, *As AIDS Meeting Ends, Research Still Lags Epidemic's Spread*, Reuters, June 21, 1991, available in LEXIS, Nexis Library, Reuters File. As of mid-1991, over one million HIV infections may have occurred in South and Southeast Asia, with over 2.5 million expected by the mid-1990s. *Id.* "More than 90 percent of these cases are projected to occur in developing countries—half in Africa, a quarter in Asia, and over 10 percent in Latin America." *Id.*; Marsha F. Goldsmith, *Rapid Spread of Pandemic in Asia Dismays Experts, Spurs Efforts to Fight Transmission*, 266 JAMA 1048, 1049 (1991) (describing high estimated number of cases in India, Thailand, and other Asian countries, but not in Japan, where there is little intravenous drug use, highest rate of condom use, and "cultural proscription of homosexuality"). In discussing governmental denial of an AIDS threat in Asia, Vulimiri Ramalingaswami, M.D., speaking at the Seventh International Conference on AIDS, stated that "we are sitting on top of a volcano and we do not know yet just when it will erupt." *Id.*; Edward Hooper, *The Villages of the Damned*, THE INDEPENDENT, Apr. 1, 1990, at 9 (one Ugandan in twenty is HIV-infected, primarily through heterosexual contact); WHO Predicts 10 Million AIDS Cases By 2000, Xinhua General Overseas News Service, May 9, 1991, available in LEXIS, Nexis Library, Xinhua File [hereinafter *10 Million AIDS Cases*]. "Seventy percent of global HIV infections in 1991 have been spread by sexual intercourse, and more than eighty percent of all infections will result from heterosexual intercourse before the year 2000 . . ." *Id.* See generally MAUREEN A. LEWIS ET AL., AIDS IN DEVELOPING COUNTRIES: COST ISSUES AND POLICY

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has entered into its second decade, having claimed over 200,000 lives in the United States alone.<sup>7</sup> Progress to eradicate this epidemic has been slow, largely due to the discrimination which accompanies AIDS and AIDS-related illnesses.<sup>8</sup> It is submitted that the United States government has magnified the stigmatization associated with AIDS by enacting an immigration law which classifies "HIV infection" as a medical ground for exclusion.<sup>9</sup> A review

TRADEOFFS 39-40 (1989) (illustrating prevalence of AIDS in selected developing countries); RENEE SABATIER, *AIDS AND THE THIRD WORLD* 125-75 (1989) (providing country by country breakdown of AIDS cases worldwide); Peter Piot et al., *AIDS: An International Perspective, in THE HETEROSEXUAL TRANSMISSION OF AIDS IN AFRICA* 39, 39-45 (Dieter Koch-Weser & Hannelore Vanderschmidt eds., 1988) (discussing global patterns of HIV in heterosexuals).

<sup>6</sup> See *HIV Prevalence Estimates and AIDS Case Projections for the United States: Report Based Upon a Workshop*, 39 MORBIDITY & MORTALITY WKLY. REP. RR-16, 28-31 (1990). According to the CDC, AIDS cases diagnosed in the United States were higher in 1989 than in 1988, and these numbers are expected to increase through 1993. *Id.*; see also Arnst, *supra* note 5 ("It is neither prudent nor reasonable to describe the pandemic as stable." (quoting Jonathan Mann, Director of Harvard University's International AIDS Center)); *10 Million AIDS Cases*, *supra* note 5 ("[M]ore AIDS cases will continue to develop from the existing pool of HIV infected persons no matter how successful worldwide efforts to curb the spread of the virus may be.").

<sup>7</sup> Telephone Recording, *supra* note 4. United States statistics compiled as of March 31, 1992 reported 214,609 AIDS deaths among adults and 3,692 among children under thirteen. *Id.*: see Dolores Kong, *AIDS Panel Assails Bush, Congress*, BOSTON GLOBE, Sept. 26, 1991, at 1 (AIDS has claimed more lives in United States than Vietnam and Korean wars combined); see also Update: *Acquired Immunodeficiency Syndrome—United States, 1981-1990*, 40 MORBIDITY & MORTALITY WKLY. REP. 358, 359 (1991) [hereinafter *AIDS Update*] (over 113,000 deaths due to AIDS reported as of June 1991).

<sup>8</sup> See REPORT OF THE PRESIDENTIAL COMMISSION ON THE HUMAN IMMUNODEFICIENCY VIRUS EPIDEMIC 119 (1988) [hereinafter 1988 PRESIDENTIAL COMMISSION REPORT] ("HIV-related discrimination is impairing this nation's ability to limit the spread of the epidemic."); RONALD O. VALDISERRI, *PREVENTING AIDS: THE DESIGN OF EFFECTIVE PROGRAMS* 265-82 (1989) (examples of barriers to AIDS-prevention programs include negative attitudes toward homosexuality, society's lack of consensus regarding sex and contraception, and debate on drug-use prevention and treatment); see also Dan E. Beauchamp, *Morality and the Health of the Body Politic*, in *THE AIDS READER*, *supra* note 3, at 408, 408-19 (discussing social intolerance towards homosexuals, drug abuse and promiscuity, and suggesting that best weapon against AIDS would be public policy allowing one "the right to be different in fundamental choices," while promoting "democratic community as one body in matters of the common health"); Harlon L. Dalton, *AIDS in Blackface*, in *THE AIDS READER*, *supra* note 3, at 122, 127-28 (discussing black community's reluctance to deal with AIDS because of negative association that blacks are responsible for origin and spread of epidemic); William Deresiewicz, *Against All Odds: Grass-Roots Minority Groups Fight AIDS*, in *THE AIDS READER*, *supra* note 3, at 534, 534-42 (minorities face discrimination in AIDS crisis).

<sup>9</sup> Immigration and Nationality Act of 1990, § 212(a), 8 U.S.C. § 1182(a) (Supp. 1991) [hereinafter INA of 1990] (setting out medical grounds, including HIV infection, for exclusion of aliens from United States); see Medical Examination of Aliens, 42 C.F.R. § 34 (1990) (list of excludable diseases); Robert Pear, *Health Dept. Loses in AIDS Rule Dispute*, N.Y. TIMES, May 28, 1991, at A18. In revising the immigration law in 1990, Congress intended that the Secretary of Health and Human Services ("HHS") identify exclusionary

of the United States' past and present immigration policies indicates that medical exclusions, as exemplified by the addition of AIDS, are often based on prejudicial notions rather than humane and scientific reasons.<sup>10</sup> As a result, our nation's legitimate concern with keeping out disease has frequently resulted in unfair administration of the law.<sup>11</sup>

diseases "based on current epidemiological principles and medical standards." *Id.* Secretary Sullivan proposed that HIV be taken off the exclusionary list since "it is not a communicable disease of public health significance." *Id.*; see also 42 C.F.R. § 34.2 (1990) (defining excludable diseases). The list of "communicable diseases of public health significance" upon which exclusion may be based includes chancroid, gonorrhea, granuloma inguinale, HIV, infectious leprosy, lymphogranuloma venereum, infectious syphilis, and active tuberculosis. *Id.*; Pear, *supra*, at A18. Dr. Sullivan's proposal, which was ultimately shelved, generated a great deal of controversy. *Id.* Jeffrey Levi, Director of Government Affairs for the AIDS Action Council said that "[t]his issue is a battle for the soul of the Department of Health and Human Services because it comes down to a question of whether the agency will maintain its professional integrity in the face of this epidemic." *Id.*

<sup>10</sup> See, e.g., STAFF OF HOUSE COMM. ON THE JUDICIARY, 100TH CONG., 2D SESS., GROUNDS FOR EXCLUSION OF ALIENS UNDER THE IMMIGRATION AND NATIONALITY ACT, 77 (Comm. Print 1988) [hereinafter Comm. Print]. One example of the lack of scientific reasons used in determining admission is the fact that until 1965 epilepsy was still on the Public Health Service's ("PHS") list of excludable diseases. *Id.* Especially troublesome however, is the legislature's specific intent to include homosexuals in the category of "psychopathic personality." *Id.* It was not until the Ninth Circuit set aside a deportation order holding that homosexuality did not necessarily equal a "psychopathic personality," that the legislature amended the list to read "sexual deviation." *Fleuti v. Rosenberg*, 302 F.2d 652, 658 (9th Cir. 1962), *vacated and remanded*, 374 U.S. 449 (1963). The sexual deviation exclusion fostered inconsistent judicial interpretations. *Compare Hill v. I.N.S.*, 714 F.2d 1470, 1480-81 (9th Cir. 1983) (INS could not exclude homosexuals absent medical certificate) with *Matter of Longstaff*, 716 F.2d 1439, 1450-51 (5th Cir. 1983) (INS could exclude homosexuals without medical certificate), *cert. denied*, 467 U.S. 1219 (1984). In 1990, however, the sexual deviation exclusion was repealed in order to comply with notions of privacy and personal dignity, and to make a statement that personal sexual decisions are not dangerous to others. See H.R. REP. NO. 723(1), 101st Cong., 2d Sess. 52-53 (1990), *reprinted in* 1990 U.S.C.C.A.N. 6732-33 (discussing need to update H.R. 4300, 101st Cong., 2d Sess. § 1 (1990)).

The term 'sexual deviation' . . . was included with the other mental health exclusion grounds expressly for the purpose of excluding homosexuals. Not only is this provision out of step with current notions of privacy and personal dignity, it is also inconsistent with contemporary psychiatric theories . . . . In order to make it clear that the United States does not view personal decisions about sexual orientations as a danger to other people in our society, the bill repeals the sexual deviation exclusion ground.

*Id.* at 56. Previous House reports had recommended replacing the specific disorders listed in INA §212(a)(1)-(5), since they represented "outmoded and inflexible notions of medical diagnoses." *Id.* at 52. See generally *Gays Note Success in Congress*, S.F. CHRON., Dec. 24, 1990 at A8 ("[I]mmigration reform bill . . . removed homosexuality as a legal basis for excluding travelers or immigrants from the United States.").

<sup>11</sup> See ROGER DANIELS, *COMING TO AMERICA* 272-74 (1990). Ellis Island was described as both an "island of hope" and an "island of tears." *Id.* Due to the arbitrary manner in

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This Note will begin with a historical overview of the AIDS epidemic. Part Two will then examine discriminatory trends in United States immigration policy from colonial times to present, including the adoption and aftermath of the "Helms Amendment," which first called for the exclusion of HIV-positive immigrants. Finally, Part Three will analyze current immigration law and discuss how and why it deters, rather than facilitates, the national and global effort to fight AIDS.

### I. HISTORICAL PERSPECTIVE ON AIDS

During the summer of 1981,<sup>12</sup> the Centers for Disease Control ("CDC"), a federal agency responsible for documenting the occurrence and distribution of disease,<sup>13</sup> reported unusual epidemic-like cases of Kaposi's sarcoma,<sup>14</sup> pneumocystis pneumonia,<sup>15</sup> and other

which immigrants were sometimes excluded, New York City Mayor Fiorello La Guardia stated that "many of those classified as mental cases were so classified because of ignorance on the part of the immigrants or the doctors and the inability of the doctors to understand the particular immigrant's norm, or standard." *Id.* at 274; *see also* BARBARA BENTON, *ELLIS ISLAND* 81, 92 (1985) (discussing how immigrants were often rejected because of Americans' lack of compassion and understanding). As noted by a federal judge in New York hearing the appeal of a rejected immigrant, "[i]f the commissioners wanted an alien drawn, quartered, and chucked overboard, they could do so without interference." *Id.* at 92; ELIZABETH HULL, *WITHOUT JUSTICE FOR ALL. THE CONSTITUTIONAL RIGHTS OF ALIENS* 20-21 (1985) (1952 Act allowed exclusions of persons who, "in the opinion" of immigration officials, were likely "at any time" to become public charge). *But see* INA of 1990, *supra* note 9 (law today still allows opinion-based public charge exclusion); *WHOM WE SHALL WELCOME. REPORT OF THE PRESIDENT'S COMMISSION ON IMMIGRATION AND NATURALIZATION* 206 (Leonard W. Levy ed., 1953) [hereinafter *WHOM WE SHALL WELCOME*] (criticizing 1952 law which allowed public charge ground for deportation to be based upon opinion of immigration officer).

<sup>12</sup> *See* David Huminer et al., *AIDS in the Pre-AIDS Era, in THE HETEROSEXUAL TRANSMISSION OF AIDS IN AFRICA*, *supra* note 5, at 70, 72-73. Although the first documented cases of AIDS were officially reported in the summer of 1981, a retrospective study revealed that cases fulfilling the surveillance definition of AIDS could be found in the United States as far back as 1952. *Id.* at 70, 72. In addition, antibodies to HIV were detected in stored serum samples from Zaire dating back to 1959. *Id.* at 73; *see also* GRMEK, *supra* note 1, at 121-22 (drawing parallels between AIDS and 1952 patient's case history).

<sup>13</sup> *See* GRMEK, *supra* note 1, at 13-14 (detailing history of CDC).

<sup>14</sup> *See Kaposi's Sarcoma and Pneumocystosis Pneumonia Among Homosexual Men—New York City and California*, 30 *MORBIDITY & MORTALITY WKLY. REP.* 305-08 (1981). Between 1979 and 1981, twenty-six homosexual men under age 51 had been diagnosed with Kaposi's sarcoma, a rare form of cancer usually seen in older, dark-skinned men. *Id.*: *see also* Lawrence K. Altman, *Rare Cancer Seen in 41 Homosexuals*, *N.Y. TIMES*, July 3, 1981, at A20 (discussing outbreak of 41 cases of Kaposi's sarcoma).

<sup>15</sup> *See Pneumocystosis Pneumonia—Los Angeles*, 30 *MORBIDITY & MORTALITY WKLY. REP.* 250, 250-52 (1981). This was the first document warning the medical community about the

clinical disorders,<sup>16</sup> all stemming from a collapse in the immune system. The following year, these apparently related disorders were classified as a viral disease<sup>17</sup> and named AIDS.<sup>18</sup> The disease spread rampantly,<sup>19</sup> and by 1983, AIDS had become the number one priority of the United States Health Service.<sup>20</sup> The groups with the greatest exposure were homosexuals, intravenous drug-users, Haitians, hemophiliacs, and prostitutes.<sup>21</sup> Except for

outbreak of *Pneumocystis pneumonia* ("PCP") in the homosexual community. *Id.* PCP is a serious illness which occurs only when a deficit in the immune system exists. *Id.*

<sup>16</sup> See GRMEK, *supra* note 1, at 1-7. The first symptoms shown by infected persons included toxoplasmosis, oral and anal thrushes (yeast infections), cytomegalovirus (CMV) (a widespread herpes-type virus), and certain mononucleosis-like symptoms, such as spiking fevers, swollen lymph nodes, and weight loss. *Id.*

<sup>17</sup> See *id.* at 47. In 1982, reports of AIDS in hemophiliacs who had received filtered blood products verified that AIDS was caused by a virus. *Id.* Blood components are filtered to remove bacteria, fungi and protozoa. *Id.* Because the infectious agent passed through the filter and remained in the blood supply, it was determined to be a virus. *Id.*

<sup>18</sup> See *id.* at 32. In the summer of 1982, the acronym "AIDS" was officially adopted and caught on through its use in the CDC reports. *Id.* Fortunately, the term "AIDS" represented a scientifically valid name, unlike earlier descriptions, such as "GRID" (Gay-Related Immune Deficiency) or "gay compromise syndrome," which were misleading and prejudicial. *Id.* A formal definition was adopted by the CDC and WHO in early 1983. *Id.* at 33.; see also *supra* note 1 (discussing GRID).

<sup>19</sup> See GRMEK, *supra* note 1, at 41. There were 10 new cases each week in 1982, and 100 new cases each week in 1984. *Id.* The combined numbers of cases reported and new cases doubled every six months. *Id.*; see also *AIDS Update*, *supra* note 7, at 358 (in 1981, 189 AIDS cases reported to CDC; in 1990, more than 43,000 cases reported). See generally *HIV Prevalence Estimates and AIDS Case Projections for the U.S.: Report Based Upon a Workshop*, 39 MORBIDITY & MORTALITY WKLY. REP. 12-15 (1990) (expecting 61,000-98,000 new cases to be diagnosed in 1993).

<sup>20</sup> Robert J. Biggar, *AIDS and HIV Infection: Estimates of the Magnitude of the Problem Worldwide, 1985/1986*, in *THE HETEROSEXUAL TRANSMISSION OF AIDS IN AFRICA*, *supra* note 5, at 26, 26 ("By 1983, [AIDS] became the number one priority of the United States Public Health Service, in recognition of the explosiveness of the outbreak and the virulence of the disease.").

<sup>21</sup> See GRMEK, *supra* note 1, at 31. "American epidemiologists . . . called the most exposed groups the 'Four-H Club': homosexuals, Haitians, heroin addicts, and hemophiliacs. Some replaced the last group with hookers, bringing in fact the fateful club membership to five." *Id.* See generally VALDISERRI, *supra* note 8, at 1-10 (discussing recognized high risk groups); Biggar, *supra* note 20, at 26-28 (same).

Initially, the number of Haitians reported as HIV-infected puzzled medical experts because the victims did not admit to being homosexual or drug users. See GRMEK, *supra* note 1, at 34-36. Research later revealed that many of the HIV-infected Haitians were actually bisexual, having homosexual relations with foreigners for pay while continuing to have heterosexual contacts for personal pleasure. *Id.* at 35. By the summer of 1982, Haitians accounted for six percent of reported AIDS cases in the United States. *Id.* at 34. By 1983, several thousand were HIV-positive and at least 250 Haitians in the United States had developed overt AIDS. *Id.* at 36. Many Americans blamed the Haitians for the origin and spread of AIDS in the United States. *Id.* at 34. Today:

[W]e can take as a proven notion that AIDS was introduced to the Caribbean after

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hemophiliacs, who were accidentally infected through blood product injections,<sup>22</sup> the initial high risk groups were often subject to unwarranted social prejudices because of their cultural background, choice of lifestyle, and physical addiction.<sup>23</sup>

The availability of statistical data on AIDS patients dramatically increased during the second half of the 1980s, with the development of seropositivity tests, which detect the presence of the HIV virus in the blood.<sup>24</sup> Using such data, medical experts determined that HIV is transmitted through sexual contact, the sharing of contaminated injection equipment, exposure to infected blood or blood products, and gestation or birth.<sup>25</sup> As the disease

1972. The virus probably came from the United States but we cannot exclude a possible African origin. Subsequently, the Haitians greatly contributed to the worldwide spread of the epidemic, first through the commercialization of sex at home, and later through emigration.

*Id.* at 36; see also SABATIER, *supra* note 5, at 34-35 (disproving popular hypotheses that global AIDS epidemic started when African monkeys passed virus to Africans).

<sup>22</sup> See Jaffe, *supra* note 2, at 16. Hemophiliacs accounted for 1% of the AIDS cases in the United States, and transfusion recipients 3%, representing individuals infected by HIV-infected blood or blood products. *Id.*; see also VALDISERRI, *supra* note 8, at 7 (development of laboratory test—enzyme-linked Immuno-Sorbent Assay ("ELISA")—detecting presence of antibodies virtually eradicated spread of HIV through blood transfusions). *But see AIDS Update*, *supra* note 7, at 359:

Although the annual incidence of AIDS for persons who have received blood transfusions and persons with hemophilia has stabilized . . . cases associated with these modes of HIV transmission continue to be diagnosed as a consequence of infections that occurred before screening of donated blood and heat treatment of clotting factors and because of the long period between the infection of HIV and the onset of AIDS.

*Id.* See generally Mark G. Pedretti & Vincent L. Gallo, Jr., *Acquired Immunodeficiency Syndrome: The Case For Anonymous Limited Discovery*, 6 ST. JOHN'S J. LEGAL COMMENT. 1 (analyzing possible liability of blood banks and hospitals for supplying individuals with AIDS-infected blood).

<sup>23</sup> See Laura R. Gasarch, *Discrimination Against the Disabled*, in AIDS AND THE LAW, *supra* note 1, at 199, 199-200 (partially attributing discrimination against HIV-infected persons to fact that most "affected individuals belong to socially ostracized groups"); Richard Goldstein, *The Implicated and the Immune*, in A DISEASE OF SOCIETY, *supra* note 1, at 17, 19 (discussing explosive response throughout art community, mentioning stigma among groups hit hardest by AIDS); see also *supra* note 8 and accompanying text (discussing discrimination against AIDS patients).

<sup>24</sup> See GRMEK, *supra* note 1, at 84-87 ("previously hidden portion of the viral invasion suddenly became visible" with use of seropositivity tests); see also *infra* notes 131-137 and accompanying text (detailing HIV seropositivity tests).

<sup>25</sup> See Macher, *supra* note 1, at 4-5 (modes of transmission include sexual contact, sharing contaminated needles, receiving transfusions of contaminated blood, perinatal transmission, and transplantation of HIV-infected tissue); *Public Health Service Plan for the Prevention and Control of AIDS*, 100 PUB. HEALTH REP. 453, 453-54 (1985) (stating modes of transmission); 1991 NATIONAL COMMISSION ON AIDS, *supra* note 4, at 20 (citing modes of transmis-



progressed, the distribution of AIDS cases among risk groups gradually began to change.<sup>26</sup> The percentage of HIV-infected male homosexuals—the largest class of HIV-infected individuals—decreased,<sup>27</sup> whereas the number of intravenous drug-abusing patients increased, with the majority of these drug-abusers being young, heterosexual minorities.<sup>28</sup> The number of HIV cases reported among the heterosexual partners of those in high-risk groups have also increased.<sup>29</sup> A growing number of women have contracted HIV,<sup>30</sup> and at the end of 1990 women accounted for ten percent of all adults reported to have AIDS.<sup>31</sup> Furthermore,

sion, including transmission via breastfeeding).

<sup>26</sup> GRMEK, *supra* note 1, at 193. Grmek notes:

Certain trends begun before 1985 accelerated. The increase among white homosexuals slowed, but took on frightening proportions among drug addicts and their families . . . . The relative number of homosexuals dropped to 63 percent while that of drug addicts increased to 19 percent . . . . The spread of the disease has now become more rapid in children than in adults . . . .

*Id.*; see NATIONAL COMMISSION ON AIDS, ANNUAL REPORT TO THE PRESIDENT AND CONGRESS 31 (1990) [hereinafter 1990 NATIONAL COMMISSION ON AIDS]. “[T]he epidemic is reaching crisis proportions among the young, the poor, women, and many minority communities. In fact, the 1990s will be much worse than the 1980s.” *Id.*

<sup>27</sup> See National Academy of Sciences, *supra* note 3, at 91 (decline of rate of HIV infection in homosexual group due to several factors, including changes in sexual behavior); *supra* note 26 (discussing changes in rate of infection among gays during eighties).

<sup>28</sup> GRMEK, *supra* note 1, at 41; see Therese Poletti, *Bush's Drug Office Accused of Ignoring Drugs-AIDS Link*, Reuters, Aug. 6, 1991, available in LEXIS, Nexis Library, Reuters File (AIDS Commission reports one-third of AIDS cases related to intravenous drug use, whether it is “sharing of needles, unsafe sex under the influence of drugs or sex with an infected drug user”); see also 1991 NATIONAL COMMISSION ON AIDS, *supra* note 4, at 32-33 (increase in HIV cases attributable to drug use has caused it to become “the number two risk factor”); 1988 PRESIDENTIAL COMMISSION REPORT, *supra* note 8, at 94-104 (explaining how drug abuse affects HIV epidemic).

<sup>29</sup> See VALDISERRI, *supra* note 8, at 56-58 (risk of HIV infection to heterosexual population has increased by sexual contact with high risk individuals, including intravenous drug users, bisexuals, and hemophiliacs); see also 1991 NATIONAL COMMISSION ON AIDS, *supra* note 4, at 27-30 (6% of AIDS cases in United States caused by heterosexual contact).

<sup>30</sup> See Tedd V. Ellerbrock et al., *Epidemiology of Women With AIDS in the United States, 1981 Through 1990: A Comparison With Heterosexual Men With AIDS*, 265 JAMA 2971, 2971-75 (1991). “Between 1985 and 1990, the percentage of adult AIDS cases that occurred in women increased from 6.6 per cent to 11.5 per cent.” *Id.*; see also *Characteristics of, and HIV Infection Among, Women Served By Publicly Funded HIV Counseling and Testing Services—United States, 1989-1990*, 40 MORBIDITY & MORTALITY WKLY. REP. 195, 195-96 (1991) (34% increase of HIV infection among women from 1989-1990, with 73% being black or Hispanic); Richard Woodman, *Millions of Women 'Face HIV Infection,'* THE PRESS ASSOCIATION LIMITED, Nov. 27, 1990, (Home News) (“AIDS is now the leading cause of death for women aged 20-40 in major cities in Western Europe, Africa, and the Americas . . .”).

<sup>31</sup> Ellerbrock et al., *supra* note 30, at 2971 (15,493 of 158,279 adults reported with AIDS in United States were women, with 51% infected through intravenous drug use and 29% through heterosexual contact).

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an increasing number of newborns were infected by their mothers during gestation or at birth.<sup>32</sup>

From a demographic standpoint, AIDS was initially concentrated in the major urban centers of Houston, Los Angeles, Miami, Newark, New York City and San Francisco.<sup>33</sup> However, by the end of 1983, people in forty-four states had contracted AIDS.<sup>34</sup> By 1990 the virus was present in every state,<sup>35</sup> with the most notable increases occurring in the South.<sup>36</sup> It is submitted that AIDS, originally thought to attack only specific high-risk groups and permeate only certain regions, has stealthily infiltrated and will continue to strike every geographic locale and socio-economic level of society.

### II. HISTORICAL OVERVIEW OF AMERICAN IMMIGRATION POLICY

A review of United States immigration policy reveals that the reception given to immigrants has ranged from hospitable to horrendous, depending on the economic, political, and cultural conditions of the time.<sup>37</sup> American immigration policy can generally be

<sup>32</sup> *Id.* In 1989, approximately 6,000 infants were born to HIV-infected women in the United States, and about 1,500-2,000 of these infants were infected perinatally. *Id.*

<sup>33</sup> See 1991 NATIONAL COMMISSION ON AIDS, *supra* note 4, at 11. "During the earliest years of the [AIDS] epidemic, from 1981-1982, nearly 80% of all reported AIDS cases were from six large metropolitan areas in five states . . ." *Id.*; see also Jaffe, *supra* note 2, at 12 (presently AIDS cases remain concentrated in certain geographic areas).

<sup>34</sup> GRMEK, *supra* note 1, at 41 (describing demographic progression of AIDS).

<sup>35</sup> AIDS Update, *supra* note 7, at 358. "In 1990, more than 43,000 cases were reported representing all states, the District of Columbia and the U.S. territories." *Id.*; see Philip R. Lee & Peter S. Arno, AIDS and Health Policy, in AIDS: PUBLIC POLICY DIMENSIONS, *supra* note 1, at 3, 3 (by 1987, at least some cases were reported from every state and District of Columbia, with metropolitan areas being hardest hit).

<sup>36</sup> AIDS Update, *supra* note 7, at 359.

<sup>37</sup> See *City of El Centro v. United States*, 922 F.2d 816, 818 (Fed. Cir. 1990) ("The Constitution vests in the Federal Government the authority and responsibility to protect the integrity of the borders of the United States."), *cert. denied*, 111 S. Ct. 2851 (1991); *Francis v. I.N.S.*, 532 F.2d 268, 272 (2d Cir. 1976) ("The authority of Congress and the executive branch to regulate the admission and retention of aliens is virtually unrestricted. . . . Enforcement of the immigration laws is often related to consideration both of foreign policy and the domestic economy."); *Gonzalez de Moreno v. I.N.S.*, 492 F.2d 532, 535 n.5 (5th Cir. 1974) ("Congress may tailor immigration procedures to meet the problems posed by the exceptional volume or nature of the immigrants from particular countries."); see also PASTORA SAN JUAN CAFFERTY ET AL. THE DILEMMA OF AMERICAN IMMIGRATION 11-37 (1983) [hereinafter CAFFERTY ET AL.] (discussing economic, political, social, and cultural problems inherent in American immigration policy); HULL, *supra* note 11, at 1-6 (observing that Americans' feelings toward aliens have ranged from warm to distinctly cruel and heartless).

divided into three phases.<sup>38</sup> During the first phase of American immigration, an appreciation of freedom and justice, coupled with an abundance of land available for settlement, resulted in an "open-door" policy.<sup>39</sup> Such liberality was hardly the norm, as subsequent policies became exclusionary, based on prejudices against certain races and social status.<sup>40</sup> It is submitted that our young nation's immigration policy had fluctuated according to the needs of the time. Sometimes the door was graciously held open, while at other times prejudice slammed it shut.<sup>41</sup>

<sup>38</sup> See CAFFERTY ET AL., *supra* note 37, at 39. Immigration legislation was categorized into three separate phases. *Id.* Before 1875, restrictions were few, and in order to develop the new nation, states would entice foreigners with job opportunities and land at minimal costs. *Id.* From 1875-1965, numerical restrictions were developed according to country of origin, and from 1965 to the present, numerical restrictions have focused on family relationships. *Id.*

Even during times when restrictions against aliens were few, however, Congress retained the power to place restrictions on immigration. See *United States v. Gordon-Nikkar*, 518 F.2d 972, 977 (5th Cir. 1975). Since Congress is granted power to establish a uniform rule of naturalization under Article I, Section 8 of the Constitution, Congress has "the plenary, unqualified power to determine which aliens shall be admitted to this country, the period they may remain, and the terms and conditions of their naturalization." *Id.*

<sup>39</sup> See CAFFERTY ET AL., *supra* note 37, at 39. The commonwealth charters of Virginia (1609) and Massachusetts (1629) opened the doors of their territories to "any other strangers that will become our loving subjects." *Id.*

<sup>40</sup> See *id.* at 40. Tension between development and immigration restrictions was evidenced by the 1790 naturalization laws which denied citizenship to "white" indentured servants, "non-white" aliens, and those who lacked "good moral character." *Id.*; see also DANIELS, *supra* note 11, at 265-84 (first phase, 1830s to 1850s, was anti-Catholic; second phase, 1870 through 1882, was anti-Asian, with subsequent anti-Asian movements from 1905-1924 and 1920-1930; and third phase which began in mid-1880s, peaked in 1924 and lasted until 1965, was against all immigrants). But see *Correa v. Thornburgh*, 901 F.2d 1166, 1173 (2d Cir. 1990). The *Correa* court noted that:

Over no subject is the power of Congress more complete than it is over the admission of aliens . . . . Indeed, it may well be that Congress can bar aliens from entering the United States for discriminatory and arbitrary reasons, and that the usual constraints of rationality imposed by the equal protection clause do not limit the federal government's power to regulate immigration.

*Id.*; *Talanoa v. I.N.S.*, 397 F.2d 196, 202 (9th Cir. 1968) ("It is within the power of Congress to make such distinctions in legislation affecting aliens." (citing *Oceanic Steam Navigation Co. v. Stranahan*, 214 U.S. 320, 342-43 (1909))).

<sup>41</sup> See CAFFERTY ET AL., *supra* note 37, at 40-41. In response to the immediate manpower shortage created by the Civil War, Congress passed the 1864 Act which allowed employers to pay for immigrant passage. *Id.* at 41. Furthermore, the building of the Union Pacific Railroad precipitated the Burlingame Treaty of June 1868 which allowed the Chinese to enter. *Id.* at 42. The mistreatment of the Chinese was widespread, causing civil rights activists to rally for the creation of the Civil Rights Act of May 1870. *Id.*

This bright spot in history was blighted by the Chinese Exclusion Act of 1882, which was the product of an intense anti-Asian movement spearheaded by restrictionist groups. See Chinese Exclusion Act of 1882, ch. 126, 22 Stat. 58 (immigration of Chinese laborers sus-

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The second phase of United States immigration policy was marked by the exclusion of three groups: undesirables, contract workers, and people of certain national origins.<sup>42</sup> The quality of immigrants became a primary concern as demonstrated by the Act of March 3, 1891,<sup>43</sup> which excluded “persons suffering from a loathsome or contagious disease,” idiots, insane persons, and paupers.<sup>44</sup> After a strong lobbying effort by restrictionist groups, the

pending for ten years because “coming of Chinese laborers to this country endangers the good order of certain localities”). The Act was extended in duration in 1892 and made permanent in 1902. See Act of April 29, 1902, ch. 641, 32 Stat. 176 (prohibiting immigration of Chinese and regulating their residence in United States). During this time period the Supreme Court held that it was constitutional to restrict a whole class of immigrants. See *Ng Fung Ho v. White*, 259 U.S. 276, 280 (1922) (“Congress has power to order at any time the deportation of aliens whose presence in the country it deems hurtful. . . .”); see also *Dunn v. I.N.S.*, 499 F.2d 856, 858 (9th Cir. 1974) (“It is firmly established that Congress has the power to exclude aliens of a particular race from the United States, prescribe the terms and conditions upon which certain classes of aliens may come to the country . . . .”), *cert. denied*, 419 U.S. 1106 (1975).

In defense of the Chinese Exclusion Act, President Cleveland said that the “experiment of blending the social habits and mutual race idiosyncracies of the Chinese laboring classes with those of the great body of the people of the United States . . . [has been] proved . . . in every sense unwise, impolitic, and injurious to both nations.” DANIELS, *supra* note 11, at 272. See generally HULL, *supra* note 11, at 11 (antipathy toward Chinese extended to almost all Asian nationalities); Kerry E. Voss, *Re-evaluating Alien Exclusion in Light of AIDS*, 6 DICK. J. INT’L L. 119, 124 (1987), reprinted in 1989 IMMIGR. AND NATIONALITY L. REV. 187, 192. In 1889, the United States Supreme Court held in *Chae Chan Ping v. United States* that the Chinese Exclusion Act was a “valid exercise of Congressional power” despite violating treaties between China and the United States. *Id.*

<sup>42</sup> See Act of Feb. 23, 1887, ch. 220, 24 Stat. 414 (providing for return of prohibited aliens to their native lands); Act of Feb. 26, 1885, ch. 164, 23 Stat. 332 (prohibiting importation of aliens under contracts for labor); Act of Aug. 3, 1882, ch. 376, 22 Stat. 214 (levying porting vessel tax of \$0.50 per passenger who is not United States citizen); Act of March 3, 1875, ch. 141, 18 Stat. 477 (denying admission to immigrants who contracted for services with immoral purposes); CAFFERTY ET AL., *supra* note 37, at 42-48. In 1875, “lewd” and “immoral” aliens were restricted, and in 1882, lunatics, idiots and persons likely to become public charges were barred, as well as persons with “loathsome” or “contagious” diseases. *Id.* at 43; see also HULL, *supra* note 11, at 10-11 (discussing first series of restrictive acts which were passed in 1875).

<sup>43</sup> Ch. 551, 26 Stat. 1084 (1891).

<sup>44</sup> See H.R. REP. NO. 3807, 51st Cong., 2d Sess. 2 (1891). “The intent of our immigration laws is not to restrict immigration, but to sift it, to separate the desirables from the undesirable immigrants, and to permit only those to land on our shores who have certain physical and moral qualities.” *Id.* (quoting House Select Committee on Immigration and Naturalization); see also Comm. Print, *supra* note 10, at 9. The March 3, 1891 Act followed a decade of significantly increased immigration—approximately 5,250,000 immigrants compared to 2,800,000 between 1870 and 1880. *Id.* Furthermore, these numbers represented a shift from Northern and Western European immigrants to Southern and Eastern European immigrants. *Id.*

Act of February 5, 1917<sup>45</sup> was passed, significantly extending the grounds for exclusion.<sup>46</sup> It is submitted that these early objectives are still supported in present law, although the language has been modified to reflect a more subtle way of closing the door to certain undesirables.<sup>47</sup>

In order to "reclaim America for Americans,"<sup>48</sup> the First National Origins Act of 1921<sup>49</sup> was passed, which limited entry to more desirable immigrant groups by way of a quota system.<sup>50</sup> However, the 1921 quota system failed to fulfill its purpose and was replaced with a more restrictive system in the National Origins Act of 1924.<sup>51</sup> The new Act proved effective in restricting

<sup>45</sup> Ch. 29, 39 Stat. 875 (1917).

<sup>46</sup> *See id.* The 1917 Act provided an extensive list of exclusions, which included "epileptics . . . persons of constitutional psychopathic inferiority: persons with chronic alcoholism: . . . persons afflicted with tuberculosis in any form," and those not able to pass a literacy test. *Id.*: *see also* *Boutillier v. I.N.S.*, 387 U.S. 118, 122 (1967) (excluding "psychopathic personalities," including homosexuals); *United States v. Esperdy*, 277 F.2d 537, 539 (2d Cir. 1960) (excluding immigrants with tuberculosis).

Italian, Greek, and Polish immigrants began to outnumber the more acceptable immigrants from Northern and Western Europe. *HULL*, *supra* note 11, at 13-17. Resentment festered, which fueled anti-immigration sentiment against certain groups. *Id.* at 14-15. Edward Ross, a respected academician during the early twentieth century, described all new immigrants as "beaten men from beaten races, representing the worst failures in the struggle for existence." *Id.* at 14: *see DANIELS*, *supra* note 11, at 276-79. Restrictionists focused on a 22-year crusade for an English literacy test aimed at improving the quality of immigrants. *Id.* Although passed by the House and Senate several times, it was vetoed by Presidents Cleveland, Taft, and Wilson. *Id.* The Act ultimately passed in 1917 was not what the restrictionists wanted because it defined literacy as being able to read in any recognized language. *Id.* The 1917 Act was the first major general restriction passed which required all adult immigrants (or at least the head of the family) to be literate. *Id.* at 278: *see also* *CAFFERTY ET AL.*, *supra* note 37, at 44 (discussing literacy test and final legislation).

<sup>47</sup> *See* INA of 1990, *supra* note 9. Instead of "loathsome" as a description for disease, grounds for exclusion now include "any alien who is determined . . . to have a communicable disease of public health significance." *Id.*; *see also* Comm. Print, *supra* note 10, at 75. In 1952, the PHS recommended dropping "loathsome" as the adjective for disease, reasoning that the word was "a non-scientific lay term and serves no useful purpose here." *Id.* (quoting H.R. REP. NO. 1365, 82d Cong., 2d Sess. 48 (1952)).

<sup>48</sup> *HULL*, *supra* note 11, at 17-18.

<sup>49</sup> Ch. 8, §2, 42 Stat. 5 (1921).

<sup>50</sup> *See* *CAFFERTY ET AL.*, *supra* note 37, at 51-52. The Act established a ceiling on European immigration by limiting the number of visas to 3% of its foreign-born population based on the 1910 census. *Id.* The purpose was to limit Southern and Eastern European immigration. *Id.* at 52.

<sup>51</sup> Ch. 190, § 11(a), 43 Stat. 5 (1924). The Act placed an annual quota of 2% of number of "foreign-born individuals of such nationality resident in continental United States." *Id.*: *see HULL*, *supra* note 11, at 18. The National Origins Act of 1924 was described as "a finely-tuned contrivance designed to restore an 'optimal' ethnic mix." *Id.* Although Great Britain had only 2% of the world's population, they got 43% of the quota. *Id.* Other

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immigration, but it also had tragic implications for those who were excluded.<sup>52</sup>

This antiquated immigration policy was perpetuated by the passage of the generally unpopular McCarran-Walter Act of 1952,<sup>53</sup> which did little to support the American ideologies of freedom, decency, and fairness.<sup>54</sup> The McCarran-Walter Act provided a broad exclusion for persons with dangerous and contagious diseases, specifically tuberculosis and leprosy—two diseases historically burdened by stigmatization.<sup>55</sup> One positive aspect of the McCarran-Walter Act was that the Public Health Service (“PHS”) became involved in restructuring the exclusionary medical provisions and recommending more appropriate classifications.<sup>56</sup> In

groups, like Southern and Eastern Europeans, were severely hurt by the new system, and the Asians were virtually excluded. *Id.*; see also CAFFERTY ET AL., *supra* note 37, at 53 (public opinion supported complete exclusion of Japanese).

<sup>52</sup> See DANIELS, *supra* note 11, at 296-302. In 1979, Vice President Walter Mondale said that the United States and other countries who could have helped, “failed the test of civilization.” *Id.* at 296.; HULL, *supra* note 11, at 19. The National Origins Act of 1924 denied entry to hundreds of thousands of Jewish refugees, and in 1939 the United States refused to save over 20,000 children from Nazi persecution, despite support from American families. *Id.*

<sup>53</sup> Ch. 477, 66 Stat. 163 (1952) (amended 1965).

<sup>54</sup> See *Nason v. I.N.S.*, 394 F.2d 223, 227 (2d Cir.), *cert. denied*, 393 U.S. 830 (1968). “It is generally conceded that in enacting the 1952 Act, Congress intended to facilitate the deportation of undesirable aliens.” *Id.*; see WHOM WE SHALL WELCOME, *supra* note 11, at i-xv. The McCarran-Walter Act of 1952 was negatively described as an “arrogant, brazen instrument of discrimination based on race, creed, color, and national origin—a return to approval of ex post facto offenses and punishments—weapons of tyranny which liberty-loving peoples have fought since the dawn of civilization.” *Id.* at 19. The recommendation made by the Commission was summed up in the statement, “the commission believes that the present immigration law should be completely rewritten.” *Id.* at xv; see also CAFFERTY ET AL., *supra* note 37, at 56 (describing Act as “remarkably unpopular legislation”).

<sup>55</sup> See 1990 NATIONAL COMMISSION ON AIDS, *supra* note 26, at 42 n.4 (“[T]uberculosis has been used as a metaphor for all that is unqualifiedly and unredeemably wicked.”). *But see* *United States ex rel. Wulf v. Esperdy*, 277 F.2d 537, 539 (2d Cir. 1960). Subsequent to her arrival in the United States, Justina Soto, a Peruvian native and United States immigration applicant, was carefully examined by doctors of the PHS in accordance with the requirements of the Immigration Act before a medical certificate could be issued. *Id.* The court stated that “considering the contagious nature of tuberculosis and the ability of medical techniques to detect its presence with substantial certainty, it was well within the constitutional power of Congress [to deny entry on those grounds].” *Id.*

<sup>56</sup> See Comm. Print, *supra* note 10, at 73-75. One of the changes recommended by the PHS was replacing “psychopathic inferiority” with “psychopathic personality.” *Id.* at 74. In acknowledging that the substituted term was “vague and indefinite,” the PHS reasoned that this was the best that they could come up with at that time. *Id.* For detailed information, see also S. REP. NO. 1137, 82nd Cong., 2d Sess. 8-9 (1952); H.R. REP. NO. 1365, 82nd Cong., 2d Sess. 45-48 (1952). See generally *Fleuti v. Rosenberg*, 302 F.2d 652, 658 (9th Cir. 1962) (Congress content to let “psychopathic personality” stand for homosexuals and sex

1961, the McCarran-Walter Act was amended, substituting exclusions for specific diseases with a general exclusion of persons with any "dangerous contagious disease."<sup>57</sup> However, the exclusionary lists from 1961 to the present continue to reflect those diseases subject to "social stigmatization."<sup>58</sup> In 1965, President Johnson abolished the McCarran-Walter Act, which he characterized as "un-American in the highest sense."<sup>59</sup>

The third phase of American immigration was marked by the Act of 1965,<sup>60</sup> which replaced the national origins system with hemispheric limits on visas issued.<sup>61</sup> Although the 1965 Act's focus on family unification principles was an improvement over its predecessors, many immigrants and refugees still encountered a closed door.<sup>62</sup> From 1920 through 1970 very few changes were

perverts because PHS advised that term was sufficiently broad enough, but in this case "psychopathic" is too vague in constitutional sense), *vacated and remanded*, 374 U.S. 449 (1963).

<sup>57</sup> *HHS Authority Over Immigration And Public Health, 1990 Hearings on H.R. 4506 Before the Subcomm. on Health and the Environment of the House Comm. on Energy and Commerce, 101st Cong., 2d Sess. 3 (1990)* [hereinafter *Hearings/HHS*]. The Hon. Ms. Nancy Pelosi, a California representative, discussed the 1961 Act, which gave the CDC the authority to maintain a list of diseases based on the "current consensus of scientific and medical experts." *Id.* Pelosi described the 1961 Act as "a general public policy which has served us well." *Id.*

<sup>58</sup> See 1990 NATIONAL COMMISSION ON AIDS, *supra* note 26, at 43. In 1963, twenty-one exclusionary diseases were listed in the PHS Manual for the Medical Examination of Aliens, causing "social stigmatization". *Id.* In 1986, PHS published a proposed rule adding AIDS to the list of dangerous contagious diseases. *Id.* "It, too, is a disease associated with social stigmatization." *Id.* In 1987, the list included five venereal diseases plus infectious leprosy and active tuberculosis. *Id.*

<sup>59</sup> HULL, *supra* note 11, at 22.

<sup>60</sup> Act of Oct. 3, 1965, Pub. L. No. 89-236, §201, 79 Stat. 911 (1965). The Act of 1965 amended the McCarran-Walter Act by eliminating quota systems and replacing them with strict numerical limitations. *Id.*

<sup>61</sup> See HULL, *supra* note 11, at 22-28. Every country in the eastern hemisphere received 20,000 visas yearly, with the total number of visas limited to 170,000. *Id.* at 22. Importantly, this was the first time a cap was imposed on the western hemisphere, limiting the number of visas to 120,000. *Id.*; see also CAFFERTY ET AL., *supra* note 37, at 57-63 (discussing 1965 Act's development of preference system based largely on family preference plus personal skills); DANIELS, *supra* note 11, at 341-44 (discussing Immigration Act of 1965).

<sup>62</sup> See HULL, *supra* note 11, at 27. Since the 1965 Act developed preferences for family and the highly skilled, three options often remained, including hiring an expensive lawyer, waiting a long time, or entering the country illegally. *Id.*; see also CAFFERTY ET AL., *supra* note 37, at 60-61 (no provisions made for refugees). The Refugee Act of 1980, Pub. L. No. 96-212, 94 Stat. 102 (1980), was passed, but was considered to be deficient. *Id.* See generally Mark Gibney & Michael Stohl, *Human Rights and U.S. Refugee Policy, in OPEN BORDERS? CLOSED SOCIETIES?* 151-72 (Mark Gibney ed., 1988) (discussing United States refugee policy).

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made on the PHS list of mandatorily excludable diseases.<sup>63</sup> However by 1970, in conjunction with the Immigration and Naturalization Service ("INS") and the State Department, the PHS revised the list with medical exclusions based on current medical and scientific information.<sup>64</sup> Although Congress had pledged to disregard "esthetic judgments concerning the outward manifestations of disease as an adequate basis for inadmissibility," the inclusion of certain diseases indicated that such judgments were still involved.<sup>65</sup>

On July 11, 1987, Congress passed the Supplemental Appropriations Act of 1987 (the "Helms Amendment"),<sup>66</sup> which added yet another "loathsome" disease to the list of dangerous and contagious diseases—AIDS. Prior to the Helms Amendment, the PHS had planned to add AIDS to the list, reasoning that AIDS, like venereal diseases, is sexually transmitted.<sup>67</sup> Despite the heated discord generated by the Helms Amendment among medical and humanitarian organizations,<sup>68</sup> Congress whisked it into law without a scintilla of intelligent debate.<sup>69</sup>

<sup>63</sup> See CENTERS FOR DISEASE CONTROL, HISTORICAL SUMMARY OF IMMIGRANT EXCLUSION BECAUSE OF COMMUNICABLE DISEASE 2 (May 29, 1987) (on file with CDC, Atlanta). PHS changes included the deletion of ringworm of the nails, and the addition of two venereal diseases and infectious keratoconjunctivitis. *Id.*

<sup>64</sup> See *id.* In 1970, the seven diseases retained on the exclusion list were chancroid, gonorrhea, granuloma inguinale, leprosy, lymphogranuloma venereum, infectious syphilis, and tuberculosis. *Id.*

<sup>65</sup> *Id.* Although Congress stated that they would no longer recognize such a classification as "loathsome" as a legitimate interest, the list in 1970 still included five venereal diseases, tuberculosis and leprosy. *Id.* at 2. In order to comply with Congress's pledge, the only differences from 1970 to 1987 were changing leprosy to infectious leprosy and tuberculosis to active tuberculosis. *Id.* at 4; see also 1990 NATIONAL COMMISSION ON AIDS, *supra* note 26, at 43. Thus, in 1987, the list contained seven excludable diseases: chancroid, gonorrhea, granuloma inguinale, lymphogranuloma venereum and syphilis (venereal diseases), plus infectious leprosy and active tuberculosis. *Id.*

<sup>66</sup> Pub. L. No. 100-71, 101 Stat. 391, 421 (1987).

<sup>67</sup> See Medical Examination of Aliens (AIDS), 42 C.F.R. § 34.2(b)(8) (1986). The Secretary of Health and Human Services proposed that "it would be anomalous to have diseases such as chancroid and lymphogranuloma venereum on such a list and not include AIDS. AIDS is added to the list because it is a recently defined sexually transmitted disease of significant public health importance." *Id.*; see also 42 C.F.R. § 34.2(b) (1987) (final rule replaced AIDS with HIV on list of dangerous contagious diseases on Aug. 28, 1987).

<sup>68</sup> See *infra* note 85 (discussing organizations' dissatisfaction with restrictions on travel and immigration).

<sup>69</sup> See 133 CONG. REC. S7405 (daily ed. June 2, 1987) (statement of Sen. Danforth). Senator Danforth stated:

This is not an issue that has enjoyed the analysis of committees before coming to the



## III. THE HELMS AMENDMENT AND ITS AFTERMATH

The Helms Amendment, which directed the President to add AIDS to the INS list of exclusionary diseases,<sup>70</sup> was implemented through PHS regulations requiring seropositivity testing of aliens.<sup>71</sup> The testing regulations differ depending on the particular status that the alien is seeking.<sup>72</sup> For example, the testing of nonimmigrants such as tourists, students, and temporary visitors is conducted at the discretion of a consular officer overseas or at the discretion of an immigration inspector in the United States.<sup>73</sup> Even if the seropositivity test produces positive results, the Attorney General has the discretionary power to allow the nonimmigrant into the country.<sup>74</sup> Originally, a balancing test was employed to determine admissibility, but the negative global response<sup>75</sup> ne-

Senate. It has not enjoyed forceful debate . . . . It is a matter that most people in the Senate feel has been thrust upon them . . . . My concern is that when we deal with it, we are going to go off half-cocked.

*Id.* at S7412-13; Susan Okie, *Public Health Experts Raise Doubts on Plans to Test Immigrants for AIDS*, WASH. POST, July 15, 1987 at A14 (opinion of public health experts). The plan to test immigrants is unlikely to stem the spread of AIDS—rather it raises the problems of adequate and accurate testing as well as producing the potential for black market false test certificates. *Id.*; see also Lynn Acker Starr, *The Ineffectiveness and Impact of the Human Immunodeficiency Virus (HIV) Exclusion in U.S. Immigration Law*, 3 GEO. IMMIGR. L.J. 87, 88 (1989) (action taken by President and Congress putting HIV on list was "rash, ineffective and discriminatory").

<sup>70</sup> See 133 CONG. REC. S7405 (daily ed. June 2, 1987) (statement of Sen. Helms). Senator Helms stated that the substance of "this amendment would direct the president, under his current authority, to add the human immunodeficiency virus [HIV] infection to the existing list of dangerous contagious diseases." *Id.*; see also Carol L. Wolchok, *AIDS at the Frontier: United States Immigration Policy*, 10 J. LEGAL MED. 127, 129 (1989) (discussing Helms Amendment).

<sup>71</sup> See Medical Examination of Aliens, 55 Fed. Reg. 32,540-44 (1987) (HIV testing stipulated by PHS).

<sup>72</sup> See 1990 NATIONAL COMMISSION ON AIDS, *supra* note 26, at 47-50 (discussing implementation of immigration testing policies for various alien statuses including nonimmigrant, permanent resident, legalization, and refugee).

<sup>73</sup> See 8 U.S.C. § 1222 (1991). This section, entitled "Detention of Aliens for Observation and Examination Upon Arrival," permits the detention of an alien for a medical examination if there are reasonable grounds to believe that person would be excluded under one of the health-related exclusions. *Id.*

<sup>74</sup> See 1990 NATIONAL COMMISSION ON AIDS, *supra* note 26, at 46. (discussing Attorney General's discretionary authority to grant waivers to nonimmigrants).

<sup>75</sup> See *Hearings/HHS*, *supra* note 57, at 66-67 (complaints received by United States embassy necessitated change in balancing test regarding granting of waivers for HIV-infected nonimmigrants); see also Richard A. Knox, *INS Policy On Foreigners With AIDS Fuels Outrage As Two Are Detained*, BOSTON GLOBE, June 8, 1989, at 16 (AIDS researchers, public health officials, and activists were outraged at detention of two HIV-positive foreigners seeking to attend AIDS conference in United States).

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cessitated a more flexible rule of allowing waivers if it could be determined that the nonimmigrant's admission would "confer a public benefit outweighing any risk to the public health."<sup>76</sup>

Legalization applicants under the Immigration Reform and Control Act of 1986 ("IRCA"),<sup>77</sup> refugees,<sup>78</sup> and other immigrants applying for lawful permanent residence status<sup>79</sup> are sub-

<sup>76</sup> 1990 NATIONAL COMMISSION ON AIDS. *supra* note 26, at 47. Under the old criteria, the Attorney General would not grant a waiver unless it could be established that:

(1) the danger to the public health of the United States created by the alien's admission to the U.S. is minimal, (2) the possibility of spread of the disease created by the alien's admission to the U.S. is minimal and (3) there will be no cost incurred by any level of government agency of the U.S. without prior consent of that agency.

*Id.* at 46; see *Hearings/HHS, supra* note 57, at 66-67 (announcing new INS guidelines for nonimmigrant visas: HIV-infected persons who wish to visit United States for tourism or who wish to stay longer than 90 days will be permitted if new "public benefit test" is satisfied); Peg Bryon, *U.S. AIDS Exclusion Policy Could Threaten Some Conference Goers*, UPI, Apr. 25, 1989 (Regional News) (discussing tension created by United States policy barring HIV positive AIDS conference goers); David Johnston, *U.S. Will Ease Visa Restrictions For Some Who Suffer From AIDS*, N.Y. TIMES, May 19, 1989, at D16 (discussing how shift in policy permits some HIV foreigners to enter United States for medical treatment or to attend conferences).

<sup>77</sup> Pub. L. No. 99-603, 100 Stat. 3359 (1986) (codified in scattered sections of 7, 8, 20, 29, & 42 U.S.C.); see FRANK D. BEAN ET AL., *OPENING AND CLOSING THE DOORS: EVALUATING IMMIGRATION REFORM AND CONTROL* 20-23 (1989) (discussing how mounting problems with illegal aliens' working in United States led to passage of IRCA containing amnesty provisions for illegal aliens as well as stiff employer sanctions for those who violated them); NANCY H. MONTWIELER, *THE IMMIGRATION REFORM LAW OF 1986*, 23-30 (1987). "This legislation seeks to close the back door on illegal immigration so that the front door on legal immigration may remain open. The principle means of closing the back door, or curtailing future illegal immigration, is through employer sanctions." *Id.* at 23 (quoting House Judiciary Committee Report, July 16, 1986); see also DANIELS. *supra* note 11, at 392. Amnesty was available for aliens who could prove they resided continuously in the United States since December 31, 1981. *Id.* In order to qualify for permanent residence, each applicant must have resided continuously in the United States since acceptance in the program, had no criminal convictions or pending prosecutions, submitted a negative HIV test, not been on welfare and be financially capable, and have a knowledge of the English language and United States history. *Id.* at 393.

<sup>78</sup> See Joseph Minsky, *Introductory Overview of Immigration Law and Practice*, in *IMMIGRATION LAW*, at 1, 12 (A.L.I.-A.B.A. Course of Study Materials 1989). "Persons who fear persecution in their home country may apply for refugee status (outside the U.S.) or political asylum (inside the U.S.)." *Id.* Both statuses are temporary and after one year they are eligible to apply for lawful permanent resident ("LPR") status. *Id.*; see also HULL, *supra* note 11, at 115-16. Refugees and individuals driven from their homes by political, religious, or social pressure create problems since their arrival is often "en masse, unanticipated, and abrupt." *Id.*

<sup>79</sup> See Minsky, *supra* note 78, at 8-9. Lawful permanent residents, also known as "immigrants," or "permanent residents," reside and work permanently in the United States while keeping citizenship in their home country. *Id.* Eligibility for LPR status is limited and can be obtained by means of a close relative, certain job skills, or being a member of a special group. *Id.*

ject to mandatory, rather than discretionary, seropositivity testing.<sup>80</sup> This policy is strictly enforced, and waivers are usually only permitted for legalization applicants.<sup>81</sup>

In December of 1989, the National Commission on AIDS was created by Congress to advise Congress and the President on the development of a national consensus on AIDS policy.<sup>82</sup> The Commission recommended a total review of United States visa and immigration laws that dealt with AIDS.<sup>83</sup> The Commission further requested permission to undertake a study to determine the effectiveness of adding HIV to the list of dangerous and contagious diseases, as well as the generous granting of HIV waivers to applicants for legalization, refugee status, or permanent residency.<sup>84</sup> Many medical, scientific, and humanitarian organizations had contacted the National Commission on AIDS, expressing their profound dissatisfaction with the federal regulations which restricted travel and immigration.<sup>85</sup> Despite the negative response to

<sup>80</sup> See 1990 NATIONAL COMMISSION ON AIDS, *supra* note 26, at 47-49 (discussing mandatory testing requirements dependent on status).

<sup>81</sup> See Immigration Reform and Control Act, Pub. L. No. 9-603, 100 Stat. 3359 (1986) (liberal waiver provisions allow applicants for legalization to get waiver if they can show compelling family unity, humanitarian interests, or public interest reasons); see also Robert S. Hilliard, *Getting Residency When You've Got HIV: Waivers of HIV-Related Grounds of Exclusion Under the 1990 Act*, IMMIGR. NEWSL. (Nat'l Immigration Project of the Nat'l Lawyers Guild, Inc., Boston, Mass.), Aug. 1992, at 3 (discussing granting of waivers to HIV-positive legalization applicants); NATIONAL IMMIGRATION PROJECT OF THE NAT'L LAWYERS GUILD, 1989 LEGALIZATION HANDBOOK §1, at 92-105 (1989) (grounds on which IRCA waivers are granted to legalization applicants are more liberal).

<sup>82</sup> National Commission on Acquired Immune Deficiency Syndrome Act, Pub. L. No. 100-607, 102 Stat. 3104 (1988).

<sup>83</sup> See 1990 NATIONAL COMMISSION ON AIDS, *supra* note 26, at 36-38 (press release dated Dec. 12, 1989). "Current practices are counterproductive, discriminatory and represent a waste of resources." *Id.* at 36; see also *AIDS Panel Calls For End To Stigmatizing Foreign Visitors Who Are HIV Infected*, TIMES MIRROR Co., Dec. 13, 1989, §A, at 4 (discussing how Commission called for INS to cease marking passports with HIV code because it subjected foreigners to stigmatization).

<sup>84</sup> 1990 NATIONAL COMMISSION ON AIDS, *supra* note 26, at 37 (discussing efficacy of adding HIV to PHS list of exclusionary diseases).

<sup>85</sup> *Id.* Sponsors of the Sixth International Conference on AIDS and the International Conference on Hemophilia expressed concern. *Id.*: see *Hearings/HHS*, *supra* note 57, at 51-53 (letter from John Ziegler, M.D. and Paul Volberding, co-chairs of Sixth International Conference on AIDS, to June Osborn, Chair of National Commission on AIDS, urging elimination of all travel restrictions because it was not intent of Congress); *id.* at 68-69 (letter from HIV and Immigration Task Force, Coalition For Immigrant And Refugee Rights And Service urging generous granting of waivers for IRCA applicants; refugees, and travellers).

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United States policy,<sup>86</sup> the Bush Administration claimed that the Helms Amendment usurped the power normally held by the Secretary of Health and Human Services to institute changes in the list of exclusionary diseases.<sup>87</sup>

With the hands of the Administration apparently tied, several members of Congress sponsored bills supporting the Commission's belief that our nation's health care is too important to be entrusted to anyone other than leading public health officials.<sup>88</sup> Consequently, Representatives J. Roy Rowland, M.D., of Georgia and Henry A. Waxman of California jointly introduced a bill calling for the Department of Health and Human Services ("HHS") to be granted the authority to determine the nation's public health policy.<sup>89</sup> In this convoluted search to determine who had the proper authority, Congress deferred its decision to the Comptroller General, head of the General Accounting Office ("GAO").<sup>90</sup> The Comptroller General concluded that the Helms

<sup>86</sup> See Medical Examination of Aliens, 56 Fed. Reg. 2484 (1991) (proposal citing extensive list of prominent American public health and medical organizations opposed to HIV-based exclusion); Philip J. Hiltz, *Jeers at AIDS Gathering Drown Out Health Chief*, N.Y. TIMES, June 25, 1990, at A12 (citing other diverse groups protesting HIV-exclusion). See generally Judy Foreman, *AIDS Conferees Vow to Boycott Hub Meeting if US Doesn't Lift Ban*, BOSTON GLOBE, June 20, 1991, at 12 (reporting protest against United States policy); Neil McKenna, *Britain Threatens to Boycott U.S. Aids Conference*, THE INDEPENDENT, Aug. 9, 1991, at 6 (reporting objection to United States immigration policies).

<sup>87</sup> See 68 *Interpreter Releases* 54-56 (Jan. 14, 1991). "The Bush administration has argued that because Congress added HIV to the list in the 1987 appropriations act, only Congress could remove it." *Id.* at 55.

<sup>88</sup> See, e.g., H.R. 4300, 101st Cong., 2d Sess. § 1, at 52 (1990) (House Reports 1119, 4427, 1280, as well as 4300, were introduced to review and revise health related grounds for exclusion); see also *Hearings/HHS*, *supra* note 57, at caption on title page (stating that purpose of bill was "to require the Secretary of Health and Human Services to review and revise the list of dangerous contagious disease used in the exclusion of aliens from the United States"); *id.* at 25-26 (Donald S. Goldman, Esq., Commissioner of National Commission on AIDS stating public health policy "should not be based upon myth, prejudice, nor social stigmatization, as so often in the past been done").

<sup>89</sup> See *Hearings/HHS*, *supra* note 57, at 3. Representative Nancy Pelosi of California, described the congressional intent of the Rowland Bill as "not adding or dropping any specific disease, including HIV—it removes confusion and allows the CDC to proceed with establishing sound health policy. It clarifies congressional intent that the authority over public health determinations should rest with those who are best able to make these decisions." *Id.* at 2.

<sup>90</sup> See *Hearings/HHS*, *supra* note 57, at 17-21 (letter from Comptroller General of the United States to Hon. Henry A. Waxman, Chairman, Subcommittee on Health and the Environment, Committee on Energy and Commerce, House of Representatives dated May 17, 1990); see also BLACK'S LAW DICTIONARY 682 (6th ed. 1990) (General Accounting Office assists and makes recommendations to Congress, its committees, and members in carrying

Amendment did not bar the President or the Secretary of HHS from making "a determination in good faith" that HIV infection should no longer be on the list of exclusionary diseases.<sup>91</sup> However, due to the inflammatory nature of the issue, and the Administration's reluctance to decide it, legislative action was recommended.<sup>92</sup>

Although the Rowland Bill never got out of committee, the goal of the Bill, which was to clarify the fact that the HHS has the authority to compile the list of exclusionary diseases, was ultimately enacted in the Immigration and Nationality Act of 1990.<sup>93</sup> The 1990 Act returned to the Secretary of HHS the power to determine the list of exclusionary diseases, a power he had really never lost.<sup>94</sup>

The 1990 Act included a comprehensive revision of all the existing grounds for exclusion and deportation.<sup>95</sup> Specifically, the Act changed the term "dangerous and contagious diseases" to

out legislative responsibilities).

<sup>91</sup> *Hearings/HHS, supra* note 57, at 17.

<sup>92</sup> *Id.* at 18-21. The letter, from the GAO to the sub-committee on Health and the Environment, stated that although the HIV exclusion may be changed at any time, it is subject to the President's power under 8 U.S.C. § 1182(f) (1991). *Id.* Since the President may restrict the entry of any alien or class of aliens if their entry "would be detrimental to the interests of the United States," legislation may be necessary to resolve this power issue. *Id.*

<sup>93</sup> INA of 1990, *supra* note 9; see Philip J. Hilts, *In Shift, Health Chief Lifts Ban on Visitors With the AIDS Virus*, N.Y. TIMES, Jan. 4, 1991, at A1. "It was only at the close of 1990 session of Congress that the lawmakers, acting on an amendment by Representative J. Roy Rowland, Democrat of Georgia, declared their previous action void and gave back to Dr. Sullivan the power to redraw the disease list." *Id.*; see also Steve Taravella, *AIDS Removed From Immigration Restrictions*, MODERN HEALTHCARE, Jan. 14, 1991, at 16 (focusing on announcement by HHS Secretary Sullivan, removing HIV from exclusion list).

<sup>94</sup> See Telephone Interview with Selby McCash, Administrative Assistant for Rep. J. Roy Rowland, M.D. of Georgia (Nov. 28, 1991) [hereinafter Telephone Interview]. Although the language of the 1990 Act was different from the Rowland Bill, it was equally acceptable to the original sponsors. *Id.* The intent was not to take HIV off or leave HIV on the list, rather, the intent was to give HHS the authority to decide. *Id.* "It was a convoluted debate in the highest levels of government to clarify that the HHS has the authority." *Id.*; see also 42 C.F.R. § 34.2(b) (1990) (listing communicable diseases of public health significance upon which to base exclusions).

<sup>95</sup> See INA of 1990, *supra* note 9 (revising grounds for exclusion); see also H.R. REP. NO. 101-723, 101st. Cong., 2d Sess. pt. 1, 52 (1990), reprinted in 1990 U.S.C.C.A.N. 6732. The report discussed legislative history regarding the need for revisions of the health related grounds for exclusions from 1981 to 1990. *Id.* H.R. 4300 proposed that the specific disorders listed under INA § 212(a)(1)-(5) be changed since these grounds, "represent outmoded and inflexible notions of medical diagnoses," preferring "more enlightened and flexible alternatives." *Id.* However, these alternatives were not enacted into law. *Id.*

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“communicable diseases of public health significance.”<sup>96</sup> For a disease to qualify as a medical ground for exclusion, it had to pose a public health threat to the United States based on current medical and scientific standards.<sup>97</sup>

Pursuant to the congressional reaffirmation of the HHS Secretary’s authority, a regulation was proposed by the Secretary of HHS on January 23, 1991 to remove HIV infection from the list of diseases.<sup>98</sup> Basing his decision on “current epidemiological concepts and medical diagnostic standards,” the Secretary stated that only infectious tuberculosis qualified as a “communicable disease of public health significance.”<sup>99</sup> Many reputable organizations from the public health community agreed with this determination.<sup>100</sup> However, during the public comment period,<sup>101</sup> over 73,000 letters were received, with about 42,000 favoring restrictions for HIV positive immigrants.<sup>102</sup>

An intense power struggle within the Bush Administration arose, with the HHS opposing HIV restrictions, the Justice Department advocating them, and the White House, always mindful of political repercussions, opting not to change the policy of HIV

<sup>96</sup> INA of 1990, *supra* note 9.

<sup>97</sup> *Id.*

<sup>98</sup> Medical Examination of Aliens, 56 Fed. Reg. 2484, *supra* note 86.

<sup>99</sup> *Id.*; see Letter from Dixie Snider Jr., M.D., Director, Division of Tuberculosis Elimination, Dep’t of Health and Human Services, to State and Big City TB Controllers 1 (Feb. 27, 1991) (on file with the CDC-N.Y.C. tuberculosis division) (new rules proposed by 1990 Immigration Act). The letter discussed that pursuant to numerous consultants, only infectious tuberculosis should remain on the list of communicable diseases. *Id.* Dr. Snider stated that the change from “tuberculosis active” to “infectious tuberculosis” was in keeping “with the intent of the law to exclude persons who represent a risk to others because the exclusion of persons with tuberculosis active had no posed risks to others.” *Id.* at 2-3.

<sup>100</sup> See Medical Examination of Aliens, 56 Fed. Reg. 2484, *supra* note 86. The list of organizations in compliance with the Secretary’s determination included the American Medical Association (favoring HIV testing and counseling of immigrants but not exclusion of those found positive), the American Public Health Association, the Association of State and Territorial Health Officials, CDC’s Advisory Committee on the Elimination of Tuberculosis, CDC’s Advisory Committee for the Prevention of HIV Infection, the Council of State and Territorial Epidemiologist, the Department of Defense, the National Association of County Health Officials, the National Commission on AIDS, the National Medical Association, and the United States Conference of Local Health Officers. *Id.* at 2485.

<sup>101</sup> See *id.* (providing for sixty-day public comment period).

<sup>102</sup> See Laurie Garrett, *Health Threat or Scapegoat?: Travelers With HIV Are Caught in Political Storm*, NEWSDAY (New York ed.), Aug. 4, 1991, at 51 (stating that CDC—Atlanta received public comment letters).

exclusion.<sup>103</sup>

#### IV. AN ANALYSIS OF THE CURRENT IMMIGRATION LAW

##### A. Current Immigration Law is Contrary to Congressional Intent

Congress intended that the exclusionary list be based on "current epidemiological principles and medical standards" and that a disease be grounds for exclusion only if it poses "a public health threat to the United States."<sup>104</sup> The Secretary of HHS initially made an effort to comply with congressional intent when, backed by the scientific and medical community, he recommended that HIV, along with other diseases marked by social stigmatization, be removed from the list.<sup>105</sup> However, the prejudice, apathy and disdain that the HIV virus has woven into our nation's fabric has proven to be too potent to allow HIV to be extracted from the list.<sup>106</sup> It is submitted that HIV remains on the list of exclusionary diseases because of society's tendency to ignorantly mark it with the brand of social stigmatization.

Unlike infectious tuberculosis, the *only* disease that was recom-

<sup>103</sup> See *id.*

[T]here is a very intense conflict going on within the Bush administration . . . . The Department of Justice wants an HIV exclusion. The Department of Health and Human Services thinks that would be counterproductive to efforts to control the spread of the epidemic. And the White House, knowing elections are not far away, seems to be publicly quiet, while lending its ear to Justice.

*Id.* (quoting Carol Wolchok of the American Bar Association's Immigration Law Project); see also *AIDS Meeting Moving: U.S. Rule to Bar HIV-Infected Participants at Issue*, *NEWSDAY* (New York ed.), Aug. 17, 1991, at 5 [hereinafter *AIDS Meeting Moving*]. President Bush, in discussing the issue, said "we're doing more in research, obviously, in AIDS than any other country. We're spending \$4 billion a year on AIDS research . . . . So it doesn't bother me." *Id.*

<sup>104</sup> H.R. REP. NO. 101-955, 101st Cong., 2d Sess. 128 (1990), reprinted in 1990 U.S.C.C.A.N. 6793.

<sup>105</sup> See *Medical Examination of Aliens*, 56 Fed. Reg. 2484, *supra* note 86 (citing Secretary Sullivan's decision to remove exclusion and widespread backing which followed).

<sup>106</sup> See, e.g., Dennis Altman, *The Politics of AIDS*, in *AIDS PUBLIC POLICY DIMENSIONS*, *supra* note 1, at 23-33 (reluctance on part of most politicians to see HIV "as a public health crisis rather than as the disease of promiscuous homosexuals who somehow infect innocent victims with the illness"); see also Timothy Westmoreland, *AIDS and the Political Process: A Federal Perspective*, in *AIDS PUBLIC POLICY DIMENSIONS*, *supra* note 1, at 47-52. "If we are losing the war against AIDS, it is because the present administration is allowing us to lose it, and because . . . a good many of the press, the professionals in health care . . . and the public are allowing the administration to allow us to lose." *Id.* at 47.

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mended as a communicable disease of public health significance,<sup>107</sup> HIV is not casually transmitted.<sup>108</sup> The virus is not transmittable through the air, and contrary to the belief of many Americans, HIV is not transmitted by shaking hands, sharing plates, or touching doorknobs or toilet seats.<sup>109</sup> These common misconceptions are exacerbated by the current Administration's refusal to treat the disease humanely and fairly, mistaking budgetary allotments as ample support for this global problem.<sup>110</sup> It is submitted that by leaving HIV on the list of exclusionary diseases, the United States is reverting to the prejudicial restrictionist senti-

<sup>107</sup> Medical Examination of Aliens, 56 Fed. Reg. 2484, *supra* note 86 (HHS Secretary proposing that only infectious tuberculosis remain on list of exclusionary diseases).

<sup>108</sup> See Mathilde Krim, *Introduction, in AIDS PUBLIC POLICY DIMENSIONS, supra* note 1, at xv. The introduction states that "it has been shown convincingly that HIV is not transmitted through casual human contact." *Id.* at xxiii; Statement from the Organizers of the VII International Conference on AIDS, *Regarding Entry of People With HIV to the United States* (1991) (on file with Harvard AIDS Institute, Harvard University). Public health experts unanimously advised Secretary Sullivan that there is no risk of casually transmitting HIV. *Id.* The congressional directive in compiling the list of communicable diseases includes only those diseases which are casually transmitted to the public. *Id.* By keeping HIV on the list of exclusions, the government is "perpetuat[ing] misinformation and fear." *Id.*; see also VALDISERRI *supra* note 8, at 12 (no cases of infection from casual contact reported from studies of households with persons with AIDS, of boarding schools with infected children, and of communities with high AIDS incidence); cf. Telephone Interview with Andrew J. Heetderks, Director of Field Services, Bureau of Tuberculosis, N.Y. City Department of Health in New York, N.Y. (June 8, 1992). "Infectious tuberculosis is highly contagious and is transmitted through shared air and casual contact and is currently posing a significant health care problem in New York City." *Id.*; See generally Marsha F. Goldsmith, *Forgotten (Almost) But Not Gone, Tuberculosis Suddenly Looms Large on Domestic Scene*, 264 JAMA 165-66 (1991) (tuberculosis is real threat once again in United States); *Tuberculosis Among Foreign-Born Persons Entering the United States*, 39 MORBIDITY & MORTALITY WKLY. REP. NO. RR-18, 1 (1990) (tuberculosis among foreigners on the rise).

<sup>109</sup> See GRMEK *supra* note 1, at 90 (emphasizing virus is not transmitted through casual contact). Grmek stated:

[T]here is absolutely no evidence that AIDS has ever been spread under normal living conditions—not in schools, not in crowded buses or trains, not in restaurants, not at the hairdressers', not in business meetings, not even between members of the same family who live in abject poverty and share the most dismal of sanitary conditions. AIDS cannot be contracted from a handshake, a swimming pool, or a toilet seat.

*Id.* "[AIDS] is transmitted by only three routes: sexual contact, direct inoculation or injection of blood in tissues or blood vessels, or mother-child transmission through the placenta or breast milk." *Id.* at 87; WHO Gives Out Special Condoms, STATEN ISLAND ADVANCE. NOV. 29, 1991, at A48 (discussing misconceptions concerning transmission of AIDS). "In the U.S. one-third of 1,000 people questioned thought the AIDS virus could be spread through shaking hands, sharing plates, or contact with toilet seats and doorknobs." *Id.*

<sup>110</sup> See AIDS Meeting Moving, *supra* note 103, at 5 (President Bush claimed 4 billion dollars is doing enough for HIV problem).



ments of its infancy. By refusing to acknowledge the factual findings of the HHS and the recommendations of its own National Commission on AIDS, the current administration backs a policy based on fear and misconceptions.<sup>111</sup> As a highly respected world leader, the United States sends a distressingly bleak message to the rest of the world when it endorses HIV-based discrimination, instead of a global commitment to combat this pandemic disease.<sup>112</sup>

*B. Like It or Not, the AIDS Epidemic is Already Here*

One argument favoring the HIV exclusion is that it would significantly reduce the incidence of HIV infection in the United States.<sup>113</sup> It is submitted that such an argument mistakenly focuses on the introduction of HIV into the country when currently there are at least one million Americans infected with HIV.<sup>114</sup> In con-

<sup>111</sup> See *supra* notes 103-08 and accompanying text (discussing struggle between basing exclusions on medical data versus basing exclusions on misconceptions); see also 1991 NATIONAL COMMISSION ON AIDS, *supra* note 4, at 111 (Commission recognized laws are passed in response to constituents' anxieties instead of in response to scientists and public health experts); 1990 NATIONAL COMMISSION ON AIDS, *supra* note 26, at 36-38 (calling for changes in United States visa immigration policies since "[c]urrent practices are counterproductive, discriminatory and represent a waste of resources").

<sup>112</sup> See Charles Petit, *AIDS Delegates Join in Immigration Protest, Armbands Show Disdain for U.S. Policy of Barring People*, S.F. CHRON., June 21, 1990, at A8. June Osborn M.D., Chair of the U.S. National Commission on AIDS said, "I would like to say how sorry I am, and how embarrassed as an American, that our country, whose tradition serves as a proud beacon for emerging democracies, should persist in such misguided and irrational current policy." *Id.*; 1991 NATIONAL COMMISSION ON AIDS, *supra* note 4, at 111-14 (stating that "discrimination against HIV disease continues to be the greatest obstacle to effectively and compassionately responding to the HIV epidemic"). See generally Nancy E. Allin, *The AIDS Pandemic: International Travel and Immigration Restrictions and the World Health Organization's Response*, 28 VA. J. INT'L L. 1043, 1045 n.6 (1988). An attempt to curb the spread of AIDS by restricting the admission of individuals who are HIV positive is contrary to the purpose of WHO's International Health Regulations, which is "to ensure the maximum security against the international spread of disease with minimal interference with world traffic." *Id.*

<sup>113</sup> See 133 CONG. REC. S7405, S7411 (June 2, 1987) (statement of Sen. Helms). "As the epidemic continues to grow and spread abroad, immigrants coming to this country in greater numbers will be bringing the AIDS virus to the United States." *Id.*; cf. Okie, *supra* note 69, at A14. "[W]e are so much more exporters than importers" of AIDS. *Id.* (quoting June Osborn, M.D., Dean of University of Michigan School of Public Health).

<sup>114</sup> See 1991 NATIONAL COMMISSION ON AIDS, *supra* note 4, at 3, 11. At least one million people are infected with AIDS and one death occurs every fifteen minutes. *Id.*; Telephone Recording, *supra* note 4 (current estimate of one million HIV-infected persons in United States).

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trast, the number of aliens excluded because they are HIV-positive under current law is quite low, with only 400 to 450 aliens testing positive out of approximately 400,000 tested.<sup>115</sup> Moreover, since HIV transmission often occurs as a result of high-risk behavior, it is erroneous to assume that aliens, as a group, will be spreading the HIV virus, absent such behavior by individual aliens.<sup>116</sup> Nevertheless, pursuant to current immigration law, an alien must satisfy rigorous admission criteria before permanent residency is granted.<sup>117</sup>

An obvious inconsistency in the HIV-testing requirement under current immigration law is that it varies with the status sought by the applicant. For example, permanent resident applicants are subject to mandatory testing,<sup>118</sup> while tourists, students, business visitors, and other nonimmigrants are tested at the discretion of the INS.<sup>119</sup> Since Congress's objective in adding HIV to the list of exclusionary diseases was to curb the spread of the virus in the

<sup>115</sup> See Larry O. Gostin et al., *Screening Immigrants And International Travelers For The HIV Virus*, 322 N. ENG. J. MED. 1743, 1744 (1990) (stating that public health benefits from excluding HIV-positive persons are marginal, accuracy of tests problematic, and screening program generates adverse effects and is infringement on human rights); Robert Pear, *Ban on Aliens With AIDS to Continue for Now*, N.Y. TIMES, May 30, 1991, at A23 (in comparison to large number of HIV-infected persons in United States, relatively small number of HIV-infected aliens 'will not impose a significant additional risk of infection' to people in the United States (quoting Secretary of HHS)); AMERICAN PUB. HEALTH ASSOC., COMMENTS ON INTERIM RULE: MEDICAL EXAMINATION OF ALIENS 6-7 (May 31, 1991) [hereinafter COMMENTS] (small number of HIV-positive aliens negates purpose of law since they will have little impact on transmission of virus).

<sup>116</sup> See 56 Fed. Reg. 2484, *supra* note 86. "The risk of (or protection from) HIV infection comes not from the nationality of the infected person, but from the specific behaviors that are practiced." *Id.*; COMMENTS *supra* note 115, at 10 (immigrants not likely to engage in high-risk behaviors such as prostitution and drug use).

<sup>117</sup> See INA of 1990, *supra* note 9. In addition to containing health-related grounds for exclusion, § 212 also includes grounds for criminality, controlled substance trafficking, prostitution and commercialized vice, as well as catch-all categories against certain undesirables. *Id.* § 1182(a)(2)(A-D). Moreover, an applicant who is likely to become a public charge is also excludable. *Id.* § 1182(a)(4).

<sup>118</sup> See INA of 1990, *supra* note 9 (outlining testing rules for various foreign entrants to United States).

<sup>119</sup> See 52 Fed. Reg. 32,540, 32,543 (1987) (to be codified at 42 C.F.R. § 34) (seropositivity testing for HIV currently required only for nonimmigrants suspected of having AIDS); see also Carolyn P. Blum & Deborah H. Wald, *Introductory Survey*, 1989 IMMIGRATION AND NATIONALITY LAW REV. xi, lix (1989) (AIDS-testing requirement does not apply to tourists, students, and other nonimmigrants); Starr, *supra* note 69, at 96 ("[N]on-immigrants are not tested because of the 'logistics, mechanics and expense' involved with screening such a large population.").

United States,<sup>120</sup> a policy which screens only certain groups undermines this objective.<sup>121</sup> Furthermore, since HIV-positive non-immigrants who are admitted into the United States also have the potential for spreading the disease,<sup>122</sup> it is submitted that current immigration policy is discriminatory, as well as ineffective, because it arbitrarily targets only certain classes for testing and possible exclusion. It is suggested that the specious effectiveness of the testing program under current immigration policy supports the movement to abolish seropositivity testing of all aliens.

C. "Merely a Numbers Issue" or "Not My Taxpayer Dollars"

Another argument in support of maintaining HIV as a ground for exclusion is that health care costs for HIV-positive immigrants would be an additional burden on taxpayers.<sup>123</sup> Politicians tend to

<sup>120</sup> See 133 CONG. REC. S4705, S7411 (daily ed. June 2, 1987) (statement of Sen. Helms) (Senator Helms stating that purpose of HIV screening is "to protect its citizenry from foreigners emigrating to this country who carry deadly diseases which threaten the health and safety of U.S. citizens").

<sup>121</sup> See Letter from over 140 medical and civil rights organizations, to the Hon. Roger Porter, Asst. to the President for Economic and Domestic Policy (Apr. 16, 1991) (on file with the authors) (objecting to discriminatory testing regulations for immigrants and non-immigrants); Starr, *supra* note 69, at 97 (imperfect screening of only certain aliens ineffective in reducing spread of HIV in United States). See generally Court E. Golumbic, *Closing the Open Door: The Impact of the Human immunodeficiency Virus Exclusion on the Legalization Program of the Immigration Reform and Control Act of 1986*, 15 YALE J. INT'L L. 162 (1990) (discussing how HIV exclusion based on irrational distinctions among visa applicants is ineffective in stemming spread of AIDS virus in United States).

<sup>122</sup> See Victoria Bennett, *Medical Examination of Aliens: A Policy With Ailments of Its Own?*, 12 U. ARK. LITTLE ROCK L.J. 739, 748 (1989/90) (although opportunity for transmitting disease during mere visit is limited, communicability remains the same); Starr, *supra* note 69, at 97 (nonimmigrant groups "equally capable" of infecting others).

<sup>123</sup> See MacNeil/Lehrer *Newshour: Persona Non Grata* (PBS television broadcast, June 18, 1991) [hereinafter *MacNeil/Lehrer*] (Rep. Dannemeyer of California arguing that United States health care system, already seriously strained by AIDS-related health care costs, and taxpayers, should not be burdened with further costs of caring for HIV-positive immigrants); Garrett, *supra* note 102, at 51 (Rep. Dannemeyer of California estimating between 3,073 and 6,146 HIV-positive immigrants enter United States yearly with lifetime health-care costs between 298 and 603 million dollars); Bernard Meyer, M.D., *Immigrants, International Travellers, And HIV*, 323 N. ENG. J. MED. 1491, 1491 (1990) (editorial in response to article by Larry Gostin et al., *supra* note 116). Dr. Meyer cited statistics regarding the potential health care costs of HIV-infected applicants as possibly averaging between \$81,240,000 and \$108,320,000. *Id.* Additionally he stated that the immigration policy provided beneficial financial effects which may "prevent further erosion of the quality of care provided to American citizens with HIV infection." *Id.* But see MacNeil/Lehrer, *supra*. In discussing the economic impact of HIV-infected immigrants on the United States, Dr. Rogers, National Commission on AIDS, compared the money spent on testing with the lifetime

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focus myopically on this money issue, fueling the taxpayers' intolerant and negative associations with the disease.<sup>124</sup> It is not disputed that an estimated \$32,000 spent on yearly medical care for someone with AIDS is a formidable sum.<sup>125</sup> However, it is submitted that this cost argument is untenable in light of the fact that current law allows exclusions for HIV-positive applicants but not for other costly chronic diseases. If cost is truly the bloodline of the policy argument then the United States simply should not admit immigrants with *any* financially draining ailment, such as cancer or heart disease.<sup>126</sup>

One safeguard to protect the taxpayer from paying the health-care bill of the HIV-infected immigrant is the INS requirement that the immigrant prove that he or she will be a contributing member of society, rather than a burden.<sup>127</sup> In addition to this

costs of an HIV-infected person. *Id.* "In the three years in which we have done this testing, 400,000 or so tests which cost us an enormous amount, [with] four hundred to four hundred and fifty actually found positive . . . if you run the costs, the costs of testing them would more than pay for the lifetime costs." *Id.*; 1991 NATIONAL COMMISSION ON AIDS, *supra* note 4, at 67-87 (calling for fundamental reforms in dealing with failing health care system of United States). With 1993 projections of persons with AIDS between 151,000 and 225,000, immediate action was recommended to provide universal health care coverage for all persons living in the United States. *Id.* at 69.

<sup>124</sup> See Malcolm Gladwell, *Reversal of AIDS Exclusion Is Said to be Shelved; 4-Year Bar to Immigration Criticized as Discriminatory and Medically Unjustified*, WASH. POST, May 25, 1991, at A6. "It is simply not in the interests of this nation to allow into this country as permanent immigrants people who have a noncurable disease." *Id.* (quoting Rep. William E. Dannemeyer (R-Calif.)); see also *supra* note 123 and accompanying text (discussing economic burden of HIV-positive immigrants on taxpayers).

<sup>125</sup> See 1991 NATIONAL COMMISSION ON AIDS, *supra* note 4, at 70 (discussing health care costs).

<sup>126</sup> See Lawrence O. Gostin, *We Shouldn't Exclude Aliens With AIDS*, N.Y. TIMES, June 12, 1991, at A26 (stating inequity of using cost as reason for exclusions when no other exclusions exist for other chronic diseases); Martin Whiteside & Sue Lucas, *U.S. Immigration Controls*, 335 LANCET 356, 356 (1990) ("If health care costs are truly the point at issue, then the prohibition on entry ought to be extended to people with cancer, heart disease, and many other infectious and non-infectious diseases."); cf. Gladwell, *supra* note 124, at A6 (immigration policy is discriminatory because United States admits people with heart disease, kidney failure and cancer placing burden on health-care system). But see Andre N. Minuth, *U.S. Immigration Controls*, 335 LANCET 172, 172 (1990) (applauding Justice Department for efforts to reduce further strain on health care system); cf. Phil Gunby, *Cardiovascular Diseases Remain Nation's Leading Cause of Death*, 267 JAMA 335, 335 (1992) (estimating health-care cost for cardiovascular disease is \$108.9 billion in 1992; 1989 statistics estimated one million persons in United States die of cardiovascular diseases).

<sup>127</sup> See INA of 1990, *supra* note 9. The INA "public charge" requirement allows the consular officer or the Attorney General to exclude an applicant if he is "likely at any time to become a public charge." *Id.*; see also COMMENTS, *supra* note 115, at 17 (public charge requirement negates economic cost argument especially since most immigrants are em-

“public charge” requirement, it should be noted that immigrants may be subject to a five-year waiting period before they are eligible for federal welfare benefits.<sup>128</sup>

Furthermore, considering that AIDS has a possible incubation period of ten years or more,<sup>129</sup> HIV-positive immigrants could be a productive asset to American society for a significant period of time.<sup>130</sup> Therefore, it is suggested that just as a person with other serious diseases can continue to be productive, a person with HIV should be afforded the same degree of compassion, dignity and opportunity.

#### *D. Erroneous Branding of Inaccurate Testing*

Another problem with the HIV exclusion law is the efficacy of seropositivity testing.<sup>131</sup> Such testing is expensive, lacks quality-control procedures, and may falsely brand an applicant with the socially undesirable AIDS label.<sup>132</sup> It is submitted that an appli-

ployed or at very least have families who have guaranteed their financial support): Marlene Cimos, *U.S. Considers New Policy For Foreigners With AIDS*, TIMES MIRROR Co., July 31, 1991, at A4 (advocates against HIV exclusions point out that “public charge” requirement demands that applicant prove “sufficient financial resources”); Gladwell, *supra* note 124, at A6 (permanent resident applicants required to show enough financial resources not to become “public charge”).

<sup>128</sup> See Minsky, *supra* note 78, at 24 (eligibility to receive such federal benefits as welfare, Social Security and Medicaid, is generally not available for five years); CAFFERTY ET AL., *supra* note 37, at 185. Immigrants are usually not eligible for food stamps, AFDC, Medicaid and Supplemental Security Income during their first five years in the United States. *Id.* If unanticipated disability arises, the sponsor is normally responsible for immigrant’s support. *Id.* However, short-term assistance may be available in emergency situations. *Id.*

<sup>129</sup> See 1991 NATIONAL COMMISSION ON AIDS, *supra* note 4, at 47. “As long as ten years may pass between infection with the virus and development of full-blown AIDS.” *Id.*

<sup>130</sup> See COMMENTS, *supra* note 115, at 18 (long incubation period means years of productivity; most HIV-positive adults will be “employed, self-sufficient, and contributing to the American economy for many years after entering the United States”); MacNeil/Lehrer, *supra* note 123 (long incubation period allows HIV-positive persons to be contributing members of society).

<sup>131</sup> See VALDISERRI, *supra* note 8, at 211-17 (high prevalence of false positive results using ELISA test requires confirmatory test, usually Western Blot test, thereby significantly increasing testing costs); Allin, *supra* note 112, at 1059 (“[t]he Western Blot is very expensive and labor-intensive and it is not designed for large scale screening programs”); Carol L. Wolchok, *AIDS at the Frontier*, 10 J. LEGAL MED. 127, 132 (1989) (problems with HIV antibody testing are inaccurate results and expense).

<sup>132</sup> See Larry O. Gostin, et al., *Screening Immigrants and International Travelers for the Human Immunodeficiency Virus*, 322 NEW ENG. J. OF MED. 1743, 1744-45 (1990). “There is no comprehensive program to monitor the quality of the tests. Thus, substantial violations of recommended technical protocols, misreading of test results, and the transmission of

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cant may suffer irreparable discrimination because of an inaccurate diagnosis. The two most popular diagnostic tests, the enzyme-linked Immuno-Sorbent Assay (ELISA),<sup>133</sup> and the Western blot,<sup>134</sup> although greatly improved, are still subject to some degree of error.<sup>135</sup> The primary flaw with all of the HIV tests is that a window period exists between infection and the detection of antibodies.<sup>136</sup> Consequently, those who are carrying the HIV virus may not discover their infectious condition and may therefore unknowingly transmit the virus to others.<sup>137</sup>

### CONCLUSION

Racism, fear, and loathing—reputedly antithetical to our values—have plagued this nation since its founding. The disdain for certain groups which has generated arbitrary immigration policies from colonial times onward, is the same disdain that pressures otherwise intelligent decision-makers to forsake effective, sound

inappropriate or inaccurate information to those tested are all possible." *Id.* at 1744. Even if the "sensitivity and specificity" of HIV tests were 99.99% accurate, "it is still likely that there will be a large number of inaccurate test results in a low risk population." *Id.* For example, there may be as many as 100 false positive tests for every million tested. *Id.* Furthermore, "even a slight decrease in overall test performance would result in a markedly larger number of errors . . . . For example, if the sensitivity and specificity were 99.90% there would be 0.7 false positive results for every true positive (998 vs. 1499). This situation would result in the unfair denial of entry to uninfected persons, without any mechanism to rectify the serious error." *Id.* at 1745.

<sup>133</sup> See GRMEK, *supra* note 1, at 84. "The ELISA, (Enzyme-Linked Immuno-Sorbent Assay) is the easiest and quickest of the tests. The presence of molecules that combine specifically with purified antigen is detected by a color reaction." *Id.*

<sup>134</sup> See *id.* "The Western blot . . . [is] a sophisticated test that makes use of electrophoretic analysis of immunoglobulins, which are fixed by incubation of the test serum by viral proteins." *Id.*

<sup>135</sup> See *id.* at 86. "The ELISA test is quite sensitive, usually with less than 1% false negatives, but it is not very specific, leading sometimes to 2 to 3% false positives even under very ideal conditions." *Id.*; VALDISERRI, *supra* note 8, at 215. "Unfortunately, the specificity, sensitivity and predictive value of the 'gold standard' Western blot are now known to be less than perfect." *Id.*; June Osborn, M.D., *HIV Antibody Testing Uses and Limitations*, in AIDS AND THE COURTS, *supra* note 2, at 45. "Most widespread testing involves a search for antibodies by the ELISA test, and is prone to errors of timing, technical mishap or biological ambiguity." *Id.*

<sup>136</sup> GRMEK, *supra* note 1, at 86. "The great drawback to all these modalities aimed at detecting the presence of antibodies is the fact that seroconversion does not occur until some weeks or months after infection." *Id.*

<sup>137</sup> See Osborn, *supra* note 135, at 47. "If unaccompanied by education and counseling, the recipient of [a negative test result] will sometimes interpret it as proof of personal immunity from the threat of AIDS, and thus it may reinforce risk behavior patterns." *Id.*

policies for irrational, discriminatory ones. For such primitive fears to be given official sanction not only betrays our national ideal, but threatens to undermine the international response to the greatest health emergency of the twentieth century. The potential for worldwide devastation requires world leaders to take a stand against unfounded prejudice as a first step towards fighting this plague. The current immigration law does not serve as "a proud beacon"<sup>138</sup> to the rest of the world, but rather as a disfiguring brand on United States history as well as on the global fight against AIDS.

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<sup>138</sup> Petit, *supra* note 112 (quoting June Osborn, M.D., Chair of 1991 Commission On AIDS); see Foreman, *supra* note 86, at 12. "The American public will not suffer or be harmed if people with HIV . . . are allowed to enter the United States. But, along with the people of all countries, we will be disadvantaged if unfounded fears are allowed to prevail . . ." *Id.* (quoting Dr. Jonas Salk).