# The X-Ray Files

## *How political correctness is destroying effective public health policy and inviting tuberculosis*

by Brenda Walker

One might think that political correctness would have no place in the more serious arenas of policy, such as public health, but that is not the case. An editorial in the Minneapolis *Star-Tribune* struck a blow for the say-no-evil variety of public debate, wherein the writer bemoaned the increasing number of Minnesota tuberculosis cases, of which four in five are immigrants. (While TB in the U.S. is on the decline overall, it is growing in states like Minnesota that have large immigrant populations.) Instead of a reasonable and responsible statement about improved screening to keep out persons with dangerous infectious diseases, the *Star-Tribune* went global, instead recommending only a worldwide effort against TB and saying that "cracking down on immigration is no answer." Evidently the writer has forgotten the history of Ellis Island, where all immigrants were given physical examinations precisely to prevent the entrance of disease-infected persons, with one to three percent of newcomers sent back to their home countries every year because of health concerns. Rejection of foreigners carrying infectious disease is part of our immigration tradition.

Considering that there are an estimated 11 million illegal aliens in the country — none of whom has had the required health screening for legal entrance — medical prudence about American public health would indicate just the sort of "crackdown" dismissed by the Minnesota editorialist. There is zero tolerance for many kinds of crime, but 11 million law-breaking, potentially disease-harboring foreign nationals are ignored by politicians and law-enforcement officials alike. Public health would be well served by repatriation of the millions whose true and legal homes are elsewhere. In addition, further illegal immigration should be prevented by border and workplace enforcement.

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### The State of Public Health in America

Public health has fallen from the nation's radar screen at our peril. A long period of medical success has been partly to blame — the remarkable results achieved with antibiotics, immunization and improved sanitation led the policy makers to conclude that the battle against communicable disease had been won. The victories over killers like polio, cholera and tuberculosis were followed by a decrease in antibiotic research and a slackening of preventive measures. At the same time memories of tuberculosis wards were fading, lawyers enlarged the concept of bioethics and individual patient's rights. That emphasis was not altogether a bad thing when one considers the cases of government plutonium injections and other radiation testing on uninformed patients that took place from 1944 to 1975. Still, the pendulum has been swinging away from public health requirements at the same time that the globalized economy has exploded with increased trade and immigration — both of which mean foreign diseases, creatures and organisms are just a plane ride away.

In the last decades, some states diluted their communicable disease-reporting laws and made it more difficult to track infectious diseases. Worse, some public health officials have come to believe that they do not have the authority to restrict individual behavior in situations of danger to the community and have fallen back into a position of merely providing care. However, a solid legal basis exists for forceful prevention as well as for decisive action in the case of disease outbreak.

On the other hand, American law sends some mixed

messages. The U.S. Centers for Disease Control (CDC) has the authority to detain, isolate, or provisionally release persons at U.S. ports of entry showing symptoms of any one of seven diseases (yellow fever, cholera, diphtheria, infectious TB, plague, suspected smallpox, and viral hemorrhagic fevers). At the same time, U.S. law prohibits the return of refugees when they have a credible fear of political persecution, even when they also have infectious diseases. In this case, the government has decided that refugee rights are more important than public health. This has serious implications, given a 1996 WHO report estimated that "as many as half the world's refugees may be infected with TB."

## Tuberculosis Is Back, Now Tougher to Treat

Tuberculosis is an airborne pathogen, propelled through tiny droplets via sneezing, talking or coughing. The disease is extremely widespread: one person in three worldwide has the infection and two million die annually from tuberculosis. The nature of how TB is passed means that crowded living conditions, e.g. among farm laborers, in illegally converted housing or in refugee camps, are likely breeding grounds in which infection can occur. Also problematic is the ability of TB to remain dormant and undetectable in the body for long periods; a legal immigrant may pass the chest x-ray, yet still develop the illness much later.

Parents wishing to expose their children to cultural diversity in their educational experience may be additionally exposing them to infectious disease such as tuberculosis. There have indeed been cases of TB being passed in classroom situations. Briefly being in contact with a TB-infected individual is unlikely to infect a healthy person; lengthy contact in an enclosed space is generally required for the TB bacteria to pass from one person to another. In 1995, the CDC confirmed a case that an eight-and-a-half hour domestic airline flight caused four passengers to be infected with TB by one infectious passenger. In March of this year, OSHA cited the Immigration and Naturalization Service's Houston office for not protecting its workers from the danger of TB infection from immigrants, stating that workers needed respirators and training to avoid the illness.

Unfortunately, antibiotic resistance in general has been developing for some time in the rapidly mutating microbes that cause disease. A World Health Organization (WHO) report last year warned that microbial resistance could plunge the world back into the "pre-antibiotic era." The director of the WHO communicable disease program stated, "The world may only have a decade or two to make optimal use of many of the medicines presently available to stop infectious diseases. We are literally in a race against time to bring levels of infectious disease down worldwide, before the disease wears the drugs down first." The situation is particularly worrisome regarding tuberculosis, which now has strains that are resistant to more than one drug treatment (multi-drug-resistant TB, or MDR TB). In Juarez, for example, about 25 percent of TB patients are resistant to at least one antibiotic. A person can develop his or her own resistance by not taking the full regimen of drugs (a minimum of six months) or may have contracted a resistant strain of the disease, particularly if the person is from a region or country where MDR TB is common (sub-Saharan Africa, Southeast Asia, Latin America, Haiti and the Philippines). The most disturbing future scenario is a U.S. in which tuberculosis is increasing in the whole population with no effective treatment available.

In addition, cultural beliefs about illness and immigrant lifestyles may make effective treatment difficult without Directly Observed Therapy (DOT). Somalis believe that TB is a curse and may be reluctant to admit their illness or seek treatment. Some illegals forego treatment because they believe they will be turned over to the INS for deportation. Migrant workers are harder to treat precisely because they are migrants. The World Health Organization warns that poorly managed tuberculosis programs threaten to make TB incurable. Rapid improvement following the start of medication may convince uneducated patients that they are cured and no longer need to continue the full schedule of antibiotics. A WHO Fact Sheet remarks, "From a public health perspective, poorly supervised or incomplete treatment of TB is worse than no treatment at all." WHO emphasizes that an effective public health approach is very serious business, requiring "political commitment, microscopy services, drug supplies, surveillance and monitoring systems and use of highly efficacious regimes with direct observation of treatment."

Of course, more public health programs mean more taxpayer expense. In March, 2002, Minnesota Governor Ventura requested $1 million from his legislature to fight increased TB in the state. Franklin County, Ohio,

approved nearly $1 million that year to deal with additional tuberculosis. In 1999, the Centers for Disease Control estimated the annual U.S. cost for TB approached $1 billion.

## Political Correctness vs Health

Sadly, the Minnesota writer who rejected effective border control as a necessary part of sound public health policy is not alone. The ignorance about public health and the nature of the threat have put Americans' safety into jeopardy. Fresno County in California has been sued twice for jailing persons who refuse to take their tuberculosis medication, the most recent being a Laotian immigrant. And while jailing is certainly a harsh measure, most parents would not want their kids sharing a classroom with the children of an immigrant who refused proper TB treatment.

Even more disconcerting than the rather frightening statistics and case studies is the reaction of some in the public health profession. A *Washington Post* story (3/3/00) contained the following remark from the chief of Maryland's Tuberculosis Control, Nancy Baruch: "My greatest fear is that there will be this terrific xenophobic response to anyone who is a quote-unquote refugee or immigrant. All that does is drive someone away from the help they need." One would expect the "greatest fear" of a person in a top public health position to be a sudden outbreak of disease or perhaps an act of bio-terrorism causing the deaths of thousands. But no, the worst horror is bad thoughts about immigrants.

Another politically correct comment was voiced in the *Washington Post* (4/11/01) by the director of the Alexandria, Virginia, Health Department. "Immigrants aren't the cause of disease," he intoned. "Tuberculosis is the enemy here. In public health, we recognize that. 'immigration' is a real general term, anyway. It's just that some, because of conditions in their own country, may be more at risk." In these remarks we find moral arrogance, patronizing doctor superiority and rather paternalistically explained views on causality. Missing, however, was concern for the public health of his community. What would this man do given the case of someone who refused to take the prescribed TB medication? Call a therapist? A shaman?

Given the nature of tuberculosis — its periods of dormancy and its enormous global presence — worldwide health organizations are quite right to call for programs to eradicate the disease globally, even though the task appears insurmountable. However, global efforts do not mean that American public health officials can be permitted to shirk their responsibility. Expanded vigilance and protective measures are clearly required.

Increased screening of populations particularly at risk would be sensible, but one can predict the ACLU response. And why does the Diversity Visa program (the annual State Department-run lottery for 50,000 lucky winners designed to increase America's diversity even further) still include countries that have very high levels of TB? An effective public health system for the United States should be the paramount concern, but we hear nothing from officials about the jeopardy posed by the current immigration chaos. The politically correct, say-no-evil philosophy of politicians and public health professionals is a dangerous denial. They must do better when the issue is life and death. •

### Migrant Tide of Killer Bugs

Deadly diseases are taking hold in Britain because of mass immigration, a new report warns.

Asylum cheats and health tourists are abusing the National Health Service, it claims.

And huge numbers of work and study permits are given to people from places where TB, hepatitis B and HIV are rife.

The Centre for Policy Studies adds: "They are contagious, life-threatening, and are taking hold."

The right-wing centre claims 95 percent of new hepatitis B cases come from abroad, each costing the NHS £10,000 a year.

Home Office Minister Beverley Hughes called the report confused. She said health checks for refugees were on the cards.

— *The Sun*, London, August 5, 2003