BRITISH MEDICAL JOURNAL

LONDON SATURDAY 11 DECEMBER 1965

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Medical Examination of Immigrants

For the past 10 years the Representative Body of the B.M.A. has passed resolution after resolution urging the Government of the day to impose health checks, particularly *x*-ray examination of the chest, on immigrants to Britain. In 1961, in response to a letter from Mr. Enoch Powell, the then Minister of Health, stating why the Government thought it impracticable to insist on their compulsory examination—a letter we described at the time as "[beating] all records for ministerial evasion"[1]—the Council of the B.M.A. sent to the Ministry the recommendation, strongly urged by the Association's Tuberculosis and Diseases of the Chest Group Committee, that "no immigrants should be admitted to the country without compulsory *x*-ray examination at port of entry."[2] At that time no health check was required for Commonwealth immigrants. In 1962 the Commonwealth Immigration Act became law. The Act gave power to an immigration officer to refuse entry if, on medical advice, the immigrant appeared to be "suffering from mental disorder, or that it was otherwise undesirable for medical reasons that he should be admitted."[3] These provisions applied almost exclusively to immigrants coming in on work permits and did not touch the large numbers who entered as dependants. The mesh of the net was not only much too coarse, its use soon proved to be administratively impracticable. Before 1955 our intake of Commonwealth immigrants had been small, but from that date their numbers in this country rose steeply, with in 1961 an estimated peak of net intake of over 136,000. Statistics kept since the passing of the Act show that in the second half of 1962 there was a net intake of 2,503, but in 1963 the net intake was 66,000, in 1964 it was 75,499, and in the first half of this year the net intake was at a rate of 98,000 a year.

The volume of this immigration in itself constituted a fresh hazard, for sooner or later, it could be supposed, the dose of exotic infection reaching these islands would pass some epidemiological flashpoint and set off dangerous epidemics or result in the reintroducing of diseases from which we had been free for some generations. Disquiet mounted and found expression in the R.B. once again, in Parliament, and in the press. More had clearly to be done, and public opinion now seemed more ready than before to accept some measure of medical control of Commonwealth citizens. In this situation, a year ago,[4] a deputation from the B.M.A. again saw the Minister of Health, now of a different Government, but was once again assured that *x*-ray examination of all immigrants at the port of entry, for which the deputation asked, was impracticable. However, after further pressure, the Minister agreed to install experimentally an *x*-ray machine at London Airport, the port of entry for the majority of long-stay immigrants, and this began to function in February 1965. The Minister also took steps to encourage immigrants to register promptly with a general practitioner on reaching their destination in this country, and arranged for medical officers of health to receive information about immigrants coming into their areas. However, the

Council was dissatisfied with these limited measures and in January 1965 it set up a small working party[5] to assemble all the facts about the medical examination of immigrants. This working party[6] under its chairman Dr. C. Metcalfe Brown, M.O.H. of the City of Manchester and M.O. to the Manchester Port Health Authority, made an interim report in July.[7] Its final report was adopted by the Council last week, and copies have now been sent to the Minister of Health and the Home Secretary.

At page 1423 of this issue of the *B.M.J.* we summarize the working party's main conclusions and recommendations. The working party stresses that *all* persons admitted to this country, other than short-stay visitors, should be medically examined before admission. There should be no differentiation in this respect, it thinks, between Commonwealth and alien immigrants. The alternatives of dispensing altogether with medical examination and the present system of examining only some immigrants are both rejected, the first because of "obvious health risks to the indigenous population." Examination should take place in the immigrant's country of origin, states the report. The practical difficulties of examining large and variable numbers of immigrants at port of entry greatly outweigh any theoretical advantages. Examination in his own country has advantages for the immigrant as well as for the receiving country. If disease is detected it can be treated, and apart from the immediate benefit to health this may result in a would-be immigrant becoming eligible for admission. If on the other hand the disease is such as to preclude admission despite treatment, he will have been spared from disrupting his life. The main argument against examination before embarkation is the possibility of widespread evasion or abuse. To minimize these hazards the working party recommends the use, on a part-time basis, of local doctors approved for the purpose by the British Government, backed up by a certain number of full-time Government medical officers from this country.

Finally there is the question of what the medical examination should cover. The working party has identified certain diseases whose presence in an immigrant it regards as a risk to the health of the inhabitants of this country. It recommends that immigrants with these conditions should not be permitted to enter "until they have a clean bill of health." The diseases in question are: tuberculosis, venereal disease, yaws, trachoma, keratoconjunctivitis, leprosy, smallpox, cholera, typhus, plague, yellow fever, typhoid and paratyphoid fevers, dysentery, and parasitic infections of the gastro-intestinal tract. For social and economic reasons, mental disorders, epilepsy, malignant diseases, drug addiction, and alcoholism are listed as additional grounds for exclusion. In order to establish an immigrant's freedom from these conditions the working party recommends a full general medical examination for all, "with special attention to the eyes and skin"; *x*-ray examination of the chest for those over the age of 12 years; and stool examination if the immigrant comes from a country where parasitic infections of the gastro-intestinal tract are common. But pre-entry examination is not considered enough. The working party emphasizes the importance of post-entry examination and follow-up of selected groups of immigrants. "We feel that the low natural immunity to disease of many immigrants, and the social conditions under which they live, make it imperative that a programme of post-entry investigation should be carried out in the interests of the immigrant himself." The working party therefore commends the steps which the Ministry has already initiated[8] to follow up those particularly at risk to tuberculosis, and hopes this policy will be pursued vigorously.

D. K. Stevenson's finding that the annual incidence of tuberculosis in Pakistanis in Bradford[9] was 30 times the rate for the indigenous population, and V. H. Springett's similar figure for Pakistanis and Sinhalese in Birmingham,[10] underline the seriousness of the situation. The crowded conditions in which many such immigrants live when first they reach this country provide ideal circumstances for further spread of tuberculosis. There is also a hazard from intestinal parasitic infections, such as amoebiasis and trichuriasis, a risk which is enhanced by the fact that many immigrants seem to gravitate to the catering trade. Hookworm infection may also prove a public health problem as S. N. Salem and S. C. Truelove have suggested.[11]

Few medical men would now challenge the need for medical screening of immigrants, whether Commonwealth or alien, before their entry to this country. Such examinations are not some elaborate form of colour bar, as has sometimes been implied, but a plain public health measure, long overdue. Apart from its first purpose in protecting the health of the citizens of these islands, proper medical examination is in the interests of the immigrant himself. From the economic aspect, too, examination before admission is highly desirable so as to prevent what could otherwise well prove a heavy burden on the hospital and other resources of this country. Now that Dr. Metcalfe Brown's working party has so clearly mapped the way, the Government should lose no time in following it.

[1] *Brit. med. J.*, 1961, **2**, 1624.
[2] *Brit. med. J. Suppl.*, 1961, **2**, 254.
[3] Commonwealth Immigrants Act, 1962, Clause 2, subsection (4).
[4] *Brit. med. J.*, 1964, **2**, 1547.
[5] *Brit. med. J. Suppl.*, 1965, **1**, 17.
[6] Dr. C. Metcalfe Brown, Dr. R. J. Dodds, Dr. H. R. C. Hay, and Dr. D. K. Stevenson.
[7] *Brit. med. J. Suppl.*, 1965, **2**, 21.
[8] Advisory letter to Medical Officers of Health on "Medical Arrangements for Long-term Immigrants," dated 22 April, 1965.
[9] Stevenson, D. K., *Brit. med. J.*, 1962, **1**, 1382.
[10] Springett, V. H., *Lancet*, 1964, **1**, 1091.
[11] Salem, S. N., and Truelove, S. C., *Brit. med. J.*, 1964, **1**, 1074.

New Rubella Syndrome

The most severe rubella epidemic for more than 20 years swept the United States during the early months of 1964. The outbreak affected some 1,800,000 people, and inevitably many women in early pregnancy were infected. The infants born to these mothers were extensively studied both clinically and with the aid of the recently developed virological techniques. It was soon apparent that many of the infants born with congenital defects were also suffering from additional disorders which had not previously been identified as part of the congenital rubella syndrome.[1]

This new syndrome has been named the "expanded rubella syndrome" or "acute congenital rubella," and appears to be due to widespread systemic infection with the virus. The most striking feature of the expanded rubella syndrome was thrombocytopenia, and many of the affected infants were born with a petechial or purpuric rash.[2–4] Though thrombocytopenia is known to be a complication of adult rubella,[5 6] it has only occasionally been noted in infants with the classical congenital rubella syndrome.[7] Infants with the expanded rubella syndrome—like those with classical congenital rubella—had a high incidence of cardiac lesions and defects of the