MEDICAL PRACTICE

Contemporary Themes

Sopley: medical services for refugees

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Although 543 Vietnamese refugees are housed in a reception camp at Sopley, the health authorities still await formal notification of their arrival. This paper discusses some of the problems encountered in providing medical services, and we hope that it will be useful to others faced with a similar problem in their own health district.

General administrative and medical arrangements

The Home Office delegated overall administrative responsibility for the camp to the British Council for Aid to Refugees (BCAR), and asked the British Red Cross Society (BRCS) to co-ordinate medical and nursing input. The National Health Service was expected to provide support at the expense of locally agreed priorities, and without any formal management control.

Attempts to plan medical services were frustrated by lack of information. The numbers of refugees, dates of arrival, and ports of entry were not confirmed until a few hours before the event, and the figures were invariably incorrect. As the refugees had been guaranteed entry to Britain, we did not know whether the usual port health-clearance procedures would apply. From the television news we learnt that the refugees had had a medical screening in Hong Kong, but no details of these health checks were available.

In view of these uncertainties a medical examination for all the refugees was considered necessary soon after their arrival at Sopley. As tuberculosis was likely to present the major personal and public health hazard, the mobile mass radiography unit was booked to attend the camp each day after a group of refugees had arrived. All staff working at the camp were offered a Heaf test and polio vaccination, and all consultants and general practitioners in the area received a letter drawing to their attention the major diseases endemic in South-east Asia.

Because up to eight people would be sharing a room, and infectious disease—for instance, typhoid—was expected to present a major problem, a sick bay had to be provided at the camp. The close co-operation of the Public Health Laboratory Service and environmental health officers was sought, and potential problems were discussed together.

The local family practitioner committee was asked to make arrangements for providing general medical services to the refugees once the initial medical screening had been performed.

Reception medical screening

Each batch of refugees flew to Heathrow and was subjected to routine port health-screening procedures; none was detained. On arrival at Sopley anyone feeling unwell was diverted to the sick bay, staffed by a BRCS doctor and nurses, while the rest were given living quarters. Volunteer doctors then visited the huts to complete an initial medical record for each person.

The BCAR provided interpreters for the camp, and the number of doctors performing medical examinations at any time was limited by the supply of translators. The actual medical screening presented few problems, but attempts to complete the identification data on the initial medical record created serious problems. The confusion caused by the extended family structure, together with the absence of a single family surname, was compounded as refugees reverted from assumed (Cantonese) names to their real Vietnamese names. Chinese calendar months created confusion over duration of pregnancy and the ages of small children. Even more puzzling were the changes in quarters made by the refugees during the medical screening, and the absence of a nominal roll made it difficult to ensure that no one had been missed. All these problems were overcome by sending a team of interpreters and clerical assistants to each hut to complete the identification details on the record form before the doctors arrived.

Completed initial medical records were used as the data source for general practitioner records. Patients who did not need sick-bay facilities but were in urgent need of investigation or treatment were identified and brought to a doctor within a few hours. The records were also used to determine the need for hospital outpatient appointments, clinics at the camp, and domiciliary nursing services.

All adult refugees had undergone radiography in Hong Kong, so the mobile mass radiography unit visits were cancelled. Local chest physicians volunteered to read all the radiographs and to give

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Heaf tests to children and staff. They also arranged hospital admission for the few with overt tuberculosis and chemoprophylaxis for a much larger group with evidence of healed lesions.

Most patients presenting with acute illness on arrival at the camp were suffering from respiratory infections or travel sickness. In addition, there were two cases of malaria, a severely jaundiced patient, and a child in status epilepticus. The screening examination showed many skin infestations, head lice, and various intestinal parasites. There were one or two cases of hypertension and glaucoma. Dental abscesses and periodontal diseases were prevalent.

Provision of long-term medical services

In response to information gained at the initial medical screening, clinics for family planning, child health, and immunisation were held at the camp. Staff from the health education department produced posters advertising these clinics in English, Vietnamese, and Cantonese; the refugees attended enthusiastically. Many refugees had lost or broken spectacles during their escape, and an optician's session was organised. Outpatient appointments, including antenatal clinics, were arranged, and one baby has already been delivered in a Dorset hospital and returned to the camp.

A local group of general practitioners agreed to take all the inmates of the camp on to their list. Although GPs normally provide their own ancillary services, because surgeries were being held at the camp health district staff continue to provide administrative and clerical support to the medical centre there.

For the first six weeks the sick bay was staffed by nurses and a doctor from the BRCS. Now that the BRCS has withdrawn, the general practitioner attends patients in the sick bay, and the health district supplies 24-hour nursing cover, which is supplemented by volunteer nursing auxiliaries.

Public health advice, although available formally from the district community physician, is supplied for two sessions a week by a port medical officer. The BCAR remains responsible for supplying transport and interpreters to refugees attending clinics outside the camp.

Conclusions

Sopley presented an organisational challenge that showed up many deficiencies in the administrative arrangements. The purpose of this article is not to allocate blame, but rather to prevent repetition of mistakes.

Government departments that delegate responsibility to voluntary bodies should ensure that other statutory authorities are kept informed. Charitable organisations may not have the staff or experience needed to maintain adequate liaison with those responsible for health and to ensure that correct information is disseminated rapidly to all who may need it. Moreover, carelessly worded statements to the press on medical matters, made in the absence of medical advice, may generate unnecessary alarm and create local unrest. Subsequent denials, however authoritative, are not as newsworthy as the possibility of an exotic disease.

Unless agencies with administrative charge of providing medical services are independent of NHS resources, NHS representatives should participate fully in administrative arrangements. Few voluntary organisations can supply the full-time trained staff needed, and there seem to be obvious advantages in collaborating with the NHS from the beginning.

It is suggested that a full-time doctor with training in management, infectious disease, and public health should be seconded to a refugee camp for the first few weeks, and that voluntary bodies should inform and invite the co-operation of the local district community physician.

Sopley's success was due largely to the personalities of the people concerned, as the administrative structure created tensions and difficulties. Nevertheless, all acknowledge with pleasure the skills and services contributed, and join together to wish the Boat People a happy and healthy stay in Britain.

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In My Own Time

Anaesthesia

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In the autumn of 1926, soon after starting a month's training at Queen Charlotte's Hospital, London,* the junior medical officer asked me to give him a hand with a case of antepartum haemorrhage on the "district." I was taken on the back step of the young obstetrician's bicycle, clutching a bag of instruments, to a poor house in the wilds of Lisson Grove, to give an anaesthetic to a bleeding multipara in the later months of pregnancy.

"Give her an anaesthetic while I bring down a leg," I was commanded. My rather alarmed statement that I had never given an anaesthetic unsupervised in my life was met with the

excellent advice: "Pour chloroform on to the open gauze mask so that the stain it makes is no bigger than a shilling, and don't forget to keep a good airway." This I did, and after some time a bipolar version was successfully performed and the bleeding from the placenta praevia controlled. The patient was removed to hospital by ambulance, I remounted the step of the obstetrician's bicycle, and we rode back to base at a slower rate than we had come.

A very basic craft

Anaesthesia was still very basic when I was resident at the Princess Mary Maternity Hospital and the Royal Victoria Infirmary, Newcastle upon Tyne in 1927-30. Induction was usually by ethylchloride, followed by ether, or an ether-chloroform mixture. Pure chloroform was sometimes used from the beginning. These agents were dropped on to an open gauze mask. The Clover nitrous oxide-ether inhaler¹ was coming to the end of its time but was sometimes used by our

*Then in the Marylebone Road.