PRACTICE OBSERVED

Practice Research

Dealing with Vietnamese refugees

Our plans

SIMON J PHILLIPS, RACHEL J PEARSON

The first intimation we had that Vietnamese refugees were arriving in Devon was given at a public meeting for interested parties on 26 October 1979. The site for the refugee centre was to be the old maternity hospital (built for 16 mothers and their babies), currently not being used by the health authority. A full-time staff of project leader, health visitor, interpreter, and two general assistants moved in on 1 November 1979, and arrangements were made to convert a derelict and condemned building into a refugee centre. Most of the work was done by volunteers. The centre was expected to take 60 refugees. The first group of 40 arrived on 20 November and the second group of 22 on 28 November.

During the three weeks before the first group arrived decisions and arrangements for dealing with the health of the incoming refugees had to be made. Unfortunately our experiences were no better than those of Houston at Sopley.¹ All aspects of medical screening were in total confusion, and we could get no guidelines or suggestions from the people in charge of refugee resettlement in Britain. Routine medical screening is done for many other countries who accept refugees by teams in Hong Kong. Despite the fact that by November there were about 5700 Vietnamese refugees in Great Britain, there was no medical feed-back at all. Regrettably little has changed since (H Miller, senior clinical medical officer, Suffolk AHA, personal communication). The same problem now exists in education (correspondence with Withshire Education Authority) and elsewhere.² In particular we could get no information at all about what sort of medical screening or immunisations the refugees might have been given in Hong Kong.³⁻⁴

Save the Children Refugee Resettlement Centre, Devon, Withshire
SIMON J PHILLIPS, MB, MRCP, medical officer and general practitioner
RACHEL J PEARSON, MB, BSC, resident health visitor

Preparation

We decided in consultation with our district community physician that medical "processing" would be organised on the assumption that nothing had been done. In the event this was probably the safest decision, as much of the information that came with the refugees was inaccurate. We issued guidelines to other members of staff about how we would try to deal with the following problems:

- (1) Full medical examination including looking for lice, scabies, and sores—*immediate priority*.
  - (2) Fuller medical history and background information—*intermediate priority*.
  - (3) Blood and serum profiles—*later priority*.
  - (4) Standard public health survey (stools)—*later priority*.
- We made recommendations about staff immunisation and reminded full-time staff of their responsibilities in respect of medical records, medical confidentiality, drugs, and illegal drugs. We considered the problems of quarantine and isolation (for common infectious diseases) and produced a standard consent form for the refugees to sign before we could undertake any immunisations or investigations (figure).

MEDICAL RESPONSIBILITY

The district community physician and the general practitioner defined their clinical responsibilities in terms of public health and primary medical care to avoid duplication. We also alerted and received full co-operation from the local public health laboratories, general pathology laboratories, environmental health officers, area dental officer, local ophthalmic services, and local ambulance and hospital car services. Similarly the consultants at hospitals that might be involved were contacted personally.

It was decided with the family practitioner committee that all

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The aircraft that our first group of refugees was on was diverted, and so some of the refugees suffered from jet-lag. Fortunately, we had arranged to do our first blood sampling the day after their arrival, and haematocrit on suitable samples showed an average haematocrit of about 15%. Under different circumstances evidence of such dehydration in children would require immediate hospitalisation for intravenous treatment. Clearly there may have been difficulties in communication and organisation in providing these refugees with adequate fluids on the flight. Barnes⁵ has stated that there is no dehydration during flight, but the advice given to civilian aircrews is to take more than 4-5 pints of fluid a day.⁶

The general exhaustion that has been described by McGurr⁷ precipitated an episode of acute congestive cardiac failure in one old woman, and 10 refugees (25%) required urgent medical treatment on arrival at the centre. Similarly one pregnant patient with hyperemesis gravidarum had been vomiting for 26 hours and had not had adequate treatment. By the time she arrived at the centre she required immediate hospitalisation and subsequently had intravenous treatment for four days.

Medical examination

We devised our own proforma to fill in when we examined the refugees. As well as including the usual medical history, past history, examination, etc., we included a list of all diseases then prevalent in Vietnam and Hong Kong that would not normally be seen in Britain. This list was made up by personal contact because no information was available during the three weeks allowed for "setting up." We also had a dental screening form, standard pathology request form, and a discharge letter for resettled refugees. (Copies of these forms and lists are available on request from Dr Phillips, Lansdowne House, Devizes, Wilt SN10 1NJ.)

Basic policy decisions

We had made policy decisions on staff care, basic refugee care, and general medical processing, all of which were mentioned above.

COMMUNICABLE DISEASES

We did not satisfactorily resolve the question of what to do if an infectious disease occurred in the centre. It was impractical to isolate any patient with an infectious disease such as chickenpox or measles, which in Britain are considered minor. Rubella, chickenpox, and measles are discussed below.

PROPHYLAXIS AND TREATMENT OF INTENTIONAL INTOXICATION

For medical and social reasons we treated intensions. Pison (piperazine phosphate and mebendazole), because it is a liquid and is safe for both pregnant women and children, was our first choice of treatment, and we could be sure it was taken. It was given in two doses at 10-day intervals followed by Vermox (mebendazole) one tablet twice a day for three days (adult dose). Initially we collected a stool sample after each day, then we collected one stool only on arrival and a second after all three doses had been taken unless there were indications for taking further samples.

ENTEROPATHOGENS

Since treating the chronic carrier state may prolong this state, we decided with the medical officer of health that anyone who was a

carrier should not be allowed to prepare food until three consecutive negative stools had been produced.

IMMUNISATION

Our policy on active immunisation was based on the standard advice given in Britain.⁸ Immunisation was complicated by the time-lag required between giving certain injections, and some inoculations also affect "Heaf testing." At this time "Heaf testing" was not available. Our priorities were to give an immediate dose of oral polio vaccine to eliminate any active polio virus and an immediate inoculation with measles vaccine to all children over 1 year of age and under school-leaving age because they arrived in the throes of a measles epidemic in Devon.

Tetanus, pertussis, diphtheria—All refugees were immunised against tetanus. Children under 5 years were given DPT, and DT was given to those aged 5-17 years. This top age limit of 17 should be reduced to 12 to avoid any reactions, although we had no reactions.

Rubella—Rubella antibody tests were done on all women of child-bearing age and on young girls in whom it was practical when serum was available. The ages ranged from 25 years to 43 years, with two children aged 4 and 7. We had the usual difficulties taking blood, and we felt it was unjustified to pursue testing children of school age as they would be immunised anyway. We did not know whether the refugee women were immune to rubella, and the Communicable Disease Surveillance Centre asked us for figures to include in their circular CDR80/9.1.

Tuberculosis—We thought that all the refugees had an x-ray examination before leaving Hong Kong. The x-ray films they arrived with were unexamined, undated, or technically poor.⁹ All the adults had to have another x-ray examination and many of the children. The results of Heaf testing and subsequent BCG immunisation are given in table 11.

The second article will appear in the next issue.

TABLE 11—Number of refugees under 16 years who had positive and negative Heaf tests and who received BCG inoculation

Age (years)	Total refugees	No who had Heaf test	No with Heaf test	No given BCG	UK	Hong Kong
Under 16	10	5	7	2	2	0
Girls	5	4	4	1	1	0
Under 5	5	4	4	1	1	0
Boys	5	1	3	1	1	0
Girls	5	0	3	2	2	0

No chest radiograph showed active tuberculosis.

References

- Houston A. Sopley—medical services for refugees. *Br Med J* 1979; **1**: 1591-2.
- Hill R. When the bomb comes in. *Health and Social Journal* 1979 Nov; **2**: 66-81.
- Christopher RT, Millum KH, Bailey KF. Indo-Chinese refugees. *Med J Aust* 1979; **191**: 286-8.
- Department of Health and Social Security. CMO702 15/CNO702/12. 1978 Aug 15.
- Communicable Disease Surveillance Centre. *Communicable diseases weekly report*. CDR 80/4. 1980 Feb 1.
- Bryan J. The children's refuge. *General Practitioner* 1979 Nov; **23**.
- Goodman M. Brongly refugees in the people in a Hong Kong newsroom. *BMA news review* 1980 Feb; **29**: 81.
- The agency of the lost people. *Observer* 1980 Feb 17:35 (col 4).
- Barnes RM. Study of fluid balance in civil aircrew. *Aerospace Medicine* 1973 Oct; **44**: 1130-5.
- Pravon FS. Feeding round the clock—physiological considerations. *J R Soc Health* 1974; **54**: 110-3.
- McGurr PO. Chestnut rhythm in flight. *Transactions of the Society of Occupational Medicine* 1967; **27**: 183-12.
- Communicable Disease Surveillance Centre. *Communicable diseases weekly report*. CDR 80/5. 1980 Mar 7.

NAME _____ ADDRESS _____ SEX _____

I HEREBY CONSENT TO IMMUNISATION AND ANY INVESTIGATIONS OR EXAMINATIONS THAT THE DOCTOR MAY FROM TIME TO TIME CONSIDER NECESSARY.

SIGNED _____ DATE _____

TÊN HỌ _____ QUỚI _____ NAM/NU _____

TÔI XIN CHẤP NHẬN ĐỂ BÁC-SĨ KHAM SÚC KHUẾ VÀ NHỮNG NHỮNG CHỮNG BỆNH LÂY VÀ TẤT CẢ NHỮNG KIỂM NGHIỆM LÂM CẦN THIẾT

KÝ TÊN _____ NGÀY _____

Consent form in English and the refugees' native language that was signed by them before any immunisations or investigations were done

TABLE 1—Family groups by age and sex

	Total No.	Age (years)									
		0-4	5-15	16-25	26-36	37-44	45-54	55-64	65+		
Male	33	1	8	9	5	11	3	6	5	1	1
Female	29	1	2	1	2	4	1	3	1	2	1
Family	18	4	2	1	1	1	1	1	1	1	1
1	1	1	1	1	1	1	1	1	1	1	1
2	1	1	1	1	1	1	1	1	1	1	1
3	1	1	1	1	1	1	1	1	1	1	1
4	1	1	1	1	1	1	1	1	1	1	1
5	1	1	1	1	1	1	1	1	1	1	1
6	1	1	1	1	1	1	1	1	1	1	1
7	1	1	1	1	1	1	1	1	1	1	1
8	1	1	1	1	1	1	1	1	1	1	1
9	1	1	1	1	1	1	1	1	1	1	1
10	1	1	1	1	1	1	1	1	1	1	1
11	1	1	1	1	1	1	1	1	1	1	1
12	1	1	1	1	1	1	1	1	1	1	1

refugees were taken on to the general practitioner's list as fully registered (and not temporary) patients in order to give them a National Health Service number as soon as possible, and arrangements were made for "bulk prescriptions" as appropriate.

Arrival of the first refugees

Because we lacked information on the 40 refugees arriving in our first group a doctor accompanied the health visitor to collect the refugees. We found that health screening at Heathrow Airport was inadequate and unsatisfactory. It is essential that a doctor is in attendance when the refugees arrive as there are some clinical decisions that need to be taken immediately. Wheelchairs should have been available. We found it easier and kinder to "process" the refugees in the arrivals lounge. The most serious clinical problem was that the aircraft had been diverted and the refugees had had jet-lag, which was aggravated for some by severe travel sickness.

The refugees had all examined within 24 hours of arrival at the centre in Devon according to the history and medical examination proforma (see below). We confirm the unreliability of history taking that has been noted elsewhere.¹ Heights, weights, and urine analysis were recorded and stools collected as soon as it was feasible. We had problems taking blood. This was in part cultural and also due to fear generated by Communist propaganda. Furthermore, there was a strong association in the minds of the refugees between "blood" and death.

On examination several medical conditions unrelated to their particular circumstances were noted: mild hypertensive heart

disease, mild heart failure, a traumatic nerve palsy, asymptomatic systolic murmurs etc. We have confined our results to problems specific to their circumstances and where they have lived.

Like others, we found that the records of what examinations and treatment the refugees had in Hong Kong were often incomplete or inaccurate¹—for example, the chest x-ray films were poor or not identified. Two patients had positive Wassermann reactions (WR) but were said to be negative in Hong Kong. One with a positive WR in Hong Kong was said to have been treated and had not been; one patient in acute left ventricular failure secondary to congenital heart disease was said to be medically unfit to travel by air and yet still managed to travel.

DEMOGRAPHIC FEATURES (table 1)

Our refugees were all ethnic Chinese except two, and including these all except one family of three were from North Vietnam (92%). There was among the adults a preponderance of "eligible bachelors," and we were told that this was true in other centres. From the purely medical point of view we saw clear evidence of

both sexual and psychological frustration as these men realised that there were not enough Vietnamese girls to go around and that they were unlikely to be able to meet, communicate with, or marry a girl of any other culture. This created major problems in this centre, and we found no reference to it elsewhere. The ratio of women to men was 1:1.3; of girls to boys 1:0.1 (1:1.4 in Vietnamese children in Australia).² Of the 29 refugees whose previous residence was known, half came from Mon Kai on the Sino-Vietnamese border, reputedly one of the most primitive areas. Furthermore, 40 (68%) had spent on average six months in Kai Tak refugee camp, the inadequacies of which have been graphically described.¹ In general our refugees knew nothing about Western hygiene and practices, so health education had to start assuming no knowledge of anything which have been graphically described.¹ The practice of Western hygiene is still rudimentary.

Initially the refugees were fearful and then respectful and (mainly) co-operative when they found that we were genuinely trying to help them. It took about two months or more to achieve this, and it required many hours of talking. None of our refugees spoke English (one spoke fluent French), and the problems of interpreting were enormous because we had only one full-time interpreter and none of the teams of clerks and interpreters that other centres seemed to have had provided.¹ With the exception of our "Frenchman" all our refugees were manual labourers of social class V. It is interesting that when they arrived in November and December 1979 they said that more than 80% of the refugees in Hong Kong were also ethnic Chinese from North Vietnam. It is a fallacy that all refugees from Vietnam had to be wealthy to escape.¹

Beyond the Surgery

Meditation in general practice

CHANDRA PATEL

Not long after I entered general practice in 1969 I realised that handout prescriptions was either inappropriate or inadequate for a large number of problems presenting to a general practitioner today. On one hand there were increasingly tired women whom one did expect to have a hysterectomy, but rarely found anaemia; countless headaches, backaches, and belly aches for which the patients sought diagnostic explanations rather than pain killers and yet none were available; men and women doing jobs that were not fulfilling or, at worst, soul destroying, and who needed the respectable label of some sickness to make their absenteeism legitimate. On the other hand there were men who worked themselves sick because they constantly had to prove their worth to themselves, their companies, or their families. They had to do most things themselves because they could not tolerate other people's imperfections or were unable to delegate work to the lower ranks. They were the products of materialistic, competitive society which nurtured overexpectation and caused insecurities for the fear of failure.

Then there were the problems of social disintegration with the disappearance of the extended family and now the fragmentation of even the nuclear family; family arguments, broken homes, divorces, sexual freedom outside marriage, divided children—multiple marriage complexes, increased pressures to comply with the changing patterns of life, and consequently multitudes of mental and emotional problems. People with increasing affluence often comforted themselves by indulging in excessive eating, cigarette smoking, and alcohol with consequent related diseases such as obesity, hypertension, diabetes, varicose veins, chronic bronchitis, lung cancer, coronary heart disease, and cirrhosis of the liver.

When the crisis came in the form of a heart attack or a stroke the patients either died or had to be bundled off to the nearest hospital, while the general practitioner was left to cope with the bereaved family of a heart attack victim or the patients who survived the attack but were discharged home with considerable physical, psychological, and economic handicaps. I felt pretty inefficient in dealing with these effectively. It did not require any special wisdom to realise that prevention was the only effective answer, that technology was overrated, and that many prescriptions given to cut short the work load were either useless or positively harmful. One felt let down by the patients when they took overdo.

I started to advise people to "stop smoking," having done chest clinics for some years I was convinced that cigarette smoking was a major evil to health. I also told them to lose weight, reduce their alcohol intake, increase exercise, stop worrying, take things easy, be tolerant of other people's weaknesses, and forget about the things that upset them, but the results were unimpressive—almost nil. The patients expected

me to cure all their problems, but my medical education, obtained in this country, had not equipped me to deal with them. Most doctors know that the public can do more for themselves than the doctors by abstaining from smoking, moderating their eating and drinking habits, taking more exercise, and coping better with their life stressors, but when people feel unable to change their habits, should we as doctors feel content by saying that there is nothing we can do and wash our hands of them?

The drug treatment of hypertension has proved beneficial in preventing strokes, heart failure, uraemia, and recently there has been some evidence that it may also prevent myocardial infarction. These patients did not complain until I started treating them! Where was the job satisfaction, or was I expecting too much? The level at which hypertension should be treated is getting lower and lower, and it is possible that before long we may have to initiate treatment when the diastolic pressure is 90 mm Hg. This means treating a third of the middle-aged population and continuing for the rest of their lives. I often wonder how many doctors would be willing to submit themselves to antihypertensive drugs if their diastolic blood pressure was only 90-95 mm Hg?

Problems like these made me feel very inadequate. The lack of satisfaction often made me sleepless. I began to convince myself that if I took half a sleeping pill and had a good night's sleep I would feel better tomorrow—and then I thought, "That's silly. I am beginning to think just like all the patients! Am not going to allow this to happen." I started getting up a little earlier and did yoga exercises, followed by a yonic type of relaxation. I knew that this was good for me, but had got out of the habit, I found an immediate benefit. I was feeling fresh during the day and had no difficulty in falling asleep, and I decided to use similar methods for my patients.

I was particularly impressed by the degree of blood pressure reduction in two women with breathing exercise and deep muscle relaxation. One had hypertension which had followed an immediate postnatal clamping fit and she had been discharged home on antihypertensive medication about 18 months before; the other was a woman in her late 60s whose blood pressure was apparently difficult to control, often reading 200/120, even on the sympathetic neuronal blockers. Of course I had no way of knowing if she was taking her medication regularly or not, but it was remarkable that soon after I started teaching them breathing exercise and deep muscle relaxation during three times a week sessions their blood pressure came down to 120/80 or less. The patients knew what was happening to their blood pressure and with their agreement I reduced their medication by a third until they were withdrawn completely and their blood pressures remained normal. A further two patients showed a similar trend and although it was possible to reduce their drugs, it was not possible to stop them altogether. I could not believe that it was just tender love and care—a placebo effect. I needed to prove this to myself, and I decided

Croydon, Surrey
CHANDRA PATEL, MD, MRCP, general practitioner