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 29 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

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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, 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

JET LAG

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 dose, 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	5	7	2	2	0	0
Girls	5	4	1	1	0	0
Under 5	4	4	4	4	0	0
Boys	1	0	0	0	0	0
Girls	1	0	0	0	0	0

No chest radiograph showed active tuberculosis.

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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 _____ QUƠI _____ NAM/NỮ _____

TÔI XIN CHẤP NHẬN ĐỂ BÁC-SĨ KHÁM SÚC KHỎE VÀ NHỮNG NHỮNG CHỮNG BỆNH LÂY VÀ TẤT CẢ NHỮNG KIỂM NGHIỆM LÂM CẬN 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	2
Female	29	1	2	1	2	4	1	1	1	1	1
Family	18	4	2	2	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 would be 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 1:0.81 (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 an 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 a month 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 headache, backache, 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 about 10 days after 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

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to study the relaxation effect systematically in consecutive patients with hypertension. To my surprise, none of them refused to participate. Whatever little scepticism they may have had at this point completely disappeared by the time they were well into the programme, and they often remarked, "I didn't realise I was so tense until I started this relaxation." Some felt even relieved that at last the doctors were paying attention to something they thought was necessary all along.

I used a biofeedback instrument, measuring and displaying by means of sound signals galvanic skin resistance (GSR) as an aid to teaching relaxation. Among other things, GSR is dependent on the sweat gland activity. As the patient relaxes GSR increases and is more difficult to control than when it stops. When that happens the sensitivity of the instrument is turned up, the sound is increased, and the patient has to relax even deeper before the sound stops once again. His task is made more and more difficult as he becomes better and better at relaxing. One of the snags I found soon after I started the study was that deep relaxation was very effective in sending people to sleep and some of the men started to snore within five to ten minutes. This may be a good thing for most but I wanted patients to control their blood pressure while still awake. The only way I could control this was by introducing some mental activity which kept them alert and yet profoundly relaxed.

A simple meditation fitted the bill but I was not confident enough at this time to mention the word "meditation" to all the patients. I used the principles of meditation—which focuses the attention on a word or an object or idea, or even a piece of music. Instead of using conventional mantra, I often asked them to repeat simple words like "relaxed" with each expiration. The results in a series of 30 patients were impressive and were replicated in a randomised controlled trial with 34 patients.⁴ The average reductions in systolic and diastolic pressure were 26 and 15 mm Hg respectively in the relaxation-meditation group and 10 and 5 mm Hg respectively in the control group, which was exposed to a comparable amount of medical attention and blood pressure measurements. If patients can be persuaded to practise relaxation on a regular basis and integrate relaxation in their daily lives, blood pressure reduction can be maintained for longer terms.⁵ In other experiments patients with hypertension managed experimental stress much better by showing a smaller rise in blood pressure and a more rapid recovery after stress.⁶ Other studies have shown that during the short term serum cholesterol seems to be reduced and smokers can be helped to stop or reduce smoking.^{7,8}

Of course it is relatively easier to measure blood pressure or serum cholesterol and count the number of cigarettes smoked, but it is harder to measure any improvement in the quality of life. If patients are happy without their sleeping pills, however, I feel that it is an improvement. You'll need proof by a sleep laboratory. It is encouraging when a patient tells me, "I started my relaxation last night when I could not sleep. I relaxed my right leg and I can't remember going beyond my left knee! I must have fallen asleep then", or, "After I started relaxation, my anger—whatever the reason—used to last hours and sometimes two or three days. Now I can get over my anger very quickly, sometimes within minutes." Once a wife of a hypertensive man came and told me, "I don't know what your advice to resign so that he could step down without losing face. Of course this would mean giving up the big house he had just bought and the children would have to leave the private school, and it would be such a disappointment to his wife. He agreed to give relaxation-meditation a try. He not only remained the

manager but also stopped all his medications and is still off them eight years later. His comments on how meditation helped him were, "Before I learned the technique, I used to feel very apprehensive because I had so many problems to attend to and they all came to my mind at once. Meditation has taught me to concentrate on one problem at a time with complete exclusion of thoughts about the other problems, with the result that I am able to cope with them."

Of course there are plenty of problems still to be solved and better health methods to be evaluated but from the experience gathered so far, I feel convinced that the proper way to help the distressed and their relatives, to promote health and general wellbeing, and to prevent diseases of the mind, is to equip individuals with appropriate knowledge, adequate coping skills, and to influence their attitudes in such a way as to help them solve their own health problems. We can't bully people into healthy behaviour, but we can help them to develop their own utmost potential. I have treated approximately 300 patients who are either hypertensive or at increased risk of having coronary heart disease and there has been a not a single incident of unpleasant side effects. In view of the proved benefits, this is really gratifying.

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WANT OF APPETITE.

THIS may proceed from a foul stomach; indigestion; the want of free air and exercise; grief; fear; anxiety; or any of the depriving passions; excessive heat; the use of strong broths; fat meats; or any thing that palls the appetite; or hard digestion; the immediate use of strong liquors, tea, tobacco, opium, &c.

The patient ought, if possible, to make choice of an open dry air; to take exercise daily on foot or on a carriage; to ride horses; and to avoid all immoderate thought. He should use a diet of easy digestion; and should avoid excessive heat and great fatigue.

If want of appetite proceeds from errors in diet, or any other part of the patient's regimen, it ought to be changed. If nausea and retchings (few that the stomach is loaded with crudities, a vomit will be of service. After this a gentle purge or two of rhubarb, or of any of the bitter purging salts, may be taken. The patient ought next to use food of the stomach's nature, infused in wine. Though gentle evacuations be necessary, yet frequent purges and vomits are to be avoided, as they weaken the stomach, and hurt digestion.

EXERCISE is an excellent medicine in most cases of indigestion, weakness of the stomach, or want of appetite. It may be taken in the form of it may be taken twice or three times a day in a glass of wine or water. It may likewise be mixed with the tincture of the bark, one drachm of the former to an ounce of the latter, and two spoonfuls of it taken in wine or water, as above.

THE chalybeate waters, if drunk in moderation, are generally of considerable service in this case. The salt water has likewise good effects; but it must not be used too freely. The waters of Harrogate, Scarborough, Moffat, and most other Spas in Britain, may be used with advantage. We would advise all who are afflicted with indigestion and want of appetite, to repair to these places of public recreation. The very change of air, and the cheerful company, will be of service; not to mention the exercise, dilution, amusements, &c.

(Bucchan's Domestic Medicine, 1786.)

Emergencies in the Home

Electrocution, drowning, and burns

A FRASER-DARLING

The three emergencies of electrocution, drowning, and burns do not often occur in the course of a general practitioner's work. It is unlikely that he will be present until after the incident has taken place. Nevertheless, a doctor trained in emergency procedures can do much to ensure the safety of the victims, and bring order to the situation and reassurance to the panic-stricken bystanders. An increasing number of general practitioners are now members of immediate care schemes and are equipped with resuscitation equipment for intubation and assisted respiration as well as equipped to do transfusions, which may be life saving on these occasions.

Electrocution

- The aims of the emergency management of electrocution are:
- (1) To ensure the safety of the victim and rescuer.
 - (2) To maintain respiration and cardiac functions.
 - (3) To provide first-aid treatment of associated injuries, particularly fractures and burns.

The effect of an electric current at the normal British domestic voltage passing through the body depends on the value of the current flow, the time it takes to flow, and its pathway through the body. Concentrations of electrical energy at the points of contact will cause not only surface burns but also deep tissue damage. Current passing from hand to foot may affect the heart, while current passing through the brain may inhibit the respiratory centre. The patient may be comatose, pulseless, and apnoeic.

PROCEDURE

- The doctor should take the following steps.
- (1) Switch off the current and if possible disconnect any apparatus. It is essential to isolate oneself by using a stick, rubber gloves, or a mat to move the victim away from the source of electricity. On no account use your bare hands, and avoid grabbing the patient by the armpits, which may be moist and therefore better conductors. Do not assume that because the current is switched off that you are safe. In these days of do-it-yourself electrical work there is always the danger of faulty wiring. If the victim is near a high-voltage cable or an electrified rail do not approach him until an engineer certifies that the current has been switched off, or you may be the next victim.
 - (2) Assess the level of consciousness. (a) If the person is conscious and speaking, treat any concomitant injuries—that is, burns or fractures from falls. (b) If unconscious, check the respiration, and if the person is breathing turn him to the "recovery" position; if not breathing, start artificial respiration.
 - (3) If there is no in-junction after 16 inflations check the carotid pulse, and if this is absent give a sharp blow to the left side of the lower edge of the sternum. If there is no response then start external

cardiac massage and artificial respiration. Doctors with resuscitation equipment should intubate the patient and continue artificial respiration using a Laerdal or other bag.

Admission to hospital for any case of electrocution is mandatory because cardiorespiratory complications may occur subsequently. Assessing all burns is also essential as they may be deeper than at first apparent, and depending on the extent of the burn they may require excision and grafting.

Drowning

For the practical management of a drowned patient it matters not whether the person has drowned in sea water or fresh water. Some people suffer respiratory paralysis associated with laryngeal spasm before water enters the lungs, and these respond well to resuscitation. The aim of emergency management is to restore respiratory and cardiac functions.

PROCEDURE

As soon as the person's head is above water artificial respiration by the mouth-to-mouth method should be started if possible and certainly as soon as he has been brought ashore or into a boat. There is a *literally* one second to be made. This should be continued for at least 15 minutes before any other measures such as loosening clothes and checking the carotid pulse. If the person recovers then continue assisted respiration, timing it to occur with his own breathing. It is important not to give pure oxygen if there is spontaneous respiration. The patient should then be placed in the "recovery" position to avoid asphyxia from inhaled vomit. Victims of drowning may have gulped large quantities of water which they are liable to regurgitate. The patient should be watched carefully because respiratory failure may recur requiring further resuscitation. If the carotid pulse is absent then external cardiac massage should be given. Again the patient should be intubated if the equipment is to hand. It is important to remember that the person will be suffering from acute hypothermia, and this may be the main condition requiring treatment. It is essential to rewarm the person as rapidly as possible.

Burns

The aims of immediate care in injuries due to burning from whatever cause are:

- (1) To prevent further damage by cooling.
- (2) To prevent or reduce the effects of hypovolaemic shock.
- (3) To prevent infection.
- (4) To prevent further damage from mechanical or chemical trauma.
- (5) To ensure early and rapid transport to hospital for severely burned patients.

The majority of burning accidents at home are due to scalds from boiling water in kettles or saucepans and to clothes catching fire. Very young and very old people are most at risk and least able to withstand the effects of burning.

It is important to distinguish managing the burning accident from managing the resulting injuries.

THE BURNING INCIDENT

Though a doctor is no more likely to be present when a burning incident occurs than any other person he must know what to do. **Flame burns**—In the event of the victim being found with his clothes on fire, the flames should be smothered as rapidly as possible with anything to hand—for example, a rug or blanket. Once the flames have been smothered it is important to soak the overlying clothes in cold water for at least 10 minutes. It is important to realise that though the flames may have been extinguished clothes may still be smouldering and therefore will continue to "cook" underlying tissue. It is essential to ensure rapid cooling to reduce the degree of injury, especially for deep burns. The rapid cooling is soothing to the patient and research has confirmed that this reduces the degree and depth of the injury without adversely affecting the definitive management in hospital. Clothing which is not stuck to the skin should be removed as it retains heat.

Scalding incidents—Immediate soaking in cold water is the best action, immediately followed by removing clothing that overlies the burnt area.

Chemical injuries—Immediate irrigation with cold water of the affected area for not less than 10 minutes is essential along with removing contaminated clothing.

ASSESSING BURNS

The "rule of nines" is the best guide for estimating the extent of burning. Burns of more than 15% of body surface in adults and 10% of body surface in children will require transfusion owing to the severe loss of circulating plasma into the burnt tissues. The patient's outstretched hand is equivalent to 1% of the body surface and any burns more extensive than this will require hospital treatment, as will full-thickness skin burns. It is the size of the area of skin burnt rather than the thickness that determines the seriousness of the injury.

The "rule of nine" for estimating the area of burns

FIRST-AID MANAGEMENT OF BURNS

Once the patient is safe from further burning then wrap all burned areas in a clean sheet. If the head or face is burnt a pillowcase may be used with holes cut for the eyes, nose, and mouth. The patient should be kept just warm with a blanket. Do not apply any medicaments whatsoever to the burnt area. If there is severe pain a small dose of intravenous morphine may be given, but pain is not usually a feature

of severe burns especially if they are full-thickness burns. Do not give fluids by mouth unless the burns are more than 10% of body surface and there is likely to be a delay before admission to hospital. In these circumstances give small, frequent drinks of water. Children may complain of severe thirst and must not be allowed to gulp fluids as this may induce vomiting with further loss of fluid and electrolytes. Doctors in immediate care schemes who carry volume-expanding fluids (Hartmann's or dextrose-saline or plasma) should set up an intravenous drip for patients with burns of more than 10% body surface.

Burns the size of a postage stamp or larger that are caused by electricity, molten metals, or chemicals require hospital treatment as they are apt to be full thickness and may require grafting. Finally, transport a severely burned patient as soon as possible to a suitable centre equipped to deal with his injuries. Burnt patients travel best soon after the injury before hypovolaemic shock occurs.

OTHER TYPES OF BURNING INJURY

Occasionally a person may swallow a corrosive chemical causing severe burning of the alimentary tract. This requires urgent admission to hospital with instructions that the person should not, if possible, vomit. Occasionally toxic gases may cause burning and irritation of the respiratory tract and the subsequent development of respiratory obstruction should be borne in mind.

NON-ACCIDENTAL INJURY

If the doctor is asked to see a child who has cigarette burns on his body, this should alert him immediately to the possibility of physical abuse, and he should take appropriate action to protect his patient.

The purpose of this article is to guide the doctor who is called to an accident caused by electrocution, drowning, or burning on how to provide immediate and essential care to the victim before admission to hospital.

I would like to thank Mr N Pyrgos, consultant surgeon, A and E Department, Lincoln County Hospital, for advice and criticism in preparing this article.

NEXT to milk, we would recommend good light bread. Bread may be given to a child as soon as it flows an inclination to chew; and it may at times be allowed as much plain bread as it will eat. The very chewing of bread will promote the cutting of the teeth, and the discharge of *saliva*, while, by mixing with the milk in the stomach, it will afford an excellent nourishment. Children discover an early inclination to chew whatever is put into their hands. Parents observe the inclination, but generally mistake the object. Instead of giving the child something which may at once exercise its gums and afford it nourishment, they commonly put into its hands a piece of hard meat, or impenetrable coral. A crumb of bread is the best pumuck. It not only answers the purpose better than any thing else, but has the additional property of nourishing the child and carrying the saliva down to the stomach, which is too valuable a liquor to be lost.

No piece of food induces the health more than the modern custom of lying a bed two hours in a morning. This is the general practice in great towns. The inhabitants of cities seldom rise before eight or nine o'clock, but the morning is undoubtedly the best time for exercise, while the stomach is empty, and the body refreshed with sleep. Before the morning air braces and strengthens the nerves, and, in some measure, answers the purpose of a cold bath. Let any one who has been accustomed to be a bed till eight or nine o'clock, rise by fix or seven, spend a couple of hours in walking, riding, or any active diversion without doors, and he will find his spirits cheerful and serene through the day, his appetite keen, and his body braced and strengthened. Custom looses renders early rising agreeable, and nothing contributes more to the preservation of health.

(Bucchan's Domestic Medicine, 1786.)

Pitfalls in Practice

Finding a practice

IV: What a contract should include

JOHN OLDROYD

This article is based on an audiovisual presentation made for vocational trainees in general practice by the MSD Foundation.

Last week Dr Ian Keen received a contract from his future partners. It had been drawn up by a solicitor known to the two senior partners. A critical reading of the contract showed that it favoured the senior partners and included clauses that could make life very difficult for Dr Keen in the future. Here are some suggestions of what a contract should include.

What a contract should include

Although there is no suitable model agreement that could cover the individual circumstances of every partnership, there are certain items that every agreement should include.

- (1) Name and title of the firm
- (2) Duration of the partnership
- (3) Capital of the partnership
- (4) Premises of the partnership
- (5) Expenses of the partnership
- (6) Income of the partnership
- (7) Division of receipts
- (8) Provision of tax liability
- (9) Holidays, study leave, illness causing absence
- (10) Conditions of expulsion of a partner
- (11) Restrictive covenants
- (12) Mandatory membership of defence society or for sickness benefit insurance
- (13) Arbitration procedures
- (14) Superannuation matters.

INCOME

What is a reasonable income for an incoming partner to expect? No hard and fast rule can be laid down. Circumstances of both the individual practice income and the local and national market in medical graduates will determine this. The wine will look at the advertisements of current vacancies. But don't be misled by high gross incomes advertised. Net incomes will be reduced by the practice expenses, and this is often a very different figure. Equally, parity will be largely dependent on the market and local circumstances.

It is usual to consider all receipts as the property of the

partnership, but some practices exclude monies from outside appointments earned by a partner. This could be justified only if the work is performed when the partner has no responsibility to the practice—that is, on his half-day or weekend off. Special NHS allowances accruing to individual partners, such as seniority payments, vocational training payments, and post-graduate training allowance, could, however, properly be excluded from the practice pool. The case of a trainee's allowance will depend on the practice arrangements.

WORK LOAD

It is unusual to describe work load in the agreement. Yet this can be done in general terms, and no agreement should be signed unless the junior partner can assure himself that the distribution of work is equitable in terms of his remuneration and expectations.

PREMISES

Premises are a frequent bone of contention in partnerships. Where these are rented it is usually advisable for the partnership as a whole to hold the lease rather than one partner. Where, however, the premises are owned by one partner, consideration should be given to the rights of the continuing partners in the event of the retirement or death of the owner.

ASSENTS

Increasingly partners are involving themselves in medico-political and NHS work at both national and local level, resulting in their absence from the practice. Mutual agreement will be necessary to define how much absence should be allowed without recompense to the partners continuing the practice. It seems reasonable, and is customary, to allow such absence for short periods without recompense because there is some intangible benefit to the practice for this necessary work. Legacies and gifts should be specifically dealt with in the agreement.

Further information

General guidance on partnership contracts is available for BMA members by asking the BMA Personal Services Bureau for their invaluable leaflet, *Medical Partnerships Under the National Health Service*, which is free of charge from the Bureau at Tavistock House, Tavistock Square, London WC1H 9JT.

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