



Refugee and migrant health: can family doctors meet the challenge?

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Europe is facing a challenge with the increasing movement of migrants and refugees across its borders. Family doctors have a role to play in coping with this but we must explore our learning needs for the health care demands of this special population. There are also moral, legal, and social questions that arise that require attention.

The personal nature of family medicine and the special relationship between the doctor and the patient transcend nationality and conflict. Patient-centered care and the use of the tools of medical anthropology have a role to play in building bridges to improve the service of migrant populations with special needs. Portuguese primary health care has historically functioned well in serving the needs of migrants from many countries.

Portugal has had some remarkable experiences in dealing with refugees. During the Second World War, the Portuguese Consul in Bordeaux, Aristides de Sousa Mendes, was instrumental in saving the lives of thousands of Jews fleeing from destruction by granting visas of safe conduct to Portugal. He was dismissed from his post and only recently his reputation has been rehabilitated.

In the 1970's, the *retornados* or Portuguese returning from former colonies presented another challenge. Although they shared a common language, they came from a different culture. The successful integration these migrants back into society, with minimal trauma, is different from the experience in France of the *pid-noirs* who returned from North Africa.

Today Portugal is not a favoured destination of refugees in spite of its peaceful nature, high standard of

living, and welcoming population. Perhaps this is due to its geographic isolation from Europe. While there are few migrants in Northern Portugal, the Lisbon area has a more varied population.

What can help us face the challenge of work with migrants? We are all alike in our basic needs. Adopting a patient-centered rather than a disease or profession-centered model of care can be effective as a first step in helping migrants get the care that they need.

The six elements of patient-centered care are helpful.¹ The first element of "disease and illness" explores the patient's explanatory model of health and disease. All patients have a unique view of their situation and expectations of care. This is especially helpful when meeting with patients from another culture.

The tools of medical anthropology provide us with a practical clinical method.² By exploring the patient's ideas and asking them what they think they have, what they call it in their culture, how they would normally treat it, and what they expect a healer to do, we are involving them in the process of care. We can use this new knowledge to build bridges, demonstrate acceptance, and provide comfort. We can also use trust to promote exploration of new ideas about causes of illness, treatment, and prevention, and build shared care.

The second element of patient centered care is whole person medicine. This involves knowing the life story of the patient and their current context. Migrants may tell stories of loss, violence, trauma, or abuse. Others share stories of heroism. We play a role in witnessing these events, recording them, and assuring survivors that their struggles will not be forgotten.

Medical associations are now publishing opinions on the duties of doctors towards refugees. This includes a strong stand against forced, closed detention of refugees and equitable access to health care.³

The clinical needs of refugees have been described

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in detail. A recent study of refugees to Canada shows a predominance of blood borne infections (such as hepatitis B and the human immunodeficiency virus) as well as intestinal parasites.⁴ There is also a significant burden of non-communicable diseases including anemia, hypertension and hyperglycemia. Refugee women have higher rates of abnormal pap smears than their Canadian neighbours, putting them at greater risk for cervical cancer.⁵ Hypertension, diabetes, musculoskeletal disease and respiratory diseases also require attention in many migrant populations.⁶

Mental health needs are important yet sometimes neglected among those fleeing the violence of war and other unbearable situations. How can the family doctor raise these issues with new patients from a different culture? The messages from qualitative research on this topic are simple: think about these issues, ask your patients about them, listen carefully to their answers, and offer them assistance.⁷

Narrative medicine teaches us how to rewrite the patient's story and give it new meaning. This can often allow people to get on with their lives. Letters from migrant and refugee patients illustrate the challenges they have faced and help us to understand the ways they have overcome them.

Family disruption is a common result of forced migration. A young refugee from South East Asia asked for help with symptoms of anxiety that she felt were related to family conflict. She explained: "My mom met my dad in a refugee camp. When I was small, she caught him with someone else. She got violent so they divorced. She was an immigrant without education and couldn't speak English when they went to court. These images in my head are loud and clear and even though I was only about 5 years old, I understood everything going on."

The family can also be seen as a source of strength for many migrants. A young refugee from South America with rheumatoid arthritis explained her ability to cope this way: "I would say I get my strength from my mom. She is a single mom who came to Canada alone with three kids and has managed to work her way up from being a refugee on welfare to getting a job and

owning a house. She is truly an inspiration given all the challenges she faced as being a single woman in a foreign country, trying to work in a language that wasn't her own."

Many refugees speak of self-reliance as the only option. A young woman was helping her mother deal with musculoskeletal pain, which began after forced detention during the Balkan war. Her approach was to 'live through it': "When I was 9 years old, I lived as a refugee in Croatia during the war. There was little food, no security, and no human rights. I never received any help for this. You just learn to live through it."

These three stories are only a small fraction of a bigger picture. There is much that we can learn from the struggles of others. Recent world events have challenged our humanity and our professionalism. We have the resources to serve those in need. I wonder if we will find the personal and the political will required to rise to this challenge.

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CONFLICT OF INTEREST

None reported

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