check

Independent learning program for GPs

Unit 477 December 2011

Multicultural health

The Royal Australian College of General Practitioners

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Multicultural health

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The five domains of general practice

- Communication skills and the patient-doctor relationship
- Applied professional knowledge and skills
- Population health and the context of general practice
- Professional and ethical role
- Organisational and legal dimensions

The Royal Australian College of General Practitioners

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Australia is a multicultural nation with a rich variety of people from culturally and linguistically diverse (CALD) backgrounds, including refugees, who may have fled horrific situations involving torture, trauma and loss. Individuals and families from CALD backgrounds can face numerous barriers when accessing healthcare. These barriers can include communication, cost and dealing with services that appear to operate from an ethnocentric perspective. The role of the general practitioner is to minimise these barriers so health outcomes are improved. They should also facilitate relocation and treat all people – regardless of their ethnicity or immigration status – with respect, dignity and fairness.

In interacting with individuals and families from other cultures, it is important to remember that we make implicit assumptions due to our own cultural norms. It is, therefore, important to be aware of the other person's cultural beliefs and clarify individual viewpoints where appropriate. Take time to listen and use an interpreter where appropriate to help promote rapport, avoid misunderstandings and optimise interactions with the healthcare system.

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The learning objectives of this unit are to:

- display increased knowledge of the essential components of health assessments of individuals and families who have recently arrived in Australia
- display increased awareness of some of the serious infections and illnesses, which are not uncommon in refugees, and increased awareness of the importance of timely referral in these instances
- recognise the importance of utilising the services of an interpreter, display increased knowledge of how to engage the services of an interpreter and how to conduct an interview using an interpreter
- appropriately assess the catch up immunisation needs of an individual who has immigrated to Australia
- understand the experiences a refugee may have endured, engage strategies to improve rapport, respectfully obtain a psychosocial history, sensitively enquire about a history of trauma, assess mental state in a culturally appropriate way and appropriately respond to a disclosure of trauma
- display increased awareness of the resources available to assist in the care of patients from CALD backgrounds.

We hope that this unit of *check* will assist you to gain a greater understanding of the issues that refugees face and help you to confidently meet the healthcare needs of patients from CALD backgrounds.

Kind regards,

Catherine Dodgshun
Medical Editor

CASE 1

MOSES AND HIS FAMILY HAVE JUST ARRIVED IN AUSTRALIA

Moses, his wife Mary, eight children (aged between 4 and 20 years), and one grandchild (aged 2 years) have been in Australia for 2 months. They are here on a '200 visa', which is part of the United Nations High Commission for Refugees resettlement program. The family fled Burundi 10 years ago and were in a refugee camp in Uganda until their resettlement in Australia. No member of the family speaks English. They all speak Kirundi, with the older family members speaking French as a second language, and the younger ones speaking Swahili.

In the refugee camp, the girls had to walk a long way to get water and wood each day and there was only dried food available. They lived in two tents set up side by side and had to share toilet and washing facilities with about 50 other people. There was only limited healthcare in the camp and this was mainly for infectious diseases, such as malaria and gastroenteritis. As part of their visa medical assessment the family had chest X-rays and HIV tests. Three days before their flight to Australia they were required to undertake a 'fitness to fly' test, which would have included a rapid diagnostic test for malaria, and measles-mumps-rubella (MMR) vaccine and a dose of albendazole tablets. However, their paperwork was temporarily misplaced and they missed out on this test.

The family are booked in to see you for their initial health assessment.

QUESTION 1

What are some practical issues related to arranging the consultation that you need to address? What Medicare Benefits Schedule (MBS) item numbers are potentially accessible for this consultation?

FURTHER INFORMATION

You ask the practice nurse to help you for the afternoon and decide to start by seeing half the family each. You phone the local refugee health service and ask for a copy of its protocols.

QUESTION 2

What will you and the nurse do at this first visit?

QUESTION 3

What screening investigations would you request?

FURTHER INFORMATION

You find out that the child, aged 2 years, and Moses both have a chronic cough. Mary is worried about two of the children, aged 8 and 10 years, as they both have a fever and a headache. These two children are also still experiencing nocturnal enuresis.

QUESTION 4

What is the most important diagnosis to consider in Moses and the 2 year old child?

QUESTION 5

What is the most important diagnosis to consider in the two children, aged 8 and 10 years?

QUESTION 6

How urgent is referral for the three children?

FURTHER INFORMATION

You refer the 2, 8 and 10 year old children promptly and they are appropriately investigated and treated.

As the family are leaving, Mary ushers everyone out the door to ask you if you could help them find a larger house as they are all living in a two bedroom house. She also mentions that the 2 year old granddaughter is actually the child of Elizabeth, the 16 year old daughter of Moses and herself, who was raped when they were in the camp. Elizabeth is not sleeping well as she complains about back pain and often has to go to the toilet at night to pass urine. This is disturbing everyone else who is sleeping in the same room.

QUESTION 7

How can you help with the housing situation?

QUESTION 8

What should you do about Elizabeth?

FURTHER INFORMATION

The entire family return for a second visit with a copy of their test results. The results show that the 8 year old has *Plasmodium falciparum* malaria antigen only and the 10 year old also has parasites on the thick film. Both have a good haemoglobin (Hb), and are given artemether/lumefantrine as outpatients. You are asked to follow up their 28 day blood test results.

The 2 year old has a negative chest X-ray, but a 12 mm Mantoux tuberculin sensitivity test (TST) and an erythrocyte sedimentation rate (ESR) of 45. She has not had a bacille Calmette-Guerin (BCG) vaccine in the past. She is given 2 months of triple therapy and 4 months of rifampicin and isoniazid for tuberculosis (TB). The entire family is screened and all have a TST over 5 mm so are given treatment depending on their age and the size of their reaction.

Four members of the family have positive schistosomiasis antibodies, but no eggs in their stools and are given two doses of the appropriate dose of praziquantel based on their weight.

The 18 year old has an enlarged spleen and has schistosomiasis eggs in his stool, as well as positive schistosomiasis antibodies. He has an ultrasound, is referred for endoscopy for assessment of possible oesophageal varices and has a review of his stools planned for 8 weeks.

Elizabeth has a vitamin D level of 15 ng/mL and is given cholecalciferol 100 000 IU stat. She does not have chlamydia or gonorrhoea in her urine, but does have an *Escherichia coli* urinary tract infection.

Moses is found to have chronic obstructive pulmonary disease (COPD) on his chest X-ray. Mary is found to be hepatitis C Ab positive.

QUESTION 9

Comment on Elizabeth's vitamin D deficiency, and the schistosomiasis of several of the family members.

QUESTION 10

As well as treating everyone, what else needs to be done at this visit?

FOLLOW UP

You realise there is still a lot of work to do with this family.

None of them have ever brushed their teeth and all have extensive dental caries. The children are referred to the school dentist and the adults to the public dentist. Elizabeth is finding it difficult to go to school as she has panic attacks and pelvic pain.

Given that Mary is found to be hepatitis C positive she needs referral to the liver clinic at the local hospital for treatment. She has had many injections over her lifetime and it is presumed that one of these caused her infection.

Moses is still smoking despite his COPD and has been smoking since he was 13 years of age. He is finding it very difficult to give up.

The 4 year old is not speaking very well and there is concern that he may be partially deaf.

QUESTION 11

Can you charge the MBS item 705 or 707 now?

CASE 1 ANSWERS

ANSWER 1

Practical issues to consider when arranging the consultation include:

- use of an interpreter
  - a Kirundi interpreter should be booked through the Department of Immigration and Citizenship's Translating and Interpreting Service (TIS) Doctors' Priority Line (see *Resources*)
- time management
  - allow half an hour appointment time for each person
  - obtain assistance from the practice nurse
- payment
  - the Australian Government Department of Health and Ageing has more information about Medicare Benefit Schedule (MBS) health assessment items for refugees (see *Resources*).

There are four time based MBS health assessment items that can be used for refugees and other humanitarian entrants:

- 701 (brief consultation, less than 30 minutes)
- 703 (standard consultation, 30 to less than 45 minutes)
- 705 (long consultation, 45 to less than 60 minutes)
- 707 (prolonged consultation, greater than 60 minutes).

The health assessment is a voluntary one-off assessment and must be provided within 12 months of the person's arrival in Australia, or grant of visa. The doctor should not conduct a separate consultation in conjunction with the health assessment on the same day, except where it is clinically required (such as when the patient has an acute problem that needs to be managed separately from the assessment).

It is available to people with the following visas:

- Subclass 200 (Refugee) visa
- Subclass 201 (In-country Special Humanitarian) visa
- Subclass 202 (Global Special Humanitarian) visa
- Subclass 203 (Emergency Rescue) visa
- Subclass 204 (Women at Risk) visa
- Subclass 070 (Refugee Pending Bridging) visa
- Subclass 695 (Return Pending) visa
- Subclass 786 (Temporary [Humanitarian Concern]) visa
- Subclass 866 (Protection) visa.

Health assessments are generally made up of:

- collecting information, including taking a patient history and undertaking or arranging examinations and investigations as required
- making an overall assessment of the patient
- recommending appropriate interventions
- providing advice and information to the patient
- keeping a record of the health assessment, and offering the patient a written report about the health assessment with recommendations about matters covered
- offering the patient's carer (if any) a copy of the report or extracts of the report relevant to the carer. The patient or their parent/guardian must be given an explanation of the health assessment process and its likely benefits, and must be asked by the doctor or practice nurse whether they consent to the health assessment being performed. Consent must be noted on the patient record.

An MBS health assessment item should generally be undertaken by the patient's 'usual doctor', that is, the doctor who has provided the majority of services to the patient in the past 12 months, and/or is likely to provide the majority of services in the following 12 months. Practice nurses may assist doctors in performing a health assessment and their time may be added to the time taken by the doctor to complete the assessment.

ANSWER 2

During this first visit, you and the practice nurse can ascertain the following information:

- country of origin
- other countries and refugee camps the family has spent time in
- if there are any immediate health problems
- if there are any health undertakings on their visas
- medications, allergies
- past history including operations, injuries and blood transfusions
- level of schooling and work history
- developmental progress of the children
- dietary adequacy
- height and weight
- blood pressure
- urinalysis.

You can also arrange for collection of specimens of blood, urine and stools in order to perform the screening investigations listed in *Answer 3*.

ANSWER 3

The Australasian Society of Infectious Diseases guidelines for the *Diagnosis, management and prevention of infections in recently arrived refugees*[1,2] offers advice on screening. The investigations recommended by this society, as well as additional investigations, are outlined below.

- General screening:
  - full blood examination (FBE), ESR
  - electrolytes and renal function tests, liver function tests (LFTs)
  - urinalysis for blood, protein and sugar.
- Asymptomatic infectious diseases:
  - thick and thin blood films and malarial antigen for malaria
  - TST and consider a chest X-ray for TB

  - hepatitis BsAg and hepatitis BsAb, hepatitis C Ab
  - syphilis serology
  - chlamydia and gonorrhoea nucleic acid amplification test (of which polymerase chain reaction [PCR] is an example) in the urine for patients over 13 years of age
  - human immunodeficiency virus (HIV) test
  - *Helicobacter pylori* antigen in stools.
- Worms:
  - schistosomiasis serology
  - strongyloides serology
  - stool specimen for other faecal parasites.
- Nutritional and other deficiencies:
  - vitamin D
  - vitamin B12
  - iron studies
  - red blood cell folate.
- Genetic and environmental problems:
  - haemoglobin electrophoresis plus or minus DNA studies for haemoglobinopathies
  - lead levels in children under 13 years of age.

ANSWER 4

One of the most important diagnoses to exclude is TB.The majority of the source countries for refugees to Australia have a TB rate over 300 per 100 000 with a mortality of over 40 per 100 000. The risk of developing TB remains at this higher rate for up to 5 years after arrival by which time 50% of cases will have been identified.[3,4]

Refugees often have many risk factors for TB, such as living in close proximity to large numbers of people from high prevalence countries in poor circumstances with limited food or health infrastructure. Fifty-two percent of Australia's 6000 refugees in 2005–2006 were living in such circumstances in refugee camps for more than 5 years and 20% for more than 10 years.[5] Only about 50% of their TB is pulmonary, compared to about 70% in those born in Australia with sites including lymph nodes, pleura, bones, joints and peritoneum.[6]

Up to 50% of refugees have positive TST. The probability that a TST response relates to TB infection will depend on factors such as the prevalence of TB in the population, the exposure risk of the individual, age and immune status and the reaction size. An abnormal TST is not diagnostic of active disease and may take 2–12 weeks to develop following infection (Royal Adelaide Hospital Chest Clinic protocol). A TST >10 mm in a patient from a high incidence country indicates:

- 40% risk of progression to TB, if aged less than 1 year
- 20–30% risk of progression to TB, if aged 1–15 years
- 10% lifetime risk of TB in adults.

The interferon-gamma release assay, which measures a person's immune reactivity to *Mycobacterium tuberculosis,* is used as a specificity tool if BCG vaccines have been given in the past.

ANSWER 5

One of the most important diagnoses to exclude is malaria.

Malaria can cause symptoms of fever, nausea, vomiting, diarrhoea, muscle pain and headache. It may present in the same way as an upper respiratory tract infection, but is the most important diagnosis to exclude in anyone, particularly a child, who arrives from Africa in the previous 3 months. Children can become very unwell due to haemolysis or cerebral malaria from *P. falciparum* extremely quickly. In Australia artemether/lumefantrine is usually given as an outpatient.[7]

Primary enuresis is not uncommon in this age group and if their urinalyses are normal and they are otherwise asymptomatic, they can be watched. However, it can also be a sign of distress in children and other signs of distress such as eating or sleeping problems, aggression, withdrawal and headaches need to be assessed.

ANSWER 6

All three children (aged 2, 8 and 10 years) need to be referred straight away. The 2 year old could become rapidly ill with TB and is potentially infectious. Even though the 8 and 10 year olds have been in Australia for 6 weeks, their immunity to malaria will be dropping, and if they do have malaria, they are likely to become rapidly ill as their parasite load rises.

ANSWER 7

You can help by offering the following to the family:

- a letter to the housing trust
- referral to a social worker
- referral to a community health worker.

ANSWER 8

Elizabeth needs urgent assessment. She will need assessment regarding possible pelvic inflammatory disease – but this might best be done by an experienced child and adolescent sexual health physician. She may also need referral to a psychologist, but this may best be done through an adolescent health service.

FEEDBACK

Many refugees arriving in Australia have resided in countries where sexually transmissible infections (STIs) are considerably more prevalent. Poverty, powerlessness, social instability, mobility and lack of protection against sexual violence can facilitate transmission of STIs in the refugee population. As most patients will be asymptomatic, or have very few symptoms, the majority of STIs are detected through screening, contact tracing or further screening for those already diagnosed with an STI.[1]

ANSWER 9

Vitamin D deficiency most commonly presents asymptomatically, but muscle pain appears to be a problem in refugee and immigrant

communities, especially those from Africa and the Middle East. Those with darker pigmentation, or keratinisation, causing darker coloured skin have decreased sunlight penetrating to the deeper layer of the skin where vitamin D is produced. Other populations at risk of deficiency include those with decreased sun exposure because much of the time is spent indoors, or being covered extensively by clothing, as seen most profoundly in women observing purdah.[8]

Schistosomiasis, also known as bilharzia, infects humans when skin comes into contact with water contaminated with certain snails. These snails contain a worm, which is a parasite. Worm pairs lay eggs in venous complexes in the bladder in *Schistosoma haematobium,* or in portal venous plexuses in *S. mansoni* and *S. japonicum*. Treatment is with praziquantel 40 mg/kg in two or three divided doses, depending on the species of schistosome. Morbidity and mortality are from thrombocytopaenia with risk of bleeding, splenomegaly with risk of trauma and oesophageal varices.[9]

ANSWER 10

You also need to:

- make appointments for immunisation and women's health checks
- examine each person's cardiovascular and respiratory systems, ear, nose and throat, lymph nodes, skin and abdomen
- discuss chronic health issues. These are unlikely to have been addressed in the refugees' country of origin, or refuge, due to the limited healthcare available. Refugees actually have a higher prevalence of some chronic illnesses such as hypertension, cardiovascular disease and diabetes
- assess for developmental issues in the children
- assess for mental health issues
- ask about social issues, eg. learning English, finances, family relationships, loneliness
- check teeth
- check vision and hearing
- do a hepatitis C PCR on Mary and consider referral for treatment if positive
- discuss and treat Moses' COPD, or refer him to a respiratory physician.

ANSWER 11

Yes, you can charge the MBS item 705 or 707 now that you have fulfilled the requirements.

In the process of completing a health assessment, you may have identified other enhanced primary care item numbers the family is eligible for, which can be completed in the coming weeks. Consider a mental healthcare plan for Elizabeth, chronic disease management plans for Mary and Moses with the option of referral for dental treatment, or social work assistance. Also consider a child health check and referral for audiology for the 4 year old.

CASE 2

MOHAMMED'S HEPATITIS RESULTS

Mohammed, aged 31 years, has been in Australia for 3 weeks and is on a permanent visa. He is originally from Afghanistan, but has been in Pakistan for the past 2 years. His wife and 4 year old daughter are still in Pakistan. Mohammed came by boat from Malaysia. The Taliban were rounding up young men in Quetta and he said he was afraid for his life. In Afghanistan he owned a small shop. Mohammed's speaks Dari, but he is also a confident English speaker.

Mohammed is hepatitis B surface Ag positive, hepatitis B surface Ab negative and hepatitis B core Ab positive.

QUESTION 1

How would you interpret these blood test results?

QUESTION 2

How is Mohammed most likely to have contracted hepatitis B?

QUESTION 3

What other tests would you request to properly assess the significance of Mohammed's hepatitis B to his current health?

FURTHER INFORMATION

Mohammed's alanine transaminase (ALT) is 54 IU/L (normal 5–45 IU/L). He is hepatitis BeAg positive, hepatitis BeAb negative and has a hepatitis B viral load of 31 000 IU/mL, which indicates a high viral load.

The rest of Mohammed's liver function tests are normal. Hepatitis D antibodies, hepatitis A antibodies, hepatitis C antibodies and an HIV test are all negative.

At his next appointment you tell Mohammed about his diagnosis. He is extremely upset and says that after all he has been through, he will now die like several of his family members who have died from 'liver problems'. He believes this is a hereditary disease and is afraid that he may have passed it on to his daughter.

QUESTION 4

What are the complications of hepatitis B and what is the risk of dying from untreated chronic hepatitis B?

QUESTION 5

If Mohammed's wife or daughter had contracted hepatitis B from him, what would their risks of developing chronic hepatitis B be?

FURTHER INFORMATION

Mohammed is worried about telling the other men in his household about his hepatitis B status as he is afraid they will not want to eat with him, or share the bathroom with him.

QUESTION 6

What should you tell Mohammed about the other men in his household?

FURTHER INFORMATION

You mention to Mohammed that you need to notify the public health authorities about his hepatitis B status. Mohammed becomes very distressed and says he is afraid he might be sent back overseas if the government knows about his hepatitis. He pleads with you not to tell the government.

QUESTION 7

What would you do in this situation?

QUESTION 8

What organisations could provide information and support for Mohammed?

FURTHER INFORMATION

You explain that treatment with medication is available. Mohammed is very pleased at the prospect of having treatment for his hepatitis B.

QUESTION 9

Mohammed asks when he can start treatment. What do you say?

QUESTION 10

Mohammed asks if there is any food he should eat or anything else he can do that will help his liver stay healthy. What do you say?

QUESTION 11

What other tests would be useful to request before Mohammed is referred for consideration of treatment?

FURTHER INFORMATION

Mohammed says he is hoping that medication can cure him.

QUESTION 12

What will you tell him about medication and the possibility of being cured?

CASE 2 ANSWERS

ANSWER 1

Mohammed has chronic hepatitis B. The hepatitis BsAg indicates that his infection is active and that he is infectious.

A guide to interpreting hepatitis B serology appears in *Table 1.*[10]

ANSWER 2

The most likely source of infection is vertical transmission from his mother at the time of birth. Mohammed comes from an area with an intermediate prevalence of hepatitis B. Most people in these areas contract hepatitis B from their mother, or from their families in early childhood. The majority of people with chronic hepatitis B in Australia have been born overseas, and they contracted the virus vertically from their mother. They did not clear the virus and develop chronic hepatitis B.[11]

Figure 1 illustrates the prevalence of chronic infection with hepatitis B virus in different parts of the world.

Table 1. Interpreting hepatitis B (HBV) serology[10]

Test	Result	Typical interpretation
HBsAg anti-HBc anti-HBs	Negative Negative Negative	Susceptible (needs vaccination)
HBsAg anti-HBc anti-HBs	Negative Positive Positive	Resolved HBV infection
HBsAg anti-HBc anti-HBs	Negative Negative Positive	Vaccinated and immune
HBsAg anti-HBc* anti-HBs	Positive Positive Negative	Active HBV infection (usually chronic) * If IgM anti-HBc is present, this may represent acute HBV infection
HBsAg anti-HBc anti-HBs	Negative Positive Negative	Various possibilities, including: • distant resolved infection (most common) • recovering from acute infection • false positive • 'occult' HBV (determined by positive HBV DNA viral load)

HBsAg = HepBsAg = hepatitis B surface antigen
Anti-HBc = HepBcoreAb = hepatitis B core antibody
Anti-HBs = HepBsAb = hepatitis B surface antibody
Adapted with permission from: Mast EE, et al. MMWR Recomm Rep 2006;55:1–33. www.cdc.gov/mmwr/preview/mmwrhtml/rr5516a1.htm

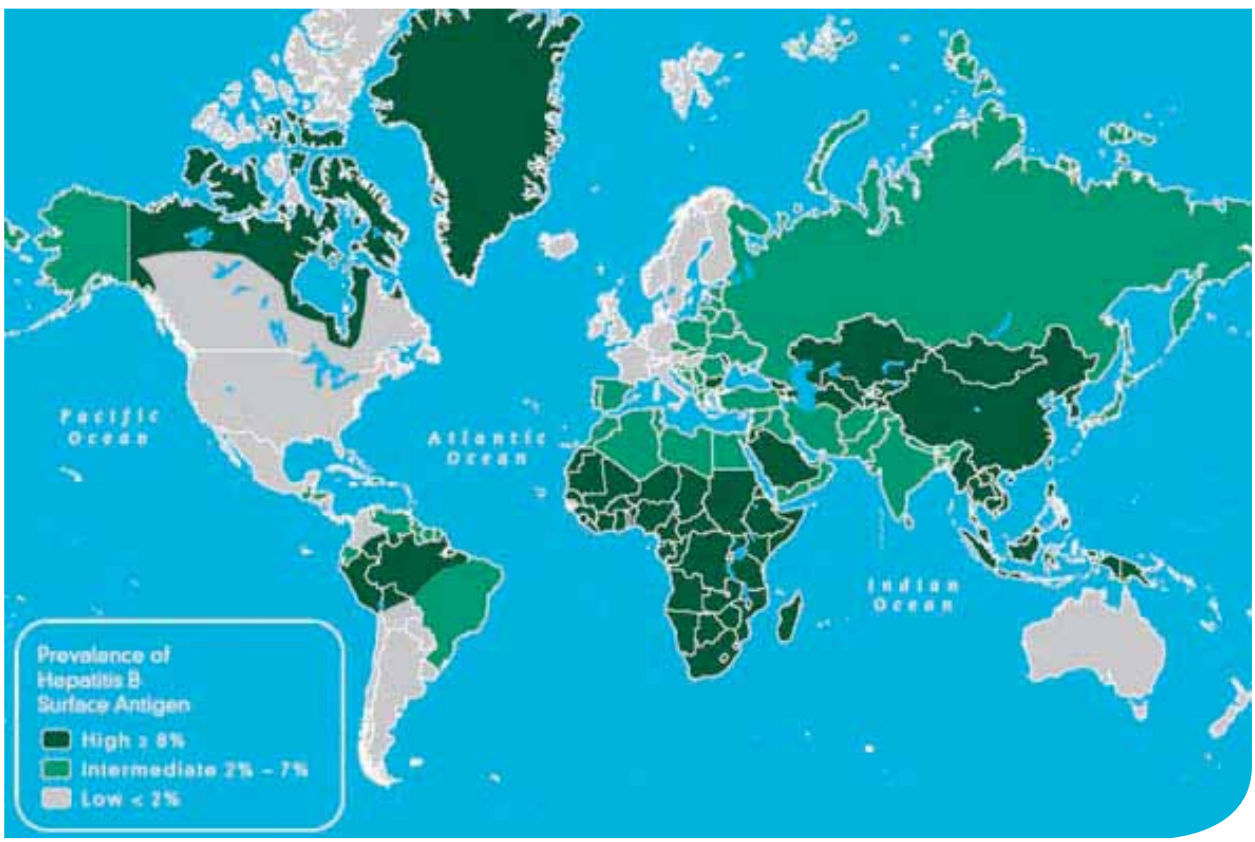

Figure 1. Prevalence of chronic infection with hepatitis B virus in different parts of the world
Reproduced with permission[12]

ANSWER 3

Tests to request include LFTs, FBE, hepatitis BeAg and hepatitis BeAb, hepatitis B viral load, hepatitis A Abs, hepatitis D Abs, clotting studies and an abdominal ultrasound. *Table 2* outlines the reasons why such tests are important.

Table 2. Tests and the reasons they are important[10]

Test	Reason why the result is important
HBeAg/Anti-HBe serology HBV DNA viral load	Quantify replication, identify phase of infection, identify who to treat and assess prognosis
HAV, HCV, HDV + HIV serology	Identify co-infection and need for vaccination (HAV)
LFTs	Assess inflammatory activity and synthetic function
FBE	Identify low platelets, which could suggest cirrhosis
Clotting studies	Help establish synthetic function
α-foetoprotein	Screen for hepatocellular carcinoma
Abdominal ultrasound including portal venous doppler	Assess for the presence of cirrhosis, portal hypertension and hepatocellular carcinoma

All these investigations are rebatable by Medicare for a patient diagnosed with hepatitis B, although there are restrictions on how often HBV DNA viral load can be performed. Reproduced with permission

ANSWER 4

Patients with chronic hepatitis B have a 20–30% risk of developing advanced liver disease and a 100-fold increased risk of developing hepatocellular carcinoma. Untreated, approximately 25% of those with chronic hepatitis B will die of the disease.[11]

ANSWER 5

There is a risk of sexual transmission of the hepatitis B virus from Mohammed to his wife if his wife is unimmunised. However, about 90% of those with horizontally transmitted hepatitis B will clear the virus. If his wife did contract hepatitis B, but had cleared the virus before pregnancy there is no risk to their child. If his wife was still infectious when she was pregnant there is a high risk of vertical transmission to the daughter with a similar history to Mohammed's.

If the daughter contracted hepatitis B as a child, from Mohammed himself – for example, through sharing contaminated nail clippers – there is a lower risk of about 30% of developing chronic hepatitis B.

Table 3 summarises the differences in hepatitis B infection according to patient's age at infection.

ANSWER 6

Household contacts of those with hepatitis B infection should be immunised. *The Australian Immunisation Handbook* recommends that all household and sexual contacts of people with hepatitis B should be vaccinated. Some jurisdictions of Australia offer free hepatitis B vaccination to household contacts. However, if the other men in his household were also from endemic areas, they should be tested for chronic hepatitis B infection, and vaccinated if appropriate, irrespective of Mohammed's hepatitis B status.

It is important to inform Mohammed that hepatitis B is not spread through casual or social contact, or through eating food prepared by a person with the virus. The virus is only found in blood and body fluids including saliva, semen, vaginal secretions and breast milk. It is only spread through mother-to-child transmission; sexual contact; contact with unsterilised needles, or other injecting equipment; or biting or sharing personal items that may have been contaminated with blood, such as razors or nail clippers.

ANSWER 7

It is important to acknowledge his fear of the government as it is likely that his experience of governments has not always been benevolent. Explain that Australia will not send him back overseas, especially as he now has a permanent visa, but those in certain professions, such as dentistry, are excluded from practising in those professions. Discuss the importance of contact tracing, public health monitoring and vaccination and explain that these are some of the reasons why the Centers for Disease Control (CDC) collect information about hepatitis B.

Table 3. Differences in hepatitis B infection according to patient's age at infection

	Perinatal	Childhood	Adult
Summary	Acute symptoms are rare, but 80–90% of infants develop chronic or lifelong infection The lifetime risk of advanced liver disease occurring for infected infants is 20–30%	Acute symptoms are uncommon; 30% of children exposed to hepatitis B develop chronic or lifelong infection The lifetime risk of advanced liver disease for children who develop chronic infection is 20–30%	Acute symptoms are common, but there is a less than 5% chance of chronic or lifelong infection The lifetime risk of advanced liver disease among people with chronic infection is 1–2%
Acute symptoms	**Rare**	**Uncommon**	**Common**
Risk of development of chronic infection	80–90%	30%	<5%
Risk of advanced liver disease (% exposed to HBV)	20–30%	5–10%	1–2%
Risk of advanced liver disease (% of those with chronic liver disease)	20–30%	20–30%	20–30%

Adapted with permission[13]

ANSWER 8

A multidisciplinary team could be helpful, especially if its members have experience in supporting people with hepatitis B.

The Hepatitis Council or other nongovernment organisations, such as the Cancer Council in each state, often have culturally and linguistically diverse or multicultural workers who can support people.

Factsheets on hepatitis B in 13 different languages can be downloaded from the website of the Australian Society of HIV Medicine (see *Resources*).[14]

ANSWER 9

You explain that in Australia people can have treatment for hepatitis B if it is needed, such as in cases where the virus is 'winning', but the patient and the virus need to be closely watched. This involves regular blood tests.

In general, there are different phases of hepatitis B and knowing what phase a person is in will help to work out whether it's a good time to start treatment with medication, or not, and what tests to conduct. So, for instance, only a baseline liver ultrasound and α-foetoprotein are usually necessary for people in the immune tolerance phase. Treatment is usually only implemented in the immune clearance and immune escape phases.

Blood tests are usually performed every 6–12 months to monitor for flares of hepatitis, seroconversion, cirrhosis or hepatocellular carcinoma. *Figure 2* outlines each of the phases of hepatitis B infection and their serological and biochemical correlates.

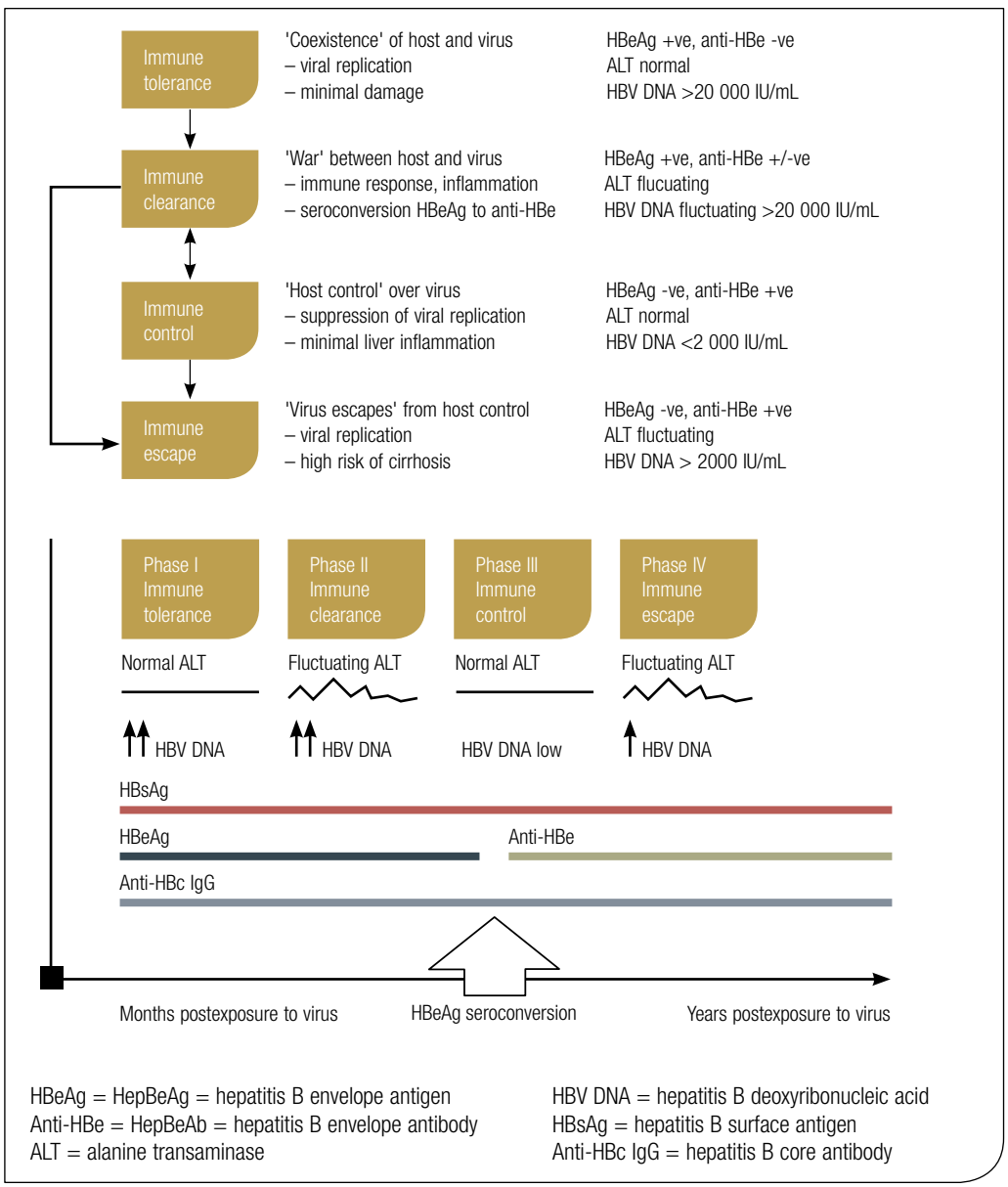

Figure 2. Phases of hepatitis B infection
Adapted with permission[13]

ANSWER 10

Mohammed should not consume alcohol as this will worsen the outcome of antiviral therapy and increase his risk of cirrhosis.

He should ensure that he does not become obese, so he needs to keep fatty food to a minimum. If he has a family history of diabetes he should keep his sugar intake to a minimum and increase his exercise. Obesity and type 2 diabetes increase the risk of hepatocellular carcinoma in those with hepatitis B. Nonalcoholic fatty liver disease and nonalcoholic steatohepatitis increase the risk for progression of liver disease and hepatocellular carcinoma.[13]

If he is smoking he should quit as there is a relationship between smoking and cirrhosis.

Since Mohammed is not immune to hepatitis A it is important to recommend vaccination against hepatitis A, in order to protect the liver from further injury.

ANSWER 11

You need to assess other causes and sequelae of hepatitis and parameters that might be affected by treatment. Each referral centre will have its own protocol, but most will include:

- blood glucose level and fasting lipids (nonalcoholic fatty liver disease)
- thyroid function tests (extrahepatitic manifestation of hepatitis)
- iron studies (haemochromatosis)
- renal function (treatment)
- α-foetoprotein (hepatocellular carcinoma)
- mitochondrial and smooth muscle antibodies (auto-immune liver disease).

ANSWER 12

It is very rare that treatment leads to a cure of hepatitis B infection. The primary goal of treatment is to reduce and maintain the level of hepatitis B virus replication at the lowest possible level. Prolonged viral suppression is associated with an improvement in morbidity and mortality by preventing progression to cirrhosis and hepatocelullar carcinoma.

Treatment is with nucleoside or nucleotide analogues such as lamivudine, entecavir or tenofovir, or with pegylated interferon – which is a long-acting cytokine. Nucleoside/nucleotide analogues have few side effects, but there is a tendency for the development of antiviral drug resistance.[15] Treatment is continued until 12 months after hepatitis BeAg seroconversion. If this does not occur the patient stays on therapy long term.

Pegylated interferon is a weekly injection with many adverse effects, both mild and severe. It can induce a flare of hepatitis and cannot be used in anyone with cirrhosis. It is given for a defined duration of 48 weeks with a 30% rate of hepatitis BeAg seroconversion.[16]

In those who are in the immune clearance phase at the time of treatment, hepatitis BeAg seroconversion to hepatitis BeAb is an important treatment aim as this is associated with a decreased viral load. Hepatitis BsAg seroconversion to hepatitis BsAb is not common and occurs in only 3–8% of people after 48 weeks of pegylated interferon and in less than 5% of those receiving nucleoside/nucleotide analogue treatment.[16]

CASE 3

COMMUNICATING WITH BRANKA ABOUT MANAGEMENT OF HER DIABETES

Branka Silovic, aged 65 years, immigrated from Serbia at 42 years of age. She has long-standing diabetes, treated effectively until recently with metformin. She presents to you with her grandson, who is 14 years of age. Her last HbA1c was 9.2%. You had intended at this consultation to discuss why her control of her diabetes is slipping and consider introducing insulin.

QUESTION 1

How would you assess whether Branka's English language skills are sufficient to conduct the consultation in English?

QUESTION 2

What are the arguments for and against Branka's grandson interpreting?

QUESTION 3

What are red flag clinical conditions or circumstances where an interpreter should be sought if you are uncertain of a patient's English language proficiency?

QUESTION 4

You determine that you need language support. What types of interpreters are available, and what are their relative advantages?

FURTHER INFORMATION

You decide to phone a telephone interpreter.

QUESTION 5

How would you ensure that this does not become an extra long consultation?

QUESTION 6

What is your approach to communication in an interpreted consultation?

QUESTION 7

Branka is concerned about confidentiality. How can you ensure the consultation is confidential?

QUESTION 8

At the end of the consultation, you would like to give Branka some written material in Serbian about insulin and blood glucose monitoring. Where can you access this?

CASE 3 ANSWERS

ANSWER 1

Ask Branka herself. Doctors frequently overestimate the English language proficiency of their patients. One in six Australians over 65 years of age speaks a language other than English at home and, of those, 40% rate themselves as not proficient in English.[17]

ANSWER 2

Family interpreters can be trusted and committed advocates for the patient, but family interpreters are also nonspecialists and are less efficient than professional interpreters. A serious consideration in this case is the quality of the grandson's spoken Serbian, which may not be sufficient for him to interpret complex parts of the consultation. Some elements of patient centred care, such as gynaecological and mental health issues, are often missed when family members act as interpreters.

ANSWER 3

There are five Cs where failure to understand the patient can have serious consequences.

Consent

Obtaining informed consent is a clinical and legal obligation, yet consent processes for those with poor English are frequently undertaken with ad hoc interpreters, or no interpreters at all.

Complex instructions

Complex instructions, which require the use of an interpreter, include those involved in making referrals to other segments of the health system, explaining essential preparations before tests and instruction about medications such as insulin, which need manipulation.

Competence to make health decisions

Decisions about a patient's competence to care for themselves or others, particularly if they wish to decline recommended treatment should not be made without an interpreter.

Crisis

Decisions to urgently transfer patients to hospital, or to intervene in matters in which the doctor has mandated obligations – such as notification of child abuse, or advising patients to stop driving if they are medically unfit – should be undertaken with an interpreter to ensure patients understand. Doctors who have not used an interpreter in these situations may find it difficult to defend their actions should a complaint be made against them.

Chronic illness management

Chronic illness management requires that patients understand their illness, the reasons for management approaches, and in many cases, how to self monitor. Using an interpreter can assist with these tasks.

ANSWER 4

Interpreters work in face-to-face or telephone modes. The idea that face-to-face interpreters are best practice runs deep with doctors, but research has not demonstrated any difference in quality between distant and face-to-face interpreters with experienced doctors.[18] Patients frequently prefer telephone interpreters, as their anonymity can be preserved.

TIS provides free telephone interpreters for doctors charging Medicare rebatable services, their receptionists and practice nurses, as well as some pharmacists. TIS will also arrange prebooked free face-to-face interpreters.

TIS covers more than 120 languages, and in most cases the interpreter can be accessed over the phone within 3 minutes. It is the most extensive and accessible healthcare interpreter service in the Anglophone world.

TIS can be contacted by telephoning its doctors' priority line, which is available Australia wide on 1300 131 450.

Many states and territories also have interpreter services for use in state funded health services. In some jurisdictions, these are also available to GPs. Indigenous languages are not covered by TIS. For further details about TIS, state and territory funded services and how to access interpreter services for indigenous clients and deaf patients who communicate through Auslan please see *Resources*.

ANSWER 5

Efficient use of interpreters demands forethought and preparation. The practice should invest in speaker phones and request TIS code numbers for all its doctors (for more information regarding request forms, see *Resources*), and a list should be kept at the front desk. Ask the receptionist to phone for an interpreter, and while you are waiting, briefly review the patient's notes. When the interpreter comes on line, check first that the patient and interpreter understand each other. If the consultation includes intensive health education, consider asking the practice nurse to undertake this part of the consultation.

ANSWER 6

Interpreted telephone calls are more formal than noninterpreted consultations. Look at the patient and speak directly to them. Use phrases such as 'How do you feel?', rather than ask the interpreter 'How does he/she feel?' Do not use the interpreter as your cultural consultant, and if you do need to specifically talk to the interpreter use some bracketing statements, for example, 'Excuse me, while I just ask the interpreter a specific question.' Sum up at the end of the consultation, and ask the patient if they need to clarify or discuss anything further.

ANSWER 7

Breaches of confidentiality are more likely with ad hoc interpreters. Trained interpreters abide by the AUSIT (Australian Institute of Interpreters and Translators) code of ethics, which foregrounds confidentiality. When requesting an interpreter from TIS, doctors are routinely asked for the patient's name, but they should simply state that it is confidential.

ANSWER 8

To access information about diabetes management in Serbian, see *Resources*.

CASE 4

CATCH UP IMMUNISATION FOR HABIBA AND HER TWO DAUGHTERS

Three new patients present to you 2 weeks after arriving in Australia under the humanitarian program from West Africa. They are Zadie, aged 4 years, Yilla, aged 9 years, and their mother Habiba, aged 32 years.

Prior to arriving in Australia they have lived in a refugee camp in Guinea, where Zadie was born. Habiba says, via an interpreter, that Zadie had immunisations as a little girl. She cannot recall ever having any immunisations herself, and she is uncertain about the number of Yilla's immunisations.

QUESTION 1

How can you find out what immunisations they have had?

FURTHER INFORMATION

From reading the World Health Organization (WHO) report of the Guinea immunisation schedule, you understand that even if Zadie was fully immunised, she has not received the full range of immunisations available in Australia.

QUESTION 2

You need to design a catch up schedule for Zadie. What resources are available to help you design this?

FURTHER INFORMATION

Zadie's healthcare record, which is written in English, reveals that she had age appropriate immunisation to the age of 9 months according to the Guinea schedule. This means Zadie has had diphtheria-pertussis-tetanus (DPT) vaccine at 2, 4 and 6 months of age; oral polio vaccine at birth, 2, 4 and 6 months of age and monovalent measles and yellow fever vaccines at 9 months of age.

QUESTION 3

What are Zadie's catch up immunisation needs now?

FURTHER INFORMATION

Yilla's records show that she has been fully immunised against polio in a campaign run in the camp. Yilla has had one dose of monovalent measles vaccine during an outbreak, and one dose of DPT vaccine at the age of 5 years. There is no record of earlier immunisations.

QUESTION 4

What are Yilla's catch up immunisation needs?

QUESTION 5

In relation to Yilla's incomplete DPT course, which particular vaccine would you use?

QUESTION 6

What catch up immunisation should Habiba have?

QUESTION 7

At what intervals should catch up immunisations be scheduled?

QUESTION 8

Can all these vaccines be supplied to a GP's office by state immunisation providers for the purpose of catch up immunisation?

FURTHER INFORMATION

You complete the immunisations for Zadie, notifying each to the Australian Childhood Immunisation Register (ACIR). Some months later her mother receives a letter from Centrelink informing her that her childcare benefit may be withdrawn because her child is recorded as not fully immunised.

QUESTION 9

What should you do?

CASE 4 ANSWERS

ANSWER 1

A summary of every country's immunisation schedules is provided by the WHO (see *Resources*).

Refugee camps use the immunisation schedule of the host country. Habiba may have a health record for Zadie from the camp, listing the immunisations she's had. Free translations of immunisation records can be provided by TIS (see *Resources*). However, deferring the decision about immunisation until the documents can be translated risks missing the opportunity for catch up immunisation, as refugee patients are often very mobile.

Attempts to check immunity via serology to measles, tetanus, diphtheria and pertussis are more costly than providing the immunisation.

ANSWER 2

The Australian Immunisation Handbook provides a comprehensive overview of catch up schedules for each vaccine, as well as worksheets listing the doses a child should have been given at specific ages. An online calculator to help you work out catch up schedules for patients under 7 years is also available (see *Resources*).

ANSWER 3

Zadie has had a complete primary course of DPT and polio immunisations, and is due for age appropriate 4 year old DPT and polio boosters. She has never had immunisation against *Haemophilus*

influenzae b, meningococcus, mumps, rubella and hepatitis B. She is now too old for immunisation against rotavirus and pneumococcus. She will need to be immunised with the following vaccines:

- *H. influenzae b* vaccine. At her age, only one dose of *H. influenzae b* vaccine (such as Pedvax® or Hiberix®)
- meningococcal vaccine (1 dose)
- hepatitis B vaccine (3 doses), if she is not immune. Refugees should have their serology against hepatitis B checked to ensure they do not have chronic disease
- MMR vaccine (2 doses). The fact that she has had one dose of monovalent measles vaccine should not dissuade you from using MMR to complete catch up immunisation
- diphtheria-pertussis-tetanus-polio vaccine (1 dose, such as Infranrix-IPV®)
- varicella vaccine if not immune (1 dose).

Alternatively, a combination vaccine such as Infanrix-Hexa® could be used to administer the first dose of several of the above vaccines.

ANSWER 4

Yilla has had an incomplete primary course of diphtheria-pertussis-tetanus immunisation. She is not fully immunised against measles, and has not been immunised against rubella, mumps and hepatitis B. She is too old now for catch up *H. influenzae b* vaccine, meningococcal and pneumococcal immunisations. She will need to be immunised with the following vaccines:

- diphtheria-tetanus vaccine. She will need 2 doses to complete her primary course. Although the course was commenced a long time ago, there is no need to start the DPT course from scratch
- hepatitis B vaccine (3 doses), if she is not immune
- MMR vaccine (2 doses).

ANSWER 5

Yilla will need one dose of adult diphtheria-tetanus vaccine (such as ADT®), and one dose of diphtheria-tetanus-acellular pertussis (DTPa) vaccine (such as Boostrix® or Adacel®) to provide some coverage against pertussis.

Children's vaccines containing diphtheria and tetanus toxoids (such as Infanrix® vaccines) are contraindicated in those over the age of 8 years. The dose of diphtheria toxoid in the child's version is fifteen times that of the dose in the adult diphtheria-tetanus vaccine, and the dose of tetanus toxoid in the child's version is twice that of the dose in adult diphtheria-tetanus vaccine. Adults given the children's vaccine may experience a severe local reaction.

ANSWER 6

Adults from war torn countries in Africa have often had no primary immunisation, due to the destruction of primary healthcare infrastructure. In one survey of African migrants in Melbourne, 53% of those over 15 years of age were not immune to tetanus.[19]

Habiba should be offered complete catch up immunisation. She will need to have:

- complete primary diphtheria-tetanus immunisation. The first dose of this should be given as DTPa vaccine, (such as Boostrix® or Adacel®) followed by 2 doses of adult diphtheria-tetanus vaccine
- complete primary MMR immunisation (2 doses)
- complete primary polio immunisation (3 doses)
- hepatitis B immunisation, if not immune. In some states Habiba can access this free of charge as she belongs to a high risk group.

ANSWER 7

The usual accelerated catch up schedule separates immunisation consultations at intervals of one month. Live vaccines (MMR, varicella, influenza) should be administered at the same time or separated by an interval of 1 month. Mantoux assessments cannot be carried out within 1 month of a live vaccine, as it affects the size of the intradermal reaction.

ANSWER 8

The answer to this varies between jurisdictions, and further advice should be sought from your local immunisation coordinator or refugee health service. Many states do not fund catch up immunisation beyond the age of 5 years.

ANSWER 9

ACIR should be informed that Zadie has completed a catch up immunisation program and her immunisations are now up to date. If possible, provide ACIR with the dates of immunisations given overseas. If this is not possible, provide a summary stating the immunisations that have been provided.

CASE 5

AYAANI DOES NOT SPEAK ENGLISH

Ayaani Ali, aged 35 years, is a woman in traditional African dress and hijab. Originally from Ethiopia, she has been in Australia for 6 months. In the last consultation, you addressed Ayaani's concerns, via an interpreter, regarding headaches and epigastric pain and then arranged for screening tests due to her refugee background.

Ayaani smiles when you greet her, but then proceeds to sit with her head downcast and makes little eye contact. You ask Ayaani if she consents again to the use of a professional interpreter. Oromo is her preferred language, so you arrange for an Oromo telephone interpreter.

QUESTION 1

If Ayaani was presenting to you for the first time, how might you increase rapport?

QUESTION 2

What initial questions would you ask to find out about Ayaani's social situation?

FURTHER INFORMATION

You establish that Ayaani is living with relatives who sponsored her to come to Australia. She is living with 10 other family members in a two bedroom house. There is a lot of tension in the house due to overcrowding. You request the help of the social worker at the local migrant resource centre to assist Ayaani, and to put in an application with the Office of Housing and the Community Housing Service.

QUESTION 3

What further information would you like to know about Ayaani's social situation in order to better understand her problems?

FURTHER INFORMATION

You ask Ayaani if she has family members overseas and she begins to weep. She explains that she was in prison for 5 years and was separated from her two children (a daughter aged 16 years and a son aged 12 years) who were being cared for by relatives. Her husband was taken away by a paramilitary unit a month before she was imprisoned and she has no idea where he is. She thinks he is probably dead.

QUESTION 4

How could you assist Ayaani in dealing with the separation from her family members?

FURTHER INFORMATION

Ayaani gratefully accepts the offer of an appointment at the Red Cross to see if a process can be commenced to determine her husband's fate. You give Ayaani your card to pass onto the immigration agent in case a letter of support from you would facilitate the immigration process of her children.

Ayaani is pleased to return to see you in a fortnight and again you engage the services of a professional Oromo telephone interpreter.

QUESTION 5

What resources might you use, before the next consultation, to improve your understanding of Ayaani's background and possible experiences?

QUESTION 6

What types of symptoms might Ayaani be suffering from in relation to trauma and torture and how may they have manifested?

QUESTION 7

You are aware that Ayaani's experiences and world view may be very different to yours. How could you assess her mental state in a culturally acceptable way?

FURTHER INFORMATION

Ayaani states that she is rarely hungry and thinks she has lost weight. She has trouble falling asleep because she worries about her children, and suffers with bad dreams 2–3 times per week. She cries out in the dreams and wakes the other people in the room, which, she says, causes her shame and embarrassment. When you ask what the nightmares are about, she puts her head in her hands and cannot speak for a few moments.

QUESTION 8

How might you ask sensitively about a torture and trauma history?

FURTHER INFORMATION

At this point Ayaani confides softly that during her 5 years in jail, she was repeatedly raped, became pregnant and gave birth to a son, whom she was permitted to keep for a year before he was taken from her. She does not know where he is. She wants to find him. She weeps quietly into her hands as you and the interpreter look on, stunned into silence.

QUESTION 9

How would you respond to a disclosure of trauma?

FURTHER INFORMATION

You decide at this point that Ayaani needs specialised counselling. You also prescribe a selective serotonin reuptake inhibitor for depression, carefully explaining the reason for prescribing and that it will take time to work. You start with a low dose to reduce possibility of adverse reactions, which may evoke traumatic memories.

QUESTION 10

What psychological interventions and services may be appropriate for refugees experiencing trauma?

QUESTION 11

How might you continue to support Ayaani?

CASE 5 ANSWERS

ANSWER 1

Rapport can be increased by:

- engaging the use of a professional interpreter in the patient's preferred language after obtaining consent
- demonstrating some knowledge of the process of resettlement of refugees, and some knowledge of the person's country of origin
- allowing adequate consultation time. If there are several issues to address, explain that you will be able to deal with some issues at this consultation, but you would like to see the person again several times to get to the bottom of their concerns
- using a gentle and holistic approach that respects the frequently comingled diagnoses of organic pathology and the possible presence of mental health problems
- obtaining a careful history and seeking permission before performing a thorough, respectful examination that engenders a sense of safety
- dealing with pressing patient concerns.

FEEDBACK

The medical setting can also evoke memories and physical sensations associated with torture and trauma. Medical personnel and equipment may be used in various forms of torture. The process of a pap smear may evoke memories of rape or female genital mutilation/cutting. Even history taking may remind survivors of interrogation.[20] Such reactions can be minimised if time is taken to explain, and a professional interpreter is used.

ANSWER 2

Ask first about immediate problems – present circumstances and stressors of resettlement, for example, by asking:

- 'Who is in your household?'
- 'How are you coping with classes?'
- 'Do you have enough money for the things you need every day?'

FEEDBACK

Unfortunately, resettlement does not always go smoothly and may exacerbate mental health problems.[21] Common issues seen in general practice include:

- breakdowns in relationships between the newly arrived individual/family and the sponsor
- housing stress and homelessness
- financial worries
- difficulties dealing with Centrelink, Job Network, and English language programs
- everyday issues such as public transport and finances, and experiences of racism.

The ongoing separation from relatives, who may be in unsafe situations overseas, may also cause ongoing anxiety and guilt in the newly arrived person who is now relatively safe.

ANSWER 3

Establish who is in Ayaani's current household, then consider those family members who may be missing. A genogram is a useful tool.

ANSWER 4

At the very least, expressing concern and understanding that Ayaani is experiencing such a painful separation is usually perceived by refugee patients to be very supportive.

A referral to the local Red Cross tracing service may be offered. A doctor's letter of support to help in the children's application may also be helpful at some stage.

ANSWER 5

Several websites (see *Resources*) provide general information about cultural beliefs and practices, as well as political and living conditions in the person's country of origin, and countries of first and second asylum. However, it is important to remember that people are also individuals within their own culture and may have their perspective on beliefs and practices. There is no substitute for questions such as 'What do you think?' and 'What do you believe about this?'

FEEDBACK

Almost all people from refugee backgrounds have been exposed to traumatic events such as threats to personal safety, forced displacement, perilous flight and separation from family members.[20] Many have also experienced torture – beatings, sham execution, sexual assault and have witnessed the torture of others.[20] It is also common for refugees to have suffered extreme poverty and deprivation, loss of their home, material goods, community and ancestral lands. Prolonged periods in refugee camps with disruption to education and work may have profound consequences on self esteem and on the ability to resume education and training in the future.

ANSWER 6

Table 4 describes common physical and psychological symptoms of torture and trauma.

Table 4. Effects of trauma[22]

Physical	Psychological
• Musculoskeletal and soft tissue injuries • Head trauma • Chronic and regional pain syndromes • Impairment of vision/hearing • Dental problems due to trauma • Motor and sensory neuropathy, gait disturbance • Female: amenorrhoea/ dysfunctional uterine bleeding, sexual assault injuries, pelvic pain, problems related to female genital mutilation • Male: erectile dysfunction, genital pain • Sexually transmitted infections, sexual dysfunction	• Post-traumatic stress disorder – re-experiencing phenomena: intrusive distressing memories, flashbacks, nightmares – avoidance and emotional numbing – hyperarousal: exaggerated startle response, poor sleep, irritability • Complex PTSD – dissociation, personality change, poor relationships, aggression, self harm, loss of meaning in life • Cognitive impairment • Somatisation • Anxiety disorders • Depressive disorders • Grief, which may be complicated and chronic • Psychosis • Substance abuse

Persistent pain should be investigated in relation to the possibility of physical trauma and injury related to torture (also consider infectious and rheumatological causes), not simply dismissed as being psychosomatic in origin.[23] A high degree of somatic symptoms should also prompt screening for post traumatic stress disorder (PTSD).[24]

ANSWER 7

Ask Ayaani about the following:

- appetite
- energy levels
- daily activities
- memory
- concentration
- sleep disturbance
- mood.

Note her reaction then ask about her plans for the future. A question about any 'big worries' she may have could elicit useful information – from housing issues, to intrusive memories, even psychotic phenomena. These questions appear to have wide cross cultural applicability.[20]

ANSWER 8

It is appropriate to put forward a little knowledge about the likelihood of maltreatment, but is not necessary to get every detail of the trauma. This may retraumatise the patient.

In Ayaani's case, a helpful question might be: 'I have heard that some women are treated very badly in jail in some African countries. You do not have to tell me all the details, but is there anything that happened that you think may be affecting your health today?'

Table 5 lists other examples of appropriate questions.

Table 5. Culturally appropriate screening for trauma[22]

'Are there any health problems for you/your children that you are very worried about today?'

'Has anything happened to you/your family in the past, which you think might be causing this problem you have today?'

'What was happening to you/your family when this problem started?'

'Many people in your situation have experienced trauma – I do not need to know the details, but has anything like this happened to you?'

'Sometimes people's health problems in Australia are due to things that have happened in the past, such as violence or detention [or specify the difficult circumstances if you know them]. Do you have any injuries or pain from those experiences that may need attention?'

'In your culture, is this problem considered serious? What is the worst problem it could cause you? What is usually done to make the problem better?'

ANSWER 9

Acknowledge the pain and severity of the experience: 'What a terrible thing to have gone through,' and the normality of her response: 'That is a terrible sadness for any person to bear.'[20]

It is important to offer hope without false or facile reassurance: 'Many people find that as they settle in Australia, over time, things begin to get a little better. I am keen to help you feel better.'

FEEDBACK

Ayaani has disclosed a significant trauma history and symptoms that suggest both a degree of depression and possibly PTSD. It would be appropriate to gently and systematically elicit more information about her symptoms – without delving into detail – and the events that may have caused them. In terms of PTSD, ask in more detail about intrusive memories, flashbacks, hypervigilance and irritability, and numbing and avoidance phenomena.

A comprehensive psychosocial assessment includes noting countries of origin and transit, date of arrival in Australia, immigration and visa status, preferred language and religion, family composition and functioning, a thumbnail sketch of trauma history, current stressors, social supports and agencies involved, and an assessment of mental state – screening for symptoms of depression, anxiety, post traumatic stress and psychosis if there is a clinical suspicion of these.[20]

ANSWER 10

Psychological interventions, which have been shown to be effective, include cognitive behavioural therapy, exposure therapy (the individual exposes themselves to trauma related thoughts and feelings in an attempt to reduce them) and the testimony method (the individual tells their story).[20,25–27]

For problems related to a person's refugee background, a specialised refugee torture and trauma service is appropriate. When discussing a referral for counselling with the patient, it is helpful to link this to the specific problem, such as nightmares, and explain that there are services in Australia that specialise in assisting refugees with these problems.[20]

ANSWER 11

A framework based on the three components of establishing safety, assisting remembrance and mourning, and facilitating reconnection to the wider community has been proposed by Judith Herman.[28]

The GP has an invaluable role in helping the refugee patient feel safe, through the reassurance of:

- physical examination
- investigation
- explanation of results and referral
- acting as an advocate with public hospitals, allied health, housing authorities, Centrelink and immigration personnel
- limited cognitive behavioural therapy where appropriate and exercises such as relaxation, activity scheduling and sleep hygiene
- ongoing monitoring for the development of chronic disease.

Encouraging the patient's efforts with education, involvement in the local community and use of its facilities, such as the library, assists in the vital task of connecting to a new community and working towards the future. Encouraging the patient to participate in their religious practice, if appropriate, can also be helpful.

As the GP, over time, becomes informed of the patient's story, it is possible to facilitate the patient's mourning. New problems in their country of origin may trigger their symptoms, and anniversaries, or the death of a close family member overseas become an opportunity for the GP to show support and allow the patient to grieve.[22]

CASE 6

HOW WOULD YOU DISCUSS PALLIATIVE CARE FOR TABITHA?

Tabitha, aged 52 years, is an Aboriginal Australian. She lives about 1 hour's drive from a regional cancer centre. She is currently undergoing chemotherapy for stage IV nonsmall cell cancer of the lung. She has known metastases in the chest wall, thoracic spine and liver. A recent onset of headaches has raised the possibility of cerebral metastases. Aside from headaches, other problems include chest pain, anorexia and weight loss and fatigue.

Tabitha has been seeing you throughout her illness. As a result of the complexity of symptoms in the face of progressive disease, you consider referring her to a palliative care service.

QUESTION 1

What cultural issues need to be considered when raising the issue of this referral with Tabitha to ensure this discussion is framed in a culturally sensitive manner?

FURTHER INFORMATION

As a result of the discussion around referral to palliative care, Tabitha's family become concerned that the doctors want to start discussions around the fact that she is dying.

QUESTION 2

How are the expressions 'death' and 'dying' viewed by some Aboriginal and Torres Strait Islander people, and why is this distressing for some of them?

FURTHER INFORMATION

As a result of the conversations initiated regarding death and dying, Tabitha makes it very clear that as she becomes sicker, her preference is not to go to hospital and states above all else that she wishes to die at home.

QUESTION 3

Where is the preferred place of death for most Aboriginal and Torres Strait Islander people?

CASE 6 ANSWERS

ANSWER 1

Past experiences have left many Aboriginal and Torres Strait Islander people with a deep distrust of mainstream services. As a result, many are fearful of services and hesitantly connect with mainstream services. This includes palliative care services. Furthermore, palliative care may be seen by some groups as distressing because of the implication that linkage with palliative care will almost certainly result in death. Consequently, palliative care is rarely accessed by Aboriginal and Torres Strait Islander people.

At a personal level, when discussing issues, such as referral to palliative care services, it is important to seek assistance from the patient as well as their family, to understand each of their preferences on how medical care should proceed. This includes agreement on disclosure of issues such as prognosis and accommodation of preferences, so that as many family members as possible can visit and spend time together.

Whenever possible, seek advice from the person and their family on whether they would like an Aboriginal health worker to be contacted, either through the hospital system or Aboriginal health services. This is especially important so the cultural diversity of Aboriginal and Torres Strait Islander people can considered and respected.

It is important to establish rapport and ensure clear communication with all. This includes checking whether an interpreter is necessary.

ANSWER 2

It is incorrect to assume that each member of Aboriginal and Torres Strait Islander communities holds the same belief. However, for many

people, the expressions 'death' and 'dying' are frightening. Due to the high rates of mortality in the Aboriginal and Torres Strait Islander communities, contact with death occurs on a regular basis. Death is viewed as an event associated with great sorrow and sometimes with fear.[29]

However, it is most important that an appropriate approach to discussing the severity of the illness is found. This may involve:[30]

- identifying who the most important members of the family are to inform you about traditions, customs and cultural values
- enquiring about how the family could be included in the discussions as much as possible, acknowledging that not all family members are related through blood ties
- checking, in a respectful manner, that the language being used for the discussion is understood
- ensuring the decisions are being made are by the person and their family
- ensuring that adequate time is taken, in a place as comfortable as possible, for the person and their family.

ANSWER 3

Like the majority of Australians, the preferred place of death for most Aboriginal and Torres Strait Islander people is at home. When providing support to indigenous people it is important to identify whether they are referring to the place they live in, or if the request to die at home involves a return to the person's place of birth.

If a return to a person's place of birth is not possible, every attempt to meet the their specific cultural needs and preferences should be made. Aboriginal and Torres Strait Islander health workers may be a valuable resource, as are the family and friends of the dying person. Even if a person is hospitalised, very simple strategies include:[30]

- encouraging people to bring items from home such as photos, quilts or other personal items
- ensuring, where possible, that the person is located in a part of the hospital that has ready access to outdoor seating and space for larger family groups
- ensuring that artwork is appropriate
- ensuring family members are given an orientation to the ward area so it is clear where services are located.

At the time of death, it is important for the hospital to be prepared for large numbers of people to be present, some of whom may be crying, or wailing. After death, the family may wish to spend 'sorry time' with the person who has just died.[29] This is a very important time for which there is no set pattern or time – it is highly individual and hospitals need to be prepared to respect this.

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RESOURCES FOR DOCTORS

General

- Australian Society of Infectious Diseases. Guidelines for the diagnosis, management and prevention of infections in recently arrived refugees, 2009. Available at www.asid.net.au/images/Documents/Guidelines/RefugeeGuidelines.pdf
- Information on a range of medical conditions in multiple languages is available in searchable databases from the NSW Multicultural Health Communication Service. Available at www.mhcs.health.nsw.gov.au/index.asp and the Victorian Health Translations Directory, available at www.healthtranslations.vic.gov.au/bhcv2/bhcht.nsf
- Ethnomed provides patient education material in various languages, as well as information on culture and a range of topics related to health. Available at http://ethnomed.org
- SBS Screen Australia. 'I'll call Australia home: refugee families from Burma and Sudan discover the joys and challenges of their new Australian home' 2008. For information go to www.nfsa.gov.au/collection/film-australia-collection/program-sales/search-programs/program/?sn=9193
- The Victorian Refugee Health Network provides information on services, clinical protocols and links to other resources for GPs and other healthcare workers. Available at www.refugeehealthnetwork.org.au.

Translating and interpreting

- Department of Immigration and Citizenship's Translating and Interpreting Service. National telephone number: 1300 131 450
- Request form for TIS National Client Code. Available at www.immi.gov.au/living-in-australia/help-with-english/help_with_translating/_pdf/medical-practitioners-client-code.pdf

- Pharmacists in your region who can access TIS and explain medications to patients through interpreters are available at www.immi.gov.au/living-in-australia/help-with-english/help_with_translating/free-services.htm#c.
- Information on accessing and working with an interpreter, as well as a comprehensive list of publicly funded health interpreting services in Australia is explained in an article by Phillips CB. Using interpreters: a guide for GPs. Aust Fam Phys 2010;39(4):188–195. It is available at www.racgp.org.au/afp/201004/36800.

Immunisation

- World Health Organization's immunisation schedule is available at http://apps.who.int/immunization_monitoring/en/globalsummary/scheduleselect.cfm
- Australian Immunisation Handbook. Available at www.health.gov.au/internet/immunise/publishing.nsf/content/handbook-home
- Worksheets listing the immunisations a child should have at certain ages is available at www.health.gov.au/internet/immunise/publishing.nsf/Content/handbook-catchup#t135
- Online calculator to help doctors work out catch up immunisation schedules for patients under 7 years is available at www.health.sa.gov.au/immunisationcalculator.

Mental health

- The Victorian Transcultural Psychiatry Unit helps support mental health services in working with consumers, carers and communities from diverse backgrounds. Available at www.vtpu.org.au/resources/communityprofiles.html.

Palliative care and indigenous health

- Caresearch provides palliative care information and evidence for doctors and patients. Available at www.caresearch.com.au
- Providing culturally appropriate palliative care to Aboriginal and Torres Strait Islander People: a resource kit. The National Palliative Care Strategy Electronic Resource. Available at www.health.gov.au/internet/main/publishing.nsf/Content/Palliative+Care-1.

Medicare item numbers relevant to refugees and other humanitarian entrants

- Australian Government Department of Health and Ageing MBS health assessment for refugees and other humanitarian entrants. Available at www.health.gov.au/internet/main/publishing.nsf/Content/mbsprimarycare_mbsitem_refugees.

RESOURCES FOR PATIENTS

- ASeTTS (Association for Services to Torture and Trauma Survivors)
  286 Beaufort Street, Perth WA 6000
  P: 08 9227 2700
  E: reception@asetts.org.au
  W: www.asetts.org.au
- Companion House
  41 Templeton Street, Cook ACT 2614
  P: 02 6251 4550
  E: info@companionhouse.org.au
  W: www.companionhouse.org.au
- Foundation House (Victorian Foundation for Survivors of Torture)
  6 Gardiner Street, Brunswick VIC 3056
  P: 03 9388 0022
  E: info@foundationhouse.org.au
  W: www.foundationhouse.org.au
- Melaleuca Refugee Centre (Torture and Trauma Survivors Service of the Northern Territory)
  Shop 33, Rapid Creek Business Village
  48 Trower Road, Millner NT 0810
  P: 08 8985 3311
  E: admin@melaleuca.org.au
  W: www.melaleuca.org.au
- Phoenix Support Service for Survivors of Torture and Trauma
  1st Floor, 191 Liverpool Street, Hobart TAS 7000
  P: 03 6221 0999
  E: phoenix@mrchobart.org.au
  W: www.mrchobart.org.au/_webapp_1094649/Phoenix_Centre
- QPASTT (Queensland Program of Assistance to Survivors of Torture and Trauma)
  28 Dibley Street, Woolloongabba QLD 4102
  P: 07 3391 6677
  E: admin@qpastt.org.au
  W: www.qpastt.org.au
- STARTTS (Service for the Treatment and Rehabilitation of Torture and Trauma Survivors)
  152–168 The Horsley Drive, Carramar NSW 2163
  P: 02 9794 1900
  E: startts@sswahs.nsw.gov.au
  W: www.startts.org
- STTARS (Survivors of Torture and Trauma Assistance and Rehabilitation Service)
  12 Hawker Street, Bowden SA 5007
  P: 08 8346 5433
  E: sttars@sttars.org.au
  W: www.sttars.org.au.

Multicultural health

In order to qualify for 6 Category 2 points for the QI&CPD activity associated with this unit:

- read and complete the unit of *check* in hardcopy or online at the *gplearning* website at www.gplearning.com.au
- log onto the *gplearning* website at www.gplearning.com.au and answer the following 10 multiple choice questions (MCQs) online
- complete the online evaluation.

If you are not an RACGP member, please contact the *gplearning* helpdesk on 1800 284 789 to register in the first instance. You will be provided with a username and password that will allow you to access the test.

The expected time to complete this activity is 3 hours.

Do not send answers to the MCQs to the *check* office. This activity can only be completed online at www.gplearning.com.au.

If you have any queries or technical issues accessing the test online, please contact the *gplearning* helpdesk on 1800 284 789.

QUESTION 1

Arghavan, aged 26 years, is a refugee from Afghanistan. She presents to your general practice for the first time and you undertake a health assessment. Which of the following is true regarding a health assessment billed under the Medicare Benefits Schedule (MBS) for refugees and other humanitarian entrants in to Australia?

A. It must be performed on all new immigrants

B. It must be provided within 2 months of the person's arrival in Australia, or grant of visa

C. It should generally be undertaken by the patient's usual GP

D. It is not necessary to record consent

E. A separate consultation should not be billed on the same day under any circumstances.

QUESTION 2

Rashad, aged 32 years, is a refugee from Ethiopia who presents to your practice for the first time. You consider what screening investigations you should request for him. Which of the following would generally not constitute a screening investigation for a newly arrived adult refugee?

A. Vitamin B12 level

B. Thyroid function tests

C. Thick and thin blood films and malarial antigen

D. Syphilis serology

E. Stool specimen for faecal parasites.

QUESTION 3

Sumalee, aged 32 years, immigrated from Thailand 6 months ago. She presents to you to discuss planning a pregnancy. You test her hepatitis serology, which reveals that she is hepatitis BsAg positive, hepatitis BcAb positive, hepatitis BeAg negative and hepatitis B eAb positive. Her ALT is normal and hepatitis B DNA is 1500 IU/mL.

You ascertain that she acquired hepatitis B infection via vertical transmission. Which of the following is true?

A. Her results are consistent with the immune escape phase

B. She requires treatment with medication at this stage

C. She is in the most infectious stage

D. Household contacts do not need to be vaccinated

E. She could be at risk of advanced liver disease.

QUESTION 4

Chia Ling, aged 76 years, recently immigrated from rural China. She presents to you, an experienced GP, for the first time with her daughter. You consider whether you should use a professional interpreter and, if so, what type of interpreter would be most appropriate. Which of the following applies to the use of interpreters during a consultation with a patient from a culturally and linguistically diverse background?

A. Family members are generally as efficient as professional interpreters

B. Face-to-face interpreters provide a better service than telephone interpreters

C. Patients frequently prefer face-to-face interpreters

D. Telephone interpreters are provided by the Translating and Interpreting Service (TIS) free of charge for doctors charging Medicare rebatable services

E. General conversation with the patient is the means by which to assess the need for an interpreter.

QUESTION 5

Reshmi, aged 35 years, recently immigrated from India. You engage the services of a face-to-face interpreter to assist you in the consultation. Which of the following is true when using a professional face-to-face interpreter?

A. Speak directly to the interpreter

B. Use phrases and questions such as: 'How do you feel?' – instead of asking the interpreter 'How does he/she feel?'

C. Give the full name and contact details of the patient to the interpreter when asked

D. Use the interpreter as a cultural consultant if unsure of cultural details

E. Ask the interpreter whether they think the patient needs to clarify anything.

QUESTION 6

Maajida, aged 6 years, fled with her family from Yemen – due to religious persecution – to a refugee camp in Eritrea before coming to Australia. She presents to your practice for catch up immunisation. Which of the following applies to immunisation including catch up immunisation in refugee children?

A. Refugee camps use the immunisation schedule of the country from which the person originated
B. The decision to immunise should be deferred while awaiting translation of immunisation records
C. The usual accelerated catch up schedule separates immunisation consultations at intervals of 2 months
D. If one dose of tetanus was given earlier in childhood, there is no need to start a course of tetanus immunisation from scratch
E. If one dose of monovalent measles vaccine has been given, this should dissuade you from using measles-mumps-rubella (MMR) to complete catch up immunisation.

QUESTION 7

Maajida's father, Maahir, aged 35 years, is also a refugee. He presents to your practice for catch up immunisation. He is not sure if he has ever had any immunisations. Which of the following applies to catch up immunisation in adult refugees?

A. Children's vaccine containing diphtheria and tetanus can be administered in place of the adult vaccine containing diphtheria and tetanus
B. One dose of polio vaccine is sufficient in adults if a complete primary course of polio immunisation has not been given in childhood
C. Live vaccines, such as MMR vaccine and varicella vaccine, cannot be administered at the same time
D. Serology to tetanus should generally be checked prior to immunisation
E. Hepatitis B serology should generally be checked prior to immunisation.

QUESTION 8

Bohlale, aged 50 years, is from Africa and discloses to you in a consultation that she was tortured in the setting of civil war prior to immigration to Australia. In assessing and managing the psychological effects of torture and trauma in general, which of the following is true?

A. Systematic questioning about the details of torture or trauma can help build rapport
B. A question about any 'big worries' appears to have wide cross-cultural applicability
C. Persistent pain should be dismissed as psychosomatic in origin
D. The patient can be reassured that psychological symptoms, as a result of torture, usually quickly resolve following immigration
E. The testimony method has not been shown to be effective.

QUESTION 9

Farrah, aged 36 years, is from Iraq. She declines to talk about her experiences in jail where she was falsely imprisoned. She describes herself as 'always being on edge', is unable to sleep and is frequently irritable with her family. She has frequent distressing flashbacks of her experiences in jail and feels a sense of panic when she goes to her local shopping centre and sees security guards at the bank and supermarket. Lately she has been avoiding these types of situations. These symptoms have been going on for the past 6 months and are affecting her relationships with her family members. What is the most likely diagnosis?

A. Generalised anxiety disorder
B. Panic disorder
C. Major depression
D. Post-traumatic stress disorder
E. Schizophrenia.

QUESTION 10

Carmel, aged 52 years, identifies as Aboriginal. She is dying from metastatic lung carcinoma. Recognising that there are individual differences within any one cultural group, which of the following is true regarding the view of many Aboriginal and Torres Strait Islander people on death and dying in general?

A. They view linking with palliative care services as reassuring
B. They view death as a hopeful event
C. They view family input in discussions as important
D. They view dying in hospital as more desirable than dying at home
E. They view leaving the person who has just died alone as essential for grieving.