

# Pod people

## *Response of family physicians and family practice nurses to Kosovar refugees in Greenwood, NS*

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### abstract

**OBJECTIVE** To explore roles of family physicians and family practice nurses who provided care to Kosovar refugees at Greenwood, NS.

**DESIGN** Qualitative study based on individual interviews with family physicians and family practice nurses.

**SETTING** Family practices in Halifax, NS.

**PARTICIPANTS** Six family practice nurses, four physician faculty members, four community-based family physicians, and two family medicine residents were interviewed. Participants were purposefully chosen from the roster of service providers.

**METHOD** All interviews were conducted by one of the researchers and were semistructured. Interviews lasted approximately 30 minutes and were immediately transcribed. Key words and phrases were identified and compared with subsequent interviews until saturation was achieved.

**MAIN FINDINGS** Data yielded four analytical categories: the clinical encounter, expectation and experience, role and team functioning, and response. Participants reported how providing care in the context of a refugee camp was both similar to and different from their daily activities in family practice, as were their working relationships with other health care professionals.

**CONCLUSION** Primary care for refugees during complex health emergencies is often underreported in the literature. Yet family practice physicians and nurses recounted that they had the requisite skills to provide care in such a context.

### résumé

**OBJECTIF** Examiner les rôles des médecins de famille et des infirmières en pratique familiale qui ont dispensé des soins aux réfugiés du Kosovo à Greenwood, N.-É.

**CONCEPTION** Une étude qualitative fondée sur des entrevues individuelles avec des médecins de famille et des infirmières en pratique familiale.

**CONTEXTE** Des pratiques familiales à Halifax, N.-É.

**PARTICIPANTS** Six infirmières en pratique familiale, quatre médecins de famille membres du corps professoral, quatre médecins de famille basés dans la communauté et deux résidents en médecine familiale ont été interviewés. Les participants ont été choisis à dessein à partir d'une liste de dispensateurs de soins.

**MÉTHODOLOGIE** Toutes les entrevues semiestructurées ont été réalisées par l'un des chercheurs. Les entrevues duraient environ 30 minutes et faisaient immédiatement l'objet d'une transcription. Des mots et des phrases clés ont été identifiés et comparés avec des entrevues subséquentes jusqu'à saturation.

**PRINCIPALES CONCLUSIONS** Les données ont permis de cerner quatre catégories analytiques: la rencontre clinique, les attentes et l'expérience, le rôle et le fonctionnement de l'équipe et la réponse. Les participants ont signalé que la prestation des soins dans le contexte d'un camp de réfugiés comportait à la fois des similarités et des différences avec leurs activités quotidiennes dans la pratique familiale, de même que leurs relations de travail avec les autres professionnels de la santé.

**CONCLUSION** Les soins de première ligne dispensés aux réfugiés dans le contexte d'urgences de santé complexes sont rarement relevés dans les ouvrages scientifiques. Pourtant, les médecins et les infirmières en pratique médicale ont rapporté avoir les compétences requises pour dispenser des soins dans un tel contexte.

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**I**n recent years, wars and “internal” conflicts, population movement, hunger, and death, collectively called “complex humanitarian emergencies,”<sup>1</sup> have resulted in an increased burden on civilian populations throughout the world. The number of refugees and internally displaced populations has increased more than six times since 1970, and refugees are now estimated to constitute about 1% of the global population.<sup>2</sup> While much current literature stems from the conflict in the Balkans,<sup>3,5</sup> the effect of such population dislocations on public health has come under scrutiny in a variety of geopolitical contexts,<sup>1,6-11</sup> occasionally with particular reference to providing primary care.<sup>12,13</sup>

Attention has focused most recently on Kosovo. Refugee camps sprang up again in Europe in May 1999, with more than 900 000 people displaced from Kosovo. Families in the neighbouring countries of Montenegro, Albania, and Macedonia hosted some of the dislocated people. Another 50 000 were evacuated to other countries, including Canada. Two military bases were selected for initial processing in Canada: Canadian Forces Base (CFB) Trenton in Ontario and CFB Greenwood in Nova Scotia’s Annapolis Valley. The Greenwood base received nearly 2400 Kosovars during May 1999, as part of the Canadian government’s effort to respond to the most recent Balkan crisis.

To process the large number of arrivals (250 every 48 hours), a substantial effort was required. Volunteers were recruited from health care facilities in the Halifax area, Dalhousie University, Nova Scotia’s Western Regional Health Board, and throughout the Maritime Provinces. Planning was coordinated with the Canadian Forces; Customs and Immigration Canada; the Laboratory Centre for Disease Control in Ottawa, Ont; and Nova Scotia’s public health officials. Medical aspects were coordinated by the Dalhousie Department of Family Medicine.

Over the course of 72 hours, comprehensive health facilities were created in a World War II-era aircraft hangar to provide medical care and immunization. Nine planeloads of Kosovar refugees were processed in 19 days through the efforts of more than 300 health professionals. Nurses from ward services, emergency rooms (pediatric and adult), and family practice constituted the largest group (123), followed by emergency

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room, pediatric, and family practice doctors (89); laboratory staff and phlebotomists (65); medics (12); and respiratory technologists (12). One “red room” was outfitted for the most ill, and 10 other clinical “pods” composed the clinic set-up. Each clinical pod team consisted of a physician, two nurses (covering pediatric and adult medicine), an armed forces medical technician, a laboratory technician, and a translator. This qualitative study aimed to understand the role of a subset of this personnel, family physicians and family practice nurses, in providing medical screening and care to Kosovar refugees.

## Methods

One-on-one interviews were selected for the study to allow family doctors and family practice nurses to express their observations about working in the pods with other health professionals. While there is no accepted number for in-depth interviewing (estimates range from 10 to 60),<sup>14</sup> this study purposefully sampled<sup>15</sup> the service roster to enrol different kinds of family physicians and family practice nurses. Six nurses employed by the Department of Family Medicine, four physician faculty members, four community-based family physicians, and two family medicine residents were interviewed. Ethics approval was obtained from Dalhousie’s Faculty of Medicine and written consents were obtained.

All interviews took place in the first 3 weeks of June, approximately a month after the first Kosovars arrived at CFB Greenwood. Interviews were semi-structured to allow comparison but were conducted informally in a private setting to allow participants to convey their experience openly and freely. Each interview was conducted by one team member (P.T.) and lasted approximately 30 minutes.

## Analysis

Interviews were audiotaped and transcribed verbatim and checked by the research associate who conducted the interviews. For each interview, key words or phrases were identified and compared with subsequent interviews until no significant new ideas emerged. Once researchers were satisfied that saturation<sup>16</sup> had been achieved, words and phrases were grouped into larger conceptual categories. A second researcher (F.B.) reviewed a subset of transcripts and critiqued and confirmed the preliminary categories. This process was repeated until the categories were clear. These categories became the basis for a coding structure within QSR NUD\*IST, software designed for textual analysis.<sup>17</sup>

## RESEARCH

### Pod people

#### Findings

Four analytical categories were developed from the data: the clinical encounter, expectation and experience, roles and team functioning, and response. Participants reported that working with Kosovar children, adolescents, elderly people, men, and women was not terribly different from the day-to-day work of family practice. Working with others within the pods was a common theme among both physicians and nurses. To capture the importance of this, comments from both groups are presented together throughout the findings.

**Clinical encounter.** Physicians identified medical assessment as their primary function. They intended to identify issues that required attention in the next 24 to 48 hours. Nurses described their main services as taking blood pressures, pulses, and temperatures and giving immunizations. Nurses also played a critical role coordinating the processing, ensuring that required procedures were complete for each person and documented. One said, "There was no question as to what the objective was. It was just get the families taken care of, make sure we found out what the needs are and deal with them, and help [the refugees] as quickly as we can and making sure that they're comfortable."

A nurse observed that they "didn't see a lot of acute problems" in the clinical pods, as most of these went to the red room. A physician concurred, suggesting that "as far as what I actually saw and dealt with that day, there were few medical needs that needed to be attended to." Hypertension and diabetes were two clinical issues frequently identified: "almost in every family someone had high blood pressure." Although it later emerged as an important area of activity for public health officials, only two participants mentioned tuberculosis. As one participant concluded, clinical encounters with the Kosovars, even in the temporary clinic at CFB Greenwood, were largely characterized by "the stuff of family practice."

Every physician cited the language barrier or requiring a translator as a chief challenge in the clinical encounter. Interpreters were "getting more information and then they just didn't pass on that information to us unless [we] really pried." Several physicians expressed frustration with this intermediary. The following is a typical example.

I still don't know exactly what I wasn't told, but there was a lot that—I mean, you'd ask a question, "Are you having any pain?" and there'd be a 5-minute answer, and then the interpreter would turn to you and go, "No, no problems." And you knew that there was a whole lot more going on that they

were talking about, but you don't know. I have no idea whether they were talking about something totally different or talking about something 10 years ago that the interpreter decided was irrelevant.

That interpreters acted as a "filter," to quote another informant, made some questioning more difficult. Mental health was cited as a difficult area of inquiry. One physician cited time constraints, while another consciously chose "not to go so much into their mental needs, because I couldn't do anything with [them]: one, I couldn't pursue [the question] further, and [two] they had then the next tier, which was the psychological assessment."

**Expectation and experience.** Nurses occasionally did some assessment work through the interpreter, but this activity was constrained because there was only one interpreter per pod. Participants were divided about how they approached going to CFB Greenwood. Some expressed anxiety; others did not. A nurse suggested that those returning from the base and retelling their experience assuaged any hesitancy she might have had. Another said "I wasn't sure then what my role might be and... thought I'd be looking after sicker people and that I would be needing to do more assessments and things that maybe I wasn't as familiar with doing in the clinic setting here. But it turned out that that was not the case." Similarly, a physician said, "I don't know that I expected it to be all that much different [from] what I do day to day, and in many ways the pod thing was very comfortable...."

How the pods functioned was important for all participants. Nurses thought that the organization of the base was excellent and that they were professionally prepared to carry out the necessary tasks. One participant captured this: "Once we... got there, got oriented, it was like, 'okay. It's fine now.'" Another nurse said, "Once we got down there and got oriented and realized how it was to be done, that it was a general screening and that people were actually fairly healthy,... I guess what I would say is I thought we would be doing more assessing, but what we did do was fine." Physicians echoed this: "Initially you think, 'My goodness, you know, this can be a tremendous task.' But actually once you get to it, it was quite simple."

**Roles and team functioning.** Given the central role of the temporary clinics and the mix of professionals, researchers posed specific questions about team interaction. Participants expressed great satisfaction

with team functioning (**Figure 1**). A physician noted that the teams “worked out really well,” while a nurse said that team functioning was “the most amazing part” of the experience. A physician stated bluntly, “The object of the exercise was to take your group of strangers [the pod team] and work together to get a task done.” Family practice nurses found the experience affirmed their skills as primary care providers. “I think that [we] were definitely very appropriate for the function that we served,” said one. Other participants commented that the team environment characteristic of the Dalhousie Family Medicine Centre helped them adjust to work in the pods.

Others cited stories of “dysfunctional pods,” though they did not experience this directly. Integrating new volunteers, personality conflicts, and working through an interpreter were named as specific difficulties directly encountered by participants. Several also suggested that Armed Forces medics were likely under-used, while a physician believed that there were “maybe too many people.”

Physicians raised other concerns pertaining to their own practices. The challenge of maintaining the smooth operation of the university’s Family Medicine Centre in the face of a steady exodus of volunteers was cited as one example. Community-based physicians had to close offices and sign out or reschedule patients, which meant that their voluntarism came with a financial burden.

**R**esponse. Within the pods, the Kosovars were processed as extended family units, and length of encounters varied according to family size. The Kosovars were generally perceived to be compliant. Participants used words such as “calm,” “very cooperative,” “passive,” “willing,” or “appreciative” to describe the Kosovars during assessment. A nurse said, “I found that they were really quite relaxed about all the things that were being done to them, poked and prodded, and they just took it in their stride.” Another nurse expressed her surprise at this response, saying “we almost anticipated that they would be very, very apprehensive,” but once the processing began, “it was almost like they couldn’t do enough to please us.”

The Kosovars did occasionally resist, however. A nurse suggested that, if they were tired from the long journey, they “refused to have things done that night,” preferring to wait until morning if possible. Reticence was also noted: “invariably every family you saw had smiles on their faces and was joking with you and seeming really up;... on the whole you just got... a sense that there was more that people weren’t sharing with you.” Perhaps more concretely, two nurse informants recounted stories of people initially



Photo credit: Dr. Stewart Cameron

**Figure 1. How will we move people through?** (Left to right) Captain Sharon Noad, Dr Scott Halperin, and nurse Dee Ross discuss refugee processing in a makeshift office.

..... refusing vaccinations, while two others encountered resistance around hospitalizing a family member.

The response of care providers to the experience varied from being “honoured and awed” by the experience to being less emotional than anticipated. One nurse recounted that “my emotions seemed to be right under the surface” and that she was overwhelmed by the pod scene, feeling that she was “going to break down and cry;... that doesn’t usually happen to me.” A physician said, “I still picture the plane landing and that whole very emotional feeling as that plane landed and the people waving. It is something that I’ll never forget...” Alternatively, two physicians reported feeling conflict about their role in a humanitarian relief effort while the federal government, as a member of NATO, was an active participant in the region’s hostilities.

Many participants suggested the experience altered aspects of their personal and professional lives. In a general sense, the response to the Kosovar refugees was a “historic moment,” one characterized by a:

... sense of pulling together as a team, as a department, as a faculty of medicine, as a community of health care workers, to help out an unfortunate group of people who need to be looked after on a temporary basis while their whole topsy-turvy life is straightened out.

One nurse articulated a “sense of bonding” with other nurses, while a physician expressed the hope that the collegial relations characteristic of CFB Greenwood might endure in clinical work upon her return. Conversely, a nurse expressed something of the unique circumstances:

## RESEARCH

### Pod people

I bet if you had some other incident... that didn't have to do with refugees and you put these same people together, you would not get a similar response, that there would be more conflict and—I think that because [it was] a special situation where you were looking after people who had gone through so much—I think flexibility, which was the big word there, really came through. [T]here's nowhere where you could take these people... and put them together;... on a floor in the hospital, you would not see the same reaction.

### Discussion

Toole and Waldman<sup>10</sup> suggest that “refugee camps are the emergency departments of international public health.”<sup>10</sup> Many works address the medical care of refugees in camp settings,<sup>18,20</sup> but few address providing that care in a setting remote from the theatre of conflict.<sup>21</sup> There are, nevertheless, similarities. The general health of the refugees was thought to be quite good, confirming reports from refugee camps closer to the conflict.<sup>22</sup> In keeping with accepted practice, local expertise and the knowledge of the Kosovars themselves were used.<sup>19</sup>

Participants noted that many health issues were entirely appropriate for primary health care teams. While physicians and nurses felt well prepared to meet the clinical needs of the Kosovars, in some ways encounters were fundamentally different from family practice. The brevity of the contact, the lack of follow up by attending physician and nurses, and the substantial application of resources set the CFB Greenwood pods apart from typical family medicine offices. Perhaps the most critical difference was the language barrier and the role of the interpreter. The sense that some stories went unsaid meant issues might be unaddressed, and this is anathema to primary care providers.

Whereas disasters and other events are widely acknowledged to be important public health problems, extended complex humanitarian emergencies (CHEs) threaten primary health care in affected areas and beyond.<sup>23</sup> In the midst of war, health services are diverted to treating war injuries or are damaged or destroyed. Also, conflict impedes people's ability to access health facilities.<sup>6,18,23</sup> The typical response to a CHE is appropriately on the direct effects, such as deaths, injuries, and disability caused by violence, or systematic torture and sexual assault. The indirect effects of CHEs, such as the collapse of primary health services,<sup>24</sup> often escape the attention of the media, planners, and officials alike. Thus, the CFB Greenwood experience is a useful reminder of these indirect effects.



Photo credit: Dr Stewart Cameron

Figure 2. **You'll be doing this a lot:** Dr Scott Halperin demonstrates BCG vaccination on Dr Rebecca McEachern.

How tasks and roles were carried out in this particular environment also raises important areas of inquiry for study of primary care teams. Flexibility is touted as a key to relief work because of the limited facilities, reduced staff, and generally adverse conditions,<sup>18</sup> and all providers interviewed mentioned teamwork. Some participants expressed hope that the collegiality that characterized the pods would carry over to routine settings after their return from CFB Greenwood. Others believed that the unique setting overcame obstacles that might otherwise limit teamwork.

Planning and the tremendous resources available clearly shaped the CFB Greenwood experience and greatly facilitated the work of the “pod people.” Nevertheless, nurses and physicians did report some uncertainty about their roles; nearly half of the people interviewed acknowledged not knowing what to expect. Future responses to emergency situations might benefit from clearer descriptions of individual roles within the team.

An unexpected area of discussion was the need to extend planning beyond the confines of the immediate relief effort. If community-based physicians are integral to similar future efforts, some consideration must be given to the financial burden of volunteering. The strong response of the Department of Family Medicine; community-based physicians; and physicians, nurses, and allied health professionals throughout the hospital also meant that substantial human resources were diverted and unable to handle regular workloads.

Planning did prepare providers for the cultural encounter with the Kosovars (**Figure 2**). Beyond language, participants did not believe that culture seriously affected their ability to provide high-quality care. In part, this was likely because of the brevity of the contact and the relatively narrow focus of inquiry.

**Key points**

- This qualitative study describes the experience of family physicians and family practice nurses who screened Kosovar refugees in Nova Scotia in 1999.
- Despite some initial apprehension, teams found results of their assessments were similar to usual family medicine problems, with a few extras unique to refugees from a war zone.
- Working through translators was an important frustration.
- Most physicians and nurses found the camaraderie and teamwork that developed very positive.

**Points de repère**

- Cette étude qualitative décrit l'expérience de médecins de famille et d'infirmières en pratique familiale qui ont examiné des réfugiés du Kosovo en Nouvelle-Écosse en 1999.
- En dépit de quelques appréhensions initiales, les équipes ont trouvé que leurs évaluations étaient semblables à celles des problèmes habituels rencontrés en médecine familiale, à l'exception des certains éléments uniques aux réfugiés provenant d'une zone de guerre.
- Le travail par l'intermédiaire de traducteurs s'est révélé une importante frustration.
- La majorité des médecins et des infirmières ont trouvé très positifs la camaraderie et l'esprit d'équipe qui se sont établis.

Nevertheless, care providers were sensitive to potential cultural differences, and this probably served to defuse any apprehension the Kosovars might have harboured regarding treatment. Physicians and nurses alike tried to provide comfort through occasional Albanian words or gestures, such as eye contact or a comforting touch, or through sitting with children and playing with them.

**Conclusion**

This study was undertaken to understand the experience of family physicians and family practice nurses who provided service to the Kosovars at CFB Greenwood. It is important to recognize that issues identified are similar to what is known about medical work during CHEs. But there are important differences. Focus on the primary care aspects of complex emergencies is rare in the literature. There is also a need to understand experiences in CHEs, relief, and other volunteer work not in isolation but as part of a broader context. An important element recounted by

participants was the many links between their service in CFB Greenwood and their clinical work at home, whether they were physicians or nurses, community-based or part of the academic centre. Finally, work in CFB Greenwood marked a personal transformative experience for some participants, while others forged new working relationships.

While findings in this study cannot be generalized to other relief settings, issues that emerged from interviews could offer insights or generate other research questions. These need not be limited to providing emergency responses, but could include areas such as team building, an important component of Canada's changing health care environment. ❀

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