

# Key role for emergency services in the unfolding tragedy of illegal immigration by sea

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Studies on healthcare for immigrants have been increasingly growing among emergency care and emergency medicine professionals as demonstrated by the 46 presentations, among others, made in the last 4 National SEMES Congresses. Some studies have been of investigation<sup>1</sup> and review<sup>2</sup> and a specific round table on "The crisis of the cayuco boats" was organised by the XIX SEMES Congress held in Tarragona. The topics covered have been varied: the characteristics of their demand<sup>3,4</sup>, their repercussion on healthcare organisation<sup>5,6</sup> (both extra<sup>7-9</sup> and intrahospital<sup>10,11</sup>), the psychiatric effects derived from their situation<sup>12</sup>, specific infectious diseases<sup>13-15</sup>, language difficulties<sup>6</sup>, etc. In this issue of EMERGENCIAS two studies have been published on healthcare provided to immigrants immediately after arrival and the following days thereafter to the coasts of the Canary Islands in cayuco boats<sup>17,18</sup>. Together with Andalusia and the Italian coast (particularly the Island of Lampedusa), the Canary Islands constitute the southern frontier of Europe by sea. To our knowledge these are the first studies on this situation of healthcare and social emergency published in a biomedical journal.

In the first years of the arrival of small boats to the Canary Islands, the receptor islands were mainly Lanzarote and Fuerteventura. Despite the relatively short journeys (120-130 Km from the Moroccan coasts and from the Western Sahara), absolutely dramatic situations were observed due to the conditions in which the occupants of these boats arrived as well as the frequent drowning produced only a few metres from the coast because of not knowing how to swim. The response of the general population, the politicians and healthcare personnel was praiseworthy from not

only a human but also a professional point of view. However, the fruit of the pressure in the places of origin as well as greater border control has led the departure ports to move further south to points along the Mauritanian coast. Thus, the journeys now cover a distance of between 870 and 960 Km and arrive to the Islands of Tenerife, Gran Canaria, La Gomera and El Hierro. These journeys usually last from one to two weeks and transport between 40 to 70 immigrants. The skill of the crews is admirable and the conditions in which the passengers travel is no less moving.

The study by Rodríguez del Rosario et al<sup>4</sup> takes into account data on all the healthcare actions of the different healthcare levels and emergency services in this collective, undoubtedly converting this study into a document of reference for future publications in this field. It is of interest that, despite the distance covered and the conditions in which it is made, only 18% of the almost 20,000 immigrants arriving require primary care assistance (including emergencies at this level) when in addition, only 38.5% of these patients are derived directly from their arrival at the coast (only 660 immigrants). Of those attended, only 865 cases (2.4%) were sent to hospitals. On the other hand, 5.5% of the immigrants were attended in hospital emergency departments obviously through transfer from the beach or port of arrival but also 54.2% of these cases were derived from shelters or temporary internment centres (CIEs). Only 111 patients were hospitalised, representing 12% of the hospital emergencies attended and 0.56% of the total of immigrants. The good health status in which these patients arrive was of note, far from

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the malicious clichés as the authors themselves mention in the discussion referring to infectious diseases. The high resolvent power of the extra-hospital healthcare services and hospital emergency departments should also once again be recognised. Perhaps the volume of patients of extrahospital care corresponding to the continued care services and the normal emergency departments should have been determined. The use of hospital emergency departments to short circuit the healthcare system was observed by the number of patients referred from the CIEs for healthcare demands corresponding to primary care without having previously passed through this healthcare level<sup>4</sup>.

The article by the nurses Matos Castro and Padrón Peña<sup>5</sup> analyses the initial extrahospital care given to these immigrants over one year also describing the method of action used on their arrival. Likewise, the good initial status of the immigrants was of note, with only 1.07% of referrals to the Regional Health System services after the first healthcare triage. Moreover, the magnificent reception, healthcare and classification work carried out on the beach or in the port are worthy of mention. As the authors point out, the improvement in this task based on the learning curve of the healthcare personnel has also been important. Indeed, on stabilisation of this curve an improvement has been observed in the results of triage, with the management of authentic situations of mass victims or even catastrophes almost daily. This has also been the fruit of the coordination between volunteer and professional personnel of public organisms and non governmental organisations such as the Spanish Red Cross, the entity responsible for the agreement with the Spanish Government related to this first healthcare and social aid.

Some aspects of our hospital experience in this crisis of the cayuco boats coincide in the contributions of these two studies. Specifically, the learning curve has had effects at an organisational and clinical level. With respect to the first, the arrival of patients directly from the beach initially produced the activation of the protocol of catastrophes, although this was later modified in parallel with the prior selection of the patients referred so that care was centred on 2 or 3 patients in the emergency reanimation area often with posterior admission in the ICU. Similarly, the care of the immigrants referred from the CIEs in later days was incorporated into the triage circuit and posterior care of

the general population. This avoided not only distortions in the working of our emergency departments but also the lack of comprehension and even xenophobic attitudes by determined emergency department users. At a clinical level, greater experience has been obtained in the initial management of these patients in relation to specific physiopathological aspects derived from the sea journeys, and the knowledge of diseases which are infrequent in our setting, as well as the elimination of distrust with respect to certain infectious diseases. It has even been learned how to survive an anamnesis with enormous language barriers.

To conclude this editorial we believe two aspects of social content which we consider to be of enormous importance should be discussed. Firstly, the situation with the unaccompanied minors has become complicated since they cannot be repatriated to their country. With the autonomous communities taking charge of their tutorship, they are interned in specific centres for minors, trapped in a small territory, dramatically far from their families, culture and friends. At present in the Canary Islands there are 1,400 immigrant minors with only 500 positions available. In addition to the physical overcrowding, the reduction in the training capacity of these youths, their social integration and future opportunities which this small territory may offer them are particularly worrying. To avoid marginalisation being the alternative, human logic makes greater interterritorial collaboration necessary to facilitate their education, integration and in one word, their future. Secondly, as Matos and Padrón point out, some calculations indicate that one third of the small boats or cayuco boats with immigrants who make the crossing to the Canary Islands do not achieve their proposal and disappear at sea. This is an authentic human drama which is occurring today before us. Only recently, the press reported the news of the arrest of the leader of ethnic cleansing in the Balkan War which took place from 1991-1995, Dr. Rado van Karadzic. To many of us it may seem incredible to think that a genocide of this proportion took place in Europe only 15 years ago and there is the feeling that perhaps something could have been done beforehand so that this would not have occurred. Although we cannot change the past, perhaps the future of the tragedy of illegal immigration lies in our hands. The emergency care and emergency medicine services are witnesses of this and have done their work well.

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