

Commentary

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## Medical risks during flight deportation of refugees

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Several medical and psychological factors should be considered regarding refugees repatriated by aircraft to their home countries. Traumatized refugees warrant special concern, but differential treatment among western countries generates controversy. Austria generally accepts that traumatized refugees, especially those suffering from post-traumatic stress disorder (PTSD), should not be subjected to forced repatriation. Medical professionals can play an important role in the recognition of the symptoms of PTSD. The treatment of refugees suffering from PTSD should be determined by treating physicians – forced repatriation could lead to retraumatization and worsening of symptoms. Treatment in the home countries from which they had fled might not reach acceptable standards of care.

As the tragic lethal example of Marcus Omofuma [1] in Austria has shown, there is a major physical risk during deportations. Physically-immobilized refugees experience considerable stress; physicians must institute appropriate preventive measures to protect their health. When medically appropriate, physicians may prescribe tranquilizers when requested, with written consent of the patient.

The medical emergency of Paris Airport reported 109 proven pulmonary embolisms between 1990 and 2000, with 4 deaths in 2000 [2]. Because of the immobilization of refugees during flight and the general risk of dehydration, measures should be undertaken to prevent limb thrombosis. Sarvesvaran reported that 20% of deaths were caused by pulmonary embolism on arrival at Heathrow airports, ten times more than on departure [3]. Therefore, the individual refugee should be informed about the risk of thrombosis and advised to make movement of the

lower extremities during flight and to drink adequate amounts of water prior the flight. Further, in subjects at high risk low-dose aspirin should be considered for prevention of thrombosis and pulmonary embolism [4,5].

Respiratory problems comprise approximately 11% of in-flight emergencies [6]. The guidelines for assessment of respiratory diseases are available online at <http://www.brit-thoracic.org.uk> [6,7]. Those individuals with a resting oxygen saturation below 92% or 92–95% on air with additional risk factors should have a formal hypoxic challenge test to identify whether they are able to compensate for the altitude. Supplementary oxygen is recommended for those patients whose arterial oxygen pressure remains below 6.6 kPa (50 mmHg) [7,8].

Finally, the limited space in the aircraft and the poor health condition of many refugees facilitate the risk of transmission of respiratory diseases in association with air travel. For example, transmission of Mycobacterium tuberculosis may occur more often during flights longer than eight hours, as the risk of infection is related to the proximity and duration of exposure to the source patient [9].

We lament the lack of formal data collection regarding health status during refugee deportation and repatriation and emphasize the likely under-reporting of medical complications beyond the few cases reported in the non-medical media. Medical professionals involved in these processes should institute preventive measures in order to minimize the possible medical and psychological complications among these groups of fragile individuals.

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