General practitioner and registrar involvement in refugee health: exploring needs and perceptions

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This article was originally published as:  

Original article available here:  
[https://doi.org/10.1071/AH17093](https://doi.org/10.1071/AH17093)

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This is the author’s version of the following article, as accepted for publication:


https://doi.org/10.1071/AH17093
GP and registrar involvement in refugee health: Exploring needs and perceptions

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Abstract

Objective: Despite the recognition that refugees should have equitable access to healthcare services, this presents considerable challenges, particularly in rural and regional areas. Because general practitioners are critical to resettlement for refugees and play a crucial role in understanding their specific health and social issues, it is important to know more about the needs of GPs.

Method: In-depth interviews with 14 GPs and GP registrars who trained with a NSW Regional training provider aimed to assess the needs and attitudes of GPs in treating refugees and the perceived impact that refugees have on their practice.

Results: The interviews, while acknowledging well recognised issues such as language and culture, also highlighted particular issues for rural and regional areas’ such as employment and community support. International medical graduates identified with re-settlement problems faced by refugees and are a potential resource for these patients. A need for greater information regarding services available to help manage refugees in rural and regional areas and greater access to those services was demonstrated.

Conclusions: Issues such as time, costs, language and culture were recognised as challenges in providing services for this population group. GPs highlighted particular issues for rural and
regional areas in addressing refugee health, such as finding jobs, problems with isolation and the impact of lack of anonymity in such communities. These social factors have implications for health, especially psychological health, which is also challenged by poor resources.

**Key Questions**

1. **What is known about the topic?**

   Providing refugees equitable access to healthcare services presents considerable challenges, particularly in rural and regional areas. Time, language and culture are commonly reported barriers in providing services for this population group.

2. **What does this paper add?**

   There are particular issues for rural and regional areas in addressing refugee health, including finding jobs, problems with isolation and the impact of lack of anonymity in rural communities. These social factors had implications for health especially psychological health which is also challenged by a paucity of services. This research suggests that IMG doctors identified with re-settlement problems faced by refugees and may be an important resource for these patients. This study highlights the awareness, empathy and positive attitudes of GPs in regional and rural areas in their approach to treating patients with a refugee background.

3. **What are the implications for practitioners?**

   International medical graduates often identify with re-settlement problems faced by refugees and are an important resource for these patients. A need for greater information regarding services available to help manage refugees in rural and regional areas and greater access to those services was demonstrated.
**Introduction**

While language and cultural differences are seen as major problems in migrant populations, diverse belief systems also impact health-seeking behaviour. Patients from a refugee background may face many unfamiliar cultural differences such as appointment making and keeping, health literacy, body language, illness behaviour, time-frames, attitudes towards medication and expectations of treatment.

While the majority of refugees arriving in Australia since 1945 have been resettled in major cities, Recent initiatives have increased the number of migrants and humanitarian entrants in rural and regional areas. Success of these initiatives relies on available local services and minimal research has been done on the needs and attitudes of general practitioners (GPs) and GP registrars in working with these refugees. This study attempts to address that shortfall.

**Methods**

Following a previously published questionnaire addressing GP needs and attitudes in relation to working with refugee patients, a need for the more indepth information available through interviews was recognised. Interviews were conducted with GP registrars undertaking GP training with CoastCityCountry General Practice Training (CCCGPT) and GP supervisors who were Fellows of the Royal Australian College of General Practitioners (FRACGP) or Fellows of the Australian College of Rural and Remote Medicine (FACRRM). Purposeful sampling was used to maximise range of viewpoints. Thematic analysis was conducted by at least two authors for each interview. Approval was obtained from the University of Notre Dame Human Research Ethics Committee. Interviews lasted between 30 and 60 minutes, were taped and were transcribed prior to thematic analysis using NVivo 10 (QRS International Pty Ltd).
Results and Discussion

The GPs interviewed were practicing in areas where refugees from Syria, Iraq, Sudan and Burma had resettled. All 14 participants practiced in rural and regional areas in south-west New South Wales, with almost 30% practicing in areas with populations of <10 000 (Table 1). Three of the four registrars (75%) and five of the ten (50%) supervisors were international medical graduates (IMGs).

Table 1: Characteristics of interviewees

<table>
<thead>
<tr>
<th>Characteristic</th>
<th>Registrars (n=4)</th>
<th>Supervisors (n=10)</th>
<th>Total (n=14)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Gender (% female)</td>
<td>50.0</td>
<td>40.0</td>
<td>42.9</td>
</tr>
<tr>
<td>Mean experience (years in general practice)</td>
<td>1.2</td>
<td>20.2</td>
<td>14.8</td>
</tr>
<tr>
<td>International medical graduates (%)</td>
<td>75.0</td>
<td>50.0</td>
<td>57.1</td>
</tr>
<tr>
<td>RRMA classification (%)*</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>R1 (25 000-99 999 people)</td>
<td>50.0</td>
<td>80.0</td>
<td>71.4</td>
</tr>
<tr>
<td>R3 (&lt; 10000 people)</td>
<td>50.0</td>
<td>20.0</td>
<td>28.6</td>
</tr>
</tbody>
</table>

*RRMA – Rural, Remote and Metropolitan Areas

International medical graduates (IMGs) and refugee patients

Australia has become highly dependent on immigration to address the geographical maldistribution of the medical workforce with nearly one third of medical practitioners gaining their initial medical qualification outside of Australia⁷. It has been suggested that IMGs contribute
to the availability of diverse healthcare providers, potentially impacting successful incorporation of former refugees into the existing healthcare system. An IMG in this study commented on this diversity: ‘I’m from a different culture, different background. I learned lots of different infectious diseases/conditions...different to doctors training in Australia.’

One IMG sympathised with refugees who had ‘given whatever they have to the smugglers to bring them in’ and were coming to a ‘new environment.’ Another said she understood the hurdles, paperwork and red-tape refugees faced and had ‘a lot of empathy with people from Africa...I’ve seen a lot of the suffering that they go through.’ She commented that IMGs can ‘understand the language and were from a similar culture’.

Some contrasted the problems faced by refugees with their own arrival. One said ‘I have a profession, that got me accepted a lot faster than coming as a refugee,’ and another said ‘I could speak English, I had a job, still it wasn’t easy.’ Lack of support for IMGs in maintaining important cultural and religious values and thus meeting personal and family needs has been raised in the literature. In addition to providing a more diverse workforce, the ability to emphasise with and relate to some of the potential problems faced with migrating to a new country makes IMGs a potential source of support for these cohorts of people.

**Different expectations of disease and the healthcare system**

A patient-centred clinical approach asks general practice to ensure that doctors understand the patients’ expectations of disease and the healthcare system, and that they are aware that patients’ expectations are often not the same as those of the GPs. GPs interviewed emphasised the need to be aware that certain groups of refugee patients may have different expectations. Some expected the doctor to have the answers, be able to ‘fix things.’ One IMG said her practice style ‘might be a bit like an authoritative management because they think the doctor is like god...that you are absolutely right.’ Another male IMG stated ‘I originally trained in Arabic, but I have been
practicing in English so long that I cannot practice in Arabic’ although his refugee patients had
an expectation that he would practice in this language. Another felt some refugee patients from
her home country had an expectation that this link meant they could bypass normal processes ‘do
it other ways.’

Cultural differences resulted in different expectations of the healthcare system and, as one
female IMG, said ‘different ways of seeing disease and illness.’ Another commented that refugees
‘only come in when they are really sick...in our country, we don’t see early diseases of anything.
No one comes for a cough.’ There was a perception among interviewees that refugees often come
from countries where there is no ‘established healthcare system,’ but, as in the case of Syria, war
has led to the widespread destruction of existing health care services with critical shortages of
personnel and medications and the re-emergence of infectious diseases.

One GP interviewed said that there is a need to ‘understand what GPs are all about and
what GPs can do for them.’ He felt refugees needed information particularly about preventive
health ‘screening’ and ‘immunisation.’ Other researchers have noted that preventive health issues
were not part of refugee patients’ expectation of care and, in war-affected populations, the health
focus is often on acute injuries and infectious disease outbreaks. Similarly, the Australian
medical system has been criticised for seeing refugees as victims, not survivors, and focusing on
clinical treatment not population health issues.

Acceptance of refugees by the community

In regional and rural areas, the predominantly Caucasian population potentially influences
acceptance of refugee patients into the community. As one experienced IMG said ‘I come from
an area where the people who are seen here as ethnic minority would have been the majority.’
Discrimination was also reported. A female patient had described her reaction to another patient
‘you are coming to this doctor who is not Australian so why do you abuse patients who are not
Australian?’ Describing the incident the GP was philosophical saying ‘it happens.’ Similarly, a
female IMG registrar reflecting upon refugee patients said they weren’t ‘recognised as a person as they don’t speak English fluently.’ This was harder for the very dark African people who ‘really stand out’. One Australian medical graduate (AMG) had the perception this was changing. ‘You are more likely to see ethnic people around town...there are issues of racism in town, but overall the community is reasonably tolerant’. Racial violence is a concern as it can trigger memories of trauma for refugees\textsuperscript{11} and has the potential to affect both health and healthcare utilisation\textsuperscript{4,13}.

Skills of the doctors /impact on the doctors

Experience and Scope of Practice

Many of the GPs interviewed felt that involvement in refugee health helped to broaden understanding, experience and scope of practice affording greater awareness of problems such as hepatitis and TB. While, for some senior GPs, being presented with ‘a whole lot of things that we don’t particularly think too much about in Australia’ was not difficult, for others, particularly the registrars, this raised some feelings of anxiety. One registrar commented that ‘I am not familiar with what their usual problems are, and what their usual protocol is,’ Another said ‘I am always scared that they are going to come up with some kind of weird topical condition that I’m not going to be able to handle.’ An Irish study of GP registrars also suggested they had multiple learning needs in cross-cultural care\textsuperscript{14}.

The difficulty for some groups of refugee patients to fit into conventional general practice was seen as problematic. Making ‘the environment more friendly’ as ‘people coming from a minority background can be intimidated by a large or a very busy practice’ was a possible solution. A commitment to providing supportive environments for refugees is important to ease the burden on already compromised individuals\textsuperscript{12}.

Confidence in management of medical issues
Most GPs were confident in their ability to deal with medical issues, however it became apparent that this confidence did not necessarily mean having skills per se but could indicate awareness of available supports. One GP working in a large regional centre said he appreciated ‘the presence of the specialist clinic in town’. A registrar commented on the educational, as well as the support role, of refugee services, ‘if we have got any issues, any special crisis…we can contact them if we need help.’ The importance of training and support for people working with asylum seekers and refugees has been noted previously. Levels of confidence in ability to deal with patients who had come to Australia as refugees increased with time spent working with this cohort. One AMG said of his confidence ‘it’s increasing rapidly. It was pretty shaky at first’.

Managing psychological issues for refugees in general practice

GPs described more problems addressing social and psychological issues with refugees. An AMG said ‘a lot of the psychological stuff is hidden, they don’t declare it’ and the ‘tip of iceberg is what you’d pick up.’ This was seen as often outside the life experience of AMGs: ‘adverse experiences they have every day we don’t have at all…siblings killed by bomb blasts and gunshot wounds, a father whose son was killed.’ One IMG felt that his past experience affected how refugee stories about trauma impacted him. ‘I don’t think it does impact very much psychologically on me…some of the stories that you hear…horror stories, the camps, coming from another country…you can understand, you get immunised a bit to some of the stuff.’ As well as the risk of becoming immune to the stories, other researchers have suggested that staff themselves are at risk of suffering personal trauma and burnout when required to support people in considerable distress, such as asylum seekers in immigration detention centres.

GPs felt there was a need to be ‘empathic and supportive’ and ‘aware of what services are available to refer people to for support’ to ‘help tap in to deal with’ these issues. The availability of counselling support services was seen as a particular issue as they were ‘pretty hard to get hold of,’ particularly in rural and regional areas. Upskilling available counsellors to be able to cope
with trauma was seen as important. One female IMG described trauma counselling as ‘basic training’ in her country of origin ‘because trauma was a really big problem, so I just presumed that every counsellor would be trained.’ One registrar said that ‘even in a non-refugee patient’ addressing psychological issues was hard ‘it’s a difficult thing to understand and deal with all the trauma.’

Impact on running of the practice

Managing time

Managing time, time taken to get things done, and cultural approach to time all impacted refugee healthcare provision. There was a perception that everything took longer: ‘to get them to understand what needs to be done and to actually get the tests done, get the scripts, go to places they’re meant to go.’ One IMG registrar commented that time management, already an issue for registrars, was harder with these patients. Another IMG said increased time was needed for assessment, ‘to work things through,’ with ‘language issues and interpreters.’ This was not a ‘simple 10–15 minute time slot,’ and didn’t fit into a very busy practice, which was ‘organised in a fixed time frame.’ Although one AMG felt with appropriate management it shouldn’t affect the smooth running of a practice, you could organise the interpreter service ‘while they are still in the waiting room...by the time the patient comes into the room the interpreter is on the line.’

The different cultural approach to time in some refugee groups was also commented on: ‘they don’t realise that time is important to you, where for them it doesn’t really matter...they come an hour early or an hour late [which is] difficult to manage.’

Cost of medical services

Cost of specialist care was also seen as a problem: ‘even if they seek medical help, if they can’t buy medication, [can’t] afford to see the specialist,’ and ‘GPs can bulk bill...we are the only support they’ve got.’ One IMG said ‘some don’t have Medicare, so even if they are seriously ill
they don’t want to stay in hospital’, and they are ‘worried about the bill.’ Refugees have full
Medicare access while asylum seekers may not depending on their visa status\(^\text{17}\). Perceived, or
actual, cost of healthcare services has been noted by other researchers to limit access to
healthcare\(^2,15\).

Language and the use of interpreters

In discussing support services, many GPs commented on the Translating and Interpreter Service
(TIS), a service provided free for doctors and often used as a telephone service. This was seen as
a ‘great resource’ but ‘not perfect’. One female AMG said, ‘I am conscious that they [refugee
patients] may not be able to express things that they are concerned about.’ This made addressing
psychological issues problematic: ‘they are talking to the interpreter, not to you….the third person
that interferes in that relationship...it’s hard to understand the emotionality behind what the
person is experiencing.’ Another GP commented on ‘the interpreter service almost trying to
interpret the meaning of what I was saying to the person,’ a problem noted by Putsch\(^\text{18}\).

Interpreters can act as information gatekeepers and bring their own beliefs and agendas to the
consultation\(^\text{10,19}\).

One IMG commented on an additional problem with dialects: ‘even within the same
language interpreter, if you have an Arabic interpreter who is from a Lebanese background who
is talking to an Arabic patient from a Sudanese background.’ Arabic, as with several other
diaspora languages, is characterised by having multiple variations, and specific interpreters need
to be requested from the TIS followed by confirmation that the patient can understand the dialect
of the interpreter. Another GP commented that there is a tendency in general practice to ‘use
relatives for translations’ and this can be problematic, for example when translating problems
regarding women health issues. A female GP also noted that the ‘elder group, especially females,
always come with one of their kids, mainly a person who speaks English to some extent.’ Despite
the introduction of the free service, interpreters are infrequently used in general practice, and
family interpreters are widely used\textsuperscript{14,20}. This tendency has serious privacy and ethical implications\textsuperscript{21}. Patients may be unwilling to divulge critical information in front of their relatives\textsuperscript{21}. Effective communication is essential to patient consent\textsuperscript{22} as is ensuring patient understanding, particularly in complex clinical problems\textsuperscript{23}. Despite the widespread availability of the TIS, it is underutilised with general practice and practice-wider interventions are required to improve its use\textsuperscript{21}.

**Rural and regional issues**

Doctors interviewed recognised that adjusting to a different culture, particularly in a rural or regional area, presented challenges and additional support was needed. Simple things like food could be a problem: ‘you walk into a supermarket and you come from an area where they eat Cassava or whatever...you cannot even understand what is a protein.’ One IMG registrar said refugees in rural areas could be socially isolated, ‘Sydney is different, you’ve got so many backgrounds, so many shops...we don’t really have these things here.’ An AMG described ‘isolation from family’ as a big issue: ‘how to connect with family when family is so precious and you have lost so much of it.’ Simple issues, such as no driver’s licence, pose problems in rural and regional areas ‘because public transport is not very handy’. Access to services in rural and regional areas is poorer than in major cities making geographical isolation and distance are major drivers in rural health outcomes\textsuperscript{24}. This is even worse for refugee patients\textsuperscript{25} and others from culturally and linguistically diverse backgrounds who are outside the ‘mainstream’ of Australian society\textsuperscript{26}.

Lack of suitable work opportunities was another problem exacerbated by rurality. One female IMG registrar in a small rural centre said work was a problem for her husband who ‘came with me and can’t find a job’ because of ‘limited job options in most of the rural communities’. She said that rural communities were ‘mostly Caucasian,’ so language and culture differences were a problem. Another GP reflected on the type of work available for refugees: ‘I don’t know if
exploited is the right term, but they really are under a lot of pressure to not miss work because of the availability of other refugees to take their place.’ While the local abattoirs was seen as providing work, there was also a perception that refugees were ‘working very hard for little.’ There is a conflict between the importance of work for successful resettlement and integration, and employment of refugees in rural areas in poorly paid farm work and in abattoirs.

The issues of discrimination were also felt to be worse in rural and regional areas. One IMG said that ‘if you go more rural they will really suffer...from direct but mostly indirect discrimination.’ This view that regional NSW is not always supportive of refugees is reinforced by incidents such as one regional council voting against refugee resettlement in their area. One IMG registrar felt that it would be easier for refugees ‘in urban compared to rural,’ where ‘the whole town...knows where they’re coming from, what they’ve got, what they don’t have.’ Lack of anonymity and lack of access to culturally specific services are particularly an issue for rural areas.

**Conclusions**

General practice faces many challenges in treating patients who have come to Australia as refugees. IMGs make up a large proportion of the GP cohort practising in rural and regional Australia. Comments in the interviews by more senior IMGs indicated that they identified with some of the migration issues faced by refugees and they felt more comfortable addressing issues such as trauma experiences.

The GPs interviewed recognised issues such as time, costs and language and culture as challenges providing services for this population group. In meeting these challenges, there is a need to guard against a lower standard of care and less preventive health care. GPs also highlighted particular rural and regional issues in addressing refugee health such as greater difficulty finding
jobs, isolation and the impact of lack of anonymity in rural communities. Doctors implied that these social factors had implication for health, especially psychological health, and expressed concerns about paucity of services in this field.

This research suggests that IMG doctors identified with re-settlement problems faced by refugees and may be an important resource for these patients. This study highlights the awareness, empathy and positive attitudes of GPs in regional and rural areas in their approach to treating patients with a refugee background. However, a need for greater information regarding services available to help manage refugees in rural and regional areas and greater access to those services was demonstrated. With the recent implementation of Safe Haven Enterprise Visas and the current policy to place more refugees in regional and rural areas, it is likely that these issues will become increasingly relevant.

Limitations

This study only addressed a small group of GP registrars and supervisors working with CCCGPT (regional training provider 2007-2015) and the results may not apply to other rural/regional areas nor to other GPs. Sampling participants from a GP training provider may have different attitudes than other groups of GPs due to their personal interest in refugee health and their involvement in training and education. Futures studies of a broader population base might be useful.
References


