

Research paper

Views of general practitioners towards refugees and asylum seekers: an interview study

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ABSTRACT

Current UK government policy is to disperse refugees throughout the country, which creates resource and other issues for healthcare providers in primary care. This study aimed to identify some of the concerns of 17 general practitioners (GPs) working in an urban environment. Approximately half worked in practices that received high numbers of refugees and asylum seekers while the others did not. Semi-structured interviews were undertaken, transcribed and analysed using a thematic framework.

Five emergent themes were identified: the political logistics and the asylum process; community issues; the impact on primary care; resources and

resource management; and training needs within primary care. This study shows that GPs are aware of, and sympathetic towards, the needs of refugees and asylum seekers, although many of them experience significant difficulties in fully meeting the needs of this population, such as psychological needs. Primary care requires additional support, education and training, and resources to efficiently provide for this patient group.

Keywords: asylum seekers, general practitioners, refugees

Introduction

At the beginning of 2005, the number of people of concern to the United Nations High Commission for Refugees rose to 19.2 million, an increase of 13%. The number of refugees fell by 4% to 9.7 million and the number of asylum seekers stood at 839 200 (United Nations High Commission for Refugees, 2005). The top five refugee hosting countries are Iran, Pakistan, Germany, Tanzania and the United States. The trend in asylum applications to the UK has been falling, with a further 33% decrease in 2004 compared to 2003 (United Nations High Commission for Refugees, 2004).

A refugee is, by definition, an individual who, owing to a well-founded fear of being persecuted for reasons of race, religion, nationality, membership of a particular social group or political opinion, is living outside the country of his or her nationality or habitual

residence, is unable or unwilling to return to it and has been granted stay by his or her host country. Upon application and during the interim of receiving the right to stay permanently in the UK, individuals hold the legal status of *asylum seeker* (United Nations High Commission for Refugees, 2005). Providing care for refugees and asylum seekers is difficult as it encompasses a complexity of social, political, and economic as well as health issues (Carey Wood *et al*, 1995). A recent study from Scotland (Katikireddi *et al*, 2004) highlighted the need for training and education of general practitioners (GPs) to manage these complex issues. Although anecdotal evidence exists, mainly from the media, there has not been any systematic evaluation of the interaction between GPs and refugees and asylum seekers in the context of the level of care that is being provided to address their complex

needs. The aim of this study was to explore the views of GPs towards refugees and asylum seekers.

Methods

A qualitative approach was used and data were collected using one-to-one semi-structured interviewing, at each practice. A previously piloted and refined topic guide was utilised with interviews ranging from 20 minutes to an hour. The following areas were covered:

- definition of refuge and asylum
- political logistics and the asylum process
- impact upon local communities and community organisations
- impacts upon primary care
- language barriers
- training needs within primary care
- resources.

One person (HB) carried out all the interviews, which were recorded, transcribed and analysed using a thematic framework (Ritchie and Spencer, 1993). Emergent themes are shown in Box 1. Data collection and analysis proceeded simultaneously, incorporating emergent themes into subsequent interviews. Emergent themes were compared by HB and PG independently before agreement and refinement of the themes. Data collection terminated upon saturation of emergent themes. Respondent validation of individual analyses was obtained to further ensure rigour. Written consent was obtained prior to the commencement of each interview, and confidentiality maintained throughout. Ethical approval was obtained from North West Multisite Research Ethics Committee.

GPs were recruited from across the greater Birmingham area. Purposeful sampling was used to recruit participants, with more or less than 10% of the ward population from the black and minority ethnic communities (www.statistics.gov.uk/census2001/default.asp). This was to ensure a representative view of practitioners according to the amount of exposure they had working with this population. This approach was adopted as no precise statistics were available on the exact settlement of refugees and asylum seekers, and it was assumed that refugees and asylum seekers would also tend to cluster together and follow the same pattern of settlement as the established minority ethnic communities (Gill *et al*, 2006). The identified areas were then confirmed with the West Midlands Refugee Council. One hundred GPs were randomly selected from the target locations using computer-generated numbers, and approached via post and a follow-up phone call. Of these, 20 GPs volunteered to participate but 17 were actually interviewed as three opted out at the last minute due to work priorities.

Although age and ethnicity were not explicitly controlled for, a wide range of GPs was recruited into the sample, in terms of sex, age and ethnic background. Practice sizes varied from single-handed to large practices (see Table 1).

Table 1 Demographic characteristics of responders

	Low-density areas ^a	High-density areas
Total	8	9
Sex		
male	5	5
female	3	4
Age (years)		
30–39	4	1
40–49	3	4
50–59	2	3
Ethnicity		
white	7	2
South Asian	1	5
Malaysian	1	0
Middle Eastern	0	1
Practice size (number of GPs)		
single-handed	0	4
2–4	3	0
5–7	5	3
8+	0	1

^a More or less than 10% of the ward population from the black and minority ethnic communities

Results

Five themes emerged from the analysis: political logistics and the asylum process; community issues; impact upon primary care; resources and resource management; and training needs within primary care (see Box 1). Each of these themes is addressed below.

Box 1 Emergent themes

- 1 Political logistics and the asylum process
- 2 Community issues
- 3 Impact upon primary care
- 4 Resources and resource management
- 5 Training needs within primary care

Political logistics and the asylum process

Four correctly distinguished between the terms *refugee* and *asylum seeker*, while 11 were unable to clearly differentiate between them, and three thought the two terms to be synonymous, for example:

‘... a refugee is somebody who has been persecuted in their own country and are fearful of their life ..., an asylum seeker, I don’t really know, I take them as the same I guess.’ (High-density area)

Only two felt unaffected by the process of asylum and refuge and had little to express by way of an opinion. The length of the asylum process was a prime concern of the majority. This impacted not only the health needs of this population but also economically upon others within the community because:

‘... with the Home Office thing pending, a lot of them are uncertain as to whether they’re gonna get the visa or not ... that stress then makes their possible illnesses worse ..., and depression becomes quite common in this group.’ (High-density area)

Concern about abuse by economic migrants masquerading as refugees and asylum seekers arose and:

‘... instantaneously you spot the ones who are genuine asylum seekers ... and those who are economic migrants ... when they come to us they will actually give you textbook symptomology of PTSD [post-traumatic stress disorder] without being prompted.’ (High-density area)

Three of the five GPs making this point further added that although they knew that there was potential abuse, they never made any effort to act as the policemen of the NHS to weed out culprits. It was felt that it was not the responsibility of GPs to play such a role but rather the government needed to enforce stricter immigration measures in the first place, to clamp down on health tourism (Borman, 2004). However, although such views are expressed widely, no objective evidence of abuse exists (House of Commons Health Committee, 2005).

Community issues

Twelve GPs commented that they were well aware of the negative role that the media played in this issue, reflecting that opinions were not based upon media reports but rather on personal experiences. Three stated that refugees and asylum seekers did in fact live up to the stories being portrayed in the newspapers and television, providing examples of personal experience. In the opinion of these GPs:

‘... these people can do a lot to try and alleviate the image that the media is creating but I don’t think they help themselves ... a typical scenario ... is that typical young male, black leather jackets, standing on a mobile phone ... idle, nothing to do.’ (High-density area)

An important and worrying point was the presence of racism within local communities:

‘... there is a degree of racism there [in the country], I think the media plays on that, I don’t think the media created that, I think it’s there anyway.’ (Low-density area)

Two GPs felt that refugees and asylum seekers were themselves to blame for the problem of racism and lack of integration, as they tended to keep to themselves. However, five other GPs concluded that the isolation was the result of lack of community services that might facilitate the integration of incoming populations:

‘... they need integration into the community, but I don’t think there’s anyone who looks after that role, from my impression they’re just housed and they’ve gotta look after themselves ... I haven’t yet met anyone who’s an advocate for them.’ (High-density area)

One GP associated the influx of asylum seekers and refugees with rising crime rates. Two further participants acknowledged benefit fraud and the abuse of community services. However, it was emphasised that any abuse that did exist was due to gaps in the system that allowed for such abuse because:

‘... like any individual if they are given the easier option that we will look after you and you don’t have to work to earn your living, then I would take that ... that’s something that needs to be looked into.’ (High-density area)

Nonetheless, the majority of GPs were very supportive of the potential skills that refugees and asylum seekers had to offer, in terms of employment, the economy and culture. Five of these expressed their regrets that unfortunately government legislations inhibited refugees and asylum seekers from giving back to their local communities earlier on during their stay.

Impact upon primary care

All GPs agreed that the majority of new asylum seekers presented with extensive physical and psychological problems:

‘... problems that are beyond the scope of any doctor anywhere in the world.’ (High-density area)

Confirming previous reports (Mina *et al*, 2005), one of the major difficulties that concerned GPs was the level of mental health issues within this population, which were especially emotionally taxing for GPs. This, alongside physical needs, social, cultural and language barriers, greatly impacted upon consultations.

As anticipated, language barriers were identified as one of the biggest impediments to delivering quality care to refugees and asylum seekers. All but one GP acknowledged that language barriers existed. Specific to this patient group, it was felt that interpreters were unable to deal with the emotional content of

consultations, potentially affecting management. In the GPs' opinion:

'... sometimes the interpreter finds it very difficult to relate to so will actually play down what these patients' needs are.' (High-density area)

Dissatisfaction was expressed by seven GPs with the availability of interpreters because:

'... there is nothing to beat in a consultation a dialogue between patients and doctor that ... an interpreter is very, a very much less satisfying way of conducting a consultation.' (Low-density area)

However, two GPs expressed approval of telephone interpreting, stating that:

'... this [telephone interpreting] is available 24 hours and is instantaneous ... it's revolutionised, all the doctors use it, the receptionists, the nurses and we're thinking of extending it to our district nurses and health visitors.' (Low-density area)

Four GPs emphasised that interpreting services were not flexible and limited to pre-booked appointments only, leading to much resource wastage and frustration.

The majority of GPs (12) highlighted refugees' and asylum seekers' lack of understanding of the NHS system. GPs commented that refugees and asylum seekers were often extremely demanding of the services. Two felt cultural barriers led to the unintentional misuse of services as:

'... it's often unwittingly misused the system, people will frequently go to A&E [accident and emergency] or frequently go to the GP with minor illnesses because they don't understand the system.' (High-density area)

Two other GPs felt extremely frustrated by the unrealistic expectations and inappropriate demands made. In their view:

'... there are groups of people over here, solicitors and so-called social workers who work with these people advising these people who sort of feed very weird ideas to these people, like "you *have* to get this, you *have* a choice, *exert* your rights".' (High-density area)

These GPs blamed social workers and solicitors for manipulating refugees and asylum seekers, teaching them to 'fight for their rights'.

The nature and complexity of refugee and asylum seeker healthcare needs alongside language and cultural barriers all acted as contributory factors in extended consultation times because:

'... generally speaking a consultation with a refugee will take twice as long [as with] a local patient.' (High-density area)

Eleven commenting on extended consultation times also criticised the lack of extra resources being made

available by local PCTs for such consultations. As one GP stated:

'... I think what PCTs can do is allow for the fact if practices are taking on asylum seekers then that should be budgeted for ... they're actually slightly harder work than somebody else [this] needs to be acknowledged.' (Low-density area)

Paradoxically a small minority of GPs felt that despite refugees and asylum seekers having extensive specialist needs, their care should be no different from that of any other patient registered at the practice. Only two GPs explicitly acknowledged any special in-practice policy to identify refugees and asylum seekers during their registration with the practice. These GPs followed guidelines (British Medical Association, 2002) that led to the implementation of specific policies within their practice, screening for mental health and infectious diseases. All other GPs denied knowledge of any such guidelines or in-practice policies. Specialist centres for refugees and asylum seekers were suggested. However, most opposed the idea of such one-stop centres, as they were perceived to encourage segregation rather than integration. An alternative solution suggested by nine GPs was that practices with high numbers of asylum seekers and refugees be given additional levels of support and resources to become specialists in refugee healthcare alongside routine healthcare delivery. As one GP argued:

'... you should have designated centres for these people where you have all the services available for these people all under one roof ... at these centres you can have interpreters, health workers, doctors, social workers, and they can handle the situation much better ... their needs are very sensitive and we cannot meet those needs in any other set up.' (High-density area)

Resources and resource management

Lack of support and lack of resources were the two major gaps identified within primary care. Eleven GPs emphasised the need for extra resources to allow adequate delivery of quality care for asylum seekers and refugees. In their view:

'... I think if the government really wants us to deliver then I think each asylum seeker should attract three or four times as much funding as an ordinary person in this area.' (High-density area)

Four expressed concerns that they were simply unable to deliver the care that was needed by this population due to the lack of funds and resources, arguing that:

'... I don't think these people get a fair, a fair service that they deserve ... a lot of the problems are being pushed under the carpet ... their problems are being overlooked, umm a lot of resources are needed.' (High-density area)

A GP who was in receipt of extra payments for registering asylum seekers and refugees confirmed that such payments made a great difference to the delivery of care to this population. The most extreme effect of lack of resources was notably the closure of lists to refugees and asylum seekers, which two GPs confirmed they had resorted to in the past and another had contemplated:

‘... most of the GPs in this locality have closed their lists; I am the only doctor in this practice now who has an open list.’ (High-density area)

Training needs within primary care

Three GPs from low refugee and asylum seeker population areas commented that although they had no specific training to deal with the healthcare needs of refugees and asylum seekers, being ‘generalists’ they were able to adequately manage the medical needs of this population, without further training. As one GP argued:

‘... I’m trained to know when I need to refer a problem and quite often we need to refer these people because they have problems that are far greater than I can deal with, but that doesn’t mean I need more training for that ...’ (Low-density area)

In contrast, GPs from high refugee and asylum populations concluded that although they might be able to deal with medical needs, they were far from able to deal with the psychological, cultural and social issues that existed. GPs were keen to be educated in the process of asylum and the social care and organisations involved in providing support in the community at large, assisting their delivery of quality healthcare:

‘... I would like to know more about their social care, I would certainly like to know about the legal side, I’d like to know the Home Office side of things because for advice, in order to support your patients you need to know the whole picture.’ (High-density area)

Frustration was felt by many GPs at the lack of guidelines and advice made available by local PCTs:

‘... we need proper advice to know what is going to happen and we need to know how various organisations work, rather than expecting GPs to pick up ... so people need to know beforehand what problems will be caused and how to address them.’ (High-density area)

Some also stressed the need for development of better support networks that were currently non-existent. It was accepted that, being quite versatile, primary care could cope with the demands placed on it as long as PCTs prepared GPs in advance for the changes required.

It was suggested that PCTs take a proactive role in dispersing the numbers of refugees and asylum seekers across selected specialised practices, alleviating the

associated burden. Training was also deemed important for other practice staff, including nurses and receptionists.

Discussion

This study showed that GPs were generally welcoming of refugees and asylum seekers. Primary care continues to accommodate many refugees and asylum seekers. Refugees tend to be young and so their physical health status on arrival is not necessarily poor (Burnett and Peel, 2001; British Medical Association, 2002). However, they can present with complex problems that need time and resources to address. Some of these problems are common to marginalised and deprived groups in general (Health Education Authority’s Expert Working Group, 1998), others arise from the countries in which individual refugees and asylum seekers originate and the factors that precipitated their decisions to leave. Significant health problems may include communicable and nutritional diseases and the after-effects of war, torture, displacement and journey (Carey Wood *et al*, 1995; Jones and Gill, 1998b; British Medical Association, 2002; Mina *et al*, 2005). There is limited UK research regarding the health problems of refugees and the effectiveness of appropriate services. Refugees and asylum seekers in the UK often receive poor healthcare (Hargreaves *et al*, 1999), despite entitlement to free NHS treatment (Jones, 2000), because GPs feel that they are simply unable to meet the demands of this population because of the complexity of their needs, lack of adequate resources and the GPs’ own lack of knowledge and training (Katikireddi *et al*, 2004).

Effective communication, which has proven to improve health outcomes (Stewart, 1995), is even more important when working with such a marginalised group with high levels of emotional and psychological needs (House of Commons Health Committee, 2005). Models are available for effecting improvements in overcoming language difficulties (Jones and Gill, 1998a), and greater incorporation of health and social care to deliver all-round care to such patients (British Medical Association, 2002). Unfortunately, however, organisational divides act as barriers to joint working and there is still some way to go before the full integration of primary health and social care in the UK will be achieved (Rummery and Coleman, 2003).

There are some well-considered reservations about the profusion of guidelines and protocols for practice generally (Rummery and Coleman, 2003), but GPs would welcome those that might help them to deliver healthcare to refugees and asylum seekers. Published guidelines are currently available but are not disseminated to the frontline where they are needed most

(British Medical Association, 2002; Department of Health, 2003).

The impact of the refugee and asylum population is much greater on small and single-handed GP practices. Primary care trusts need to liaise with local authorities and the Home Office to identify areas to which large numbers of asylum seekers are dispersed. Resources and funding are essential if primary care is to cope with the demands placed upon it by this patient group (Hargreaves and Holmes, 2000). A definite need exists to re-evaluate how best to deliver refugee and asylum seeker healthcare within identified dispersal areas.

Limitations of the study

This study was based on interview accounts and hence is not an objective measure of the impact of refugees and asylum seekers on primary care and GPs. The views expressed are those of a selection of GPs across one metropolitan area. Their experiences may differ from those of GPs from other regions that receive refugee and asylum seekers. Field notes were not taken and may have provided further information about interview conditions. Given the highly sensitive and political nature of the topic and the fact that a female medical student from a minority ethnic community conducted the interviews, it was anticipated that GPs would be hesitant in expressing their views. In fact, all GPs were forthcoming and frank; transcripts documented a wide range of views. Recruitment bias was of concern, hence GPs were recruited from various different backgrounds with high and low contact with the asylum-seeking and refugee population. GPs with strong opinions about the subject matter are more likely to have agreed to participation. However, most GPs took part as a goodwill gesture, as opposed to their own personal interests. Many GPs opting out of the study did so due to time limitations following introduction of the new GP contract, which coincided with this study (Roland, 2004). The use of multiple coding based on the thematic framework approach (Ritchie and Spencer, 1993) helped to control for bias (Britten *et al*, 1995) and in identifying themes, exploring discrepancies and modifying findings. Further respondent validation was obtained with no discrepancies reported (Ritchie and Spencer, 1993).

Conclusions and recommendations

There are currently many potential gaps within primary care in meeting the complex set of healthcare needs that refugees and asylum seekers often have. Although GPs endeavour to meet these needs, they generally struggle to deliver the level of care that refugees and asylum seekers suffering with extensive

physical and mental problems require. The root of these difficulties is a combination of lack of time, support, education, training and, most importantly, financial resources. This study aimed to explore the views and opinions of GPs and has highlighted some important issues surrounding the delivery of care to this population. However, further studies are needed to further explore each of these.

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CONFLICTS OF INTEREST

None.

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