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Refugee Healthcare: Towards Healing Relationships

Geraldine Frances Duncan[a],*

[a]Rural Clinical School, University of Notre Dame Australia Sydney Clinical School, Wagga, NSW, Australia.
*Corresponding author.

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Abstract

Do Australian doctors provide competent and appropriate healthcare to refugee patients? What facilitates pathways and removes barriers towards optimal healthcare?

This essay explores literature regarding health professionals' abilities, when providing healthcare to refugees and asylum seekers towards optimal health status facilitating progress with their lives. It reflects upon factors affecting quality primary care delivery to refugees in Australia including reference to overseas literature.

Method: A literature search was undertaken including Google, Google Scholar, ANU online library; Factiva; Pub Med and the RACGP website. Ultimately 77 references were selected with nine themes identified regarding the provision of healthcare to refugees; particularly what aided development of healing relationships between doctors and refugee patients.

Conclusion: Australian studies do suggest that general practitioners have enthusiasm and resilience when working with refugees. Significant factors include sustainability of health-services, risk of burnout of providers, the need for peer support and the ability to control workload. Enablers include deriving strength and resilience from working with marginalised groups, recognition and pride in the advocacy role while valuing ethics and social justice issues in healthcare.

Key words: Refugees; Primary health care; Minority healthcare; Health care access; Trust; Health literacy; Interpreter

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INTRODUCTION

We can all be refugees
Nobody is safe,
All it takes is a mad leader
Or no rain to bring forth food,
We can all be refugees
We can all be told to go,
We can be hated by someone
For being someone.
(Benjamin Zephiniah, "We are Refugees")

Australia, a signatory to the UN convention on refugees, has a well-established humanitarian settlement program (Millbank, Phillips, & Bohm, 2006). The 2012 Federal Government announcement that Australian intake of refugee resettlement be increased to 20,000 from 13,650 p/a placed Australia as resettling the largest number of refugees per capita globally; second largest to the USA (DIAC ,2012). However this should be taken in the context of over 40 million persons displaced worldwide.

The 2011 UNHCR Resettlement Handbook noted resettlement involved… *selection and transfer of refugees …to a State which has agreed to admit them ... with permanent residence status...* which… *ensures protection against refoulement and….**with access to rights similar to those enjoyed by nationals.***

Rights similar to that enjoyed by nationals, implies access to adequate healthcare provision. Adequate and therefore competent provision of healthcare for refugees implies health professionals understand the effects of cultural dislocation, persecution and trauma, including role and identity changes, and challenges associated with re-starting life in entirely different cultural, social and political contexts (Benson, 2004). Adams reminds us that *a society's moral strength can be measured by how it treats it most vulnerable citizens* (Adams et al., 2004). Babacan (2004) iterates a need to *critique our understanding* of *access, equity and barriers to service provision* as we face the challenge of being *an inclusive* *society* (Babacan, 2004). Ager and Strang (2008) propose core domains facilitating successful social, economic and health connections aiding integration for refugees with safety and stability. They posit that health problems keep individuals on the periphery, preventing quality of life achievement (Ager & Strang, 2008).

1. METHODOLOGY

To provide insight into healthcare provision for refugees a literature search was undertaken to identify emergent themes. Entering search words "refugee healthcare" revealed several thousand articles; thus the search was refined with further search words depicted in Table 1. Articles were selected to reflect a range of refugee groups and health practitioner, communication and cultural understanding as well as discussing Australian practice and systems. By preference research chosen was qualitative in type. Bibliographies of articles sourced were manually examined for further relevant journals. Each article had themes summarised and ultimately common themes were collated.

Significant texts relevant to culture and the doctor-patient relationship were also consulted for further clarification.

Table 1
Search Words

Search Words.
Refugees, healthcare
Refugees+ general practice;
Cultural competence in healthcare;
Cultural preparedness for refugee healthcare;
Cultural competency training;
The doctor patient relationship;
The healing relationship;
Cultural, healthcare;
Cultural + refugee health;
Healthcare for refugees.

Table 2
Emergent Themes

Provision of healthcare to Refugees—Themes
1. Right to appropriate healthcare needs/ Ethnic minority groups experience poor health and receive a lower standard of care
2. Help-seeking behaviours/ Barriers to health services
3. Xenophobia/ racial discrimination
4. Recognise previous trauma history
5. Cultural competence—throughout the system
6. Communication; health literacy and use of interpreters
7. Relationship paradigm of health care/healing relationship/ listening with compassion
8. Education: undergraduate and vocational
9. Need for more cohesive approach/ Models of care/ Need for further research

2. EMERGENT THEMES

2.1 Right to Appropriate Healthcare Needs

The Universal Declaration of Human Rights, article 25, proclaims everyone's rights *to a standard of living adequate for the health and well-being of himself and of his family….*

Nonetheless literature suggests that refugees and ethnic minorities in fact receive lower standards of healthcare than dominant societies (Murray & Skull, 2005; Ribera et al., 2008; Pollok et al., 2012). Significantly, refugees risk a *rapid decline in self-reported health after arrival as are low-income immigrants and immigrants with limited English…..* (Pottie et al., 2011, p.E827). The National Health and Medical Research Council (NHMRC) guide for cultural competency (2005) highlights health risks for migrants and refugees noting under-recognised cardiovascular disease; poor oral health; sedentary lifestyle after migration, impact of smoking; genetic susceptibility to some diseases and pervasive impact of poor psychological health (NHMRC 2005), (also Tiong & Smith, 2006). Ribera (2008) stresses that patients with limited language proficiency for the dominant society showed less comprehension of diagnoses, prognoses, therapy and less attendance at follow-up.

Cooper et al. (2005) discussing evidence for lower quality care of ethnic and minority groups cite an U.S. Institute of Medicine 2002 reports confirming that *disparities in healthcare exist in the broader historical and contemporary context of social and economic inequality, prejudice and systemic bias*. Disparities, explain Fergusen & Candib, include: access to health care, screening, diagnostic and treatment interventions as well as morbidity and mortality (Fergusen & Candib, 2002).

While these are American papers, similar sentiments are expressed in research by Hannah (2012) on intermarried migrant Filipino women in Tasmania. This research, based on participants "*lived experience*" reported episodes of mismanagement and misunderstandings. Similarly Clark and Phillips' article "End of Life Care" (AFP 2012) note *there is little doubt that ethnic minority groups continue to have less access to health care systems, let alone culturally appropriate care.* Murray & Skull (2005) describe significant barriers to healthcare: economic, legal and cultural factors, under trained workforce with competencies to deal with the particular needs of refugees, and the impact of government policy (access to care determined by visa category) (Murray & Skull, 2005).

However while Jackson Bowers (2010) acknowledges the vulnerabilities of refugees with respect to significant health and psychological conditions on arrival he states that an accurate overview of health service needs was difficult to obtain with few published Australian data on health needs of refugee groups and experiences with primary health care services.

A Netherlands paper reported that refugees often felt doctors did not take them seriously and feared misjudgement. Cases were reported where misjudged long-standing symptoms, subsequently found to be serious physical disease, then circulated *as a general narrative of mistrust* in refugee communities (Feldman et al., 2004).

Throughout literature accessed, themes of social justice, equity, trust and accountability, negative experiences, structural barriers impacting upon health and healthcare provision were repeated. Kai et al warned that health professionals *may inadvertently contribute to ethnic disparities in healthcare by uncertainty and inertia.* Migration and displacement being adverse health determinants required doctors to take especial care with diagnosis to not undermine the development of trust. Working with cultural safety and recognising hurdles and barriers for refugee and asylum seeker patients was reiterated (Kai et al., 2007). As well the special needs of older refugees were highlighted by Wall et al. (2011) stressing elderly refugees might become increasingly isolated because of experiences and history creating layers of loss and grief.

2.2 Help Seeking Behaviours/ Barriers to Health Services

Issues raised in the literature regarding refugee experiences with health services are shown in Table 3.

Table 3
Barriers to Healthcare

Barriers to Healthcare
Lack of knowledge and unfamiliarity and uncertainty in approaching health systems
Feeling incapable
Language barriers
Convenience of access (e.g. ED vs. GP)
Experiences of being a refugee and asylum seeker in itself a barrier (Reach project Glascow)
Primary healthcare services lacking regarding the need for comprehensive health care for refugees
Health literacy
Prevention not part of refugees' expectations (Peterson et al 2010)
Age related factors
Increased exposure to the health system lessens uncertainty

Henderson and Kendall's (2011) study of culturally and linguistically diverse communities in Queensland identified unfamiliarity with health services and access as key barriers. Many participants highlighted problems with appointment times, reported forgetting them and voiced lacking understanding of the health transaction affecting follow up.

I worry why so much blood is taken…. I worry they will sell the blood like in Sudan

Peterson et al raised the importance of development of trust with health services for refugees. Trust could be engendered by even simple acts of kindness while failure to develop a trusting relationship affected the delivery of healthcare. They also found that as preventive screening/ activities from healthcare professionals was not part of refugees' expectations the therapeutic relationship was negatively affected if screening activities deflected care from more immediate health concerns. They also highlighted problems with health literacy and gaps between expectations and the reality of Australian systems (Peterson et al., 2010).

Poor communication between service providers also affected use of health services. Farley, Askew and Kay (2012) report that the broader Australian healthcare system provided limited support and flexibility and the system, being complex, was challenging for patients and providers. They also highlighted that many providers, originally trained overseas, were themselves uncertain of the health system especially as it pertained to refugees. A Canadian study of Iranian immigrants (Dasterji 2012) found that increased exposure to the health system lessened uncertainty over time. However, this was not so in all cases and some, not coping with the challenges, remained disconnected, withdrew, returning home, despite troubles there. Dasterji identified several stages to adjust and feeling competent in a new health system:

- Becoming a stranger
- Feeling helpless
- Navigating/seeking information
- Employing strategies
- Becoming integrated and self-sufficient

Emotions throughout included feeling lost, disconnected, hopeless and incompetent while trying to find the way in the new systems. Participants reported feeling overwhelmed and exhausted because of the energy and time required in negotiation (Dasterji et al., 2012).

Several articles reported language and communication as barriers; also age-related factors and the experience itself of being a refugee or asylum seeker. Construction and reconstruction of personal and social worlds impacted upon health-related choices for immigrants and Dasterji urged that health systems facilitate new arrivals' acquisition of cultural knowledge of health systems including the language for transacting health (Dasterji et al., 2012).

2.3 Racial Discrimination

Biomedicine culture… *is now seen as key to the transmission of stigma, the incorporation and maintenance of racial bias in institutions and the development of health disparities across minority groups… (*Kleinman & Benson, 2006).

Literature demonstrates discrimination in health care. Apalata et al. (2007) reported xenophobic attitudes in public hospitals expressed as refusal of health care facilities; inappropriate medicating (e.g. analgesia despite the complaint) lack of informed consent in testing and discharge without diagnosis. Ollif, writing for youth multicultural issues in Victoria (2007) reported high anxiety for young people when attending agencies, not knowing what to expect and uncertain how they would be treated. In rural and remote Australia Janie Dade Smith reports an existing discord between the Australian (western) rural culture and new arrivals with backgrounds of war, displacement and victimisation. She notes that racism operates both overtly and covertly.

Important also is Kai's (2007) discussion regarding the potential for professional uncertainty and disempowerment contributing to institutional racism. Cooper (2006) highlighted that negative attitudes could be expressed not only towards ethnic minority patients but also towards clinicians treating them. Pollock et al. (Canada, 2012) further unpacked the broad themes of refusal of health care, staff acting as gatekeepers, insensitivity and persisting communication barriers in their qualitative study on discrimination in healthcare settings (Pollock et al., 2012).

Inherent risks from discrimination are increased severity of health conditions due to avoidance, confusion and lack of self-esteem. Pollock reported that any single incident heightens uncertainty and distrust while Babacan noted that public debate in Australia reflects scepticism, ambivalence and *modern racism* (Babacan, 2004). Fontes (2008) discussed heightened sensitivity to disrespect for immigrants noting that the dominant group can *underestimate how constant, far-reaching and distressing…discrimination can be*. Indeed research from Brough et al from in-depth interviews with young people across Australia showed racism was a major stumbling block to forming relationships in Australia. He highlighted that racial violence triggers *memories of mistrust where I couldn't trust my own shadow* (Brough et al., 2003, p.201). Furthermore; Furler and Kokanovic (AFP, 2012), discussing mental health care, warn that *working across culture can highlight our own cultural 'baggage', based on our personal backgrounds*. They quote research demonstrating interference of assumptions where, for example, patients from Asian cultures were less likely referred for secondary care because of misguided beliefs that Asian cultures were *inhibited about discussing their emotional problems* (Furler & Kokanovic, 2012).

2.4 Recognise Previous Trauma History

Misfortune has a way of choosing some unprecedented means or other of impressing its power on those who might have forgotten it. A single day strews in ruins all that was raised by a train of construction extending over long spans of time (Seneca, Roman Philosopher, Moore, *The Missing Medical Text: Humane Patient Care* 1978 p.36 *The Significance of Suffering)*. While Moore's text is not specifically about refugees his thoughts and challenges urge understanding what is real for patients in their suffering. Moore notes that *sometimes a patient has the courage to confront his identity, his beliefs, his standards, his aspirations and ambitions- but more commonly he is too vulnerable to undertake such a task* (Moore, 1978, p.37). Applying such concepts to the situations in which refugees (and asylum seekers) are placed it is not difficult to recognise the sensitivity and responsibility required for doctors to gain understandings of their patients' journeys.

Eisman's research reported one in fifteen patients born outside the US have histories of trauma and that the primary care physicians studied were unaware of that trauma! They explain that eliciting history for previous traumatic events was important in order to diagnose, treat and refer appropriately (Eisman et al., 2000). Equally Shannon et al. (2012) cite 2/3 of participants in their study reported never having initiated conversation with their doctors about previous trauma and never having been asked by doctors about these things. While participants believed they should defer to the doctors' authority and not initiate discussions they indicated a willingness to talk if asked; particularly if it helped their health. Both Eisman and Shannon suggest further physician education to encourage enquiry about trauma histories and to provide education as to the potential long term impact on health outcomes of trauma.

Remembering that doctors historically have been complicit with torture Weinstein et al advise that primary care physicians must show sensitivity so as to *elicit information about trauma and offer support to those who have been brutalised*. Smith (2003) suggests *abstract empathic enquiry* and a *gradual staged approach* to help normalise the symptoms resulting from torture and trauma.

2.5 Cultural Competence: Throughout the System

Berlin and Fowkes (1983) wrote of *increasing awareness of the impact of diverse health and disease belief systems on the interaction of health care providers and patients of a different cultural heritage.* In 2009 Michael Winkleman's text *Culture and Health* asserts that *culture affects patients' and providers' perceptions of health conditions and appropriate treatments*. He further notes however that *cultural differences between physicians and their diverse clients make cross-cultural misunderstandings inevitable.*

The Australian NHMRC urges each individual professional working alone or within organisations to be proactive in matters of cultural competence and the NHMRC cultural competency guide (2005) states that all Australians have the right to access health care that meets their needs and… *in our culturally and linguistically diverse society, this right can only be upheld if cultural issues are core business at every level of the health system.*

The NHMRC stresses each individual's capacity to influence the *organisation, profession and system* in cultural matters. (NHMRC, 2005). See Figure 1.

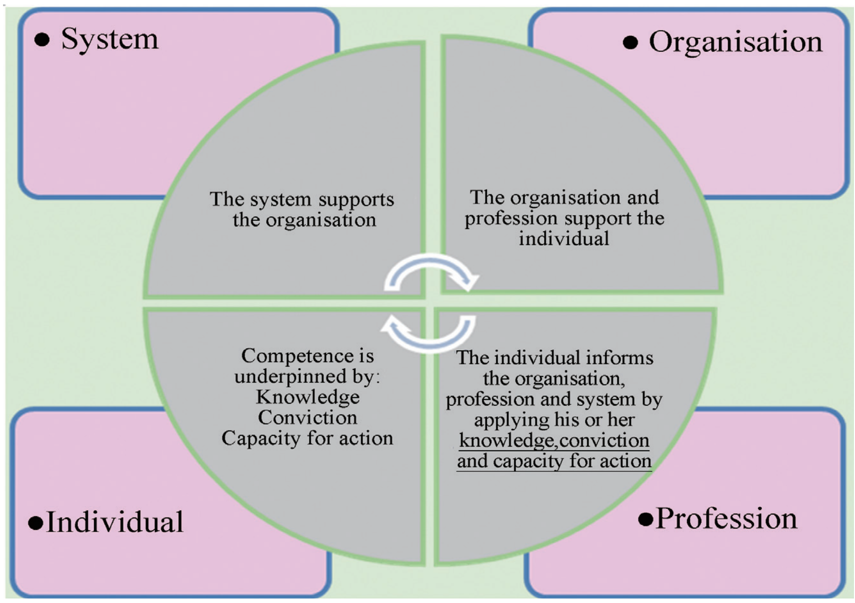

Figure 1
NHMRC "Interplay Between the Dimensions of Cultural Competency"

The Royal Australian College of Physicians (RACP) notes physicians' *responsibility to manage their own development of cultural competency* with the RACP being proactive in ensuring competency and skills in advocacy are fostered. Bean (2006) however argues that cultural competence is not an innate characteristic, requiring learning through experience, education and training. He posits that evaluation of cultural competency programmes and efficacy is yet to be thoroughly researched. This need for programme evaluation was also stressed by Fergusen and Candib (2002) while Kleinman and Benson (2006) suggested that robust research has not demonstrated that *attention to culture* has resulted in an improvement in clinical care.

Nonetheless Rachel Lee's editorial in *Culture and Diversity* (AFP April 2012) examined her own cultural lens while commencing work in a practice with a high refugee patient demography. She notes the potential for cultural divides in the healthcare provision: *how pervasive our own medical culture is to our way of thinking, and how much we take for granted in the way we interact with, and care for, our patients.*

2.6 Communication; Health Literacy and Use of Interpreters

An Australian study reported problems with communication for refugees and therefore difficulties in establishing clinician rapport. Expectations were low that GPs would engage interpreters and at times interpretation services had questionable quality. …*Sometimes the interpreter does not interpret the actual issues*. Waiting for interpreter availability took time and sometimes the professional behaviour or linguistic competency of the interpreter was questionable. Importantly, poor communication led refugees to feel disempowered and lost (Peterson et al., 2010).

Wilson and Drozdek (*Broken Spirits,* p.197) remind us of the importance of non-verbal communication as well as verbal; and the value of therapists taking time to explain approaches, questions and treatments. Therapists might not always recognise when misunderstandings occur and continual self- reflection is encouraged. Regarding interpreters we are reminded that this is a situation where a third person becomes influential in the consultation which might make the patient feel less safe in expressing some innermost emotions but equally can be a great help (*Broken Spirits,* Chapter 8, p.199).

Ribera's critical review of the literature (2008) concerning interpreter use in medical consultations noted that health professionals frequently didn't make use of interpretation services, citing time loss waiting for an interpreter and extended consultation times when an interpreter is used (although she cites that studies do not fully support this). Significant literature existed however demonstrating consequences from persisting linguistic barriers; not only for the patient (missed diagnoses) but also for the system with respect to unnecessary testing; duplication of investigations; unnecessary referral to specialists; wasted medication; and length of stay (also Wiking, 2013; Kalengayi, 2012). Apart from the enhancing quality of care, concludes Ribera, use of interpreters improves cost efficiency in the health system when one considers the above issues.

Hannah (2012) notes that language impacts upon ability to book appointments while Ager and Strang (2008) highlight the impact of health literacy upon understanding and interpreting the dominant system. Language affects what might be mutual understanding (or misunderstanding) of what constitutes satisfactory consultation outcomes. Similarly an Australian study by Attard urged communication with NESB patients should occur where possible in the patient's primary language and that *general practice staff must increase their awareness* about available services to facilitate encounters (Attard et al., 2013).

Wiking et al. (2013) in a Swedish study of immigrants, interpreters and GPs further stressed that the GP, interpreter and patient dynamic crucially affected the relationship between patient and GP impacting upon mutual understanding. The patient needed to trust the interpreter.

Interpreter stress and uncertainty were also noted by Wiking: "*The brain is not a factory for transforming words from one language to another. One needs a lot of imagination and undivided present to convey the intended message in the best way.*"

The use of family as interpreters discussed in this and other articles suggests family was better used as facilitators to interpretation rather than as the interpreter. Family members could interfere in consultation outcomes by interpreting incorrectly or providing incomplete information but could *facilitate the interpretation process with professional interpreters helping the GP to establish a relationship with the whole family* (Wiking et al., 2013).

Kalengayi et al. (2012) discussed issues of previous educational levels and health literacy on understanding the body and its functions. They noted that without checking literacy levels written materials and websites when gave to patients could be useless. These authors also highlighted the inability of migrants and refugees to comfortably use information technology to book (or cancel) appointments preferably relying on "drop in" strategies.

2.7 Healing Relationships

Moore's chapter *Human Oddity* instructs us that *in medical practice…the most profound insight is furnished not by painstaking observation of what is separate and individual but by the intensity with which the whole is comprehended. We must put ourselves in our patients' position* (Moore, 1978, The Missing Medical Text).

Equally Kleinman and Benson (2006) posit problems with concepts of cultural competency and the suggestion that culture *can be reduced to a technical skill* to be learned. They propose an ethnographic approach for clinicians to empathise with the lived experience of the illness for the patient with respect to understandings, feelings and responses. Berlin and Fowkes' (1983) proposed "LEARN" guidelines are similar in ethos to help overcome obstacles to providing cross-cultural healthcare (Figure 2).

L=listening with sympathy and understanding;

E=explain;

A=acknowledge differences and similarities;

R=recommend treatment

N=negotiate treatment.

Figure 2
"LEARN"

Scott et al. (2008) studied primary care physicians and patients sharing *healing stories*. Physician participants recognised as *exemplar healers* generated powerful *healing connections* with patients. From the study Scott's team created what they called *healing model components* which included items such as valuing, managing power structures, continuity of care, not giving up, mindfulness, trust and hope as well as knowing the patient as a person. These functions are shown in their diagram reproduced below as Figure 3.

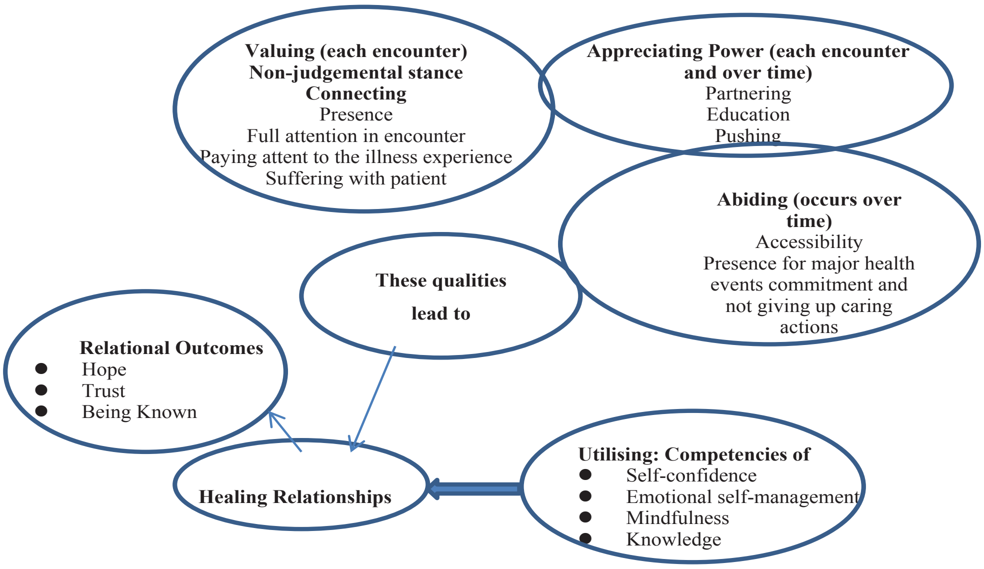

Figure 3
Healing Relationships Scott et al 2008

The Canadian text *Patient-centred medicine: transforming the clinical method* by Stewart et al. (2nd ed., 2003) reminded us that listening in order to build up sustained relationships with patients should be the foundation of community–based primary care. Stewart invited readers to reflect upon differences between doctor-centred versus patient-centred styles; the latter allowing physicians to respond better to patient needs achieving more favourable outcomes. The importance of integrating disease and illness into understanding the whole person and seeking common ground was stressed. Similarly, considering cross-cultural healthcare Jacobi (GP, May 2011) suggests that GPs providing multicultural consultations should "*remain genuinely curious about other cultures"* utilising a patient-centred style while being aware of one's limitations and assumptions and "*asking when in doubt"*. Wiking highlights the importance of patient-centred care also noting that this approach seeks an understanding of the patient's world and the whole being: - emotional needs and life issues. "*It enhances the continuing relationship between ... patient and ... health care provider"* allowing identification of problems and joint decision making (Wiking et al., 2013). Cooper also stresses clinician self-awareness to work towards relationship-centred paradigms including inter-clinician communication and community understanding to improve the quality of care (Cooper et al., 2004).

2.8 Education: Undergraduate and Vocational

"I'm worried about what I missed…"

Pieper & MacFarlane's study of GP Registrars in Ireland uncovered multiple learning needs in cross-cultural care across diverse communities. Participants worried they provided sub-standard care and revealed negative emotions towards cross-cultural consultations including anger, frustration, helplessness and even resentment. The authors noted GP Registrars' learning needs were outside curriculum which was concerning given *wide national and international acceptance that medical undergraduate and postgraduate education should address issues related to human diversity* (Pieper et al., 2011).

Spencer et al.'s (2008) literature review exploring extents to which cultural competency was included in health professional undergraduate curricula raised concerns about what constituted cultural competency training and assessments. They found fragmented approaches to program evaluations and complex problems with data extraction due to lack of standardised descriptors of course content and varied definitions of cultural competency training. Variation in content and approaches to teaching cross-cultural care between medical schools was also noted by Lyons and Laugharne (2011) despite endorsement by accreditation bodies that courses needed to improve training in these areas.

Communication teachers, curriculum heads, policy makers and students when interviewed by Dogra exhibited diverse opinions as to what "cultural diversity" and its teaching meant. Students wanted to have certainty of cultural expertise fitting in with current trends to *create expert students who never make mistakes*. However cultural diversity teachers felt that goals should be for students to understand individual patient needs while learning to cope with ambiguity and uncertainty (Dogra et al., 2007).

Similarly Kai et al. (2007) argued that health professionals need to *accept and work creatively with uncertainty* otherwise they may *perpetuate inequality*. They suggested a shift away from "*cultural expertise*" towards viewing the patient as an individual.

Overall the literature on undergraduate teaching suggests a need for preclinical teaching on cultural diversity with plentiful subsequent opportunities for practice and refinement. The message of seeing a person as an individual and learning to cope with uncertainty was evident in much of the literature.

2.9 Need for More Cohesive Approach/ Models of Care/ Need for Further Research

Johnson, Ziersch and Burgess' South Australian study (2008) reported *that the responsibility of providing initial care to refugees should not lie with GPs in private practice* due to significant barriers. Farley et al. (2013) reported general practices (mainly urban in their study) felt isolated and unprepared despite enthusiasm, while Sypek et al. (2008) noted fragility of health services in rural Australia with quality comprehensive care for refugees threatened by *low numbers of practitioners and high levels of turnover in healthcare staff.*

Margaret Kay (2010) while noting each state in Australia provides very different services for refugees and valuing the role that primary health care has to play (despite lack of support and inadequate resources) proposes a model of health care:-the Primary Amplification Model. Here a "Beacon Practice" provides initial care, developing expertise and best practice for a range of services. It also provides linkages with other general practices involved in continuing care and supports them in education. Johnson, Ziersch and Burgess (2008) also raised alternative models of care.

The NSW Refugee Health Plan 2011-2016 discusses "*High Quality health-service provision*" (p.25) which translates to 31 strategic actions (pp.34-37). However it is difficult to see from the plan where overarching responsibility lies to foster development. Across Australia more research is needed to assess effective models of care (Henderson et al., and Jackson Bowers and, among others).

CONCLUSION

Taking into consideration the literature findings and discussion above, what lessons are there for primary care in Australia?

Refugees experience poor health and frequently a decline in health after arrival and during resettlement (Smith, 2003; Tiong, 2006; Pottie, 2011; NSW Refugee Health Plan, 2011). Despite a universal right to health it is well documented that refugees often receive a lower standard of healthcare (Fergusen & Candib, 2002; Murray & Skull, 2005; Clark & Phillips, 2010). Furthermore Kai et al. (2007) warn that health professionals contribute to healthcare disparities by "*uncertainty and inertia*".

Wilson and Drozdek note specifically under-reporting of psychological distress, lack of awareness of culture specific symptoms and the questionable applicability of diagnostic criteria designed in western settings. (*Broken Spirits;* Chapter 23, p.627).

Several barriers exist for refugees acquiring care for their health needs. These include lack of knowledge, unfamiliarity and uncertainty in approaching health systems (Kendall, 2011); feeling inadequate and incapable, not having cultural knowledge of the health system; as well as the language in which to transact health (Dasterji, 2011).

Convenience of access is a consideration while primary healthcare services often lack comprehensive healthcare provision for refugees (Farley, Askew, & Kay, 2012).

Unfortunately evidence of xenophobia exists and the culture of biomedicine can incorporate and maintain racial bias (Kleinman & Benson, 2006; Lee, 2012), while the public debate continues to reflect scepticism and ambivalence (Babacan, 2008). Such attitudes potentiate the seriousness of health conditions through avoidance, confusion and lack of self-esteem (Pollock, 2012).

Healthcare provision for refugees (and all patients) requires recognising the need to reach out and connect with the whole person.

Throughout the literature sourced considerations of language, communication and cultural competence highlighted reappraisals of doctor approaches to refugee healthcare. The person-centred approach, concentrating upon understanding the individual with respect to broader socioeconomic and psychological paradigms by the healthcare professional is reinforced (Cooper et al., 2004; Kelinman & Benson, 2006; Jacobi, 2011; Wiking, 2013). As Feldman (2007) noted clinicians with a human interest approach for their refugee patients tended to be more satisfied with outcomes of their consultations; whereas those whom they termed "*technocrats*" emphasised strangeness of complaints and "*cultural distance*".

Importantly doctors should appreciate their need to gain knowledge, skills and ability to use cultural as well as medical diagnostic skills whilst incorporating social issues when treating refugee patients.

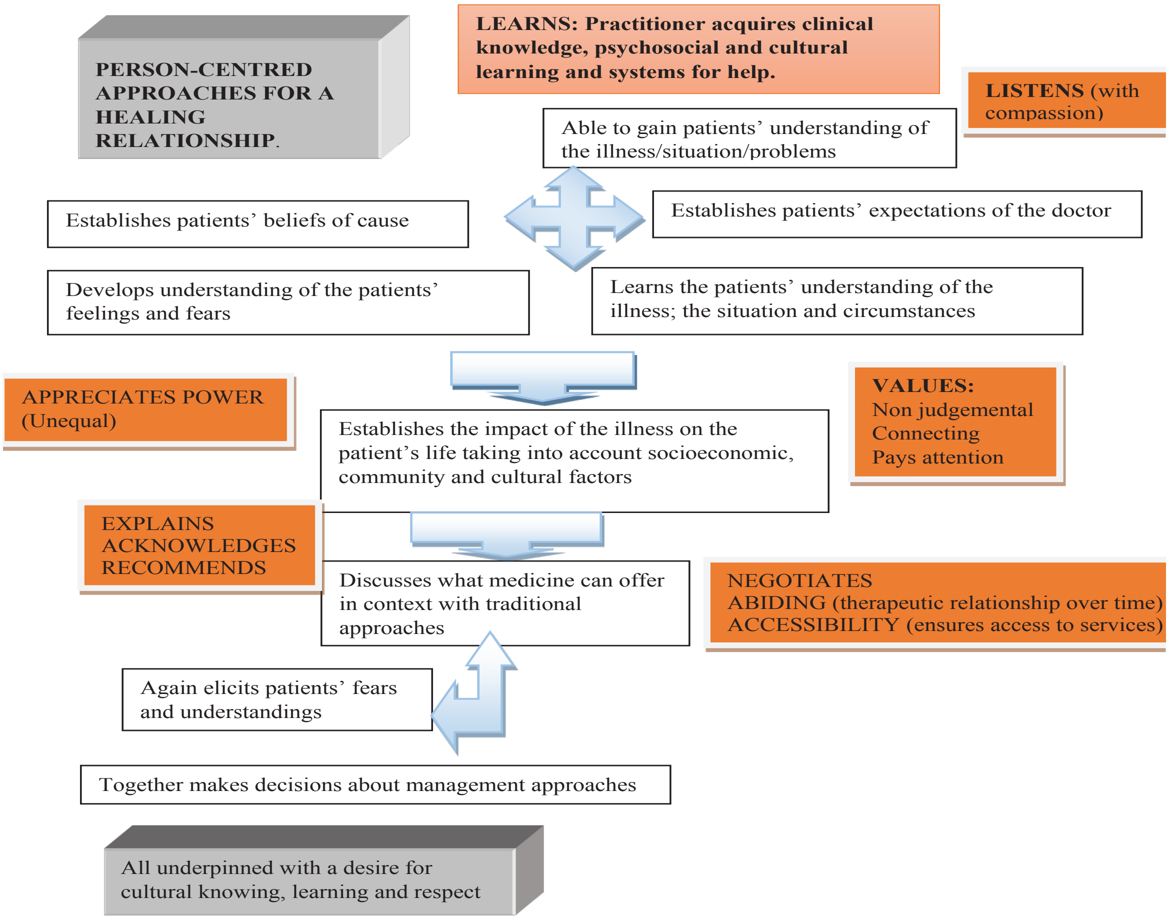

Figure 4
Person-Centred Approaches for a Healing Relationship

Australian studies do suggest that general practitioners working with refugees have enthusiasm and resilience but need a more co-ordinated systematic approach (Sypek et al., 2008, Kay et al., 2012). Significant factors include sustainability of health-services, the risk of burnout, need for peer support, ability to control workloads and organisational and professional support in this. Enablers include: deriving strength and resilience from working with marginalised groups, recognition and pride in advocacy roles while valuing ethical and social justice issues in healthcare to help heal those brutalised by injustices of forced change in social, spiritual and economic circumstances.

Thus despite Johnson, Ziersch & Burgess' concern that general practice should not be the frontline for refugee healthcare, general practitioners can reflect upon their personalised approach to refugees; recognising that trust and respect underscore healing relationships. Indeed as Furler et al. (2010) remind us we can negotiate across transcultural worlds with sensitivity.

Themes demonstrating concepts of healing relationships as discussed above are depicted in the following diagram *Person-centred approaches for a healing relationship* (Figure 4.).

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