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ORIGINAL ARTICLE

Approaches to delivering appropriate care to engage and meet the complex needs of refugee and asylum seekers in Australian primary healthcare: A qualitative study

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Abstract

This study aimed to provide insight and learnings from Australian general practitioners in facilitating positive interactions with refugee and asylum seeker patients and the role they play in helping those community members engage with healthcare. We conducted semi-structured individual remote interviews with 12 general practitioners (GPs) who worked in areas with high refugee and migrant populations. Interview transcripts were coded inductively and deductively, based on the research questions, using Thematic Analysis. Extensive debriefing and discussion took place within the research team throughout data collection and analysis. Creating a culturally safe environment was an initial step taken by GPs to minimise the inherent power imbalance, in addition to applying the principles of trauma-informed care (TIC) to appropriately listen and respond to their patients' needs and individual social circumstances. GPs at times were involved in using their role to advocate on behalf of their patient and played a key role in helping build their patients' health systems literacy. This study highlights the important role that GPs play in advocating and engaging refugee and asylum seeker patients, as well as helping them navigate the healthcare system. Whilst GPs practice can be made more efficient through experience and time; to deliver the care required GPs need to provide care in response to the individual's capacity and social circumstances. Enabling time and the application of the principles of TIC and cultural safety may allow for GPs to provide the quality of care that is needed in supporting patients from refugee and asylum seeker backgrounds.

KEYWORDS
cultural safety, primary healthcare, refugee health, trauma-informed care

1 | INTRODUCTION

The United Nations High Commission for Refugees reports an estimated 26.4 million refugees worldwide, with many more individuals forced into involuntary migration globally (UNHCR, 2020). Refugees are defined as those who have fled their countries due to 'a well-founded fear of persecution due to race, religion, nationality, membership in a particular social group, or political opinion' (UNHCR, 2018). As a result of this fear, they are unable to return to their country of nationality or permanent residence. Similarly, 'asylum seekers' are people who have sought protection in another country but have not yet had their refugee status determined (UN Refugee Agency, 2015). In multicultural societies, such as Australia, clinicians are increasingly presented with patients from various backgrounds and arrival pathways (White et al., 2018).

In Australia, refugees who have been granted residency through the offshore humanitarian resettlement pathways receive free voluntary health assessments within 12 months of arrival or grant of visa (Parliment of Australia, 2016). These health assessments aim to help detect acute and chronic health conditions and provide preventative healthcare such as catch-up immunisations. When this population group arrives in Australia private general practices or state-funded community health centres are usually the first point of care and many of these patients have complex health needs which include both psychological and physiological issues (Milosevic et al., 2012). These individuals who are refugee's have access to Medicare, which provides bulk-billed services, in comparison asylum seekers are individuals who have not been granted residency and as such often may not have access to Medicare (Harris, 2018).

The demonstration of compassion and caring for the individual mindfully are important facets when providing care (Ranjbar et al., 2020). This is particularly crucial when engaging with refugees and asylum seekers who may arrive with experiences of mental and/or physical trauma (Fair et al., 2018; Gisselquist, 2020). Trauma-informed care (TIC) is grounded in acknowledging how trauma affects people's lives and understanding that healthcare delivery must ensure individuals are not retraumatised (Miller et al., 2019). This is achieved by listening, responding, and working in partnership with the patient regarding their boundaries and expectation to avoid further trauma or stress (Ranjbar et al., 2020). TIC also highlights awareness and sensitivity to a person's experiences and is relevant to this population group, as they have particular experiences of displacement and trauma (Robertshaw et al., 2017).

Another central component to provide responsive, compassionate, and equitable care to refugees and asylum seekers is the concept of cultural safety. Both cultural safety and TIC involve acknowledging the barriers to clinical effectiveness occurring from the inherent power imbalance between provider and patient (Curtis et al., 2019; Laverty et al., 2017; Ranjbar et al., 2020). Cultural safety also seeks to allow the patient to determine whether a clinical encounter is safe (Curtis et al., 2019). The key to cultural safety is the clinician's examination or reflection of themselves and the potential impact of their own culture on clinical interactions. Existing research has highlighted the complexities of applying cultural safety, for example, the skills needed when working with interpreters (Mortensen, 2010) and the potential harms when communication is not effective. A study conducted with Indigenous peoples in Australia found that patients felt 'unsafe' when they had an inability to communicate or felt they were not understood or listened to (Johnstone & Kanitsaki, 2007). Literature and cultural safety models for providing care for people from refugee backgrounds suggest that knowledge about the patient's culture could be disempowering for those who are disenfranchised from their own culture. This could be seen as the continuation of a colonising process that is both demeaning and disempowering or appropriating (Reavy et al., 2012). Approaches to effective communication and generating a culturally safe space within the consultations highlight the importance of listening to develop an interest in the individual's personal circumstances and avoiding making generalisations about refugee groups (Rowe & Paterson, 2009). Key to this is ensuring that the patient is engaged in being able to understand and confidently participate in a meaningful and constructive dialogue in their clinical care (Perloff et al., 2006).

Existing literature has found that communication behaviours play a vital role during patient-clinician interaction, and strongly impact patient satisfaction during consultations (King & Hoppe, 2013; Korsch et al., 1968; Wanzer et al., 2004). A qualitative study looking at the communication barriers between refugees with trauma histories found that they were hesitant to initiate conversations about trauma with their clinicians. Despite hesitancy to initiate conversations relating to their personal histories, the effectiveness of these conversations shape the ongoing relationship and help with building trust (Shannon et al., 2012). A literature review of refugee and asylum seeker patient and clinician experiences of communication during consultations found that alongside language barriers, cultural factors and cues from the clinician, including hand gestures and listening to non-medically

What is known about this topic?

- Patient-clinician interactions play a key role in patient satisfaction for refugee and asylum seeker patients.
- Refugee and asylum seekers have multiple healthcare needs.
- Compassionate and responsive care is needed by the clinician.

What this paper adds?

- Creating a culturally safe environment helps minimise the inherent power imbalance in consultations.
- GPs at times use their role to advocate on behalf of their patient with consideration of the individual's capacity and social circumstances.
- Enabling time is key in supporting refugee and asylum seeker patients.

relevant information, were also influential in shaping the overall patient experience and degree of satisfaction (Patel, Bernays, et al., 2021).

Multiple studies and reviews have been conducted to understand the direct communication challenges in primary healthcare with patients from refugee and migrant backgrounds; however, these have largely focused on language barriers and challenges in accessing healthcare services (Cheng, Vasi, et al., 2015; Hargreaves et al., 2000; Robertshaw et al., 2017). In an Australian context, primary healthcare services have access to and routinely use the free telephone interpreter service to access interpreters during consultations (Milosevic et al., 2012). Even with the access and help of professional interpreter services, there were problems associated with availability and concerns regarding confidentiality and accuracy (Cheng, Drillich, et al., 2015). Whilst existing literature establishes that the verbal and non-verbal exchange of information is an important step in primary healthcare settings (Perloff et al., 2006), how this in turn is influenced by the application of cultural safety and TIC, is limited.

The aim of this study is to provide insight into the experiences and learnings of general practitioners (GPs), who are one of the key members of the primary healthcare team, providing care to refugee and asylum seeker patients and how they interact with their patients to help further improve patient engagement in primary healthcare. With this qualitative study we focused on two main research questions: (1) What do GPs do to help their refugee and asylum seeker patients feel comfortable during consultations? (2) How do they help these individuals become better engaged with healthcare?

2 | METHODS

2.1 | Study design

Using qualitative semi-structured remote interviews with general practitioners, this study describes the experiences of GPs in engaging refugee and asylum seeker community members and the particular needs they need to respond to which are in addition to their broader patient group. Parallel to GP interviews we also conducted qualitative interviews with community members from refugee and asylum seeker backgrounds to understand their experiences of general practice in Sydney, Australia. The findings from this component of the study have been published elsewhere (Patel, Muscat, et al., 2021). The reporting of this qualitative study follows the consolidated criteria for reporting qualitative research (COREQ criteria; Tong et al., 2007). Ethical approval was obtained through the Western Sydney Local Health District Ethics Office.

2.2 | Setting

The study was conducted in Sydney, Australia. The majority of GP participants worked in Western Sydney, a geographical region in Sydney which serves a large culturally and linguistically diverse population; more than 50% of people in the Western Sydney region speak a language other than English at home (NSW Government, 2017).

2.3 | Study participants

A range of GPs who worked in Western Sydney was invited through professional networks and practices to participate if they had had a consultation with at least one patient from a refugee or asylum seeker background in the last year. Based on national census data, (NSW Government, 2016) these GPs were identified as working in practices within the local suburbs which had high refugee and migrant populations. In Western Sydney, 38.6% of the population were born overseas and 43.6% spoke a language other than English at home; the top 10 countries for those who were born overseas were: India, China, Vietnam, United Kingdom, Philippines, Lebanon, New Zealand, Iraq, Fiji and South Korea. In addition, we invited GPs working at a specialised asylum seeker clinic in Melbourne, Australia to participate as we were unable to recruit from the Sydney-based clinic due to a conflict of interest within the research team. This clinic was chosen as it is in a similar metropolitan city within Australia.

2.4 | Participant recruitment

Using GP contacts and professional networks, individuals who worked in the Western Sydney region, were sent invitations to be involved. This was done to purposefully target a diverse range of GP characteristics (languages spoken, years of experience etc). The invitation flyer contained details on how to receive further information on the aims and procedure of the study. For those who expressed interest, the first author, contacted them to check eligibility, discuss informed consent and organise a date and time for an interview either through Zoom videoconferencing or via the telephone. All GP participants were given a choice between written and verbal consent processes; eight GPs provided verbal consent and four GPs provided written consent. Two interviews were conducted over the phone and the other 10 were conducted over Zoom videoconferencing.

2.5 | Data collection procedure

The first author, a female public health researcher from a migrant background with experience in qualitative interviews, conducted all GP interviews. These interviews were semi-structured and conducted using telephone and videoconferencing facilities between February 2021 and August 2021. All GP interview transcripts were audio-recorded and transcribed verbatim. All the interviews were conducted at a time convenient to the GP, lasting 30 min on average.

The semi-structured individual interviews were based on a flexible topic guide (Appendix S1) developed by the research team covering topics such as the approaches used to make their patients comfortable and engaged and what tools and resources are used to

support consultations. Participants were also given the opportunity to receive a copy of the interview transcript if they wished to review it. The development of the topic guides was based on the research questions and reflected the findings from our literature review which highlighted the importance of non-verbal cues, appropriate access to professional interpreters, cultural understanding of health and beliefs and providing compassionate care (Patel, Bernays, et al., 2021). The topic guides were revised throughout the data collection, informed by iterative data analysis. All transcripts were anonymised before beginning the analysis.

2.6 | Data analysis

Extensive debriefing and discussion took place numerous times within the research team throughout the data collection and data analysis process. The first author read all the transcripts whilst the other authors read different subsets of transcripts each to guide the development of the coding framework. The interview data were analysed using the Thematic Analysis method, (Clarke et al., 2015) with data managed in Word and Excel spreadsheets. We analysed data in an iterative manner, using an analytical approach that was both inductive (data-driven) and deductive (researcher-driven), based on the research questions, to develop a coding framework to reflect emerging patterns and themes. This process allowed for the data to be triangulated with both existing literature, but also parallel qualitative interviews conducted with refugee and asylum seeker community members (Patel, Muscat, et al., 2021). In discussion, all authors identified relationships amongst and between categories to generate themes. This refined framework was then applied to all transcripts and the pertinence of emerging themes was corroborated and checked across the full coded dataset.

3 | RESULTS

A total of 12 GPs took part in the provider interviews; of these participants, four were males and eight were females. Eleven of the participants worked in Western Sydney and one worked in a specialised asylum seeker clinic in Melbourne. The median years working in general practice for the GPs was 24.5 years. However, the level of experience ranged from being recently qualified to extensive experience over multiple decades. Five participants reported seeing patients from refugee backgrounds daily, one saw them weekly, three saw them monthly and three saw patients from refugee backgrounds a few times a year. The GP participant characteristics are outlined in Table 1.

The GPs involved in our study were highly engaged with the social context of their refugee patients and felt a responsibility to involve their patients in their own care. We identified four themes reflecting how GPs engage patients from refugee backgrounds: (1) Creating a culturally safe environment. (2) TIC is used to listen, identify, and respond to complex needs. (3) GPs as advocates and guides in the navigation of healthcare. (4) Time: a cross-cutting theme. The themes and codes derived from this data were used in data analysis as shown in Table 2. Integral to our analysis is the findings of the GP participant datasets and how they intersect with the refugee context in Australia. Therefore, we have included some of the interpretations within the results section.

TABLE 1 General practitioner (GP) participant characteristics

Participant characteristics	Number (%)
Sex	
Female	8 (67)
Male	4 (33)
Years working in GP	
Less than 5 years	1 (8)
5–9 years	3 (25)
10–19 years	1 (8)
20–29 years	2 (17)
30+ years	5 (42)
Consult refugee or asylum seeker patient	
Daily	5 (42)
Weekly	1 (8)
Monthly	3 (25)
Few times a year	3 (25)
Language other than English spoken	
Yes	11 (92)
No	1 (8)
Country of medical training (university)	
Australia	4 (33)
India	2 (17)
Sri Lanka	2 (17)
Egypt	1 (8)
Iraq	1 (8)
United Kingdom	1 (8)
Wales	1 (8)

3.1 | Creating a culturally safe environment

The GP participants felt that the initial invitation and welcome was an integral part of consultations with their patients from refugee and asylum seeker backgrounds. Creating a welcoming environment for their patients included the ways in which they were greeted, invited into the room, and positioned once seated. The GPs in some instances used these greetings as a way to lessen the formality of the interaction so that they could create a space which was less intimidating.

TABLE 2 Themes and codes derived from the qualitative analysis

Themes	Codes
Creating a culturally safe environment	Warm greeting
	Welcoming environment and physical positioning
	Engaging patients in conversation and social talk
Trauma-informed care used to listen, identify and respond	The need to listen and be attuned to nuances of conversations
	Interpreting non-verbal cues and body language
	Address broader experiences and social circumstances
	Mindful of previous experiences of trauma
	Importance of language concordance to apply trauma-informed care
GPs as advocates and guides in the navigation of healthcare	Guide for navigation of healthcare
	Helping patients develop health systems literacy
	GP's role in advocating for their patients
Time	Allocating more time to patients
	Building relationships over visits

> Well, I mean, first of all, an extremely warm greeting. I have to remind myself where I'm seeing his patient to go over the top in being pleased to see him. I've got to remember that they might be the twentieth patient I've seen today, but I'm the first doctor they've seen. [P9]

This was seen as the first step in really creating a culturally safe space for their patients and ensuring that the physical environment did not leave their patient feeling vulnerable or trapped. Many explained this using patient examples highlighting how they felt this was a crucial step when many came from previous experiences of trauma and other healthcare systems where doctors were seen as authority figures. The physical positioning and environment were also influential part of the interaction. The GPs tried to use the way in which they were positioned in the consultation room to reduce the power dynamics, which can often impact cultural safety and the application of TIC.

> And when I sit them, I make sure I'm sitting at the same level. [P5]

In some instances, these efforts alone were not enough to engage the patient in a comfortable conversation, and some participants reflected that their patients were sometimes initially wary due to prior experiences in formal settings.

> So, a lot of them actually sort of they, they sort of hold back initially, because they're actually scared because they're sort of in a surrounding and a new sort of environment. [P3]

Being able to speak to their patients in the patient's preferred language was reported by some GPs as further supporting an initial connection. Nine of the GPs interviewed spoke a language other than English with their patients from refugee and asylum seeker backgrounds; in addition to having language concordance, many of the participants had varying ethnic backgrounds which they felt provided them with an additional benefit when connecting with their patients. Some reflected that they felt that their appearance also gave their patients a sense of reassurance and inherent trust.

> So, in one way, speaking that same language and belonging to the same ethnic group and sharing the same cultural beliefs, has helped us a lot in able to be reaching out to them. [P2]

3.2 | TIC used to listen, identify and respond

A large component of the consultation required GPs to listen to identify and respond to their patient's needs. This often required adopting TIC approaches. Numerous participant narratives highlighted the importance of listening and they felt that their approach to their patients was grounded in *the art of listening [P7]*. Listening and showing the patient that they were engaged in the conversation was an essential part of not only responding to their concerns but to help them build a relationship and rapport.

> I do spend my time to get to know what their problems are and to address them, you know, so I think they like that quality. [P10]

In the time-pressured environment of GP consultations, participants described that they had to actively make time, which is the key enabler of listening, to ensure they had the conditions to apply principles of TIC and create a safe space. Some described ways in which they ensured that they were able to actively schedule their appointments accordingly so that more time was allocated to these consultations to

create a space where their patients could disclose information and ask questions.

> The main thing is listening, patience and time. So, it better for them being first in the morning, or later in the day, you know where you can spend some time with them, like not rushing. [P6]

All GP participants interviewed in our cohort acknowledged that although being responsive through active listening was a key element for providing good care, it was a critical component with their patients from refugee backgrounds. This was especially useful in helping them navigate treating their patients who had experienced trauma.

Active listening was also about paying attention to non-verbal communication, for example, through noticing and attending to silences and hesitations. The majority of participants highlighted the importance of interpreting body language as a mechanism to identify and respond to some of their patients' hesitancy. These nonverbal actions and visceral ways of communicating were seen as just as important, as verbal cues, in helping to connect with their patients. Having adequate time for the consultation supported GPs to find sensitive ways to ask their patients questions about their broader experiences and social circumstances, in recognition of the indirect determinants of health, whilst also being mindful of their patient's boundaries.

> If you can't empathize verbally, something like 80% of communication is nonverbal anyway, so you've got to kind of show people that you know, that you are interested. [P11]

> Knowing when to ask what and when to back off, and when to go into it and how to spend time forming a rapport with patients understanding where they're coming from. [P2]

The experiences of the GPs highlight how much of their routine practices are grounded in their previous skills development and medical training to apply care which is sensitive to the persons' needs and conducted in a respectful manner. Given the language needs of this patient group, having access to professional interpreters or the ability to speak the same language were prerequisites to their ability to be responsive and provide quality care.

Most GPs interviewed commented that in instances where there wasn't language concordance, they would usually use the telephone interpreter. Whilst almost all participants could remember using a telephone interpreter with their patients at some point, the majority commented that although good they did not have to use the service routinely. Instead, reflecting the local community composition of their GP practices, staff members were often able to provide interpreter assistance which was considered an accessible and satisfactory alternative.

> We also have a lot of Afghani receptionists, who are, you know, who can speak Dari or Iranian languages. They can come and interpret for me. [P10]

Less common was the patient's reliance on family members and support people for interpreting. Whilst some GP participants highlighted the harms that may result from having family and friends interpret for their patients, others felt that in certain instances having a support person who could act as an interpreter was beneficial.

> And because it was her husband, she could explain that feeling, so that sort of issue I don't know how interpreter and the patient would be comfortable. [P6]

3.3 | GPs as advocates and guides in the navigation of the healthcare

Another core component of the GPs' role was acting as an advocate to support their patients to connect and navigate the health system whilst also meeting their complex needs.

3.3.1 | Guide for navigation of healthcare and health systems literacy

Integral to culturally safety is ensuring that the patient is engaged in being able to understand and meaningfully participate in the dialogue during the medical consultation. Many participants emphasised that they invested considerable time guiding their patients to develop their own health and health system literacy. The GPs drew on available resources and experience to guide their practices, these included their own shared language, the use of professional interpreters and the use of visual resources and prompts, as well as guidance about the processes of referral.

Once their patients were comfortable, GPs reflected that it became more likely that they would be able to maintain an ongoing relationship which made communication easier and more open.

> So, you know, usually if the one patient is comfortable with the one GP, they always come (back). [P8]

Whilst the concept of shared decision-making may have been relatively unfamiliar to some initially, the GPs suggested that the idea was slowly developed over visits and accepted as good care by the patient. The GPs felt that their efforts in prioritising and helping their patients navigate the health system were part of assisting individuals with their skill-building and led to individual empowerment.

> But once they realize that, you know, ultimately, we are after their own well-being they understand really well. And they're quite happy to jump on board and become a partner in a management situation, which

> ultimately will actually be quite successful when they've shown an interest and they want to take part in their health process. [P2]

Participant narratives also suggested that the previous experiences of healthcare services were one of the factors impacting their patient's ability to be involved. Additionally, few participants noted that their patients from refugee backgrounds had many other priorities which they were often more acutely concerned about which meant that making their health a priority was something which took time.

> Because in their minds, the eye can see, as I said, when you come from a refugee country, your health will be the last thing to think about. But when you come here, it will take time for them to learn the health will be the first priority. [P7]

General practitioners (GPs) suggested that health was lower on the list of priorities for patients from refugee backgrounds who had other concerns which were of importance to their social well-being. These included things such as housing, employment, education, visa status and concerns about family and friends in their home countries. Participants considered that their role as GPs involved needing to be understanding of all these additional social determinants of health that particularly impacted their patients from this population group, especially when guiding them through the process of referral to other healthcare providers and services.

3.3.2 | GP role in advocacy

Although some commented that their patients slowly took more active roles in decision-making about their health, others commented how they felt that it was their role to help advocate for their patients with specialists to account for their social concerns. This was largely commented as something the GP would engage in when the patient had limited English proficiency and if the GP felt that they would not be able to verbally advocate for themselves.

> Sometimes we just, you know, talk to the specialist and explain to their financial situation and ask them to bulk bill the patient or sometimes see them, quickly and also, we make an appointment, sometimes, because of the language barrier and, we do a lot of things like, make an appointment and that kind of thing. [P8]

Whilst the majority of participants mentioned that they feel that some patients are able to navigate the healthcare system and that the patients sometimes have support from case workers and other community members, they still felt that they needed to advocate for their patients. A large part of their role as GPs involved additional administrative tasks to help them navigate the system. This needed to be done with the consideration of the costs of healthcare and recognition of their patient's financial situation. Some participants commented how they actively took roles in linking and contacting specialists and other health services to provide their patients with bulk-billed services so that the out-of-pocket cost to their patients would be minimal.

3.4 | Time

The presence of time was cross-cutting in that it was an overarching requirement to enact any of the above themes and as such was a key component towards patient engagement.

Time and a safe space meant that they could encourage their patients to talk about their clinical needs indirectly by asking questions about other concerns and experiences. Without time though this was very difficult to achieve satisfactorily. The emergence of trust, safety and understanding of the broader context could be supported by techniques but could not be accelerated so that time was irrelevant.

In addition to providing time within the consultation to be able to facilitate elements of cultural safety and TIC, participants noted the importance of follow-up visits and time to build the relationship. Rather than in individual singular interaction, the patient-GP relationship was developed slowly over multiple visits, and this was vital in slowly helping their patients not only engage with healthcare but also their ability to engage.

> May have not been seeing doctors regularly like we do here … so it takes time, you have to take your time. [P1]

4 | DISCUSSION

The findings of this qualitative study with Australian GPs illustrate how the role of the GP in the context of refugee patients is largely focused on engaging them in their care whilst giving consideration to their social context and preferences. Creating a culturally safe environment and applying the principles of TIC, through physical positioning, warm greetings and speaking in their patients preferred language, enabled the GPs to appropriately listen and respond to their patients' needs. Additionally, GPs often used their position to act as advocates and guides in the navigation of healthcare, with consideration of their individual patient's social circumstances. This paper specifically highlights methods and support used by GPs to help engage patients to help their health and health systems literacy and also provides insights into the experiences of GPs.

During the interviews, GPs commented that many of their patients from refugee backgrounds had experiences of trauma and that they had underlying post-traumatic stress disorder. Whilst none of the participants explicitly commented on applying TIC, from the thematic analysis of the dataset many of the practices and values being applied by the GPs in their interaction with patients from refugee backgrounds were closely aligned with the key principles of TIC,

including safety, trustworthiness and transparency, collaboration and peer support, empowerment and choice (Bowen & Murshid, 2016). One of the essential principles of TIC is the importance of trusting relationships. As shown through our study, GPs have enormous potential to increase a patient's engagement with healthcare. GPs invest both time and effort in helping someone know how to navigate the processes and the systems so that they feel more capable of engaging in the system. This is important to a sense of being equipped to navigate the system and to engage with the opportunities offered within the system. GPs were using their role to not only advocate on behalf of their patient but also using their role and relationship with their patient to identify their patient's capacity to engage in the healthcare structures. One of the core findings is the role GPs play in engendering genuine empowerment by facilitating their refugee patient's engagement at a level that is reflective of their individual capacity. This was conducted by not only helping them navigate the system but also by helping them build their health system's literacy when engaging with other health services.

The creation of culturally safe environments in which the patient feels welcome is an essential component of healing, alongside empathy to help establish safety (Miller et al., 2019). Our findings highlight that GPs routinely use physical positioning, language preferences and both verbal and non-verbal communication to create a positive environment which can help promote cultural safety. Building these methods into their practice GPs were acknowledging and trying to minimise the power imbalance which is a key component of cultural safety and TIC. Additionally providing the patients with opportunities for choice such as with the use of interpreters, whether professional or informal use of family or friends, furthers their opportunities for autonomy and empowerment.

The findings also highlight the complexity of interpreter use and the conflicting experiences of GPs using professional interpreters, staff, and family/friends to interpret in consultations. The Royal Australian College of General Practice (RACGP) guidelines recommend caution when using family or friends to interpret and state that GPs should discourage the use of children to interpret (The Royal Australian Colllage of General Practitioners, 2015). Whilst the GPs in the study acknowledged that there may be concerns when not using professional interpreters, there was a belief that patients preferred using family and friends as interpreters. These findings are consistent with broad national GP data which also found that during consultations in a language other than English, one in five GPs used family/friends to interpret (Bayram et al., 2016).

Language can be an insurmountable barrier which makes navigating healthcare services daunting and this is in addition to other social determinants of health impacting many patients from refugee backgrounds, such as access to safe housing, employment, and transportation—nearly impossible (Molina & Kasper, 2019). The general practice consultation is an opportunity for GPs to help patients overcome some of the social factors that impact their health and wellbeing (Nápoles-Springer et al., 2005). Through our study, we highlight that GPs are already acting as trusted guides within the healthcare system and play a key role based on personal and professional characteristics from the GP. However, to address and enable all these additional aspects time was needed. Time was an underlying element in all participant narratives. This aligns with the literature suggesting that providing adequate time is a key element to developing trust with people from refugee backgrounds (Cheng, Drillich, et al., 2015).

The strengths of this study include that adds to GPs' experiences of promoting patient engagement and their roles in advocacy. We also interviewed doctors with a broad range of clinical expertise our dataset also included both recently trained GPs and those with extensive experience which broadened the scope of opinions and experiences we received. Our sampling of GPs who were actively involved in treating refugee patients provides an opportunity to learn from their wealth of experience but also highlight what is needed to support them. This study has some limitations. The generalisability of our findings is limited as the study was conducted in a specific location. Additionally, this study was conducted during the COVID-19 pandemic, during this time many GPs were pressured with a high caseload and adapting to new platforms of delivery by having to engage predominately in virtual consultations. This is likely to have impeded their ability to engage in other activities, such as health research. As a result, another limitation was the lack of perspectives and experiences from other members of the primary health care team, who are often also a large part of the support team with refugee and asylum seeker patients and future work on those is needed.

5 | CONCLUSION

This study highlights the vital role general practitioners may play in helping to build the capacity of refugees and asylum seekers to engage with healthcare by acknowledging and addressing their individual capacity to engage. By incorporating cultural safety and a trauma-informed lens to relationship-building, management and patient engagement, we show implications for practice. Particularly that to provide the care that is needed demands time. Providing what in some instances is complex care requires greater time than more straightforward consultations with close recognition of the individual's social and financial circumstances. Even with a wealth of experience, a key requirement is enabling time either through longer consultation or multiple visits to provide the quality care that is needed in supporting patients from refugee and asylum seeker backgrounds. Future interventions for general practice need to also consider the benefits of explicitly applying the model of cultural safety and TIC principles but also the value of time to promote patient engagement and enhanced healthcare delivery for refugee and asylum seeker community members.

AUTHOR CONTRIBUTIONS

Pinika Patel, Danielle Marie Muscat, Emerita Lyndal Trevena, Dipti Zachariah and Sarah Bernays conceived this study and its design. Pinika Patel conducted the data collection. Pinika Patel, Emerita Lyndal Trevena, Dipti Zachariah and Sarah Bernays conducted the coding and analysis. All authors were involved in interpreting and

discussing the results. Pinika Patel wrote the original draft. All authors were involved in reviewing and editing the submitted manuscript.

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CONFLICT OF INTEREST

The authors declare that they have no conflicts of interest.

DATA AVAILABILITY STATEMENT

The data that support the findings of this study are available from the corresponding author upon reasonable request.

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SUPPORTING INFORMATION

Additional supporting information can be found online in the Supporting Information section at the end of this article.

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