ResearchOnline@ND

The University of Notre Dame Australia
ResearchOnline@ND

Medical Papers and Journal Articles
School of Medicine

2017

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

C Harding
The University of Notre Dame Australia, Catherine.Harding@nd.edu.au

A Seal
The University of Notre Dame Australia, alexa.seal@nd.edu.au

G Duncan
The University of Notre Dame Australia, geraldine.duncan@nd.edu.au

A Gilmour

Follow this and additional works at: https://researchonline.nd.edu.au/med_article

Part of the Medicine and Health Sciences Commons

This article was originally published as:
Harding, C., Seal, A., Duncan, G., & Gilmour, A. (2017). General practitioner and registrar involvement in refugee health: exploring needs and perceptions. *Australian Health Review, Early View (Online First)*.

Original article available here:
https://doi.org/10.1071/AH17093

This article is posted on ResearchOnline@ND at
https://researchonline.nd.edu.au/med_article/830. For more information, please contact researchonline@nd.edu.au.

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

Harding, C., Seal, A., Duncan, G., and Gilmour, A. (2017) General practitioner and registrar involvement in refugee health: exploring needs and perceptions. *Australian Health Review, Online First.* doi: 10.1071/AH17093

https://doi.org/10.1071/AH17093

GP and registrar involvement in refugee health: Exploring needs and perceptions

Catherine Harding, Alexa Seal, Geraldine Duncan, Alison Gilmour

Abstract

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

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

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

Conclusions: Issues such as time, costs, language and culture were recognised as challenges in providing services for this population group. GPs highlighted particular issues for rural and

regional areas in addressing refugee health, such as finding jobs, problems with isolation and the impact of lack of anonymity in such communities. These social factors have implications for health, especially psychological health, which is also challenged by poor resources

Key Questions

1. What is known about the topic?

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

2. What does this paper add?

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

3. What are the implications for practitioners?

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

Introduction

While language and cultural differences are seen as major problems in migrant populations,[1] diverse belief systems also impact health-seeking behaviour[2]. Patients from a refugee background may face many unfamiliar cultural differences such as appointment making and keeping, health literacy, body language, illness behaviour, time-frames, attitudes towards medication and expectations of treatment [3-4].

While the majority of refugees arriving in Australia since 1945 have been resettled in major cities, Recent initiatives have increased the number of migrants and humanitarian entrants in rural and regional areas[5]. Success of these initiatives relies on available local services and minimal research has been done on the needs and attitudes of general practitioners (GPs) and GP registrars in working with these refugees. This study attempts to address that shortfall.

Methods

Following a previously published questionnaire addressing GP needs and attitudes in relation to working with refugee patients[6], a need for the more indepth information available through interviews was recognised. Interviews were conducted with GP registrars undertaking GP training with CoastCityCountry General Practice Training (CCCGPT) and GP supervisors who were Fellows of the Royal Australian College of General Practitioners (FRACGP) or Fellows of the Australian College of Rural and Remote Medicine (FACRRM). Purposeful sampling was used to maximise range of viewpoints. Thematic analysis was conducted by at least two authors for each interview. Approval was obtained from the University of Notre Dame Human Research Ethics Committee. Interviews lasted between 30 and 60 minutes, were taped and were transcribed prior to thematic analysis using NVivo 10 (QRS International Pty Ltd).

76

77 # Results and Discussion

78

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

84

85 **Table 1: Characteristics of interviewees**

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

86 *RRMA – Rural, Remote and Metropolitan Areas

87

88 **International medical graduates (IMGs) and refugee patients**

89 Australia has become highly dependent on immigration to address the geographical
90 maldistribution of the medical workforce with nearly one third of medical practitioners gaining
91 their initial medical qualification outside of Australia[7]. It has been suggested that IMGs contribute

to the availability of diverse healthcare providers, potentially impacting successful incorporation of former refugees into the existing healthcare system[2]. An IMG in this study commented on this diversity: *'I'm from a different culture, different background. I learned lots of different infectious diseases/conditions…different to doctors training in Australia.*'

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

Some contrasted the problems faced by refugees with their own arrival. One said *'I have a profession, that got me accepted a lot faster than coming as a refugee,'* and another said '*I could speak English, I had a job, still it wasn't easy.'* Lack of support for IMGs in maintaining important cultural and religious values and thus meeting personal and family needs has been raised in the literature[8]. In addition to providing a more diverse workforce, the ability to emphasise with and relate to some of the potential problems faced with migrating to a new country makes IMGs a potential source of support for these cohorts of people.

Different expectations of disease and the healthcare system

A patient-centred clinical approach asks general practice to ensure that doctors understand the patients' expectations of disease and the health care system, and that they are aware that patients' expectations are often not the same as those of the GPs[9]. GPs interviewed emphasised the need to be aware that certain groups of refugee patients may have different expectations. Some expected the doctor to have the answers, be able to *'fix things.'* One IMG said her practice style *'might be a bit like an authoritative management because they think the doctor is like god...that you are absolutely right.*' Another male IMG stated *'I originally trained in Arabic, but I have been*

117 *practicing in English so long that I cannot practice in Arabic'* although his refugee patients had
118 an expectation that he would practice in this language. Another felt some refugee patients from
119 her home country had an expectation that this link meant they could bypass normal processes '*do*
120 *it other ways*.'

121 Cultural differences resulted in different expectations of the healthcare system and, as one
122 female IMG, said '*different ways of seeing disease and illness.'* Another commented that refugees
123 '*only come in when they are really sick…in our country, we don't see early diseases of anything.*
124 *No one comes for a cough.'* There was a perception among interviewees that refugees often come
125 from countries where there is no *'established healthcare system*,' but, as in the case of Syria, war
126 has led to the widespread destruction of existing health care services with critical shortages of
127 personnel and medications and the re-emergence of infectious diseases[10].

128 One GP interviewed said that there is a need to *'understand what GPs are all about and*
129 *what GPs can do for them*.' He felt refugees needed information particularly about preventive
130 health *'screening'* and *'immunisation*.' Other researchers have noted that preventive health issues
131 were not part of refugee patients' expectation of care[9] and, in war-affected populations, the health
132 focus is often on acute injuries and infectious disease outbreaks[10]. Similarly, the Australian
133 medical system has been criticised for seeing refugees as victims, not survivors, and focusing on
134 clinical treatment not population health issues[11].

135

136 **Acceptance of refugees by the community**

137 In regional and rural areas, the predominantly Caucasian population potentially influences
138 acceptance of refugee patients into the community. As one experienced IMG said '*I come from*
139 *an area where the people who are seen here as ethnic minority would have been the majority*.'
140 Discrimination was also reported. A female patient had described her reaction to another patient
141 '*you are coming to this doctor who is not Australian so why do you abuse patients who are not*
142 *Australian?*' Describing the incident the GP was philosophical saying *'it happens.'* Similarly, a

143 female IMG registrar reflecting upon refugee patients said they weren't '*recognised as a person*
144 *as they don't speak English fluently.'* This was harder for the very dark African people who '*really*
145 *stand out*'. One Australian medical graduate (AMG) had the perception this was changing, *'You*
146 *are more likely to see ethnic people around town...there are issues of racism in town, but overall*
147 *the community is reasonably tolerant'*. Racial violence is a concern as it can trigger memories of
148 trauma for refugees[11] and has the potential to affect both health and healthcare utilisation [4,13].

149

150 **Skills of the doctors /impact on the doctors**

151 *Experience and Scope of Practice*

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

161 The difficulty for some groups of refugee patients to fit into conventional general practice
162 was seen as problematic. Making '*the environment more friendly'* as *'people coming from a*
163 *minority background can be intimidated by a large or a very busy practice'* was a possible
164 solution. A commitment to providing supportive environments for refugees is important to ease
165 the burden on already compromised individuals[12].

166 *Confidence in management of medical issues*

167 Most GPs were confident in their ability to deal with medical issues, however it became apparent
168 that this confidence did not necessarily mean having skills per se but could indicate awareness of
169 available supports. One GP working in a large regional centre said he appreciated '*the presence*
170 *of the specialist clinic in town'*. A registrar commented on the educational, as well as the support
171 role, of refugee services, '*if we have got any issues, any special crisis…we can contact them if we*
172 *need help.*' The importance of training and support for people working with asylum seekers and
173 refugees has been noted previously[15]. Levels of confidence in ability to deal with patients who
174 had come to Australia as refugees increased with time spent working with this cohort. One AMG
175 said of his confidence '*it's increasing rapidly. It was pretty shaky at first'*.

176 *Managing psychological issues for refugees in general practice*

177 GPs described more problems addressing social and psychological issues with refugees. An AMG
178 said '*a lot of the psychological stuff is hidden, they don't declare it*' and the *'tip of iceberg is what*
179 *you'd pick up.'* This was seen as often outside the life experience of AMGs: *'adverse experiences*
180 *they have every day we don't have at all…siblings killed by bomb blasts and gunshot wounds, a*
181 *father whose son was killed.'* One IMG felt that his past experience affected how refugee stories
182 about trauma impacted him. *'I don't think it does impact very much psychologically on me…some*
183 *of the stories that you hear…horror stories, the camps, coming from another country…you can*
184 *understand, you get immunised a bit to some of the stuff.*' As well as the risk of becoming immune
185 to the stories, other researchers have suggested that staff themselves are at risk of suffering
186 personal trauma and burnout when required to support people in considerable distress, such as
187 asylum seekers in immigration detention centres[16].

188 GPs felt there was a need to be *'empathic and supportive'* and *'aware of what services are*
189 *available to refer people to for support'* to '*help tap in to deal with*' these issues. The availability
190 of counselling support services was seen as a particular issue as they were *'pretty hard to get hold*
191 *of*,' particularly in rural and regional areas. Upskilling available counsellors to be able to cope

192 with trauma was seen as important. One female IMG described trauma counselling as *'basic*
193 *training'* in her country of origin *'because trauma was a really big problem, so I just presumed*
194 *that every counsellor would be trained.*' One registrar said that *'even in a non-refugee patient'*
195 addressing psychological issues was hard *'it's a difficult thing to understand and deal with all the*
196 *trauma.*'
197

198 **Impact on running of the practice**

199 *Managing time*

200 Managing time, time taken to get things done, and cultural approach to time all impacted refugee
201 healthcare provision. There was a perception that everything took longer: *'to get them to*
202 *understand what needs to be done and to actually get the tests done, get the scripts, go to places*
203 *they're meant to go.'* One IMG registrar commented that time management, already an issue for
204 registrars, was harder with these patients. Another IMG said increased time was needed for
205 assessment, *'to work things through,'* with *'language issues and interpreters.'* This was not a
206 '*simple 10–15 minute time slot,'* and didn't fit into a very busy practice, which was *'organised in*
207 *a fixed time frame.'* Although one AMG felt with appropriate management it shouldn't affect the
208 smooth running of a practice, you could organise the interpreter service '*while they are still in the*
209 *waiting room…by the time the patient comes into the room the interpreter is on the line.'*
210 The different cultural approach to time in some refugee groups was also commented on:
211 '*they don't realise that time is important to you, where for them it doesn't really matter...they*
212 *come an hour early or an hour late* [which is] *difficult to manage.'*

213 *Cost of medical services*

214 Cost of specialist care was also seen as a problem: '*even if they seek medical help, if they can't*
215 *buy medication,* [can't] *afford to see the specialist,'* and '*GPs can bulk bill…we are the only*
216 *support they've got.'* One IMG said '*some don't have Medicare, so even if they are seriously ill*

217 *they don't want to stay in hospital',* and they are *'worried about the bill.'* Refugees have full
218 Medicare access while asylum seekers may not depending on their visa status[17]. Perceived, or
219 actual, cost of healthcare services has been noted by other researchers to limit access to
220 healthcare[2,15].

221 *Language and the use of interpreters*

222 In discussing support services, many GPs commented on the Translating and Interpreter Service
223 (TIS) , a service provided free for doctors and often used as a telephone service. This was seen as
224 a '*great resource*' but *'not perfect'*. One female AMG said, *'I am conscious that they* [refugee
225 patients] *may not be able to express things that they are concerned about.*' This made addressing
226 psychological issues problematic: '*they are talking to the interpreter, not to you….the third person*
227 *that interferes in that relationship…it's hard to understand the emotionality behind what the*
228 *person is experiencing*.' Another GP commented on *'the interpreter service almost trying to*
229 *interpret the meaning of what I was saying to the person,'* a problem noted by Putsch[18].
230 Interpreters can act as information gate-keepers and bring their own beliefs and agendas to the
231 consultation[10,19].

232 One IMG commented on an additional problem with dialects: *'even within the same*
233 *language interpreter, if you have an Arabic interpreter who is from a Lebanese background who*
234 *is talking to an Arabic patient from a Sudanese background.'* Arabic, as with several other
235 diaspora languages, is characterised by having multiple variations, and specific interpreters need
236 to be requested from the TIS followed by confirmation that the patient can understand the dialect
237 of the interpreter. Another GP commented that there is a tendency in general practice to *'use*
238 *relatives for translations'* and this can be problematic, for example when translating problems
239 regarding women health issues. A female GP also noted that the '*elder group, especially females,*
240 *always come with one of their kids, mainly a person who speaks English to some extent*.' Despite
241 the introduction of the free service, interpreters are infrequently used in general practice, and

242 family interpreters are widely used[14,20]. This tendency has serious privacy and ethical
243 implications[21]. Patients may be unwilling to divulge critical information in front of their
244 relatives[21]. Effective communication is essential to patient consent[22] as is ensuring patient
245 understanding, particularly in complex clinical problems[23]. Despite the widespread availability of
246 the TIS, it is underutilised withing general practice and practice-wider interventions are required
247 to improve its use[21].

248

249 Rural and regional issues

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

262 Lack of suitable work opportunities was another problem exacerbated by rurality. One
263 female IMG registrar in a small rural centre said work was a problem for her husband who *'came*
264 *with me and can't find a job*' because of *'limited job options in most of the rural communities'*.
265 She said that rural communities were '*mostly Caucasian,'* so language and culture differences
266 were a problem. Another GP reflected on the type of work available for refugees: '*I don't know if*

267 *exploited is the right term, but they really are under a lot of pressure to not miss work because of*
268 *the availability of other refugees to take their place.'* While the local abattoirs was seen as
269 providing work, there was also a perception that refugees were *'working very hard for little.'* There
270 is a conflict between the importance of work for successful resettlement and integration[27], and
271 employment of refugees in rural areas in poorly paid farm work and in abattoirs[28].

272 The issues of discrimination were also felt to be worse in rural and regional areas. One
273 IMG said that *'if you go more rural they will really suffer…from direct but mostly indirect*
274 *discrimination.'* This view that regional NSW is not always supportive of refugees is reinforced
275 by incidents such as one regional council voting against refugee resettlement in their area[29]. One
276 IMG registrar felt that it would be easier for refugees *'in urban compared to rural,'* where '*the*
277 *whole town…knows where they're coming from, what they've got, what they don't have.'* Lack of
278 anonymity and lack of access to culturally specific services are particularly an issue for rural
279 areas[30].
280

281 # Conclusions

282

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

288 The GPs interviewed recognised issues such as time, costs and language and culture as
289 challenges providing services for this population group. In meeting these challenges, there is a
290 need to guard against a lower standard of care and less preventive health care. GPs also highlighted
291 particular rural and regional issues in addressing refugee health such as greater difficulty finding

292 jobs, isolation and the impact of lack of anonymity in rural communities. Doctors implied that
293 these social factors had implication for health, especially psychological health, and expressed
294 concerns about paucity of services in this field.

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

303

304 Limitations

305

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

311

312

313 # References

314

315 1. Hannah C, Lê Q. Factors affecting access to healthcare services by intermarried Filipino women
316 in rural Tasmania: a qualitative study. *Rural Remote Health* 2012; 12(4):2118.

317 2. Murray SB, Skull SA. Hurdles to health: immigrant and refugee health care in Australia. *Aust*
318 *Health Rev* 2005; 29(1): 25-9.

319 3. Benson J. Smith MM. Early health assessment of refugees. *Aust Fam Physician* 2007; 36(1-2):
320 41-3.

321 4. Duncan GF. Refugee healthcare: Towards healing relationships. *Can Social Sci* 2015; 11(9):
322 158-68.

323 5. Karlsen E, Phillips J, Koleth E. Seeking Asylum: Australia's humanitarian program,'.
324 *Parliamentary Library of Australia*, 11, 2011. Accessed June 30, 2014. Available
325 at http://www.aph.gov.au/binaries/library/pubs/bn/sp/seekingasylum.pdf.

326 6. Duncan G, Harding C, Gilmour A, Seal A. GP and registrar involvement in refugee health-a
327 needs assessment. *Aust Fam Physician* 2013; 42(6): 405-8.

328 7. Australian Institute of Health and Welfare. Medical workforce 2012. National health workforce
329 series no. 8. Cat no HWL 54 Canberra:AIHW, 2014. Accessed March 3, 2017. Available
330 at http://www.aihw.gov.au/publication-detail/?id=60129546100.

331 8. Han G, Humphreys J. Overseas-trained doctors in Australia: Community integration and the
332 intention to stay in a rural community. *Aust J Rural Health* 2005; 13: 236-41.

333 9. Stewart M, Brown JB, Weston WW, McWhinney IR, McWilliam CL, Freeman TR. Patient-
334 centered medicine: transforming the clinical method. Second edition. Radcliffe Medical
335 Press Ltd. Oxford 2003.

336 10. Taleb Z B, Bahelah R, Fouad F A, Coutts A, Wilcox M, Maziak W, Syria: health in a country
337 undergoing tragic transition. Int J Public Health 2015 60 (Suppl 1):S63-S7210.

338 11. Peterson P, Sackey D, Correa-Velez I, Kay M. Building trust: Delivering health care to newly
339 arrived refugees.(n.d.) Mater Health Services Brisbane Ltd. Accessed July 30, 2014.
340 Available at http://www.materonline.org.au/getattachment/Services/Refugee/Clinical-
341 Resources-and-Publications/Building-trust_-Delivering-health-care-to-newly-ar.pdf.

342 12. Brough M, Gorman D, Ramirez E, Westoby P. Young refugees talk about well-being: a
343 qualitative analysis of refugee youth mental health from three states. *Aust J Soc Issues*
344 (Australian Council of Social Service) 2003; 38(2): 193-208.

345 13. Edge S, Newbold B. Discrimination and the health of immigrants and refugees: exploring
346 Canada's evidence base and directions for future research in newcomer receiving countries.
347 *J Immigr Minor Health* 2013; 15: 141-8.

348 14. Piper H-O, MacFarlane A. "I am worried about what I missed": GP Registrars views on
349 learning needs to deliver effective health care to ethnically and culturally diverse
350 populations. *Educ Health* 2011; 24(1): 494.

351 15. Hadgkiss E, Lethborg C, Al-Mousa A, Marck C. Asylum Seekers Health and Wellbeing
352 Scoping Study: St Vincents Health Australia. 2012. Accessed March 3 2017. Available
353 at https://svha.org.au/search?q=hadgekiss

354 16. Sweet M. Call for action on asylum seekers' health. *Aust Nurs J* 2007; 14(9): 16-8.

355 17. Milosevic D, Cheng I, Smith M. The NSW refugee health service: Improving refugee access
356 to primary care. *Aust Fam Physician* 2012; 41(3): 147-9.

357 18. Putsch RW. Cross cultural communication: the special care of interpreters in healthcare. *JAMA*
358 1985; 254(23): 3344.

359 19. Dastjerdi M, Olson K, Ogilvie L. A study of Iranian immigrants' experiences of accessing
360 Canadian health care services: a grounded theory. *Int J Equity Health* 2012; 11(1): 1-15.

361 20. Atkin, N. (2008). Getting the message across-professional interpreters in general practice.
362 Australian Family Physician, 37(3), 174-176.

363 21. Huang YT, Phillips C. Telephone interpreters in general practice - Bridging the barriers to
364 their use. *Aust Fam Physician* 2009; 38(6): 443-6.

365 22. Avant Mutal Group. Consent in difficult situations. 2016. Accessed July15, 2017. Available
366 at http://www.avant.org.au/resources/public/20130809-consent-in-difficult-situations/.

367 23. Western Sydney Local Health District. Use of family or friends as Interpreters. Accessed on
368 May 30, 2017, Available at http://www.wslhd.health.nsw.gov.au/Health-Care-Interpreter-
369 Service-/Use-of-family-or-friends-as-Interpreters.

370 24. Bourke L, Humphreys JS, Wakeman J, Taylor J. Understanding the drivers of rural and remote
371 health outcomes: A conceptual framework. *Aust J Rural Health* 2012; 20: 318-23.

372 25. Sypek S, Clugston G, Phillips C. Critical health infrastructure for refugee resettlement in rural
373 Australia: Case study of four rural towns. *Aust J Rural Health* 2008; 16: 349-54.

374 26. Townsend R.A, Pascal J. Therapeutic landscapes: Understanding migration to Australian
375 regional and rural communities. *Rural Soc* 2012; 22(1): 55-66.

376 27. Ager A. Strang A. Understanding Integration: A Conceptual Framework. *J Refug Stud* 2008;
377 21(2): 166-91.

378 28. Colic-Peisker V, Tilbury F. Employment niches for recent refugees: segmented labour market
379 of the 21st century Australia. *J Refug Stud* 2006; 19(2):203-29.

380 29. Norrie J. You're not welcome, town tells refugees. Sydney Morning Herald, 2006. Accessed
381 July 15, 2014. Available at http://www.smh.com.au/news/national/youre-not-welcome-
382 town-tells-refugees/2006/12/14/1165685828180.html.

383 30. Bourke L, Sheridan C, Russell U, Jones G, DeWitt D, Liaw S-T. Developing a conceptual
384 understanding of rural health practice. *Aust J Rural Health* 2004; 12: 181-6.

385