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Conceptualising difference: a qualitative study of physicians' views on healthcare encounters with asylum seekers

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ABSTRACT

Objectives In many high-income countries, structural, legal, social and political barriers to adequate healthcare interfere with the ability of health professionals to respond to the healthcare needs of a fluctuating and superdiverse population of asylum seekers. However, the relationship between individual, interpersonal and structural factors is not well understood. We explore the views and experiences of physicians working with asylum seekers in Germany and aim to identify how these may impact the provision of medical care.

Methods A secondary analysis of 16 semistructured interviews conducted in two qualitative studies was performed. These explored the delivery of medical care to asylum seekers in Germany. In order to examine physicians' views towards their work with asylum seekers, we analysed evaluative judgements on interpersonal relationships, workplace factors, the external environment, the physician's own self and individual medical conduct. Analysis was conducted by identifying cross-cutting themes through thematic analysis and mapping these onto a framework matrix.

Results Physicians perceive the provision of medical care to asylum seekers as 'different'. This 'difference' is conceptualised at three levels: patients' perceived cultural attributes, the workplace or contextual level. Evaluative judgements on patients perceived as 'other' and the difference of the space of care provision were found to impede appropriate care, while physicians emphasising contextual factors reported more responsive medical practices.

Conclusions Concepts of difference at patient level resemble processes of 'othering' asylum seekers as a 'different patient group', while differences in rules, norms and practices in settings of medical care to asylum seekers create heterotopic spaces. Both appear to endanger the doctor–patient relationship and responsiveness of care, while an understanding of differences attributed to context seemed to foster a more caring approach. Training in contextual competence, sufficient physical and human resources and encouraging support between physicians working with asylum-seeking patients could counteract these processes.

STRENGTHS AND LIMITATIONS OF THIS STUDY

⇒ The analysis benefits from the direct accounts of physicians involved in healthcare provision for asylum seekers from a wide range of personal and professional backgrounds and medical settings.

⇒ The analysis was carried out by researchers with different academic backgrounds, offering both a medical perspective, and a social science and public health perspective on the issue.

⇒ The study is limited because it is a secondary analysis, but interviewees may have been more candid about their views and opinions when speaking about a tangential topic that was not the main interview focus.

⇒ All researchers had extensive field experience and insights into the different settings, which allowed them to contextualise the data despite the secondary analysis.

⇒ Only interviews with physicians were available to us; further interviews with other healthcare professionals, including nurses, psychologists, midwives and reception staff, are required to corroborate our findings.

INTRODUCTION

The world is experiencing a steadily rising number of asylum seekers and refugees, currently estimated at 29.4 million worldwide.[1] In Germany, 165 930 asylum seekers applied for protection status in 2019 alone.[2] Health systems and individuals providing appropriate healthcare for asylum seekers in Germany and elsewhere are faced with and must respond to a number of unique challenges.[3] Physicians are expected to care for an increasingly diverse patient population but also need to navigate structural, legal and procedural regulations governing healthcare provision in the host countries' asylum system.[4–6]

As a consequence of the increasing heterogeneity of the patient population and

linguistic diversity, healthcare professionals may need to find new ways to communicate with their patients to understand their concerns and relay information about diagnosis, treatment and follow-up.[7] Varying experiences with healthcare systems and services in their countries of origin and different conceptualisations of illness may lead to differential expectations of medical services on arrival to Germany, which healthcare professionals must manage.[8] Different religious beliefs, health practices and health literacy, among others, may further affect the doctor–patient relationship when providing care to asylum-seeking populations. These factors intersect to form 'superdiverse' asylum-seeking populations whose composition as well as total numbers may change rapidly.[9 10]

Among asylum seekers, the context of healthcare provision in many high-income countries provides a unique set of structural challenges for the healthcare encounter.[5] In Germany, asylum seekers are required to live in large reception centres upon arrival with shared sleeping arrangements and sanitation facilities. Here, primary healthcare services are often provided on-site in clinics set up on an 'ad-hoc' basis during the 2015 'summer of migration'.[11] After several weeks, most asylum seekers are transferred to other reception centres or regional accommodation centres. Those asylum seekers coming from so-called 'safe countries of origin' (eg, Serbia, Senegal, Ghana) may be kept in reception centres until their asylum application has been processed.[12] The coordination of care during transfer between different facilities has proven to be challenging, in part because of differences in the services provided.[13] In addition, many reception centres are at remote locations with little access to structures of everyday life and routine medical care.

In many countries, asylum seekers also face legal restrictions that affect health and access to health services in the host country.[4 5] For asylum seekers living in Germany for less than 18 months, healthcare entitlements are restricted to services addressing 'acute illness and pain' only (§4 Asylum Seekers' Benefits Act). Any services going beyond this provision need to be requested by a physician in writing from the regional authorities.[13] This can lead to severe delays in treatment, causes uncertainty for doctors and patients alike[13] and separates asylum seekers from routine care.

The diversity of the patient group and the structural, legal and procedural regulations which determine access to healthcare services means that the provision of care for this patient group may be more challenging for physicians than it is in routine settings in Germany. However, little attention has so far been paid to the ways in which physicians experience these challenges in the healthcare encounter and how individual, interpersonal, and structural aspects may interfere with physicians' ability to deliver responsive care. We aimed to explore views of physicians towards their work with asylum seekers and understand how their attitudes influence reported medical conduct in terms of the responsiveness of care

provided. From these findings, we derive potential strategies that may enable physicians to provide responsive care in this challenging context.

METHODS

We conducted a secondary qualitative analysis drawing on qualitative data from two studies which explored the delivery of medical care to asylum seekers in Germany.[14–16] Between November 2016 and January 2017, SZ, RJ and a third female researcher conducted a total of 16 semi-structured interviews with 11 physicians working in six reception centres for asylum seekers (study 1) and five gynaecologists regularly delivering care to asylum seekers from reception centres in their private practices (study 2) in Germany's third largest federal state (Baden-Wuerttemberg). In both studies, interviews centred on the experience of providing care to asylum seekers, covering the physician–patient interaction, barriers and facilitators to care as well as external influences on the care process. In study 1, the interview schedule focused specifically on experiences with the implementation of a patient-held medical record in reception facilities. A purposive maximum variation sampling strategy was adopted, aiming for diversity among participants regarding medical specialty and work experience in the reception centre setting. Study 2 covered experiences with the provision of care for women in the perinatal period in gynaecological outpatient clinics. Study 2 applied a purposive sampling strategy, aiming for recruitment of gynaecologists who functioned as referral wards for two large reception centres or provided on-site services, and hence had experience in caring for pregnant asylum-seeking women living in these settings. All interviewers had previous experience in conducting qualitative semistructured interviews. Potential interview candidates were approached personally and informed about purpose and extent of the study by the researchers. After written consent was obtained, the researchers scheduled private interviews with the participants at their places of work. All interviews were conducted in German and lasted 15–90 min with mean duration of 43 min. Interviews were recorded digitally and transcribed verbatim using F4 transcription software. Interviewers kept field notes to document the interview context and emerging themes.

Theoretical frameworks

In order to examine physicians' attitudes towards their work with migrants in general, Suphanchaimat *et al*[17] propose an adapted version of the 'Four-Level Model of Health Care Systems'. They state that physician attitudes toward migrant patients are shaped by (1) interpersonal relationships between patients and providers, (2) workplace factors such as infrastructure and resources, and (3) the external environment such as laws and regulations.[17] Following the notion of an attitude as 'a psychological tendency that is expressed by evaluating a particular entity with some degree of favour or disfavour',[18] the analysis

included favourable or unfavourable statements made by physicians with regard to personal relationships with asylum-seeking patients ('personal interaction'), aspects of their immediate working surroundings ('workplace factors') as well external factors impacting their work with asylum-seeking patients ('external factors').

To understand the influence of these attitudes on individual medical conduct, we drew on the concept of 'health system responsiveness'.[19] This concept—originally developed by the WHO and enshrined as a key outcome of well-functioning health systems—describes the ability of the health system to meet the 'legitimate expectations' of its users and serves as a measure of the non-technical quality of care provided in the physician–patient encounter.[20] In this study, we operationalise this concept by paying particular attention to the expressed willingness or unwillingness of physicians to adapt their practice to patient expectations.

Analysis

The analysis was conducted in two steps: the identification of themes cutting across interviews through thematic analysis[21] and the subsequent mapping of these themes onto individual interviews to reveal individual narratives.[22] These steps were carried out by RJ and LB (public health background, female, doctoral candidate) with frequent exchanges and checks for consistency involving all authors. MaxQDA (V.12) software was used to facilitate the coding process.

In the first step, the authors familiarised themselves with the interview material and subsequently coded three preliminary interview transcripts for evaluative judgements falling under the categories derived from the theory above: 'personal interaction', 'workplace factors' and 'external factors'. Through thorough discussion of these preliminary coding results, we developed an analytical framework of codes and categories for coding the remaining transcripts. Every category included an 'other' code to retain a degree of openness towards unexpected findings. Both coders regularly discussed and adapted the coding tree in an iterative process. All changes to the coding tree were protocolled in detailed notes and both coders kept a research journal, contributing to a comprehensive audit trail and strengthening the dependability of the study. During the adaptation of the coding tree, relevant categories were added to the three initial categories. These included a category on statements regarding 'the participant's own self', such as general attitude towards work, and a category on 'individual medical conduct'. For the latter category, particular attention was paid to favourable or unfavourable statements regarding the flexibility of the physicians' medical conduct to meet the needs of the patient population or the responsiveness of care.[19] The cross-cutting themes identified through this process consisted of 'difference of the work environment', 'difference of the patient group' (perception of the patient group as different), 'disenchantment' (statements regarding disappointment and frustration in the work with asylum seekers) and 'flexibility' (statements regarding the ability or inability to adapt medical practice to asylum-seeking patients).

In the second analytical step, these themes were mapped onto a framework matrix as proposed in the Framework Method,[22] summarising key findings from every interview. The framework matrix also considered the discipline and place of work of each interviewee in order to facilitate comparisons between interviewees. The populated framework matrix was then discussed with all authors, including the interviewers, to develop possible interpretations of the data and support the credibility of the analysis. During this discussion, the cross-cutting theme of 'difference of the work environment' was further differentiated into statements regarding the immediate working situation in the facilities ('work environment') and statements regarding the effects of the wider context of the asylum seekers' living situation on the healthcare encounter ('context'). Similarly, the statements regarding flexibility of individual medical conduct could be distinguished by three aspects: willingness to compromise on medical standards ('compromise'), emphasis on legitimate patient expectations ('responsiveness') or focus on perceived needs of the patient group ('group-based'). The resulting final framework matrix can be found in table 1. Anchoring quotes illustrating the intensity rating shown in table 1 are provided in the online supplemental appendix. Based on these analytical steps, we identified evaluative statements regarding differences in the work with asylum-seeking patients, as well as possible manifestations of underlying views in the physicians' provision of medical care.

Patient and public involvement

Patients or the public were not involved in the design, conduct, reporting or dissemination plans of our research.

RESULTS

The experience of providing care to asylum seekers was perceived as being different from routine medical care by all participants. In particular, the medical care setting in reception centres was described as a space with its own rules, roles and routines. We found the way in which participants described the difference of this setting to be closely related to the way in which they constructed their narratives about their work. Providers expressed views on the challenges of dealing with differences in the management of information systems, resources and personnel as well as challenges stemming from language barriers in care settings for asylum seekers when compared with their regular practice. Comparing interviews with one another, however, we found that the way in which this 'difference' was described varied markedly between participants. Physicians were found to be a heterogeneous group, both in the concerns which they raise about their work and the way in which these are voiced.

Table 1 Populated framework matrix

ID	Discipline	Place of work	Difference			Disenchantment	Flexibility of care provision		
			Context	Work environment	Patients		Group-based	Compromise	Responsiveness
G2	Gynaecologist	PP		x	xxx		xxx	x	
G1	Gynaecologist	PP	x		x		x		
G3	Gynaecologist	PP		x	xx		x	x	
A5	General practitioner	RP5			x		x		
A8	General practitioner	RP2, RP3		x	xx	x			
A1	General practitioner	RP1		x	x	x			
A4	Orthopaedic specialist	RP2		xxx		xxx		xx	
A7	General practitioner	RP4		xxx		xxx		x	
A9	General practitioner	RP2		xxx		x		x	
A10	Paediatrician	RP6	x	x					
G5	Gynaecologist	PP/RP1	xx	x					x
A11	Psychologist	RP1	x	x					x
G4	Gynaecologist	PP	xx						x
A6	General practitioner	RP1	x						x
A3	General practitioner	RP1	x						x
A2	General practitioner	RP1	xx						xx

Number of x's indicates intensity of expressed attitudes, as rated jointly by RJ and LB ('x': low intensity, 'xx': medium intensity, 'xxx': high intensity); anchoring quotes to illustrate the intensity rating for the 'difference of patients' category are provided in the online supplemental appendix.
PP, private practice; RP, reception centres 1–6.

We found three different ways in which 'difference' was described: as a difference of the patient group, difference in the immediate work environment and difference in the wider contextual determinants of the doctor–patient interaction. Although not every interview could be attributed neatly into one of these categories, we found that participants emphasise one of these three conceptualisations of difference.

Difference of the patient population

The first group of interviewees emphasised *differences in the patient population*, focusing in particular on the perceived negative characteristics of their patients. For example, interviewees described patients as being unpunctual or disorganised, having repressive gender roles, being unaware of medical issues or as exhibiting bad health promotion and utilisation habits. These characteristics were often inferred by virtue of belonging to a specific culture, religion or nationality: 'that is just the mentality in these countries' (A5).

These narratives were often paired with undertones of paternalism—perceived immaturity and ignorance of

the patient group resulted in a perceived duty to guide, educate and control on behalf of the healthcare professionals. In a few cases, this went beyond medical guidance and included cultural education on issues such as gender roles and feminism.

Once she came [into the doctor's office] by herself or her husband was still finding a parking space and then I said we can start already–"I have to wait for my husband"–and then I said–"You do not need your husband"–wasn't possible, not a chance we had to wait for the husband […] and of course this raises the question why is she so dependent on him and doesn't take the chance of–or just seize the opportunity? Not a chance. (G2)

In the specific case of the patient-held personal health record in reception centres, patients were educated and monitored to enforce compliance with bringing the health record to all physician visits.

I have introduced my own method of educating the patients here a little bit […], I tell the patients that I

am making notes here, if they have already received [the patient record] or if they have forgotten it. […] And then they will bring it with them. So if they know they are being controlled, they will bring it with them. (A5)

A focus on differences of the asylum-seeking patient group, despite sometimes accompanied by paternalistic and prejudiced undertones, was found to be associated with reports of adapting the individual medical practice to the perceived needs of the patients. Changes in physicians' medical routine and adaptations to a particular patient were most often made based on the assumption that belonging to a certain religion or country of origin was associated with certain taboos or behavioural rules. This could be seen particularly in the gynaecological profession, where they adapted the routine vaginal examination, as they perceived this to be uncomfortable for Muslim women for 'cultural' reasons.

But of course especially for the Muslim women who have been brought up so prudishly, it's all very taboo down there–they often suffer in hellish agony when they are in the stirrups, and then of course when they are pregnant they constantly have to lie there and that is constantly torture and because of course they have been conveyed a completely different picture. (G2)

Most of the time I then said ok, we will just leave [the vaginal exam] out, but the next time we will do it please. So that they are just prepared that it will come the next time and sometimes that worked, sometimes not>laughs<. But I didn't do anything they did not want. (G1)

Differences in the work environment

Another group of interviewees emphasised the *difference of their immediate work environment* in reception centres as opposed to the working conditions in routine care settings or their private practices. Narratives describe situations ranging from mismanagement to utter chaos, making it difficult for the physicians to continue their work in the way they are used to. Important factors include administrative burdens such as documentation, lack of communication with other doctors, the use or non-use of interpreters, time pressure and safety issues. These factors lead to immense pressures on the physicians in an environment where human resources and medical supplies are scarce.

I have to write the prescriptions all by myself. The transfers all by myself. I am meant to document in [the computer]. And I am meant to keep up the health record. And I am supposed to somehow convey to this person what I actually want and what he wants. That is really intense sometimes. […] Seven patients can be as exhausting as 50 in a normal consultation. (A9)

Describing difference in this way was in some cases linked to feelings of anger and disappointment regarding the complex reality of providing care to asylum seekers. Such feelings of 'disenchantment' were often accompanied by a perceived erosion of trust between physicians and patients and were exclusively found in the interviewed healthcare providers working at reception centres. Interviewees in this group described conflicts with 'cheeky and insolent' (A4) asylum-seeking patients, including patients being non-compliant or aggressive. In contrast to other interviewees, they feel personally betrayed and disappointed by such incidents, leading to negative sentiments and mistrust towards the entire patient group.

When you work here for a long time you question much more what goes on here than if you were completely fresh, so, you are really so far that if something isn't documented you don't believe people anymore. (A7)

These feelings are compounded by a perceived lack of security infrastructure to provide support in challenging situations or initiate emergency protocols.

It's a catastrophe if something happens until someone is here, right […], until someone has noticed that I have, perhaps been knifed down somewhere, well you can already organise a coffin for me. (A4)

In some instances, interviewees described feeling his/her own medical authority being called into question. Other interviewees cast doubt on the motives of the patients for seeking care as they believed that an illness or medical claim could prove beneficial in their asylum case. Both these factors had a large potential for conflict between physician and patient.

And no matter how angry they get, well somewhere I still decide what to do. And that's what I'll do, somewhere that's what I have to… I mean, I am responsible for this and I'll sign it off then I also have to determine the therapy. And then the people are very demanding and absolutely want the medications they show you and they're not flexible about that. Even if you explain that, with the interpreter, they want it anyway. And then I'm the evil one that doesn't write that down because I just can't justify it medically. (A7)

Others, of course, have found out that if they suffer badly then they're allowed to stay […] that means they often make things worse than they are. So that's difficult. (A9)

The disenchantment with the work environment had repercussions for the way in which these individuals carried out their work. In the face of adversities, lack of support and challenges regarding the behaviour and expectation of patients, interviewees described being prepared to forego certain aspects of medical care. These include documentation or explaining therapies and examinations in an understandable way.

Well, I mean, I try. But you've seen yourself how it's just sometimes too much in one go. […] If I have to do everything myself and I know the consultation finishes at 1pm and then I should really go. Then maybe sometimes you just have to drop a few things. (A9)

And then there were five different things you had to fill in for each patient which, of course, is also a time factor. And then sometimes you just can't be arsed. (A7)

Instead, these interviewees frame their medical practices with asylum seekers in business terms, where one has to 'work off the refugees–let's say like on an assembly line' (A4).

We found that individuals who emphasised the difference in their work environment and described a feeling of disenchantment as well as compromising on their medical conduct had a very unique set of contextual factors which shaped their work environment. They worked in reception facilities where medical care was contracted from a commercial medical service provider and staffed by just one doctor for every shift.

Additionally, interviewees at these two reception centres explicitly blamed the working conditions on local health authorities, expressing anger at the mismanagement of a work environment inadequate to support their normal way of providing medical care and the 'squandering' of funds at the bureaucratic level; with one interviewee, in particular, suggesting an unnecessary degree of control by the authorities.

The [authorities] are sadly not prepared to [provide IT equipment] because of data protection and what not, blah blah blah, a thousand different excuses really it can't be the money, because they squander the money so much for things that no-one can understand, so it can't be that. […] You could really make it a little easier for us but there's no willingness to make compromises. (A7)

Partly due to a large number of residents, the other reception centre included in this set of interviews has multiple physicians on shift and regular meetings have been set up for the doctors to exchange experiences and discuss cases ('quality circles'). Interviewees from this facility did not exhibit the same degree of disenchantment.

Difference of the refugee situation

A third group of interviewees focused on the wider context in which asylum seekers live and receive care when framing the differences experienced by the physicians. They pointed out issues such as the living conditions, mobility issues, uncertainties of asylum application outcome, and language barriers that make it more difficult for asylum seekers to access information or understand and adhere to medical advice. These interviewees were noticeable due to the relative lack of negative views towards both asylum seekers and the environment in which they worked, seeing the circumstances of their work less as the fault of any one individual or group but rather as a consequence of the wider social, political and structural determinants.

This uncertainty about what happens now, do I stay here in [CITY] may I or can I get used to this environment or will I be somewhere completely different tomorrow. Then the uncertainty will my asylum application be accepted and–this uncertainty means that often what we do here is sidelined a bit because… I think they are just scared of the future and that overshadows everything. (G4)

A good biographical anamnesis is so important; are they here alone, do they have relatives, what is going on at home. Really sad stories emerge, some come from these countries like Nigeria and the parents have been murdered in conflicts between Muslims and Christians. (A3)

This group of physicians emphasised the need for a flexible medical practice in these settings, adapting the way they provide medical care to views or concerns expressed by the individual patient, rather than making assumptions about them based on their religion or country of origin. At the same time, several interviewees also emphasised the need to respect the dignity of the patient and adhere to certain medical and quality standards just as they would for the general population. Experiences of rejection or ungratefulness were conceptualised within the wider context, avoiding the disenchantment and erosion of trust found in physicians who ascribe such experiences to the individual patient.

That you really acknowledge these people, and understand on a medical level what it means to retain their dignity […] the many layers—it's often the little things and then you get annoyed at the patients. But behind the little things there are needs which need to be understood. There's a multilayered emotional process which happens to me when I have these people here. (A2)

Sometimes I get the suspicion that they [other physicians] [overprescribe] because they are refugees and they get their stuff, right–and maybe this is about appreciation and recognition–that you wouldn't expect Germans to put up with this, with [the refugees] you just don't look quite so closely and give the double the highest dosis, because they are just refugees. That for me is a little bit of […] carelessness. (A11)

In some cases, awareness and concern regarding the individual situation of asylum-seeking patients led to attempts to address underlying factors. In one case, a gynaecologist, concerned about the safety of the pregnant women and the unborn child in an unhygienic accommodation centre, intervened to effect a transfer to different living quarters: 'I wrote a report that this is not acceptable in my view and she actually got transferred. And then she felt great' (G4).

In other situations, the physicians described how changes were made to the organisation of care and the organisational culture to make responsive care for asylum seekers possible. This included, for example, devising a system to schedule and work with translators and establishing a coordinated network of specialists to call on for advice or to refer patients for further treatment: 'Now, if a problem occurs, we can either solve it internally, or we can get expertise externally […]. And all these people, you can say, we have acquired ourselves. That was hard work, establishing this network, and that was really the crucial part' (A6).

In particular, physicians emphasised the importance of regular exchange and good communication between colleagues. Some felt that 'exchanges at lunch' were sufficient, but in other cases, systematic structures for communication, such as quality circles, were made an essential part of the work culture. In one specific case, these quality circles helped resolve some of the misgivings which gynaecologists initially had towards midwives and the central role which these played for the provision of frontline services for pregnant women in reception centres.

> In [reception centre 1] they have established a good service by midwives, which works well and we've had a meeting with them and they co-operate very well and do good preparatory work. […] In the beginning we didn't really realise [that the service was set up], but then the midwives turned to us gynaecologists. We have this quality circle and then we invited them to come along and since then it all works a lot better. (G5)

Crucially, structures for improved communication and cooperation garnered trust between colleagues, and meant that a higher degree of continuity could be ensured even if working with a large team or with numerous external colleagues. One participant, in particular, described that this required a shift in thinking for physicians, who were accustomed to relying only on their own judgements when treating patients. In this environment, good-quality care was dependent on a degree of flexibility in physicians' approach to their own work.

> Us physicians we are designed so that, what I hear and what is my judgement is right. So that first you question what has happened before. That's almost how we're trained. But here it's completely different. It needs to be different, because otherwise you make a mistake, or waste time. You have to accept what the previous colleague entered or has evaluated and that's what you can base your further work on. (A2)

DISCUSSION

Physicians working with asylum seekers tended to concentrate evaluations of their work with asylum-seeking patients around one of three different notions of 'difference': either of the patient group, the workplace environment or the wider structural determinants of the doctor–patient interaction. The way in which 'difference' was defined, in turn, was closely related to the way in which physicians reacted to the challenges of care provision and influenced the perceived degree of flexibility they have in providing appropriate care to their patients.

Interviewees reporting particularly negative evaluations of their workplace environment and high workload or stress tended to describe some of their medical practices as inflexible and unresponsive. These narratives describe the impossibility of continuing to provide responsive care given scarce resources and professional support in these contexts. In some cases, there was a certain 'devil may care' attitude arising from mistrust towards the patients and a perceived lack of support by the authorities. The coping mechanism, in this situation, was to do only what was utmost necessary to get the job done—a mechanism that ultimately may affect quality of care provided. It is possible that contextual shortcomings translate into observable attitudes and human actions which are unfavourable for high-quality responsive care provision.

Physicians who framed 'difference' in terms of the patient group did report the freedom to adapt their practice to suit the patient's needs. However, patient characteristics as well as medical needs were often ascribed based on the patient belonging to a specific national, cultural or religious group, thus constructing the patient group/s as an 'other' based purely on these attributes. Perceived patient characteristics often included typical group stereotypes regarding gender roles, punctuality or health literacy.

In contrast, a third group of physicians emphasised the difference of the living conditions, as well as psychological and legal situation of asylum seekers when framing care provision to these patients. Issues such as missed appointments or lack of hygiene were attributed to the context in which asylum seekers find themselves and the structures of care, not on individual patients or a perceived patient group. Similarly, experiences of rejection or ungratefulness by asylum-seeking patients did not lead to disenchantment or negative sentiments but were conceptualised within the broader context. Patient needs were assessed and addressed based on individual preferences, considering that every human is different, and in this asylum seekers are equal to the general population—equality in diversity.

In this context, the concept of 'othering' can help us further understand the potential influences of physician views on the healthcare encounter. 'Othering' can be considered as the social construction of certain groups as different, with the explicit purpose of reinforcing a notion of normalcy by the dominant group.[23] 'Othering' is accompanied by feelings of social exclusion, disempowerment, and marginalisation and thus may have serious consequences for health and health service accessibility, especially if healthcare professionals are perceived to be actively engaged in the 'othering' process.

Our findings suggest that a process of 'othering' of the asylum-seeking patient group may take place at two intersecting levels: first, an interpersonal level, in which group characteristics are attributed by physicians to individual patients based on their 'otherness' while neglecting their context. Second, by the specific context which creates a 'different space' with its own rules, norms and practices in which medical care provision for asylum seekers takes place, potentially creating or re-enforcing attitudes among physicians which are at odds with the provision of responsive healthcare.

The 'otherness' of the individual asylum-seeking patient tended to be framed in terms of cultural and religious differences, rather than personal or medical needs. Such 'othering' of individuals and groups based on perceived ethnic, religious, or cultural attributes constitutes a racialisation of the asylum-seeking patient and may contribute to acts of racism towards the 'othered' group.[24 25] Experiences of racism in the healthcare encounter have been shown to negatively affect healthcare access, quality and outcomes.[26] Where dimensions of discrimination such as gender, race and immigration status intersect, these effects may be compounded.[27 28] Moreover, the present analysis as well as other empirical studies have found evidence of the construction of the racialised asylum seeker, particularly women, as immature, ignorant and in need of education about the values, norms and medical practices in the host country.[29–31] This suggests an understanding of the 'Western' moral and medical system as superior and presupposes the asylum-seeking patient as a (un)grateful recipient of healthcare with little agency to engage in the shared decision-making process which has become the gold standard for care provision in the host population. Coupled with the power imbalance already inherent in the patient–doctor relationship, such views of ethnic superiority may corroborate the position of power of the physician and further disempower the asylum-seeking patient.[24 32 33]

Based on our analysis, individuals who acknowledged structural determinants seemed better equipped to address individual needs and preferences and consequently appeared to provide responsive medical care. This ability to acknowledge the importance of broader context in the healthcare encounter has been termed structural competency, defined as 'the trained ability to discern how a host of issues defined clinically as symptoms, attitudes, or diseases […] also represent the downstream implications of a number of upstream decisions about such matters as health care and food delivery systems, zoning laws, urban and rural infrastructures, medicalisation, or even about the very definitions of illness and health.'[34 35] Proponents of this idea have argued that it is not primarily the cultural barriers of migrant patients that restrict access to healthcare services, but instead the biomedical gaze of the physicians, preventing them from identifying structural barriers to care.[36] The interviews presented here support this idea, as those physicians whose evaluative judgements emphasised the structural vulnerabilities of patients had a more positive narrative when it came to their patients, reporting less frustration and greater flexibility to provide responsive care. Importantly, an awareness of structural barriers to care led to attempts to systematically address issues such as a lack of communication and cooperation between colleagues, improving processes of care by fostering trusting relationships.

Furthermore, the structures and organisation of medical care provision in Germany pose significant challenges for physicians. The legal restrictions and bureaucratic hurdles involved in the care of asylum seekers create uncertainty for physicians regarding what medical procedures can or cannot be provided, adding to the administrative workload. Care provision in reception centres for asylum seekers is not just spatially separated from structures of routine medical care, it also lacks standards, regulations and procedures usually associated with routine care. In combination, these factors seem to contribute to the creation of 'heterotopic' spaces—that is, spaces which are separated from the normal and in which commonly accepted rules and structures are changed or reversed.[37 38] Our findings suggest that physicians experience care provision in these settings as challenging and that difficulties are exacerbated by resource constraints, lack of guidance or collegial exchange, high administrative burden, as well as a high number of patients. Thus, there remains little capacity for the emotional and medical effort required to provide responsive care to a diverse, multilanguage patient group subject to post-migration stressors such as insecurity and uncertainty. Furthermore, the lack of oversight, rules and systems for quality control in these 'heterotopic' spaces further empowers the physicians in an already fraught doctor–patient relationship. In particular, the legal requirement for physicians to request in writing any medical care that goes beyond emergency treatment or pain relief installs the physician as a 'gatekeeper' with the power to regulate access to what would otherwise be considered standard healthcare.

Our findings confirm previous qualitative research on the challenges faced by physicians in the provision of care for asylum seekers. In line with conclusions from a recent review on the issue,[39] we also identified key challenges surrounding health system factors (professional support, resourcing and capacity, organisation of care) and in the healthcare encounter (communication and building a trusting relationship with patients). In addition to previously identified demand-side factors such as culture and health literacy of patients, however, we also found that processes of 'othering' patients on the supply side can pose a substantial barrier to the provision of responsive care. Further studies are needed to determine how 'othering' processes develop and how they can be mitigated in the healthcare encounter. Furthermore, we found that factors including the spatial separation of the healthcare setting from regular structures of care, the lack of adequate professional support and the implications of healthcare processes for the asylum claim may intersect

to create heterotopic spaces which make the provision of appropriate care exceedingly difficult. Our results suggest that such conditions may evoke strong negative emotions among physicians towards their workplace and patient group and compromise the conduct and quality of medical care they would normally provide in routine care settings.

As such, the most immediate solution to increase the responsiveness of healthcare services for the asylum-seeking population would be to reduce or remove the heterotopic nature of medical care provision for asylum seekers through integrative health policies. In Germany, this could include measures such as expanding legal entitlements to healthcare, removing the need for written requests for medical procedures, integration of asylum seekers into routine medical settings of the German health system, and equitable treatment of asylum seekers with regard to standards and guidelines for care provision and quality management.

However, faced with the current political reality in Germany, it is unlikely that such 'radical' reforms will take place in the immediate future. Our findings suggest that in the meantime, other measures can be taken to mitigate the potential *effects* of heterotopic spaces on the healthcare encounter. These include:

► Giving physicians sufficient professional support and space (in terms of time, resources and decision-making power) to be able to adapt their practice to the needs of their patients. Clinics and reception centres need to be provided with sufficient human and physical resources to give physicians the time to provide responsive care.

► Encouraging structured and regular exchange between healthcare professionals, for example, in quality circles[40] or Balint groups, to reflect on principles of good practice and discuss ongoing challenges. Staff working in clinics must be given sufficient support and professional respect so that any arising issues can be discussed promptly and transparently.

► Providing physicians with comprehensive information about the structural determinants which shape the lives of asylum seekers in Germany and the required training to apply this knowledge in the healthcare encounter. This training needs to include information on healthcare regulations, the asylum process and living arrangements.[41] Such measures can avoid 'patient blaming' and break down stereotypes, which may cloud judgements of the most appropriate medical course of action.[36]

Strengths and limitations

This research benefits from the analysis of direct accounts of physicians involved in the provision of healthcare services for asylum seekers from a wide range of personal and professional backgrounds and medical settings. Furthermore, the analysis was carried out by researchers with different academic backgrounds, offering both a medical perspective and a social science and public health perspective on the issue. In addition, the methods applied by the authors were designed to satisfy the four criteria of trustworthiness of qualitative research: credibility, dependability, transferability and confirmability.[42] All researchers had extensive field and research experience including insights into the different settings, allowing for the contextualisation of the data and supporting the credibility of the results. The detailed description of the analytical process, including the populated framework matrix, ensured the confirmability of the findings. Given the detailed description of the study setting as well as the work environment of the study participants, this paper provides substantive background for readers to judge the transferability of results to their own setting. Since refugee reception is organised very heterogeneously within Germany, readers and care providers in other regions of the country will be able to judge the applicability of presented findings to their own local context. Transferability may also extend beyond Germany, as care provision to refugees is similarly haphazard, fragmented and lacking in specific diversity-sensitive training for care providers in other European countries, too.[43] Lastly, the study's audit trail of coded and annotated transcripts, reflexive coding journal and extensive meeting notes support the dependability of the findings.

The study is limited by the fact that it has been carried out as a secondary analysis. Interviews were taken from two primary studies with different objectives, and as such, the interview material was inevitably influenced by the respective interview schedules. Although care was taken not to analyse statements made in direct response to a thematic question, interviewees may have held back on their views regarding their work more generally if they did not think it was relevant to the interview topic. However, the fact that we did not ask questions directly about interviewees' views could also be a major strength: interviewees may have been more candid about their views and opinions when asked about a tangential topic than if they knew that these views were the object under study. A further limitation of this study is that only interviews with physicians were available to us; further interviews with other healthcare professionals, including nurses, psychologists, midwives and reception staff, all of whom are instrumental to the healthcare provided in healthcare settings for asylum seekers, are required to corroborate our findings. Conducting a secondary data analysis also precluded us from participant checking our findings. Our research has shown the various ways in which physicians conceptualise the 'difference' of their work with asylum seekers and the interaction of these narratives of 'otherness' with their expressed ability to provide responsive care. However, further research is needed to better understand how the reported attitudes towards work actually manifest in terms of impact on perceived or evaluated quality of care. Furthermore, the present study was unable to entangle the complex interplay between the 'heterotopic' nature of the healthcare setting and 'othering' processes operating at the individual or societal level. Further work

is needed to better understand contributing factors and their interactions in this process so that targeted intervention can be implemented to adequately support physicians in providing high-quality, responsive care for asylum seekers.

CONCLUSIONS

All physicians providing care to asylum seekers describe this healthcare encounter as being different to routine medical practice, but the way in which this difference was experienced appeared to impact their ability to provide responsive care. Frustration in the healthcare encounter and conflict or perceived mistrust of patients arose from conceptualisations of difference which were rooted in stereotyped understandings of the patient group or misgivings surrounding the structural, legal and organisational context of the workplace environment. In these situations, the healthcare setting itself, the perceived lack of support from authorities and the realities of the asylum process intersected to form 'heterotopic' spaces, which substantially impinged on the ability to deliver responsive care. The accounts of physicians who focused on the structural differences of the asylum situation, however, were characterised by their relative absence of negative judgement towards patients or colleagues. Instead, these individuals appeared to be able to find ways to overcome challenges in the healthcare encounter that made provision of responsive care possible. In order to promote responsive care, policy strategies should focus on reducing or removing either the heterotopic nature of the healthcare settings themselves though integrative health policies, or mitigate the potential negative effects of such settings on the healthcare encounter, for example, through the provision of adequate financial and human resources, clear structures for reporting and exchange and appropriate upfront training.

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