

Views of emergency care providers in providing healthcare for asylum seekers and refugees

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ABSTRACT

Background The number of asylum seekers awaiting decisions on their claims in the UK has more than tripled since 2014. How we meet international obligations to provide appropriate healthcare to asylum seekers and refugees (ASRs) is therefore an increasingly important issue. The views of frontline healthcare workers are vital to ensure the development of sustainable and effective health policy when it comes to caring for this group.

Method A single-centre qualitative study in the form of semistructured interviews was conducted at the Queen Elizabeth University Hospital ED in Glasgow, Scotland, between January and March 2023. Volunteering ED care providers (EDCPs)—doctors and nurses—working in the ED were interviewed and the data analysed and presented through a thematic analytical framework.

Results 12 semistructured interviews were conducted—6 doctors and 6 nurses. Analysis revealed four themes: (1) 'staff attitudes' highlighted in particular the positive views of the participants in providing care for ASRs; (2) 'presentation patterns' revealed significant variations in opinion, with one-third of participants, for example, believing there was no difference in presentations compared with the general population; (3) 'challenges to optimal care' outlines multiple subthemes which impact care including the unique challenge of the ED triage system; and (4) 'transition in care' discusses participant concerns regarding arranging safe and appropriate follow-up for ASR patients. Ethical dilemmas in providing care, as highlighted in previous studies, did not feature heavily in discussions in this study.

Conclusion This study provides an insight into the views of EDCPs in providing care to ASRs in the ED. Study findings can potentially contribute to the development of ED-specific guidelines as well as inform wider health policy and provide a focus and direction for further research.

BACKGROUND

According to the United Nations High Commissioner for Refugees, 2022 has seen the largest ever increase in the number of forcibly displaced people globally.¹ In the UK, the number of people awaiting a decision on their asylum claim has more than tripled since 2014 reaching 215 500 in 2023.²

How we care for those seeking or recently granted asylum in the UK is therefore an increasingly pertinent issue. All asylum seekers and refugees (ASRs), regardless of their asylum status, are eligible for emergency and primary healthcare in the UK.^{3–5} However, despite these entitlements, ASRs have unique health and social care needs and face a variety of barriers to healthcare.^{3–5} ASRs'

WHAT IS ALREADY KNOWN ON THIS TOPIC

⇒ The views of both asylum seekers and refugees (ASRs) and healthcare professionals have been studied extensively internationally. There is limited research, however, exploring the views of ED care providers (EDCPs) providing healthcare to ASR patients in the UK using a qualitative approach.

WHAT THIS STUDY ADDS

⇒ Although in keeping with many findings of previous studies, this study highlights new themes and perspectives including challenges around ED structures like triage and concerns regarding safe discharge and follow-up of ASR patients. It also contradicts findings in previous studies including the emphasis around healthcare workers' moral dilemmas around eligibility. The findings in this study strongly emphasise the positive attitudes and behaviours among EDCPs.

HOW THIS STUDY MIGHT AFFECT RESEARCH, PRACTICE OR POLICY

⇒ This study aims to inform the development of ED-specific guidance. It also highlights areas for future research and has the potential to directly inform wider healthcare policies. Education for ASRs, training and guidance for staff and language-specific information leaflets were highlighted by participants as simple, low-cost measures to improve care for these patients while also alleviating pressure on the ED.

and healthcare providers' lack of knowledge over eligibility, for example, has led to healthcare being avoided, delayed and even refused at times.^{6–8} Language and cultural barriers and a lack of clarity over the services available negatively impact the quality of care this population receives.^{6,7} Studies in the UK have shown that ASRs' mental and physical health can deteriorate once they become residents in the UK.^{6,9} Improvements are therefore necessary to provide an equitable level of care to ASR patients.

The ED is a key frontline service. For ASRs who have limited understanding of the UK health system, the ED may be the only known avenue for accessing healthcare.^{10–11} However, EDs across the UK are under ever increasing pressure, as illustrated by the increasing percentage of attendances to the ED across the UK waiting more than 4 hours to be admitted, transferred or discharged (averaging



Box 1 Terminology

- ⇒ Refugee—according to the 1951 United Nations (UN) Convention on Refugees is a person 'who is unwilling or unable to return to their country of origin owing to a well-founded fear of being persecuted'.²⁸
- ⇒ Asylum seeker—a person who has applied for protection against persecution under the 1951 UN Convention on Refugees.²⁹
- ⇒ Resettled refugee—a person granted refugee status while abroad and then brought to the UK via a resettlement programme.²
- ⇒ Failed asylum seeker—a person who has failed to meet the legal criteria to be granted protection under the 1951 UN Convention on Refugees.²⁸

approximately 5–20% in 2013 to 30–45% in 2023 in England, Scotland and Wales).¹² Robust health policy is therefore necessary to improve healthcare for ASR patients that ideally also relieves some pressure on EDs as well.

An understanding of healthcare workers' opinions and experiences is vital to ensure the development of sustainable and effective health policy.¹⁰ To this end, this study aims to inform the development of ED-specific guidance on ASRs by exploring the views of ED care providers (EDCPs)—doctors and nurses—towards providing healthcare to ASRs in the UK. The term ASR (Box 1)—although a heterogeneous group both in relation to nationality, length of stay in the UK and legal status—was chosen, in order to include all asylum seekers and recently granted or resettled refugees, while excluding other types of migrants. A qualitative design was chosen and, although this topic has been explored in other healthcare settings, limited research was found exploring this topic qualitatively in EDs in the UK. Experiences and views of healthcare workers can vary depending on the geographical region and healthcare setting they work in,^{5 10} and it is therefore expected that this study will add unique perspectives and new information, potentially directing future research and informing wider health policy.

METHODOLOGY**Population and sampling**

This was a single-centre study based at the Queen Elizabeth University Hospital ED in Glasgow. Glasgow City is the local authority with the most asylum seekers per resident in the UK (71 per 10 000 residents), although exact numbers of ASR attendances to the ED are not publicly available.² Participants were voluntarily recruited by email via staff distribution lists and the study was advertised at departmental meetings. The sample size target was between 10 and 12 EDCPs (reflecting sample sizes of similar studies) or to the point of thematic saturation. Participants gave informed written consent and were able to withdraw their consent up to 10 days after the interview, after which their data were anonymised. Purposive sampling technique was used to achieve a balance between doctors and nurses (including advanced nurse practitioners and emergency care practitioners). Participants had to have worked in EDs in the UK for a minimum of 5 years in total before the interviews were undertaken. Although more than other similar studies,^{13 14} this was selected to increase the overall experience participants are likely to have had caring for ASRs. There were no additional exclusion criteria and participant feedback on the findings was not sought.

Semistructured interview

The interview structure was informed by reviewing existing literature on studies with similar aims.^{5 10 14–22} One interview per participant was carried out between January and March 2023. They were face-to-face in a private room within the ED and aimed to be approximately 30–40 min in duration. The interviews were carried out by the principal investigator (PI), who is also the first author. A phenomenological approach was used to conduct the interviews with participants being asked to think about their views, including challenges and facilitators, along certain sections and themes as shown in Box 2.

Ad hoc probing questions were used to explore unexpected topics expressed by participants. Neutral terminology was used to reduce bias and it was highlighted to participants the study aimed to inform policy and improve care for this group. The interviews were recorded and transcribed by Microsoft Teams and checked manually by the PI. No additional field notes were taken.

Analysis

After the transcriptions were anonymised, a collaborative thematic framework approach was used to analyse the data, informed by relevant guidance literature.^{23 24} Analysis was carried out by the PI and a second analyst. A step-by-step analytical structure was developed for both analysts to follow (see online supplemental appendix A). Steps included identifying codes within the transcripts (ie, paraphrases to describe significant findings), from which themes and subthemes were then developed (see online supplemental appendix B). Themes were refined through sharing of information between the two analysts until a final thematic analytical framework was developed. A framework matrix was also developed which outlined relevant quotes and examples from the transcripts according to the themes. Although the interview questions were informed by previous studies, the data were analysed independently from existing data and themes.

Reflexivity

The PI and first author is an ED doctor who was working at the study site over the study period. He has prior experience carrying out semistructured interviews and developed the project as part of a public health dissertation project. He developed an interest in the topic through his own experience working in EDs caring for ASRs. The second analyst and author is also an ED doctor with prior experience in carrying out semistructured interviews. She was not working in a clinical role at the time of this study but had previously worked in low-resource settings and had an interest in improving care for ASRs in the UK setting. DJL has multiple professional roles including emergency medicine consultant at the study site and AK is a research academic specialising in health inequalities and does not work clinically. The research team were aware of their pre-existing cognitive constructs and how this may influence the data collection and analysis. Data were handled within the context of the researcher's circumstances while also recognising how this context may also facilitate the investigatory process.

Patient and public involvement

Although not engaged directly, literature and research from relevant charities which explored the views of ASRs and challenges around ASR healthcare informed the interview structure.^{18–22} The importance of patient and public involvement (PPI), in

Box 2 Semistructured interview structure

Section 1: demographics

Participants are initially asked to not include any identifiable information about patients or staff.

- ⇒ Occupation
- ⇒ Years of experience working in EDs in the UK (5–10 years, 10–15 years, >15 years)
- ⇒ Experience with caring for asylum seekers or refugees (ASRs) in the ED—none, minimum (0–5 patients), moderate (5–20 patients), significant (>20 patients)

Section 2: phenomenological questions

- ⇒ From the title of this study, are there any views that you'd like to share?
 1. The topic has been divided into three broad categories relating to themes highlighted in previous similar studies, which I'd like to get your views on: specific encounters caring for ASR patients attending the ED:
 - a. What are your views or experiences caring for ASR patients in the ED?
 - b. Can you think of any specific examples caring for ASR patients to illustrate your views? How did this differ from care for the general population? Any specific challenges or facilitators?
 - c. Themes that have been highlighted in previous studies on ASR healthcare include: communication, behaviour, culture, carer–patient relationship as well as health and social condition. Do you think any of these themes are relevant to your encounters?
 - d. Are there any specific presentations or ASR patient characteristics which influence these encounters? For example, pregnancy, children, chronic conditions. How do you think this would differ from the general population?
 2. System organisation in relation to ASR care:
 - a. When thinking about the health system you work in, are there any factors which assist or act as a barrier to caring for ASR patients?
 - b. Can you think of any interventions which would improve care for ASR patients?
 - c. Some themes that have been highlighted in previous studies on ASR healthcare include: training and guidance, support, resourcing and capacity, connection with other services. Do think any of these are relevant to the system you work in?
 3. Ethical concerns or dilemmas with managing ASR patients:
 - a. Do you have ethical concerns or dilemmas around eligibility to healthcare or extraclinical roles, for example, gatekeeper roles?
 - b. Are you ever unclear what level of care this group of patients are eligible for?

Section 3: vignette

In this section, I will read out the following vignette in order to explore further any differences between caring for ASR patients compared with the general population:

The patient arrived in the UK as an asylum seeker 6 months ago. He is 25 years of age and of Middle Eastern origin. He speaks limited English and is having intense lower abdominal pain.

- ⇒ Are there any differences in this patient's care to someone presenting similarly from the non-ASR background?

Continued

Box 2 Continued

- ⇒ Does this case evoke anymore thoughts or views in relation to your patient encounter, the system you work in or any ethical concerns? Including any challenges or facilitators?

particular the views and perspectives of minority populations like ASRs, is appreciated and it is recognised as a limitation of this study.

RESULTS

12 semistructured interviews were carried out in total, including 6 nurses and 6 doctors. No participant who initially expressed an interest dropped out. There was a balance of occupation, years of experience and experience caring for ASRs as shown in table 1. The interview average duration was 35.3 min.

Following thematic analysis of the data, four themes with multiple subthemes were developed as shown in table 2 (see also online supplemental appendix B).

Individual participants are referenced throughout the text and quotes are included that exemplify certain subthemes.

Staff attitude

The participants unanimously had no concerns around eligibility or moral dilemmas in providing care for ASRs in the ED (P1–P12). Many were keen to go above their duty to make patients feel comfortable, reassure any eligibility concerns and provide care, as illustrated in the quotes below:

...the way I see it is free at point of entry. No judgments, no nothing. (P4)

I'm here as a nurse. I'm here to make somebody feel safe, secure and valued as a patient. (P8)

I think we're generally kind of like open to giving them care and kind of looking after them a little bit more. (P6)

We're quite an open minded, you know, warm department. (P10)

Table 1 Participant characteristics

Participant	Occupation	Years of experience working in ED in the UK (5–10 years, 10–15 years, >15 years)	Experience caring for ASRs in EDs in the UK (none, minimum (0–5 patients), moderate (5–20 patients), significant (>20 patients))	Duration (min)
P1	Doctor	5–10	Significant	46
P2	Doctor	5–10	Significant	33
P3	Doctor	5–10	Minimum	29
P4	Nurse	>15	Moderate	48
P5	Nurse	10–15	Significant	32
P6	Nurse	5–10	Minimum	36
P7	Nurse	10–15	Moderate	28
P8	Nurse	10–15	Moderate	39
P9	Doctor	>15	Significant	19
P10	Nurse	>15	Significant	41
P11	Doctor	5–10	Moderate	30
P12	Doctor	10–15	Significant	42

ASRs, asylum seekers and refugees.

Table 2 Themes and subthemes

Themes	Subthemes
Staff attitude	Positive attitude, minority negative opinions
Presentation patterns	Heterogeneity of views, mental health, multiple family members
Challenges to optimal care	Language, culture, health system literacy, triage, time pressure
Transition in care	Safe discharge, interaction with other services/specialties

...I would like them to feel valued and welcome when they come to the department after, you know, they've had horrific experiences that most of us will thankfully never ever experience... (P8)

He was like worried that he would be charged...I kept trying to explain: "No, no, it's free". "Like don't worry we'll look after you." (P6)

Although participants agreed that this largely reflected the department as a whole, some did state concern that a minority of staff expressed negative views related to perceived ASR entitlements as described in the quote below:

Some people have got quite entrenched beliefs that, you know, that they're here and they're getting more than everybody else and they're getting free houses and they're getting free this and they're not. And that's a lie. (P8)

...it's the 'Oh they get mobile phones, they get taxis everywhere'. Well, no. Have you seen the situation they're living in? (P4)

Presentation patterns

Discussions on presentation patterns revealed significant heterogeneity among the participants, with one-third of participants believing there was no significant difference in presentations compared with the general population (P5, P9, P10, P11). No patterns were universally agreed upon and contradictions arose on issues such as acuity. Some described patients presenting with 'minor stuff' (P12) or early in their illnesses (P8, P10), whereas others described a pattern of delayed, undertreated and often complex presentations not traditionally managed in the ED (P1–P3, P6). In many cases, participants described having to 'start from scratch' (P2), 'wing it' (P1) and being 'back to square one' (P11) as patients' full medical records were not available.

Mental health presentations featured heavily in many discussions. Participants described challenges managing aspects of patients' psychological trauma which they have had little experience with as illustrated below:

The idea of true sympathy and empathy for these people is almost impossible, because I have no idea. I can't put myself in their shoes because I can't get there. (P4)

Yeah again I would say in triage, quite a lot of mental health. Probably more so after COVID than ever before. (P5)

...don't think it's right place for them, if it's mental health related. (P12)

A further common topic of conversation was around multiple members of a family presenting to the ED together (P1, P2, P7). This was believed to be primarily a consequence of a lack of social support in the community (eg, parents unable to arrange childcare) (P2, P4, P7). This highlights the vulnerability and social isolation of ASR patients which may put them at higher risk of exploitation, substance misuse and mental health problems (P4, P5).

Challenges to optimal care

Despite the positive attitude towards caring for ASR patients, many of the difficulties with managing this group were related to challenges within the ED to deliver optimal care. Language barrier was the most frequently mentioned and emphasised challenge among participants (P1–P12), with many expressing concern that it likely affected patient care as highlighted by the quotes:

Definitely, there's been a couple of instances recently where I think that the language barriers have made someone's care not as good... (P3)

Sometimes you're just using kind of basic communication skills like 'pain' and like 'sore' which probably isn't ideal really. (P6)

...you might underestimate his pain. Because of the language barrier. (P12)

It was however highlighted that this issue is no different to any foreign national who does not speak English (P9). 'Language Line'—the telephone translation service—was the most used translation tool and although largely easy to use and arguably the only financially feasible option for translation (P5, P6, P9), dialogue could be lost in translation and it could impede the patient–carer relationship (P1–P3, P11). Face-to-face translation was preferred, as illustrated in the quotes below; however, time pressures and limited language diversity in the department meant that this option was rarely possible (P1, P6, P8):

When you go to the telephone system, they can't see you. You know there's a different understanding from looking someone in the eyes, watching the body posture. (P2)

You can't really get the emotions across as much. (P3)

The level of defensiveness drops when there is somebody there that they can look at and speak to, who understands what they're saying makes a massive difference. (P4)

I found it a bit more like artificial if you communicate using a device, an electronic device... (P11)

The challenge of language barrier and time pressure is perhaps most evident at ED triage—the process by which a nurse has approximately 5 min to assess a patient's acuity and reason for attendance.²⁵ Telephone and face-to-face translation options are often too time-consuming to be feasible and participants instead resort to using 'Google translate' or even simple hand gestures (P8, P10). Difficulties in accurately assessing often complex presentations risk patients being 'undertriaged' (P2, P5, P6, P8):

...you need to take the time [at triage] to make sure you're asking all the questions at the one time on that one telephone call because you're going, you know, to predict that patient's journey throughout. (P5)

Time pressure was highlighted as an ongoing challenge by participants in their ability to holistically address many of the complex social, physical and mental issues that ASR patients present with (P5–P8, P10):

...essentially we're trained to going 'what's the reason for presentation?', 'why you here?', 'do you really need to be here?' (P2)

They are not aware maybe that the NHS is snowed under and is struggling...and are hopeful that they can have it fixed pretty quickly here, but unfortunately nobody's getting fixed pretty quickly here. (P8)

P12 describes that because senior doctors must maintain an overview of the department, they are less likely to see ASR patients as they are often more time-consuming to manage (P12):

Maybe that's why, as a consultant I see less of them, I think now, because I avoid picking them up. They get discussed with me. But I would not go and see them. (P12)

Participants also perceived that the subsequent long waits and overcrowding associated with EDs in the UK currently are likely to be confusing and exacerbating for ASRs (P2, P6, P11). P8 highlights that the overcrowding meant that there was often a lack of spaces in the ED to provide 'privacy and dignity' to female ASR patients in cultural dress-wear (P8).

Cultural issues were not emphasised by participants when asked and did not feature heavily in discussions with the main cultural difference described relating to gender norms, for example, female patients requesting a female doctor (P3, P5, P8, P10, P11). Participants did however highlight concerns over health system literacy. Many participants described ASR patients' lack of system literacy impacting on their care as illustrated below (P2, P8–P12):

They don't know where they can attend. They don't know about NHS24, they don't know about the Out Of Hours. And I think sometimes it's the first thing, first port of call, is they will come to us here. (P2)

... I do understand that health care systems are really different and what they'll experience from whatever country they come from to the experience in Scotland would be. (P5)

You got someone, who's needing follow up with the GP [general practitioner], I find that that's often very difficult. One to communicate how our health system works, if they're the first few times experiencing the situation and then two to actually trust that there are the processes in place or services. (P1)

...they come across with the expectation that you do all the investigations required to come up with a diagnosis as similar to their own country. (P11)

According to many participants, this perceived limited system literacy among ASR patients may result in unachievable expectations when attending the ED (P2, P3, P8, P11). Some participants felt that this not only led to ASR and medical staff frustration but may delay ASRs receiving the right healthcare (P4–P5). Participants also admitted their own lack of knowledge, for example, in terms of what community care and services were available for ASR patients (P1, P3–P6, P12). None of the participants had received any training or were aware of any guidance in relation to caring for ASRs (P1–P12):

On our guideline page how much is there about it, hardly anything, plenty about child protection, plenty about asthma, plenty about all your main presentation. There's no guideline on refugees, in children or adults. (P2)

The perceived barriers cause more problems than the real barriers. (P4)

You only seem to find out how to get something done when you have to get something done. (P4)

I can't say there's specific training in the department for this, there isn't. I think it's just like your morals as a nurse, lead you to do the right thing. (P5)

Transition in care

Safe discharge is a critical component of caring for patients in the ED: 'it's not just a case of, you know, OK. Cheerio. That's you you've been discharged' (P7). This can be more risky in ASR patients due to a language barrier and the lack of language-specific information leaflets outlining, for example, under what circumstances to return to the ED (P3, P5). Participants also

expressed concern that ASR patients may be lost to arranged follow-up from the ED due to limited system literacy and concerns about integration with primary care as well as a lack of financial means, social support and transport knowledge making it difficult for them to attend follow-up appointments (P1, P2, P4–P8, P10–P12). This added complexity and risk leads many to have a lower threshold to admit ASR patients to hospital as outlined in the quotes below:

...where is this [discharge] letter going?; is there anyone on the other end?; does the patient have the skills—language, financial whatever—to be able to link into this entire system, to understand what needs to happen next for their own health. (P1)

I always find myself with language barriers, cultural barriers, issues with risk of loss to follow up. Those things create a lower threshold to admit or lower threshold to scan or lower threshold to intervene on first attendance... (P4)

...we don't have it translated into a language for them to refer back to. So they're relying on them memorizing what you're telling them, which can be a higher risk depending on what the medication is. (P5)

Participants had varying views and experiences when it came to connecting ASR patients with other services. Some participants expressed that the often unique ASR challenges meant that services like social work or mental health did not know how to manage these patients (P1, P5). Others, however, saw no unique challenges connecting ASR patients to other services as highlighted below (P3, P7, P9):

We're all singing off the same hymn sheet. (P7)

We have challenges with all services for all people these days. (P10)
[Social Work] take this into account that these are asylum seeker... they kind of speed up the process for them. So I think they should take a credit for that. (P11)

DISCUSSION

This study examined the views of EDCPs in providing healthcare for ASRs in an ED. 12 participants were interviewed, and 4 themes were developed: staff attitudes, presentation patterns, challenges to optimal care and transition in care. Of note were new insights into challenges around ED triage as well as nuanced views around safe discharge and follow-up.

Although there is limited similar previous research in EDs in the UK, there is a significant international body of literature on the views of healthcare professionals on providing care to ASRs as well as other migrants in primary and ED settings. A Europe-wide survey of healthcare professionals including paediatric emergency physicians which focused on child refugee health, for example, identified many of the same themes and challenges with providing care to this population as this study has including the impact of language and concerns around safe discharge.²⁶ Of particular note are two systematic literature reviews; the first reviewed 26 qualitative studies conducted in high-income countries (7 in the UK) exploring the experiences of primary healthcare professionals in providing healthcare for asylum seekers.⁵ It highlights the importance of cultural competence, trusting relationships and communication to improve care while also recognising language barriers and complex medical problems as a challenge for healthcare professionals.⁵ The second literature review evaluated 11 qualitative studies also in high-income countries (none in the UK) looking at the views of doctors, nurses and paramedics providing emergency care to migrants.¹⁰ It echoes the importance of cultural competence and language as a key barrier as well as describing

concerns around health system knowledge among patients, and ethical dilemmas in treating 'undocumented migrants'.¹⁰ Ethical dilemmas highlighted were around decisions to inform authorities of undocumented migrants as well as concerns over healthcare entitlements and use of health resources, particularly where there was a perception that certain patients could be manipulating the system.^{10 13 17}

Many of the findings in this study reflect and support themes gathered from previous studies including the impact of language barrier and health system literacy on care, illustrating their generalisability across different healthcare settings and geographical locations.^{5 10} Building on these themes, this study brings to light the particular impact of language barrier and time pressure on the triaging system: a system designed to improve safety by assessing and prioritising patients according to acuity, it may disadvantage ASR patients who cannot be fully and accurately assessed and therefore at risk of being 'undertriaged'. This study also draws focus not only on the health system literacy of ASRs but also that of EDCPs and how both can impact on the care provided. Not only do ASRs often not know where to receive appropriate healthcare but care providers have uncertainty about how to arrange safe ongoing management beyond the ED. This uncertainty and risk to discharging ASRs is compounded by a language barrier, a lack of a social support network, limited financial means and knowledge of transport options.

In contrast to existing literature, ethical dilemmas around eligibility and the emphasis around cultural competence were not reflected in the data gathered in this study. Participants unanimously expressed the view that unconditional emergency care should be provided to all patients regardless of status and instead expressed the desire to make ASRs feel welcome. The positive attitude of the participants is likely to have greatly facilitated care of these patients. This is perhaps in part reflective of migrant healthcare entitlements in Scotland (namely free-of-charge emergency, primary and secondary healthcare regardless of migrant status³), but also reflects the value of a positive departmental culture. Participants instead focused more on structural challenges which impeded optimal care. Participants described care being impacted by time pressures and an ED structure not conducive to dealing with multifaceted presentations including complex mental health problems, multiple family members presenting simultaneously and nuanced social issues. Participants did highlight, however, that this is not unique to ASRs, and similar challenges exist with other vulnerable groups, for example, the elderly.²⁷

Limitations of this study

Although a large department within a city with a relatively high population of ASR (71 per 10 000 residents),² the exact number of ASR attendances to this ED was not available. Furthermore, as a single-site study, findings may not be generalisable to other EDs across the UK where views and experiences may vary. Nonetheless, identified issues like language barrier and triage are likely to be universal in the UK as EDs have similar structures. The selection and sampling process, it is important to note, may result in selection bias as those who volunteer to participate may have stronger views on the topic. Despite all data gathered from interviews being confidential and anonymous, interviewees may censor what they say due to the sensitivity of the topic and since the interviewer is also a healthcare professional and colleague. Conversely, a colleague interviewer can lead to a degree of perceived understanding and so participants may be more open with their views. Lastly, although the focus of this study was the views of EDCPs, PPI was not sought from relevant stakeholders.

PPI will be required when developing ED-specific guidance as well as further research to study how the findings in this study relate to ASR views, their healthcare utilisation and outcomes.

Implications for practice and policy

The aim of this study was to inform the development of ED-specific guidance. It is also anticipated that the data gathered from this study will help to guide the direction of future research and inform good practice. Interventions highlighted by participants included educational resources for ASR, training and guidance for staff and language-specific information leaflets. These are low-cost measures which are likely to improve care for ASR while also alleviating pressure on the ED.

CONCLUSION

The perspectives of frontline staff are crucial to ensure effective and sustainable health policy. This study highlights multiple factors to consider when caring for ASRs from the perspective of EDCPs. Particular points to consider include unique challenges of the triage system and ensuring safe discharge and follow-up. The findings provide a focus and direction for the development of ED-specific guidelines to improve care for these patients, as well as informing wider health policy and further research.

X Joanna Quinn @joannaquinn1

Contributors CD was the principal investigator (PI) and led all aspects of study including the development of the methodology, conducting interviews and reporting of the study. AK was the PI university supervisor for the project and reviewed the methodology and the final report and assisted in obtaining KCL REC and HRA approval. JQ was the second analyst of the interview data and assisted in the final report. DJL primarily assisted in gaining local site approval and gave practical support in conducting the study as well as reviewing the final report. AK and CD are joint guarantors.

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