**Matching physicians to newly arrived refugees in a context of physician shortage: Innovation through advocacy.**

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**Abstract:**

Purpose. Access to a continuum of care from a family physician is an essential component of health and wellbeing. Refugees have particular barriers to accessing medical care. The MUN MED Gateway Project is a medical student initiative in partnership with a refugee settlement agency that provides access to and continuity of health care for new refugees, while offering medical students exposure to cross-cultural health care. This paper reports on the first six years of the Project.

Method. A mixed-method approach was used, including statistical data collection on patient participation and physician matching, a survey of physicians, interviews with student coordinators, and participant observation research.

Findings. Here we report on: (1) Patient uptake and demographics, (2) Health concerns identified through the Project, and (3) Physician uptake and rates of patient-physician matches. Results demonstrate that the Project integrates refugees into the health care system and facilitates access to medical care. Moreover, it provides learning opportunities for students to practice cross-cultural health care, with high engagement of medical students and high satisfaction by family physicians involved.

Innovation. Research has shown that student run medical clinics may provide less than optimum care to marginalized patients. Transient staff, lack of continuity of care, and limited budgets are some challenges. The MUN MED Gateway Project is markedly different. It connects patients with the mainstream medical system. In a context of family physician shortage, this student-run project provides access to medical care for newly arrived refugees in a way that is effective, efficient, and sustainable.

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Introduction

The refugee experience in Canada[[1]](#endnote-1), as with elsewhere, has been linked to adverse health outcomes compared with the general population (Beiser and Stewart, 2005; Kiss et al., 2013). In particular, mental health problems and communicable and infectious diseases characterize populations of those who have spent a protracted period of time in refugee camps en route to the host country (Dillmann, Renator and Wilson 1993; Pottie et al., 2007; Keyes 2000; Schweitzer et al., 2006). Refugee claimants are particularly vulnerable because they have limited access to employment and health care (Lacroix, 2004). Access to a continuum of care from a family physician is particularly important for this population; yet refugees have particular barriers to accessing medical care, including language, complex histories and unfamiliarity with the healthcare system (Mckeary and Newbold, 2010; Gagnon, 2002; Pottie et al., 2008; Newbold, 2009a, 2009b; Birch et al., 1993).In Canada, refugee claimants are only provided with federal health benefits covering them for limited health services (Kiss et al., 2013). In 2012, legislative changes made to Canada’s asylum system through Bill C-31 and an order respecting the Interim Federal Health Program (IFHP) have made it even more difficult for refugee claimants to access adequate health care. Prior to the changes, most classifications of refugees were eligible for supplementary care coverage, whereas now health care covers only government assisted refugees, victims of trafficking granted temporary residence permits, and people being resettled in Canada on the Minister’s own initiative who receive income support through the Refugee Assistance Program (or equivalent in the province of Quebec). Refugee claimants only have health care coverage for medical issues deemed to be of an urgent or essential nature; refugees from a Designated Country of Origin (DCO) only have coverage if the health condition is a threat to public health and safety. Neither refugee claimant group has access to medication coverage unless the illness is deemed a threat to public health and safety (Citizenship and Immigration Canada, 2012). Some provinces have decided recently to cover partial health care costs for refugee claimants to fill the void left by cuts to the IFHP.

The problem with access to primary health care for refugees in Canada is compounded by a lack of family physicians (McElroy 2004; Asanin and Wilson, 2008; McKeary 2010). In the province of Newfoundland and Labrador, on the east coast of Canada, the physician shortage parallels that found in many of the rural and remote areas of Canada – it is in a crisis state (Canadian Labour and Business Centre, 2003). Those few physicians who might be willing to take on additional patients and families are sometimes reluctant to open their doors to patients with language barriers and very complicated medical histories.

In 2006, in response to the growing crisis of physician shortage for newly arrived refugees to the province , the MUN MED Gateway Project was formed. The Gateway Project is a medical student initiative, in partnership with a local refugee settlement agency, which provides access to health care for newly arrived refugees[[[2]](#endnote-2)]. The specific objectives of the Gateway Project are: (1) to provide access to continuity of care for newly arrived refugees by (i) conducting medical histories, with provision of some basic physical screening, and (ii) matching each patient or family with a family physician; and (2) to provide opportunities for medical students to practice cross-cultural health care and to mentor medical students in advocacy for underserved populations.

A review of student-run clinics in the Canadian context has argued that the clinics are successful at teaching clinical skills, but less so in providing optimum access to medical care for marginalized communities (Mancuso and Graham, 2011). This is in keeping with findings of the U.S.-based Society of Student Run Free Clinics (SSRFC), which reports challenges including: transient staff, lack of continuity of care, erratic hours, mobile locations, and limited budgets (Lev-Tov, 2009). The Gateway Project adapts the model of student-run clinics but departs significantly in design. Rather than providing medical care to a disadvantaged population, the goal is to connect refugees with the existing mainstream medical system, avoiding many of the challenges faced by student-run clinics.

Research was conducted to determine the effectiveness of the Gateway Project during the first six years of the project (August 2006 – August 2012)[[[3]](#endnote-3)]. This paper reports on the first objective of the Project -- to provide access to continuity of care for newly arrived refugees -- reviewing patient and physician uptake of the service, describing the health needs of the patients served and highlighting the challenges and strategies that impacted effectiveness and sustainability of the project in providing access to and continuity of care.

1. **Context**

The small eastern Canadian province of Newfoundland and Labrador attracts about 700 newcomers annually, comprising 0.3% percent of admissions to Canada. Newcomers settle in Newfoundland, the island that comprises the southern portion of the province. Approximately one third of the newcomers are admitted as protected persons (primarily as convention refugees) or on humanitarian and compassionate grounds (Citizenship and Immigration Canada, 2011; Newfoundland and Labrador, 2007). According to the province’s resettlement agency, those numbers are declining. In 2008, 156 refugees were accepted to the province; by 2012 the numbers had declined, with 104 refugees, primarily government assisted refugees, being admitted (Association for New Canadians settlement services , personal communication, March 11, 2013).

The Gateway Project began in 2006 with a preliminary trial period at the end of the medical school year. The project pairs first and second year medical student volunteers with newly arrived refugee patients of the local refugee settlement agency. Patients are matched with family doctors in the community who have been recruited to take on Gateway project patients. The students, working through interpreters, conduct a medical history and provide basic screening including measurement of blood pressure, height and weight measurements, growth charts for children, hearing and vision screen, dental screen and eye and ear exam as needed. Tuberculosis (TB) skin tests are also offered to patients who are from countries with a high incidence of TB. Screening is based on the Canadian Collaboration for Immigrant and Refugee Health (CCIRH) guidelines (Pottie et al., 2011) and offered in conjunction with the public health authority which also provides structured follow up. This information is entered into a secure personal health information database, which summarizes the history and screening into a report. The report and any referrals made during the Gateway session are forwarded to the matched physician [[[4]](#endnote-4)]. The history and screening sessions take place weekly, at the resettlement agency language school, under the supervision of an attending physician and in association with the settlement agency’s public health nurse. Patients are referred directly to dentists, optometrists, ophthalmologists, ENT specialists and other health care providers as necessary.

By 2008, the Project was fully operational with a volunteer corps that comprised more than 75% of first and second year medical students led by two student coordinators (who hold the position for one academic year) and regular weekly sessions. The Gateway Project is a joint project of the Discipline of Family Medicine and the Division of Community Health and Humanities, with logistical and financial support from Memorial University’s Faculty of Medicine. It is managed by a part time coordinator and three faculty advisors with expertise in clinical care, teaching, community health and database management. The advisory committee, which meets monthly, consists of the three faculty advisors, the Global Health coordinator, two medical student coordinators, the project coordinator, the settlement agency public health nurse, health worker and social worker. The project was approved as an educational activity by the Newfoundland & Labrador College of Physicians and Surgeons and as an extracurricular educational program by the Undergraduate Medical Education Office of the Faculty of Medicine.

1. **Methods**

Research was conducted during the first six years of the project (years 2006-7 to 2011-12) to determine the effectiveness of the Gateway Project at meeting its objectives for patient care and education. Our method itself is grounded in social justice, both as objective and as process. Specifically, it addresses the ways in which researchers can effectively participate in community efforts at transformation and empowerment (as in Mertens 2007). The project was evaluated using a mixed methods approach comprised of four components: (1) Statistical data was collected on patient demographics and usage, volunteer engagement, physician involvement, and numbers of patients matched to physicians. (2) A survey of physicians involved during one academic year of the project (2009-2010) was conducted, to collect physician perspectives on the strengths and challenges of the project. The survey was emailed to 10 physicians; 8 responses were received. (3) Open-ended interviews were conducted with four medical student Coordinators. These interviews focused on challenges and strategies experienced with coordinating student volunteers and collaborating with the resettlement agency. (4) Participant observation research was conducted throughout the five-year pilot phase of the project. Careful notes were kept of all team meetings, telephone conversations, and informal feedback from students, faculty advisors, and Gateway staff. All emails and other correspondence were kept, no matter how insignificant. Medical students were debriefed informally following interview sessions and perspectives were recorded in the form of notes by the debriefing faculty. Debriefing focused on the experiences of history taking, translation and overall perceptions of Gateway as an educational method of achieving cross-cultural competency. Difficulties and challenges were noted and discussed at monthly meetings, with strategies for overcoming challenges implemented. All steps taken in the development and implementation of the project were carefully recorded in the form of observational notes by the participant observer ([Faculty name]). At the completion of the six-year pilot phase, a text-based analysis of participant observation notes and archival materials was conducted for themes relating to project challenges and strategies. We combined related concepts under common sub-themes, and combined those in turn under larger themes (Boyatzis, 1998). We then considered our data and our interpretation of challenges and successes of the Project in light of the existing literature.

Patient consent for research was obtained verbally at the time of the medical history-taking visit by the Gateway Project coordinator. Patients were invited to participate by having their medical histories retained for research. The histories have been stored in a database on a secure Faculty of Medicine server that was created and is maintained by the Faculty of Medicine. The period covered for this data extraction is: March 24, 2009 to July 31, 2012.

Health history data for each consenting participant that had been stored in the secure database was reviewed and entered into a more concise spreadsheet using Microsoft Excel. Data was stored on the spreadsheet under headings to display information about sex, age, country of origin, refugee camps, transit countries, arrival in Canada, family supports, marital status, smoking, alcohol use, over the counter medication use, illicit drug use, herbal remedy use, languages spoken, education, occupation, major medical concerns, history of present illness, social history, psychological history, past medical history, medications, allergies, family history, obstetrical/gynaecological history, cervical cancer screening, sexually transmitted infections, review of systems, immunization history, communicable diseases, height, weight, oral health, visual acuity, hearing tests, and referral to specialists.

1. **Patient uptake and demographics**

Since 2008, virtually all of the new patients of the refugee resettlement agency participate in the Gateway Project (exceptions are those who upon arriving at the settlement agency require immediate and urgent medical care and enter the health care system through the emergency system). Most Gateway patients are single young adults between the ages of 20 and 50; more men than women are seen; slightly more than half have lived in refugee camps; most arrive as part of a family group; and the majority requires interpretation services.

[Insert Table 1]

Between March 24th, 2009 and July 31, 2012, 343 patients, representing 27 countries, participated in the Gateway Project. Figure 1 shows the number of patients by country of origin. The country of origin of the largest percentage was Bhutan; however many of these refugees had lived in refugee camps in Nepal for a number of years.

[Insert Figure 1]

Approximately 68% of patients reported having spent time in a refugee camp prior to their arrival in Canada, with the length of stay in camps ranging from one month to twenty-three years (Fig. 2).

[Insert Figure 2]

The vast majority required interpretation services for the Gateway Project medical history interview. Forty-eight different languages were represented by the 343 participants. The education level reported by patients varied, from having no formal education to having a doctoral degree. Many reported having obtained their formal education or professional skills while living in refugee camps (Fig.3).

[Insert Figure 3]

The number of adult males with a formal education far exceeded the number of adult females. In addition, 28% of adult females reported receiving no formal education, whereas only 11% of adult males reported the same (Fig. 4).

[Insert Figure 4]

The majority who arrived since 2009 were accompanied by one or more family members. Most had family support in the host city (Fig. 5)

[Insert Figure 5]

1. **Health concerns identified through Gateway**

*5.1 Tobacco, Alcohol and Medication Use*

Approximately 14% of the patients reported using tobacco on a regular basis; 47% reported the regular use of alcohol. Acetaminophen was reported as being the over-the-counter medication used most by patients. Headaches were the number one reason for patients reporting medication use. Other reported reasons included toothache, yeast infection, allergy relief, epigastric pain, and treatment for stomach ulcers (Fig. 6).

[Insert Figure 6]

*5.2 Illicit and Alternative Drug Use*

Only one patient out of 343 reported using illicit drugs (this low figure is not surprising, given the perceived and potential risks of reporting illegal drug use). Approximately 20% of patients reported using herbal remedies, including tea (Green Tea, Black Tea, Herbal Tea, Tea with flowers, Mint Tea), stomach ulcer treatment made from oily flower seeds, cough suppressant made from honey and salt, colon cleanse made from herbs and fruit juices, jaundice treatment made from plant roots, tablets made from fruit, remedy for a leg wound (unspecified), and sage (purpose unspecified).

*5.3 Major Medical Concerns*

Medical concerns most commonly reported included dental, vision, and musculoskeletal concerns (Fig. 7).

[Insert Figure 7]

Dental concerns included tooth and gum pain, bleeding gums, dental caries, infections, missing and broken teeth, and dental sensitivity to temperature extremes. Vision problems included poor or worsening vision, eye pain, and glaucoma. Ear concerns included hearing loss, infections, tinnitus, and ruptured tympanic membranes. Musculoskeletal problems included injuries, arthritis, joint and muscle pain, muscle cramps, and amputations. Skin conditions included rashes, fungal infections, pruritus, cysts, lumps, and burns. Chest pain was reported by 13 patients, however it is unknown what type of chest pain was being described (i.e. cardiac, musculoskeletal, etc.). Gastrointestinal concerns included digestion problems and stomach ulcers. Of the 343 patients, 108 reported having no major medical concerns. Less commonly, patient self-descriptors of medical conditions included:

[Insert Table 2]

*5.4 Cervical Cancer Screening*

Out of 90 adult females above the age of 19 years, only 13(14%) women reported having had a pap test in their lifetime; 44 (49%) adult women reported that they had never had a previous pap test (Fig. 8). Nearly half was unscreened (49%) and 37% had an unknown history of previous screening. The vast majority of women (86%), then, were either unscreened or had a poor cervical cancer screening history.

[Insert Figure 8]

*5.5 Immunizations*

In many cases, patients were unsure of whether they had received vaccines or unsure of which particular vaccines they had received. Records were often not brought to Canada (Fig. 9).

[Insert Figure 9]

Commonly reported vaccines included: Bacille Calmette-Guérin (BCG), Cholera, Diphtheria/Pertussis/Tetanus (DPT), Hepatitis A, Hepatitis B, Influenza, Measles/Mumps/Rubella (MMR), Meningitis, Pneumococcal, Polio (oral and injection), Rotavirus, Smallpox, Tetanus, Typhoid Fever, Varicella, and Yellow fever.

*5.6 Specialist Referrals*

Between March 8, 2011 (when referrals to specialist physicians through the Gateway Project began) to July 31, 2012, approximately 74% of patients screened were referred to speciality services such as optometry, audiology, and dentistry due to abnormalities found at the time of screening (Fig. 10).

[Insert Figure 10]

*5.7 Communicable Diseases*

While the medical history of many patients regarding communicable diseases was often unknown, 79 individuals reported having been affected at some time in their lives by a communicable disease (Fig. 11).

[Insert Figure 11]

1. **Physician uptake and satisfaction**

The project goal of advocacy for newly arrived refugees comprised two sub goals: (1) to match patients to a family physician, with the aim of enabling continuity of care; and (2) to provide health histories to the physicians, with the aim of making the first clinic visit less cumbersome. Our intent was that providing the detailed histories would encourage physicians to accept new refugee patients. In this way, in a context of severe shortage of family physicians, this vulnerable group would be accommodated by physicians with otherwise closed practices. Since most practices in the city were closed to new patients, the primary challenge in providing access to and continuity of care for the refugee patients was recruitment and retention of physicians. Recruitment processes used that did not result in sufficient numbers of physicians were: written invitations sent out from the provincial medical association; written invitations sent out from the Gateway Project coordinator; a news article about the project featured in the provincial medical association physician publication; written invitations targeted to alumni of the medical school; notices of the need for physicians for the project posted in physician newsletters; and announcements at continuing medical education events. These processes, collectively, yielded 2 positive responses. Subsequently, personal contact with family physicians was attempted by the medical student volunteer coordinators; however, the gate keeping function of medical office administrators limited that method as a possibility for successful recruitment. In the early stage of the project, the problem of lack of physicians was compounded by a difficulty with scheduling appointments. Some physicians agreed to participate but failed to inform their administrative staff, who then refused to book appointments since the physician was, in theory, not accepting new patients. Some matches were not appropriate due to distance and lack of easy public transportation. The strategy that has proven successful for physician recruitment is one of face-to-face contact with individual physicians to explain the Gateway Project and ask the physician to consider accepting one or two Gateway patients into their practice despite having a full case load.

By the first fully operational year of the clinic (2008-9), 100% of the resettlement agency patients who participated in the Gateway project were being matched with a family physician through the project. By 2010-11, the corps of physicians affiliated with the project, which began with a small handful of physicians who were already predisposed to accepting refugee patients, had grown to 15 physicians -- most with practices otherwise closed to new patients – accepting new patients through the Gateway Project.

[Insert Table 3]

Seven of the eight physicians surveyed reported that the medical histories provided by Gateway were very helpful for their initial visit with the patient. The eighth physician commented that the histories were not able to replace his own history with the patient, but that social data (family supports locally; context prior to arrival) was a useful supplement. Several commented on the importance of being provided background information related to personal and familial physical and psychological harms sustained prior to arrival, time spent in refugee camps, and other contextual information. Most deemed it important to have the medical history records of Gateway patients sent to them in advance; one physician stated that having the histories in advance was not necessary as long as the histories accompany the patient’s visit.

Six of the eight physicians said that they encountered greater difficulty developing an effective physician/patient relationship with Gateway patients compared with other patients due to language and culture barriers. Importantly, the two physicians who reported no undue burdens associated with language and cultural differences attributed this to the support provided by the Gateway Project.

Seven of the eight physicians reported that they would continue to see Gateway patients in their practice. Of those, one added the caveat that she/he would not see these patients during extremely busy periods and one noted that while he/she would accept Gateway patients at a later date, there was no possibility for accepting new families at the present time. The same majority (seven of eight) reported that they would recommend accepting Gateway patients to their colleagues. The physician who reported that he/she would not continue to accept Gateway patients expressed the concern that Gateway patients typically require longer appointments and more than one appointment because of the complexities of language and cross-cultural communication.

Difficulties with communication related to a lack of available and affordable interpretation was a common concern. Of the two physicians who reported having no problems with language, one was able to communicate in the language of the patient, and the other stated that histories were sufficiently detailed and interpreters had accompanied the patients. Only two physicians reported that patients were regularly accompanied by interpreters. Four physicians stated that interpreters are not always present; and one physician reported that most of the time the patients are not accompanied by an interpreter. Some physicians identified a concern about additional communication barriers related to educational level, social-economic status and health literacy; that is, that even with an interpreter, patients were unable to appreciate and follow medical recommendations and instructions.

There is no provision in the province of Newfoundland & Labrador for access to interpretation (other than French) for medical reasons, free of charge, outside of the hospital setting. The Office of Citizenship and Immigration Canada only funds interpretation for the first medical appointment with a family doctor. Thereafter, patients are to provide their own. In Newfoundland, the settlement agency works hard to find and fund additional interpretation; provision of this service is an ongoing challenge in a context of limited resources. This highlights the fact that in both federal and provincial spheres in Canada, the relevance of interpretation services in the context of health and social services has been under-rated (Mckeary and Newbold, 2010; Pottie et al., 2008) and is a significant patient safety issue (Johnstone and Kanitsako, 2006; Lindholm et al., 2012; Flores et al., 2012).

The concern with patients not presenting for the initial physician visit, or not following through with subsequent visits, was reported by physicians to be a significant barrier to continuity of care.

*“Some miss booked appointments and at times they do not even know or remember that they have an appointment with me.” [P1]*

*“This was a big problem when [the clinic] first got involved and there were many no-show appointments that were not cancelled by [the resettlement agency] when a translator could not be found.” [P3]*

Generally, non-attendance was related to barriers of access typically associated with low socio-economic status. In the cases described in the quotes above, physicians reported that there had been no assistance with interpretation, childcare, and/or transportation. This in turn had a potential impact on recruitment and retention of physicians for Gateway.

**7. Conclusion**

The MUN MED Gateway Project eases the transition for refugees into the health care system and facilitates access to medical care. Six years into the project, 100% of the resettlement agency patients are participating in the physician matching service and are being effectively matched with a family physician. In a context of severe family physician shortage, this student-run project efficiently provides access to medical care for newly arrived refugees.

Our findings also demonstrate the importance of early physician involvement. Fully three quarters of Gateway Project patients who underwent medical screening were in immediate need of a referral to a specialist service. Of particular concern is the health of women newcomers, 86% of whom were either unscreened or had an unknown history of screening for cervical cancer.

The task of recruiting physicians with closed practices to accept newly arrived refugee patients and families -- with all of the additional practice burdens associated with overcoming language and cultural barriers -- was challenging but ultimately successful. Most of the physicians surveyed reported that the medical histories provided by Gateway were very helpful for their initial visit with the patient; the outlier stated that the histories were valuable as a supplement to the physician’s own history. The vast majority of the physicians recruited said that they would continue to accept Gateway patients into their otherwise closed practices and would recommend that their colleagues do so as well.

In terms of effectively overcoming barriers to accessing family physicians, the Gateway project is successful. Moreover, the provision of a family physician, along with the medical screening provided through the Gateway project, leads to the early identification and management of infectious diseases, oral health problems and other conditions associated with refugee health inequities. These results are generalizable to other contexts, in Canada and elsewhere, where physician shortages mean that the special health needs of this vulnerable group are going unmet. Future research will be needed to ascertain whether the successful matching of refugee patients to physicians has a ‘snowball’ effect of removing other significant barriers to health, for example addressing the psychosocial distress associated with the refugee experience.

Many challenges remain that are beyond the scope of what the Gateway Project can facilitate. The provision of professional and cost-effective interpretation services on a longer-term basis requires commitment at federal, provincial, and health regional levels, at a time when health costs are being downsized at each of those levels. The fee-for-service system of physician remuneration in Newfoundland and Labrador does not compensate physicians for the additional time required by physicians to work with refugee patients and this is unlikely to change. Recent cuts to the Interim Federal Health program, as described earlier, make access to healthcare very difficult for many refugees. In spite of these broader political and economic constraints to providing health care for refugees, the training of new generations of physicians through the Gateway Project lends hope that future physicians will be sufficiently trained and aware of the special needs of the population and that they will open their clinic doors to refugee patients. Research on the medical careers of those who volunteered with Gateway is underway and will shed light on whether participation in the program leads to further acceptance of refugee patients and whether the training eases the burden of physicians working across languages and cultures.

Our study’s implications are limited by the uniqueness of the setting. The Newfoundland context is different from that of other Canadian provinces in that the numbers of refugees annually entering Newfoundland and Labrador is relatively low, with the great majority of refugees falling into the category of government-assisted refugees (CIC, 2012b). The province has only one entry point for government-assisted refugees, with one community agency providing services. The success of the Gateway Project is linked in part to the ease of this relatively uncomplicated system: all newcomers are streamed through the one agency, and all are therefore seen in the Gateway Project. The success of our project is likely biased because of this.

The Gateway Project adopts the model of student-run clinics but departs significantly in design. It thus avoids the challenges to effective patient care that are experienced by other student-run clinics, such as transient staff, lack of continuity of care, erratic hours, and mobile locations. By connecting refugee patients with the existing mainstream medical system, the Gateway Project has been effective, efficient and sustainable in its provision of care to this vulnerable patient population.

**References**

Asanin, J. and Wilson, K. (2008), Wilson “I spent nine years looking for a doctor”: Exploring access to health care among immigrants in Mississauga, Ontario, Canada. *Social Science & Medicine*, Vol. 66, Issue 6, pp. 1271-1283.

Birch, S., Eyles, J. and Newbold, K.B. (1993), “Equitable access to health care: Methodological extensions to the analysis of physician utilization in Canada”, *Health Economics,* Vol. 2, pp. 87-101.

Boyatzis, R. (1998), *Transforming Qualitative Information: Thematic Analysis and Code Development*. Thousand Oaks: Sage.

Canadian Labour and Business Centre (2003), Physician workforce in Canada: Literature review and gap analysis. *Final report, Task Force Two,* Ottawa.

Citizenship and Immigration Canada (2007), *Backgrounder – Refugees and Canada’s refugee system.* http://www.cic.gc.ca/english/department/media/backgrounders/2007/2007-06-20.asp

Citizenship and Immigration Canada (2011), *Annual Report to Parliament on Immigration*.

<http://www.cic.gc.ca/english/pdf/pub/annual-report-2011.pdf>

Citizenship and Immigration Canada (2012), *Interim Federal Health Program: Summary of Benefits.* <http://www.cic.gc.ca/english/refugees/outside/summary-ifhp.asp>

Dillman, E., Renator, P., and Wilson, A. (1993), “Patterns of health problems observed among newly arrived refugees to Canada. In: Masi R., Mensah L., and McLeod K.A., editors. *Health and Cultures: Exploring the Relationships*. 2nd ed. Oakville: Moasaic Press, pp. 253-8.

Flores, G., Abreu, M., Pizzo Barone, C., Bachur, R and Lin, L. (2012), “Errors of medical interpretation and their potential clinical consequences: A comparison of professional versus ad hoc versus no interpreters”, *Annals of Emergency Medicine,* Vol. 60 No. 5, pp. 545-553*.*

Gagnon, A. (2002), “Responsiveness of the Canadian health care system towards newcomers”, Discussion Paper 40. *Commission on the Future of Health Care in Canada (Romanow Commission).*

Government of Newfoundland and Labrador (2007), *Diversity, Opportunity and Growth: An Immigration Strategy for Newfoundland and Labrador.*

<http://www.nlimmigration.ca/media/2842/strategydoc-mar07.pdf>

Johnstone., M and Kanitsaki, O. (2006), “Culture, language, and patient safety: Making the link. *International Journal of Qualitative Health Care”,*Vol. 18 No. 5, pp. 383-388.

Keyes, E.F. (2000), “Mental health status in refugees: An integrative review of current research”. *Issues in Mental Health Nursing*, 21 (4); 397-410.

Lev-Tov, H. *Quality of Care. Society of Student Run Free Clinics*. 2009;1:2-5.

<http://www.med.wisc.edu/files/smph/docs/medic/ssrfc-may-newsletter-final.pdf>

Lindholm, M., Hargraves, J., Ferguson, W., and Reed, J. (2012), “Professional Language Interpretation and Inpatient Length of Stay and Readmission Rates”, *Journal of General Internal Medicine,* Vol.27 No.10, pp.1294-1299.

McElroy, R. (2004), “Canada’s shortage of physicians”. *Canadian Family Physician*, Vol. 50 No. 3, pp. 349.

Mancuso, F. and Graham, R. (2011), *A Critique of Student-Run Clinics in Canada*. Unpublished Manuscript. Health Rehab Sciences Faculty of Health Sciences University of Western Ontario. 2011.

Mckeary, M. and Newbold, B. (2010), “Barriers to care: The challenges for Canadian refugees and their health care providers”, *Journal of Refugee Studies,* Vol. 23 No. 4, pp. 523-545.

Mertens, D.M. (2007), “Transformative paradigm: Mixed methods and social justice,” *Journal of Mixed Methods Research*, Vol 1, No. 3, pp. 212-225.

Newbold, K.B. (2009a), “The short-term health of Canada’s new immigrant arrivals: Evidence from LSIC. *Ethnicity and Health”,* Vol. 14 No. 3, pp. 1-22.

Newbold, K.B. (2009b), “Health care use and the Canadian immigrant populations.” *International Journal of Health Services”,* Vol. 39 No. 3, pp. 545-565.

Pottie, K., Greenaway, C., Feghtier, J., Welch, V., Swinkels, H., Rashid, M., et al. (2011) “Evidence based clinical guidelines for immigrants and refugees”. *Canadian Medical Association Journal*, 183; 824-925.

Pottie, K., Ng, E., Spitzer, D., Mohammed, A. And Glazier, R. (2008), “Language proficiency, gender and self-reported health: An analysis of the first two waves of the longitudinal survey of immigrants to Canada”, *Canadian Journal of Public Health,* Vol. 99 No. 6, pp. 505-510.

Pottie, K., Janakiram, P., Topp, P. and McCarthy, A. (2007), “Prevalence of selected preventable and treatable diseases among government-assisted refugees: Implications for primary care providers”. *Canadian Family Physician*, 53 (11): 1928-34.

Schweitzer, R., Melville, F., Steel, Z. and Lacherez, P. (2006), “Trauma, post-migration living difficulties, and social support as predictors of psychological adjustment in resettled Sudanese refugees, ” *Australia and New Zealand Journal of Psychiatry*, 40(2): 179-87.

1. Citizenship and Immigration Canada (CIC) currently has two established systems in place for admitting refugees to Canada: The first system is the Refugee and Humanitarianism Resettlement Program, which is designed to manage Convention Refugees Abroad whose initial resettlement in Canada is supported by the Government of Canada or Quebec (CIC, 2007). Under this program, Canada relies on the UNHCR and other referral organizations to identify and refer refugees disproportionately more at risk than the general refugee population, for resettlement to Canada (CIC, 2007). The second system , the In-Canada Asylum Program , is designed to manage individuals making refugee protection claims from within Canada (CIC, 2012 November 26). In 2013, it is estimated that Canada will resettle up to 14,500 refugees (CIC, 2012 November 26), up slightly from previous years. In 2009 Canada admitted 12,500 refugees identified by the United Nations High Commission for Refugees (UNHCR) for resettlement (UNHCR, 2010). [↑](#endnote-ref-1)
2. These are government-assisted refugees, clients of the partnering resettlement agency. [↑](#endnote-ref-2)
3. This research was reviewed and approved by the research ethics board of Memorial University. The authors have no conflicts of interest with this research. The project required no funding. [↑](#endnote-ref-3)
4. Initially only a history was done, however since 2011 screening and TB testing is also included. [↑](#endnote-ref-4)