Experiences and Future Needs of Primary Care Physiotherapists Encountering Asylum-seeking Patients in Västerbotten County

A pilot study

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Acknowledgements

I want to direct my warmest appreciation to the informants of this study. You made this happen. Together we continue to shape the physiotherapeutic profession in a compassionate and including fashion!

Finally, this also goes out to my classmates, my supervisor Helene Johansson and my loving family and friends. Thank you for your never-ending love and support!
Abstract

**Introduction:** Currently, there are one billion migrants worldwide, with Sweden being a common host country. In Swedish primary care, physiotherapists are usually the first instance for patients with musculo-skeletal complaints, ASPs included. Currently, there are no physiotherapeutic guidelines addressing the management and treatment for ASPs. Furthermore, there are some qualitative studies discussing the interaction between health care providers and ASPs or migrant patients, however, none of them are exclusively exploring the phenomenon from the physiotherapists’ perspective. The aim of this study was to explore Swedish primary care physiotherapists’ experiences and professional needs when encountering ASPs.

**Methods:** Using a qualitative methodology with an inductive approach, a case-study consisting of four semi-structured interviews with primary care physiotherapists located in Västerbotten county were conducted between the 13th of March and the 6th of April 2018. Thematic analysis (TA) was used to analyze data.

**Results:** Two main themes were identified; Our most challenging patient group and Demand for knowledge and frameworks. These were discussing the reasons behind the challenges when encountering ASPs, and the desire for an increased organization on a higher level to prepare physiotherapists for their encounters with ASPs.

**Conclusion:** Findings suggest there are challenges and a request for an increased knowledge among primary care physiotherapists when encountering ASPs. These findings serve as a foundation for further research in the matter and for future adjustments in how the physiotherapeutic bachelor program is designed, how employers and the Physiotherapy union (Fysioterapeuterna) provide their employees and members with adequate knowledge, preparing them for encountering ASPs in the best possible way.
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List of abbreviations

ASP – Asylum-seeking patient
HSL – Häls- och sjukvårdslagen (the Swedish Health Care Act)
IOM – International Organization for Migration
SCB – Statistiska centralbyrån (Statistics Sweden)
TA – Thematic analysis
VLL – Västerbottens läns landsting (Västerbotten County Council)
WHO – World Health Organization
Introduction

Migration from a global perspective
Currently, there are one billion migrants worldwide, making it the largest number of people on the move in modern times (WHO, 2018a). Out of these, 65 million people are forced to leave their homes (WHO, 2016a) due to armed conflicts, the presence of terror, climate change, cultural and religious discrimination and oppression (WHO, 2018b), in search for a better future elsewhere for themselves and their families (UN, 2015). On their journey, migrants are exposed to several factors that can impact their health. Limited health care access and discrimination stemming from misconceptions about migrants negatively impact migrants’ health (IOM, 2013). Furthermore, even in situations where health care is accessible, not all health systems are able to provide migrants with culturally and linguistically appropriate care (IOM, 2013). This indeed puts a demand on the government and health system in the actual countries in adjusting and overlooking the competency among health care professionals in the pursuit of the best possible health for all (IOM, 2013).

Migration in the Swedish context
During 2017, there were 25,666 applications for asylum in Sweden (Migrationsverket, 2018). This was a large decrease compared to the 162,877 asylum applications in 2015 (Migrationsverket, 2018), however still significant. According to Migrationsverket (2018), Syria, Iraq, Afghanistan, Somalia and Eritrea represented the five most frequent countries of origin for asylum seekers in Sweden.

Similarly to many other countries, Sweden has been struggling with the issue of unmet needs in health care (Socialstyrelsen, 2016b). Along with this issue, there are significant difficulties in the long-term planning regarding asylum-seeking patients’ (ASPs) health care needs due to a lack of translators, financial resources, adequate knowledge and specific cultural competence among health care professionals (Socialstyrelsen, 2016b). In the report by the Swedish Board of Health and Welfare (Socialstyrelsen) (2016b), it is stated that the county councils are having difficulties in developing long-term plans for ASPs due to uncertainties regarding the number of ASPs that will remain in the county. There is also a lack of communication between the municipalities that are hosting ASPs and the county councils (Socialstyrelsen, 2016b). Furthermore, ASPs that count as children (<20 years) hold the same rights to Swedish health care as children with Swedish citizenship (Sveriges Riksdag, 2008). However, Swedish health care is limited for adult ASPs, and services offered are “care that cannot be postponed”, maternal care, care during abortion, contraceptive counselling, prescriptions of medications during the mentioned situations, and initial health assessments (Sveriges Riksdag, 2008). These factors along with the legal barriers all challenge the ability of reaching out and providing health on equal terms to this patient group (Socialstyrelsen, 2016b).

Another challenge stated by Socialstyrelsen (2016b), is the differing health care seeking patterns of this patient group. ASPs more often require unplanned and more specialized care compared to the rest of the Swedish population (Socialstyrelsen, 2016b). In addition, a larger demand for psychological resources can be seen among these patients, due to post-traumatic stress disorder (PTSD), stress in waiting for residents permits, and other social and emotional stress factors related to family reunions and current housing conditions.
(Socialstyrelsen, 2016b). In primary care, two of the main challenges described in the report by Socialstyrelsen (2016b) are administrative and differing views on the health care system. Due to insufficient information about booking appointments and language barriers, ASPs commonly show up at the reception trying to book an appointment in person. The differing views on health care and how patients seek care among ASPs result in difficulties to respond to the expectations of the patient group (Socialstyrelsen, 2016b).

**The Swedish health system**

The Swedish health system consists of three levels; national (state), regional (county councils) and local (municipalities). The organization and responsibilities of the Swedish health system are divided between the three levels, primarily regulated by the Health Care Act (Hälso- och sjukvårdslagen – HSL) (SCB, 2015). The HSL provides freedom to the councils in determining how the health care is organized in the actual county (SCB, 2015). Furthermore, the Swedish health system is financed mainly by taxes, seeking to provide the whole population with equal access to high-quality care (SCB, 2015). Primary care functions as the base in Swedish health care, dealing with non-acute medical conditions. The next level consists of regional hospitals holding the capacity to treat several conditions in need of specialized care. At the highest level, there are the university hospitals dealing with more complicated or rare conditions demanding specialized competency (SCB, 2015). To attend primary care, the patient must book an appointment through the telephone service or, if this is not possible, in person at the care center. The personal number provided to all Swedish citizens gives full access to health care. However, as mentioned previously, there are some restrictions in the health care access for adult ASPs (Sveriges Riksdag, 2008).

In Sweden, an initial and health assessment is provided to ASPs shortly after their arrival through the Health and Medical Care for Asylum Seekers and Others Act (SFS 2008:344) (Sveriges Riksdag, 2008), also entitling them to “care that cannot be postponed”. The purpose of the initial assessment is to examine individuals’ health status and address eventual complaints, as well as to identify and prevent the spread of communicable diseases (Socialstyrelsen, 2011). Additionally, participation in the health assessment is voluntary (Sveriges Riksdag, 2008). ASPs are given information about the voluntary health assessment through Migrationsverket, while the health care centers are responsible for the invitations, assessments and further services (Sveriges Riksdag, 2008). Pacheco, Jonzon & Hurtig (2016) pointed out shortcomings in the invitations to the health assessment appointments and the information given about its purpose. Improvements will be required to reach the target population in a successful manner (Pacheco, Jonzon & Hurtig, 2016). Furthermore, the concept of “care that cannot be postponed” entails, to name a few, conditions that demand immediate care and treatment, conditions in risk of becoming threatening to the patient if untreated, care to prevent more severe conditions, and care to prevent a more comprehensive demand for care and treatment (Socialstyrelsen, 2016b).

However, campaigns for improving the health care for ASPs seems to be on the rise. During the second half of 2016, Sveriges Kommuner och Landsting (SKL) was granted financial support from the Swedish government to operate “Hälsa i Sverige”, a national program designed to spread and enhance awareness, knowledge and competence among health care professionals encountering ASPs (SKL, 2017). The primary goals of the program were to improve the quality of health assessments, to faster identify and avert a negative health
development and to offer a well-functioning recovery and integration for ASPs (SKL, 2017). All county councils and regions in Sweden participated in the program, and between years 2016 and 2017 an estimated 15,000 professionals had received or were planning to receive education from the “Hälsa i Sverige” program (SKL, 2017). Although several efforts have been conducted, a large amount of work remains to gain, maintain, and spread knowledge (SKL, 2017).

The physiotherapeutic profession
Along with doctors and nurses, physiotherapists are a common instance in health care for asylum seekers, however, physiotherapists are the first instance for musculoskeletal complaints and for patients in need of guidance for a healthy lifestyle (Broberg & Lenné, 2017). Physiotherapists encounter a diversity of patients in all ages with different complaints, personal backgrounds and notions about health. In health care, physiotherapists are found in both the public and private sector. In the Swedish context, physiotherapists are represented in county councils at primary health care centers or hospitals, in municipalities at centers for elderly or disabled and within schools, and at private clinics. As physiotherapists are qualified to work within a variety of disciplines, from psychiatry to ergonomics and any specialized care to quote a few examples, they have a given place within public health (Broberg & Lenné, 2017). Physiotherapists as professionals share a common notion how movement and physical activity contribute to health. The science of physiotherapy adopts a holistic view of human beings. In the paradigm of physiotherapy, the human being is viewed as:

“[…] a physical, psychological, social and existential entity that interacts in its physical and sociocultural environment.“ (Broberg & Lenné, 2017: 22).

Furthermore, Broberg & Lenné (2017) highlight this paradigm as a prerequisite to the ability of seeing human beings as capable of being active and participatory in their own development and thus their health. Human beings hold intrinsic resources that are used individually or in collaboration with others to maintain or gain health.

Additionally, the physiotherapeutic profession rests upon ethical principles of equality and respect for all human beings irrespective of their gender, religion, ethnicity, sexual orientation or disabilities (Fysioterapeuterna, 2017). These principles are the fundaments of the treatment towards patients, ensuring the issue of dignity, integrity and autonomy are protected.

In order to become a physiotherapist in Sweden, one needs to complete a bachelor’s degree at one of the eight universities where the degree is offered. The profession title physiotherapist is protected in Sweden. To be able to practice as a physiotherapist after completing the bachelor’s degree, approval from the National Board of Health and Welfare is required for receiving the title Licensed Physiotherapist.

The education plan can differ in some respects between the eight universities. For instance, not every university offers their students courses discussing the topics of public health or cultural competency. Currently, only half the universities in Sweden with a Bachelor of
Science in physiotherapy are offering courses where public health is integrated. However, there is no clarity whether or not cultural competency is present in any of the courses in the eight universities’ educational plans.

**The concept of cultural competency**

Cultural competency could be viewed as an ongoing process in which the health care provider aims to increase their abilities to work in symbiosis with the patient in their cultural context (Capinha-Bacote, 2002). According to Campinha-Bacote (2002), cultural competency constitutes the issues of cultural awareness, cultural knowledge, cultural skill, cultural encounters and cultural desire. Cultural awareness is the self-reflection of the health care provider’s own cultural and professional background and potential prejudices about other individuals. Cultural knowledge is the process in where the health care provider seeks to understand other peoples’ values, practices and beliefs by finding out more about other cultures and worldviews held by the people within them. Based on the cultural knowledge, the health care provider will be able to collect data relevant to the patient’s complaints and to carry out a cultural based physical assessment tailored to and in collaboration with the patient, also referred to as cultural skill. Cultural encounters are the situations where the health care provider is exposed to cross-cultural interactions with patients culturally diverse from themselves. This is believed to, in a positive way, change the health care providers' already existing beliefs about a different culture and to decrease or prevent eventual stereotyping. Cultural desire emphasizes the motivation and drive among health care providers in wanting to engage in cultural competency, compared to a feeling of “having to”. Cultural desire is based on the genuine interest and caring for others, resulting in an urge to learn. Campinha-Bacote’s model of cultural competence in the delivery of healthcare services is described further in her paper from 2002 (Campinha-Bacote, 2002).

Moreover, culture could be defined as the shared norms and beliefs in a group that guides and decides how the group members think and act (Leininger & McFarland 2006, cited in Hendersen et al., 2018: 2). This tacit knowledge determines the roles individuals will undertake towards different groups in the society, such as family, friends, colleagues, acquaintances, and authorities (Holland, 2018). In the context of health care, three cultures can be identified; the professional culture, the patient’s culture and the culture of the setting where the professional and the patient interact (Holland, 2018).

**Cultural competency among health care professionals**

For health care providers in cross-cultural primary care, it becomes important to be aware of their own cultural background and biases about health and illness (Rothschild, 1998). Cultural awareness is crucial in understanding patients belonging to another culture, but there is a balance in order to avoid stereotyping (Rothschild, 1998).

Lundvik Gyllensten et al. (1999) concluded that a successful treatment outcome in primary care depended on the interaction quality between the physiotherapist and her patient. Furthermore, to activate the patients’ intrinsic resources, the physiotherapist was required to be genuine and sensitive, showing respect and empathy, and being able to actively listen (Lundvik Gyllensten et al., 1999). Gard (2007) discusses that the physiotherapeutic profession demands higher knowledge in cross-cultural communication. This expertise is
crucial to consider cultural diversity among patients and to be able to tailor the encounters to the patient’s individual needs (Gard, 2007).

Conceptual framework
The right to health could be translated into the right to a health system which enables equal opportunity for everyone to enjoy the highest attainable standard of health (WHO, 2007; Hunt & Backman, 2008). Furthermore, the right to health has been broken down into four aspects by the Committee on Economic, Social and Cultural Rights (CESCR), namely availability, accessibility, acceptability and quality (WHO, 2007). With regards to the scope of this study, the focus will lie on the acceptability component as it is of relevance for cross-cultural interactions between physiotherapists and ASPs in primary care.

Acceptability entails medical ethics and cultural appropriateness. Health care professionals should be guided by ethical principles of equality and respect when encountering and treating patients, as well as being culturally and ethnically sensitive and showing acceptance towards patients’ way of living their lives (WHO, 2007; Hunt & Backman, 2008). Subsequently, access to adequate knowledge in how to encounter patients is the key for physiotherapists to achieve acceptability in their interactions with ASPs (Hunt & Backman, 2008).

Rationale
Migrants, people belonging to other cultures, and ASPs show both a different kind of health seeking pattern and other expectations of the health system compared to other patient groups in Sweden (Socialstyrelsen, 2016b). Despite this, there are currently no physiotherapeutic guidelines addressing the management and treatment for ASPs (Fysioterapeuterna, 2018). There are some qualitative studies discussing the interaction between health care providers and ASPs or migrant patients (Hultsjö & Hjelm, 2005; Nkulu Kalengayi et al., 2012; Suphanchaimat et al., 2015), however, none of them are exclusively exploring the phenomenon from the physiotherapists’ perspective. This study aims to fill this knowledge gap and pave a way for further research in the topic.
Aim
To explore Swedish primary care physiotherapists’ experiences and professional needs when encountering asylum-seeking patients.

Research questions
How do physiotherapists experience the interaction with ASPs?

How do physiotherapists experience their competency when meeting with ASPs?
Methods

Methodological design
This case-study was designed using qualitative methodology with an inductive approach (Creswell, 2013; Dahlgren, Emmelin & Winkvist, 2007). Understanding the phenomenon of encountering ASPs must be from the perspective of those experiencing it (Vaismoradi, Turunen & Bondas, 2013). Thematic analysis (TA) was the methodology and analysis of choice for this study exploring Swedish primary care physiotherapists’ experiences when encountering ASPs. TA is a method in qualitative data analysis known for its flexibility and systematic procedure (Braun & Clarke, 2012), allowing for wealth of details in its representation of data (Braun & Clarke, 2006). This methodology facilitated a better understanding of the experiences and the professional needs when encountering ASPs as a primary care physiotherapist.

The point of departure of this study was the holistic social construct of reality, to explore the subjective reality of the informants in the context of their everyday lives (Dahlgren et al., 2007).

Study setting and participants
Primary care centers and private physiotherapists in Umeå, Västerbotten county, and the surrounding municipalities were contacted via telephone. Based on recommendations from potential study participants, primary care centers close to Skellefteå were also contacted.

As the research aim required detailed information from the reality of the informants, purposive sampling was carried out to recruit study participants (Dahlgren et al., 2007). The criterion for participating in the study was being a physiotherapist with experience of encountering ASPs. The criteria for being an ASP according to Migrationsverket (2015) were adopted for this study; a person in need of protection, having foreign citizenship currently applying for asylum in Sweden (Migrationsverket, 2015).

Four primary care physiotherapists were interviewed via telephone. The informants consisted of two women and two men. One physiotherapist was self-employed and having a contract with Västerbottens läns landsting (VLL), and the others were employees at public health care centers. There was a wide range in the respondents’ working experience, and all the informants represented different locations in Västerbotten county. This variety of the respondents was important to capture the experiences and thoughts from physiotherapists with differing characteristics. A brief description of the study participants is given in the following section.

- PSG1 – self-employed at a private clinic north of Skellefteå with several decades in the profession
- LSG1 – employee at a public primary care center south of Umeå, most recent graduate among informants
- LSG2 – employee at a public primary care center south of Skellefteå with two years’ experience in primary care
• LSG3 – employee at a public primary care center south of Skellefteå with the lowest frequency of ASPs among informants

Data collection
Prior to the interview, the respondents received an information letter and informed consent via email. The informants were advised that their participation was voluntary, of their ability to withdraw at any timepoint and the non-requrement of revealing any sensitive information about their patients. Once the informant gave their consent, a date and time for the telephone interview was set.

This study used semi-structured in-depth interviews to gather informants’ experience and thoughts about the topic. Every interview was initiated with the open-ended question: “Can you please describe what sessions with ASP can look like?”, to encourage the informants to open up. The interview guide was thematically structured, based on the research questions mentioned previously. The interview guide consisted of five main themes of questions with probing questions that were used when needed. If a new probing question was added during an interview and provided additional insights, this could be used during the next interview. A pilot interview of the first draft of the interview guide was held in the autumn of 2017. This enabled assessment to determine if the interview questions were appropriate in the setting. See Appendix 1 for the detailed interview guide in Swedish.

Interviews
The four telephone interviews, all conducted in Swedish, were completed between the 13th of March and the 6th of April 2018. The length of the interviews ranged from the shortest being 28 minutes and the longest being 39 minutes. Before the interview started, the participants gave verbal consent. The interviews were recorded using an Olympus VN-7800 Digital Voice recorder. To ensure the respondents’ confidentiality, the audio files were deleted directly after the transcriptions were completed. Data was transcribed within two days of each interview. The transcriptions resulted in a total of approximately of 13 800 words.

Data analysis
The data analysis followed the six phases according to Braun & Clarke (2012) to ensure that the analysis was carried out in a systematic way. In the first phase each transcript was read in its whole at least once after transcription, to familiarize with the data before the coding process started. Notes with initial ideas were written down at this stage. This allowed searching for codes without actually coding the material. During the initial coding process, the second phase, OpenCode 4.03 software was used (ICT Services and System Development and Division of Epidemiology and Global Health, 2013). Every part of the transcript that could potentially serve as a code was recorded. After initial coding, the material was reread and analyzed several times to discover new codes and change or merge existing codes. Coding was done in Swedish to avoid losing valuable information in the data during the translation process. Codes were kept in Swedish until the final sorting into sub-themes. During phases three and four the identification and the reviewing of themes occurred simultaneously. In these phases, codes were sorted into preliminary sub-themes broadly discussing physiotherapists’ experiences of language and cultural barriers, the demand for

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guidelines and routines, the lack of current knowledge, and unawareness of the physiotherapeutic profession. Codes were adjusted as the sub-themes emerged and changed. Subsequently, there were 19 sub-themes. Those that did not contribute more knowledge or insights to the aim and research questions were discarded. This was in line with the idea of TA according to Braun & Clarke (2006) of capturing something important in the data which corresponds to the aim and research questions. In phase five, the process of sub-themes went through several rounds of rereading and analysis before the final two main themes and 9 sub-themes emerged. Phase six, producing the report, was an integrated part of the whole analysis of the data, as Braun & Clarke (2012) highlights. Table 1 below illustrates the coding process.

Table 1 – An example of the coding process

<table>
<thead>
<tr>
<th>Transcriptions</th>
<th>Codes</th>
<th>Sub-themes</th>
<th>Theme</th>
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</thead>
<tbody>
<tr>
<td>“[…] the care becomes a bit different due to the use of interpreters, unfortunately the explanations become less detailed compared to a conversation without an interpreter. In addition, there is a difficulty in the interpreter not seeing what I am doing, because we are not using video input, only the telephone speaker” – LSG3</td>
<td>Appointments using interpreter demands more</td>
<td>Did I understand correctly? Language as a barrier</td>
<td></td>
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<tr>
<td></td>
<td>Difficult to communicate via interpreter</td>
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<td></td>
<td>Communication via interpreter becomes incomplete</td>
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<td></td>
<td>The information is scarce</td>
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<td></td>
<td>Not informed about Swedish health care</td>
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<td></td>
<td>“I am not sure how they get informed”</td>
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<tr>
<td></td>
<td>Lack of information</td>
<td></td>
<td></td>
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<tr>
<td></td>
<td>The cultural aspects of expressing themselves” – PSG1</td>
<td></td>
<td></td>
</tr>
<tr>
<td>“I think it is because they are not well-informed. It might be the fact that they got some sort of information, but I think they surely have very, very much to think about. And they receive a lot of information at the same time and it is not so sure all the information sinks in, but I am not sure how they get informed about the function of Swedish health care. It could be that they do not receive any information at all. Lack of information, plainly” – LSG1</td>
<td>The information is scarce</td>
<td>They are not informed about Swedish health care</td>
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<td></td>
<td>Not informed about Swedish health care</td>
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<td>Lack of information</td>
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<tr>
<td>“There are cultural differences in pain experience and how this is expressed during appointments in health care. Both in their home countries and here in Sweden, they have different ways of expressing themselves” – PSG1</td>
<td>The cultural aspects of pain experience</td>
<td>A culturally &amp; linguistically diverse patient group</td>
<td></td>
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<tr>
<td></td>
<td>The cultural aspects of expressing pain</td>
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</tbody>
</table>
Results

According to primary care physiotherapists in Västerbotten, there were challenges when encountering ASPs due to the diversity of the patient group, ASP’s past experiences, communication difficulties, unawareness of the physiotherapeutic profession, information insufficiency in the health system, and lack of specific knowledge and guidelines among the physiotherapists. Furthermore, the physiotherapists showed a creative and problem-solving mindset when discussing different ways to better understand and treat this patient group. There was a desire for organization in the issue in the whole profession. The physiotherapists could not recognize any training from the bachelor program, specific courses, or information dealing with encounters of ASPs and demanded activities and guidelines from employers and the union on this topic. Themes and their belonging sub-themes are illustrated in Figure 2.

**Figure 2 - Thematic map illustrating themes and sub-themes**

**Our most challenging patient group**

* A culturally and linguistically diverse patient group
* Embodiment of past experiences
* Did I understand correctly? Language as a barrier
* The physiotherapist as an unknown profession
* They are not informed about Swedish health care

**Demand for knowledge & frameworks**

* The demand for knowledge about ASPs is high
* Lack of structured support in training & guidelines
* Guidelines would be used - if there were any
* Wanted: activities to increase cultural competency

**Our most challenging patient group**

*A culturally and linguistically diverse patient group*

Diversity is mainly expressed by the physiotherapists as stemming from different cultures or countries, and this is said to challenge several dimensions of the appointment. ASPs could be distinguished as a single patient group, however, there are intra-group differences. The physiotherapists expressed difficulties in tailoring the appointments in an appropriate way to the ASPs as they differ in the aspects of culture, religion, education level, and the views on
pain experience and how this is expressed and delivered to health care professionals. Simple things such as greeting the patient, conducting the examination, explaining the problem and giving treatment, need to be considered carefully. There is frustration in not being able to treat ASPs like other patients due to the difficulty in understanding their complaints. This was said to affect the ability to provide efficient care for this patient group. In summary, there is an urge in wanting to give ASPs proper encounters along with a positive experience of Swedish health care but there is a knowledge gap obstructing this ambition.

“I find it is the knowledge that is lacking, it is difficult when they come from so many different countries […] If you meet several patients coming from the same country it becomes easier to gather knowledge in that area” – LSG3

“It is very difficult to map the complaints and I wish I could handle and treat them just as I do with other patients with pain, but the situation is different” – LSG2

“There are cultural differences in pain experience and how this is expressed during appointments in health care. Both in their home countries and here in Sweden, they have different ways of expressing themselves” – PSG1

Furthermore, different understandings about being sick and reasons for sickness were perceived as something common within this patient group. The collision between patients’ health care experiences from their home countries and the grading of complaints in Swedish health care was described:

“I assume there are large differences in culture and if you require health care and perceive yourself seriously ill…because many (patients) arrive urgently […] I think when they contact health care, they really suffer from pain, and had they been in their home countries they might have been looked after by a doctor, and that might explain why they want to see the doctor here, too” – LSG2

**Embodiment of past experiences**

In general, physiotherapists perceived a lower level of mental well-being among ASPs’ compared to other patient groups. Their symptoms hide behind a mask of traumatic experiences and coping strategies. Physiotherapists found it very common with symptoms being psychosomatic. Anxiety among ASPs was found to be present in many cases, as well as a comorbidity with mental illness that was perceived as more severe compared to other patient groups. The protection mechanisms that many ASPs present, are challenging the physiotherapists’ ability to reach out to them and to overcome the psychological obstacles in gathering relevant information prior to and during the physical examination. The issue of psychosomatics is resting in the back of the physiotherapists’ minds, well aware of the fact that anxiety can aggravate the pain perception.

“The challenge with asylum-seekers is the mental baggage. […] and they are usually having issues that could influence symptoms and those things” – PSG1

“Something I notice very often among asylum-seeking patients is anxiety, a comorbidity with mental illness that is common among non-asylum-seekers too, among common people, but to a larger extent and sometimes more serious…and this anxiety aggravates the pain perception hugely” – LSG1

One physiotherapist mentioned a decreased body awareness among ASPs, thinking the reason behind this was due to the severe traumas they had experienced. When examining
and giving treatments, the signs of decreased body awareness show and can act as a fence between the physiotherapist and the patient. The physiotherapist explained how before giving these patients any recommendations and exercises, there is an initial need to increase their body awareness. One physiotherapist brought up the issue of embodiment:

“I think it is a protection mechanism after physical and psychological trauma, it becomes embodied” – LSG1

Another challenge mentioned related to mental health was resignation. Resignation was described as an external locus of control, where the patient turns over their health and well-being to the hands of the health care provider. Physiotherapists felt some patients had given up and lost their autonomy and self-efficacy. As one physiotherapist concisely described it:

“[…] some are very help-seeking expressing things like “you have to help me”, “I cannot go on having it like this” – LSG2

Did I understand correctly? Language as a barrier
Physiotherapists perceive that there is difficulty in the initial contact with health care for ASPs. The first barrier they face is the Swedish language. The telephone service used to make appointments is only available in Swedish and the invitation letters to appointments are also written in Swedish. ASPs are trying to navigate their way around this issue by coming to the reception and trying to make an appointment in person. Another aspect of language barrier is evident when patients are determined to be in need of specialized care, physiotherapists sometimes cannot refer them to these instances due to lack of language skills. There is a sense of being caught in the middle without any options.

“Most often the patients show up at the reception due to the difficulty in our telephone service being available in Swedish only. If they do not have anyone to help them with the telephone service, they show up physically trying to get an appointment via the reception” – LSG2

“Sometimes, we try to offer pain or stress management programs (specialized care), but these instances do not encounter them unless they manage the Swedish language, English is not sufficient. I think that is deficient care for these patients” – LSG2

Furthermore, interpreters were used frequently during appointments with ASPs, often even if the patient could master some Swedish. Using an interpreter during the appointments was described as a necessity but also a complicating factor. First and foremost, the use of an interpreter is time-consuming forcing the anamnesis and examination to be extended far beyond the normal time-scope. The importance of having enough time was emphasized, along with a description of the amount of information lost in the translation process and the difficulty in using an interpreter through the telephone.

“I make sure there is a lot of time, because lack of time and appointments with an interpreter do not go well together. Above all, making sure there is enough time to confirm to the patient you understood them correctly and received the right picture” – LSG2

“[…] the care becomes a bit different due to the use of interpreters, unfortunately the explanations become less detailed compared to a conversation without an
Due to the difficulties in using interpreters, one physiotherapist experienced that trust decreased and so too did the treatment effect. The sense of not being able to deliver the message to the patient is enormously frustrating as it is a prerequisite for interaction. Trust was viewed as essential in building a healthy provider-patient-relationship and if there is no trust, there are no results. Many ASPs were perceived as being unclear about the physiotherapeutic profession in the first place, and the issue of not being able to communicate properly further impeded this understanding. The variation of the interpreter quality was also described as a complicating and stressing factor as it easily determines the success of the appointment.

“Of course, it becomes more difficult for the patient to understand, more difficult to gain trust and to be on board when I am not sure if the message was received. And if that is due to the interpreter’s or my ability to deliver the message or if the patient does not understand due to other reasons. That drives the treatment effect to become less good...trust becomes affected and diminished if you cannot understand each other” – LSG3

A significant amount of frustration accompanied these appointments. As physiotherapists are taught to be independent problem-solvers, the striking reality of not being able to help their patients adequately in addition to a distinct uncertainty and powerlessness, frustration became inevitable. One physiotherapist illustrated this stating:

“We all agree that it never feels good having an appointment that requires an interpreter. When we have discussed this, no one is super-satisfied after this type of appointment, feeling that this will end up being something good, you rather feel – did I get everything correct, understood the problem, did the examination provide me with something leading to positive results...you never feel sure that the (treatment) plan you have set out will be followed or if it is sufficient or if there will be any possibilities to follow-up. It is very seldom you are satisfied with this kind of appointment, and the only thing you want in the end of the day is for it to become better for the patient. I would say it is our most challenging patient group” – LSG2

The physiotherapist as an unknown profession

Physiotherapists described a distinct confusion about their professional competence and role in health care among ASPs. Common in primary care, the physiotherapist acts as a gatekeeper, the first instance for patients with musculoskeletal complaints, and this is experienced as something unfamiliar to these patients. Instead of focusing on examination and treatment, the physiotherapists are trying to convince their often-skeptical patients that other or further examinations are not necessary. A lack of trust in physiotherapists is also mentioned. Patients are asking for appointments with a doctor repeatedly, giving the impression that the doctor is the only one that can help them.

“The trust in physiotherapists are usually less. Frequently, they want to see a doctor, receive help from a doctor, demand medicines and they are not very interested in treatment at our clinic or a period of training. What we can offer, aqua training, stress release and such, they are more often interested in interventions from a doctor” – LSG2
“Some do not have any expectations at all, they do not even know how they ended up with me, it might be the fact that some are not used to the physiotherapist as a first instance” – LSG2

The skepticism is both towards the profession itself and the interventions. Physiotherapists experienced that there is a discrepancy between their own and their patients’ views on what is treatment and what is adequate treatment in the given situation. A large part of the appointment was dedicated to explaining and convincing the patient instead of initiating treatment and coming up with a treatment plan.

“They do not experience they receive any treatment...they are on board with movement and physical activity having a pain-relieving effect, but it is very seldom it works without something additional (medications). It depends on the level of pain, but it is a challenge to persuade them and explain this to them” – LSG3

They are not informed about Swedish health care
Information insufficiency is perceived as common among ASPs. The provision of information to ASPs in how the Swedish health system works and how to access health care is lacking. These patients are described as trying to navigate in an unfamiliar health system accompanied by information shortage, and many times they are not aware of who they can turn to. As newly arrived in Sweden, ASPs are thought to be receiving an overload of information. Knowledge about the health system might become pushed aside in favor of accommodation and where to access everyday necessities. When the need for visiting the health care becomes urgent, ASPs might face difficulties in recalling how access to health care is working.

“If we are going through it from the beginning of the process they seldom come straightly to us, seldom do they know how Swedish health care works, who they can turn to...” – LSG1

“I think it is because they are not well-informed. It might be the fact that they got some sort of information, but I think they surely have very, very much to think about. And they receive a lot of information at the same time and it is not so sure all the information sinks in, but I am not sure how they get informed about the function of Swedish health care. It could be that they do not receive any information at all. Lack of information, plainly” – LSG1

Even though physiotherapists have been directly accessible for years, physiotherapists perceived a large unawareness regarding this issue. Direct access as a facilitating factor for patients are perceived as something inaccessible to ASPs. One physiotherapist described it concisely:

“They might ... they might not be informed about the direct access, that you are able to get in contact with health care without referral” – PSG1

Demand for knowledge and frameworks

The demand for knowledge about ASPs is high
Physiotherapists expressed a need to immerse themselves in knowledge about other cultures to better understand them, thus making it easier to know how to encounter ASPs in a better
way compared to the present situation. This is not something exclusive for primary care, but useful in all health care instances in society. Furthermore, the importance of knowledge about cultural aspects of illness was also mentioned, and the possible consequences on the outcomes. Discrepancy in how symptoms are interpreted was said to affect the treatment effect due to the missing component of understanding. If the physiotherapist and the patient did not agree on the genesis of the complaints, how can they then agree on the treatment plan? Patients not carrying out the training or self-treatment, and maybe not showing up at appointments, could then be close at hand.

“[…] it would not be too bad getting some information about the most common cultures, how to approach these people. I think this would be useful regardless of whether you are working in a hospital, out-patient clinics or in the municipality” – LSG2

“There is a need to gain knowledge about other cultures and aspects of being ill. From my experience, this issue can affect the treatment possibilities” – LSG1

Treating every patient equally is a rule of thumb although there is a sense of not having enough knowledge in how to handle the encounter in a manner that patients would prefer. There is a struggle in wanting to treat ASPs with dignity and to avoid violating their integrity, but at the same time lacking the knowledge of how to do so. The inability to provide culturally appropriate care is described.

“Anyway, I try to treat them the way I do with every patient. I wish there was more knowledge about cultures and such to avoid crossing the line” – LSG2

Lack of structured support in training and guidelines
Physiotherapists described how the absence of adequate training is an issue throughout the whole profession. In their work places, physiotherapists are missing manuals or guidelines dealing with the whole process in how to encounter ASPs. They expressed this in a concise way and in consensus:

“It is not something established, but I help those in need of help” – PSG1

“We do not have certain routines, we do not” – LSG1

“I have to say no, unfortunately” – LSG3

“No, there are no established written routines” – LSG2

The physiotherapists could ascertain there is a lack of valuable knowledge in this topic already in the bachelor program. The most recently graduated physiotherapist said there was training in Motivational Interviewing (MI), a method to promote behavioral change among patients, which could be useful for these patients too. However, this method was not tailored to ASPs and as there were language barriers and differing views on health and the responsibilities of health care, it was not an accessible method. Furthermore, there were no courses providing sufficient knowledge in encountering ASPs from the experiences of the newly graduated physiotherapist.
“I did my bachelor in *** and from my experience we did not get equipped with anything. Basically, I am taking the point of departure in work experience and help from my colleagues. Nothing from the bachelor program” – LSG2

“If we look at the bachelor program, if the point of departure is our physiotherapeutic profession and the education within, it is very limited” [...] – PSG1

“Very limited I would say, either I have suppressed it or do not remember we had anything discussing that during the bachelor” – LSG3

Although the Physiotherapy union has a magazine for their members distributed regularly throughout the year, and a well-established webpage with relevant information for members, the physiotherapists described an absence of material regarding ASPs. On one hand, the physiotherapists had not done thorough research on the webpage, but on the other hand, not been overwhelmed with any information either. They were not sure if there is any material at all, and if there is, it is not marketed nor reaching out to its target group.

“Not that I have seen. I have not searched extensively, on the other hand. But I have not seen any material or certain pictures or ingresses and such discussing patient treatment. It might exist, but the marketing is not there, I do not know” – LSG1

[…] “I have not thought that I would be able to search specifically, but I have not felt I have been provided with any information from the union in this matter, no hint about continued education or articles” – LSG3

Courses and continued education about other cultures and ASPS are described as vague and distant memories in need of refreshment. There is a disappointment with both frequency and the fact that available courses are optional. Seldomly, the courses are tailored to physiotherapists, but directed towards all professionals in health care, which too is a source of disappointment. Participating in courses is also a matter of available resources and a question of prioritizing.

“What I do remember is a half or a whole day six or seven years ago, during my previous employment, when they discussed other cultures and refugees and provided us with some recommendations...but this knowledge needs an update and all knowledge cannot be accessed through reading” – LSG3

“We are offered courses discussing communication and asylum-seekers’ and refugees’ ill-health. However, they are very seldom tailored to physiotherapists, and they are not as frequent as they should be. They are not compulsory, either, and you can choose by preference” – LSG1

“Resources are scarce, and you cannot be enrolled in courses all the time. We must prioritize and so must the employers” – LSG1

As employees, the physiotherapists experience they are strongly influenced by their employers and would follow the agenda set out by management. By this, they are requesting a clear leadership that provide guidance and clarity about which courses and continued education should be prioritized. Ideally, the employers would also decide that some courses are compulsory due to their importance.

“It would be preferable if there was a clear direction from the employers, that it is important and should be prioritized. And perhaps, participating in these courses should not be something optional” – LSG1
Guidelines would be used – if there were any
The joint experience is that there are no guidelines in how to encounter ASPs adequately. Physiotherapists with long work experience might face some challenges in the acceptance of new guidelines, while for new graduates it will become easier to adapt to them as they have not fully established their professional routines yet. However, there is an overall positive mindset towards developing and using guidelines as it could provide more preparedness and act as a supportive tool to physiotherapists. Examples brought up to be included in guidelines were how to go about with making and cancelling appointments from the patients’ perspective, primarily due to the difficulty in contacting health care in another language. Examples of the consistence of guidelines were permeated by the desire to facilitate for ASPs, helping them getting the foot in the door. The time-frame of the appointments was also suggested to be longer than regular appointments, at least one hour.

Sometimes it is hard to teach old dogs new tricks, but I would gladly use them myself if there were any guidelines. I think many, when I discuss with my colleagues we experience these patient appointments the same way, and I think my colleagues would like to have it as a support – LSG2

One physiotherapist mentioned that even if there are established routines elsewhere, they are not easily accessible. There is knowledge about other primary care centers that have successfully developed procedures how to go about with the encounters of ASPs, but the employees’ resources are too scarce to be able to take part of them. The issue of finding adequate literature and information is viewed as time consuming and there is difficulty in knowing where to begin. The primary task for primary care physiotherapists is the clinical work and therefore, they need some other arm overseeing the seeking, finding and allocating valuable information among primary care centers. In this case, the physiotherapy union should have taken responsibility in spreading this knowledge further among their members.

“I am also thinking they (the union) hold the possibility to influence regionally too, if needed. I know some health care centers are better in helping these people, having specific established routines. But it is not very common that knowledge gets shared, so to speak. In this case, the union should be more engaged in collecting that knowledge and experience and try to spread it” – LSG1

Wanted: activities to increase cultural competency
To achieve cultural competency, physiotherapists are demanding more activity and cooperation from the union. This was expressed both as simple interventions such as mailing lists and summaries on the unions webpage, to comprehensive events such as arrangement of theme days and workshops on the annual Physiotherapy Days (Fysioterapidagarna). During these days, a large number of Swedish physiotherapists gather to gain new knowledge and to widen their networks, making it a suitable target for the wanted activities of increasing cultural competency.

“Or let us say, if there was any information on the union’s webpage, some summary discussing things to have in mind when meeting these patients” – LSG2

“Mailing lists are central to encourage people to join workshops and theme days, so that is important, but the other things mentioned are important too. Theme days, workshops, a lecture on Physiotherapy Days” – LSG1
Furthermore, there are some ideas about how the bachelor program can be designed regarding the courses. As all interviewed physiotherapists had been students themselves, they recall which lectures were labelled as interesting or not. One physiotherapist mentioned the value in providing the physiotherapy students with real-world examples, rather than having professors or lecturers discussing something they have no experience in but from books and articles. The understanding could be enhanced if someone is speaking from their own personal experience, and there is more room for interactions grounded in reality in the lecture hall. Overall, the knowledge of cultural competency should plainly be present from the beginning in the bachelor program.

“[...] it does not have to be a huge course, lectures or some stuff. About language. Or it would be most preferable with someone coming from a different country rather than a Swedish professor giving lectures based on books that they read” – PSG1

“Then I would say, it must be integrated in the bachelor program, at least be a part of it” – LSG2
Discussion

The interviewed physiotherapists described challenges when encountering ASPs due to heterogeneity in the patient group, ASP’s past experiences, communication difficulties, unawareness of physiotherapists’ competency, information insufficiency in the health system and the lack of specific knowledge and guidelines in encounters. There was a desire for an increased organization from the bachelor program, employers and the union in preparing physiotherapists for their encounters with ASPs.

Study findings

Physiotherapists express ASPs as a diverse patient group coming from many different countries and cultures. This is in line with the findings in a study by Nkulu Kalengayi et al. (2012) interviewing health care staff encountering migrants in Sweden. The views on illness, how that is expressed and how the health system is supposed to deal with illness differs not only from the Swedish views, but also among different groups of ASPs. Another similarity to the findings by Nkulu Kalengayi et al. (2012) in this topic is the experience of ASPs seeking health care when they are already very sick. One of the physiotherapists thought this was due to the patients’ previous experiences from their home countries, where they might had been looked after by the doctor when they arrive at the health care center. This in turn could explain why these patients want to see the doctor and no other health care professionals when they are seeking health care in Sweden.

Furthermore, the study by Nkulu Kalengayi et al. (2012) also described a lack of information about the Swedish health system and different experiences of health systems among migrants or, in this case, ASPs. Challenges stemming from booking an appointment via the telephone service when one does not master the Swedish language and how the booking system is working in general were mentioned. The different experiences of health systems were resulting in other expectations on health care (Nkulu Kalengayi et al., 2012). In the Nkulu Kalengayi study (2012), there were no interviews with physiotherapists, however, a nurse discussed issues and topics similar to that of the present study: migrants or ASPs would rather see a doctor than any other profession in health care, even though professions like nurses and physiotherapists have their own specialty and competency in Swedish health care. Especially one physiotherapist (LSG2) in this study experienced a low trust in physiotherapists among ASPs.

The findings according to Nkulu Kalengayi et al. (2012) hold several similarities to the findings of the present study, especially the corresponding settings of Northern Sweden. However, the fact that the Nkulu Kalengayi et al. (2012) study interviewed informants from different areas of the health care system must be kept in mind. There was also a different terminology and definition of “migrant” and “ASP” between the studies. The definition of “migrant” in the Nkulu Kalengayi study (2012) was “all foreign-born persons living in Sweden”, as opposed to an “ASP being a refugee, currently applying for asylum in Sweden” used for this study.

Cultural and communication barriers, lack of familiarity with a new health system and the competency of health care staff were also reported in a recent systematic review (Suphanchaimat et al., 2015). These findings were congruent with the ones in the present
study. The definition of the patient group corresponded with the one of the present study, although the terminology differed. However, the majority of the studies in the review were conducted in Europe and thus the health systems could vary a lot across countries, making it difficult to generalize. Furthermore, no experiences from physiotherapists were represented in the review.

A Swedish study exploring experiences of health care staff encountering ASPs in emergency care (Hultsjö & Hjelm, 2005) also described the organizational issues that could occur. Among other things, health care staff experienced ASPs as uninformed about the Swedish health system and where in health care they should turn to, along with cultural differences and language barriers (Hultsjö & Hjelm, 2005). However, the settings of ambulance service and emergency ward could be difficult to compare to the settings of a physiotherapy clinic in primary care.

This study aimed to explore the encounters with ASPs from the providers’ (physiotherapists) lens. There are some qualitative studies from Sweden exploring this interaction, however, none are exclusively interviewing physiotherapists, and many are taking the patients’ perspective having both a different terminology and definition of the patient group (Nkulu Kalengayi et al., 2016; Seffo et al., 2014; Svenberg, Skott & Lepp, 2011).

As there were no qualitative studies exploring physiotherapists’ experiences of encountering ASPs in any instance in care, an issue of not being able to compare and connect findings of this study to others occurred. Therefore, comparisons have been made to studies exploring health care staff’s experiences when encountering migrants or ASPs.

Furthermore, some of the findings in this study are valid for not only ASPs but migrants in general and people that do not speak Swedish or experience other communication problems. Cultural differences and other health system experiences influencing the view on health and expectations on health care and the communication barriers are not exceptional for ASPs (Hultsjö & Hjelm, 2005; Nkulu Kalengayi et al., 2012; Suphanchaimat et al., 2015). What distinguishes ASPs from migrants and other groups are their vulnerable position and exposedness to stress in waiting for decisions about residence permits while adjusting to an unfamiliar environment (Socialstyrelsen, 2016b). Furthermore, the legal aspects that hinder ASPs to full scale health care also increase ASP’s vulnerability, which questions the concept of “The right to health” (IOM, 2013).

The issue of acceptability
One aspect of acceptability are medical ethics. One physiotherapist described the frustrating aspect of being guided by professional principles and medical ethics, and at the same time experiencing that they are not followed due to the legal restrictions. When providing health care, or physiotherapeutic interventions, the asylum-seeking status had to be taken into consideration. This suggests asylum-seeking status as a determinant of the legal entitlement to health care. The thoughts on this was that ASPs are not receiving equal access to the highest attainable standard of health, which could be viewed as not in line with the law on international human rights, and the “the right of everyone to the enjoyment of the highest attainable standard of physical and mental health” (IOM, 2013).
The other aspect of acceptability is cultural appropriateness. All informants of this study experienced they did not have the cultural competency required to provide care that could be labelled as culturally sensitive. This was due to lack of sufficient education during the bachelor program, during their previous or current employments, and an absence of information from the Physiotherapy union. They mentioned a desire to treat ASPs as other patients, despite the difficulties. They perceived that encounters with ASPs were demanding something more from them, currently outside the scope of their profession. Additionally, with more knowledge the goal of providing cultural sensitive care could be realized. These findings are in line with a study by Nkulu Khalengayi et al. (2015) interviewing nurses conducting health screenings on newly arrived migrants. The nurses experienced the lack of appropriate training and skills to perform their tasks towards migrants and felt restricted by their inadequate knowledge and understanding of culturally diverse patients (Nkulu Kalengayi et al., 2015). A qualitative study interviewing Swedish and Danish physiotherapists encountering migrants that had suffered torture (Gard, 2007) highlighted factors important for a good patient-provider interaction. One factor discussed was the sensitivity to cultural aspects such as norms, values and preferences when encountering patients coming from countries and cultures different to those of the provider (Gard, 2007).

**Methodological considerations**

The issues of truth value, applicability, consistency and neutrality were considered in the design to enhance trustworthiness of the study (Dahlgren et al., 2007). The author made an effort to contextualize the results to enhance the readers’ ability to decide whether the results could be applicable in other settings. Furthermore, purposive sampling was performed to recruit informants able to contribute to the aim and research questions. The physiotherapists participating in the study showed a variety in gender, age, and working experience. Member-checks were performed to ensure that the descriptions and interpretations of data was in line with the informants’. In combination with the variety of informants, this contributes to enhance credibility of the study (Carter et al., 2014). The author of this paper has working experience as a primary care physiotherapist at a private clinic in Västerbotten and had encountered many ASPs throughout her clinically active years. This experience inevitably gave the author an insider status. When interviewing the physiotherapists, the author was aware of the risk of “collegial influence” on the informants, making them believe the author “already knew it all” and therefore, some information could risk getting lost. This was handled by turning over the expert status to the informants, not trying to guide them in any direction by leading questions or statements. On the other hand, the author’s insider knowledge in the situations that were described by the informants, served as an asset which facilitated spontaneous probing during the interview. However, the idea of “putting preunderstanding in brackets” permeated the interviewing process (Dahlgren et al., 2007). To enhance dependability, an emergent design was applied. If a probing question contributed to more insights it was used during the next interview. For instance, “What are your perceptions of ASPs’ views on the central concepts of movement and physical activity in physiotherapy?” was an additional spontaneous question in the second interview that was asked during the following two interviews. Furthermore, translation into English did not occur until sub-themes emerged. This allowed for staying close to the text and minimizing the risk of losing information.
This study followed the six phases of analysis described by Braun & Clarke (2006) which could be viewed as a methodological strength. The guidance of a framework provided a systematic and thorough procedure for conducting TA. Furthermore, it gave insights to common mistakes when conducting the data analysis, increasing the author's awareness of them.

Interviews were conducted with physiotherapists working in Västerbotten county only. In Sweden, the physiotherapeutic profession is regulated by the Hälso- och sjukvårdslagen, HSL 2017:30 (Sveriges Riksdag, 2018), resulting in physiotherapists working along the same lines irrespective of where in the country they are situated. One of the interviewed physiotherapists owned a private clinic, however, that did not result in another way of treatment of ASPs. Furthermore, the clinic had an agreement with VLL and thus the same was of organizing health care and patient fees as the public health care centers. With respect to this, the findings could possibly be applicable to other settings in Sweden.

**Strengths and limitations**

This study highlights a blind spot in health care and paves the way for further knowledge in the topic. Primary care physiotherapists in Västerbotten county experience their encounters with ASPs as challenging due to several factors, and demanding guidelines in these situations to enhance the patient-provider interaction.

Due to the short time frame, only four interviews were done for this study possibly affecting the ability to reach saturation. More informants might have given an increased insight in the topic. Additionally, informants could have been recruited from more counties in Northern Sweden to further increase the diversity of informants. On the other hand, purposive sampling was carried out enabling the recruitment of eligible study participants which was considered a strength of the study. The study aim required study participants that could share their unique slice of reality to provide the readers with sufficient insights in the topic.

The fact that all the interviews were done via telephone could have affected the authors’ perception of informants’ body language such as facial expressions and gesticulations that strengthen the spoken language. To compensate, the author noted if the informants’ emphasized any word or sentence with capitols in the transcripts and eventual pauses, hesitations or laughter.

Another limitation stems from the fact that interviews, transcribing, and coding were performed by the same person. This potentially leads to a lack of independent verification. However, the systematic process and defined steps utilized for this study enable independent reproduction of themes and results identified in this paper.
Conclusions

The findings of this study provide new knowledge in Swedish primary care physiotherapists’ experiences and professional needs when encountering ASPs. These findings serve as a foundation for further research in the matter and for future adjustments in how the physiotherapeutic bachelor program is designed, how employers and the Physiotherapy union (Fysioterapeuterna) provide their employees and members with adequate knowledge, preparing them for encountering ASPs in the best possible way.

Providing physiotherapists with tools to better encounter and treat ASPs could pave the way for the provision of the best attainable care for this patient group. The stated goal of Swedish health care is to achieve an equal and accessible health for all citizens (Regeringskansliet, 2015), therefore, ASPs need to be included in order to achieve this.
References


Fysioterapeuterna (2018). Profession > Riktlinjer. Available at: https://www.fysioterapeuterna.se/Profession/Riktlinjer/ [April 2018]


SKL – Sveriges Kommuner och Landsting. (2017). Hälsa i Sverige för asylsökande och nyanlända: Nationell spridning av insatser från förstudien om positiv hälsoutveckling för asylsökande och nyanlända. Available at: [https://skl.se/download/18.18efb8de15a60e54b23a68f9/1488290534341/halsa-i-sverige-for-asylsokande-och-nyanlanda.pdf](https://skl.se/download/18.18efb8de15a60e54b23a68f9/1488290534341/halsa-i-sverige-for-asylsokande-och-nyanlanda.pdf) [June 2018]


Appendix 1

Intervjuguide

Inledande

- Kan du berätta om hur möten med asylsökande patienter kan se ut?
  - Särskilda rutiner?

Behov av fysioterapi

- Kan du beskriva vanliga kontaktorsaker för asylsökande patienter?
  - Hur skiljer sig asylsökande patienters kontaktorsaker från icke asylsökande patienters?
- Hur upplever du compliance hos denna patientgrupp jämfört med icke asylsökande patienter?
  - Kan du ge något/några exempel?

Patienternas förväntningar & attityder

- Hur upplever du förväntningarna på dig som fysioterapeut från asylsökande patienter?
  - Hur faller det inom ramarna för din fysioterapeutiska kompetens?
  - Har du förslag på hur detta behov kan adresseras?
  - Hur skiljer sig förväntningarna från asylsökande patienter från icke asylsökande patienters?
- Hur upplever du asylsökandes bild av fysioterapins centrala begrepp rörelse och fysisk aktivitet?

Bemötande och verktyg

- Hur agerar du (bemötande, förklaringsmodeller, undersökning, behandling, osv.) när du möter nämnda patientgrupp?
  - (om annorlunda från icke asylsökande patienter) Hur känns det i egenskap av fysioterapeut?
- Hur upplever du verktygen för att hantera denna patientgrupp:
  - Från grundutbildningen?
  - Från nuvarande arbetsgivare?
  - Från förbundet?
  - Ifall mer agerande – hur? Kanaler?

Utmaningar och möjligheter

- Kan du beskriva några utmaningar i mötet med denna patientgrupp?
- Vilka är möjligheterna?

Avslutande

- Är det något du vill tillägga?