# General practitioners' repertoires of patients with a migration background and mental health problems

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**Abstract**

**Purpose** – *Despite a higher prevalence of mental health problems among people with a migration background, recent studies indicate these patients have more unmet medical needs and are under-represented in mental health services. General practitioners (GPs) are central gatekeepers in treatment and referral to specialised mental health care. However, their recommendations can be influenced by beliefs, social norms and practices that might prejudice people with a migration background. This study aims to examine GPs' accounts of patients with a migration background suffering from mental health problems and their related decision-making processes.*

**Design/methodology/approach** – *Thirty-nine in-depth interviews were conducted with Belgian GPs. An analysis based on critical discursive psychology was performed to (a) examine how GPs discursively construct their decision-making regarding patients with a migration background and (b) identify how GPs position these patients.*

**Findings** – *The authors identified three distinct interpretative repertoires in GPs' accounts: the legal-political repertoire, the culturalising repertoire and the humanitarian repertoire. GPs often view patients' health beliefs and integration as obstacles to proper care, focusing primarily on biological and psychological aspects while neglecting social elements. This can lead to cultural stereotyping and prejudicial treatment outcomes. Even when adopting a humanitarian stance, GPs can diminish patients' agency and impede patient-centred care.*

**Originality/value** – *These findings have implications for policy, medical training and future research. Policies should address biases and stereotypes in health care by promoting the inclusion of social elements without diminishing patients' agency. Medical training should emphasise the biopsychosocial model, recognising and addressing biases, promoting patient-centred care and fostering therapeutic relationships based on shared power and responsibility. Future research should explore the impact of patients' cultural health capital on medical interactions and outcomes.*

**Keywords** *Discourse analysis, Ethnicity and health, Mental health, Primary care, Discrimination*

**Paper type** *Research paper*

(Information about the authors can be found at the end of this article.)

Received 12 April 2024
Revised 31 March 2025
Accepted 29 April 2025

The authors thank all health-care professionals who were willing to share their experiences with us as part of an interview. This work was supported by the BELSPO under Grant [B2/191/P3/REMEDI]. Furthermore, the authors thank all members of the follow-up committee for their valuable help during the project.

*Declaration of interests*: The authors report there are no competing interests to declare.

## Introduction

The promotion of health equity and assurance of equity in care for people with a migration background and asylum seekers have emerged as significant policy objectives in Europe. Belgium has a long history of labour migration, primarily involving people of Moroccan and Turkish descent during the 1960s and 1970s (Lievens, 2000; Reniers, 1999). More recently, the country has faced a substantial arrival of asylum seekers, particularly since the onset of the refugee crisis in 2015 (Myria, 2022; Myria, 2018). These influxes of migrants have highlighted the necessity of addressing existing ethnic disparities in health and health care. Moreover, this need is substantiated by several studies that identify a higher prevalence of mental health problems such as depression, anxiety disorder and post-traumatic stress

disorder among people with a migration background (Hadfield *et al.*, 2017; Levecque and Van Rossem, 2015; Missinne and Bracke, 2012). Paradoxically, various studies have observed an underrepresentation of people with a migration background in ambulant and residential mental health-care services (Bell and Zech, 2009; Buffel and Nicaise, 2018; Lepièce *et al.*, 2014). Consequently, this underscores the significance of establishing enhanced accessibility to mental health care for these patients, thereby emphasising the imperative for equitable care (Satinsky *et al.*, 2019).

Previous studies have explained the underutilisation of mental health-care services in relation to cultural, linguistic and structural barriers hindering patients with a migration background (Ahmed *et al.*, 2017; Buffel and Nicaise, 2018; Ohtani *et al.*, 2015; Paternotte *et al.*, 2015). However, some studies have shifted their attention towards the role of provider bias among health-care professionals regarding disparities in health-care utilisation. Predominantly, in the USA, researchers have focused on a possible provider bias that may contribute to racial and ethnic inequalities (FitzGerald and Hurst, 2017; Van Ryn *et al.*, 2006). In this sense, health-care providers may apply unconscious stereotypes when assessing and referring patients with a migration background, consequently unintentionally contributing to disparities in mental health-care use (FitzGerald and Hurst, 2017). Moreover, these unconscious stereotypes may also influence the medical encounter between general practitioners (GPs) and patients with a migration background. Although research on provider bias in the European context is scarce, several studies in the Belgian context offer evidence for provider bias among GPs (Duveau *et al.*, 2023; Delaruelle *et al.*, 2022; Ceuterick *et al.*, 2020; Lepièce *et al.*, 2014). The studies by Ceuterick *et al.* (2020) and Delaruelle *et al.* (2022) demonstrate the significance of concentrating on the crucial gatekeeping role of GPs to overcome ethnic disparities in mental health care in Belgium. The Belgian health-care system is organised according to the stepped care model. Consequently, GPs are often the first actors patients encounter in primary care. In this way, GPs are the main gatekeepers towards treatment and referral to more specialised mental health-care services (Mistiaen *et al.*, 2019). An important consideration is that, in Belgium, patients can consult psychologists without a referral from a GP. However, the federal report by Mistiaen *et al.* (2019) highlighted the need for more accessible psychological care, also in cases where no GP referral is involved, due to financial and accessibility barriers. Subsequent reforms in mental health care, have improved access to psychological care by introducing a limited amount of reimbursed consultations with psychologists registered at the National Institute for Health and Disability Insurance (RIZIV-INAMI), even without a GP referral (Gerkens *et al.*, 2024). Despite these improvements, the total number of registered psychologists remains limited and structural, language and cultural barriers continue to impede access to psychological care.

This study seeks to add to the body of research highlighting the crucial role of GPs in creating ethnic disparities in mental health-care use, by investigating GPs' accounts of patients with a migration background[1]. In discourse analytical terms, accounts refer to the ways in which individuals explain, justify or make sense of events or experiences (Fairclough, 1992a; Wood and Kroger, 2000; Wodak and Meyer, 2009). They are crucial for understanding how people construct and negotiate meaning in social interaction. Therefore, we focus on GPs' language use, as it provides insights into how these accounts are constructed and how language shapes the understanding of these experiences. Language has a constitutive role in the set of social practices encompassing primary health care and thus general practices. Language does not merely reflect the world, it actively shapes and engages in the construction of meaning (McCreanor and Nairn, 2002). Moreover, language comprises the power to construct and transform identities, knowledge and beliefs in interaction (Fairclough, 1992b; Fairclough, 2013). Therefore, McCreanor and Nairn claim "the study of language in action is a fruitful approach to understanding how power is manifest, implications for social practices and for social change" (2002, p. 510). As GPs work within the realm of dominant social institutions, this analysis will allow us to unravel the

power relations and broader professional discourses influencing their accounts of these patients. Furthermore, GPs' discursive accounts of patients with a migration background suffering from mental health problems may influence their decision-making regarding treatment and referral. Seymour-Smith and colleagues state "in an important sense, health and illness are mediated through discourse" (2002, p. 254). This aligns with the social constructionist epistemology in discourse analysis, which posits that discourse plays a constructive role in shaping certain versions of social reality. Discourses construct shared understandings about the world through language, which can be both empowering and disempowering. GPs, like all individuals, are influenced by and contribute to wider societal, institutional and professional discourses. These discourses are not merely tools to achieve social practices but are integral to the social world. While the social practices are inherently discursive, through their language, GPs both influence and are influenced by the discourses within which they operate (Edley, 2001). In this way, treating and referring patients can be considered as significant social practices that rely on GPs' beliefs and broader social norms. One of GPs' basic responsibilities as gatekeepers is to provide patients with a non-judgemental medical encounter and a decision-making unbiased by prejudice or stereotypes (Farrell and Lewis, 1990). However, we argue from a social constructionist perspective that the accounts of GPs are constructed by using several discursive strategies to describe and position patients, potentially even in a stereotypical manner (Farrell and Lewis, 1990; McCreanor and Nairn, 2002). For this reason, we performed a discourse analysis inspired by the principles of critical discursive psychology (CDP) (Edley, 2001; Potter and Wetherell, 1987) to (a) examine how GPs discursively construct their decision-making regarding patients with a migration background suffering from mental health problems and (b) identify how GPs discursively position patients with a migration background suffering from mental health problems like depression.

## Methods

### *Contextualisation of the study*

To identify the discursive resources GPs draw upon when talking about consultations and the related decision-making process, 39 in-depth interviews with Belgian GPs were conducted in Flanders (Dutch-speaking region of Belgium), Brussels (capital region of Belgium with both Dutch and French native speakers) and Wallonia (French-speaking region of Belgium). The 39 participants in the interviews included 29 GPs as well as 10 trainee GPs, who had completed their master studies in medicine and were currently in one of three respective training years to become a fully qualified GP. Moreover, we included both GPs working in rural and urban areas. Given the knowledge that GPs in urban areas have more experience in encountering patients with a migration background, it is of importance to take this into account during the analysis (Wets *et al.*, 2023). Finally, GPs could be part of a solo practice, a group practice or a multidisciplinary health centre. Table 1 includes an overview of all participants per type of practice.

### *Data collection*

The interviews were carried out between December 2021 and June 2022 by the lead author (CW) and second co-author (CD), respectively, in Dutch and French. Interviews were conducted either face-to-face or online, according to prevailing COVID-19 restrictions. The average duration was 1 h 10 min (with the shortest interview lasting 47 min and the longest lasting 1 h 44 min). During the in-depth interviews, we focused on the personal experiences and perceptions of GPs regarding treatment and referral of patients with a migration background and asylum seekers. A semi-structured interview guide was used to ensure consistency across interviews, and an overview of the guide is provided in the appendix (Appendix 1). At the start of each interview, a video vignette was used, depicting a consultation of a Syrian asylum-seeking patient suffering from depression (Appendix 2).

**Table 1** Overview of interviewed participants per type of practice

| *Type of practice* | *General practitioners (Dutch-speaking [D] or French-speaking [FR])* |
|---|---|
| Solo practice [S] | 7 general practitioners<br>■ 3 Dutch-speaking (SD1, SD2 and SD3)<br>■ 4 French-speaking (SFR1, SFR2, SFR3 and SFR4) |
| Group practice [G] | 14 general practitioners<br>■ 7 Dutch-speaking (GD1, GD2, GD3, GD4, GD5, GD6 and GD7)<br>■ 7 French-speaking (GFR1, GFR2, GFR3, GFR4, GFR5, GFR6 and GFR7) |
| Multidisciplinary health centre [C] | 18 general practitioners<br>■ 9 Dutch-speaking (CD1, CD2, CD3, CD4, CD5, CD6, CD7, CD8 and CD9)<br>■ 9 French-speaking (CFR1, CFR2, CFR3, CFR4, CFR5, CFR6, CFR7, CFR8 and CFR9) |

**Source(s):** Table by authors

This video vignette was designed as part of a related research project to explore potential differences related to provider bias. Specific design details and the content of the video are extensively discussed in a methodological article by Ceuterick and colleagues (2020). In the context of our current qualitative study, this video vignette was included to stimulate GPs to reflect upon their personal experiences with asylum-seeking patients and to elicit further discussion regarding their consultations with patients with a similar migration background (Blackburn and Stathi, 2019). Moreover, we were inspired by the study of Blackburn and Stathi given their notion that "vignettes facilitate the exploration of topics which are often considered sensitive due to moral and ethical dimensions" (2019, pp. 167–168).

Given the sensitivity of our research topic, we acknowledge the potential for interviewer biases and social desirability among participants. To mitigate these, we assured participants of the confidentiality and anonymity of their responses. In addition, we primarily used open-ended questions and encouraged GPs to share their genuine experiences and perspectives, further stimulated by the use of the video vignette. The vignette also played a crucial role in overcoming recall bias and confirmation bias by providing a concrete scenario for GPs to reflect upon, thereby enhancing the authenticity of their responses (Barter and Renold, 1999; Tremblay *et al.*, 2022).

Finally, the interviews were audio recorded and transcribed *verbatim*. The final transcripts were checked against the original audiotape and pseudonymised according to the informed consent protocol respondents agreed upon. Given our focus on GPs' accounts, it is important to mention that the quotes presented in the findings section have been translated from Dutch or French to English. The translation of quotes in discourse analysis presents inherent limitations, as translations may not fully capture the sensitivities and nuances of the original language. Therefore, we exercised caution in translating the quotes to ensure a high level of accuracy and integrity in our discourse analyses, enabling both ourselves and the reader to reflect upon the notions present in the different repertoires.

### *"Critical discursive psychology"*

This study employed a discourse analysis based on the theoretical and methodological principles of Critical Discursive Psychology (CDP). Grounded in a social constructionist

epistemology, which posits that knowledge and meaning are created through social interactions and discourse (Burr, 2015), CDP examines how language constructs social realities. Wetherell (1998) argued upon the necessity to consider both the situated nature of accounts and the institutional and social structures in which accounts are constructed. In this way, she deliberated on CDP as a fitting discursive approach, investigating both micro-analytic elements (i.e. how discourse and interaction are forms of social action) and macro-analytic elements considering socio-cultural and historical contexts of discourse (Edley, 2001; Locke and Budds, 2020; Wetherell, 1998). Thus, CDP allows for a more comprehensive analytical understanding of this topic by centring on ideology and subject positions, aspects more central to macro-social constructionism (Burr, 2015). In this study, we analysed GPs' accounts to understand how they construct their experiences regarding the treatment and referral of patients with a migration background. Therefore, CDP centres on three essential concepts: interpretative repertoires, subject positions and ideological dilemmas (Edley, 2001). Firstly, this study investigates which interpretative repertoires GPs rely on in their decision-making processes concerning patients with a migration background experiencing mental health problems. Interpretative repertoires refer to "basically a lexicon or register of terms and metaphors drawn upon to characterize and evaluate actions and events" (Potter and Wetherell, 1987). These repertoires encompass a range of linguistic and discursive practices facilitating the construction of coherent meanings (Edley, 2001). Moreover, they are characterized by a specific routine of argumentation, description and evaluation that can be recognised by familiar clichés or anecdotes (Seymour-Smith *et al.*, 2002) and offer varied accounts of events (Edley, 2001; Wetherell, 1998). Consequently, these resources contribute to a shared understanding among GPs talking about patients with a migration background with mental health problems.

Moreover, this study examines how GPs discursively position patients with a migration background with mental health problems in their accounts. This relates to the concept of subject positions. Davies and Harré (1990) argue that who one is will always shift depending on the positions that are made available through language and interaction. This demonstrates how people can be provided with a specific position to speak from and how this allows them to position others as characters with distinct roles and rights according to the available interpretative repertoires (Davies and Harré, 1990; Seymour-Smith *et al.*, 2002). Furthermore, it is relevant to recognise that GPs, by adopting particular interpretations of cultural stereotypes, can position patients with a migration background in the sense that these patients "are 'invited' to conform" to this interpretation (Davies and Harré, 1990).

Finally, the concept of ideological dilemmas also guided the analysis. Billig *et al.* (1988) argue that a culture's common sense or lived ideology inherently involves dilemmas and characterise ideological dilemmas as situations where dominant societal ideologies shape our thinking. This concept underscores individuals' active engagement and interpretation of prevailing societal ideologies. Therefore, GPs' accounts of their encounters with patients with a migration background suffering from mental health problems can revolve around various dilemmas. Consequently, ideological dilemmas offer the opportunity to examine how the intersection of ideology and discourse shapes the decision-making processes by GPs concerning patients with a migration background with mental health problems.

### *Data analysis*

The data analysis was inspired by Locke and Budd's (2020) analytical phases for CDP and the coding process was conducted in Nvivo 14. The coding of the full body of transcripts was carried out by the first author, with discussions specifically related to the coding process primarily involving the second and last author. The second author, being a native French speaker, assisted in resolving any ambiguities in the transcripts of French-speaking GPs to ensure consistency in this part of the data analysis. While the last author provided

insights throughout the coding process, drawing on her extensive knowledge and expertise in the broader field of discourse analysis. Throughout the subsequent stages of coding and data analysis, the first and last author collaboratively reviewed the analyses and findings. This joint effort ensured a thorough examination of the data. Ultimately, the other authors predominantly contributed their theoretical knowledge in discussing the findings of our data analysis. The diverse backgrounds of the authors proved invaluable in identifying potential individual or professional biases and ensuring that the interpretations remained accurate and closely aligned with the data.

The coding process involved several specific steps (Locke and Budds, 2020). Firstly, detailed readings of the body of transcripts were required leading to a thorough familiarisation with the data. This was followed by a round of open coding, where we identified specific text segments (inVivo) to facilitate a descriptive analysis of how GPs experience consultations and decision-making processes with patients with a migration background suffering from mental health problems. Consequently, we identified the most common ways of talking in the interviews, categorising the text extracts into different themes based on recurring descriptive patterns. This process allowed us to gain a more detailed understanding of the data, forming the basis for further analysis and the identification of the available interpretative repertoires. Aiming to discern different repertoires, we investigated how GPs' accounts were constructed using various discursive and linguistic devices (Edley, 2001; Wood and Kroger, 2000), such as vocabulary use, modality, pronoun choices, metaphors and figures of speech. Ultimately, this analysis resulted in the identification of three interpretative repertoires constructed by GPs in their accounts of consultations with patients with a migration background suffering from mental health problems, for instance in terms of "us" versus "them". The analysis proceeded with a focus on the positions that were made available through these identified interpretative repertoires. We examined GPs' discursive use of each repertoire and what this reflected in terms of positioning themselves and patients with a migration background. Finally, these findings served as a framework to discern the availability of specific ideological dilemmas and their relation to broader societal and professional discourses in (mental) health care.

## Findings

The following sections present the findings of our discourse analysis. We identified three interpretative repertoires: *the legal-political repertoire*, *the humanitarian repertoire* and *the culturalising repertoire*. For each interpretative repertoire, we discuss (a) how it discursively shapes GPs' experiences during consultations with patients with a migration background and mental health problems, as well as the decision-making processes of the GPs, (b) how GPs and patients with a migration background are positioned and (c) how these repertoires reinforce broader societal, institutional and professional discourses within the field of (mental) health care. The different repertoires highlight the availability of several, sometimes conflicting discourses influencing the accounts of GPs.

### *Legal-political repertoire*

A first available repertoire stems from the juxtaposition in GPs' accounts between patients with a migration background and asylum seekers. Although the concept of "being Belgian" is often mentioned by GPs, this juxtaposition is mainly constructed around the notion of "integration" or "being integrated" within Belgian society. GPs refer to patients with a migration background as "an integrated person" and "integrated in society", whereas asylum seekers are discursively positioned as "immigrants" who are not integrated. Nevertheless, the following quote illustrates the notion that GPs may perceive asylum seekers as integrated individuals after they have resided in Belgium for an extended duration:

> We've got- I don't have any refugees where I'm at for the moment, I might have one or two, but they've been here for years and they're completely integrated and I think they've even been here since they were young, so there are more cultural differences at that point (GFR1).

Moreover, inherently linked to the notion of integration throughout the interviews is the notion of speaking the predominant language. This appears more nuanced in the interviews with French-speaking GPs, as for a portion of asylum seekers French is their native language. GPs frequently mention language proficiency as a key factor in integration and as a facilitator for better health care: "because once they speak the language, all doors almost open, many doors open" (CD1). However, integration is also constructed around broader sociocultural factors, such as employment opportunities and social networks: "language leads to opportunities for work, knowledge about the health care system, functioning in society" (GD1). This illustrates how integration involves multiple dimensions. Furthermore, the notion of integration influences GPs' accounts on treatment and referral for patients. One GP articulates this by stating: "it is a more difficult treatment [for an asylum seeker] than for an integrated person" (GD2). This statement illustrates how being more integrated, which is often not considered to be the case for asylum seekers according to the GPs, facilitates decision-making on treatment and referral. Integrated individuals are perceived to have better access to care and resources, making it easier for GPs to provide an effective decision-making. Conversely, asylum seekers face more challenges due to their perceived lack of integration.

The notion of integration is also questioned by several GPs, in the sense that they acknowledge possibilities for integration are limited due to several societal and political factors. Here, it is of interest that GPs often use the pronoun "we" when talking about these limitations, suggesting the collective responsibilities of these factors:

> It makes me lose my temper, when you experience such things, that people have a clear need for care and that they are not eligible because of political pressure and the like, because we oblige them to meet all the conditions, they have to prove everything. [. . .] We are taking away those people's prospects. And we actually do that to those people all the time as Belgium or as Western countries, we don't give them a chance to integrate. We have all kinds of demands, we have all kinds of suspicion and mistrust. But we don't give them a chance to settle in and move forward (GD4).

GPs position themselves as part of the broader societal structures that influence the integration opportunities of asylum seekers, using the personal pronoun "we" to denote collective responsibility. They thus identify with an "us" group and implicitly position patients with an asylum-seeking background as belonging to a "them" group of outsiders. This implicit positioning reflects the process of "othering", where asylum seekers are viewed as fundamentally different and separate from the integrated community. However, GPs do not position themselves in a way that would enable them to help asylum seekers overcome these limitations. Rather, they utter a sense of frustration and disbelief: "I think that for me, it's something that [opportunity of asylum seeker to integrate being influenced by political and societal factors] strikes me, that challenges me a lot" (GFR6). This repertoire aligns with values inherent to a neoliberal ideology on integration and the more conservative perspectives on civic integration. Neoliberalism places strong emphasis on individual responsibility to integrate into society and the health-care system, including by learning to speak the predominant language.

### *Humanitarian repertoire*

Given the use of the video vignette depicting a consultation with an asylum-seeking patient, GPs initially reflected on their experiences with patients in a similar legal situation. This almost automatically evolved into broader discussions about their experiences with other patients with a migration background. However, our data analysis revealed a distinct

repertoire specifically constructed around GPs' notions of asylum-seeking patients; the humanitarian repertoire.

GPs acknowledge the difficult situation inherent to being an asylum seeker, by adopting a humanising lexicon that portrays the powerlessness of asylum seekers: "The fundamental uncertainty is overpowering" (CD1), "that burden of being in a foreign country without many rights, the family that is often left behind. Those worries are so big that they can no longer be bearable" (GD1), "they are people who are lost. They have no point of reference. They don't feel accepted and besides, like here, there's nothing to do, well, they feel all alone" (GFR1), "it is a population in which we regularly find very great distress and terrible life courses" (CFR4). It becomes clear how the accounts of GPs construct patients with an asylum-seeking background as having reduced agency by using strong language to emphasise their difficult living situations. The focus on their experience and states, rather than their actions, illustrates GPs' perceived powerlessness and lack of control over patients' circumstances. GPs' accounts highlight external factors impacting asylum-seeking patients' health, portraying them as unable to influence these conditions. This narrative framing suggests these patients are at the mercy of their environment, further diminishing perceived agency in managing their health. Moreover, we observed a pattern of empathic language use regarding these patients:

> Finally, I thought to myself, I imagine myself in a country and then here, I am told 'well stay in your corner, don't move, shut up and manage yourself'. We can't live like that, nobody, the Belgians either. That said, I think that's a huge problem in our society. It's all these people that we push, that we force to be inactive (GFR6).

> The situation that those people are in is, I don't think we would sleep anymore either (GD1).

These quotes illustrate the availability of solidarity markers in the accounts of GPs. Both GPs express understanding of the situation of asylum seekers and establish a sense of shared concern by bridging the gap between their perspective and the experiences of asylum seekers ("I imagine myself" and "I don't think we would sleep anymore either"). Although solidarity markers might be an indication of mobilising support for asylum seekers, GPs construct themselves as "powerless" regarding the situation of these patients:

> Often, we are powerless, but you have to see them. Often it is the case that they do not feel that they- that the doctors and other social workers and the like see them, that they see them as human beings who are regarded with the same rights and obligations as someone else (GD4).

In this repertoire, GPs construct their decision-making with empathic and solidarity linguistic devices, by stating they will have to consider "the fragility" (GFR4) of these patients and their "migration path" (CFR2). Most of the GPs agree that a mere medical treatment in this case is not "the right solution":

> It is clear that the symptomatology that is described [in the video vignette] is something that could not be more common and that we are very powerless to treat it because it makes no sense to treat it with medication, it is treating with a share of time, by empathy, by listening. They have to tell what happened to them, as long as they haven't filed this, they will have all these physical symptoms, which are related to stress (SFR3).

> But clearly only medicated, with people who've been through what they've been through, who often don't feel ready to actually talk about it, because it's too much, it's too traumatic. I think just putting on a medicated bandage is clearly not the right solution (SFR4).

This repertoire is built on values of empathy, solidarity and the acknowledgement to humanise patients, which relates to broader health-care discourse that resides in the biopsychosocial model. Nevertheless, by constructing asylum seekers in ways that diminish their agency, GPs reinforce the notion that these patients are dependent on their expertise, rather than being empowered to take control of their health (care). Consequently, such

linguistic and discursive constructions can inadvertently perpetuate a power imbalance between GPs and asylum-seeking patients.

### *Culturalising repertoire*

A last repertoire we recognised is related to multiple challenges GPs experience during encounters with patients with a migration background regarding their cultural background. In the subsequent sections, we will use these "challenges" as a framework to discuss the findings related to the culturalising repertoire. This structuring is data-driven, as GPs were questioned in the interviews about the "difficulties" they experience in consultations with asylum-seeking patients and patients with a migration background. However, our data analysis revealed that several GPs describe these difficulties in terms of "challenges" attributed to patients' cultural background within this specific repertoire. Therefore, we will outline the findings according to three challenges: countering the physical trail to the psychological trail, Western medical dominance and the lack of a shared vocabulary.

### *Challenge 1: Countering the physical trail to the psychological trail*

Firstly, this repertoire is observed in the accounts of GPs about difficulties regarding the understanding of the medical problem as a psychological or mental health issue. This is present in the next quotes:

> The entry point is very often centred on general pain and the pain is somewhat diffuse, with its ubiquitous characters but at the same time remaining very, very vague. [. . .] It is not easy to be able to make them understand, to make them admit that the problem is not physical. Often, indeed, there are difficulties (SFR2).

> Clearly this kind of complaint: 'I have a headache, I have pain while urinating but finally there is nothing in the urine, I have a stomach ache'. These are really things that we struggle to pinpoint. But we quickly come to turn to the psychological aspect of the symptoms (GFR1).

In this way, we have identified a juxtaposition between the health beliefs of patients with a migration background and the health beliefs of GPs. The use of the pronoun "we" when talking about GPs, illustrates the construction of a shared sense of belonging which consolidates the professional positioning in GPs' accounts. This professional positioning is also present in the caption by CFR2: "So it depends on whether they can, like me, grasp the idea that perhaps the headaches come from a lack of sleep, which in turn stems from the anxiety caused by what's happening behind the scenes". The construction "like me" invokes the position of GPs as the experts with the powerful knowledge to claim there is a psychological problem and not a mere physical issue present. At the same time, we identified a modal lexicon when GPs are talking about making clear to patients they have a psychological problem: "to make them understand, to make them admit" (SFR2), "to make them accept" (GFR3, GD3). Modal verbs such as "to make (them)" indicate a sense of obligation or necessity. This reflects GPs' positioning according to the notion of "epistemic authority" (Stevanovic and Peräkylä, 2012; Heritage and Raymond, 2005), where GPs position themselves as experts with the authority to determine the psychological nature of patients' problems and the necessity for patients to accept this. By constructing their professional identity as knowledgeable and authoritative professionals, GPs reinforce their expertise, using their agency to make informed decisions on behalf of these patients.

On the other hand, when talking about patients with a migration background, GPs mainly use pronouns like "them" or "they". This language use consolidates the juxtaposition between GPs and patients. Here, we also identified a lexicon by which GPs position patients with a migration background as not complying with their expectations as medical experts. This further illustrates GPs' positioning as medical authorities, however, this time according to the notion of "deontic authority". This refers to GPs' authority to make decisions

based on medical guidelines (e.g. referring patients to a psychologist for psychological issues) and to act as agents who follow these guidelines (Stevanovic and Peräkylä, 2012). Consequently, GPs expect patients to comply with these decisions, assuming agency and responsibility on the patients' side:

> But in fact, as soon as we touch on something more cultural where I think even they do not capture the issues. Well, they go and say 'Why would I go to see a psychologist? I have a headache doctor' (CFR2).

> Well, there are certain patients who don't accept having psychological problems, they come with somatic complaints, and it sometimes takes a very long time to agree to say 'well, okay' (GFR3).

Another interesting finding related to this repertoire is one of the French-speaking GPs using the expression of "the Mediterranean syndrome":

> On the other hand, when there is this cultural shock or moreover: they have all the symptoms, finally what is sometimes called the somewhat Mediterranean syndrome. I find, in fact, for me, I'm sure, it must be related to a malaise which means that in some cases, migration brings so much suffering that in fact there are symptoms like fibromyalgia or stuff like that that will cause a lot of pain, in fact, sometimes it's so hard to make the patient understand there might be a psychological component, that it's irritating, in my opinion (CFR2).

This is remarkable, given the fact that "the Mediterranean syndrome" is a dated expression in medicine (Ernst, 2000) and a cultural prejudice that is still present in the French medical world (Lambert *et al.*, 2022). The expression refers to the fact that minorities migrated from around the Mediterranean Sea will exaggerate their complaints and pain, leading to a failure of the medical encounter and the coherent decision-making process. In this way, this is a clear example of cultural stereotyping by a GP. We can observe how the GP tries to mitigate this claim by using several hedging devices: "the somewhat", "for me", "in my opinion". As such, the GP mitigates what is expressed by acknowledging their personal viewpoint to indicate this is a subjective opinion and may not be universally held by GPs.

### *Challenge 2: Western medical dominance*

A second notion related to this repertoire is that of "Western medicine being almighty" (SFR4). Our attention was drawn to this construct, reflecting the perception among GPs that patients with a migration background often view Western medicine as highly effective and powerful, particularly in providing quick solutions through medication and advanced diagnostic tools. As present in this quote, GPs often refer to the fact that patients with a migration background "have this desire to have a medicine that fixes everything":

> These are people who don't really want a psychologist or other support. Finally, they often have this desire to have a medicine that fixes everything and this belief, in my opinion, that the medication will fix everything, even though it is never the case (GFR1).

In this way, the repertoire is characterised by language use referring to "the magical aspect of medication" (SFR2), "a small pill that will solve everything" (GFR6) or even the metaphor of "magic wand pill to make your headache go away and make you sleep well" (GFR6). This illustrates the same juxtaposition between the beliefs of GPs and those of patients with a migration background, in this case with a focus on the role of medication regarding mental health issues. Throughout their accounts, pronouns such as "we" and "ours" are used to recognise GPs' medical expertise: "We still do have our own way of functioning in our medicine" (GFR6). Moreover, we identified several expressions of reported speech in which GPs attribute a modal lexicon to these patients:

> But it's true that there, for me, I see among first-generation Africans or Maghreb, it's often, well, Western medicine is almighty: 'You have scanners, you have plenty of things, so you must find

> out what I have in fact'. It's a bit more difficult for them to hear that it's something functional, that there's nothing actually damaged (SFR4).

This quote exemplifies how the perception of Western medicine as all-powerful encompasses the expectation for medication that can resolve issues. In addition, it illustrates how some GPs perceived that migrant patients expected various physical examinations as a solution for mental health issues. Furthermore, similar indirect and direct reported speech is used by several GPs talking about the request for mere physical examinations by patients with a migration background:

> They will insist, they will imagine, finally they will ask to do a CT scan, an MRI, to go to the neurologist, to say that there is something serious, that we cannot find what they have, that it's, that it's not going well, finally they will be very demanding of, essentially, medical care. And when we address the fact that there may be a link with insomnia and stress, that post-traumatic stress can cause these kinds of symptoms, very often, people disconnect and go back into the physical. So, it's as if they're closing the door, like we can't talk about that. [. . .] I can imagine saying, 'Yes, we'll do a scan, we'll run tests'. For us, it's our way of ruling out serious conditions. And then, if the complaints persist, we would like to address the more psychological aspects, the life-related issues. But then, sometimes, we hit a wall where we don't know what to do, but at the same time, the person keeps coming back with the same complaints. The person closes off that possibility, and that's where we constantly find ourselves confronted. Sometimes it's exhausting because we think 'What else do you want me to do for you?' (GFR6).

By adopting reported speech, GPs are also able to present their personal viewpoint on this matter in an indirect way, shifting the emphasis and responsibility towards the beliefs of patients with a migration background. Therefore, this represents a discrepancy between the health beliefs of patients with a migration background and those of GPs, from a professional position as medical experts. This aligns with the findings regarding the notion discussed above. The modal lexicon GPs attribute to the perspective of the patients also underscores how patients in this repertoire are constructed as active agents engaging in the decision-making process for their treatment. However, given the coercive character of the language use and the way in which GPs refer to be obstructed by the desire of patients with a migration background for physical examinations and medication, GPs do not consider them as active complying agents in the medical encounter.

### *Challenge 3: The lack of a shared vocabulary*

Finally, there is the notion of vocabulary related to this repertoire, which is available in several of GPs' accounts.

> But we quickly come to turn to the psychological aspect of the symptoms. And there, that poses a problem, because we don't really know how to take care of them at the psychological level, because the vocabulary is not there and because it's mainly culturally, we don't really know how to approach it (GFR1).

> I think people function differently in their way of thinking, their conception of health, of illness and also, as I said, of the health care system (GFR6).

> They have codes that are different, codes of life that are different. They don't necessarily understand, for example, that well, even in the way we practice, huh, it's finally sometimes, sometimes they're going to be more demanding, so they have to be seen right away, et cetera (CFR6).

The conceptions of "vocabulary" and "codes" illustrate a semantic difference with "not speaking the predominant language" (available in the legal-political repertoire). These concepts refer to the knowledge of meanings and the usage of words in various contexts. Therefore, we can claim this aligns with the notion of "health literacy", to which some GPs

literally refer in the interviews. Although speaking the language or language proficiency is also of importance to comprehend information in a medical encounter, vocabulary or codes may refer to understanding specific terminology in communication with health-care providers like GPs. Consequently, vocabulary is a crucial component of health literacy. The excerpts above may illustrate the discrepancy between the level of health literacy of patients with a migration background and the expected level by GPs, due to different conceptions of health, illness and the organisation of the health-care system. Once more, GPs construct notions of "vocabulary" and "codes" in a way that positions them as medical authorities with both epistemic and deontic authority, expecting patients to comply with a certain level of health literacy. At the same time, several GPs acknowledge their role as "health advocates" and discussed various tools they used to overcome communication difficulties (e.g. interpretation services, online translation tools, visual aids). However, these tools were often deemed insufficient to bridge differences in conceptions of health and illness. Consequently, GPs still place the responsibility for meeting a certain level of health literacy on the patients, rather than fully embracing their role as health advocates:

> For me, that is something essential. I think it's something essential to make the patient responsible for his disease. There is often, and there too I find according to cultural origins, the tendency of distinguishing between the disease, which is something external, that we will treat and then everything will be better. And no, as in this kind of situation too, no, that's one entity. And so, it's true that it's precisely on this that we try to work and make them understand how they themselves can change certain things to get better for all pathologies; diabetes, hypertension, chronic pathologies that are related to lifestyle. Here too, finally, it is super important. And for me, it is essential that the person can understand what is going on within them to help them also do their share of the work, so to say, in getting better (GFR6).

Conclusively, this repertoire aligns with values of biomedical expertise and neoliberalism. The powerful positioning of GPs as medical authorities reflects their understanding of the biomedical model from their professional standpoint. However, they interpret it more as a "biopsychological" model rather than a "biopsychosocial" model. This interpretation aligns with a neoliberal ideology in (mental) health care, attributing the responsibility for health literacy to patients with a migration background themselves.

## Discussion

We distinguished three interpretative repertoires on consultations with patients with a migration background and the decision-making of GPs. Each of these repertoires revolves around (conflicting) ideologies and aligns with ideological values present in broader societal and institutional discourses.

Firstly, the legal-political repertoire entails a contrast between patients with a migration background and asylum seekers and primarily revolves around the notion of (civic) integration. This concept significantly influences how GPs frame their decision-making concerning the treatment of asylum seekers, as it prompts consideration of the challenges faced by asylum seekers in accessing health care. In this way, the legal-political repertoire reflects elements of formal citizenship, as it acknowledges the limits imposed by societal and political factors related to the legal status of asylum seekers (Schinkel, 2010). Central in this repertoire are the elements referring to moral citizenship. The necessity for integration and proficiency in the dominant language both exemplify established norms associated with good citizenship. In this way, the discursive positioning of these patients by GPs appears to correspond with the framing of immigrants as "the probationary citizen immigrant" by Waerniers and Hustinx (2019). Their study explores the complexities and contradictions within Belgian immigration and integration policies concerning the framing of immigrants. Although asylum seekers frequently experience uncertain legal status while awaiting decisions on their asylum applications, a connection can be drawn to their concept of "the probationary citizen immigrant". The positioning of these patients, which reflects the

process of othering, illustrates how asylum seekers are expected to "earn" the legal status of citizens by integrating according to established normative conditions. This aligns with the idea of deservingness where those conforming to normative expectations merit being integrated. Despite GPs acknowledging the integration possibilities of these patients being limited by different societal and political factors, it becomes clear how their accounts are influenced by a neoliberal stance that is also present in several policy discourses (Waerniers and Hustinx, 2019; Wets *et al.*, 2024). Similar to the assertion that "learning the Dutch language is a condition for integrating into society, a means to bridge the ethnic gap and to foster social cohesion" (Waerniers and Hustinx, 2019), a comparable line of reasoning is evident in GPs' accounts. GPs construct it to bridge the ethnic gap related to health-care system knowledge to enhance access to high-quality health care.

The central juxtaposition between patients' health beliefs and those of GPs in the culturalising repertoire reveals an aligning neoliberal stance on health-care practice. This is constructed through GPs' expectations for patients with a migration background to recognise the psychological nature of their health problems, comply to related decision-making and meet a certain level of health literacy during consultations. In this sense, we argue that this repertoire comprises the concept of "Cultural Health Capital" (CHC). This concept pertains to "a specialised form of cultural capital that can be leveraged in health care contexts to effectively engage with medical providers" (Shim, 2010). As both GPs and patients exchange health-relevant cultural capital within clinical encounters, CHC is a relational concept. In this way, patients encompassing CHC that corresponds with the expectations of GPs will be able to extract certain rewards from the medical interaction. While patients who are deemed to lack these dominant cultural skills may receive worse health care (Gengler, 2014). Shim (2010) claims that "knowledge of medical topics and vocabulary, which in turn depends upon an understanding of scientific rationality and health literacy" is one of the characteristics of CHC that tends to be rewarded in clinical interactions. This can be seen in GPs' assessment of the psychological nature of patients' health problems and their perceived necessity for patients to accept this. In addition, this is exemplified in how GPs often perceive patients with a migration background to perceive biomedicine as highly effective and powerful, especially for quick medical solutions and advanced diagnostic tools. This finding is also particularly consistent with the research conducted by Dauvrin and Lorant (2014) and Vandecasteele *et al.* (2024). Both findings illustrate how, according to GPs, these patients lack scientific knowledge on medical topics, which goes into their expectations. This clarifies how in health interactions with patients with a migration background, the compatibility of patients' CHC and GPs' CHC can shape a medical encounter and its possible outcomes regarding treatment and diagnosis (Dubbin *et al.*, 2013). However, it is important to acknowledge that extensive literature highlights how certain physical conditions in minority populations are systemically underdiagnosed due to ethnic and other biases (Stepanikova, 2012; FitzGerald and Hurst, 2017; Hamed *et al.*, 2022). These individuals are often taken less seriously in health-care settings, as GPs may attribute their symptoms to psychosomatic or psychological causes. Therefore, while our findings illustrate that the perceptions of GPs are valid, we must also be aware that some of these issues may stem from GPs' own biases.

Moreover, the way GPs position themselves as medical authorities, "others" patients with a migration background and places responsibility for health literacy on these patients, also aligns with the concept of CHC. From their position of medical authority, GPs hold professional CHC and set expectations regarding the CHC patients should exhibit and what constitutes normatively "good" patienthood (Dubbin *et al.*, 2013; Madden, 2018; Shim, 2010). The findings illustrate both instances of epistemic and deontic authority, which are essential in understanding how GPs position themselves as medical experts and authorities (Stevanovic, 2021; Pilnick, 2022; Stivers and Timmermans, 2020). GPs construct their medical expertise through epistemic authority, based on their medical knowledge, which ultimately provides the basis for their deontic authority, suggesting they have the right to

expect compliance in terms of CHC from patients in the consultation setting (Stevanovic, 2021; Pilnick, 2022; Stivers and Timmermans, 2020). Related to these findings, is the positioning of patients' health beliefs by GPs as obstacles to proper care, placing the responsibility on patients rather than recognising it as an aspect they, as health advocates (Decat *et al.*, 2019), need to address. We argue that GPs adhere to their understanding of the biopsychosocial model, but focus only on the biological and psychological elements, neglecting the social or sociocultural aspects. Essentially, GPs follow a "biopsychological" model instead of a "biopsychosocial" model. This focus on patients' health beliefs as hindrances to appropriate care excludes the possibility for patient-centred care, which requires addressing the full range of biopsychosocial elements and fostering a therapeutic relationship based on shared power and responsibility (Timmermans, 2020; Pilnick, 2022; Pilnick, 2023; Stivers and Timmermans, 2020). Thus, a critical question posed by Timmermans (2020) is relevant to our findings: "If the normative expectation is that patients take an active role in their health advocacy, what happens to those who lack the cultural health capital to engage?" Our findings suggest that such patients are positioned and may be treated differently than those who meet GPs' expected level of CHC.

A last element identified in the culturalising repertoire was that of "the Mediterranean syndrome". This expression is a clear example of cultural stereotyping in which GPs' decision-making may be influenced by cultural prejudice. Consequently, this highlights the possibility of GPs' accounts contributing to prejudicial treatment outcomes for patients with a migration background, possibly in an unconscious manner.

On the contrary, the humanitarian repertoire does align with the biopsychosocial model in health care (Frazier, 2020). It is constructed on values of empathy and solidarity, also addressing various social and sociocultural aspects to asylum-seeking patients' health and care. Although the repertoire is constructed on these values, GPs' positioning of asylum-seeking patients diminishes their agency regarding their own health (care). This can impede the possibility for patient-centred care by perpetuating a power imbalance between "fragile" patients and GPs, hindering an equal therapeutic relationship to come to shared decision-making in consultations (Timmermans, 2020; Pilnick, 2022; Pilnick, 2023; Stivers and Timmermans, 2020). Nevertheless, it becomes evident how GPs find themselves in an ambiguous position. While they are still positioned as powerful medical authorities, their possibilities are constrained by wider societal factors. GPs utter the question whether their support for asylum seekers is just another drop in the bucket as their treatment possibilities are limited. In this way, the responsibility is ascribed to their professional limitations as GPs. Moreover, this finding could explain why the humanisation intervention does not always mitigate differences in medical decisions between migrant and native patients (Duveau *et al.*, 2023).

Ultimately, we identified three distinct interpretative repertoires GPs rely on to construct their decision-making and position patients with a migration background as suffering from mental health problems. The findings reveal that GPs often position patients' health beliefs and integration as obstacles to appropriate care, focusing primarily on biological and psychological aspects while neglecting social and socio-cultural elements. This approach can lead to cultural stereotyping and prejudicial treatment outcomes. In addition, even when GPs adopt a more humanitarian stance, it can diminish patients' agency and impede patient-centred care. Moreover, it is imperative to critically reflect upon the used methodology and its efficacy in addressing our pre-determined research inquiries. We acknowledge that conducting a discourse analysis of in-depth interviews entails a meta-analysis of GPs' accounts, with the potential persistence of social desirability. While the methods section provides a detailed account of our approach, it is important to recognise that the design of the interview questions and the use of video vignettes were intended to mitigate biases and enhance the authenticity of responses. Despite these efforts, the

influence of interviewer effects and the specific design of the questions remain important considerations in interpreting our findings.

Finally, the findings of this study have several important implications for policy, medical training and future research. Policy should address biases and stereotypes in health care, by promoting the inclusion of social and sociocultural elements in medical practice without diminishing patients' agency. It is crucial for policies to support GPs in their role as health advocates, ensuring they actively manage patients' expectations and provide comprehensive patient education. These interventions should aim to reduce disparities in decision-making between migrant and native patients with mental health problems. In terms of medical training, programs should emphasise the full biopsychosocial model, including social and sociocultural aspects. Trainings can focus on recognising and addressing biases and stereotypes, promoting patient-centred care and fostering therapeutic relationships based on shared power and responsibility. Future research should explore the impact of cultural health capital on medical interactions and outcomes, investigating how biases and stereotypes affect health-care delivery and developing strategies to address these issues. Therefore, we posit that future observational studies in medical encounters could augment the scholarly discourse in this field of research. While such a study was considered within the present project, ethical consideration such as the impact on genuine patients time, prompted us to conduct interviews with GPs.

## Note

1. In this study, "patients with a migration background" refers to individuals from diverse backgrounds, including asylum seekers and first and second generation migrant patients.

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## Appendix 1. English translation of semi-structured interview guide

PROTOCOL – IN-DEPTH INTERVIEWS

INTRODUCTON

Informed consent and framing of the interview in the context of the research project. (More information on the informed consent part of this interview can be requested by contacting the first author of this manuscript).

TOPICS

1. INTRODUCTIONARY QUESTIONS

*(Before showing the video vignette, the interviewer asks the interviewee to introduce themselves. Drop-off manner questions can be asked in case of more information needed)*

Personal details

- Name
- Age
- Gender (how do they identify themselves)

Professional details:

- (GPs) How many years of experience do you have as a GP?
- (GP in training) In what year of your training are you now?
- In what kind of practice do you work for the moment (solo, group, community health centre, other) and what is the location of that practice?
  - [PROBE – motivation] Why did you chose to work within this kind of practice?
  - [PROBE – experiences] Did you already work in other settings as a GP? Why did you chose to change from practice "x" to practice "x"?

Motivation to take part in this interview:

Why did you accept to take part in this interview?

2. VIDEO VIGNETTE *(Showing the video vignette with the asylum-seeking patient)*

Introduction of the video vignette:

*"You will now see a short video clip. This video clip is a simulation of a consultation between a general practitioner and Mohammed. Mohammed is a patient who fled from Syria to Belgium a year ago, applied for asylum, and is still awaiting the decision regarding his refugee status. Mohammed previously visited due to persistent headaches. Despite a thorough medical history, physical examination, and a CT scan, no physical cause for the headaches could be found. Mohammed has no psychiatric history, nor any family history of psychiatric disorders. There are no precedents regarding substance use. Currently, Mohammed is not taking any medication, except for paracetamol. He is not working at the moment".*

3. PERSONAL EXPERIENCES AND PERCEPTIONS

1. What are your thoughts after watching the video vignette of the consultation with this asylum seeker?
2. What elements from the consultation with Mohammed do you recognise from your experiences in your own practice?

[PROBES]

a) Do you sometimes have consultations with asylum seekers in your own practice?
b) Do you sometimes have consultations with asylum seekers who present themselves with similar symptoms or complaints as Mohammed?
c) When you have consultations with asylum seekers who present themselves with similar symptoms or complaints, are these mainly male or female patients?
d) When you have consultations with asylum seekers who present themselves with similar symptoms or complaints, are these mainly patients from the same age group of Mohammed?
e) When you have consultations with asylum seekers who present themselves with similar symptoms or complaints, are these mainly patients with the same ethnic background as Mohammed?
(c – e: what can you tell me in terms of "gender", "age", "ethnic background"?)

3. Which elements from the consultation with Mohammed do you believe differ from reality?
   a) [PROBE] In what way does this differ from your experiences in your own practice?
4. What specific difficulties do you experience during consultations with an asylum seeker?

5. Do these difficulties vary depending on the type of symptoms the asylum seeker presents with?

[PROBES]

a) Do you experience different difficulties when these patients present themselves with physical complaints or psychological complaints? [PROBE – ask for examples from their own practice]

b) Do you experience different difficulties depending on the gender of asylum seekers? [PROBE – ask for examples from their own practice]

c) Do you experience different difficulties depending on the age of asylum seekers? [PROBE – ask for examples from their own practice]

d) Do you experience different difficulties depending on the ethnicity of asylum seekers? [PROBE – ask for examples from their own practice]

(a – d: what can you tell me in terms of "physical and psychological complaints", "gender", "age", "ethnic background"?)

6. Do you think these difficulties differ from consultations with other patients with similar symptoms?
7. In what way do you think these difficulties differ from consultations with other patients with similar symptoms?
8. What other patients do you come into contact with in your practice?
   [PROBE] a) How would you define a "x" patient? (based on the GPs' account)
9. When you have a consultation with a patient with similar symptoms, what elements do you consider when determining the diagnosis?
10. When you have a consultation with a patient with similar symptoms, what elements do you consider when determining the treatment?
11. When you have a consultation with a patient with similar symptoms, what elements do you consider when determining the referral?

[PROBE]

a) What treatment would you recommend here? Based on which elements?

b) Would you recommend a pharmacological or non-pharmacological treatment or a combination of both?

c) How do you arrive at the decision to recommend this treatment?

[PROBE]

I. Do you ask your patients if they have already used non-pharmacological treatments or options to manage their symptoms or complaints? How?

II. Do you ask your patients if they are open to trying non-pharmacological treatments?

III. Have you ever recommended the use of CAM (complementary and alternative medicine) to patients?

d) Do you think the asylum seeker status or migration background of a patient can influence your treatment advice?

e) In what way do you think this can influence your treatment advice?

[PROBE]

I. Why would you be more likely to recommend a pharmacological or non-pharmacological treatment to them?

f) What decision would you make regarding the referral of a patient with similar symptoms?

g) How do you arrive at the decision to refer a patient with similar symptoms?

h) Do you ask patients if they are open to visiting another healthcare provider or trusted person?

i) Do you think the asylum seeker status or migration background of a patient can influence your referral advice?

j) In what way do you think this can influence your referral advice?

[PROBE]

I. Why would you be more likely to refer these patients to "professional/person/organization X"?

II. Would you be inclined to refer asylum seekers to therapies specifically developed for asylum seekers, such as Mindspring?

III. Would you be inclined to refer asylum seekers or patients with a migration background to professionals with the same ethnic background?

12. In what way do the various difficulties you may experience during a consultation influence your decision-making?

(start each question based on what has already been mentioned by the interviewee in terms of possible difficulties)

How does the fact that a patient does not speak Dutch/French affect the consultation?

a) How do you take the language difference into account during a consultation in your own practice?

b) How do you deal with a difference in spoken language during a consultation in your own practice?

I. How do you act during such consultations?

II. What actions do you take to help the patient in such consultations?

c) Are there certain services or tools you can rely on in your practice for support?

[PROBE – services/tools] Can you use a professional interpreter? Can you use an intercultural mediator?

How do you inquire about the cultural background of a patient during a consultation in your own practice? (first ask if they do this)

d) How do you take this information into account during a consultation in your own practice?

I. How do you act during such consultations?

II. What actions do you take to help the patient in such consultations?

e) Are there certain services or tools you can rely on in your practice for support?

How do you take into account the motivation of a patient in your decision-making?

f) How do you act during a consultation where you experience difficulties regarding the patient's motivation?

I. What actions do you take to help the patient in such consultations?

g) Are there certain services or tools you can rely on in your practice for support?

How do you inquire about a patient's adherence to therapy during a consultation?

h) How do you take a patient's adherence to therapy into account during a consultation?

i) How do you act during a consultation where you experience difficulties regarding the patient's adherence to therapy?

I. What actions do you take to help the patient in such consultations?

j) Are there certain services or tools you can rely on in your practice for support?

13. What is included in the training for general practitioners regarding consultations with people with a migration background or asylum seekers? [PROBE – own experiences and opinions about the current curriculum/curriculum that the GP or trainee GP underwent]

14. Suppose you were responsible for the Ministry of Health, in which services or tools would you invest to improve care for asylum seekers or patients with a migration background in general practice? [PROBE – motivation]
15. In the context of overcoming or dealing with the various difficulties we have already discussed, are there certain practices, levers, services or tools that you think are too difficult to implement in your general practice? [PROBE – experiences in their own practice]
16. Based on your own experiences, what are the specific strengths of how your practice is organised in terms of care for asylum seekers or patients with a migration background?
    a) What limitations are associated with the organisation of your practice?

To close off: Summarize the most important points discussed and check with the interviewee if they would like to add anything or discuss anything further before concluding the interview.

## Appendix 2. Link to video vignettes

The patient featured in the video vignette spoke English, and subtitles in either Dutch or French were displayed depending on the native language of the interviewee.

The link to the video vignette used during the in-depth interviews with Dutch-speaking GPs: www.youtube.com/watch?v=a2ngrnc50xg

The link to the video vignette used during the in-depth interviews with French-speaking GPs: www.youtube.com/watch?v=Cv8yZgZkxtc&feature=youtu.be

*Source(s):* By author

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