Crisis management through contextual resilience in public service design

The curious case of the general practice in Scotland dealing with the refugee crisis

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1. Introduction

Major crises tend to impact public administration (Christensen et al. 2016) hence crisis management, preparedness and the way in which these shape organisational capacity in the public sector are important to understand in order to enable action. Yet government capacity to deal with major crises is a subject that public administration scholars have yet to explore at length (Boin and Lodge 2013). This paper addresses this gap in the literature by unravelling issues to do with the way in which uncertainty caused by a severe humanitarian crisis shaped operations in general practice (primary care) in Scotland, UK.

The UK primary healthcare system is arguably already in a state of crisis, facing problems of staff recruitment and retention as well as reduced funding and increased patient expectations (Appleby, 2014; Roland & Everington, 2016; Wilkinson, 2014). The refugee crisis that is currently affecting Europe and the provision of healthcare to this patient population has been challenging to the primary healthcare service (Farley et al., 2014; Le Feuvre, 2001). Coping with increasing asylum seeker numbers will require strategic planning and review of organisational capacity, particularly for General Practice given that Primary Care is the front line of the NHS. Workload within General Practice is already very high and this is reflected in the high levels of burnout in GPs (Pedersen & Vedsted, 2014; Soler, Yaman, & Esteva, 2007; Zenasni, Boujut, Woerner, & Sultan, 2012). It is thus all the more important that the challenges of dealing with all patients, including asylum seeker patients, are dealt with effectively and efficiently by General Practice without placing undue pressure on General Practice staff. In addressing these issues in this paper, however, we do not suggest that the problems associated with any coping mechanisms are insurmountable, nor that the effects on professional staff and on other patients could justify resistance to any particular patient group, but rather describe the effects and reflect to further knowledge in public service design and crisis management literature areas. Indeed, we refer to the asylum seekers’ influx as a proxy for, and an example of, a crisis.

Extant literature has considered the types of issues and challenges that asylum seeker patient population pose to healthcare services. This has mainly been within the Australian (Cheng, Wahidi, Vasi, & Samuel, 2015; Farley et al., 2014; Milosevic, Cheng, & Smith, 2012) and Canadian (Fowler, 1998; Kirmayer et al., 2011) healthcare systems. In their review of mainly US, Australian and Canadian Healthcare, Joshi et al (Joshi et al., 2013) were able to show that improved access and quality of care for refugees was associated with non-clinical issues such as the use of specialist refugee healthcare staff, interpreters and bilingual staff. The views of asylum seekers and their expectations of UK General Practice have been examined briefly in the literature (Bhatia & Wallace, 2007; O’Donnell, Higgins, Chauhan, & Mullen, 2008). However, there seems to be a lack of research looking at the challenges arising from asylum seeker patients’ influx from the point of view General Practice staff, both clinical and non-clinical.
Starting from these gaps in literature, this research investigates the challenges and impact that asylum seeker patients have on UK General Practice and how best these challenges are currently being met— from the perspective of General Practice staff. The theoretical constructs adopted to make sense of our data are those of ‘fractal crisis management’ and ‘contextual resilience’. The paper conceptualises these first and then considers empirical data from a Scottish region which has been affected by the refugee crisis more than most other places in the UK.

2. Setting the scene: rational and fractal theories of crisis management

Rosenthal, Charles, and ‘t Hart (1989) define a crisis as “a situation in which there is a perceived threat against the core values or life-sustaining functions of a social system that requires urgent remedial action in uncertain circumstances” (p.10). To facilitate understanding of such a conceptually rich notion, various typologies have been put forward. While many of these typologies are based on the causes of crises (Boin 2005; Boin, McConnell, and ‘t Hart 2008; Rosenthal and Kouzmin 1993), we take Christensen’s and colleagues’ (2016) argument on board that two dimensions are crucial to our understanding of crises: first, the degree of uncertainty and uniqueness of the crisis, and second, the degree of transboundary features. The most demanding crises are those which transcend administrative levels, sectors, and ministerial areas and at the same time are unique, ambiguous, complex, and involve considerable uncertainty. Transboundary crises can escalate along geographic, political, and functional lines and produce significant governance challenges (Ansell, Boin, and Keller 2010; Boin, Ekengren, and Rhinard 2014). There are a few crises that can better illustrate these features than the refugee crisis in Europe—it is large transboundary par excellence, as not only it literally spreads across geographical borders and cultural, administrative and legislative boundaries, but also it demands cross-sectoral mobilisation in terms of multiple public, private and third sector services coming together to gather intelligence as well as achieve efficiencies when tackling the issue together.

Specific organizational arrangements may exacerbate crises or limit loss or damage. As such, and building on Pearson & Mitroff’s guidance (1993), Kovoor-Misra and colleagues (2000) offer prescriptive guidance on how to improve crisis preparedness, ranging from crisis prevention, containment, and recovery.

Table 2.3: Prescriptions for Crisis Preparation

<table>
<thead>
<tr>
<th>Crisis Prevention</th>
<th>Identify and deal with underlying aetiology of potential crises</th>
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<tr>
<td></td>
<td>Early Warning Systems to prevent incubation and escalation of crises.</td>
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<td></td>
<td>Ongoing review and learning of crisis prevention plans</td>
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<td>Crisis Containment</td>
<td>Develop Crisis Containment Plans</td>
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<td></td>
<td>Review and test the above plans</td>
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<td>Integrate plans across organisation</td>
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<td>Develop Crisis Management Teams</td>
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<td>Ensure adequate training for team members</td>
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Crisis Recovery

- Highlight psychological trauma of crises to all affected by the crisis
- Group therapy and counselling for individuals experiencing a crisis
- Ongoing review and appraisal of processes, learning from crises and near misses.
- Leaders should ensure above activities are given priority and not disregarded

Source: Kovoor-Misra et al., 2000

Kavoor-Misra’s (2000) model is not unique—a similar one can be identified, inter alia, in the earlier work of Smith (1990, 1995) who distinguished between crisis of management, operational crisis and crisis of legitimization.

Organisations tend to focus on crises that they or other similar companies within their industry have encountered in the past, but will neglect other technically feasible crises that have as yet been unseen (Kovoor-misra et al., 2000). This will create vulnerabilities in terms of crisis preparedness for the organisation. Black Swan events (Taleb 2001) however pose particular challenges to such mechanisms, as they are rare events for which learning from others cannot apply. However, Topper & Lagadec (2013) argue that, in crisis preparation, the world should be viewed devoid of “normality”; in such a world, outlier events such as a “black swan” are not simply one-off events. Topper & Lagadec (2013) propose a “fractal theory” of analysing crises, removing the linear and stable assumptions of the world. The “fractal” approach allows for crisis management to occur at multiple levels simultaneously in dimensions of both time and space. This then encompasses the multiple perceptions and sense-making processes of all the individuals and entities experiencing the crisis within the organisation. In this paper, we contrast earlier, more linear, understandings of crisis management, with this fractal approach.

Fractal theories seem compatible with current organisational practices where decision making is delegated throughout its workforce. In such organisations, central leadership tends to be less involved in the crisis management and preparation decision making process. Any crisis plans developed will likely follow the organisation’s existing structure, be it a functionally segmented organisation or one that revolves around a central workflow or processing line (Kovoor-misra et al., 2000). Therefore speaking of organisational capacity to deal with crises, either through prevention mechanisms or through containment, looks like the cumulative efforts of an organisation’s workforce at various levels of hierarchy.

3. The role of organisational resilience capacity in dealing with crises

An organisation’s capacity to deal with crisis is often defined in terms of “organisation resilience capacity” (Akgün & Keskin, 2014; Lengnick-Hall, Beck, & Lengnick-Hall, 2011), where resilience is the “capability of a strained body to recover from or adjust smoothly to external changes” (Watanabe, Kishioka, & Nagamatsu, 2004). Applying this to an organisation, this equates to the “capability and ability of an organisation to return to a stable state after a disruption” (Akgün & Keskin, 2014). This implies that the organisation is “rebound orientated” and is concerned with reaching its normal pre-crisis level of functioning after dealing with the challenges it face (Horne & Orr, 1998; Sutcliffe & Vogus, 2003).
Another perspective of “organizational resilience” looks at not only restoring pre-crisis levels of functioning but also to develop new capabilities to keep pace with the external environment and indeed create new opportunities (Lengnick-Hall et al., 2011). This “transformational” view of resilience is in essence the ability of an organisation “to learn, adapt and self-organise in the face of any challenges” (Linnenluecke & Griffiths, 2010). Flexibility (being modified easily without malfunctioning), agility (actioning plans easily and quickly), and adaptability (adapting to new conditions) are also key to capacity (Lengnick-Hall et al., 2011; McCann, 2004). Many organisations, in order to deal with the extra task demands that arise during a crisis, may demand that an organisation has extra slack capacity. However, if there is too much capacity this will be perceived as inefficient, yet if the organisation is too lean it will not be able to cope with even a small crisis (Fischbacher-Smith, 2014).

Organisational resilience capacity may also be defined as a “unique blend of cognitive, behavioural and contextual properties” that allow an organisation to understand its environment and the challenges that it faces (Lengnick-Hall & Beck, 2005). This then shapes its ability to respond to environmental change through maintaining a breadth of routine and abilities that improve capacity and capabilities (Horne & Orr, 1998; Lengnick-Hall & Beck, 2005). Having high resilience will allow for an organisation to better understand its environment and thus develop more appropriate strategies for its challenges, be it for complexity absorption or complexity reduction (Lengnick-Hall & Beck, 2005). 

Cognitive Resilience is the ability to embrace a challenge and develop solutions that allow the organisation to excel and thrive in the face of that challenge, as opposed to only just managing to survive (Lengnick-Hall & Beck, 2005). Sense-making at the individual and organisational level is critical (Mallak, 1998). Behavioural resilience is the aforementioned routines, capabilities and skills that an organisation possesses and can use as and when required depending on the external environmental challenges (Lengnick-Hall & Beck, 2005). Contextual resilience is the ability to fully engage and act out cognitive and behavioural capabilities, through “deep social capital” and a “broad resource network” (Lengnick-Hall & Beck, 2005). This allows organisations to engage and elicit help from people and resources either internal or external to the organisation, allowing enactment of their plans (Inkpen & Tsang, 2005; Kwon & Adler, 2014). It is this third type of resilience which we find of greatest relevance in tackling uncertainty in public service planning, as it appears to be conceptually compatible with Topper’s and Ladec’s (2013) fractal approach to crisis management.

4. Organisational resilience in healthcare

In terms of crisis management and disaster planning in healthcare, there has certainly been a lot of research within the area, mainly pertaining to Emergency Departments and Secondary Care (Auf Der Heide, 2006). Hick, Hanfling, & Cantrill (2012) in particular emphasise the advantages of planning ahead and being “proactive” rather than “reactive” in such a crises. One should anticipate the types of logistic and clinical problems that may be encountered and plan accordingly, helping to create a “patient surge capacity” and hence resilience across both Primary and Secondary Health Care systems. (B. Braun et al., 2006; Hick et al., 2004; Koenig, Lim, & Tsai, 2011; Stratton & Tyler, 2006). Yet crises are often affected by a lack of time and resources, and this can create ethical dilemmas in terms of allocation of resources especially in a healthcare context (Geale, 2012).

Koh et al (2006) looked at developing surge capacity in Community Health Centres in the US to help with emergencies. The importance of secondary surge capacity in Primary Healthcare is also identified, as those individuals injured in the initial disaster event seek follow-up care to their initial
injuries, be it physical or psychosocial health needs (Runkle, Brock-Martin, Karmaus, & Svendsen, 2012). Published literature reviews have shown that there is a relative lack of studies looking at the role of Primary Healthcare in health emergency and disaster management (Redwood-Campbell & Abrahams, 2011).

Mallak (1998) describes resilience in healthcare organisations as the capability of being able to efficiently develop and put into action effective solutions to meet the immediate challenges faced from the external environment while experiencing little strain. Smith and Toft (2005) describe the ideal of having “an organisation with memory” to create a resilient healthcare organisation with minimal susceptibility to adverse events. Elements that help instil such characteristics include being able to make sense of complex situations, having an appropriate organisational culture centred around patient care and being able to learn from past mistakes, be it their own or that of others (ibid.). Other elements include having managers and clinicians working well together to deliver services geared for the clinical challenges being faced (ibid.). These issues are reminiscent of arguments in a different literature area, of public service dominant approach in public management (e.g. Osborne et al. 2012). This literature postulates that, in public services dealing with trans-boundary issues (the majority of public services, that is), co-production of service is essential, where service users interact dynamically with both front-line professionals and managers (Osborne and Strokosch 2013) and, in some services where users are vulnerable, unwilling or coerced to use services (e.g. clients of police or prisons), services are co-produced by management with front-line professionals as custodians. This line of argumentation opens the door for accepting a rather substantial contribution from front-line professionals to public service design. It is therefore all the more important to think of resilience in human services organizations as requiring a “healthy” workforce and strong workforce protocols that ensure the long term goals of the organisation’s service users are prioritised (Van Breda, 2016). The importance of a healthy workforce- both physically and psychologically- towards meeting organisational goals have been further highlighted (Salanova et al. 2012).

5. Methodology

This study aimed to look at how crisis shapes organisational resilience capacity, using the case study of the refugee crisis effects on General Practice—the refugee crisis is a good example of a transboundary crisis, able to pose real challenges to public service design and delivery, while health is an essential public service. Given the novelty of the issues at the heart of this research, we adopted an exploratory, inductive methodology through a case study in primary care settings in Scotland, UK. This allowed for a detailed exploration of the phenomenon, as its exact nature, boundaries and limits were unclear (Flyvberg, 2011; Yin, 2014)-the refugee crisis is ongoing and its effects on the UK in general and on the general health practice in particular, are embryonic.

The data in this study came from semi-structured interviews, piloted with one General Practitioner to refine and develop further the interview protocol. This interview format allowed for set themes and topics to be addressed while at the same time giving flexibility during the interview process to adapt the line of questioning according to the issues raised by each participant. The questions explored primarily the impact of refugee and asylum seeker patients on General Practice staff, and how this extra workload is affecting their day-to-day work. Then, the questions also elicited views on how well General Practices feel they are prepared for crises- in this case the refugee crisis- and how,
if at all, this shapes their organisational capacity. Access to interviewees was granted through the local health board of a large area in East of Scotland which has received a large number of asylum seekers recently. A number of 27 people agreed to be interviewed—a mix of genders and occupations (general practitioners, practice nurses and practice managers, healthcare assistants and administrative staff, including a Senior Executive of a Scottish NHS Health Board) in various general practices. The interviews were 20-30 minutes in length, reflecting the limited time available to health professionals for non-clinical work. By keeping the interviews relatively short, we have minimised any participation bias and error (Saunders et al., 2016), e.g. not agreeing to participate or rushing through the questions.

The interviews were audio recorded and then transcribed verbatim to facilitate analysis. The interview transcripts were also sent to the research participants for member validation of the research data. The interviews were then analysed using general thematic analysis (e.g. Saunders, 2006; Corley and Gioia, 2011). More specifically, a preliminary coding structure was compiled following inductive ‘free coding’ (Boyatzis, 1998), then these codes were aggregated into second-order codes. Our Findings section reports on these aggregated themes. When illustrating these themes with quotes, interviewees will be referred to only by interview number and job position, for example [Participant-6 GP] or [Participant-13 PM]. This is to maintain confidentiality and to comply with the terms of the ethics approval received to conduct this study.

6. Findings

6.1. Specific challenges raised by the refugee crisis in the Scottish general practice

6.1.1. Language barriers

Language barrier was universally cited as one of the most significant challenges in dealing with asylum seekers by all General Practice staff interviewed, clinical and non-clinical. The language barrier necessitates the use of an interpreter, and the challenges entailed in that process are to do with booking interpreters and ensuring they turn up on time.

“The first challenge is that [asylum seekers] might not speak English, so they might not understand... certain things like how you would register, forms and [so on].... The second major one is that when we have interpreters, sometimes they don’t turn up, so that’s quite annoying for everybody concerned.” (Participant-8 PM)

“The language problem.....and the need to arrange consultations via interpreters... It is particularly challenging when they are just newly registered... you know nothing about them, and [on] their initial consultation...they often come with an agenda, with issues they want addressed, and you have to try and get to know them from scratch while also trying to deal with an Interpreter coming,... and [the interpreter] sometimes being late...” (Participant-3 GP)

A solution to these problems has been the Language Line, a phone line with interpreters who are generally available in a set office, but technology can pose a separate set of challenges, alongside the predictable issue of telephone communication being more impersonal than the face to face type:
Also we have now a thing called Language Line [telephone interpreting service],... sometimes you get cut off... actually, it's not very good.” (Participant-8 PM)

[Language Line] has its own problems as well, because clearly you do not see someone visually who is translating so that adds to the complexity of the communication challenges...” (Participant-3 GP)

The language barrier, which seems to be augmented by technology failure and distance in communication, makes patient interaction in General Practice more complex than is the case with standard patients, from simple tasks such as booking an appointment through to exploring difficult psychosocial issues during a GP consultation. GPs normally rely on building a rapport with their patients, which helps facilitate the patient’s open discussion of their ailments and any other concerns they may have. This process is somewhat inhibited through the use of an interpreter. Some GPs also raised concerns about information being “lost in translation” and this can cause ambiguities in a medical context, particularly when dealing with psychological issues.

When an interpreter is booked for a patient consultation, be it face-to-face or over the phone, this usually requires a double appointment. This has consequences on overall appointment availability.

“Obviously, when it comes to GP resources, they are divided into money and time. So, each patient is given ten minutes [per appointment].... you might just think one asylum seeker means one patient, but in fact per asylum seeker [requires] two slots per appointment and also, you also need an interpreter, and when they have got to see a Nurse and Allied Health Professional/ experts they also would require double slots and interpretation, so that actually is double the time and resources.” (Participant-2 GP)

A consequence of this is that appointments, of which there are only a set amount allocated every week per GP working, are used up more quickly. This places further resource pressures on General Practice.

“Appointments then become a problem because we’ve no more appointments than we had before we started receiving all the [asylum seekers]. So that’s the main problem – it’s the language and time....” (Participant-9 PN)

“To make an everyday appointment it can take 2 or 3 weeks. So it’s getting longer and longer.” (Participant-11 HCA)

Many interviewees emphasised that “routine” non-asylum seeker patients subsequently face a reduced availability of appointments, which may decrease their level of satisfaction with the overall service they are receiving. One practice manager suggested that asylum seekers should perhaps learn English to help break down the language barrier. However, expecting already traumatised asylum seekers to learn a new language to a level where they can fluently and confidently express themselves is not easy and will take time. One GP noted that even those asylum seekers that speak some English prefer to arrange an interpreter as it is easier for them to communicate and express themselves in their native language. From the asylum seekers’ point of view, the interpreter is less of a barrier and more of a facilitator. It is the general practice system which perceives it as an obstacle to their operations.
6.1.2. Knowledge capturing and sharing

One theme raised was a lack of full understanding of who asylum seekers are, their legal status and their rights. This was an issue among clinical and non-clinical staff. This can create misunderstandings and misconceptions, and may subtly affect staff attitudes and subsequent service provision to this patient group.

“I don’t fully understand where [asylum seekers’] rights are in terms of their rights to access [public services]... in terms of onward referral hospital treatment and so on... I’ve always assumed that they had access to it all,... but I have to say I think there is maybe a little bit of a gap in my knowledge there....” (Participant-3 GP)

“General understanding amongst staff on protocol for asylum seekers,..., I think there has to be more awareness there...[It’s important that] you don’t see an asylum seeker at the desk, you see a person... ... so more education for the staff.” [Participant-1 PM]

As the last quote highlights, there is perhaps a greater level of empathy that is needed from General Practice staff, as this can help instil a sense of compassion and understanding towards the patient, and consequently improve standard of care. Interestingly, the Practice Manager in the last quote was referring to his Reception staff. He recognised that all of the doctors in his practice were “very professional” but mentioned “I have people in working in the reception area, and they do not have that same standard and people will [get] frustrated at times...” (Participant-1 PM).

NHS staff’s knowledge of asylum seekers’ and refugees’ rights and entitlements is as limited as the latter’s knowledge of the NHS. Indeed, GP staff’s observation is that many asylum seekers are not aware of the functioning of the NHS, and this can lead to problems and inappropriate use of the system. Some asylum seekers have unrealistic expectations, demanding that all their medical conditions are treated by the GP, without realising that a referral to a Hospital specialist may be required. Perhaps because of the language behaviour or lack of access to transport, many asylum seekers also seem to miss appointments as well, both at the General Practice and at hospital.

“[asylum seekers] tend to turn up sometimes just at whatever time they want [regardless of appointment time]. Whether they haven’t understood their [appointment] time or that’s just their culture, I’m not sure. That can cause quite a problem.” (Participant-12 PM)

This lack of time keeping may be because of difficulties in public transport, being held up at other appointments (e.g. immigration related) or indeed a genuine cultural difference. Many of the countries that the asylum seekers come from will have poor public health systems; thus they are perhaps accustomed to attending private healthcare facilities where services are generally accessed rapidly provided one can pay. Perhaps, then, the asylum seekers believe that the NHS has similar functionality as it is the health system of a wealthy western nation.

Asylum seekers also have unrealistic expectations of what the GP is expected to do. This may reflect the fact that they may feel socially isolated and they have no-one else to turn to. It may also reflecting past experiences of their interaction with healthcare systems in their countries of origin:
“[Asylum seekers] feel that everything can be done by the GP,... money problems, transport problems, problems with the neighbours,... one tries to make them understand that that is not possible.” (Participant-16 GP)

“I think sometimes [there] are huge cultural differences, and expectations. And often, people come having had some kind of investigation in their country of origin, but want reinvestigated again because they think there is a cure or a better answer here. I've seen a few situations like that.” (Participant-10 GP)

Missed appointments and inappropriate use of the NHS can be frustrating for all staff involved, and also uses up valuable NHS resources- in terms of both time and finance. Many GPs suggested that this should be a subject that the asylum seeker patients should be formally taught by central agencies at their time of arrival in the UK.

Not only are the new patients unaware of what the NHS can do for them, but so are other agencies they get in contact with first –i.e. the non-state agencies such as the humanitarian charities. Many GPs highlighted the lack of awareness of the different agencies that provide help for asylum seekers. These organisations also seemed to have limited communication with General Practice, despite their involvement with asylum seekers. Such organisations included the likes of the Scottish Refugee Council and the British Red Cross. This inefficiency again adds to the task demands placed on General Practice.

“We often find that we’ll have [asylum seekers] who are registering here and we have no background information at all. Which then means you’re trying to go through the history again. A lot of these people will have obvious psychological trauma and they need specialist help which could be arranged at [their] point of entry.....I think asylum seekers are not well signposted when they arrive. You often have them coming with basic questions, about where to access health [services] and what have you. And also, they will often come with issues that have nothing to do with General Practice. [for example]....something to do with their asylum claim...” (Participant-14 GP)

Limited knowledge also exists amongst the GP practice staff in regards to other agencies which asylum seekers and refugee patients can access:

“I [am unsure of] what specific services may be available for us to refer into or to signpost patients towards in terms of non-NHS support organisations but also what may be available on the NHS..... there is no use having lots of services in place if the people at the front line don’t know about it.” (Participant-3 GP)

Many GPs end up investigating and finding out about such resources on their own, in order to aid their own clinical practice and that of their colleagues within the Medical Practice.

“One of our GPs, she went on a study day [on asylum seekers] and came back with [information]. She made herself an A4 sheet of resources and various other services that are available for our asylum
seeker patients. It was very useful. We’ve not had anything like that from the health board that I can remember...” (Participant-14 GP)

Certainly this is an example of being proactive and adapting to the task demands placed upon them. However, not all practices have taken such steps and end up struggling along trying to cope.

That individual professionals are important in muddling through all this complex regulatory context is further suggested by the fact that one practice manager was actually aware of many services available: “We do have a list [of services and agencies] that we can signpost them to. There are lots of agencies.” (Participant-8 PM)

Lack of interagency communication will be a limiting factor in terms of organisations helping and cooperating with each other during times of crises. If the organisations do not know of each other and do not have trusted established relationships and networks before any crisis strikes, then coming together during or after a crisis will be more difficult.

6.1.3. Clinical challenges

Many Doctors and Practice Nurses mention the additional clinical challenge that asylum seekers present to their day-to-day work. This is partly due to the different conditions they may present with. The asylum seekers will also have a different cultural and religious background, which will influence their health beliefs and consequently modes of presentation.

“[Asylum seekers] are difficult patients because of language barriers, their health beliefs are often very different to what we may have, [and] often a lot of asylum seekers or refugees have got mental health issues ... and, again, we as a practice have no specific extra funding to help cope with that.” (Participant-14 GP)

Torture and being the victims of war-crimes was also something that many GPs had to deal with and manage:

“Often asylum seekers that I’ve come across will have been victims of some sort of torture or beatings .... I don’t really have any particular expertise in assessing injuries and historical injuries and.... [the] kind of forensic type work that can be required. That’s something that I don’t feel very confident on.” (Participant-3 GP)

Dealing with such issues are complex enough on their own, but with the language barrier and the inhibiting factor of the interpreter being present, everything is all the more made more taxing and more time-consuming. Exploring psychological symptoms can be problematic as it is difficult for patients to discuss personal issues such as depression and anxiety via an interpreter. A few GPs mentioned that many asylum seekers will have relatives in their country of origin and this separation will be a source of anxiety. Moreover, some patients will be waiting on their asylum seeker application and if this fails, often their mental health worsens considerably as a result.

A few GPs mentioned concerns about their lack of knowledge about some of the clinical conditions asylum seekers may present. They may have conditions that are common in their country of origin but not so in the local West of Scotland population. This will add to the task demands placed upon GPs.
“I think there is always a fear of, you miss something. With the sickle cell and thalassaemia [patient] groups ... there is lots of new pathologies that we would never see. If there were any tropical diseases you don’t [know]... our experience with them is practically zero.” (Participant-10 GP)

“We now see a lot of people with skin that is not Caucasian ... All our Dermatology [training] is to do with Caucasian skin. So we find that any African, Middle Eastern, South Asian skin, the Dermatology is particularly difficult, because it is a whole different new book of conditions that you hardly ever see, [and] that you don’t see examples of.” (Participant-10 GP)

It is important that GPs can identify any learning needs they have and use this to develop a personal development plan, to improve their ability and capacity to deal with asylum seeker patients. Of course the majority of asylum seeker patients will present with “common” problems which would be typical of patients in the West of Scotland. Some GPs mentioned that many asylum seekers will have pre-existing medical conditions, but because of lack of treatment in their home countries, this will have been neglected and consequently they present with relatively advanced disease.

6.1.4. Wellbeing of general practice staff

Another important element of dealing with the influx of asylum seekers in the geographical area of this study’s interest in the UK is the level of support available to General Practice Staff to ensure that they themselves have adequate health and psychological support to deal with the significant demands of both business as usual in General Practice and the sudden surge of refugee and asylum seeking patients. Healthy, well supported employees are crucial in building a resilient organisation with capacity for change and taking on new challenges.

“I think the big majority of [asylum seekers] have been severely traumatised .... I understood their trauma and the type of torture that they had- but we were not prepared for that. .... there should be some sort of psychological support in that respect for GPs... it is very very demoralising to think that fellow man can do that to other people. That is...that was traumatic, for me it was traumatic to hear, and some of the things- the patient told me once- but I wouldn’t actually bring it up again for them- it was just horrific. That was one thing that we weren’t prepared for, that we weren’t trained for and I don’t think we got any sort of counselling for that” (Participant-6 GP)

Other GPs mentioned similar issues, stating that working with asylum seekers can be emotionally draining and stressful. Consequently, it is important that all staff, but particularly clinical staff, are supported and given adequate resources to prevent “burnout”. All interviewees, however, mentioned that at the same time, working with asylum seekers was very rewarding.

6.2. The impact of tightness of tightly coupled operations in primary care
When asked if General Practice was coping with their day-to-day general workload including the extra task demands placed upon them by asylum seeker patients, almost all respondents stated that they were struggling, being at either full capacity or over capacity.

“We all [try] our very best to cope, but the challenge is unprecedented, in terms of the scale of the problem and also the total number of asylum seekers and the time scales in which the inflow of all these asylum seekers come. Well, I mean it’s a bit of a humanity crisis, so that has difficulties. It is unprecedented.” (Participant-2 GP)

This shows the vulnerability of General Practice and an apparent sense that the crisis was unforeseeable. As such, the perception is that the systems was not built for such patient volumes and for such complexity of need. Nonetheless, practices are adapting and trying to cope:

“I think it’s always “firefighting”..... we’re using multiple appointments to try and get through, ... The patients themselves often have multiple issues which have not been dealt with previously wherever they have been. And so you’re trying to deal with lots of issues in one consultation.” (Participant-14 GP)

“Well, like everything in General Practice, I think we are just trudging along, teetering on the brink. If we had a sudden influx [of asylum seekers], we would need increased capacity to cope with that.” (Participant-23 GP)

These quotes illustrate that GPs know they are running at over capacity, but they are displaying resilience and are working with commitment and dedication to help manage the task demands placed upon them. Many GPs mentioned that they have a sense of fulfilment and duty towards providing a good service to their patients.

6.3. Current Organisational Capacity

Although the term ‘organisational capacity’ was used frequently by our research participants, they found it difficult to define it. However, most interviewees knew they were over-capacity but had not previously considered how exactly to define organisational capacity. Most respondents were aware of how many patients they had registered with their practice, and while this gives a rough indicator of what demand is likely to be, it does not define their capacity in terms of being able to provide an adequate efficient level of service.

“I think that there is probably some thinking that does go on [about capacity]. In my current job as a salaried GP,... there is obviously a practice manager and there are two partners....I think it is something that everybody does think about... whether anyone has a precise grip on it or not, I think that varies.” (Participant-3 GP)

“My view just now would be that probably there isn’t anything fairly robust around assessing the demand and capacity, because we have quite crude indicators like populations wise and numbers of GPs” (Particpant-4 SE)
This illustrates that many practices do not seem to be adequately engaged with the idea of organisational capacity. By virtue of their profession, most GPs will want to help their patients, and will accept demands as they are made, demonstrating resilience and determination to deliver a good service. Arriving at an exact figure of how many extra patients one practice can cope with is difficult as each patient is different and can place varying demands on the GP Service.

The notion of organisation capacity seems to be a concept that is not defined in facts and figures, but more in levels of flexibility and agility of the General Practice team:

“I think the Practice is.... I can’t give a direct answer I’m afraid...... Maybe it is a fact that maybe we can’t [take on extra patients] but we would [anyway] because we just “get on with it” and I think in General Practice, we are quite stoic as a profession and organisation.... It’s a case of “bring it on”.... Would it dilute our service though? I don’t know. I’d like to think not, but I think we would just tire ourselves out even more.” [Participant-1 PM]

In terms of organisation capacity in the broader sense, it seems that many practices do not see organisational capacity as a limiting factor dictating how much they can or cannot deal with. Instead, it seems to be an arbitrary malleable concept.

One of the practices that had been caring for asylum seekers for many years had a better grasp on organisational capacity and meeting demand:

“Somewhere along the line in [the past 15 years], I think we took our eye off the ball,....this caused a major problem, with lack of space, and crowding in the waiting area, and it was for that reason we had to put on another £200,000 extension and going upstairs and kit out other rooms.... we had to expand it to cope with what we have and what we might have in the future. “ (Participant-6 GP)

Here is clearly an example of the organisation adapting to responding to their environmental task demands. This certainly shows organisational resilience, from both being to restore themselves to a normal pre-crisis level of functioning yet also improving their capabilities to create new opportunities and thrive in the post-crisis world. In this case, however, the desire to increase organisational capacity was followed by funding via the Health board.

Most interviewees stated that they did not have specific plans in place to deal with crises, but rather they would deal with these as and when they arose. Within the context of the ongoing refugee crisis, most had not considered the possibility of having to deal with an extra influx of asylum seeker patients within their locality.

“If there’s an increase [in asylum seekers], then we’ll just have to go with it, basically..... Of course, you do your best and if we can’t cope we’ll just have to point them to maybe another practice that can [take them on]” (Participant-8 PM)

One of the GPs replied somewhat hesitantly, perhaps indicating that this was something that had not been given much thought, either at an individual or practice level.

“Ohm, even.... at present... I would sort of say we are.... The supply and demand ratio is at a critical point. If we had a huge influx [of
asylum seekers] that would make a big difference…. Because of double appointments, language barriers, extra work for staff,... so it would be very difficult. “ (Participant-14 GP)

This lack of crisis preparedness perhaps reflects the fact that a healthcare organisation, the practices and their doctors feel they have a duty of care to their patients, no matter what the scenario is. Mirroring this, a few GPs mentioned that sudden problems and crises are part and parcel of Medicine as a profession. Accordingly, if crises arose affecting General Practice, then the practice would be able to rise to the challenge. However, there was no mention of specific crises plans drawn up to deal with different scenarios.

“I think when push comes to shove, in Medicine, we are accustomed to it. You know [in crises] the adrenaline flows and you kick up a gear; you’ve done that in Casualty and Emergencies, you’ve done that here when a child comes in with an asthmatic attack, or when somebody has chest pain, you know. You forget everything else and you deal with that. So I think we are [prepared], in that respect, if it is an immediate thing, yeah we can do. ….I think as doctors we just sort of tend to accept it, that is it, I mean that goes with the job,...” (Participant-6 GP)

Dealing with medical crises affecting patients, then, seems to affect the doctor’s attitude in dealing with organisational and management crises. Again, underlying this is the element of duty of care to the patient. One GP mentioned that no matter what the workload, they would somehow manage.

“It is difficult to know..... all the GPs are there beyond their standard hours or working from home. So, it does feel as though we are close to the limit of our capacity but......, there is this thing that however close we seem to be to the limit to our capacity, things always seem to sort themselves out somehow.....We always seem to cope even when things appear to be insanely busy at times. You know, somehow you get through it, so, I don’t know I think it is a very difficult thing to know. (Participant-3 GP)

The last quote in particular highlights the point that there is perhaps an overall lack of awareness and perhaps even indifference towards crisis preparedness (from a non-clinical administrative process point of view). Certainly the doctors and nurses will know how to manage medical crises (eg cardiac arrest). A few GPs did mention general steps they would be able to implement if there was a sudden general medical crisis (e.g. an infectious disease outbreak), but no specific plans had been drawn up for dealing with extra refugee patients wanting to register at their practice.

“We do try to look at other ways of dealing with people. So for example the Nurses will sometimes try and see minor illnesses [patients]. We try and be very clear with the staff about who does or doesn’t need an appointment. If things can be dealt with by say the Health Care Assistant... We try and direct people and signpost people to other services. Ehm, So that’s the other way we try to reduce demand, by signposting people and trying to get people to see the right [Healthcare Professional] at the right time. “ (Participant-14 GP)
6.4. Impact of crisis on organisational capacity: the test for organisational resilience

When asked the broader question if crisis preparedness shapes organisational capacity, most interviewees said that crises are dealt with as and when they arise. They had not really considered shaping their organisation capacity according to how they would respond to crises. Often simply keeping the practice running on a day-to-day basis was in itself a significant undertaking.

“We’ve not really thought about that. If people need help you just help them. We don’t really...worry about coping. Can we cope or not cope....We just get on with it really.” (Participant-8 PM)

“I know we do step back and think, “If this happens, what will we do”. But sometimes in those situations it’s [just a case of] if it happens, you’ll seek help at that point, because by the time you’ve read all this information and then months later when something happens, everything has completely changed or you’ve forgotten it all because it’s somewhere in the ether. You have to practical in General Practice.” (Participant-14 GP)

In a world where the pace of change is alert, it is understandable that information easily gets out of date. Hence, old protocols and crisis management plans also become outdated. However, the ideal solution to this would be to constantly revise one’s crisis preparedness, but in a setting where time is so limited, this will be difficult. One GP mentioned that in the event of a crisis, the Health board would have to direct the General Practices and give guidance. The notion of each practice independently developing their own crisis preparation plans was considered inefficient.

“The government has to take the lead and this then filters down to the local health board and they in turn give directions to the local practices.... It is difficult to know what to do in isolation.... There were strategies whereby practices were to join together if there was a major epidemic to help each other and share patient care.... It is in the interest of the health board and the GP to talk to each other if there are problems” Participant 16-GP

This shows that some GPs value the support and direction from the health board, and perhaps feel that to manage large crises requires collaborative efforts rather than solitary efforts. One practice did how clear evidence of crisis preparedness shaping their organisation capacity:

“Well, as you know, we did [build an extension] and the reason for that is we got more consulting rooms so that was, in part, to do with the asylum seekers because we needed extra rooms. We have got a healthcare assistants which we didn’t have a couple of years ago so that was supposed to help with the new patient medicals for asylum seekers” (Participant-8 PM)

Another practice manager explained:

“All practice has to have a Business Continuity Plan in accordance to health board Guidelines. We are no different to that....From a staffing point of view, we are interlinked with [another] practice
down the road, and so if we are ever caught short we can help each other out.” [Participant-1 PM]

This does show evidence of developing a collaborative approach, developing networks and relationships to help with crisis management efforts.

7. Conclusion

Crises management is an important function of public service design and therefore, of government work at all levels. Where crises are transboundary, they become complex, ‘wicked’ issues for policy makers and public service designers in the UK and elsewhere. Response to such complexity can understandably be delayed to accommodate an understanding of the issues unravelling. What our data revealed is what happens in public service operations while policy-makers inevitably take the time to develop such understanding.

There was little crisis preparedness for the refugee crisis which led to any increased organisational capacity in primary care in the area examined in our study. This is curious, given that the refugee crisis is hardly a case of a Black Swan event. Indeed, before the crisis came to affect any part of the UK and therefore Scotland, it affected Europe as a whole and often in the most severe and visible of ways. Yet when asylum seekers reached Scotland organisational capacity for this patient influx appeared to be zero at best. But there was some organisational resilience capacity of a ‘contextual’ nature, in Legnick-Hall’s and Beck’s (2005) understanding: non-clinical coping mechanisms developed in a bottom-up fashion by doctors and nurses to support their work while muddling through the challenges raised by a high influx of patients with multiple affections and significant language and cultural barriers. It is these coping mechanisms which we have found most interesting and we have focused our analysis on.

This contextual resilience in primary care is good news to patients, practice managers and policy-makers. The fact that health professionals have their patients’ best interest at heart and are used to ‘kick up a gear’ through intensive training and professional socialisation is particularly good news to sociologists of professions with faith in the elite profession of medicine. To most of us, the idea of the unsung heroes of our health service system, always ready to bend backwards despite organisational constraints and, indeed, capacity, is inspiring and reassuring. However, stretching to bridge over organisational and inter-organisational gaps poses concerns for staff wellbeing, de-professionalization and undue emotional labour. These come with serious implications for the future of the medical profession, perhaps exacerbated in political environments where cost-cutting is an important policy drive. Scholars interested in public service co-production have already lamented the use of such techniques as cost-cutting mechanisms and, where professionals as patients’ custodians ‘co-produce’ the service with managers and policy-makers by simply filling in the gaps, this can be seen as a clear incentive for those gaps to stay unfilled.

Implications of our study for policy-makers include support for service design by omission whereas for professionalism in public service there are concerns around de-skilling and emotional labour in crisis situations. Notwithstanding the usual limitations of case study research designs, the study contributes to the limited literature on crisis management in the public sector by highlighting the role of front-line professionals in contextual resilience when other forms of organisational resilience capacity are lacking. Then, the paper also contributes to the debates around co-production in the
public sector service excellence by opening the way for future research to investigate service co-production when traditional service production is compromised by enhanced uncertainty in the wake of crises and where frontline professionals act as custodians for service users.

References


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# Annex: Research Study Participant Information

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