

BMJ Open Beliefs and challenges held by medical staff about providing emergency care to migrants: an international systematic review and translation of findings to the UK context

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ABSTRACT

Objective Migration has increased globally. Emergency departments (EDs) may be the first and only contact some migrants have with healthcare. Emergency care providers' (ECPs) views concerning migrant patients were examined to identify potential health disparities and enable recommendations for ED policy and practice.

Design Systematic review and meta-synthesis of published findings from qualitative studies.

Data sources Electronic databases (Ovid Medline, Embase (via Ovid), PsycINFO (via OVID), CINAHL, Web of Science and PubMed), specialist websites and journals were searched.

Eligibility criteria Studies employing qualitative methods published in English.

Settings EDs in high-income countries.

Participants ECPs included doctors, nurses and paramedics.

Topic of enquiry Staff views on migrant care in ED settings.

Data extraction and synthesis Data that fit the overarching themes of 'beliefs' and 'challenges' were extracted and coded into an evolving framework. Lines of argument were drawn from the main themes identified in order to infer implications for UK policy and practice.

Results Eleven qualitative studies from Europe and the USA were included. Three analytical themes were found: challenges in cultural competence; weak system organisation that did not sufficiently support emergency care delivery; and ethical dilemmas over decisions on the rationing of healthcare and reporting of undocumented migrants.

Conclusion ECPs made cultural and organisational adjustments for migrant patients, however, willingness was dependent on the individual's clinical autonomy. ECPs did not allow legal status to obstruct delivery of emergency care to migrant patients. Reported decisions to inform the authorities were mixed; potentially leading to uncertainty of outcome for undocumented migrants and deterring those in need of healthcare from seeking treatment. If a charging policy for emergency care in the UK was introduced, it is possible that ECPs would resist this through fears of widening healthcare disparities. Further recommendations for service delivery involve training and organisational support.

Strengths and limitations of this study

- This review performed a thematic meta-synthesis of qualitative studies to enable a deeper understanding and exploration of emergency care providers (ECPs) beliefs and challenges surrounding the provision of care to migrants.
- All studies reached theoretical saturation.
- If the study results did not separate out ECPs responses from other healthcare professionals, they were excluded, potentially missing key data.

INTRODUCTION

International context

International migration is at its highest ever level and increasing, with the 2017 estimate at 3.4% (258 million people) of the global population, a 49% increase since 2000.¹ The UK experienced significant migration during the 1970s after joining the European Union (EU) and between 1993 and 2015, the foreign-born population more than doubled from 3.8 to 8.7 million (7%–13.5%) with a peak net increase of 336 000 in 2015 during the European migration crisis. The UK immigration figures currently sit among the top five countries in the world.¹ While most migration occurs legally, there were an estimated 533 000 undocumented migrants (UMs) in the UK in 2007.^{2 3}

Definitions

There is no apparent consensus on the definition of a migrant which makes drawing scientific conclusions based on the data challenging.⁴ For this review, the terminology in [table 1](#) was used to ensure clarity and consistency.

Migrant health as a public health concern

The majority of migrant populations are healthy when they arrive, however, a number,

Table 1 Migrant terminology

First-generation migrant	Foreign-born resident who has become a citizen or permanent resident in a new country.
Second-generation migrant	Naturally born to one or more parents who were born elsewhere.
Asylum seeker	A person who has left their country of origin and formally applied for asylum in another country but whose application for refugee status has not yet been concluded.
Refugee	The asylum seeker has their claim for asylum accepted by the government.
Undocumented migrant	Foreign-born person with no legal right to stay in the host country. These include: persons who have entered illegally, failed asylum seekers, overstayers (migrants who remain in the host country after their resident permit or visa has been revoked or expired), undocumented by birth (born into a family who have no legal right to stay).

particularly, refugees, asylum seekers and UMs suffer a disproportionate burden of morbidity.⁵ Providing effective healthcare for migrants is of key public health importance, not only for treating the individual, but also in reducing the spread of communicable disease and the impact of future non-communicable diseases on the economy.

The key role of emergency departments in migrant healthcare

The UK National Health Service (NHS) emergency services play a key role in the nation's public health as the first and only contact some migrants may have with the health system. However, emergency departments (EDs) are overstretched with yearly increases in patient presentations. The '4-hour target', a proxy measurement of system effectiveness has not been met since 2015. Some UK politicians have quoted migrants as a causative factor,⁶ which has fed a media debate about eligibility for care. A recent systematic review has demonstrated that in Europe, migrants use EDs more than the native population, often for lower acuity presentations.⁷ Most migrants, however, comprise a healthy labour force, and make a positive overall contribution to the exchequer.

The issue of charging non-British citizens for emergency care

In an effort to recover costs to the NHS, charging non-British citizens for secondary healthcare is the current practice, as per the 2016 Immigration Act. Extension of this into emergency care has been proposed, challenging the NHS's three core principles that it should meet the needs of everyone, it should be free at the point of delivery and it should be based on clinical need, not on the ability to pay.⁸ Healthcare advocacy groups have warned about the potential impact on the most marginalised populations.^{9 10} In this climate of the pressurised ED where migrants are portrayed as a burden, and the identification of paying 'customers' and UMs is expected, ED providers' views towards migrant patients could point to whether health disparities exist, as in the way patients are handled or dealt with.

Staff attitudes and cultural competencies

There are no qualitative studies examining the emergency care provider (ECP) perspective of providing emergency care to migrants in the UK. In Denmark, two surveys based in the ED found that less satisfaction was expressed

by healthcare professionals (HCPs) when patients were non-Western, and when the visit was felt to be less relevant.¹¹ Most of participants knowledge on migrants came via the media.¹² Other studies identified challenges surrounding language and cultural differences, time constraints, lack of awareness by healthcare staff of what health services were available to the migrant—especially UMs—and lack of healthcare connectivity.¹³ Although some HCPs have expressed desirability for cultural competence, some felt it was the responsibility of migrants to adapt to the local context.^{14–16} 'Cultural competence' has been defined as, 'an overall ethos of awareness and openness towards diversity,' as opposed to assumptions concerning the values or behaviour of particular groups.¹⁴

Study aims and objectives

The primary objective of the study was to synthesise findings concerning ECPs beliefs and challenges for providing healthcare to migrants as found in reports of research studies based in high-income settings. The notions 'beliefs' and 'challenges' were based on the results of pilot searches which suggested these meta-themes as a good way of organising the extant literature. 'Beliefs' is here shorthand for staff views and opinions in relation to the perceived presentation, motivations and behaviour of migrants (according to the definition presented above) in EDs. What do migrants need? What is the clinical presentation? How do they conduct themselves? 'Challenges' relates more to the staff or institutional response, or the 'fit' (or lack of it) between system or cultural expectations and migrant behaviour. Pertinent issues would include language translation, and presence of relevant identity documents (as required by individual services).

A secondary aim was to relate the findings to current NHS policy and practice. The issue of charging patients in ED, a current UK policy proposition, was to emerge as an underlying consideration in the extracted findings from the studies. In a process, the authors have labelled 'translation', the study findings were, therefore, reflected against these current proposals in order to imagine the potential consequences of charging migrants for ED care in the UK or other high-income country contexts.

Table 2 Inclusion and exclusion criteria

Inclusion criteria	Exclusion criteria
Studies published from any time point	
English language	Non-English language
Primary qualitative studies using qualitative methods of data collection and analysis, including semistructured interview studies, focus groups, ethnographies and participant observation	Non-qualitative studies for example, surveys and questionnaires, quantitative Systematic reviews
High-income setting	Low and middle-income settings
Emergency care provider=nurse, doctor, paramedic, healthcare assistant	Other secondary healthcare providers seeing emergency patients for example, doctors assessing acute stroke or orthopaedic surgeons assessing fractures, even if in the ED. Primary healthcare providers
Based in the emergency department (ED) or 'prehospital emergency' field	Out of the ED or prehospital environment, for example, cardiologists performing PCIs in a catheter laboratory, primary care, outpatients, hospital wards

PCI, Percutaneous Coronary Intervention.

METHODS

A systematic review of studies of ECPs attitudes to migrant care in high-income country settings was undertaken. Qualitative meta-synthesis was used as an organising and analytical frame for findings extracted from included studies. Qualitative studies were selected from high-income settings such as (Western) Europe, North America and Australasia to facilitate potential generalizability to the UK. The specific inclusion and exclusion criteria are shown in [table 2](#).

Information sources

The search for relevant texts involved databases, websites, conference proceedings, abstracts, policy documents and book chapters.¹⁷ The bibliographic databases searched were: Ovid Medline, Embase, PsycINFO; CiNahl, Web of science, PubMed, Trip database and Google scholar. The Websites of WHO, The Migration Observatory, the International Organisation for Migration, the Department of Health and Social Care (DHSC) (UK), Public Health England and Doctors of the World (DoW) were searched, along with the emergency medicine specific websites: Life In the Fast Lane and Royal College of Emergency Medicine (RCEM) learning.

Backward and forward searching through the references lists and the citations for all eligible papers was undertaken to identify any further studies. A handsearch through the three highest impact emergency care journals: the UK Emergency Medicine Journal, the European Journal of Emergency Medicine and the Journal of Emergency nursing, was conducted as well as a search for unpublished grey literature.

The primary searches were performed between 1 February 2018 and 31 March 2018. The bibliographic database searches were rerun during the article submission process to find additional relevant material. In this manner, Ovid Medline, Embase (via Ovid), PsycINFO (via OVID), CINAHL, Web of Science, PubMed, Trip Database and Google Scholar were all searched again (using

the original searches) on 16 March 2019 and no additional studies were found.

Search

Key databases were searched using a refined range of keywords and terms individually and then in combination using Boolean operators 'AND/OR' to ensure searches were sensitive and specific.^{18 19} Although specifically looking for beliefs and challenges, broader search terms were used. An example of the Medline search is shown in [table 3](#) (further search terms in online supplementary appendix 1).

Study selection process

Two reviewers (H-LH, GD-W) independently scanned titles. If relevant, abstracts were then screened against the inclusion criteria. Full texts were obtained for the screened list of abstracts to further assess eligibility. Both authors assessed their inclusion for reliability. Several articles were reported under the umbrella of 'Best Practice in Health Care Services for Immigrants in Europe (EUGATE)' ([table 4](#)). These were treated as different studies as they employed different participant subsets and analytical sampling frames.

Table 3 Medline search

Database	Ovid (1946 onwards) Medline
Search terms	Exp emergency service, hospital/or exp emergency medical services/or emergency care provider or exp emergency medicine/or exp emergency nursing/or exp emergency nurse AND Exp emigrants and immigrants/or exp transients and migrants/or exp refugees/or exp undocumented immigrants/or asylum seeker/or displaced person
Results	436

Table 4 Study characteristics

Citation	Topic	Participants	Migrant definition used	Methods	Critical Appraisal Skills Programme	
					score (/10)	Key themes or findings
Ozols and Hjälm, 2003 Sweden ³³	Nurses' experiences of problematic situations with migrants in emergency care in Sweden.	49 nurses: emergency, anaesthetic, ICU, theatres.	Assumed migrant.	Explorative using questionnaire asking for written 'thick descriptions' Naturalistic paradigm—to develop theory.	5	9 themes: (1) Behaviour (2) Language (3) Relatives (4) Reliance on authority (5) Organisational factors (6) Gender (7) Threatening situations (8) Previous experiences of violence (9) Natural remedies.
Hultsjö and Hjälm, 2005 Sweden ³⁴	Immigrants in emergency care: Swedish healthcare staff's experiences.	35 nurses: 12 emergency ward, 12 ambulance service, 11 psychiatric ward.	Migrants—born outside Sweden.	Explorative, semistructured focus group Krueger and Casey analysis.	8	9 themes: (1) Asylum seeking refugees, (2) Cultural behaviours (3) Relatives (4) Gender (5) Organisational factors (6) Language (7) Perceived threatening situations (8) Earlier experiences of migration (9) Reliance on Health Care staff.
Jones, 2008 USA ²⁴	Emergency nurses caring experiences with Mexican-American patients.	5 Emergency nurses.	Mexican heritage regardless of citizenship status. 1st or 2nd generation.	Interviews with open ended questions Culture care theory.	9	Key themes were: language barrier, Continuity of care and limited cultural knowledge.
Terraza-Núñez <i>et al</i> , 2010 Spain ²⁵	Health professional perceptions regarding healthcare provision to immigrants in Catalonia.	49 professionals and managers: primary and secondary care. 7 ER doctors—demographics unclear. Immigrants—Bolivia, China, Morocco, Romania, Gambia.		Semistructured interviews and focus groups. Narrative content analysis.	7	Providing healthcare caused distress, overload and exhaustion. Problems: Communication, specific immigrant characteristics, inappropriate use of services, HCP attitudes, organisational, structural deficiencies.
Priebe <i>et al</i> , 2011 Europe (Best Practice in Health Care Services for Immigrants in Europe (EUGATE) study) ²⁶	Good practice in healthcare for migrants: views and experiences of care professionals in 16 European countries.	240 healthcare professionals (HCPs). From each country 3 emergency care providers (ECPs) (48), 6 general practitioners (GPs) (144), 3 mental health HCP (48).	First-generation migrants. Persons born outside the country of current residence aged 18–65 years.	Structured Interviews—open questions Thematic content analysis.	9	8 problems: Language, difficulty arranging care, social deprivation, traumatic experience, lack of familiarity with healthcare system, cultural diff, understanding of illness and treatment, negative attitudes among staff/patients, lack of access to medical history.
						HCP in different services experience similar difficulties and similar views on good practice. Implementing good practice needs resources, organisation, training and positive attitudes.

Continued

Table 4 Continued

Citation	Topic	Participants	Migrant definition used	Methods	Critical Appraisal Skills Programme score (/10)	Key themes or findings	Implications
Priebe <i>et al</i> , 2011 Europe (EUGATE study) ²⁷	Good practice in emergency care: views from practitioners.	48 ECPs, 3 ECPs from each of 16 countries.	First-generation migrants. Persons born outside the country of current residence aged 18–65 years.	Structured Interviews—open questions Thematic content analysis.	9	Key themes: language, cultural factors, treatment expectations and system understanding, access, staff–patient relationships, resources, migration stressors, access to medical history.	To improve care need all of translator services, cultural training, guidelines, organisational support.
Jensen <i>et al</i> , 2011 Denmark (EUGATE study) ²⁸	Providing medical care for undocumented migrants (UMs) in Denmark: what are the challenges for health professionals.	12 HCPs: 3 ER physicians, 9 GPs; 3 managers psychiatric unit.	UMs—without a valid residency permit.	Structured Interviews—open questions Qualitative content analysis—Graneheim and Lundmann.	9	Emergency medicine care no different from treatment of another person. Complicated by lack of medical records and contact person.	Lack of guidance means HCP are unsure how to deal with UMs thus leaving it to the individual's decision.
Biswas <i>et al</i> , 2011 Denmark ²⁹	Access to healthcare and alternative health-seeking strategies among UMs in Denmark.	8 ECPs: 3 head nurses, 4 nurses. 10 UMs.	UMs	Semistructured interviews and observations Malteruds principle for systematic text condensation.	10	Willingness to treat despite migratory status. Challenges: language, barriers, false identification, insecurities about correct standard procedures, not always being able to provide appropriate care.	Need for policies and guidelines to ensure access for UMs and clarity to HCP.
Dauvin <i>et al</i> , 2012 Europe (EUGATE study) ³⁰	Healthcare for irregular migrants: pragmatism across Europe. A qualitative study.	240 HCPs. From each country: 3 ECPs (48), 9 GPs (144), 3 mental health HCP (48).	UMs	Structured Interviews—open questions Thematic content analysis.	9	Key themes: access problems, communication, legal complications. ECP's reported less of a difference in care for undocumented versus documented migrants. Notifying authorities was uncommon.	Organisation, local flexibility and legislation might help improve care for UMs.
Gullberg and Wihlborg, 2014 Sweden ³¹	Nurses' experiences of encountering UMs in Swedish emergency healthcare.	16 nurses: 5 ECPs, 5 emergency psych, 2 delivery, 2 primary healthcare, 2 non-governmental organisation.	UMs	12 semistructured open-ended interviews Phenomenographic.	9	Key themes: (1) Nurses confused by migrant status and social existence. (2) Conflicts in encounters—identification system, judgments and emotional reactions (3) Shifts within and between arbitrary boundaries—unclear conditions for interaction, creative manoeuvring.	Guidelines, structural support and increased training for nurses requested.
Kietzmann <i>et al</i> , 2015 Germany ³²	Migrants' and professionals' views on culturally sensitive prehospital emergency care.	41 migrants, 02 HCP - 15 ECPs in executive positions, 3 psychologists, 2 medical ethics.	Migrants	Semistructured individual interviews Qualitative content analysis by Mayring.	7	6 categories from the ECPs: importance of basic cultural knowledge, awareness, attitude, empathy, ambiguity tolerance, communication skills.	8 recommendations: reflecting on self, sharing cultural knowledge, improve basic social competencies, communication skills, interpreters, transparency.

ICU, Intensive Care Unit; ER, Emergency Room.

Data extraction process

Study data were collected and tabulated in an Excel spreadsheet. Where studies included other populations, such as general practitioners, only results clearly pertaining to ECPs were extracted. Following a pilot phase, data were extracted by H-LH.

To facilitate the systematic synthesis of results, all extracted data were inputted into an Excel spreadsheet under two columns: 'beliefs' and 'challenges'. Papers were read line by line, relevant lines were extracted and entered under the headings and coded into themes, akin to framework analysis in primary qualitative research.²⁰ Subsequent studies were coded into pre-existing concepts and new ones were formed when possible. The papers were reread several times to ensure all data was extracted and codes were revised if new information was found that required a modification. The findings from this iterative process were discussed between both authors on a periodic basis in order to refine the coding schema and conceptual understanding of the themes.

Quality appraisal

All studies were subject to quality assessment scoring as per the qualitative Oxford Critical Appraisal Skills Programme (CASP) assessment tool of ten questions. Only studies that answered 'yes' to the first two screening questions were included.²¹ Although a total CASP score out of ten was given for each study (see [table 4](#)), due to the nature of qualitative research the scores were not used to weight the papers. Papers were assessed according to ability to answer the research question.¹⁸

Synthesis of results

Codes were grouped inductively into cross-cutting themes to enable deeper interpretation of what the beliefs and challenges were. A meta-synthesis was conducted by aggregating and summarising the studies in order to produce themes that could introduce larger interpretations into how the beliefs and challenges could affect emergency care provision in the high-income country context.²² Drawing on this synthesis, a translation to the UK NHS context, with reference to other literature, law and policy was undertaken.

Patient and public involvement

Patients and the public were not involved in this review.

RESULTS

A total of 4185 studies were found of which 11 were deemed relevant and included. The Preferred Reporting Items for Systematic Reviews and Meta-Analyses flow diagram ([figure 1](#)) demonstrates the search process with reasons for study exclusion.²³

Study characteristics

Eleven qualitative studies, published between 2003 and 2015, were included: one from the USA and the remainder

from Western European countries. Four studies came from the EU-funded EUGATE study group [table 4](#).

Risk of bias

First and second-generation migrants were studied, however, as how ECPs identified them as such was unclear, the risk of stereotyping was evident. Only 8 of the 11 studies detailed the decision behind choice of population, stating the reasons as migrant load and ECP exposure to migrants.²⁴⁻³¹ Populations of high migrant contact may demonstrate more compassionate behaviour than areas of less contact or, be able to self-regulate whether an experience is specific to a migrant. Conversely high burden areas may feel under higher pressure, with limited resources and feel more negatively towards migrants. Only three papers commented on the origin and ethnicity of the ECP.^{24 31 32} It should be acknowledged that an ECP from a migrant background might respond more favourably towards a migrant patient as compared with a non-migrant ECP. One study³³ used an explorative questionnaire with open-ended questions, enabling thick descriptions but missing opportunity to clarify points, which the remaining studies using interviews benefited from. However, these risked response bias, such as through not admitting the denial of care to an UM for risk of seeming socially undesirable.

Five studies asked about experiences caring for migrant patients, and five asked for specific problems migrants may pose, suggesting that immigrants are already problematised and perhaps leading to more negatively biased responses. Terraza-Núñez *et al's* study²⁵ was the only study to describe triangulation of results through comparing data from different sources and groups of informants. All qualitative studies by their nature risk recall bias and there was no mention of self-reflexivity in any of the papers, which could create interviewer bias. All studies reported that theoretical saturation was reached.

Most studies were undertaken in EU countries and this, together with the issues raised above, indicates that if the findings were easily synthesizable, there is fairly high confidence that they represent a valid picture of the perceptions of ED staff working in a Western European context.

Study quality

The explorative questionnaire study returned the lowest CASP score (see [table 4](#)), perhaps highlighting the hybridised nature of the method, although an open-ended questionnaire schedule might be considered 'qualitative' on a continuum. The findings were nevertheless found to fit with those from other studies and the article was not excluded. The remaining studies scored between 7 and 10 according to the CASP checklist. Typically, articles failed to discuss researcher-participant relations; although this is not unusual in applied research concerning health services. Overall, the reporting quality of the studies was high, with 7 of the 11 (63.63%) scoring 9, 10 or higher.

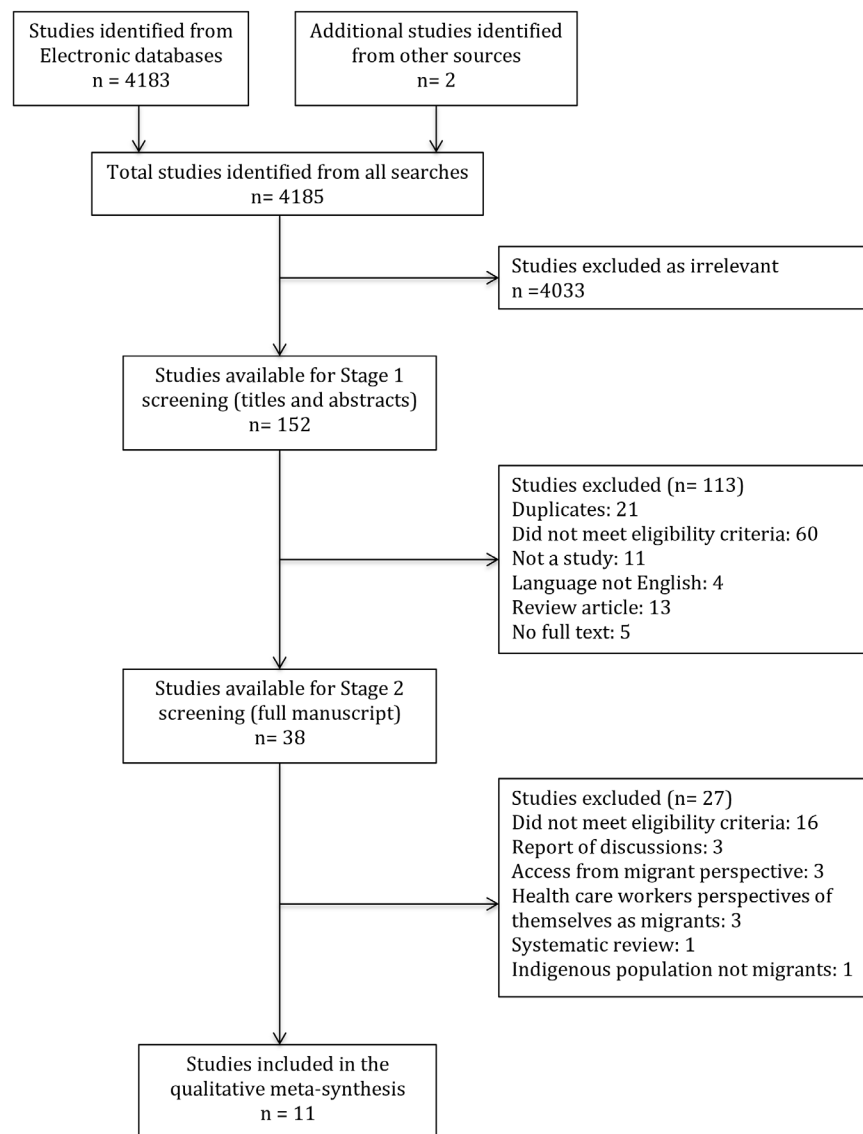


Figure 1 PRISMA diagram of included and excluded studies. PRISMA, Preferred Reporting Items for Systematic Reviews and Meta-Analyses.

Thematic synthesis results of the beliefs and challenges

Three overarching analytical themes were found: cultural competence, system organisation and ethical dilemmas. These are described below.

Cultural competence

On the basis of their experiences of treating migrant patients, difficulties were identified around potential clinical misunderstanding due to the social distances often involved. These issues coalesced around communication, (associated) problems in the clinical reading of patient behaviour and differing social expectations. The latter principally involving interpersonal gender dynamics and respect for medical authority. Staff felt this power imbalance and constructed stereotypes of migrants as they encountered the difficulties outlined below.

Language

Communication difficulties meant that some ECPs felt unable to make an assessment of severity of illness leading to over or under investigation and potential mismanagement.³⁴ For example, in one case it was unclear whether a patient was unconscious or just did not understand Swedish.³³ Struggling to articulate advice to the patient led to frustration on both sides.^{28 34} The use of relatives or close friends as interpreters was felt to be suboptimal.^{24 33 34} The use of professional interpreters was stated as good practice^{24 26 28 32–34} although accessing them 24 hours a day was difficult.²⁴

Behaviour

ECPs found certain migrant behaviours difficult to comprehend. For example, screaming during venesection³³ and staying silent following bereavement were

perceived as over and under reactions by ECPs.²⁴ This risked mismanagement, such as the case of a migrant suffering a cardiac event who was believed by the ECP to be over exaggerating to keep a single room.³³ Or the migrant who complained of chest pain believed to have had a heart attack, but was actually displaying an acute stress response to past events of torture and conflict.³⁴ Aggressive and problematic patient behaviour was noted by ECPs,³³ however, two studies also reported, negative attitudes and hostile behaviour by staff towards migrant patients.^{26 27}

Gender

The importance of migrant gender dynamics and need to find healthcare providers of the appropriate sex was respected by ECPs. However, ECPs found male migrants speaking for female patients uncomfortable, and, female ECPs found male migrants who lacked trust in their abilities, frustrating.^{30 33 34} Importantly, in an emergency, ECPs stated that delivering emergency care would take priority over finding an ECP of the required gender.²⁷

Respect for authority

Some Swedish emergency nurses perceived that migrants had less respect for them compared with for physicians, by questioning their competence and refusal of treatment.^{31 33 34} Conversely, nurses managing Hispanic patients in the USA²⁴ experienced only appreciation towards them. This is in line with Hispanic cultural ethos of *respeto*, towards authority and suggests that challenges are likely to be migrant specific, or related to the nature and culture of the host nation.²⁴ ECPs stated that ethnically diverse ECPs are beneficial to managing a migrant population.²⁶

Relatives

Large numbers of relatives created a disruptive environment and disagreements on care between the ECP and relatives, was occasionally described, creating a hindrance to optimal patient care.^{33 34} However, ECPs did acknowledge the importance of strong family links for gaining a collateral history and social support.^{24 26 27}

Stereotypes

ECPs often portrayed migrants, in particular UMs, as being of low socioeconomic status, perhaps struggling to integrate, engaged in misuse of drugs and alcohol, sex work or crime; reflecting their socially marginalised and stigmatised status.^{26 27 34} Some perceived UMs as a burden on society through not working or having a child to attempt to gain access to (in this case) Swedish citizenship. However, some ECPs were concerned at being portrayed as a racist by a migrant if their care seemed not to be fairly prioritised.³⁴ Interestingly, ECPs felt that migrants perceived them to be in positions of power, holding the autonomy to make decisions about their healthcare as well as their migration status (through access to documentation or conversely power to report to the authorities).^{26 31}

System organisation

The difficulties and stereotypes described above led ECPs to form explanations, not only for migrant health seeking behaviour and presentation, but also for the legal or organisational contributors to the perceived behaviour. The primary issues concern problematics related to the timely use of ED by migrants, seen as realistically the 'only option' for healthcare and the opacity of arrangements around an individual migrant's legal status and access to other health services.

Migrants use of the health system

ECPs constructed a view of migrants as having lower education and health knowledge, thereby lacking understanding of the host country's health system. They associated this with perceived suboptimal health behaviours. They were more likely to call an ambulance or attend ED frequently for non-acute medical problems.^{25 27 33 34} Other perceived migrant behaviours, such as late presentation, were seen to reflect social vulnerability and reduced primary care access.²⁸ Interestingly, negative media portrayal of migrants was also seen as a factor for migrants not wanting to appear troublesome by attending EDs.²⁶ ECPs recognised that for UMs, fear of being reported to the authorities delayed them from seeking healthcare^{24-26 29 31} and were frustrated that this delay sometimes led to deterioration of illness.²⁷ ECPs felt that certain health conditions were not disclosed, for fear of requiring referral to inaccessible services²⁹ and that often the ED is the only option for UMs to seek healthcare.²⁶

Organisational support for UMs

ECPs expressed uncertainty on providing emergency and ongoing care to UMs due to a lack of or unclear guidance for the circumstances of no residency status or insurance.^{25-28 31 33} Guidelines in existence were open to interpretation, leading to subjective management and potential for ECPs to exert 'power' in decision making.^{28 31} ECPs recognised this lack of consistency would lead to anxiety by UMs when accessing healthcare. UMs were often noted to not attend appointments for fear of being reported to the authorities.³¹ ECPs that attempted referral of UMs onto the welfare system found that the migrant was not adequately supported, which increased ECP disillusionment with the system.³³

Ethical dilemmas

Migrant patients were seen to impose ethical dilemmas on ECP staff in EDs. In common with views expressed above, it was universally accepted that the decision to provide care would always be taken without other considerations, although a decision to inform the authorities appeared to operate more on a case-by-case basis which took other factors into account. Other dilemmas surfaced around fair use of health resources in the context of underfunding and where some patients were perceived to be 'gaming' the system to assist with applications, for example, for refugee status.

Immigration status does not affect emergency care

ECPs claimed that immigration status would not affect their decision to provide emergency care.^{24 28–31} However, legal versus ethical and professional conflicts are experienced by ECPs on whether to inform the authorities about UMs. Some ECPs removed the decision from their role believing it was not their responsibility to decide,^{29 31} for example, one such attitude taken was ‘[I] don’t ask so [I] don’t have to make the decision’.²⁸ There were some situations where ECPs were more likely to inform the police, such as when they suspected a serious crime was involved or if the patient was a danger to themselves.^{27 28 30}

Health professionals as gatekeepers

ECPs recognised the increased resources, such as diagnostic tests and administrative time, required to manage non-resident migrant or UM patients.^{26–28 30 34} ECPs, therefore, felt compelled to consider the ethics of rationing the service. In some contexts, prepayment of the full fee was demanded in cash, in accordance with rules for foreigners.³¹ In others, health services, such as non-governmental organisations were used as an alternative provision of care.^{27 30} Many ECPs felt that more funding for this patient group would improve their ability to provide adequate patient care.²⁷

Gaming

Some ECPs perceived asylum seekers to feign illness and fake documentation in order to obtain medical certificates to support asylum and residency permit applications. Some ECPs felt this behaviour to be dangerous and foolish, however, many expressed helplessness at being unable to assist.^{31 33 34} Individual clinicians attempted to game the system using fake social security numbers, submitting laboratory samples in their own name and prescribing cheaper (or giving out free samples) of medicine.^{26–28 30}

DISCUSSION

This study set out to review and synthesise findings related to the perceived ‘beliefs and challenges’ of migrant care, as articulated by ECPs in findings of published, primary qualitative studies. Eleven studies published during 2003–2015 were included, although one (which was borderline according to both inclusion criteria and CASP score, see [table 4](#)) was only partly qualitative in that an open-ended questionnaire was used. The remainder were of high reporting quality and most were undertaken in Western European countries. The thematic synthesis of findings extracted from the primary studies found that they comprised three main themes: cultural competence, organisational contributors to the perceived problematics of migrant care and ethical dilemmas. The question of charging patients emerged as an issue which cut across several aspects of clinical management, although ECPs were adamant that in an emergency, giving treatment would always trump other considerations.

Limitations

Studies which included ECPs but did not separate out their responses from other health professionals were excluded, potentially missing valuable material. However, the authors argue that this focus strengthens the validity of the findings so far as ED workers in Western European contexts are concerned. This focus means it is also important to stress that the staff views expressed in the studies relate solely to users of EDs, who are likely to be unrepresentative of the total migrant population in the local area in question. There was mixed representation of different ECP occupational groups across the studies, potentially biasing conclusions made. Only studies of ECPs were included in the review and the beliefs of counsellors, administrative staff, receptionists, porters and others who may influence the migrant experience of the ED and decision-making around the use of emergency care were not considered. Finally, the data were extracted by one author only, although in practice the review and synthesis process entailed reading each included study report several times over.

Findings

All ECPs described the cultural challenges of a language barrier, migrant behaviour that was unusual for the host country and gender dynamics. In some instances challenges were met relating to migrant respect for authority and the number of relatives. ECPs expressed that these challenges can lead to frustrations, delays in care, and risked the mismanagement of patients. These findings are not unsurprising, and similar issues have been described frequently in UK literature going back over 25 years.³⁵ However, this apparent lack of progress is concerning. Stereotyping of migrants was largely evident and it is well documented that this can occur implicitly in high-pressure crowded environments, such as the ED.³⁶ It was interesting that migrants were often stereotyped as being from the lower socioeconomic classes and of marginalised status,³¹ which, although true for some populations, the majority will have regular jobs and contribute to society. This perhaps reflects the wider societal concerns about asylum seekers and economic migrants who enter illegally, for example, in relation to the 2010 Arab Spring where ECPs may have had first-hand experience of a large influx of refugees and exposure to negative media footage.

ECPs perceived that some migrants, particularly from lower socioeconomic backgrounds, lacked understanding of the host country’s health system, leading to inappropriate access of services, supporting the finding in a recent systematic review of migrant use of EDs in Europe.³⁷ However, it is important to note that this behaviour is not only isolated to migrant groups but is seen in lower socioeconomic populations lacking health insurance.³⁸ ECPs also expressed a lack of migrant health knowledge, however, the concept of a parallel migrant care health system was rejected due to the risks of an unintegrated

service that worsens social isolation, an opinion shared by WHO.^{27 39 40}

With over 300 different languages spoken by London's school children in 2015,⁴¹ and an estimated 500 000 UMs, maintaining cultural competence and organisational support within the NHS is essential. The ECPs in this review recognised the need for this,^{24–34} however, only a minority^{26–28 30} reported that their service had sufficient human and technical resources to support it, suggesting an inability to meet rapid migration changes. Within the UK, equality and diversity training for healthcare workers, interpreter services and resources such as the DHSC 'migrant health' webpage⁴² are among initiatives supporting clinicians. Additionally, one-quarter of the NHS health workforce are migrant born.⁴³ Importantly, this workforce diversity improves compassion and the skills required to care for migrant patients.⁴⁴ Unfortunately, anecdotal evidence since the 2016 EU referendum suggests that increasing numbers of migrant workers are leaving the NHS, although how this specifically impacts on EDs is as yet unknown given wider pressures on the service.

Ethical dilemmas when treating UMs'

All ECPs in this review reported a lack of guidance or support in the context of law and governance policies relating to the management of UMs. The Geneva Declaration, 1948 stated that 'It is the duty of a doctor to be dedicated to providing competent medical service in full professional and moral independence, with compassion and respect for human dignity.'⁴⁵ However, the ECP faces an ethical, moral and legal dilemma: a choice to treat an UM could move scarce resources away from someone else in greater need. On the other hand, the rationing of resources and not treating an UM risks widening health inequalities. A choice to inform the authorities will almost certainly mean deportation. Emergency care to migrants was not withheld at any of the study sites, even within the chargeable contexts (Finland, Sweden and USA). However, for UMs, there was mixed opinion on informing the authorities and willingness to 'game the system' to enable ongoing care.

The Home Office actively seeks UMs in the UK and formally used a data-sharing agreement with NHS Digital to collect relevant data. This was abandoned following interventions from health and civil liberties groups.⁴⁶

Reliance for recognising and reporting UMs now falls on HCPs when UMs access the health system. The General Medical Council and Home Office both state that the decision to report is a balance between patient confidentiality and their medical needs, weighted against the public interest.⁴⁷

UK policy context: NHS emergency care charging policy

To help alleviate overstretched EDs of unnecessary attendances and to increase NHS funding, the DHSC (formerly Department of Health) has advised introducing a charging policy for non-resident migrant patients accessing

emergency care.⁴⁸ Several organisations (British Medical Association, Royal College of General Practice (RCGP) and DoW) state that there is limited evidence that NHS use by migrants is a substantive problem.^{49 50} Activist groups, such as DoW and 'Docs not cops' have campaigned aggressively to oppose these proposals^{51 52} stating that the policy challenges the NHS's core principles⁸ will affect the most marginalised populations, through inability to afford a chargeable service, leading to widening health-care disparities and impacting on public health. Stereotyping is evident from this review and the identification of chargeable patients⁵³ risks implicit racial profiling by ECPs, an issue which the 'UK Guidance on implementing the overseas visitor charging regulations' strongly advises against.⁴⁸ The views of ECPs in this review suggest that if this policy was introduced there would be likely moral, ethical and procedural confusion for ECPs. This could lead to opposition, resistance or variable implementation of the policy for possibly spurious reasons. Currently, the medical union Doctors in Unite support health workers who refuse to check migrant patients' eligibility for NHS care before treating them, and who may face disciplinary action for doing so.⁵⁴

The evidence base in migrant health

A bibliometric analysis of global research in migrant health pointed to the over-representation of studies in 'high-income destination countries',⁵⁵ although only one of the cited articles was based in an ED. The reasons for the lack of such research in the UK are unclear, but future studies could be used to validate the findings presented here. The proposed 'Million Migrants study of health-care and mortality outcomes in non-EU migrants and refugees to England',⁵⁶ and other initiatives around the UCL-Lancet Commission on Migration and Health will provide better intelligence on which to base decisions about health services more broadly.⁵⁷

Meta-synthesis

Two interpretations were drawn from putting the findings of the studies together. The first concerns the pre-eminent role of clinical autonomy in the delivery of migrant healthcare in the ED. A line of argument that follows from this realisation is that documentation is a secondary consideration in emergency care. Questions arise about the outcomes which could arise from instituting a charging policy.

► Clinical autonomy.

A migrant, with reduced knowledge of the host country's health system and culture, will be in a position of vulnerability. A migrants' experience will depend on the ECPs knowledge and willingness to make adjustments for them. The constraints of the 'system', that is, a pressurised ED may lead to reduced tolerance for adapting to the needs of migrants and potentially increase healthcare disparities. However, importantly, ECPs will not allow culture or tradition to impact on immediate life-saving treatment.

Table 5 Recommendations

Recommendation 1	Improved awareness of healthcare disparities through regular context specific migrant training.
Recommendation 2	Training on contextually appropriate migrant cultures and specific health conditions.
Recommendation 3	Cultural and organisational support, for example, interpreters available 24 hours a day.
Recommendation 4	Advice for emergency care providers (ECPs) on National Health Service system organisation.
Recommendation 5	Accessible guidance on the law and regulations that affect the delivery of care to undocumented migrants.
Recommendation 6	Awareness campaign for undocumented migrants on the law and ethical boundaries that ECPs are held to.
Recommendation 7	Implementation of a charging policy into emergency care should not occur without wide professional consultation and a full public health assessment of the impacts on undocumented migrants and wider communities.

- Immigration status does not affect emergency care delivery by ECPs.

For UMs, the ED may be their only option for healthcare. Despite the ethical, moral and legal dilemmas experienced by ECPs when managing migrant patients, when it is an emergency ECPs will act in the patient's best interest. It is extremely unlikely that a policy to identify chargeable migrants would be accepted by ECPs. However, the variation in ongoing healthcare response and the decision on whether to report an UM to the authorities will continue to reinforce the barriers for UMs to seeking healthcare.

RECOMMENDATIONS

From this review, recommendations for health service providers and policy-makers are outlined in [table 5](#).

CONCLUSION

This is the first qualitative meta-synthesis of ECP perceptions of beliefs and challenges to the delivery of emergency care to migrants within developed settings. The key findings that cultural, organisational and ethical barriers exist to providing optimal care are not insurmountable. However, the care delivered by ECPs will depend on their clinical autonomy and ethical stance. Charging within UK EDs appears difficult to implement against the context of the evidence presented within this review.

Several avenues for further research are indicated, beginning with a UK study in the same field, which would also assist with validating the findings of the approach adopted here. In general, there would be value in comparative studies which move beyond the general category of 'migrant' to understand the health needs of different groups. Future studies might also include the perspectives of administrative staff, who are usually the first point of contact with a patient. Finally, studies of the effects of staff views or attitudes on the health outcomes of migrant patients would help to evaluate training or initiatives, for example, aimed at furthering the cultural competencies of NHS or other health service staff.

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