J. García Campayo[1]
C. González Broto[2]
B. Buil[2]
M. García Luengo[3]
L. Caballero[4]
F. Collazo[5]

Attitudes of Spanish doctors towards immigrant patients: an opinion survey

[1] Servicio de Psiquiatría
[2] Medicina Familiar y Comunitaria
Hospital Universitario Miguel Servet
Universidad de Zaragoza
Zaragoza (Spain)
[3] Medicina Familiar y Comunitaria
Hospital Clínico Universitario
Zaragoza (Spain)
[4] Servicio de Psiquiatría
Hospital Universitario Puerta de Hierro
Madrid (Spain)
[5] Servicio de Psiquiatría
Hospital Vall d'Hebron
Barcelona (Spain)

Introduction. We assess the attitudes of Spanish doctors towards immigrant patients.

Material and method. Design: cross-sectional descriptive study carried out in January-June 2003. Sample and setting. Family doctors and third-year residents of 15 health care centers in Zaragoza, Spain. Instrument: specifically designed interview answered in anonymously and on a voluntary basis.

Results. A total of 62.3 % of the sample responded. Nearly 75 % of the doctors had received training on immigration, mainly from a theoretical point of view. Almost 25 % of immigrant consultations are not related to health matters. Doctors think that immigrant patients somatize more than Spanish ones but they do not suffer from more psychiatric illness. They also think immigrants show less treatment compliance and are more demanding. They disagree about possible racial biases in diagnosis or treatment of these patients. Spanish doctors consider that the different ethnic groups present similar management difficulties. The group with the most negative stereotype was the patients from Muslim North African countries.

Discussion. These findings are discussed from a psychological and anthropological perspective.

Key words:
Inmigrantes. Attitudes. Doctor-patient relationship.

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Actitudes de los médicos españoles hacia los pacientes inmigrantes: una encuesta de opinión

Introducción. Se evalúan las actitudes de los médicos españoles hacia los pacientes inmigrantes.

Material y método. Diseño: estudio descriptivo transversal mediante encuesta de opinión realizado en enero-junio de 2003. Población y entorno: médicos de familia y residentes de tercer año (n = 191) de 15 centros de salud de Zaragoza. Instrumento: encuesta diseñada al efecto (cuyas características psicométricas fueron evaluadas en un estudio piloto independiente) cumplimentada de forma anónima y voluntaria.

Resultados. Respondieron el 62,3 % de los entrevistados. Alrededor del 75 % de los médicos había recibido formación en emigración, principalmente de tipo teórico. Casi el 25 % de los inmigrantes consultan por problemas diferentes a cuestiones de salud. Los médicos piensan que los inmigrantes somatizan más que los autóctonos, pero que no presentan más patología psiquiátrica. También opinan que son peores cumplidores del tratamiento y más reivindicativos que los pacientes españoles. Están en desacuerdo en que puedan existir sesgos raciales en la práctica médica, tanto a nivel diagnóstico como terapéutico, con estos enfermos. Los médicos españoles consideran igual de difíciles de manejar a todos los grupos étnicos, pero los que presentan un estereotipo más negativo son los magrebíes.

Discusión. Se discuten estos hallazgos desde una perspectiva psicológica y antropológica.

Palabras clave:
Inmigrantes. Actitudes. Relación médico-paciente.

INTRODUCTION

In 2002, there were approximately 175 million persons who lived in a country other than where they were born, which are equivalent to approximately 3 % of the world population[1]. Massive migratory movements constitute one of the sociocultural and political phenomena having the greatest importance in the XXI century. Spain has maintained very low immigration rates for decades, however in recent years, these have been increasing exponentially while birth rates are decreasing alarmingly[2]. At present, the immigrant population is approximately 9 % of the patients in the Spanish health care system[3]. In spite of this, there has been little interest in the mental health problem of immigrants in our country[3], attention being focused on infectious problems[4,5] or morbidity and use of services[6] that this population has.

The problem of the doctor-patient relationship in immigrants and how this influences the patient's treatment is in-

Correspondence:
Javier García Campayo
Av. Gómez Laguna, 52, 4.º D
50009 Zaragoza (Spain)
E-mail: jgarcamp@arrakis.es

tensely related with the subject of mental health[7]. This phenomenon, called «cultural contratransference»[8,9], refers to the feelings of the clinicians towards patients of a different ethnic group. Many of these thoughts and feelings are not conscious while others, being conscious, are not «acceptable» by the clinician (due to their clear dose of racism), but contribute to promote inappropriate behaviors towards certain patients.

This study aims to know some aspects on the attitudes of the family doctors of our country (as a representative group of the rest of the Spanish doctors) in relationship to immigrant patients.

MATERIAL AND METHODS

Design

Descriptive, cross-sectional study using opinion survey.

Setting

Fifteen primary health care sites chosen randomly and representative of the different health care areas of the city of Zaragoza.

Population

Family doctors and third year residents of family medicine of these sites. A representative sample was calculated for alpha = 0.05; an estimated error of 5 % and p = 0.5 (supposing the most unfavorable case, because there were no previous studies). The survey was administered to a total of 191 clinicians and was filled out anonymously and voluntarily. Administration period was between January and June 2003. Of the 191 family doctors and residents to whom the interview was provided, 119 returned it filled out, which accounts for 62.3 % of those interviewed.

Instrument

Survey designed to know the attitudes of the primary health care clinicians towards immigrant patients. The survey was made up of a total of 17 questions and followed the method recommended for it to improve the quality of the results[10,11]. A previous independent pilot study was conducted (n = 40) to evaluate the main psychometric characteristics of the survey such as validity (alpha = 0.68-0.84 for the different items) or test-retest reliability (0.69-0.77 for the different items), the results being satisfactory. The authors have taken advantage of the previous experience in the design of interviews on attitudes[12] and on the validation of psychometric questionnaires[13-15].

We have defined immigrant as a «person who arrives to a country other than his/her own to settle in it». The classification by ethnic groups of the immigrants does not follow the recommendations of Centers for Disease Control and Prevention of the United States[16], but rather another one that is more adequate for the type of immigration that is occurring in Spain and that we have defended previously[17]. This model classifies immigrants into five ethnic groups: *a)* Muslim North Africans; *b)* Latin Americans; *c)* Asians; *d)* Subsaharans, and *e)* Eastern Europeans. The data on the characteristics of the immigrants are based on the physician's opinion, since we are always speaking of subjective attitudes of the clinician. It is not an objective descriptive study. The study was approved by the ethics committee of the health area where is was conducted.

Statistics

Descriptive. Chi square statistics was used for the comparison between qualitative variables. The 0.05 value was considered as significance level. SPSS program was used for statistical calculations.

RESULTS

A total of 119 out of the 191 family doctors and residents given the survey filled it out and returned it, this accounting for 62.3 % of those interviewed. The sociodemographic characteristics of the sample are the following: more than half of those who responded were women (52.1 %). Regarding age, the most numerous group (47.8 %) were aged 40-49 years, followed by 50-59 years (18.4 %) and 30-39 years (15.9 %). In regards to professional category, less than one fourth (23.5 %) were residents and the rest family doctors. A total of 58.8 % of the doctors had less than 5 % of the immigrant population, this group accounting for 5 %-10 % of the total for 29.4 % of the clinicians and more than 10 % of their total patient load were immigrants for remaining 11.8 % of the doctors.

In relationship to the characteristics of the immigrant patients who consulted the doctor, mean age was mostly (71.4 %) between 26-35 years, although the 36-45 year old group made up the second most important group (18.4 %). According to the family doctors and residents, 23.5 % of the consultations were not motivated by health problems, but rather for other reasons such as social, economic or family ones.

Regarding the training received, 73.9 % of the doctors state they have received specific training on immigration subjects in the last 5 years, mostly in form of isolated courses or speeches, although with theoretical content in both cases (81.2 %), while only 3.1 % have received practice training in workshops. In this question, 45.7 % did not respond

Table 1 Characteristics of immigrant patients and professional practices of the Spanish doctors with these patients according to the family doctor's opinion

	In agreement/totally in agreement	In disagreement/totally in disagreement	DNK/DNA
Characteristics of the patients			
Somatize more	67 (56.3%)	44 (36.95)	8 (6.7%)
More psychic pathology	50 (42%)	57 (47.8%)	12 (10%)
Worse compliers	42 (35.2%)	17 (14.2%)	60 (50.4%)
More demanding	65 (54.6%)	43 (36.1%)	11 (9.2%)
Practices of the clinicians			
Possibility of erroneous diagnosis of psychiatric pictures (psychosis type) due to cultural beliefs (evil eye, spells, etc.)	52 (43.6%)	62 (52.1%)	5 (4.2%)
The treatments given to immigrants are different (less dose, cheaper drugs, fewer complementary tests, etc.) than the indigenous	3 (2.5%)	110 (92.4%)	6 (5%)

DNK: does not know; DNA: does not answer.

on the type of training received. The Organic Act on rights and freedoms of foreigners in Spain and their social integration was only known by 31% of the doctors surveyed. When asked on the type of training they needed on subjects of immigration, most did not answer (74.6%) and the rest opted for training in tropical diseases (17.4%) or for workshop type practice training (11.7%).

In the specific block of attitudes, they were asked which are the most important difficulties with the immigrant patient. A total of 36.9% thought it was language, 27.7% cultural differences, 15.1% follow-up and 2.5% tropical diseases. Finally, 7.5% offered other reasons in minimum percentages and the remaining 10% did not answer. They were also asked about the greatest difficulties to access health care in relationship with the indigenous population and the answers were: illegal situation (35.2%), difficulty to understand their disease (28.5%), language (22.6%) and economic situation (10%). There were no differences by age groups or gender.

After, they were asked about some characteristics of the immigrant patients and about some of the practices of the clinicians that are summarized in table 1.

They were also asked about what ethnic groups (of the five that we have differentiated for this study) are the most complex to manage and independently what group causes the greatest rejection or most negative feelings. These results are summarized in table 2.

Table 3 summarizes the question on which are the reasons why immigrant patients were more difficult to manage or produced greater rejection.

They were asked what the solutions could be to try to modify the rejection that the immigrant patients produced and the answers were: change doctors (8.9%), give more time to the patient (6.7%), help of cultural mediators (4.2%). Most did not answer (73.9%) or thought there was no possible solution (6.3%).

DISCUSSION

This is the first study on attitudes of doctors of any speciality regarding immigrant patients conducted in Spain and it is also a pioneer study internationally on this subject. Other previous studies have evaluated attitudes of the clinicians by clinical cartoons in which the main actors

Table 2 Ethnic group that is the most complex and that causes greater rejection

	Group with mots complex management (n = 119)	Group that causes greatest rejection (n = 119)
Muslim North Africans	16 (13.4%)	24 (20.1%)
Latin Americans	17 (14.2%)	9 (7.5%)
Sub-Saharans	16 (13.4%)	4 (3.3%)
Asians	12 (10%)	2 (1.6%)
Eastern europeans	8 (6.7%)	1 (0.8%)
None	11 (9.2%)	10 (8.4%)
Does not answer	39 (32.7%)	69 (57.9%)

Table 3 Reason why immigrant patients are more complex or cause greater rejection

	More complex group (n = 119)	Group with greater rejection (n = 119)
Distrust	10 (8.4%)	18 (15.2%)
Culture	29 (24.3%)	6 (5%)
High visit frequency	18 (15.1%)	3 (2.5%)
Way of being	4 (3.3%)	12 (10%)
Does not answer	58 (48.7%)	80 (67.2%)

were immigrants and on which they had to give their opinion[18] or directly by the evaluation of the differences in the diagnosis[19,20] and treatment[21,22] that the doctors made with immigrant patients in comparison with the indigenous population of the country in study. The racial biases have also been analyzed when developing clinical research studies[23,24].

Some of the strong points of this study are the large and representative sample of the primary health care physicians of Zaragoza (that can be extrapolated to the rest of Spain) and the response rate (62.3%) similar to that found in similar studies on attitudes[18]. The study was conducted before the subsequent terrorist attack that occurred in Madrid that could have modified the opinion of the Spanish population on the Muslim religion immigrants. This datum grants the study even more value. In regards to the limitations, the main one is the high rate of neutral responses such as does not know/does not answer on questions having high emotional content such as, for example, «what ethnic group causes you the greatest rejection?» This problem is difficult to solve in spite of the strict anonymity with which the surveys were filled out.

The study sample is relatively young since almost 25[1]% of all the sample are third year family doctor residents. Most of them (more than 70[1]%) have received training in subjects of immigration in the last 5 years, which shows the concern of the administrations for this problem. However, this training is mainly based on theoretical contents. When some specific aspects of the theoretical knowledge of the clinicians are evaluated, such as the Organic Act on rights and freedoms of foreigner residing in Spain and their social integration, it seems that its circulation has been scarce, probably because knowledge about this law is not perceived as a usable skill in the daily consultation with these patients. On the other hand, the insufficiency of the theoretical methods to modify attitudes such as feelings the patients produce, whether immigrants or not, in the clinicians, is well-known[12,17]. In psychoanalytic terms, this is called «contratransference». The clinicians also do not seem to be very interested in practical training since it is only demanded by 11% of them and this fact may be an important limitation when modifying attitudes.

Regarding the attitudes of the doctors, the most important difficulties identified in the management of the immigrants are, in the first place, language (36.9% of the sample) followed by cultural differences (27.7%). The first problem can be solved by translation systems and cultural mediators, but the second one also requires specific training to decrease the negative consequences on the diagnosis and treatment of these patients, as has already been described in other countries[18-120].

In regards to the characteristics of the immigrants, the doctors think that they somatize more than the indigenous but that they do not have more psychiatric illness than they do. Both answers are coherent with the research studies on the subject[7,25]. They also consider that they adhere to treatment worse and are more demanding than the Spanish patients. Although there are no specific studies in Spain, there are in other countries and they would confirm that there is really less compliance in comparison with Western patients and that it would probably be linked to mistrust in Western medicine[7,26]. There are no objective studies on a greater demanding attitude of the immigrants, although it seems to be a generalized clinical impression that could be explained as a way of defending themselves from the perception the immigrants have that they are racially discriminated against[27].

It stands out that the clinicians mostly disagree that there may be racial biases in the medical practice with the immigrant patients on the diagnostic and, above all, therapeutic level, when there are multiple studies that document this fact[17-20]. The explanation may be that the members of the indigenous ethnic groups of a country are much less sensitive to the detection of racial discrimination behaviors in the setting that members of ethnic minorities[28].

Finally, when the ethnic groups that cause the greatest difficulties in their management are analyzed, the doctors do not show any differences between them and they consider managing Latin Americans, Muslim North Africans, sub-Saharans and Asians equally difficult. Only Eastern Europeans pose less management difficulties than the rest. When asked about the causes of this management difficult, the cultural differences and high frequency of visits of some of these patients stand out. These causes are observable and relatively aseptic. However, when the doctors are asked what ethnic group causes the greatest rejection in them, besides an elevated abstention (57%) which demonstrates the elevated emotional burden of the question, the results are completely different. There is an ethnic group that stands out as it produces a much greater rejection than the rest and these are the Muslin North Africans. In this case, when asked about the causes of rejection of these patients, the answers are very different from those listed previously. Here, culture

Annex	Survey used in the study

Socio-demographic characteristics of the clinician

- Gender
- Age
- Professional category: resident (1, 2, 3). Family doctor

Characteristics of the immigrant population

- Percentage of immigrant population in total patient load
- Mean age of immigrant population seen (5 year range)
- Reasons why they consult and percentage

Training received on immigration

- Have you received specific training on immigration in the last 5 years? Yes/No
- Of what type?: courses/theoretical speeches - Practical workshops - DNK/DNA - Others (specify)
- Do you know the Organic Act on rights and Freedoms of Foreigners in Spain?
- What type of training would you need on this subject?

Attitudes on immigration

- What are the main difficulties with the immigrant patient?
- What are the major difficulties for the immigrants to access health care in relationship with the indigenous population?
- Which of the 5 ethinic groups is the most complex to manage? Why?
- Which of these groups causes you the most rejection or most negative feelings? Why?
- What could the solutions be to try to modify the rejection that the immigrant patients produce?

and high frequency of visits are not important, but rather more weight is given to answers related with the distrust these patients produce or «their way of being». These causes are not very observable and are more rooted in the basic stereotype this ethnic group has and thus are more difficult to modify.

Different possible explanations of the ethnic discrimination behaviors between the health care professionals[29] could be considered, the most consistent being that of the influence of ethnic and cultural stereotypes[28]. One of the clearest examples in this sense is the extended perception among the dominant North American white society that the black minority is intrinsically violent and that it hates the white population[30]. This would be one of the main reasons that patients of the black race in the United States are more frequently diagnosed of schizophrenia, are administered higher doses of neuroleptics, are more frequently injected with the deport form because it is thought they will not adequately follow treatment and, in general, are considered to be more violent and dangerous patients[19-22]. This ethic group has the same stereotype with similar consequences in other countries such as Great Britain where they also make up the main group of patients admitted to secure psychiatric facilities[31].

In the case of our country, and according to our survey, the ethnic group that seems to have the most negative stereotype is the Muslim North Africans. It is not the first time that similar data has been found in Spain: there is another study that shows that the Moroccans (the main national group making up the Muslim North Africans) were the group of patients that generated the most rejection among the health care clinicians[32]. Circumstantial reasons such as the terrorist attack of September 11 in the United States or the March 11, 2004 one in Madrid (the study was made before this date) could be considered. This phenomenon, that causes important psychological sequels in the general population[33] was associated to a clearly more negative trend of the stereotype of this ethnic-cultural group, direct physical aggressions against its members even being described[34]. However, there could be deeper historic-anthropological reasons. For many historians, the national identity of Spain was established during the Middle Age in the fight against the Muslim invasion, leaving an enormous mark on our national symbols*[35]. The current significant presence of the Muslim North Africans in our country could revive atavistic feelings related with the Muslim invasion.

In any event, this study only aims to be a starting point of a reflection on the attitudes of the Spanish doctors with the immigrants (which is only an approach of the attitude of the Spaniards in general towards this group) and on possible solutions to improve the negative stereotypes of some ethnic groups. Although the clinicians surveyed are pessimistic regarding the possibility of modifying attitudes, there are specific training programs that could make us more aware of our biases and that would make it possible to limit the negative impact of these attitudes in the treatment of the immigrant patients[17].

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* Some examples are: a) the patron saint of Spain is Santiago «kill the Muslims.»; *b)* the official coat of arms of Aragon (place where the study has been made) has, in one of its lower quadrants, a cross of Saint George with four heads of Muslims with their throats cut that represents the capturing of the city of Huesca in 1096 by Peter I.

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