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Physicians' experiences of providing emergency care to undocumented migrants arriving in Spain by small boats

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ABSTRACT

Introduction: Access to emergency care for undocumented migrants (UMs) is a public health problem. Spain receives thousands of UMs who arrive by sea. A multidisciplinary team of the Spanish Red Cross, made up of physicians, nurses, police, and cultural mediators, developed emergency care for UMs.
Aim: The aim of our study is to describe and understand the experiences of physicians in emergency care for UMs who arrive in Spain by small boats
Methods: Qualitative study, based on Gadamer's phenomenology. Convenience and purposive sampling was carried out and included sixteen in-depth interviews with physicians, between June 2019 and March 2020 in Spain.
Results: Three main themes emerged: 1) Rediscovering humanistic medicine; 2) Leaving the personal and professional comfort zone; 3) Improving medical emergency care.
Conclusions: Triage, pharmacological prescription, and the closure of the emergency care process are the key contributions of medical care. Cultural, language and security barriers make emergency care difficult.

1. Introduction

The European Union (EU) receives a third of global migrants, many of them undocumented migrants (UMs) [1,2]. UMs lack documentation, refugee status or permission to enter a country [3]. UMs risk their lives crossing the Mediterranean Sea in small boats towards Europe [4]. Spain is a destination country for UMs, and in the year 2020, 37,527 UMs arrived by small boat in Spain (>96% of the total) from countries such as Algeria (39,5%), Morocco (20,3%), Mali (12,6%), Guinea (7,6%), Ivory Coast (6,6%), Senegal (4,8%), and others (8,6%) [5]. In Spain, after rescue from the sea, emergency care is provided by a Spanish Red Cross Emergency Response Team [6]. Emergency care for UMs includes basic needs, first aid, diagnosis and treatment of mild diseases, sexual violence and people trafficking [7]. Emergency care for UMs is performed by volunteer physicians, an experience about which it is necessary to have more information.

2. Background

The movement of UMs towards the European Union (EU) is a political, social and public health challenge [8]. Although the United Nations 2030 Agenda for Sustainable Development aims to respect the human rights of migrants and refugees, barriers in access to countries and health systems continue [9]. In 2019, 123,700 refugees and immigrants arrived in Europe, 32,500 of them made it to Spain (26,200 by sea) [10]. UMs risk their lives crossing the Mediterranean Sea in inflatable, semi-rigid boats, 5–10 m long, carrying 40–50 people. In this dangerous journey, almost 5,000 migrants died in 2016, >2,000 in 2018 and 1,319 in 2019 [10–12]. Although the majority of UMs that arrive in the EU are men, nearly 20% are women, and 25% children [10,13]. Since 2003, the

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Spanish Red Cross and the state security forces have provided emergency care to UMs that arrive in small boats. Emergency Response Teams are made up of physicians, nurses, police, civil protection and cultural mediators. UMs suffer from chronic health problems, from the migratory journey, waiting in North Africa, and the sea crossing. Also, they suffer dehydration, malnutrition, urinary retention, infectious diseases, burns, myalgias and injuries [2], along with problems of sexual violence and people trafficking [7,13,14]. After being rescued at sea, the emergency team provides thermal blankets, hydration and food [14]. Emergency care also includes screening, first aid, diagnosis/treatment of mild health problems and hospital transfer as needed for diagnostic tests or if there is suspicion of a serious illness [7]. Subsequently, UMs spend up to 72 h in police facilities (custody phase), then are transferred to temporary immigration centres to manage the return processes to humanitarian rescue shelters or their country of origin. In Spain, volunteer physicians (in pediatrics, internal medicine and general practice) attend to UMs who arrive by sea by providing triage, general care, and first aid. Serious cases are sent to the emergency department at the hospital, and are cared for by specialists (public health, critical care …) [15]. Although there are epidemiological [2,16], demographic [17], and cultural studies [18], little is known about nurses and physicians' experiences in the emergency care given to UMs [7,19–21].

3. Aim

The aim of our study is thus to explore, describe and understand the experiences of physicians in emergency care for UMs who arrive in Spain in small boats.

4. Method

4.1. Study design

A qualitative study that uses Gadamer's hermeneutic phenomenology [22] was developed. Gadamer suggests that human beings' experience of the world is connected with language, in a temporal and historical context. Preconceptions and provisional knowledge are always reviewed in the light of experience and reflection.

4.2. Sample and recruitment

Through convenience and purposive sampling, sixteen physicians of the Emergency Response Team of the Spanish Red Cross were selected (Table 1). The criteria for inclusion were: being a physician, having at least 1 year of experience in providing emergency care to UMs through the Spanish Red Cross, speaking Spanish, and having given informed consent. The exclusion criteria were: refusing to participate in the study. Four physicians refused to participate in the study due to work requirements.

4.3. Data collection

Sixteen in-depth interviews (IDIs) were conducted in Spanish, lasting on average 49 min. They were made in a Red Cross classroom. Participants were contacted by phone, their participation was requested, and an appointment was made. Each participant gave only one individual interview. A guide to relevant questions was designed (Table 2). The IDIs were carried out by trained researchers. Before the IDIs, interviewers informed the participants of the aims of the study, sociodemographic data was collected, and they signed the consent form. After the IDIs, participants were given a chance to read the transcriptions. Data collection ceased when data saturation was reached.

4.4. Data analysis

The interviews were audio recorded, transcribed literally, and analyzed by three researchers following the method described by Flemming et al. [23]. Firstly, understanding of the topic was gained

Table 2
Interview protocol.

Stage	Subject	Content/Possible Questions
Introduction	Motives, reasons	Learn about their experiences in emergency care for undocumented migrants arriving in small boats.
	Ethical issues	Inform about volunteering, recording, consent, possibility to withdraw, confidentiality.
Beginning	Introductory question	Tell me about your experience of treating UMs.
Development	Conversation guide	How has it affected your personal and professional life?
Explain the gaps in the care for UMs in the different phases of emergency care		
How can we improve care for UMs?		
Closing	Final question	Is there anything else you would like to tell me?
	Appreciation	Thank them for their participation, remind them that their interview will be of great use, and place ourselves at their disposition.

Table 1
Demographic characteristics of interviewees (n = 16).

Participant	Age	Sex	Marital status	Children	Organ	Speciality	N°. years volunteer
MIDI1	60	Man	Married	Yes	Red Cross	Geriatrics	32
MIDI2	28	Man	Single	No	AHS	Family medicine	7
MIDI3	61	Woman	Divorced	Yes	Red Cross	Family medicine	2
MIDI4	67	Man	Married	Yes	AHS	Pediatrics	3
MIDI5	59	Man	Married	No	Red Cross	Anesthetics	2
MIDI6	34	Woman	Single	Yes	Red Cross	Family medicine	16
MIDI7	28	Woman	Single	No	AHS	Forensic medicine	9
MIDI8	53	Man	Married	Yes	Red Cross	Tropical medicine	7
MIDI9	63	Man	Married	Yes	Red Cross	Oral medicine	4
MIDI10	69	Man	Single	Yes	AHS	Family medicine	4
MIDI11	30	Man	Single	No	Red Cross	Family medicine	2
MIDI12	58	Woman	Single	No	Red Cross	Geriatrics	35
MIDI13	43	Woman	Married	No	Red Cross	Family medicine	7
MIDI14	45	Woman	Married	Yes	Red Cross	Family medicine	15
MIDI15	54	Woman	Married	Yes	AHS	Pediatrics	10
MIDI16	39	Man	Single	No	Red Cross	Family medicine	8

MIDI: Medical in-depth interview. AHS: Andalusian Health Service.

through dialogue with participants. During interviews new questions arose such as "What can the physician do to improve emergency care for UMs?" Secondly, each sentence of the transcripts was analyzed line by line, and the researchers identified units of meaning, subtopics and themes. Third, a copy of the transcripts was given to each participant to identify the answers and confirm the results. The data analysis was carried out with the help of the Atlas-Ti.8.0 program.

4.5. Rigour

The quality criteria of Lincoln and Guba [24] were adopted to assess the quality of the study. Credibility: the data collection process was detailed, the analytical process was supported by triangulation of researchers. Transferability: a detailed description of the study environment, participants and method was carried out. Dependability: interpretations were examined by two expert researchers from outside the study. Confirmability: results were returned to the participants to verify the interpretations.

5. Results

All the participants self-identified as volunteer physicians The mean age of the participants was 49.4 years old, (SD = 13.7). The average period of experience in emergency care was 10.2 years. Three themes and six subthemes emerge from inductive data analysis (Table 3).

5.1. Rediscovering humanistic medicine

The figure of the physician, traditionally linked to the patient, is currently connected to an ideal of the positivist scientist. However, when the physicians go beyond technological knowledge and skills, they expand their understanding of the patient's world, and their own. Emergency care for UMs is an opportunity for clinical practice, understanding the feelings, life trajectory, and suffering of the other.

Table 3
Themes, Subthemes and Units of meaning.

Theme	Subtheme	Units of meaning
1. Rediscovering humanistic medicine.	1.1 Physicians can close emergency care process.	Clinical eye, drugs, close care process, save materials and time.
	1.2 A chance for personal growth.	Ethical commitment, satisfaction, social service, gratitude, leaving the microscope.
	1.3 Leave the microscope to approach life.	Medical techniques, applying knowledge, awareness, emergency training.
2. Leaving the personal and professional comfort zone.	2.1 It is not the pathology you expected.	Chronic, infectious, forgotten pathology of the sea crossing, few vital emergencies or mental pathologies.
	2.2 Prioritizing attention to risk groups.	Women, children, rape, genital mutilation, intimacy, time, age, transfers, custody.
3. Improving medical emergency care.	3.1 Adjusting functions and detecting symptoms.	Triage, acute/severe, chronic/acute, hospital transfers, little time, cultural mediator, simulate symptoms, medication, beliefs.
	3.2 Promoting continuity of the healthcare process.	Health history, custody phase, police do not provide healthcare, therapeutic compliance, coordination between countries.
	3.3 Improving training and potential of the team.	Lack of training, health at origin, tropical disease, vulnerability workshops, emergency care is not my specialty, police pressure.

5.1.1. Physicians can close the emergency care process

Physicians' participation in emergency care to UMs is important because it allows "in situ" diagnosis and treatment of mild emergencies, sending only serious cases to the hospital. This saves time, personnel, ambulance, transfers and inconvenience to UMs. As one participant says, this allows for better management, more quickly referring UMs to hospital care or police custody phase.

If the patient has an ailment, and I say that it is nothing more than that, they don't go to the hospital and legally it stops there. (MIDI1)

Pharmacological prescription is the right of the physician by law, and in emergency care it is important to administer antibiotics, antipyretics or anti-inflammatories. Most problems are mild pathologies that can be resolved in the emergency care, UMs can start the treatment before the police custody phase. As one physician says, this means saving time for better treatment and helps the well-being of UMs.

UMs arrive with headaches, muscle pains, … if the physician then prescribes an anti-inflammatory, they improve quickly. (MIDI6)

5.1.2. A chance for personal growth

Physicians have an ethical commitment to the person, health and life. As one participant says, a personal perspective of the migration problem involves them in emergency care, they contribute their knowledge and time in order to improve the health of UMs.

This work gratifies us internally, serving society is a way to have peace in our soul. (MIDI14).

Physicians feel comforted when they see "someone else" feeling good. Emergency care makes the physician aware of the reality of UMs, their fears and health conditions. Their aim is diagnosis and treatment, but also humanitarian support.

This helps us to become aware of the health needs of Ums, behind each health problem, there is a life story, …. (MIDI8)

The participants say that they train and specialize in medicine, but lack knowledge and awareness of the migration problem. The long length of their studies and family obligations may explain the lack of time available for volunteering. Furthermore, information is lacking and retired physicians have little chance to help.

Spanish College of Physicians should promote a pool of volunteer physicians for emergency care for UMs, and establish agreements with institutions such as Spanish Red Cross (MIDI5)

Although healthcare providers participating in emergency care may be frowned upon as it may seem to be encouraging UMs, this does not have a negative effect on the physicians. However, when they are parents of small children, they feel more affected by the harshness and frustration of caring for the most vulnerable people, especially women and children. One doctor explains it in this way:

My baby is one year old, and when I have taken care of a small boat where there's a baby, you feel very bad, … What will become of them? (MIDI 6).

5.1.3. Leave the microscope to approach life.

Physicians believe that there is a lot of ignorance about UMs and their health situation, when they arrive in small boats. Participating in emergency care allows them to work with other teams, means and pathologies, and expands their overview of the UMs care process.

Being a volunteer makes me feel important, because they really need you. There is a lack of physicians who dedicate part of their time to these aims (MIDI13)

Participating in emergency care for UMs allows physicians to know the triage process, emergency reports and documentation, social and gender problems. As one physician says, is to return to the essence of medicine.

My job does not have patients, it is just looking into a microscope, … and sometimes it's forgotten that there's a person behind the sample. (MIDI7)

Most UMs do not arrive sick, and any experienced physician can solve the problems that are found. Family physicians, emergency or

internal medicine physicians are ideal for this care. Many physicians are not prepared to diagnose children, gyneco-obstetric pathology, or female mutilation.

Idon't deal with emergencies in my usual job. If UMs need a venipuncture or wound suture, …I'd rather an experienced nurse do it. (MIDI4)

5.2. Leaving the personal and professional comfort zone

Taking part in emergency care separates the physician from their professional routine, focused on pathologies in their specialty.

5.2.1. It is not the pathology you expected

It is common to find banal pathologies resulting from the voyage: ingestion of sea water, insolation, dehydration or malnutrition. UMs are very vulnerable to a variety of diseases, as well as physical and psychological abuse throughout their migratory journey. Despite this fact, they still take on the sea voyage, as they are strong and are used to suffering. Physicians are surprised by their capacity of endurance:

The last small boat we attended had been at sea for 4 days. They didn't arrive very wet, nor were there signs of dehydration, they nor did they have diarrheal syndromes, only some sunburn … I can't explain it! (MIDI16).

Other times they may find illnesses that are not very prevalent in Europe, such as scabies or tuberculosis, together with HIV, or hepatitis B or C. To these are added chronic diseases or sequels of previous surgical interventions. The low number of tropical diseases in the initial triage is surprising. It is common to detect myalgias, conjunctivitis, odontostomatological problems and poorly treated or decompensated diabetes.

He brought his Apidra pen, only fast insulin and glycemia > 500 mg / dl, … you understand that they lack diabetes education. (MIDI5)

Serious pathologies are rare, and when there are fractures or hypertensive crises, physicians refer UMs to the hospital for specialized treatment. Some participants highlight the absence of mental pathologies or psychological problems.

Psychologically most UMs have normal behaviour. Their goal was to get Europe and it is a moment of "Aarrhh! We've arrived!" (MIDI10).

5.2.2. Prioritizing attention to risk groups

Physicians carry out gynecological inspection on the women, and if they are pregnant, the fetal heartbeat is listened to in order to detect any abnormalities. Undocumented female migrants may have suffered genital mutilation, sexual exploitation or unwanted pregnancies. Undocumented child migrants also may have been victims of sexual violence and people trafficking. Women and children receive emergency care in specific areas, physical examination and clinical interviews can help detect humanitarian problems.

For me, it is a challenge to detect why they have come, if they have been raped or if they have been victims of human trafficking…they are very afraid, and it is not easy. (MIDI6)

Children usually arrive well, they undergo a physical examination, and if they are newborn babies, their umbilical cord is checked. Little children are often scared, vomiting from seasickness, with cough and possible respiratory infections. During the examination, the mother answers questions, including her previous health history; but sometimes the children arrive with women who are not their mothers.

Iattended a women and her niece, the mother had asked for her to be taken away because the father's family wanted to perform genital mutilation. (MIDI15)

Physicians show their concern by caring for children, a population unknown to them if they are not pediatricians. They also point to the lack of health care for children during the "custody phase": they are not criminals but are held together with their mothers in cells.

They end up by spending 72 h there, they are children who do not have freedom, do not have a crib or bathtub, …. who have nothing! (MIDI4)

5.3. Improving medical emergency care

Participants point to organizational elements, teamwork and lack of specific training as key points for improvement in medical care for UMs.

5.3.1. Adjusting functions and detecting symptoms

Most physicians believe they should keep to triage, treat urgent problems and refer any more severe problems to hospitals. Triage includes visual inspection, interrogation about previous or travel pathologies, physical examination, and vital signs. Their name, age, origin, previous problems and allergies to medications are asked. If they cough, they are auscultated; if their stomach hurts, their abdomen is palpated.

Our goal is to be efficient, to specify what needs urgent attention from the chronic problem or what to expect. (MIDI1)

Emergency care lasts two to three hours, but the physicians see themselves as not being able to do their job fully. The COVID 19 pandemic has revived this issue, as physicians have been forced to perform tests on UMs. Furthermore, although cultural mediators speak Arabic, French, and English, UMs speak dialects. If the cultural mediators do not know their dialect, it is difficult to translate symptoms or concepts of Western medicine, and much information is lost. As one participant notes, this happens upon examining for chronic diseases, parasites, or when explaining how/when to take medicine.

From what you want to ask, to what the interpreter understands, to how the question is transferred to the language of the UM, … a great deal of clinical information is lost. (MIDI16)

Another problem the physician faces is distinguishing when UMs feign having symptoms. Some UMs think that if they show symptoms they will be better taken care of. Physicians know that some UMs bring trained responses that make it even more difficult to distinguish the real problems. As one physician states, if there are any doubts, diagnostic tests are ordered, and if the problem persists, the patient is sent to the hospital.

The UM pointed to his chest, said he had chest pain, ¡heart, heart! I explored it, auscultated, the nurse checked his vitals and we did an electrocardiogram…it turned out to be fine. (MIDI1)

In traumatic pathologies, it is difficult to verify whether they are acute or chronic. Cultural issues like undressing for exploration or questions about sexuality need trust and intimacy, but there is no time. The physical examination must be careful and observe cultural aspects, for example, touching the head can be interpreted as an assault on one's privacy. Radiological evaluation of bone age (Greulich and Pyle atlas) is common in emergency care to UMs. An X-ray is taken of the non-dominant hand and wrist, and is compared to standards to estimate the patient's chronological age. UMs may hide their age, which can also generate doubts on a clinical or legal level.

Some say they are minors, so they go to the hospital to carry out a wrist X-ray. Sometimes the tests show the age of an adult, … but the UM says ¡no¡. (MIDI2).

5.3.2. Promoting continuity of the healthcare process

Physicians cannot guarantee follow-up/therapeutic compliance. Spanish Red Cross provides emergency care upon arrival in the port and transfers specific cases to hospital. After this care, UMs go through the police custody phase and are detained in cells for three days, but there are no physicians or nurses there.

We treated a diabetic UM, he was given insulin doses and I recommended that he should take another dose the next day, we left a glucometer with the police … but we don't know what happened. (MIDI1)

Physicians say that dialogue between the Red Cross and police institutions is necessary. Although the physician prescribes medicines to be taken, this is a health and not a police responsibility. As one physician explains, emergency nurses could perform these functions to ensure continuity of care.

I wrote out a prescription, and a volunteer went to the chemist's to pick up the insulin. They took it to the police, and they said "Very well,

but I'm not going to do this." (MIDI2)

Another important issue is clinical documentation. Physicians miss having a unified medical history that includes diagnosis, treatment and care in their original country, emergency care, and hospital care. When the Red Cross team transfers UMs to the hospital or to the police, they hand over a copy of the assessment sheet, then the hospital report is attached. As one participant says, UMs do not keep it.

We know that the documentation is given to them, but I don't know what they do with it, … it is a cultural problem. If they then go to the physician in another country, they cannot know what treatment has been carried out. (MIDI 4)

5.3.3. Improving training and potential of the team

Physicians recognize important advances in organizing emergency care for UMs. However, there should be a possibility of separating febrile patients, putting masks on everyone after landing and improving privacy. In addition, participants point to a lack of specific training.

I have taken courses in first aid, treating wounds and tropical medicine. But we lack training on burns, wounds, dermatology … human trafficking. (MIDI14)

Knowledge of the health system in countries of origin, common diseases, vaccination dates, and health care in transit is lacking. Improvements could include carrying out visual inspection of UMs when disembarking (how they walk, breathe, whether they cough), making a rapid diagnostic test for HIV or hepatitis, and cardiac auscultation.

We have resources, but we need to use them … and time. There should be a physician and a nurse in all the teams, to measure blood pressure, pulse oximetry, electrocardiography; we could detect hypertensive crises, arrhythmias, … (MIDI10)

Physicians also agree on the difficulty of carrying out their work in a police environment. The police wait for them to finish doing their work, and the physicians feel pressure to finish quickly. As one participant says, there is a lack of unified action protocols with the police.

UMs arrive anxious, scared, they need time to calm down… The police should leave us with them longer. (MIDI3)

Physicians also ask for feedback on their performance from the rest of the team, which would allow them to improve. Of particular relevance are their views on the work with nurses, whom they consider well-prepared and experienced in emergency care for UMs. In your opinion, an experienced nurse detects the severity and need for a hospital transfer, they have a general vision of the emergency and skills that an ophthalmologist or dermatologist may lack.

The nurses are prepared for emergency care to UMs. There are medicines that nurses can administer, and they are able to solve emergency care. " (MIDI15)

6. Discussion

The aim of our study was to explore, describe, and understand the experiences of physicians in emergency care for UMs arriving in small open boats. Increased migration to the European Union requires access by UMs to health services [3,4], knowing about the experiences of UMs and healthcare providers can improve their care [7]. Although a medical perspective has been studied in primary care [25], this has not happened in emergency care. The role of the physician in the diagnosis, treatment and the early pharmacological prescription of UMs should be valued [16]. Individual positioning explains medical participation in emergency care, but dissenting public opinion [20,26], fear of vulnerability or risk of contagion places a mental burden on the physicians. The treatment of UMs is similar to that of the rest of the population [20], emergency care addresses infectious, dermatological, gynecological and traumatic problems [16]. Physicians treat pathologies that are not very prevalent in Europe [26,27] and they give priority to treating women and children [7,13]. We agree with Olukotun et al. (2020) [28] that women mistrust medical care; privacy needs to be provided, with reserved areas, and more consultation time. Our results do not detect prejudices, but they do detect cultural, communication and time constraints [21]. According to Kerbage et al., 2020 [29], physicians detect simulation of symptoms in UMs though this is uncommon and does not alter the therapeutic relationship. Physicians disapprove of austerity in the care of UMs [25], people-centered health systems are the key to improving care [8]. Our results indicate that health records help medical emergency care for UMs [9], but the continuity of care implies coordination with the police [7,13], separating medical treatment from legal status [14,20]. Physicians are committed to a comprehensive approach in emergency care for UMs [30], but they require training in compassionate and cultural care [31]. Emergency medical care for UMs suffers from limited resources, depends on volunteer physicians [32], and there is a lack of training in people trafficking procedures [33]. Although the socio-sanitary problem of care for UMs is known, clinical and social considerations are left out of medical studies [34], that medical schools should include these issues in curricula [35].

6.1. Limitations

All our participants are Spanish physicians; including physicians of other nationalities could have changed the results.

7. Conclusions

Medical participation in emergency care for UMs is an opportunity to return to practice humanistic medicine away from their professional activities. Along with the diagnosis and treatment of diseases, understanding the life history of UMs and their relationship to the disease is the key to comprehensive treatment. Pharmacological prescription and referral to the custody phase or hospital centre bring the emergency care process to closure. Emergency care for UMs allows the physician to work in another environment, team and area, out of their comfort zone and facing problems outside their specialty. Although they may be trained in infectious or tropical diseases, they seldom treat these pathologies but rather health problems linked to social problems in risk groups. The physicians interviewed believe that emergency care for UMs is limited to triage. Language barriers, simulation of symptoms, and cultural problems are aspects to improve in medical care for UMs. Carrying out their health work in a secure environment creates tensions and disagreements with security forces. Physicians require joint action protocols, team meetings, preservation of clinical documentation and the continuity of the healthcare process.

8. Compliance with ethical standards

Approval was obtained from the Spanish Red Cross Ethics and Research Committee [Grant Number: CR-20–01].

Ethical Statement

Approval was obtained from the Spanish Red Cross Ethics Research Committee [CR-20-01].

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CRediT authorship contribution statement

José Granero-Molina: Conceptualization, Funding acquisition, Writing - original draft, Writing - review & editing. **María del Mar Jiménez-Lasserrotte:** Conceptualization, Funding acquisition, Formal analysis, Writing - review & editing. **María Dolores Ruiz-Fernández:**

Data curation, Project administration, Writing - review & editing. **José Manuel Hernández-Padilla:** Methodology, Formal analysis, Writing - review & editing. **Isabel María Fernández-Medina:** Data curation, Methodology, Writing - review & editing. **María del Mar López-Rodríguez:** Formal analysis, Writing - review & editing. **Cayetano Fernández-Sola:** Conceptualization, Methodology, Writing - review & editing.

References

[1] De Vito E, de Waure C, Specchia M, Riciardi W. Public health aspects of migrant health: a review of the evidence on health status for undocumented migrants in the European Region. Avaliable from: Copenhagen: WHO Regional Office for Europe; 2015. http://www.euro.who.int/en/publications/abstracts/public-health-aspects-of-migrant-health-a-review-of-the-evidence-on-health-status-for-undocumented-migrants-in-the-european-region-2015.

[2] Eonomopoulou A, Pavliv A, Stasinopoulou P, Giannopulos SA, Tsiodras L. Migrant screening: lessons learned from the migrant holding level at the Greek—Turkish borders. J Infect Public Health 2016;10:177–84. https://doi.org/10.1016/j.jiph.2016.04.012.

[3] Sesti F, Rosano A, Ingleby D, Baglio G, Bell R, Geraci S, et al. Policies for tackling health inequities in migrants in an irregular situation: learning from Italy. Eur J Public Health 2019;29(4):394. https://doi.org/10.1093/eurpub/ckz186.031.

[4] Fotaki M. A crisis of humanitarianism: refugees at the gates of Europe. Int J Health Policy Manage 2019;8(6):321–4. https://doi.org/10.15171/ijhpm.2019.22.

[5] UNHCR (United Nations High Commissioner for Refugees) (2020) Availaable from: https://data2.unhcr.org/en/country/esp.

[6] Cusumano E. Emptying the sea with a spoon? Non-governmental providers of migrants search and rescue in the Mediterranean. Mar Pol 2017;75:91–8. https://doi.org/10.1016/j.marpol.2016.10.008.

[7] López-Domene E, Granero-Molina J, Fernández-Sola C, Hernández-Padilla JM, López-Rodríguez MM, Fernández-Medina IM, et al. Emergency care for women irregular migrants who arrive in Spain by small boat: a qualitative study. Int J Environ Res Public Health 2019;16(18):3287. https://doi.org/10.3390/ijerph16183287.

[8] Puchner K, Karamagioli E, Pikouli A, Tsiamis C, Kalogeropoulos A, Kakalou E, et al. Time to rethink refugee and migrant health in Europe: moving from emergency response to integrated and individualized health care provision for migrants and refugees. Int J Environ Res Public Health 2018;15(6):1100. https://doi.org/10.3390/ijerph15061100.

[9] Chiesa V, Chiarenza A, Mosca D, Rechel B. Health records for migrants and refugees: a systematic review. Health Policy 2019;123(9):888–900. https://doi.org/10.1016/j.healthpol.2019.07.018.

[10] UNHCR (The United Nation Refugee Agency). Refugees & migrants: sea and land arrivals in week 16 (Spain). Available from: https://data2.unhcr.org/es/documents/download/75681; 2020.

[11] Kovras I, Robins S. Death as the border: managing missing migrants and unidentified bodies at the EU's Mediterranean frontier. Polit Geogr 2016;55:40–9. https://doi.org/10.1016/j.polgeo.2016.05.003.

[12] SG (Spanish Goverment). Balances e informes inmigración 2020. Available from: http://www.interior.gob.es/prensa/balances-e-informes/2020; 2020.

[13] Jiménez-Lasserrotte MM, López-Domene E, Fernández-Sola C, Hernández-Padilla JM, Fernández-Medina IM, Granero-Molina J. Accompanied child irregular migrants who arrive to Spain in small open boats: experiences and health needs. Glob Public Health 2019;15(3):345–57. https://doi.org/10.1080/17441692.2019.1665083.

[14] De Bono D. In defiance of the reception logic: the case for including NGOs as human rights monitors in the EU's Policies of first reception of irregular migrants. J Peace Psy 2018;24(3):291–5. https://doi.org/10.1037/pac0000297.

[15] Harrison HL, Daker-White G. 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. BMJ Open 2019;9(7):e028748.

[16] Ponce-Blandón JA, Mérida-Martín T, Jiménez-Lasserrotte MD, Jiménez-Picón N, Macías-Seda J, Lomas-Campos ML. Analysis of prehospital care of migrants who arrive intermittently at the coasts of southern Spain. Int J Environ Res Public Health 2020;17(6):1964. https://doi.org/10.3390/ijerph17061964.

[17] Kadir A, Battersby A, Spencer N, Herm A. Children on the move in Europe: a narrative review of the evidence on the health risks, health needs and health policy for asylum seeking, refugee and undocumented children. BMJ Paediatr Open 2019;3(1). https://doi.org/10.1136/bmjpo-2018-000364.

[18] Granero-Molina J, Jiménez-Lasserrotte MM, Fernández-Sola C, Hernández-Padilla JM, Sánchez-Hernández F, López-Domenne E. Cultural issues in the provision of emergency care for irregular migrants who arrive in sain by small open boats. J Transcult Nurs 2019;30(4):371–9. https://doi.org/10.1177/1043659618803149.

[19] Vogel L. Medicine at sea: the front line of the migrant crisis. CMAJ 2016;188(1):E6. https://doi.org/10.1503/cmaj.109-5200.

[20] Jensen NK, Norredam M, Draebel T, Bogic M, Priebe S, Krasnik A. Providing medical care for undocumented migrants in Denmark: what are the challenges for health professionals? BMC Health Serv Res 2011; 11. 154. https:///doi.org/10.1186/1472-6963-11-154.

[21] Harrison HL, Daker-White G. Beliefs and challenges held by medical staff about providing emergency care for migrants: an international systematic review and translation of findings to the UK context. BMJ Open 2019;9(7):e028748. https://doi.org/10.1136/bmjopen-2018-028748.

[22] Gadamer HG. 2005. Verdad y Metodo. Salamanca: Sígueme; 2005.

[23] Fleming V, Gaidys U, Robb Y. Hermeneutic research in nursing: developing a gadamerian-based research method. Nurs Inq 2003;10:113–20. https://doi.org/10.1046/j.1440-1800.2003.00163.x.

[24] Lincoln YS, Guba EG. Naturalistic Inquiry. Newbury Park: Sage; 1985.

[25] Heras-Mosteiro J, Sanz-Barbero B, Otero-Garcia L. Health care austerity measures in times of crisis: the perspectives of primary health care doctors in Madrid. Spain. Int J Health Serv 2016;46(2):283–99. https://doi.org/10.1177/0020731415625251.

[26] Teunissen E, Tsaparas A, Saridaki A, Trigoni A, van Weel-Baumgarten E, van Weel Ch, et al. Reporting mental health problems of undocumented migrants in Greece: a qualitative exploration. Eur J Gen Pract 2016;22(2):119–25. https://doi.org/10.3109/13814788.2015.1136283.

[27] Mipatrini D, Addario SP, Bertollini R, Palermo A, Mannocci A, La Torre G, et al. Access to healthcare for undocumented migrants: analysis of avoidable hospital admissions in Sicily from 2003 to 2013. Eur J Public Health 2017;27(3):459–64. https://doi.org/10.1093/eurpub/ckx039.

[28] Olukotun O, Kako P, Dressel A, Mkandawire-Valhmu L. A qualitative exploration of the experiences of undocumented african immigrant women in the health care delivery system. Nurs Outlook 2020;68(2):242–51. https://doi.org/10.1016/j.outlook.2019.08.002.

[29] Kerbage H, Marranconi F, Chamoun Y, Brunet A, Richa S, Zaman S. Mental health services for syrian refugees in lebanon: perceptions and experiences of professionals and refugees. Qual Health Res 2020;30(6):849–64. https://doi.org/10.1177/1049732319895241.

[30] Dalma A, Karnaki P, Riza E, Zota K, Veloudaki Linos A. Health services provision to migrants/refugees in Greece: a qualitative study. Eur J Public Health 2018;28(4). https://doi.org/10.1093/eurpub/cky218.184.

[31] Van Loenen T, van den Muijsenbergh M, Hofmeester M, Dowrick Ch, van Ginneken N, Mechili EA, et al. Primary care for refugees and newly arrived migrants in Europe: a qualitative study on health needs, barriers and wishes. Eur J Public Health 2018;28(1):82–7. https://doi.org/10.1093/eurpub/ckx210.

[32] Linke C, Heintze C, Holzinger F. Managing scarcity'– a qualitative study on volunteer-based healthcare for chronically ill, uninsured migrants in Berlin, Germany. BMJ Open 2019;9(3):e025018. https://doi.org/10.1136/bmjopen-2018-025018.

[33] Albright K, Greenbaum J, Sherry A, Edwards SA, Tsai C. Systematic review of facilitators of, barriers to, and recommendations for healthcare services for child survivors of human trafficking globally. Child Abuse Negl 2020;100:104289. https://doi.org/10.1016/j.chiabu.2019.104289.

[34] Samra S, Taira BR, Pinheiro E, Trotzky-Sirr R, Schneberk T. Undocumented patients in the emergency department: challenges and opportunities. West J Emerg Med 2019;20(5):791–8. https://doi.org/10.5811/westjem.2019.7.41489.

[35] Mor Z, Cadesky A, Halleluyan R, Sheffer R. Attitudes of Israeli medical students towards the medical treatment of uninsured migrants. BMC Med Educ 2020;20(1):72. https://doi.org/10.1186/s12909-020-1973-4.