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XENOPHOBIA AND MEDICINE (PROFESSION OF A DOCTOR): CAN THE TWO COEXIST IN THE 21ST CENTURY?

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Abstract: This study was conducted to reveal how physicians view the access of refugees, who have difficulties in accessing health services and who may experience various health rights violations, to health services and to discuss the case in terms of medical ethics and deontology. Xenophobia, which is one of the main causes of discrimination in health, needs to be evaluated. In this context, quantitative research methods were used to measure the xenophobia levels of physicians working in Eskişehir province. Stratified sampling method was used to evaluate the views of the physicians. The study data were collected through the Xenophobia Scale developed by Kees Van Der Veer et al. and a questionnaire created by the researchers. The age distribution of the physicians in the study was 38,069±10,337. The distribution of the scores obtained from the xenophobia scale was found to be high (56.20±11.54). Of the physicians in the study, 34.3% stated that they would not want to provide health services for refugees if they were given the right to choose. They mainly thought that health services should not be provided free of charge for refugees and should be provided in separate places, refugees affected the access of the citizens of the Turkish Republic to health services negatively, the number of children should be limited, refugees would increase violence in health and public health problems, and that there should be an interpreter in health institutions. "Refugees do not deserve discrimination in health services" in terms of medical ethics. "Physicians should reach a common consensus against all kinds of discrimination while carrying out their profession." When xenophobia shows its effect in the field of health, it turns into a phenomenon that damages human dignity, causes all kinds of inequality, and moves medicine away from its deontology.

Keywords: medical ethics, deontology, refugee, right to health, xenophobia, medical xenophobia, medical racism

Xenofobia y medicina (profesión del médico): ¿pueden ambas coexistir en el siglo XXI?

Resumen: Se realizó este estudio para revelar cómo ven los médicos el acceso de refugiados con dificultades para acceder a servicios de salud y que sufren violaciones a sus derechos de salud, y para discutir el caso desde la ética médica y la deontología. La xenofobia es una de las principales causas de discriminación en cuidados de salud, por lo que necesita ser evaluada. En este contexto, se usaron métodos de investigación cuantitativa para medir los niveles de xenofobia de médicos que trabajan en la provincia de Eskişehir. Se usó un método de muestra estratificada para evaluar los puntos de vista de los médicos. Los datos del estudio fueron recolectados mediante la escala de Xenofobia desarrollada por Kees Van Der Veer y colaboradores, y mediante un cuestionario creado por los investigadores. La distribución de la edad de los médicos que participaron en el estudio fue de 38,069±10,337. Se encontró que la distribución de los puntajes obtenidos de la escala de xenofobia fue alta (56.20±11.54). De los médicos del estudio, 34.3% manifestó que no proporcionarían servicios de salud a los refugiados si se les diera el derecho a elegir. Principalmente pensaban que los servicios de salud no debieran proporcionarse gratis a los refugiados, debiera hacerse en lugares separados, los refugiados restringen el acceso a los servicios de salud de los ciudadanos de la República de Turquía, debiera limitarse el número de niños, los refugiados incrementan los problemas de violencia y salud pública y debiera haber intérpretes en las instituciones de salud. De acuerdo con la ética médica, "los refugiados no merecen ser discriminados en los servicios de salud". "Los médicos debieran llegar a un consenso común en contra de toda clase de discriminación mientras que cumplen con su profesión". Cuando la xenofobia muestra sus efectos en el campo de la salud, se transforma en un fenómeno que daña la dignidad humana, causa toda clase de desigualdades y lleva a la medicina a apartarse de su deber.

Palabras clave: ética médica, deontología, refugiados, derecho a la atención de salud, xenofobia, xenofobia médica, racismo médico

Xenofobia e medicina (profissão de um doutor): podem os dois coexistirem no Século 21?

Resumo: Esse estudo foi realizado para mostrar como médicos veem o acesso de refugiados —que tem dificuldades em acessar serviços de saúde e que podem experimentar diversas violações em direitos à saúde— a serviços de saúde e para discutir o situação em termos de ética médica e deontologia. Xenofobia, que é uma das principais causas de discriminação na saúde, necessita ser avaliada. Nesse contexto, métodos de pesquisa quantitativa foram utilizados para medir os níveis de xenofobia de médicos trabalhando na província de Eskisehir. Métodos de amostragem estratificada foram utilizados para avaliar o ponto de vista dos médicos. Os dados do estudo foram coletados através da Escala de Xenofobia desenvolvida por Kees Van Der Veer et al. e um questionário criado pelos pesquisadores. A distribuição etária dos médicos no estudo foi 38,069±10,337. A distribuição dos escores obtidos na escala de xenofobia foi alta (56.20±11.54). Dos médicos no estudo, 34,3% afirmaram que eles poderiam não querer prestar serviços de saúde para refugiados se fosse dado a eles o direito de escolher. Eles principalmente pensam que serviços de saúde não deveriam ser fornecidos gratuitamente para refugiados e que deveriam ser fornecidos em lugares separados, que refugiados afetam negativamente o acesso de cidadãos da República Turca a serviços de saúde, que o número de crianças deveria ser limitado, que os refugiados poderiam aumentar a violência na saúde e os problemas de saúde pública, e que deveria haver um intérprete nas instituições de saúde. "Refugiados não merecem ser discriminados em serviços de saúde" em termos de ética médica. "Médicos deveriam alcançar um consenso contra todas as formas de discriminação quando no exercício de sua profissão". Quando a xenofobia mostra seus efeitos no campo da saúde, ela se transforma em um fenômeno que danifica a dignidade humana, causa todas as formas de desigualdades e afasta a medicina para longe de sua deontologia.

Palavras chave: ética médica, deontologia, refugiado, direito à saúde, xenofobia, xenofobia médica, racismo médico

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Introduction

The war climate that broke out in the Middle East after 2000 has forced millions of people to migrate in masses, and the bordering states have had to cope with this situation. The Republic of Turkey has implemented an open-door policy in the face of the great migration wave from Syria since 2011, and the Syrians located in the camps at the beginning of the migration have been sent to 81 provinces of Turkey upon the migration figures reaching millions*(1)*.

Today Turkey hosts the largest refugee population in the world, with people coming from Afghanistan, Iran, Iraq, Syria, and other countries. The State of the Republic of Turkey took significant initiatives to provide services, such as improving refugees' health, public health measures, and vaccination of children, the procedures to be applied to foreigners were determined with the Law on Foreigners and International Protection (LFIP) dated April 4, 2013 and No 6458, and the Temporary Protection Regulation issued on October 13, 2014 with No 6883 determined necessary conditions and provisions for Syrians within this scope for the provision of health, education, access to the labor market, social assistance and services, interpreter assistance, and similar services*(2)*.

According to the definition of the World Health Organization (WHO), health is "a state of complete physical, mental, and social well-being and not merely the absence of a disease or disability"*(3)*.

With the European Social Charter (1961), "the right to benefit from all kinds of measures that make it possible for *everyone* to benefit from the highest level of health that can be achieved" has been adopted. Also, protection of health, the right to social and medical help, and the prohibition of discrimination have been introduced, so it has been emphasized in the relevant condition that the subject of rights is *everyone*. In the article on the Right to Health of the International Covenant on Economic, Social and Cultural Rights (ICESCR, 1976), it is emphasized that "No discrimination can be made on the basis of language, religion, or any other status".

The right to health in the ICESCR includes the following elements: Availability (A) (facilities, goods and services, and health personnel); Accessibility (A) (non-discrimination, physical, economic, access to information); Acceptability (A) (respects medical ethics, culturally appropriate); Quality (Q). While the right to health framework promotes high quality available, accessible and acceptable healthcare for everyone, it is stated that migrants' health often deteriorates in the new country (destination countries) and that the AAAQ can be hampered by poverty, discrimination, lack of health services, and misunderstandings, respectively. It has been pointed out that health professionals in regions with high migrant populations should try to include cultural mediators in the planning, implementation, and evaluation of interventions*(4)*.

The literature shows that the right to access health services, defined by basic international agreements, is not yet fully respected and that some countries do not accelerate their policies to provide it*(5)*. In the Global Refugee Forum held in December 2019, health was not included among the six main priority issues, and the harmful health consequences of restrictive migration policies were not taken into account in the forum*(6)*.

The concept of xenophobia

According to Benveniste, who examined the relationships between the Latin words hostis 'enemy' and hospes 'guest', hostis is another equivalent of 'enemy'. In Greek, xénos means "foreigner" and xeinízō means "hospitable behavior". In Indo-European languages, the concepts of "enemy, foreigner, guest", which are semantically and legally three separate entities, show close links*(7)*. Xenophobia, known as fear of foreigners, is the combination of the words xénos (ξένος) and phóbos (φόβος/fear), meaning someone outside the boundaries of the community*(8)*, new, unexpected, and alien to society, and is defined as the fear of and hostility towards things that are unknown and foreign to us.

Medical xenophobia

Crush and Tawodzera define medical xenophobia as 'the negative attitudes of health professionals

and workers towards refugees and migrants during carrying out their work. A xenophobic healthcare professional classifies and treats patients based on language, appearance, and national origin—contrary to ethical principles and codes of conduct [professional deontology] that should govern their professional behavior and responsibilities for their patients. It has been stated that healthcare professionals have no excuse for mistreating patients and that medical xenophobia is a well-established and harmful phenomenon*(9)*.

It has been claimed that refugee women face health professionals' xenophobic attitudes in their attempts to access and benefit from reproductive health services*(10)*, health professionals' attitudes towards refugees range from negligence to hostility, and refugees are exposed to humiliations such as "hospital invaders" and "drug devourers" in health facilities*(11)*.

Xenophobia can emerge in medical settings and encounters, where people who are expected to be apolitical and have ethical responsibilities perform their duties, between patient - patient (hostile attitudes of the physician towards the patient who is considered foreign); physician - physician (the hostile attitude of physicians of different ethnic identity or status to each other); patient - physician (the hostile attitude of domestic patient toward a foreign or black physician); patient - patient (the hostility of patients with different ethnic identity, social status, cultural difference, etc. to each other).

A cross-sectional and descriptive design was used in this study. Data were collected between April 2019 and August 2019. The study was conducted to determine how the physicians working in Eskişehir view the refugees' access to health services, and to evaluate the resulting picture in terms of medical ethics and human rights.

Materials and methods

Health personnel other than physicians were not included in the study. To reach the calculated sample size of 379 physicians, approximately 600 physicians were interviewed, and more than 200 physicians (approximately 37%) did not want to participate in the study due to the sensitivity and political aspect of the subject and expressed their uneasiness, although it was stated that the data would be included in the study anonymously.

The validity and reliability study

The validity and reliability study data of the Xenophobia Scale were collected through questionnaires from the physicians working in Family Health Centers (FHC), Yunus Emre State Hospital, Eskişehir City Hospital, and ESOGU Faculty of Medicine, in Eskişehir.

Being a clinician and agreeing to participate in the study were determined as inclusion criteria for the volunteer participants. The number of people to be sampled was determined as 10 times the number of the items on the scale. All physicians participating in the study were informed about the study, and their verbal consent was obtained. Individuals who did not agree to participate in the study and who answered the questions on the questionnaire incompletely were excluded from the study group. Eventually, the study was conducted with 140 physicians determined by using the non-probability sampling method.

Research design

Since the scale was adapted from a different language and culture, validity and reliability studies were carried out in two stages. In the first stage, language and content validity, and in the second stage, construct validity, internal consistency, and factor analyses were conducted. The hypotheses and statistical analysis of the research, whose content validity we measured, are shown in Table 2.

The sample group was selected from physicians serving both citizens of the country and refugees. The sample size was calculated by using the stratified sampling method and consisted of a total of 379 physicians, including 70 working in Eskişehir Family Health Centers, 143 working in public hospitals, and 166 working in ESOGU Faculty of Medicine.

Tools and materials used in data collection

The Xenophobia Scale developed by Kees Van Der Veer et al.*(12)* was used to measure xenophobia in physicians. The total score of the 14-item

6-point Likert-type scale ranges from 14 to 84. In addition to this scale that evaluates xenophobia, another 11-item 5-point Likert-type questionnaire created by the researchers based on the information compiled from the literature was applied to evaluate the reflections of the subject on the field of health.

Data analysis

Categorical data were represented by frequency values and percentages, and mean, standard deviation, median, lower, and upper values were used for representing continuous data. The normality of the data was tested with the Shapiro-Wilk test. In the analysis of the data with non-normal distribution, the Mann-Whitney U test was used for comparing two variables and Kruskal-Wallis for comparing three or more variables. In the comparison of continuous data, Pearson and Spearman correlation analyses were used based on the validity with normal distribution.

The data of specialized physicians from Internal or Surgical sciences were included in the paired comparisons. Pediatrics, Gynecology, and Emergency units, which constitute the most vital parts of health services for refugees, were added to the 5-specialty major branch comparisons.

Ethical principles

To carry out the research, the approval of Eskişehir Osmangazi University Non-Interventional Clinical Research Ethics Committee was obtained (Decision no: 25403353-050.99-E.128676 date: December 05, 2018). Anonymous questionnaire forms were used for quantitative research.

Findings

Confirmatory Factor Analysis (CFA) was conducted on the data of the 14-item single-factor scale. As the multiple normality assumptions between the items were not met, parameter estimation was made using the asymptotic covariance matrix with the Robust Unweighted Least Squares (ULS) method. As seen in Figure 1, it was observed that the t value of the 7th item was not significant. Therefore, this item was removed, and CFA was repeated.

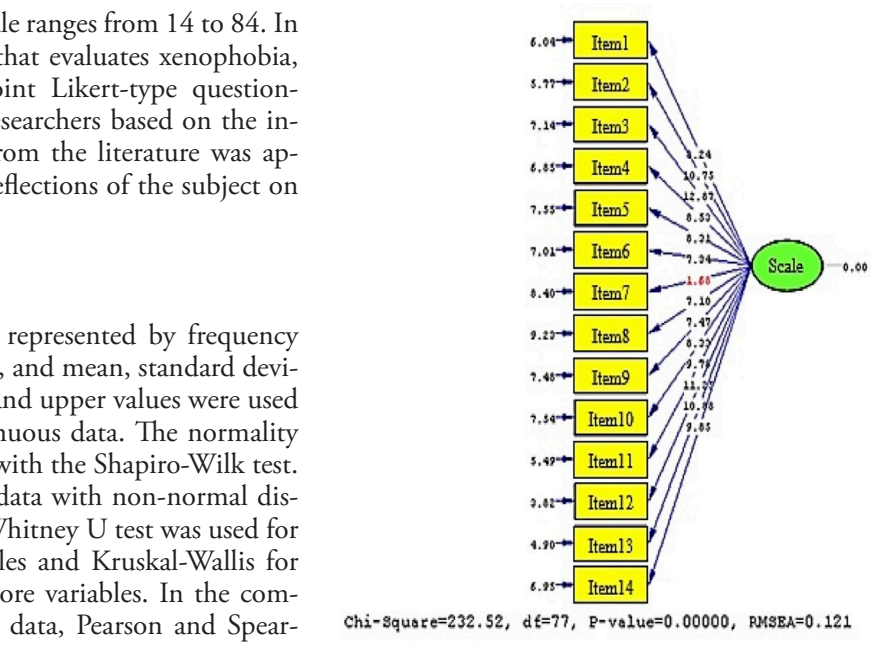

Figure 1. Path diagram for the Xenophobia scale developed by (12), after the participants are collected in this current work.

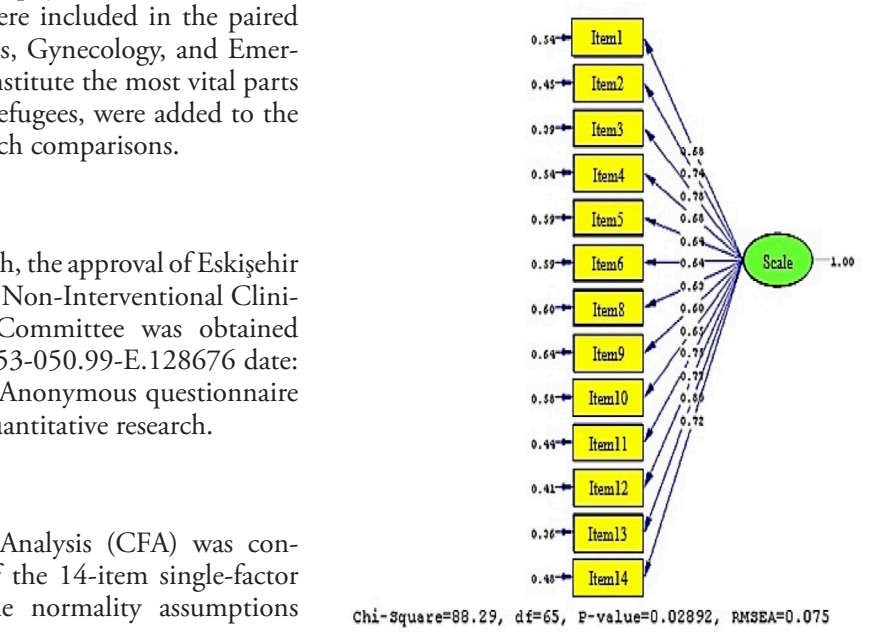

Figure 2. Confirmed path diagram for the Xenophobia scale developed by (12), after cultural adjustment performed in this current work.

According to the CFA results, factor loadings of all items were observed to be between 0.60 and 0.80.

The explained variance values were also found to be high. Fit indices are used to evaluate whether the observed data fit the one-dimensional model. The model-data fit indices of the 13-item scale are shown in Table 1.

Table 1. Goodness-of-fit indices for the factor structure of the scale items

Goodness-of-fit indices	Acceptable Limit *	Value
X^2/sd	<5 Moderate fit <3 Good fit	88,29/65 = 1,36
GFI	>0.90	0,98
CFI	>0.90	0,98
NFI	>0.90	0,93
NNFI	>0.90	0,97
RFI	>0.85	0,91
S-RMR	< 0.08	0,071
RMSEA	< 0.08	0,075

As seen in Table 1, the Chi-square statistics of similarity rate was calculated as $X^2(65)= 88.29$, $p<0.01$; the ratio of chi-square statistic to degrees of freedom as (X^2/sd)=1.36; the root-mean-square error of approximation as (RMSEA)=0.075; standardized root mean square residual as (S-RMR)=0.0671; comparative fit index as (CFI)=0.98; goodness of fit index as (GFI)=0.98; normed fit index as (NFI)=0.93; and relative fit index as (RFI)=0.91. All fit indices were found above acceptable values. Thus, the structural validity of the 13-item scale was accepted. The path graph for the scale items is shown in Figure 2.

The reliability of the scale was tested with Cronbach's alpha coefficient, which was 0.917 for the 13-item scale. A reliability coefficient of close to 1 means that the reliability and the internal consistency between the items are high.

In the analyses conducted for content validity, it was seen that the scores obtained from the scale confirmed the hypotheses (see Table 2 at the end of the article).

One of the hypotheses established in the study, "(H-8) Medical institutions should not have interpreters for refugees," was not confirmed.

The age of the physicians in the study ranged from 25 to 65, with the mean age being 38,069±10,337 (see Table 3).

Of the physicians, 46 (12.1%) were pediatricians (pediatrics, pediatric surgery, and pediatric psychiatry), and 35 (9.2%) were obstetricians. A grouping was made based on the fields of specialization, namely Internal and Surgical Sciences. Of the physicians, 273 (72%) were serving in Internal Sciences and 106 (28%) in Surgical Sciences. In the 5-group classification of the fields of specialization, the groups consisted of 65 (17.5%) physicians from Surgery Department, 206 (54.4%) from Internal Sciences, 46 (12.1%) from Pediatrics (pediatrics, pediatric surgery, and pediatric psychiatry), 35 (9.2%) from obstetrics, and 27 (7.1%) from emergency medicine department.

The reverse expressions on the question paper are shown as (R).

In this evaluation, the highest score was obtained from the item "Births are increasing because the state provides health and social services for refugees free of charge." (3.66±1.102), and the lowest score was obtained from the item "There should be no interpreters in health institutions for refugees." (1.63±0.95) (see Table 4).

The highest score distribution on the Xenophobia Scale was obtained from the item "Migration in this country has gotten out of control." (5.01±1.12), and the lowest score distribution was obtained from the item "Interacting with migrants disturbs me." (88±1.429) The mean score of the scale was 56.20±11.54 (see Table 5).

The score distribution of female and male physicians on the Xenophobia Scale was determined as 57.79 ± 10.73 and 55.10 ± 11.97, respectively. There was a significant difference between genders (p=0.045). The score distribution of specialist physicians working in internal sciences was determined as 55.29 ± 12.01, and the score distribution of physicians working in surgical sciences was determined as 58.55 ± 9.91, with the difference between them being significant (p=0.022). When three important branches of specialization (obstetrics, pediatrics, and emergency medicine) were excluded and a 5-point assessment was made, the highest distribution was observed in obstetricians (60.00 ± 9.824)

and a significant difference was found between each other (p=0.020). The scale score distribution of the physicians who wanted to give service to the refugees if they were offered the right to choose was 52.59±10.99, while the score of those who did not was found as 63.11±9.22, with the difference between them being significant(p<0.001) (see Table 6).

As the number of patients treated by the physicians increased, the scores they got from the Xenophobia Scale also increased (p=0.006, r=0.141). Rs=0.14 (since Rs<0.3) indicated a weak relationship between them.

In this evaluation, a significant relationship was found between the physicians' views about non-citizens' access to health services and the phenomenon of migration and the Xenophobia scale (see Table 7). The responses of the participants were consistent.

Discussion

In most of the studies measuring xenophobia, the mean scores of males on xenophobia scales were found to be higher than those of females*(13, 14)*, while no significant difference was found according to gender and marital status in some of the studies*(15)*. The opposite was true in our study. This suggests that medicine is not a gender-dependent profession and that gender is not an important variable, but rather an identity.

In a study conducted with family physicians in England, it was found that family physicians saw them as patients difficult to follow*(16)*. In a study conducted in the Netherlands, it was revealed that 25% of the migrants who requested service were refused treatment by health professionals*(17)*. In our study, the rate of physicians that would not want to serve refugees if they were given the right to choose was found to be higher than the Dutch experience.

According to Savulescu, 'if a physician is not prepared to provide effective and beneficial healthcare that is legally permitted because it conflicts with his or her values, such a person should not be a physician.' Physicians who conscientiously refuse their patients should ensure that they can receive this service, and should refer them to another colleague who can provide the service*(18)*. Physicians are not entitled to a special status of ethics that allows them to refuse to give patients the medical care they deserve*(19)*.

Physicians who do not want to give service to refugees is an important topic. Medical ethics and deontology should act as a barrier to physicians who do not want to provide service for refugees.

As can be understood from the item scores, the fact that migration is getting out of control emerges as a factor that increases xenophobia.

Statistical analysis shows us that the statement "Migrants cause an increase in crimes." does not reflect the truth*(1)*. The anxiety that migration creates in society, the compulsory change it causes, the feeling of insecurity arising from not knowing the migrants, and uncertainties about the future feed the fear of crime against migrants on local people*(20)*. This is, in turn, fed by a culture of fear strengthened by social and individual prejudices and discontent caused by socioeconomic problems*(21)*.

The belief that refugees will undermine welfare, take away people's jobs, and cause cultural degeneration in the host country, as well as fears that they will bring communicable diseases to the country and accelerate the collapse of the health system*(22)* seems to have caused the distribution of the scores of the related items to be high.

According to a study published by the International Labor Organization, migrant workers work in more dangerous and dirty jobs that require no skills compared to the citizens of the country they migrated to. In Japan, migrant workers undertake jobs that local workers avoid, and these jobs, which are called 3D, are coded as dirty, dangerous, and demeaning jobs, and they are actually exposed to more risks than local workers*(23)*.

Communication is one of the most basic components of the patient-physician relationship. It is clear that the uneasiness of any of the parties in this relationship will impede the ethical relationship between the patient and the physician. Healthcare providers should be willing to communicate so that this group in need can access services*(24)*.

Even basic communication, which is undoubtedly one of the most influential factors on healthcare access, health outcomes, and patient safety, can become problematic when patients and physicians do not share the same language or culture*(25)*. When communication is avoided and there is no interest in reinvigorating it, foreigners' alienation is doomed to deepen*(26)*. Language barrier is already one of the problems that negatively affect access to health services and equity. Despite the efforts to include Arabic-speaking healthcare professionals in healthcare services in Turkey, it has been shown by various clinical studies that language constitutes the biggest barrier to healthcare services*(27-29)*. In a meta-analysis, three main difficulties in the provision of health services for refugees were reported as communication, continuity of care, and trust*(30)*.

In cases where clinicians actively listen to patients or get help from an interpreter, these actions help overcome misunderstandings and elevate patients' epistemic authority*(31)*.

Migration is a public health issue. Migrants' diseases are seen as a potential threat to the health of the host community*(32)*. The lack of previous health records of migrants, failure to access data on their chronic diseases, vaccination histories, and depression and psychosocial problems of the incoming people supports and nourishes this perception in the minds of the host community*(33)*. There is a widespread belief that when migrants live collectively in a region, they may cause an increase in the health problems of that region *(34)*. Governments take certain security measures at the border to prevent people with high-cost chronic diseases from entering their countries*(35)*.

It is a tangible fact that migration, especially mass migration, can adversely affect public health*(36-38)*.

Beliefs that refugees are vectors of disease are already common among individuals, and such beliefs have caused related scores to be very high, even among physicians.

The report of WHO and some studies indicating that refugees pose a health threat in host countries due to poor living conditions, poor financial status, and epidemic diseases (HIV, malaria, etc.) are noteworthy*(39,40)*. This situation may negatively affect the quality of care given by physicians and reduce their self-sacrifice.

Mariani demonstrated that crime rates among refugees were not higher than the rates among natives and that a more restrictive migration policy could lead to an increase in refugee crimes in the destination country*(41)*. In a study examining the problems of healthcare workers serving refugees, it was seen that cases of health violence that was committed by refugees were almost non-existent*(42)*. There are already many studies showing that hate speech in the media and that this discourse increases xenophobia and prejudices*(43-45)*. Refugees in Turkey, who are mostly on the agenda with acts of social violence, first of all appear in the press as a social adjustment problem. Problems arising from different languages, cultures, and lifestyles between refugees and host country citizens are the most important reasons for the reactions of host country citizens*(1)*.

The inadequacy of health institutions in migration areas prevents some people from accessing health services. It is unacceptable that physicians see the culture, people, communities, and society of the country they serve as superior to and more important than the migrant population and reflect this on the practice of medicine. Mardin revealed that 14.3% of the physicians working in Istanbul and 29.4% of the physicians working in Eskişehir agreed on the proposition, "Turkish citizens cannot receive healthcare if asylum seekers are provided with free healthcare," and that 53.3% of the physicians working in Istanbul and 61.8% of the physicians working in Eskişehir agreed on the proposition, "Providing health services to asylum seekers increases the workload of health workers"*(46)*.

Population growth is associated with the fulfillment of the most basic human rights. Behind this thought lies the reasoning that the migrant groups have no education and can have children thoughtlessly and that there is eventually a population explosion due to the free provision of social services. This idea has the potential to reproduce the discrimination that starts with the indifference of physicians to their patients*(47)* in every environment where healthcare is provided.

Of the health workers in the study, 48.3% stated that refugees use health institutions unnecessarily, and 54.6% stated that they affected the working environment negatively*(48)*. In a study, the idea that health services should not be provided free of charge for refugees was supported with the evidence that they did not take care of themselves in terms of health or illness and used institutions unnecessarily*(49)*. In another study, it was revealed that health workers tend to view access to healthcare for precarious migrant children and pregnant women as a 'privilege rather than a right', and in this context, some perceived migrants with no health security as those who 'do not deserve free care'*(50)*.

The exclusion of refugees from healthcare is a political reality in many countries. Occasionally, patients with acute diseases in these countries can benefit from some health services, and treatment is limited to emergency care, especially for undocumented migrants*(51)*.

Do the physicians or citizens want a health facility that is more luxurious or comfortable than the health facility where they receive their services, containing modern medical tools and equipment, and served by famous and well-known physicians to offer services to refugees? Economic isolation is one of the biggest components of the isolation phenomenon. Thus, minds are ready to perceive it as enough provision of services that refugees deserve once they are provided with prefabricated spaces and helpful physicians who serve them.

It was shown in a study that childbirths facilitated the economic and cultural adjustment of refugees with the same effect as their length of stay in the destination country*(52)*. Even some refugee discourses support this*(53)*. Refugees' attempts to have children in their destination country can be considered as a part of this understanding of ownership and integration.

Making an official application in the country of destination, obtaining an identity card, and subsequently giving birth are among the factors that facilitate the rooting and integration of refugees. The low mean score for this item among physicians suggested that they were worried that their workload would increase and that the social integration of a group was denied.

Mardin found that 3.8% of the physicians working in Istanbul and 5.9% of the physicians working in Eskişehir did not agree on the proposition, "Educated interpreters should be provided for asylum seekers within the scope of health services"*(46)*. This showed us that some of the physicians did not even want to communicate with refugees.

Conclusion

Exhibiting racist and possessive approaches towards refugees while practicing medicine increases violations of rights of these people, who should be considered as vulnerable groups, to access to health services.

Turkish validity-reliability study of the Fear-Based Xenophobia Scale developed by Kees Van Der Veer et al. was conducted, and it was revealed that the scale was valid and reliable in the evaluation of xenophobia in the physician group.

The physicians in the study agreed on the statements that the increase in the number of refugees would negatively affect the access of the citizens of the country to health services, childbirths would increase as the state provides health services and social services for refugees free of charge, and that refugees should not be provided with health services free of charge. They were undecided about the statements that it would be easier for refugees to adjust by giving birth in Turkey and that they should be provided with health services free of charge. They agreed on the statements that health services should be provided for refugees in separate units, the increase in the number of refugees would increase violence in health, there should be an interpreter in health institutions, and that there should be a limit on the number of children for refugees. Most of the physicians participating in the study saw migration as a public health problem.

With this research, it was revealed that xenophobia existed in health services. It is clear that more research is needed on this subject. Such studies should be carried out on different samples, covering all health professionals in different geographies.

Conflicts of interests

None.

Table 2. Testing of the total scores obtained from the scale with research hypotheses in terms of Content Validity

	Total score from the Xenophobia scale					
	Mean	Standard Deviation	Median	Lower	Upper	P value*
(H-1) If you had the opportunity, would you like to give service to refugees?						
Yes	53,65	10,32	54,00	22,00	75,00	0.001
No	64,48	8,97	66,00	39,00	78,00	
(H-2) The increase in the number of refugees affects Turkish citizens' access to health services negatively.						
Disagree	44,97	11,39	45,50	13,00	73,00	0.001
Agree	59,11	9,66	59,00	30,00	78,00	
(H-3) Childbirths are increasing because the state provides free health and social services for refugees.						
Disagree	45,97	11,98	47,00	13,00	73,00	0.001
Agree	58,47	10,14	59,00	15,00	78,00	
(H-4) Refugees should not be provided with health services free of charge.						
Disagree	48,05	11,71	49,00	13,00	73,00	0.001
Agree	59,08	10,02	59,00	22,00	78,00	
(H-5) Refugees will adjust more easily when they give birth in Turkey.						
Disagree	58,56	10,34	59,00	13,00	78,00	0.001
Agree	51,68	12,39	53,00	15,00	78,00	
(H-6) Refugees should be provided with health services in separate places.						
Disagree	50,36	12,04	50,50	24,00	77,00	0.001
Agree	57,66	10,95	58,00	13,00	78,00	
(H-7) The increase in the number of refugees increases violence in health.						
Disagree	49,31	10,86	50,00	13,00	77,00	0.001
Agree	60,96	9,41	61,00	32,00	78,00	
(H-8) Medical institutions should not have interpreters for refugees.						
Disagree	55,65	11,40	57,00	13,00	78,00	0.006
Agree	61,63	11,68	65,00	39,00	78,00	
(H-9) The news in the media and social media affects the provision of health services to refugees.						
Disagree	52,95	11,67	54,00	27,00	77,00	0.006
Agree	57,04	11,38	58,00	13,00	78,00	
(H-10) Health services should be provided for refugees free of charge.						
Disagree	61,12	9,33	61,00	22,00	78,00	0.001
Agree	50,93	11,38	52,00	13,00	74,00	
(H-11) Refugees should be limited on the number of children.						
Disagree	49,97	11,75	51,00	13,00	78,00	0.001
Agree	59,16	10,20	59,00	15,00	78,00	
(H-12) Adjustment of refugees to Turkish culture is necessary for quality delivery of health services.						
Disagree	60,36	11,06	60,00	30,00	78,00	0.001
Agree	55,26	11,46	56,00	13,00	78,00	

*Mann Whitney U test.

Table 3. Distribution of demographic data of physicians

Groups		Count (n)	Percentage (%)
Gender	Male	224	59,1
	Female	155	40,9
Age	25-30	129	34,0
	31-36	75	19,8
	37-42	50	13,2
	43-48	41	10,8
	49-54	60	15,8
	55-60	17	4,5
	61-66	7	1,8
Marital status	Single	134	35,4
	Married	245	64,6
Children	Yes	203	53,6
	No	176	46,4
Hospital	Medicine	166	43,8
	Public	143	37,7
	FHC	70	18,5
Distribution of general practitioners/specialists	General practitioners	81	21,4
	Specialists	298	78,6
Have you given service to refugees before?	Yes	351	92,6
	No	28	7,4
Would you give service to refugees if you were offered the right to choose?	Yes	249	65,7
	No	130	34,3
Total		379	100,0

Table 4. Distribution of physicians' views about non-citizens' access to health services and the phenomenon of migration

Descriptive statistics				
Items	***N***	***Min.***	***Max.***	***Mean***
1. The increase in the number of refugees affects Turkish citizens' access to health services negatively.	*379*	*1*	*5*	*3,43±1,139*
2. Childbirths are increasing because the state provides free health and social services for refugees.	*379*	*1*	*5*	*3,66±1,102*
3. Refugees should not be provided with health services free of charge.	*379*	*1*	*5*	*3,27±1,087*
4. Refugees will adjust more easily when they give birth in Turkey. (R)	*379*	*1*	*5*	*2,27±1,058*
5. Refugees should be provided with health services in separate places.	*379*	*1*	*5*	*3,57±1,167*
6. The increase in the number of refugees increases violence in health.	*379*	*1*	*5*	*3,05±1,205*
7. Medical institutions should not have interpreters for refugees.	*379*	*1*	*5*	*1,63±,955*
8. The news in the media and social media affects the provision of health services to refugees.	*379*	*1*	*5*	*3,30±,978*
9. Health services should be provided for refugees free of charge. (R)	*379*	*1*	*5*	*2,50±1,063*
10. Refugees should be limited on the number of children.	*379*	*1*	*5*	*3,34±1,288*
11. Adjustment of refugees to Turkish culture is necessary for quality delivery of health services.	*379*	*1*	*5*	*3,56±1,114*

Table 5. Distribution of physicians' responses to the Xenophobia Scale

Descriptive statistics				
Items	N	Min.	Max.	Mean
1. Migration in this country has gotten out of control.	379	1	6	5,01±1,126
2. Borders should be made more secure to prevent inflow of migrants into this country.	379	1	6	4,65±1,282
3. Migrants cause an increase in crimes.	379	1	6	4,47±1,239
4. Migrants take away jobs from local people.	379	1	6	4,26±1,324
5. Interacting with migrants disturbs me.	379	1	6	2,88±1,429
6. I enjoy interacting with migrants (R)	379	1	6	4,24±1,257
7. I welcome interaction with migrants (R)	379	1	6	3,48±1,312
8. I am worried that migrants may spread unusual diseases.	379	1	6	4,76±1,111
9. I am afraid that in case of war or political tension, migrants will be loyal to their country and roots.	379	1	6	4,39±1,327
10. I trust that migrants will support my country in times of crisis (R)	379	1	6	4,84±1,118
11. I am afraid that our way of life will change for the worse with increasing migration.	379	1	6	4,70±1,210
12. I doubt that migrants will give priority to the interests of this country.	379	1	6	4,77±1,154
13. I am afraid that our own culture will be lost with the increase of migration.	379	1	6	3,74±1,548
Xenophobia	379	13,00	78,00	56,20±11,54

Table 6. Comparison of physicians' responses to the Xenophobia Scale with the demographic Data

Group		Xenophobia				
		Mean	Median	Minimum	Maximum	P value
Gender	Male	55,10 ± 11,97	55,00	13,00	78,00	0,045*
	Female	57,79 ± 10,73	59,00	24,00	78,00	
Age	25-30	57,26 ± 10,75	58,00	22,00	78,00	0,312**
	31-36	53,84 ± 11,58	54,00	31,00	77,00	
	37-42	58,18 ± 9,90	59,50	15,00	73,00	
	43-48	56,76 ± 12,22	57,00	24,00	78,00	
	49-54	54,53 ± 14,05	53,50	13,00	77,00	
	55-60	57,41 ± 9,11	58,00	37,00	73,00	
	61-66	55,71 ± 12,34	60,00	30,00	67,00	
Marital status	Single	56,83 ± 11,50	58,00	22,00	78,00	0,524*
	Married	55,85 ± 11,57	57,00	13,00	78,00	
Children	Yes	56,10 ± 11,72	57,00	13,00	78,00	0,911*
	No	56,31 ± 11,37	57,00	22,00	78,00	
Institution	Faculty of Medicine	56,64 ± 10,94	58,00	22,00	78,00	0,942**
	Public Hospital	56,13 ± 11,22	56,00	15,00	78,00	
	FHC	55,29 ± 13,53	57,00	13,00	75,00	

Specialization	General practitioner	54,54 ± 14,37	55,00	13,00	78,00	0,380*
	Specialist physician	56,65 ± 10,63	57,00	22,00	78,00	
Distribution of specialization main branch	Surgical sciences	58,55 ± 9,91	59,00	31,00	78,00	0,022*
	Internal sciences	55,29 ± 12,01	55,00	13,00	78,00	
Distribution of specialization main branch II	Surgical sciences	58,18 ± 10,19	58,00	31,00	77,00	0,020**
	Internal sciences	55,49 ± 12,43	57,00	13,00	78,00	
	Pediatrics	56,43 ± 10,70	56,00	33,00	76,00	
	Obstetrics	60,00 ± 9,82	61,00	39,00	78,00	
	Emergency	51,52 ± 9,60	51,00	31,00	70,00	
Status of giving services to refugees	Yes	56,08 ± 11,65	57,00	13,00	78,00	0,589*
	No	57,68 ± 10,14	57,00	33,00	75,00	
Willingness to give service to refugees	Yes	52,59 ± 10,99	53,00	13,00	76,00	<0,001*
	No	63,11 ± 9,22	64,00	39,00	78,00	

*Mann-Whitney U **Kruskal-Wallis.

Table 7. Comparison of physicians' views about non-citizens' access to health services and the phenomenon of migration and their responses to the Xenophobia Scale

Items	Groups	Xenophobia				P value
		Mean	Median	Min.	Max.	
1. The increase in the number of refugees affects Turkish citizens' access to health services negatively.	Strongly disagree	40,71 ± 13,90	42,00	13,00	73,00	<0,001
	Disagree	46,54 ± 10,01	48,00	22,00	68,00	
	Undecided	53,19 ± 8,14	53,00	30,00	73,00	
	Agree	59,91± 8,01	60,00	39,00	77,00	
	Strongly agree	66,96 ± 7,61	67,00	43,00	78,00	
2. Childbirths are increasing because the state provides free health and social services for refugees.	Strongly disagree	37,22 ± 13,58	42,00	13,00	54,00	<0,001
	Disagree	47,28 ± 11,27	47,00	22,00	73,00	
	Undecided	51,01 ± 9,85	52,00	15,00	77,00	
	Agree	57,67 ± 8,56	58,00	33,00	76,00	
	Strongly agree	65,56 ± 7,10	66,00	47,00	78,00	
3. Refugees should not be provided with health services free of charge.	Strongly disagree	37,31 ± 12,05	41,00	13,00	55,00	<0,001
	Disagree	49,67 ± 10,83	49,00	24,00	73,00	
	Undecided	55,79 ± 9,13	55,00	23,00	77,00	
	Agree	58,54 ± 9,43	59,00	22,00	77,00	
	Strongly agree	66,74 ± 8,60	67,00	39,00	78,00	
4. Refugees will adjust more easily when they give birth in Turkey. ***	Strongly disagree	62,67 ± 9,23	63,00	42,00	78,00	<0,001
	Disagree	56,11 ± 10,21	55,00	13,00	78,00	
	Undecided	50,62 ± 11,94	51,00	22,00	77,00	
	Agree	53,28 ± 10,36	53,00	23,00	77,00	
	Strongly agree	53,00 ± 19,00	58,50	15,00	78,00	
5. Refugees should be provided with health services in separate places.	Strongly disagree	53,13 ± 15,75	48,00	32,00	77,00	<0,001
	Disagree	49,56 ± 10,78	51,00	24,00	77,00	
	Undecided	52,98 ± 11,52	54,00	13,00	75,00	
	Agree	57,40 ± 8,84	57,00	23,00	77,00	
	Strongly agree	62,34 ± 10,56	63,00	15,00	78,00	

6. The increase in the number of refugees increases violence in health.	Strongly disagree	43,87 ± 15,82	45,00	13,00	77,00	<0,001
	Disagree	50,31 ± 9,44	51,00	22,00	73,00	
	Undecided	55,64 ± 8,74	56,00	33,00	75,00	
	Agree	61,45 ± 8,10	62,00	32,00	76,00	
	Strongly agree	67,84 ± 6,90	68,00	47,00	78,00	
7. Medical institutions should not have interpreters for refugees.	Strongly disagree	56,06 ± 12,10	57,00	13,00	78,00	0,029
	Disagree	54,95 ± 10,12	55,00	23,00	78,00	
	Undecided	58,55 ± 13,08	62,00	39,00	77,00	
	Agree	60,78 ± 13,07	64,00	42,00	77,00	
	Strongly agree	64,4 ± 9,77	66,00	50,00	78,00	
8. The news in the media and social media affects the provision of health services to refugees.	Strongly disagree	49,77 ± 15,18	49,00	27,00	75,00	0,034
	Disagree	53,58 ± 10,87	54,00	30,00	77,00	
	Undecided	57,20 ± 9,95	57,00	23,00	78,00	
	Agree	56,78 ± 10,43	57,00	30,00	77,00	
	Strongly agree	57,38 ± 17,94	64,00	13,00	78,00	
9. Health services should be provided for refugees free of charge.	Strongly disagree	65,53 ± 8,10	67,00	44,00	78,00	<0,001
	Disagree	58,38 ± 9,01	59,00	22,00	77,00	
	Undecided	53,47 ± 9,85	53,50	23,00	74,00	
	Agree	46,45± 11,51	45,00	13,00	73,00	
	Strongly agree	48,18 ± 17,49	54,00	15,00	73,00	
10. Refugees should be limited on the number of children.	Strongly disagree	45,07 ± 15,74	44,00	13,00	78,00	<0,001
	Disagree	51,36 ± 10,02	52,00	23,00	77,00	
	Undecided	52,90 ± 10,71	53,00	15,00	72,00	
	Agree	58,27 ± 7,99	58,00	42,00	76,00	
	Strongly agree	64,79 ± 8,53	66,00	37,00	78,00	
11. Adjustment of refugees to Turkish culture is necessary for quality delivery of health services.	Strongly disagree	67,19 ± 7,66	70,00	50,00	78,00	<0,001
	Disagree	57,43 ± 11,06	59,00	30,00	78,00	
	Undecided	55,48 ± 11,54	55,00	22,00	78,00	
	Agree	54,70 ± 10,66	55,00	23,00	77,00	
	Strongly agree	56,12 ± 12,91	57,50	13,00	76,00	

*Kruskal-Wallis H Test.

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