

## RESEARCH PAPER

# Caring for Immigrants: from interacting in practice to building nurses' cultural competencies

Cuidar de Imigrantes: das interações em contexto à construção de competências culturais nos enfermeiros

Atender a los inmigrantes: de las interacciones en el contexto a la construcción de competencias culturales en enfermeros

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## Abstract

**Background:** Immigrant care provides nurses with a new way to look at themselves and those they care for. According to Leininger and Meleis, the interaction between them underlies the development of cultural competencies in nurses and a balanced experience of transition processes in immigrants.

**Objectives:** To study the process of building cultural competencies in nurses based on the identification of the meanings assigned in dyads in health care settings (family health units and immigrants' households).

**Methodology:** This qualitative and ethnographic study mobilised the researcher to be present in loco with the participants. Data were collected using narratives, participant observation, ethno-biographical interviews and focus groups with a group of volunteers selected from health care units: 23 nurses, 27 immigrants and 2 privileged informants (a cultural mediator and a physician).

**Results:** In health care contexts, nurses' cultural competencies are built in a procedural way. This process begins with their interaction with immigrants; nurses then identify deficit areas in their cultural knowledge and skills; and recognise the bilateral cultural heritage during those meetings.

**Conclusion:** In nurses' clinical practice, cultural awareness, combined with the motivation to take care of immigrants, is based on an evolutionary basis, from ethnocentrism to ethnic relativism.

**Keywords:** cultural competency; nurses; emigrants and immigrants.

## Resumo

**Enquadramento:** Cuidar de imigrantes proporciona aos enfermeiros uma nova forma de olhar sobre si mesmos e sobre aqueles de quem cuidam. As interações entre estes atores estão na base do desenvolvimento das competências culturais nos enfermeiros e da vivência equilibrada de processos de transição nos imigrantes, de acordo com Leininger e Meleis.

**Objetivos:** Estudar o processo de construção das competências culturais nos enfermeiros, partindo da identificação dos significados atribuídos nas díades em contexto de cuidados (unidades de saúde familiar e domicílios dos imigrantes).

**Metodologia:** Este estudo qualitativo e etnográfico mobilizou a presença do investigador com os atores no contexto. Utilizámos na recolha de dados: narrativas, observação participante, entrevistas etnobiográficas e grupos de discussão. Participantes selecionados: integrantes de unidades de saúde e voluntários para o estudo – 23 enfermeiros, 27 imigrantes e 2 informantes privilegiados (mediadora cultural e médico).

**Resultados:** As competências culturais nos enfermeiros constroem-se de forma processual no contexto de cuidados. O processo inicia-se nas interações com os imigrantes; os enfermeiros identificam as áreas deficitárias nos conhecimentos e habilidades culturais; e tomam consciência do património cultural bilateral nos encontros.

**Conclusão:** A consciência cultural, associada à motivação para cuidar de imigrantes, assenta numa base evolutiva do etnocentrismo para o relativismo étnico na prática clínica dos enfermeiros.

**Palavras-chave:** competência cultural; enfermeiros; emigrantes e imigrantes.

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## Resumen

**Marco contextual:** La atención a inmigrantes proporciona a los enfermeros una nueva forma de verse a sí mismos y a los que cuidan. Las interacciones entre estos actores están en la base del desarrollo de competencias culturales en los enfermeros y de la experiencia equilibrada de procesos de transición en los inmigrantes, de acuerdo con Leininger y Meleis.

**Objetivos:** Estudiar el proceso de construcción de las competencias culturales en los enfermeros a partir de la identificación de significados asignados en las díadas, en contextos de atención (unidades de salud familiar y hogares de los inmigrantes).

**Metodología:** Este estudio cualitativo y etnográfico permitió que el investigador estuviese con los actores en el contexto. En la recogida de datos, se utilizaron: narrativas, observación participante, entrevistas etnobiográficas y grupos de discusión. Participantes seleccionados: integrantes de unidades de salud y voluntarios – 23 enfermeros, 27 inmigrantes y 2 informantes privilegiados (mediadora cultural y médico).

**Resultados:** Las competencias culturales en los enfermeros se construyen de forma procesual en los contextos de atención de enfermería. Este proceso comienza en las interacciones con los inmigrantes; los enfermeros identifican las áreas deficitarias relativas a los conocimientos y las habilidades culturales, y toman conciencia del patrimonio cultural bilateral en los encuentros.

**Conclusión:** La conciencia cultural, asociada a la motivación para atender a los inmigrantes, se basa en una evolución del etnocentrismo al relativismo étnico en la práctica clínica del personal de enfermería.

**Palabras clave:** competencia cultural; enfermeros; emigrantes e inmigrantes.

Received for publication: 16.05.13

Accepted for publication: 21.01.14

## Introduction

Nowadays, health care contexts are characterised by ethnic and cultural diversities and nursing care subjects are often immigrants with different backgrounds and, therefore, experiencing the inherent phases of transition (Meleis, 2010). The interactions established in health care settings between nurses and immigrants and the cultural competencies resulting from such interactions are the backbone of this study. According to the Report on Immigration, Frontiers and Asylum by the Immigration and Borders Service (SEF – *Serviço de Estrangeiros e Fronteiras*) (Serviço de Estrangeiros e Fronteiras. Departamento de Planeamento e Formação. Núcleo de Planeamento, 2012), in 2011, the migratory flow to Portugal decreased by 10.6% compared with 2010. However, these citizens are still relevant as health care consumers, particularly as nursing care consumers, and have their own cultural specificities in health care settings. In this study, immigrants are understood as foreigners “holding a residence permit and foreigners whose long-term stay has been extended” (Serviço de Estrangeiros e Fronteiras. Departamento de Planeamento e Formação. Núcleo de Planeamento, 2012, p. 15).

In agreement with the perspective pointed out by the United Nations High Commissioner for Health in Portugal, we emphasise the importance assigned to immigrant health and care. According to Machado, Pereira, and Machaqueiro (2010), two key issues emerge: the importance of ensuring the immigrants' health-related challenges within the boundaries of the national territory and the definition of strategies that ensure people's health in their cultural diversity. These dimensions also support the interest of our study.

According to the *Ordem dos Enfermeiros* (Portuguese Nurses' Association) as regards the nurses' professional exercise and general care skills, we realise how pivotal it is for them to be sensitive to deal with cultural differences while interacting with people in their clinical practice (Ordem dos Enfermeiros. Conselho de Enfermagem, 2003).

As in the study of Serrano, Costa, and Costa (2011), we value the interaction processes between nurses and subjects of care, together with the acquired *experiential learning* developed meanwhile and the building of competencies. Our research study focused on the development of cultural competencies.

Several authors have emphasised the importance of the cultural dimension in interaction processes with and while caring for immigrants, as it is the case with the national studies of Anes (2006) and Pereira (2008), with objects of study and approaches that are cross-sectional to the care provided by health teams. That is also the case with some international studies, such as the study of Skott and Lundgren (2009), who specify different interactions in multicultural contexts of nursing care.

We set out to study the process of building cultural competencies in nurses, based on the identification of the meanings assigned in dyads in health care settings, specifically in family health units and immigrants' households. On this reflective basis, we posed the question: how is the process of building nurses' cultural competencies to care for immigrants developed? In order to answer to this research question, we applied a methodological triangulation of actors and contexts in support of the intended interpretative statements. This was in line with the ethnographic orientation of the study.

## Background

### **A theoretical framework in clinical practice with immigrants**

We understand our theoretical perspective as “versions or perspectives, through which the world is seen” (Flick, 2005, p. 44) and, therefore, we consider it to be in line with the discovery process of the qualitative research which we have developed.

Thinking about multiculturalism in nursing is also thinking about the role, visibility and recognition that cultural competencies have had in the development of clinical practice and also, conversely, about how the latter has contributed to the nurses' cultural competencies, as stated by different authors (Campinha-Bacote, 2011; Purnell, 2011). While studying the process of building cultural competencies in nurses, we used a two-dimensional perspective based on the different actors involved: *some of them* - the nurses, because they are responsible for the planning, development and assessment of care, and the *others* - the immigrants, because they are the focus of the nurses' professional attention. In this way, we hoped that these subjects of care would express the *visible side* of the nurses' competencies during their health and illness experiences.

For the conceptualisation of the study, we selected the Leininger's theory of cultural care diversity and universality (1994), considering that it proposes the *discovery* of cultural diversities (differences) and universalities (similarities) in human care, such as those we found in the nurses/immigrants dyads for the production of new knowledge to guide the nursing practice. According to Purnell (2011), by adopting the former author's perspective, we were able to understand the cultural care specificities related to beliefs and behaviours associated with each specific context, which define the interactions between those who care and those who receive care. According to Leininger's theory, we valued the holistic view, which is distinct from the fragmented way of looking at people and comprehensive in multicultural care contexts. This theory is based on the concept of culture, which is also mentioned by Purnell as "the specific pattern of behaviour that distinguishes any society from others and gives meaning to human expressions of care" (Culture Care Theory: A major contribution to advance transcultural nursing knowledge and practices, 2002, cited in Purnell, 2011, p. 532). We used this perspective as an ontological support for the explanations and interpretations of the phenomenon under analysis: building cultural competencies in nurses. Still according to Leininger's theoretical perspective, we distinguished between *care* and *caring*: the first concept implies the provision of the "required and customised services that help the person maintain his/her health status or recover from illness", and the second one, "used as a verb, implies a feeling of compassion, interest, and concern for people" (1994, p. 30).

We also based our analysis on Meleis' transitions theory (2010) regarding the analysis of human relationships and changes - transitions, which, according to the author, occur in particular situations and contexts over a span of time. This theoretical perspective sustained our analysis of the immigrants' health and illness processes, which Meleis mentioned in particular, as well as the analysis of their interactions with nurses in health care settings. The concept of transition in this study followed Meleis' perspective (2010), which considers it to be central to the nursing clinical practice and the genesis of changes in people's lives, health, relationships and environment. Nurses have taken on an important role in monitoring the entry, passage and exit from these

phases. Specifically in relation to immigrants' concept of transition, in this study, as in Meleis (2010), we considered that such experiences go far beyond geopolitical boundaries, overcoming life stages and conditions, and contributing to the immigrants' self-definition as people. We thought about what nurses would need to overcome these situations, as Meleis mentioned (2010) and which Purnell (2011) referred to as the need for nurses to "acknowledge themselves as culturally competent" (p. 529). Such need was also emphasised in the study of Vega (2010), who pointed out, as Leininger had done in the past (1994), the contributions of anthropology as potentially contributing for nurses to develop a greater reflective capacity on themselves and their clinical practice, particularly in caring for immigrants.

In line with various authors, we discussed the fact that the subjects of care are people with different cultural references than those which are dominant in the care contexts of the host country (Fonseca, Silva, Esteves, & McGarrigle, 2009; Meleis, 2010). We highlighted the importance of the nurses' self-reflection on their own cultural values to construct their cultural competencies (Campinha-Bacote, 2011; Purnell, 2011). We also valued the reflection on the cultures and subcultures of the nurses' organisational health context in line with the studies of Vega (2010) and Serrano et al. (2011). This valuation resulted from the assumption that the most important aspect for human behaviour and development is often connected to how the environment is "perceived and not as it could exist in the «objective» reality", as Bronfenbrenner (2002, p. 6) mentions in the ecological model of human development. Focusing on the cultural dimension of the actors (nurses and immigrants) and the care contexts, we became progressively aware in this study of a need for a dynamic valuation of the acquisition of experiences and competencies throughout the nurses' professional path in clinical practice. This aspect is also emphasised in the study of Serrano et al. (2011). The process of building nurses' cultural competencies was also associated with the perspective of Campinha-Bacote (2011), who argues that the professionals' development involves the active construction of *similarities* between themselves and immigrants in health care settings, in addition to their necessary *identification*, as it had already been mentioned by Leininger (1994).

Similarly to Campinha-Bacote (2011), as a reference for this study, we mobilised the nurses' cultural competencies built based on: cultural sensitivity; self-awareness; knowledge; humbleness and cultural skills; and planning of interactions with immigrants in specific cultural meetings, assuming the necessary initial motivation of nurses.

In this line of thought, we established the following research questions: how are the interactions between nurses and immigrants in care contexts characterised? What difficulties and gains are identified in multicultural contexts?

In accordance with our perspective, we considered that the influence of the nurses' interactions with immigrants promotes adjustments in the dyads of care and results in the development of attitudes, motivations and behaviours towards the building of cultural competencies in nurses.

## Methodology

Based on the abovementioned theoretical perspective and to answer the research questions, we adopted an inductive and interpretative logic of study, valuing the meanings assigned by the actors in the interaction contexts.

This is a qualitative and ethnographic research study, in which we reconstructed the meanings of the process of building cultural competencies in nurses. The sample was composed of a total of 52 volunteers who consented to participate: 23 nurses, a cultural mediator and a physician - professionals working at the health care units where the study was conducted; and 27 immigrants - users of the same units. Participants *opened the way to the researcher* through a *snowball* effect as they threw it from one to the other, while we stood in the field and progressively experienced different roles, moving from strangers to members, as Flick had pointed out (2005). According to Durand and Blais (2003), mobilising the cultural mediator and the physician for data collection, both working at the health care units, ensured the internal validity of the study based on their conceptual knowledge of the phenomenon.

### Data collection procedures

By defining the research methods in the study design, we aimed at constructing a logical chain of evidence, in

a recursive perspective of data collection and analysis as pointed out by Streubert and Carpenter (2013), one that would allow us to elaborate a heuristics compatible with the cultural characterisation of the nurses' competencies when caring for immigrants.

The following ethnographic research methods were used in data collection: analysis of written narratives focused on interaction and care, which we requested to the nurses and immigrants of those specific units; participant observation with a descriptive and, subsequently, focused record (Spradley, 1980) of the nursing care provided to immigrants; and ethno-biographical interviews to nurses, immigrants and also privileged informants (cultural mediator and physician). The interview script was structured based on the collection and analysis of data from the narratives requested and also based on the initial phase of participant observation, using a semi-directive method (Flick, 2005). In line with Streubert and Carpenter (2013), we considered that "using multiple data collection methods is important because it increases the reliability of the results" (p. 206).

The field work took place during intermittent periods between September 2011 and October 2012. The study was carried out in primary health care settings in the Health Region of Lisbon and Tagus Valley in contexts of nursing care to the immigrant population - family health care and health care units within the community in situations of home care to immigrants. These characteristics were chosen based on the opportunities given to better access and develop the research study. According to the Mighealthnet Portuguese State of the Art Report (Fonseca et al., 2009) and the perspective of Machado et al. (2010), we observed that primary health care settings are often the immigrants *entry gate* into the host country's national health system, in particular through health promotion and illness prevention in child health (their children's health). This observation is compatible with the fact that these individuals continued to adhere to care throughout the study, thus making the accessibility and continuity of our research possible.

In relation to our ethical concerns as researchers, they were specifically related to the participants' protection. In this regard, the need arose as to conciliate the clarity of the study objectives with the use of different data collection methods,

without either imposing constraints on participants or causing the loss of the desired spontaneity in the data collection process. Being aware of the sensitivity inherent to participant observation situations in care processes in immigrants' households or health care units, and even in focus groups, we committed ourselves to fully respect the confidentiality and privacy of data in all data collection methods, as well as the anonymity of all participants in the care process. To this end, we explained and completed the informed consent form with each participant, as proposed by Streubert and Carpenter (2013). We progressively accessed the cultural knowledge of both nurses and immigrants, by developing the necessary cultural inferences (Streubert and Carpenter, 2013) given the way they perceived themselves in relation to their cultural competencies (the nurses) and whether they felt more or less *culturally helped and understood* during their health – illness transitions (the immigrants). It was a process of progressive focalisation as we analysed the data from participant observation and the narratives, the *corpus* of the ethno-biographical interviews, placing our attention on the pivotal moment, i.e., the interactions and care between nurses and immigrants.

In the final phase of the field work, we returned the analysed data to both types of subjects, aiming at the validation of our interpretations as well as the data saturation based on the obtained redundant information. Two distinct focus groups were used for this purpose (one with immigrants and another with nurses), first by encouraging answers to general questions, and, then, gradually, to questions that were more specifically concerned with the issues under study. This planning was made following the taxonomic and component analysis of the data resulting from the descriptive and focused participant observation (Spradley, 1980). Therefore, the focus groups were based on scripts that allowed the participants' discourses to be recorded in their specificity, in accordance with the proposal by Geoffrion (2003). In line with this author, these moments allowed us to observe if the questions made to one or both groups had common or different meanings, which valued the possibilities to, on the one hand, *obtain quick results* and, on the other hand, use a flexible technique that allows for the inversion

and/or reformulation of questions. To develop the nurses' script, the conceptual approach of the model of cultural competencies of Campinha-Bacote (2011) was used based on the following constructs: cultural awareness, cultural knowledge, cultural skill, cultural encounter, and cultural desire. For the immigrants' group, the dimensions of awareness, response patterns and perceptions of the concept of health-illness transition were used, as suggested by Meleis (2010). By reflecting on our role in using this type of research technique and knowing that we could easily influence the production of data in the field, we first conducted the nurses' focus group. We believed that our presence in this group would be quickly associated with the indigenous culture, thus promoting our appropriation of the social reality and the possibility of it being used later on while conducting the immigrants focus group. This was in line with Flick (2005). Moreover, in line with Purnell (2011), regarding the need for each subject to *acknowledge himself/herself* in his/her culture, both individually and collectively, and considering that we aimed at identifying the specificities of the different types of subjects, we defined a key question for each group based on the mentioned author and the issue under analysis:

– Nurses' group: "To what extent do you acknowledge yourselves as builders of your cultural competencies when caring for immigrants?"

– Immigrants' group: "To what extent do nurses help you during your health-illness transition processes?"

## Results and Discussion

We had previously been granted access to the field (Flick, 2005), as had happened with the immigrants' family nurses. Thus, we were able to effectively mobilise these subjects to the focus group which aimed at the validation and saturation of the data obtained from the previous techniques.

Based on the above-mentioned constructs and dimensions for both nurses and immigrants, we discussed the results with the two groups of participants. The results were presented according to the previously raised research questions.

In relation to the question "how are the interactions between nurses and immigrants in care contexts characterised?", we obtained the following results:

## **In immigrants**

### **Response patterns identified in encounters with nurses**

In the immigrants' characterisation of these patterns, a comparison was made with the nurses from their country of origin, and the closeness to these professionals in Portugal was valued. We believe that this closeness is associated with the individualisation experienced in the preparation and course of these meetings, since the immigrants acknowledged the nurses' role in helping them find balance and safety during the health-illness transition processes. A reference was also made to the *privileged treatment* that they experienced during the cultural encounters with nurses for being as immigrants in the condition of a *minority*. This contrasts with the feeling of marginalisation that is more frequently pointed out by these groups, as suggested in other studies (Skott & Lundgren, 2009; Vega, 2010).

## **In nurses**

### **Planning and course of the cultural encounters**

The need for more time to develop a relationship in the dyads of care was experienced in both family health units and home visits to immigrants. The nurses identified the need to be more *cautious* in validating the conveyed and received messages, which implied more time spent interacting. In line with the study of Skott and Lundgren (2009), the nurses also highlighted situations of constraint during the meetings whenever the interpreters were the immigrants' relatives (sometimes their children). Here we identified a feeling of ambivalence by the nurses when they were in the presence of interpreters (relatives or not) because, on the one hand, they had someone to translate for them but, on the other hand, their presence might constrain the person who is being cared for.

### **The manifestation of cultural desire**

In this study, the nurses' motivation to care for immigrants was associated with the idea of greater professional development. The nurses stated that if they learned to adequately care for immigrants, they would know how to provide care individually, in any situation, and to any person. We believe that this attitude is consistent with the line of thought of Campinha-Bacote (2011) regarding the

characteristics of cultural flexibility and humility mentioned by the author as essential for the development of cultural competencies in nurses, learning from others and looking at them as cultural informants.

In response to the question "What difficulties and gains are identified in multicultural contexts?", we obtained the following results:

## **In immigrants**

### **The awareness of the nurses' influence in their health-illness processes**

As a gain, the immigrants emphasised the idea that the nurses working at family health units and home visits passed on important knowledge from a perspective that they believed was similar to the one experienced by Portuguese citizens in their health-illness processes. There was a need for a feeling of belonging and relational symmetry that focused on the universalities rather than the diversities during the meetings, in line with the study of Vega (2010). There were situations of persistent doubts throughout the communication process, particularly during the nursing consultations. The immigrants assumed, in a less-than-explicit way, the occasional record of an insufficient contribution to their health-illness transitions. However, they relegated the analysis of this observation to the need to discuss who was responsible for that, thinking that both parties in the dyads of care shared responsibility. We believe that the immigrants' *lack of openness* to explicitly assume their difficulties in communicating and interacting during the care process was associated with our overlapping roles, both as researchers and nurses. This was considered to be a study limitation at this point.

### **Perception of the nurses' contributions to their stability in the experienced transitions**

The dyadic closeness emerged as an added value to the immigrants' decision-making in both their individual and family health-illness processes. This aspect seemed to emerge together with the differences that they identified and valued with regard to the competencies of the nurses who cared for them at the time and those that they remembered of the nurses in their countries of origin. The nurses' use of humour was clearly pointed out by immigrants as a facilitating factor and a synonym for safety while

caring for their children, thus contributing for the loss of fear among both adults and children.

## **In nurses**

### **Development of cultural awareness**

The nurses considered that the encounters with the immigrants had them question the way they looked *inside* themselves, to better understand *the others* in their individual health and life projects. They valued the possibility of developing their capacity for empathy in those encounters as they often tried to put themselves in *other people's shoes*. They pointed out difficulties in reflecting on their clinical practice and on the moments planned for discussion in peer and multidisciplinary teams. We believe that these difficulties were associated with the self-examination and self-exploration proposed by Campinha-Bacote (2011) regarding the development of cultural competencies in nurses.

### **Identification of cultural knowledge areas**

The nurses in this study believed that caring for immigrants stimulated their search for what caused some of these people's behaviours. They emphasised difficulties in understanding how the immigrants culturally contextualized their health and illness. In our opinion, this attitude is in line with one of the axes identified by Campinha-Bacote (2011) for the development of culturally competent care, based on the knowledge of the immigrants' health beliefs and values. On the other hand, the nurses also emphasised that one of their aims when caring for immigrants was to allow them to understand what the health care institutions could offer them. This concern is in line with the study of Serrano et al. (2011), who emphasise the importance of developing a collective competence among individuals, based on a learning environment between them and the institution.

### **Cultural skills used in situations of interaction**

The characterisation of these skills was associated with the promotion of safety and with specific attention. This assumption was in line with the immigrants' observation in their focus group, stating that they felt as a focus of *special attention* for being immigrants. The nurses identified difficulties in planning individualised care with these people

and in communicating with them due to linguistic barriers and the cultural background of the message. Nevertheless, the presence of children (the immigrants' daughters) emerged as a facilitating factor during the encounters.

## **Conclusion**

Nurses become gradually aware that their personal, professional and organisational culture in these dyads with immigrants is not the only possible matrix to the immigrants' health-illness transitions. This awareness opens up other opportunities for the nurses' professional development as they move from an ethnocentric view to a more relative view, in which the professionals' own culture is only an organising aspect among many other possibilities that they manage to identify in the people whom they care for. This process takes place as their cultural competencies are built.

The interactions between nurses and immigrants in this study were characterised based on the answers given to our first research question.

As regards the difficulties and gains in the studied multicultural contexts, which we also questioned, we concluded that the nurses' active identification and search for deficient areas in their knowledge and skills in caring for immigrants were valued by the professionals to build their cultural competencies. The presence of children (the immigrants' daughters) was particularly identified by both participants as an added value, presenting itself as a facilitating factor during the encounters, while aiming at care consistency. The nurses identified the children's presence as an increased possibility of a quick and easier interaction with their parents in clinical practice. We believe this to be an important line of research. The participants in this study also assigned a special meaning to the relational symmetry in the dyads, and the closeness and flexibility in the established interactions, which are also sometimes a source of difficulties.

These findings are important for building cultural competencies in nurses, as well as creating harmony and a quicker balance in the immigrants' health-illness transitions.

Taking into account that the emergence of the scientific knowledge prioritises quality in the

multicultural clinical practice, we suggest that further studies should investigate the perception of the different health professionals regarding their need to build cultural competencies to care for immigrants within a multidisciplinary team.

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