



Discourse of nurses and doctors on the use of the emergency service by immigrants

Discurso de enfermeiros e médicos sobre a utilização do serviço de emergência por imigrantes

Discurso de enfermeros y médicos sobre la utilización del servicio de urgencias por inmigrantes

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ABSTRACT

Objective: To describe the discourse of nurses and physicians on the use of emergency services by immigrants. **Method:** Descriptive and exploratory study, with qualitative approach, carried out in an emergency public unit located at the north of Paraná. Sixteen health professionals were interviewed through a semi-structured questions. The interviews were audio-taped and their contents, after transcription, submitted to French discourse analysis. **Results:** It was identified, according to professionals, that immigrants seek emergency services mainly due to work-related problems, because they are unaware on how the Brazilian health system works and because they have difficulties to access other services. In addition, communication, cultural, professional, socioeconomic, and prejudice barriers were highlighted as influencing the care for the immigrant population. **Conclusion and implications for practice:** Given such findings, it is imperative to develop orientation and preparation activities for the immigrant population on the Brazilian culture and health system and health professionals regarding the cultural and socio-sanitary profile of the immigrant population, thus enhancing the adequate search of the users and the qualified care.

Keywords: Health Personnel; Emigrants and Immigrants; Emergency Medical Services; Nurses; Physicians.

RESUMO

Objetivo: Descrever o discurso de enfermeiros e médicos frente a utilização dos serviços de emergência por imigrantes. **Método:** Estudo descritivo e exploratório, de natureza qualitativa, realizado em uma unidade pública de pronto atendimento localizada no norte do Paraná. Participaram 16 profissionais que foram entrevistados por meio de um roteiro semiestruturado. As entrevistas foram áudio-gravadas e seu conteúdo, após transcrito, submetido à análise de discurso francesa. **Resultados:** Identificou-se, segundo os profissionais, que os imigrantes buscam os serviços emergenciais principalmente por problemas relacionados ao trabalho, porque desconhecem o funcionamento do sistema de saúde brasileiro e porque tem dificuldades para o acesso a outros serviços. Além disso, houve destaque para as barreiras comunicacionais, culturais, profissionais, socioeconômicas e de preconceito como influenciadoras no atendimento à população imigrante. **Conclusão e implicações para a prática:** Diante desses achados é premente que sejam desenvolvidas atividades de orientação e preparo da população imigrante sobre a cultura e o sistema de saúde brasileiro e dos profissionais de saúde acerca do perfil cultural e sócio-sanitário da população imigrante, potencializando assim, a busca adequada dos usuários e o atendimento qualificado.

Palavras-chave: Pessoal de Saúde; Emigrantes e Imigrantes; Serviços Médicos de Emergência; Enfermeiras e Enfermeiros; Médicos.

RESUMEN

Objetivo: Describir el discurso de enfermeros y médicos ante la utilización de los servicios de emergencia por inmigrantes. **Método:** Estudio descriptivo y exploratorio, de naturaleza cualitativa, realizado en una unidad pública de pronta atención ubicada en el norte de Paraná. Participaron 16 profesionales que fueron entrevistados por medio de un itinerario semiestructurado. Las entrevistas fueron audio-grabadas y su contenido, después de transcritos, fueron sometido al análisis de discurso francés. **Resultados:** Se identificó, según los profesionales, que los inmigrantes buscan los servicios de emergencia principalmente por problemas relacionados al trabajo, porque desconocen el funcionamiento del sistema de salud brasileño y porque tiene dificultades para el acceso a otros servicios. Además, hubo destaque para las barreras comunicacionales, culturales, profesionales, socioeconómicas y de preconceito influyentes en la atención de la población inmigrante. **Conclusión e implicaciones para la práctica:** Ante estoshallazgos es urgente que se desarrollen actividades de orientación y preparación de la población inmigrante sobre la cultura y el sistema de salud brasileño y de los profesionales de salud acerca del perfil cultural y socio-sanitario de la población inmigrante, potenciando, así, la búsqueda adecuada de los usuarios y una atención cualificada.

Palabras clave: Personal de Salud; Emigrantes e inmigrantes; Servicios Médicos de Urgencia; Enfermeros; Médicos.

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INTRODUCTION

Human mobility is a historical phenomenon that accompanies the development of societies from their beginnings.¹ Data from the United Nations (UN) indicate that in 2015 there were 65.3 million people that have been displaced from their countries. This was the first time that forced displacement has exceeded 60 million people. This index has shown 10% annual growth approximately, motivated, in particular, by the political, environmental, social and economic changes that occur in the most diverse parts of the world, imposing, above all, on the European countries, the increasing reception of immigrants.²

However, the Brazilian scenario is no different. For a long time, new configurations of the population panorama are constructed in the face of the growing wave of international immigration, which is sustained mainly by the entry of Venezuelans, Africans and Haitians, who are looking for employment opportunities and better living conditions.³ Brazil has been one of the destinations of choice because these groups find it relatively easy to cross national borders, especially those located at the northern region, and they envisage the possibility for obtaining permanent visas quickly and less bureaucratically, when compared to other countries.⁴

The presence of new immigration flows to Brazil has confronted the country with issues related to the social, economic and cultural integration of this population. Another aspect that has been discussed is access to healthcare, and according to the Law 8.080/1990 it is the duty of the state to guarantee to the foreigner who is living here, healthcare and universal and equal access to the actions and services for their promotion, protection and recovery. To such an effect, the state has the responsibility to assure the care, being concerned mainly with the basic attention, since it is understood as fundamental right of all the human beings.⁵

Thus, the relationship between healthcare and immigration should therefore be considered, because, when upon establishing themselves in a new country, the immigrants routinely face a diversity of factors that confront, condition and determine the health-disease process. Among the challenges are: communicational, linguistic and country-adaptation related difficulties; racial and ethnic prejudice, stereotyping and discrimination; supply of low-paid and low-skilled manual labor jobs; and lack of formal and informal social support, which is known to be reflected in isolation, information difficulty, illness, poor access to basic healthcare services and a more search for emergency services.¹

In the meantime, sometimes, even without adequate preparation, it is evident that the responsibility assigned to the health professionals as for the cares directed towards the immigrants, being necessary to build competences to care for this population.⁶ However, in spite of the increasing global and national migratory trend and the well-known relation between the migratory process and people sickness - which, consequently,

leads to the search for healthcare services⁷ - it is evident in the current literature a gap,¹ with regard to knowledge about how the professionals in the emergency units perceive the use of health services by the immigrants. This lack of scientific data should be considered in view of the increased vulnerability that these populations show regarding health issues and possible inconsistencies in the provided cares. Knowing these challenges allows to contribute to assistance adaptations that favor the inclusion and access of immigrants to emergency services and others, with attention to their particularities.

In view of these points, the study's objective was delineated as following: To understand the discourse of nurses and doctors regarding the use of emergency services by immigrants.

METHODOLOGY

A descriptive and exploratory study, with qualitative nature, carried out with nurses and physicians working in a Municipal Care Unit located at the northern region of the state of Paraná. The Unit has 11 beds and treats, on average, 200 patients per day among children and adults, and the team consists of three nurses and two physicians per shift.

Data were collected in August 2018, through an individual interview, conducted by two researchers, in a reserved room, in the unit's premises. The criteria for inclusion were the following: being a physician or nurse working in the emergency department and have provided care to immigrants at this location. In turn, those under maternity leave, in vacations or sickness leave, were excluded. To increase data variability, one sought to interview professionals from different work shifts (morning, afternoon and night), who were randomly selected.

In order to facilitate the participation of a larger number of professionals, the interviews occurred during the work period, considering the availability of each one so that there was no interference in the care for the users. The instrument used during the interview was a semi-structured script, elaborated by the authors based on the literature and the proposed objectives and was made up by two parts: the first with questions regarding the personal and professional profile of the interviewees and the second with questions related to their perceptions regarding the use of the emergency health service by immigrants, guided by the following question: *How do you perceive the immigrant's search for the emergency service? Tell me about it.*

The interviews, with an average duration of 25 minutes, were recorded in a digital device, once it was authorized by the interviewee, and then, fully transcribed, allowing for data analysis. For this process, the French Discourse Analysis was used, which allows to articulate the linguistic with the social and the historical. Thus, the method is not only studies the discourse in its linguistic form, but also as a material form of the historicity and cultural ideology of the individual.⁸ The analysis starts from delimiting the corpus, which corresponds to the clipping made by

the analyst on the discursive surface of their object of study and is conducted through the following steps: de-superficialization of the corpus, explication of the discursive formations and identification of ideological formations.

For the de-superficialization, readings and re-readings of the transcribed interviews were carried out with the purpose of identifying signs, traces and clues that pointed out to the thread of the discourse. The explication of the discursive formations occurred from the identification and clipping of the signifiers or discursive sequences responsible for the effects of meaning, produced in the empirical material. Then, the discursive formations were organized and related to the ideological formations of the subjects and their relation with other discourses regarding the interdiscourse and the discursive memory, was identified.⁹ From this meticulous analytical process one can identify and density the findings within the discursive blocks.

The interviewees were selected consecutively until reaching data saturation within the formations and the discursive blocks,¹⁰ that is, until the time when new data were not located or the new data located did not expand the formations and the discursive blocks and the understanding of the investigated phenomenon. At the end, two discursive blocks were identified: Contributing factors in the search for the emergency service by immigrants and; Care to the immigrants: understanding the difficulties of the professionals.

The study was developed in accordance with the guidelines disciplined by Resolution 466/12 of the National Health Council and the project approved by the Permanent Committee on Ethics in Research with Human Beings of the State University of Maringá (Written Opinion: 2.759.712). The free participation, confidentiality of the information and the anonymity of the interviewees who read and signed the Free and Informed Consent Term were guaranteed in two ways. And, in order to maintain data confidentiality, all participants were identified according to their respective professions followed by a numerical sequence (Ex: Doctor 01 and Nurse 01).

RESULTS

The population of the study was made up by 16 health professionals, divided equally between physicians and nurses. Age varied between 24 and 59 years old and the majority (11 cases) were men. As to the employment relationship, eight had more than one job and in terms of the time for completing this course it ranged from 6 months to 15 years. In relation to academic qualification, ten had a specialization course, five of which were in the emergency and emergency area and two declared to be studying or have already completed an academic master's degree.

Contributing factors in the search for the emergency service by immigrants

In this discursive block, the interviewees pointed out three factors that, according to their perceptions, trigger/favor the search for the emergency health service by immigrants, giving

rise to three discursive formations, namely: "Unawareness on the functioning of the Brazilian public health system"; "Difficulties of access" and "Problems associated with work", which will be described below.

Unawareness on the functioning of the Brazilian public health system

It was observed in this discursive formation that the immigrants, often, do not know the functioning of the Public Health System of Brazil. This, therefore, triggers the search for more complex healthcare services to deal with resolvable complaints in areas of lower technological density, such as, Basic Health Units.

"They also have difficulty understanding SUS, the form of [...] where to look for the drug, what kind of care is done here, what kind of care is done at the post [...] they do not have a very good understanding on how the issue of urgency and emergency and basic care works". (Doctor 01)

"The complaints are very simple so that they could be cared at a Health Post [...] I think that Brazil or the city do not guide these people about how the Unified Health System works and these patients come to the Emergency Department with a complaint that could be answered in the First-Aid Post, they do not know what is a health center". (Doctor 04)

Also, some professionals suggested that there should be a mutual adaptation between the immigrant and the health system, in relation to understanding the patient's needs and the how the services work. To such an effect, there is a clear indication that it is necessary to prepare the immigrants so that they may know the local reality of healthcare, thus contributing to a better choice of the environment where they will be taken care.

"And if they are part of our city, our country, I think the first thing that should happen is to inform these patients. Inform about how healthcare works, how does the citizenship form of living here in our country work". (Doctor 06)

Access difficulties

Some professionals reported that immigrants have difficulty locating and getting around the city and, therefore, are unaware on the location of the Basic Health Unit (BHU). This, in turn, causes them to look for the emergency unit.

"They have difficulty to locate in the city". (Doctor 01)

"This week I attended a patient from Venezuela and she had back pain about 15 days, I told her that she could have gone to the health post. But, she told me that she did not know where the post of her neighborhood was located". (Doctor 08)

Other professionals revealed in their speeches that there is ease in using transportation by means of municipal ambulances to reach the emergency unit, which is not available for assistance in Basic Care.

"Once the patient told me that to go to the BHU they need to get a bus and to come here [First-Aid Unit] they may get an ambulance, so that they prefer to come here". (Nurse 01)

Finally, one interviewee revealed that the difficulty in scheduling consultations at the BHU is what leads to more demand for emergency services by the immigrants. However, the interviewee stressed out that this is not an exclusive difficulty of the immigrant, as it also affects the Brazilian population.

"I have heard them reporting, several times, that they can not schedule a consultation at the BHU, so that they have a little difficulty to have access, which also happens to Brazilians, but maybe for them, it is a bit more difficult". (Nurse 03)

Problems associated to the work

Some professionals pointed out that the immigrant population sometimes ends up acting in precarious working conditions, which has repercussions on their health condition. This, consequently, leads to the search for emergency services, because it is an acute health problem.

"Usually, they come for flu-like symptoms or low back pain and they come with a lot of pain. Maybe, for the exhaustive work day that they have here in Brazil when they come, those are the main [motives]". (Doctor 02)

In addition to the aforementioned fact, another justification found in the professionals' speeches, which evidences the demand for the service by immigrants, was related to the request for a medical certificate.

"Sometimes it happens that those who do not like working and are looking for, wanting medical certificate". (Nurse 03)

"The immigrant, the main one we have here in the First-Aid Room is the immigrant who comes from Haiti [...] due to a city company that brought many [...] the ones that come are adults and the companies require that when they are absent to work, they need to get a medical attestation [...] they already arrive to us in the risk classification and they already request attestation". (Nurse 07)

"I am talking like this from my experience, most of them look for attestation, I do not know what it's like down there in their country [...] the first thing they talk about is that they are very sick and they can not work today, this is the impression I get". (Nurse 08)

Assistance to Immigrants: understanding the difficulties of the professionals

When analyzing the professionals' speeches, there was a wide discussion about the barriers experienced in providing assistance to immigrants. Thus, five discursive formations have emerged which address the difficulties encountered by the professionals while providing care to immigrants, they are as following: communication, culture, socioeconomic and educational level, professional unpreparedness and the prejudice.

Communication barrier

Most interviewees pointed out the language barrier as a limiting factor for care. This is because collecting information about the clinical condition and signs and symptoms, as well as providing guidance by the professionals were impaired.

"They are very complicated patients for you to attend [...] sometimes they do not report the whole clinical history. You have to investigate further more this patient due to poor communication [...] these days came an Arab man came here, he came from Lebanon and was living here a short period, he did not understand almost anything in Portuguese, it was difficult to understand him". (Doctor 03)

"The anamnesis is not well-done often because the patients do not understand what I say or I do not understand what they are really talking about. Even today I had a call that I did not know what the person had because I could not understand the vocabulary. So, it's very difficult, I think for all [...] the affection is the same, the attention, only that the understanding is different, the communication, and then the difference is this". (Doctor 04)

Some professionals revealed that they apply different strategies in the attempt to settle an effective communicational process with the patient. They use, for example, gestures and mimics to seek to understand the main complaints and health needs of these users.

"It was very complicated because we tried to communicate, in the case of two that I had here the communication was more by mime, their Portuguese were very limited, which ended up restricting us from knowing exactly what they had [...] in relation to whether I knew they had

improved was complicated because I tried to talk to them and they could not answer exactly". (Nurse 06)

"They gesticulate a lot, placing the hand where it hurts". (Nurse 08)

Still, one interviewee revealed that she was often frustrated about the services provided to immigrants. This feeling was due to defective communication, which led to a dehumanized and unfriendly/little enlightening attention.

"It is a little frustrating [the attention], because the Haitians speak French [...] And an experience that I had with a Haitian pregnant woman was very remarkable, she was in the fourth gestation and had not even done the prenatal, had no healthcare card. She began aborting [...] and I could not explain it to her, there was no humanized part, it was frustrating, not knowing what to do and she keeps on looking at you and you simply can not explain that she lost her baby, it was intense". (Nurse 03)

Cultural barrier

In addition to the effective communication, the discourses found in this discursive formation refer to the cultural differences. These differences could be evidenced from the identification of an inhibited behavior on the part of the immigrants during the care, as well as the lack of the habit of looking for the health service in a preventive manner or early upon the first signs and symptoms.

"The Haitians have a hard time reporting what they are feeling, it seems they have a bit of a fear when talking with the doctor. I do not know if it is an experience of their country, how they were treated there. But, here they get quite repressed". (Doctor 02)

"They are very complicated patients for you to attend because they are very inhibited, do not talk much [...] they are different, they are very bashful". (Doctor 03)

In their country of origin it is different from here, sometimes they only seek care in the last case, last minute, then think that Brazil is like that too. Then, many arrive here only in the extreme condition. Last week, a Paraguayan came here, I understood that there it is more difficult to get basic care there, then they only look for it when the condition is more acute, more severe". (Nurse 03)

In addition to the aforementioned aspects, cultural habits were also cited as divergent for the Brazilian culture and reality, which are possibly triggers and perpetrators for transmissible diseases.

"They try to bring this culture to us [...] on rape they say it is not a rape because for them for three, four men to have a relationship with one woman is normal [...] these rapes have usually a cultural origin, for them it is normal. But it causes a lot of illness. For me their culture is a barrier". (Nurse 07)

Socioeconomic and educational barrier

Socioeconomic factors were also indicated as a care handicap. Immigrants, for the most part, are in a socioeconomic fragility situation and financial limit, which may directly lead to increased vulnerability in the health-related aspects of this population, as stated below:

"Sometimes you have to make a treatment with some kind of drug that has to be bought and they do not have conditions, then you end up using a drug from the health post [...] and sometimes that choice would not suddenly be the ideal and because of their social issue of not having the conditions, we find these problems". (Doctor 07)

"For example, a pregnant woman has arrived and it is very difficult to consult a pregnant woman because she does not know the LMD date [Last Menstruation Date], you ask what LMD is but she ignores, then you have to explain to her that it is when she got pregnant and she does not know when". (Nurse 08)

"Wow, their educational level is very low! How will you guide these folks to wash their hands if even cat meat they eat?" (Doctor 07)

Professional barrier

It can be seen from the following clippings that there is some professional unpreparedness to deal with the epidemiological diversity of the immigrant's origin country while using the health service.

"We have a deficiency in care for the population of other countries because we have little knowledge of their diseases and the main death causes". (Doctor 06)

"We are not prepared to receive this type of patient, mainly by the epidemiology, so often the patient comes from Haiti bringing something [...] and the health professional is not prepared to diagnose [...] then it's a country that we have to study better, study the epidemiology, because they often end up bringing infectious-contagious diseases from there. Ah! We also have to better understand their genetic diseases". (Doctor 05)

Prejudice barrier

At some moments from the discourses the participants also described the existence of prejudice, discrimination and stigmatization situations on the part of the health professionals, as evidenced by the following clippings:

"We know that there is prejudice, many think that they should not be here, for example, I think it happens mainly with the Haitians, who now are the vast majority". (Nurse 06)

"There is a difficulty yes [...] also by the doctors, not all of them, but there is a doctor who refuses to attend promptly to the immigrant. They say: place it to the other colleague, because I will not attend". (Nurse 01)

There are some professionals who, sometimes, are not very engaged and this is annoying, it is very bad, there are certainly people who do not like to attend [...] There is a whole question, unfortunately such prejudice also exists [...] the right thing would be to attend with enough affection and be sufficiently human for the entire population, inclusive, for them. But, unfortunately, we see that sometimes some people out there do not do that". (Doctor 07)

In the submitted discursive formation, it was possible to verify that during the care to immigrant patients, the prejudice is still present among some professionals.

DISCUSSION

According to the results identified in this study it was possible to verify that the first discursive block refers to factors that, according to professionals, favor the search for the emergency service by immigrants. During the analysis, it was identified that this discursive block was constituted by three discursive formations, where the interviewed subjects pointed out common practices regarding the behavior of the immigrants in front of the emergency service.

In the first formation the enunciators emphasized in their discourses that the immigrants "have difficulty to understand", that "they do not have an understanding", or that "they do not know". In the context where they were stated, they indicated that the professionals perceived difficulties on the part of the immigrants in relation to the understanding of the organization and the working mode of the Brazilian health system. These lines have an inter-discursive relationship with a study carried out in Australia with 231 immigrant patients, where it was possible to observe that these subjects used less the Basic Healthcare before looking for care in emergency units, than the local population. Thus, the authors suggested that foreign patients did not choose emergency units according to the

urgency of their clinical condition, but rather to solve non-urgent problems, which resulted in overcrowding the emergency units and sometimes, inadequate care to the users.¹¹

Also, in this same formation, one of the enunciators pointed out in the discursive sequence "to inform these patients" producing the understanding that it was necessary to increase the access of the immigrants to the information given their health demands. A literature review study performed by researchers from New Zealand showed that, among other things, it was necessary to provide more information to immigrants so that the search for the health service were timely and adequate.¹² Therefore, it can be verified that the immigrant can not be blamed for the misguided search for healthcare services, but rather, they must take advantage of the moments when they are in the unit to offer guidelines regarding the local health system *modus operandi*.

Regarding the second discursive formation, it was observed that enunciators pointed out the words "difficulty in locating" and "did not know where the post was located", establishing the understanding that access to healthcare for immigrants was hampered by the lack of knowledge on the territory. There is an inter-discursive relationship with other authors that turns explicit the question on the immigrant's ability to enjoy healthcare services, related to the accessibility provided for their cares.¹³ And, for interventions to take place, it is essential to prepare the scenario, providing more mobility for the immigrant and more access to health services, reducing, in particular, the locomotion barriers.

It can be verified in the second discursive formation that according to the analyzed terms, it was highlighted that the search on the part of the immigrants for emergency units is directly associated to the difficulties in access to the health system. To such an effect, it seems opportune that a reflection by health professionals on the means of integrating immigrants in healthcare services and their social conditions should be accomplished, with a view to increasing the demand for these new users in the emergency sectors.¹⁴

As for the third discursive formation it is noted in the linguistic clipping "comes with a lot of pain, perhaps because of the exhaustive work day", that one of the subjects correlated the search for the unit for the pain resulting from the work done by the immigrants. This makes it possible to understand that this population is exposed to work-related precariousness, a fact that is already described in a Brazilian study carried out with 452 immigrants, which mentions that the long work days and poor working conditions that they undergo, routinely, trigger pains in the body and intense fatigue, compromising their quality of life and health.³

Following the analysis of this discursive formation the following sequences were identified "do not like to work", "absent to work" and "do not manage to work", which produce a feeling

that for the health professionals, the immigrants sometimes seek to deceive companies using medical records originated from medical appointments unnecessary in emergency units. On the other hand, this practice may be only a reflection on the exhaustive work associated with a greater occurrence of incidents that lead to searching the health service. A study of 452 Haitians living in Cuiabá, Mato Grosso, found that 52.7% were working. Among them there were perceived physical risks for accident, as well as psychosocial suffering, with work hours exceeding 48 hours per week, which was reflected in the immigrants falling sick.³ However, studies that simultaneously address the immigration-work-health triad, according to contemporary authors,¹⁵ are meager, leaving the work in the background, as a rule. To such an effect, it is necessary to conduct research on the migratory phenomenon in the worker health spectrum, since that there are still gaps to be filled in this area.

The second discursive block deals with the professional understanding of the difficulties encountered during the immigrant care, resulting in constituting five discursive formations, which specify the communication, cultural, socioeconomic, professional, and prejudice barriers that involve emergency care.

Regarding the discursive formation referring to the communicational barrier, it was possible to verify the following sequence "the anamnesis is not well done, because the patients do not understand what I say or I do not understand what they are really talking about", which institutes the meaning that there is difficulty on the part of the professionals working in emergency units, to collect the information necessary to ensure adequate care for immigrant patients, due to the limitations of both parties given the language barriers. Under these conditions, a similar study was identified that highlighted the language barrier as a limitation for the professional performance, namely, for formulating diagnoses and prescribing treatments. In addition, these difficulties prevent the users from expressing their needs while using the healthcare services.¹⁶

Also, some enunciators pointed out the development/use of strategies, with the purpose of favoring the dialogue during care, these were expressed through the words "communication was more by mime" and "they talk a lot by gestures". To such an effect, authors reveal the importance of verbal and non-verbal communication, considering the interpersonal relationship in the care for foreign patients, identified by the need for health professionals to become aware on the meaning of messages sent by the patients, in order to be able to provide care that is more appropriate for their needs.^{17,18}

In the discursive sequence referring to the cultural barrier the following signifiers emerged: "they have a little fear of talking to a doctor", "they are very inhibited" and "they just seek last case healthcare" that demonstrate the perception of the professionals regarding the behavior of the immigrants in the emergency sector care. Findings from another research also revealed that culturally minority groups interact poorly

with the health professionals, being verbally less expressive in comparison with other groups, making this ethnic minority more prone to not having their needs met, as well as having difficulty receiving help to solve their problems.¹⁹

In addition, this situation in the discursive sequence "three, four men having a relation with one woman is just normal", reveals different cultural experiences between the professionals and the immigrants, being in some situations, misinterpreted, since that the culture is inevitably influenced by traditions, ideas and beliefs absorbed during the cultural formation of each individual, and may interfere in the quality of interpersonal interaction and using the healthcare services.¹

Regarding the discursive formation entitled by socioeconomic barrier, it was observed in the linguistic clipping "they can not buy such drugs", that health professionals perceive the situation of socioeconomic fragility and financial limitation of the immigrants as being determinant with regard to health-related aspects. This circumstance was also found in a study carried out in the city of São Paulo with 28 Bolivian immigrants, showing that most of them used public healthcare service, considering that their financial conditions did not allow them to pay for healthcare provided by private establishments.²⁰

As for the discursive formation concerning the professional barrier, the following signifiers were identified: "we have little knowledge on their illnesses" and "we have to study better, study the epidemiology", these refer to reports of professionals through unpreparedness feelings experienced during healthcare to immigrants in emergency units. A study carried out in Portugal with 32 health professionals showed that physicians had difficulties in clinical practice to diagnose and treat diseases in immigrant populations, noting that they did not feel sufficiently prepared to treat the new population profile with infirmities, which are, sometimes, specific and particular.²¹

Another highlighted important formation to be analyzed is the prejudice barrier, where the interviewed subjects scored the following discursive sequences: "we know that they have prejudice", "there is a doctor who refuses to attend an immigrant" and "there are people who do not like to care", these words indicate that professionals witness situations where prejudice permeates the healthcare to immigrant patients. This reinforces the social exclusion of this portion of users. However, it is important to emphasize that this practice violates the precepts of bioethics and is contrary to the principles settled by the Brazilian health system, which recommends universality, completeness and equity as a way to guarantee access and quality of care provided to the population in the healthcare services in Brazil.¹⁷

Finally, it was possible to verify during the analysis that the meanings produced by the professional discourses, in this discursive block, refer to the presence of limiters that interfere in the healthcare provided to the immigrant population that uses emergency services. To such an effect, it becomes imperative to develop strategies to ease these obstacles by providing

comprehensive and holistic healthcare to the immigrant population. An example for the strategy to be implemented would be the continuous training of professionals in order to prepare them to facilitate the overcoming of communication, prejudice and lack of knowledge barriers about the culture and socio-sanitary profile of this population, improving, consequently, the healthcare.

LIMITATIONS

This study has some limitations. One of them is related to the fact that the interviews were carried out at the emergency unit, which may have limited participant responses, since that some showed an interest in returning to work activities quickly. However, if they had been held elsewhere, there would be fewer participants. Another limitation is related to the fact that the professional experiences are more closely related to the search for the emergency service by the Haitian immigrant (being the largest population in the studied city), and other populations of immigrants, such as Arabs, Asians and South Americans, may use emergency healthcare services in a diverse mode, which circumscribes the found results. Finally, the fact that more men than women took part, can, in a certain mode, print such a gender perspective on the collected data.

CONCLUSION AND IMPLICATIONS FOR THE PRACTICE

From the results of this study we verified the perceptions of professionals working in emergency units regarding the use of healthcare services by immigrants, both in relation to their search for the service and the obstacles encountered by professionals in providing healthcare to this population. In summary, the search for the unit is due to a lack of understanding about the local health system *modus operandi*, the difficulty of access to other services and work-related diseases. The barriers experienced during healthcare related to communication, culture, socioeconomic aspects, lack of professional knowledge and prejudice.

Considering that it is not fair to blame the immigrant for not knowing the rules and laws of the country chosen to escape a socially chaotic situation, turns imperative for the healthcare system to take part in initiatives and strategies that promote the preparation of this specific population, through educational activities, to be carried out in different contexts, for example, in the social scopes for Portuguese teaching, in companies where there are great concentration of this public, among others. This may favor the proper use of the healthcare system in the basic healthcare setting and, consequently, reduce the number of users who attend emergency services improperly.

Another important point to highlight is the relation regarding the occupational health of the immigrants, making it necessary to elaborate strategies on the part of the companies/employers that may favor the improvement in the working conditions experienced by them.

It is also possible to perceive that the professionals pointed out some difficulties in the context on providing healthcare to immigrants, stating that it is necessary to carry out frequent training on issues related to their health and the ethical and human issues of the professionals, in providing healthcare for this population. It is suggested furthermore to include the theme in the training of the professionals, subsidizing the development of scientific skills, making them able to deal with such diversity.

Therefore, in order to include themes approaching healthcare to immigrants in the training of the professionals, it is essential to develop future research. For example, a useful search would be one that would link aspects related to the working conditions of immigrants seeking emergency services, once that knowing how work has impacted the immigrants' health can improve the quality of healthcare.

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