
Turkish Nurses' Experiences of Caring For Migrant Patients

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Abstract:

Aim: *This study was carried out by following qualitative methods in order to identify the opinions of nurses who work in Mersin on migrant population and their experiences in the process of health care of migrant patients.*

Methods: *For this qualitative descriptive study, data were collected in Mersin in 2009 by carrying out six focus groups with a purposive sample of 48 nurses who work in a public hospital in Mersin. The raw data for the study were obtained by converting the tape-recorded data which were gathered through focus group interviews into computer files and analyzed through content analysis.*

Findings: *The thematic groups achieved by analyzing the expressions of the nurses were "Health problems of migrant patients", "adaptation problems of migrant patients", "migrants patients' attitudes towards the services", "attitudes of the nurses towards migrant patients", "relationship between nurses and relatives of patients".*

Conclusion: *The findings of the study revealed that the nurses involved in the study thought they experienced problems in their communication and relations mainly with the relatives of these patients. The nurses participated to the present study also mentioned that these problems have tended to decrease relatively in time. It is thought that there is a need for education and support for nurses and health caring system to resolve the problems experienced in the process of caring for migrant patients.*

Keywords: *Migration, Health, Nursing, Turkey*

1. Introduction

Migration is a voluntary or obligatory movement of individuals and groups in the social structure from one place to another because of economic and cultural factors (Aker at al. 2002; Yılmaz 2005; Topçu & Beşeri 2006). In addition to offering great opportunities, settling in a new city may lead to various dangers and a new period of crisis. This is because changing the social, cultural and physical environment brings about a problem of adaptation to new situations for people. Leaving their usual places may cause people to have feelings such as loneliness, alienation and unworthiness. They are limited in terms of their communication and interaction with the society which they emigrate into and they may get stressed out playing their social roles (Şahin 2001; Ekşi 2002; Choe at al 2007). Stressful incidents, major social changes, moving from one's own culture to another and socio-economic incapability may deteriorate people's physical and mental health (Aker at al. 2002). Migrants may have problems accessing the sources from which they can receive help when they have an acute or critical health problem. Socio-cultural factors such as whether migrants can adapt to the new culture in areas like behavior, language and food or whether they are exposed to discrimination or not determine the formation of health and illness concepts and perception of health service (Topçu & Beşeri 2006; Kuşçu at al 2007).

Nurses who give health care service have to provide all patients with service in line with basic human and patient rights and without making any discrimination. Nurses

should take cultural differences into consideration and be capable of evaluating migrants' social and economic variables, belief and value systems. They should also regard and treat migrant people as priority risk group (Topçu & Beşeri 2006). Nurses are supposed to know the characteristics of this risk group, be aware of the values of individuals in different cultures, understand this group and offer their service accordingly. Nurses' thoughts and feelings about migrants will be reflected in their operations and this, in turn, will affect those people's perceptions about the service given.

Push-factors of rural areas and changes in rural structure are more effective than pull-factors of urban areas on internal migration in Turkey. Because of regional inequalities, destination of internal migrations has been occurred from less-developed areas to developed regions, from east to west, and from rural to urban areas (Erjem, 2009). After 1980, with the effect of terror and increased instability in Eastern and Southeastern Anatolian Regions urban population rates in these Regions have increased because of internal migrations and significant rates of migration have taken place from this region to larger urban centers to the west of Turkey (Gündüz & Yetim, 1997; Erjem, 2009). Mersin has been one of the most popular internal migration destinations in Turkey during this period.

Mersin is a large city on the Mediterranean coast of southern Turkey. The city is one of the important economic centers because Mersin has the Turkey's biggest Mediterranean port, an oil refinery and a free trade zone too. Mersin has a high urbanization rate because of internal migrations. According to 2007-2008 data from Turkish Statistical Institute, 30% of the migration to Mersin is from the Eastern and Southeastern Anatolia regions, 21% is from the Mediterranean Region and 14% is from the Central Anatolia Region (Migration Received by Cities, 2010).

This study stems from the idea that opinions and experiences of nurses working generally with migrant population may help us to understand existing problems and develop solutions for caring for migrant population. Because of its closeness to districts which have migrant population

from both Eastern and Southeastern Anatolian Regions who constitutes the majority of internal migrants, a public hospital which is located at the center of the Mersin and the nurses who work in this hospital constituted the case of the study.

2. Method

Aim

This study was aimed determining nurses' experiences, thoughts and opinions of caring for migrant patients in Mersin.

Design and sample

This is a descriptive study in which the data were collected by means of focus group interviews.

The study population included all of the nurses working in a public hospital that serve migrant population very often. The sample of the study, on the other hand, consisted of 48 volunteer nurses who were 18–60 years old and employed in the same hospital between 1st October and 31st December 2009.

The public hospital in which the study was carried out is located at the center of the city and serves generally patients with low socio-economic level and the population who migrated from Eastern and Southeastern Anatolian Region. This public hospital has currently 506 bed capacity, 206 doctors and 400 nurses. Nursing education in our country is carried out high school, college and university level. 80% of the nurses working in this hospital have associate degrees and 95% of them are female. Since new nursing law which enabled males to become a nurse was adopted in 2006, the number of male nurses across the country and in the province of Mersin is still limited. In order to achieve a homogenous sample only female nurses were included in the sample. Because of their limited number male nurses were not included in the sample of the present study.

Data Collection

Qualitative methods were used for data collection.

Collection of qualitative data

During the focus group interview, the nurses were asked the following six questions: “What kind of health problems do you think migrant population has?”, “Do migrant individuals have any problem receiving service in the hospital?”, “Do the cultural characteristics of migrant patients affect the care they receive?”, “What kind of experiences do you have with the relatives of migrant patients?”, “What do you want to say about the reactions from patient relatives when a patient deteriorates or dies?” and “What factors do you suggest considering when caring for individuals with different cultural characteristics?” Although Mersin is a city which faces migration from all parts of Turkey, while they were defining migrants, all of the nurses involved in the focus group interviews gave their responses with regard to individuals coming from only the eastern and Southeastern Anatolian Region of Turkey.

The nurses in the study were grouped into six focus groups, each of which consisted of six-nine people, according to their seniority and educational background. The groups were managed by three-member teams including a moderator, an observer and a secretary. The nurses participating in the focus groups were explained about the aim of the study, their consents were taken and the ethical and confidentiality considerations were taken into account. Permission was asked for note-taking and tape-recording. All of the participants provided consent for the use of tape-recorder. The data about the participants were kept confidential and were only used in the analysis of this study. The focus group interviews lasted about 60-90 minutes. Before the interview sessions, the participants were allowed to choose a nickname if they wished and recordings were conducted this way.

Ethical Considerations

Approval from the ethical committee and permission from the institution were granted before starting the research.

Data Analysis

As the first step in data analysis, the tape-recording scripts were converted into computer files and 88-page raw data were obtained by combining them with the interview observation notes. In the qualitative analysis of the data, content analysis was carried out by taking not only words themselves into consideration but also points such as the generality of the comments in the responses given, the number of participants making the same comment and using the same words, the main idea in the statements and the originality of the responses (Streubert & Carpenter 1999; Kümbetoğlu 2005). The raw data were coded independently by each researcher. The researchers' independent studies were discussed by the whole group and the themes were determined by combining the agreed-upon codes. The theme groups, coding patterns and raw data were then submitted to a qualitative research expert to get expert opinion. A total of six main themes were obtained as result of this process. Since the vast majority of the research data couldn't be interpreted in numbers, the principle that these findings cannot be generalized and only apply to the participants in this study was adopted (Streubert & Carpenter 1999; Kümbetoğlu 2005).

3. Findings

Among the 48 nurses involved in the study, 50% were 30-39 years old, 72.9% had associate degrees and had worked 11-20 years (46%).

Theme 1. Health problems of migrant population

The nurses' opinions about the health problems of migrant population were classified under two headings: mental problems and physical problems:

Mental problems. The nurses (33.33%) thought that migrant individuals severely suffered from symptoms like

stress, depression and anxiety. Their observation that mental problems were usually caused by the factors within the family and particularly experienced by women is an important finding of this study. The nurses emphasized that extended and crowded families, marriages at very early ages and having too many children were among the underlying factors of women's mental problems. The following is a statement made by a nurse about this point: *"Women's health dysfunctions in particular are caused by their early marriages. A 20-year-old woman with 3 children. The poor girl can barely stand. She is desperate to tell about her problems. She is really in a difficult situation. Girls like this are walking around like a bomb ready to explode because they are extremely stressed out and suffer from serious psychological problems"* (Associate Degree Graduate, 25-year Nurse).

Physical problems. The nurses (16.66%) stated that migrants had problems about infectious diseases, injuries, non-healing gastroenteritis, diarrhea etc. and these problems were caused by giving birth at frequent intervals, accidents, fights, stabbing, and poor sanitary and dietary habits. Moreover, not caring about hygiene, nutritional disorders, poor toilet habits and inefficient self-care were regarded by the nurses (54.16%) as the major causes of physical problems. For example, one of the participant nurses expressed this opinion with the following words: *"They have no habit of cleaning, a patient's relative puts the bedpan on the floor and then on the dining table again. I warn them not to do it but they won't listen to me and they just keep doing the same thing. In one incident, I had to take a pair of shoes from the fridge. They just say 'It's ours so we can do it'. Well, are they putting their shoes in the fridge at home? Their urinary tract infection does not heal then"* (Associate Degree Graduate, 19-year Nurse).

Theme 2. Adaptation problems of migrant population

The nurses thought that migrant individuals had serious adaptation problems which, they thought, were associated with communication (85.41%), education (79.17%) and cultural characteristics (56.25%).

Communication Problems. The nurses pointed out that migrants faced communication problems because of speaking a different native language and of their attitudes in general. Patients and their relatives couldn't exactly understand what was told by medical staff, express themselves or talk about their problems and complaints and consequently nurses had difficulty in announcing the rules, setting up an environment of cooperation, sympathizing with them or offer training about some issues. The nurses also stated that sometimes they had problems with patients because they asked too many questions since their native language was different and nurses had to answer over and over. One of the nurses said: *"When we're hindered by language barrier there are sometimes quarrels because neither of us can properly express ourselves and this leads to a crisis"* (Vocational High-school of Health Graduate, 25-year Nurse).

Education Problems. The nurses thought that migrant individuals had very poor educational backgrounds, which affected the relationship between the person providing the service and the one receiving it. The nurses also stated that the inefficiency of migrant population's education led to problems such as missing control visits, disruption in taking drugs, accidents, not following the diet, poor hygiene, failure to protect health and insufficient involvement in family planning. One of the nurses said: *"A patient's relative is supposed to be in hospital to take care of his or patient. But they just knit a pullover by their patients. We expect them to move their patients from time to time so that their patients do not have bed sore but they just sit by the bed. They think this is the way to care for their patients. I believe this is because they are not well-educated"* (Associate Degree Graduate, 19-year Nurse).

Cultural Characteristics. A point made by the nurses about migrant population's cultural characteristics was migrant people's view of the male and the female. The nurses stated that this understanding of man and woman, which was based on the belief that man was superior, was sometimes reflected on male patients' attitudes towards nurses. One of the nurses, for example, said: *"In the East, a*

man is the leader and the person with the right to speak for the family. That's why they don't like being told what to do by nurses in hospital. They tend to treat us roughly and we have problems even when we politely ask them to be patient. They shout at us claiming that we do not help them. They try to force us to do what they want immediately. They try to make us solve their problems as if we were their wives and say we have to do as they say because we are women anyway" (Associate Degree Graduate, 18-year Nurse).

The nurses, who stated that the traditional view of man and woman was reflected in patients' behaviors, say that female patients could not freely express their complaints; they did not want to show their bodies and male patients refused to be touched by female nurses because it was against their religious beliefs.

The nurses also believed that cultural characteristics influenced the behaviors of patients' relatives and visitors and stated that particularly heavy visitor traffic and ignoring hospital rules caused various problems.

Theme 3. Migrant patients' attitudes towards the service

The nurses' statements regarding their assessment of the service offered to migrant population were examined under five headings: "migrant people are generally responsive, aggressive and prejudiced" (66.66%), 'they distrust in health professionals' (16.66%), 'they are satisfied with the service they receive' (33.33%), 'they are not satisfied with the service they receive' (12.5%) and 'gradual change observed in relations' (6.25%).

Migrants are generally responsive, aggressive and prejudiced. The nurses stated that migrant people thought they were discriminated and they didn't believe nurses. Therefore, they exhibited attitudes and reactions like anger, fight, insulting, shouting, making complaints to higher authorities, physical assault and damaging hospital property. A nurse's opinion regarding this point is below: "*They overreact to medical staff. They are aggressive. They believe people are biased against them*" (Associate Degree Graduate, 25-year Nurse).

The nurses, on the other hand, stated that patients started their relationship with hospital with a prejudice in their mind although health staff did not make any discrimination at all. The nurses attributed this attitude to the fact that those people regarded themselves to be members of a minority group and they acted on the bias that they would be socially excluded, ignored and maltreated since they were immigrants from the southeastern region of the country.

They distrust in health professionals. A nurse, who mentioned signs of distrust such as testing doctors, checking the service offered in detail, being unsure about the information provided and having doubts about the interventions made, told about her experience with the following words: “...I think it was in X city. We went there to inform a family about a problem. They said “You are going to install some devices in our bodies and learn about what we do and how we live!” (Associate Degree Graduate, 20-year Nurse).

They are satisfied with the service they receive. The nurses stated that migrant patients mostly left hospital satisfied with the care they were given, sometimes they didn't even want to leave, they asked nurses how they were doing, they appreciated nurses' work and they sincerely thanked when they left hospital. One of the nurses explained: “We understand their gratitude by the expressions on their faces. They show their appreciation by thanking over and over. They come to us when they leave hospital or come for control visits and ask how we are doing. They say that they are really pleased with our work and thank again” (Associate Degree Graduate, 24-year Nurse).

The nurses stated that those patients who left hospital dissatisfied actually did not like the service partly because of their prejudices and partly because of the problems caused by hospital procedures and they expressed their dissatisfaction.

Change in relations. The nurses stated that there had been a gradual increase in tolerance of migrant individuals; language was not as big a problem as it had been, they

trusted health personnel more and relationships had changed. It seems that both adaptation to urban life and the increase in receiving hospital services had led to this change. Regarding this point, one of the nurses said: *“It used to be more... well... you know what I mean. They were always making comparisons and asking “Why is that patient allowed but not me? Why is he or she treated that way but not me? Is it because I come from a village?” However, now things have changed; we don’t see these things much nowadays”* (Associate Degree Graduate, 30-year Nurse).

Theme 4. Nurses attitudes towards migrant patients

The nurses (54.1%) stated that they did not make any discrimination while caring for migrants, treated them tolerantly and offered the best care. They attributed the problems occurring in hospital to migrant patients’ prejudice against the institution. A nurse explained her opinion with the following: *“Nobody makes any discrimination against any patient because they are Kurdish or Turkish. We are all human beings and we all see things in conscience. We always try to be sympathetic with patients and their relatives”* (Associate Degree Graduate, 9-year Nurse).

One-fourth of the nurses (27%) listed the following among negative attitudes: some nurses did not appropriately inform migrant patients, some doctors prevented nurses making explanations and nurses too might respond negatively when there was tension. It is interesting and significant to note that these nurses stated that they did not exhibit negative behavior but they had heard or seen a doctor or a nurse speaking negatively about migrant patients. A nurse, for example, said: *“There both nurses and doctors among our colleagues who do not make proper explanations”* (Associate Degree Graduate, 25-year Nurse).

Theme 5. Nurse-patients’ relatives relationship

The nurses who stated that they had a good relationship with patients’ relatives and they had been involved in a negative incident so far in their career (13%) attributed this situation to setting up an efficient communication and sympathizing with them. Regarding this point, one of the

nurses said: *"There's no problem with their relatives. As far as I'm concerned there are problems about education and communication. I cannot see any other problem. Some of them are satisfied. Personally, I don't think they are different from other people..."* (University Graduate, 15-year Nurse).

Most of the nurses (65%) stated that they had had a negative relationship with patients' relatives because patients' relatives broke hospital rules, they did not want to wait in the queue for treatment, they wanted health staff care for their patients before others, they came hospital in crowded groups to visit their patients, they had language problems and they tended to make complaints about the smallest disruption.

Another important finding of the study is that nurses were sexually, physically and emotionally harassed by patients' relatives. The nurses stated that they were exposed to emotional harassment by patients' relatives (19.5%) and they faced insults, threats, yelling and giving orders. The statement made by one of the nurses is below: *"This is something we face quite often. In fact, they want to force us do what they want saying 'I'll shoot you, I'll kill you, I'll make my connections to send you somewhere else, I haven't forgotten your face' We see this kind of things very often"* (University Graduate, 13-year Nurse).

Eight nurses (17%) stated that they were exposed to physical harassment while giving care by patients' or patients' relatives and they had experienced assaults including slapping, manhandling, damaging hospital furniture, beating, battering and lynch attempt. For example, a nurse said: *"They 'want to' batter in general but there are nurses who they literally battered"* (University Graduate, 13-year Nurse).

Two of the nurses stated that they had been sexually harassed while on duty by patients' relatives twice. One of the nurses gave the following example: *"There are sexual harassments as well. At one incident, a patient was having an epileptic attack and I was both trying to inject diazepam and trying to tell the patient's relative to hold the patient at the same time. The patient's relative was pretending to help"*

but he was actually holding the patient and me together. We face this kind of sexual harassment” (Associate Degree Graduate, 19-year Nurse).

The majority of the nurses (55%) stated they faced even more serious troubles, in addition to these problems, in case a patient passed away. They said that patients’ relatives threatened nurses and their reaction was more extreme in case of a sudden death and death of a young patient in particular. *“There is no doctor or any other person. They directly attack you. A patient’s relatives attack us directly claiming ‘You killed him or her! You didn’t call the doctor! You didn’t show interest!’ Things like that” (Associate Degree, 7-year Nurse).*

Theme 6. Suggestions for improving the quality of care

The nurses’ suggestions for improving the quality of care were grouped under two sub-themes: ‘individual’ (71.7%) and ‘institutional’ suggestions (100%).

Individual Suggestions. In order to improve the quality of care, the nurses suggested improving communication skills; adopting an approach based on patience, love and tolerance; learning about patients’ religious beliefs and traditions; being more constructive and supportive by setting up communication with patients and their families; making more time for patients and respecting patients’ privacy.

It is interesting to note that one of the nurses said *‘the solution for any problem is love’*.

Institutional Suggestions. All of the nurses suggested that migrant population should be given education; girls should be sent to school and get education; there should be educational programs on TV; educational programs should be held in the areas migrants live or in the cafes they go to; the ministry of health should offer nurses language courses; necessary action should be taken to prevent migration; there should be translators, psychologists and social services experts in departments; people should get health service at home, too; and patients’ relatives shouldn’t be allowed to stay in hospital to care for their patients. Regarding this

point, one of the nurses said: *“At this point, everybody, I mean everybody living in Mersin and in Turkey, should undertake responsibility. This is necessary if we want to find a solution. Institutions, individuals, the government... everybody should be involved in this process to find a solution. Those people should take responsibility for solution, too. But, here we’re talking about a big problem. It requires a big solution”* (Associate Degree Graduate, 20-year Nurse).

4. Discussion

This study investigated nurses' experiences of caring for migrant patients and found that migrant patients, particularly female patients, had communication, education and adaptation problems as well as mental and physical problems; they exhibited aggressive and prejudiced behaviors in hospital and they did not trust in medical professionals.

Aker et al. (2002) state that forced migrants have depression, stress, somatization and panic disorder. Similar studies also report that individuals in this population are at high risk of having mental illnesses due to factors like cultural conflict, change in roles and domestic violence (Murphy & Macleod-Clark 1993; Pumariega & Rothe 2005; Conrad & Pacquiao 2005; Turan 2008; Gül & Kolb 2009; Missinne & Bracke 2010; Kirmayer et al. 2010; Aksu & Sevil 2010; Shin 2010)

Evidence from the relevant literature suggests that migrant individuals are more exposed to serious diseases such as measles, diarrheal diseases, heart attack, cancer, diabetes, stroke and HIV/AIDS caused by poor economic conditions, nutritional disorder, poor hygiene and inefficient infrastructure (Yılmaz & Akman 1997; Ertem 1999; Hultsjö & Hjelm 2005; Topçu & Beşeri 2006; Vydellingum 2006; Kreps & Sparks 2008). In this sense, the evaluations of the nurses in our study about the living conditions and health problems of migrant population seem to be consistent with findings of other studies in the relevant literature. Therefore, it is sensible to suggest that nurses know about the

population which they provide care for and their general health problems.

The nurses in our study stated that migrants suffered from adaptation problems caused by their educational and cultural background. Some studies in the relevant literature similarly point out that migrants cannot adapt to city life because they cannot speak Turkish, most of them communicate in an environment limited only to their relatives or other migrants from the same city or town and they cannot adequately benefit from health institutions (Aker et al 2002; Yilmaz 2005; Aksu & Sevil 2010). Evidence also shows that nurses have difficulty in understanding migrants because of the language problem of the ethnic group and therefore services like providing information or consultancy about issues such as diseases, adaptation to diseases and continuation of care fail to be efficient (Lauderdale et al 2006; Vydellingum 2006; Hoye & Severinsson 2008; Lassetter & Callister 2009; Bernosky de Flores 2010).

The nurses in our study stated that they had problems with patients from migrant population caused by their cultural background. They mentioned their disturbance especially about male patients' manners towards female nurses and they associated this situation with cultural notions. As suggested by a similar study, learning about the beliefs, behaviors and cultures of ethnic groups will ensure the efficiency of care and problem solving process (Richardson, Thomas & Richardson 2006; Omeri, Lennings & Raymond 2006).

The nurses in our study stated that migrant people generally exhibited responsive, aggressive and prejudiced behaviors, they distrusted in health professionals, but they were satisfied with the service they received and there was gradual change observed in relations. It is reported in some studies that the family structure and reactions of people with different cultural backgrounds may create tension in a workplace (Hultsjö & Hjelm 2005; Richardson Thomas & Richardson 2006; Whitman & Davis 2009) and migrants may face discrimination more often due to speaking a different native language and their income levels (Yilmaz 2005; Ovalı 2010).

The nurses stated that they tried to understand migrant patients and they did not make any discrimination but some health staff might have a negative attitude towards these patients. Similarly, some other studies report that although nurses state that they provide equal and quality care for migrant patients and it is migrant patients who are prejudiced against health staff, nurses do not have adequate information about their patients' cultural backgrounds, they cannot offer cultural care and they unconsciously make discriminating while giving care (Cortis 2004; Richardson, Thomas & Richardson 2006; Vydellingum 2006; Hoyer & Severissson 2008; Whitman & Davis 2009; Campbell 2011).

It was determined in this study that most of the nurses had a negative relationship with patients' relatives more than with patients themselves and they were exposed to sexual, physical and emotional harassment by patients' relatives. Evidence from other studies suggests in the same way that nurses are exposed to every kind of violence (Chenoweth et al. 2006; Kwok et al. 2006; Arcaç & Kasımoğlu 2006; Chen et al. 2008; Coşkun & Öztürk 2010).

The nurses made individual and institutional suggestions to improve the quality of care. The nurses suggested improving communication skills; adopting an approach based on patience, love and tolerance; learning about patients' religious beliefs and traditions; being more constructive and supportive by setting up communication with patients and their families; making more time for patients and respecting patients' privacy. They also suggested that nurses should learn ethnic language as well as getting medical training, there should be translators in hospital departments, patients' relatives shouldn't be allowed to stay in hospital to care for their patients and the number of nurses should be increased. Each of these suggestions are also made in similar studies (Berlin, Johansson & Törnkvist 2006; Lauderdale et al. 2006; Vydellingum 2006; Whitman & Davis 2009; Bischoff & Hudelson 2010).

The nurses involved in this study properly defined migrant population's health problems and regarded leading a crowded life, early marriage, giving birth to too many children and poor hygiene as the underlying factors. They

also believed that not speaking migrant patients' native language caused communication problems for them.

The nurses in this study finally stated that they had problems due to the traditional views of migrant population. They thought that migrants believed they were discriminated only because of their own prejudice and they behaved aggressively and showed distrust in medical personnel. At the same time, however, the nurses believed that these problems decreased in comparison with the past. 27% of the nurses mentioned negative nurse behaviors. Two-thirds of the nurses were in conflict with patients' relatives and they claimed that was because patients' relatives ignored hospital rules, insulted and threatened them and exhibited a bossy manner.

5. Conclusion

It could be suggested in light of the findings from this study, which evaluated care service in nurses' perspective, that nurses need to be supported and their educational needs should be met by the health system and that future qualitative studies which assess the care service in migrant population's perspective are required.

There have been intensive internal migration in Turkey and migrant individuals suffer from adaptation, communication and health problems. Studies investigating nurses' knowledge and experiences about migrant people's health care are limited. Nurses recognize migrant individuals' adaptation, communication, economic and health problems. Nurses think that migrant individuals discriminate against and do not trust in health professionals due to their own biased attitudes. It is vital that nurses be supported with intra-organizational training so that they can sympathize with and learn about individuals from other cultures and improve their empathic communication skills.

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