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Title: Important Factors When Communicating with Sami Patients About Health, Illness and Care Issues

Short title: Communication with Sami Patients

English abstract

Communication is essential for the provision of competent nursing care. The purpose of this study is to explore how Sami describe communication in encounters with health care providers, when talking about health, illness, and care, as well as important factors in this context. Semi-structured interviews of eleven Sami participants in northern Norway were conducted in North-Sami language and subsequently transcribed and translated into Norwegian. There were men (n=2) and woman (n=9), young and elders which either have been patients or next of kin, or both, in encounter with health care providers. Their stories was from GP`s office and hospitals. Our study found that the Sami communicate in a circular and unique way about health issues, and that sufficient time is essential in conversations. Healthcare providers must be aware of this and 'beat around the bush' when asking questions, approaching private or sensitive issues indirectly. According to the respondents, the use of Sami language in encounters with healthcare staff expressed a confirmation of their Sami identity, and that interpretation service is required during talks about health issues. Some of the participants turned the question around and placed the need for interpretation services with the healthcare providers instead, arguing that the Sami do not need interpretation services, but the health care providers do. They maintained that interpretation services were set up to help healthcare providers fulfill their statutory healthcare duties to Sami patients. Use of Sami

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language in healthcare helps to ensure comfort, safety and respect, and thereby promotes health and helps to create a safe environment.

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Norwegian abstract

Kommunikasjon er viktig i utøvelsen av god omsorg. Formålet med denne studien er å utforske hvordan samer beskriver kommunikasjon i møte med helsepersonell når de snakker om helse, sykdom og omsorg og i tillegg hvilke faktorer de utpeker som viktige i denne konteksten. Elleve semi-strukturerte intervju ble gjennomført på samisk og transkribert til norsk. Det var både menn (n=2) og kvinner (n=9), yngre og eldre som alle hadde vært enten pasienter eller pårørende, eller begge deler, i møte med helsepersonell. Våre funn viser at samer kommuniserer på en sirkulær, unik måte der de 'snakker rundt grøten' om helse spørsmål og at det er viktig med god tid i samtalen. Helsepersonell må være klar over at dette når de spør om direkte, private og sensitive spørsmål. Deltagerne i studien sier at å bruke samisk språk i møte med helsepersonell uttrykker en bekreftelse av deres samiske identitet, og at det er påkrevd med tolk når man skal diskutere helsespørsmål med helsepersonell. Spørsmålet om hvem som egentlig tenger tolk ble snudd om, til å gjelde helsepersonellet. Det er ikke de samiske pasientene som trenger tolk, det er helsepersonellet som gjennom lovverket er pålagt å gi likeverdige helsetjenester og informasjon på en måte som pasientene oppfatter og forstår konsekvensene av. Tolketjenesten er på plass for å hjelpe helsepersonell til å utføre sine lovpålagte oppgaver for samiske pasienter. Bruk av samisk språk i utøvelsen av pleie- og omsorg bidrar til å gi sikkerhet og respekt for samiske pasienter, noe som og fremmer helsen i et trygt miljø.

Introduction

Samis, the indigenous people of Norway, live in Sápmi, which is located in the middle and north of Norway, northern Sweden and Finland, and Russia's Kola Peninsula. Sami language is recognized as an official language in Norway, not all Sami speaks Sami language. Historically, there was an official government policy of assimilation and Norwegianizing of the Sami people during the period from 1850 to about 1980 (1,2). This spurred a still ongoing struggle to keep Sami language alive and to develop Sami language in daily life in North Sápmi (3). Maintaining and developing the language is essential in resistance to colonizing approaches and is a vital element and foundation for empowering the Sami population (4).

Sami have reported feelings of marginalization and misunderstanding when they are unable to speak their native language within the predominantly Norwegian healthcare system (5-8). The most of the Sami population are bilingual (4,8). If you are bilingual and healthy, the choice of language may be optional for some speakers, but if an individual is sick and vulnerable, his/her native language has a particular significance because it is the language in which one finds rest, comfort, understanding, and which does not require effort because it is the language that one masters (9-12). All patients may have a sense of unease when they enter a place where they cannot naturally speak their native language.

Misunderstandings or lack of clarification when a patient does not understand or ask medical staff about important issues affecting his/her health are major causes of adverse events (AE) in hospitals (13).

Culture, Language and Communication

Sami have their rights in relation to their language and their way of life which are safeguarded in the Sami Act (14) and ILO convention no. 169 (15). Cultural background influence what you expect from healthcare providers services (16). A person's identity is based on where one comes from, age, gender, language, education and socioeconomic factors, all of which contributes to defining a person's perception of life, lifeworld, and assumptions (17).

Communication is the exchange of meaningful content between people through the use of a shared system of symbols, paralinguistic cues, language and body language. Communication is both contextual and socially and culturally constructed, and language is significant as transmitter of codes, symbols, and values when socializing with others in a community (11-12,17).

Sami ways of communication are described in some studies (6-8,10-12,18). These researchers indicate that Sami communication is indirect; they 'beat around the bush', heavy in the use of circumlocution and innuendoes. Møllersen (19) points out how cultural differences can be embodied by symbolic actions, an example being the understanding that "silence gives consent," whereas in Sami communication, silence generally means the opposite. Within the healthcare system, providers do not always have the time required to get to know patients before communicating serious matters to them. This does not always suit the patient's communication style and may, in fact, be considered demeaning and disrespectful (6). In addition, healthcare providers use medical language that patients not are familiar with, and which can therefore be difficult to understand.

One study from outpatient mental healthcare found that clinicians were not aware of patients' language preference when patients arrived (20). When therapists offered a choice in language

services, some Sami-speaking patients chose the Norwegian language or switched between both languages and were seemingly comfortable with non-Sami consultants. The clinicians left it to the patients to address language issues and discovered that, in retrospect, patients would complain (20). In addition, a survey reveals that there is an underutilization of interpretation services in the public healthcare system in Norway as well as a need to raise awareness and sensitivity among healthcare providers regarding their responsibility to ensure sufficient communication with their patients in general (21).

A study from mental health care including four Sami patients, revealed that the topics they choose to talk about, with whom and in what way is influenced by cultural norms and that particularly sensitive topics are emotions, mental health problems, and physical /sexual abuse (5). Cultural norms could be bypassed by speaking Norwegian with the healthcare providers, and the choice of language was based on language competence and other personal conditions related to living in small, rural communities (5).

The purpose of this article is to explore how participants describe communication regarding health issues in encounters with healthcare providers and to identify the factors Sami-speaking participants in this study consider important.

Methodology

This study uses a descriptive, qualitative method to investigate the encounter of Sami patients with the Norwegian National Health Service. Our research seeks to uncover the main issues in relation to communication in encounters with healthcare staff and the ways in which participants handle it.

Recruitment and Sample

Participants (n=11) were recruited through purposive and convenient sampling (22), using a media broadcast on Sameradio in Finnmark which broadcasts daily in the Sami language and which has many Sami listeners. The participants contacted the Sami researcher and volunteered to participate and they were suggesting her to contact people, which she did, it is called snowballing (22). They were given information about the study and signed informed consent forms. The interviews were conducted in North-Sami language to welcome the participants to use their mother-tongue during the session. Maybe they felt more free and comfortable speaking Sami when explaining situations. The inclusion criteria were that participants identify themselves as Sami, speak Sami language and have had encounters with the healthcare system. This is narrow and exclusive definition, and findings are not representative for Sami people in general. Participants do not only represent their ethnicity, gender, affiliation and role as next of kin, this complexity of intersectionality reflects the social life of the participants, which influenced the conversations in the interviews (23). Nine of the participants were women, ranging from 24 to 76 years old, there were one middle-aged- and one elderly man, some were educated on bachelor level, and some not. Five of the participant affiliation was into health care and they were familiar with expected standards of care, which may have influenced why they wanted to participate in the study. All was

bilingual and had stories to address, for the most by negative experiences from somatic hospitals and GP`s office, where they have been patients themselves, next of kins or as parents. In addition, two participants (interview 8 and10) told how they communicate with Sami patients about pain and intimate details about what they meant in terms of cultural congruent approach.

***Table 1.*Description of participants**

Descriptors	**n=11**
Sami identity and language	11
Gender Men	2
Female	9
Age 24-40 years (young)	5
41-60 years (middle aged)	3
61-76 years (elderly)	3
Role in the narrative	
• **Patients**	4
• **Relatives**	7

Data Collection and Analysis

Semi-structured interviews were used to collect data. The interviews lasted from 20 to 90 minutes in duration and took place in the respondents' homes or at the university office and respondents were alone. The Sami researcher transcribed the interviews and translated them directly from Sami into Norwegian. After a preliminary content analysis identifying meaning units, condensation of those and making sub-themes, as described in Graneheim and Lundman (24), four of the interviews were selected for translation into English so that the third author could contribute to the analyses. The preliminary analysis showed that these interviews covered the breadth in the data collected and would provide a good basis for

further analytical discussion with our Canadian co-researcher. Related sub-themes from all eleven interviews were categorized into main themes, all was done without software.

Ethics

The project is registered in the Norwegian Center for Research Data, project number 39276 and the Sami parliament financed the data collection. Anonymization of the data was done by numbering the informants quotes and excluding name of persons, staff, hospital and municipalities.

Findings

Three themes were selected from entire data analyses for explication; 1) Ways to communicate,2) Feeling at home in the language, 3) and The use of interpreters.

Ways to communicate

Almost all of the participants emphasized the importance of taking one's time in the encounter with Sami patients. Participants advised that it is generally polite to introduce oneself by family name and family affiliation, because who you are, where you are living and the family to which you belong is important in Sami culture. It is a connection that immediately situates and grounds the encounter, as in all encounters between healthcare providers and patients.

Four participants said that Sami patients will not tell everything about themselves during the first encounter. It is necessary first to talk generally about broader topics before coming to the point. One must wait for information to be offered by the patient. A participant said that they often 'beat around the bush', a way of providing discreet cues to see if the other person perceives that something important is at stake and must be addressed at a later occasion. One of the accounts involved an uncle who would not readily admit that he had cancer to his nephew. It was important to him that no one in the family or local community should find out about it.

> *…when the time went on he (the uncle) started to call me everyday, but he did not tell me about his illness (cancer). Eventually I had to ask him, why are you calling every day, are you sick? Before he confirmed, I had to promise him not to tell the family or someone in the municipality about his illness. He asked if I would like to escort him to the hospital* (Interview 5).

This quote is an example of how he reaches out and takes stock of the other before he confides about his illness and asks his nephew to escort him to the hospital. This kind of

sensitivity in relation to the manner of communication is important to be aware of for health-care staff.

In several of the accounts, the participants say that the Sami people do not speak directly about illness or symptoms, but instead suggest that something is wrong, downscale their pain, and many wait a long time before contacting the GP, as described in this interview:

> *Sami often delay their visit to the GP. When they finally do go, the GP must know that it is serious business. My experience is that Sami patients do not want to complain too much because they will describe their complaint in a way where they downscale the issues, claiming they only feel a "little pain". This means that they are in a lot of pain and ought get priority at the GP's office[…] (* Interview 7).

She state that Sami in general do not complain. This perception may be based on her cultural understanding of how to express or holding back expressions about pain and complain when feeling sick. Another participant (a nurse) confirms that:

> *My experience is that Sami do not complain. If they have a lot of pain, they tell you that they only have a little pain. I have to engage in everyday conversation and thereby get to the real problem, the pain. Then they might be honest and tell me how they really feel* (Interview 8).

These quotes describe a kind of communication in which expression of pain is repressed, thereby creating an obstacle to communication between patients and healthcare providers. A participant who also worked in hospital said:

> *I have worked in the gastrointestinal unit. In the Norwegian language, there are many fancy words to describe bowel movements, passing gas, etc. Perhaps this makes it easy to answer in Norwegian. But Sami patients find it uncomfortable when they are asked whether passing intestinal gas has been functioning normally, or whether he has had normal stool. These are private matters. A little time must be spent explaining why it is important to pay attention to these things before one poses direct questions about them* (Interview 10).

The participant explains that it is considered impolite to speak explicitly about bodily functions like this, in Sami. Although she herself was a Sami nurse and was able to approach

the issue with complete cultural congruence, it was still necessary for her to spend a long time explaining why she needed to ask about matters considered private. This reinforces the importance of transmitting medical information and questions to Sami patients in a respectful and careful way, ensuring that the patient understands that sharing private information with a healthcare provider is necessary for a positive health outcome. If nurses want to review a problem or ask for more details about health conditions, they may not answer at once; it is necessary to pursue the topic to get the entire message (*gavvilastit* in Sami). Hence, if nurses continue to use direct questioning, Sami patients may feel offended and disrespected.

Those findings show contradiction according to expressing illness, symptoms and pain. Some state that Sami do not talk about it, but in the next there are explanations on how to conduct into a conversation about this. It is about adapting the conversation into an appropriate way, to get connected with the patients and pursuing information, by using time.

Feeling at Home in the Language

Participants described feeling at home in the Sami language as opposed to the Norwegian language. This applies to both women and men, young and old. When one is ill, having to explain one's illness in Norwegian to the physicians or nurses poses an additional problem.

> *When it comes to me personally in encounters with healthcare, I shut down my feelings. I just describe the illness and symptoms and do not talk about inner emotions. Norwegian-language is so "poor", I can't find the words to describe* (Interview 7)

She tries to express herself to the GP, but has difficulty when it comes to using the Norwegian language, which she finds so poor according to her Sami language. A midle aged woman stated this;

> *I used to go for long walks alone in the countryside. I did not like the tone when talking to the Norwegian-speaking [nurses] and therefore often went on hiking trips on my own. The staff had discovered that I spent a lot of time alone. They asked me if I felt lonely. I told them that I felt very lonely and that the reason was the language. I do not know how to express what I want to say* (Interview 8).

Those quotes reveal that they are longing for speaking Sami to express nuances and symptoms in a descriptive way, using Sami words. A young, female participant said that when she wanted to convey her somatic complaints in Norwegian to the physicians, she heard her own voice and felt unable to communicate the seriousness of the situation. In the end, she concluded that she was not ill, and she distrusted her own assessments. Explaining how she felt in Norwegian became an additional problem for her, on top of her illness. She explicitly stated that a Sami-speaking GP "is safe" for her;

> *It is difficult to explain your inner feelings and problems in Norwegian. When I speak Norwegian, I cannot express symptoms and problems. The things that come out of my mouth are not things I had planned to tell. I cannot speak freely and tell the right things. I am not sure whether they understand me and whether they know my Sami cultural heritage. At home, I have a Sami general practitioner, he is safe, he understands everything that I express in Sami. I feel insecure about whether the Norwegian GPs understand me and whether I can express myself in an understandable way to them… I do not want misunderstandings in the conversation* (Interview 7).

Several of the participants spoke of their own vulnerability and that of others when they are unable to speak Sami when they are ill. In these cases, one is exhausted and weak from the illness but must simultaneously muster the strength to communicate one's illness in Norwegian. Therefore, many elderly patients want to bring their next of kin along as interpreters, or to have a 'set of extra ears to listen' and someone to help clarify what happens during the physician's visit and what the physician says. They were afraid of not understanding everything, giving wrong answers, and thereby receiving incorrect treatment.

Having to deal with two languages all day long is described as exhausting, particularly when you are ill, here described as somatic problems.

Use of Interpreters

In the participants' accounts, only one describe the use of professional interpreters commissioned by the institution, and six have been unpaid interpreters for family or other patients. One participant said that after three weeks had gone by, just when her evaluation of her hospital stay was to take place, they commissioned a Southern Sami interpreter for her, despite the fact that she speaks Northern Sami. She remained persistent, insisting that she required an interpreter even though she understood Norwegian and could make herself understood in Norwegian. She wanted an interpreter to ensure that she performed rehabilitation exercises correctly and that she had understood all the information provided by the rehabilitation hospital. However, it was too late, because her stay there was over. She said;

> *I wonder if they will have improved the communication for Sámi speaking patients? I told them that back home, I would never feel different or stupid. I feel stupid here. I do not need an interpreter; the nurses need one* (Interview 8).

The lack of an interpreter increase the patient's vulnerability, in this case by making the patient feel 'stupid'. Another patient also highlights the power imbalance, questioning where responsibility lies with regards to issues of language in healthcare;

> *When you are really ill, you do not have power to fight for your human rights. I want to speak Sami. If they do not speak Sami, then they have a problem. The nurses need a interpreter* (Interview 9).

However, the nurses must also be able to understand the patient in order to assess the situation properly, and the respondents here suggests that the need for an interpreter lies with the healthcare provider. Parents often interpret for their children, as described in the following;

> *I went to the GP for the second time, in a Sami way, with all five of my children and my mother-in-law. I asked the GP if it was really possible that my child was allergic to food and animal hair. Yes, he said. Then I went home and thought about it all. Do we really have to stop reindeer herding because of my son's allergy? In my Sami world, I was unaware of this issue. I thought everybody could eat reindeer and wear fur clothes and shoes made of reindeer fur at home. But it was not like that, we had to stop. I was exhausted and had almost given up seeking help for my child's problems. I felt that our reindeer herding life was at stake; this was our way of life and our source of income. Now we would have to separate one of our children from this way of life, separate him from an upbringing in a reindeer herding family, with all our common activities surrounding the animals. It will impact the whole family…it is sad….*(Interview 6).

Allergy can be devastating for a reindeer herding family because physical contact with the reindeer, fur clothes and shoes and herding dogs are such an integral part of their daily life. The allergic child will therefore be excluded from the activities that are central to their cultural heritage and way of life. This mother worries about the many issues allergy gives rise to, including the consequences for her son's future in the family and the business. She was the person who had to tell the boy and the family about his future. Another respondent similarly describes the difficulties of the intermediary position one assumes when taking on the role of interpreter.

> *At Christmas I accompanied my father to hospital. There was no interpreter available because of vacation. They asked me to do the interpreting. It was awful because I know that my father would not want to tell me about his private issues. I am still his child and he wants to protect me, but I had to tell him bad stuff from the physician. I have never asked him if he felt awkward in that situation, but I did. I was very uncomfortable doing that, I felt sad* (Interview 10).

It is neither appropriate nor constructive for persons who are the next of kin to serve as interpreters. When relatives act as interpreters, there is a risk of disruption in family cohesion and increased vulnerability of family members. It may cause a patient to lose trust in a once trusted family member. When next of kin serve as interpreters, there is also a risk that messages between healthcare providers and patients are not communicated accurately because of the emotional pressure to spare and protect one's family.

Limitations

We acknowledge that culture, use of language and communication are dynamic, situated, in constant change influenced by factors such as migration movement, mixed marriages, bringing up children, political movements, gender and modernity. Hence, this study describes ways that some bilingual Sami communicate about healthcare issues and cannot automatically be transferred to all situations, all times and all places where Sami and healthcare providers meet.

The researchers represent both insider and outsider positions, ranging in age from 56 to 68. One is a North-Sami-speaking Sami, living in a Sami community, who has experiences of the colonialization and assimilation process from her childhood and is familiar with some of the issues of Sami people in encounters with healthcare, all of which situates her as an insider in this study. The second is a mixed Sami-Norwegian living in northern Norway, and the third is a researcher from northern Canada with a research background in indigenous perspectives of female health. All of us are former nurses, now scholars, privileged women and have between 14 and 25 years of clinical experience with indigenous patients of all ages. The analysis is influenced by our background and experiences, which Olsen (25) describes as a privileged and empowered position. Our analysis is conducted from both an insider (indigenous) and an outsider (non-indigenous) position, as described in Wilson (26). The motivation to this study is based on the wish to contribute to knowledge influencing healthcare providers to deliver cultural congruent care to Sami patients and their relatives.

No accounts exist regarding municipal home care services, but many from GP`s office and hospitals. This may indicate that the participants, recruited by our convenience strategy (22),

took the possibility to participate for addressing their experiences in encounters with health-care providers, which were not so good.

Discussion

These findings address the impact of communication for Sami patients and offer important insights regarding the communication process for healthcare providers. It is vital that communication in Sami language occur in the provision of healthcare in Norway as guaranteed in laws and directions (14-15,27-28).

Our findings confirms that Sami communication can rightfully be characterized as indirect and by hinting, as in a few other studies (6,11-12,18,29). Rather than coming directly to the point, participants describe how addressing issues indirectly by circling around a topic and making innuendos, for example. While some participants state that Sami do not express pain or talk directly about illness, one of the youngest women said that she was not afraid to talk about her illness; instead, her concern was whether the GP could understand what she expressed. This is in contradiction to findings from Dagsvold et.al.`s study (20), where Sami patients with bilingual therapists would switch between Norwegian and Sami language and they talks about their problems with therapists. In our interviews, participants told stories involving somatic issues and symptoms that might have been more difficult to describe in a second language than emotions and feelings. Failure in symptoms descriptions can be fatal for patients, both in mental healthcare and in somatic hospitals. Spending extra time because of the language barrier, and adapting into the 'beat around the bush' technique with the patient, can make progress for healthcare providers in the conversation. Communication style is to be identified, recognized and adapted in context, as the healthcare provider develops a

relationship based on sensitivity with the patients. If not, the outcome of the dialogue between healthcare provider and patient can be misunderstandings (9-10,19,29).

When information is addressed directly to patients, in a language and terminology which they are not familiar with, cultural dissonance occurs. All patients can feel overwhelmed by direct questions on private matters and medical information in a foreign language, especially when being put in an unprivileged position in the process of it. Sami have an extended right to use their language in the healthcare and social service sector in Norway (14-15,28). By using a professional interpreter who possesses the linguistic and cultural insight that allows them to reconcile direct and indirect forms of communication, healthcare staff can bridge the gap between Norwegian caregivers and Sami patients and make the stay in hospital safe for the patients. To ensure that information is correctly communicated, healthcare providers must use a professional interpreter to ensure that the information is provided and understood by the bilingual patients (21-30) and they are obligated by law to do this(14,27). Using family members as interpreters is not best practice (21). According to Norwegian guidelines for using interpretations staff is advised how to accommodate professional interpreters who also possess cultural competence (31). Participants described switching between Sami and Norwegian languages involuntary and having to ask for interpreters. This caused patients to experience fatigue, but it simultaneously demonstrated their resistance to healthcare providers, which do not accommodate the need of interpretation services. This is in contradiction to Dagsvold et al.`s (5) findings where patients switch easily between Norwegian and Sami in therapy, and seems to have a benefit of being bilingual. On the other hand, the study of Kale and Syed (21) states that healthcare providers are aware of the underutilization of interpretations services in Norway and it is not the responsibility of patients to address shortcomings in relation to language services in hospitals. Healthcare providers must be sensitive and provide culturally congruent care (16,30). Our participants

describe layers of barriers when meeting healthcare providers, therefore, it is important that staff provide a Sami interpreter when they are giving important information to patients. This may help reduce the burden and fatigue that the interaction can cause for patients and their next of kin (30), and frequent use of the interpreter service is often a good quality indicator for the hospital in question (13).

For children, parents often serve as first interpreter (21), both in terms of describing the child's symptoms and explaining to the child how treatment will be performed. They are concerned parents who must simultaneously convey what the physician says to the child. Information that makes an impact on the whole family's life and lifestyle should be given by a professional interpreter (21,30). Several participants express the view that the need for an interpreter lies with the healthcare providers, not the patients. Healthcare staff is obligated by the law to provide information deliver equal healthcare services (14,28), which means the participants' views are legitimate. Forcing a Sami patient to speak Norwegian may be experienced as harassment, violation, marginalization and provocation from the dominant culture, and thereby a continuation of Norway's historical colonization of the Sami (2). Silencing others by not using interpreters is a form of harassment, and our findings point to resistance against this. Bilingualism is a challenge in healthcare (4), therefore healthcare staff has a special responsibility to acknowledge the importance of the Sami language and make every effort to provide services in Sami (3-4). When patients are sick and weak, they require support from others to advocate for their human rights. Hence, healthcare providers in Norway must have knowledge of the Sami history of assimilation (2) to understand that the choice of language is important.

All of the narratives in this study came from encounters within the somatic hospitals and GP`s. It is possible that this is where the participants have experienced the worst culture and language collisions, because the hospitals are located outside administrative areas for the

Sami language in the north. Norwegian hospitals are required to enquire about patients' preferred language and Sami must express and claim their right to speak their mother tongue during admission (27-28). If not, the Sami patients are invisible during admission to hospitals. Hence, when a nurse conducts the traditional admission interview with patients, it must be kept in mind that all information may not be voluntarily offered at once from patients, also Sami, even if you ask specifically about certain things. Patients need extra time to adapt into a new milieu, especially when they are ill and not speaking Norwegian.

One of our respondents described his uncle's concerns of being identified at the hospital when he wanted to remain anonymous. Whether you are Sami or Norwegian, patient or staff, there is a lack of anonymity when you live in rural and remote areas (32).

Conclusion

The acknowledgement of cultural approaches in communication is essential to ensuring the health and wellbeing of Sami. Participants highlighted some of the core values in the Sami form of communication, including politeness, presentation of family name at the beginning of conversations, and taking into account the circular and indirect approach to communication of the Sami. Furthermore, some participants also emphasize that despite being bilingual, switching between Norwegian and Sami when they are ill is difficult because they are exhausted, under emotional stress, and afraid of misunderstandings and mistreatments they need more time in conversations. There are layers of barriers in the communication. This underlines the necessity for healthcare providers to provide professional interpreters when giving patients important information, not only because of the patients need, but to fulfill their duty as healthcare providers. This is an explorative study of eleven men and women`s experiences to take into consideration. It is also important to recognize that in this study there

are pointed out some important factors in communication, and it is not representative for all Sami patients communication with healthcare providers.

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