The purpose of this study was to explore Somali refugees’ experience of their encounters with Swedish health care. Individual interviews with 20 Somalis were transcribed verbatim and interpreted according to a hermeneutic approach. The findings were expressed in three themes. The first theme, ‘expectations when approaching health care’, conveys an ambivalence regarding confidence and expectations of treatment and care. The second theme, ‘rejection in the clinical encounter’, dealt with negative experience when encountering medical staff, physicians in particular, who often responded to complaints by saying ‘it’s really nothing’. To the informants, this fitted into a general narrative of distrust in health care. The third theme, ‘going abroad for help’, described how, as a result of reduced confidence in Swedish health care, many Somalis seek medical advice and treatment in other countries. The study adds knowledge to the way Somali refugees experience Swedish health care, set in the context of medical encounters with refugees in general. Their voices need attention so as to achieve care practices based on respect and equality.

Keyword: ambiguous expectations, confidence, experience, health-care encounters, Somalia, Sweden, trust, refugees

Introduction

This study sought to give a voice to some Somali refugees and their experience of Swedish health care. This is of importance for improving communication in clinical encounters, facilitating improved medical and psychological care for this group whose experience of medical encounters in Sweden has not been studied. Previous research in Sweden regarding Somali people in health care concerns obstetrical issues (Wiklund et al. 2000; Högberg 2004;
Essén 2001), conceptions of pain among women (Finnström and Söderhamn 2006) and experience of living with diabetes mellitus (Wallin 2009).

Internationally, research regarding Somali refugees’ experience of encounters in health care is scarce. In the US, women from this group reportedly experience unmet expectations in health care (Pavlish et al. 2010; Carroll et al. 2007). Others are reported to go directly to hospitals rather than using primary care centres even for milder complaints, having high expectations of health care treatment and low preparedness for preventive medicine (DeShaw 2006; Norredam et al. 2004). Reports from the UK express dissatisfaction with improper examinations and highlight the importance of not stereotyping this group in clinical work (Whittaker et al. 2005; Warfa et al. 2006). Perceptions of harsh and offensive treatment, but also appreciation of clinical care, are described in a study of how Somali women experienced giving birth in Canada (Chalmers and Omer-Hashi 2002). The experience of being discriminated against seems common (Ellis et al. 2008; Hadley and Patil 2009; Fangen 2006). These findings demonstrate significant concerns about Somali refugee patients’ encounters with the health care sector.

Refugees from Somalia have been arriving in Sweden since the early 1990s, coinciding with the collapse of Somali society due to civil war and famine, as a result of which, around two million Somalis have fled their country. Many have remained as internal refugees in their homeland or in neighbouring countries under poor conditions (MacDonald 2009). Others have formed large communities in the USA (Heger Boyle and Ali 2009) and have created a worldwide diaspora. Complex experience of their life in exile has influenced many Somalis (Farah 2000; Warfa et al. 2006; McMichael 2002; Svenberg et al. 2009). After many years in Sweden, the present informants still considered themselves refugees, dreaming of returning to their homeland—which arguably justifies the use of the word ‘refugee’ in this study. Around 40,000 Somali-born refugees are currently living in Sweden, which, as well as other countries in contemporary Europe, is facing an emerging cultural and demographic diversity (Vertovec 2007; Samarasinghe et al. 2010). In the light of this, the purpose of this study was to explore some Somalis’ experience of their encounters with Swedish health care.

**Methods**

**Informants**

The study comprised 20 informants of Somali origin, eight women and 12 men, aged between 17 and 75. All except two had lived in Sweden for more than 10 years.

**Procedure**

The study was conducted in two steps between spring 2008 and autumn 2009. Initially 13 informants were interviewed as to their own and kinfolks’
conceptions and explanatory models regarding health and illness which formed the basis for a previous study (Svenberg et al. 2009). During these interviews experience of contacts with Swedish health care and the treatment given the informants, their relatives and friends, was also explored. In the second step, these data were expanded with seven additional individual interviews, thus providing material for the present study. The guiding question was ‘could you tell us about your own and your family’s experience of meeting Swedish health care?’

Contacts with the informants were arranged in collaboration with two key persons in Somali communities in two major Swedish cities, acting as gate-openers. The key persons were contacted by the first author through connection with a Somali community organization close to his place of work. Their relations with the informants were hard to estimate but presumably based on their wide connections within the community. Information concerning the aim and background of the study was printed and distributed to the informants, and repeated orally before the interview. On four

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<thead>
<tr>
<th>Participant</th>
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occasions an interpreter was used. The interviews were individual and held in
the informants’ homes. On average, the interviews lasted for 1.5 hours with
a break for coffee.

The informants willingly discussed the topics raised and communicated in a
relaxed and cooperative way. Questions were open-ended and non-directive.
This approach allowed the informants to express their views any way they
wanted, inviting a collaborative exploration of the issues raised (Phillips
2007). Field notes were written in connection with the interviews, describing
environmental settings and serving as an aid to subsequent reflection.
The interviews were tape-recorded.

Hermeneutical Interpretation

An interpretative approach in the tradition of hermeneutics was used, aiming
at deepened understanding of certain human conditions (Gadamer 1994).
Interpretations of texts are always influenced by preconceptions and preju-
dice. These should not be regarded negatively but as something giving us
access to the unknown and as a starting point for new understanding
(Gadamer 1977; Koch 1996). The pre-understanding of the first author had
been influenced for 18 years by seeing Somali patients daily as a general
practitioner working in a multiethnic suburban area in southern Sweden.
Over the years, his consultations with patients from Somalia have been
marked by feelings of both joy and despair and sometimes by confusion.
This has been confirmed by talking to colleagues with similar experiences.
However, a previous study widened the first author’s understanding of
Somali patients and raised further questions, influencing the work of the
present study (Svenberg et al. 2009). Research may challenge previous under-
standing, rendering it susceptible to change provided it is open to other
points of view, not cutting the link with the researchers’ own experience
and background. This is another way of describing a fusion of horizons,
essential in bringing about a change of practice (Koch 1996). One engages
in a process of mediation and dialogue, leading to an understanding of human
experience, rather than a unilateral one-way process characterizing traditional
clinical research, leading to explanation, defined as a primarily epistemologic-
al, cognitive process (Holroyd 2008).

The interpretation started during the interviews, when listening and taking
part in conversational dialogues. Language, a fundamental concern of her-
meneutics, functioned as a medium in the creation of new meaning, stressing
the priority of the question over the answer. The interviews were subsequent-
ly transcribed verbatim by the first author, which created opportunities for
deeper understanding. The texts were read repeatedly and the hermeneutical
circle of understanding was applied by referring to each individual part of the
text in reference to the whole. This circular movement of understanding was
created by returning to the text and replaying the tapes. The parts of the text,
as represented by sentences and passages, were scrutinized and finally
considered within the text’s entirety to reach a higher level of comprehension, rechecking the parts for agreement. Three themes emerged, summarizing the new common meaning of the interpretation—by no means final, and bearing the cultural attachment of the interpreters.

**Ethical Considerations**

The study was performed in accordance with the principles of informed consent and confidentiality and general ethical procedures. According to Swedish law, research interviews need not be subject to scrutiny by an ethics committee. Standard ethical procedures were, however, pursued. Personal details of the informants were changed to avoid identification. During the conversations, the informants were entirely in charge of what they wanted to speak about. Theoretically, interviews may provoke strong or even harmful emotions due to the subjects raised; but no such feelings were noted during the process. However, without follow-up interviews we cannot entirely rule out this possibility.

**Findings**

The themes reflected the fundamental topic of trust in medical encounters. The first theme, ‘expectations when approaching health care’, described notions and ideas at the prospect of encountering health care. The second, ‘rejection in the clinical encounter’, dealt with the experience of the informants and their relatives in their encounters with Swedish health care and the attitudes of health-care staff. The third theme, ‘response: going abroad for help’, demonstrated how the informants reacted to their unfulfilled medical needs by going abroad to seek help.

**Expectations When Approaching Health Care**

There seemed to be an ambivalence among the informants regarding their confidence in and expectations of the medical encounter. Some expressed their gratitude to the Swedish health care system and to the doctors they met. One stated: ‘There are a lot of positive things to be mentioned, compared to the conditions back in our homeland.’ Another expressed his appreciation of Swedish hospital standards and the low charges, comparing them to expensive private care abroad. But these statements were often subject to reservations, as shown by one informant:

Swedish doctors are very knowledgeable, their system is advanced, but they still sometimes do not help immigrants.

A majority of the informants wanted more patience, respect and impartiality when seeing a doctor. They expected the doctor to inform them about how their illness could be translated into a disease and a diagnosis, to show
respect and to treat them irrespective of their ethnic origin. Language problems should not be allowed to jeopardise the meeting. Elderly patients, particularly, expected to be given medications, to which they were accustomed in their homeland. A majority of the informants did not approve of the doctor’s using a medical reference book to find any suggestions for treatment: they expected to be told immediately what was wrong without being asked too many questions. According to one informant, a joke among Somalis goes:

The Somali patient sees a doctor and the doctor says: ‘So, what’s your problem, then?’ And the Somali says: ‘But, oh my God, if you can’t tell me, what kind of a doctor are you?’

Note that many informants stressed the habit of intra-community gossip and chat regarding their health and medical matters in general. One factor influencing their expectations was the fact that some informants, discussing their condition with their compatriots, developed a strong feeling of group disapproval after being told by the doctor that their symptoms probably had a ‘psychological’ cause. A division between ‘physical’ problems and ‘psychological’ ones with no interrelation was evident among a majority of the informants, resulting in rejection of such connections made by the doctor.

Confidence in physiotherapists was low as regards preventive health care such as ‘physical training’, according to the informants. Another evident feature was that some stressed their appreciation of Swedish doctors and other medical staff in contrast to those with an immigrant background. One informant, a young woman, said that ‘immigrant medical staff’ usually show a more authoritarian attitude than native Swedish staff, who were experienced as more caring and affectionate. An elderly man declared that he didn’t like ‘immigrant doctors’, no matter whether they came from Somalia, Iran or the Arab states. He felt that they did not show him enough respect.

A case in point: informant 11 (a woman in her forties) explained her expectations before meeting the doctor:

The doctors should have to help the patients regardless of their origin. They should listen more to the patient and get to know the person, even if they are an immigrant. It happens all too often that the doctor says the patient is OK in spite of the patient feeling sick. Perhaps they are telling lies, I don’t know. And one day it might be too late…. 

Rejection in the Clinical Encounter

Some informants noted a suspicious attitude towards Somalis in Swedish health care, as if the staff felt the informants were imagining things or using the health services for no real reason. They felt that the health service did not meet their needs ‘because they were Somalis’. This was put into words
by one informant who stated: ‘I would rather stay sick than go to the hospital’, and another: ‘Swedish health care just ignores immigrants.’

‘It’s really nothing’, was a comment used by many doctors when responding to the informants’ complaints. This expression was perceived by the informants as a rejection and an uninterested response. Some informants earned their living as interpreters. One recalled a client, an elderly Somali woman in pain. After seeing the doctor, she was given no clear explanation as to the cause of her pain and therefore she felt rejected. Walking out of the health-care centre the woman, who was crying, told the informant:

The doctor just will not listen. He says he cannot find anything wrong with me. I feel he thinks I only come to see him and waste his time because I have nothing better to do.

Another interpreter stated that a majority of his clients were dissatisfied after having met the doctor, given their low confidence in his or her competence even prior to the visit. They felt this presupposition was confirmed during their meeting. Several informants were upset by the general perception that elderly patients seemed to receive less care because of their age. Discriminatory treatment seemed to be frequent. As one example, a male informant said that he had wanted to give blood. At the blood bank, he was told that owing to his Somali origin any blood donation was out of the question. He was given no further explanation. As a result, he felt discriminated against and rejected. A female informant visited a hospital together with her family to see her father who was critically ill and being treated in a single room. Appearing upset, a nurse entered the room and commented:

You all seem to think that this is some sort of recreation centre and not a hospital!

A majority of the informants felt that their poor Swedish was a major contributory cause of being rejected during medical encounters. A female informant said:

Knowing the language is important but should not determine the value of any human being.

Female informants in general seemed dissatisfied with treatment in connection with their deliveries. There was a fear of surgical procedures such as caesarean section, and one informant, having previously experienced a complicated delivery, feared that the obstetrician would want to ‘cut out her uterus’. Reports about severe obstetrical complications are frequent among the informants, their relatives and friends, encouraging distrust and suspicion of Swedish maternity hospital care.

A case in point: informant 2, a man in his thirties, had experienced pain and discomfort in his chest. He could feel his heart beating abnormally and
he was sweating profusely. He went to the emergency unit at the nearest hospital in the middle of the night. Having examined his heart, the doctor said: ‘It’s really nothing serious, why have you come here?’ The doctor then asked the patient if he had only come to obtain a sick-leave certificate, which he had never even thought of.

Going Abroad for Help

Many informants and their close relatives reported going abroad, mainly to Germany, to obtain medical care. The costs involved were covered by donations or loans from relatives or friends in Sweden or abroad. Among the reasons given for this were the rumours of maltreatment and overlooked diagnoses in Sweden. Everyday tips and hints regarding the possibility and potential for care abroad were related by the Somali community in Sweden and within their transnational networks. Rumours concerning any medical mistakes travel fast. A male informant expressed this as follows:

We all talk about what I have been told in Sweden, and what my friends and relatives say. They believe that in Germany there is always a private doctor waiting for you. If you suffer from any serious disease you can be cured much faster in Germany. In Sweden, you have to wait and while you are waiting you can die.

A female informant expressed her low trust in Swedish doctors and the need to go to Germany for a ‘second look’:

If I go to the doctor here and tell him my heart is sick, they will give me some medicine for the heart. But you do not really trust them, so you go to Germany. There, the doctor says you have no heart problems at all. It would be better if they told us directly here that they do not want us to bother them.

Another informant put it:

There is a general feeling that Swedish health care does not really want to help Somalis. Many therefore go to Germany and the hospitals there, others to Luxemburg, some to Italy. What the Somalis like about being treated in Germany is that if you say you have a problem with your liver then they will look at your liver, give you blood tests and everything, it is all very speedy. They try to respond to the wishes of the patient. If you have any complaints or troubles in your head you are always X-rayed.

Medical doctors in Germany are perceived by many informants as being more efficient than their Swedish colleagues. German clinics used by Somalis are often private and appreciated for their speedy logistics, thorough physical examinations and wide variety of technical diagnostic procedures. German doctors seemed liberal in writing prescriptions, which was appreciated by many informants, in comparison with their treatment in Sweden and reminding them of conditions back home. Examples of differences in the
perceived quality of care which led to their decision to seek medical help and treatment abroad were frequent. One woman, a friend of one of the informants, had been suffering from protracted abdominal pains. As she could not get a satisfactory diagnosis in Sweden she went to Germany. There, she was examined, and the doctors informed her that she had tuberculosis of the abdomen. A female informant consulted a Swedish doctor for pains in her legs. Receiving no remedy, she went to Germany, where the doctor told her she was suffering from rheumatism and offered her a suitable medication. Subsequently, she reported an improvement.

A case in point: informant 12, a 42-year-old teacher, said that he woke up one morning with a pain in his back, and feeling very tired. As his condition deteriorated, he consulted several doctors without getting any real help. He sweated during the night, had lost several kilos in weight and his sedimentation rate (a measure of inflammation) was very high. His local family doctor had dismissed his complaints as ‘psychological’. Finally, after more than six months of futile consultations, his friends decided to take him to a hospital in Germany, lying in the back seat of a car as he could not sit down. There, he was investigated thoroughly and the doctors found he had tuberculosis of the lumbar spine.

Discussion

This study sought to explore the experience of Somali refugees in their encounters with the Swedish health care system. Interpretation of the findings suggests unfulfilled expectations of the medical encounters, resulting in disappointment among the Somali informants. This entailed a lack of trust and feelings of rejection and, ultimately, decisions to seek private medical care abroad.

A general feeling among the Somali community based on their perceived negative experience seems to be a lack of trust in Swedish health care, creating a general narrative of not being taken seriously. A study from the Netherlands reporting on complaints in the Somali community there regarding expectations of health care bears much resemblance to what was reported and expressed in the present study. The patients want recognition, adequate examination and a welcoming attitude, though feelings of being discriminated against and not taken seriously are common (Feldmann et al. 2006). Among Somali refugees in the US, similar expectations have been reported. Many patients expect doctors to know what is wrong with them without being asked too many questions, relying on the possibilities of bio-medical treatment (DeShaw 2006).

There was, however, a certain diversity among the Somalis interviewed, the negative majority experience of the medical encounter sometimes being contradicted by expressions of gratitude and appreciation of Swedish health care. However, the positive statements were often followed by reservations which reduced the level of praise to conform with the overall negative
opinion of the majority. An ambiguity in the perception of the doctor as being omniscient, not posing too many questions, and at the same time emphatic, is worth noting.

Feelings of rejection and of not being taken seriously when meeting health-care providers, doctors in particular, were expressed by a clear majority of the present informants. The findings suggest that Swedish health care has been negligent in paying attention to symptoms and signs of suffering among Somali patients, in some cases overlooking severe organic disease and dismissing presentations as subject to ‘psychological’ problems. This does not seem to be limited to Swedish health care. In Norway, Somali patients report extensive health-service delays in diagnosing tuberculosis. This was ascribed to a lack of awareness of the symptoms of this disease, but the study also reports patients being humiliated and not being taken seriously by the doctor (Sagbakken et al. 2010). Tracing tuberculosis among Somali refugees in Sweden is problematic for the Somalis, who fear that information given to the health-care provider might be passed on to the immigration authorities, increasing the risk of deportation (Kulane et al. 2010).

The present informants seemed to rely on bodily symptoms as indices of biomedical disease. Somatic symptoms as expressions of psychological or social suffering seldom seemed to be within the interpretative framework of many Somalis, possibly due to a social stigma which prohibits discussion of silent worries and mental disorders (Pavlish et al. 2010). This is a delicate problem for clinicians, whose inclination whether to adopt either a somatic or a psychological explanation could be influenced by the patient. This could lead to a narrowed therapeutic outlook, favourable to neither party. Attention has been paid to the ‘medicalization of distress’ among populations from war-affected areas, leading to an under-estimation of these people’s own systems of meaning and priorities. These represent a shared power of resilience often overlooked by ‘western’ counselling aspirations (Summerfield 1999). Even more, to the Somali patient, who rarely seeks health care for psychological problems, a somatic complaint could be the only way to obtain access to a health-care provider, putting him or her at risk of being labelled as a somatizer (Adams and Assefi 2002).

Influenced by their own experience of disappointment as well as a narrative among the informants, their friends and relatives that Swedish health care is no good for them, the informants reported that a decision was often taken to go abroad to receive medical care. This could apply to different health problems but included the seeking of assistance for potentially life-threatening diseases, such as tuberculosis, which are sometimes not detected in Sweden. Others wanted a ‘second opinion’, feeling insecure about their diagnosis. These findings are confirmed by two Dutch studies reporting low confidence in health care among Somalis, who accordingly tend to use health care abroad, in Germany in particular (Gerritsen et al. 2006; Feldmann et al. 2006). The reputation of German health care may also represent an aspiration for those in search of ‘greener pastures’ in a broader context with
Conflicts of Interpretation

Instead of shared insights and appreciation, the present informants experienced non-communicative responses to illness and suffering. Feelings of rejection following medical encounters seemed common and were exemplified by the informants using an expression commonly uttered by the doctor: ‘It’s really nothing’. As with many other refugees, a majority of Somalis have experienced harassment and deceit on the part of authorities, mainly in their homeland but also in the country of resettlement. As a consequence, suspicion is common, resulting in a basic lack of confidence in authority, including health care providers, as well as experience of discrimination. This has also been demonstrated in the UK and Norway (Palmer 2006; Fangen 2006). Similar experience is reported among Somalis in the US and in Sweden (Hadley and Patil 2009; Svenberg et al. 2009). Discrimination against Somalis in Swedish health care has not been studied previously, but reportedly occurs among other immigrants in Sweden, notably those of Iranian, Kurdish and other Middle Eastern origin (Sharareh et al. 2007; Taloyan et al. 2006; Lindencrona et al. 2008). In these circumstances, the expression ‘it’s really nothing’ often used by physicians gains an extra dimension. To many informants, it served as a dismissal, leaving them alone with their suffering, often with no somatic explanation but sometimes with a possibly hazardous disease.

To the physician, rather than expressing a discriminatory attitude, ‘it’s nothing’ could well be intended as a message of comfort and relief. Conflicts of interpretation may arise, where biomedical explanations of suffering are absent, leaving not only the patient but also the physician in uncertainty and despair. Clinicians may find themselves caught in a limbo, realizing the limits of biomedical care, being frustrated as well as compelled in the meeting with the cultural Other, who might both invite and repel medical attention (Ong 1995). Approaches emanating from ‘predefined’ and ‘compartmentalized’ contexts, minimizing personal experience and socially-determined causes and effects, could negatively influence the medical encounter (Watters 2001; Palmer 2006). Biased ideas and preconceptions regarding refugees seem common in health care in general (Eastmond 1998). To some extent the responses experienced by the present informants seemed marked by categorizations, normative conceptions and discriminatory attitudes among Swedish health care providers. This points to the need for research and empirical studies, including the views of Swedish medical doctors and other health care staff.
Towards Policies of Trust

To the Somalis, just like any other persons approaching health care, mutual trust is a decisive factor for a beneficial medical encounter. Trust depends on both the professional and the moral qualities of the health-care provider and, from the patient, a firm belief ‘that the other, the trusted one, will act in your best interest’ (Fugelli 2001). When trust is absent, the healing process risks harm (Ottosson 1999). Building trust depends on humane medical care, not letting the ‘voice of medicine’ silence the ‘voice of the life-world’ (Mishler 1984). Medical encounters seem too often guided by a low emotional involvement with the patient, destructive of morality and favouring humiliation (Malterud and Hollnagel 2007). In an environment of continuity, refugee patients should be enabled to tell their stories of past and present in an attempt to re-negotiate their experience in relation to new contexts (Eastmond 2007). To this end, a ‘cultural interview’ has been proposed to reduce the gap between the doctor and the refugee patient. Illuminating the cultural identity of the patient could help explore the meanings of illness and the interrelationship in the health-care meeting (Groen 2009). Others have proposed a clinical ‘mini-ethnography’ to find out what really matters for patients from different ethnic backgrounds, paying attention to pitfalls such as cultural stereotyping (Kleinman and Benson 2006). For the patient set outside the scope of predominant norms, the consultation is problematic; and the building of trust is hampered (Fioretos 2009).

To the Somali informants in this study, trust in the Swedish health care system was at stake. In medical encounters, their voices were seldom heard. Their hopes for and expectations of relief and of being given explanations and reasons for their suffering were often unfulfilled. The subsequent feelings of rejection and of not being taken seriously were of deep human significance for their experience. Preconceived rules or fixed formulas are of little value in this interactive situation. Rather, a basic approach to the encounters between Somali refugees and health care should be interpretive, shared understanding. This is a universal quest in medical practice but of particular importance when meeting many refugee patients whose life-worlds are bounded by horizons distant from many a clinician’s.

Limitations

The findings of this study are restricted to a limited number of Somali informants in Sweden and do not claim to reflect the conceptions of the Somali community in general. By only paying attention to Somali refugees, there is an inherent risk of contributing to stereotyping and stigmatization. However, when examining any minority group, a strategy of ‘silence’ could result in overlooking major issues related to maltreatment or discrimination.

Being retrospective, the informants’ accounts might result in a recall bias. A few third-hand accounts were presented as findings, e.g. interpreters’ recollections, because of these people’s specific experience of health encounters.
The interviewers came from the medical sector. This could have influenced the responses of the informants, who may have wished to avoid offence by reducing their criticism of the health care system. The use of an interpreter in four of the interviews might have negatively influenced the openness of the dialogues.

Conclusion

This study has revealed a considerable lack of trust in the Swedish health care system among a number of Somali informants. Expectations when meeting health care were often unfulfilled, leaving the patient with a feeling of being dismissed and not respected. Told by the doctor that their complaint was ‘really nothing’, patients often felt rejected and their trust and confidence was diminished. As a consequence, many Somalis went abroad to get medical help. To the informants, the lack of trust in Swedish health care was of deep human significance, emphasizing their feelings of alienation. Ambivalent expectations among the Somalis regarding Swedish health care, reinforced by internal rumour and gossip, and by the care providers’ biases and preconceptions, are important. Asymmetrical power relationships between health-care providers and Somali patients need to be given attention in research, and this is also of particular significance in medical encounters with refugees in general.

To improve the encounters between Swedish health care and Somali refugees, strategies of human interest, enhanced medical skills and relationship-building with the patient over a period of time need to be initiated. It is hoped that the examples of defective clinical practices illustrated here could serve as a reminder of the importance of counteracting bias and establishing shared understanding in the clinical encounter with refugees. This study has inspired further research into the views of Swedish health-care providers regarding their experience of meeting Somali refugees.

Acknowledgements

The authors wish to express their gratitude and respect to the informants and their families, as well as to the key persons who were instrumental in the performance of this study. Grants from the Gothenburg Primary Care Council and the Gothenburg Medical Association funded and facilitated the study. No conflicting interests occurred.


