Received: 26 November 2020 | Accepted: 14 March 2021

DOI: 10.1111/scs.12986

Scandinavian Journal of Caring Sciences

EMPIRICAL STUDIES

Sámi language in Norwegian health care: 'He speaks good enough Norwegian, I don't see why he needs an interpreter'

Janne Isaksen Engnes RN, PhD Student[1] | **Nina Sivertsen RN BNg (Hons), Grad Cert Ed (Higher Ed), PhD, Senior Lecturer**[2] | **Berit Andersdatter Bongo RN, Associate Professor**[1] | **Grete Mehus RN, Associate Professor**[1]

[1]Faculty of Health Sciences, Department of Health and Care sciences, UiT The Arctic University of Norway, Hammerfest, Norway

[2]College of Nursing and Health Sciences, Flinders University, Adelaide, SA, Australia

Correspondence
Janne Isaksen Engnes, Faculty of Health Sciences, Department of Health and Care sciences, UiT The Arctic University of Norway, Hammerfest, Norway.
Email: janne.i.engnes@uit.no

Funding information
Universitetet i Tromsø

Abstract

Introduction: The Indigenous people of Norway are legally entitled to use their Sámi language in encounters with healthcare services, yet these encounters are generally conducted in Norwegian language. The right to Sámi language and culture in health is particularly relegated when Sámi healthcare personnel is not present. This neglect of Sámi language and culture in the Norwegian healthcare system impacts on the quality of care Sámi patients receive.

Aim: This paper describes and interprets healthcare interactions between nurses and Sámi-speaking patients in Norway.

Method: Qualitative semi-structured focus group interviews were conducted with Sámi ($n = 13$) and Norwegian nurses ($n = 10$). Participants were included if they had experience working with Sámi-speaking patients and two years clinical practice in the Sámi area of northern Norway. Interpretive and descriptive analyses were conducted.

Findings: Obtaining only basic patient information and lack of mapping of native language in admission documents or patient notes makes it challenging to recognise Sámi patients. In encounters with Sámi patients, Norwegian nurses must navigate linguistic challenges with an additional layer of interplay between culture and care. Misunderstandings in this area can undermine patient safety and be directly contrary to health legislation and patient rights. As remedy, Sámi nurses often improve the nurse–patient dialogue by translating and explaining cultural nuances, thus improving understanding of healthcare interactions, and bridging the gap to the Norwegian staff.

Conclusion: To integrate Sámi language and culture into nursing care new guidelines to implement knowledge of Sámi patients' culture and language rights in healthcare education is needed. In addition, the authorities have to facilitate implementation of laws and regulations, research and guidelines in practical health care. At last, the number of Sámi-speaking nurses has to increase.

KEYWORDS

culturally safe health care, implementing laws, knowledge translation, linguistic challenges, nursing, patient safety, Sámi language

INTRODUCTION

Linguistic challenges in health care are well-documented [1–8]. Yet, in spite of legislation to remedy this challenge, Indigenous Sámi patients in Norway are still experiencing lack of inclusion of Sámi language in healthcare services, impacting on culturally safe healthcare provision.

The official majority language and culture are Norwegian, with Sámi languages legally established as additional official national languages [9–11]. In Norway, there are three different Sámi languages: Northern Sámi, Southern Sámi and Lule Sámi [12]. About 25,000 people speak Northern Sámi, which is spoken mainly in the Sámi core area of northern Norway where this study is set [10]. Sámi and Norwegian are different languages and not mutually comprehensible [12].

Sámi patients are legally entitled to use the Sámi language in healthcare interactions. Norwegian laws and governmental white papers stipulate equal and accessible health care for all [11–18]. Although most Sámi are bilingual, many have difficulties when discussing health matters in the Norwegian language and prefer to speak Sámi language in health encounters [2–4, 7, 13, 19–24]. This creates cross-cultural communication challenges because there is a lack of Sámi-speaking health personnel in the work force [1, 7, 8, 12, 13, 25]. Health care in the north is mainly provided in Norwegian sometimes resulting in misunderstandings or missed care, and inequity in healthcare access for Sámi patients [1, 3, 7, 8, 12, 13, 24–27].

Research shows that lack of competence around Sámi language and culture in clinical practice is a barrier to fully achieving equity in health services for Sámi patients [1, 13, 27]. Even though preserving, revitalising and promoting the Sámi language as a governmental goal, Sámi language lacks presence in healthcare institutions [1, 7, 8, 12, 28]. This is problematic especially in settings such as residential aged care, when due to illnesses such as dementia, some Sami-speaking patients have reverted to their native language only [12, 19, 20]. This is supported by studies of Sámi patient experiences of clinical communication showing inequity, especially regarding patient involvement around decision-making processes. This is evident in particular for older patients outside their Sámi-speaking community, where some have difficulty following medical conversations in Norwegian [2–5, 12, 19–21, 24, 25, 27]. Despite this, most Norwegian healthcare staff in northern Norway expect all Sámi speakers to be proficient also in Norwegian. In some situations, this compromises patient safety for Sámi-speaking patients and is contrary to legislation around patient safety and quality of care [3, 7, 8, 27, 29, 30].

Communication problems are also pertinent for challenges around recruitment and retention of qualified healthcare staff in northern Norway, a rural area with large distances, such as 500 km between its two hospitals. There is an overall lack of Sámi cultural competency in current healthcare services [1, 7, 8, 13, 21, 22, 31]. Many clinicians are foreign workers on short-term contracts who speak other Scandinavian languages and are not familiar with the historical impacts of the assimilation policy on health, well-being and identity of Sámi peoples [12, 13, 31–33]. The cultural context can be difficult to grasp for people in Norway, and doubly so for foreign healthcare workers only temporarily there. It is, however, important to achieve health care that includes and understands contextual factors, such as how health disparities have arisen and persisted. For more than 250 years, the oppressive Norwegianisation assimilation process had a devastating effect on the Sámi language and culture, and in some communities, Sámi was oppressed and became totally replaced by Norwegian [10, 12, 13, 31–34].

Equity is defined as the absence of avoidable or remediable differences among groups of people [35], and in Norway, equity in healthcare services for Sámi patients means improved access to services adapted to individual cultural needs. To achieve this goal, competence and capacity building around language and culture integration into health services and care plans are important [14] to improve successful clinical outcomes [3, 4, 31, 33, 36–40].

This paper explores the complex intersectionality of clinical and cultural care and adds knowledge to the landscape and realities around linguistic and cultural challenges in healthcare interactions with Sámi patients. Literature shows that more research is needed in this area to improve quality of care and culturally safe nursing interactions with Sámi patients. We acknowledge that not all Sámi are proficient or prefer to speak Sámi language due to the consequences of the longstanding assimilation process in Norway, and in this paper when referring to Sámi patients, it encompasses nurses' experiences of working with Sámi-speaking patients. This research revolves around linguistic challenges as a major issue in nursing encounters with Sámi patients in Norwegian health care.

Aim

This paper describes and interprets nurses' experiences of encounters with Sámi patients in healthcare services in northern Norway.

METHOD

Study setting – Indigenous context

This study is the third and final part of a major project about Sámi Nursing, lasting from 2015-2020. The first part explored patient and relative perspectives of being Sámi in the

healthcare system [3, 4], and the second part investigated Sámi culture-content in Norwegian nursing education [41]. The overall aim of the three-part research project is to improve health systems, services and healthcare outcomes for Sámi patients. The study is done at the interface of Indigenous and Norwegian worlds where the two cultures meet. Although Sámi and Norwegian cultures have throughout history grown to become more similar, there are marked cultural differences, in particular in situations around health and illness [42]. It was important to anchor this research in Indigenous research methods, such as the theoretical lens of decolonisation, developed by the Māori scholar Linda Tuhiwai-Smith from Aotearoa [39]. Smith's theory of decolonising practices orbits around a principle of reversing consequences of colonisation and is highly compatible with this research, as the two peoples, Māori and Sámi, share space and experiences as Indigenous. With Sámi people's similar history of colonisation and cultural reclamation, Smith's research principles are equally applicable in Norway. Health care in Norway need to take into account the injustices and consequences of the Norwegianisation process on health and well-being and listen to what Sámi peoples, patients and healthcare professionals express that they need [43]. Indigenous knowledge have existed for thousands of years, yet only recently been experiencing acceptance among Western scholars and research settings [44].

Two of the researchers are Sámi and two identify as both Norwegian and Sámi. For Indigenous peoples worldwide, the word *research* is often negatively laden [39], due to the fact that Indigenous people have been researched, explored, observed and investigated from the majority perspective, yet as Indigenous knowledge holders never been centred, but left at the margins of society, education and research systems. We still see this in healthcare education, systems and settings in Norway – Sámi culture is an appendix, an addition, but not quite seen important enough to include in healthcare curricula [41]. This research study is challenging the traditional storyline and centring Sámi knowledge, Sámi research and placing Sámi nurses and researchers as main knowledge generators. For this reason, each step of the research process has been completed through a lens of decolonisation principles, such as centring Indigenous knowledge and employing research processes rooted in the heart of Indigenous culture and ways.

Study design

Sally Thorne, a Canadian professor and nurse researcher, has developed a non-categorical, interpretive and descriptive methodology to analytically explore and understand human health in order to create change in clinical practice and healthcare settings. Methodologically, this study was undertaken in line with Thorne [45, 46]. Practically, this study was guided by Smith's theoretical lens of decolonisation [39], centring and applying Indigenous ways of knowing, being and learning to remedy impacts of colonisation. Six semi-structured focus group interviews with Norwegian- and Sámi-speaking nurses ($n = 23$) were conducted. The focus group interviews provide critical insight and knowledge about how nurses experience their encounters with Sámi patients.

The research team consisted of Sámi nurses and researchers familiar with nursing in northern Norway and Australia, and by interpreting the contextual and practical realities that Norwegian and Sámi nurses describe from encounters with Sámi patients, we acquire knowledge that may benefit Sámi patients by impacting change to health policy, clinical practices, healthcare curricula or health systems and inclusion of cultural safety in praxis.

TABLE 1 Social characteristics of the participants ($n = 23$)

Descriptors	Sámi nurses ($n = 13$)	Norwegian nurses ($n = 10$)
Native language:		
Sámi	13	0
Norwegian	0	10
Bilingualism:		
Sámi/Norwegian	13	0
Norwegian/Sámi	0	2
Age:		
25–40	5	1
41–55	5	9
56–65	3	0
Experience as a nurse:		
2–4 years	4	1
5–15 years	4	3
16–35 years	5	6
Current occupation		
Hospital/specialist services	1	2
Community care/rural nursing	12	8

Recruitment and participants

An email invitation with participant information was sent to the heads of nine municipalities and two hospitals, in the Sámi area. Inclusion criteria to partake in the study were minimum two years of clinical nursing practice with Sámi patients in northern Norway, and self-identification as either Sámi or Norwegian based on cultural background and native language. Twenty-three nurses were recruited by purposive sampling and snowballing [47], see Table 1. All participants expressing interest in the study were female. Overall, there are more women nurses than men, and this gender imbalance

according to gender representation is represented also in this study.

Data collection

All focus group interviews took place outside of the nurses' workplaces and lasted 55–115 minutes. They included a facilitator and an observer. The third author facilitated interviews with Sámi-speaking participants. A semi-structured interview guide encouraged participants to give examples of both positive and negative patient interactions especially around culture in practice. Examples of open-ended questions were as follows: 'describe an interaction with a Sámi patient', 'how do you establish trust with your Sámi patients?' and 'how do you know that a patient is Sámi?' Follow-up questions clarified participant responses and provided more knowledge about their experiences, as for instance linguistic challenges (Table 2). Field notes were written after each focus group interview.

Norwegian and Sámi-speaking nurses were invited to participate in order to have both insider and outsider perspectives from Sámi culture represented in the findings [48]. The focus groups were separated into Sámi and Norwegian groups to elicit a culturally safe environment void of barriers that could possibly impede on readiness to speak or express true thoughts and experiences. Creating groups of nurses with similar experiences to facilitate exchange of ideas is social consciousness building, according to Thorne [45]. Morgan [49] describes how homogeneous focus groups can generate data in a reliable way, because the participants have compatible experiences. Mixing the focus groups may have given other data due to other types of discussions. The last two interviews provided no new themes, suggesting that data saturation was reached [50]. Concluding the data collection was transcriptions checks, where group transcripts were sent to one participant in each focus group for possible clarification or amendments. Only one participant requested to clarify one section about introducing oneself as a nurse.

Data analysis

This research is grounded in an Indigenous-centred approach using Smith's [39] principles of reciprocity. Thorne's methodological framework ensured that participants' shared experiences were analysed as critical insight into the findings in relation to existing knowledge [45]. In practical terms, the blend of the Smith's theory of decolonisation [39] and the non-Indigenous interpretive descriptive research approach of Thorne [45] was appropriate for this research as they both support the investigation of organisational capacities and individual practices from a perspective of improving health care. This blend guided the research design, interview questions and maintained methodological integrity based on the research objectives.

According to Thorne [45], all data analysis consists of cognitive processing (comprehension, synthesis, theory generation and re-contextualisation), which included four stages: (a) reading and re-reading the transcripts to enhance familiarisation with the data and coding through word frequency and text search, (b) categorising the codes into sub-themes and themes, (c) defining the themes and sub-themes in relation to the theory and (d) reviewing the themes and sub-themes based on the nursing context.

This interpretive design aided analysis of themes and subthemes of the contextual realities of nurses' perceptions of Sámi healthcare interactions in northern Norway. Narratives between focus group participants were explored and discussed, before being categorised as patterns and themes in the data in relation to the nurses' experiences of working with Sámi patients in healthcare settings in northern Norway. The analysis resulted in three key themes: There is not enough patient information about who are Sámi or Sámi-speaking; nurses are struggling to navigate linguistic challenges

TABLE 2 An overview of focus groups, language, participants, numbers of pages and coding of quotes

Focus group interview	Norwegian = N Sámi = S	Number of participants	Numbers of pages of interviews	Coding of quotes
FG1	N	4	17	N1, N2, N3, N4
FG2	S	6	12	S1, S2, S3, S4, S5, S6
FG3	N	3	33	N5, N6, N7
FG4	S	4	9	S7, S8, S9, S10
FG5	N	3	33	N8, N9, N10
FG6	S	3	22	S11, S12, S13
Sample size Total	Norwegian = 10 Sámi = 13 $n = 23$	$n = 23$	Pages: 126	$n = 23$

especially in acute care situations; and finally, this may lead to misunderstandings or even patient safety being at risk (Table 3).

Ethical considerations

This study was registered with the Norwegian Centre for Research Data (No. 50578) [51], and complied with the Declaration of Helsinki [52] and standard ethical codes and legal regulations to ensure the absence or minimisation of harm, trauma, anxiety or discomfort of human participants were followed. It is noted that Indigenous research ethics guidelines have existed for quite some time in other parts of the world, yet Norway have only recently formalised a culturally responsive policy for how to work with Indigenous communities [53]. Because this study includes Sámi participants, great emphasis has been placed on the Indigenous research context to counteract the way dominant research historically has been undertaken, as outlined in the earlier section 'Study setting – Indigenous context'. All participants received verbal and written information about the study in Sámi or Norwegian, to enable informed written consent. Participants were informed they could withdraw from the study at any time with no retribution or negative consequences.

FINDINGS

The participants give voice to experiences set across acute care, specialist services, primary health care and district nursing. They all reside and work in northern culturally and linguistically diverse communities and have experience working alongside Sámi patients and colleagues. All themes are discussed in the following sections: (1) Obtaining basic patient information, (2) Navigating linguistic challenges and (3) Patient safety at risk. Each of the themes will be presented with the excerpts that represent the voices of participants in this research.

Obtaining basic patient information - 'it is difficult to recognise patients as Sámi'

The participants conveyed that it can be difficult to know who are Sámi to ensure that culture is integrated in care provided, even if resources are available. If a patient arrives from a Sámi township within the Sámi core area, it is automatically assumed they are Sámi speaking. However, if they arrive from any of the culturally and linguistically diverse communities, it is not that straight forward, and it can be difficult to define the cultural background or language preference of patients. Both Sámi and Norwegian nurses stated that it was a difficult task to identify Sámi patients.

> S8: I have met Sámi patients without knowing they were Sámi, talking Norwegian to them for several days. When their relatives came visiting, they told me he was Sámi.

It was discussed that it may be helpful if Sámi nurses carry nametags showing *their* Sámi name, because the patients will openly talk in Sámi language if they know that the nurse is Sámi. However, some Sámi have Norwegian-sounding names. Perhaps a Sámi flag on nametags could be used instead to signify an ally, a healthcare professional of Sámi background, or someone who knows a lot about Sámi culture and would be open and supportive to including and accommodating Sámi culture into care.

> N2: We may have patients with Norwegian names, but with Sámi background, and we did not map them [as Sámi patients].

These quotes illustrate that recognising and mapping patients' language and culture on admission is complex. Patient records are not always correct, and patients may not be able to have a health-related conversation with staff in Norwegian language. To provide optimal care for Sámi patients, culture in care is important. Many Sámi may have lost the Sámi

TABLE 3 Sub-themes and key themes from the analysis

Research question	Key theme	Sub-themes
Are Sámi language and Sámi culture integrated in care provided and in the Norwegian healthcare setting?	Obtaining basic patient information – 'it is difficult to recognise patients as Sámi'	Challenges in recognising Sámi-speaking patients
		Universal nursing treats everyone equally
		Lack of mapping native language
	Navigating linguistic challenges – 'Sámi patients need to hear and speak Sámi language'	Nurses navigating linguistic challenges
		Shared/common language makes connection
		Underutilisation of interpreters
	Patient safety at risk – 'I don't see why he needs an interpreter'	Misunderstandings in treatment
		Misdiagnosis, misunderstanding of the patient's situation
		Emergency call centre without Sámi-speaking staff

language, but not their connection to Sámi culture. The Norwegian nurses discussed the consequences of the assimilation process on health and health care and connected the Norwegianisation to some of the covert complexities nurses face when working with Sámi patients today.

> N10: My grandmother was refused to speak Sámi language, even though they were Sámi. It became a shame…it marked a whole generation.

Even if nurses are not Sámi or can speak Sámi themselves, one can still have good nurse–patient interactions. The participants discussed how they meet patients as individuals, with respect for their background, showing interest in their Sámi culture and getting to know them on a deeper level. This discussions demonstrates the importance of nurses working in true partnership with patients, modelling person-centred care, always asking the patient what is important for them and whether there are any cultural or linguistic considerations to integrate into the care provided to them.

Navigating linguistic challenges – 'Sámi-speaking patients need to hear and speak Sámi language'

The participants all agreed that there are many linguistic challenges to overcome in practice encompassing Sámi patients. They discussed different strategies for minimising and overcoming linguistic barriers, such as planned use of authorised Sámi interpreters, planned use of Sámi-speaking nurses during shifts, identifying Sámi-speaking employees and integrating Sámi-speaking relatives in care practice. District nurses practising in peoples' homes reported feeling 'dependent on relatives for interpreting deeper and more demanding conversations'. Several participants told of strategies where Sámi nurses are listed as a primary contact for patients, and how in some residential aged care facilities they endeavour to have a Sámi-speaking employee allocated to every shift. However, participants stated that this was not always possible, and some patients had to wait for days to meet any Sámi-speaking staff. Some Norwegian nurses interjected that they tried to learn a few Sámi words, but using a phrasebook could lead to misunderstandings:

> N6: When a nurse starts to talk to patients using the phrasebook, the patients are so happy to hear Sámi spoken that they respond in Sámi. Then the nurse doesn't understand the patient response, often resulting in that the patient is upset.

Even so, the Norwegian nurses talked about the value for Sámi patients to hear them try to express a few individual Sámi words or pleasantries, and that this was seen as a sign of respect and attempting to establish a relationship and trust.

In main Sámi townships, often both patients and nurses speak Sámi language and share Sámi cultural backgrounds. Outside of these communities, where Sámi nurses are few and far between, the Sámi nurses expressed a feeling of additional responsibilities for Sámi patients. This consisted of being experts on communicating with Sámi patients and relatives, and often these Sámi nurses were used as interpreters. The Sámi nurses stated that the positives of this were that Sámi patients trusted them like relatives:

> S12: Sámi patients often said, 'I'm glad you're here, that's good to know'. It was like they expected me to be always available for them. Sometimes I almost had to hide so I could work in other patient rooms.

The Sámi nurses found that Sámi patients strongly appealed to them for help to communicate. The nurses rarely refused to do so because they wanted to help these patients. The nurses explained that Sámi interpreters were not frequently used. In such situations, one needs to reflect on why the Sámi language is not is emphasised or seen as important, and why staff proficient in Sámi language is not engaged. If it was, then healthcare interactions would most likely have more successful outcomes and truly offer person-centred care, meeting Sámi patients' needs.

Patient safety at risk – 'I don't see why he needs an interpreter'

In one of the focus groups, a comprehensive discussion took place around language and whether Sámi language use was necessary in health care. A Norwegian nurse living in a majority Norwegian-speaking community said: 'Language isn't a problem, because most Sámi usually speak Norwegian'. Patients were expected to speak Norwegian 'well enough' to get by, in these residential aged care facilities.

> N10: Sometimes… Sámi patients want an interpreter for the doctor's round. Then someone says, 'But I've talked to him… he speaks good Norwegian. I don't see why he needs an interpreter'. A bit sort of … condescending… he understands Norwegian well. But what the nurse needs to realise is that speaking Norwegian varies a lot… from everyday talk to starting to explain pneumonia or medication, or like… medical… hospital words. That's completely different.

During this discussion, participants changed their perception of what was 'good enough' Norwegian [language skills]

in order for patients to participate in decision-making around health care and realised the importance of using one's native language to enable rich vocabulary and facilitate true meaning and description. Such discussions in the focus groups provided the researchers with rich data around impact of culture in health care. This led to a consensus that an interpreter was often needed for Sámi-speaking residents. The participants concluded that thoughtlessness, not discrimination, lay behind most decisions not to engage an interpreter. Individual assessments determine whether an interpreter is engaged and is based on nurses' ideas of what constitutes 'good enough Norwegian' without considering the patients' preferences. The participants indicated that without Sámi-speaking healthcare professionals, patient care and safety can be compromised.

> S8: Yesterday there were only Norwegian speakers at work and a patient was very angry and kept shouting at the staff. When I got to work, the patient told me, 'I didn't understand what they were saying, and they didn't understand what I was saying'. The patient had been given food but nothing else [nursing care] had happened.

Only one Sámi nurse mentioned nurses' legal responsibility to provide an interpreter to ensure patient safety and avoid errors, saying that patients often had to request an interpreter themselves.

> S12: If patients don't ask, nurses don't offer anything, such as an interpreter… This shows how little Sámi patients have been valued and the interpreter was mostly used when Norwegian-speaking nurses themselves needed an interpreter.

This statement may be related to Sami patients' experiences from the assimilation process and that Sami patient do not want to be a burden and ask for interpreter. They may instead try to keep up with the Norwegian language. The importance of Sámi-speaking staff in emergencies is also highlighted as follows:

> N3: There was a phone call to the emergency ward. They [the person on the phone] said, 'We need help. Somebody here has drunk lots of water'. 'Oh, has he vomited?' 'What? No, he has got lots of water in his mouth'. 'Is he in water?' 'Yes, he's in the river'. She tried to explain that he was drowning. The nurse I was with realised that. We contacted the rescue service…but it could have been worse…language can save lives. Things could have gone very wrong.

This story confirms the importance of cross-cultural education and ongoing professional development. All nurses need to have Sámi cultural understanding. As well, Sámi-speaking nurses must be present at all levels of health care offered in the north, especially Emergency Control Centres.

A Sámi nurse recalled her mother's hospital stay:

> S11: She couldn't speak Norwegian… She said if she called the staff [used the call button], they got angry with her, so she didn't dare call anymore: She couldn't think and use Norwegian quickly… I think it's terrible they send elderly Sámi patients there without interpreters. My mother's memory wasn't weak but because she couldn't speak Norwegian she was diagnosed with 'memory impairment' by the staff.

The participants explained that when nurses do not realise there is a language problem, the patient may be labelled uncooperative, non-compliant or even worse be misdiagnosed as having memory impairment, early dementia or retardation.

Working within healthcare settings in northern Norway presents challenges for both staff and patients around Sámi language and culture. Nurses' cultural sensitivity, awareness, knowledge and skill in facing these challenges are vital for patients' treatments and for nurses' chosen strategies, patient safety and professional responsibility.

DISCUSSION

Norwegian and Sámi language is by law equal. All townships are responsible for providing equitable health services adapted to the linguistic needs of Sámi patients [13, 14, 16, 32]. Even though on paper healthcare services should meet the needs of both Sámi and Norwegian clients, the reality is that mainstream healthcare services in northern Norway are operating in Norwegian language, with Norwegian culture and from a Norwegian perspective [1, 9, 12, 13, 25, 27, 33]. The Sámi participants in this study reported that Sámi patients are longing to be able to speak Sámi language and have Sámi culture included as an integral part of their health care. Their views were that qualified interpreters were underutilised. These findings are in line with other studies pointing to under-utilisation of qualified interpreters in Norwegian healthcare settings [3, 4, 54, 55].

Nurses' views that Sámi patients are not valued and that they know Norwegian 'well enough' to understand the healthcare interaction may be due to the history of assimilation [12, 13, 25, 32]. This everyday preconception described by the participating nurses as 'thoughtlessness' also exists elsewhere in society. Midtbøen [56] describes it as cumulative discrimination over generations. It may not be deliberate, but may be the result of accumulation across spheres, settings and generations throughout society [28, 31, 33, 56].

Boge [28] claims that Sámi language is often positioned as inferior to Norwegian in a nursing home, and that this is cumulative discrimination [56]. This indicates that Sámi identity still carries stigma [21]. The Norwegianisation process resulted in shame attached to being Sámi, and the assimilation policy is blamed for why the Sámi language weakened and why the Sámi patient does not always want to be identified or appear as Sámi. On the outside, Sámi and Norwegian people often blend in and look alike, and if Sámi patients do not mark themselves as Sámi, or nurses do not ask, they risk being overlooked [4, 28, 56], as described in the quote 'if patients don't ask, nurses don't offer'. The views are generally that health care is run according to the majority language and culture in Norway, and everyone else must submit to and accept this way. Although it is Sámi peoples' right to be heard, communicate and receive care mindful of Sámi culture and language, it is only accommodated if seen possible. In other words, health legislation and policy are not always adhered to. The participants gave examples of this from community health care where some patients did not speak Sámi language for days, and other situations where misunderstandings due to linguistic challenges even led to patient safety being at risk.

Both Norwegian authorities and nurses must realise that deeply rooted, unconscious preconceptions may linger from the assimilation period, and in some situations hinder the best intentions during everyday life in a post-colonial era [39, 57]. This indicates that the colonisation in northern Norway has not ended, but is ever present and continuing, just in different forms. The Norwegian majority culture have shaped the health care in Norway and is still dominating the Sámi minority culture as long as Sámi patients cannot use Sámi language freely or have Sámi culture included in all care, nor expect that all healthcare professionals have special education around Sámi cultural understanding in health care [39]. Facilitating Sámi patients' use of Sámi language and culture in health care would be giving back, in a reciprocal way, a way to decolonise and make a step towards complete equity in Norwegian health care.

The participants' perspectives of what is needed in the current healthcare system, is to educate more trained Sámi nurses. This workforce improvement strategy would bridge the linguistic challenges, reduce the need for interpreters, improve equity in services for Sámi patients and be a step towards improving the implementation of the legislation [58]. This could establish a link between language, culture and patient safety and be a start of a gold standard for the health care in northern Norway [29]. Knowledge about Sámi people and their culture as Indigenous people is in laws recognised as important and became mandatory in Norwegian healthcare education from 2020 (59), including nursing [60].

Health practitioners, healthcare organisations and health systems need to work towards cultural safety and cultural consciousness by critiquing and amending the *taken for granted* power structures like laws and guidelines and preparing for challenging our own culture and cultural system [40]. The laws are set, but the implementation into practical health care seems delayed [9, 11–13, 16, 25]. The Ministry of Health- and Social Services has the overall responsibility for implementation of health services [14], but every nurse also has a duty of care to patients and responsibility to ensure that patients understand what health care, procedure or treatment they are providing [61]. To turn around, new knowledge and research must be implemented in practice, so nurses can change and improve the way they work. The most important step to embed Sámi language and culture in care is that the authorities take responsibility for implementation at system level. The knowledge that research brings has to be translated for implementing, and Chesla [62] estimates this to take approximately 10–20 years. British research from municipality health services claims it is difficult to implement evidence-based practice into municipality service [63]. This research found that clinicians, such as nurses and GPs, rarely used self-sourced research-based or other evidence-based sources directly. Instead, they trusted collective attitudes and knowledge gained during education and practice sessions, instead of searching out written guidelines and research themselves. Relying on such a collectivist practice, for example practising 'the way it has always been done' instead of implementing new directives, directly disregards Sámi culture and language provision and exposes patients to misunderstandings and less than optimum care and should be reported as breach of healthcare legislation [11, 16–18].

All nurses and other healthcare personnel, especially foreign short-term contract workers, should undergo compulsory education around Sámi culture in health and well-being, learn about relevant legislation, policy and guidelines around Sámi health, as well as attend Sámi language classes. In recruiting clinicians for northern Norway, Sámi speakers should be given priority. To improve interactions with Sámi patients and provide culturally safe care, nurses need to learn, individually and in groups, cultural understanding and reflect on their own culture and power position and how this impact on their interactions with patients. Further research is needed on other aspects of culturally safe nursing for Sámi patients. This study from northern Sámi areas of Norway may not reflect nurses' views in general in Norway.

CONCLUSION

This focus group study with Sámi and Norwegian nurses found that obtaining basic information about Sámi patients in northern healthcare settings can be challenging. To fulfil Sámi patient rights and include Sámi language and culture into care and the health system, nurses have to identify and map native language of their patients. in this study Sámi nurses reports

deep connections with patients by their shared language and culture, and somtimes they have to navigate co-worker challenges and often assume and carry total responsibility of care for Sámi patients. Norwegian nurses in this study often struggle to navigate linguistic and cultural challenges when working with Sámi-speaking patients and underutilise qualified interpreters when caring for Sámi clients. The consequences of too few Sámi-speaking staff in the northern healthcare setting sometimes leads to misunderstandings in treatment or diagnostics, resulting in patient safety at risk.

To remedy the current healthcare system situation, new guidelines for how to implement knowledge of Sámi patients' culture and language rights in healthcare education are a start. The second step is for the authorities to facilitate implementation of laws and regulations, research and guidelines in practical health care. The third is to increase the number of Sámi-speaking nurses. However, continuous evaluation and close monitoring are needed; legislation and guidelines do exist, yet there seems to be no consequence for breaching protocol. Legislation is in place to maintain accountability, and continuous evaluation and monitoring may help enforce and improve Sámi patient rights. Furthermore, systematic and continuous training of all health personnel around language, culture, the impact of the Norwegianisation assimilation process and power relationships is also required.

ACKNOWLEDGEMENTS

The authors are grateful to the participants for sharing their knowledge and experiences. Funding was provided by UiT The Arctic University of Norway.

ORCID

Janne Isaksen Engnes https://orcid.org/0000-0002-0610-1158

REFERENCES

1. Angell E, Balto ÁMV, Josefsen E, Pedersen P, Nygaard V. Kartlegging av samisk perspektiv i kommunesektoren [An investigation of the Sámi perspective in the public sector]. 2012.
2. Dagsvold I, Mollersen S, Stordahl V. "You never know who are Sami or speak Sami" Clinicians' experiences with language-appropriate care to Sami-speaking patients in outpatient mental health clinics in Northern Norway. Int J Circumpolar Health. 2016;75:32588.
3. Mehus G, Bongo BA, Moffitt P. Important factors when communicating with Sami patients about health, illness and care issues. Nordic Nurs Res. 2018;8:288–301.
4. Mehus G, Bongo B, Engnes JI, Moffitt P. Exploring why and how encounters with the Norwegian health-care system can be considered culturally unsafe by North Sami-speaking patients and relatives: A qualitative study based on 11 interviews. Int J Circumpolar Health. 2019;78:1612703.
5. Pohjola A, Laitinen M, Väyrynen S. Language as a cultural mediator in social work: Supporting Sámi culture with services in Sámi. Int Soc Work. 2016;59(5):640–52.
6. Sivertsen N. Circumpolar nursing : exploring Sámi Nurses' experience of culture in their practice. Saarbrücken: Lambert Academic Publishing; 2010.
7. The Patient Representative. Annual Report Finnmark2019 [Available from: https://www.helsenorge.no/globalassets/dokument enter/pobo/arsmelding-2019-pasient--og-brukerombudet-i-finnmark-norsk-og-samisk-utgave.pdf.
8. The Patient Representative. Annual Report Finnmark 2018 [Available from: https://www.helsenorge.no/globalassets/dokument enter/pobo/arsmelding-2018-pasient--og-brukerombudet-finnmark-norsk-samisk.pdf.
9. Ministry of Culture. Law on language. 2020.
10. Norwegian Government. Facts about Sami Language 2018 [Available from: https://www.regjeringen.no/no/tema/urfolk-og-minoriteter/samepolitikk/samiske-sprak/fakta-om-samiske-sprak/id633131/#nord.
11. Sámi Act. LOV-1987-06-12-56. 1989.
12. NOU 2016: 18. Hjertespråket -Forslag til lovverk, tiltak og ordninger for samiske språk [Language of the heart: Proposals for legislation, measures and schemes for Sámi languages]. Ministry of Local Government and Modernisation. 2016.
13. Ministry of Local Government and Modernisation. Samisk språk, kultur og samfunnsliv [Sámi language, culture and community]. 2019.
14. NOU 1995:6. Plan for helse- og sosialtjenester til den samiske befolkning i Norge [Plan for health- and social services for the sami population in Norway]. 1995.
15. Ringard Å, Sagan A, Sperre Saunes I, Lindahl AK, Ringard Å. Norway: health system review. Health Syst Transit 2013;15(8):1–162.
16. Health and Care Services Act. LOV-2011-06-24-30 (2011).
17. Specialist Health Services Act. LOV-1999-07-02-61 (1999).
18. Patient Rights Act. LOV-1999-07-02-63 (2001).
19. Hanssen I. The influence of cultural background in intercultural dementia care: exemplified by Sami patients. Scand J Caring Sci. 2013;27(2):231–7.
20. Hanssen I. Dementia, communication and culture implications of linguistic and cultural diversity in intercultural dementia care. J Intercult Commun Res. 2015;2015(39):N_A-N_A.
21. Dagsvold I, Møllersen S, Stordahl V. What can we talk about, in which language, in what way and with whom? Sami patients' experiences of language choice and cultural norms in mental health treatment. Int J Circumpolar Health. 2015;74:26952.
22. Larsen LS, Normann HK, Hamran T. Collaboration between Sami and non-Sami formal and family caregivers in rural municipalities. Ethnic Racial Stud. 2015;1–19.
23. Nergård RJM. Psykiske helsearbeideres erfaringer med å inneha samisk språk- og kulturforståelse i møte med samiske pasienter [Mental health workers' experiences of having an understanding of Sami language and culture in encounters with Sami patients]. Master's thesis. Tromsø: UiT The Arctic University of Norway; 2017.
24. Nystad T, Melhus M, Lund E. Sami speakers are less satisfied with general practitioners' services. Int J Circumpolar Health. 2008;67(1):116–23.
25. NOU 2014: 8. Tolking i offentlig sektor - et spørsmål om rettssikkerhet og likeverd [Interpreting in the public sector: A question of legal protection and equality]. Ministry of Children, Equality and Inclusion. 2014.
26. Directorate of Health. Veileder om kommunikasjon via tolk for ledere og personell i helse- og omsorgstjenesten [Guidelines for

communication using interpreters for leaders and personnel in healthcare services]. 2011.
27. Olsen RM, Devik SA. Trygghet uten særomsorg? [Safety without special care?]. J Care Res. 2020;6(2):70–86.
28. Boge J. The inferior position of the Sámi language in a bilingual nursing home in Norway. J Multiling Multicult Dev. 2020;41(3):195–205.
29. Johnstone M-J, Kanitsaki O. Culture, language, and patient safety: making the link. Int J Quality Health Care. 2006;18(5):383–8.
30. van Rosse F, de Bruijne M, Suurmond J, Essink-Bot M-L, Wagner C. Language barriers and patient safety risks in hospital care. A mixed methods study. Int J Nurs Stud. 2015;54:45–53.
31. Dankertsen A. Samisk artikulasjon : melankoli, tap og forsoning i en (nord)norsk hverdag [Sami articulation: melancholy, loss and reconciliation in a (northern) Norwegian everyday life]. [Dissertation]. NORD University; 2014.
32. Minde H. Assimilation of the Sami – Implementation and Consequences 1. Acta Borealia. 2003;20(2):121–46.
33. Ryymin T, Andresen A. Effecting equality: Norwegian health policy in Finnmark, 1945–1970s. Acta Borealia. 2009;26:96–114.
34. Norwegian Government. What Defines an Indigenous People? 2020 [Available from: https://www.regjeringen.no/no/tema/urfolk-og-minoriteter/samepolitikk/midtspalte/hvem-er-urfolk/id451320/.
35. World Health Organization. Equity [updated 02.october. Available from: https://www.who.int/healthsystems/topics/equity/en/.
36. Papps E, Ramsden I. Cultural safety in nursing: The New Zealand experience. Int J Quality Health Care. 1996;8(5):491–7.
37. Paradies Y. Colonisation, racism and indigenous health. J Popul Res. 2016;33(1):83–96.
38. Kirmayer LJ. Rethinking cultural competence. Transcult Psychiatry. 2012;49(2):149–64.
39. Smith LT. Decolonizing methodologies research and indigenous peoples, 2nd edition. S.l.]: S.L.: Zed Books; 2012.
40. Curtis E, Jones R, Tipene-Leach D, Walker C, Loring B, Paine S-J, et al. Why cultural safety rather than cultural competency is required to achieve health equity: a literature review and recommended definition. Int J Equity Health. 2019;18(1):174-.
41. Eriksen L, Bongo B, Mehus G. Urfolksperspektiv i utdanning. Sykepleieutdanninger i Norge uten urfolkskunnskap? [Indigenous peoples' perspective in education. Nurse education in Norway without knowledge about indigenous peoples?] Nordic Nurs Res. 2017;7:239–49.
42. Bongo BA, Elstad I. "Samer snakker ikke om helse og sykdom". Samisk forståelseshorisont og kommunikasjon om helse og sykdom. En kvalitativ undersøkelse i samisk kultur [Sami don't talk about health and illness. Sami horizon of understanding and communication about health and illness. A qualitative study in Sami culture]. [Dissertation]. Tromsø: UiT The Arctic University of Norway; 2012.
43. Niemi E, Semb AJ. Research ethical context: Historical injustice and research as abuse 2009 [Available from: https://www.forskningsetikk.no/ressurser/fbib/bestemte-grupper/historisk-urett-og-forskning-som-overgrep/.
44. Ryder C, Mackean T, Coombs J, Williams H, Hunter K, Holland AJA, et al. Indigenous research methodology – weaving a research interface. Int J Soc Res Methodol. 2020;23(3):255–67.
45. Thorne S. Interpretive descriptions; qualitative research for applied practice. 2nd edn. New York, London: Routledge; 2016.
46. Thorne S, Kirkham SR, Macdonald-Emes J. Interpretive description: a noncategorial qualitative alternative for developing nursing knowledge. Res Nurs Health. 1997;20(2):169–77.
47. Polit DF, Beck CT. Nursing Research : generating and assessing evidence for nursing practice, 10th edn. Philadelphia: Wolters Kluwer; 2017.
48. Olsen TA. Decentring and the challenge of being (Non-) indigenous in the study of indigenous issues. Aust J Indigenous Educ. 2017;47(2):206–15.
49. Morgan DL. Successful focus groups: advancing the state of the art. Newbury Park, Calif., London: SAGE; 1993.
50. Fusch P, Ness L. Are we there yet? Data saturation in qualitative research. Qual Rep. 2015;20(9):1408–16.
51. Norwegian Centre for Research Data. About NSD 2019 [Available from: https://nsd.no/nsd/english/index.html.
52. Førde R. Declaration of Helsinki - Ethical Principles for Medical Research Involving Human Subjects 2016 [Available from: https://www.etikkom.no/en/library/practical-information/legal-statutes-and-guidelines/helsinkideklarasjonen/.
53. The Sami Parliament. Forslag til etiske retningslinjer for samisk helseforskning og forskning på samisk humant biologisk materiale [Proposal for ethical guidelines for Sami health research and research in Sami human biological material] 2017.
54. Kale E, Syed HR. Language barriers and the use of interpreters in the public health services. A questionnaire-based survey. Patient Educ Couns. 2010;81(2):187–91.
55. Czapka EA, Gerwing J, Sagbakken M. Invisible rights: Barriers and facilitators to access and use of interpreter services in health care settings by Polish migrants in Norway. Scand J Public Health. 2018;47(7):755–64.
56. Midtbøen A, Lidén H. Kumulativ diskriminering [Cumulative discrimination]. Sosiologisk Tidsskrift. 2016;24:3–26.
57. Fiarman SE. Unconscious bias: when good intentions aren't enough. Educ Leadersh. 2016;74(3):10–5.
58. Norwegian Government. Ensuring Sami nurse education is specially adapted to sami patients 2020 [Available from: https://www.regjeringen.no/no/aktuelt/skal-sikre-at-samisk-sykepleierutdanning-er-spesial-tilpasset-samiske-pasienter/id2689632/.
59. Norwegian Ministry of Education and Research. Forskrift om felles rammeplan for helse- og sosialfagutdanninger FOR-2017-09-06-1353 [Regulations on a National Guideline for Health- and Social Science Education]. Oslo: Ministry of Education and Research; 2017.
60. Norwegian Ministry of Education and Research. Forskrift om nasjonal retningslinje for sykepleierutdanning FOR-2019-03-15-112 [Regulations on a National Guideline for Nursing Education]. Oslo: Ministry of Education and Research; 2019.
61. Health Personnel Act, LOV-1999-07-02-64 (1999).
62. Chesla CA. Translational research: Essential contributions from interpretive nursing science. Res Nurs Health. 2008;31(4):381–90.
63. Gabbay J, May AI. Evidence based guidelines or collectively constructed 'mindlines?' Ethnographic study of knowledge management in primary care. Br Med J. 2004;329(7473):1013.

How to cite this article: Engnes JI, Sivertsen N, Bongo BA, Mehus G. Sámi language in Norwegian health care: 'He speaks good enough Norwegian, I don't see why he needs an interpreter'. *Scand J Caring Sci*. 2022;36:275–284. https://doi.org/10.1111/scs.12986