



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

Grete Mehus, Berit Andersdatter Bongo, Janne Isaksen Engnes & Pertice M. Moffitt

To cite this article: Grete Mehus, Berit Andersdatter Bongo, Janne Isaksen Engnes & Pertice M. Moffitt (2019) 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, International Journal of Circumpolar Health, 78:1, 1612703, DOI: [10.1080/22423982.2019.1612703](https://doi.org/10.1080/22423982.2019.1612703)

To link to this article: <https://doi.org/10.1080/22423982.2019.1612703>



© 2019 The Author(s). Published by Informa UK Limited, trading as Taylor & Francis Group.



Published online: 09 May 2019.



Submit your article to this journal [↗](#)



Article views: 285



View Crossmark data [↗](#)

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

Grete Mehus ^a, Berit Andersdatter Bongo ^a, Janne Isaksen Engnes^a and Pertice M. Moffitt ^b

^aDepartment of Health and Care sciences, UiT The Arctic University of Norway, Hammerfest, Norway; ^bAurora Research Institute, Aurora College, Yellowknife City, NWT, Canada

ABSTRACT

Background: Citizens of Norway have free and equal access to healthcare. Nurses are expected to be culturally sensitive and have cultural knowledge in encounters with patients. Culturally safe care is considered both a process and an outcome, evaluated by whether the patients feel safe, empowered and cared for, or not. All patients request equal access to quality care in Norway, also Sami patients.

Objectives: The aim of the study is to identify whether Sami patients and relatives feel culturally safe in encounters with healthcare, and if not, what are the main concerns.

Methods: This qualitative study used semi-structured interviews in the North Sami language, with 11 North Sami participants. The transcribed data were analysed through a lens of cultural safety by content analysis.

Findings: Data analysis explicated themes including: use of Sami language, Sami identity and cultural practices, connections to positive health outcomes to enhance cultural safe care and well-being for North-Sami people encountering the Norwegian health-care system.

Conclusion: Culturally safe practices at the institutional, group and individual levels are essential to the well-being of Sami people. An engagement in culturally safe practices will facilitate (or) fulfil political and jurisdictional promises made to the Sami people, consequently improving positive impact of healthcare.

ARTICLE HISTORY

Received 26 October 2018

Revised 23 April 2019

Accepted 23 April 2019

KEYWORDS

Cultural safety; indigenous; equality in healthcare; healthcare; nursing; general practitioners; Sami language

Introduction

In some circumpolar jurisdictions, cultural safety is considered an outcome to be incorporated within the health-care system creating programs and services for indigenous people whereby they are safe, accepted and respected [1]. In northern Canada, cultural safety has been adapted from the Maori people in New Zealand to address the inequities for indigenous peoples resulting from colonial policies and practices within the health-care system [2–4]. Similarity in Norway, the history of the Sami is one of colonization, assimilation and discrimination and many Sami are traumatized by their embodied memories from this [5]. The results of this governmental discrimination process were that some Sami lost their native language, family names, traditions, and ethnic identity and felt oppressed for decades after the official ending of the assimilation process [5]. All citizens of Norway have free and equal access to health-care services and the Sami are recognized as indigenous people of Norway through

ratification of the ILO Conventions 169 from 1990 [6], which no other country in Fennoscandia has. However, several studies report ineffective outcomes within health-care services for Sami with the biggest challenges are the language barrier, health-care providers' lack of Sami cultural competence and the marginalization of Sami in the Norwegian health system [7–12], making Sami feels disempowered, with unequal access to health-care services. There are descriptions of culturally safe communication among North Sami, where the definition of family names and affiliation is important when introducing oneself, and indirect communication, hinting and taking one's time are described as important in communicating [13].

By contrast, one study interviewing four patients from mental healthcare revealed that some clients define being bilingual as a positive factor, because when they could not find words, they sometimes chose to speak Norwegian, especially when describing feelings and emotions in therapy [14]. However, Dagsvold et al. [15] also report that

CONTACT Grete Mehus  grete.mehus@uit.no  Faculty of Health Sciences, Department of Health and Care Sciences, UiT The Arctic University of Norway, Hammerfest, Norway

© 2019 The Author(s). Published by Informa UK Limited, trading as Taylor & Francis Group.

This is an Open Access article distributed under the terms of the Creative Commons Attribution-NonCommercial License (<http://creativecommons.org/licenses/by-nc/4.0/>), which permits unrestricted non-commercial use, distribution, and reproduction in any medium, provided the original work is properly cited.

clinicians do not know prior to admission if patients are Sami-speaking, and their patients do not identify a need for interpreting in the clinical context. Some do share their needs afterwards and/or to others. Clinicians left it to the patients to address the manner of communicating their needs. In addition, political documents dealing with health-care and social services for Sami have identified that they have suffered and felt neglected and disempowered in encounters with healthcare, and therefore recommend that culturally congruent care for Sami patients is required [16–19]. A document analysis by Blix et al. of Norwegian policy documents regarding care services for elderly Sami reveals that *“communication difficulties occurred not only because personnel did not understand or speak the Sami language but also because they did not master the Sami culture or way of being, which implies the existence of ‘a Sami way of being’”* (20, p. 89). A study of health-care professionals’ discursive constructions regarding the needs of older Sami with dementia revealed a risk of offering little or no appropriate healthcare services to Sami patients with dementia because of established opinions such as: *“Sami take care of their own people”* [20]. This stereotypical presumption may lead to further marginalization and unequal access to health-care services, including effective treatment to healthcare services. Equal access to healthcare is established in Norway [16–19], and corresponds with Kvernmo’s [21] arguments for developing medically and culturally safe healthcare services for Sami patients.

Cultural safety

Cultural safety in nursing (CS) is a critical theory, build upon a concept developed in New Zealand to address colonial processes of inequity, discrimination and oppression that negatively affect the health status of Maoris [22–25]. The concept has been adopted in other countries with indigenous, colonized populations [26,27] and raises awareness of institutional racism as it *“seeks to change nurses’ attitudes from those which continue the present system to those which promote Maori health in accord with the treaty of Waitangi”* (29, p. 453), which is an agreement between the Crown and the Maori, the indigenous people of New Zealand. CS moves beyond traditional notions of cultural sensitivity and competence and is based on nurses being sensitive and person-centred, questioning power dynamics in nurse-patient relationships, and reflecting on how people are marginalized and/or essentialized within health-care [22–27]. CS requires sensitivity and reflection on the impact on people being colonized, reciprocity, respect, collaboration, culturally safe communication and language, and recognition of CS practices [28].

This corresponds with the expected standard of care for all professionals providing healthcare in Norway [29–31]. CS is described as a socio-ethical, relational and reflective practice where the outcomes of service provision (patient-centered, respectful, compassionate care) are carefully considered by health-care practitioners [32] and evaluated by patients [22]. When CS is not present, cultural dissonance, confusion or conflict in a new environment place patients and their families at risk in the health-care system and are detrimental to health and well-being [32]. To our knowledge, the concept of cultural safety and Sami cultural beliefs and practices are scarcely addressed in nursing education in Norway [33].

In summary, many previous studies [7–13,20,21,34], political documents [16–19] health-care licences and laws and regulations [29–31] identify a call for culturally competent health-care providers, the use of Sami language in healthcare services, and culturally congruent care for Sami in the Norwegian healthcare system. Therefore, it is important to investigate how North Sami-speaking patients and their relatives, in Northern Norway, experience encounters with healthcare today, what they expect of healthcare providers and whether they feel culturally safe in encounters with healthcare and the cultural effectiveness of their treatment.

Methodology

Research design

This explorative, descriptive study used qualitative methods of semi-structured interviews [35] and content analysis [36] utilizing a conceptual lens of cultural safety, to address the following research question: How do Sami-speaking patients and relatives experience encounters with the Norwegian healthcare system?

Semi-structured interviews

The interviews were open-ended and responsive to the participants’ narratives. They began by collecting demographic data on their role as a former patient, relative to a patient or both, age, ethnicity and occupation. Then, followed an open-ended question: *“How have you experienced encounters with healthcare in your municipality or in stays in hospital?”* Probes were also used to elicit further information based on the narrative.

Recruitment and sample

The North Sami participants (n = 11) were all recruited by advertising and promoting the research project on

Sami radio in 2015, (Table 1) which was a convenient strategy [37]. The inclusion criteria were self-identification as Sami-speaking Sami and previous encounters with the healthcare system as patients, relatives or both. The language criterion is narrow and exclusive, and findings are not representative for Sami people in general. There are many non-Sami-speaking Sami; these were excluded from this study. Our purpose in conducting interviews by a Sami researcher, in the North Sami language, was to create a culturally safe and equitable environment between researcher and participants. The interviewer is a former nurse, has lived in Sami areas, and is currently researching cultural codes and practices. She also has a shared history of former colonization and assimilation. This affords congruence with some aspects of acceptable indigenous methodology, where the interviewer is positioned as what Wilson names an indigenous researcher [38]. Participants contacted the researcher in various ways, directly in the local shop, through a common acquaintance, or by telephone. Snowball sampling, as described by Malterud [35], occurred when some participants recommended the interviewer to contact other people. In qualitative research, the researcher is the data collection instrument, influencing the data intentionally or unintentionally, as she holds a shared history of colonization. The interview is an interpretive practice: “a way of bringing the world into play” (39, p. 25). Sample saturation is considered as repetition of data, confirming that data collection is complete for the phenomenon being addressed [35]. There was repetitive and confirmatory data after nine of eleven interviews.

Participants were women (n = 9) and men (n = 2), with North Sami as their mother tongue. All had grown up and lived in the Sami administrative area. The mean age was 47.5 years, 56.5 for men and 45.5 for women. The oldest was 76, and the youngest was 24 (Table 1). They were former patients (n = 4) or relatives to a patient (n = 7); they included two pensioners, two teachers, two civil servants and five health-care providers, paraprofessional (n = 2) and professional (n = 3). The narratives, in general, reflected how patients and relatives experienced meetings with health-care personnel (doctors, nurses

and undergraduate nurses) at hospitals and in GPs’ surgeries, but not in homecare. Only recruiting participants from those who reported mostly negatively may be due to: 1) convenience sampling and snowballing and/or 2) participants’ feeling of cultural safety when invited to speak their mother tongue with the researcher and/or 3) participants’ desire to improve healthcare for Sami-speaking patients.

Setting, data collection and analysis

Data collection took place in two inland Sami administrative municipalities in northern Norway, from April to October 2015; interviews were conducted by the second author in private, in her office or the participants’ home and were transcribed verbatim directly by the bilingual interviewer into Norwegian. The audio-recorded interviews lasted between 20 and 90 min.

Content analysis

The data were examined using the following steps. All interviews were reviewed, translated and coded. The coding identified various sub-themes, which were then sorted under the main themes [36] (Table 2). Two of these main themes were predetermined by our lens of cultural safety.

We examined the data for 1) what feels culturally safe and 2) what feels culturally unsafe (Table 2 and Table 3).

All transcripts were read by the first, second and third authors several times, for clarity and overall understanding of the data in sub-themes and main themes. Four interviews were then selected as they provided a broad picture of the narratives. These four audio files were delivered to a professional bilingual Sami/English translator, and were translated into English for submission for co-analysis with the fourth author. The aim was to validate the translation process and avoid bias. Comparison of the English texts with the Norwegian transcribed texts shows that both translators have performed an approximately equivalent transcription, which is one criterion that strengthens credibility, according to Twinn [40].

Table 1. Descriptors of participants.

Descriptors of 11 ^a participants	Sami ethnicity	Gender		Age span	Role in the narrative	
		Woman	Men		Patients	Relatives
	11	9	2	24–40 years (youngest)	4	7
	-	-	-	41–60 years (middle-aged)	-	-
	-	-	-	60–76 years (oldest)	-	-

^aThey are bilingual. North Sami is their first language and mother tongue.

Table 2. Examples of statements from interviews which were analysed as contributing to feelings of being culturally safe and unsafe.

Contributions to the feeling of being culturally safe	Contributions to the feeling of being culturally unsafe
Meeting Sami-speaking staff and patients	Not using Sami language and not allowed to speak Sami in public
Having Sami activities and symbols in hospitals	Feeling violated, invisible and vulnerable without Sami music, art and handicraft
Meeting staff that listen and spend time with patients	Staff talking above your head and giving no information
Having interpreting services	Neglect of Sami language and no offer of interpreting service
Having the feeling of being at home	Not feeling at home
Meeting other Sami-speaking patients	No one to speak Sami with

Ethical approval

Ethical approval from the Norwegian Committees for Medical and Health Research Ethics was unnecessary.

Findings

The findings were explicated by three sub-themes regarding feeling unsafe: limited Sami language; family as interpreters; neglect, discrimination, social isolation and disconnection. These themes overlap to describe a culturally unsafe environment.

Limited sami language in health-care services

Several participants point out that the biggest short-coming between health-care personnel and Sami-speaking patients is that there is no or limited spoken Sami language. This was communicated by the youngest and oldest patients (aged 24 and 76, respectively), and by women and men. Two women said about meeting their GP:

When I'm about to explain to the GP what's happened, in Norwegian, I feel I lack words, and I can't explain everything. That's frustrating, because I'm not fluent in Norwegian. I can't explain the seriousness of the situation. But when I meet a Sami-speaking GP, everything's easy to explain with a few words (Interview 3).

When I couldn't express what I wanted to say to the doctor, I start doubting messages from my body (Interview 7).

Even younger patients, who have learned both Norwegian and Sami at school, describe stress and worry when meeting Norwegian health-care personnel, because they cannot describe their symptoms and illness profiles adequately in Norwegian. When Sami words cannot be used, symptoms become difficult to express, leading to self-doubt in their ability to get help. Another participant said:

I couldn't speak or write Sami in my evaluation of the stay. I felt incapacitated because I couldn't write well enough in Norwegian. When I finally got an interpreter,

Table 3. Examples of content analysis from transcription to sub-topics to main themes.

Meaning units	Condensed meaning units	Interpretation of the underlying meaning	Sub-topics	Main themes
I hope I get healthcare providers who speak the Sami language, when I'm old. Sami staff also understand Sami culture (Int 3).	Wish to speak her mother tongue her whole life and to meet staff who know her culture in her old age.	Recruitment of Sami staff is important in healthcare.	Safeguarding the culture of a person in old age with Sami healthcare providers.	Contributions to the feeling of being culturally safe
Just before dad died, I had a little contact with him. Before he died, I sang his yoik very quietly in the ICU. His body and face seemed to completely relax while I was singing his yoik. After a few minutes, he left me and us (Int 6).	The father was on his deathbed in the ICU and the son decided to sing his personal yoik for his last moments. The father seemed to relax then, just before he left them.	To sing someone's yoik is the best and most affectionate thing you can do for a Sami.	Traditional Sami way of honouring someone.	
As a Sami patient, I feel that I'm treated as if I don't understand anything at all and I don't feel I'm very welcome there (Int 4).	As a Sami patient, she does not feel respected or welcome.	Feels she is considered as inferior and unwanted.	Feels discriminated against as a Sami.	Contributions to the feeling of being culturally unsafe
I have accompanied Sami patients who don't know a word of Norwegian, so that all communication between the doctor and patient went via me. I don't think that kind of situation is right for the patient because I'm the one doing the talking. (...) I find that the patient never gets to say what he really thinks and the patient's feelings don't come out (Int 7).	The person who accompanies a Sami patient is also used as an interpreter, but does not feel this situation is right. The patient's personal perspective and feelings are not expressed.	Interpreting for others represents a barrier to conveying their innermost feelings.	Interpreting is not best practice.	

I told the nurse exactly what I felt, and her tears flowed (Interview 8).

Perhaps the nurse realized that she should have arranged for interpreting earlier, that she had limited cultural knowledge in this situation, and that her hospital did not acknowledge that Sami and Norwegians are not one culture; all this made her sad on behalf of the patient.

Family as interpreters

Family members are often relied upon to speak or interpret on a patient's behalf. One participant said:

My mother died last year. When she got old, it was difficult for her to understand and speak Norwegian. However, she pretended she still understood. When we were at the hospital, she always asked me when the staff had left the room: "What did they say?" (Interview 11).

According to this relative, there is a performance in that the patient pretends to understand, but the health-care provider is unaware of this, because the family interprets afterwards. Another relative, who interpreted for her husband, stated:

I was admitted with my husband because he needed an interpreter who understood his language, codes and signs. He lost his ability to speak because of a stroke. How can a professional interpreter understand a stranger who's lost his ability to speak? (Interview 2).

Those two stories show how relatives act as interpreters when a professional interpreter is unavailable or unable to understand the patient's articulations. Having relatives as interpreters for help in remembering, deciphering codes and interpreting the context is vitally necessary, but may also provide limited information because of taboos in the family and patients may, therefore, be selective in sharing information. However, these places both relatives and patient in a vulnerable position, because it can be difficult to combine translating and being a supportive family member. These findings are regardless of age and underline the feeling of neglect and lack of Sami language in healthcare, thus leading to a perception of being unsafe in the context of care.

Neglect, discrimination, social isolation and disconnection from sami culture

One participant (Interview 11) heard that her 92-year-old mother had taken a cognitive test (Mini-Mental Status) in Norwegian in the hospital and had scored poorly. The daughter asked for the MMS test to be translated into Sami, to ensure that her mother had not been diagnosed

and treated incorrectly. The daughter was surprised that the nurses obviously ignored signs of her mother's Sami ethnicity, although she spoke Sami and wore Sami clothes every day. The daughter spoke up for her mother, asking who could be more Sami than her mother, and the nurse answered: "...they hadn't thought about it that way" (Interview 11). The nurse answered on behalf of the medical team administering the cognitive test; they had obviously ignored the Sami woman's ethnicity and language by not considering having an interpreter present to validate the results, thus putting a patient at risk.

Another participant shared observations of Norwegian versus Sami nurses' approaches in conversations:

I've experienced a major difference between Norwegian and Sami-speaking nurses. The Norwegians talked "above my head", but the Sami didn't. When I was lying there in the bed, no one came into my room and informed me or just talked with me. The other patient got that service. I always had to ask and beg for information. I felt alienated. (Interview 3).

Patients will feel neglected if a nurse does not spend time communicating with them or talks above their head, which is rude and inappropriate in care provision. One young patient described her perception of a nurse's attitude in the following quote:

I have a Norwegian surname and often the Norwegian-speaking staff don't understand it before I start speaking Sami. Then, when you get sick you're extra vulnerable and your emotions are almost outside your body. I can feel in my body when the staff know I'm from a Sami village, they're more unfriendly both to me and my family. Their attitude changes, and I don't feel safe. And when they hear me speaking Sami, I'm not respected any more as a human being (Interview 4).

She also said:

I also accompanied my dad to hospital. I felt they didn't care enough. They didn't acknowledge Sami values. I felt sorry for my dad. They treated him like he didn't understand anything at all, like he was stupid....that's sad... (Interview 4).

In these three quotes, the participants share a perceived change in the care and attention they received, which they found disrespectful and possibly discriminatory. Health-care providers' position of authority creates a power imbalance. This can negatively affect patients' feelings and create isolation and unequal access to information and care for Sami patients. If nurses are made aware of this, they can acknowledge and understand that their actions and responses demonstrate disrespect, insensitivity and discrimination.

Although most narratives were related to hospital stays, there were also some visits to GPs, where several

participants shared these views of a young participant: *"I'm a Sami and speak Sami. I've been a patient in the Norwegian world. I want to tell my experience from the Norwegian world"* (Interview 7). This participant and two others (Interviews 4 and 6) make it explicit that *"the Sami and the Norwegian world"* are different. These statements confirm a perception of having a different ontology and epistemology from the majority Norwegians. This perception fuels the disconnection experienced when being and knowing in the other's world is not understood. One participant revealed her feeling of isolation and disconnection in the healthcare system through the following stories:

I was at the rehabilitation hospital for three weeks, and everything was in Norwegian. When I asked for translated information material, they didn't have any. The staff encouraged me to ask if I was wondering about anything, but I didn't want to disturb them with my questions about some simple Norwegian word [...].

Even though I was there among other people, I felt very lonely. I walked a lot in the mountains, alone [...]

After some time I met a man who was a relative of another patient. He was a Sami from the coast. I visited him often. It was nice because we could talk Sami to each other, then I felt peace inside me and I felt at home (Interview 8).

The theme here is loneliness, isolation and disconnection from Sami language and culture. She found some solace and felt more at home by walking in the mountains and meeting another Sami speaker. She also reported a lack of Sami art and music in therapy, and there was no skin to make coffee bags in the patients' handicraft room at the hospital, which may make Sami patients feel excluded and unwelcome.

In summary, these findings indicate that the participants were dissatisfied with the outcome of health-care services at the institutional, group and individual levels. The lack of opportunity to use the Sami language and feelings of discrimination and misunderstandings are putting Sami patients at risk. The 11 participants' statements reveal a lack of attention and disconnection from the Sami world among health-care providers, giving them unequal access to information, attention and support and leading to a feeling of being in an unsafe place.

Discussion

This study aimed to explore how Sami-speaking patients and relatives experienced encounters with healthcare. All participants, regardless of age, described suboptimal experiences of what we identify as cultural safety in the health-care system, because there is no or limited use of

the Sami language or professional interpreters, and perceived discrimination, which does not fulfil the promises in white papers and legislation [16–19,29,31].

The discussion will be addressed through a cultural safety lens at three levels: the institutional, group, and individual levels [41]. Each level represents possibilities to diminish, demean and disempower patients, or alternatively, to offer good relationships, reconciliation and respect [22–28,32]. The combined effect of each level will thus influence the total quality of care provision [25,41].

The institutional level is the agency or facility level providing cultural resources, policies and infrastructure. Patients and relatives described their experiences here as suppression and denial of Sami culture, including not being allowed to speak Sami in public areas, lack of interpreters, lack of Sami art, music and handicraft. This points to a moral and ethical absence of the distinctness of Sami people throughout the organization. Language is a bearer of communication practices and beliefs. No or limited use of Sami language in health-care demonstrates no reciprocity, inclusivity or collaboration [5–13]. If patients have a history of oppression, discrimination and colonization by authorities or through narratives handed down by generations, they may be particularly conscious of all types of discrimination in healthcare, which clinicians should take into consideration [22–27]. Countermeasures could be endorsed by management by translating information into Sami and providing alternative music in therapy and suitable equipment for traditional Sami handicraft. Management should provide advice and training to staff in cultural issues, including accepting the use of the Sami language in all situations, without negative comments [5,7,12,13]. Interpreting services are a statutory right for patients [42,43], and should be an example of the institutional implementation of political and legal statements [5,16–19,42,43].

Cultural safety at the group level represents the care team, which includes all health professionals and leaders meeting Sami patients and their families. The patient who had to take an MMS without an interpreter was put at risk. This risk outcome speaks to the connection between culturally unsafe treatment and ineffective treatment, since the reality of misdiagnosis, and mismatched treatment options were present. Health professionals need to adopt reflexive practice and discuss how their cultural competence and cultural sensitivity are present in their workplace [22–28,32]. Tests must be translated into patients' mother tongue to ensure a correct diagnosis. Use of a common language between clinician and patient will reduce adverse events and enhance communication [13,44,45]. Interpreting services must be integrated into

consultations with GPs, doctors' rounds to hospital patients and rehabilitation programmes. Access to interpreters, and thus equal access to information about personal health matters, are stipulated in-laws [42,43] and white papers at the institutional level [16–19,42], which should contribute to culturally safe care and may prevent adverse events. More Sami-speaking staff were requested by these participants, as in many other studies [5–13,21].

Our findings showed that the participants felt their Sami culture and language to be invisible, they felt emotionally and spiritually isolated, they doubted their symptoms. Cultural safety at the individual level means providing inclusive care that accepts Sami culture, the history of colonization and assimilation and the ongoing reconciliation process [5,16–19]. This is part of person-centred care, as described by many researchers [22–28,32], here, patients and families are considered partners in care.

The findings in this study that participants longed to use the Sami language in encounters with health-care providers diverge from the findings of Dagsvold et al. [14] from mental healthcare. This may be because our participants' preferred language were Sami, and most of their health-care experiences were from areas with few Sami speakers. However, lack of Sami language was also reported from a GP's office in a Sami municipality, in social work within Sami people in Finland [44,45]; this confirms that language is a cultural mediator for Sami patient and is important for feeling connected and safe in encounters and communication with health-care providers [46,47].

As well, any meeting with any patient is unique and illness makes patients vulnerable. Patients may feel defenceless and disempowered, as seen in many examples from the findings; this must be taken into consideration when health-care providers meet Sami-speaking patients. Dominant discourses in cultural safety can either “diminish, demean and disempower” people's identity as culturally unsafe practices [32], or offer relationship, reconciliation and respect as culturally safe practices. Duke, Connor and McEldowney [28] argues that cultural competence skills cannot be taken for granted and that process-orientated adaptation is necessary to minimize risk and avoid wrong diagnosis and adverse events because of misunderstandings, as described in Johnstone and Kanitsaki [46].

Conclusion

The examples of how and why Sami-speaking patients and relatives feel culturally unsafe in all levels of health-care in Norway reveal the following reasons: there are limited Sami-speaking staffs, staff do not reflect on the

importance of interpreting for patient safety, there is no cultural validation of medical tests leading to diagnosis, interpreters are not planned for doctor-patient encounters or when introducing important information, and finally, Sami objects, art and music are less present in institutions outside Sami areas. All these factors make Sami patients feel disconnected, discriminated, diminished and disempowered, and thus culturally unsafe. This can be perceived as a reminder or echo from past, officially terminated, assimilation policies [5], and may be recognizable for other minorities in circumpolar areas.

Highlighting the concept of culturally safe care as a goal at the individual, group and institutional level is considered important; this can be done during internal group discussions on existing narratives from patients' reports, to improve practice. Sami-speaking staff can reduce misunderstandings in communication [13,21,44,45]. Their internalized Sami cultural competence [7–9] implies the understanding of “the Sami way of being” [34], which was reported by three participants as different from the Norwegian. Sami-speaking health-care staff have triple cultural and language competence, i.e. Sami and Norwegian language and culture, and the language and culture of Western healthcare. They may be able to convert all this competence into a context with a Sami patient and thus provide culturally safe care.

Our findings can encourage dialogue between health-care staff and management to discuss whether their practices are culturally safe for Sami people in Norway, or, if not, whether they can form a basis for transition, as described in Browne, Varcoe, Smye et al. [48]. All health-care providers meeting patients from minority groups in circumpolar areas, including instructors on nursing degree courses in Norway, have to be reflexive and engaged in culturally safe ways to meet patient needs. This involves the integration of perspectives of power imbalances, and inequitable social relationships in healthcare by considering what are culturally safe/unsafe practices, as identified by the North Sami participants in this study.

Additionally, further research should focus on how nurses handle patient admission information on ethnicity, language choice and interpreter needs, and how Sami and Norwegian nurses experience encounters with Sami and Sami-speaking patients.

Limitations

The researchers were experienced, privileged, well-educated nurses and teachers who have worked rurally and with indigenous patients, Sami in Norway and

Dene, Métis and Inuit in Canada. This intersectionality influenced the study approach. Our understanding of indigenous people comes from either an indigenous, mixed-indigenous or settler northern context, and is based on recognition and acceptance of our common history of colonisation, assimilation, suppression and experiences of institutional and personal violation of indigenous people [5]. The analysis was conducted from both an insider (indigenous) and an outsider (non-indigenous) position, influenced by our background and experiences, which Olsen [48] describes as a privileged and empowered position.

Announcing the project on the radio reached only Sami speakers who happened to be listening, giving us a convenience, not a representative, sample [37], but still provided some insights. The analysis revealed sub-themes related to the importance of the Sami language, interpreters and feelings of discrimination and disconnection, perhaps influenced and reinforced by our strict Sami-language criterion for participation. However, other Sami interviewees may have provided different insights.

Most of our participants were women, and five of eleven worked in healthcare but participated as patients or relatives, or both. Who people are and their background will affect the stories told and the analysis performed by the researchers [48]. Being both a health-care provider and a relative makes one capable of expecting and evaluating quality in professional care. This includes the expectation of a Sami-speaking Sami of being culturally safe in encounters with healthcare.

Disclosure statement

No potential conflict of interest was reported by the authors.

ORCID

Grete Mehus  <http://orcid.org/0000-0002-9615-499X>
Berit Andersdatter Bongo  <http://orcid.org/0000-0002-5599-0537>
Pertice M. Moffitt  <http://orcid.org/0000-0001-6184-5072>

References

- [1] Government of the Northwest Territories (Canada). Caring for our people: cultural safety action plan (2018-2020). (2019). Available from: <https://www.hss.gov.nt.ca/sites/hss/files/resources/cultural-safetyaction-plan.pdf>
- [2] Adelson N. The embodiment of inequity. *Can J Public Health*. 2005;96(2):45–61.
- [3] Allen B, Smylie J. First peoples, second class treatment. The role of racism in the health and well-being of Indigenous people in Canada. Toronto, ON: Wellesley Institute; 2015.
- [4] McGibbon EA, Etowa JB. Anti-racist health care practice. Toronto, ON: Canadian Scholars' Press Inc; 2009.
- [5] Minde H. Assimilation of the Sami - Implementation and consequences. *Acta Borealia*. 2003;20(2):121–146.
- [6] Ministry of Local Government and Modernisation. The ILO Convention No. 169 concerning Indigenous and Tribal People in Independent Countries. Oslo: Regjeringen; 1990.
- [7] Bongo BA. Samer snakker ikke om helse og sykdom - samisk forståelsehorisont og kommunikasjon om helse og sykdom [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: Faculty of Health Sciences, UiT The Arctic University of Norway; 2012.
- [8] Bongo BA. "Hva er en bærer?": belysning om "en" måte å forstå psykiske lidelser på i den samiske kulturen ["What is a 'baerer'?": a perspective on how to understand mental disorders, in the Sami culture]. (Master's thesis). Tromsø: Faculty of Health Sciences, UiT The Arctic University of Norway; 2002.
- [9] Hedlund M, Moe A. "De forstår ikke hva som er viktig for oss" [They don't understand what's important to us: health services and South Sami]. *Steinkjer: Nord-Trøndelag forskning*; 2000. (Report no. 2).
- [10] Nystad T, Melhus M, Lund E. Sami speakers are less satisfied with general practitioners' services. *Int J Circumpolar Health*. 2008;67(1):116–123.
- [11] Sorlie T, Nergard JI. Treatment satisfaction and recovery in Saami and Norwegian patients following psychiatric hospital treatment: a comparative study. *Transcult Psychiatry*. 2005;42(2):295–316.
- [12] Angell E, Ám BV, Josefsen E, et al. Kartlegging av samisk perspektiv i kommunesektoren [Mapping Sami perspective in the municipalities]. Oslo: Norwegian Ministry of Government Administration, Reform and Church Affairs; 2012:5. (NORUT. Rapport). (NORUT - Northern Research Institute. Report 2012:5)2012:5. Oslo:Norge.
- [13] Mehus G, Bongo Andersdatter B, Moffitt P. Important factors when communicating with Sami patients about health, illness and care issues. *Nord Nurs Res*. 2018;8(4):303–316.
- [14] 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(11):26952.
- [15] Dagsvold I, Møllersen 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.
- [16] Ministry of Health and Care Services. Report no. 47 (2008-2009) to the Parliament. The Coordination Reform. Proper treatment - at the right place at right time.

- (Stortingsmelding nr. 47 (2008-2009) Samhandlingsreformen. Rett behandling på rett sted - til rett tid). Oslo: Helse- og omsorgsdepartementet; 2009.
- [17] Ministry of Health and Care Services. *Mestring, muligheter og mening*. Oslo; 2005. (Report no. 25(2005-2006) to the Parliament. Long-term care. Future challenges. Care plan 2015).
- [18] Ministry of Health and Social Affairs. *Plan for helse og sosialtjenester for den samiske befolkningen i Norge*, NOU 1995:6 [Plan for health and social services to the Sami population in Norway]. Oslo: Norgesoffentlige utredninger, Statens forvaltningstjeneste; 1995. (Norwegian Official Report NoU 1995).
- [19] Ministry of Health and Social Affairs. *Action plan for the health and social services for the Sami population in Norway, 2001-2005. Diversity and equality. (Mangfold og likeverd. Regjeringens handlingsplan for helse- og sosialtjenester til den samiske befolkning i Norge 2002-2005)*. Oslo: 2001.
- [20] Blix Hansen B, Hamran T. "They take care of their own": healthcare professionals' constructions of Sami persons with dementia and their families' reluctance to seek and accept help through attributions to multiple contexts. *Int J Circumpolar Health*. 2017;76(1):1328962.
- [21] Kvernmo S. Developing Sami health services - A medical and cultural challenge. In: Gaski H (Ed.). *Sami culture in a New Era*. Karasjok: Davvi Girji. 1997. p. 127-142.
- [22] Papps E, Ramdsen I. Cultural safety in nursing: the New Zealand experience. *Int J Qual Healthcare*. 1996;8(5):491-497.
- [23] Williams R. Cultural safety - what does it mean for our work practice? *Aust N Z J Public Health*. 1999;23(2):213-214.
- [24] Smye V, Browne AJ. 'Cultural safety' and the analysis of health policy affecting aboriginal people. *Nurse Res*. 2002;9(3):39-60.
- [25] Polaschek NR. Cultural safety: a new concept in nursing people of different ethnicities. *J Adv Nurs*. 1998;27:6.
- [26] De D, Richardson J. Cultural safety: an introduction. *Paediatr Nurs*. 2008;20(2):39-43.
- [27] Woods P, Schwass M. Cultural safety: a framework for changing attitudes. *Nurs Praxis*. 1993;8(1):4-15.
- [28] Duke J, Connor M, McEldowney R. Becoming a culturally competent health practitioner in the delivery of culturally safe care: a process oriented approach. *J Cult Divers*. 2009;16(2):40-49.
- [29] ICN [Internet]. ICN Code of Ethics: international Council of Nurses. 2012. p. 12. [cited Feb 29]. Available from: <http://www.icn.ch/who-we-are/code-of-ethics-for-nurses/>
- [30] Forskrift om felles rammeplan for helse- og sosialfagutdanninger. [Regulation on a Common Plan for Education in Health and Social Sciences]. FOR-2017-09-06-1353; 2017.
- [31] Helsepersonelloven [Health Personnel Act]. LOV-1999-07-02-64. 2001.
- [32] Woods M. Cultural safety and the socioethical nurse. *Nurs Ethics*. 2010;17(6):715-725.
- [33] Eriksen LT, Bongo BA, Mehus G. Indigenous peoples perspective in education. Nurse education in Norway is without knowledge about indigenous peoples? *Nordic Nurs*. 2017;7(3):239-249.
- [34] Blix BH, Hamran T, Normann HK. "The Old Sami" - who is he and how should he be cared for? A discourse analysis of Norwegian policy documents regarding care services for elderly Sami. *Acta Borealia*. 2013;30(1):75-100.
- [35] Malterud K. *Kvalitative metoder i medisinsk forskning (Qualitative methods in medical research: an introduction)*. 3rd ed. Oslo: Universitetsforlaget; 2011.
- [36] Graneheim UH, Lundman B. Qualitative content analysis in nursing research: concepts, procedures and measures to achieve trustworthiness. *Nurs Edu Today*. 2004;24(2):105-112.
- [37] Polit DF, Beck CT. *Nursing research: generating and assessing evidence for nursing practice*: wolters Kluwer. Philadelphia, PA: Lippincott Williams & Wilkins; 2017. p. 773.
- [38] Wilson S. What Is an Indigenous Research Methodology. *Can J Native Educ*. 2001;25(2):175-179.
- [39] Denzin NK. The reflexive interview and a performative social science. *Qual Res*. 2001;1(1):23-46.
- [40] Twinn S. An exploratory study examining the influence of translation on the validity and reliability of qualitative data in nursing research. *J Adv Nurs*. 1997;26(2):418-423.
- [41] Ferlie EB, Shortell SM. Improving the quality of care in UK and the USA. *Milbank Q*. 2001;79(2):281-315.
- [42] Sameloven [The Act of Sami Government and other Sami Jurisdictions]. LOV-1987-06-12-56. 1987.
- [43] Pasientrettighetsloven [The Patients' Rights Act]. LOV-1999-07-02-63. 1990.
- [44] Häkkillä L, Laity-Hedemäki E, Pohjola A. good life of the Sami and Welfare services. [Buorre eallin. Saamelasten hyvä elämä ja hyvinvointipalvelut]. Rovaniemi: Lapin yliopistokustannus; 2013.
- [45] Pohjola A. Language as a cultural mediator in social work: supporting Sámi culture with services in Sámi. *Int Soc Work*. 2016;59(5):640-652.
- [46] Johnstone MJ, Kanitsaki O. Culture, language, and patient safety: making the link. *Int J Qual Healthcare*. 2006;18(5):383-388.
- [47] Browne AJ, Varcoe C, Smye V, et al. Cultural safety and the challenges of translating critically oriented knowledge in practice. *Nurs Philos*. 2009;10(3):167-179. 16
- [48] Olsen TA. Privilege, decentring and the challenge of being (Non-)Indigenous in the study of indigenous issues. *Aust J Indigenous Educ*. 2017;47(2):1-10.