

# University of Alberta

“You need to be double cultured to function here”: Toward an anthropology of  
Inuit nursing in Greenland and Nunavut

by

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## Abstract

Working towards an anthropology of nursing, I explore what it means to become and be an Inuit nurse, using as a lens the experiences and voices of Greenlandic and Canadian Inuit nurses and nursing students who are educated and practice in settings developed and governed by Southerners (Danes and EuroCanadians), functioning largely on Southern cultural norms (Danish and EuroCanadian), in Southern languages (Danish and English).

I argue that Inuit nurses and students are the Arctic health care systems' most valuable assets. They offer unique knowledge, qualifications, and spirit to the Arctic health care systems while being affected by health care politics, a lack of permanent health care staff and high turnover rates. These challenges are compounded by Inuit nurses' and students' need to negotiate the languages and cultures of the nursing field, the Southern systems and their Southern colleagues, with the languages and cultures of the patients, their families, and the societies from which they come.

Inuit nurses' and students' success, therefore, hinges on their possessing double *cultural and social capital*. This includes the ability to communicate in at least two languages and cultures, and in the field of nursing. It also includes the ability to understand, negotiate, and interact, using at least two ways of being in the world, two ways of learning and teaching, and two ways of perceiving the body, health, and disease.

I suggest that communication difficulties between Southern and Inuit health care practitioners, as well as between Inuit clients and some Inuit and

Southern practitioners, may arise because they possess different cultural capital. This, I maintain, is complicated by the educational and health care systems in the Arctic continuing to be colonial in nature and catering to Southern cultures and *habitus*, and because some Southern health care practitioners preserve a colonial attitude that creates obstacles to the provision of optimal care to Inuit clients and barriers to equity in workload and professional demands for Inuit and Greenlandic nurses.

In order for Inuit nurses' and students' knowledge and abilities to have the greatest impact on patient care and recovery they need to be acknowledged, supported and embraced by the Arctic educational and healthcare systems.

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### Clarification of terms

Unless otherwise specified, when I use the word *Inuit* in this work I mean both Greenlandic Inuit<sup>1</sup> and Canadian Inuit, when I use the word *Arctic* I mean the Canadian Arctic and Greenland, and when I use the word *Southerners* I mean both Danes and EuroCanadians. Further, unless distinguishing is necessary to make a point, I do not use the terms *Inuktitut*, *Greenlandic*, *Danish* or *English*, but rather an *Inuit language* and a *Southern language*. I do this in order to further protect the identity of those I have quoted. I also want to note that when I use the concept of *Southern* (which I use interchangeably with Western), for example in relation to culture/ways/values/systems, I accept that the concept has been criticized as a largely “implicit foil against which to contrast a ‘native point of view’” (Ingold, 2000, p. 6) and realise that my use of the term, although it is not my intention, may be perceived to fall in this category. I recognize that the Western “tradition of thought, closely examined, is as richly various, multivocal, historically changeable and contest-riven as any other” (Ingold, p. 6) and also that there are vast variations among as well as within Inuit societies – including between and among Greenlandic and Canadian Inuit (Sejersen, 2004). I argue, however, that there are characteristics that are dissimilar in Inuit and Western (Southern) culture/ways/values/systems and that this has implications for nurses and the field of nursing in the Arctic.

### Quotations

Any quotes that are in *italics* are those of the participants in this study. In order for the reader to be able to follow the origin of the quotes, at the end of each quote I use T for transcript and the number attached to a particular transcript as assigned in the software program Atlas.ti as well as the number of the line in which the quote begins. The transcript numbers do not reflect the order of interviews. In some places to further protect participants I have used more than one signifier for the same transcript and have saved these also in the key. All

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<sup>1</sup> It should be mentioned that some people of Danish descent who were born, grew up and live or have lived much of their lives in Greenland also consider themselves Greenlanders.

quotes from Greenlandic participants have been translated from Danish into English by me. In a few instances quotes have, for ease of reading, been corrected for repetitions and incorrect grammar. In these instances, however, I have been very careful not to change the meaning and feel of quotes. In order to maintain participants' anonymity, and unless needed to explicate a difference, within quotes I have changed *Danish* and *Qallunaaq* to *Southerner*, *Denmark* and *Southern Canada* to *the South*, *Greenland* and *Nunavut* to *the Arctic*, and both *Greenlander* and *Canadian Inuit* to *Inuit*. The Danish and English languages I have changed to *Southern languages* and Greenlandic and Inuktitut to *Inuit languages*.

## 1. Introduction

### *1.1 Genesis of the Study: The ‘Culturedness’ of Nursing*

*“I think you need to be double cultured to function here” (T32:32).*

Forms of caring, similar to what we call nursing, have existed in non- European cultures, nursing as a profession, however, was initially a European construct.<sup>2</sup> Through my work as a nurse, researcher, and teacher of Inuit medical interpreters in Nunavut, I became acutely aware of the limitations of my nursing education from both Danish and Southern Canadian educational institutions. Although I had learned about the body, disease, pathology, health and healing as well as the instrumental, caring, communicative, and educational aspects of nursing, I had not learned about these or any other aspects of nursing in the context of the Arctic or Inuit culture, ways and values, and there was much I had to learn on site.

The field of nursing is generally identified as “holistic”<sup>3</sup> (Hoff, 1994; Holm-Petersen, Asmussen & Willemann, 2006; Lashinger & Boss, 1984; Osbourne, 1969, 2001), yet, contemporary nurses and students in Southern nursing programs and health care settings are often immersed in institutions reflecting a homogeneity in values, ideals, and educational approaches that do not match the heterogeneity of the people and diversity of the societies they serve (Barbee, 1993; Cekic, 2004, 2006; Hoff, 1994; Pedersen, 2007). Nursing programs do teach students about cultural diversity; still, Southern institutions do not provide adequate preparation for nurses to practice in cultures and societies that are different from their own (Benkert, Guthrie & Pohl, 2005). Nor is the predominant pedagogy utilised necessarily congruent with that preferred by non-Southerners. Working in Nunavut, this became evident to me as I began to learn about common patterns of communication among Inuit community members, the

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<sup>2</sup> According to *The New Oxford Dictionary of English* the English word nurse finds its origin in the Latin word “*nutricia*, feminine of Latin *nutriciu*, (person) that nourishes, from *nutrix*, *nutric* - nurse, from *nutrire* nourish” (Pearshall, 1998, p. 1273).

<sup>3</sup> The holistic approach of nursing is often defined along the lines of: “the notion of treating the *whole person*, and care about *the patient as a human being* rather than a case of pure pathology... the notion that nurses *involve themselves* with the patients” (Holm-Petersen, Asmussen & Willemann, 2006, p. 40. Translated from Danish by the author. Emphasis in original).

limited success of generic public health campaigns, and the ways that I might obtain the information that was necessary for me in order to provide proper care for individual community members (Møller, 2005, 2010).

Becoming a nurse and practicing as one requires that the practitioner learns to navigate (and perhaps negotiate), if not master, the field of nursing as it plays out at his or her place of practice. Perhaps even more important, I suggest, practicing as a nurse or nursing teacher requires that the practitioner has an ability to engage with, and relate to, all aspects of what it means to be human. This includes our sense of self and identity; how we prefer to learn and receive information and how we teach or impart knowledge to others; our patterns of behaviour and communication and our mother tongue; how we perceive the body, health and disease; our religious orientation and traditions; our socioeconomic status and level of formal and informal education; and much more. This makes the question about what it means for Inuit students and nurses to be educated and practice in Southern languages and cultures, and in systems developed and run by Southerners, particularly interesting.

Furthermore, a nurse is situated in the historical and political contexts of the country, region, and/or culture in which she or he practices. In short, nursing is, as well as being a very social profession, also a very ‘cultured’ profession.<sup>4</sup> Nurses may best provide care to heterogeneous populations by looking inward at who they are themselves and what their role is - in other words by being reflexive (Holden & Littlewood, 1991). I believe the ‘culturedness’ of nursing creates profound effects on the learning experience of nursing students, the experience of

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<sup>4</sup> That nursing is cultured should be understood in relation to nursing being a *field*, that our *habitus* enables us to enter and have success in a field and that our habitus is a cultural expression. *Field* and *habitus* will be explained in more detail in Section 1.6; in short, however, the particular areas of practice of professions such as lawyers, various academic specialties, doctors and also nurses may be seen as *fields* (Bourdieu, 1990). *Fields* are “historically constituted areas of activity” with their own institutions governed by their own laws (Bourdieu, 1990:87) that are “relatively autonomous but structurally homologous” with other fields (Bourdieu, 1993, p. 6). *Habitus* is a concept that expresses people’s lifestyle and their total set of personal choices, benefits and practices. It governs how agents view and classify the world, as well as what they perceive as good or bad, tasteful or tasteless, right or wrong, and fine or vulgar, and thus determines how they act and practice. *Habitus* is also, in part, what enables people to enter a field or community of practice and be successful in making the culture of practice in that specific field their own.

practicing nurses, and on the people in their care, perhaps particularly when students become educated and practice across cultures.

The ‘culturedness’ of nursing was further brought home for me when, as part of my master’s research on the socio-cultural experiences of tuberculosis in Nunavut (Møller, 2005, 2007, 2010), I presented the preliminary findings to various groups in the two communities where the research was carried out. After a presentation to nursing students and teachers at Nunavut Arctic College in Iqaluit, an Inuk nursing student said she would like to meet and talk further. During our talk she said: “As an Inuk student I feel I have no freedom of speech.” She continued to explain that her views of the body, health and disease were labelled as unscientific and that some Inuit students felt discriminated against in the program, leading some to drop out (Møller, 2005, p. 63).

I knew that the program in Iqaluit had difficulty recruiting and retaining students, particularly Inuit students. Articles in *Sygeplejersken*, the Danish biweekly nursing magazine (Kjærsgaard, 1998; Madsen, 2000; Olesen & Karlsen, 1999; Steinfeldt, 1998), had indicated that the nursing program in Nuuk, Greenland had also experienced recruitment and retention difficulties at that time, and that some students judged the program to not always be culturally appropriate. This made me wonder what it might mean for Inuit students and nurses to be educated and practice in languages other than their mother tongue, in cultures different from their own, and in educational and health care systems that are developed and largely run by the ‘previous’ colonizers of the Arctic. The question intrigued me. The programs in Nuuk, Greenland and Iqaluit, Nunavut, Canada are the only two continuing programs that I know of that focus on educating Inuit nurses.

### ***1.2 The Central Argument of This Thesis***

In this dissertation I explore what it means to become and be an Inuk nurse, using as a lens the experiences and voices of Inuit nurses and nursing students educated and practicing in education and health care settings that are developed and governed largely by Southern cultures and function mostly in Southern

languages. As much as possible I want to let the nurses' and students' experiences and voices be at the forefront of this work. However, I also contextualise these experiences and voices in the political and historical realities of Nunavut and Greenland and analyse the meanings that emerge when they are related to, and combined with, each other, other voices, field-notes, and relevant news-items and debates, using relevant anthropological and other theory.

Based on my experiences in Nunavut and the literature available on Indigenous nursing students, Indigenous nurses, and Indigenous and minority education, I entered the field with the assumption that Inuit nurses and students might struggle in mainstream "Southern" nursing programs. I assumed that they would prefer to be educated in their mother tongues and preferably by other Inuit, and that many would desire that the nursing programs and health care systems incorporate Inuit culture, ways, and values, to a larger degree than they do. In other words, I assumed that as part of a needed decolonizing process, they would perhaps object to the continuing colonialism evident in both Greenland and Nunavut. Discussions of this continuing colonialism have been offered by many scholars including Robert Paine in *The White Arctic* (1977a,b,c), Hugh Brody in *The People's land* (1991) and *The other side of Eden* (2000), in several articles by Derek Rasmussen including *Qallunology: A pedagogy for the oppressor* (2002), by Robert Petersen in *Colonialism as seen from a former colonized area* (2002) and Aviaja Egede Lynge in *The best colony in the world* (2006a). The two latter scholars are Greenlandic.

I also assumed that nurses and students might have a desire to embrace the linguistic and cultural revitalisation or 'reinvention' that, at least politically, is taking place in Nunavut today (Graburn, 2006; Searles, 2006) as evidenced in the government's guiding document *Pinasuaqtavut 2004-2009* (Government of Nunavut, 2004). This document proposes a revitalisation or reinvention that would also be supported by some political parties in Greenland (Christensen, 2000; Thorleifsen, 2003; Zwinge, 2008). *Pinasuaqtavut 2004-2009* mandates the

inclusion of *Inuit Qaujimagatugangit*<sup>5</sup> in all aspects of government and public works. I did not find things to be as I had expected. As has been observed by other anthropologists about the nature of ethnographic work, we often do not find in the field what we initially expected (Ferguson, as cited in Thompson, 2008, p. 29; see also Olofsson, 2004; Thompson, 2008).

What I argue here is that Inuit nurses are pioneers who offer unique knowledge and qualifications to the Arctic health care systems. I purport that while Inuit nurses and nursing students are affected by health care economics, politics, high rates of turnover, and a lack of permanent health care staff, these issues are, for Inuit nurses and students, compounded by their need to negotiate and interweave the languages and cultures of the nursing field, the Southern systems and their Southern colleagues, with the languages and cultures of the patients, their families, and the societies from which they come. Contrary to my early assumptions, however, this does not mean that a majority of Inuit nurses and students would prefer to be educated in an Inuit language by Inuit educators, or wish that their colleagues were mostly Inuit, or that this is the focus of the dissertation. Rather, I argue that the success of Inuit nurses in the health care field in the Arctic hinges on their possessing double *cultural (including linguistic) and social capital* (Bourdieu, 1986).<sup>6</sup> This includes the ability to communicate in at least two languages and cultures as well as within the field of nursing.<sup>7</sup> It also

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<sup>5</sup> *Inuit Qaujimagatugangit* [IQ], although often translated as ‘traditional knowledge,’ is more properly defined as: “*The Inuit way of doing things: the past, present and future knowledge, experience and values of Inuit Society*. This definition makes clear that it is the combining of the traditional knowledge, experience and values of Inuit society, along with the present Inuit knowledge, experience and values that prepare the way for future knowledge, experience and values” (Tapardjuk & Awa, 2002, p. 7, emphasis in original). IQ, in its traditional context, consists of six basic guiding principles: “a) Pijitsirnjiq: The concept of serving (a purpose or community) and providing for (family and/or community) b) Aajiiqatigiingni: The Inuit way of decision-making. The term refers to comparing views or taking counsel. c) Pilnimmaksarniq: The passing on of knowledge and skills through observation, doing and practice. d) Piliriqatigiingni: The concept of collaborative working relationships or working together for a common purpose. e) Avatittinnik Kamattiarniq: The concept of environmental stewardship. f) Qanuqtuurniq: The concept of being resourceful to solve problems” (Tapardjuk & Awa, 2002, pp. 7-8).

<sup>6</sup> In section 1.6 I review Bourdieu’s (1986) ‘*Forms of capital*’ in further detail and discuss how the concepts are used within my theoretical framework.

<sup>7</sup> Nurses, if not able to speak Greenlandic or Inuktitut, need to be able to communicate through an interpreter, read the body language of the patient with whom they communicate, and take into account his or her cultural ways and values.

includes the ability to, if not actually live within two worlds, then at least understand and be able to negotiate and interact, using at least two ways of being in the world. These ways of being in the world comprise at least two ways of creating a sense of self and identity, at least two ways of learning and teaching, and at least two ways of perceiving the body, health, and disease.

Furthermore, I suggest that communication difficulties between Southern and Inuit health care practitioners as well as between Inuit clients and some Inuit and Southern practitioners may arise because they possess different cultural *capital*. This, I maintain, is complicated by the educational and health care systems in the Arctic continuing to be colonial in “spirit” and catering to Southern cultures and *habitus*<sup>8</sup> (Bourdieu, 2000). It is also complicated by some Southern health care practitioners maintaining a colonial attitude that creates obstacles to the provision of optimal care to Inuit clients and barriers to equality in workload and professional demands on Inuit and Southern health care practitioners, taxing Inuit health care practitioners.

To summarize, in this dissertation, I argue that Inuit nurses and nursing students are pioneers who offer unique knowledge and qualifications to the Arctic health care systems and whose success in the health care field in the Arctic hinges on their possessing double *cultural* (including *linguistic*) and *social capital*. Their practice is affected by the fact that other agents in the health care system (be they health care practitioners or patients) do not all possess the same *cultural capital*, and that some Southern health care practitioners preserve colonial attitudes.

After this very brief review of the main arguments of the dissertation, situating the work in the existing literature on what may be called *an anthropology of nursing* seems in order. This includes a short review of the origins of nursing as a field and its status when it was introduced in the Arctic. It also includes a discussion of the sparse anthropological (and other) literature that focuses on what it means to be a nurse, particularly that concerning Indigenous and Inuit nurses and nursing students working in colonial settings.

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<sup>8</sup> A description of Bourdieu's notion of *habitus* will also be provided in chapter 1.6

### ***1.3 Toward an Anthropology of Nursing***

The field of *medical anthropology* and the journal of the same name, although highlighting folk or traditional perspectives, have both been criticised for focusing predominantly on medicine and “medical diseases, symptoms, and pathologies” rather than on “wellness and illness patterns” (Leininger, 2001, p. 797), or “health and care” (Chrisman, 2001, p. 808; see also the special issue of the *Western Journal of Nursing Research*, 2001, volume 23, issue 8, on nurse anthropologists). Such a perspective is mostly lacking in the literature.

Anthropologists have been criticised for a tendency to subsume the field of nursing under medicine, which may partly explain why an anthropology of nursing or an anthropology of care has not been developed and why what it means to be a nurse has received little attention (Leininger, 2001). In this context I mean nursing as the profession has evolved (differently in different places) since Florence Nightingale.

The idea of an anthropology of nursing frames this study. In the following sections, in order to give a background for nursing as it has evolved in the Arctic, I will start with a brief review of the history of nursing in the West. This is followed by a discussion of Western nursing as it was ‘transplanted’ to non - Western countries as part of a colonial enterprise using India, Uganda, and Japan as examples. I then describe the sparse literature on Indigenous and Inuit nurses and finally argue for the utility of an expansion of the field of an anthropology of nursing.

#### ***1.3.1 Nightingale nurses***

The role of nursing has existed since before 500 BC (Leslie & Wujastyk, 1991). The feminine role of nursing, the professionalization of which was advocated for by Nightingale in the mid-1800s (Gamarnikow, 1991), however, did not exist in the early days of Western health care history.<sup>9</sup> Women were healers of women

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<sup>9</sup> The ancient medical treatises *Caraksamhita* and *Susrutsamhita* describe how individuals who assisted the doctors in India from about 500 BC to 1000 AD had roles and characteristics similar to many of those conceptualised by Florence Nightingale.

(only) and women's diseases generally, and if they cared for sick men it would be under the strict guidance of male *iatros* (doctors) or other men (King, 1991).<sup>10</sup> Later nursing existed as a job in hospitals, in the category of domestic service, but not as a profession (Gamarnikow, 1991). Rather, many of the functions that we customarily connect with the nursing role were carried out by women who were related to the one requiring care, by people of the Church – mainly nuns – or by “uneducated healers of low quality” (Ackerknecht, 1982, p. 209; see also Strathern, 2005).

The first school for nurses was opened in Kaiserwerth on the Rhine by the German clergyman Theodor Fliedner in 1836 (Ackerknecht, 1982; Strathern, 2005). Florence Nightingale initially attended the school in Kaiserwerth. In 1860 she opened a training school for nurses at St. Thomas Hospital (Garmanikow, 1991). Nurses should, according to Nightingale, be educated. They should not only be practically able but also theoretically knowledgeable. Despite education, however, nurses from Nightingale and far into the 1900s were expected to “observe and report [to the doctors] without expressing a (medical) opinion” (Garmanikow, 1991, p. 118), and be “faithful servants” who were “happy” in their “dependence” (former matron as cited in Garmanikow, 1991, p. 118). Furthermore, nursing students and nurses were expected to be symbols of “order, discipline and morality” (Holden, 1991, p. 70) both on and off the job, and as late as the 1950s the students “had their entire lives controlled by the school as though in a convent” (Arnstein, 1956, p. 541). Initially, this was in order for the nurse to “establish her character in a profession proverbial for its immorality” (Woodham-Smith as cited in Arnstein, 1956, p. 541). As Arnstein laments in the mid 1950s, “the influences [of Nightingale] that have outlived their social usefulness are almost entirely related to the conduct of student nurses” (p. 541). Still, many of the nurses who initially were employed to care for the Inuit residents of the Arctic were hired on the basis of being versions of this model of nurses. Although no literature exists that discusses nursing in the Arctic during this period from a

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<sup>10</sup> Despite the doctor always being male the role of the helpers was not gendered but dependent on the sex of the patient. Male helpers tended male patients and female helpers tended female patients (Leslie & Wujastyk, 1991).

cross cultural and perhaps more academic perspective, material that describe the nursing experiences from a subjective perspective does (Copeland, 1960; Balle, 2006; Helms 1984; Rosing, 2007; Scott & Kaiser, 2002, 2005). I will elaborate on this in chapter four.

### ***1.3.2 Nursing and Anthropology***

Although Florence Nightingale, working with Australian Aborigines, was the first nurse to do trans-cultural nursing (Morse, 1989), the Caucasian American Madeleine Leininger is probably one of the earliest scholars, with graduate degrees in both nursing and anthropology, who has made enquiries into the field of nursing from an anthropological point of view. Already while working as a nurse in the 1950s and 1960s, Leininger realized that anthropology and nursing had many common areas of knowledge and research interest (Leininger, 1997). At the same time she acknowledged that nurses in general were “deeply entrenched in learning medical symptoms, many disease entities, and to *take care* of physicians with their orders and many medical treatments and tasks” (Leininger, 1997, p. 32). Leininger graduated as the first professional nurse with a PhD in anthropology in 1965 (Reuter Wayne Archives, 2005). She was followed by the African American male nurse Oliver Osborne (Osborne, 2001). Osborne graduated as a nurse in 1952 and in 1968 he earned a PhD in socio-cultural anthropology. Since then a number of nurses have pursued graduate work in anthropology. This is evidenced, for example, in the 1989 edition of *Medical Anthropology: Cross-cultural nursing: Anthropological approaches to nursing research*, edited by Janice Morse, and in the 2001 special issue of the *Western Journal of Nursing Research* in which nurse-anthropologists talk about their anthropology.

Since the late 1960s and early 1970s much has been written on cross-cultural nursing with a focus on “the patient rather than the medical problem, on illness or health rather than disease” and with an emphasis on “viewing the patient in the context of family and culture” (Morse, 1989, p. 4). These works have been from an anthropological point of view, by anthropologists, and

particularly by anthropologists who are also nurses (see for example: Aamodt, 2001; Brink, 2001; Byerly, 2001; Kay, 2001; Leininger, 2001; McKenna, 1984; Osborne, 1969, 2001; see also *Medical Anthropology*, 1989, Volume 12, Number 1). Little anthropological work, however, has focused on the role of the nurse *per se*, the experiences of nurses or nursing students in their role as nurses, or on the experiences of nurses and students who learn and practice in ‘colonial’ health care systems. By colonial health care systems I mean systems that were superimposed by colonial powers where the health care services offered may not be in accord with the cultural ways, norms and values that prevail in the society in which the system is situated or among the people who receive the health care. Exceptions include the authors who contributed to *Anthropology and nursing* edited by Holden and Littlewood (1991) and the book *Nursing contradiction, ideals and improvisation in Uganda*, by the Danish anthropologist Helle Max Martin (2009). Martin describes the experiences of nurses employed in the resource-poor health service of Uganda, “who they are, what they do and why” (p. 1).

While Martin situates her work in the field of hospital ethnography, I believe her work also lies in the realm of an anthropology of nursing. According to van der Geest and Finkler (2004), the editors of an issue on hospital ethnography in *Social Science and Medicine*, hospital ethnography is based on two ideas; firstly, that “Hospitals take on different forms in different cultures and societies” with significant differences in “medical views and technical facilities... leading to different diagnostic and therapeutic traditions” (p. 1995). Secondly, that hospitals are domains “where the core values and beliefs of a culture come into view. Hospitals both reflect and reinforce dominant social and cultural processes of their societies” (p. 1995). As such, an anthropology of nursing may also be carried out as hospital ethnography – I believe that the field and the act of nursing also reflect the values and beliefs of the local culture while reflecting and reinforcing dominant social and cultural processes. The description in the next section of how colonial nursing was introduced, and has evolved in some non-Western countries, attests to this.

### *1.3.3 Colonial nursing*

As will be demonstrated below, very little literature exists that describes nursing as it was experienced by Inuit nurses when Western nursing was first introduced. Therefore, in this section, as a way to explore nursing as experienced in colonial contexts, I draw on work describing these experiences in India, Uganda, and Japan, where nursing was introduced along with Western medical culture, and culture, ways and values more generally, as was also the case in the Arctic.

Authors contributing to Littlewood and Holden (1991) mentioned above bring to the reader's attention how, in many non-Western countries after the mid to late 19<sup>th</sup> century, nursing as a profession was introduced by the colonial power along with 'Western medicine' and Western notions of health care (Hendry & Martinez, 1991; Holden, 1991; Somjee, 1991). The nursing role was a direct transplant from the colonizing country and nursing positions were initially held by nurses who were also transplanted from the colonizing powers, similar to the situation in both Greenland and Nunavut, which I will describe in section 2.3.

Somjee (1991) describes how the revival of Hinduism in India, and the subsequent changes in society that accompanied it, eliminated the nursing role that existed as women, and in particular women of higher castes, were not allowed to touch or otherwise be affiliated with the bodies and excretions of people not related to them. It was not until after the second decade of the 1900s that Indian women, and initially only Christians and Hindus who were untouchables or those of low caste, began to partake in the caring for the sick – at this time predominantly sick soldiers (Somjee, 1991). Prior to 1914 the nurses caring for the army had been imported from Britain and any leading and educational positions remained with imported staff.

When India regained its independence in 1947, the societal and political changes this entailed enabled more Indian people (particularly those of lower castes and Christian), to begin to engage in both principal and auxiliary health professions, and since the 1970s a dissolution of the traditional role of women nurses has taken place. As a result, middle and higher class Indian families began to see the profession as affording their daughters (or sons if they married a nurse)

a ticket to employment overseas, higher wages, and increased social standing (Somjee, 1991). Despite this the nursing profession continues to be stigmatised among higher caste Indian families, who “feel that nurses do the dirty job of touching ‘unknown’ men” (Sreedevi, 2005, para. 9). Many nursing graduates leave the country because of their low status and wages and the opportunity to make more money overseas.<sup>11</sup>

In relation to what it means to be a nurse in India, Somjee (1991) continues that those who stay juggle the culture of India and that of the nursing profession. In contrast to past traditions, they are often married, maintain a family, and are to some degree respected by the Indian population. For nurses in India, however, although they share roles similar to their British, other European, and North America colleagues, there are definite differences. Indian nurses have a stronger focus on the “technical work, often leaving the polluting part of their job to the lower cadres of the service” (Somjee, 1991, p. 53), and they involve themselves less in patient care than would be expected of their Western counterparts. In India, it is not the role of a nurse to be caring for a patient in a ‘mothering’ way as in many Western societies. In India a nurse may be acting as an experienced and knowledgeable guide who nourishes the patient back to health through therapy, care, personal interest, and by boosting their morale so that the patient “join[s] in the process of recovery set in motion by the doctor and the nurse” (Somjee, 1991, p. 37). In India patients are seen as having primary responsibility for their own health and recovery (Somjee, 1991), and since many pay for the majority of their health care cost (Abraham, 2007), they often wait to seek help until they are quite ill.<sup>12</sup> Thus, although having been educated in institutions that educate nurses in the spirit of Nightingale, Indian nurses perform their roles in ways that may be more acceptable to Indian values or culture.

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<sup>11</sup> Today the Indian health care and educational systems spend money educating Indian nurses, particularly in the northern, more Christian areas of the country, and the feeling is that the country is very much in need of their services (Naik, 2004).

<sup>12</sup> In this connection it may be of interest for the reader that the Nursing Association of India is not a member of the International Council of Nursing [ICN], which by now holds 112 members, among those India’s close neighbours Bangladesh and Nepal (ICN, 2010a). One of the objectives of ICN is to improve the status of nurses within their countries (ICN, 2007).

After the restoration of political power to the emperor or *Meiji*<sup>13</sup> in 1868, Japan became an industrialized country, military power, and colonizer in order to maintain sovereignty at a time when the United States and European powers were in essence dividing the world between them (Kako, 2002; Smith, 2005). Thus, the history of nursing and midwifery in Japan was “shaped by the nation’s imperial quest” and attempt to “become a modern, imperial nation by using the tools of the West to compete with and protect itself from western imperialism” (Smith, 2005, p. 14). Part of this quest involved a focus on women and women’s education, for example midwifery and nursing. Western midwifery was introduced and legislated, along with Western medicine, in the nineteenth century (Smith, 2005). Nursing was introduced at the same time but was not recognized as an occupation until 1900, at which time an actual nursing regulation was issued in Tokyo. In Japan, nursing is “still closely associated with western ideas about medicine” (Hendry & Martinez, 1991, p. 56; Izumi, 2006), but Western health care, although highly appreciated, is by no means the predominant, or sole choice made by those in need of care (Hendry & Martinez, 1991; Suzuki, 2004). A recent survey showed that over the previous 12 months, a higher percentage of Japanese had used complementary and alternative medicine compared to conventional Western medicine (76.0% versus 65.6%) (Suzuki, 2006).

Many of the roles that would often be associated with nursing in Europe and North America are carried out by the family members of the patient in Japan (Hendry & Martinez, 1991). These include attending to intimate bodily functions, provision of food, watching the patient’s progress, and being in charge of visitors, of whom there are many if the patient and his or her family and social circles abide by Japanese traditions. These customs have also been described by Ohnuki-Tierney (1997). The family member also maintains some resemblance of an “inside” space around the patient. In Japan there is still a strong separation between inside (clean) and outside (dirty) with regard to both people and places. A person’s family members, close friends and home, as well as his or her school

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<sup>13</sup> *Meiji* means “Era of Enlightened Rule.” It was the reign name the emperor took with the restoration of his power (Smith, 2005, p. 14).

or workspace, belong to the inside and are seen as clean, whereas strangers, the homes of strangers and other public buildings belong to the outside and are seen as dirty (Ohnuki-Tierney, 1997). The health of an individual is associated with his or her ability to keep clean, and illness itself is seen as polluting (Hendry & Martinez, 1991). Japanese nurses are thus affected by strong notions of: segregation between the close or known (inside and clean) and distant or foreign (outside and dirty); pollution; hygiene; and cleanliness. Japanese nurses are also affected by being equivalent to a stranger/outsider in relation to the patient, which according to social norms and conventions for some Japanese patients demands that the nurse maintain a certain respectful distance and not be overly personable or 'intimate' (Izumi et al., 2006). Further, Japanese nursing ethics, which are a reflection of Japanese culture and spirituality, differ, when examined, from Western nursing ethics. This has an impact on the ways in which nursing is provided and received. Izumi (2006), who conducted a study focusing on nursing ethics in Japan, writes that

Japanese nurses' ethical concerns are bound to the culture in which they practice. Through seeing and experiencing the consequences of an act in Japanese clinical settings, nurses learn what is good or bad or right or wrong in a situation. Nurses also admire western logic and technology (as do other Japanese professionals); however, what they admire and what they feel to be good and right in their actions are not the same. Although they admire imported ethics, they do not believe that it works in their clinical settings, in Japanese society, in Japanese culture, and in the treatment of Japanese patients. Therefore, Japanese nurses admire imported ethics but they use their own sense of what is right and good that they have gained through actual practice. (Izumi, 2006, p. 277)

Although Japan has seen a shift in societal norms and values, with gender roles becoming more flexible and women having more options in regards to professions (Kako, 2002; Ohnuki-Tierney, 1997; Smith, 2005), nursing continues to be a low status and gendered job in Japan; that is, it is considered a woman's job<sup>14</sup> (Kako, 2002; Kawasima & Petrini, 2004). This genderedness, is reflected in

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<sup>14</sup> Some authors argue that nursing, from the perspective of the Japanese patient, is no longer gendered (Izumi et al. 2006), but according to others (Kawashima & Petrini, 2004) the system does not reflect this reality. As opposed to India, Japan is a member of the ICN.

settings such as hospitals, where both nurses and doctors practice and the primary function of the nurse continues to be to serve the physician (Hendry & Martinez, 1991; Kako, 2002; Kawasima & Petrini, 2004).

While Western nursing was introduced to Japan by the Japanese themselves, Japanese nurses still perform in ways that are particular to Japan and hold “one standard for public display (*tatema*) and a second for actual work situations” (Izumi, 2006, p. 277). As many Japanese people do, Japanese nurses

accept imported concepts and keep them visible but secure, like a picture in a frame, but they do not take them out of the frame to use in real life situations. Their practice follows the customary values that reside in common sense in everyday life. (Izumi, 2006, p. 277)

Holden (1991) focuses on nursing in Uganda. She recounts that Uganda, along with other African countries, saw the colonial European nursing profession introduced in the early 20<sup>th</sup> century, although ‘serious training’ of Ugandan women in the nursing profession did not begin until the 1940s. This time lag in educating local women hinged on the fact that few educational opportunities existed for Ugandan women at the time; therefore, few possessed the educational requirements deemed necessary to start training as a nurse. Many women were not literate in their native language and spoke no English. Initially at the university hospital Mulago in Uganda’s capital, Kampala, Ugandan nurses were trained using male Ugandan nurses to translate the British nurses’ teachings. In addition to this training, and “in order to become good nurses,” Ugandan women were expected to separate “from their home background” and learn and appropriate the culture and moral universe of the colonists’ nurses (Holden, 1991, p. 72). This included avoiding male company, sexual activity, pregnancy, and becoming mothers or wives, all of which would be reason for dismissal if detected (Holden, 1991). As such, the Ugandan nursing students and nurses were required to move at least mentally, if not physically, into another country and culture when entering the realm of the health care system.

Beginning in the 1970s, a change in political and economic circumstances in Uganda with a subsequent breakdown of the health care system disallowed the

maintenance of the British nursing role as established. As a consequence, the personal and societal status of Ugandan nurses decreased significantly. Although the hospital and health care system crumbled around them and despite the fact that they were often not paid or paid wages that did not allow them a livelihood, the Ugandan nurses did their best to hold on to their role as a way to maintain their self-respect and status (Holden, 1991). Others write that since then a rebuilding of the health care system in Uganda has taken place (Nguyen et al., 2008; Okello et al., 1998). Today, according to some authors, nursing programs in Uganda seem more geared towards Ugandan conditions, and although they still need personnel, equipment and material, nurses are working as the backbone of the health care system, performing many of the roles that trained doctors and other staff carry out in other regions of the world, and doing so at local health care clinics where they are more accessible to local people than in hospital settings (Nguyen et al., 2008; Okello et al., 1998). Martin (2009) seems to disagree with this optimism. She describes nursing in Uganda as still highly affected by the poor economy of the country generally and of the health care system specifically, leaving nurses with few means to practice the way that they and their patients envision nursing in Uganda should be practiced. One Ugandan nurse explained the contradiction of her desire for her practice and her actual practice in the following way:

As a nurse, you want to see your patient recover and go away healthy. You have that spirit of nursing that she is almost your relative, and you want her to be your friend. So when she walks out, you feel so proud. And when she gives you that recognition, says ‘thank you, nurse’, and maybe gives you something like a gift, the motivation is high. That’s when you really enjoy your work. But most times you just find yourself in this place without the proper equipment, you cannot use your skills, you are improvising, even doing some bad, bad things because the wages are small. (cited in Martin, 2009, p. 1)

Although a widespread reform of the culture of nursing and nursing education may not have taken place in Japan or India or Uganda, the younger generation of nurses are redefining nursing to align with local conditions, cultures, and traditions (Kodama, cited in Hendry & Martinez, 1991; Somjee,

1991). This may or may not include ideas about healing and care as practiced by the local healers and midwives, who cared for (or nursed) these populations prior to the introduction of European nursing and who continue to care for the populations today. In Japan, as in Uganda, many nursing functions now take place at the local level, and may even be in the home of the patients. This allows the Japanese nurse to provide the holistic care that Japanese patients demand and integrate the Japanese notion of bodily imbalance as a cause for disease into the Western notion that diseases create symptoms that may be treated (Hendry & Martinez, 1991).

Using India, Uganda and Japan as examples, I have described how nursing was introduced as part of a colonial project in some countries, or a project used to demonstrate the country's modernity and maintain sovereignty, as was the case in Japan, in the early to mid 1900s, which is the time period when nursing was also introduced to the Arctic. While in the case of Japan its own leaders chose to introduce Western nursing, much of the implementation still resonates with the colonial situations I have described. I have discussed how colonial nursing, the way it is taught and practiced, and its place in an institutional and social hierarchy, has at times been in opposition to local social and cultural norms. I have also described how local nurses have integrated local norms and values into their practice, and how nursing practice has changed as local conditions have changed.

Reviewing nursing as it is practiced in countries that are not of European origin exemplifies some of the variation that may be found within the profession cross-culturally. Variations certainly exist between the ways in which nursing is practiced in various European countries also. I have not found literature that focuses on nursing as a 'cultured' profession within the context of European countries, however, or that in a local or national context describes the role of the nurse *per se*, or the experiences of nurses or nursing students in their role as nurses. While recognizing that differences exist and seeing this gap as another reason to pursue an anthropology of nursing, I still imagine that there might be more overlap between the role of a nurse in the European countries of Britain,

Sweden and Greece (all 'Western' countries) than would be the case between those countries and, for example, Japan, Uganda or India. Having this in mind I will, in the coming text, use the term *European nursing* and *European nursing role*, starting in the coming section where I examine the existing literature on Indigenous and Inuit nursing.

### ***1.3.4 Indigenous and Inuit nursing***

As observed by Schuster in Zaire, and as discussed in the context of India, Japan and Uganda, it is not a given that “young women recruited to nurse training programmes in [non-Western] countries fit into the Western cultural paradigm, either in terms of their own motivation to enter professional training, or in terms of their reception as nurses by their societies” (Schuster, as cited in Holden, 1991, p. 76). I would add that what may be defined as a European nursing role and model of care might generally be ill fitted to communities not of European origin. Asking how European nursing, as practiced in Southern Canada and Denmark, aligns with Arctic needs and notions of care might have been appropriate when developing the nursing programmes there. One nurse in Greenland lamented that the model for the nursing school in Greenland was based on already existing models in Denmark rather than attempting to find a Greenlandic model (T30).

The sentiment that an Inuit, or otherwise Indigenous, model of nursing might be different from one of Western origin reflects the conclusions drawn by many authors discussing nursing and nursing education among various Indigenous peoples. It should be noted, however, that Ruth Lange, in her recently published book, *Når en tanke bliver født: Sygeplejens og sundhedsuddannelsernes udvikling fra 1970-2004 (When a thought is born: The development of nursing and the health educations from 1970-2004)*, writes that prior to the establishment of the nursing programme, the intention of the Greenlandic chapter of the Danish nursing union was that nursing education in Greenland “should accommodate the society of Greenland” and make it possible “for Greenlandic patients to be served by Greenlandic nurses who spoke Greenlandic and were rooted in the Greenlandic culture” (Lange, 2010, p. 80).

Similar sentiments were expressed prior to the establishment of the nursing school in Nunavut (personal communication, Ruth Bainbridge, then Director of the Nunavut Arctic College Nursing Program, February 8<sup>th</sup>, 2008).

The experiences of Indigenous nurses and nursing students have not been discussed by anthropologists, although authors from other fields have done so (Alagalak & Barnebas, 2006; Curran et al., 2008; Dickerson & Neary, 1999; Dickerson, Neary & Hyche-Johnson, 2000; Goold & Liddle, 2005; Kjørgaard, 1998; Madsen, 2000; Martin & Kipling, 2006; Olesen & Karlsen, 1999; Petrak, 2008; Ryan, 1992; Steinfeldt, 1998; Usher et al., 2005; Weaver, 2001). The work of Goold and Liddle needs special mention. Both are Indigenous Australians. Liddle is a journalist and the chair of the *National Aboriginal Cultural Institute* in Australia and Goold a nurse with a PhD in nursing whom, among other posts, holds the directorship of the *Congress of Aboriginal Torres Strait Islander Nurses*. Their book is comprised of Aboriginal Australian nurses' stories and is a valuable contribution to the description of Indigenous nurses and their experiences in learning and practicing in colonial educational and health care systems.

Few have portrayed the experiences of Inuit nurses and those who have, have done so as part of a review of a nursing program (Curran et al., 2008) or college (Alagalak & Barnabas, 2006), through a report on issues of recruitment and retention of Inuit nurses (Aarluk Consulting, 2009), and lastly through the article series in the Danish nursing magazine that was spurred by Steinfeldt's (1998) research on Greenlandic nursing students (Kjørgaard, 1998; Madsen, 2000; Olesen & Karlsen, 1999). What the works on Indigenous, including Inuit, nurses and students have in common is that they describe Inuit nurses and students as somewhat culturally displaced within the systems in which they function.

Books, book chapters and some journal articles have also been published in which Southern nurses write or are interviewed about their experiences as nurses in the Arctic (e.g., Balle, 2006; Copeland, 1960; Rosing, 2007; Scott & Kaiser, 2002, 2005) or where the author has consulted archives in order to give a picture

of the lives of early Arctic nurses (e.g., Farrell, 2004; Helms, 1984; Rutherford, 2008)<sup>15</sup>. Many of the contributors to these works have focused on the novelty and exotic nature of their experiences and the cultural otherness they experienced in relation to the people and communities they cared for and lived in, with few detailing the systems in which they functioned or how their role as nurses fitted to the culture in which they were immersed (these few include Balle, 2006; Copeland, 1960; Helms, 1984; Rutherford, 2008). Finally, in the Greenlandic context the book *Sana*, which is about the national hospital and health care in Greenland, Ruth Lange and Lisa Ezekiassen (2004)<sup>16</sup> have written a short chapter that describes the history of the health educations in Greenland and, as mentioned above, Lange (2010), interspersed with her own experiences and involvement, describes how the nursing and health educations changed from 1970-2004. Also in *Sana* are two other contributions of particular interest. One is that of Therkildsen (2004) who, based on an interview, writes about the experiences of the Greenlander Elna Stigers. Stigers started as a nursing student in Denmark in 1949 and later had a long career as a nurse in Greenland. Another is Aase Nygaard (2004) who was born in Greenland of Danish parents, became a nurse in Denmark in 1965, and then worked in Greenland for more than 25 years in various positions. Stigers and Nygaard both relay their experiences as nurses in

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<sup>15</sup> Also of interest, although not focusing on nurses but rather on the Inuit support staff upon whom missionary doctors and nurses depended when practicing at St. Luke's Hospital in Pannirtuuq from 1930-1970, Emily Farrell and Meeka Alivaktuk presented a paper together at First Nations first thoughts, 30th Anniversary conference at the Centre of Canadian studies at the University of Edinburgh, Scotland on May 5, 2005 entitled "The work we have done: Relationship, investment and contribution: The Inuit workers of St. Luke's hospital, Pannirtuuq, 1930-1972" (Farrell & Alivaktuk, 2005).

<sup>16</sup> Ruth Lange who is of Danish descent arrived in Greenland as a 22 year old nurse in early 1970 and met her partner Storch Lange, who was of Greenlandic descent, later that same year. Lange was instrumental in establishing the nursing and health educations in Greenland, the home care nursing program in Greenland, and the Greenlandic nursing organization, all of which led to her being awarded the International Florence Nightingale medal in 2003. Lange became the director of the *Centre for Health Education* in 1993 and retired from the position in 2004. After her retirement she remained connected as an examiner for the nursing education and as a consultant for the development of basic health education and courses to upgrade the existing programs. Lisa Ezekiassen is the principal of the *School for Health Educations* under which all health education diplomas and certificates are offered. Before nursing became a university degree all health education diploma and degrees were offered through the *Centre for health Education*. She has also worked as a nursing teacher, as a nurse, and has been part of the development and upgrading of the basic health education courses (Ruth Lange, personal communication, April 27<sup>th</sup>, 2010).

Greenland with happiness. Although they worked long hours for little pay<sup>17</sup> they felt a strong sense of community between doctors, nurses, other health care workers, and the patients (Nygaard, 2004; Therkildsen, 2004). They do not relay any experiences of “cultural displacement” or differentiation between Inuit and Southern nurses, a fact that may be understood if seen in light of the social and political realities at the time, where Danes were “natural authorities” that were not questioned (Hans Holm, as cited in Bryld, 1998, p. 55; see also Berthelsen in Ulnits, 2000; Thisted, 2002).

It is not surprising that so little has been published about Inuit nurses, nursing students, Arctic nursing, and what it means to be an Inuit nurse, as the Arctic Nursing programs are still young and although the number has grown substantially over the last 10 years, there are still relatively few Inuit nurses. With this work I contribute to a body of literature on Inuit nursing and work towards what may be called an anthropology of nursing.

### ***1.3.5 Working towards an anthropology of nursing***

Through a discussion of what it means to be a nurse using the experiences of Inuit nurses as a lens, I contribute to a discussion of what nursing is and the forms it takes in different settings of our world, and particularly to a discussion of what nursing is in an Arctic context. This discussion is already underway: it has been taking place in Greenland for more than 25 years (Ruth Lange, personal communication, September, 2007), it was present in the establishment of the nursing education in Nunavut (personal communication, Ruth Bainbridge, then Director of the Nunavut Arctic College Nursing Program, February, 8<sup>th</sup>, 2008), and it seems to be germinating among the Inuit nurses in Nunavut. Through this work I also contribute toward developing *an anthropology of nursing* as a subcategory of the anthropology of health (or medical anthropology), which

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<sup>17</sup> When Stiegers and Nygaard worked in Greenland, something called “birthplace criteria” was in effect. This meant that anyone born in Greenland received less pay for the same job as someone born outside Greenland who had come there to work. The birthplace criteria was implemented in an attempt to attract Greenlanders who had moved abroad to come back to Greenland and work, but it meant that the paycheck of nurses born in Greenland (whether of Greenlandic or other descent) was significantly lower than that of nurses who were born outside Greenland (also those of Greenlandic descent) (Nygaard, 2004).

would then encompass the anthropology of medicine and nursing both, as suggested by Leininger (2001) and Chrisman (2001).

The focus of an anthropology of nursing should be on nursing as it is experienced and practiced by nurses and on how nursing is experienced and desired by those in need of nursing care locally, regionally, nationally and internationally, taking into account local narratives, cultures, ways and values. As such, an anthropology of nursing will help identify needs in relation to nursing education programs and the upgrading of nursing knowledge locally, regionally, nationally and internationally. This may help guide administrators in determining where to recruit staff and in thinking about how much and what kind of orientation or upgrading may be necessary for nurses hired from abroad.

Research into the nature of nursing should be carried out locally among nurses, as well as those in need of nursing, using anthropological research methods such as fieldwork with observation, participant observation, and interviewing of both nurses and patients. “A core conceptual feature of anthropology is that what is ‘rational’ is seen to be socially and culturally specific and valid in its local context” (Lambert & McKeivitt, 2002, p. 211). Anthropology recognizes that just as the knowledge and practice of lay people is locally variable so is the knowledge and practice of professionals (Lambert & McKeivitt, 2002), including nurses. This is an important point. Nursing, as defined by the International Council of Nurses [ICN],

encompasses autonomous and collaborative care of individuals of all ages, families, groups, and communities, sick or well and in all settings. Nursing includes the promotion of health, prevention of illness, and the care of ill, disabled, and dying people. Advocacy, promotion of a safe environment, research, participation in shaping health policy and in patient and health systems management, and education are also key nursing roles. (ICN, 2010b, para. 1)

In order to promote health, prevent illness and care for individuals, families, groups and communities, nurses draw on their theoretical and practical knowledge and the experience they have gained in their practice about what works best for the populations they serve. Simultaneously, they practice according to the forms of *capital* they possess that include culture, language and

education as well as the norms and laws of their field and according to the dictum of their *habitus*, in a Bourdieuan (1986) sense as discussed below. In its code of ethics, ICN stipulates that inherent in nursing:

is respect for human rights, including cultural rights, the right to life and choice, to dignity and to be treated with respect. Nursing care is respectful of and unrestricted by considerations of age, colour, creed, culture, disability or illness, gender, sexual orientation, nationality, politics, race or social status.... In providing care, the nurse promotes an environment in which the human rights, values, customs and spiritual beliefs of the individual, family and community are respected. (ICN, 2006, pp. 1-2)

In order for nurses to advocate for and respect the members of the communities they serve they need knowledge, not only about how their own and their patients' culture, *habitus*, language and education, values, customs, and spiritual beliefs, affect the clinical encounter and its outcome, but also about the "power relations that produce and shape sickness" (Lambert & McKevitt, 2002, p. 211). Power relations include those in society at large as well as those between health practitioners and patients and between various fields of health practitioners. Knowledge about power relations takes into account how these affect practice and patient outcome. In order to promote and educate about health and prevent illness and disease, nurses need to take into account culture, *habitus*, language, and education (their own as well as that of the individuals they serve). They also need to take into account the various pedagogies and educational technologies that work best where they practice, and in order to do so they need to have knowledge about what they are. Nursing educations today include courses such as communication, nursing history, cross-cultural nursing and various nursing courses that include anthropological and sociological theory and the examination of power-relations between health care providers and patients, all of which should pay attention to the knowledge nurses need as discussed above. It appears, however, that when nurses practice outside of their own culture, whether as caregivers or teachers, or care for individuals with a very different cultural background, their own culture and *habitus* will often direct the encounter – and often to the detriment of the patient (Barbee, 1993; Cekic, 2004, 2006; Hoff,

1994). Including research sprung from an anthropology of nursing in the education of nurses would be beneficial as it would demonstrate the need for nurses to know, and continue to learn, about themselves and their own background and history, as well as about the people they care for, and how both may affect the patient-caregiver encounter.

Using a combination of anthropological methods would help the researcher to distinguish between ‘normative statements’, ‘narrative reconstructions’ and ‘actual practices’. It would, in other words, help the researcher distinguish between what people say should be the case or their ideals about reality, their re-interpretations of what happened in the past, and what really happens (Lambert & McKevitt, 2001, p. 211). Even when interpreting interview data, an anthropology of nursing utilizing anthropological methods would be able to situate narrative information in the practical and personal context of the interviewee’s life.

Previous studies and popular accounts that compare nursing practices in different countries have been criticized for encouraging definitions of nursing, the nature of nursing and values relating to care as either Western or non-Western (Martin, 2009, p. 8). This is not the goal of an anthropology of nursing. Rather, an anthropology of nursing, by viewing nurses as agents in a local context, attempts to illuminate the ways in which they practice their profession locally, taking into account the historical, political, social and also cultural context of the individual, the profession and the society. With this in mind, the work of Martin (2009) and the authors contributing to Holden and Littlewood (1991) may be viewed as contributors to an anthropology of nursing. While giving voice to local nurses, these works consider nursing in the local, historical, political, social and cultural contexts and use anthropological theory to analyse and interpret their material. In chapter seven, I will return to an anthropology of nursing, how this dissertation works toward an anthropology of nursing, and how an anthropology of nursing might be further developed.

I have briefly described the history of nursing as a profession and discussed the European ancestry of the profession. I have discussed the scant literature that exists on nursing in a colonial context, and highlighted how nursing was

introduced in non-Western countries such as India, Japan and Uganda along with Western medicine, Western medical doctors and Western notions of culture, ways and values. In this, I have described how the Western hospitals in these countries may be seen as “microcosms” within the macrocosm of the country where nurses, while needing to function within the hospital milieu, also need to function or be able to perform according to the norms of the society in which the health care institution is immersed. I have highlighted the gap in the literature dealing with the experiences of Indigenous and Inuit nurses and suggested that this dissertation contributes to filling this gap, and will also contribute to an anthropology of nursing. Now I will discuss the practical rationale for carrying out this project beyond my own academic curiosity.

#### ***1.4 Arctic Nursing Matters***

Below I discuss some of the issues presented to me in my work as a nurse, teacher and researcher in Nunavut, in the Danish nursing journal *Sygeplejsken* (*The nurse*), and in media about Inuit and non-Inuit nurses and nursing in the Arctic which led to my desire to know more about Inuit nurses’ views and experiences in regards to being nurses and nursing students in the Arctic.

The health care systems in Greenland and Arctic Canada have experienced – and continue to experience – difficulties in recruiting and retaining health professionals, particularly nurses (Hogan, 2006; KNR, 2008b, 2008c; Roberts & Gerber, 2003). In order to address the shortage, nursing programs were established in Nuuk, Greenland in 1993 and in Iqaluit, Nunavut in 1999 to educate local nurses. Both programs have, however, themselves experienced recruitment and retention problems (personal communication, Ruth Bainbridge, then Director of the Nunavut Arctic College Nursing Program, February, 2008; Enoksen & Mozfeldt, 2006).

One factor influencing retention and recruitment may be the language of instruction, which is Danish in Greenland (Kjærgaard, 1998), and English in Nunavut (personal communication, Ruth Bainbridge, February, 2008). The

exclusively English instruction in Nunavut recently led an Inuk nursing student, who was interviewed during a review of Nunavut Arctic College, to say:

I learned Inuktitut terms for body parts and such when I was young but I am older now and I am losing it. ... I would like to be able to use my own language but there is no Inuktitut programming. I don't want to work with an interpreter later on but if this continues I will have to. (cited in Alagalak & Barabas, 2006, p. 18)

Language of instruction has also been an issue in Greenland. Greenlandic students have noted that differences in language between teachers whose mother tongue is Danish and students whose mother tongue is Greenlandic can create difficulties (Olesen & Karlsen, 1999).<sup>18</sup>

Another possible barrier to recruitment and retention is discrimination. Inuit students in both nursing programs have previously expressed feelings of being discriminated against in the programs and in the health care system in which they practice (Møller, 2005; Olesen & Karlsen, 1999). Indigenous nursing students elsewhere in Canada have previously voiced similar experiences (Ryan, 1992), as have nurses and students in America and Australia (Dickerson, et al., 2000; Dickerson & Neary, 1999; Gregory & Barsky, 2007; Usher et al, 2005; Weaver, 2001). From my own personal experience, I do not find this surprising. When I worked in Nunavut, I was confronted with several dichotomies in the health care system. One was that health care professionals were Euro-Canadians who spoke English as their mother tongue while community members were generally Inuit who spoke Inuktitut as their mother tongue. Another was that most health care professionals led lives that were quite different and separate from those of Inuit community members, and practically no socialising existed between the two. A

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<sup>18</sup> Recently there has been an increased focus on recruitment of Inuit nurses and nursing students, particularly in Nunavut, where Inuit compared to non-Inuit nurses and students have been a very small minority (Aarluuk, 2009; Gregory & Barsky, 2007). The information about the nursing education at the Nunavut Arctic College website can be found in Inuktitut, Inuinnaqtun, French and English, whereas information for the nursing programme at Ilisimatusarfik/University of Greenland is currently in Danish only. Despite this, the nursing programme in Nuuk saw more applicants for the 2010 fall start of the programme than any other year, with all seats being filled and even an initial waiting list (personal communication Suzanne Møller, chair of the Institute for Nursing and Health Research, University of Greenland, September 6, 2010). Both programmes also advertise in local newspapers, radio, and TV, in Danish/English and Inuktitut/Greenlandic, and the Greenlandic nursing union recently elected their first Greenlandic union leader (Pedersen, 2010).

third was that sometimes the attitude of health care givers towards Inuit patients presented a barrier to communication and understanding (Møller, 2005, 2010).

These dichotomies have previously been noted in what is now the Kivalliq region in Nunavut<sup>19</sup> (O’Neil, 1989a). They have also been noted by Indigenous nursing students and nurses elsewhere in Canada, Australia and America (Bond, 2005; Gregory & Barsky, 2007; Ryan, 1992; Usher et al., 2005; Weaver, 2001), and by those working in Greenland (personal communication, Gert Mulvad, District MD in Nuuk, June 16<sup>th</sup>, 2006). While competing educational opportunities exist in both places that may affect recruitment, experiences in the nursing program and in the health care system, such as those outlined above, may contribute to discouraging Inuit from applying to the nursing programs or diminish their desire to persist in the education.<sup>20</sup> I will address these issues further in chapters 5, 6 and 7.

Recruitment problems aside, while the schools were established in order to have local Inuit nurses who would care for local Inuit, it is uncertain whether Inuit nurses educated in a Southern model will practice differently than imported nurses. Chelsea Bond, an Indigenous nurse educated in Australia, noted that the ways she learned to provide public health programming in the Australian (and Western) nursing program, were, in her experience, ill-fitted to the needs of Australia’s Indigenous population (Bond, 2005). In another Aboriginal context, First Nations people educated as teachers have stated that because they were educated in a Western educational system they felt unable to educate their First Nations students in ways that matched the students’ needs, although they

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<sup>19</sup> O’Neil (1989a) did research in the former Keewatin region of the Northwest Territories, which is now the Kivalliq region in Nunavut.

<sup>20</sup> While drawing on his experiences in Algeria, the post-colonial thinker Frantz Fanon (1925-61) theorises that a colonized people will see the Indigenous doctor to be a “link in the colonialist network” and in the camp of the oppressor (Fanon, 1965, p. 131). He further theorises that the Indigenous doctor him or herself will identify with the ways of the colonizer at the expense of Indigenous ways and thinking, which may, if not alienate the Indigenous doctor from his or her people, make the meeting between them fraught with difficulty (Fanon, 1965). It is not difficult to imagine that in addition to language differences and discrimination, this may also contribute to deterring students or nurses from continuing in the field, or prospective students from entering. Two of the First Nations students in health educations interviewed for the pilot project preceding this dissertation (Møller, 2007b) both expressed experiences of alienation from their home-communities, with some of their peers resenting their having moved away and become educated, criticizing the students for harbouring feelings of superiority.

intuitively sensed that the methods they used were not very successful (Graham, 2005). Nelson-Barber and Dull (1998) make the same point in the context of teaching Alaskan Yup'ik students and Hansen (2007) suggests that many Greenlandic Inuit students today intuitively feel that there is something wrong with the way they are taught, although they may not be able to express what it is.

A compounding factor to recruitment and retention difficulties is that the current small population base, low high school graduation rate, and competing possibilities for post secondary education that exist in Greenland, which are similar in Nunavut, make it unlikely that these regions will be able to educate enough local nurses to meet the need in the near future (Præst, Jokumsen & Zober, 2002). Therefore, imported nurses who are not Inuit will continue to be needed in the Arctic health care systems. This necessitates that the barriers to optimal collaboration between local and foreign health professionals, educators, and patients be understood, and by illuminating the experiences of Inuit nurses and nursing students I shed light on these barriers.

Recruitment and retention difficulties and the other issues described above led me to believe that there would be great value in understanding who Inuit nurses and nursing students are, and what their experiences are being educated and practising in Western systems. The questions that have guided the research, then, are presented in the next section.

### ***1.5 Who Are the Inuit Nurses and What Do They Think?***

The questions guiding this research are:

1. What are the personal and background characteristics of the Canadian Inuit and Greenlanders who are, or have been, nursing students and nurses?
2. How do Canadian Inuit and Greenlanders who are, or who have been, nursing students and nurses describe the pedagogy, ontology and epistemology of their place of education and practice?
3. How do Canadian Inuit and Greenlanders who are, or have been, nursing students and nurses experience and negotiate their role and practice in Western education and health care systems?

Already in the beginning phases of fieldwork, which I started in Greenland, I realised that including two different regions in the field would give me answers to questions I had not posed, but which were nonetheless valuable – these being comparative questions. I entered the project with the notion that the two different Arctic regions, although geographically separate, comprised one field. While I know that Arctic Canada and Greenland have both historical and current differences, and that intra-regional differences also exist, I believed that the similarities in the experiences of Canadian and Greenlandic Inuit nurses and nursing students would be greater than the differences. I do think this study shows that they are. In this work, however, I also highlight differences in experiences and ideas between Greenlandic and Canadian Inuit nurses and students that I find significant, and which I connect with both historical and current differences between the two regions.

These differences include the timeframe during which the colonization of the regions took place, when Greenlanders and Canadian Inuit were introduced to Southern schooling, Southern health care, and nursing, the politics that governed these processes, and how they took place. Other differences include the economic base of the regions historically and today, the degree to which the colonizers and Inuit have mixed, and the degree to which they have an educated workforce, including health professionals.

Arctic Canada and Greenland are similar in that both cover vast Arctic areas and have very small populations, they both have limited and very expensive infrastructure with travel mainly by air as towns and settlements are not connected by roads, they are both inhabited by about 85% Inuit, of whom 85% speak an Inuit language, and they have both been colonized by people of European descent. Other similarities include that although Greenland and Nunavut today have forms of self-government,<sup>21</sup> their health care and educational systems are versions of those used by the previous colonizing countries, Canada and Denmark, and are staffed mainly by Danes and EuroCanadians, the vast

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<sup>21</sup> Although Nunavut has a public government in which all residents of Nunavut can participate, "Nunavut is primarily about Inuit needs and Inuit approaches to governance" (Hicks and White, 2000, p. 30)

majority of whom are not permanent residents of Greenland or Nunavut. The theoretical frameworks that have guided and helped me in the analysis of the material as a whole are the focus of the next section.

### ***1.6 Theoretical Frameworks***

As stated in the opening chapter, I assumed that the experiences of nurses and students would generate a theoretical stance that would include a discussion of the process of decolonisation and cultural and linguistic revitalization or reinvention. As also noted, ethnographic work rarely reveals that which the ethnographer initially assumes. Knowing this, I did not enter the field with a set notion of a theoretical framework. Rather I allowed the framework to emerge as the research unfolded, as had happened in my master's work (Møller, 2005). In this section I describe the frameworks that have guided my analysis and writing.

Although I at times found it challenging to not look for what I to some degree expected, the framework I have employed in this work has emerged during the fieldwork, and even more so in the pauses in between and after: during transcribing, considering and analysing notes and interviews, preparing and presenting conference papers based on preliminary findings, and in discussions with Inuit nurses and others that followed these presentations, both in person and online. As stated by Bernard (1995), "the way social science really works much of the time is that you don't predict results, you 'postdict' them" (p. 48). In other words, the theoretical frameworks that seemed appropriate to employ for my interpretation became apparent very slowly, and were based on the data I gathered, some of which contradicted my assumptions, and the analytical process in which I engaged.

Through the process emerged what may simplistically be described as two general systems of thinking and actions, one that was Southern and one that was Inuit.<sup>22</sup> Although the Southern system was the one given most credence in the

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<sup>22</sup> I say simplistically because, as would be the case in any setting, there are great variation among Inuit and Qallunaat ways and thinking, as will also be discussed in this dissertation, and which basically all Inuit nurses and students underlined. However, Inuit nurses and students also

educational and health care systems in the Arctic, both systems appeared to have the ability to help and hinder the agent in his or her practice depending on where the agent was situated. The statement “you need to be double cultured to function here” with everything that double-culturedness implies, was reiterated in many different ways by many nurses and students. This led me in my analysis of the material to understanding both systems as ‘giving access to’, which brought Bourdieu’s (1986) forms of *capital* to mind.

While Bourdieu (1986) draws on the French bourgeoisie and what may be seen as *capital* in this context, I believe the concept is also useful as a descriptor of, and when analysing, the ‘benefits’ afforded non-Western, or in this work Inuit, peoples, by their cultures, languages, education and *habitus* when negotiating their family, social, educational and professional environments. I am cognizant of the fact that using the concept of *capital* for the cultural, linguistic, and other characteristics or abilities of a people may be seen as objectifying and in opposition to an anti-colonial research approach. I want to strongly underline that objectification is by no means my intent. I also want to stress that, rather than a means to objectify, I use the concept *capital* as a means to demonstrate a colonialism that in Paine’s words is “non-demonstrative”, a colonialism that is based on two “illegitimate positions; the colonizers are illegitimately privileged, whereas the colonized are illegitimately devalued” (Paine, 1977a, p. 3). As does Bourdieu, I equate *capital* with power (Bourdieu, 1986, p. 2), and find the concept helpful in analysing the ways in which colonial or Southern ways and values have superseded and continue to supersede those of Inuit in health care generally, and nursing specifically, affording Southern health care staff more ‘power’, as it were, than Inuit.

Thus the overarching theoretical framework for this dissertation is based on my belief that Inuit nurses and nursing students possess several forms of *capital*, as conceptualised by Bourdieu (1986). Not all the people with whom they interact in the educational system and in their practice possess all the same forms of

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described ways and thinking that they perceived to be generally representative of Qallunaat and others that they perceived to be generally representative of Inuit.

*capital*. These differences create areas of tension within the field of nursing and between different agents in the health care and educational systems, of which the Inuit nurses and students are but one group.

*Capital*, according to Bourdieu (1986), comes in three forms, *economic*, *cultural*, and *social*. *Economic capital* can be directly converted into money and can be institutionalised as property rights. While *economic capital* is not unimportant for the ways in which particular societies function and for the ways in which their populations coexist, economy has not been among the most salient features in the experiences of the Inuit nurses and students in their education and practice and will not be given as much attention as *cultural* and *social capital*. *Cultural capital* (of which *linguistic capital* is a part) and *social capital* are the forms of *capital* that are of particular concern to my analysis. In interviews, conversations, and observations, as well as during data analysis, it was apparent that it is experiences in these areas that have the greatest impact for Inuit nurses and students on their road to becoming practicing nurses and in their practice once they have reached the end of that road.

*Cultural capital* also exists in three forms in, an *embodied*, an *objectified*, and an *institutionalised state*. In the *embodied state* *cultural capital* takes “the form of long lasting dispositions of the mind and body” (as *habitus*) (Bourdieu, 1986, p. 2). Bourdieu (2000) describes *habitus* as the generative encompassing concept that expresses an individual’s lifestyle and his or her total set of personal choices, benefits and practices. An individual’s *habitus* are the principles that govern how that agent views and classifies the world, as well as what she or he perceives as good or bad, tasteful or tasteless, right or wrong, and fine or vulgar, and thus determines how she or he acts and practices. In the *objectified state*, *cultural capital* can be found “in the form of cultural goods (pictures, books, dictionaries, instruments, machines, etc)” and in the *institutionalized state capital* can be found for example “in the form of educational qualifications” (Bourdieu, 1986, p. 2).

“*Social Capital* [is] made up of social obligations (‘connections’)” (Bourdieu, 1986, p. 2). It is the “aggregate of the actual or potential resources

which are linked to possession of a durable network of more or less institutionalized relationships of mutual acquaintance and recognition... to membership in a group” (Bourdieu, 1986, p. 6). The particular fields of practice of groups or professions such as lawyers, various academic specialties, doctors and also nurses may be understood as *fields* in Bourdieu’s (1990) sense. *Fields*, as envisioned by Bourdieu, are “historically constituted areas of activity with their specific institutions and their own laws of functioning” (Bourdieu, 1990b, p. 87), as well as “concrete social situations governed by a set of objective relations” (Bourdieu, as cited in Johnson, 1993, p. 6). Fields constituting social formations are individually structured, have their own space, are governed by their own laws and are “relatively autonomous but structurally homologous with the others” (Bourdieu, as cited in Johnson, 1993, p. 6). Agents, Bourdieu contends, act within these fields, rather than in a vacuum.

As mentioned above, is it mainly cultural and social *capital* that I will concern myself with in this work, as experiences in these areas have been most salient for Inuit nurses and students. In order to earn a nursing degree, Inuit, as do Southerners, need to earn a high school diploma with grades that allow them to even enter a nursing education. Degrees and diplomas are both *institutionalised cultural capital*. In order to obtain that level of education and earn that degree Inuit need a certain level of *linguistic capital*. They need to be able to speak, read, and write a Southern language well enough to excel in educational systems that employ many teachers who speak only a Southern language, and where most textbooks are written solely in Southern languages. In terms of *objectified cultural capital* as it relates to the health care educations and systems, Inuit are disfavoured compared to Southern nurses, since medical and nursing textbooks, as well as instructions on wards and other official texts, are written in languages other than Inuktitut/Greenlandic; this again requires particular *linguistic capital*. Apart from the *linguistic capital*, they also need the *embodied cultural capital* that will allow them to excel in educational institutions where the structure, pedagogy, values, and ways of being are mainly Southern, and in order to understand and best service Inuit patients, they need the *embodied cultural*

*capital* that allows them to understand their Inuit patients' embodied ways of acting and communicating, and to act and communicate in ways that their patients understand.

In order to be able to practice as nurses and stay in the nursing field Inuit also need *social capital*. They need to recognize themselves as nurses, and be recognised and accepted as nurses by other nurses, by the institutions that authorise them, the institutions that hire them and the other professions and agents working in those institutions. They need to be seen as playing and being willing to '*play the game*' (Bourdieu, 1990) so to speak, of the nursing field, as well as of the broader organization at their place of practice.

Bourdieu's concepts of *capital*, *habitus* and *field* are not encompassing enough in themselves as a framework, however. While Bourdieu provides the rough structure, other theorists serve to strengthen and support the framework and in places refine it. As noted above when discussing *capital*, Bourdieu (1986) draws on the French bourgeoisie and what may be seen as *capital* in that context; I use the concept more broadly to include the *economic*, *cultural* and *social capital* in any form of any people that would serve said people best in their aspirations at the family, community, and societal levels, nationally and internationally, including their aspirations in both private and public spheres, in their pursuit of healthy, individual, social, educated and working lives. I want to note that while individuals, groups, *fields*, communities, and institutions may valorize particular *capital*, as I will demonstrate, I do not.

In order to expand on Bourdieu's *cultural capital*, I find support in Jenkins' (1996) ideas of identity and selfhood and also heed the critique he offers to Bourdieu's *habitus*. What Jenkins finds particularly problematic is that Bourdieu appears to leave agents in their habitus, unable to change or make choices. Bourdieu explains this unchangeability as durability (Bourdieu, 1993, 2009): "The *habitus* is the result of a long process of inculcation, beginning early in childhood... the dispositions represented by the habitus are 'durable' in that they last throughout an agent's lifetime" (Bourdieu 1993, p. 5; see also Bourdieu, 2009 [1972], pp. 79-80). This belief in the lack of an agent's ability to make different

Each agent wittingly or unwittingly, willy nilly, is a producer and reproducer of objective meaning. Because his actions and works are the product of a *modus operandi* of which he is not the producer, they contain an “objective intention”... which always outruns his conscious intentions.... It is because subjects do not know what they are doing that what they do has more meaning than they know. (p. 79)

The supposedly unchangeable nature of *habitus* would be problematic in light of the generally accepted idea that both culture and identity are plastic concepts (Hastrup, 1986). I note, however, that Bourdieu (1993, 1997 [2000]) in his later works espouses that individuals may *develop* a certain “feel for the game” when engaged in a field, and that part of this “feel” is an expression of *habitus*. He allows that “*habitus* changes constantly in response to new circumstances” (Bourdieu, 2000, p. 161), although he also notes that this change is never radical because the changes are based on “the premises established in the previous state” (Bourdieu, 2000, p. 161).

Inuit nurses and nursing students differentiate themselves from other nurses and other Inuit in multiple and varied ways. The differentiation is ontological in nature; it relates to ways of being in the world. Ways of being in the world include how we move in the world, how we carry ourselves and our bodies, our gestures and how we act, and which actions we do or do not find acceptable. These ways are all included in Bourdieu’s definition of *habitus* as embodied cultural *capital*, but our ways of being in the world also include the ways in which we relate to health and disease and the ways in which we communicate and relate to other human beings, including colleagues, patients and their kin. Further, it relates to how we teach, how we prefer to learn, and how we relate to the people whom we teach or are being taught by. These are other areas where Inuit nurses and nursing students differentiate themselves from non-Inuit nurses or from other Inuit.

In order to address these points I borrow from Lave and Wenger (1991) who were inspired by Bourdieu and his concepts of field and *habitus*, and his emphasis on the “integration in practice of agent, world and activity” (Lave and Wenger, 1991, p. 50) to conceptualise situated learning or *legitimate peripheral participation* [LPP] as a “descriptor of engagement in social practice that entails

learning as an integral constituent” (Lave & Wenger, 1991, p. 33). Through LPP agents situated in the social world form identities, and through participation, “absorbing and being absorbed in the culture of practice” (Lave & Wenger, 1991, p. 95), they evolve from novice to full membership in the communities of practice. In this process, the agent also learns who other members of the community are, what (and how) they do and do not do, as well as who people who are not members are, what they do and do not do, and how they interact with the community of practice. Simultaneously the agent also influences the community, which is as ever evolving as the agent him or her self. I believe that a person’s *habitus* is what enables him or her to enter a field or community of practice, be successful in making the culture of practice his or her own, and engage in the process of going from novice to full member. The person’s *habitus* is in part what allows him or her access to a particular field or group, that which gives him or her access to *social capital* as conceptualised by Bourdieu (1986).

While Jenkins offers a critique of the idea that *habitus* is stable, he applauds Bourdieu’s identification of “the thoughtlessness of habit as a factor enabling individuals to go about their daily lives without having to consider every move they make” (1992, p. 98), the dual ability of *habitus* to be applied collectively as well as individually, and the idea that *habitus* is part of our identities. Jenkins writes about identity as a social construct that simultaneously allows us to be different from and be similar to, and that is a continuous process; our identity, or who we are, is both singular and plural and always ‘becoming.’

Hastrup has previously discussed the idea that our identity is in a continuous state of becoming, although she has done so in relation to the position anthropologists assume during field work – learning, and incorporating new understandings, ways and values which ultimately impact identity (Hastrup, 1986, 2004). As Jenkins does, and with which I believe Hastrup would agree, I suggest that our identities are never ‘finished’; they are matters of meaning and “meanings are always the outcome of agreement or disagreement, always a matter of convention and innovation, always to some extent shared, always to some extent negotiable” (Jenkins, 1996, p. 4). So it is with the identity of Inuit

nurses and nursing students. Some Inuit nurses and nursing students are of mixed heritage and some are not, and although they all self-identify as Inuit and through their becoming and practicing as nurses identify with the nursing role, they also to some degree differentiate themselves from Southern nurses and from other Inuit, but they do not appear to be in doubt or conflict about who they are or encounter the sort of identity conflicts experienced by some other Indigenous people who have been affected by colonization and colonialism (Battiste & Henderson, 2000; Csonka & Schweitzer, 2004; Henderson, 2000; Lavallee & Poole, 2010; Olofsson, 2004; Smith, 1999; Taylor, 1997). On the contrary – Inuit nurses and nursing students appear to have a strong sense of self.

A part of *cultural capital* that Bourdieu leaves out but which I think is important, is *history*. Historical *capital* includes an individual's knowledge of his or her own family history and the history of his or her people, community, society, where they come from, where they are and how they got there, and how their history relates to the histories of the peoples with whom they interact. This leads me to the histories of colonialism in the Arctic.

As are other Inuit in Greenland and Arctic Canada, Inuit nurses and students are affected by the regions' histories of colonization and colonialism. This is evident not only in the colonial “spirit” of Arctic educational and health care systems, and in their tendency to cater to Southern languages, cultures and habitus, but also in that some Southern health care practitioners preserve a colonial attitude that creates obstacles for the provision of optimal care to Inuit clients, and barriers to equality in workload and professional demands on Inuit and Southern health care practitioners.

Like some Indigenous authors (see, for example, Smith, 1999), I believe that few colonized countries or areas that still have a heavy presence of, and are influenced by, the previous colonizers (like Greenland and Nunavut), can in fact be called post-colonial. The Aboriginal Australian woman Bobbi Sykes articulated it clearly when she, at an academic conference on post-colonialism, stated: “What? Post-colonialism? Have they left?” (cited in Smith, 1999, p. 24). The term ‘post-colonial’ is defined in the Canadian Oxford Dictionary as

“occurring or existing after the end of Colonial rule” (Barber, 2004, p. 1212). I believe that the Arctic, despite Southern countries having officially released their colonial hold, is still to varying degrees under colonial rule. Yew (2002), drawing on several post-colonial scholars, might call this neo-colonialism. He suggest the term to mean “an indirect form of control through economic and cultural dependence” (para. 1), where people native to the area are involved in the perpetuation of the politics, culture, and values of the previously colonizing powers. The Canadian Oxford Dictionary defines neo-colonial as “the use of economic, political or other pressures to control or influence other countries especially former dependencies” (Barber, 2004, p. 1041). Leaning towards Yew’s (2002) definition of neo-colonialism and including Paine’s (1977a) definition of what he calls *welfare colonialism*, I prefer to call that which exists in Nunavut and Greenland *continuing colonialism* and see this as a *colonialism* that indirectly, through government institutions which perpetuate colonial values, language and culture, maintain economic and cultural dependence, and under which people native to the area are also involved in the perpetuation of the politics, culture, and values of the previously colonizing powers, although not necessarily consciously supporting the previous colonizers or their continuous domination.

As opposed to the experiences presented by authors such as Fanon (1965, 1963), Ngugi wa Thiong’o (1986) and Said (1989, 2003 ) the colonial experience of Inuit has not generally been overtly violent,<sup>23</sup> and the Inuit response to experiences of colonization as well as ‘post-colonialism,’ as it were, has been dissimilar to those in African and many other nations. Still the socio-cultural *effects* of colonization share many similarities, whether the colonial encounter has

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<sup>23</sup> Writing that the colonial experience of Inuit has not generally been violent, I recognize that boarding school and other educational experiences both within and away from the Arctic have for many been violent (Anawak, 2009; Qikiqtani Truth Commission 2010; Bryld, 1998 ), as have experiences of relocations, whether for reasons of Inuit health and wellbeing (e.g., for TB treatment, treatment of mental illness or due to physical and mental handicap) (Grygier, 1994; Jensen, 2010) adoptions (se for example the collection of articles by Tine Bryld (2010) in the journal *Social Kritik* (Social critique) #123) or in the name of sovereignty (Arke, 2003; Grygier, 1994; Qikiqtani Inuit Association, 2010; Tester & Kulchyski, 1994), and experiences of the RCMP shooting Inuit sled dogs (Qikiqtani Truth Commission, 2010; Tester, 2010).

been overtly violent or not, and regardless of where the previous colony is located. I find inspiration in the words of Dennis Walder (1998) who, in his discussion of when, where, how, and if, the term post-colonial should be used at all, writes that

‘post-colonial’ carries an unignorable historical weight which, if thought about coherently in relation to a particular cultural-geographic time and space, can help develop an appropriate – but not appropriating – sense of the themes, issues and values with which the literary texts of those areas are concerned. (p. 190)

I think this approach holds true not just for literary texts but also for speech (and I would include other non-verbal forms of communication) as proposed by Ricoeur (2001).<sup>24</sup>

Scholars who did research in nursing and health among Indigenous populations in Canada evaluated the relevance of post-colonial theory in this endeavour (Browne, Smye & Varcoe, 2005). Drawing on post-colonial thinkers from various disciplines, the authors echo Walder’s position, stating that post-colonial theory converge on the need to

revisit, remember, and ‘interrogate’ the colonial past and its aftermath in today’s context; the need to critically analyze the experience of colonialism and their current manifestations; the need to deliberately decentre dominant culture so that the perspectives of those who have been marginalized become starting points for knowledge construction; and the need to expand our understanding of how conceptualizations of race, racialization and culture are constructed within particular historical and current neocolonial contexts. (Browne, Smye & Varcoe, 2005, p. 20)

Simultaneously, however, they caution that some Indigenous scholars object to the term post-colonial as it presupposes that colonialism is over while in fact both the “institutions and the legacy of colonialism have remained” (Smith, 1999, p. 98). Browne, Smye and Varcoe (2005) are also aware that post-colonial theory may be seen as an imposition of “Eurocentric theory onto

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<sup>24</sup> Ricoeur (2001) argues in *Tekstmodellen: Meningsfuld handling betragtet som tekst*, that the action that he perceives language to be can be analysed as text. I discuss this further in section 4.1.3

issues of importance” to Indigenous peoples (p. 22) and that the use of post-colonial theory may maintain a binary of difference between the colonizer and the colonized which precludes the ‘complexities and ambiguities’ of social categories, identity, and agency, among both. These and other concerns about post-colonialism have been extensively addressed by authors such as Ashcroft, Griffiths and Tiffin (1998), who are also mentioned by Browne, Smye and Varcoe (2005).

I have chosen Bourdieu’s concepts of *capital*, *field* and *habitus*, as the overarching theoretical framework, believing that these concepts help explicate the power, cultural and social relations (Anderson, Kirkham, Browne, Lynham, 2007) that Inuit nurses and students are engaged in and affected by, as well as the forces that shape these relations. I recognize that colonialism is one of these forces. Therefore, though mindful of the critiques of post-colonialism, I also look to postcolonial theory to complement the Bourdieuian framework. Thus, in my analysis I find inspiration in Foucault’s discussion of power, particularly *bio-power* (1995), and Said’s (1989, 2003) discussions of Othering and Western cultural domination.

To sum up, in my analysis of Inuit nurses’ and students’ experiences, I have used Bourdieu’s concepts of *capital* (1986), *habitus* (2000) and *field* (1990, 1993) with Jenkins’ (1996) ideas of identity and selfhood. I have also found inspiration in Lave and Wenger’ (1991) *legitimate peripheral participation*. Lastly, recognizing that the experiences of Inuit nurses and students are wrapped in a history of colonization and continuing colonialism, I attend to the writing of Foucault (1995), Ngugi (1986), Said (1989, 2003) and others.

Having presented the dissertation and its genesis, myself, the field of the dissertation, the historical background of the field relevant to this dissertation, and the theoretical framework, I provide a review of the structure of the main part of the dissertation next.

### ***1.7 Structure of the Dissertation***

In chapter two I describe the field(s) where this research has taken place.

Although for this work I consider the regions of Nunavut and Greenland as one field, I will for ease of overview describe the geography, demography, and socioeconomic makeup of the regions individually. I will also review the history of colonization and path towards self-determination of each region individually, and in the last part of this section on the field, I will describe the history of health care and nursing in both regions. This chapter provides background information that is needed in order to understand the context of this research.

After describing the field I include an account of how I gained access to the field. This I do in chapter three. In chapter three I also situate myself as a researcher, including what it means to carry out research in two previously colonized areas as a person representing one of the previously colonizing powers myself, while claiming to use a decolonizing framework, not being able to speak the languages that participants in this research call their mother tongue, and sharing English as a second language with participants in Nunavut. Having thus given a field background, given an account of how I gained access to the field and situated myself in relation to the field, I provide a general picture of the Inuit nurses and students practicing in Greenland and Nunavut and the demographic and socio-economic conditions under which they live. Lastly in chapter three, I provide a description of the methods I have employed in carrying out this research. These have included observation, participant observation, formal interviews, informal conversation both in public and social situations, and the reading of documents – including newspaper stories and the printed and online debate these have elicited.

Chapters two and three may be seen as a general review of the practical and ethical considerations of the research as well as a description of the field, field methods and participants. This gives a background for chapters four to six, which discuss the major findings of the research. Findings are divided into three overarching themes of *social* and *cultural capital* as ‘determinants of success’ for Arctic nurses, namely language, education, and identity.

Language is considered in terms of language differences and the acquisition and mastering of both the Southern and Inuit languages and the health care language. Participants' vocabulary and terminology have been pivotal when discussing nurses' and students' educational and professional experiences. Therefore, as an introduction to the findings of this ethnographic study, I start with a discussion of Inuit nurses' and nursing students' experiences in relation to language in chapter four. Chapter four includes discussions on differences in meaning making despite speaking the same language, the importance of mastering and understanding body language, the ways in which language is connected to identity, and how the use of more than one language affects health care and education.

In chapter five I discuss education in relation to *social* and *cultural capital* as 'determinants of success'. This includes a discussion of which forms *educational capital*, as conceptualised by Bourdieu (1986), takes for Inuit nurses and students, what it is that allows Inuit nurses and students access to this *capital*, and the challenges and successes they have encountered based on differences in *capital* between themselves, other Inuit in the educational system, and Southern educators and colleagues in the health care system. First, I examine the experiences of nurses and students in the realm of the public educational system and then introduce the nurses and students and what characterises them as a group, before I describe their experiences as nursing students and becoming members of the community of practice of nursing. Lastly, I explore the ways in which nursing students and practicing nurses use teaching in their role as teachers of their peers and teachers of the patients in their care. This takes me to a discussion of differences in learning preferences and how these are connected to sense of self and identity.

In chapter six the focus is identity in relation to nurses' and students' *social* and *cultural capital* as 'determinants of success.' In order to give some context for the ensuing discussion on identity, and how sense of self and identity affect Inuit nurses in their learning and practice, I start chapter six with a general discussion of the concept of identity and continue with a brief discussion of how

colonisation has affected identity in the Arctic, then I discuss Inuit identity as it is described in current literature and how sense of self and identity affect health. This leads me to a discussion on Inuit concepts of the body, health and disease as described in the current literature and the ways in which these are connected to identity, which carries over to Inuit nurses' and students' reflection on Inuit identity. Hereafter, I consider the ways in which nurses and students characterise themselves in relation to the general description of Inuit identity markers. This is followed by a reflection on Arctic health care and the working conditions and environments that are particular for Inuit nurses and students studying and practicing in Arctic settings. The final two parts of chapter six deliberate on how Inuit nurses see themselves as similar to, and different from, Southern nurses and what it is that characterises Inuit nurses and the ways in which they nurse or provide care.

Chapter seven pulls together and analyses the information provided in chapters four, five and six. I argue that continuing colonialism is what frames the experiences of Inuit nurses and students. I use Bourdieu's three-step analysis of a field (Bourdieu & Wacquant, 1992) to demonstrate how the experiences of Inuit nurses and students are thus framed. This leads to a conclusion and recommendations, which I provide in chapter 8.

Chapter 8 closes the dissertation. First, I discuss the ways in which this dissertation contributes to an anthropology of nursing and the ways in which future work may be framed to do so. Second, I discuss the implications of the findings of the work for the Arctic nursing programmes and nurses, and recommendations for ways in which Inuit nurses, students, and nursing may be promoted and supported in order for Inuit health care recipients to reap the most benefit of the care they receive in Arctic health care settings. This includes increasing the draw for Inuit to enter and complete the nursing education and the incentive for Inuit to stay in the vocation once they have graduated.

## 2. The Field

I consider the regions of Nunavut and Greenland as one field, but for ease of overview I describe the geography, demography, and socioeconomic makeup of the regions individually. I also review the history of colonization and path towards self-determination of each region individually, and in the last part of this section on the field, I describe the history of health care and nursing in both regions. This chapter provides background information that is needed in order to understand the context of this research.

### *2.1 Inuit Homelands*

#### *2.1.1 Nunavut*

Nunavut covers a very large area (1,900,000 km<sup>2</sup>), much of which is situated above the Arctic Circle, although most of the population live just below. Nunavut is comprised of many large and smaller islands plus a large area of mainland North America. Most communities in Nunavut are located in coastal areas, giving access to ocean fishing, the hunting of sea mammals, and travel on the sea ice.

In 2006 Nunavut had a population of 29,325 (Statistics Canada [StatsCan], 2006a), of which 24,915 (approximately 85%) self-identified as Inuit and 20,200 (approximately 80%) of these as Inuktitut speakers. About 4,410 residents are non-Inuit (StatsCan, 2006b). The people of Nunavut live in 28 communities ranging in size from Iqaluit (the capital), with almost 7000 people, to Bathurst Inlet with only 25 inhabitants. Nunavut is divided into three regions: the Kitikmeot, Kivalliq and Qikiqtaaluk regions. The latter is often referred to as the Baffin region in government publications (Government of Nunavut, 2008). The Kitikmeot is the westernmost and smallest region with only 5,361 inhabitants (18 % of Nunavut's population), with Cambridge Bay or Iqaluktuttiaq as its regional centre. The Kivalliq region is the middle region both geographically and with respect to population, with 8,348 inhabitants (28% of Nunavut's population) and Rankin Inlet as its regional seat. Kivalliq is the most southerly of the 3 regions and most of its area lies on mainland Canada. The Qikiqtaaluk region is

Nunavut's largest both in area and population. It is also the most northerly, although it includes the small archipelago of the Belcher Islands that lie in the southernmost part of Hudson Bay. The Qikiqtaaluk region has 15,765 inhabitants (almost 54% of Nunavut's population) and Iqaluit is its regional seat. Nunavut's population is far from stable; it is the youngest population in Canada and the fastest growing, having increased 8 percent in 5 years from 2002-2007 (Government of Nunavut, 2008).

Nunavut's geographical size and span provides diverse conditions for its inhabitants: environmentally, climactically, and in relation to infrastructure, goods and services and the availability and pricing of food. In terms of shopping possibilities, all Nunavut communities have as a minimum either a Co-op store, a Northern Store, or both, where it is possible to purchase everything from nails and power tools, foodstuffs both fresh and dry, to furniture, clothing and gas. Larger towns have stores that sell various forms of building materials and most communities also have one or more stores that sell and possibly also produce local arts and crafts. Almost all communities have at least a fast food restaurant and some also have other restaurants or cafés. Some of the larger communities have bars, restaurants or hotels where alcohol can be bought and consumed, and while it is not possible to buy alcohol in any stores in Nunavut, most communities have a liquor board through which it is possible to be registered and buy monthly quantities.

There are a few treatment or health maintenance options outside the health care system in Iqaluit, including the possibility of seeing massage therapists and attending various yoga classes and fitness centres. These options are generally not continually offered in other Nunavut communities. As the only town in Nunavut, Iqaluit also has a public pool, a fitness centre and a racquet club. The latter, however, has prohibitively high fees and is mainly used by Qallunaat.<sup>25 26</sup>

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<sup>25</sup> "Qallunaat" is a word used by Inuit for non-Inuit, or, as Brody (2000) puts it, "anyone who comes to the north from the south" (p. 319). The singular of Qallunaat is "Qallunaaq." I use the word to mean "non-Inuit."

<sup>26</sup> Communities and towns in Nunavut and Greenland are of relatively recent origin, with those in Nunavut moreso than those in Greenland. Where the three largest towns of Greenland today, Nuuk, Sisimiut and Ilulissat had 8,545, 3,741, and 3,573 inhabitants in 1976, the three largest

The cost of living in Nunavut is 1.6 to 3 times higher than in Southern Canada and educational and economic disparities exist within the population as a whole, and between Inuit and Qallunaat, both those who live and work in Nunavut for short periods and those who call Nunavut home. The average Inuit income is sharply lower than that of other Canadians and especially lower than the average income of Qallunaat living in Nunavut (StatsCan, 2001). In Canada as a whole, the median total family income is \$63,600,<sup>27</sup> while in Nunavut it is \$54,000 (StatsCan, 2008c, 2008a). In Nunavut the median income of a single parent family is \$25,500 compared to \$33,000 in Canada as a whole (StatsCan, 2008b). Almost 30% of all families in Nunavut are single parents families, in Canada as a whole 15% of families are single parent families (StatsCan, 2006e), and the average family size in Nunavut is significantly larger than in Southern Canada. Comparing Inuit and non-Inuit income statistics in Nunavut makes it evident that non-Inuit family and individual income is significantly higher than that of Inuit (StatsCan, 2008a, 2008b, 2008c, 2008d, 2008e), and taking into account that the cost of living in Nunavut is higher, these statistics paint a picture of the challenging economic situation faced by many Inuit families.

All communities in Nunavut except Bathurst Inlet offer kindergarten to grade 12 and almost all communities also have a branch of Nunavut Arctic College, although the variety of programs varies significantly, and most Inuit would need to travel to a community other than their home community to pursue further education.

Although crowded housing is the norm for many (Tester, 2006), and the quality of many houses as well as the current condition of sewage and waste

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‘towns’ in what is Nunavut today; Iqaluit, Rankin Inlet & Arviat, had 2,333, 1,109, and 1,022 inhabitants (Det rådgivende udvalg vedrørende Grønlands Økonomi, 1999; Government of Nunavut, 2007d).

<sup>27</sup> Referring to the sum of the total income of all members of that family, total income includes: wages and salaries (total), net farm income, net non-farm income from unincorporated business and/or professional practice, child benefits, Old Age Security Pension and Guaranteed Income Supplement, benefits from Canada or Quebec Pension Plan, benefits from Employment Insurance, other income from government sources, dividends, interest on bonds, deposits and savings certificates, and other investment income, retirement pensions, superannuation and annuities, including those from RRSPs and RRIFs, other money income, social assistance, transfer payments, etc. (StatsCan, 2011, para. 14).

management may leave something to be desired (Government of Nunavut, 2008), all houses have plumbing and running water, which in most places is delivered and collected by water and sewage trucks, a significant improvement over the ‘honey buckets’ that were used in Nunavut between the 1950s and 1970s.<sup>28</sup> The majority of my fieldwork in Nunavut took place in Iqaluit, which is in the Qikiqtaaluk region. A small portion of my work took place in one of the larger towns of the Kivalliq region, which was chosen because this is the other centre in Nunavut where several Inuit nurses practice. The Inuit nurses and students who participated in the research, however, came from several towns and settlements in Nunavut and a few came from outside of Nunavut.

### **2.1.2 Greenland**

Greenland or Kalaallit Nuunat<sup>29</sup> is the world’s largest island, the majority of which lies above the Arctic Circle. Greenland’s landmass is 2,175,600 km<sup>2</sup>, but only 341,700 km<sup>2</sup> or 15% is habitable because of the ice cap (Grønlands Hjemmestyre, 2008a). Its population has been stable for the last 8 years and was 56,648 in 2007, approximately 89% of whom are ethnically Inuit and self-identify as Kalaallit/Greenlanders with the last 11% of the population being mostly ethnically Danish (Grønlands Hjemmestyre, 2008b). Eighty-five percent of the

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<sup>28</sup> A honey bucket is a bucket lined with a plastic bag that is exchanged when full. Full bags were collected from outside the dwelling.

<sup>29</sup> Kalaallit Nuunat means “the people’s land” and Kalaallit “the people.” However, Kalaallit often refer to themselves as Greenlanders and their language as Greenlandic, and these are the terms I will use in this dissertation. The name Greenland, or in Danish ‘Grønland,’ was given to the enormous island by the Norse Erik the Red when he first saw the deep and fertile fjords of southern Greenland (Mikkelsen & Kuipjers, 2000). Prior to Greenland’s vote on self-government there was an article in the newspaper *Sermitsiaq* and subsequently heated online debate among readers about the terms Inuit and Kalaallit, on account of a question from Doris Jacobsen, who is a member of the Home Rule government in the Greenlandic parliament, about whether Greenlanders should call themselves Kalaallit or Inuit with the advent of self-government (Aaqqissuisoqarfik, 2008). The majority of debaters seemed to agree that the proper name for Greenlanders, in Greenlandic today, is Kalaallit. This despite the fact that Greenlanders are ethno-historically of Inuit descent, and that the origin of Kalaallit (singular: kalaaleq) may be *skræling*, which some sources point to as meaning skin in the Icelandic language, with reference to the skin clothing that the Inuit wore when the Norse first encountered them (Gulløv, 2000). According to other sources, *skræling* originates in the Scandinavian languages and means scrawny, which is how the Norse described the first Inuit they met (Gulløv, 2000). In modern Danish (and Norwegian) the word *skrælling* means weakling, and the historical origin of the word in the dictionary is connected to the word Eskimo (Vinterberg & Bodelsen, 1998, p. 1884).

Inuit speak Greenlandic/Kalaallisut, an Inuit language, as their mother tongue, and Danish as their second language.<sup>30</sup>

The population of Greenland lives in 16 towns and 56 villages. Similar to Nunavut, Greenland is divided into regions. The majority of Greenland's population (approximately 50%) including the majority of ethnic Danes (both those born in and those living in Greenland for shorter or longer periods) live in the "middle region" which is also called the "open water region" and is comprised of the hamlets of Paamiut, Nuuk (the capital), Maniitsoq and Sisimiut. Approximately 19% of the population lives in the "Disco region" that includes the hamlets of Kangaatsiaq, Aasiaat, Qasignianguit, Qeqertarsuaq and Ilulissat. About 17% live in the "hunter regions" that include the hamlets of Ummannaq, Upernavik, Ammassalik and Ittoqqortoormiit; about 14% live in the "southern region" comprised of Nanortalik, Qaqortoq and Narsaq hamlets (Grønlands Hjemmestyre, 2008 b).

Greenland spans from 59,46 N to 83,39 N and covers 3 time zones. This means that, like in Nunavut, climactic and other conditions vary significantly. Although jets fly to and from Greenland, scheduled transportation between towns and villages is by boats, helicopters and smaller aircraft (Grønlands Hjemmestyre, 2008a). The availability of fresh produce, goods and services varies greatly between the major towns and smaller villages, and also varies based on proximity to Nuuk. Prices for food are generally 1.5 to 3 times more than those in Denmark (Petersen, 2007). All towns in Greenland have at least one store where it is possible to buy food, clothing, and everything else needed on a daily basis and many towns also have one or more stores selling local arts and crafts. Many larger towns have several different stores and Nuuk has several stores similar to those found in Copenhagen, Denmark, selling things such as clothes, household items, jewellery, furniture, building material, and various forms of arts and crafts.

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<sup>30</sup> Two decades of Greenlandization from 1979 to 1999 included an increased focus on Greenlandic culture and particularly language. Greenlandic language was promoted in all areas of society, from the political arena to the schools, such that some younger people's Danish should be considered a 'first foreign language' rather than a 'second language' (Langgård, 2003).

In some of the larger towns in Greenland it is also possible to find treatment or health maintenance options alternative to the health care system, including weight loss programmes, foot therapy, reflexology, chiropractic, massage, physiotherapy, fitness centres, yoga and other body maintenance classes, as well as coaching, psychotherapy and traditional Inuit psychic healing (Nuuk Ugeavis, 2009). Nuuk, however, is the town with most choices. All towns in Greenland have schools, although some of the smaller ones continue only to grade 7. Only the larger towns have high schools and post secondary educational possibilities and most of the latter are situated in Nuuk.

As opposed to conditions in Nunavut, indoor plumbing and running water are not available in all small villages and the quality of family dwellings in small villages can be poor (Grønlands Hjemmestyre, 2008a). As in Nunavut and particularly Iqaluit, there are vast differences between dwellings in Greenland. Particularly in Nuuk, quality of dwellings varies significantly – from very new, large and very expensive one-family homes in some areas, older two-story or high-rise apartment buildings that look rundown and in need of care, to very small wooden one family dwellings that look even more in need of maintenance.

Social conditions also vary greatly, both between and within towns and villages. In contrast to some immigrant groups in European countries, in Greenland it is the recent immigrant<sup>31</sup> Danes and first, second and even third generation Danes living in Greenland rather than Inuit Greenlanders who generally hold privilege, both in terms of educational attainment and economic wealth (although over the past few decades a well-off Inuit Greenlandic elite has also formed). The difference between the wealthiest and poorest is dramatic. In 2003 the wealthiest 10% of families with one child had a yearly income of CDN \$200,000 and the poorest 10% of families with one child had a yearly income of CDN \$16,000 (Wulff, 2006). Most of the employment opportunities are available in Nuuk.

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<sup>31</sup> I use the term immigrant here as that is the term used by the author Wulff (2006). I also note that many Greenlanders similarly use the term immigrants about Danes moving to Greenland, and differentiate between Greenland and Denmark as separate countries although Greenland, despite increased self-governance, is still officially part of Denmark.

## ***2.2 Histories of Colonization and Roads to Self-Determination***

### ***2.2.1 Greenland***

Although Greenland may have already been visited in the 800s (Sigurdson, 2000) the history of European colonization in Greenland started with the Norse in the 900s. While trade and bartering did exist between Greenlandic Inuit and whalers after the demise of the Norse settlements in the early 1400s, serious colonial activities began with Christian missions in 1721 led by the Danish missionary Hans Egede (Arnborg & Seaver, 2000; Dahl, 2000). Egede, who established the first Danish-Norwegian colonial station in Greenland, close to present-day Nuuk, was involved in activities beyond missions as well; since “Danish colonial policy was based on mission *and* trade” the activities of Egede was as well (Dahl, 2000, p. 31, emphasis added).

Egede had expected to meet the descendants of the population of the Norse that settled in Greenland between the 980s and 1300. It was his goal to reintroduce these later generations of immigrant Norse to Christianity. Upon landing on Håbets Ø (Hope Island) he did not meet any descendants of the Norse but rather “Eskimoes”.<sup>32</sup> It did not take Egede long to realise that in order to convert the Inuit to Christianity, literacy would be necessary. The Evangelic-Lutheran faith, to which Egede subscribed, demanded that the individual had to personally consider and agree with various individual components of the faith. This meant that either it was necessary for Egede to learn Greenlandic, have a bible translated into Greenlandic, and teach the Greenlanders basic literary skills, or it was necessary for Greenlanders to learn to speak and then read Danish. Both seemed insurmountable problems (Gad, 1965). Egede did teach some Greenlandic children Danish. He also chose a few of his students to be catechists, in order for them to support him in his missionary endeavours. Already in 1727, Egede proposed that seminaries should be built in all Greenlandic colonies<sup>33</sup> and that they could be used to educate catechists *and* as a means to cultivate “Eskimoes” to become more Western in their ways and thinking. Throughout the

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<sup>32</sup> The term ‘Eskimo’ is no longer widely used in Greenland or the Canadian Arctic. It has generally been replaced by ‘Inuit.’ Unless directly quoting, I use the term Inuit.

<sup>33</sup> Each settlement area was considered to be a colony (Gad, 1965).

1700s the need for catechists grew, as Greenlanders all over Greenland converted to Christianity. This led to the establishment of a few small seminaries. Although the number of graduates from these remained relatively small, the goal of Westernizing and schooling the Greenlandic Inuit was certainly made easier with the aid of the Greenlandic catechists – both those educated in Greenland and the few who went to school in Denmark (Gad, 1965).

In the late 1700s more local educational initiatives emerged, partly because the children, and particularly the boys born of immigrant Danish men and Greenlandic women, were not naturally taught traditional occupations. Furthermore, it was proposed by a governor of the trading company that the trades positions that were necessary in Greenland should be held by Greenlanders rather than immigrant Danes. This resulted in 13 Greenlanders receiving training in Denmark, 12 as different tradespeople and one as a priest. They returned to Greenland between 1837 and 1848. Also, two seminaries were established in the mid-1800s that have continued to educate catechists and teachers until the present day. At the same time, several women were sent to Denmark to be educated as midwives, a fact I will return to below (Gad, 1965).

After the mid-1800s, Hinrik Rink, a Danish scientist who in 1885 became both the colony manager in Godthaab today Nuuk and the director of South Greenland, further developed the idea of Greenlanders being educated in Denmark (Steenstrup, 1894). This initiative resulted in 31 Greenlandic men being educated as tradespeople between 1874 and 1891. Prior to this and occurring simultaneously, many Greenlanders received less formalised training in various trades and public institutions within Greenland. In 1870 native Greenlanders “were performing most of the semi-skilled tasks in the larger settlements and managing trade stations in two or three minor outposts” (Ostermann, cited in Jenness, 1967, p. 54). By 1880, 95 % of the people employed within the church and school systems in Greenland were Greenlanders and 72% of the people employed in the trading company were as well (Berthelsen, cited in Gad, 1965, p. 259).

It is thought that the schooling that had commenced with Hans Egede contributed to Greenlanders being able to obtain this education and these positions (Gad, 1965). By 1850, due to the efforts of the Moravian missionary Samuel Kleinsmith, Greenland already had a standardised writing system using Roman orthography as the base (Dorais, 1993). This was to Rink's advantage when he established the first Greenlandic newspaper *Atuagagdliutit* in 1861. The paper was written in Greenlandic, often by Greenlandic people, and it discussed matters important to Greenlanders; it was printed in Nuuk by a Greenlander, who was trained by Rink (Jenness, 1967; Steenstrup, 1894). By 1950, essentially all Greenlanders were literate in Greenlandic (Jenness, 1968). Although in a slightly different form, the newspaper still operates today, almost 250 years after its inception. In 1952 it was amalgamated with another local paper 'Grønlandsposten', which was written in Danish. The current paper is bilingual, called *Atuagagdliutit/Grønlandsposten A/G*, and is generally referred to as AG (*Atuagagdliutit/Grønlandsposten*, 2008).

Rink's initiatives have been thought to be spurred by a concern for the welfare and love of Greenland and Greenlanders (Steenstrup, 1894). Simultaneously, his aim was to "better" the Greenlanders (Gad, 1965) and raise their status and morale by giving them an 'authoritative voice' in local administration with an eye to future self-government (Jenness, 1967). Acculturation inevitably resulted. Although the stated policy of the Danish Government throughout its colonial rule was that the Greenlandic people should maintain their traditional hunting way of life (Dahl, 2005) the colonies, by their mere existence and cooperation with the missions, and particularly the increasing educational initiatives, slowly and intentionally brought change to the Greenlandic way of living and thinking (Gad, 1965).

Trade and trading arrangements also brought about major changes. The Kongelige Grønlandsk Handelskompagni (the Royal Greenland Trade Company) or KGH was owned by the Danish state and played a major role. The main objective of its protectionist approach was to "seek the best interest and advantage of the Royal Trade and Fishing with diligence and zeal" (Gad, cited in

Nuttall, 1992, p. 18). The Danish Government attempted to ensure this by limiting – in effect forbidding – trade between Greenlanders and all others. Despite this approach, contact with European whalers and traders did take place (Jenness, 1967). This contact, coupled with trade and contact with the KGH, led Greenlanders to be increasingly dependent on foreign trade goods and technology and also increasingly on Danes (Nuttall, 1992). Later, with the United States recognizing Danish sovereignty over Greenland in 1941 and the subsequent development of American military bases there, the Danish government abandoned its “isolationist policies towards Greenland” (Nuttall, 1992, p. 18) further increasing Greenland’s contact with the surrounding world and the Greenlandic people’s access to trade goods.

Because of the conditions of the sea, sea ice, and general geography, East Greenland is and was less accessible to visitors and prospective colonizers (Søby, 1983). Therefore, the history of colonization in East Greenland is somewhat different than that in West Greenland. East Greenland was colonized by Denmark early in the 20<sup>th</sup> century, almost 200 years later than West Greenland. It started in Ammassalik (now called Tasiilaq) in August 1884. Gustav Holm, a naval officer and Arctic explorer, sailed from Southeast Greenland with *umiaks* or ‘women’s boats’ filled with female rowers, equipment, food, tents, and other supplies, followed by men in kayaks (Mikkelsen, 1994). His mission was to map and scientifically describe the Eastern coast of Greenland. Because of the means of transportation, the expedition was called “konebådsekspeditionen” the Danish for ‘women-boat expedition’ (Mikkelsen, 1994).

Holm met the Inuit who lived in the Ammassalik district, and aided by the Greenlander Johan Petersen, he conducted ethnographic research. He subsequently published work describing the Ammassalik Inuit. After successfully completing his mission, Holm left in 1895, but not before he had promised the Ammassalimmiut<sup>34</sup> that he would return and help alleviate the dire conditions

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<sup>34</sup> ‘miut’ is a suffix added to a place name that creates a word meaning residents of the place (personal conversation, Mick Mallon, November, 2003). It can also mean ‘people of’: Ammassalimmiut means ‘people of, or residents of the capelin’ (ammassat = capelin) (personal communication, Mark Nuttall, September 20, 2010).

under which they lived. Due to hunger, 32 people had died between 1883 and 1884, and another 30 who had migrated north in order to find better hunting grounds had also succumbed. Many historical reports from Eastern Greenland give evidence of the devastating results of foreign diseases brought by whalers and traders (Mathiassen, 1935). When Holm departed in 1895, the population of Ammassalik had totaled 413 people. When he returned in 1894, only 243 people remained. Many had abandoned hope that conditions would improve and left. About 100 previous inhabitants, however, returned to the Ammassalik area when they learned that a trading station had been built (Mikkelsen, 1994).

Before Holm returned in 1894 after convincing Danish administrators about the need for another mission to Eastern Greenland, a Norwegian trading expedition had visited the settlement and bought everything that the population had collected to trade with Holm when he returned (Mikkelsen, 1994). Holm described how the Ammassalimmiut had changed appearance in the 9 years that had passed since he left. Many were wearing European clothing, often worn to rags, a development that Holm blamed on the Norwegians. After Holm returned to Ammassalik, a mission and trading station was built and colonization began in earnest. Despite hardship, epidemics of diseases, and an initial decline in Ammassalik's numbers, the population, according to Holm, began to thrive and grow. Thirty years later, in 1925, another expedition with 70 people from Ammassalik and a number of Danish builders set forth to colonize the area around Scoresbysund (today Ittoqqortoormiit), 1000 km further north (Mikkelsen, 1994).

This next step in the colonization of Eastern Greenland was the result of a dispute about sovereignty rights to Eastern Greenland between Denmark and Norway. In the public forum, however, it was said that further colonization was brought about for the sake of the Greenlanders (Mikkelsen, 1924, 1989). Ejnar Mikkelsen (1989), the founder of the colony, writes in his accounts that apart from an initial epidemic that left some community members dead and created a four-month hiatus of depression and inability to work among the settlers, the colonization enterprise went very well. Mikkelsen also writes that the colonizing

party had to decline passage to several prospective Inuit settlers wanting to join the first trip to Scoresbysund, that those who went did so more than voluntarily, and that he encountered only happy and very content settlers when he returned to the community a year after its foundation. Pia Arke (2003), a descendant of one of the settlers, paints a different picture as she recounts the hardship settlers faced and writes that not all relocations were as voluntary as described by Mikkelsen. Thus since Scoresbysund was not colonized until 1925 it did not, logistically, remain a Danish colony for more than 33 years.

The colonial status of all of Greenland was abandoned in 1953, which in theory gave Greenlanders equal status to Danes (Nuttall, 1992), but colonization continued nonetheless (Balle, 2006; Nuttall, 1992). Greenlandic values, knowledge, and ways were increasingly devalued after the Second World and a heavy influx of Danish labourers, professionals, and administrators, and encouragement by the Danish Government, led many Greenlanders to abandon traditional hunting camps, hunting, and whaling in order to take up fishing. This change in policy was based on the “warming of Greenland’s southern coastal waters,” a subsequent migration of seals further north, and the appearance of fish, notably cod, in the warmer waters in the south (Nuttall, 1992, p. 19). The Government focused its attention and investment on the fishing industry in Central Western coastal towns where housing and schooling were made available. Settlements elsewhere were neglected, forcing inhabitants to move from the outlying districts and to send their children to schools in larger towns (Dahl, 2005). For some, compulsory school attendance meant several years of residence at boarding schools where, in some cases, only Danish could be spoken (Bryld, 1998).

The history and legacy of residential schools has seemed less dire in Greenland than in the Canadian Arctic (Anawak, 2009). Recently, however, there have been heated debates in the Danish and Greenlandic governments and media about 22 children who were relocated from Greenland to Denmark in the 1960s in order to attend school and become part of a new Greenlandic elite when reaching maturity. The children were taught in Danish according to Danish norms and

values (Buch-Andersen, 2009), many never moved back to their native families and many lost the ability to speak their native language.<sup>35</sup>

With the increased influx of Danes in the 1960s the tension that already existed between Greenlanders and immigrant Danes grew, in part because of Greenlanders feeling discriminated against in terms of available jobs, payment and privileges compared to their Danish contemporaries. This feeling increased with the forced joining of the European Economic Community or EEC in 1972, a move that most Greenlanders voted against (Dahl, 2005). That Denmark, and by default Greenland, joined the EEC was seen by Greenlanders as further foreign rule being imposed upon them. This resulted in an intensified Greenlandic demand for autonomy from Denmark. In 1973 the Greenlandic Home Rule Committee was established with the aim of securing autonomy for Greenland. The Home Rule Committee drafted, adopted and submitted a report to the Danish Government that advocated for a regional (as opposed to ethnic) home rule government in Greenland. Subsequently a Danish-Greenlandic Home Rule Commission was established, the work of which resulted in all statutes proposed for Greenlandic Home Rule being adopted by the Danish parliament on January 17<sup>th</sup>, 1979, at which time Greenlandic Home Rule began (Dahl, 2000).

Ever since the advent of Home Rule there have been discussions, often heated, in Greenland, in Denmark and between Greenlandic and Danish politicians about Greenland obtaining self-government. This led to the development of a Greenlandic Commission for Greenlandic self-government in 2000. On April 11<sup>th</sup>, 2003 a white paper was delivered to the Home Rule government after which negotiations took place between Denmark and Greenland about how to realize the content. On June 21<sup>st</sup>, 2004, a Danish/Greenlandic

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<sup>35</sup> The debate arose on account of a film being made about the children based on a book by Tine Bryld (1998) a Danish social worker and author. Bryld purports that more than 100 children were relocated and adopted to Danish families. Newspaper articles, radio programs and online debates have revealed differences in opinion about the issue. While some have expressed that ripping up old wounds will cause further hurt and that the relocating of some children was their best option at the time, a majority of the opinions depicted in the media have been very negative and placed the responsibility squarely on the Danish Government. The Home Rule chair Kuupic Kleist (Buch-Andersen, 2009a), among others (Dahl, 2009; Jacobsen, cited in Berlingske, 2010) believe that these children and their families should receive an apology as well as compensation from the Danish government.

Commission for Greenlandic self-government was created, the work of which ended on April 17<sup>th</sup>, 2008 (KNR, 2008a). The task of the Commission was, according to the Greenlandic parliament, to: “1. Consider and propose how the Greenlandic government may take over further competence, where this is constitutionally possible. 2. Propose the legal terms for how this may be done including how to tackle the financial issues that exist between Denmark and Greenland” (Government of Greenland, 2009, para. 4). Part of the discussions between Denmark and Greenland in relation to the self-rule commission have revolved around Greenland’s dependency on transfer payments from Denmark and how they would decrease as Greenland gets revenue from extraction of subsoil and non-renewable resources. Greenland exerts its independence by negotiating terms of agreement with foreign business that will allow potential extraction to occur (Nuttall, 2008), an ability that may be seen as decolonizing, since any extraction in Greenland until now has been a Danish colonial enterprise (Nuttall, 2008).

Since the establishment of the Commission and even before, the Greenlandic media published numerous articles and reader/listener discussions about what self-government would imply and what it would mean for the future of Greenland and a continued Greenlandic and Danish cooperation (see, for example, Gad, 2009a, 2009b; KNR, 2008a). On November 25, 2008 the Greenlandic population voted to accept the proposal that the Commission had put forth with 75% voting “yes” and 23% voting “no” (Mølgaard, 2009). On June 27<sup>th</sup>, 2009 Greenland’s self-rule was affirmed and legislated by the Danish Queen and government (Magrethe R & Rasmussen, 2009). This further step of “self rule” rather than “home rule” has not settled the question of what the relationship between Denmark and Greenland should be; the debate continues among the population, politicians, and in academic circles in both Denmark and in Greenland (Gad, 2009a). Governments throughout the world as well as Inuit organizations congratulated Greenland on the day of their voting yes to enhanced self-determination. Canadian Inuit political leader Mary Simon (Nuttall, 2008) and Duane Smith, the president of the Canadian office of the Inuit Circumpolar

Council, both saw Greenland's yes as a "hope and opportunity for [other Inuit]... to gain better control of their own destinies" (Smith, 2008, p. 1). Although Greenland has widely been "considered a model for Indigenous government... it has been a process of nation building rather than an ethno political movement" (Nuttall, 2008, p. 65). Still, there are voices in the parliament and general population that assert ethnic Greenlandicness to be very important in relation to political decision-making and Greenland becoming independent, which is evidenced, for example, in discussions about language and identity between members of parliament from *Siumut*, which some call a 'nationalist party,' and *Demokraatit*, which on the other hand some accuse of wanting Greenland to be equivalent to a 'discount Denmark' (Berthelsen, 2010; Lybert, 2010; Thomsen, 2010).

As I will discuss in the following chapter, the people of Nunavut appear to be less in favour of becoming totally independent of Canada than many people in Greenland, who over time appear to favour independence from Denmark.

### **2.2.2 Nunavut**

There is evidence of the Norse having visited what is today Nunavut between 1000 CE and 1200 CE. The impact of these visits, however, appears to have been fairly insignificant. The activities of whalers and explorers, on the other hand, particularly after Martin Frobisher's landfall on Baffin Island in the mid-1500s, had many implications for Baffin Island Inuit. These included afflictions by new diseases and changing subsistence and habitation patterns for some (McGhee, 1994). The Canadian Government did not attempt to "preserve" Inuit hunting practices, as was the official Danish policy in Greenland, or support local control of renewable resources. Rather, the Hudson Bay Company controlled trade in the Arctic, and from the late 17<sup>th</sup> into the 20<sup>th</sup> century encouraged Inuit to partake in the fur-trade. This made Inuit increasingly dependent on southern goods, changed cultural values and altered the pre-existing "spiritual relationship between the Inuit and the animals they hunted" (Nuttall, 2000, p. 383).

Canada's Arctic was never considered a colony of Canada the way that Greenland was considered a colony of Denmark. Despite this, the policies and actions initiated in the Arctic by the Canadian government, largely a result of Canada's struggles for sovereignty, were still colonial, and institutions structured and controlled by outsiders were the norm.<sup>36</sup> Government policy saw groups of Inuit forcibly relocated to areas thousands of kilometres from their original homelands in order to be able to claim the northern reaches of Canada inhabited. The outcomes of these movements were often socially and culturally disastrous. In the new settlement areas, known hunting practices sometimes failed, as the animals were different or absent, resulting in hunger (Tester & Kulchyski, 1994).

Many of the changes brought about by the incursions of Southerners and Southern institutions led to a more sedentary lifestyle for Inuit. Participation first in the whaling industry and later in the fur-trade led to an increasing dependence on foreign goods and a need to be close to the Hudson Bay Company's trading posts in order to trade for these goods. Diseases brought by whalers, missionaries and explorers, assisted by an increasingly more sedentary lifestyle, gained a stronghold among the Inuit of the Canadian Arctic and further decimated many camps and settlements (Grygier, 1994).

Although the Canadian Inuit were not schooled in the same formal way that Egede initiated in the first quarter of the 1700s among the Greenlandic Inuit, Canadian Inuit also learned to read and write initially in conjunction with conversion to Christianity. There were quite significant differences in the ways and the times that Inuit across Arctic Canada were introduced to European reading and writing. Inuit literacy started in Greenland with Hans Egede. The Inuit of Labrador were introduced through the German Moravian missionaries about 60-70 years later than the Greenlanders. Using a similar orthography to that used in Greenland, Moravians taught the Nain Inuit to read and write in 1791, and by the time they had finished translating the scriptures, few of the Christian Inuit remained illiterate (Jeddore, cited in Dorais, 1993). Apart from Greenland and

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<sup>36</sup> In this connection it is worth noting that Mary Simon, the president of ITK, recently asked the Canadian prime minister Steven Harper for an explanation of his comment at a G20 meeting in the US that "Canada has no history of colonization" (Simon, 2009).

Labrador, Inuit literacy was limited until the mid-19<sup>th</sup> century when reverend E. A. Watkins, using a series of syllabic graphic symbols, taught the Inuit who traded at Fort George and Little Whale River, on the Hudson Bay coast, to write in their own language. Originally a Wesleyan missionary among the Ojibway, Reverend James Evans had devised the 36 characters that resembled the syllabics in order to reproduce the consonant and vowel combinations found in Ojibway. Later, Reverend James Peck translated the Bible into Inuktitut and in syllabic script and “brought the new writing system to the whole Canadian Eastern Arctic (except Labrador)” (Dorais, 1993, p. 112).

The ability to read and write Inuktitut in syllabics spread quickly over Nunavik<sup>37</sup> and the Baffin Regions from family member to family member and camp to camp with the spread of Christianity and the Inuktitut Bible. “Around 1925, most Eastern Arctic Canadian Inuit could read and write their own language even if outside of Labrador none of them had ever gone to school” (Dorais, 1993, p. 113). This way of writing did not spread to the Western Arctic. From the Netsilik country in the Central Arctic and westward, Inuinait and Inuvialuit<sup>38</sup> had adopted the Roman orthography, to which they had been exposed through whalers, traders and missionaries since the late 1800s. Although high levels of literacy were achieved, when compared to Greenland, formal schooling was introduced relatively late in the Canadian Arctic. “The first federal day schools for Inuit were opened in 1949” (McLean, 1997, p. 184), and by the mid 1950s, “Canadian governments were committed to building a significant network of schools in the North, and to administering a public school system” (McLean, 1997, p. 184). The desire to be close to their children, and government threats to discontinue financial support for those who did not send their children to the settlements to attend school, helped to pressure the most resilient camp-dwellers to become settlement-dwellers during the 1950s and 1960s (Tester & Kulchyski, 1994).

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<sup>37</sup> Nunavik is the Inuit territory in Northern Quebec.

<sup>38</sup> ‘Inuinait’ and ‘Inuvialuit’ are terms used instead of ‘Inuit’ by peoples in the Central and Western Canadian Arctic.

The creation of settlements, subsequent relocations, and the creation of a system of schooling with its mandatory attendance requirement tied to family support payments, in essence forced Inuit to abandon camps previously spread along the coasts. While some scholars perceive sovereignty issues to be a very important factor in the Canadian Government taking responsibility for the health care of its Arctic population and the building of hospitals,<sup>39</sup> its creation of settlements, and program of relocations (Paine, 1977b; Rutherford, 2008; Tester & Kulchyski, 1994; Tester & McNicoll, 2008), Damas (2002) interprets the government's concern for Inuit welfare to have been the major driving force behind the settlements, and writes that Inuit readily accepted the advantages of village living. The Canadian Government itself also explained these developments as hinging on the need for Inuit to have access to health care, schooling and policing (Tester & Kulchyski, 1994). Regardless of motivation, an attempt to re-socialize the Inuit via Christianization, health care, and schooling, along with the creation of settlements, resulted in great social and cultural disruption (Brody, 1991; Jenness, 1972; Rutherford, 2008; Tester & Kulchyski, 1994). The education program that was developed in order to educate Indigenous northern people was, according to one observer, "undeniably socially destructive" (Freeman, cited in Paine, 1977b, p. 21).

Also in the 1950s and 1960s, the mining activities in some regions and influx of Southern Canadian workers, administrators, managers, teachers, and nurses to all settlements in the Canadian Arctic brought further change (Dahl, 2005; Jenness, 1972; Nuttall, 2000; Tester and Kulchyski, 1994).<sup>40</sup> The general sentiment among the "Southerners" was that Inuit should be assimilated into EuroCanadian society and eventually "become modern Canadians" with the

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<sup>39</sup> Medical Doctors Frederic Banting and Leslie Livingstone, who served in the Canadian Arctic, Livingston starting in 1922 (Copland, 1967) and Banting in 1927 (Bliss, 1984), were initially against the building of central hospitals, feeling that "roaming" medical personnel would better serve the needs of a "nomadic" Inuit population, and would support them in continuing their way of life (see Copland, 1967, in particular pp. 61, 95, and 107; see also Tester & McNicoll, 2006, 2008).

<sup>40</sup> According to Jenness (1964) the nickel mine in Rankin Inlet was the only one employing Inuit workers. About 80 of the 300 workers employed in 1958 were Inuit. The Rankin Inlet mine closed in 1962 creating a void in wage employment and in health care services that had been provided by the mine (Tester & Kulchyski, 1994, pp. 345-351).

opportunities and improvements this implied (Nuttall, 2000 p. 383). Some Inuit felt resentful of the EuroCanadians' presence and superior standards of living (Amagoalik, cited in Kulchyski, 2005; Brody, 1991; Freeman, 1992; Ipellie, 1993). Some Inuit resented being mere onlookers to development initiatives such as oil and gas extraction, which exploited, polluted, and scarred the lands they considered their homelands without offering the Inuit any control of, or benefit from, the process or profits. This experience was shared by many Indigenous peoples and resulted in the formation of organizations that shared a concern for the livelihoods and cultures of Indigenous peoples and advocated for their rights. In Canada, the Inuvialuit of the western Canadian Arctic formed the *Committee of Original People's Entitlement* [COPE] in 1969 and, as a voice for all Canadian Inuit, *Inuit Tapirisat of Canada* [ITC] was formed in 1971 (Nuttall, 2000).

Despite the formation of ITC (now called Inuit Tapiriit Kanatami [ITK]), and the work the organization did to prepare for the creation of Nunavut in 1999, it still took more than two decades before Inuit in Arctic Canada obtained what many Nunavummiut perceive to be a form of self-government, although it is in fact a public government. John Amagoalik, a strong proponent of Nunavut and a former president of ITC, said in 1993 that obstacles to the creation of Nunavut included a lack of readiness to embrace the change among Inuit and the general Canadian public alike, as well as a lack of commitment from the politicians in the Northwest Territories and the federal government (Kulchyski, 2005).

However, Nunavut Tunngavik Incorporated (NTI), which is the former Tunngavik Federation of Nunavut, was established to represent Inuit under the Nunavut Lands Claims Agreement. NTI, in cooperation with representatives of the Canadian Government, signed the Nunavut Political Accord in April 1992. The Accord set the creation of Nunavut as April 1<sup>st</sup>, 1999. This was ratified by a Nunavut-wide vote in November, 1992, adopted by the Canadian Parliament in May, 1993, and resulted in the creation of Nunavut as planned on April 1<sup>st</sup>, 1999. With it the territorial government took charge of education and health care, among other portfolios (Government of Nunavut, 2008).

Similar to the Inuit living in the eastern part of Greenland, the Inuit of the far eastern Canadian Arctic in Labrador (an area now called Nunatsiavut) experienced a somewhat different history of colonization than Inuit in Nunavut. But where European influence came to East Greenland later than West Greenland, the Inuit of Nunatsiavut were exposed to Western influences more intensely and earlier than Inuit in Nunavut. Missionaries, fishers and whalers made a significant impact on Labradorean Inuit (now Nunatsiavumiut) already in the mid 1800s. First Moravian missionaries set up missions and started Christianizing and ‘educating’ the Nunatsiavumiut. Then the Newfoundland fishing fleet and land fishermen moved north, settled close to the missions, and started attending the Moravian services. The Moravians in turn started to also offer these services in English, to the benefit of the European settlers, whereas previously the services had been given in Inuktitut. Christian male settlers and Christian Inuit women married and enrolled their ethnically mixed children in the Moravian schools and the “entire coast became a melting pot in which it was no longer easy to separate native from white” (Jenness, 1967, p. 20). By 1900, although not educated in a European sense, 90% of the population was literate, and settlers and Inuit apparently lived peacefully and orderly together. In the first third of the 20<sup>th</sup> century motor-boats and aircrafts brought in further white settlers and a temporary boom in the fur trade enticed Inuit to abandon sealing and cod fishing and start to trap fox, mink, and other furred animals. This development inevitably made the Inuit more dependent on the outside world (Jenness, 1967).

At the end of WWII, Newfoundland’s government negotiated the terms under which the colony would enter the Canadian confederation. Newfoundland rejected the idea that the Labrador Inuit should be classified under Eskimo-Indians as had happened to other Inuit and First Nations people in Canada. Rather, Newfoundland claimed that there were no “real Eskimos” in Labrador, and that all people were of European or part-European descent. The region’s official demanded that all inhabitants should enjoy the same constitutional rights as every other Canadian, and so it was. Constitutionally, there are no Inuit in Labrador (Jenness, 1967). This has not prevented the descendants of these “non-

Inuit” from negotiating their own land claim, although it was ratified later than the Nunavut land claim, on January 21<sup>st</sup>, 2005. Nunatsiavut has, like Nunavut, taken charge of portfolios such as education and health (Government of Nunatsiavut, 2005).

The histories of health and health care in the two regions is the topic I will turn to now, starting with a description of ‘health and sick care’ as it functioned in Nunavut and Greenland prior to Western health care being superimposed. Then before I review the changes that health care in Nunavut and Greenland have undergone, I will offer a short discussion of the ways in which nursing has been introduced in other non-Western countries, and end with a brief description of the health care systems as they function today.

The sections above (2.1-2.2) reveal that although Nunavut and Greenland share many similarities in relation to geography, demography and socio-economic realities, and have had similar trajectories in relation to their histories of colonization and roads to self-government, their timeframes have been different and the political considerations of the colonizing powers in relation to language, schooling, and outside contact, have also been different. Differences that are most apparent include that Greenland has been ‘marinated’ in Danish culture through the church, schooling, and health care for more than 275 years whereas the strong Southern Canadian influence on Nunavut has been significantly shorter. From early on Danes and Greenlanders have intermarried to a degree that has not taken place in Nunavut until recently. Despite (and also because of) the long history of culture contact, Greenland has had its own literature and newspapers in Greenlandic and also international literature translated into Greenlandic. In Arctic Canada, any literature and other reading material in Inuktitut, apart from the Bible, has largely been produced in Inuktitut over the past 50 years, and few international authors have been translated. Denmark used a protectionist policy towards Greenland in relation to both culture and trade, and to a large degree kept other nations from interacting with Greenland (and Greenland from interacting with other nations), whereas no such policy was upheld in Arctic Canada as long as Canada’s sovereignty was not at

risk. Both Greenland and Nunavut have gone through periods of Greenlandization/Inuitization and Danification/Anglicization, but have not done so simultaneously and Nunavut has politicised issues of language and culture to a much stronger degree than Greenland has, although these topics have received increased interest lately. And last but not least, Nunavut appears not to seek absolute independence from Canada, whereas Greenland, or at least some of Greenland's political parties, are strong advocates for such a separation from Denmark. These differences colour the opinions and perceptions of contemporary Inuit in Greenland and Nunavut, including the nurses and students and the ways they feel about, and wishes they have for, the future in relation to language, schooling and independence. In relation to the histories of health care in Nunavut and Greenland, again the regions have followed similar trajectories while timeframes and political decisions in the regions have also had many differences. These histories is the topic of the next section.

### ***2.3 Arctic Health Care Past and Present***

In this section I will first review the ways in which Arctic health and sick care have been described in the literature. I describe both regions simultaneously as is done in most literature available on the subject. Then I highlight the changes in health care delivery that each region has undergone since the initial introduction of Southern doctors and nurses, and how the health care systems look and function today.

While much literature and archival material exists that describes these changes<sup>41</sup> a very detailed account is beyond the scope of this thesis. The goal here

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41 In a Canadian context, authors writing about the history of health and health care in the Arctic include Bliss (1984), Copland (1967), Tester (2002), Tester & McNicoll (2006, 2008), Tester, McNicoll & Irniq (2001), McNicoll, Tester & Kulchyski (1999), and Tester and Kulchyski (1994). They draw extensively on archival material such as that available in the National Archives of Canada, the National Research Council Archives, the Alex Stevenson Collection, the Royal Ontario Museum, the Thomas Fisher Rare Book Library at the University of Toronto and the Glenbow Museum Archives in Calgary. In a Greenlandic context, authors writing about the history of health and health care in Greenland include Rønsager (2002) and Lange (2010). They draw on archival material from sources such as the Archives of the Royal Library, the Arctic Institute, the periodical *Meddelelser om Grønland* (Monographs on Greenland) which was established in 1878 and since 1979 split into three journals (Man & Society, Bioscience and

is to give the reader an appreciation of the development and the rapid changes that have taken place in the Arctic as a whole in relation to health and sick care, a flavour of the thinking of the health care providers and administrators in relation to these developments, and an appreciation of the similarities and differences that characterize the regions historically and currently. This will provide the reader with background that will help to understand the findings of this dissertation, including the similarities and differences between findings in Greenland and Nunavut, and between participants practicing and studying in each location.

### ***2.3.1 The inseparability of individual and community health***

The following review discusses how, at the point of first contact with Southern notions of health care and health care professionals, health and sickness care in the Arctic was a familial and communal experience and responsibility. It will provide a foundation for an appreciation of differences that exist between Southern and Inuit ways of providing health care in the systems as they function today, as they are experienced by contemporary Inuit nurses.

Early anthropological works on Inuit life and culture include descriptions of how various Inuit groups approached disease, medicines, cure, and the individuals who provided health and sick care (see, for example, Balikci, 1970; Freuchen, 1961; Rasmussen, 1930a, 1930b, 1930c, 1930d, 1952). Generally, these works were part of a much larger cultural inquiry and the descriptions of health and disease often focused on exotic beliefs and curing practices, magic, and fetishism. They did, however, show how concepts of health and disease had strong moral connotations and were tied to all areas of life, living, actions, and behaviour with proscriptions and taboos that were often mediated by shamans, spirits, and the use of amulets. The wellbeing of an individual was inseparable from the wellbeing of the whole community and the actions and behaviour of an individual had the ability to affect the whole community for better or for worse.

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Geoscience), the journal "*Tidsskriftet Grønland*" (The Greenland Journal) published since 1953, and *Geografisk tidsskrift* (The Journal of Geography).

There is a consensus about the importance of shamanism in relation to maintaining health and curing illness across the Arctic as it is described in this early literature<sup>42</sup> and in later works that discuss past practices as they are remembered or have been transmitted orally (Aupilaarjuk et al., 2001; Lynge, 2005; Okpik, 2007; Ootoova et al., 2001; Terrien & Qamaq, 1992; Tungilik & Uyarasuk, 1999). According to this literature, shamans or *angakkuit*<sup>43</sup> did not care directly for the sick, but rather played a significant role in the attempt to cure or reverse individual and camp or community illness and misfortune. They also played a significant role in the attempt to avoid or change bad weather and make the animals that Inuit relied upon plentiful. If a person was falling ill an *angakkuq* (shaman) would try to find out which taboos or proscriptions the individual had violated by making the person say it him or herself, or making his or her body “say” it, for example by tying a cord around the person’s head and asking helping spirits which taboo the sick person had transgressed causing him or her to become ill. If it was easy to lift the head the answer to the question was no and if it was difficult the answer was yes. This method was called *qilaniq* in Arctic Canada (Aupilaarjuk et al., 2001). Sessions where the *angakkuq* attempted to find the reasons for a person’s illness often took place amidst other family and community members rather than between the *angakkuq* and the suffering individual in seclusion. The *angakkuq* might also send out one or more *tuurngait* (spirits) to seek out and fight the *tuurngaq* (spirit) or *tuurngait* sent by someone with the aim of causing the sufferer trouble, sickness, or even death (Aupilaarjuk et al., 2001).

*Tuurngait* had the ability to do both good and evil (Freuchen, 1961; Rasmussen 1930b; Tunnuq, cited in Bennett & Rowley, 2004, p. 182); those causing evil were and are called *tupilaq* by some and were considered to be the servants of Satan (Tungilik & Uyarasuk, 1999). According to some, *tupilaq* or

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<sup>42</sup> From the eastern coast of Greenland through its northern and southern parts (Freuchen, 1961; Rasmussen, 1930a, 1930b, 1930c, 1930d) west over the area that today is Nunavut (Balicki, 1970; Freuchen, 1961; Rasmussen, 1930a, 1930b, 1930c, 1930d) and the northern parts of the Northwest Territories all the way to Alaska (Rasmussen, 1952).

<sup>43</sup> In Greenlandic, shaman (in Danish *åndemener*) is termed *angakkoq* in singular (Berthelsen et al. 1997, p. 65), in plural *angakkuq* (personal communication, Mark Nuttall, October 17, 2010). In Inuktitut shaman is termed *angakkuq* in singular, in plural *angakkuit* (Schneider, 1985).

*nunarluk*<sup>44</sup> is a spirit being that has been made by a human being, either an *angakkuq* or another person with witchcraft abilities. The creature is generally made from animal and human parts and has both animal and human features, but always a human face. It is often made in order to harm someone but can return to harm its creator if the person whom it was intended to harm has a stronger *tupilaq* or is too strong himself or herself for the offending *tupilaq* (Aupilaarjuk et al., 2001; Rasmussen, 1921). Others say that *tupilait* are like little pouches of blood, which have either grown out of the dirt of abandoned *igluit*<sup>45</sup> and resemble germs that can grow very large, or are the dissatisfied souls of dead people, both of which make people sick (Aupilaarjuk et al., 2001).

Depending on the author and region, becoming an *angakkuq* could happen in various ways. According to some, individuals would become *angakkuuit* through a form of apprenticeship, and with some knowing right when they were born or through older *angakkuuit*'s predictions that they would become *angakkuuit* (Aupilaarjuk et al., 2001; Rasmussen, 1930a). Others became *angakkuuit* later in life through dreams or visions telling them that that was what they should do (Aupilaarjuk et al., 2001). According to some, becoming an *angakkuq* required the individual to seek a helping spirit (Rasmussen, 1930e). It has also been suggested that a person who failed to become an *angakkuq* because he or she was unable to receive inaugural visions during apprenticeship ended up being a witch or *ilitsiitsoq*<sup>46</sup> who was able to make a *tupilaq* (Andersen, 1971) and would use it as a means to inflict evil. If illness, hunger or bad weather affected a whole community or camp, a shaman might attempt to get into a trance to enter the spiritual world or travel to the underworld to appease the gods and spirits (Aupilaarjuk et al., 2001; Egede, cited in Erngaard, 1973; Freuchen, 1961; Rasmussen, 1930a,e). *Angakkuuit* were respected and both men and women could be *angakkuuit*, although they were most often men (Aupilaarjuk et al., 2001;

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<sup>44</sup> In Igloolik, Nunavut, *nunarluk* is used rather than *tupilaq* (Aupilaarjuk et al., 2001, p. 255). *Tupilait* is the plural form of *tupilaq* (Aupilaarjuk et al., 2001, p. 185).

<sup>45</sup> *Igluit* is the plural form of *iglu*, which in English is snowhouse (Aupilaarjuk et al., 2001, p. 247).

<sup>46</sup> Andersen does not provide the Greenlandic word for witch. According to the Greenlandic/Danish dictionary the Greenlandic term is *ilitsiitsoq* (Berthelsen et al. 1997, p. 112).

Bennett & Rowley, 2004). As one Elder expressed in 1972, “the shamans were seen the same way we see doctors. The shamans were serious men” (Kallak, cited in Bennett & Rowley, 2004, p. 181).

There is also a consensus in the literature about the past importance of amulets in order to maintain good health for Inuit in both Greenland and the Canadian Arctic. Amulets would also help to cultivate particular human qualities and the ability to be a successful provider or seamstress. Similarly, there is consensus about the past importance of heeding taboos and abiding by social norms and conventions in order to maintain good health (Aupilaarjuk et al., 2001; Balikci, 1970, 1998; Freuchen, 1961; Lynge, 2005; Okpik, 2007; Ootoova et al., 2001; Rasmussen, 1921, 1930a, 1930b, 1930c, 1930d, 1952; Terrien & Qamaq, 1992; Tungilik & Uyarasuk, 1999). Apart from these more psychologically oriented and primarily preventative measures, curative remedies were also known and used.

Women generally took responsibility for their own families in terms of giving actual sick care and they gathered and provided remedies for ailments and injuries (Bennett & Rowley, 2004; Freuchen, 1961; Ootoova et al., 2001). Although it has been suggested that care for the sick was relatively undeveloped among the Inuit pre-contact, and that those who were unable to contribute to the community were left to fate (Harvald, 1998), other authors reject these ideas (Steckley, 2008). Hart-Hansen suggests that archaeological bone evidence demonstrates that a person who was clearly unable to provide for himself had been looked after and reached old age, although this would have caused hardship in the group (cited in Nuttall, 1999). Furthermore, while some foods and animal parts had certain taboos connected to them for certain people and certain times, many were also known to have health benefits and curative qualities. Knowledge about remedies and treatments was passed from one generation to the next through oral tradition, observation, and participation (Bennett & Rowley, 2004; Ootoova et al., 2001).

Birthing assistance was often given by the labouring woman’s partner, mother, mother-in-law, or other female relative present during the birth.

Sometimes women who were not related would be sought for help, because they were known, trusted and experienced, and had extensive knowledge about labour and birth (Pauktuutit, 1995). Younger women learned how to assist at births by being present and observing when older and more experienced women assisted a labouring woman (Rønsager, 2002).

The following section will demonstrate, however, that some Greenlandic women received Western midwifery training already in the first half of the 1800s (Rønsager, 2002), something that did not happen in Arctic Canada. As in other non-Western countries, and in contrast to the midwifery role, the nursing role was not in existence prior to the superimposition of Western medicine and Western doctors upon Arctic traditions of health and healing.

I have briefly described health care as it existed in the Arctic prior to the introduction of Southern doctors, nurses, and ultimately health care systems. I have demonstrated that although the approach to curing the sick and the remedies and tools used were vastly different, a role similar to that of today's medical doctors did exist in the Arctic in the guise of *angakkuit* or shamans, although the *angakkoq* could also bring misfortune in the form of *ilisiitsoq*. Depending on location and the source of the information, individuals could become *angakkuq* through various forms, including a form of apprenticeship and/or acquiring a helping spirit. The women of a household or camp would generally be the ones helping other women with birthing, although sometimes a woman who was particularly knowledgeable would be sought for assistance. Knowledge about and the ability to assist with birthing would likewise be passed on mostly through observation and participation. The role of nurses as such did not exist; however, some of the roles and responsibilities that we would attribute to Southern nurses were carried out by the women in individual households. This included gathering, procuring, saving and providing that which was necessary to keep individual family members healthy including proper clothes, amulets, foods and medicinal plants and remedies, and the keeping of taboos. The knowledge of these things would be passed on through participation, observation, and orally through the telling of stories.

Having discussed health and sick care as it existed in the Arctic prior to serious introduction of Southern health care in the two regions, I will now discuss how Southern health care was introduced and evolved in each of the two regions, beginning with Greenland.

### ***2.3.2 The history of Western health care in Greenland***

With the establishment of the mission of Hans Egede in 1721 just outside of what is today Nuuk, Western views on sickness and health care were slowly introduced to Greenlandic Inuit. This happened through the missionaries banning Inuit practices and introducing those of Christianity (Rink, cited in Erngaard, 1973), and by the missionaries, colony managers<sup>47</sup> and village constables sharing their own small supply of medicines, first aid remedies, and knowledge about Western diseases and how to deal with them (Bjerregaard, 2005; Jenness, 1967), and last but not least through the very gradual introduction of Danish medical doctors, nurses and midwives. It should be noted that apart from the Herrnhutterites, a German missionary group (Wilhjelm, 2000), both trading companies and missions functioned under the auspices of the Danish state in Greenland, whereas they were independent of the state in Arctic Canada as I will discuss below.

Already in 1742 there was a physician stationed in Nuuk, although he left after 2 years (Jenness, 1967). Hereafter, it took many years before any physicians were in Greenland on a more permanent basis. In 1802, however, the physician H. J. F. Lerch arrived on account of an initiative from the Royal Greenlandic Trade to vaccinate the Greenlandic population against smallpox. In 1838, two medical doctors who were appointed according to the Danish Royal Decree serviced all of Greenland and from 1851 onward there were three (Harvald, 1998). In 1900, only 4 doctors serviced all of Greenland and in 1923, ten did so.

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<sup>47</sup> The Danish word “kolonibestyrelse” translates directly to “colony manager”. The word described a person who oversaw the “running” of a settlement established with the idea of trade, but which often grew as people, particularly those who were unable for whatever reason to take care of themselves, sought work or handouts, knowing that they were available in the colony settlement. Often the mission would also be located where the colony was. The colony manager would receive a certain sum of money, food, and other basic items from the Danish King that could be distributed according to need and he would then serve as a ‘social worker’, ‘law enforcement person’ and often also ‘medical officer’ as well as a trade manager (Jenness, 1967).

Although the population at that time was significantly smaller than it is now, the doctors working there had enormous distances to contend with in order to serve the whole population of Greenland. The first hospital was built in Nuuk in 1856 and after that small hospitals were gradually built in all of the larger settlements, primarily in order to care for the increasing number of people suffering from tuberculosis (Harvald, 1998). Despite hospitals, medical doctors, early vaccinations, and social support and sick care provided by some of the missions, the Greenlandic population diminished between the late 1700s and 1900s due to increasing exposure to Western diseases and trade. According to some, the latter brought malnourishment and under-nourishment as well as dire poverty among the Greenlanders (Bobe, cited in Jenness, 1967; Harvald, 1998; Rink, cited in Erngaard, 1973).

In 1820, the doctor who serviced the population in northern Greenland complained about the high mortality of women in labour and their children, which he blamed on the practices of the traditional midwives or local birthing assistants (Rønsager, 2002). Their techniques were seen as primitive and quite violent. Later, one of the duties the first Royal Decree prescribed for the medical doctors in Greenland was the education of “midwives” and the finding of suitable Greenlandic women who could be sent to Denmark for this purpose (Permin & From, 2004). From the 1830s, Greenlandic women received training in practical midwifery in Denmark and in 1837-38 the first Greenlandic woman received a Danish midwifery diploma (Permin & Vedbæk, 1979). Most of the young women who received training in midwifery, though, did so in Greenland on site, provided by the residing doctors. The trained women who did not have an actual Danish midwifery diploma were in Danish called “*fødselshjælpere*” which translates to birthing assistants; the Greenlandic name for them was *juumuut*, the plural of *juumoq*, which is a Greenlandization of the Danish word for midwife – *jordemoder* (pronounced yourmor) (Rønsager, 2002).

Lerch had started educating Greenlandic midwives before it became part of the Royal Decree. He had also written a document describing the work and responsibilities of the ‘*juumuut*’ (Balle, 2006) although Gad (1965) claimed that

this initiative was likely based upon laziness and wanting others to do his work for him. For most of the 19<sup>th</sup> century the *juumuut* were the only aids or co-workers of the doctors in Greenland (Balle, 2006), and well past the mid-20<sup>th</sup> century they were considered the “bone marrow” or back bone of the Greenlandic health care system (Bøggild, cited in Balle, 2006; see also Petrussen, 2006; Rønsager, 2002). In many places they were *the* health care system. The educated midwives, and often the locally trained birthing assistants as well, received training not just in labour and delivery but also in nursing care and in Western medical procedures that would normally be performed by a physician (Rønsager, 2002), as such they were Greenland's nurses prior to Danish nursing entering the scene.

The Greenlandic women who became educated midwives were “pioneers” as they were the first among their fellow Greenlanders to receive Western education. They were often the daughters from mixed marriages or young women from the Greenlandic elite who had worked as maids in the homes of the Danish colonizers and who spoke both Greenlandic and Danish. The Danish administrators and government officials placed high expectations on these midwives’ ability to influence Greenlandic health care practices and ways of living. They were expected to serve as well-educated, cultivated and civilised role models, and to teach the Greenlandic people in their own language and homes about “civilized living” and hygiene (Rønsager, 2002). It is not difficult to equate the ways in which prospective Greenlandic midwives were chosen to the colonial British attempt to choose as prospective nursing students those Indigenous African and Indian women whom it was thought would most readily ‘convert’ to British moral and cultural values (Holden, 1991). This role as a mediator between Greenlandic and Danish culture, values, expectations, and preferences was not always easy and not all Greenlandic women choose to call an educated midwife when they were to give birth, even when they could. In 1914, 24% of the Southern Greenlandic population choose to use uneducated local birthing assistants (Rønsager, 2002 ). The population in East Greenland did not have the

option to use educated midwives at that time as Danish contact with East Greenland was in its infancy.

It is necessary to understand the developments in midwifery and health care in the context of other changes that happened in Greenland during the same timeframe. For example, increasing Christianisation meant that older Greenlandic practices and taboos were abandoned and particularly the younger population started to embrace “Danish” practices, including birthing practices and some ways of providing infant care. However, it would still have been significantly more difficult for Danish obstetrics and medical practices to be accepted by the Greenlandic people had it not been for the Greenlandic midwives (Rønsager, 2002). The introduction of a Southern health care system also entailed and expected that the Greenlandic patients relinquish all of the responsibility for their health to the health care system. Lange (2010) writes that when she started working in Greenland in 1975, the best choice for a patient was to follow the authority (the doctor) “who made the decisions about what was going to happen with his disease, submit to the rules of the ward, eat the food that was served and do as he was told” and that the patient did not need to care about his disease as “that was what ‘we’ the health care system did” (p. 25).

Although a few Danish nurses in Greenland worked in nursing stations that were not staffed with medical doctors on a permanent basis (Helms, 1984), generally, as was the case with European nurses in India and Uganda, Danish nurses were ‘invited’ to Greenland because the doctors located there needed someone to whom they could delegate care of patients once they had initiated or finished treatment (Lange, 2010). As revealed in the nurses’ description of responsibilities at the time, doctors also needed someone to whom they could leave the treatment and care of the patients in the hospital, as well as those not admitted but needing treatment and care, when they were absent (Arctic Institute Archives [AIA] A395). The first Dane educated as a nurse who was hired to work in Greenland was hired in 1904 as a private initiative and paid with the private funds of the hiring medical doctor Deichman, who serviced the district of Julianehåb (now Qaqortoq). The Greenlandic Directorate saw the benefit in this

arrangement and officially hired the first educated nurse from Denmark in 1906 (Dispatches from the RGT, cited in Kristiansen, 2004). After the first Danish nurse was hired their number slowly increased until in 1935 there were more Danish educated nurses than doctors, with 16 nurses and 11 doctors. It is important to keep in mind, however, that the Greenlandic birthing assistants and midwives continued to be greater in number than both Danish nurses and doctors. In 1935, 112 Greenlandic birthing assistants and midwives worked as paid health care staff (Dispatches from the RGT, cited in Kristiansen, 2004), but where the majority of the Danish nurses were hired to serve in the hospitals and under the medical doctors, many midwives and birthing-assistants served the populations in the smaller settlements in their homes as the only health care provider (Kristiansen, 2004).

In an interview with Sarah Helms (1984) Signe Vest talks about her work as a nurse in Ammassalik. Vest was one of the Danish nurses hired by the Directorate who worked as the sole Danish educated health care provider in one region. She established the nursing station in Ammassalik in 1933 and headed the regional health care system there until a medical doctor was appointed in 1946 (Helms, 1984). Vest had a health care philosophy that required a close relationship with the people she served. She quickly learned to speak Greenlandic and paid visits to all settlements and families within her district to get to know people. She also learned about food habits and how to prepare various traditional dishes from local women. As well as maintaining a surgery and consultation, Vest saw Greenlandic food as an essential remedy to help Greenlandic patients restore health. Greenlandic food, however, could not be ordered or bought, so Vest bought with her own funds an umiak, a kayak, and nets. This allowed her to catch enough seal and fish to preserve for the winter in order to be able to feed her patients and their family members, who would often stay with the patient at the hospital if admission was necessary. In all ways Vest attempted to make the hospital a place where Ammassallimmiut felt at ease and at home (Helms, 1984).

The first 15 years of Vest's residence she lived in the hospital among patients and staff 24 hours a day, also after a medical doctor was appointed to the

district and a large residence had been build in 1948 to accommodate the appointee. Not until 1949 when a barrack was build just across from the hospital did Vest move into more private quarters. The Greenlandic midwife Sofie Jørgensen worked with, and supported, Vest greatly during all the time she worked in Ammassalik. Vest was well liked, respected, and received by all for her health care philosophy, dedication and engagement. Although dedication and hard work were expected (and given) by early nurses in Greenland, Vest was not an average Danish nurse working in Greenland<sup>48</sup>. In 1938 Vest was rewarded the King's Rewarding Medal for her dedicated work (Helms, 1984).

The letters of another Danish nurse, Amalie Lind, to a close friend reveal another experience (AIA A395). Although, and in some ways also because, Amalie Lind does not describe her work and relations with her patients in much detail, the perception the reader gets of her work experience and philosophy as a nurse working with people who do not share her linguistic and cultural background is very different from that of Vest. While Lind, in her letters, tells her friend that the Greenlanders are friendly and welcoming and that it is evident that she cares for the people with whom she works, she also focuses on what she perceives to be their childishness, exoticness and backwardness, and describes her social interactions to include only other Southerners. Lind's letters hint at a preoccupation with orderliness and cleanliness rather than a cultural awareness, and although she writes to her friend that she will have difficulty working in a hospital in Denmark again because of the hierarchy and her lack of independence, she also, as opposed to Vest, describes how she finds the short occasions where she is on her own, because of one doctor's sickness and another's duty travel, to

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<sup>48</sup> The orders for Danish nurses working in Greenland between 1927-28 and in 1958 state that, among other things, it is the nurse's duty with the help of those under her charge to: keep the hospital clean, cook, care for patients according to the doctor's orders, do the doctor's work when he is absent and avoid doing so when he is present, make sure the hospital is stocked with everything necessary for its running in terms of medical material, bedding, food and everything else, train Greenlandic students, keep financial account for the running of the hospital if asked to do so and be stringent with the hospital funds, and carry out regular home visits to all households although without making anyone feeling comfortable or giving advice in the form of reprimanding or interference (AIA A425)

be quite stressful, and that she is looking forward to returning to Denmark after her 2 year contract is up, to her known foods and other comforts (AIA A395).

The Greenlandic birthing assistants and midwives had been educated by the residing doctors until the Danish nurses were hired. With an increasing presence of Danish-educated nurses in Greenland, more Greenlandic women were trained through a form of apprenticeship in basic nursing care, and many obtained positions in the small local hospitals. These women were also called *juumuut* or birthing assistants. Few went to Denmark and received an actual nursing diploma. According to one source, the first two Danish-educated Greenlandic nurses received their diplomas in 1934 and 1935 (Lange 2010), according to another source the first Greenlandic nurse was Netta Heilman, from Nuuk (Permin & Vedbæk, 1979).

Netta Heilman earned her nursing diploma, prior to earning her midwifery diploma, in 1925. At that time it was necessary to be educated as a nurse prior to becoming a midwife. As was the case with many who were 'chosen' to become midwives, Netta worked as a maid for the colony manager. The colony manager had Knud Rasmussen for dinner one night and Netta was among the maids serving. Rasmussen asked her who she was in Greenlandic and she told him her name. Some time later she was called to the colony manager's office. Rasmussen was there and he asked whether she would like to go to Denmark to become a nurse and a midwife in order to work as a nurse in Thule. And that was how it went, although her mother was not eager to let Netta go as she was a single parent and depended on the money Netta earned. Rasmussen visited Netta's mother and got her to accept. It was not easy for Netta to be in Denmark; she did not know the language and she was terribly homesick, but she stuck through it. Just after graduation Netta was hired as a nurse-midwife in Thule where there were no other doctors or nurses (Permin & Vedbæk, 1979). Here she met her husband to be Hans Nielsen, a friend of Knud Rasmussen, who apparently had talked him into going there and had also played a part in Netta and Hans coming together. Rasmussen made sure Netta was provided for during her education and invited her to visits and parties with him and his family and friends when he was in

Denmark. Netta saw in Knud Rasmussen a sort of foster parent. They kept close contact till his death and Netta kept in contact with his daughter in Denmark after (Permin & Vedbæk, 1979).

Although Netta's situation appears unique, it also has some similarities to that of the young children who were sent to Denmark for education on the urging of Danes in authoritarian positions such as teachers, and whose parents did not say no. Netta was an educated nurse and a midwife who could be employed anywhere in Greenland or Denmark, but Rasmussen had provided for her and had planned for her to go to Thule, so that was where she went although her family was in Nuuk. It is not difficult to imagine that the situation described by Netta might be characteristic of many of the young Greenlandic women who were 'chosen' as appropriate for a midwifery education in Denmark. Netta, however, recounts her experience only in positive terms (Permin & Vedbæk, 1979).

After the Second World War, during which time little attention had been paid to improving the health and welfare of the people in Ammassalik as well as to the population in Greenland generally, increased focus was turned to health care issues needing immediate attention. The extent of tuberculosis was one of these (Kristiansen, 2004). It was decided that medical expeditions with visits to all of Greenland's settlements needed to be carried out in order to gauge the health care challenges and needs of the Greenlandic population. The first expedition, which took place in 1946, found that 70% of all hospitalisations in Greenland were on account of tuberculosis (Kristiansen, 2004). Subsequent recommendations included the establishment of a tuberculosis sanatorium in Greenland and commission of a tuberculosis or x-ray ship. This, and further medical expeditions, led to BCG vaccinations (Bacillus Calmette-Guérin/tuberculosis vaccination) of the Greenlandic population, the building of the tuberculosis sanatorium in Nuuk which opened in 1954, and the launch of the x-ray ship the *Missiguut*. *Missiguut*'s inaugural journey commenced in the summer of 1955 and both the first and subsequent x-ray expeditions were able to cover, on average, 90% of the Greenlandic population; the ship was supposedly very popular and well received by everyone (Kristiansen, 2004).

Despite the arrival of Danish nurses and Greenlandic women being sent to Denmark for education, the greatest group of Greenlandic health care workers continued to be the birthing assistants. The birthing assistant education had existed for a long time in the local hospitals when a formal 3-year birthing assistant education started in 1957 in Aasiaat. This program, however, was already considered lacking in the 1960s and the number of applicants to the program was decreasing. A resolution to this dilemma was the establishment of a health assistant (in Danish, *sundheds-medhjælper*) program (Lange, 2010; Lange & Ezekiassen, 2004).

The health assistant program took 3 years to complete and contained both theory and practical training, but as was the case with the birthing assistant program, it was exclusively available in Greenland, and aimed at the particular conditions of the Greenlandic health care system (Lange & Ezekiassen, 2004). Health assistants worked in all towns and villages and had the qualifications to assist at births as well as take responsibility for much nursing care. The health assistant program was terminated in 1995, several years after Greenland assumed responsibility for the health care portfolio in 1992. At that time the Home Rule government wished to establish a nursing program in Greenland in order to educate “home-grown” nurses. The idea was that the nursing education would replace the health assistant education. The government wanted the education to be equivalent to the nursing education in other Nordic countries and internationally, which meant that the entrance qualifications would be higher than those for health assistant students, but it also meant that the education would be portable and that the nurses would have authorization to do more than the health assistants (Lange, 2010; Mohr-Lybert, cited in KNR, 2006).

This change was not welcomed by everyone (Lange, 2010). A recent reader debate of a news story in the online version of Kalaallit Nunaata Radio [KNR], the Greenland National Broadcasting Company, is interesting. On June 5<sup>th</sup>, 2008 the top story was that Greenland’s National Hospital, because of staff shortage, had to cancel all planned operations for at least three months (KNR, 2008b). On June 9<sup>th</sup> the top story was the reaction of the Patients’ Council to this initiative

(KNR, 2008c). Comments from the 10 readers who responded to these stories online included laments over the termination of the health assistant education and observations that since then only bilingual Greenlanders who have graduated from high school with high levels of math and biology are able to enter the nursing education. One reader wrote that the health assistant education was equivalent to the Danish nursing education before it became a university program, with the added bonus that health assistants were trained to assist with births (Ujaraq, cited in KNR, 2008b).

The same reader wrote that the termination of the health assistant education, and only educating “real nurses,” has meant a reduction in possible health professionals from 17 health assistant graduates a year to 5 nursing graduates a year<sup>49</sup> (Ujaraq, cited in KNR, 2008b). This, the reader wrote, is because the recruitment of students for the health assistant education was much broader and allowed entrance to individuals from small towns and villages who returned to their hometowns to work; the reader added that few of these individuals had graduated from high school but were nevertheless very capable.

Another reader wrote that many Greenlanders who graduate as nurses end up working only a couple of years as frontline nurses before they enter administrative or political positions because of their bilingualism, and that many others choose to go to Denmark to work or remain in Denmark upon graduation if they took the nursing program there (Inuk, cited in KNR, 2008b). Chemnitz (2001, 2005) also wrote about the large number of Greenlanders who stay in Denmark once educated there, and this idea is corroborated by research conducted in 2006, which found that 108 nurses of Greenlandic descent were employed in Denmark (Smith, Persson, Qujaukitsoq, Dahl & Olsvig, 2007). This number, however, needs to be seen in light of who is counted as a Greenlander by the researchers. Of the more than 18,800 Greenlanders who live in Denmark, the numbers in the report included 1<sup>st</sup>, 2<sup>nd</sup>, and 3<sup>rd</sup> generation Greenlanders; that is, the adult Greenlanders who moved to Greenland and their children and

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<sup>49</sup> Five nurses graduated in 2008; however, statistically there appears to be 8 nursing graduates on average (Enoksen & Mozfeldt, 2006).

grandchildren, regardless of their cultural and familial connections to Greenland (Smith et al., 2007).

Replacing the health assistant program with a nursing program has, according to Ujaraq (cited in KNR, 2008b), meant a decrease in the number of Greenlanders educated and employed as frontline health professionals. This may be true despite the more recent addition of a 1-year health aide program (in Danish *sundhedshjaelper*) that was established in 1993 with a possible 1-year extension called a health associate program (in Danish *sundhedsassistent*) established in 2000 (Centre for Health Education, 2008a, 2008b; Lange & Ezekiasen, 2004). The health aide program provides the training required to provide assistance to the ill, elderly or handicapped in their homes, nursing homes and elders' facilities (Centre for Health Education 2008a). The health associate program qualifies the graduate to provide basic health and nursing care and provides the foundation for special training within certain areas of health care either as on the job training or through speciality courses (Centre for Health Education, 2008b). Neither of these programs provides the same qualifications as the terminated health assistant program did. It should be mentioned that several of the older nurses, some of whom were educated in Denmark and already practicing when the Greenlandic nursing program was proposed, mentioned that the medical doctors working in Greenland seemed to be those who opposed the "lift" of the nursing education the most. As one nurse in this study said:

*It was a little too progressive for them. They were wondering whether it would be worth it as nurses are 'difficult'. You know, you can't make nurses do just everything [the way you can with assistants] and they do not clean up after you. (T30:287)*

Lange similarly observes the resistance among the medical doctors and writes, "the administration of the official health care system remained firm that a nursing education was unwanted" (Lange, 2010, p. 80). Lange and several nurses mentioned that health assistants were more like nurses in the Nightingale sense of the word; health assistants functioned as doctor's helpers and obeyed the doctor's beck and call. It is interesting that the objections that arose against nursing becoming a university degree in Greenland (Lange, 2010) are similar to the

objections that Nightingale and her followers encountered with the reformation of the nursing profession in last half of the 19<sup>th</sup> century (Gamarnikow, 1991).

In 1995, when the health assistant education was cancelled, the areas of responsibility for health assistants were also severely curtailed. A number of the “old” health assistants upgraded their education through a merit program lasting two years and now hold nursing degrees (Lange, 2010; Lange & Ezekiasen, 2004); however, shrinking the areas of responsibility of health assistants has meant that Greenland’s health care system still relies on Danish nurses and other highly-educated health professionals, and that it therefore continues to be governed and staffed by a majority of Danish speaking Danes, while also being cast in a Danish mould (Aaen-Larsen, 2004; Dahl, 2005). This situation is very similar to that in Canada, despite the two regions’ quite different histories concerning health care, which the following section on the history of Western health care in Nunavut will demonstrate.

### ***2.3.3 The history of Western health care in Nunavut***

Nunavut, unlike Greenland, did not have any residing Western medical doctors until well into the 1900s (Wenzel, 1981). In this connection it is worth remembering that Canada was not a nation until 1867 whereas Denmark has been a nation since the 900s. According to Wenzel, Canadian Inuit were already introduced to Western ideas about health care in the 16<sup>th</sup> century on account of the presence of whalers, missionaries, and traders in the Arctic. At that time, however, it was unusual that Inuit benefited much from Western health care, and any care given came simultaneously with the introduction of otherwise unknown Western diseases.

In the early 1900s when Canada first “become aware” of the potential of the Arctic, health care continued to be scarce, and rather than the Canadian state taking responsibility for the medical needs of its Northern population, this continued to be done by the Church, industry, and police, when it was done at all (Waldram, Herring & Young 2007; Wenzel, 1981). There are several accounts from travelling doctors and others in the Hudson Bay area between 1812 and

1828 (Fortune, 1971), long before any hospitals or health centres were built. Although the travelling doctors were not there to take care of the Inuit, they did notice their state of health, which, their accounts purported, was generally good, apart from many cases of eye problems/inflamations. This trend soon changed; already in 1822, the explorer Parry wrote about an epidemic that killed more than 10 % of the population during his second winter in Igloodik. He did not name the disease responsible for this epidemic. Parry did mention that no sickness was observed among the Inuit of Igloodik in his first year, but that in his second year, they had developed the practice of isolating sick individuals, which could indicate familiarity with epidemics (Parry, cited in McGhee, 1994). After visiting southern Baffin Island in 1861, Hall wrote that consumption (tuberculosis) had killed more Inuit than all other diseases combined (Grygier, 1994). Another early account came from Lucien Turner in 1889. He stated that: “half of the Inuit in Kuujuaq died of ‘pulmonary troubles’” (cited in Grygier, 1994, p. 56).

Dr Frederic Banting, the Canadian doctor celebrated for his discovery of insulin, also enjoyed painting. His friend the painter A.Y. Jackson, with whom he went on painting forays, was scheduled to join the Canadian Department of the Interior supply steamer *Beothic* in the summer of 1927. Banting had a keen interest in joining and sent a letter to the department applying for the position of Medical Officer of the *Beothic*. It turned out that they had one already, but they agreed to accept Banting as a guest. When he asked if there was anything he could do to be useful, he was told that it would be valuable “to have his opinion of the effect of the white man’s food and clothing on the Eskimo” (Bliss, 1984, p. 174). Subsequently, Banting submitted two reports about the health and conditions of the Inuit at Arctic Bay and Port Leopold to the Department of the Interior, the first on September 15, the second on November 8, 1927 (Tester & Kulchyski, 1994, p. 374). Prior to submitting these reports he shared his findings with a friend, Greenaway, who was also a reporter from the Toronto Star. He did so on the train ride from Montreal to Toronto. As Banting had promised the Department of the Interior that he would not make any statements to the press not cleared by the Department, he only allowed himself to be interviewed about his

Arctic exploits as a painter. After the interview Banting had what he perceived to be an ‘of the record’ conversation with Greenaway about the HBC’s exploitation of the Inuit, and the deplorable conditions under which they lived. When Banting bought the *Star* to read what was supposed to be an innocent story, the headline “Banting regrets Hudson Bay use of Eskimo” assaulted him. The Department and the governor of the HBC were outraged. The Department because Banting had not made any such report to the Department, the HBC denying Banting’s charges as false and slanderous (Bliss, 1984, p. 175). Despite Banting standing his ground in the reports he submitted, and that the article in the *Star* caused some public reaction, neither was enough to actually bring any change to the Inuit. Apart from the critique of the HBC, Banting described tuberculosis cases, general malady, and deplorable living conditions with Inuit being clad in “cheap” EuroCanadian clothing totally unsuited to the Arctic (Tester & Kulchyski, 1994, p. 107; see also Bliss, 1984, pp. 175-176).<sup>50</sup> These observations are very similar to those made by Holm in East Greenland in 1895 (Mikkelsen, 1994).

Similar accounts had come and kept coming from doctors appointed to serve in the Arctic from the 1920s through the 1930s, asking officials for help in dealing with the all consuming disease and the deplorable conditions under which people lived in general, and lobbying for the development of hospitals and nursing stations in the North (Grygier, 1994; Tester & Kulchyski, 1994). The hospitals that did exist at the time were mission hospitals. They included the one that was built in Aklavik in 1920 (Copland, 1967), one built in Chesterfield Inlet in 1929, and the one in Coppermine, which was built in 1929 in collaboration with the federal government (Jenness, 1972). The Anglican mission also ran the only hospital in the Baffin Island area at that time. It opened in 1902 and was located close to Pangnirtung on Blacklead Island. Prior to opening the hospital

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<sup>50</sup> Banting was furious at Greenaway, for what he perceived to be a deceit, and after a loud fall-out did not speak to him for the next 10 years (Bliss, 1984). Greenaway in turn said that he had perceived the conversation as a carry-on of their interview begun in Montreal and that, while taking notes, he had warned Banting about slandering the powerful company. A few years later the first issue of the *Canadian Geographical Journal* published an article by Banting describing his trip. This article was ‘vetted’ by the Department and provided a more ‘balanced view’ “concluding that changes should come slowly and the government had things well in hand” (Bliss, 1984, p. 177).

the Anglican mission had provided medical care to the Inuit on Blacklead Island since 1894 (Farrell, 2004).

The report by Dr. Banting mentioned above included a paragraph indicating that the plans to build a new hospital in Pangnirtung “would be a waste of money” (Copland, 1967, p. 95). Where the government found the report an embarrassment, Dr Livingstone, who was the medical officer on the *Beothic*, agreed with Banting. The government was certain that the bishops would go to Ottawa to protest Banting’s statement. The Anglican church was in the midst of soliciting funds from private individuals and already two mission hospitals operated in Aklavik. Although the report set the building of a new hospital in Pangnirtung back a little, it was built in 1929 as part of a medical headquarters, in the end on the recommendation of Dr. Livingstone himself after he had been appointed to the permanent position of Senior Medical Officer of the Northwest Territories and Yukon in 1928. Since there were no other doctors available for northern service, Livingstone decided to take on the duty himself. He was relieved in the early fall of 1929 by H.A. Stuart and returned to Pangnirtung again as a resident between 1931 and 1933 (Copland, 1967). The new St. Luke's hospital in Pangnirtung was build while Stuart served there. It received its first patients in 1931 (Copland, 1967) and operated until 1972 (Farrell, 2004). On account of the work started by Livingstone, in 1930 there were six medical officers in the Northwest Territories (Copland, 1967); despite this the health and living conditions of the Inuit continued to deteriorate.

In 1934, four years after St Luke’s Mission Hospital was built, Dr. J. A. Bildfell, who had relieved Dr Livingstone, wrote that tuberculosis was so prevalent in Pangnirtung that it appeared to be the only disease present. He continued that tuberculosis was the principle reason for very high child morbidity and mortality (cited in Grygier, 1994). Many of the Blacklead Island inhabitants moved to Pangnirtung with the decline of the whaling industry. Many converted to Christianity and were supportive of the hospital. The shamanic leaders had apparently given way to Western medicine, accepting that against Western diseases they had no power, and many community members “were engaged as

hospital workers, caretakers and relied upon as guides for outpost travel” (Farrell, 2004, p. 137). None were apparently involved with the medical care of their fellow Inuit except in the delivery of food and already poured medication, a point that deserves further discussion and to which I will return to below.

As opposed to St Luke’s, most other mission hospitals that opened often closed again a few years after their construction. This included the ones in Aklavik, Chesterfield, and Coppermine (Jenness, 1972). Although the medical officers of these hospitals were often federally employed (Waldram et al, 2007), and the federal government supported the hospitals financially to some degree (Farrell, 2004), “medical care and culture change were often viewed by the EuroCanadian caregivers to be interrelated” and medical aid was used as an attempt to Christianise the Inuit (Waldram et al., 2007, p. 199; see also Tester & McNicoll, 2006). In 1943 in the Northwest Territories, of which Nunavut was a part until 1999, there were 11 hospitals: 9 owned by missions and 2 by mining companies, and in 1946 there were 9 physicians employed (Duffy, 1988).

Despite appalling accounts from doctors, traders and explorers into the early 1940s, nothing much was done by the Canadian Government to help Inuit improve living conditions and overcome severe health issues (Grygier, 1994; Tester & Kulchyski, 1994; Vanast, 1991). Rather, money and effort spent by the government and others in the North was aimed mainly at assuring sovereignty (Brody, 1991; Tester & Kulchyski 1994), documenting for posterity these “strange, happy and naive people” and their cultural curiosities before they became extinct (Vanast, 1991, p. 77), pursuing commercial endeavours that would enrich people from elsewhere (Tester & Kulchyski, 1994), and ideologically transforming the Inuit to conform to EuroCanadian religion, beliefs, and values (Brody, 1991; Grygier, 1994; Tester & Kulchyski, 1994). This is exemplified in documents such as *The Book of Wisdom for Eskimos* discussed by McNicoll, Tester & Kulchyski (1999). The book was produced in 1947 after the Department of National Health and Welfare had, in 1945, assumed responsibility for both Indian and Inuit care, and Inuit began receiving family allowance benefits for the first time (Jenness, 1972). It was in the Canadian Government’s

interest that the Inuit looked after themselves in the best possible way so that the Government did not have to, and the book was an attempt to “regulate bodies and practices of Inuit to suit the exigencies of the welfare state” (McNicoll, Tester & Kulchyski, 1999, p. 199). It instructed the Inuit on how to live, work, and to keep themselves clean and healthy with advice often totally unsuitable for Arctic residents. For example, bottle-feeding rather than breastfeeding was advised, even though no milk was available (McNicoll, Tester & Kulchyski, 1999).

Sovereignty concerns accelerated government control of health care in the Arctic after WWII. The Eastern Arctic Patrol boat *Nascopie*, and then the *CD Howe*, were commissioned to fight the tuberculosis epidemic from the mid-1940s. The ships visited all Arctic settlements and camps, and medical professionals examined and x-rayed most inhabitants during the ice-free months of the year, shipping those with disease to southern hospitals. Particularly Grygier (1994), but also Tester, McNicoll and Irniq (2001) and Tester and Kulchyski (1994) elaborate on the difficulty and hardship Inuit suffered during these TB campaigns. Although the Southerners involved in the campaigns worked hard to help the Inuit and the campaigns were seen as a success from an administrative perspective, they were a cultural and social disaster for the Inuit. The initial reports stemming from passengers on the ship who were neither staff nor patients were very critical of the way the Inuit were treated and the travelling conditions and provisions underway, and although conditions improved greatly over time, being sent to the south for TB treatment was never easy for the individual or for his or her family (Grygier, 1994).

The *CD Howe*, which was commissioned in 1950, did not only serve as a sailing tuberculosis clinic. The medical staff on *CD Howe*'s inaugural journey included a medical doctor, a medical attendant, a dentist and an x-ray technician, and the group was enlarged with a nurse and another medical doctor midway in their journey. Although the number of staff varied from one year to the next, it always included a doctor, a dentist and an x-ray technician, and sometimes an ocular team joined the medical group. In the mid 1950s the staff increased to also include a social worker and beginning in the early 1960s the medical party was

up to 25 people with several doctors including an ophthalmologist, an ear- nose-throat specialist and a radiologist, two dentists, dental assistants, an x-ray technician, social workers, ward-aides, assistants and translators. The ship was also able to report back to community members about their families in the south since it visited virtually every community every year, and the addition of social workers and their concern for both the patients' welfare and entertainment, and the welfare of the family members left in the community, eased the journey for the patients and the pain of separation for both (Grygier, 1994).

With the increase in government control of Canadian Arctic health care the remaining missionary hospitals were eventually taken over or shut down by the federal government and replaced with nursing stations, the first opening in 1947 at Port Harrison (now called Inukjuak) situated in Nunavik, and the second in Coppermine (now called Kugluktuk) situated in the Kitikmeot region of Nunavut (Duffy, 1988). In the early 1960s nursing stations were operating in 12 major Inuit settlements and also servicing another 14 smaller outposts (Jenness, 1972), and "by 1970 most communities with a population over a hundred people had fully equipped nursing stations" (Brett, cited in O'Neil, 1989b, p. 285). Nurses had contact, although unreliable, with physicians, and medical evacuations and transportation to Southern hospitals for more extensive treatment became more common (Jenness, 1972). The nursing stations were operating with non-Inuit nurses, and as in other non-Western countries, they were often recruited from Britain because of their advanced skills in midwifery (O'Neil, 1989b). An important difference between Arctic Canada and Greenland was that while nurses in Greenland were generally brought there in order to support the doctors, the nurses in Arctic Canada were expected to take the role of sole health care provider with a doctor visiting only very sporadically, as has been described in Uganda (Nguyen et al., 2008; Okello et al., 1998). Although these nurses provided excellent health care, many often simultaneously fostered "a situation where the Inuit were dependant on their services for all aspects of their well being" (O'Neil, 1989b, p. 286), resulting in a medicalization of community life

with a nurse that monitored community members as if they were “patients on a hospital ward” (O’Neil, 1989b, p. 286).

Using the Archival material from the Glenbow Museum and Archives collected as part of the Frontier Nursing Project, Mary Rutherford (2008) describes three different types of Southern nurses who worked in the Arctic in the early days of Arctic nursing. She calls the three types of nurses *cleansers*, *cautious caregivers*, and *optimistic adventurers* for the approaches they had to their work and lives in the North. While maintaining that the categories are fluid, Rutherford describes the cleanser nurse to be obsessed “with cleanliness, hygiene, comportment and appearance... wanting to remake or reconstitute Aboriginal bodies” (Rutherford, 2008, p. 58). As an example of a cleanser, she describes Donaldda McKillop Copeland. In the book “*Remember Nurse*” Copeland described her time as a nurse in Coral Harbour from 1950-1955. Among many other initiatives undertaken while she worked in Coral Harbour, Copeland instituted a clinic at the schoolhouse where she carried out bodily inspections, took the weight and height of each child, and cut the hair of those she thought needed it for health and hygienic reasons. On one such occasion she provoked the wrath of a father who, after Copeland had cut his daughter’s hair, came to the clinic in the afternoon carrying a gun and angrily addressed Copeland in Inuktitut. The nursing station caretaker, Tommy, afterwards explained that Inuit women were not supposed to have their hair cut, but this did not deter Copeland from continuing her practice (Copeland, 1960). Copeland also initiated a bathhouse in the schoolhouse and invited all community-members to come and bathe or wash clothes there at any time. She later laments that, although she has had some success with the Inuit children, her attempts at improving the hygiene of the adult population was not very successful. Copeland’s daughter became close friends with a young Inuk girl, Nana, who despite having a family of her own frequently shared the meals and home of the Copelands. In a similar show of hygienic fanaticism, Donaldda took “over the regular washing and bathing of the little girl and the care of her clothing” (Copeland, 1960, p. 78).

Cleansers, in Rutherford's description, bring to mind the critique of *the Book of Wisdom for Eskimoes* (McNicoll, Tester & Kulchyski, 1999) as mentioned above, and how the Canadian Government with *the Book* and its support of cleanser nurses perpetuated the medical politics and values outlined in European countries in the 18th century, with a focus on “the family-children complex as the first and most important instance for the medicalization [and normalizing] of individuals” (Foucault, 1995, p. 281). As I have mentioned elsewhere (Møller, 2005), the nurses and other health care professionals employed by the Arctic health care system of the early 1900s were among the *disciplines*<sup>51</sup> which, in the name of the State (and colonial power), used that which Foucault (1995) called *bio-power*<sup>52</sup> to regulate both public and private life and the behaviour of individuals and whole communities. Within the norms stipulated by *bio-power* and by extension nurses (including Copeland), Inuit had a ‘right’ to life and health, which made resistance to this medicalizing and normalizing power almost a resistance to life and health themselves (Foucault, 1995). *The Book* and the memories of Copeland, as described in *Remember nurse*, offer a historically accurate reflection, I believe, “of the general Qallunaat attitude towards Inuit, an attitude of paternalism, placing power and knowledge with the white colonizers and infantilising the Inuit, while placing the blame for poor Inuit

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<sup>51</sup> Foucault describes a *discipline* as a type of power, and at the same time that which makes exercising this power possible, its “instruments, techniques, procedures, levels of application, [and] targets” (Foucault, 1995, p. 215). Thus, disciplines are agents who have the power to exercise that which is necessary “for assuring the ordering of human multiplicities” or populations (Foucault, 1995, p. 218) as well as the techniques and procedures needed to do so. The disciplinary institutions possessing the power to exercise these techniques include the army, the educational system, the medical system and the judicial system.

<sup>52</sup> Bio-power is a form of insidious power/control which, rather than being overtly repressive, uses subtle means to regulate the ways in which people conduct themselves and relate to each other (Hogle, 2002). The ability to do this requires knowledge; therefore, the state is preoccupied with the collection of statistics, through which, the so called experts, the *disciplines*, can label ways of behaviour as deviant, abnormal, or immoral, and bodily states as diseases, thus legitimising systematic attempts at medicalizing both behaviour and body (Hogle, 2002). In this way bio-power, through creating “a domain of expertise, constitutes its own objects of analysis to which it then responds” (Lock & Kaufert, 1998, p. 6). Due to the nature of bio-power, “subjects are made to feel autonomous; in fact there is a fetishism of empowerment that results in individuals being even more complicit with apparatuses of governmentality” (Rose, cited in Hogle, 2002, p. 236).

health on the Inuit” (Møller, 2005, p. 58). The Danish Nurse Amalie Lind, mentioned in the previous section, may be characterized as another Southern nurse belonging to the category of cleanser. Cleansers, however, were just one of many different kinds of nurses choosing to be employed in the Arctic. Cautious caregivers and optimistic adventurers were the others described by Rutherfordale.

Rutherfordale characterizes the cautious caregivers as lacking the missionary zeal of the cleansers. Cautious caregivers, rather, are characterized by being self-reflective, self-questioning even, interested in Native medicine rather than wanting to change local health and hygiene practices, and “conscious of moving forward carefully, both culturally and medically” (Rutherfordale, 2008, p. 61). As an example of the cautious caregivers Rutherfordale describes Dorothy Knight, who questions both her own role as a nurse in an Inuit community and the entire Northern medical enterprise (Rutherfordale, 2008). When Knight was asked why she wanted the job in a Northern community, her immediate reply was, “because I am curious” (Rutherfordale, 2008, p. 61). She did not take on her Northern position thinking that she could ‘save’ the Inuit, and often felt that she needed their help more than they hers while she lived and worked in the Arctic. Still, when Knight arrived in Lake Harbour (Kimmirut) in 1957, she wholeheartedly invested herself in her work. Knight did, however, realise the futility in attempting to introduce practices that would not be possible to carry out in most Arctic homes. For example, once when she attempted to clean a small child infected with impetigo in a bathtub she abandoned the idea when she saw the terror in the child’s eyes, heard her screaming, and felt her bodily protests. Instead, she then instructed the mother to wash the child using a familiar pot in her home. She also did not favour the practice of evacuating TB patients to southern sanatoria, with the long stays away from the community and the subsequent cultural and social disruption this often implied. She thought Inuit should be trained as nurses so that they who knew about Inuit culture and practices could practice in their own communities. Her thinking was very radical for the 1950s in Canada and probably not characteristic of most health care staff working in the Arctic at the time.

The third kind of nurses described by Rutherfordale (2008) is the optimistic

adventurer. This kind of nurse, she writes, was someone who could be critical without stereotyping and who, rather than trying to change Indigenous behaviour, were positive about Indigenous culture and sought to learn as much as possible about local healing practices. Furthermore, this kind of nurse would not question her place as a White nurse in the North, generally did not complain about the North, and was more likely to break rules. As Rutherfordale's discussion of nurses working in outpost settings generally indicates, a sense of adventure and a willingness and ability to be fiercely independent were basic requirements for these nurses. She also cautions that historians make a strong case tying the qualities of the adventurer nurses to imperialism; there was often the romantic, adventurous and heroic idea that Northern nurses follow the early explorers into unknown lands, and a colonialistic and hegemonic rhetoric of the North as human versus nature (Rutherfordale, 2008).

The optimistic adventurer described by Rutherfordale is Lucy Wilson<sup>53</sup> who worked in Cambridge Bay (Iqaluktuuiak) for a year in the early 1960s. Wilson's letters to her parents describe, "fishing expeditions, flight mishaps" and special community events (Rutherfordale, 2008, p. 68). Her goal was apparently to see as much of the North as she could while there and she felt at home with the other newcomers to the North as well as the local residents, without questioning her place there, or attempting to change local hygienic or other practices. She did not, though, question why Northerners were not trained to be health care providers. She enjoyed the other optimistic adventurers around her, but "couldn't stand to work with anyone who insisted on getting frantic about things or were unhappy about the North" (Wilson, cited in Rutherfordale, 2008, p. 68). Signe Vest, the Danish nurse mentioned earlier, might also be characterized as an optimistic adventurer, although, as Rutherfordale writes, the categories of cleansers, cautious caregivers, and optimistic adventurers are fluid and the characteristics of one may on occasion be found in another. Regardless of how we might characterize individual nurses who choose to work in the Arctic in the early days of Arctic nursing, from their writing there is no doubt that they had the best intentions, that

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<sup>53</sup> Lucy Wilson is a pseudonym (Rutherfordale, 2008).

they did what they thought would be in the best interest of the people in their care, and that they worked hard. Although the degree to which a colonial agenda of assimilation was pursued by early Arctic nurses varied greatly, they were still part of the colonizing project, and the use of Inuit in nursing-like roles appears to have been sparked by need, rather than planning, as I will discuss further below. As the populations grew, even with the help of Inuit, it became increasingly difficult for nurses to provide the quality of care and preventative public health programming needed, as the staffing at the stations was quite sparse and the turnover great (Duffy, 1988).

Some Inuit worked in the nursing stations as caretakers and in other support positions, and some who worked over many years in the nursing station received on-site training enabling them to serve a triage function to determine whether a client was in need of actually seeing a nurse. Some Inuit in the small settlements, where there was no nursing station, would receive 6 weeks of intensive instruction in basic medicine and then serve as the settlement's lay dispenser of medicine (O'Neil, 1989b). Little or no encouragement was apparently given to Inuit to become trained medical professionals (Jeness, 1967). One of the Inuit who worked at St. Lucas hospital in Pangnirtung, however, reminisces that she and another Inuit hospital worker were asked to go to Aklavik to be trained as nurses by the missionaries but that they were not able to get their parents consent to do so. Another of the previous Inuit hospital staff recount how she would relieve the nurses in order for them to 'visit, 'go for a walk' or otherwise just 'do their things' and get a chance to be the one 'to look after everything' (Farrell & Alivaktuk, 2005).

The little evidence of Inuit having been encouraged to train to become nurses, nurse's aides, or medically trained midwives can be seen in the context of other Canadian realities. The nursing education had been barred for Aboriginal people, people of colour, and Asian immigrants until WWII. Even well into the 1960s it was difficult for anyone who was not of European descent to receive nursing training in many Canadian provinces (McPherson, 2003). Another fact worth mentioning was that when the northern nursing stations were built and

staffed, Denmark, which educated Greenlandic Inuit midwives, had a long tradition of midwifery and midwifery education. In Canada, on the other hand, midwifery was not legal (O'Neil & Kaufert, 1995). This has only slowly changed and is still in the process of changing, as some Canadian provinces and territories are still without legislation concerning midwifery (Canadian Association of Midwives, 2010), and only since 1993 has it been possible to become educated as a midwife in Canada (Tyson, 2001). Currently, there are 6 midwifery degree programs in Canada, three in Ontario, one in British Columbia, one in Quebec and one in Manitoba. On top of that there are four Aboriginal midwifery diploma programs, one in Nunavut, one in Nunavik, one in Manitoba, and one in Ontario (Canadian Association of Midwives, 2010).

After WWII some Inuit were educated in Southern Canada as nurses, although no differentiation was made between Inuit and First Nations People, which makes it difficult to give a clear number. McPherson (2003) writes that in 1951 fifteen Inuit and Indian students were enrolled in nursing programs in Canada and in 1961 the number had increased to 38. One educated Inuit nurse was the first to be hired at the newly established nursing station in Sukluktuk in Nunavik. It was, however, difficult for her to be accepted by the Inuit community members: "they preferred the services of the missionary who had been treating them for more than a decade and who was 'White'" (Graburn, cited in Waldram et al., 2007, p. 206).

Although midwifery was not legal in Canada, British nurse-midwives were hired to serve in the north for their training in midwifery. They were not, however, recognized in authority or in pay for these qualifications, as the Canadian Medical Association was unwilling to relinquish responsibility for childbirth, and physicians saw labour and births as belonging under the auspices of medical doctors (Dodd & Gorham, 1994; Mitchinson, 2002). Often the non-Inuit nurses elicited help from and worked with traditional Inuit midwives (Morewood-Northrop, 1997; O'Neil, 1989b). Up to the mid-1970s, 70% of births took place in the communities, but both this and the cooperation between traditional midwives and nurses has totally disappeared. As nursing stations

emerged in all communities and more Canadian-born nurses who lacked the midwifery component to their education were hired, and coupled with the changing legislation towards birthing practices, all women were soon sent to southern hospitals to give birth (O'Neil, 1989b).

Giving birth became, and still is, a concern of the government; the health care system in the vast majority of communities flies women to hospitals to give birth either to Iqaluit, Rankin Inlet or to Southern Canada (O'Neil & Kaufert, 1995), sometimes against their wishes (O'Neil & Kaufert, 1995; Paulette, 1990; Tokolik, 1990). The privileging of hygiene and medicine became an "instance of social control" (Foucault, 1995, p. 282). There have also been developments over the past decade that have brought birthing, and some control, back to some Nunavut communities. I discuss this further in the coming section where I describe the health care systems as they function in both Nunavut and Greenland today, beginning with Greenland. These sections then, also include a discussion of the current state of midwifery and the other forms of health education available in both regions, as I believe these programs are relevant when discussing the nursing programs and the students' and nurses' experiences.

#### ***2.3.4 Health care in Greenland today***

Despite the advent of home rule in Greenland in 1979, the Danish government continued to hold responsibility for certain portfolios, including health care. Gradually, the Home Rule Government increased their responsibility in all political areas, assuming responsibility for health care on January 1<sup>st</sup>, 1992 (Aaen-Larsen, 2004). Today the highest authority in the Greenlandic health care system is the Directorate of Health. Dronning Ingrid's Hospital [DIH] (Queen Ingrid's Hospital) in Nuuk is the national hospital where much specialist treatment is carried out. More specialized treatments and larger surgeries take place in Denmark if it is not possible to do so at DIH in Nuuk. Greenland has 16 health care districts, each with a health care centre employing one or more physicians, nurses, and other health care personnel, depending on the size and need of the population in that district. The health care centres are responsible for basic

primary health care covering all towns and settlements within their district. They carry out “primary health care, uncomplicated births, minor surgery, legal abortions, common treatments in internal medicine and district psychiatry” (Aaen-Larsen, 2004, p. 50). Furthermore, in villages with more than 300 people where there are no health centres or hospitals, resident nurses service village clinics with emergency beds. Most health care is free of charge in Greenland, including transport to an appropriate facility and prescription medicine (Aaen-Larsen, 2004). Local newspapers and phonebooks give evidence of the availability of a variety of private physical and mental health care options such as acupuncture, chiropractic, massage, physiotherapy, reflexology, psychic healing, neuro-linguistic programming and more. These options are mainly available in Nuuk with some in a few of the other bigger towns; in smaller towns and villages, alternative care is limited or unavailable.

Access to quality basic health care remains a problem in Greenland for several reasons, among them a shortage of all health care professionals: only “34% of physician jobs outside of Nuuk are filled on a permanent basis” (Aaen-Larsen, 2004, p. 52), and similar statistics characterize the nursing profession. In November 2007, about a third of all nurses employed at DIH were short term agency nurses (personal communication, Birta Bianco, Director of the Greenlandic Nursing Union, November 22, 2007), and 5 out of 9 nursing positions were vacant at Sisimiut Health Care Center in November 2007 (personal communication, Niviaq Lind, hospital director, November 7, 2007). The difficulty in recruitment and retention results in loss of continuity and poorer quality of care. It also greatly increases health care expenditure as very expensive Danish agency nurses are hired to temporarily fill vacant positions (personal communication Birta Bianco, November 22, 2007). Furthermore, geography and the structure of the health care system results in great expenditure on transportation for the treatment of diseases such as cancer, when specialist treatment is not available in Greenland, or available only at DIH in Nuuk. Transportation and cancer treatment each take up 12% of the whole health care budget, whereas health promotion and prevention is afforded only 1% (Aaen-Larsen, 2004).

These difficulties, in combination with socio-historical and socio-political issues, are reflected in the level of health among the Greenlandic population, whose morbidity and mortality statistics are significantly higher than the Danish population's. Infectious diseases are prevalent in Greenland with, for example, 157 cases of TB per 100,000 in 2002 (Skifte, 2004), while the number of cases in Denmark is about 10 per 100,000 (Lange, 2005). Sexually transmitted infections, and cervical cancer are also areas of great concern (Kjaer et al., 1989; Lomholdt, 2005; Svare et al., 1998). In Greenland the percentage of planned abortions far exceeds the percentage in Denmark (Meldgaard, 2004), infant mortality remains 4 times higher, and life expectancy is 10 years lower than in Denmark (Aaen-Larsen, 2004). Health statistics seem to be more dire for the population in East Greenland than in West Greenland and health care positions there are even more difficult to staff (Bjerregaard & Dahl-Petersen, 2008).

When Greenland assumed responsibility for the health care system, it inherited a system developed by Danes in a Danish mould, staffed mostly by health care professionals who do not speak Greenlandic, despite most patients being Greenlandic-speaking Greenlanders (Becker-Christensen, 2002). In an attempt to remedy this and with the hope of improving health matters, a nursing school was opened in Nuuk in 1994 that had, by January 2010, graduated 90 nurses (personal communication, Chair of the Institute for Nursing and Health Research University of Greenland: Suzanne Møller, April, 2010). Although it has an Arctic component and is located in Nuuk, and is now a bachelor degree officially under the University of Greenland, the nursing program is still a reflection of the nursing education in Denmark (Becker-Christensen, 2002; Kjærgaard, 1998). Most instructors are Danish, teaching takes place mainly in Danish, and resources are primarily Danish (Kjærgaard, 1998). Thus, the culture of the school up to 2008, and now as the Institute for Nursing and Health Research, is Danish, characterized by Danish epistemology, ontology, and pedagogy. Most students, however, are Greenlanders who have grown up in Greenland, share various degrees of what might be considered Greenlandic

culture, and speak Greenlandic as their mother tongue. A majority of the people they will serve in their practice are Greenlandic speaking Greenlanders.

Prior to being part of the university, the school had the capacity to enrol 18 nursing students annually (Merril, 2005); with 90 graduates by 2010, this means a yearly average of about 8 graduating nurses, indicating either recruitment problems, a high dropout rate, or a combination of both. These 90 Greenlandic nurses could fill about 30% of the 300 nursing positions distributed in municipalities, coastal hospitals, and the hospital in Nuuk, but not all nurses who graduate in Greenland stay in Greenland or in the profession. A few take residence in Denmark, a few change careers, and a few continue on to teach either in the nursing or the basic health education program. So, although there is a long tradition of Greenlandic people receiving nursing diplomas and degrees in Greenland and abroad, it has remained difficult to reach the potential capacity for graduates that the nursing education allows, and to retain all graduates in the profession. That being said, it appears that this is also becoming more difficult in Denmark and other Nordic countries. Further, nursing is not the only health profession in Greenland or Denmark suffering from shortages, and as noted above, a change may be under way in relation to recruitment to the nursing program as in 2010/2011 more people initially applied to the program than there was capacity to take in.

As previously mentioned, there is a long history in Greenland of midwifery, as well as birthing assistants and health assistants with a labour and delivery component to their program. However, also as mentioned, the inauguration of the nursing education and the termination of first the birthing assistant and then the health assistant education, meant that midwives are also lacking in Greenland. The nursing education in Greenland does have a labour and delivery component and the graduated nurses are expected to be able to assist at births. This is a help, but is not enough, since less than a third of the nurses in Greenland are educated in Greenland and the labour and delivery component in the Danish nursing education does not qualify Danish nurses to assist at, or evaluate, planned or acute births (Bæk-Jensen et al., 2002).

About 11 Greenlandic speaking persons have been educated as midwives in Denmark over the past 20 years, but only 4 have chosen to return to Greenland (personal communication, previous director of the midwifery school in Copenhagen, Denmark and midwife in East Greenland, Susanne Houd, June 29, 2010<sup>54</sup>). Having Greenlandic midwives present in the region allows most East Greenlandic women to stay in their community to give birth – something that is highly valued by prospective mothers and their families (Houd, 2002). For a number of years there have been discussions in Greenland about establishing a midwifery program (personal communication, Susanne Houd, June 29, 2010), but the Greenlandic parliament has, so far, not considered it to be economically feasible or necessary (Fontain, 2010; Maje, 2010). A nine-month birthing-assistant diploma has been established, however, to which health assistants may apply after 2 years of experience. By the summer of 2010 five birthing-assistants had graduated from this program. The birthing assistants are not authorized to independently take responsibility for women in labour; therefore, a midwife and/or medical doctor are still required on site (personal communication Susanne Houd, June 29, 2010).

The majority of health care professionals in Greenland, then, remain imported from Denmark. Non-Greenlandic medical professionals who do not speak Greenlandic work with an interpreter when caring for unilingual Greenlandic speakers, and most patients receive treatment from people from outside their home culture, a situation very similar to that in Nunavut, which I will turn to now.

### ***2.3.5 Health care in Nunavut today***

As mentioned earlier, Nunavut, in contrast to Greenland, assumed responsibility for health care and education immediately upon its inception in 1999. It also took

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<sup>54</sup> Susanne Houd has been a midwife for 35 years and, apart from filling the director chair of the midwifery school in Copenhagen and practicing as a midwife in Denmark, Greenland, New Zealand and Inukjuak, Canada, has also led the program to further educate the midwives at the Danish Nursing School in Aarhus, Denmark, been responsible for a midwifery program in Eritrea through Danida (a Danish aid organization), been a collaborator in establishing the midwifery programme in Ontario, Canada, and served as a consultant for WHO (Exner, 2002).

over a health care system developed and governed by outsiders, in this case EuroCanadians, and employing English-speaking health care professionals, even though most clients have Inuktitut as their mother tongue. The Government of Nunavut Department of Health and Social Services is the highest governing body in terms of health care. The structure of the health care system is somewhat different than in Greenland, in that residing doctors are only found in Qikiqtani General Hospital in Iqaluit, in the Rankin Inlet health centre, and until recently in Pond Inlet where the same doctor serviced the community from 1999 until 2008 (Ridlington, 2010). According to Dr. Sandy MacDonald, the director of medical affairs for the Department of Health and Social Services in Nunavut, the "department is looking at getting a doctor to each community in Nunavut" (cited in Ridlington, 2010, para. 6).

Rankin Inlet also has a birthing centre and residing midwives, and recently the Kitikmeot Health Centre in Cambridge Bay has also employed registered midwives, allowing women to stay closer to home during delivery (George, 2009a). The centre has been equipped to handle birth since its opening in 2005, but now has the staff to run the facility. The hope is that eventually this centre will also employ trained Inuit midwives and maternity workers (George, 2009b). This community, as well as the other 25 without hospitals, are also serviced by health centres that employ varying numbers of Community Health Nurses depending on the size and needs of the community. In theory, one Community Health Nurse is hired for every 200 people in the community; in addition, some communities also have a mental health nurse, a TB nurse, or a homecare nurse. But Nunavut, like Greenland, is plagued by recruitment and retention issues, a subsequent shortage of health care professionals, and ensuing problems with continuity and quality of care (McCarthy, 2006). The Community Health Nurses in the health centres in Nunavut have expanded authorization that allows them to provide primary health care almost comparable to a family doctor or general practitioner. They examine patients, diagnose illness, and prescribe and conduct tests. They evaluate some test results and initiate some treatment on their own or in consultation with a doctor via the phone or fax, or they send tests to the labs and specialists in Iqaluit

for evaluation. They also offer general public health programs and provide emergency care (McCarthy, 2006).

Health care, travel related to health care, and most medication is free of charge for Inuit residents/beneficiaries of Nunavut and for government employees through health plans. Despite this, access to quality health care remains a problem in Nunavut as in Greenland. This is partly due to the retention and recruitment difficulties mentioned above, and to geography, which is an obstacle necessitating expensive infrastructure, including the cost of transporting patients from the communities to the hospital in Iqaluit or to specialists in Southern Canada (Hoey, 2003). These factors, combined with socio-historical and socio-political influences, are also reflected in health statistics. Inuit in Nunavut experience the same health issues as do Greenlanders. Mortality and morbidity rates are much higher among Inuit in Nunavut than Southern Canadians, with a 10 year lower life expectancy, higher infant mortality, and infectious disease statistics that are similar to those in Greenland (Waldram et al., 2007). One difference in health statistics is that the number of abortions in Nunavut remains very low, a fact that may be connected to the widespread practice of custom adoption (From et al., 2004) and perhaps also to a higher degree of religiosity in Nunavut than Greenland.

The nursing school in Iqaluit was inaugurated in 1998. Due to funding issues the school suspended operations for one year and started up again in 2000. The program is a transplant from Southern Canada, delivered by Nunavut Arctic College [NAC] under the auspices of Dalhousie University (personal communication, Ruth Bainbridge, then Director of the Nunavut Arctic College Nursing Program, February, 8, 2008). Teaching only takes place in English, all teaching materials are English, and no teachers are Inuit. Almost all Inuit students' mother tongue, on the other hand, is Inuktitut. The school has a capacity to enrol 14 students annually but few students have so far finished the program. From when the school started to May 2008, eight Inuit and nine Qallunaat nurses had graduated (personal communication, Penny Dominix-Nadeau, Nunavut Arctic College Registrar, May 5, 2008). The Inuit nurses are employed in the

hospital in Iqaluit, and the health centres in Rankin Inlet and Arviat, and some are employed in non-nursing positions.

There are also some Inuit nurses employed in Nunavut who were educated elsewhere in Canada. This is also the case in both Nunavik (an Inuit area in northern Quebec) and Nunatsiavut (an Inuit area in Labrador). Furthermore, in Nunatsiavut, a one-time nursing program that educates Inuit was operating at the time of fieldwork<sup>55</sup>. When I visited this program in Happy Valley Goose Bay, there were 14 students enrolled, none of whom spoke Inuktitut as their mother tongue, but considering the history of colonization in Labrador this is not difficult to understand. From this program, 8 students had continued and moved on to either the 2<sup>nd</sup> or 3<sup>rd</sup> year of the nursing program at the Corner Brook campus of Memorial University in 2009 (Herbert, 2009).

Between the students educated at that time, and some who have received their training outside of Labrador, in 2007 there were about thirty Inuit who had registered as nurses over the past 30 years in Labrador (Nunavut Tunngavik Incorporated, 2009), although probably less than half of them were practicing at that time (personal communication, Gail Turner, Nunatsiavut Director of Health Services, Health and Social Development, April 3, 2007).

As opposed to Greenland, Nunavut does educate its own Canada-wide recognized midwives and has since 2006. In November, 2009 the first two Inuit, Catherine Connelly and Rachel Jones, received their midwifery diplomas after completing a three year program through NAC and writing a national licensing exam. They are also the first to be licensed under Nunavut's new *Midwifery Act* (Greer, 2009). A satellite midwifery program of the one currently running at Nunavut Arctic College was planned to start in Cambridge Bay in 2010 with the resident midwives providing training for the midwifery students there (George, 2009a). According to the NAC website, the program would only start provided

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<sup>55</sup> In this program the students take nursing courses while also taking high school courses that they may not have completed or may not have received an adequate mark in. The first two years of study take place in Happy Valley Goose Bay, Labrador, which for most is not home, although it is closer than Corner Brook, Newfoundland where the last two years of the education takes place. The program in Corner Brook, to which students transfer after the second year, is a mainstream rather than an Indigenous program (Curran, et al. 2008).

there were the required number of successful applicants. This appears to not have been the case at the beginning of November, 2010, as the program was not listed to be running. As noted above, about 85% of people living in Nunavut are Inuit, and about 85% of these speak Inuktitut as their mother tongue (Dorais & Sammons, 2002). Non-Inuit nurses rely on interpreters when caring for unilingual Inuktitut speakers, who according to Dorais and Sammons (2002) account for a majority of the population over 50 years of age, which is the population that is also likely to use the health care system more. Often small children living in the smaller communities are also unilingual, but they would often rely on their parents for interpretation.

#### ***2.4 Chapter Summary***

In sections 2.3.1-5, I have discussed health care as it existed in the Arctic prior to the introduction of Southern doctors, nurses, and health care facilities. I have demonstrated that health and sick care in the Arctic was a family and community responsibility rather than the responsibility of an individual, that a role similar to a doctor role existed in the form of an *angakkuq* or shaman, and also that a role similar to that of a midwife existed prior to the introduction of the midwifery profession as envisioned in a Southern context. The role of nursing, on the other hand, was performed by female family members. I have described the history of Southern health care in Greenland and Nunavut and demonstrated that although the regions share similarities, the inhabitants there have also had very different experiences. One difference is that hospitals were built and doctors posted in several communities in Greenland already in the beginning of the 1900s, whereas hospitals came later and were fewer in Nunavut, as was the ratio of doctors to the population. Another difference is that where nurses were called to Greenland in order to support the medical profession, in Arctic Canada nursing stations staffed with nurses only, albeit nurses with expanded authorization, could be found in all communities in the early 1960s. Furthermore, where in Greenland local people were educated in the health care fields early in the 20<sup>th</sup> century (and even before), this only really started happening in the very latter part of the 20<sup>th</sup>

century in Nunavut. This fact is reflected in the number of doctors, nurses, and other health care professionals employed in each region today; a significantly larger number of local people having been educated and employed in Greenland than in Nunavut. Conversely, the Nunavut midwifery program has seen its first two midwives as well as a number of maternity care workers graduate, whereas there is no midwifery program in Greenland. These and other differences in the histories and general conditions in Greenland and Nunavut have affected the nurses and students in various ways and resulted in variations in some of the findings, as I will discuss later in the dissertation. What follows now is a description of my starting the research and accessing the field.

### 3. Accessing and Being in the Field

When finishing my master's research I wondered about the experiences of Inuit nurses and nursing students and thought that a study that explored this could have value in both Nunavut and Greenland. I knew that in order for people, institutions, and communities to want to collaborate in such a study they needed to feel that it had value and that they would like to see it carried out. Therefore, at the end of 2005, I sent a description of a draft research project along with an inquiry about their interest in participating to the directors of the two nursing schools Ann Birkekjær Kjeldsen and Ruth Bainbridge<sup>56</sup>. They both responded with excitement. After receiving a more detailed proposal and discussing it with both staff and students, they endorsed my proceeding with the development of the study in the spring of 2006. We agreed that I would discuss and finalise research protocols with students and staff in person at a later date. Subsequently I planned, sought, and received ethical approval for, and carried out, a small pilot project as a way to test the value of an interview guide I would use as part of the research.

The pilot study involved interviewing four First Nations people in health-educations at a university in Ontario, Canada about their experiences (Møller, 2007b). Two of the 4 reported that they experienced a dissonance between the pedagogy used at their place of study and how they would have preferred to be taught. They perceived this dissonance to be culturally related. Their teachers were Euro-Canadian. The same two students felt that the cultural content of their programs was very limited and rather than finding support for their cultural identity felt they were being discriminated against within their programs. One noted that both teachers and non-Aboriginal students made racist comments and both felt they were expected to be, act, learn and study like everyone else; that is, not as First Nations persons (Møller, 2007b). The pilot further supported the need for a study with a focus on the experiences of Indigenous students in health education.

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<sup>56</sup> Both directors were Southerners who had lived and worked in the North for many years.

The study was very small, but findings from the study are very similar to a larger study done with 132 American Indian students in the helping professions – nursing, social work and psychology (Weaver, 2000). In this study one third of the students felt discriminated against, struggled with stereotypes and racist attitudes, were not able to find any support for their cultural identity, and missed cultural content in their education. Another study involving Indigenous (First Nations) nurses and nursing students (Weaver, 2001) reported similar findings as did a 2009 report on recruitment and retention of Inuit nurses in Nunavut (Aarluk Consulting, 2009). These findings suggested that further work was necessary in this area among Indigenous nurses and nursing students, and specifically among Inuit.

Halfway through the pilot project I was accepted as a PhD student in Anthropology at the University of Alberta and started in September 2006. In the fall of 2006 I discussed the project with Catherine Carry, who is a Research Officer at Ajunnginiq Centre, the Inuit branch of the National Aboriginal Health Organisation. She also expressed support for and interest in the project. In the fall I also visited both nursing schools as well as a “one time” nursing program in Happy Valley Goose Bay in Labrador, which I had been invited to visit by Gail Turner, the Director of Health Services and Health and Social Development in Nunatsiavut.

I spent a week in Nuuk from February 15<sup>th</sup> to 23<sup>rd</sup>, 2007, where I met staff and students at the nursing school and spent the afternoon of the 19<sup>th</sup> presenting the proposed project and the findings from the pilot study (Møller, 2007b) and from my master’s thesis about the socio-cultural experiences of tuberculosis in Nunavut (Møller, 2005). Staff and students expressed support for the study and a willingness to participate. Approximately 30 students and 10 staff were present. After the visit I applied for permission to carry out the research at *Det Videnskabsetiske Udvalg for Sundhedsvidenskabelig Forskning i Grønland* (*The Science-Ethical Board for Research within the Health Sciences in Greenland*), which is equivalent to a Greenlandic Research Institute. I also submitted the proposal to the Research Ethics Board at the University of Alberta and received

approval in the spring of 2007; this permission was extended in the spring of 2008 and 2009. The Greenlandic Research Institute informed me prior to my entering the field that their approval was not necessary as the research did not involve medical procedures.

From April 15<sup>th</sup> to 23<sup>rd</sup>, 2007, I was in Iqaluit where I presented the proposed PhD research to staff and students at the nursing school on the afternoon of the 21<sup>st</sup> and 23<sup>rd</sup>. Five staff and 10 students attended the presentations. I was to present the findings from the pilot study as well as the proposed research on April 19<sup>th</sup>, but a major snowstorm closed the town on the 19<sup>th</sup> and 20<sup>th</sup>. As a consequence, fewer students than initially hoped were able to attend, and because of time constraints I chose to focus on the proposed PhD project, adding findings from the pilot project where appropriate. Also in Iqaluit, both students and staff expressed their support for and interest in participating in the research. I had a summary of the project description and the consent-form translated into Inuktitut and obtained a research licence from the Nunavut Research Institute prior to entering the field; the license was renewed in January 2008, amended to include a smaller town in April 2008, and renewed again in June 2009.

From April 1<sup>st</sup> to April 4<sup>th</sup>, 2007 I visited the nursing program in Happy Valley Goose Bay. During this visit I presented the findings from the pilot study and the planned PhD project and used these presentations to discuss with the students their experiences of being educated in a Western program, including the benefits and difficulties of going through this particular program, and their expectations upon graduation. I also discussed the content of the program, the thinking behind its development, and its obstacles and benefits with the staff and coordinator, and met with Gail Turner. She gave me contact information for a few of the 18 Inuit nurses who were educated in Labrador and who still practice, in order that I might contact them and discuss their experience as students and practicing nurses. Knowing that some of the Inuit nurses who work in Nunavut have been educated outside of Nunavut just as some of the Inuit nurses in Greenland have been educated outside of Greenland, I chose to interview the

Inuit nurses from Labrador that I was able to reach and who volunteered to participate, and included their experiences as Inuit nurses and students in the study as well. This has increased the number of both possible and actual Canadian Inuit participants and thereby also their level of anonymity.

While the research topic was my idea, very early in the stage of developing the research I discussed possible research questions and goals with the directors of both programs who in turn discussed these with staff and students. Prior to receiving the endorsement of teachers and students to go ahead with the project, I addressed concerns that had been raised during e-mail correspondence, and spent a week in both Iqaluit and Nunavut discussing the project with teachers and students and presenting a draft of the proposed project to various groups that could be affected by the project to receive further input, answer questions and address possible concerns. During the fieldwork in each region I discussed preliminary findings with students, teachers, and others with vested interests in the study and sent the same people summaries of the preliminary findings via e-mail. Further, I have sent all transcribed interviews back to students and nurses for correction, validation and clarification. Feedback from emails and discussions are incorporated in the final analysis of the dissertation. Thus, while the study was not initiated by the research participants and the researcher has been me, in the spirit of Smith (1999), Hogan (2006), and the Association for Canadian Universities for Northern Studies (2003), I have sought to conduct a respectful and transparent study with as much input from participants as possible. Furthermore, once in Greenland and Nunavut I sent press releases to the local papers about the project, the reasoning behind it, and the methods used to carry it out.

I have attempted to keep the populations of Nunavut and Greenland maximally informed in keeping with thoughts on respectful research with Indigenous peoples (Hogan, 2006; Smith, 1999). I have also attempted to employ a decolonizing, “anti-colonial” approach in setting up and carrying out the research (Dei, 2000; Smith, 1999). An anti-colonial approach “interrogates the power configurations embedded in ideas, cultures and histories of knowledge

production and use” and theorizes “issues, concerns and social practices emerging from colonial relations and their aftermath” (Dei, 2000, p. 117). This approach fits with the National Aboriginal Health Organization’s [NAHO] (2006) recommendations for conducting health research with Aboriginal communities and speaks to the realities of the nursing education in Nunavut and Greenland.

The press release I sent to the local papers was published in Greenland but not in Nunavut. I sent similar descriptions of the project to the governments, ministers of health and local health care administrators in both places. In Greenland this project description was made public through a website accessible to the general public. In Nunavut information about the project was made available through the website of the Nunavut Research Institute. The question remains, of course, whether I, as a researcher who is a representative of the ‘previous colonisers,’ can carry out research in a respectful if not anti-colonial fashion. I will leave it up to the reader to make that judgement and will describe below my reflections about why it should be necessary.

### ***3.1 Colonial Researcher doing Research in Areas Characterized by Continuing Colonization***

Belonging to a colonizing power and carrying out research in two areas characterized by *continuing colonization* demands reflection. I choose to write *continuing colonization* because I, as mentioned in Chapter 2, believe that few previously colonized countries or areas that still have a heavy presence of, and are influenced by the previous colonizers (like Greenland and Nunavut), can in fact be called post-colonial.

Prior to starting this study and throughout my time in the field I have been very conscious of who I am in relation to where the study has been carried out and who the participants in the study are. I am a Caucasian woman of Danish descent. I am also a nurse and have worked in that capacity in Nunavut and in Denmark. I teach at a EuroCanadian university and started fieldwork in Greenland teaching a first year course in the nursing program there. I taught the course in Danish. I have previously taught medical interpreters at Nunavut Arctic

College in Iqaluit, filled in for absent teachers, and guest lectured in the nursing program while I did fieldwork there. When I returned in 2008, I again taught part time for one month and in the final stages of writing I taught full time for one month in the nursing program in Nuuk.

All this can be viewed as an asset in terms of knowing the field and being familiar with the cultures of the field to some extent, and knowing or getting to know some of the people whose collaboration I needed in order to carry out the study. I also have the advantage of being able to speak both Danish and English fluently. These particulars of my background may also have negatively influenced the outcome of the study. They render me a representative of the former colonizing power in Greenland as well as the health care and educational systems in both Greenland and Nunavut, all of which may have influenced what participants were willing to share with me. Thisted (2002), in her book about the contemporary art of storytelling, wrote that none of the Greenlanders interviewed spoke negatively about the previous Danish colonizing regime or the colonizing people, the Danes, although she felt it would have been obvious to do so. Also in a Greenlandic context, the social worker Henriette Berthelsens notes that many Greenlandic people will not generally complain about, or discuss difficult issues, and will not complain about or to Danes about anything pertaining particularly to Danish ways or systems (Berthelsen cited in Ulnitz, 2002).

My experience in Nunavut during previous research was very similar. Most people I formally interviewed did not critique Southerners or the health care system, or if they did, they did so very indirectly (Møller, 2005). As Tompkins (2002) writes, this may be connected to the fact that “the legacy of colonialism has left tremendous power imbalances between Inuit and Qallunaat” (p. 407). For the parents of Tunu Napartuk (2002), the former President of the National Inuit Youth Council, this imbalance meant that they grew up with feelings of *ilarasuk* towards Qallunaat. He conveys the concept as: “when so much respect is given to someone that it borders on fear, it’s when you take another person’s words without ever questioning or arguing” (Napartuk, 2002, p. 67). Napartuk continues that moving “beyond this will require better education in our generations. If we

manage this, the youth of the future will be better equipped to tackle both worlds” (p. 67). Before Napartuk, others had also discussed how Inuit often defer to and do not openly disagree with Qallunaat (Annahatak, 1994; Briggs, 1970; Brody, 2000, Paine, 1977c). This may mean several things in the context of this research. Firstly, students and nurses who have more to critique may not have volunteered to participate; secondly, those who did participate may have had more critique to offer than they felt comfortable sharing with me in both formal and informal conversations in relation to the nursing programs, the health care system, and the previous colonizers, including their own non-Inuit colleagues.

As well as being a representative of a former colonizing power and of the health care system, that my field is anthropology may also have influenced the outcome of the study. Sadly, anthropologists have a tarnished reputation among many Indigenous populations (Said, 1989), including Inuit and Greenlanders, due to the way research has been conducted and presented in the past and possibly also the present (Schnarc, 2004). Early anthropological researchers described Inuit as savages (Kublu, Laugrand & Oosten, 2000) whose strange habits and beliefs were documented with no concern for their health or continued life and welfare (Nungak, 2001; Vanast, 1991). Some even allowed sick Inuit to die when they could have prevented it, even when an intervention would not have required them to overly extend themselves (Vanast, 1991). Later anthropologists have conducted research in Inuit communities and subsequently made statements about Inuit, their ways, and values, as so called “experts” – statements that some Inuit find irrelevant, inappropriate or even blatantly incorrect (Kublu, Laugrand & Oosten, 2000; Nungak, 2001).

Adding to the problems, I do not speak either Greenlandic or Inuktitut, the mother tongues of the majority of the participants in the study, a fact that may also have influenced the outcome of the study. That I have only been able to converse in English and Danish may have meant that meanings expressed have been understood differently by the conversation partners, as we often, even when speaking our first language, assign words different meanings and value depending on our background and previous experiences. But this is especially possible when

we use a second language, and particularly one that is very different from our mother tongue, as is the case when comparing Greenlandic and Inuktitut with Danish and English (personal communication, linguist Susan Sammons, April, 2008).

When conducting my master's research for example, I realized that the English word 'shy' had different meanings for Inuit participants than it did for me. I understood the word to mean that a person was "diffident, or uneasy in company, timid" as described in *The Canadian Oxford Dictionary* (Barber, 2004, p. 1441). When I asked an Inuk colleague which Inuktitut word she would use for feeling shy, she said "*takkusivuuq*" (Møller, 2005, p. 63). According to Schneider (1985), *takkusivuuq* means that a person feels embarrassment and fear in front of someone who she has done wrong. Embarrassment, particularly, seemed to be the meaning that people wanted to convey when they used the word 'shy' in conversation with me. Perhaps in this case I have developed a fair understanding of the intended meaning, but in general, imprecision in language may limit my understanding of some concepts discussed in interviews and other conversations. As a Greenlandic participant said when we discussed the issue of patients and health care staff speaking two different mother tongues, making it necessary to use an interpreter: "*For example when we in Greenlandic say a lot and then translate it into Danish, a whole lot, which is important to translate in the right way, is lost, and then misunderstandings can easily happen*" (T73: 368). As an example of a single Greenlandic word that it would be difficult to confer the appropriate meaning of, she mentioned *ajunngilaq*. According to Berthelsen et al. (1997), *ajunngilaq* can mean that 'something is ok or fine' and 'that someone is well' (not sick). These definitions, along with "*just leave it, it's ok*", "*I can handle it*" and "*I can manage the way things are*" (T73: 377) were verbal translations that the participant mentioned. She stressed, however, that a Greenlandic person would be able to 'feel' the meaning of the word in a way that

a Dane would not. She continued that when a person is saying *ajunngilaq*<sup>57</sup>, she is not necessarily conveying that she is feeling well; she might imply that she is able to live with a disease or endure the pain that is accompanying a condition. At the same time she might also readily accept a painkiller if it is offered. As Edmond Leach writes about ordinary language and any utterance that has originated in the human mind: “The central puzzle is to determine how far the ‘meaning’ which is conveyed to the listener is the same as that which was intended by the originator” (1976, p. 6).

Attempting to determine ‘meaning’ is made easier when we have the possibility to repeatedly spend time with, converse, interact and observe each other and this is why being immersed in the field when conducting research and drawing on observation, participant observation, casual conversations, being together informally and conducting formal interviews has the ability to add greater understanding and breadth to the questions being asked. Like many others conducting socio-cultural research, I have employed a “cheerful promiscuity of method” (Jenkins, 1992, p. 55). In order to determine whether ‘meaning’ is the same to the speaker and the listener it is also helpful to know something about both and their backgrounds.

One example where this was brought home to me was when I visited and had dinner with a student and her partner in their home. During an interview the student had relayed to me that an Inuit language was her mother tongue but that she considered herself bilingual. When people said that a language is their mother tongue, I presumed that this was the language of at least one of their parents and the language they have grown up with and speak most comfortably<sup>58</sup>. During our visit the student and her partner sometimes spoke to each other in an Inuit language. During their conversations the student mixed many Southern words into their conversation whereas her partner did not, and at times she said something in an Inuit language which it appeared her partner did not understand.

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<sup>57</sup> *Ajunngilaq*, the negative form of *ajorpoq* (personal communication, Mark Nuttall, October 17, 2010) is translated as “1. Is good; it is fine; it is ok 2. Is well; feels good” (Berthelsen et al., 1997, p. 53). *Ajorpoq* means is bad/wrong (Berthelsen et al., p. 52).

<sup>58</sup> Mother tongue is according to the Oxford English Dictionary “One’s native language” or “a language from which others have evolved” (Barber, 2004, p. 1011)

She would then explain in a Southern language, to which he replied in an Inuit language. Although she identified her mother tongue to be an Inuit language and herself as bilingual, she seemed to have a larger vocabulary and be better able to make herself understood in a Southern language. Similarly, some nurses from both regions who had learned only a Southern language as children and later in life learned an Inuit language, identified the Inuit language to be their mother tongue. This, of course, needs to be understood in relation to the political and personal discussions that take place regarding language in both Nunavut and Greenland and the sensitivity that surrounds the question of native language proficiency. I recently had a conversation with a friend who is Cree and identifies Cree as her mother tongue, although she does not actually speak the language. For her, mother tongue is the original language of the people from which she originates and although English is her first language, it is not a language she identifies with, as it has been ‘forced upon her and her people’. Thus, even when self-identifying as having one mother tongue or another, the ways that people define the concept may not be a measure of proficiency; language identification may be used as a measure of ethno-cultural affiliation in a Tolkienesque (1963) sense<sup>59</sup> as was the case for my Cree friend. Thus, spending time together helped me understand things I might otherwise have missed. Here, I realised that identifying a particular language as one’s mother tongue does not necessarily imply that one speaks it best, or at all.

Returning to the title of this section, and the question of whether it is possible to have a respectful research approach as a representative of the previous colonial power, I do think it is. Specifically, I think that going beyond just consulting the prospective participants in the initial set up of the research, to also sharing the findings and inviting discussion about their interpretation are steps in that direction. I realise that being a representative of the previous colonizers is not the only challenge I have to contend with. The fact that I am Danish (in

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<sup>59</sup> J. R. R. Tolkien makes a distinction between that which he calls the ‘native tongue’ and the ‘cradle tongue’. According to this distinction, the cradle tongue is the language a person happens to learn to speak during early childhood and the native tongue is the language toward which one feels affinity (Tolkien, 1963, p. 36).

Greenland), have worked as a nurse (in Nunavut) and am a nurse (in both places) also makes me an insider to some degree in both places. Being an “insider” can give me access to information that an “outsider” might not have access to. Being a health professional may have given me easier access to the health care system and nursing schools and it may have allowed me a greater understanding of professional terminology, jargon, and the function of the health care systems, which may have made it easier for me to navigate within the system. It may also have made it easier for other health care professionals to engage in conversation with me. At the same time being ‘native’ to the culture of nursing may have made me miss that which someone who is not ‘native’ might notice or experience. As Hastrup (2004) puts it, sometimes it is necessary to deliberately be alienated

from the world under study in order to understand it as it cannot understand itself. This is where we can substantiate the anthropological ‘effort’ at understanding...and where we can make new claims to the necessity of fieldwork even though we cannot claim experience to be foundational. (p. 468)

In the preceding chapters and sections I have introduced the field and myself and discussed the challenges of attempting to conduct respectful research as a representative of a colonizing power. I have briefly described the challenges presented by not being able to speak the mother tongue of many of the participants in the study, and explored questions surrounding the very notion of mother tongue. Now, I will introduce the nurses and nursing students who were part of this study.

### ***3.2 Participants and Analytical Object***

Life is lived as differently by individual Inuit nursing students and nurses as it is by everyone else. Inuit nursing students and nurses, however, share being immersed in education and health institutions that were developed, and to a great extent are still governed, by their historical colonizers as described in section 2.3. The analytical object of this study is the multifaceted worlds of the Inuit nursing students and the ontologies and epistemologies that form the basis of their being and of their practice as nurses. This includes the language and pedagogy utilised

to educate them, the language and pedagogy they utilise in meeting with their clients in the professional milieu, how they view and present themselves in their roles as nurses, how they perceive others in this role, and the language and pedagogy that they utilise privately and socially. The life-worlds of the nursing students and nurses thus includes their place of education, practicum, and their professional milieu, as well as their social and private milieu, and it includes their patients' reactions to them as nurses and to their actions and the pedagogy they employ in their practice, and finally their actions, reactions to, and interactions with other nurses.

Some of the nurses and nursing students in Nuuk were educated health care workers before starting nursing school, and some worked in the health care system as unskilled labour. Many have families of their own, and many come from small settlements from which the only connection to Nuuk is by plane, helicopter, or boat. The former president of the Nurses' Union in Greenland estimated that about 25% of the 300 nursing positions distributed in the municipalities, coastal hospitals, and the hospital in Nuuk are staffed with Inuit nurses. These nurses are made up of a combination of those who have received their training in Denmark but are practicing in Greenland and some of the Inuit nurses who have been educated in Nuuk, the remainder of whom are in Denmark, in administrative positions, or have left the profession (personal communication, Birta Bianco, Director of the Greenlandic Nursing Union, November 22, 2007).

In Iqaluit, as in Nuuk, many of the students are mature, have families, and have been in the workforce for a number of years. Many call one of the 26 smaller settlements of Nunavut home, to which regular access is only possible by plane. This means that they, like many of the students in Nuuk, are outside their habitual social milieu and away from their families for as long as they are students. In Nunavut, the actual number of Inuit nurses employed is not recorded. However, from conversations with nurses there, I estimate that 13 Inuit nurses work in Nunavut, which would comprise approximately 3% of the 400 or so

nursing positions distributed in towns and settlements in Nunavut's Qikiqtani General Hospital and nursing stations<sup>60</sup>.

I am cognizant of the fact that I have captured only a partial 'truth,' namely that of the people who have elected to participate. Findings and subsequent recommendations that come out of this research are based on the experiences of these participants – which in their own right are also very diverse. The pilot study (Møller, 2007b) revealed that the 4 First Nations students that I interviewed had vast differences in preferred modes of education and in concepts of health and healing. These differences appeared to correspond to differences in parental ethnic background and upbringing. Research from Greenland, however, has shown that the educational system caters to those Greenlanders who have the best comprehension of Danish and often one Danish parent, and that the people in Greenland who are the furthest away from Nuuk speak the least Danish (Kristiansdottir, 2004; Lund & Nathanielsen, 2001). In Nunavut this is a little different. Kitikmeot, the westernmost region of Nunavut, and not the region where the territory's capital is situated, appears to be the region in which more people speak more English than Innuinaqtun the western dialect of Inuktitut. This area, along with Iqaluit, is also where most Inuit nurses and students in Nunavut come from. Three others originate from Southern cities, and two of these were also educated in the South. A majority (17 of 31) of the participating Greenlandic nurses and students originate from the larger cities of Nuuk, Sissimiut, Maniitsoq, and Illulissat, with an additional two having moved between those cities and Denmark and one having grown up in Denmark.

Generally, if people feel at home in a culture, know what to expect, what is expected of them, how to react, and how to interpret other peoples' reactions, they will, for lack of a better word, 'succeed' in that culture. Knowing that, it should come as no surprise that the majority of participants seem to be more at home with Southern languages and cultures than other Greenlanders and

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<sup>60</sup> There are no statistics obtainable that separate the number of nurses employed in Nunavut from the number of nurses employed in the Northwest Territories. The statistics given are estimated by the author based on the number of nurses employed in Nunavut and the Northwest Territories (Canadian Institute for Health Information, 2007), the ratio of nurses to population (Canadian Nurses Association, 2007) and number of people living in Nunavut (StatsCan, 2008aa).

Canadian Inuit are. Thirty-six percent of participating nurses and students grew up with one Southern parent. More than twice as many Greenlandic participants grew up with one Danish parent compared to the general Greenlandic population (25% as opposed to the 12% reported by the 2007 pan Arctic report *Social Living Conditions in the Arctic* or [SLiCA]) and 50% of Nunavut Inuit participants grew up with one non-Inuit parent, which is at least 5 times as many as the general population of Nunavut<sup>61</sup>. Ninety percent of Greenlandic and 85% of Inuit participants were most comfortable reading, writing and being taught in a Southern language. In addition, almost 50% of Greenlandic and 65% of Inuit participants said that they spoke more, or only, a Southern language in their current home. The statistic for all of Greenland is 7% and for all of Nunavut 8% (Poppel, Kruse, Duhaime, & Abryutina, 2007). It has previously been pointed out that in order to have educational and employment success in Inuit societies today it is necessary to be bilingual and bicultural, and that the current elite in Inuit societies are those who are (Bjerregaard, Young & Berner, 2008).

The social reality affects the students' experience of, and approach to, their education and practice. For me, this reinforces the benefit of using the variety of data collection methods employed in the study. These have included observation, participant observation, formal interviews, informal conversation both in public and social situations, and the reading of documents including newspaper stories and the printed and online debate these have elicited.

### ***3.3 Field Methods***

#### ***3.3.1 Observation and participant observation***

Prior to going to Greenland, aware of my ancestry, I was apprehensive that the prejudice many Danes have towards Greenlanders (and express as if it is their birthright) would colour Greenlandic people's judgement of me. However, my

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<sup>61</sup> This number is based on an estimation of about 10% of Nunavummiut having one non-Inuit parent. Unfortunately SLiCa does not provide this statistic for Nunavut. However since only about 8% speak a Southern language mostly or only in their home (Poppel et al., 2007), I do not think the number is much larger, particularly as the presence of a non-Inuit parent in an Arctic household often means that the language most spoken in the household is Southern rather than Inuit (Dorais & Sammons, 2002).

concerns proved unfounded, and I was welcomed, met with interest and friendliness, and felt very included by everyone who was involved in the study or somehow touched by it, Danes and Greenlanders alike. The few not so positive experiences I had involved Danish health care people who recognized me as another Dane and gave me their uncensored and unsolicited opinion about “Greenlanders” (their lack of ability to run things and how badly needed Danes are in Greenland in order to educate and help Greenlanders develop), which was perhaps considered a justification for their own presence. I do think these people had good intentions, and if questioned, would not see their statements as being discriminatory or racist. While I tried to question their statements I also felt acutely aware of being in a public place, and did not wish anyone to overhear the musings of my interlocutor as I found what they said to be paternalistic and ethnocentric.

It is still amazing to me how “at home” I felt in Greenland. Having previously lived and worked in another country, using another language, and functioning in another culture both in Southern Canada and in Nunavut, I connect this feeling of being at home in Greenland with being at home in the Danish language and Danish culture. Although many Greenlandic Inuit have a distinct Greenlandic culture, many, and particularly those who have spent some years in the post secondary educational system and have been influenced by Danish culture for so long, also function seemingly effortlessly in Danish culture. Many of the Greenlanders I came into closer contact with are what they themselves termed “double cultured,” and while some are very aware of shifting between two cultures, others are able to culturally code shift the way that some code shift between languages, appearing effortless to an observer.

My experience in Nunavut was also very positive. Here I already had friends and knew about local history and current conditions. I also had an idea about how to navigate the health care system, although many of the people I had met in various positions had changed positions or, if originally from the South, had moved back to the South. Although they had condoned the study, the teachers in the program took a little longer to warm up to my presence. Some of the

reasons for this may revolve around English being my second language and the ways I described how I envisioned the study would be carried out during my introduction meeting with the teachers just after my arrival in Iqaluit. Although I would describe myself as fluent in English, it is my second language, and in other contexts I have experienced this to be important. For example, my partner of 17 years is Canadian, we speak Danish together, and he is fluent in Danish, but we still sometimes misunderstand each other because of using the language in a way that the other misinterprets. My language use may also have cultural overtones and thus be connected with my ways of being as a Dane – not just the language *per se* but how I choose to use it. As Geoffman puts it, when an individual speaks in the presence of others, our “tone of voice, manner of uptake, restarts and variously positioned pauses” (Geoffman, 1981, pp. 1-2) as well as the exact words we choose, the ways we move our bodies, and the gestures we use, are the ways we have learned to communicate and we expect our audience to catch the significance and meaning of these words and gestures. I would add that this is true at least when we converse with people who have learned what we have, but may not always be the case when ethnically diverse individuals engage in conversation. In this connection I also include Danes and EuroCanadians. Lastly, the initially cool response of the program teachers may be connected with the fact that the genesis of the study involved a fairly critical remark made by a previous student in the program. This remark is quoted in the introduction on page 3 in section 1.1. After a while I was invited to be in the classes of most instructors and felt very comfortable among both staff and students. Apart from being present as an observer, I was also invited to guest lecture in both the nursing and in other programs and volunteered to fill in for an absent teacher. In both Greenland and Nunavut, I was privileged to be included in the social lives of some teachers, students, and nurses.

I was present as an observer for more than 120 combined instructional hours, covering most levels of the nursing educations, and stretched over a semester in both Iqaluit and Nuuk. I observed some of the students in their places of practice, although I was allowed to do this only in Greenland. Although being

well received in the nursing school, in Nunavut I was refused permission to be present as an observer or follow any nurses or students within the health care system. Administrators felt it would be uncomfortable for patients to have “a stranger present.”

I have also had conversations with students about their experiences in the clinical encounter after the observation took place. While following and observing students, I conversed with nurses, students and other health care workers and professionals in the setting. I also conversed with various health care workers and professionals socially and casually in social fora in the communities of both Greenland and Nunavut. In order to conceptualise and articulate the epistemology of the nursing students in relation to nursing, health and disease, and how this affects their practice, I believe it is necessary to be part of their life-worlds while they act and reflect. As stated by Barth (2002), “knowledge provides people with materials for reflection and premises for action” (p. 1). Being present allows insight into the pedagogy and practices of the nurses in different contexts and sheds light on their beliefs about how knowledge is created and passed on.

Being an observer allowed me, for example, to contextualise the statements of students about how they themselves thought they would prefer to learn and how they taught or lectured for their fellow students in various contexts. I observed various forms of classroom teaching being performed; groups of students speaking to the class with a teacher present and single students speaking to a group of mixed students (in terms of programs and year) in a meeting room in the clinical setting with no teacher or clinical instructor present. During interviews and conversations students informed me that they would like to be involved in their learning, and rather than just having the teacher lecture or do all the talking, they wanted a form of discussion between teacher and students and for the teacher to use a variety of teaching methods including PowerPoint, blackboard, different illustrations, role play, and other activities that engaged the students. When educating their peers in the classroom setting, students often lectured and used a PowerPoint with little interaction or input from their fellow

students. When the students taught each other in a mixed group with no instructor present it took the form of a discussion where the students present drew on each other's knowledge and experience. I am aware that certain settings may naturally allow for different kinds of interaction, but still think it is noteworthy to mention these differences.

Also in relation to participant observation: in Greenland at the 2007 and 2010 NUNAMED conferences I facilitated 2 different three-hour workshop on cross-cultural health care. Both resulted in much discussion in participant groups and in plenum. The ensuing synopses (Møller, 2007a, 2010a) were sent to all participants, with the 2007 synopsis having been translated into Greenlandic by the Greenlandic Department of Health, and posted on their website in both Greenlandic and Danish. The 2010 synopsis has been published in the conference proceedings. These documents are part of the data. Workshop participants in 2007 numbered more than 60 people and included people from the Ministry of Health, Greenlandic and Danish medical doctors, nurses, psychologists, dentists, social workers, health aides and more. The workshop in 2010 numbered around 50 people.

In the smaller community in Nunavut, I was invited to be present in the staff coffee room at the health centre while I was in the community. This opportunity and visiting another health facility in the community allowed me to converse with a wide variety of health care workers, professionals, and supporting staff, the notes of which are also part of the data. Along with the notes from participant observation, observation, transcribed interviews, and other casual conversations, they help to provide both breadth and depth of perspective (i.e. a variety in perspectives, both of and from the same particular people, and of and from many different people, situations and settings). In July 2009 I presented preliminary findings at the International Circumpolar conference on Health in Yellowknife and in September 2010 I did so at the 10<sup>th</sup> Annual Aboriginal Nurses Conference and received feedback from both Inuit and First Nations nurses afterwards, the notes of which similarly add to the overall perspective (Møller, 2010b).

### 3.3.2 Interviews and questionnaires

Interviewees were recruited on a voluntary basis through my presenting the research and its objectives at the nursing schools, through posters in the nursing schools, via a common email, and by word of mouth. In order to preserve confidentiality I did not ask students to sign up for interviews at the presentations. In Greenland and Nunavut I interviewed nursing students at all levels of the education, including some students who had opted out of the education. I also interviewed practicing Inuit nurses. When permitted by interviewees, interviews were digitally audio recorded. All interviews took place at a location chosen by the interviewee. Many took place in the home of the interviewee, some at a coffee shop or restaurant and some in a classroom at the nursing schools. When interviewees are able to be interviewed at a location they themselves choose it is likely that they feel more comfortable: “finding out about people through interviewing is best achieved when the relationship of interviewer and interviewee is non-hierarchical and when the interviewer is prepared to invest his or her personal identity in the relationship” (Oakley, 1981, p. 41)<sup>62</sup>. As I have stated elsewhere (Møller, 2005, p. 9) engaging as a whole person, and not only as a researcher in the interview situation, may help make the interview become a dialog through which both interviewer and interviewee contribute and learn about themselves and the other.

I do agree with Bourdieu (2001) when he argues that my presence, and asking questions, may engender thoughts in the interviewees about their own practice and that of others that they otherwise might not have. I do not, however, believe that this is detrimental to the outcome of the interview. Rather, I believe that asking and answering questions and provoking thoughts “is part of an ongoing reflection” that contributes to changes in the way we relate to our experiences (Møller, 2005, p. 9) and that the benefits of a personally engaged approach outweigh the possible drawbacks. The comment from one nurse during an interview is a good illustration of this point. She said:

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<sup>62</sup> Oakley (1981), in research on pregnancy and motherhood which she conducted with pregnant women who became mothers as the research progressed, answered personal questions and questions about pregnancy and labour to the best of her ability.

*What I tell you now is... not really something I have articulated. Maybe it is also new for me, the idea that my thoughts and experiences are expressed in words.... It is exciting that you open up for these things and make us say all sorts of things; no one has really delved into things that way before and asked us, 'Well, then, what do you think?'. (T32:215)*

Another nurse said that being asked questions made her think about things in a new light and made her understand the things that had happened in the past in relation to the current situation in a different way (T24).

When I returned to Greenland in the fall of 2008, and with the help of the director of the nursing school Suzanne Møller (no relation)<sup>63</sup>, I sent 20 questionnaires to students who have opted out of the nursing program, and received 8 completed questionnaires back. The questionnaires contained the same core questions as those used when interviewing. In addition, the questionnaire contained some questions that asked about people's reasons for opting out and whether anything could have been done differently that would have supported them in staying and finishing the program. Administrators at Nunavut Arctic College agreed to do something similar before I left there in late May of 2008, but it turned out not to be possible.

I conducted semi-structured interviews after obtaining demographic information such as where interviewees grew up, their family make up, level of schooling obtained by those the interviewees grew up with and were raised by, those they live with today, and their own highest level of schooling completed. In the semi-structured part I have used a narrative approach, similar to Ricoeur (1983), where I understand the stories or narratives that the interviewees share with me to have the function of giving explanations both to actions (their own and others') and events they have taken part in. Thus, I asked the students to tell me their stories and experiences of learning and being taught in primary, secondary, and nursing school, in their homes when they grew up, and the learning and teaching that they themselves are involved in today. The semi-structured part of the interview was supported by an interview guide (Kvale,

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<sup>63</sup> Suzanne Møller is now the chair of the Institute for Nursing and Realth Research at the University of Greenland, under which the nursing programme is now run.

1994), which provided topics for discussion when necessary. This approach had proved fruitful in both my master's research (Møller, 2005) and in the previously mentioned pilot study (Møller, 2007b). A copy of the questionnaire/interview guide can be found in Appendix D.

Some students and nurses elected to answer a questionnaire rather than participate in an interview. The questionnaire contained all the same questions as did the demographic part and interview-guide used for the interviews. In Greenland I formally interviewed 11 students and 13 nurses<sup>64</sup> and received completed questionnaires from an additional 7 students and 2 nurses. This amounts to 18 of 34 possible students and 15 of 77 possible nurses of Greenlandic descent formally sharing their experience<sup>65</sup>. Additionally, as mentioned above I received questionnaires from 8 students who had opted out of the education. I have not, however, been able to obtain the number of students who have opted out of the education since the education started.

In Nunavut I have formally interviewed 6 of the 8 Inuit students enrolled at the time of fieldwork, and another two who had opted out of the program. I interviewed 11 Inuit nurses, 5 of whom were educated in Nunavut and 2 who worked in other Canadian Inuit regions. I have not been able to obtain the actual number of Inuit nurses employed, as the Nunavut Employees Union does not note the ethnicity of its members<sup>66</sup>. I estimate, as mentioned above, that there were 13 Inuit nurses employed in Nunavut during the time the field work was carried out, so 9/13 or 61% of nurses employed in Nunavut plus another two employed elsewhere at the time of fieldwork were interviewed. Additionally, I have received a completed questionnaire from one Inuk who opted out of the nursing program in Nunavut<sup>67</sup>.

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<sup>64</sup> I have chosen to use an interview of one older retired nurse as background material only. She is the only retired nurse that I have spoken to and was educated in an era different from all the rest.

<sup>65</sup> This is the number of Greenlandic nurses registered with the Greenlandic Nursing Union in December 2007 (personal communication, Union president Birtha Bianco, December 2007).

<sup>66</sup> As a note of interest it should be added that the Greenlandic Nursing Union does not make note of member's ethnicity either, but the Union president knew all registered nurses by name.

<sup>67</sup> This former student was contacted by a nurse who was interviewed about her interest in taking part through an interview or alternatively through a questionnaire. The former student chose to take part through a questionnaire.

In relation to using a narrative approach for the second part of the interview, I believe, as Garro and Mattingly (2000) do, that “stories can provide a powerful medium, for learning and gaining understanding about others by affording a context for insights into what one has not personally experienced” (p. 1). I also believe that “how we hear and tell stories is as much part of our cultural response to the human experience as why we tell the stories in the first place” (Erasmus, 1989, p. 272); the structure of narratives are culturally specific. Sometimes a narrator may not directly inform the listener of the “point” to his or her story or parts of the story, or the listener may simply fail to understand the implicit point (Erasmus, 1989). Conversing with Greenlandic and Nunavummit friends and interviewing Nunavummit for my master’s thesis, as well as the doctoral research, and my work as a nurse, has led me to believe that Inuit, as do Persons of First Nations Ancestry, sometimes “recall the significant importance of the story of events, and leave the meaning-making lesson-finding to the audience” (Deloria, cited in Calliou, 1998, p. 44)<sup>68</sup>.

Knowing that differing ideas about the meaning of an interview or shared story and differing cultural communication patterns and cultural backgrounds have an impact on the outcome of the interview make it important to attempt

to listen in such a way that we heed the *effect* people are trying to make and the *relevance* of their words in terms of how they are positioned and where they want to go rather than the message that their words might seem to create. (Wikan, 1993, p. 197, emphasis in original)

This, I believe, is particularly important when one or both of the interviewer and interviewee are speaking in their second language. I also believe that understanding the effect people are trying to create and where they want to go with what they are saying becomes easier when I talk to someone more than one time and spend time with him or her, both in other settings and in the company of other people. Talking to someone more than once and in various settings rather than only through an interview is particularly beneficial when I attempt to learn

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<sup>68</sup> Deloria also states that non-Persons of First Nations Ancestry, church, and state are dependent on “print recorded history,” and in their history writing are “chronologically fixated, striving for objective and linear documentation” (Deloria, as cited in Calliou, 1998, p. 44).

something about another person's perceptions, experiences and understanding of something. Drawing on accounts from informants "differently located in the setting" (Hammersley & Atkinson 2001, p. 230) may also be one step towards decreasing researcher bias.

In my previous work, I found that people were more willing to share understandings about health and disease that were different from my understanding in informal conversations, rather than in formal interviews (Møller, 2005). This was also the case when I had casual conversations with people who I had interviewed previously. People with whom I had casual conversations also more readily raised historical and contemporary issues of colonialism and racism. I had the same experience with some of the nurses and students I interviewed for this work.

My experience with differences in what interviewees and casual conversation partners felt comfortable addressing (Møller, 2005) again speaks to the importance of being immersed in the field. In an interview situation, where I define the topic of research and may ask specific questions or otherwise lead the conversation, the asymmetry of power (Kvale, 1994) is much more tangible. Interacting as a person rather than an anthropologist and spending time in people's homes, visiting, chatting, eating, being silent and just hanging out, taking part in community events and workshops, or going for a coffee, to a restaurant or a bar, allows for more equal togetherness and allows the interaction to unfold without the role-based power dynamic of the interview situation. Although I am cognizant of the fact that my having worked as a nurse in Nunavut might influence the outcome of interviews I also, as mentioned elsewhere (Møller 2005), again noted the difference resulting from not being part of the community as a nurse. I think because of returning to Nunavut repeatedly and because I did not hold the position of power that I believe nurses and other health care people do, interactions and communications between community members and myself

felt more equal or level somehow, despite my role as a researcher and anthropologist<sup>69</sup>.

Apart from the Inuit nurses and nursing students who are key informants, I informally interviewed and/or had several conversations with other individuals who held particular knowledge about nursing, nurses' work conditions and the nursing education in Greenland and Nunavut. These include Ann Birkekjær Kjeldsen, Ruth Bainbridge, Birtha Bianco and Ruth Lange, Suzanne Møller, Turid Bjarnason Skifte, and Cheryl Young. Ann Birkekjær Kjeldsen was the director of the Center for Health Educations in Nuuk when I initially visited the Centre from February 15<sup>th</sup> to 23<sup>rd</sup>, 2007 in order to discuss the project. Ruth Bainbridge was the director of the nursing education at Nunavut Arctic College in Iqaluit when I initially visited from April 15<sup>th</sup> to 23<sup>rd</sup>, 2007 and also while I carried out fieldwork from February to June 2008. Birtha Bianco was the Director of the Greenlandic Nursing Union during my fieldwork in Greenland between September and December 2007. Ruth Lange is a previous director of the Center for Health Educations in Nuuk (see also footnote 14 on page 19). Suzanne Møller is the chair of the Institute for Nursing and Health Research at the University of Greenland, under which the nursing programme is now run, and was the director of the nursing education during my initial visit to Nuuk during the September – December 2007 fieldperiod. Turid Bjarnason Skifte is the chief nurse in the office of the chief medical officer of health for Greenland and has been since I initially visited Nuuk in 2007. Cheryl Young was the Nunavut nurses' representative in the Nunavut Employees Union during my field work in Nunavut between February and June 2008.

As have many other anthropologists (Ohnuki-Tierney, 1997; Olufsson, 2004; Thompson, 2005), I found that having casual conversations anywhere, and with a variety of people, provided a wealth of information both in relation to the topic of research specifically and also more generally about the setting and the culture, ways, and values of the people living there in a broader sense. These

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<sup>69</sup> I am aware that these were my feelings and that they may not match those of community members.

casual conversations also helped to reveal people's perceptions of a variety of topics that informed the research both directly and obliquely.

In addition to Interviews, questionnaires and casual conversations, I have paid attention to the voices of Greenlanders and Nunavummiut who express their opinions in the local newspapers, on paper and online, as journalists and readers. In Greenland the papers were *Sermitsiaq* (2007, 2008, 2009, 2010) and *Atuagagdliutit/ Grønlandsposten A/G* (2008, 2009). In Nunavut the paper was *Nunatsiaq News* (2007, 2008, 2009). In relation to both personal conversations and voices from newspapers, I indicate all direct quotes used throughout the dissertation.

I recognize that I am positioned within and exist as part of my material (Hastrup, 1986) and that "our understanding of others can only proceed from within our own experience, and this experience involves our personalities and histories as much as our field research" (Jackson, 1989, p. 17). Therefore, as another step towards decreasing researcher bias, I carried out initial analysis of interviews and field notes while in the communities and subsequently shared these with participants in order for them to be able to comment on, contest, verify and further explore the initial analysis and data. I used this method of sharing preliminary findings in previous research and found it very worthwhile; it both enriched and supported my final analysis (Møller, 2005), and it is also recommended by NAHO (2006). In previous research, preliminary findings were shared through public presentations and conversations with people from the general public, people I taught at Nunavut Arctic College, Inuit friends and acquaintances and people at the residence where I stayed. For this project I enhanced the sharing of preliminary findings and, after leaving Greenland, sent a description of preliminary findings from Greenland via e-mail to all current nursing students and nurses through the nursing school and through the Greenlandic Nurses' Union. I also sent preliminary findings via e-mail to Canadian Inuit nurses and students and discussed findings with nurses socially both in Nunavut and Greenland.

Furthermore, as mentioned in the previous section, I presented findings from the project at several conferences and received feedback from attending nurses and other health professionals from both Nunavut and Greenland. The comments, verifications, questions and corrections that came out of the presentation, distribution of preliminary findings, and social discussions about them are also part of the final analysis. The sharing of preliminary findings may be particularly important because I speak neither Greenlandic nor Inuktitut, and furthermore because English is my second language and the second language for most Canadian participants, and Danish is the second language for most Greenlandic participants. This has meant that I have not had access to conversations that students and nurses had with each other and other people in their mother tongue. In some cases I was given a summary afterwards, but much nuance must be left out that gives meaning, and gives depth and breadth with that meaning. So, even when the participants in the current project describe themselves to be equally proficient in an Inuit and in a Southern language, by sending out written synopses of preliminary findings, presenting, and discussing them with participants in different fora, I may have helped to improve accuracy in communication.

Proficiency in more than one language, then, along with communication styles and at times proficiency in the terminology and language of nursing were among the issues that affected the quality of communication between the nurses, students, other people and myself in the course of carrying out this research project. Apart from these issues, and as previously mentioned, Inuit nurses in their education and practice are also affected by being educated and practicing in cultures that may differ from their own. As mentioned in the opening chapter, they have to negotiate and interweave the languages and cultures of the nursing field, the Southern systems and their Southern colleagues with the languages and cultures of the patients, their families and the societies from which they come. On top of this they are affected by health care economics, politics, high rates of turnover, and a lack of permanent health care staff. These issues are interconnected; they effect and are affected by each other and have as a common

dominator the idea of *capital* as conceptualised by Bourdieu (1986). After providing the closing remarks on chapter three, I will in chapter four discuss the determinants of success for Arctic nurses and nursing students utilising Bourdieu's (1986) social and cultural capital.

### ***3.4 Chapter Summary***

In this chapter, I have described that the seed for this project was planted already in the course of my master's work when I met a nursing student who felt that she, as an Inuk, was supposed to disregard her values and traditions in relation to health in order to be a nursing student. I have outlined how I approached and subsequently was welcomed by the sites of research in both Nunavut and Greenland and discussed the possibility of doing respectful research while acknowledging myself as a person stemming from a colonial power, and particularly the colonial power that colonised Greenland. In conclusion of this last discussion, I proposed that a respectful approach in these circumstances is possible but requires particular transparency and reflexiveness on my part as the researcher. I have given an overall presentation of the nurses and nursing students in Greenland and Nunavut and stressed that, although they share many historical and educational commonalities, the ways they live their lives are as varied as they would be among other people sharing the same ethnicity and/or profession. Finally, I have outlined the methods I have employed to gather the material upon which this dissertation is based and shared the thoughts that guided my methodological choices, which include observation, participant observation, interviews, questionnaires, and current and historical online and paper documents.

#### **4. *Social and Cultural Capital* as ‘Determinants of Success’ for Arctic Nurses: The Importance of Language**

In section 3.2 I mentioned that twice as many Greenlandic participants grew up with one Southern parent compared to the general Greenlandic population and that 5 times as many Canadian Inuit participants compared to the general population of Nunavut did so. I also mentioned that 90% of Greenlandic and 85% of Canadian Inuit participants were most comfortable reading, writing and being taught in a Southern language and that almost 50% of Greenlandic and 65% of Inuit participants said that they more frequently or exclusively spoke a Southern language in their current home. Still, the vast majority of nurses and nursing students, as mentioned, (and taking into account the caveats mentioned in using the term “mother tongue”) considered an Inuit language their mother tongue. This has meant that language differences, the acquisition and mastering of both the Southern and Inuit languages and the health care languages, their vocabulary and terminology, were pivotal when discussing nurses’ and students’ educational and professional experiences. Therefore, as an introduction to the findings of this ethnographic study I will start with a discussion of Inuit nurses’ and nursing students’ experiences in relation to language.

These experiences include: that even when speaking the same language as their interlocutor, Inuit nurses and students do not always feel able to understand or to make themselves understood; the difficulties of not having a complete terminology concerning health, disease and care in an Inuit language; the importance of body language and what not understanding body language may imply; the experiences of ties between language and identity; and the effect varying language competence has on Inuit nurses and nursing students and their colleagues and patients. That nurses and students are (relatively) comfortable speaking and reading a Southern language in everyday interactions but perhaps find it difficult in relation to doing so in a professional context could be seen as an ‘inherent contradiction’. Taking into consideration the discussion about the uses of the term mother tongue as well as the discussion on language education in

the schools in Nunavut and Greenland, which I will return to below, I think this seeming ‘contradiction’ makes a lot of sense. Jacobsen (2004) writes that Greenlandic is losing ‘domain’ and that many Greenlanders find it problematic that professional vocabulary and terminology is not developed in Greenlandic.

#### ***4.1 Linguistic Capital***

Inuit nurses and nursing students have *linguistic capital* as envisioned by Bourdieu (1986) in the form of their mastering both a Southern and Inuit language. The *Southern language* allows them to excel in primary and secondary school, to continue their education in the post secondary system, and to function in the health care system where a majority of their colleagues speak only Southern languages. The Inuit language allows Inuit nurses and nursing students to interview, engage and interact with Inuit patients and their kin and to pass on information in the language that most of their patients speak. Possessing *linguistic capital* does not, however, mean that the need to master and use two languages poses no challenges.

##### ***4.1.1 Shared language does not imply shared meaning***

Participants from both regions noted that although they speak an Inuit language as their mother tongue, they do not always find it easy to explain things to their patients. The two participants who did not find this to be a problem had either grown up or spent much time with their grandparents and had taken part in many activities involving harvesting, procuring, and preparing food from the land. A few stated that they would feel more comfortable if they could have an interpreter present when they were to teach patients about particular health issues, just to be sure they got it right. One said:

*At present I feel that I would need an interpreter to explain certain words and phrases. But then again when I was in clinical I talked with an interpreter and because we use different words for Saturday and Sunday than each other it became confusing. Sometimes the dialect differences makes things pretty difficult. (T45:63)*

As did this nurse, a student also mentioned dialect differences, saying:

*When I did my first year of nursing it was difficult for me because of the language barrier.... I had a hard time when I did my practicum at the hospital. The clients would become frustrated because I was speaking my language dialect.... Then I spoke [a Southern language] instead. I didn't feel welcome at times because I am from another region. (T47:9)*

So even though she spoke the same mother tongue as her Inuit clients she sometimes had a difficult time conversing with them and reverted to speaking a Southern language. This statement also speaks to the differentiation that takes place between Inuit from different regions, and how although all participants identified as Inuit, the idea of Inuitness, while taking a front seat in relation to non-Inuit, takes a backseat when it comes to coming from a certain region where not only dialect but also dietary and other choices differ from one area to another. I will address the significance of identity further in chapter 6.

Many participants spoke about difficulties conversing with patients in their mother tongue because they lacked anatomical and medical terms. For example: *“Although I have been insistent in learning a Southern language, it can be a problem that we lack the vocabulary of an Inuit language when we communicate with Inuit patients – particularly in relation to anatomy and physiology” (T76:75)*. While finding the lack of vocabulary difficult, it was mentioned that the differences in educational level of many patients and the nurses/students themselves was also a source of difficulty and something that created frustration. One nurse said:

*I get tired of trying to explain properly to try to get the message across. I find sometimes that it is difficult to explain things in an Inuit language. Both because of the language and because of the patient's educational level, they often do not understand. (T43:64)*

While the second last quote reveals the differentiation that takes place between Inuit from different regions, this quote exemplifies how many, particularly younger, nurses and participants differentiate themselves from Inuit who have less education (who often originate from the smaller settlements) and who according to some “are backwards” in their thinking and ideas about health issues, as one participant put it. This point will also be further elaborated in

section 6.

#### **4.1.2 Body language**

Many participants as well as individuals with whom I had casual conversations highlighted that body language carries great weight in Inuit communication and that not mastering, or being aware of, this aspect of communication plays a part in the recurring misunderstandings and misinterpretations that take place between Southern health care providers and Inuit patients. As one nurse stated:

*There are many differences between Southern and Inuit nurses but mainly the culture. Many things are part of the culture. Like knowing when to speak and when not to.... Body language is also important. I have heard Southern staff say that when Inuit patients have pain they keep it inside. I do not think that is true. One should not think that Inuit patients do not have pain just because they do not say anything.* (T24:149)

That some Inuit patients do not verbalize what they feel does not mean that they do not communicate what they feel. It means, rather, that some health professionals who care for Inuit patients do not have the same *cultural capital*, here in the form of both *linguistic* and *embodied cultural capital*, as their Inuit patients, that would allow them to comprehend the message communicated. Inuit health professionals, though, do understand non-verbal patient communication, as evidenced by the following statements from two Inuit nurses: “*It is not always that my patients need to say anything. By looking at them one can see how they feel*” (T20:193); and: “*The body language is very important. Many Southerners think that if we move our eyebrows up and down a little it means something kinky, but that is not it. It is a way of communicating, right<sup>70</sup>?*” (T29:310).

Body language, however, is not just an important factor in the interaction between health provider and patient, it also has an impact on how two nurses are able to work together. As one nurse said: “*When I work with other Inuit nurses and we are caring for an elder, there’s a lot of non-verbal communication that is going on, whereas if I’m working with a Southerner, the non-verbal*

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<sup>70</sup> Inuit in Arctic Canada as well as Greenland use the facial expression of raising eyebrows as a way of saying yes and also as a way of acknowledging someone or silently greeting someone.

*communication is not picked up at all*” (T39:349). Another nurse similarly commented: “*There might be times that a Southerner might not see what an Inuk elder is trying to say, because he’s not verbalizing it, because there is body language to it*” (T40:823). Several nurses talked about the consequences for the patients when Southern nurses and other Southern health care professionals are not able to pick up the body language of their patients, and even if Southerners are aware and look for it, many mentioned that they “*may look for it without noticing it*” (T44:66).

That many Southerners are not able to interpret Inuit body language has to do with them not possessing the same embodied *cultural capital* as their Inuit colleagues. Particular gestures and movements used in lieu of words or to emphasize or diminish that which is said, which is a natural part of the *habitus* of many Inuit, is not part of the *habitus* of most Southerners. Irving Goffman terms these “movements, looks, and vocal sounds we make as an unintended byproduct of speaking and listening” a process of “ritualization” (1981, p. 2). This process is never innocent, rather

within the lifetime of each of us these acts in varying degrees acquire a specialized communicative role in the stream of our behavior... we specialize these acts, performing them with no felt contrivance right where *others in our gestural community* would also. (Goffman, 1981, p. 2, emphasis added)

As I understand Goffman, these others of ‘our gestural community’ are generally those others with whom we share more *habitus*. Where Bourdieu (1986) believes that *habitus* is largely unchangeable, while also noting that it is both inoculated and can be learned, I agree with Jenkins (1992) that *habitus*, similar to identity of which it is part, is more plastic than unchangeable. Goffman would also agree, I believe, that once gestural conventions are established in a community they can be acquired, although

the purpose and function of these displays cannot of course be caught by the term “expression”, but only by closely examining the consequence each gesture commonly has in samples of actual occurrences – with due consideration to the sorts of things that might

be conveyed in the context had no such gesture been offered.  
(Goffman, 1981, p. 3)

Body language also had importance in the interaction between teachers and students. One teacher said that she used body language as a means to ask a particular student to participate in class without confronting the student verbally. A student relayed how she would be able to read from the body language of an Inuit mentor whether she was on the right track at an exam, whereas she would not be able to read anything from a Southerner. Although the Inuit nursing student possesses *linguistic capital* in the form of having mastered the Southern language, which allows her to make herself verbally understood and to verbally understand her Southern mentor, the body language or the *embodied cultural capital* that she also possesses and draws on with her Inuit mentor and Inuit patients is of no value with her Southern mentor. Unfortunately, some Southern mentors asked Inuit students to conduct their conversations with Inuit patients in a Southern language using an interpreter in order for the mentor to be able to understand and evaluate. This speaks to the power relations (Bourdieu, 1986) at play where one language, and what that language symbolizes (the unilingual speaker is closer to the field of power than the bilingual speaker), affords more *capital* than another. The African writer and theorist of postcolonial literature Ngugi Wa Thiong'O (1986) might see this not only as describing the power relations between two languages and their speakers, but also as alienating the speaker from him or herself, or as he writes, "of seeing oneself from outside oneself as if one was another self" (p.18).

I will discuss power relations further in chapter 7. As mentioned, *linguistic capital* is part of *cultural capital* and simply speaking, *habitus* and *cultural capital* are conceptually the same. It is unsurprising then that many nurses and students strongly connect language and identity, also in relation to their education and practice.

### 4.1.3 Language and identity

As has been observed by several authors discussing issues of language and identity, many Inuit feel a strong connection between the two (Brody, 1991; Dorais, 2001, Dorais & Searles, 2001; Gad, 2009b; Hot, 2009; Langgaard, 2003; Sørensen, 1997; Timpson, 2009; White, 2009) and some connect the preserving and strengthening of the Inuit languages with the overall cultural survival and even physical and mental health of future Inuit (Simon, 2008). One nursing student said:

*I can say it like this; this land is our land, and this language is our language, our mother tongue. If we are to reach independence, we have to feel responsible and use the language with which we can identify; our mother tongue. (T2:195)*

When asked, this student said she thought that language, identity and feelings for the land were connected. She continued that being educated in a Southern language as an Inuk affects her motivation in the program. As an example, she brought up the educational material used: *“It is appropriate for a Southern system. It fits the system in Southern towns. It is true that we are under a Southern system, but it is difficult to just apply Southern material to an Inuit culture”* (T2:283).

Many participants in both regions thought it would be appropriate to have more literature describing regional or pan-Arctic issues, case stories and research and many connected having more literature with a regional or pan-Arctic focus with the preserving of pride in Inuit ways, values and identity. A participant talked about how a “real Inuk” would teach as opposed to a how a Southerner would teach and I asked her what she meant when she said “real Inuk.”<sup>71</sup> Her reply was: *“Someone who speaks the Inuit language as her mother tongue and knows the culture”* (T6:213 ). Several others also connected the Inuit language with Inuit identity. Another participant stated that health care practitioners who knew the language, identity and background of their clients would be better

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<sup>71</sup> Several authors discuss Inuit identity (Briggs, 1970, 1982, 2001; Brody, 1991; Hansen, 2007; Lyng, 2005; Searles, 2000; Stairs, 1992) as well as the notion of being *Inummarik* or “a genuine Inuk” (Brody, 1991; Dahl, 2000; Dorais, 2001; Nuttall, 1992; Stairs, 1992). This will be discussed further in chapter 6.

equipped to provide care to those clients. When I asked her what she meant by Inuit identity, she continued: “*Inuit identity is being Inuit, having the Inuit language, being part of the Inuit culture - what can I say?*” (T29:297). When probed, however, she did note that an Inuk who did not speak an Inuit language could still be considered “a real Inuk.”

Langgård (2003) writes that young Greenlandic people who only speak Danish or are not good at speaking Greenlandic are stigmatised and that the bumpy road to self-governance has increased the need to focus on ethnicity and thereby language. Other work describes the experiences of Greenlanders who are not able to speak Greenlandic fluently. Many of these feel that they are not viewed as real Greenlanders by their fellow Greenlanders and some feel more comfortable in a Danish environment where they can present themselves as Greenlanders and hold on to their Greenlandic identity without being questioned about their language proficiency (Chemnitz, 2001; Gad, 2009a; Lund & Nathanielsen, 2001). Similarly, one participant stated that she felt like an imposter as an Inuk because she was not able to speak an Inuit language. Connecting identity with language ability seems to me to be less politicised and maybe even less emotionally charged among the general population, if not in the government of Nunavut, than it appears to be in Greenland. On the other hand, Dorais and Searles (2001) write that Inuit residing in Iqaluit link the Inuktitut language to an Inuit identity and, for residents of Qaqtak, “an Inuk who cannot speak Inuktitut cannot be considered a real *inutuinnaq*” (Dorais, 2001, p. 87). Despite this, research shows that the percentage of Canadian Inuit who describe themselves as fluent in Inuktitut and who choose to speak Inuktitut in their home is ever decreasing, a fact that Mary Simon, President of ITK, laments and says is detrimental to Inuit health (Simon, 2008).<sup>72</sup>

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<sup>72</sup> According to the StatsCan 2006 census, 64% of all Inuit in Inuit Nunat (all the Inuit regions across Canada) report Inuktitut to be their mother tongue and 69% that they have enough knowledge of Inuktitut to converse in the language. This is down from 72% in 1996. The statistics vary significantly between different regions. In Nunavut the numbers are 78 and 84% respectively and in the Inuvialuit region 14 and 20%. The number of Inuit residing outside the Inuit regions who consider Inuktitut their mother tongue and are able to converse in Inuktitut are significantly lower with 14 and 15% respectively (StatsCan 2006d). I have not been able to find similar statistics for Greenlanders. SLiCA estimates that 5% of Inuit Greenlanders do not speak

That identity and language, and language and knowledge, should be intimately related (Crick, 1982) is by no means a recent assertion although the ways that these concepts are connected has been widely debated in anthropology. In 1920 the German anthropologist Franz Boas wrote that language forces itself upon our thought processes and affects the way we perceive reality, ideas and culture (cited in Hastrup, 1999). According to Boas, then, language affects what we know and what we can know. In the mid 20<sup>th</sup> century Boas' idea was taken a step further and crystallised in the famous hypothesis of the linguists Benjamin Lee Whorf and Edward Sapir (Hastrup, 1999; Thomson, 1975). Their hypothesis held that language not only *affects* our perception of reality, experience and knowledge – *it actually shapes it* (Crick, 1982; Hastrup, 1999; Thomson, 1975). The Sapir-Whorf hypothesis is no longer in favour among anthropologists and the idea that language shapes reality, experience, and knowledge is no longer seen as valid (Crick, 1982; Hastrup, 1999).

Although some scholars may not perceive language to shape culture, identity, and reality, exceptions exist. One is Ngugi (1986), who gives evidence of this when he writes:

Language as communication and as culture are then products of each other. Communication creates culture: culture is a means of communication. Language carries culture and culture carries, particularly through orature and literature, the entire body of values by which we come to perceive ourselves and our place in the world. (pp. 15-16)

Many statements from Inuit nurses, nursing students, and others show that the general public may still see strong connections that correspond to the Sapir-Whorf hypothesis. Apart from participants in the study several authors mention that Canadian Inuit (Brody, 2000; Burnaby, Martin, 2000; Minor, 1992), and Greenlandic Inuit (Sørensen, 1997) make the same connections. Sørensen (1997), for example, quotes one of his participants as stating: “The Greenlandic norms

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Greenlandic at all, or do so with effort, and that between 12 and 15% do not read or write it at all, or only with effort. It is estimated that Inuit in Nunavut who do not speak Inuktitut at all, or only with effort, is 1%, in Nunavik 8%, in Inuvialuit 56% and in Labrador 32% (Poppel et al., 2007, p. 155).

and the Greenlandic attitude towards life, you can only really grasp if you speak Greenlandic, I believe. You know that deeper meaning” (Sørensen, 1997, p. 355, translated from Danish by author). Sørensen adds that this view on the connection between language and culture is very common; he underscores this statement by quoting an earlier interviewee who stated: “You know, the Greenlandic way of thinking, that is our language, our culture...you can only understand it if you speak Greenlandic” (Sørensen, 1997, p. 355).

I am comfortable with Hastrup’s assertion that language is understood to be socially embedded and “inseparable from its usage” (Hastrup, 1995, p. 35). This notion does not preclude the possibility of identifying with a particular culture and being able to grasp and live it while not being able to speak the original language of that culture. I believe it is possible to experience and think the world culturally as Inuit but in English or Danish. The way you use the language is socially embedded and the meaning or feeling you convey is dependent on tone of voice, body language and much more. In other words, that you are fluent in a native language, whether, for example, Greenlandic or Danish, does not mean that you are fluent in the “native culture” or value system of that language as noted by some of the participants. Conversely, that you do not speak a native language does not mean that you cannot be “fluent” in the native culture of that language. As Dorais and Sammons (2002) point out about the Tlingit who live on the Southeastern Coast of Alaska: “Some 90% of them do not speak their aboriginal language anymore. This does not prevent them from being proud of their culture and making efforts at preserving it.” They continue: “This means that, as suggested by many of our Baffin informants, culture may subsist without the language” (p. 118).

Other authors might disagree with this, noting, for example, that by being forced to speak or write in a language that is not one’s own, “one has to convey in a language that is not one’s own the spirit that is one’s own. One has to convey the various shades and omissions of a certain thought-movement that looks [or sounds] maltreated in an alien language” (Raja Rao, cited in Walder, 1998, p. 43). Rao continues that his use of the word *alien* does not imply that English is alien

to Indian people, but rather that English is the language of Indians' intellectual but not emotional makeup – something that Inuit nurses and students also noted. Ngugi (1986) takes this notion a step further when he writes that language was “the most important vehicle through which [colonial] power fascinated and held the soul prisoner. The bullet was the means of physical subjugation. Language was the means of spiritual subjugation” (p. 9, square brackets in original). Ngugi also argued that by accepting a language one also accepted the values of that language, implying as noted above that language is socially embedded and inseparable from its usage. That language is socially embedded and “inseparable from its usage” (Hastrup, 1995, p. 35) also finds support in Ricoeur’s (2001) idea about discourse. Ricoeur and the structurally oriented ethnologist Claude Lévi-Strauss were both influenced by the thinking of Saussure, who is thought of as the founder of structural linguistics (Brügger, 2001a). As opposed to Lévi-Strauss, Ricoeur states that language, as a system, is useful only as a tool to explain a sequence of events, but not to understand them. Lévi-Strauss’ proposed language to be a model for culture in the mid-20<sup>th</sup> century. Taking a synchronic approach, he perceived language and social relations to be functioning in the same ways, as systems (Brügger, 2001b). Lévi-Strauss envisaged the role of anthropology, in its dealing with societies, to be analogous to the role of phonology (which does not treat the elements of language as independent entities, but rather as elements dependent on the relations which join and oppose them) in its dealing with the auditory elements of the language. As the task of phonology is to uncover the systems and unconscious infrastructure of the elements of these systems, he continues, so is the role of anthropology, not to focus on single entities in a culture, but rather to see these entities as parts in larger systems of correlations and uncover the infrastructures of these systems (Brügger, 2001b).<sup>73</sup> Ricoeur perceives Lévi-Strauss’ analytical usage of language as a system to be limiting. He advances instead that language, spoken (phonologically) or written (lexically),

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<sup>73</sup> Later, Pierre Bourdieu (2000) correlates *habitus* and how individuals express *habitus* to function like the language systems described by Saussure. In all societies, Bourdieu states, the different components of different *habitus* have “the same function as for example the set of phonemes in a language” and are only parts of the larger system or “distinctive signs” within that system (Bourdieu, 2000, p. 24).

should be analysed as action, but that in order to do that it is necessary to analyse language according to Saussure's (2001) idea of 'language use'.

Early in the 20<sup>th</sup> century, Saussure differentiated between 'language use' (the act of speaking) and the 'language system.' He perceives the language system to be the concern of the linguist, and further divides the focus of linguistics into a synchronic and a diachronic part. The synchronic deals with the relationships between the different parts of the language system and the diachronic with the development of, and changes that happen with, that system over time (Saussure, 2001). Ricoeur terms language use "discourse" (2001, p. 222) and argues for the usage of a new hermeneutic<sup>74</sup> process, which is valid for discourse, in order to "examine which world the text opens up" (Ricoeur, p. 218).<sup>75</sup> Ricoeur continues that as opposed to language as a system, discourse or language as action is time-bound, self-referential, embedded in the world which it refers to, and addresses an interlocutor.

As do Ricoeur (2001) and Hastrup (1995), I understand language to be embedded in the world, which it refers to, and to be socially embedded and an action, which is inseparable from its usage. Hence, knowledge of a language does not afford a gateway to a culture although it enables a person to make herself understood (Hastrup, 1995). Even the latter may be questioned. When conversation takes place between individuals belonging to various *fields* as envisioned by Bourdieu (1993) and described in section 1.5, be it lawyers, various academics, nurses or medical doctors, a certain choice of words and phrases, a certain way of communicating, of using the language is implicitly expected, even required in order to be understood, accepted and comfortable. It follows then that if two people who interact are not "members" of the same field or fields, if they share membership of a professional but not cultural field, or the other way around, their sharing the same mother tongue or speaking the same

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<sup>74</sup>According to the Canadian Oxford Dictionary, hermeneutics is the branch of knowledge dealing with interpretation, especially of text (Barber, 2004). New in Ricoeur's proposal, then, is a hermeneutics which can also be used to interpret verbal language.

<sup>75</sup>Ricoeur (2001) argues in *Tekstmodellen: Meningsfuld handling betragtet som tekst* (The textmodel: Meaningful action viewed as text), that the action that he perceives language to be can be analysed as text.

language fluently may not be enough for either to make themselves understood or to understand their interlocutor, if both do not share the language or linguistic *habitus* of the same field.

For example, Good and Good (2000) describe how medical students at Harvard Medical School, during their medical training, learn to engage in a set of distinct practices necessary for the ‘lifeworld of medicine.’ The students enter ‘medical discourse’ where they learn particular ‘writing patterns’ and ‘speaking practices’ (Good & Good, 2000). Learning to communicate ‘the right way’ is a very important part of learning medicine, students confide, and until they have incorporated the particular language of the *field*, speaking at rounds and with patients can be very anxiety provoking. The increasing ability to incorporate the language of the field, on the other hand, leaves the students feeling in control and increasingly enjoying what they do. Simon Sinclair (1997), an MD and anthropologist who conducted research with medical students over two years at a teaching hospital in London, England found the same in his interviews as well as during observations in lecture-theatres and in the clinical setting.

As mentioned in section 1.5, when an agent does master a language or has a certain linguistic competency, he or she has *linguistic capital*, which can be “measured in relation to a specific linguistic market where often unrecognized power relations are at play” (Bourdieu, as cited in Johnson, 1993, p. 7). For Inuit nurses and nursing students, *linguistic capital* is not only the ability to speak and understand a Southern language but also to speak and understand the language of nursing or the health care field in order to understand and be understood by colleagues who are non-Inuit. At the same time, *linguistic capital* for Inuit nurses and students is the ability to switch into an Inuit language and also act in an Inuit language in order to make themselves understood and understand their Inuit patients.

#### ***4.1.4 Health care across languages***

Nurses and students from both regions found it problematic that Southern health care practitioners do not speak an Inuit language, both in relation to patient care

and in relation to the work environment and sharing of workload. Most participants also noted that having an Inuit language course in medical and health care terminology as part of their nursing education would have been a great benefit, and said that they would recommend it even if it meant prolonging the programs by three to six months. Two participants even speculated about going back to take a three month medical interpreter course to feel more confident. There were a few who thought it would involve too much work for students and nurses to attempt to learn the medical and health care terminology in an Inuit language compared to the benefit that would accrue. One reasoned:

*I think that trying to relearn the language and a new vocabulary in an Inuit language would not allow everyone to know these words. I am not going to learn new words about different treatments and such in an Inuit language. I don't think it is possible and generally do not think people would be interested. (T43:71)*

When I enquired further she stated that emotions are easier to express in her mother tongue than in the Southern language. A nurse who also stated that it was easier talking about emotions in her mother tongue explained:

*When I speak a Southern language more rational things kick in. When I speak an Inuit language it is different, it is difficult to explain. When I speak a Southern language I talk about something I have learned through school, something I have learned through my education, professional language. Something that is tied to something rational, but when I speak an Inuit language then we can speak professionally but we can also revert to something more intimate. (T30:395)*

This explanation echoes that of Rao noted above (cited in Walder, 1998). Many participants relayed how they felt they functioned in two parallel worlds when at work or school. When talking to one nurse about nursing theory and its translation to an Inuit language, she said:

*It is tremendously difficult to translate those theories to an Inuit language. Without knowing whether what I say is absolutely true, I simply believe that we work with two things in our brains simultaneously. Something like, I understand this theory in a Southern language, I am not able to translate it into an Inuit language, but then I just relate to it in a Southern language and do not even attempt to translate it into an Inuit language. Although I act*

*on it as an Inuk, I just have the Southern understanding with me all the time. (T32:185)*

In other words the Inuit nurses understand, relate to, and employ that which they have learned in the language they have learned it in regardless of whether they act while being immersed in the other language. Inuit nurses and students, as suggested by Ricoeur's theory (2001), use and think the language and the knowledge tied to the world of that language, and according to the Inuit nurses and students this also holds true when they act in another language. Another participant stated that it would be a benefit to the Inuit patients if all health care practitioners spoke an Inuit language, but that it would not be enough. Being able to relate properly to Inuit patients would require knowledge about Inuit identity, society, and history. She further stated that *“even if you speak the language you may not know about the background”* (T29:289). This could mean, as pointed out by another nurse: *“so, even if you understand, you don't really understand anyway...[which means that] lots of misunderstandings occur”* (T20:219).

Some Inuit found that Southern nurses, because they did not speak the Inuit language, were reluctant to speak to Inuit patients; one, for example, said: *“new or casual nurses only talk to the patients if they speak a Southern language. They inquire about their ability to speak a Southern language”* (T10:99). Some felt that when Southerners do approach Inuit patients and find they cannot speak a Southern language they believe the patients are stupid. As one said: *“Because of the language differences some Southerners have a tendency to speak extremely loudly and slowly to the Inuit patients as if they are deaf or slow”* (T15:100). Or Southerners may, even when trying our best, sometimes miss pertinent information or misunderstand/misinterpret the information given as the following example from a nurse demonstrates. She said:

*I was the second nurse on call, and when the first nurse on call was swamped with patients on a Friday night, she asked me to come in to give her hand, so I did, and I took over care for this elderly man with a cardiac arrhythmia. When I came in... I asked him, “Can you tell me what's going on?” and he knew, he explained to me in an Inuit language in great detail; he knew exactly what was going on. And the Southern nurse came to me and said, “What's going on? What are we*

*going to do?” I said, “He knows exactly what’s going on and we’re going to do this, we’re going to do that.” And she looked, “Whoa, that just blows me away,” because she was going to write down that he was a poor historian – and it was all because she was trying to get that information in a Southern language. (T39:358)*

Many other examples were given where nurses and students had experienced that patients had not been understood by a Southern nurse, or the patient had not understood the questions that a Southern nurse had asked and subsequently answered *yes* to being well rather than *yes* to experiencing pain, as the following quote exemplifies:

*When I worked at the hospital a nurse was with a patient. She came out and said he was all right, everything was fine and dandy. Just after when I saw the patient he said to me that he had pain here and there and did not feel well, although he just said he felt well. It turned out he had just said yes to everything. (T75:182)*

Several pointed out that Southerners generally are less engaged with Inuit patients because of not understanding the language and therefore not understanding what the patients want. But as one nurse stated, “*it is the patients that suffer when they are not understood. Sometimes I do not understand that they do not make any more complaints than they do*” (T29:354). This may, as several noted, make it understandable that some Inuit patients prefer to be cared for by Inuit nurses:

*The patients that we have that speak only an Inuit language they prefer to speak with an Inuk. I think I develop a better contact with the patient than one who speaks a Southern language. It makes it possible to speak about everyday things... about the patient’s day to day life. I do not think that is something people do if they speak a Southern language. Then you need an interpreter. I do not think that you as readily have that intimate conversation with the presence of an interpreting interpreter. (T19:244)*

Another participant expanded on the difficulty of having intimate conversations across languages:

*It must be very difficult to be an Inuit language speaking patient at the hospital here where the majority of the staff are Southern. We have been taught that it is very important to express your feelings, but*

*how are people who speak an Inuit language supposed to express their feelings? (T2:414)*

Having a bilingual health care system offers challenges for both patients and health professionals. It greatly affects the working conditions of the Inuit nurses and students. Many participants relayed experiences of needing to work “double work” because of being bilingual while many of their colleagues are unilingual, and speak a language that many of their patients do not. As one nurse said: *“The patients do not understand the Southern nurses, which means that misunderstandings often occur. It also means that we as Inuit have to explain to the patients afterwards and that creates double work for us” (T11:97)*. Another nurse said:

*If I have an evening shift with a Southern nurse she cannot answer the phone; well she can answer but she passes it on to me because she does not understand what the person on the other end is saying. Often she cannot carry on a conversation with the patients because she does not speak an Inuit language and the patients often are unilingual Inuit language speakers. (T25:102)*

Several others reiterated the idea that working with Southern nurses who were unilingual increased the workload for Inuit nurses, but whereas the extra work that these first examples describe was not directly solicited, some Southern nurses would directly ask Inuit nurses to take responsibility for unilingual patients. One Inuk nurse stated:

*Some will say to me, “You are an Inuk. You try to talk to the patient,” rather than trying themselves. That means that I sometimes have more (too many) tasks that I need to do at the same time because I need to care for my own patient as well as talk to the Southern nurse’s patient. (T24:86)*

Another said something very similar when she talked about being one of two Inuit nurses in a ward where all other nurses were Southern:

*It was difficult being only two Inuit nurses because the Southern nurses push you, saying, “but, you speak the language, can’t you just...?” We were given many of the ‘heavier’ patients at the same time, as the Inuit patients themselves prefer to have someone who speaks an Inuit language. (T31:137)*

It is understandable that it in some ways may feel as a relief to Inuit nurses when they are able to work with other Inuit nurses, as one nurse stated:

*If a nurse has the language, she is much better equipped in her contact with the patients. She can by listening only, without saying anything and just listening, catch other signals than a non-Inuk would be able to. By listening, looking, observing, everything will seem recognizable to her whereas the strangeness in the situation for a Southern nurse will make her focus on certain practical tasks and areas. (T30:375)*

Another nurse focussed on patient comfort when she said:

*I have been lucky in that I have worked at a place where there were more health care staff that spoke an Inuit language. There my experience was that the patients felt much safer if the nurse they turned to spoke an Inuit language and was able to understand what they say. The atmosphere in the ward was totally different if there were nurses at work who spoke an Inuit language. (T29:285)*

Despite these descriptions, everyone, when asked directly whether it would make a difference to them if they worked with Inuit or Southern nurses, said no. Although working with a Southern nurse could create a heavier workload for Inuit nurses they all said that as long as the nurse was capable and respectful it did not matter what her or his ethnic background was. Some mentioned that sometimes a particular Southern colleague could be nicer to work with than a particular Inuk colleague; it all depended on personalities. Some Inuit nurses also mentioned that they appreciated the great experience that many Southern nurses brought with them and which they themselves, particularly if new and less experienced, could draw upon and learn from.

That participants said “no” when directly asked whether it would make a difference to them if they worked with Southern or Inuit nurses may have to be seen in the light of me being a ‘Southern nurse’, and also with the context of the interview. If participants said anything that was not very positive they would often relay an experience in the form of a story, but this often occurred outside of the formal interview. Some, although they said “no,” subsequently told me about experiences with Southern colleagues that they had found challenging. Some of the same people and others also related experiences with Inuit colleagues they

had found challenging. In previous research in Nunavut I experienced that interviewees rarely, if directly asked, would say anything negative about Southerners, whether health care professionals or otherwise (Møller, 2005, 2007). Thisted (2002) described similar experiences in the context of interviewing older Greenlandic people, and the Greenlanders whom Tine Bryld (1998) interviewed about having been sent to Denmark to be raised in foster care also did not say anything directly negative about anyone; rather, they shared stories.

Participants' responses to whether it would make a difference if they were to be taught by Inuit or Southern teachers were a little more varied with about a third saying they would prefer Inuit teachers, about a third saying they would prefer Southern teachers, and about a third saying it did not matter. This is described in more detail in section 5.1.4, but the main reasons for preferring a Southern teacher was that the literature was in a Southern language or that participants were used to being taught in a Southern language. The main reason that some would prefer Inuit teachers was that it would provide the option of discussing things in an Inuit language. As one student said: "*The experience of being a nursing student would be very different with an Inuk mentor. Language and communication is so interconnected. It would change the way we are able to communicate, which is a big part of nursing*" (T36:81). This brings to mind the words of Ngugi, mentioned above (cited in Walder, 2008). Not being able to discuss experiences in an Inuit language could be viewed as a way to hold the soul prisoner. Evident in Ngugi's words as well as those of Ashcroft, Griffiths and Tiffin (2002),<sup>76</sup> and as noted by Walder (1998), the question of language is important to colonial and post colonial experiences. This is also the case for Canadian Inuit and Greenlanders (T. Berger, 2006; Gad, 2009b). Inuit nurses and students, however, were generally quite pragmatic when they discussed the

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<sup>76</sup> In *The empire writes back*, Ashcroft, Griffiths and Tiffin (2002) discuss the ways in which the colonized *appropriate* or *abrogate* of the dominant colonizing language. When abrogating the language, they explain, communities refuse "the categories of the imperial culture, its aesthetic, its illusory standard of normative or 'correct' usage, and its assumption of a traditional and fixed meaning 'inscribed' in the words" (p. 37). "Appropriation is a process through which the language is made to 'bear the burden' of one's own cultural experience. . . . [the dominant colonizing] language is adopted as a tool and utilized to express widely differing cultural experiences" (Ashcroft, Griffiths and Tiffin, 2002, p. 38-39).

presence and domination of Southern languages in the health care field, as will be discussed further in chapter five. Rather than either abrogating or appropriating<sup>77</sup> the dominant colonizing language as conceptualized by Ashcroft, Griffiths and Tiffin (2002), it appears that Inuit nurses and students have generally retained their mother tongue and use it to discuss and describe emotion and social relations, while having also acquired the colonizing language which they use in their academic and professional spheres.

Apart from language, cultural and pedagogical differences in the context of learning were also mentioned. In the following section, however, I will focus on the experience of being educated across languages and then pick up cultural and pedagogical considerations along with students' and nurses' schooling experiences in both primary, secondary and nursing school, in chapter 5.

#### ***4.1.5 Education across languages***

Even though they would describe themselves as bilingual or fluent in a Southern language and even though many had grown up with Southern relations, many, particularly younger nurses and students, relayed how they sometimes had difficulty expressing themselves in the Southern language in a way that would make their Southern teachers or colleagues understand. For example, in relation to a question about whether ethnically Southern and Inuit educators might teach and approach students in similar or different ways, one student replied:

*I do believe that there will be differences.... I remember that during classes, sometimes when we students thought about something in an Inuit language and then were trying to express it in a Southern language to make the teacher understand, it did not work, because we were not able to translate our thoughts in the Inuit language into the Southern language. (T26:152)*

She continued that:

*It would have been very different then if we had just been able to express our thoughts in the Inuit language, rather than having to translate into the Southern language. I think that has been a problem. Because the teacher has been Southern, we've had to discuss things*

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<sup>77</sup> See footnote 75.

*in the Southern language. And if emotions are a bit high or you are affected by something it can be difficult. (T26:152)*

When we discussed whether the nursing education should be taught in an Inuit language, another student said: *“Well the best for the patients is that you speak the language, but the education should not be offered in an Inuit language. There are many Southerners in the health care system and they speak a Southern language”* (T76:105). She continued that she thought that well educated Inuit were often better at speaking a Southern language and would therefore either stay in or leave for the South. The notion that the nursing education should not be offered in an Inuit language could give pause for thought about why it makes more sense to nurses and students to accept the Southern language as a natural part of their work life, and something that Inuit need to deal with, rather than thinking that Southerners should learn an Inuit language if they want to work in the Arctic, or even suggesting that it would be better if that was the case. Only a few voiced that thought and a majority of those who did were Canadian Inuit.

In this connection it is worth mentioning that an Inuit health educator noted that recently when she offered a course in health promotion, participants thought it weird that it was offered in an Inuit language, with some voicing their preference for it to be offered in a Southern language, which they found easier. These were people living in the Arctic, upgrading their education outside their hometown in order to go back home and continue their practice.

The fact that about a third would prefer to be taught by Inuit teachers fits well with the fact that seven of 33 (21%) Greenlandic Inuit participants, and seven of 16 (38%) Canadian Inuit participants<sup>78</sup> believe it would be desirable if the nursing programs over time were offered in the mother tongues, Inuktitut and Greenlandic, of about 85% of Inuit in the regions. Almost twice as high a percentage of Canadian compared to Greenlandic Inuit participants think it would be desirable for the nursing program to be offered in their mother tongue. The participants who share this desire were all among the older participants, identified

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<sup>78</sup> This does not include students who had opted out of the program. Unfortunately, that questionnaire did not ask if they thought the program should be in an Inuit language.

one of the smaller or more remote towns/settlements as their home community, or were raised in what they identified as a home with more traditionally Inuit values. That more Canadian than Greenlandic Inuit (and predominantly the older Greenlanders) would like to see the programs offered in their mother tongue has to do, I believe, with the differing historical and political realities of the two regions and the different historical and political experiences of the younger and older generation of Greenlandic participants. As noted by Hastrup (1995) and Ricouer (2001), language as the action it is, is time-bound and embedded in the world which it refers to, and therefore affected not only by the changes that affect language over time but also by the historical and political experiences a person connects with a particular language at a particular time. The histories of the educational systems and roads to self-governance are described in depth in Section 2.2. In the following I will highlight the parts that are relevant for this discussion.

In Greenland many nurses who attended school between the 1960s and 1980s were educated during a period of intense “Danification,” the G-50 and G-60 period as some of the nurses called it.<sup>79</sup> During this time, public institutions and systems, including the educational system, were made into replicas of those in Denmark, structurally, culturally and linguistically (Thorleifsen, 2003). The G-50 report was followed by a new primary school law in May 1950. The law placed the Danish language centrally in the Greenlandic school. This was thought necessary in order for Greenland to reach the goals that had been set in G-50 and after Greenland’s status as a colony was abolished in 1953. It was thought that focusing on the Danish language would help Greenland reach a level of development comparable to Denmark and allow the Greenlandic people to obtain

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<sup>79</sup> G-50 and G-60 are the popular terms for *Betænkning fra Grønlandsudvalget af henholdsvis 1950 and 1960 (Report from the Greenland Commission of 1950 and 1960 respectively)*. These reports or policy papers came about in order to “develop the economic, social and cultural life in Greenland and make Greenland an integrated part of the Danish kingdom with the same economic system, standard of living and the same rights for all citizens in all parts of the kingdom” (Thorleifsen, 2003, p. 105). The idea was that this would make an end to all kinds of inequalities and poverty that were known in the colonial era.

the same rights and privileges as other Danes in the Danish Kingdom. It would allow Greenlanders to be educated and subsequently be able to manage their own affairs in their new modern society (Heilman, as cited in Chemnitz, 2001).

The choice to educate children in the dominant language may have been done with the best intentions, but in Greenland, as in places described by post-colonial writers like Ngugi (1986), it came at a high cost. Ngugi calls the result of this sort of policy ‘colonial alienation.’ He explains that colonial alienation arises on account of children being taught in a foreign language, using foreign books and conceptualisations, breaking the harmony that would otherwise exist between education, family and community. This results in a “disassociation of the sensibility” of children from their “natural and social environment” (p.17). Sending children away to school would increase this alienation.

In the 1960s many children were sent to Denmark for one year at age 10-12 in order to improve their Danish language skills, and the new education laws meant that Danish was made the dominant language in the schools in Greenland. Greenlandic was offered as a second language from grade 3, but those who wished could choose not to take Greenlandic at all (Sørensen, 1983). Greenlanders who wished that their children went beyond grade 7 had to send them to Denmark where special Greenlandic post-grade 7 schools had been created (Jensen, as cited in Chemnitz, 2001). According to Chemnitz (2001), it was, at the time, thought to be a positive thing to send the children away in order to increase their future possibilities.

The practice was abandoned after a government initiated project that investigated the outcome of sending Greenlandic 5<sup>th</sup> graders to Denmark for a year found that the relationship between the children and their families in Greenland became less close and that they spoke their native language less well upon returning, while other skills, apart from mastering the Danish language, did not increase (Follin, as cited in Chemnitz, 2001).

Eva Illum, one of the Greenlanders who were sent to Denmark in foster-care, said: “Luckily this practice was stopped. The experience was that the children became confused about whether they were Danish or Greenlandic” (as

cited in Bryld, 1998, p. 83, translated from Danish by author). Although officially abandoned, Greenlandic communities continued the practice of sending students to friendship towns in Denmark, but for 3 months rather than a year at a time.

Residential schools also impacted Inuit language use in the Canadian Arctic, with children often forbidden to speak in Inuktitut, and punished for it (Anawak, 2009; Manning, 1976). None of the participants in this study had personal experiences with Residential schooling and only two spoke of family members or friends who had; however, many participants and community members at large mentioned the fact while I was in the field and it appeared to be politicized in Nunavut in a way it did not appear to be in Greenland until recently.

Almost all Greenlandic nurses and students above the age of 35 relayed how they had been sent to school in Denmark for shorter or longer periods. Some thought the experience had been great and that leaving home or coming to Denmark was the best thing that could have happened to them. One stated:

*When I came back to Greenland and had to take care of my siblings again I felt homesick for Denmark because there I was free and could be with peers, but now I needed to cook and clean again and... for me Denmark was high up on a pedestal; I had only seen all the positive.*  
(T32:241)

It should be added that this participant later felt she had been fooled while being in Denmark, exactly because she had only seen the positive and not the ‘backside of the medal’ as she called it, which she experienced when she returned in order to be further educated later in life.

Whether their comments about having been sent to Denmark were positive or negative, most did not feel that they or their parents had had a choice in the matter. They were sent to Denmark because a Danish teacher or principal said they thought it was a good idea, and their parents accepted the suggestion because saying no to Danish authority was generally not done. Several of the Greenlanders that Bryld (1998) interviewed also matter-of-factly made this remark, one saying to Bryld: “You have to understand how it was.... The Danes told us how thing should be. They gave directions. You did not discuss with Danes, you did not talk to Danes, just like you do not talk to God” (Hans Holm,

as cited in Bryld, p. 55, translated by author). From the late 1980s Nuttall (1992) discusses the prevalent feelings of shyness and inferiority among people in Greenland when faced with Danes, particularly those in roles of authority such as doctors (and I would add nurses). Nuttall recounts that even a local midwife, through association, could evoke these feelings; her “experiences of other parts of Greenland (such as Nuuk), and of Denmark, her education and training as a midwife, her status and lifestyle put her at one remove from the other villagers” (Nuttall, 1992, p.105). About Greenlanders believing Danes to be superior and in authority, the nurse who was sent to Denmark and subsequently saw the country through very rose coloured glasses, said:

*In reality I was never really asked. I did not feel that I could say no and was also not offered any alternatives... My mother has since talked to me about how difficult it was to send me away. But then life was more like if the school suggested something... you did it.... It was like... ‘this is the way it is’, and then... ‘okay, if you say so, we’ll do it’ and then one did. (T32:21)*

Many of the older Greenlandic participants feel that they have lived under unnecessary Danish authority, influence and language and for them the use and continued retention of the Greenlandic language held high value and seemed to be a political, cultural and emotional question. The Greenlandic students and nurses below the age of 35, on the other hand, attended school after the event of Greenlandic Home Rule in 1979 when the educational portfolio, as one of the first, was transferred to the Greenlandic government. This transfer of responsibility for education to Greenland brought a significant change in the focus of the educational system, which shifted from Danification to Greenlandization. The Greenlandic language, which for 10-15 years had been overshadowed by the Danish, was reprioritised and politically the aim was to make the school more Greenlandic (Heilman, Jensen, as cited in Chemnitz, 2001). A problem, however, was that the number of Greenlandic speaking educated teachers was not high enough (and still is not high enough) to ensure that the education took place in Greenlandic, particularly at the senior public and high school levels (Chemnitz, 2001; Gad, 2009a; Lund & Nathanielsen, 2001).

Furthermore, few educational books have been published in Greenlandic, especially at the senior public and high school levels. For the younger cohorts this has meant that while the focus was on the Greenlandic language, many were still educated only in Danish in the senior years and in high-school, and for some this posed a barrier for educational success because their mastery of the Danish language was not at a high enough level to switch from being taught and learning mainly in Greenlandic to being taught and learning mainly in Danish. Only about 25% of the Greenlandic participants below the age of 40 were educated in Greenlandic in the senior public school years and in high school. Many felt that their Danish language abilities had been a major asset in their educational journey, and also that many of their contemporaries who had less Danish (and who generally had not proceeded to high school) had not been able to succeed in school because of it.

So, although the younger cohorts felt that the political decision to focus on Greenlandic was a good one in theory, they also felt that without the abilities they themselves had in Danish, they would not have been able to take a higher education; as expressed by one student: *“I definitely notice that it is to my advantage that I speak a Southern language as well as I do. I have many friends who have problems with the Southern language where I definitely notice that I have a huge advantage (T71:71).*

Sadly, not mastering a Southern language did, for some of the Inuit I spoke to, mean that they were not able to pursue a career in health or might not pass the exams of the health education they were pursuing. One young Inuit woman was pursuing an education as a health assistant; her mentors described her as excellent in her knowledge and abilities but were worried that she would not pass the written exams, which were given in a Southern language. Her abilities in the Southern language, particularly in writing, were not deemed to be at a high enough level. Another young woman who worked as a health aide said she would never be able to become more educated, even though she generally had good grades from high school. The particular topic she found problematic was Danish. She was contemplating leaving Greenland for Denmark, for a while, in order to

learn to speak Danish ‘the natural way’ as she said, but found the prospect of leaving friends, family, and Greenland, daunting. As another, although older, participant stated when we discussed which factors had contributed to her being able to complete her education: *“The Southern language must be mentioned also. If I spoke an Inuit language only, I would not have been a nurse”* (T25:73).

Furthermore, some participants, who believed their overall Danish abilities to be very good, found that they were almost not ‘good enough’ and being educated at a post secondary level in Danish proved more difficult than they had envisioned. As one nurse said:

*I thought that since I spoke Danish, I could also write in Danish. But after I started I realised that I could not. I was not able to properly express myself in written Danish. It was pretty tough having to learn to write in Danish in some kind of proper fashion.* (T20:18)

Some participants raised another concern in relation to speaking a Southern or Inuit language, with one stating: *“Many educated Inuit are also better at speaking a Southern language. I am afraid that they will leave for the South and not come back”* (T76:105). Some have raised the concern that Greenlandic students in Denmark may not return to Greenland. Chemnitz (2001) found that only 4 of the 11 Greenlandic students in her research who were studying in Denmark wished to return to Greenland. Lund and Nathaliensen (2001) found that 3% of the 190 participants who responded to a questionnaire about Greenlanders enrolled in a post secondary education did not wish to return to Greenland, while 33% were not sure and 64% wanted to return to Greenland after graduation. In 1972, a project focused on Greenlanders in Denmark interviewed 97 Greenlanders under education in Denmark (cited in Chemnitz, 2001). At that time more students wanted to return to Greenland after graduation, fewer were unsure, and more wanted to stay in Denmark. The number of those who were unsure and those who wanted to stay in Denmark combined was larger in 2000, however, than in 1972. One reason for this may be that 36% of the “Greenlandic students” in Lund and Nathaliensen’s project had two Danish parents, 44% one Danish parent, and only 20% had two Greenlandic parents (Lund & Nathaliensen, 2001). Although 36% of Lund & Nathaliensen’s participants had two Danish

parents their research still confirms that many Greenlanders who go South for education end up staying South.

In the context of Nunavut, since the creation of the territory in 1999 there has been a strong territorial governmental movement, at least in rhetoric, towards increasing Inuit culture and language in the running of the Government, the educational system and workplaces generally (Government of Nunavut 2004, 2007a, 2007b, 2007c; Hot, 2009; Timpson, 2009; White, 2009) and all the nurses and students who are, or have been, educated in Nunavut have been under education while this has been a major political focus. Furthermore, whereas salaries in Greenland often are lower than those in Denmark, salaries in Nunavut are generally higher than in Southern Canada, and part of the political focus in Nunavut has been to increase the number of Inuit in government positions through on the job training or apprenticeship like programs where Southern staff train Inuit staff to take over their jobs. This increase is also sought through hiring policies, which favour the pool of Inuit applicants before considering non-beneficiaries, and, by hiring non-Inuit only in term positions to allow maximum employment for beneficiaries (Nunavut Department of Human Resources, as cited in (G. White, 2009).

Murray Angus, founder of Nunavut *Sivuniksavut* [NS],<sup>80</sup> recently said: “Because people can go on to very good paying jobs [with a certificate from NS] at a young age making \$50,000 it’s hard to go back to being a poor student” (as cited in De Souza, 2009, p. 16). Most students who graduate from NS come back to Nunavut and find jobs in the government of Nunavut. As Angus said to De Souza: “In the beginning parents feared sending their children to Ottawa. They were afraid they’d never come back. But virtually everybody goes home. Why? Because they understand what Nunavut is about” (Angus, as cited in De Souza, 2009, p. 16). So maybe in the context of Nunavut, the fear that Inuit who go to

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<sup>80</sup> Nunavut Sivuniksavut is a program originally devised in 1985 by the “Tunngavik Federation of Nunavut to train young Inuit to carry news of the land claims negotiations back to their home communities” (De Souza, 2009, p. 15). More recently, it has become a program that functions as a crash course for Inuit in big city living and what post secondary schooling may entail. For some it has become a year of transition between high school and college or university. The program receives 22 students a year.

the South to get educated will stay there may be unfounded? That being said, in the South, students who have graduated from NS would likely not find it easy to be hired for the kinds of jobs or the kinds of pay that they could find in Nunavut.

Further, De Souza (2009) writes that eighty percent of the students who graduate from NS return to Nunavut and 15% continue on to university. He does not indicate, however, whether the 15% are contained in the 80%; that is, whether the students who continue on to university return to Nunavut or not. Thus, whether Inuit who go on to post secondary education in the South remain in the South, is uncertain.

Although on the rise, the percentage of Inuit Nunavummiut between the ages of 25-64 who have a high-school diploma remains significantly lower than the Canadian average; in 2006 it was 49% while the Canadian average was about 84%. About 4 % of Inuit in this age group had a university degree while the Canadian average was 23% (StatsCan, 2006c). A third of all university graduated Inuit Nunavummiut hold a degree in education. The teacher education program was the only university education that it was possible to obtain in Nunavut for many years. The program started in 1979, became part of Nunavut Arctic College in 1986, and has altogether graduated 181 teachers, 50 of those in the last 5 years. An additional 20 master's of education students graduated in July 2009, from the first master's program at Nunavut Arctic College (Government of Nunavut, 2009).

The high percentage of Inuit who hold a teaching degree may partly rest on the fact that this program is available in Nunavut, which means that people do not need to travel to the south. On the other hand, Hicks (2005), while not sourcing the statement, claims that 380 Nunavummiut are pursuing post secondary education in the South, which seems unlikely as in 2005 only about 180 students graduated from high school. This would mean that what is equivalent to more than 2 whole cohorts of Nunavummiut high school graduates would be enrolled in Southern educational institutions.

In relation to Greenland again, the region went through first a period of Danification and then a period of Greenlandization. This may have resulted in the

older nurses and students, who remember being forced to speak and learn in Danish, valuing and wanting to revive the Greenlandic language in a different way than the younger population. The younger students, on the other hand, after the Greenlandization period, have experienced that not mastering the Danish language was equivalent to fewer educational opportunities for some of their peers, and that it made taking an education more difficult for themselves. The younger population, who are currently under education (and of whom many have close ties to Danish language and culture through their upbringing or partners), may be less political in terms of focusing on Greenland as a nation and ‘nation building’, but rather focus on what may work for them in the global society that Greenland also is.

The premier of Greenland, Kuupik Kleist, appears to have a more relaxed view on Greenlandic needing to be spoken in all public institutions than his predecessor. He suggests that issues in relation to education and the lifting of the educational level in Greenland are more acute (Kleist, as cited in T. White, 2009). After the Greenlandic population had voted yes to the new Home Rule legislation that, among other things, made Greenlandic the official language in Greenland, many people noted that two new ministers are not able to speak Greenlandic, although the social minister Abelsen is currently learning and herself can see the challenge of not being able to speak the language of many of her constituents (T. White, 2009). Acknowledging that the educational system in Greenland needs improvement, the government started a reform of the educational system called *Atuarfitsialak/Den gode skole* (The good school) (Sørensen, 2007).<sup>81</sup> The hope is to increase the number of public and high school graduates and increase their academic level through the introduction of new pedagogies, collaboration, teacher training and upgrading.

Nunavut, on the other hand, where a higher percentage of participants thought it desirable to have the education in Inuktitut, is a territory where politically and socially the focus is on reviving Inuit language and culture,

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<sup>81</sup> The 2007 (#3 May) issue of the Greenlandic teaching magazine *Ilinniartitsisoq (The Teacher)* is dedicated to updates and discussion about *the good school*.

something that has previously been tied to land claims negotiations and is still tied to a desire to have further independence from Ottawa (Hot, 2009; G. White, 2009).

From the preceding, it is easy to surmise that the *linguistic capital* valued at a particular time may be measured in relation to the specific linguistic market and the “unrecognized power relations” at play (Bourdieu, 1986). At the time when it was thought that the only way for Greenlanders to get ahead in life was to speak Danish (by the Greenlandic elite and Danish administrators and politicians), Danish had high value and allowed those who spoke it to further themselves both socially, academically and financially. Greenlanders who spoke Danish increased their *capital*. In the Greenlandization period, on the other hand, when politically and emotionally Greenlanders wanted to separate from things Danish, the Danish language was devalued (although still spoken) and Greenlandic was the language affording the speaker *capital*. That is, speaking Greenlandic offered the speaker *capital* socially and emotionally, but not academically or financially. Today, in the period of increased separation from Denmark, and despite a continued focus on Greenlandic, it remains true that academic and financial *capital* are not gained by speaking an Inuit language, and the language situation also remains similar in Nunavut.

#### ***4.2 Chapter Summary***

I have discussed what it means to be educated and practice across Southern and Inuit languages. This seemed to be the most verbalised issue among nursing students and practicing nurses from both regions when talking about their experiences, and one that they kept returning to when raising other issues. Nurses and students feel that *linguistic capital* in the form of speaking an Inuit language, a Southern language, and mastering the language of the field of nursing, are all necessary in order to have success in the health care field in the Arctic. Simultaneously, however, possessing these forms of *capital* does not preclude that nurses and nursing students experience difficulty in using them in their education and practice. Nurses and nursing students found it problematic that

Southern health care practitioners do not speak an Inuit language in relation to patient care and in relation to the collegial work environment and the workload Inuit nurses need to take on. Also, despite describing themselves as bilingual or fluent in a Southern language, and having grown up and/or currently living with Southern relations, many, particularly younger nurses and students, relayed that they sometimes had difficulty expressing themselves in the Southern language. At the same time many had a desire for further education in health and medical terminology in one of the Inuit languages, the mother tongues of most of the nurses and nursing students as well as their Inuit patients. Still, a majority of participants had no desire for the nursing education to be in an Inuit language, a fact that nurses and students tied to the current and historical social, educational, and political reality of the two regions and that the majority of health care practitioners in the Arctic are Southern, and likely will remain so for a while yet. Lastly, many nurses and students made connections between mastering an Inuit language and possessing an Inuit identity, and felt that this connection affected the ability to afford Inuit patients the best possible care.

I believe this review of the meaning of language in the context of Arctic health care as experienced by Inuit nurses and students gives a good context for the ensuing chapters of findings where I will focus on the experience of being educated and practicing as nurses in a broader context, and will discuss how identity and history may have shaped these experiences.

## **5. *Social and Cultural Capital as ‘Determinants of Success’ for Arctic Nurses – Education***

As noted in chapter one, where language is a form of *cultural capital*, education is a form of *social capital*. This chapter discusses the form of educational *capital* Inuit nurses and students possess, what allows Inuit nurses’ and students’ access to this *capital*, and the challenges and successes they have encountered based on differences in *capital* between themselves and other Inuit in the educational system and Southern educators and colleagues. The chapter commences with a discussion of the experiences of Inuit nurses and students with primary and secondary school.

### ***5.1 What Were the Primary and Secondary School Educational Experiences of Inuit Who Chose to Become Nurses?***

P. Berger, in his doctoral thesis (2008) on Inuit visions for schooling in Nunavut, provides an extensive review of the literature on Indigenous and minority education. As a contrast to this literature, which paints Inuit students as often struggling, almost all nurses and students who participated in this research expressed that their experience in the formal schooling system had been good, that they had liked school and been among the “good students” who had received “good grades.” This section describes these experiences. This helps in understanding how exceptional these nurses and nursing students’ school experiences were, and how the education systems privilege certain forms of *capital*.

#### ***5.1.1 Being a ‘good student’***

As expressed by one nurse about her time in high school: “*I was a good student, I studied. I was competing with my classmates*” (T34:305); another, who talked about the more creative classes, said: “*I really liked shop. We were graded according to what we made... and I used to get the highest grades*” (T6:165). Several current and former students, although mostly Canadian Inuit, relayed how

their peers who had opted out of the nursing program appeared to be students who generally were less dedicated to school and who, it seemed, had done less well in the school system before entering the nursing program.

One Danish study shows that students who enter nursing programs in Denmark have about average good grades and that those who opt out of the education have either the highest or the lowest grades (Gravenhorst & Stigsen, 2001). Another study shows a correlation between lower entrance grades and a higher likelihood of opting out, and conversely, a higher likelihood of staying in the education with increasing entrance grades (Jensen et al., 2006). These works do not discuss whether students enjoyed school, however, and I did not ask participants in this study what ‘good grades’ meant to them. While it might seem obvious that getting grades that are good enough to be in a postsecondary program are a prerequisite, educational statistics reveal that nurses and students in the Arctic are part of a small group who actually get grades good enough to think about pursuing further education. This is a fact I will return to later in the dissertation.

### ***5.1.2 Positive school experiences and parental support***

The positive experience described by nurses and nursing students from their public and high school days was striking, especially given the low high school graduation rates in Nunavut and Greenland (Hicks, 2005). This positive school experience holds true for those who started school speaking only an Inuit language, as demonstrated by the following statement:

*When I started school I did not speak a Southern language at all.... At that time we only had Southern teachers. The Inuit teachers came later.... Nevertheless, I remember my schooling as having been fairly easy. I actually really liked school. I was one of the brightest I remember. Already in grade one I received a prize because I was the smartest in the class. (T31:46)*

It also holds true for students who spoke more of a Southern than Inuit language, as experienced by another nurse who said:

*But it was fun going to school, no doubt about that. And, my grades were simply fantastic, because I was able to speak a Southern language. I did not need to have an opinion about anything; my ability to speak a Southern language was enough. (T28:78)*

Many also expressed that the learning on its own, and just being in school, had been very important to them and something they had preferred not to miss. One said: *“I loved [school]. It was an adventure. Throughout my life school fascinated me. I loved learning. I loved school”* (T46:326). Another stated:

*I really liked school. I remember that once I had mumps during the Christmas break – I was happy that it did not affect my attending school. I do not remember many details but I always did my homework and really enjoyed school. (T21:30)*

One student mentioned that in public school she would never play hooky as some of her classmates did because school was too good to miss out on and also because she would be in trouble with her parents if she did. As was the case for her, the parents or other close adults of most other nurses and students expected them to study, supported their taking an education, and to some degree pushed this. Another student said:

*I think most things came easy to me, and if I found something difficult my parents helped me. I remember I really liked math but was not very good at it. So my father taught me a way to do something. I showed it to my teacher who said it was wrong. But I was stubborn.... I did not want to give in, because my father was good at math and if he had taught it to me it was correct. (T19:148)*

A third said that she found essay writing difficult and was always helped by her mother in order to come up with good ideas (T78:48), and a nurse mentioned that a teacher one time asked all the students in her class to write on a piece of paper what their wishes for the future were; she reminisced:

*I remember I wrote ‘I want to become something.’ I did not quite know what, but I had played with different ideas with my aunts and cousins – one had suggested midwife, one home care nurse, one nurse.... So even though I did not know what I wanted to become I knew I wanted to become something. (T26:23)*

Some participants relayed how their parents had pushed them if they were

falling behind or not doing as well as expected and others mentioned that their parents made sure they were challenged in school if their abilities went beyond what was generally expected at the level they were at. One, for example, said she was given “*extra lessons in the Southern language because I knew more than the others.*” She continued: “*mom gave me a lot of support... she was always there and I think she was also instrumental in my getting extra lessons*” (T29:42). One of the older nurses stated that her father had gone to the school’s principal and with big words protested against the physically aggressive disciplinary methods the principal used towards her and her siblings, when he himself would never raise a hand against them (T31:51).

In a Canadian Inuit context P. Berger (2008) echoes these participants’ stories of the importance of parental support for success in the school system, as do the works from Denmark discussing nursing students’ decisions to opt out or continue in the program (Gravenhorst & Stigsen, 2001; Jensen et al., 2006). Although being a ‘good student’ and reporting high levels of parental support was common in the present study, they were not ubiquitous.

A few nursing students and nurses noted that they were not among the best students, such as one who said:

*At school I did not do very well. I was about to be thrown out because I was the unruly element in the class.... You had to do really well to be considered for high school, but I was not one of these star-pupils.* (T30:143)

Others, although only 4 out of 50, pointed out that their parents had offered little or no support to their going to school, such as one who said:

*My parents had very little interest in my education. They preferred that I worked and made money, but I followed my own head and continued to go to school, as I liked to learn and be able to understand my world.* (T74:50)

It would seem that for most of the nurses and nursing students, parental support was important and they reported enjoying school. These do not appear to be prerequisites for success, though their predominance makes it seem much less likely that students without strong parental support or with very poor school

experiences would make it through to postsecondary schooling and into the nursing program. And while poor grades could obviously prevent students from graduating from high school, most of these participants reported doing much better than just getting by. It appears that as students most of the participants were quite extraordinary.

### **5.1.3 Camaraderie**

Much like Lipka (1991) has noted in relation to Yup'ik students, and others describe in both Aboriginal and non-Aboriginal contexts (O'Neil et al., 1997; Parke & Welsh, 1998), many participants stated that having classmates and the support, solidarity and camaraderie between them, both within and outside the classroom, was very important to their success. When asked about what stood out in relation to her schooling, one said: *"I remember that I had friends, how important it was to have friends, recognition you know? How important it was to be part of a group"* (T20:95). Friendship and camaraderie also included that those who were very good at something would help those who were less so, as explained by another: *"I received the highest grades in my class in the Southern language and helped classmates who could not understand"* (T37:39). A third reminisced along the same lines, saying: *"I remember public school as a good experience. One of the best things was the camaraderie"* (T25:38).

The importance of social relationships and peer support for the achievement of academic success seems to be universally recognized (Parke & Welsh, 1998) although the helping attitude between students, or tendency towards communal or social learning, I have only found mentioned in relation to Indigenous students (Backes, 1993; Crago & Eriks-Brophy, 1994; Crago, Eriks-Brophy, Pesco & McAlpine, 1997; Lewthwaite & McMillan, 2010; Lipka, 1990; Maguire, 2001; Pewewardy, 2002). It should also be noted that although Indigenous or Inuit students might be more inclined to help each other in the classroom, this does not necessarily mean that they prefer to do group work. Some participants said that group work was very beneficial, and that it is easier to learn when finding information, interacting with the topic, and presenting it for fellow students.

Others thought group work a waste of time and difficult to make function properly because group members rarely have the same ideas about what needs to be done and how. As one student put it:

*Well, that means you have to cooperate, you have to compromise, and, if there is something I've always had difficulty with it's [group work]. Not that I argue with people, but I always feel that aaargh, there is someone we need to drag along, there is someone who needs to delegate, there is someone who can't be bothered and someone who does not understand or misunderstands, and I also misunderstand all sorts of things, it is just so onerous.... I think it would just be easier if we could work on our own. (T4:282)*

#### **5.1.4 The teacher's attitude**

Many, mainly Greenlandic Inuit, stated that the attitude of teachers toward students had also been a decisive factor in their liking or disliking school or a particular topic. One student said, *"I think I can only point to one teacher that was more discouraging than anything; that was my math teacher. Everyone else was so enthusiastic about what they were teaching; it made you want to learn (T34:294).* That teachers were dedicated and role models in other ways, for example by being constants in the student's school experience, was also important as another pointed out:

*I remember one teacher in particular who was a really good teacher.... Everyone respected that teacher and felt that the teacher respected us. That particular teacher was never sick. The subjects that that teacher taught were my favorites, because of the subjects and because of the teacher. (T17:58)*

Some also mentioned that including creativity in the learning by, for example, *"incorporat[ing] music and the making of earrings to create some hands on experiences"* (T47:60), or in other ways being innovative, showed that the teacher cared and increased student engagement. A student mentioned *"a good teacher"* who had not learned the Inuit language before starting to teach but wanted to learn. By using dictionaries and the help and knowledge of the students, *"she wrote a bunch of little notes, which she stuck on everything with the names in both the Southern and the Inuit language, for example table,*

*window. Lots of little notes and it actually helped”* (T77:63). The teacher attitude toward students or the quality of the relationship between teachers and students has been recognized as very important for academic success for a long time both in Inuit contexts (Aylward, 2004; Berger, 2008; Lipka, 1990; Maguire, 2001; Stairs, 1991; Tompkins, 2004), and in other Indigenous as well as non-Indigenous contexts (see for example Backes, 1993; Klem & Connell, 2004; Komarchuk, Swenson & Warkocki, 2000; Muller, 2001; Pewewardy, 2002;).

As part of the preparation for school reform in Greenland, Inerisaavik (the Centre for Educational Development) interviewed students about their views on, and wishes for, their schools and teachers. Asked what would characterize a good teacher, often repeated comments included that the teacher has good contact to, shows interest in, and respects and cares for, the students and that he or she is knowledgeable, well prepared and good at teaching (Undervisere, 1999). Lipka, writing from an Alaskan viewpoint, wrote that *social relationships* are an essential part of indigenous education which create “conditions that make learning feasible and likely” (Lipka, 1991, p. 219), and P. Berger, writing about Nunavut, recommended “a warm and caring environment where the teacher is seen as part of the team” (Berger, 2007, p. 9). These authors’ work resonates with my findings in terms of what Inuit students prefer from their teachers, and, in the case of participants in this study, the memories that stood out for them and which they shared. There is not an extensive literature on Inuit students’ perceptions of schooling with which to compare, but P. Berger’s (2008) work in Nunavut again suggests that the nurses and students in this study by and large were unusual in the especially positive relationships they described as having with their primary and secondary school teachers.

### **5.1.5 Learning styles**

Arnakak (2001) suggests “that [an Inuk] learns best by observing, doing and experience” (p. 3) and students in the Nunavut-wide *Sivuniksamut Ilinniarniq* consultations expressed a preference for experiential, hands-on learning (Tompkins, 2004). Maguire (2001), a long time educator in Nunavut, who did a

master's project on reasons for Inuit dropping out of the formal school system, also notes that concrete, contextualized and kinaesthetic learning help second language and Inuit learners. Deputy Minister of Education Kathy Ookpik said in June 2007 that the Ministry of Education was working on a new approach to education in Nunavut in order to make curriculum more appealing to students and thus increase graduation rates. She notes that students in Nunavut were also interested in less academic careers, "for example trades, pre-trades, innovative technology arts and crafts. We're looking at culture, and language and entrepreneurship" (as cited by CBC, 2007). Caution is necessary, however, as observed by P. Berger, who, citing Hodgson-Smith, writes that

despite strong indications that learning style is important, and literature that suggests a preference for learning by observation and doing by many Aboriginal students, the concern exists that differences might not be as dramatic as perceived, that they might lead to stereotyping and low expectations, and that difference in learning style might come to be seen as a learning disability. (Berger, 2008, p. 173)

Further, as pointed out by Darnell and Hoem (1996), it is naïve to assume that Inuit or other native cultures "remain unaltered or at the same stage of social development" (p. 143), which of course they do not. Rather, Inuit societies are constantly exposed to and "implementing new ideas and technology and weighing value systems both from within their own societies and from without" (Darnell & Hoem, 1996, p. 143). Ultimately, in terms of student success, learning style and pedagogy may "not be as important as student feelings of loneliness, frustration and alienation" (Hodgson-Smith, cited in P. Berger, 2008, p. 198). Generally, these issues did not seem salient or salient enough to affect the success of the nurses and students partaking in this research; however, as will be discussed below, they may have played a role for those who were not able to pursue a higher education in Nunavut and Greenland.

### ***5.1.6 Language and culture in schooling***

While nurses and students generally described themselves as dedicated to, and doing well at, school, they also noted that students who were not as comfortable as themselves in both languages and cultures did not do as well, neither while going to school, nor in the quest to find a vocation after leaving school. This resonates with the results of research which showed that students who spoke mainly Greenlandic had lower test scores than their bilingual and mainly Danish speaking counterparts (Petrossen, 2010). Some participants who reported to be of mixed ethnic heritage who talked about experiencing difficulty with particular topics, or some parts of school, felt lucky because they had one Southern parent. This meant they were familiar with both the Inuit and the Southern culture and the Inuit and the Southern language. Several participants of both single and mixed ethnic heritage, in interviews as well as in classrooms and social settings, highlighted differences between themselves and Inuit who were more traditional, from smaller settlements, or not obviously of mixed heritage. Although having attended an Inuit language school, one noted that her classmates who mostly spoke an Inuit language had trouble keeping up with those who spoke both languages. She said “*we had some in our class who spoke an Inuit language mostly and I felt that there were differences between their ability to keep up in school and ours [the bilingual students]*”(T19:93). Inuit nursing students in various ways felt different from other Inuit and their language abilities, which allowed them success in the Arctic educational system where many teachers, particularly in the senior years, were Southerners. In chapter six I will discuss further ways in which Inuit nurses and students differentiated themselves from many other Inuit.

### ***5.1.7 Critiquing schooling***

That participants liked and did well at school does not imply, however, that they did not offer any critique of the educational system or of the fact that much of their schooling had taken place in a language other than their mother tongue; many did. Some offered their critique very directly while many did so more

obliquely. The older nurses and students were less direct in their critique than those who were younger. When offering critique, many compared the educational system and academic level in Arctic schools with those in the South, finding the former lacking. This has previously been noted by P. Berger's (2008) participants and by Watt-Cloutier (2000) and Simon (2008). Many also noted that they had learned less in the early, compared to the later years of their schooling. Both of these points are well described in the following three quotes:

*My experience is that there is more unrest in the [Arctic] classes.... When going to school in the South I felt that the level was higher than in the [Arctic]. I did not feel that I was at the same levels as the other students in the South whereas I was always one of the top students in the Arctic. Maybe, in the Arctic, there is not as much discipline in regards to homework. (T76:54)*

*What I remember most about elementary school is the shift from an Inuit language to a Southern language in grade 5 and how difficult that was. I was unilingual and in a solely Inuit language class until grade 5. From grade 6 the teaching language was Southern. Up to grade 5 teaching consisted mainly of storytelling and singing. Students did not learn [much] math... and never learned to count to more than 10 in an Inuit language. I feel that there is an enormous amount that has not been taught. (T45:29)*

*I thought I missed out on learning a Southern language and I feel that generally I was not taught very much in elementary school, particularly the lower classes. I feel that I did not have any "proper" teachers until I reached grade 11-12. I was struggling when I reached high school. I would have liked if there had been more English and more project work earlier. (T43:36)*

A number of students and nurses, particularly younger ones, also felt that the expectations of students where they went to primary school were not very high and that students were allowed to "play" rather than "learn." As one said: "I mostly remember that you didn't get too much from the teaching. We could choose what we wanted to do and if we wanted to play we did" (T13:51). Another stated: "If I was to say something about my primary school it would be that it was all fun and games. That's why we were sent to the South.... In order to be able to get an education" (T28:78). Some nurses' and students' experiences of just playing, being able to do what they wanted to do, and not learning much in the

early years of their public schooling, may in part be a result of the educational system not having enough educated teachers, neither Inuit nor Southern, and therefore having employed community members without giving them much direction. It may also in part result from the difference in focus between some Inuit and non-Inuit teachers. Lipka (1990, 1991), discussing Yup'ik teachers in Alaska, notes that it is very common for non-Inuit teachers and others to misinterpret Inuit teaching, which may prioritize cultural imperatives like perseverance and contributing to the group, embedding them in instruction in ways not immediately apparent to non-Inuit. It is possible that some participants, straddling Inuit and Southern cultures, may judge their early school experiences from a mostly Southern perspective, though this is necessarily speculative.

While many said they learned more in the older classes and often in a Southern language, some felt they had had to pay a price for being taught in a language and culture different from what they would consider their own. These were often older students and nurses. For example:

*I did not know much about my own area...I knew more about the South than I knew about the [Southern, Western or Eastern Arctic].... Isn't it funny? The way things were closed off... that education was that controlled. I remember all my books from school. They were very colorful and talked about farms and such. I clearly remember that those were the things we were taught about. (T32:29)*

Some of the younger participants, though, were also aware that it had an impact to be taught in another language and about another culture, as the statement from the following student indicates:

*I appreciate my mother tongue more after I have become an adult. When I was younger I just accepted that I was educated in a Southern language. Today my approach is more – imagine if we had been taught in an Inuit language and had been told about our ancestors before [contact] in an Inuit language. Why did we not hear more about Inuit history? I know for me, I would have had more self-confidence if I had learned something about my own roots in an Inuit language rather than about Southern history in a Southern language. That original feeling of being Inuit could have been held up. It would have given more self-esteem and self-confidence. That feeling was erased when we were children and continues to be erased in adulthood; therefore we need to find it again as grown-ups.... I*

*wonder if anyone knew anything about what it means for a people and their children to be educated about their own land, culture and history? (T24:34)*

Compared to the number of nurses I spoke to and interviewed, it was relatively few who talked about the impact that being taught in a Southern culture and language, rather than an Inuit one, might have on their Inuit sense of self and identity, or about the impact it might have on the continuation of the Inuit languages and cultures. Although many acknowledged that they had been taught more in a Southern language, many did not – in their conversation with me – reflect further or offer any obvious indication that they thought this inappropriate or possibly damaging in any way. One nurse, who was taught in both a Southern and Inuit language in primary school, for example, said that she liked school very much and did not want to miss any classes, and in relation to being educated in a Southern language reminisces: *“What I remember most is the Southern language classes where we were not allowed to speak a single word of the Inuit language. I just kept my mouth shut and got all the prizes” (T21:30).*

Participants’ general success in and enjoyment of the elementary and secondary school system may be linked to their high level of comfort in both cultures, and in this connection, particularly with their comfort in the Southern cultures. That most, in their conversation with me, do not reflect on what being educated in a language different from that which they call their mother tongue might mean in a wider context, could be tied to me being, or being seen as, a representative of the previously colonizing people, and to a reluctance among some Inuit – maybe particularly older Inuit – to criticize other people generally and the previous colonizers specifically (Brody, 1991; Bryld, 1998; Møller, 2005; Thisted, 2002). Some of the nurses and students themselves spoke of this issue, one with particular feeling, when she said that she was not sure why Inuit, herself included, did not discuss how the heavy Southern presence in education, health and otherwise had affected Arctic social relations, culture and language:

*It is strange isn’t it that we, ourselves as Inuit, haven’t... I am a fairly intelligent and modern human being, so, why haven’t I... why haven we? But we haven’t. This is a statement of fact; we may have*

*discussed a little in small groups but not really thought further.... I am not sure why. In relation to myself, I have a tendency to be overly considerate of people from the South and maybe thankful that they are here and have helped us, and maybe I do not really like to criticize. (T32:221)*

As also stated by this participant, not talking about the possible effects of being educated in a Southern language and culture could also be tied to many of the participating nurses and students having Southern relations and friends and having been immersed so much in Southern language use that they simply do not give it a second thought. “*That was just the way it was*” (T2:155); several of the younger nurses stated about how it felt to be educated in a Southern rather than Inuit language.

This acceptance of ‘*the way it was*’ may also be tied to the possibility that students and nurses, through their schooling experience, have developed a pro-White bias as described by Bougie, Wright and Taylor (2003), which these authors suggest can happen when Inuit students shift early and abruptly from learning in their mother tongue to learning in a dominant language. A pro-White bias may also be related to that which Aviaja Egede Lynge (2006c) calls *colonial amnesia*.<sup>82</sup> *Colonial amnesia* was particularly perpetuated through schooling and therefore also has the possibility of being reversed through it – if Inuit realise that standards for success can be measured according to Inuit rather than Southern values and culture, thus to some degree moving against the grain of the Southern or previous colonizers’ ways and values. Lynge believes that many Inuit are against, or fearful of, working towards an educational system that embraces Inuit culture and values. She believes that this is so because

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<sup>82</sup> The concept “colonial amnesia” (in Danish *Kolonial hukommelsestab* and in Greenlandic *Nunasiataasimanermi tappingrneq*) in Lynge’s use covers the idea that a previously colonized people do not know how they have been assimilated or formed by their colonizers because they have been denied access to this knowledge through public institutions (educational and other) as well as their social and familial milieu (although the latter unconsciously). Over time, the colonized people become increasingly ignorant about the history of colonization and the societal and personal effects and costs this history has had. This lack of knowledge jeopardizes cultural identity and survival (Lynge, 2006a,b). As opposed to Lynge, other authors generally use the term *colonial amnesia* to describe the amnesia among previous colonizers and our role in the functioning and condition of previously colonized areas or countries (see, for example, Gregory, 2004).

there is a lot of ‘security’ in upholding the mentally colonized identity, because that is what [Inuit] are used to. For some the postcolonial reality [of self-determination and having the ability to make choices] is terrifying, because it demands that people take responsibility. (Lyng, 2006b; Para 23-24, translation from Danish by author; see also Lyng, 2008)

According to Lyng then, colonial amnesia among Inuit results from colonization or oppression, an explanation that is very similar to Freire’s (1984) theory of ‘the oppressed’ – the idea that the oppressed may not perceive themselves as oppressed but rather identify with, conform to, and strive to be that which the oppressor has prescribed, while being fearful of ‘freedom’: “Freedom would require them to reject this image and replace it with autonomy and responsibility” (Freire, 1984, p. 31). This notion may be true for some Inuit; I do not, however, believe it to be the reality for most Inuit nurses and students.

That many nurses and students did not reflect on, or disagree with, being educated in a language other than their mother tongue may instead have resulted from their having had a Southern parent or other significant Southern influence in their upbringing and simply felt it to be “normal” to speak both a Southern and an Inuit language, even though doing so also offered some challenges on their educational journey. Further, many expressed the pragmatic view that since they would always need Southern staff and since developing and printing educational material in an Inuit language would be extremely costly, speaking a Southern language made sense. But whereas possessing this background and these views may be the reality for many students in nursing and for practicing nurses, I do not think this reflects the reality of many Inuit who do not finish public school, high school, or post secondary education.

### ***5.1.8 Cultural capital***

It is evident that Inuit who choose to become nursing students and nurses, apart from possessing *linguistic capital*, also have *cultural capital* that allows them to excel in the Southern educational and health care systems. This does not imply that some of those who do not finish public school or high school or take a post secondary education do not have the ability to do so. Wright, Taylor and

Ruggiero (1996) and Taylor, Caouette, Usborne and Wright (2008) found that Inuit children in the first 4 grades did better overall than their white North American and Quebecois counterparts in relation to intellectual capacity, and furthermore showed “a steady increase in their scores through each grade, indicating a strong intellectual development through their first school years” (Taylor, Caouette, Usborne & Wright, 2008, p. 77).

There are many reasons why a lot of Inuit do not finish elementary or secondary school and do not apply to, or finish, post secondary educational programmes. These reasons include that the languages, cultures and habitus of the educational systems may not be languages, cultures and habitus that they have learned and incorporated or been ‘inoculated’ with in their upbringing because they have not had much Southern influence. Although I recognize that many factors play a part in educational attainment I also, like T. Berger (2006), believe that if more Inuit have the opportunity to be educated in the languages and cultures with which they are most familiar and comfortable, and are able to perform in ways that fit their own *habitus*, their schooling results would be very different. Many authors conclude that when teaching Indigenous students in their local language, using local pedagogical practices, and incorporating local knowledge, educational achievement increases significantly (e.g., Cadwallader, 2004; Dion, 2009; Goulet, 2001; Kawagely & Barnhardt, 2005; Lewthwaite & McMillan, 2010; Lipka, 1990, 1991). But as T. Berger (2006) and Gad (2009) note, people whose mother tongue is not a widely spoken language must speak more than one language in order to have more than local educational and vocational choices. The majority of students and nurses I spoke with did not say they had wished for more local pedagogical practices and knowledge in elementary or secondary school. The nursing programs in Greenland and Nunavut incorporate little, and most nurses and students appear not to desire an increase, as I will explain below.

### ***5.2 Experiences in the Nursing Education***

The nursing programs in Nunavut and Greenland are both four-year bachelor degrees; they are not, however, homogenous in terms of the groups of teachers teaching the students or the student bodies. The classes in Greenland, while this project was carried out, had between 10 and 18 students, and all students spoke both Greenlandic and Danish. Although some described themselves as not being very good at speaking, reading or writing Greenlandic, most conversations among the students took place in Greenlandic when at school and when outside of school. When students conversed with each other while doing group work or between classes, this took place in Greenlandic sprinkled with Danish medical and nursing terminology. The classes in Nunavut had between three and 12 students, with a majority of non-Inuit students who did not speak Inuktitut. Two of four classes had only one Inuit student, and the language that students spoke among themselves was English, also when there were more Inuit together; why this is so was explained by one student in the following way:

*Because of the dialect, the different areas of Nunavut that we come from.... It's probably to do with understanding each other better. It's just the different dialects that we have difficulty understanding when we try to speak in Inuktitut to each other. (T40:296)*

Others talked about speaking English in order to avoid conflict about which person's choice of words was more correct than that of the other. It is, in other words, sometimes easier for Canadian Inuit, both in terms of linguistic understanding and social stability, to use their second language of English rather than attempting to converse in Inuktitut. This has been pointed out by others in a Canadian (Dorais & Sammons, 2002) as well as Greenlandic context (Langgård, 2003).

In relation to the teachers the two programs employed while this study was carried out, the program in Greenland had three and then two Greenlandic Inuit teachers connected to the program. The program in Nunavut has previously employed two Indigenous teachers, but no Inuit or other Indigenous teachers were employed during the fieldwork for this study. In Greenland, while most teaching and interaction between students and teachers took place in Danish,

Greenlandic students and teachers also sometimes discussed things in Greenlandic. In Nunavut, teaching and interaction between teachers and students, and generally also between students, always took place in English, except for a few times when an Elder was invited to partake in a class, or as one student said, when it was preferred that others present could not understand the conversation.

The two sites are different in ways that an Inuit language is used, in cultural, political, and historical dimensions, and in some experiences and particular issues the students and nurses noted and emphasized. In the following sections I will describe both the similarities and the differences expressed except where it would compromise the anonymity of participating students or nurses. To give some contextual information I will start with a description of who the students and nurses were at the time the research was carried out.

### ***5.2.1 The Inuit nurses and nursing students***

As previously stated, of the 49 (out of 50) who talked about their parents' ethnicity, many (18/49 = 36%) participants grew up with one Southern parent and one Inuit parent and an additional two grew up with one or two parents of mixed background. A large proportion (34/50 = 68%) of the nurses and students who chose to participate via interviews or questionnaires had children; additionally, one was pregnant and one lived with the child of a family member. All Canadian Inuit except one had one or more children in their household or were pregnant (N=1). Of the participants who did not have children (N=14), many were students (N=9) and most Greenlandic (N=12). Of the 17 Canadian Inuit participants with children, 13 had two or more, while of the 18 Greenlandic Inuit participants with children, only 5 had two or more. Two Canadian Inuit were single parents while all Greenlandic Inuit who had children also had a partner. Forty-three out of 50 participants had a partner while the study was conducted. Of the 7 who did not have a partner, 5 were students and 5 were Greenlandic. Of the 43 who had a partner, 37% (N=16) had what they described as a Southern partner (12 of whom had two Southern parents while four had one Southern and one Inuk parent). Eight participants (three Greenlandic and five Canadian Inuit) had both a

Southern partner and one Southern parent and 25 out of 50 had either a Southern partner or one Southern parent (11 Canadian Inuit and 13 Greenlandic). The partners who were of mixed background had, according to participants, grown up in a largely Southern home.

In both Arctic Canada and Greenland students are supported financially and receive extra support for any children they might have. In both regions students are provided housing if needed. In Canada students also receive support for housing and books that are required for the education. In Greenland, students with children are prioritized for financial support for childcare unless they have a partner whose income makes the combined household income ineligible to receive the support. In both regions, however, many current and previous students found, and find, their financial situation as students challenging.

These findings show that the social background of many participants is different from that of Canadian and Greenlandic Inuit generally, and also that there are differences between Greenlandic and Canadian Inuit participants, with Canadian Inuit participants more often living in ethnically mixed relationships and often having more parenting responsibilities because of having a larger number of children or being single parents, while more Greenlandic Inuit students lived with no partner and no children.

Some nurses and students chose nursing because they were not able to take the education they most desired in Greenland or Nunavut; most students, however, entered the field of nursing with a feeling that they knew what it was about and that it was what they wanted to do. About 60% (29/50) of participating nurses and students choose nursing primarily because they wanted to work with people or help people, with a comparatively larger percentage of Canadian (71%) than Greenlandic Inuit (53%) choosing nursing for this reason, and with most Canadian Inuit emphasizing that it was important to them that they were able to help and nurse particularly “their own” or “Inuit” people in their own language. For about 10% of participants the independence of the job was important, for another 10% it was the skills development that counted, and about 20% had

chosen the education because they were not able to choose their first career in Nunavut or Greenland or because the grades they had did not allow them access.

Research involving Danish nursing students found that many students entered nursing programs because they were not accepted into their first choice of education, or stopped it, and had to choose something else, although 5 out of 13 stated that they chose nursing specifically because they wanted it and felt they had a particular ability to be something for, and help, other people (Kragh, 2009). Despite this low number on entrance, for the majority of the Danish students the feeling that they made a difference in other people's lives was what made them stay in the program.

In the current study conversations and participant observation with, and observations of, students and nurses yielded evidence that in the Arctic nursing programs students are generally engaged, motivated and willing to ask questions if room is given for them to do so, whether in the classroom or in their field placements. Students are willing to discuss subjects and share their own experience and knowledge, again if room is given for them to do so. I have experienced students taking responsibility for their own education by, for example, expressing to the leadership that a given subject or educator did not live up to what they thought was reasonable to expect. In Greenland, the students reported to the leadership that a positive change had occurred after their points of critique had been addressed. As has previously been described in a Greenlandic context (Steenfeldt, 1998), and as some students themselves noted, there are some students in both programs who are fairly quiet. Generally, however, being quiet or not talking much did not characterise the Inuit students in either program during this project.

Although most nurses and students reported that they preferred to read and write in a Southern language, and although all the Greenlandic students in a class that I observed chose to read a document in Danish rather than Greenlandic when given the choice, many Greenlandic and Canadian Inuit said that it is difficult to take a university degree in a language that they view as their second language. Inuit students in nursing and other university programs have expressed this

previously (Eggertson, 2008; Lund & Nathanielsen, 2001; Madsen, 2000). The papers I saw when helping to edit the students' written work gave evidence of having been written in a second language. This means that students need more time and energy to write assignments than Southern students who are educated in the South, or others learning solely in their mother tongue.

That the nurses and students who participated in this project found being educated in the Southern language challenging, while describing themselves as being among the best students in their elementary and secondary schooling and often among the best to speak, read and write in the Southern language, furthermore speaks to the limited success that the educational systems have had in preparing Inuit for post secondary programs in the systems as they have functioned until now. Even amongst the elite this is very salient. Two older nurses stated that because they felt fluent in the Southern language and had had no problems working (and writing) in the health care system before starting in the nursing program, it had been a shock for them to realize that their ability to express themselves in writing in the Southern language was not very good.

That students and nurses prefer to be educated in the Southern languages, despite this, also indicates that the instruction they have received in their mother tongues in their elementary and secondary schooling may not have been adequate. This idea is not new. Thomas Berger, in his recent inquiry on the state of the implementation of the Nunavut Land Claims Agreement, reported about Nunavut Schools: "The schools are failing. They are not producing graduates truly competent in Inuktitut; moreover the Inuit of Nunavut have the lowest literacy in English in the country" (Berger, 2006, p. iv). Berger continues that it is immensely important to recognize that loss of language is inescapably linked to schooling underachievement. He further notes that the program used in Greenland in the 1990s was "designed solely to develop competence in Greenlandic... [and] has produced high school graduates who are not competent in Danish or English, foreclosing any post secondary study except in Greenland" (Berger, p. iv). Langgård (2003) also notes that many parents and young people in Greenland feel that the "Greenlandization" policy has meant that children and young people

are not proficient enough in either English or Danish. This corresponds to a statement from a Greenlandic student who said to the Inerisavik researchers: “I am a mongrel<sup>83</sup> so I speak both one and the other language, and neither of them properly” (Undervisere, 1999, p. para. 8, translation by the author). I see these as critiques of the elementary and secondary school systems in Nunavut and Greenland, neither of which have moved past their colonial roots to become able to provide bilingual, bicultural education that is suited to their students.

One younger nursing student said that she had been enrolled in a different program before starting the nursing education. In the period that she attended the other program she realized that her writing abilities in the Inuit language were not nearly as good as she had been led to believe when she graduated from high school; although she had *linguistic capital* in both a Southern and an Inuit language, neither were as ‘valuable’ as she initially thought. This particular student did not, like many others do, feel that the Inuit language is more difficult than the Southern language. She just felt that she did not have enough practice in writing at an advanced level. Several Inuit students and nurses felt that they were not proficient in writing in their mother tongue because of lack of practice. Hence, some had decided to make an effort to read, write, and speak it more whether at home or at work/school. This strengthening of the Inuit language in the homes and communities is, as it happens, also one of recommendation made by T. Berger (2006) and Langgård (2003) along with the strengthening of the Inuit language in the school through the introduction of a strong bilingual education.

In 2000 Rina Reimar Madsen, who was educated in the nursing program in Nuuk and who has one Danish parent, expressed her hope to the Danish nursing magazine that “the Greenlandic nursing students one day may be taught by Greenlandic teachers in Greenlandic” (Madsen, 2000, para. 3, translated from Danish by author). Whether this will be possible or generally desired in Greenland or Nunavut in the future, I believe, depends on whether the

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<sup>83</sup> The word the student used was *bastard* which in Danish, like mongrel in English, means a hybrid or not purebred - often - dog.

suggestions made by T. Berger (2006) and Langgård (2003) are implemented. It would require more Inuit educators in the primary and secondary schools who are able to speak and teach in the Inuit languages. Recent calculations from the Greenlandic Home Rule government estimated that 15% of high-school teachers in Greenland are Inuit (Grønlands Hjemmestyre, 2005) and calculations from Nunavut estimate that less than 10% are Inuit (Aylward, 2004) with most Inuit teachers in both Greenland and Nunavut teaching in the primary grades. I expect that this means that both language and pedagogical style change as the Inuit students advance in the schooling system. Students' experience with their teachers and the pedagogies or teaching styles utilized in the nursing education is the focus of the following section.

### ***5.2.2 The experience of being a student in an Arctic nursing program***

No students or nurses with whom I communicated orally or in writing expressed the sentiment of the student I quoted at the beginning of this work, and which, along with other observations and conversations, spurred the desire to carry out this PhD research. Rather, the students and nurses I communicated with in the context of this research expressed that they had had very good, as well as not so good, experiences with both Inuit and Southern teachers. Most felt that, overall, their teachers had been culturally and academically competent and good at meeting the students where they were at. Mueller's (2006) study found that especially teachers who had been in the Arctic for a number of years and knew about the history and culture of the Inuit peoples, and those who attempted to learn the language, were noticed and cherished by students. Many participants in this study expressed that most teachers, although predominantly those who had lived in the north or taught in the programs for longer periods, had been very understanding, supportive and encouraging. Simultaneously, many expressed that they were less impressed with teachers who displayed little knowledge about Inuit culture or history or who spent most of their time lecturing with little room for discussing that which was lectured about. As stated by one student:

*I think it is very important [that the teacher has] cultural knowledge. If the teacher does not have [cultural knowledge], and there have been some, we students sense it and then not many of us pay attention to that teacher. (T76:88)*

In response to the question: “Is there any difference in the ways that an Inuit and a Southern teacher teach?” most answered that differences between teachers are individual rather than ethnically based and have more to do with the individual teacher’s personality and level of academic and cultural competence. Differences also have to do with the individual teacher’s ability to listen to and make room for students to fully participate in the teaching/learning and to give students enough time to ask questions and reflect when questions are asked. When asked whether they thought it would be better for them to be taught by Inuit or Southern teachers, 24% answered Inuit and 40% Southern, while 36% said it did not matter. The students who preferred an Inuit teacher said Inuit teachers will understand the students and their background and they can speak an Inuit language when needed, they are easy to relate to and to understand, and they know more about Arctic circumstances and can draw on that knowledge in their teaching. Some, especially Canadian Inuit, mentioned that an Indigenous teacher was much more aware of cultural identity and celebration than Southern teachers would be, which positively affected their self-esteem and learning in the classroom setting. Some stated that there was a different ‘feel’ in the classroom with Indigenous teachers, without being able to define it, and a couple of students noted that Inuit teachers would have a different approach to the students generally.

One student, when asked if she thought there was any difference in the ways that an Inuit and a Southern teacher would teach, said:

*Yes.... It is difficult to explain... sometimes a Southerner explains all sorts of things that are not necessary, because we know already... go on to the next point already! The Inuk teacher does it in a way so that we are all equal. An Inuk teacher does not act as if he or she is the teacher, something special, an authority... that is the difference that I see. (T6:211)*

This resonates with Klaus George Hansen's (2007) speculation that a notion of egalitarianism exists among Inuit that does not exist among Western peoples and that while hierarchy is an integral part of Western schooling, with the teacher filling the higher position and the student the lower position, interaction and socialisation among Inuit, including transmission of knowledge or teaching, are governed by the principal of non-hierarchy. Lewthwaite and McMillan (2010) interviewed Inuit students and Inuit and Qallunaat teachers in the Qikiqtani region in Nunavut about what works and what does not when learning as Inuit. They reported that although neither students nor teachers negated the teacher's role of authority, both groups "emphasized the role of a teacher of working with students to facilitate a common vision for the learning conditions of the classroom" (p. 157) with one teacher expressing that she doubted collaborative work of that kind would work in the south as teachers there are used to everything being on their terms.

Some of the students who said it did not matter whether their teachers were Inuit or Southern, reflected further with one student saying that it was better for her to have an Inuit supervisor because she felt that it made it easier for her to interpret how she was doing during an exam and therefore she would not be as nervous. She was able, she said, to 'read' the Inuit supervisor through body language and mime. Several others added that it was nice to be able to have their discussions in Greenlandic at times.

Those who responded that they would prefer a Southern teacher said it was because they were used to being taught in the Southern language and that because all the books and curriculum were in the Southern language it would be easier. Some added that Southern teachers were better and more knowledgeable teachers, perhaps because they had more experience as nurses and as educators. Of those who preferred to be taught by Southern teachers, several still thought it would be nice to be able to converse in the Inuit language.

I wonder what role, if any, a pro-White bias caused by an early and abrupt switch to a dominant language such as English (Bougie, Wright & Taylor, 2003) might play in the low number of participants who would prefer to be taught by

Inuit teachers. I also wonder whether those who preferred Southern teachers compared them to less experienced and self-assured Inuit teachers, as some stated, or whether their preference hinged on having a fairly strong Southern educational, and for some personal and social, background which rendered an Inuit way of teaching less familiar and easy to relate to and understand. I wonder too if my role as a Southern nurse and sometime teacher or guest teacher in the nursing programs impacted their answers.

### ***5.2.3 Becoming part of a “community of practitioners”***

When entering an education such as nursing it is necessary to learn theory as well as practice. In that way nursing – as medicine – is a form of apprenticeship; for many of the Inuit nurses and students the practical part was the most enjoyable, just as it is for some Southern students and nurses. This section examines educational preferences and their meaning in the context of Arctic nurses and students.

Most current students and those who were already nurses felt that the Arctic programs had offered a variety of educational methods, while more experienced nurses who had been educated elsewhere had typically been taught through lectures. Many, although comparatively more Canadian than Greenlandic Inuit, and among the Greenlandic Inuit often those who were older, said they had learned through hands on experiences outside of the school system and both younger and more mature students and nurses said that this was the way they preferred to learn generally, also during their nursing education. For example:

*We [Inuit] are really good at learning those hands on things, those practical things and here we learn quite early to be part of the household and do the things that need doing, at least when you are the oldest child, and so I think the way we learn is the same way as between me and my grandmother. I see her do it and then I copy her really well. (T32: 77)*

Another of the older nurses who was educated in the south noted the difference between herself and the Southern students. Where Southern students had the

*habitus* of the Southern educational system she did not, and found just sitting and listening to lectures very hard:

*There was this alienation in the daily interactions, also because my fellow nursing students were already very disciplined in their ability to just listen. We were about 30 students and everyone but me was very disciplined in listening. I tended to fall asleep. I was much more 'embodied' or physical at that time, but that has been stripped away now. (T30:161)*

One nurse, when I asked her whether she would consider being a nursing teacher, replied: “No. I have no patience. I’m a hands-on nurse. I have to do things. I just can’t sit there and read or like correct papers and stuff” (T33:100). When I asked a student whether the educational approaches used by the teachers in her program fit the way she preferred to be taught, she said: “Yes, but I prefer that there should have been more tactile learning... other than the teacher providing examples and... well, that’s me” (T40:378). Others, when talking about learning best by doing, referred more to the learning in the practical part of their education and felt that immersed in the “real work” of nursing was when they felt most at home in their learning processes, as the following two quotes demonstrate:

*The topics that I have enjoyed the most are probably the practical ones. Like nursing assessment hands on body things. I learn best by observing. And I still do not understand theoretical stuff as well. When we grew up we were taught facts things that were more concrete than abstract. (T45:47)*

*I guess I would have to say I like the hands-on learning [the most], like taking care of people when they’re sick, trying to prevent things. Its more hands-on than I thought it was gonna be. It is a good thing I learn better that way. Like if I see somebody do it the proper way once the first time I’m sure I’ll make a couple of mistakes but after that I’ll pick it up. (T42:374)*

Inuit nurses’ and students’ general preference for hands-on work and experiences may not differentiate them from other nurses and nursing students. Authors have previously stated that a proportion of nursing students and nurses are more practically than theoretically inclined (Frankel, 2009; Jensen et al., 2006; Jensen & Lahn, 2005; Kragh, 2009; Laschinger & Boss, 1984), but it has

also been noted that nursing students become more theoretically inclined and enjoy the combining of theory with practice as they reach the final year of their education (Jensen & Lahn, 2005). The difference may be the proportion of Inuit students and nurses who define themselves as more practically than theoretically inclined, and also that there seems to be only a small difference in this regard between junior and senior Inuit students. Another difference may be that Inuit nurses and students connect their preference for hands-on work to the ways they prefer to learn and the ways they have learned outside the formal educational system.

Greenlander Ella Skifte, who received her education as a nurse in Denmark before a program was established in Nuuk, and who later worked as a nursing consultant in the Greenland Home Rule Government, stated that Greenlanders are very good at approaching tasks from a practical point of view, but perhaps not very used to thinking abstractly (cited in Kjærsgaard, 1998), a sentiment much along the lines of Arnakak (2001) who, as cited previously, stated that Inuit *Qaujimajatugangit* “is something one learns best by observing, doing and experience” (para. 22).<sup>84</sup> Skifte also noted that the Greenlandic way of thinking is very different from the Danish (cited in Kjærsgaard, 1998).

For some Inuit, knowledge is said to only have value if it is based upon personal experience. Several Elders have expressed this sentiment, including in the *Interviewing Elders series* (Oosten & Laugrand, 1999, 2002). Pauloosie Angmarlik, interviewed for the book *In the words of the elders*, said, “I never say what I have heard, I only tell what I have experienced, because I do not want to lie” (Angmarlik, 1999, p. 272). A man interviewed in my master's research about TB expressed a similar sentiment (Møller, 2005). Most who were interviewed then were in fact reluctant to claim knowledge about TB if they did not have personal experience with the disease, and hedged factual statements with things like, “*what I have been hearing is*” (Møller, 2005, p. 26). P. Berger (2008), who

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<sup>84</sup> Arnakak does not say that academic knowledge is learned best by observing, doing and experience; he has also urged caution about the notion that IQ should be an official policy of the government, though he worked with the government to create the *Pinasuaqtavut* document which mandated the inclusion of *Inuit Qaujimajatugangit* in all aspects of government and public works.

conducted fieldwork in the context of education in Nunavut, made a similar observation. This suggests that a preferred way to learn for some Inuit may be by personal experience, by doing or participating rather than by being told, or by reading others' accounts of how to do something.

Whether students are successful in their particular educational context hinges in part on compatibility between the educational style most used by the teachers and the students' preferred learning styles. It also hinges on the *habitus* of the learner and the teacher in other regards, for example in expectations of interpersonal relations between teacher and student as noted by Hansen (2007) and discussed previously.

Attitudes toward hierarchy are even manifested in basic patterns of interaction, and are especially salient in schools (Hansen, 2007). Hansen also suggests that while Westerners, since biblical times, have accepted the idea of violating the personal integrity of others, with the encouragement to do so via proselytising as promoted in the Bible, Inuit perceive individual integrity to be absolutely inviolable. So, Hansen describes, Westerners are socialised to argue and discuss (albeit in a "good way") in order to change the opinion of our counterpart, and there is a certain prestige in being good at argument and persuasion, but among Inuit attempting to change someone's mind is seen as a violation of the counterpart's personal integrity. The right to tell another what is right, though, and therefore what he or she should think, is taken for granted in Western schools and is a sign of the hierarchy, which is also unquestioned (Hansen, 2007).

Both hierarchy and teacher-student interactions are very important in a cross-cultural educational context, since one way of defining teaching includes that the teacher, while teaching, respects the students' "common sense, judgement, and personal integrity" (Winther-Jensen, cited in Hansen, 2007, p. 165). Hansen purports that the formal teaching that has taken place in Greenland since Egede in the 1700s cannot be characterised as teaching, as seen from the Greenlandic student perspective, since the Western teaching methods do not respect the students' personal integrity. Hansen believes that the

incommensurability between the two ontologies may in part explain the intuitive feeling among Greenlanders that formal education, although well intentioned, has been an injustice. Likewise, it may also in part explain why so many Greenlandic students have not done well in the educational system that has been, and is, run according to Danish norms and values. Inuit nurses and nursing students are among the few who have done well in Southern educational systems, but as previously mentioned, this particular group of Inuit are also advantaged in the Southern system in their possessing dual *social* and *cultural*, including *linguistic*, *capital*. The preference of Inuit nurses and nursing students for a more hands-on-learning or apprenticeship approach, however, is important. I think this is connected both to the ideas about a more equal or less hierarchical relationship between teacher/mentor and learner, as discussed above, and also with notions of identity and *habitus*.

Inspired by Lave, Ingold (2000) suggests that the way an agent<sup>85</sup> learns his or her “trade” is through a form of apprenticeship in which the apprentice learns to be attentive to, and in tune with, his or her environment while also leaning to be attentive to the actions and movements of the mentor. Ingold sees this as a process of “enskilment” where the novice acquires skills through being involved with the environment under the guidance of a practiced mentor, “in the conduct of their everyday tasks” (Ingold, 2000, p. 36). Through this “education of attention” (Gibson, cited in Ingold, 2000, p. 36) and through repeated practical trials guided by observations, the novice gradually gets “the feel of things for himself... learns to fine tune his own movements” or in Bourdieuan terms – he or she develops “a feel for the game” (Bourdieu, 1993, p. 5) and in the end achieves the abilities of the “accomplished practitioner” (Ingold, 2000, p. 353). Ingold equates enskilment, the mastery of a skill, with Bourdieu’s *habitus*, explaining that *habitus* is carried in our bodies and

acquired not through formal instruction, but by routinely carrying out specific tasks involving characteristic postures and gestures.... A way of walking, a tilt of the head, facial expressions, ways of sitting and

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<sup>85</sup> Ingold’s (2000) agent is a hunter. I believe, however, that the agent could equally well be a midwife, a tailor... or a *nurse*.

using implements – all of these and more comprise what it takes to be an accomplished practitioner, and together they furnish a person with his or her bearings in the world. (Ingold, 2000, p. 162)

*Habitus*, then, is what leads “people to orient themselves to their environment and to attend to its features in the particular ways that they do” (Ingold, 2000, p. 162). It is what leads some Inuit to prefer to learn by observation and doing. People do not ‘perform’ *habitus*: “*Habitus* is not expressed in practice it rather subsists in it” (Ingold, 2000, p. 162). In his discussions of *habitus* Bourdieu does not theorize about learning as such.<sup>86</sup> Inspired by Bourdieu, however, Lave and Wenger (1991) do. They call the process of becoming an accomplished practitioner *situated learning* or *legitimate peripheral participation* (Lave & Wenger, 1991). In their theorizing about learning through legitimate peripheral participation Lave and Wenger posit that novices are not necessarily under the guidance of a mentor, as suggested by Ingold, although they may be. Novices may just be present performing ‘peripheral’ activities and observe what a “master” who is present nearby does. When learners participate in communities of practitioners their increasing mastery of knowledge and skill will eventually move them from newcomers “toward full participation in the socio-cultural practices of community” (Lave & Wenger, 1991, p. 29), and with time they become part of these communities of practice.

Legitimate peripheral participation is understood to happen when the agent, while being located and acting in the socially and culturally structured world as a whole person, “engage[s] in social practice that entails learning” (Lave & Wenger, 1991, p. 35). While doing so they define and are defined by the community of practice to which they are “apprentices” while they themselves form identities as community of practice participants. This notion is relatively close to the ways in which Bourdieu (1993, 2000) defines the *feel for the game* that agents develop in certain fields, but which are dependant on the *habitus* of

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<sup>86</sup> Bourdieu (1990, 1993, 2001) theorizes rather about how a particular *habitus* is connected to having success in particular educational systems (particularly the French) and how educational systems are often set up in such a way that they cater to the *habitus* of the dominant, ruling and often upper classes.

the person who enters that field. Where *habitus* is defined as relatively stable<sup>87</sup> the process of becoming full members of a community of practice or developing the feel for the game of a particular field is just that – a process – where change takes place over time.<sup>88</sup> In order to have success in, and even think about, entering specific communities if they are not ones we naturally enter into, such as is the case for midwife apprentices in Yucatan according to Jordan (cited in Lave & Wenger, 1991), we are, as I understand Bourdieu, dependant on our *habitus* having been set up, so to speak, for that field, although we are not cognitively aware of this fact (Bourdieu, 2000).

In that sense, a preference for learning by observation and doing may be an expression of an epistemological stance as expressed by Arnakak (2001). An experience from one of my stays in an Inuit community may illustrate this. A young Inuit woman visited and tasted a sample of some bread that I had volunteered to make for a community feast. She asked if she could come and learn to bake it with me next time, and she joined me for more baking the next day. When we finished, I asked her: “So now you know how to make this bread?” And she told me every step and the measurements of things we had used quite accurately, although we had not discussed it while we baked, she had just mirrored my actions. I believe most Danes or North Americans would ask for the recipe and would not as accurately remember the steps and amounts as she did. Several participants at the 2007 NUNAMED conference workshop on cross-cultural health care discussed how they as Inuit had learned by observing and doing things alongside someone who was very experienced, with one woman telling a story from her experience about learning to sew kamiks. She was waiting for verbal instruction but soon realised that the person from whom she was supposed to learn had already started the process and expected that an individual who wanted to master the skill of sewing kamiks would watch and learn (Møller, 2007a). P. Berger (2008), in his research about *Inuit visions for schooling*, found

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<sup>87</sup> Bourdieu, as previously mentioned, does write that *habitus* constantly changes in response to new experiences, with dispositions “being subject to a kind of permanent revision, but one which is never radical” (Bourdieu, 2000, p. 161).

<sup>88</sup> The “feel for the game”, however, is also part of the existing *habitus* that allows us to even contemplate entering a particular field (Bourdieu, 2000).

that, similar to this woman, Inuit participants had learned through watching and doing outside the schooling system; he felt that this way of learning should be paid more attention to in the formal schooling system.

Lave and Wenger (1991) stress that legitimate peripheral participation should not be understood as an educational form, a pedagogical practice, or a teaching theory, but rather as a way of theorizing about, an analytical view of, and a way to understand, learning. Even when used as an analytical tool, as a way to understand learning and how we learn, produce knowledge and become knowledgeable, I do not think it is a way that most Western educators or educational institutions think about learning, even when teaching skills that we often connect with apprenticeship in some form such as midwifery (Jordan, as cited in Lave & Wenger, 1991), tailoring (Goody, as cited in Lave and Wenger, 1991), medicine (Good & Good, 2000; Sinclair, 1997) or nursing (Smedley & Morey, 2009). It may, on the other hand, be how some Inuit educators would theorize about learning and becoming knowledgeable participants in communities, and it may be a theory of learning that – when put into practice – will work well for some Inuit. I am not implying that learning nursing only by doing nursing – as an example – would suffice. Further, although several authors have pointed out that learning by observation and doing is desired by Inuit and may fit their ways of learning better (Maguire, 2001; P. Berger, 2008, 2009), I recognize the danger in proposing that most Inuit prefer to learn by observing or doing, as it may lead to stereotyping and ignoring differences among and within different Inuit populations (Abdallah-Preteuille, 2006; P. Berger, 2008; Dehyle, 1995).

A particular epistemological stance may be the reason why all four First Nations students in the pilot study (Møller, 2007), as discussed in section 1.4 and 2.7, feel more comfortable with learning alongside a practitioner rather than by being told or reading about how to do things. On the other hand, this predisposition may also be one reason why an individual, any individual, would choose a nursing education; that they, regardless of ethnic or cultural background, prefer a “hands-on” career – as the four students in the pilot study put it.

Interestingly, the two who identified least as ‘Indigenous’ believed their preference was individually based, while the two who identified most strongly as ‘Indigenous’, believed it had to do with their Indigenous background and the way they had been taught at home, similar to my findings with Inuit nurses and students.

The question is, then, whether preferences in ways of learning differ more, or at least as much, between as within cultures. In this connection, Dunn (1984) writes that human beings have different learning styles that include a continuum of variations across many categories that all need to be taken into consideration in order to determine the optimal learning experience for an individual. Dunn claims that when an individual knows his or her own learning style it is possible to plan the learning experience such that the individual learns in the best way possible. Dunn also claims, however, that few educators or learners are aware that these variations exist and therefore do not take them into account. Authors who have made meta-analyses of research based on the Dunn and Dunn model suggest that there are ethnic (as well as gendered and professional) preferences in learning styles (Lovelace, 2005; Mangino, 2004) and much research suggests that variation in learning styles among students accounts for many students opting out prior to finishing a degree or college program (Lovelace, 2005; Mangino, 2004; Rochford & Mangino, 2006). Perhaps those Inuit who have grown up exposed to both Southern and Inuit ways are more able to successfully negotiate the discontinuity between their preferred ways of learning and the teaching in the Nunavut and Greenlandic education systems – despite to some degree wishing that the systems could be different.

#### ***5.2.4 Teaching as emerging and full practitioners***

Only a quarter of the nurses and students said they thought they would use educational methods and approaches with Inuit patients that would be different from those they would use with Southerners. This surprised me, given nurses’ and students’ descriptions of what they think characterize Inuit and see as being part of an Inuit Identity (to be discussed in chapter 6), the learning preferences of

the students and nurses themselves, my own experience teaching Inuit students, and literature on Inuit education (P. Berger, 2001, 2008; T. Berger, 2006; Crago & Eriks-Brophy, 1994; Crago et al., 1997; Darnell & Hoem, 1996; Hansen, 2007; Leavitt, 1991; Lipka, 1990, 1991; Stairs, 1988, 1991, 1994; see also the 2009, volume 33(1-2) of *Inuit Studies* dedicated to *Education and transmission of Inuit knowledge in Canada*). As will be demonstrated below, however, Inuit nurses in their interaction and communication with Inuit patients actually use approaches that differ from those used by most Southerners. This discrepancy may indicate a failing in the way that my question about which educational methods Inuit nurses and students would use with Inuit patients was framed.

The fact that most nurses and students felt that the differences in their teachers' teaching styles were individually rather than ethnically based, and that only a quarter had a preference for being taught by Inuit, corresponds well with so few thinking they would use different educational approaches for teaching Inuit and Southerners. Still, when asked at a more practical level which teaching methods they would use to teach their patients (who are mainly Inuit), several students and nurses said that the methods chosen would be based on the individual and his or her level of education, prior knowledge and age. Many, including several who did not think they would choose different methods, added that they would use visual rather than textual educational aids because most Inuit do not have much education, or much knowledge about anatomy and physiology, or they would possess an understanding that might be different from that which is the norm in most Southern (and thus also Arctic) health care systems. As one student said:

*Southerners are much more used to you explaining things theoretically. Here in the Arctic you have to cut it out in cardboard because not many people are educated.... You have to show people, practically, what they need to do.... I feel people here more easily understand if you show them how. (T71:258)*

Other students, like the following one, said that with an Inuit patient it would be beneficial to use "*pictures or a model and use it in such a way that it makes it more comprehensible for the patient*" (T73:445, T6, T7). One student said she

felt trapped as she did not feel quite able to teach Inuit or Southern patients to her own satisfaction. She said she had only learned medical vocabulary in a Southern language and so did not feel she had the proper vocabulary in the Inuit language, and she did not feel her mastery of the Southern language to be good enough to teach as well as she would like, despite having the medical terminology.

As mentioned in chapter three, I have observed both classroom teaching performed by groups of students to the class with a teacher present, and by single students to a group of students from different health educations with no teacher or clinical instructor present. During interviews and conversations students informed me that they would like to be involved in their learning, not have the teacher just lecturing or doing all the talking, but rather have a form of discussion between teacher and students and have the teacher use a mix of teaching methods including PowerPoint, blackboard, different illustrations, role play, and other activities that engaged the students and made the theoretical information more applicable to practice. One student said there was an awful lot to read and that she found it difficult to retain the information as she did not have much to ‘pin’ it on, saying:

*I think it is difficult to remember... you just know you have read.... I think it would be better if they took some examples from the real life.... You know, in real life you could meet these things... then we would be better able to imagine how the patients would react, or what we are supposed to do.... We should have some tasks where we don't just read all the time. (T6:261)*

Another student praised a specific teacher for the ability to make theory understandable and practically applicable:

*Our science instructor, he was really good at making things practical. So you know when this and this and this happens, this is how it ends up. And it could be something very abstract, like how your liver functions, how you adapt, how ATP is synthesized, those kinds of specific things. I think he was really good at piecing it all together visually. I like the visual and not just all textbook. (T34:351)*

As mentioned in the introductory chapter, when I saw students educate their peers in the classroom setting, students generally did a lecture supported by a

PowerPoint presentation with little interaction with, or input from, their fellow students. They generally used few practical aids or hands-on examples. When the students taught each other in a mixed group with no instructor present, however, it took the form of a discussion where the students present drew on each other's knowledge and experience. Perhaps students, when situated in the classroom and the atmosphere of formal schooling, default to a *habitus* that generally fits that *field* in the Bourdieuan sense, whereas when they are in the practical setting they default to a *habitus* that would also be applicable in other more practical fields, even though they may be dealing with theory.

Other examples where something similar seems to have taken place include the experiences of James Ryan (1989) when he worked as a teacher in an Innu community and the experiences of a group of Aboriginal Language teachers (Graham, 2005). Ryan, in his doctoral work, sought to understand how the complexities of the wider society shaped the Labrador Innu response to schooling and school leaving. When Ryan finished fieldwork he was employed by the school board under which he had carried out his research. He was surprised to discover that his understanding of how schooling affects many Innu did not enable him to act differently from how he had been trained to teach, although he knew it might not be the best approach for Innu students. As he writes: "I found myself shackled to those teaching practices that I as a former student and teacher had been immersed in for years" (Ryan, 1989, p. 399). Barbara Graham (2005) worked with developing and implementing Aboriginal language programs and was told by the Aboriginal language teachers that they had similar experiences. Although their "early learning experiences of observing and participating in the work of the home and community were at odds with their experiences at school and at church" (Graham, 2005, p. 333), and although they did not believe it was a good model, when it came to teaching Cree or Ojibway their teaching strongly resembled the way they had been taught (and disliked being taught). "Their early experiences learning English initially interfered with their ability to become effective teachers" (Graham, 2005, p. 329).

Although both Ryan and the Aboriginal language teachers were aware of

the shortcomings of their approach, they were not initially able to change it. Ryan (1989) did not stay in the teaching position long enough to change, whereas the Aboriginal language teachers did (Graham, 2005), which speaks to the changeability and perhaps reversibility of *habitus*. Bourdieu points out that in the face of crisis or sudden societal and political change such as occur with colonization, particular dispositions or *habitus* may become dysfunctional. In this situation, what previously worked as *cultural capital* is virtually turned into a living liability. Individuals in this position are forced to “keep watch on themselves and consciously correct the ‘first movements’ of a *habitus* that generates inappropriate or misplaced behaviours” under the new rule/dominance (Bourdieu, 2000, p. 163). Those who remain unable or unwilling to make changes, Bourdieu writes, are often those who were “best adapted to the previous state of the game” (Bourdieu, 2000, p. 161). They will plunge into failure in the new order of things.

In this discussion Bourdieu (2000) uses the French aristocracy as an example, and although I understand the point he makes, I also see the issue as more complex, particularly when discussing the effects of colonization and colonialism. It appears that often the Indigenous people, including Inuit, who have a strong sense of their own culture and history, are those who are successful (Cappon, 2008; Lavallee & Poole, 2010; Wright, Taylor & Ruggiero, 1996). Having a strong sense of one’s own culture and history does not imply that one ‘holds onto’ ‘traditional’ ways or is unable to embrace new ideas and ways, or unable to mix the new with the old. This mixing includes using new technologies as alternative means of pursuing traditional activities and practices, as demonstrated by Dahl (2000), Dorais (2001), and Nuttall (1992). As noted by Ngugi (1986) and Rao (cited in Walder, 1998), having a strong sense of one’s own culture and history affects one’s sense of self and identity, and one’s sense of self and identity affects the ways in which we engage with other people as participants in communities of practice and as individuals generally. I will discuss the meaning of *identity* in the context of Arctic nurses in chapter 6, but will prior to that offer a summary of chapter 5.

### 5.3 Chapter Summary

Inuit nurses and students have experienced degrees of success and wellbeing in the educational institutions they have attended that many other Inuit, according to the exiting literature, have not. This has to do with their possessing *social* and *cultural capital* that ‘fits’ with that of the system. And, although most nurses and students had not given it a second thought that they were taught in Southern ways and languages, some students did, upon reflection, feel they had paid a price for being educated in a system where the language was not their mother tongue and the learning did not include Inuit specific history, language, and culture to a larger degree. Further, some did recognise that there are differences in the ways that Inuit teachers and Southern teachers teach, with one particular example appearing to be salient – that of equality between teacher and learner when both are Inuit. Some reported preferring this student/teacher relationship.

Most Inuit nurses and nursing students I have talked to have a preference for learning through participation and doing, or learning alongside an expert rather than being told or reading about what to do. This is not significantly different from that which is the rule among many nursing students in the South. What may be different for Inuit nurses and students is that many connected this preference with the ways they preferred to learn outside a formal educational setting. Also different, it seemed that the preference for practical learning did not shift to a preference for theoretical learning as they progressed in the education. Despite a general preference for being involved and engaged in their learning, students, when educating each other in a classroom setting, generally chose a lecturing style that included minimal engagement of their peers, whereas when they taught each other less formally it involved more discussion and engagement from both the student teaching and those she was teaching. Students evidently comply with the rules that govern where they act as agents, whether these rules are perceived or actual, and their ability to change according to the situation they are in speaks to their possessing dual *cultural capital*.

## **6. *Social and Cultural Capital* as ‘Determinants of Success’ for Arctic Nurses – Identity**

When I first moved to Canada to be with my partner I was not able to work or study for about 8 months as I did not have landed immigrant or permanent residence status. Being away from family, friends and all other known social relations as well as my habitual environment, not having the ability to use my mother tongue to form new relations, and also not being able to work, made me realize how much part of my identity, sense of self, and idea about who I was in the grand scheme of things was tied to me being both a Dane and a nurse – despite there being many Danes and also many nurses to whom I do not feel akin. When I moved to Nunavut after living in Canada for just under a year and started working as a nurse, however, I realized that my identity as a nurse was not necessarily immediately portable. Until then I had largely been working with colleagues who shared my mother tongue, who, like me, had lived the political and historical shifts of the Danish society and health care system over the years, and who, to a large degree, shared my cultural and social background. I felt I needed to develop a new identity as a nurse working in Canada – I would have had the same experience had I accepted a position in Southern Canada – a compounding factor in Nunavut was that the people I cared for and all the support staff came from cultural and historical backgrounds and experiences that were different from both mine and the other nurses. My experience was challenging, despite being fluent in the language that I was required to work in, and despite the other nurses being relatively closer to me culturally than I imagine is the feeling for many Inuit nurses when they start to work as an Inuk among Southerners. With my own experience in mind, it is unsurprising to me that Inuit nurses and students, while self-identifying as Inuit or Greenlanders, also differentiate themselves from other Inuit and Greenlanders, and that Inuit nurses and students identify with being nurses and the idea and role of nursing, while also differentiating themselves from many Southern nurses and ways of nursing.

As mentioned in the opening chapter, identity is always a social construct

that simultaneously allows us to be different from, and be similar to, singular and plural, and in a continuous process of becoming (Hastrup, 1986, 2004). Our identities are never ‘finished,’ then, but rather matters of meaning and “meanings are always the outcome of agreement or disagreement, always a matter of convention and innovation, always to some extent shared always to some extent negotiable” (Jenkins, 1996, p. 4). Becoming, being and practicing as a nurse engages, affects and shapes the personal identity of the practitioner as well as his or her identity as a nurse or participant in a community of practice.

Simultaneously, the practitioner, in his/her engagement with patients and colleagues, affects and is affected by their personalities and identities as individuals and as participants of various communities of practice. As Bourdieu (2000) writes, although similar basic *habitus* allow people to enter many fields, once they have entered and learned the *habitus* of a particular field, are engaged in the ‘game’ and master and ‘play’ by the embodied rules and language of that field, the practitioners of the various fields may be unable to properly communicate with individuals from other fields. This gap in communication led the national hospital in Copenhagen to hire an anthropologist to serve as a mediator between staff from various fields in the early 1990s<sup>89</sup>.

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<sup>89</sup> Although anthropologists have a long history of working with issues in health, medicine and health care, much work initially focused on making sense of non-Western medical practices (Leslie, 2001; van der Geest & Finkler, 2004; Whyte, van der Geest & Hardon, 2003) and then on the meaning and use of Western medicines or biomedicine and medical pluralism in non-Western settings (Whyte, van der Geest & Hardon, 2003). Only recently has anthropology turned its gaze on biomedicine and the workings of Western institutions (van der Geest & Finkler, 2004), resulting in the emergence of a growing body of hospital ethnographies (van der Geest & Finkler, 2004; see also volume 59 issue 10 of *Social Science and Medicine*, 2004; Long, Hunter & van der Geest, 2008; Martin, 2009). The focus of these range from Ugandan nurses and the ways in which hospital structure replicates the class structures of the wider society (Martin, 2009) to how Dutch parents and health providers negotiate whether newborns should or should not receive life prolonging treatment, a negotiation that mirrors “Dutch cultural values of mediation and bargaining” (van der Geest & Finkler, 2004, p. 2000). Other anthropologists who do not claim to do hospital ethnography, although they do their work in hospital settings, have had the following sorts of goals: to help describe the intricacies of the work involved in coordinating, accumulating and documenting knowledge on a ward in preparation for exchanging paper-based patient charts with electronic ones (Bossen, 2001); to document the paths of knowledge production and verification in a neuroscience laboratory (Roepstorff, 2003); and to prevent hospital readmissions, while evaluating a project working with young first time mentally ill people while acting as their interpreter and advocate (Larsen, 2003). Still, only a few anthropologists’ work documents or discusses the work of nurses and nursing, one of the major professions in the health care system and one that may have the largest impact on patient outcomes.

In order to provide some background and context for this chapter I will briefly discuss some implications of colonization on Inuit identity, then how Inuit identity is described in contemporary literature, before discussing Inuit identity as perceived by Inuit nurses and students. In the latter I will first describe Inuit nurses' and students' reflections on Inuit identity generally, and then the ways in which nurses and students describe themselves relative to other Inuit. Then I will go on to describe the ways in which Inuit identify as nurses and with the role of nursing and thereafter discuss the characteristics that Inuit nurses and students feel reflect Southern nurses and nursing. The chapter will close with a discussion of the implications that these differences may have in the Arctic health care systems.

### ***6.1 Background: The Meaning of Identity***

Identities, like cultures, are plastic and changing and may be explained both in terms of individual identity and in terms of group or collective identity.

Individual identity is a western notion and it is tied to self – the discrete, bounded Cartesian self (Sutphen & Andrews, 2003). A collective or social identity on the other hand is not perceived as a kernel within a person that may be more or less realized. Rather, it is equivalent to 'identity discourse', a discourse created through the stories we tell others and ourselves about who we are (Gad, 2009a). This identity discourse can also be seen as a process of identification where we sort our "environment into like and unlike self and other" (Sutphen & Andrews, 2003, p. 1).

Richard Jenkins (1996), the British/Irish social anthropologist, theorizes about social identity in a manner that offers useful insights about the dichotomies that Inuit nurses and students offer in their perceptions of identity as Inuit and as nurses or developing nurses. Drawing on theorists such as Herbert Mead, Irving Goffman and Fredrik Barth, but finding support also in the works of Pierre Bourdieu and others, Jenkins purports that individual identities which are 'embodied in selfhood' are developed in early infancy and may be seen as 'primary identities' which are "more robust and resilient to change in later life

than other identities” (Jenkins, 1996, p. 21).<sup>90</sup> Jenkins continues that individual identity or selfhood is a necessary prerequisite for social life while selfhood at the same time is ‘thoroughly socially constructed’ and meaningless if isolated from the social community. As such, identity needs to be validated by others; identity is not ‘unilateral’ – we cannot just assert an identity on our own. Therefore, how we present ourselves in our interaction with others is important, although we cannot be sure that the people with whom we engage ‘receive’ or ‘interpret’ our presentation as we intend. In other words, there may exist areas of tension between our “*self-image* and *public image*” (Jenkins, 1996, p. 22, emphasis in original) in our pursuit “to ‘be’ – and to ‘be seen to be’ – ‘something’ or ‘somebody’” in our pursuit to “assume successfully particular social identities” (Goffmann, as cited by Jenkins, 1996, p. 22). Borrowing from Bourdieu, Jenkins sees that which takes place when we negotiate our self and public images as being improvisational, just as *habitus* “in the presentation of self operates neither consciously nor unconsciously, neither deliberately nor automatically” but is both collective and individual as well as embodied (Bourdieu, as cited in Jenkins, 1996, p. 22). Apart from identifying ourselves we also identify and are identified by others. The operations of identifying ourselves and being identified by others, which Jenkins calls “*group identification* and *social categorization*” (Jenkins, 1996, p. 23, emphasis in original), often have political resonance and are associated with questions of power.

## ***6.2 Inuit Identity – Forever Changing and Forever the Same***

### ***6.2.1 Colonial influences on identity***

Greenlandic ways of living and identity have been under Danish influence for close to 300 years (Adolphsen, 2003), and Canadian Arctic people have seen European influence for as long, although it was less intense until just before the Second World War (Duffy, 1988). The identity and language of any people who have been colonized invariably undergo changes that are different from the

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<sup>90</sup> This statement leads to reflections on the notion that Bourdieu’s *habitus* is relatively stable and Jenkins’ critique of this relative stability as mentioned earlier.

changes that would have happened if they had not been colonized, and many Inuit from both places reject the historical and continuing Western colonial influence and the colonial desire to change Inuit ways and values to Western ones (Sejersen, 2004). One is Greenlandic Aviaja Egede Lyng (2006c), who at a conference in Nuuk about self-government and autonomy stated: “How good Danes do we Greenlanders have to become before we are acceptable? It is time that we take responsibility for our own history and our own lives as a people if we are to reach mental independence” (para. 1). Lyng (2006a) writes that the educational system in Greenland, which thus far has been a copy of Danish or European educational systems, continues to hold Greenland in a colonial grip where Greenlanders believe that in order to be modern and successful the European way is the only way. She argues that in order to mentally decolonize Greenland, a different kind of thinking where the educational system is based upon Greenlandic ways and values is necessary, and that it is necessary to measure educational success from a Greenlandic rather than Danish frame.

Another person who disagrees with continual Western influence is the journalist and Canadian Inuk Zebedee Nungak (2001) who coined the term *Qallunology*, which is the study of “White folks”. With *Qallunology*, Nungak brings the message that Euro-Americans ought to study themselves and the reasons behind their own actions rather than those of Inuit. As Derek Rasmussen wrote: “if Qallunaat really want to rescue indigenous peoples they should stop pushing them overboard to start with” (Rasmussen, 2002, p. 1).

Robert Petersen (2007) discusses Greenlandic identity and socialization seen from a historical as well as a contemporary point of view. He writes that Greenlandic children, at a young age, through playing and through silent socialization (e.g., with adults ignoring rather than verbally or physically disciplining what was deemed inappropriate behaviour) learned to conform and submit to the ways, norms and values of the time and to suppress some wishes and desires. Children and parents were close, lived fairly co-dependently and supported and cared for each other; children were trusted to be able to take care of themselves, be responsible community members and relieve their parents of

some of their 'burdens' very early in life (Dybbroe, 2007; Petersen, 2007; Stairs, 1991, 1992). In Petersen's (2007) view this was fitting in a society that had few options or alternatives, and Briggs (1970, 1998) wrote that these ways of raising children were also prevalent in Arctic Canada. Generally the only "teachers" that children had were their parents or other close family relations (Petersen, 2007).

Today Greenlandic children have educational needs that for many surpass their parents' abilities. Children spend much time separated and disconnected from their parents in order to go to pre-school and school. This has, in some cases, caused the close ties that existed between parents and children in the past to disappear, while nothing else has appeared to take their place (Petersen, 2007). Western schooling among Canadian Inuit, which has a similar albeit shorter history, has led to similar results (Brody, 1991). It has also been suggested that these realities of the recent past, along with more recent developments such as increasing contact to the surrounding world via media and the ability to travel (Dybbroe, 2007), continue to affect the development of individual identity in Greenland (Petersen, 2007) and in the Canadian Arctic today (Tompkins, 2006), both in terms of the education of children and of adults (McLean, 1997). McLean argues that adult education in the Canadian Arctic, whether intentionally or not, has worked at assimilating Inuit into mainstream Canadians by individualizing education through evaluating, counselling, and testing adult learners before, throughout, and after participating in educational programming. In essence this worked at changing Inuit collectivist, or community oriented identities, upon which Inuit society was built, to identities that were "individualistic in [a] Western sense" (McLean, 1997, p. 5). McLean also argues that absenteeism, high attrition, and low graduation rates may be seen as resistance to this assimilationist project. This argument makes sense to me and I will forego further discussion and turn to discussing notions of Inuit identity in more detail.

### ***6.2.2 Past and present Inummariit and other representations of Inuit identity***

Despite heavy colonial presence and influence, contemporary authors who describe Inuit identity see significant differences between Western or Southern European-based and Inuit (Greenlandic as well as Canadian Inuit) identities, and the identities of Canadian and Greenlandic Inuit are described in very similar ways, which is why this section includes both.

Stairs (1992) writes that *Inummarik*, which in Inuktitut means “a most genuine person,” is “the basis for Inuit identity” (p. 117), and that becoming *Inummarik* requires the development and maintenance of *correct interactions* with people, animals, and community. Stairs describes *Inummariit* (plural) in both past and present tense, and similarly to McLean (1997) cautions that the exposure to Western schooling, institutions, ways and values are threats to maintaining identity as a most genuine Inuk, although it is not impossible to do so. Brody (1991), also from time in the Eastern Arctic, describes *Inummariit* mostly in the past tense, although he also stresses that *Inummariit* still exist and that their qualities as Inuit are of high importance to Inuit. Brody also stresses that becoming *Inummarik* happens with age and having accrued much knowledge and wisdom, maintaining proper relationship to, and knowledge about, people, the Inuktitut language, flora, fauna and geography of the land, hunting, and more. Brody, similar to Stairs, purports that an *Inummarik* is perceived to be even tempered, disciplined, versed in the Bible and a respected authority who does not need to assert his or her authority. Many of these same qualities, Brody suggests, are also true for good Inuit men and women who may not have the knowledge and experience of *Inummariit*.

Dorais (2001), writing from Nunavik about Quaqtamiut – people from Quagtaq – recounts that they are of the opinion that *Inutuinnait* (the ‘genuine Inuit’ in Quaqtamiut dialect) were “those who knew how to survive by themselves, without the help of modern technology” (Dorais, 2001, p. 12), people who lived before Qallunaat established themselves in the area. Dorais wrote that Quaqtamiut believe that “nowadays Inuit are not *Inutuinnait* any more because they have adopted Euro-Canadian culture” (Dorais, 2001, p. 15). At the same

time, though, Dorais demonstrates that Quaqtamiut “are quite able to reconcile their deepest identity [which shares many qualities with the *Inutuinnait*] with what the modern world has brought to their shores” (Dorais, 2001, p. 61). From a Greenlandic perspective, Nuttall (1992) writes that Kangersuatsiarmiut use the term *kalak*<sup>91</sup> to imply the ‘real’ or ‘genuine Greenlander’ – the term “conveys the quintessential features of *Kalaaliussuseq*; identity as a Greenlander” (p. 149). As both Stairs (1992), Brody (1991) and Dorais (2001) write about the genuine Inuit, being *kalak* is connected to qualities of personal character and specialised knowledge about language, the environment, animals, hunting, and the weather held by particular Greenlanders (often hunters) in the past (Nuttall, 1992).<sup>92</sup> They represent the “real” things (as opposed to the negative outcomes – on personalities and otherwise – of Westernization) that are for most Inuit “representations of human goodness, honesty and strength” (Brody, 1991, p. 142). Simultaneously, Nuttall observes that many of the qualities of *kalak* continue to be qualities that Kangersuatsiarmiut hold in high esteem and praise if exhibited, and quietly condemn if contradicted. These include sharing or giving freely, and not displaying anger or being loud.

Markers of Inuit identity that are mentioned also, outside a discussion of *Inummariit/Inutuinnait*, include: being independent and autonomous (Briggs, 1970, 1982, 2001; Brody, 1991; Lynge, 2005); being able to respect others’ independence and autonomy (Briggs, 1970, 1982, 2001; Searles, 2000; Hansen, 2007); being social, generous, kind, and nurturing (Briggs, 2001; Lynge, 2005); not being inquisitive or interfering (Brody, 1991; Hansen, 2007; Lynge, 2005; Searles, 2000), but discrete, and disciplined (Briggs, 1970; Brody, 1991); and not being moody or aggressive (Briggs, 1970, 2001; Brody, 1991; Lynge, 2005). Further, Inuit identity is closely tied to partaking in the hunting, procuring, and eating of land-foods (Borré, 1994; Brody, 1991; Dahl, 2000; Dorais, 2001;

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<sup>91</sup> Berthelsen et al. (1997) translates *kalak* to mean “en vaskeægte Grønlænder” (a genuine Greenlander) (p.144).

<sup>92</sup> Nuttall also notes that some use *kalak* as a derogatory term “when people talk about the old hunting life” (Nuttall, 1992, p. 148). Being synonymous with *eskimuut* (eskimoes) it is also used in a derogatory manner by some people in the town of Upernavik to describe people who live in the smaller settlements outside Upernavik. Even people who use *kalak* as a positive descriptor may connect the qualities a *kalak* possesses with village rather than town living (Nuttall, 1992).

Freeman 1992, 1996; Hensel, 2001; Olsen, 2010; Rasing, 1999; Togeby, 2002) and to feelings of self-determination (Dahl, 2000; Dorais, 2001; Dybbroe, 1996; Searles, 2001; Lyngne, 2006). Language also continues to play an important role as a marker of identity in both Greenland (Dahl, 2000; Nuttall, 1992; Petersen, 2002) and most of Arctic Canada (Dorais, 2001; Dorais & Sammons, 2002) despite the reality that some ethnic Greenlandic and Canadian Inuit are unable to speak Greenlandic or Inuktitut (Dorais, & Sammons, 2002; Langgård, 2003).

Concepts of self and identity are closely linked to our perceptions of our physical self or body image and concepts of sickness and health (Freeman, 1992). Few authors write about contemporary Inuit concepts of health, illness and the body; the points they make, however, I find useful to contextualise the discussion of Arctic health care and Inuit nurses and nursing, and thus I provide a summary of these below.

### **6.3 Identity and Health**

#### **6.3.1 Concepts of health/disease and the body<sup>93</sup>**

Writing on environment, society, health, and quality of life issues in the North, Freeman (1992) argues that self-image or identity is central to a discussion about Inuit conceptualizations of health, disease, and the body. I agree with Freeman's argument since for some colonized peoples the effects of colonization include a decrease in feelings of cultural identity (Battiste, 2005; Dion, 2009; Lavallee & Poole, 2009; Smith, 1999), individuals with "a solid foundation in their traditional culture are better adapted to subsequent stresses of life" (Freeman, 1992, pp. 2-3; see also Dion, 2009; Lavallee & Poole, 2010), and acculturative stress may lead to increased susceptibility to physical and mental illness (Dion, 2009; Freeman, 1992; Lane, Bopp & Bopp, 2003). My research on the socio-cultural experiences of TB in Nunavut related high rates of TB to socio-cultural stresses and acculturation, which, I argued, were connected to colonialism

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<sup>93</sup> This section is an revised edition of two sections in my master's thesis (2005): *A Problem of the government? Colonization and the socio-cultural experience of tuberculosis in Nunavut*. The sections were: 3.4 *The experience and meaning making of health, illness, disease and cure among Inuit* & 3.4.1 *Good health allows Inuit to do what they want*.

(Møller, 2005, 2007, 2010). Others have stressed this connection (First Nations Centre, 2005; Reading, 2010; WHO, cited in Korhonen, 2002; Wolsko, 2007).

A person's quality of life depends on his or her self-image or sense of identity and "a positive self-image results more often than not in the perception that life is good, and that the effort required to improve one's well-being is both worth-while and likely to be successful" (Freeman, 1992, p. 3). Tamusi Qumaq, an Inuit elder who has worked with the French anthropologist Michele Therrien on several projects and who is the author of the first published Inuktitut dictionary (Qumaq, 1991), similarly combines health with notions of identity. He states that a healthy Inuk is independent and able to do whatever he wants, is able to "work, hunt, bring home food" and visit his family (in Therrien & Qumaq, 1992, p. 1). Borré (1994) echoes Qumaq's statement, writing that: "health allows one to fulfill personal needs, the family's needs, and social needs and results in a feeling of control and contentment which in turn generates high self-esteem" (p. 5).

As part of a larger cultural inquiry, early anthropological work describes Inuit views on health, disease, and healing (for example, Balikci, 1970; Boas, 1964; Freuchen, 1961; Rasmussen, 1930a,b,c,d,e). These descriptions often display a focus on exotic beliefs, practices, magic, and fetishism. In the early 1970s, medical anthropology grew as a specialized field and while "a homogenous, static view of local culture and society" was often presented (Whyte, van der Geest & Hardon, 2002, p. 10), Indigenous medical practices and medicines were placed "in relation to the cosmology, ritual and knowledge of a local (often ethnic) group" (Whyte, van der Geest & Hardon, 2002, p. 10). Thus, seemingly exotic healing practices were shown to make sense.

The 1980s saw a change in philosophical and anthropological thought that included a shift from a structuralistic and modernistic understanding of culture to one that was post-structural and post-modern (Hastrup, 1999). As part of this shift, it was recognized that it is not possible to finitely describe cultures or base these descriptions on meta-narratives (Hastrup, 1999). Subsequent work dealing with health and disease among Inuit has been impacted by this change. Sparse

literature is available on the subject, and it is characterized by not being highly theorized. As a consequence of this paradigm shift, the voices that we hear in this more recent, small body of literature are generally those of Inuit rather than those of the anthropologists or other scholars who have edited or compiled the works. In the following discussion on Inuit experience and meaning making of illness, disease, healing, and cure, I draw on these voices. I also draw on a few contemporary works focused on health, disease and other topics. These are written from the point of view of various non-Inuit scholars.

### **6.3.2 Good health allows Inuit to do what ever they want**

Health is a “complex reality” consisting of “*breath (anirmiq), soul (tarniq), [and] name (atiq)*”<sup>94</sup> and harmony and peace need to exist between and within these essential components of the human body for an individual to remain healthy (Therrien & Qumaq, 1992, p. 11, emphasis in original). As stated by Qumaq, “[When I am healthy] I can do whatever I want. I have no misfortune” (in Therrien & Qumaq, pp. 10-11). Borré (1994) researched the connection between the seal and health in Clyde River in northern Baffin Island. He explains that *tiimiut* is the physical body and its functions, and *tarneg*, the mind, the emotional state, and the expression of consciousness. The integration of the two is that which creates a person. Health is present when “*tiimiut* and *tarneg* are adequately nourished and at peace with other sensate beings and the environment” (p. 5).

Similar to Borré (1994), Nuttall’s (1992) informants describe the components of a person to be *timi*, the person’s body, “the material and temporal part of a person [which is] subject to disease and decay” (p. 65), and the person’s soul, which has 3 parts to it, as also mentioned by Therrien & Qumaq (1992). One part, the *tarneg*, is a person’s ‘personal soul’, which is present from birth and is nurtured and develops as a child grows “with emphasis on religious development” (Nuttall, 1992, p. 66). The second part, the *anersaaq*, is

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<sup>94</sup> I have used the the same spelling of the Inuktitut word for soul as the author whose work I refer to. In the Greenlandic/Danish dictionary the Greenlandic word for soul is spelled *tarneg* (Berthelsen et al. 1997, p. 331). In the Inuktitut/English dictionary of Northern Quebec, Labrador and Eastern Arctic dialects the word for solul is spelled *tarniq* (Schneider, 1985, p. 397).

conceptualized as breath or God's breath, contains aspects of mind, and "is slightly more autonomous during a person's life" (Nuttall, 1992, p. 66). It is able to leave the person while he or she is alive and upon the death of the person stays in the land of the living as a memory or reflection of the dead. *Tarneq* is more passive and only leaves the person's body upon death. Finally the third part; the *ateq*, the person's 'name soul,' closely tied to identity and given to a child upon birth, is given with the name of a recently deceased person; the qualities and social identity and genealogy is 'reborn' in the new child when he or she receives the name of someone recently deceased (Nuttall, 1992, p. 66).

Qumaq further explains health as "the absence of misfortune" (in Therrien & Qumaq, 1992, p. 10), and says that when an Inuk is *qanuinnngituq*<sup>95</sup> he is comfortable, is deprived of nothing, has no disorder, has no need of care and is independent. Health is a state of balance or harmony, *isuaqtuq* (Therrien & Qumaq, 1992). Health, furthermore, "allows one to fulfill personal needs, the family's needs, and social needs and results in a feeling of control and contentment which in turn generates high self-esteem" (Borré, 1994, p. 5; see also Dahl, 2000). Both younger and older Inuit state that for people to be healthy they need to be physically, socially, and mentally able and active (Atagutsiak, 2001; Ootoova, 2001; Shea, 1989),<sup>96</sup> otherwise they will become "lazy, think too much and get sad" (Uyarasuk, 1999, p. 264).<sup>97</sup> Many Inuit state that a healthy person is a happy person with happy family relations (Ootoova, 2001; Shea, 1989), and in order to stay healthy it is necessary to have a cheerful demeanor, not to worry about things, and not to carry anger inside (Ootoova, 2001). As an older woman

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<sup>95</sup> 'Qanuippit' is the Inuktitut translation of 'how are you?' Literally translated, it means: "what is wrong with you?" In order to answer that I am fine or well, I say 'qanuinnngi.' This means I do not have any misfortune; there is nothing wrong with me (Therrien & Qumaq, 1992, p. 10). Qanuinnngitug then, is equivalent to saying "he or she is well." In Greenlandic in answer to "Qanoq ippit?" people reply "Ajunngilanga," literally translated – "I am not bad" (or, "I am not feeling bad"). Ajunngilanga is the negative form of ajorpoq, meaning: is bad/is feeling bad (personal communication, Mark Nuttall, October 17, 2010).

<sup>96</sup> Ootoova and Atagutsiak were both interviewed for the series *Interviewing Inuit Elders* in the volume titled *Perspectives on Traditional Health* by Ootoova et al. (2001), which was edited by Michele Therrien & Frederic Laugrand. Shea's (1989) study focused on concepts of health among young Inuit adolescents.

<sup>97</sup> Uyarasuk was interviewed for the (1999) book, *The Transition to Christianity* (Tungilik & Uyarasuk, 1999).

told Borré, “you have to be happy to be healthy and you can’t be happy without country food” (Borré, 1991, p. 9). The eating of country foods or Inuit food is thus, for some, part of maintaining optimal health and preventing sickness (Borré, 1991; 1994; Dahl, 2000,<sup>98</sup> Freeman, 1992; Al Joamie, 2001; Klevian, 1996; Pitseolak, 2001; Shea, 1989), as is going out on the land (or sea), and the hunting, procuring, and sharing of land-foods (Borré, 1991, 1994; Dahl, 2000,<sup>99</sup> Freeman, 1992; Shea, 1989).

Although differing interpretations exist, current literature on Inuit concepts of health and disease agree that health is a combination of a strong mind in a healthy body. Being healthy means that the individual can do whatever he or she wants, is independent, and autonomous, though health is not an altogether individual matter. Rather, health is a holistic concept where harmony and balance need to exist between mind, body, and spirit, in interpersonal relations, and relations to game and the environment. The maintenance of balance is important for health. I now explore what causes imbalance to occur, and mental or physical disease to develop. I also explore what can be done to restore balance, in order to return to health.

### ***6.3.3 Becoming sick and restoring health***<sup>100</sup>

Some have expressed the view that, prior to settlement living or prolonged contact with Europeans, Inuit were seldom sick, and very rarely seriously sick, if they were not dying (See for example Awa, 2001). This sentiment may account for Donald Suluk’s statement: “it has been said that one of the hardest things to do is cure a sick person” (as cited in Bennett & Rowley, 2004, p. 209). Various

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<sup>98</sup> Although Dahl (2000) does not specifically state that the going on the land, hunting, procuring, sharing, and eating of Inuit foods maintains health, his references to comments, ways of living, etc., of the people of Saqqaq indicate that this is the case.

<sup>99</sup> See footnote 97.

<sup>100</sup> As has been noted by Rønsager (2002), there is not much literature describing Greenlanders’ conceptualization of sickness and health historically. Similarly, although many organizations and institutions that care for Greenlanders who are sick note that Greenlanders have distinct ways of conceptualizing health and disease, what these are remain unsaid. I have not been able to find descriptions or discussions of how contemporary Greenlanders conceptualize health and sickness. The descriptions from the Canadian Arctic that are referred to in this chapter, however, bear much resemblance to the historical Greenlandic views as described by, for example, Rønsager (2002).

treatments, remedies and cures for common ailments like earaches, stomach aches, infections, boils, injuries such as cuts, and broken and dislocated bones, existed and still do exist, however, (Angugaatiaq, 1980; Awa et al., 2001; Bennett & Rowley, 2004; Rønsager, 2002), and according to Inuit memory, people tended to heal quickly (Awa et al., 2001; Ootoova, 2001).

When Inuit started to experience serious physical sickness through diseases and epidemics brought by the Southerners many were at a loss in terms of how to deal with them. Through the early TB epidemics Inuit learned that others, the Southerners, knew how to deal with these diseases, and that they were expected to comply with Southern ways and rely on Southern treatments (McGrath, 1991; Minor, 1992; Rønsager, 2002; Tester & Kulchyski, 1994). The people who did not receive Southern treatment often died. While most Inuit accept and to some degree are comfortable with the preventative measures, ways of examining, and diagnostic and treatment options offered in most Southern health care systems, many simultaneously maintain notions about disease and cure that are different from notions maintained in western bio-medicine (Møller, 2005, 2007, 2010).

For many Inuit, sickness requires a holistic approach with the physical body, the mind, and the spirit all requiring tending (Bennett & Rowley, 2004, p. 219), because “our mind is part of our body” (Atagutsiaq, 2001, p. 96). Therrien and Laugrand (2001) write that today, as in the past, some Inuit in Nunavut understand sickness to be originating from outside the body and believe it has the ability to “travel through the body,” that in order to become well it is necessary to get rid of the offensive element (which in the case of depression may happen by talking it out) and also to “rehabilitate the sick person in the community and eventually among the ancestors” (Therrien & Laugrand, 2001, p. 5).

Historically, Inuit were not supposed to talk about bad, sad, or difficult experiences, and many have been brought up this way. Today, many Inuit stress the benefit of talking about that which weighs them down mentally in order to get through it (Atagutsiaq, 2001; Kral et al., 2000; Ootoova, 2001; Uyarasuk, 1999). Some state that if they do not talk, but keep worrying and being tense, they might not recover from mental or physical illness or they might become physically sick

(Awa, 2001). The participants in Rasing's study of social order and non-conformity among Inuit in Igloodik mentioned open disclosure to be "a major strategy for dealing with unhappiness, depression, worry, anxiety, guilt, etc." (Rasing, as cited in Korhonen, 2002, p. 49). Some state that people need to disclose their hurts, and the person who might have hurt them needs to apologize. After an apology has been given and the person has had the possibility to talk through the hurt, it is possible to forgive and start recovering (Korhonen, 2002). For some, words have healing power (Therrien & Laugrand, 2001). Words, however, are not only seen to be healing, they can also hurt. Therefore some also state that not everything shall be talked about. For some, transgressing social norms and conventions by talking or thinking badly or negatively about people or behaving disrespectfully towards people may cause illness or other misfortune in the offender or his or her loved ones (Katsak, 2001; Ak Joamie, 2001; Al Joamie, 2001, Møller, 2005, 2007, 2010). Even mistreating or behaving disrespectfully towards animals may have this outcome (Ak Joamie, 2001; Al Joamie, 2001).

Silence was and still is seen by some to have healing properties. Minor (1992) stresses the importance of the concept of *ajurnarmat*,<sup>101</sup> the silent acceptance of that which cannot be changed. She states that "the ability of Inuit to accept things as they are alleviated a tremendous amount of interpersonal struggle and clarified interactions and expectations" and continues that *if* someone asked for help, he or she did so thinking that "there was a chance that the situation could be changed to benefit his own emotional health" (Minor, 1992, p. 54). Minor also mentions that silence can be healing in times of grief and stress when the one suffering shares the silent company of others. This group support will strengthen the one grieving and enable him or her to move forward, while not burdening others. The key, though, is that the struggle and the healing is a group effort. This is also the case with physical illness. As Bennett and Rowley (2004) write, "when individuals fell sick, the family members tried everything to assist them" (p. 219). All attempts are made to provide a sick individual with the food that she desires

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<sup>101</sup> *Ajurnarmat* is conceptualized as the idea that "things are the way they are, and it makes no practical sense to despair over something that has already occurred and cannot be changed" (Minor, 1992, p. 53).

(Bennett & Rowley, 2004; Al Joamie, 2001; Pitseolak, 2001). Particularly food from the land is helpful in the attempt to cure sickness, and certain animals or parts of animals are good for restoring health in case of certain illnesses (Angugaatiaq, 1980; Awa, 2001; Borré, 1994; Therrien & Laugrand, 2001). Attempts are also made to ensure that people the sick one wishes to see are present (Bennett & Rowley, 2004, p. 219).

Illness and disease, then, may occur when there is an imbalance between the physical body, the mind and the spirit, and all require tending in order to heal. Sickness comes from outside the body and a healing process will often involve getting rid of the offensive element, either physically or verbally, and acceptance, communal silence, and the eating of special foods and company of special people can be helpful in both maintaining and restoring health.

In contemporary literature on Inuit identities and the very sparse literature on Inuit health, concepts of sickness and health continue to be described in ways different from those often used to describe Southern or European identities and concepts of sickness and health – despite long term colonial influences. Differences also characterised the ways in which Inuit nurses and students described Inuit mentality and identity and their ideas about the nursing practices that would often be helpful when caring for Inuit.

#### ***6.4 Nurses' and Students' Perspectives on Inuit Identity***

While most participants noted that they themselves, in some respects, were different from many other Inuit, most also noted that Inuit recognize traits in each other and share certain characteristics that they do not share with Southerners. As stated by one nurse:

*As Inuit we recognize something in each other, our sense of humour being an Inuit woman in an Inuit society, the men whom we can turn against, the circumstances of the children, we have many things in common right? And the jokes we tell in an Inuit language are not the same [as those told by Southerners] are they? (T30:412)*

The characteristics that nurses and nursing students, in formal interviews and casual conversations or in the educational setting, said they felt resonated

with Inuit identity/mentality were generally characteristics that also resonate with those described in the literature. Characteristics that several nurses and students mentioned include mastering an Inuit language, avoiding conflict and being non-confrontational, talking when it is necessary, not being loud or inquisitive or asking many questions, valuing independence, and respecting the individuality and autonomy of other people. As one nurse said: *“My parents taught me to be respectful of other people... to respect people as they are, respect their personalities and ways of being, also when they are different than other people”* (T19:246). Another nurse said that *“the concept of autonomy”* prevented people from telling others how they ought to live or behave (T28:58). Many also mentioned that Inuit are shy of conflict and that some easily follow authority and are humble, although several mentioned that particularly the latter two traits are very generationally dependant.

Other intergenerational as well as urban and rural differences among Inuit populations were also mentioned. These included that not just older but also more rural and “traditional” Inuit might be more likely to follow authority without question, might ask fewer questions, and might more often than younger or urban Inuit say they had understood things when they had not, and that they more often than younger Inuit might not indicate that they were in pain, and might even say they were not, if asked. Differences also included that older Inuit would be less likely to answer questions that came as bullets from a gun or very direct questions, but would tell stories from which the listener would be able to glean the important information. I was also told that if someone talks a lot it might make older people just not speak altogether, because it would be presumed that someone who talks a lot knows everything already (T40:818).

Inuit were also described as people who laugh easily and like to have fun, as commented by a nurse when she talked about a group of Inuit who had livened up a particular ward where they were all admitted to have hip operations:

*They just laughed so much at themselves and at each other, despite pain, the need for training and everything. But, that is the way it is when many Inuit are together. There is much laughter and silliness,*

*self-irony and; 'go ahead, laugh at me!' You know, that way of being.*  
(T32:34)

Further, some described Inuit as not being prone to openly analyze or discuss things at great length. In a discussion about parts of the nursing program that had been challenging, one of the more mature nurses who had taken her education in the Arctic stated:

*Well, the part about needing to have a critical opinion about everything was one of the most difficult things about the education. You had to critically evaluate everything, every choice you made – why did I do this and not that? Why and why and why? .... You know, when I was a child things were just the way they were, there was not given long explanations to things. You did not have long conversations about things. That was not the way my parents were. You were able to gauge from body language, you know, when you could speak and when you could not. It was not that my parents were particularly strict or anything, you just did not have to analyze everything. My husband's parents [who are Southern] have a totally different mentality. They talk and talk and talk.... I entered a totally different world when I was introduced to his family. It was very uncomfortable for me in the beginning. I had to get used to it. I really do care for them, but it was difficult in the beginning. I needed to get to know them first.... It was not until I was being educated that I realised that we come from two different worlds. That theirs was very Southern influenced, Southern culture and traditions.* (T20:150)

She continued: *"The thing that was most difficult for me [as a nursing student] was likely that I had to think in a way that was different from the way I have been brought up to think"* (T20:161). Another mature nurse echoed this statement, saying about the nursing education: *"It was a huge personal development... to learn to reflect about and question things"* (T31:77). Several younger and older nurses and students who had worked in the health care system as nurses' aides prior to entering the nursing program similarly commented on the vast difference they saw between the reflections that formed the basis for their actions as nurses compared to their reflections as nurses' aides. Some of the older nurses stated that this need to question and reflect, coupled with an expected proficiency in a Southern language that some did not have, and a level of schooling that left a gap between that which they had when leaving their basic

education and that which was expected when starting the nursing program, made it impossible for some of the nursing aides who initially entered the program to finish it. This indicates the likelihood that those who did finish were equipped with *capital* in the form of Southern *habitus*, both *linguistic* and *cultural*, in amounts that those who did not finish did not possess.

Particularly the older nurses and students described Inuit to be fairly relaxed and pragmatic, with one nurse saying:

*The Inuit mentality, as I see it, is to be more relaxed about things. Yes of course you need to make plans, but then again it depends – are we alive tomorrow? Is the weather bad? Will we go or not? We cannot really make plans about it; yes we can make plans but we cannot predict what we will do, we take things more in stride. Then we say, okay the weather is with us, so let's go. (T26:179)*

Another nurse echoed this when she talked about how Inuit approach life and said:

*Inuit have been used to living a risky life, you know. The hunters and fishers have lived with their lives at stake when they went out and never knew what the weather could bring. You are used to the possibility of huge weather-dependant catastrophes. (T28:284)*

The unpredictability of the environment and fragility of life was also used as a means to explain the trait of being non-confrontational:

*Inuit are non-confrontational, which may be related to the historical cultural fact that it was necessary to be able to get along with everyone in your close environment in order to survive. Southerners may have a greater need to talk about everything and nothing and are more confrontational in the way they approach both colleagues and patients. (T27:36)*

As has also been noted by Nuttall (1992), Briggs (1970, 1998, 2000) and Brody (1991, 2001), several participants connected the trait of being good humoured with the trait of being non-confrontational, a way of averting feelings of anger or physical pain as with the group of hip operation patients mentioned above. One nurse said:

*Here in the [Arctic] we've never been very good at telling someone that she hurt us. We'll just laugh, and then when the person leaves*

*we'll think, 'Who does she think she is!' We are a people who are very shy of conflict. (T4:52)*

Another nurse echoed this when she said that being non-confrontational could also mean that people avoided talking about professional issues, as they might not agree. Talking socially, on the other hand, would not put anyone in danger of disagreement. In relation to sociality, many also talked about the importance of family and not just the importance of supporting and feeling supported by both close and extended family, but also the expectation that you will support your family members both emotionally, practically and financially if needed. This was considered to be both positive and negative. One informant explained that she had left her home community and had no plans of moving back because her family would expect her to be their provider, since she as a nurse would have a regular income whereas they did not, whether by choice or circumstance. Another informant took care of a younger family member whose parents were unable to care for him, a third was very happy that an extended family member had chosen to move from their home community to care for her child while she was a nursing student, and others again mentioned that grandparents had taken over the care of grandchildren to allow parents the freedom to leave their hometown to attend an education elsewhere. Many talked about the importance of having grown up as part of extended families and feeling a close connection to their hometown, whether they would choose to move back there again or not. This connectedness to place is also mentioned by Nuttall (1992), as is the way of extending familial relations wider by including in the familial context the family of one's *atiq*, as well as others with whom one shares the same name. Participants also noted this.

Some connected Inuit approaches to planning with Inuit being task rather than time oriented, a notion that has been highlighted by others discussing Inuit and Indigenous schooling and learning (see, for example, Rasmussen, Baydala & Sherman, 2004). The chair of Greenland's National Museum and Archive explains, in an article about Greenlandic food as an immaterial cultural heritage, that Danes have difficulty accepting the notion of immaterial culturality because it is broad and difficult to define. Greenlanders have no difficulty accepting the

concept. This, she says, is because Danes have more linear thought processes influenced, among other things, by evolutionism, where concepts generally can be explained as having cause and effect relationships. Greenlanders, she writes, have a more holistic and cyclic way of thinking and accept that occurrences and phenomena cannot necessarily be explained, but just are (Olsen, 2010).

I discussed with one nurse whether or not it would be beneficial to have the nursing education in an Inuit language; she said:

*I think sometimes even just in terms of wellness. I think there'd be more flexibility if [the program] was in an Inuit language. I think so. Even if it meant... well that means you're going to have to cover 2 chapters next week and let's add another hour to next week's class so that we can be more flexible. I think the time... looking at a timeline is different. I think there'd be more flexibility ... a different view, a different view of time.... It doesn't have to be schedule-based as much. Still a schedule, but for flexibility it would be different.*  
(T34:546)

A student used the way one of her Southern teachers planned and compartmentalised time and tasks to similarly explain the benefits of being task rather than time bound. She said:

*This Southern teacher, she always has a program for the day that she shows on a PowerPoint slide. At this time we will do this, at this time we will do that. So everything is very scheduled. That is difficult, because you can't always follow the schedule. Sometimes we spend more time doing one thing than was planned.* (T77:379)

The student continued that she thought that scheduling tasks on the clock in the end stressed both the instructor and the students. The student did not think an Inuit teacher would schedule things that way but would rather go through things and spend the time that was required to finish each task, without feeling that certain things would need to be accomplished at certain times, and without being stressed about it.

Food appears in the literature as an important marker of Inuit identity (Borré, 1994; Dahl, 2000; Freeman, 1996; Nuttall, 1992; Olsen, 2010). Many participants confirmed this. Still, regardless of feeling that eating Inuit foods was

part of Inuit identity a few made clear that they would eat only some Inuit foods, as indicated by this student:

*There are lots of people here from the same town so they are closer and know more about the same things and speak the same dialect and relate to the same things. Like in relation to food. “We are going to eat Inuit food, will you come and eat?” Well, that means that they will have VERY Inuit food. I eat Inuit food, but I do not eat VERY Inuit food. (T4:35)*

Many still connected hunting for and eating Inuit foods and the need to have certain foods at certain times with Inuit identity. Many had also been part of hunting or fishing, though few had killed and prepared the animals themselves. Not partaking in the killing and procuring of the animals is different from the information given by informants in Quaqtuaq (Dorais, 2001) and Northwest Greenland (Nuttall, 1992). Many of these were men, whereas the vast majority of people I interviewed and had conversations with were women. It may also play a role that the work of Dorais and Nuttall is almost one and two decades older. One nurse explained the desire for food in season:

*Right now everyone is craving mattaq and clams ‘cause they know it’s spring, it’s a certain amount of time ‘til they get whales, clams. It’s only a few months away until the summer; everyone is like, ‘can’t wait ‘til it’s summer, we’re gonna get what’s in season.’ And caribou that you catch now, it’s gonna taste different in the summer ‘cause right now they’re digging; when they feed on fresher vegetation it’s gonna taste different. (T34:578)*

Olsen (2010) similarly states that some Greenlanders, if they have not had it for a while, *need* Greenlandic food, and she explains that the Greenlandic word for Greenlandic food – *kalaalimernit* – directly translated means “a piece of Greenlandic” – in Danish “et stykke Grønlander” (Olsen, p. 224).<sup>102</sup>

Inuit nurses and students, then, describe Inuit identity in ways that resonate with the extant literature, repeating descriptions used to characterise *inummarit*

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<sup>102</sup> This terms arose on account of needing to differentiate between ‘colonial’ imported food and Greenlandic food, the word for food generally being *nerisassat*, which by Berthelsen et al. (1997) is plainly translated as “mad [food]”. Olsen continues, however, that some Elders told her that another word used prior to colonization which is still in use is *inumineg*, which directly translated means “et stykke menneske [a piece of human]” (Olsen, 2010, p. 224).

that have been noted by others (Dorais, 2001; Nuttall, 1992; Stairs, 1992) or characteristics explained to be the outcome of Inuit historically needing to live in close proximity, simultaneously being very interdependent and also very dependant on the natural environment and weather. In their descriptions of what characterises Inuit or is part of Inuit identity, nurses and students included: to value and maintain family relations and support family members, to avoid conflict and be non-confrontational, to avoid being loud and inquisitive but to talk when it is necessary, to be humble, to value independence and respect the individuality and autonomy of other people, to be relaxed, pragmatic and flexible and be task rather than time oriented. Furthermore, mastering an Inuit language and the hunting, procuring, sharing and enjoying of Inuit food were also mentioned as being connected to Inuit identity.

The ways that nurses and students described themselves, however, did not always correspond to the ways they would describe Inuit generally. That being said, and after having ‘listed’ particular characteristics that Inuit nurses and students connected with a ‘general Inuit identity,’ it should be noted, again, that many stressed the differences that exist both within and between Inuit regions, communities and families. Simultaneously many differentiated between the ways and values of people in larger towns and those of people in smaller towns and villages.

### ***6.5 Nurses’ and Students’ Perception of Self***

*“I am not all Inuit so I am not as humble as some” (T28:267)*

First I want to reiterate that 36% of participants grew up with a Southern parent (twice as many Greenlandic participants compared to the general Greenlandic population and 5 times as many Canadian Inuit participants compared to the general population of Nunavut). While again stressing the caveat mentioned earlier about different interpretations of mother tongue, I also want to reiterate that all but three out of 50 consider an Inuit language their mother tongue, even though 90% of Greenlandic and 85% of Canadian Inuit participants were most comfortable reading, writing and being taught in a Southern language and almost

50% of Greenlandic and 65% of Inuit participants said that they spoke only or primarily a Southern language in their current home. Furthermore, all nurses and nursing students whom I formally interviewed or had casual conversations with self-identified as Inuit/Kalaallit, although some added various qualifiers such as: “*being a town Inuk, not a village Inuk,*” and “*being mixed but...*,”

That all nurses and students describe themselves as Kalaallit/Inuit, however, is, as mentioned, not an indication that they would necessarily describe themselves as similar to the Inuit in their care, Inuit family and friends, Inuit from their home towns, or Inuit from other towns and settlements, let alone all of Greenland, Nunavut, or the whole circumpolar region. As mentioned in chapter one, identity, apart from being a social construct, is also an ever changing process that allows us to be both different from and similar to, and both singular and plural (Jenkins, 1996). Dorais (2001) who, like Jenkins, was inspired by Barth and others, explains that:

Identity is a dynamic and creative process that is best expressed through the strategies developed to relate to one’s physical, social and spiritual environments. These environments may change over time and space and thus identity is never fixed once and for all. It fluctuates constantly. An individual or group may possess more than one identity – or develop varying relationships to the world – without losing his, her, or its sense of self. (Dorais, 2001, p. 5)

With this in mind, and also taking into consideration that relatively few Inuit have the educational level of Inuit nurses and students, it is unsurprising that many nurses and students described aspects of themselves that set them apart from Inuit generally or from the rest of their family or peer group, and particularly set themselves apart from “*small town or settlement Inuit*” as stated by one student during a class. Small towns and settlements are places where education beyond elementary school is often out of reach and where according to participants inhabitants often live what is considered more traditional lives, as also noted by Dahl (2000), Dorais (2001) and Nuttall (1992). Most participants, on the other hand, at the time of interview lived in larger towns where not only education, but also other possibilities that by many are connected with city living and globalization, are accessible. Another student, during an interview, said that she

felt left out when she was with people “*who come from the smaller communities. There are significant differences between them and people from [the city]*” (T4:35).

While many feel that a common trait among Inuit is to not argue or talk back, several nurses and students do not feel that this applies to them, as noted by this nurse:

*Inuit generally do not talk back to Southerners, and all the Southern students do is talk a lot. It would be helpful if they would give Inuit a chance to express themselves but they just take over. I myself, I was taught to talk back when I was in the South. (T37:55)*

Another nurse reminisced about her time as a student and that she had been taught to “*give care from a Southern point of view*” and said that it would be up to the students themselves “*to make it fit an Arctic practice once we are in our practicums.*” I asked her if she had been able to do that once practicing, to which she answered: “*Yes I took my right to do that. I am not all Inuit, so am not as humble as some*” (T28:267). In relation to a discussion with another nurse about what would be beneficial to consider when caring for Inuit, I mentioned that others had noted that Southerners ask many, and sometimes maybe too many questions. I asked her what her take on that was. She said:

*I know a couple of Inuit nurses who... had some problems... getting used to the fact that we have to ask all these questions. But with me I grew up in a large town.... I lived in the South for 5 years, so I was not exposed to that traditional Elder point of view. So for me... to work here as an Inuk nurse and ask questions to Elders... it doesn't cause me any problem. It's making sure I'm doing my job right, you know. (T38:449)*

Ryan (1992) noted that the expectation to ask many and direct questions was one of the things that the Aboriginal nursing students he interviewed in Canada found culturally difficult. As indicated by the student above, this may have changed since then with the generation that is under education today, or this may be particular to those who make it through the educational system and become nurses as I discuss below. Along the same lines, a student said that she had always felt different than the rest of her family and siblings and that she was

not willing to conform to the ways they felt were most appropriate for her. She said:

*I used to challenge my stepparents and my stepsiblings. In their upbringing they were always taught do not argue with older people, respect elders, respect older sisters, respect older brothers, but for me it was different. I argued a lot. They didn't like it. I disappointed them in a way, but today they say, "You have so much courage... you don't even know."* (T46:571)

Several others similarly mentioned that their families were more traditional than they perceived themselves to be, that it made them feel like outsiders, and that they thought it was hindering development, as indicted by the following student:

*Sometimes, sometimes I have the feeling that they [my family] do not understand me. There was this time a funny episode occurred where my aunt said to me 'we women decide the sex of a baby.' [I said] 'For God's sake, it's the man who does.' [She said] 'No it's not, we know all about that – you will not understand!' Very traditional [way of looking at things].* (T73:182)

When I asked this student what she meant by traditional, she said: *"that you are too old-fashioned like, that you are unable to think anything new"* (T73:182).

Some also differentiated themselves from their fellow community members or even siblings in their language capabilities and noted that mastering a Southern language as well as they did had been a major advantage, whereas not mastering the Southern language was perceived to be detrimental. For example:

*I am very happy that I went to a school where the language of instruction was Southern. Had I not done that I am not sure that I would have achieved what I have today. I say that also from the experiences other people my age have – [who did not go to a Southern language school] – in terms of what they have achieved. They dropped out of high school; maybe they took a shorter education, maybe not.* (T22:118)

Another nurse who had previously noted that not many of her peers had reached beyond high school in their educational path connected this fact with the community being fairly traditional and with few speaking a Southern language:

*My home community, although it has a large population, it's a very traditional community... it's kind of old fashioned and... not very*

*many people speak a Southern language there. A lot of my friends that I went to school with, they speak an Inuit language, not very much of the Southern language. (T39:425)*

The older and mainly Greenlandic nurses who had grown up as unilingual Greenlandic speakers did not (obviously perhaps) speak of the benefits of having mastered the Southern language. Several, as previously mentioned, rather lamented the fact that the emphasis on the Inuit language has been, and is, as limited in the Arctic societies as they thought it is and was. Several, particularly older participants, also mentioned that their partner or social circle would detest their speaking a Southern language in their company, and some mentioned having been bullied for speaking a Southern language, while many of the younger nurses and students said that they spoke both a Southern and an Inuit language with family and friends.

Another area where several felt that their experiences had been different from many of their peers was in the ways they had been brought up and the support they had received from their parents. For example:

*My parents' encouragement and support has meant a lot for my ability to go to school. They have always encouraged me to go to school and to do my homework. My dad used to say, 'this is for your future.' When your parents are no longer around you need to support yourself. My parents' way of disciplining was different from what I saw in other children's homes. I saw children being neglected and fighting each other. Not in my home. (T36:61)*

As mentioned in chapter 5, most participating nurses and students noted that their parents or other significant adults had encouraged and supported their taking an education, and many of the younger participants stated that they had been spoiled (as seen from their own perspective) both financially, emotionally and socially when growing up, in contrast to many of their peers and some siblings. Also in the social relationships that their parents had enjoyed, some noted differences between themselves and other community members:

*My parents were with the Southern teachers and principals a lot and were accepted among them and I probably learned Southern ways through that interaction. That may be why I feel very comfortable in*

*both cultures. I don't think many other Inuit had much interaction or social relations with the Southerners the way my family did. (T48:30)*

Another, older nurse, said that because of the type of employment her father had had, her family lived in a area where more Southerners lived and she and her family had 'access' to Southern families in a way that most other Inuit in her community did not, since when she grew up Inuit and non-Inuit lived fairly segregated.

Although perhaps coincidentally, two of the students who have not completed the programs did not highlight the ways they felt different from other Inuit, rather they highlighted some of the traits in themselves that are 'stereotypically' described as Inuit. One of these is that of not speaking unless one has something particular to say. One of the students came from a larger town, another from a small village – an indication of the similarities and variation to be found among people living in similar or different cityscapes or townscapes.

### ***6.6 Reflections on Arctic Health Care, Nurses and Nursing: Sense of Self/ Identity and its Effect on Health Care***

Health care in the Arctic and health care in the South is different, and not just based on infrastructure, distances, and language issues. Arctic nurses and doctors, physiotherapists and occupational therapists, mental health workers and dieticians, and all the other health care professionals, workers and support staff, have different work day experiences and deal with slightly different issues, on a daily basis, compared to people working in the Southern health care systems. Or they work with similar issues that may need to be dealt with in slightly different ways than those working in Southern settings. The question is whether there are also differences in the ways that health care is provided. When you give quality care in the Arctic, do you do that differently than you would in the South? Do you need to? And do health care providers who originate from the Arctic provide care differently than their Southern colleagues? If they do, does it matter for the patients they care for or is it just a matter of providing good care in slightly different ways? Below I will discuss the particular conditions under which Inuit

nurses and students work. Then I will examine the characteristics that Inuit nurses and students define as particular (and necessary) to Inuit who practice nursing and to Arctic nursing. This will be followed by a consideration of the characteristics that Inuit nurses and students describe as particularly Southern.

### ***6.6.1 Arctic health care systems as learning and working environments***

Having described, in chapter two, the history of the health care systems in Greenland and Nunavut and how they function today, and having discussed in chapter three issues surrounding language and language differences among Inuit and Southerners in the student/teacher positions, as colleagues, and in the patient/caregiver positions, some of the following echo points from these discussions. Repeating these points, albeit now as experienced by the nurses and students, gives a fuller picture of the particular work and learning conditions by which they are affected.

The Inuit nurses and nursing students that I have been in contact with formally and informally are generally hardworking, dedicated, and enjoy their work and study. They work hard to ensure that the patients in the Arctic health care systems are cared for in the best ways possible and that their places of work and practice, and thereby the health care systems, function in the best possible ways. At the same time nurses and students acknowledge that limitations exist, that some things could work better, and also that the Arctic health care systems do not have all the technological advances that the systems in the South do. One nurse reminisced about how Southern staff, upon arrival, might say something along the lines of:

*'What, don't you have this machine worth several 100,000 [Danish Crowns]?' and 'No we do not, and we manage quite well without, we always have.' And, really, I think everything functions ok.... I believe that yes, we are understaffed and need all sorts of things, but generally we do all right as long as we help each other. (T22:250)*

Attitudes among Inuit nurses were mostly positive and optimistic like this one. Furthermore, a positive sentiment would often be expressed in conjunction with, or as an add-on to, discussing experiences that were not particularly

positive. Nurses and students were also generally very positive towards their colleagues, whether permanent or agency nurses, whether long or short term and whether Inuit or Southern (at least until positive expectations had been disappointed), all despite the fact that parts of their work and practicum experiences offered challenges in many ways. The Inuit nurses and students I have connected with in both Nunavut and Greenland seemed generally to be enjoying their profession, if not always the working conditions. Inuit nurses and nursing students *are* affected by working conditions particular to the Arctic that at times make studying to become, and practicing as nurses, taxing.

Particular conditions that affect Inuit nurses and students include high turnover and shortage of health care staff (especially nurses), including staff shortages that are often significantly more serious than those experienced in Southern institutions. Particular conditions also include the need to work with a majority of colleagues that speak a language different from the mother tongue of most Inuit – patients, nurses and students. At the time of fieldwork there were, according to the homepage of Dronning Ingrid's Hospital [DIH] (Queen Ingrid's Hospital), more than 20 vacant nursing positions at DIH and of the 133 positions staffed, 58 (43%) were filled with temporary or agency nurses (personal communication, Birtha Bianco, Director of the Greenlandic Nurses Union, November 22, 2007). In November 2007, five out of nine nursing positions were vacant at Sisimiut Health Centre (personal communication, Niviaq Lind, Director of the Sisimiut Health Centre, November 5, 2007). In Maniitsoq and Ilulissat vacant nursing positions was also the norm, with 3 agency nurses arriving the last day of my stay in Maniitsoq. They planned to stay for one, three, and six, months. High numbers of vacant positions have remained a concern (Orientering, 2009; Trolle, 2009).

In Nunavut similar conditions have prevailed, and still prevail (Aarluk Consulting, 2009). In the spring of 2008 there were about 200 full time nursing positions. Of these, 86 were filled with permanent employees, another 30-40 with casual staff who travel back and forth between the South and Nunavut, and the final 75 positions were filled with agency nurses or were vacant (personal

communication, Cheryl Young, Nunavut nurses' representative in the Nunavut Employees Union, May, 2008). In January 2008, 97 of a total of 215 full time nursing positions were vacant (Aarluk Consulting). Of all nurses in Greenland more than 2/3 are Southerners who speak only a Southern language,<sup>103</sup> while in Nunavut more than 90% of nurses are Southerners and speak only Southern languages.

High vacancy and turnover rates with many temporary agency nurses staffing positions significantly impacts practicing nurses and nursing students, as does working with a majority of colleagues who do not speak an Inuit language. These things impact how much nursing and other staff expect students to participate independently in the day-to-day work, and students' ability to learn in their practicum because of no, few, or ever changing mentors. Even when students are allocated a mentor they are often not able to spend much time with him or her because the mentor needs to take a large load of shift-work. This means that some nursing students, throughout their education, have very few nurse role models or, as was the case for several Greenlandic students, need to accompany their mentors doing evening and night shifts, be mentored by nurses' assistants rather than nurses, or work independently on the ward. Furthermore, nurses who do serve as mentors may not have received the training required to be a mentor, although in Greenland, much is done to train as many mentors as possible.

When working independently, students, for various reasons, may perform tasks that they have not yet been recognized as mastering theoretically or practically (although they may perform the task absolutely correctly and know the theory behind the practice) or they may be stuck only doing tasks at a level they are supposed to have moved past, because there are is no one with whom they may discuss and practice new skills.

In this way the high vacancy and turnover rates affect the amount of

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<sup>103</sup> A nursing student in Nuuk allowed me to use one of the papers she had written in her last year of study as a source. As part of this paper she examined in the fall/winter 2007 how many of the nurses employed at DIH were bilingual (Danish/Greenlandic). She found that 22/133 (16%) considered themselves to be bilingual (Kleist, 2007).

responsibility students need to take to ensure that they learn what they are supposed to learn in relation to the formal requirements for the individual levels of the education. Several students related that the orientation, including a conversation about mutual expectations and responsibilities for the period of the students' practicum, which is supposed to happen on one of the first days of practicum periods, happened after having been there for a month. One student observed that her first very short practicum:

*could have been better planned.... The first day I was there I was supposed to have been teamed up with someone, but was just left to my own devices. That disappointed me.... The assistant head nurse did not seem particularly friendly, but perhaps that has to do with so many different staff being there for such short periods. Maybe people think... 'Yet another!' The second day things went better, but I also think it helps that I am as outgoing as I am, and ask to get to do what I would like to do. If you are not that way I think it may be difficult.*  
(T17:88)

Another nursing student, who described herself as quiet and not very outgoing, did find it difficult. She had been told several times that she needed to be more engaged, to which she responded:

*I don't know what they mean... they are probably just trying to push me a little. They say: 'you have to say that you would like to do this and that.' I do. I do that sometimes. I don't know, maybe they just think I am too quiet... even when I have written notes about what I would like to do and have been given the primary responsibility for something, someone else has nevertheless gone and done that which I was supposed to do.... The way people say things makes me think they do not think I am responsible enough for my education.... It's the tone being used... like people accuse me, or maybe not accuse but like they don't think what I do is good enough.* (T8:236)

Recently graduated nurses in Greenland are asked to mentor students very early after graduation, sometimes just a few weeks after starting their first job as nurses, and many students have had new graduates as mentors. One nurse and her colleague who graduated at the same time were both assigned the role of mentors to students two weeks after starting at a health centre as new graduates. She said that it was close to being de-motivating and demoralizing:

*My colleague was assigned a 3rd semester student and I a 5th semester student who was also supposed to deliver medication and whatnot. That was probably the worst. I also had not had a mentor course... that was, well... it was hard.... We just graduated ourselves... but you don't feel like showing your weakness anyway, so it was difficult. I discussed things with the student, said this is the way it's going to be, 'cause I just finished so you have to know there are things I do not know yet, but then we just have to find someone who knows. We will just have to play it by ear. But today, in hindsight, I can look back and be proud, but I also feel that I don't want others to be in that situation. (T22:190)*

In Nunavut, on the other hand, just graduated nurses currently have difficulties getting a job at the hospital in Iqaluit. The Qikiqtani General Hospital administration will not hire nurses without experience because there are so few senior nursing staff available who can act as mentors (Aarluk Consulting, 2009). That is another difference between graduates from Nunavut and Greenland. In Greenland, a newly graduated nurse is 'seen' as a qualified nurse, is expected to perform as one, and counts as a 'full' nurse at his or her place of employment. In Nunavut new graduates who have also passed the national Registered Nursing Exam and are thus fully qualified, are mentored for the first 3-12 months of their employment and do not 'count,' although they are paid as regular nurses. Some find their being mentored very valuable, while others find it demeaning.

Because they must be mentored, the lack of nurses and high turnover in Nunavut also means that some new Inuit nurses may have to wait months before being hired after their application has been received, even with several vacant positions needing to be staffed. One nurse applied for a position and was interviewed for it in early May. She was not approved and hired until late August. She said another Inuit colleague had to wait even longer.

Some have expressed concern that these conditions send the message to Nunavummiut that the territory is not willing to accept the credentials of their own graduates (participant quoted by Aarluk Consulting, 2009, p. 22), resulting in statements from the public like "*I don't want to be seen by an Inuk nurse,*" "*They are not smart,*" or "*They have been educated over at that college*" as told by one nurse (T35:586). A sad example of the mistrust in Nunavut's own nurses

was provided by a previous high school counselor in Nunavut who, in a letter to the editor of Nunatsiaq News, lamented that programs such as the nursing program in Nunavut “were so watered down that... their grads would not be hired elsewhere in Canada” (Athawale, 2008). An accusation that prompted the executive director of the Registered Nurses Association of the Northwest Territories and Nunavut to ‘issue a denial’ in the same newspaper ‘assuring the public’ that the nursing program in Nunavut is nationally and internationally approved with students passing the same exams as are required of students Canada-wide (Leck, 2008).

Another difference between Nunavut and Greenlandic nurses is that while new graduates in Greenland generally have no desire to work in the smaller communities, many new graduates from Nunavut have a strong desire to go back to their home communities to work with “their” own. Generally, however, nurses that do not have experience are not accepted as nurses in the settlements because of the very independent and varied nature of the work (personal communication, Cheryl Young, Nunavut nurses’ representative in the Nunavut Employees Union, May, 2008). They are required to have hospital experience first, which they currently cannot easily get.

There are several reasons why Greenlandic nurses said they have no desire to work in the smaller and often well-known communities, and many of these reasons are also expressed as conditions that Inuit nurses in Nunavut find challenging when they do work in their home communities. These include the closeness between the people the nurses care for and themselves. As expressed by one nurse:

*If you come to a settlement as an Inuk, you know too much, it becomes too complex. If you come to a settlement as a Dane, you may not know as much and maybe it is easier to relate [objectively]. It may sound harsh, but I know there are certain problems in relation to incest, in relation to suicides, and the way the some people have unhealthy eating habits. Maybe they don't get the necessary exercise even though they are close to nature.... Not to say that this is the case for all settlements, but a certain number don't function that well. Of course you need to learn about many things when you arrive in a settlement and you get to know how things are, no matter who you*

*are, but I think an Inuk knows too much and it makes it overwhelming. There are perhaps too many things to deal with for it to seem manageable is what I think.... And, maybe it is better if someone from the South comes there to work. It may be easier for her to go home and read a book, draw some lines, and people will not have the same expectations of her. I think as an Inuk you may have more social relations to the inhabitants than you would as a Southerner, because maybe... some are family, and some I know and they know my family. And those kinds of relations make things more complicated. I might be able to handle that for a summer, but being involved at that level for, say, 3 years would be more than I could handle. (T32:126)*

Inuit nurses who chose to work in their home or smaller communities reported that, especially initially, they faced very similar challenges. One said:

*It can be hard to know difficult things about family and friends that they may not have talked to me about socially but I get to know professionally. In the beginning, when I started nursing in my own community it could be difficult for people to respect the boundaries of the professional and the social me and some people would ask about things that belonged to my professional life. (T50:66)*

While it could be difficult for the nurses to work in their home communities, some also felt it could be difficult for the client to be cared for by someone they knew. This nurse named both:

*The things that can be difficult too if working as a community nurse are that you can't know the people that you have to care for too much. When I go home I don't want to know about their problems. I don't want them to call me at home when I am off work with work related problems. People in the communities need to learn that Inuit nurses also need their time off but before people can learn that, it needs to be addressed. I also sometimes experienced that people were not comfortable with me being their nurse because they know me too well. (T37:82)*

Quick promotion can be another challenge. Because of vacancies and high turnover of nurses, recently graduated nurses in Greenland will be 'pushed' to accept leadership positions – because the administration expects a Greenlandic person to stay in the position longer than someone from outside Greenland. This means that Greenlandic nurses in leadership positions, while attempting to find their 'legs as practicing nurses,' at the same time have to learn leadership and

management from ‘the bottom’ and most have little or no support while climbing this steep learning curve. Some feel that especially the position as nurse in charge can be quite challenging because staff both ‘above’ and ‘below’ them are Southerners who may express their critical opinions and ideas about how things are and should be run, often comparing with how things function in the South. Some Inuit nurses enjoy the challenge and have been able to set limits for the amount of work they can and should do, others have been broken by the challenge and needed significant recuperation time in order to practice as nurses again, and then not as a leader.

Lack of nurses and vacant positions also means that it may be difficult to get time off to do the necessary upgrades in knowledge that for most nurses are seen to be part of staying professional and maintaining their professionalism. This was mentioned to be a concern more by Canadian than Greenlandic nurses. One nurse found not being able to upgrade her knowledge and abilities quite difficult. She applied for a release for an upgrading course several times but she kept getting refused because there was no one to take over her responsibilities:

*I’ve applied for that research course twice now.... it’s about Inuit health... research and planning, and twice I haven’t been approved to go. And it’s fully funded; it’s not going to cost you anything other than to cover my shifts for 3 weeks. (T54:61)*

She said the problem is tied to short staffing and to the fact that she is still considered a junior nurse. She continued: *“The schedule alone is pretty stressful, but I really enjoy what I do... I think if we were fully staffed, I think there would be a possibility (T54:73).*

With many vacant positions the nurses who are there need to do more shift work and on call, which is taxing and can be logistically difficult when raising a family. Although working conditions seemed to be more or less equally difficult for nurses in Nunavut and Greenland, nurses in Nunavut spoke more about the help and support they felt non-Inuit nurses provided. As an example:

*The non-Inuit nurses here, they’ve been living here for at least 2 years or more, so it’s not like they’re new to this place. I enjoy*

*working with them. They do a great job.... To me it all depends on their point of view, if they're willing to help people and they're willing to learn and take part in the community here, I think that makes a difference. (T38:419)*

Another nurse, talking about the senior nurses who are all Southern, said: *"The senior staff here is very important and very important to me too, because I just graduated not too long ago, and I've had help from the senior nurses and I'm lucky 'cause I learn lots from them (T53:59).*

Simultaneously, Inuit nurses in Nunavut seemed more dissatisfied with their working conditions. This may have to do with the fact that the actual number of Inuit nurses in Nunavut is still significantly lower than in Greenland. It may also, as mentioned in chapter 5, have to do with the fact that all the Canadian Inuit nurses have children, most more than one, and that some raise their families singlehandedly or with a partner who may not always be available to take over childcare and domestic responsibilities when they do shift work or are on call. One nurse, whose partner was not working, was under stress since she found it hard to make ends meet:

*All the senior staff are leaving, the ones that have been here for a while are starting to leave now because they don't like what they see, they can't afford to stay up here. And I won't be able to stay up here.... This is what I worked for... to work... with my own people.... [Although] I claim whatever my husband does not claim because he's not working [it is not enough]. My rent is so high and the cost of living is so high 'cause especially boys growing up, it's horrible. I can't keep up with them. I have to buy extra which means waiting 'til later on before I get clothes for my kids 'cause food comes first before their clothing. (T53:70)*

Some Inuit nurses, then, experience pressure from both the home and the work environment and pressures coming from the home environment may be difficult to change.

That Canadian Inuit feel more dissatisfied with working conditions may also be because Canadian Inuit nurses experienced mistrust in their abilities from the system and what some called jealousy from other Inuit because of their accomplishment. Conversely, Greenlandic nurses felt celebrated and respected by

their fellow countrymen and women for their accomplishment and their practicing as nurses. Some Nunavummiut, both Inuit and non-Inuit, also expressed mistrust in Inuit nurses' abilities in casual conversations, or related that others had expressed it to them. At the same time, some Inuit nurses and students reported that Inuit patients were very appreciative of being cared for by someone who knew their culture and language. One nurse related:

*I've had Inuit patients say 'I don't want to have a Inuk nurse,' but I've had many Inuit patients say 'I'm so glad to have a Inuk nurse and I'm glad I'm not with the Southern.' I think it goes both ways sometimes. When the first couple of Inuit nurses were here, people had to warm up to it, but then once the idea of an Inuk nurse got into their head, they were more happy.... They were not used to Inuit nurses, or.... being this far along in terms of education maybe and [perhaps they thought] that the Inuit nurse doesn't know as much as the Southern nurse.... I don't know. (T38:539)*

A nursing student who initially wanted to become a nurse in order to go back to her home community had changed her mind because

*there's that small community mentality, like gossiping and jealousy and all that, little things that come with living in a small community that affect people to the extreme. So I don't see myself going back to live there. At first that was my intention, when I first got into nursing school, but no, I don't see myself working amongst people... everybody that I know.... They can't separate professional and personal... like home and professional life.... It would mean that I am constantly being looked at, like watched to see if I'll slip.... They try to focus on what bad things have I done, rather than what I've accomplished. (T60:586)*

I asked whether people watching to see if she would slip and focusing on bad things was what she meant when she said that people were jealous, to which she replied 'yes'. Another nurse said that one of her Inuk colleagues had said to her that

*her own people resent the fact that she is doing what they call a White person's job and they resent the fact that she has got an education, and they are bitter about that, that she [may] think she is better than them. (T55:554)*

It is easy to imagine that these extra stresses may play a role in Canadian Inuit nurses' level of satisfaction with their working conditions.

Finally, that Canadian Inuit nurses are more dissatisfied with their working conditions may have to do with some Canadian Inuit nurses experiencing more differential treatment (regardless of the reasons there may be for this) between themselves and Southern nurses than Greenlandic nurses do, for example finding it hard to secure a position as mentioned above, and because they earn significantly less than Southern nurses who are agency nurses do when they work in Nunavut<sup>104</sup>. Also, newly graduated Greenlandic nurses are seen as “full nurses” whereas newly graduated nurses in Nunavut are judged to need a mentor for a significant amount of time after they have graduated. Although the last difference may rest in fear of possible lawsuits in Canada that would be less likely under a Danish or Greenlandic legal system, it may still send the message to Canadian Inuit nurses that they are, or the education they have received in the Arctic is, not good enough as alluded to by Aarluk Consulting's (2009) participant quoted above.

In relation to the language difference between Southern and Inuit staff and Southern and Inuit patients, some students and nurses experienced challenges because they and their clinical supervisors had different mother tongues. The challenges included that the Inuit student needed to speak a Southern language and include an interpreter in the interaction between student and patient when the supervisor was present in order for the supervisor to understand what was going on. In some instances, however, the supervisors accepted the student and patient conversing in an Inuit language and the student afterwards explaining the interaction. Another effect of differences in mother tongue between Inuit and Southern nurses, coupled with the fact that there are relatively few bilingual nurses, doctors and specialists, is that Inuit nurses and students are sometimes pulled, or attempted to be pulled, from their own patients and responsibilities (in one instance it was reported that a nurse had been ordered) in order to interpret

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<sup>104</sup> Agency nurses have their housing and travels to and from Nunavut paid and are also are paid a higher wage (Aarluk Consulting, 2009)

for other staff if interpreters were not available or accessible. Some state that they will resist and say no, while most find doing so difficult – others again do not even think about the possibility of saying no but just interpret, particularly if they have previously worked as interpreters. When nurses are pulled, it means that they have increased workload because no one is taking over their other responsibilities while they interpret. This has also been reported by Aarluk Consulting (2009).

Language differences also result in Inuit nurses taking on extra tasks, such as being called to answer phone inquiries because the Southern nurses do not understand what the caller is saying when they speak an Inuit language. While nurses and students relate these difficulties, most also state that there is generally nothing wrong with their Southern colleagues – they are not to blame – it is all grounded in language differences and despite mentioning challenges and noting differences, the majority of Inuit nurses and students, as previously mentioned, state that for them it does not matter whether they work with Southern or Inuit colleagues as long their colleague is respectful, qualified, and willing to help make things work.

### ***6.6.2 Inuit nurses identifying with the general ‘nurse’***

*“A nurse is a nurse is a nurse” (T33:44).*

Many Inuit nurses and students feel that being in the field of nursing implies some shared common ground and a willingness to be a certain way despite possible differences. As one nurse put it when I asked whether she thought there were differences between the ways that Inuit and Southerners nursed:

*I can see some subtle differences, but I can also see a lot of similarities, where we want to be professional and we have this professional... it's like an agreement that we made, being nurses and working under a nursing association where we've agreed to be professional and to be a certain way. (T39:341)*

To the same question another nurse answered very similarly: *“I don't think the approach as nurses between Inuit and Southerners as such would be different. We*

*are all nurses and the nursing role takes over. We are similarly educated here as nurses are other places”* (T19:226).

Many identified strongly with the nursing role and felt that they had found the vocation that they were meant to have, saying things like: *“I can’t work anywhere else. Nursing is my life. I love what I’m doing. I can’t do anything else”* (T33:32), and: *“After finishing as a nursing aide my dream was to become a nurse. When I worked as a nursing aide I saw the big difference there was between nursing aides and nurses, and I thought I could give more as a nurse”* (T20:16).

As the following statement attests, many feel that entering the profession will allow them to help fill the need for nurses generally: *“I wanted to become a nurse because the profession talked to me, and I knew there was a lack of nurses here and I could be part of covering that need”* (T31:121). Many also specifically noted wanting to help fill the need for Inuit nurses. Most feel that being able to care for Inuit in their own language and culture helps Inuit to *“understand what is happening to them, what their care is about. It must be great for people to have a nurse who speaks an Inuit language and who has the same cultural background”* (T73:316). A few, particularly Canadian Inuit, feel that nursing is close to a calling for them with one nurse stating, *“I believe that God has given me the gift that I have, being able to be caring and to be understanding and to be patient, to be the outgoing person that I am”* (T39:285). Another nurse felt similarly and had no time for colleagues who appeared bothered by their patients:

*I love nursing so much.... I come to work, I do what I’m expected to do, sometimes even more because you know to help the patients.... When I hear people complain about this and this patient is not doing this and that, I think... I think why are you here?* (T33:490)

She continued that anyone who just wanted to complain about the patients might as well find another job. As mentioned earlier, some Inuit nurses emphasize the benefit of having a mix of Southern and Inuit nurses as they all come with the same nursing background, but where the Southern nurses generally have more, and perhaps more varied experience, than the Inuit nurses do, the Inuit nurses

have the cultural knowledge and know about people from their community, and as such they can learn from and compliment each other.

The above, and many other expressions, give evidence that Inuit nurses and students identify with the general nurse and nursing role. Nurses and students identify with the community of practitioners that the field of nursing is. The Inuit nurses see themselves as nurses and identify with the field of nursing – evoking the general standard of the education, the professionalism, that Inuit nurses – like others – agree to be a certain way and work under a nursing association and are taken over by the role when working. These all speak to the fact that Inuit nurses also would like to be identified by others as nurses. In describing themselves as nurses, who are like other nurses, while simultaneously needing to be *socially categorized* as nurses, Inuit nurses and students are involved in ‘*group identification*,’ a process identified by Jenkins (1996). Most nurses and students seem to believe, however, (as do I) that identifying as a general nurse does not preclude the possibility of also identifying as an Inuk nurse and with a group of Inuit nurses who share characteristics that they generally do not feel they share with Southern nurses. Identity is, as stressed by Jenkins (1996), as much about being similar to as being different from, and that is also the case within a social *field* such as nursing, where “struggles or manoeuvres take place over specific resources or stakes” (Bourdieu, as cited in Jenkins, 1996, p. 84). In the health care system in Greenland and Nunavut what is at stake is a recognition of the culture or *habitus*, and the nature of the nursing practice subsequently defined by that *habitus*.

### **6.6.3 Reflections on Inuit nurses and Inuit nursing**

Many noted ways in which particular Inuit cultural traits, *habitus*, or traditions, would affect how care was best given and how knowing about these traits or traditions would equip the health care provider to provide better care. As one nurse said when providing care to Inuit patients, she does so in

*their own culture, their own language. You're providing... I don't know. It's like you can understand the person more if it's an Inuk person, and maybe – I'm not saying this to be rude – maybe they get*

*better care 'cause you understand their background. And you can speak the language.... And delivering your care to your patients in their own language, maybe that would help them be more comfortable. It affects patient outcome. [The Inuit patient] gets more of an understanding of what they need to do... what they have to do to make themselves better. (T41:683)*

The particular cultural traits or *habitus* that affect how care should be given include that some Inuit, particularly older Inuit, are humble and have been raised to not make particular demands or express distinct wishes. It also includes that some Inuit may not be verbally expressive but may rather express themselves using facial expressions, body language, and indirect requests. According to one nurse:

*You can recognize, like Elders... they don't want to be a burden to me and they will never completely say, 'I want things this way.' But they'll say, 'Oh it might be better this way,' but they will never specifically say, 'This way is definitely not good.' And they will have a different way of saying... more of a suggestion instead of a complete disagreement. (T34:550)*

As discussed in chapter 4, this also meant that some might not express pain or say yes to experiencing pain, resulting in their not receiving pain medication despite their need if the attending nurse is not able to read body language. One nurse stated:

*Body language is also important. I have heard Southern staff say that when Inuit patients have pain they keep it inside. I do not think that is true. One should not think that Inuit patients do not have pain just because they do not say anything (T24:149).*

Another nurse said she had made a note of informing Southern staff when they came to the Arctic about this particular trait in some Inuit in order to make sure that the patients were cared for in the best way:

*When the Southern nurses came to where I worked previously I told them that an Inuit patient might not ask for pain medication even if he needs it. It is necessary to go in there about every 4<sup>th</sup> hour and offer pain medication more directly, because he can have great pain and just 'swallow' it. But in order for him to get up and about quicker you need to be more proactive in relation to pain management. In some respects you need to act in a roundabout way with an Inuit patient.*

*Maybe you need to be the active one. The Inuit patients are more passive when they are hospitalised. (T32:318)*

It was also commented that, in relation to interpreting body language and Inuit expressing pain without verbalizing it, some of the Southern nurses who have been in the north for longer periods learn to notice:

*They'll physically see this person in pain or looking tired and [the patient] is like, "No I'm OK," but if [the patients] are guarding... [the nurses] can see.... A lot of the people that have nursed here for a long time can see that. (T34:554)*

A reliance on body language, perhaps coupled with an ability to learn well by observing and doing as discussed in chapter five, may be why some Inuit patients reportedly assume that when a doctor palpates a patient he or she is able to diagnose the patient:

*I have noticed that if a doctor palpates the abdominal area of patients, the patients do not say anything. I tell them, 'remember to say if something hurts or feels uncomfortable.' I know they just lie there and assume that if the doctor palpates he or she can feel if something is wrong, they do not have to say anything. (T22:206)*

Inuit nurses' ability to use and interpret body language correctly, as discussed in chapter four, is stressed by many to be a particularly important part of Inuit *habitus*. A lack of ability to interpret body language might hinder proper communication, as may not "knowing when to speak and when not to" (T24:149), which is another part of Inuit *habitus* that Southerners generally do not share. As one nurse said:

*Inuit may be more patient in their communication and wait for particularly Elders to be ready to talk and give you the information you need to assess a situation. A Southerner will ask and ask and ask to get the information they need as quickly as possible and it may have the opposite effect making an Elder clam shut. I am comfortable to just sit quietly and wait for an Elder to be ready and tell his or her story about their health. They may not tell me right now what I need to know, but they will get to it if I just wait. (T50:37)*

Another nurse similarly stressed the importance of not asking Elders a lot of questions and talking a lot because, "suddenly... that Elder is shut off because

*he'll think that you know everything that there is to know, so they shut themselves off from saying something* (T40:818). It should be noted that there are significant differences in the ways that Elders/older people are viewed in Greenland and Nunavut. In Nunavut, as in Alaska, older people or Elders occupy an acknowledged position of authority whereas it may be said that “there are no elders in Greenland, only old people” (Sejersen, 2004, p. 46). This does not mean that old people in Greenland are not respected, listened to or have authority in the private sphere as mentioned by several in Greenland, but older people are not “appointed as the ones to consult and contact to get approval or knowledge” (Sejersen, 2004, p. 48), or invited to partake in educating the students in public schools and post secondary programs such as nursing and law as is the case in Nunavut. On the other hand, not all younger people in Nunavut think that what the Elders have to offer is useful, or something they could not get elsewhere. One nursing student expressed this about the information shared by an Elder in her programme.

The reason why an Elder/older person may not speak when someone asks many questions may be different in Greenland and Nunavut. In Nunavut this may hinge on the Elder feeling he or she is not given the respect that he or she should have. In Greenland it may hinge on the fact that people generally do not ask many questions as discussed above, and it may also be related to feelings of intimidation in the face of authority (as doctors, nurses and Danes may be seen) as also discussed above. However, the *habitus* of not asking questions and feeling intimidation in the face of perceived authority might very well be reasons for an elder Inuk, Greenlandic or Nunavummiuq, falling silent upon being barraged with questions.

An Inuk nurse, who is aware that a patient may say only “*that which is necessary*”, as several participants noted, or use non-verbal expressions to show how he or she is feeling, said

*[that a nurse] can, by listening only, without saying anything and just listening, catch other signals than a non-Inuk would be able to. By listening, looking, observing... everything will seem recognizable to*

*her whereas the strangeness in the situation for a Southern nurse will make her focus on certain practical tasks and areas. (T30:375)*

As well as saying little generally, nurses and students also noted that it is common that Inuit do not feel the need to talk about illnesses and the restrictions and problems illness brings. They said that many Inuit prefer to focus on the things they are able to do and enjoy despite their illness. One participant, while she thought it was a way of living in denial, explained it this way:

*Let's say someone has TB.... Although they have it they're not going to think about it too much or stay focused on it. They will try to occupy themselves to better themselves and not worry about it too much. For instance, we were just talking about this not too long ago when we were visiting a small community, and we heard this all the time from the elderly: 'We may have the highest rate of teen pregnancy, we may have the highest rate of sexually transmitted infections, we may have the highest smoking rate, those may be our weaknesses but we're not going to concentrate on that. We will concentrate on something else that will lead us to a better well-being of the community.' (T46: 987)*

Others said when nurses do not know that some Inuit prefer not to talk about disease, illness or problems but rather focus on the positive aspects of life they might erroneously interpret this to be a sign of denial and may end up pathologising a cultural trait:

*Southerners have more of a tendency to verbalise and also attempt to make the patients verbalise. It can be difficult for a Southerner to understand a lack of desire to talk about problems and emotions and not need to talk. A Southern health care person may interpret such behaviour in a patient as denial. (T27:48)*

Several nurses and students noted that it was not a custom to talk about illness or disease in their childhood homes. *Not* talking about illness, disease or bad experiences was similarly mentioned by many Inuit participants in my research on the socio-cultural experiences of TB (Møller, 2005, 2007, 2010). Some participants in the research on TB connected the sharing of illness and bad experiences with spreading unhappiness. The historical *habitus* of not sharing illness and bad experiences has, as mentioned above, been noted in the literature as has the fact that many Inuit now stress a need for the opposite. From

expressing the benefit of acting in a certain way, however, it does not naturally follow that people will actually act in that way, particularly not if it is contrary to the way that people would habitually act. Furthermore, talking about difficult issues, for many, requires both that they have a trusting relationship with the person they talk to and a certain level of mastering the language in which they converse. As mentioned in chapter four and stated by a nursing student:

*It must be very difficult to be an Inuit language speaking patient at the hospital here where the majority of the staff are Southern. We have been taught that it is very important to express your feelings, but how are people who speak an [Inuit language] supposed to express their feelings? (T2:414)*

Knowing that some Inuit may not appreciate being asked many questions, may not talk much generally, and may prefer not to discuss disease and bad experiences specifically, enables Inuit nurses to approach Inuit clients in ways that increase the possibility that the encounter will be useful for both parties. Not knowing or not being able to act on that knowledge may hinder collaboration and ultimately prevent the patient from getting the help he or she needs:

*I think many Southern nurses are more direct; like they do not consider the patient and how he or she will react to something they say.... When I have to say something to a patient, for example, I consider how it would be good to say it in our culture.... A Southerner would not know about that. Southern nurses also ask a lot more, and that is something that may irritate the patients. I have had that experience many times – they become irritated. My Inuit colleagues also become irritated when they [the Southerners] ask too much. (T25:141)*

A home care nurse made a similar point about speaking:

*I know my clients well. I can sense how they are, whether they are in a good mood or down. They do not always have to say something; you can see it by looking at them. Also... I take the time that is needed. I do not have to quickly ask all sorts of questions. I just need to sit there, then it comes. They need to think a little, then, maybe I just need to say a few words to encourage communication, and then we sit again without saying anything. That is the way we are. We can sit a little and think about things and then it comes. I cannot push the clients by asking all sorts of questions. I am able to see when people do not want to speak, and if that is the case it is not my job to push*

*them, if it is not their need. I just need to sit and give them time, then it comes when they are ready. (T20:193)*

That some Inuit are withdrawn, shy or not very outspoken is perceived to be something that a Southerner might misinterpret. One nurse explained:

*A Southern nurse perceives a patient to be depressive because the patient does not say very much and does not have the chin up. In other words the patient is Inuk, does not speak the Southern language well, and comes from a small community. The patient meets a loud speaking Southern nurse who wants long explanations to particular situations and feelings. (T25:85)*

Another nurse said something very similar:

*A very young woman comes from a small very northern community to a larger city. She comes to a big hospital in the city. She is not used to being away from her community. It is the first time she is away. She is there with her sick baby. She is met by a Southern nurse who according to her own background and values has her own ideas about how to take care of a little baby and so on and so forth. She asks the young girl, who does not share her background in relation to educational level, values or anything else, a slew of questions. The young girl shuts down more and more until there is no contact at all and the encounter according to the nurse really leads nowhere. Then another nurse, an Inuk nurse arrives, who suggests that maybe it would be a good idea to try to meet the girl where she is at. Try to convey to her that you have an interest in her, and where she comes from, her family, her parents, her siblings, how they live in her community. And doing that made the encounter more "successful." She tried to show an interest in the person instead of all the professional talk, nursing knowledge and all that. The girl likely felt attacked with all that nursing knowledge and big words. She comes from a tiny place where big words and big movements are not used and then she closes in on herself more and more. (T26:169)*

As in all other aspects of dealing with human beings, remembering that we are all different is important. Many people (Greenlanders as well as Nunavummiut) I have worked with as a nurse and teacher or have befriended in the communities have shared many difficult experiences and readily discussed disease and how it affected themselves and family members, as, for example, discussed in my work on the sociocultural experiences of tuberculosis (Møller, 2005). This, of course, could be due to my not being kin and also not being a

permanent fixture in the communities.

Many noted that Inuit like to laugh together and that laughing and approaching patients with smiles and while making little jokes are ways that Inuit use to make each other comfortable and relax. As one nurse said: *“I will approach a patient with a smile on my face or by making little jokes; that makes them surprised happy, which calms them down because it is less formal”* (T22:206). Many noted that although they perceive Inuit and Southern humour to be different; just meeting the patient with a smile and a light tone, initiating conversations about the client’s family, home life and home environment and things the patient likes to do, will create an atmosphere where the patient is comfortable.

Meeting patients with a smile and talking to a patient about that which is known and comfortable, rather than initially about problems, illness, and what should be done about it, creates a space where nurse and patient can meet on more equal terms, a space where the nurse is not seen as someone who sets herself above the patient. This may be related to the value of being humble, not loud and not inquisitive. It may also be related to the preference of not speaking about illness and bad experiences and not dwelling on the limitations of illness, but rather focusing on that which makes a person happy and makes him or her feel good.

The Inuit use of body language and that some do not say much may be connected to the fact that many note a level of comfort with physical contact and proximity among Inuit that most do not see among Southerners, but which is perceived to be helpful in the patient/nurse contact. For example, *“laying a hand on the patient and being able to laugh together... gives greater confidence and respect”* (T76:100). I spent time with students in both programs in the classrooms, between and after classes, and with some nurses and students in social situations and at their place of practice. During these times I noted a physicality and comfort with close physical contact that I do not think I would experience in Southern settings or among Southern health workers or

professionals to the same degree. In fields notes from one day in a Greenlandic hospital I highlight this experience when I write:

*One health care worker was massaging another health care worker's back, which made me think about another Greenlandic participant who expressed that she thought Greenlanders might be 'better' at being physically close with their patients than Danes.... Would I see a Danish health care worker massage another in a ward in a Danish hospital? And, would I see Danish students be as intimate with each other as I experience students are here? It is difficult to give a qualified response when I am not immersed in the milieu myself. (FN12)*

Not only an ability to have close physical contact to the living but also to the dying and the dead was highlighted by several nurses and students. Two nurses explained the difference in this regard between Greenland and Denmark, with one saying:

*When you die in Greenland you are not wrapped in a white sheet and rolled out down the hallway while everyone else is sleeping. The dead are "sung out." A priest arrives, the family is there, and a short ceremony is held where the priest gives a brief talk, psalms or hymns are sung, and the door is open with the whole ward being quiet as a way of showing their respect to the dead. And then the patient is "sung out" after the required 6 hours and driven away. Just in that regard there is a vast difference between Greenland and Denmark. There the other patients are not supposed to discover that someone died. (T28:284)*

The other nurse, who was educated outside of the Arctic, talked about Southerners noticing and appreciating her ability to be with the dying in a way that many of them did not seem comfortable with themselves. She said:

*That is something I feel we are very good at here in Greenland. Being many people around the dying. In my family me and my siblings cared for our father the last two weeks before he died at home. Even the grandchildren were there sometimes. Because my father had said he would like to die at home me and my siblings gave him pain medication and washed and bathed him and all that. So in some ways I don't think it is that foreign to us, you know? Even our children were there with us and with grandfather, so I think it is more natural for us. (T32:72)*

The custom of “singing out” the dead has likely existed in Greenland since Christianity became an established part of life there. In the 18<sup>th</sup>, 19<sup>th</sup> and into the 20<sup>th</sup> century it was a common custom in Denmark too (Krag, 2004). Apart from some places in West Jutland (Hansen, 2003), it seems that the use of this custom has more or less faded away starting in the 1900s, although some believe that there is a slow revival taking place (Gyldendal, 2010). In the Danish context, Krag describes that when the deceased has been washed and clothed in his or her best clothes, often by the family as described in Greenland, family members and a priest speak a few words. After this the deceased is rolled from the room in the hospital or at home out to a hearse while the attending family members, friends, neighbours or fellow hospital patients sing the psalms chosen for the occasion. The family follows to the hearse and watches it be driven away. In Nunavut the custom of singing people out is not used, and none of the participating nurses and students mentioned particular practices relating to the dead, although traditions in relation to dying were discussed. I will return to these below.

In Nunavut, when a community member dies it is not uncommon that the majority of the population in the smaller towns and settlements will be present for the memorial service at the church and at the burial site and also that schools, shops and government offices may close for the duration of the ceremony in order to show respect for the deceased and allow everyone connected to the deceased to be present at the sermon. I did not experience this in the larger towns I visited in Greenland.

In the village of Kangersuatsiaq in the Upernavik district in the late 1980s, although relatives might assist, it was often the local midwife who assumed responsibility for the washing and dressing of the dead (Nuttall, 1992). According to Nuttall, death and mortuary procedures among Kangersuatsiarmit was fairly institutionalized. The making of a coffin which took place locally, however, “remained in sphere of kin” (Nuttall, 1992, p. 107) and signalled a return of the person to the community both in body – for the funeral – and in spirit “through the transfer of the name to an *atsiaq*” (namesake) (Nuttall, 1992, p. 107). As in Nunavut, much of the community attended the funeral and also similar to

Nunavut villages burials would have an air of ‘normalcy’ with non-close kin attending in their everyday clothes and returning to their everyday task quickly after the coffin had been lowered into the ground (Nuttall, 1992). This should not be seen as callousness; rather, “the funeral is a community occasion as well as a family occasion, that centres around the return and burial of a loved and valued member” (Nuttall, 1992, p. 109).

In both Greenland and Nunavut nurses and students talked about the importance of particular Arctic foods being tied to feelings of identity and also to health and to death and dying. As explained by one nurse:

*In my culture if you're craving a certain kind of food and, say you're expected only to live 'til the spring, and you're craving something that's only available in the spring or it tastes best in the spring, and you have a colostomy and you're not supposed to eat raw meat and stuff, you're still going to give that. Like in my mind, I'm like 'well they are dying, they want to have a peaceful' .... You're giving them something that their body is probably craving to have and give them nutritional value, yeah, and they're going to have lots of symptoms of.... But that's what medication is for. You know what I mean? And they [the Southern nurses] are like, 'Why are they bringing him this kind of food? He can't tolerate it!' .... Well, it's his wish. (T34:578)*

The nurse continued that it might create more work for the nurse caring for the patient as the colostomy would need changing more often; she also noted that it would probably go against general procedures, but for her the patient's wish and likely increased quality of life felt more important. She thought that traditional food should be available and that Southern staff as well as students in the nursing program should be educated about the nutritional value of Northern foods so that they might be able to advocate for the offering of alternatives to the fairly Southern menu often available at the hospital. She thought that staff and students should be taught to know when certain foods are in season and when not and which foods patients might crave. Informing new staff upon or before arrival about particular food preferences, and that they might meet these foods in the wards, would perhaps help the staff to show acceptance rather than revulsion – as the quote below indicates – which would allow patients the pleasure of eating these foods while admitted to the hospital in order to increase their quality of life:

*Like when different foods are in season, like ptarmigan is in season right now and more traditional people even my age, people like, not so much the younger generation, like to eat it fresh and raw, and we don't have it as much in the hospital. Say a [Southern] nurse who just started out walks out and 'They're eating a raw bird in that room!' Like their facial expression. And it's a strong smelling bird, so when you walk in and it's got that smell and if their roommate is not Inuit and they're kind of not too keen on it, the nurse has her facial expression but she's still doing her vitals, but you can tell that she's kind of like... totally grossed out. And those kinds of things are totally normal to me; it's like, 'Oh you've got some... that's great, then I'll come back and I'll do all this other stuff when you're finished.' So you're reacting differently to some things because what's normal to me is not normal to someone else. (T34: 552)*

There is, as noted previously, a body of literature indicating that many Inuit today connect both health and identity with the eating of Inuit food. As an older woman told Borré (1994), “you have to be happy to be healthy and you can't be happy without country food” (p. 9). The eating of country foods or food from the land (or sea)<sup>105</sup> has also been connected to maintaining optimal health and preventing sickness (Borré, 1991, 1994; Freeman, 1992; Hensel, 2001; Klevian, 1996; Al. Joamie, 2001; Pitseolak, 2001; Rasing, 1999; Shea 1989; Therrien & Laugrand, 2001; Togeby, 2002), as has going out on the land (or sea), and the hunting, procuring, and sharing of land-foods (Borré, 1991; Brody, 1991; Freeman, 1992; Hensel, 2001; Klevian, 1996; Olsen, 2010; Shea, 1989; Togeby, 2002). But not only will Inuit food maintain health, particular parts of animals are also said to be helpful in the attempt to cure particular illnesses and restore health (Angugaatiaq, 1980; Awa, 1999; Borré, 1991, 1994; Dahl, 2000; Klevian, 1996; Therrien & Laugrand). According to Al. Joamie (2001) and Pitseolak (2001), when someone is sick, all attempts are made to provide her with the food that she desires, just as the nurse quoted above said.

That health care practitioners and other individuals in the Arctic self-identify as Inuit does not mean that they identify with all the values, ideas, norms

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<sup>105</sup> Inuit food, food from the land, or country food, includes any food harvested by the Inuit themselves in areas reachable from where they live, or which has been sent from family and friends from other communities who have harvested it. Seal, caribou, and beluga meat as well as char are common, but country food also includes walrus, narwhal, clams, geese and ducks, ptarmigan and other fowl and game, and local plants and berries, which vary from settlement to settlement.

and customs generally perceived to be Inuit – even by the health care practitioners themselves. This is probably also the case among different ethnic groups in Denmark and Southern Canada. Still, it may be very valuable for health care practitioners to know that individuals in their care may eat certain foods or respect certain holidays. Some feel that knowing and addressing such customs may allow health care practitioners to show respect for those in their care and may also help diminish barriers that might otherwise exist. One said:

*There are also the norms to consider, you know how we relate to each other, habits. If, for example, I go to work as a nurse on the 6th of January, that is 'helligtrekongersdag' [the 12th night of the Epiphany], then I will shake the hands of the patients I care for and say happy 'helligtrekongersdag' because that is a religious holiday here, whereas it is not in the South, is it? So when I acknowledge to the patient that... I understand, here you are and it is the 6th of January and a holiday... well, you wish them a happy holiday on the holidays. (T28: 245)*

In relation to tradition, when I visited a smaller town and talked to a nursing student about what she had found challenging in the education, she said attempting to put into practice what she had learned theoretically was challenging, not because she did not understand what was expected but because the book theory was ill-fitted to an Inuit practice. Particularly what she had learned theoretically about communication she found difficult to put into practice with Inuit patients. She said:

*Many here are not educated, or they have a shorter education, so some might have less understanding of what happens in the body and such. Maybe one could try to formulate things in a more cultural context and maybe also more traditionally. Many here are very traditional. (T73:344)*

I asked her what she meant when saying 'more traditionally' but she had difficulty being specific, other than saying that many have the idea that "well my mother says and mother knows best" (T73:344) and her own experience had been that her mother's advice in relation to health and childrearing did not make sense to her with the knowledge she had.

Also in relation to ‘traditional,’ ‘traditional Inuit medicine’ came up in various conversations. There were mixed ideas about whether traditional healing methods and remedies had a place in the nursing education and the health care system altogether, with some feeling that anyone who had an interest could pursue it as a personal rather than school endeavour, while others felt that including traditional medicine and healing methods in the curriculum would increase their sense of identity and pride in their culture.

There was a significant difference between Greenlandic and Canadian Inuit in relation to their desire to learn from and with Elders about traditional medicines and healing methods as part of the program, as well as to be able to use these medicines and methods in their professional work. Some students said:

*I think it may also have helped me to go to school that I was comfortable and proud about my culture and my background. I think it is important to encourage young people to practice and be proud of our culture. Today after attending the nursing program and graduating I question why we are not practicing with traditional remedies. (T36:62)*

*I would really like to see Elders come in and share with us Inuit traditional remedies, like for treating cuts.... Because we are in Nunavut. I would really like to combine both Inuit traditional knowledge and the Western academic sciences. It would be interesting like which type of herbal medicines were used, like from the land, taken from the land. (T40:381)*

If learning about traditional medicines, some students said, it should not just take place in the classroom but should include a “hands-on” component where students would also engage in the picking, procuring and preparing of the remedies:

*If we’re learning about things, say about herbal remedies and certain kinds of health and healing type information, I think it’s important not just to learn it and see it and have someone talk about it, I think you actually have to try it. You have to go out and find the plants when they’re in season, find that stuff, learn where to find it, know when to find it, and know what to do with it, otherwise it just stays on paper. You just learned it, you researched it, you put it on paper, you hand it in, you got a good grade, but you didn’t actually do it, you didn’t actually use it. Where’s the value in that? (T34:355)*

I believe that the desire, among nurses and students in Nunavut, to have Elders teach in the nursing program and include traditional medicine in the curriculum may be connected to the foregrounding of Inuit collective identity and culture that has taken place in Arctic Canada both before and after Nunavut's inception. This desire was not evident among Greenlandic nurses and students. In Nunavut where a higher percentage of participants also thought it desirable to have the education in Inuktitut, is a territory where politically and socially the focus is on reviving Inuit language and culture. Despite many Southern Canadians' limited knowledge about the Canadian North, it has had, and continues to have, a defining role for Canadian identity and for Canada as a Northern nation (Grace, 2010). Saul (2008) goes further than interpreting Canada as a Northern nation and proposes that Canadian identity may be more influenced by the thoughts and values of Canadian Indigenous populations than those of Britain, France or Europe generally. Therefore, while there is no doubt that most Canadian Inuit see themselves as Canadian (Kusugak, 2004) it is also very important, I believe, for many Inuit to set themselves apart from Southern Canada and Southern Canadian governance in their working towards increased self-governance.

Inuit nurses and students, then, highlight aspects of caring that they consider particularly important in relation to Inuit patients. These include: being able to speak the language of their patients and converse about things familiar to them such as family, everyday activities, and their home community; being able to laugh with and have a friendly demeanor towards their patients and being able to be physically close; knowing when to talk and when not to, and what about, and understanding and mastering the use of silence and body language; knowing about, acknowledging and being able to participate in customs and traditions, for example, in relation to death and dying and particular holidays; and understanding preferences for Inuit food both generally and as a means to maintain health and happiness. The ability to understand a patient's situation holistically and to be non-confrontational, both as a teacher of nursing students and as a nurse, and the ability to accept the autonomy of individuals, also when

they make choices with which the nurse or student may not agree, were other aspects of caring that came up as important in relation to Inuit patients.

It appears that some Southern nurses who choose to work in the Arctic, where the linguistic and cultural background of many of their patients and some of their colleagues is different from their own, come from a standpoint of 'knowing best' or 'being right,' which is part of the *habitus* that they bring with them. A lack of ability or willingness to respect and understand, or attempt to understand, may also be interpreted as a display of continuing colonialism or where the colonized 'I/us' and our knowledge, language, ways and values are assumed to be superior to the colonized 'other' and his/ her knowledge, language, ways and values (Said, 2003).<sup>106</sup> As noted by Anderson et al. (2007), when cultural categories and associations are used in today's healthcare system they are often deeply rooted in colonizing hegemonic relationships: "Often when the notion of culture is evoked in healthcare settings it is not western European culture that is being put to question" (p. 180). Even if some of the nurses who find themselves in this colonising role may sense a moral predicament, they may, as previously discussed by Paine (1977c) about Whites in the Arctic, be "unwilling or find it too difficult (for theirs looks like a double bind situation) to admit as much" (p. 78). Paying attention to such a predicament would imply the questioning of our roles, actions, knowledge, rights and responsibilities in the North as Southerners (similar to the *cautious caregiver* described by Rutherford [2008]). Not doing so allows us to continue to be there, stay there, and act there,<sup>107</sup> without changing ourselves. Personal change would require hard work, it

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<sup>106</sup> In *Orientalism*, Said (1978/2003) helps the reader understand how the 'Orient' (as opposed to the Occident) and the 'Oriental' was constructed, and used as a means of 'Othering' people in the 'Orient'. As Said writes, "indeed it can be argued that the major component in European culture is precisely what made that culture hegemonic both in and outside Europe: the idea of European identity as a superior one in comparison with all the non-European peoples and cultures. There is, in addition, the hegemony of European ideas about the Orient, themselves reiterating European superiority over Oriental backwardness, usually overriding the possibility that a more independent, or more skeptical thinker might have had different views on the matter" (Said 1979/2003, p. 7). Of note in postcolonial analysis is how the 'Other' was constructed as inferior to those following Western European rationality.

<sup>107</sup> This notion is inspired by Said (1978/2003), who writes, "The scientist, the scholar, the missionary, the trader, or the soldier was in, or thought about, the Orient because he *could be*

might put us in a situation of being the ones who need to learn, rather than being the teacher or tutor as Paine (1977c) would put it, it might even require that we leave the North (Gad, 2009b).

### **6.7 Chapter Summary**

In their daily work, Inuit nurses and students are affected by structural challenges in the form of high rates of vacancies, staff turnover, and differences in mother tongue between themselves and a majority of their colleagues and between a majority of their colleagues and many of their patients and patients' families. These challenges translate into Inuit nurses carrying a heavier workload than their Southern counterparts, much shift work and on call duties, a limited ability to take time off to maintain their nursing knowledge, and sometimes rapid promotion into leadership positions, sometimes without being properly prepared or supported in their development as leaders. They also translate into Inuit nursing students not always having regular mentors and guidance when they are in their practicum, and in Nunavut to new nurses having difficulty being hired because of a lack of senior nurses to mentor them.

In their learning and practicing, Inuit nurses and students are also affected by their backgrounds, sense of self and social identities, and the differences they experience between themselves, their colleagues, and their patients. Sense of self and identity are connected to ways in which we perceive the body, health and disease and our approaches to healing; they are also connected to how we choose to provide health care and how we prefer to receive it. Finally, they are connected to how we choose to teach and how we prefer to learn. These were some of the areas where Inuit nurses and students experienced differences between themselves and their non-Inuit colleagues and between themselves and their Inuit patients, exemplifying the importance of possessing more than one form of *cultural* and *linguistic capital*. It appears that some Southern nurses facing differences between themselves and Inuit nurses, Northern and Southern health

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*there*, or could think about it with very little resistance on the Orient's part" (p. 7, emphasis in original).

care systems, and practices in the North and South, come from a stance of continuing colonialism where Southern knowledge, language and habitus is thought superior to Inuit knowledge, language and habitus; those who do may find it difficult to change their stance, even if they are aware of it (cf. Paine, 1977c).

## 7. Colonialism, *Capital* and the Field of Arctic Nursing

In this chapter, while also adding new information, I pull together and analyze the information from the six preceding chapters. This chapter is, in other words, even more than chapters one to six, my interpretation of conversations, observations, interviews, and written and electronic material. I argue that, although neither the term colonialism nor other terms that would imply the same meaning are used by Inuit nurses and students to characterize their working or learning spheres, colonialism is what frames these spheres and nurses' and students' experiences within them. In order to demonstrate this point I will analyze nurses' and students' experiences in the Arctic fields of nursing using the steps to analyse a field as suggested by Bourdieu (Bourdieu & Wacquant, 1992).

### *7.1 Situating the Experiences of Inuit Nurses and Students in an Analysis of the Field*

According to Bourdieu, in order to study a field three steps are necessary: 1) to “analyse the position of the field vis-à-vis the field of power” (Bourdieu & Wacquant, 1992, p. 104), 2) to “map out the objective structure of the relations between the positions of the agents or institutions who compete for the legitimate form of specific authority” where the field is situated (Bourdieu & Wacquant, 1992, p. 105), and 3) to “analyze the *habitus* of agents,” the systems of dispositions they possess that most likely will be actualized within the field in question (Bourdieu & Wacquant, 1992, p. 105).

As the first step in analysing the arctic nursing field, I will analyse where the nursing field is positioned in relation to the field of power in Greenland and Nunavut. The field of power in Nunavut and Greenland is made up of the government and by extension the ministries or departments and institutions that are part of or regulated by the government such as the Department of Health and Social Services and the Department of Education in Nunavut, the Department of Health and the Department of Education and Research in Greenland, the office of the Chief Medical Officer in Greenland and the Nursing Association of the

Northwest Territories for Nunavut,<sup>108</sup> the unions under which the nurses are employed and the educational institutions through which nurses in Nunavut and Greenland earn their degrees. In the second step of Bourdieu's analysis of field I see the competition for the legitimate form of specific authority to lie between the Southern nurses and the Inuit nurses as alluded to in chapters four and six. In the third step of Bourdieu's analysis of field, analysing the *habitus* of the agents of the field, I will analyse the Inuit nurses' and students' embodied *habitus* as well as the sum of *capital* and "external determinations" that affect the nurses as agents in the field of nursing in relation to their entering the nursing education, having success as students, and subsequently as practicing nurses.

Bourdieu recognizes fields to be contested spaces where agents struggle to have their particular *capital* recognized in order to gain power. He also recognizes the state as the ultimate holder of power in its ability to grant, recognize, and reproduce the power of particular *capital* and thus how particular fields are constituted; this happens particularly through the educational system. Despite this, Bourdieu does not, or only in 'limited' and 'pathological' cases, recognize the State or any of the institutions through which it functions and is reproduced to be equivalent to 'apparatuses' or 'total institutions.' Bourdieu continues that this limit is actually never reached even under the most repressive regimes (Bourdieu & Wacquant, 1992).

While I perceive the insidiousness of the reproduction of the power granting *capital* that is needed in order to enter and be successful in various fields in Nunavut and Greenland as part of the insidious reproduction of that which is perceived to be 'normal' and 'right' by the previously colonizing Southern powers, Denmark and European Canada, Bourdieu has a point. The governments of Nunavut and Greenland, although to a large degree governed by Inuit (T. Berger, 2006), are ultimately still part of the sovereign states Denmark and Canada, and subject to, and partly dependent on, the Danish Government and Government of Canada. This has implications for a field such as nursing, as it

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<sup>108</sup> The office of the Chief Medical Officer of Health and the Nursing Association in the Northwest Territories are responsible for granting the nursing authorizations in Greenland and Nunavut, respectively.

operates under the auspices of a larger governmental institution – the health care system. Still although the quest for change has been a struggle, as I will discuss further below, some changes have been and are happening in Nunavut and Greenland that supports Bourdieus notion.

### ***7.1.1 The position of the field of Arctic nursing vis á vis the field of power***

As mentioned above, the first step in Bourdieu's study of a field is to "analyse the position of the field vis-á-vis the field of power" (Bourdieu & Wacquant, 1992, p. 104). The following pertains to this step.

As discussed in chapter two, systems and institutions in Nunavut and Greenland were introduced by Southern colonial powers. When Nunavut became a territory and Greenland obtained Home Rule they took over these already functioning systems and institutions. Although governments changed, the way that systems functioned, including the educational and the health care systems, did not change much, and to a large degree they still function according to Southern models, although many initiatives have been realized and are underway that may change this.

Currently, there are more Inuit working in the health care systems than there has ever been. Furthermore, certificates, diplomas and programs that place content and practices more squarely in the Arctic have been developed and some have already seen several graduates. These include the midwifery program, maternity care certificate, and mental health worker diploma in Nunavut and the health aide diploma, health assistant diploma, birthing assistant diploma, and paramedic certificate in Greenland as mentioned in section 2.3. Currently, as discussed in section 4.1.5 there are also more Inuit teachers in the educational systems than there has ever been and the reform of education that is taking place (albeit slowly, and perhaps more in rhetoric than in practice) in both Greenland and Nunavut speaks to the desire to make these more appropriate to Inuit language and ideas about what a good school is (Government of Nunavut, 2009; Sørensen, 2007).

The students and nurses who are currently under education and practice in

Greenland did not grow up or attend school while the above-mentioned initiatives and changes were underway. Rather, they grew up and attended school during times where Southern power and influence were particularly pronounced as described in chapter two. Today, they work in health care systems where a majority of nurses and other health care staff are, and will in the near term continue to be Southern, given the size of the populations, the number of health care practitioners needed, the number of high school graduates, and career choices available other than those in health (Præst, Jokumsen & Zober, 2002). In order for Inuit and Southern colleagues to understand each other, and because local nurses and other health care professionals have been educated in Southern languages, the working languages in the health care system will in the near term remain Southern. For some, however, this is a necessity rather than desire and also a source of resentment, as expressed by one nurse:

*Somehow I resent the fact that Southerners that come here are learning an Inuit language in their work time, they are paid to learn an Inuit language. Us Inuit were never paid to learn another language, so why should they get paid?... A lot of times people from the South do not make an effort to learn about Inuit culture and language. (T36:81)*

Although the politicians in Nunavut and Greenland are mostly Inuit, most political advisors and bureaucrats remain Southern (T. Berger, 2006; Gad, 2009b) and in Greenland a majority of Greenlandic public servants have taken their education in Denmark (Gad, 2009b). Since Southern advisors and bureaucrats speak only a Southern language, or have been educated in a Southern language, the working language remains a Southern one (T. Berger, 2006; 2009).<sup>109</sup>

This may not be the case in the future, but for now it seems inevitable. When asked about how the government would implement the law about Greenlandic becoming the official language in Greenland, Jens B. Frederiksen from the Greenlandic political party ‘The Democrats’ said:

I do not think that the law about the Greenlandic language becoming the official language will be put into practice the same day self-

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<sup>109</sup> Politicians in both Greenland and Nunavut can speak an Inuit language when speaking in the parliament.

governance is a reality. We do not have the resources for that. If more Greenlandic speakers become well educated and start to use the language publicly and work wise, then the law will be realizable. (Frederiksen, as cited in Olsen, 2009, p. 35, translated from English to Danish by author)

The premier of Greenland, Kuupik Kleist, stressed that the mere fact that it is in the law is very special, “as it is the first time in the history of Greenland, that such a law has been made” (Kleist, as cited by Olsen, 2009, p. 35). The decision to make Greenlandic the official language, while knowing that full implementation is not immediately attainable, may be comparable to the previous premier of Nunavut, Paul Okalik, ordering all senior bureaucrats to learn Inuktitut or lose their jobs (Okalik, cited in Thomson 2006). This has not happened yet (and is not likely to happen soon), although many more Inuit today occupy positions that were previously occupied by Southerners. Higher-ranking positions in the bureaucracies continue to be predominantly occupied by Southerners (T. Berger, 2006; Gad, 2009b).

These facts speak to the power that Southern (colonial) language, thinking, and thereby ways and values have in both Greenland and Nunavut. From the recognition that the governments and their institutions, including the health care and educational systems, continue to be colonial in form, it follows that the various fields operating under those systems, including nursing, and the institutions that nursing is regulated by, operate under, or within, are colonial in form as well.

One would assume that the field of nursing would be positioned fairly close to the field of power because it is staffed by a majority of Southern nurses who share *social, cultural* and *linguistic capital* that is recognized by that field via both their affiliation with the previous colonizing power and because the field of nursing is a colonial construct to begin with, as discussed in chapter one. In practical terms, however, the fields of nursing in Greenland and Nunavut are split fields. Many of the agents in the fields who presumably would share most *capital* with the field of power do not call the Arctic their home, and therefore perhaps do not have a vested interest in the field of nursing in the Arctic. Several nurses in

Greenland and Nunavut, while they had experiences with Southern nurses being dedicated to nursing where they were, also had experiences with nurses who came to the Arctic as “tourists” or just to “make money,” whom they did not perceive to be invested in their positions.

The following quotes exemplify these experiences and perceptions. One nurse said: *“I think the language issue is sometimes used to hide behind in order to avoid the need to go deeper into the issues. That’s anyway what I see”* (T31:205). A nursing student said: *“You can feel that some just come to make money and be tourists, while others come to help.... We have many tourists here, and we get so tired of orienting the new ones”* (T6:324). The ‘optimistic adventurer’ described by Rutherford (2008), mentioned in chapter two, comes to mind here. A nurse with whom I had many face-to-face conversations and corresponded with by email once commented that she and some of her nursing colleagues felt that Southern nurses do not engage with the Inuit patients and their care or needs. She also said that there could be several reasons for this, including culture and language differences as well as Southern nurses’ unwillingness to integrate in the North; she questioned their desire to integrate at all when only working in the country for a few months at a time. She felt that lack of engagement was a general phenomena among nurses not permanently employed in the Arctic.

There are several factors compounding some Southern nurses’ lack of investment in the Arctic nursing field. One factor revolves around unions. Agency nurses and permanent nurses in both Greenland and Nunavut do not work under the same union, and therefore may not work towards the same goals in relation to working conditions in the Arctic. Furthermore, the union to which nurses in Nunavut belong, called the Nunavut Employees Union, is a general, rather than nursing-specific union, representing many government of Nunavut employees. Thus, the union is not a strong speaker for nurses as a group, which has different interests than many other government employees. Most other government employees do not work shift, for example. And, neither in Nunavut nor in Greenland, is there a chapter under the union that focuses specifically on

Inuit nurses and nursing. In Canada as a whole, however, an Aboriginal Nurses Organization, which includes Inuit nurses, does exist. In the future there may be an entity for Inuit nurses, given the growing openness around differences in approaches to health care as mentioned by some nurses in chapter six, and the fact that the head of the nursing union in Greenland is Greenlandic for the first time.

Another factor compounding some Southern nurses' lack of investment revolves around leadership in the health care system. In many hospital wards and nursing stations in Greenland, and all wards and nursing stations in Nunavut, the permanent or casual leading nurses are Southern language speaking Southerners. This is also the case for leading doctor positions, and, although the Ministers of Health in both places are Inuit, most other leading positions in the health care systems remain occupied by Southerners. While some Southerners employed in the health care systems are well integrated into Northern societies and work towards increased Inuit leadership and control, the high turnover in these positions and the comments made by Inuit nurses and students indicate that this number is small. As mentioned in chapter 6, some Southerners come from a hegemonic stance that favours Southern language, knowledge and ways, and this must include approaches to leadership. We know in the case of teaching methods that Southern pedagogy may not be readily applicable to Northern settings (see chapters 5 & 6, and Aylward, 2007; Berger, 2008; Hansen, 2007). Coupled with comments from some Inuit nursing leaders, I believe this also may be the case for leadership strategies. Unfortunately even if some Southerners recognize this, acting on the knowledge may prove to be 'impossible' for many (cf. Gad, 2009b; Paine, 1977c).

So, although the field of nursing in the Arctic *per se* is positioned relatively close to the field of power, the nursing field is split with one part comprising nurses who may be relatively un-invested, at least in the field of nursing in the Arctic,<sup>110</sup> while the other comprises Inuit nurses who are invested in the field of

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<sup>110</sup> Many Southern nurses who *are* vested in Arctic nursing are still, albeit unconsciously, contributing to the split in Arctic nursing. This is so because they generally will have a stronger

Arctic nursing but who do not share all the same *capital* as the field of power, positioning them further away from the field of power. Compounding this is the fact that leaders in health care in the Arctic, more often than not, are Southerners who, whether knowingly or unknowingly, favour southern *capital*.

The Inuit nurses possess the *capital* necessary to have success in the educational system and as practicing nurses, but they do not possess all the same *capital* as their Southern colleagues. Conversely Inuit nurses and students possess *capital* that affords them success in their caring for Inuit patients because much of this *capital* is shared by the people they care for, but many Southern nurses do not share this *capital*. I will discuss this further below when I discuss the second step of the analysis of the Arctic nursing fields.

### ***7.1.2 Two fields of nursing competing for the legitimate form of specific authority***

Bourdieu's second step of analyzing a field involves a mapping out of the "structure of the relations between the positions of the agents or institutions who compete for the legitimate form of specific authority" where the field is situated (Bourdieu & Wacquant, 1992, p. 105). In these Arctic contexts, I see the competitors for the legitimate form of specific authority to lie between the Southern nurses and the Inuit nurses, as I will demonstrate below.

The experiences of Inuit nurses and students in health care systems, as discussed in chapters four and six, exemplify the idea that Inuit and Southern nurses compete (although unconsciously) for the legitimate form of specific authority in relation to defining the field of nursing in the Arctic. The following quotes reinforce this. Inuit nurses and students share experiences of their ways and ideas not being taken into account by Southern colleagues or teachers:

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investment in nursing as the colonial construct it is due to their own background, *habitus* and capital, and because they have been educated in a Southern educational and health care system in the South. Some Southern nurses may operate as Rutherford's (2008) cautious caregiver, actively challenging the assumptions that usually come with Southern professionals and reflecting on their own *habitus*.

*I have noticed that we were taught about nursing or how to nurse a different place than here. I mean in the health care system in the South. Our books are not created with the Arctic in mind. They are created for the health care system in the South. So we learn about something that we then reformulate or recreate in our minds to ways we would do it in the Arctic. We do that automatically. And, the teachers often do not know how things are here in the Arctic, what Arctic conditions imply. We are taught according to Southern conditions, in Southern ways and then we have to adapt it to Arctic ways when we enter the practical field. (T28:263)*

*Sometimes Southern nurses arrive with their Southern knowledge and ways of thinking, but you can't just change Inuit into something Southern. You have to try to understand the person and the underlying causes. (T20: 205)*

*Sometimes here we experience that people come with all this big knowledge and all these good ideas and then we need to do this and this and this.... So of course you sort of react with... hold your horses!... That is where I think respect and equality or equal status with and acceptance of the person you talk to enters the picture. I think that is very important that you feel that acceptance when you meet someone. If you meet people with that look and perhaps have prejudices already and label the person you a going to talk to, then the encounter is perhaps influenced by that. (T26:169)*

Several other nurses and students talked about the need among Southern nurses to respect the people they meet in the health care system and attempt to understand their ways and values and a few gave examples of situations where they, or a colleague, had attempted to help a Southern health professional, but only when they were asked directly to do so.

Although, as noted by both Greenlandic and Canadian Inuit nurses, Inuit nurses have gained increasing confidence in their value and abilities as nurses as exemplified in the quote below, it appears that this has not resulted in nurses openly questioning actions or statements of Southern health care staff in practical situations. One nurse stated: “*when I first went into nursing I saw myself way down here, a Southerner way up there, but now I can pretty much level myself where I am now*” (T33:748). Another nurse in a casual conversation lamented the fact that Inuit health care workers who had been in the system for many years and had a lot of knowledge and experience referred patients and their families to

Danish nurses rather than answer questions themselves, although this nurse said she was quite sure they were very capable of answering themselves.

Most situations where Inuit nurses' and students' knowledge, ways and ideas are sought after by Southerners, on the other hand, are an attempt to make sense of patients acting in ways that seem unusual to us – for example when eating 'strange' foods or when not talking or expressing emotion as mentioned in section 6.6.3 – or for guidance about leisure activities. To me this resembles exoticism or *othering* (Said, 2003) as discussed in section 6.6.3 and self-interest rather than genuine interest in learning about, understanding, and respecting Inuit. A few quotes provide examples of this:

*I sincerely hope more Inuit nurses will be educated. I have experiences that Southern co-workers ask me a lot about cultural issues like: 'Why does he do that? Why does he do that? How do you eat that stuff? If I go on a trip what do I need to bring?' There are different questions that come up while you are working. That is okay, but then you need to spend time explaining to your co-workers what Inuit culture is about. It would be easier if the agency nurses had more knowledge about Inuit culture before they came to the Arctic. Maybe they should seek out some knowledge about Inuit culture before coming to the Arctic. Sometimes it is too much with all these questions, but it is also good that people ask, but recently I have thought about the amount of time that is actually spent during working hours to discuss Inuit culture; maybe we could use that time with the patients... maybe it could take place outside of work. It is both good and bad, but if someone asks while we are busy I have to say, 'now you have to wait'. (T75:193)*

*Southern nurses question a behaviour that they just cannot understand which Inuit have no problems understanding. There is the typical example: 'Oh, I cannot understand that this patient gets into these difficulties and alcohol all the time, I just do not understand.' An Inuk on the other hand looks at why and understands the issues behind it. And when you know the person you know the background for that lifestyle. (T31:189)*

As demonstrated in chapter six, situated in the field of nursing in the Arctic there is a subfield of Inuit nursing. Although this field is governed by the same rules and regulations as nursing generally and Southern nursing specifically, and although only the possession of specific *capital* will grant prospective students

the ability to enter and excel in the nursing education, and the possession of specific *capital* is needed in order to succeed as practicing nurses, Inuit nurses and students also possess *social* and *cultural capital* that most other nurses practicing in the Arctic do not, in the form of knowledge, language and *habitus* which makes them particularly valuable in the Arctic setting (I will discuss this in more detail in chapter 7.1.3). This fact notwithstanding, the Inuit nursing subfield is positioned further from the field of power, as explained in the previous section, than the general field of nursing in the Arctic because of difference in the makeup of the Inuit sum of *capital* and the fact that leading positions in the health care system are predominantly occupied by Southerners. The Inuit nursing field finds little recognition in the health care system as a whole and as a group of employees under the government, despite the fact that their knowledge and qualities are great assets to the field, the system, and the people they care for. This is demonstrated in several ways. a) Health and medical terminology is not taught in the Arctic nursing educations in the Inuit languages as mentioned in chapter four; b) although Inuit language instruction is offered for free in Nunavut and all government employees are encouraged to learn an Inuit language in both Nunavut and Greenland, this encouragement is not supported in actions that make this possible or desirable (Ottawa Citizen, 2007); c) In both Nunavut and Greenland orientation of casual and agency nursing staff takes place but it does not include a cultural or historical orientation (Aarluk Consulting, 2009; Møller, 2010a); this has, according to Aarluk Consulting (2009) “exacerbated difficulties in the workplace, leading to poor communication between staff and patients” (p. 6) – people employed in the Greenlandic health care system corroborate this (Møller, 2007a); d) southern public health strategies generally rely upon printed materials such as pamphlets, posters and web-based information. In Arctic communities, the most effective communication is often verbal, and one-on-one. This approach, however, requires, if not fluency in the patient’s language, at least a familiarity with local ways of communicating (Aarluk Consulting, 2009; Møller, 2005, 2010, 2010a); e) Inuit nurses are not remunerated for their being bilingual English/Inuktitut speakers (Nunavut Nurses, 2011; personal

communication Turid Skifte, Leading Nurse, Greenland National Board of Health, March 16, 2010).

The language, *habitus* and knowledge pertaining to the ‘Inuit’ in Inuit nurses and students are not recognized as “the right” language, *habitus* and knowledge by the system, and therefore they are given little status. As such the hegemony of Southern language, knowledge and *habitus*, and thus colonialism, is perpetuated. As one nurse said when discussing the need of some graduates to leave the north, because they were not able to be hired: *“I don’t think they realise how important it is for us Inuit nurses to stay here in the North; how much the patients value us. I think [the patients] value us more than the politicians do”* (T33:823).

Another discussed the two different areas in which she had learned and continued to learn about health, both of which she enjoyed. An “Inuit” or cultural way she had learned in the community while the “scientific way” she had learned through her nursing education. She thought there must be ways to provide services that include both, “even though that is not something that is immediately visible in the hospital or clinic” (T34:343). In other words, she saw no recognition of Inuit ways in the services the current health care system offers, something that participants in my work on the socio-cultural experiences of TB in Nunavut also noted (Møller, 2005) as did the participants in the workshop on cross-cultural care and treatment in Nuuk, Greenland (Møller, 2007a). In a plenum discussion a group raised the point that “all encounters between community members and the health care system in Greenland takes place on the premises of the health care system” – in other words on Danish premises (Møller, 2007a, p. 5). In the workshop it was also questioned why a Greenlandic health conference should take place solely in Danish. During a casual conversation in another setting, a nurse said that when Inuit health care staff come to their workplaces, they change from speaking their mother tongue to speaking a Southern language because many of their colleagues are Southern or speak only a Southern language, placing the responsibility to adapt on the Inuit nurses rather than the “visiting” health care staff. Another nurse echoed this statement, saying

that she had had one Southern colleague whom she had been able to speak an Inuit language with, which she thought was wonderful, but although she had tried, she felt that no other colleagues wanted to take the time to attempt to learn the language (T33:614).

In relation to the workshop in Greenland, another nurse commented in an interview that at one point Greenlandic nurses had, under the Greenlandic Nurses' Union, established an Arctic Nursing Group with the idea that this forum would give Greenlandic nurses the opportunity to discuss Greenlandic medical, nursing and health terminology, but

*there were a lot of Danish nurses who would like to be part of such a group based on some romantic notion, but when they were there, all of a sudden it took place in Danish and it was much more difficult for us to discuss things.* (T32:189)

She noted that at that time (about 15 years ago) it would have been inconceivable to make the group 'Greenlandic only' and said that "*the way of discussing as we did in the workshop* [the workshop at the Nunamed conference about crosscultural healthcare] *was also totally new to us... to be able to express such things in an open room*" (T32:187).

Inuit nurses have specific knowledge about the ways and values of Inuit patients, successful approaches in the educating, interviewing, examining and following up situations with Inuit patients, and they understand the language (*linguistic capital*) and body language (*embodied capital*) that many Inuit employ in communication. Still, the knowledge of Inuit nurses is not sought by the health care system and available information is built on Southern concepts, ideas and theories that are not always useful, but which Southern nurses are used to employing and continue to employ when working in the Arctic.

The competition between Inuit and Southern nurses for legitimate forms of specific authority in relation to nursing and caring behaviour in the Arctic health care systems is not an "open competition". This is because Inuit nurses, apart from Inuit-specific *capital*, possess Southern *capital*, some of which has been "inoculated" during their upbringing (Bourdieu, 1986), some of which has been learned during their nursing education. As a consequence, nurses and students

unconsciously recognize the actions and explanations of Southern nurses to be valid while recognizing, because of their *embodied capital* as Inuit, that these actions are not always successful and in some cases even harmful. Southern nurses, on the other hand, may or may not recognize that some of their actions and behaviour have little success in the Arctic setting. As noted by some Inuit nurses and students, those who do recognize their nursing actions to be unsuccessful may blame it on the Inuit clients' lack of ability or willingness to understand, or lack of ability or willingness to do that which is asked of them, rather than acknowledging differences in communication styles and understandings of the body, health and disease, as discussed in chapter six, and the need for Southern nurses to learn about these differences and adapt their approaches accordingly. The idea of change and what this implies may, as noted above, consciously or unconsciously be viewed as insurmountable.

That Inuit nurses and students recognize some Southern actions and explanations as valid, while also recognizing them to be unsuccessful, somewhat resembles the experience of a group of Aboriginal language teachers trained in a Western program who, as teachers, taught in ways they recognized as *not* working because they were initially unable to change their teaching *habitus* (Graham, 2005). It also brings to mind the experience of the Indigenous Australian nurse Chelsea Bond (2005), who initially taught Indigenous Australian clients public health according to the model she had learned through her nursing program, and in essence blamed her Aboriginal clients for being unwilling to receive the message and change their behaviour. Bond later recognized that the way she had been taught to deliver public health messages was ill fitted to the learning *habitus* and ideas about health of her Indigenous community members. Not questioning Southern actions and behaviour may also be related to the history of colonization in the Arctic and Inuit historical reverence for Whites as discussed in chapter two, combined with the tendency of many Inuit to avoid conflict. These examples from the literature suggest that learned *habitus* in a professional field, even if it goes against the practitioner's culture and sense of what is right, can be resilient, something also noted by Ngugi (1986). It is, then,

unsurprising that many Southern nurses working in the Arctic may need help to unlearn unsuccessful practices and behaviours. In a milieu that prized Inuit culture and nursing practice, this help would be available and mandatory.

The competition for legitimate authority within the nursing field, then, is a competition that happens between Southern and Inuit nurses. It is a consequence of the kinds of *capital* that Southern nurses and Inuit nurses possess – an unconscious competition that may leave both less satisfied with their working environment. A nurse in casual communication noted that because Arctic health care systems are multicultural and multilingual, there will be miscommunications and misunderstandings, frustrations, and feelings of powerlessness at all levels in the system, unless the employees in the system have an understanding of, and solidarity with, each other and work together towards the common goal of better health for all residents.

The differences in *capital*, including *habitus*, is that which makes understandings and solidarity difficult and the *habitus* of Inuit nurses is what I will discuss in the next section.

### ***7.1.3 The habitus of Inuit nurses and students as agents in the nursing fields of the Arctic health care systems***

The third step in Bourdieu's analysis of a field is to "analyze the *habitus* of agents," the systems of dispositions they possess that most likely will be actualized within the field in question (Bourdieu, as cited in Bourdieu & Wacquant, 1992, p. 105). In this context I will analyse the Inuit nurses' and students' *habitus* and other *capital* and the "external determinations" or social, historical and political realities that affect the nurses as agents in their field in relation to their entering the nursing education, having success as students, and subsequently as practicing nurses.

For all fields there are certain kinds of properties that agents entering the field need to possess in order to be eligible for participation in that field. These properties are, in the context of nursing in the Arctic, divided into several layers. The first layer concerns the exams, rules, and regulations that all nurses need to

pass and follow in order to be able to practice as registered nurses. In order to pass the required exams, nurses need to go through the nursing education, the second layer, consisting of both theory and practice. In order to enter the nursing education, individuals need to have passed high-school with certain grades, a third layer. For this to be possible individuals need to master the *habitus* of the educational system that affords access to, and success in, high school, a fourth layer. As seen from my perspective, this is where the crux lies.

When students and nurses participating in this study attended public school the school systems were reflections of Southern systems, and these demanded that students possessed a certain learning *habitus* in order for them to have success. This learning *habitus* included: being competitive (Stairs, 1988), working individually and for individual gain (Crago et al., 1997), being vocal in class in order for the teacher to be able to evaluate their participation and level of understanding (Okakok, 1989), accepting the hierarchy that Southern teaching implies – that the teacher is the authority and the evaluator of whether knowledge is correct or not (Hansen, 2007), accepting that teacher knowledge and book knowledge are facts (Briggs, 2001), and also considering natural the demand that students sit still and listen (P. Berger, 2007). In this study nurses and students highlighted most of these to be things they themselves were comfortable with, which allowed them to have good schooling experiences and obtain good grades as discussed in chapter five. This learning *habitus*, as any other *habitus*, is not something individuals are born with, it has to either be ‘inoculated’ in childhood and as a child grows up or it has to be learned later in life (Bourdieu & Wacquant, 1992).

Some nurses, particularly the older ones, experienced needing to learn this *habitus* later in life and found it challenging as described in chapter five. From the notion that this *habitus* was, for most, learned in childhood, follows that most Inuit nurses and students had close contact with adults while growing up who also exhibited this *habitus*; from chapter one we know that many more nurses and students than Inuit generally had a strong Southern influence. The educational systems that Inuit nurses and students were educated within have catered to

Southern *habitus*. Whether intended or not, educating Inuit in systems that cater to the ways and values of the South, or previously colonizing power, is one way to perpetuate a Southern hold on power in the Arctic, or at least to assimilate the Inuit, who are the majority population, into a Southern minority culture (see Ngugi, 1986; Said, 2003).

In this connection it is interesting that many nurses and students considered the factors that allowed them to be educated to generally be the same factors they saw as differentiating themselves from other Inuit. As discussed in chapter six, these, for some, included strong parental support and encouragement to pursue higher education; the affiliation of their family with Southern families; being outspoken and outgoing; being able to question things and ask questions generally; and being scientifically inclined.

Areas of Inuit nurses' and students' *habitus* where they perceived themselves to generally be similar to other Inuit and different from Southerners were in their familial relations and the ways in which they felt social, emotional, and economic responsibility towards family members as discussed in chapter six. One nurse said:

*I feel I have a lot of social responsibility and I need to be able to live with that also. I can't respond to work e-mails all weekend... but I think my [Southern] colleagues who do not have their families here expect me to, because they have the time to also work on the weekends.... I want to care for potential guests and go hunting with my husband.... In the winter I do work one of the weekend days, but in the summer I prioritise my family.... It also depends on one's sense of belonging. (T32:297)*

Inuit feelings of connections to their home community (whether they chose to go back to it to practice or not) and to the land were also mentioned as well as their need to be close to and participate in activities on the land and/or sea. When we discussed educational possibilities and why she had chosen an Arctic nursing education, one student said: “*I wanted to be educated here; not necessarily in this town but here in the Arctic. It's also because I can't do without the nature*” (T8:190).

*Habitus* as it relates particularly to nursing as a field was also discussed, but

characteristics of this *habitus* were generally divided into those that fit the Southern nurses and those that fit the Inuit nurses. The nursing-related characteristics mentioned by Inuit nurses and students that were similar for Inuit and Southern nurses generally had to do with having gone through the same education, needing to abide by the same rules and regulations, and a desire to work with and help people. A shared *habitus* for Inuit and Southern nurses did not really come forth during interviews, casual conversations, observation or participant observation. This may be on account of the way I asked questions, however, and to that which I paid attention. I did not ask nurses and students to describe what they thought characterized a general nurse in the Arctic; rather, I asked whether they thought that which characterized a nurse in the Arctic was similar or different between Southern and Inuit nurses. I also presupposed that differences would exist, which may mean that I was not paying as much attention to similarities.

Returning to the nursing *habitus* of Inuit nurses, this was closely tied to Inuit identity and included mastering the use and understanding of body language, having a sunny disposition and being able to use humour with patients, being very engaged with and spending the necessary time with patients and being able to be physically close, respecting individual autonomy and integrity, being non-hierarchical, and being non-confrontational. This nursing *habitus* was more or less opposite to that of Southern nurses who were described as being time-bound, precise and quick in their care, focused on instrumental nursing, very talkative, inquisitive, and direct, but also cold, distant and confrontational. The Southern nursing *habitus* as described by Inuit nurses, to a much larger degree than Inuit nursing *habitus*, resembles the *habitus* that is necessary in order to have success in the educational system. This is not surprising. Although Inuit nurses evidently have possessed the *habitus* needed to have success in the educational system, they do not connect this to being part of their identities when not in the educational system. However, that Inuit nurses did not also cite these characteristics to be part of some Inuit nurses' *habitus* may, as mentioned above, also be connected to the way I worded questions and where my attention was

focused. Still, it is quite evident that the *habitus* that allows Inuit entry into the field of nursing is connected with that which is generally Southern, and which may perhaps be most recognized by other Southerners working in the health care system. That Inuit nurses and students did not cite the characteristics that allowed them to be successful in the nursing education to be part of their characteristics as Inuit nurses may also reflect an unconscious distancing from that which is perceived to be ‘Danish’ and colonial, which generally happens in ‘post-colonial’ societies as discussed by Gad (2009b) and Said (2003).

The nursing *habitus* that is more Inuit may not be recognized *capital* in Southern minds (cf. Andersen et al., 2007) for the same reasons that Southerners may not be able to reconcile their own moral predicament in relation to imposing southern language, knowledge, and values (cf. Paine, 1977c; Said, 2003) as discussed above. It is a *capital*, however, in the health care setting and in the Inuit nursing field, where it is recognized and valued by other Inuit health care professionals and by the Inuit patients. This gives Inuit nurses and students a feeling of pride and satisfaction in their work that Southern nurses may not experience. The Inuit nursing *habitus* may also gain more recognition as more Inuit nurses and other health care workers are educated and with the emerging politicization of nursing that is happening in Nunavut and Greenland, a notion expressed by many participants present at the workshop on *the cross-cultural aspect of health care in Greenland*, at the NUNAMED conference in Nuuk, 2010 (Møller, 2010a) and by Inuit nurses present at the Aboriginal Nurses Conference in Toronto, 2010, when I presented there (Møller, 2010b).

## **7.2 Chapter Summary**

I have used Bourdieu’s three steps to analyse a field (Bourdieu & Wacquant, 1992) to demonstrate that colonialism is what frames the learning and working spheres of Inuit nurses’ and students’ and their experiences within them. Firstly, I have argued that the field of power in the Arctic is colonial, because the Governments and their institutions continue to be colonial in form. The field of nursing is situated below, and has little access to, the field of power because it is

split between Southern nurses, many of whom are not invested in the field of Arctic nursing, and Inuit nurses, who are. This split weakens the Arctic nursing field and has particular implications for Inuit nurses who are already removed from the field of power due to differences in *cultural* and *linguistic capital*.

Secondly, I have argued that the struggle for a “legitimate form of specific authority” (Bourdieu & Wacquant, 1992, p. 105) takes place between Southern and Inuit nurses. The struggle or competition revolves around the authority to define the field of nursing in the Arctic. The specific knowledges and abilities that Inuit nurses have and employ are not sought by Southern health professionals or the health care system. Rather, available information is often built on Southern concepts, ideas and theories that do not always apply in the Arctic. Because Inuit nurses possess both ‘Inuit-specific’ *capital* and Southern *capital* the competition that takes place between the two is not an open competition. Where Inuit nurses and students unconsciously recognize Southern actions and explanations as valid while also recognizing that they are not always successful, Southern nurses may not recognize their actions and behaviour as unsuccessful or they may blame lack of success on Inuit clients. The unconscious competition that happens on account of differences in cultural, social and linguistic *habitus* may leave both dissatisfied with their working environment.

Thirdly, Inuit nurses and students recognize Southern explanations and actions as valid because they possess both Inuit specific *capital* and Southern *capital*. Inuit nurses and students possess the *habitus* that affords access to, and success in, Southern high schools, which they need in order to get access to the Southern nursing programmes. Other factors that Inuit nurses and students saw as contributing to their educational success differentiated them from other Inuit. Areas of *habitus* where Inuit nurses and students felt similar to other Inuit and different from Southerners did not generally play a positive role in educational attainment in the Southern systems. There were marked differences between that which Inuit students and nurses described as Inuit nursing *habitus* and Southern nursing *habitus*, with the latter resembling the *habitus* needed to have success in the Southern educational systems. Although Inuit nursing *habitus* is not a

recognized or valued *capital* in Southern minds and therefore carries little weight in Arctic health care systems, it is a *capital* that is recognized and valued by other Inuit health care professionals and Inuit patients and it may gain increasing recognition as more Inuit health care professionals are educated.

## 8. Conclusion

By no means does this work cover all aspects of what it is possible to include in an anthropology of nursing focusing on Inuit nursing. It does, however, provide a starting point upon which to build. In the following I will first detail how this work contributes to the field of anthropology and describe areas in relation to an anthropology of nursing that would benefit from further research. Next, I discuss ways in which Inuit nurses, students, and nursing may be promoted and supported in order for Inuit health care recipients to reap the most benefit of the care they receive in Arctic health care settings, and ways to increase the ability, and motivation, of Inuit to enter and complete the nursing education and stay in the vocation once they have graduated.

### ***8.1 The Experience of Inuit Nurses and Students; a Contribution to an Anthropology of Nursing***

In chapter one I suggested that an anthropology of nursing would discuss and analyse what nursing is, taking into account local accounts and the cultures (including language, *habitus*, education, values and spiritual beliefs) of the nurses and students themselves as well as of their patients. Furthermore, I suggested that an anthropology of nursing would discuss and analyse the power relations that shape and produce not only sickness but also the field of nursing itself. These power relations include those that exist between patients and nurses and among and between nurses and other health professions with whom they interact in pursuit of the common goal of furthering the health of their patients.

Using the experiences of Inuit nurses and nursing students as a lens, I have provided a view of how the beginning of an anthropology of nursing might look. In chapters four to six I have discussed how *habitus* and culture in relation to language, education, and identity have shaped Inuit nurses' and students' paths towards their profession and practice and how these affect their interaction with patients and colleagues, and how they, through this interaction, affect patient outcome. I have used the material presented in chapters four to six as a basis for

the analysis – in chapter seven– of the power relations that exist within and also surround nursing as an action as well as a field in a Bourdieuan (1990) sense, as explained in chapter one. In chapter 7 I have demonstrated how Bourdieu’s “analysis of a field” (Bourdieu & Marquart, 1992) may be a useful analytical tool in research focussing on an anthropology of nursing. Bourdieu’s concepts of *habitus*, *field* and *capital* have been used recently in a variety of works concerning both the field and the act of nursing (e.g.: Brown, Crawford, Nerlich & Koteyko, 2008; Gibb, Forsyth & Anderson, 2005; McNamara, 2005; Rhynas, 2004). Scholars in nursing have authored these works. I have found no work authored by anthropologists that focus on nursing and use Bourdieu’s conceptual frameworks.

An anthropology of nursing focusing on Inuit nurses would benefit from also having non-Inuit nurses’ experiences with, and view of the field of, nursing in Greenland and Nunavut illuminated as well as Inuit patients’ experiences with, views, understandings, and expectations of nurses and nursing.<sup>111</sup> I propose that further work be done where non-Inuit nurses and other health care practitioners are interviewed individually and in focus groups to discuss their view on nursing in the Arctic, which changes/adaptations they have made to their nursing practice since being employed in an Arctic setting, and why and whether areas exist where they feel they would like to know more in order to provide nursing that would be better suited to Arctic patients. Further, I propose that anthropological work examining the view of nursing and expectations of, and wishes for, nursing as a field and as an act, among the local populations in Greenland and Nunavut, would add tremendously to an increased understanding of what nursing in the Arctic is and should be.

Apart from working toward and contributing to an anthropology of nursing, this work contributes to the field of hospital ethnography as it is described by van der Geest and Finkler (2004). This is achieved by shedding light on the ways in

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<sup>111</sup> Two studies conducted through Institute of Nursing and Health Research, University of Greenland, that focus on *Patient experiences in the secondary health system in Greenland* (Jokumsen, 2010) and *The quality of the practice of care from a patient and health care staff perspective* (Aagaard, 2010) are currently underway.

which Inuit nurses' and students' *habitus* and socio-cultural and linguistic backgrounds affect the specific culture of nursing in the Arctic. The culture of nursing, in the Arctic as elsewhere, contributes to hospital culture and plays a significant role in patients' experiences when in contact with the health care system. This is so because of the very close proximity to patients that nurses have, particularly in the hospital setting, and also because of nurses' role as mediators between doctors, other health care professions, and patients. As stated by van der Geest and Finkler (2004) "*biomedicine and the hospitals as its foremost institution, is a domain where the core values and beliefs of a culture come into view*" (p. 1996, emphasis in original), and there is significant variation "*in hospital cultures in different countries*" (van der Geest & Finkler, 2004, p. 1996, emphasis in original), just as there is in nursing cultures. Although not claiming to be hospital ethnographies, some ethnographic work has been done that focuses on current health care and health care providers (institutionalised and otherwise) in Nunavut and Greenland in terms of mental and psychological therapy, helpers and healing (Fletcher & Denham, 2008; Korhonen, 2002; Minor, 1992), experiences of tuberculosis within and outside the health care system (Møller, 2005, 2007, 2010), birthing practices (Montgomery-Andersen, 2007; O'Neil & Kaufert, 1995) and communication between health care practitioners and patients (Curtis, 2001; O'Neil, 1989a), but nothing with a focus on nursing.<sup>112</sup>

Educational anthropology is another field where this work adds valuable insights, particularly within Indigenous and minority education. Scant work exists that focuses on post secondary education among Inuit, whether Canadian or Greenlandic (some of the extant literature includes Chemnitz, 2001, 2005; Eggertson, 2008; Lund & Nathanielsen, 2001; Russell, 2006) and none of it is anthropological. Furthermore, educational anthropology focusing on Inuit expectations of, and experiences in, postsecondary education would illuminate areas of success and challenges in the existing programs. This work would be particularly helpful if combined with work focusing on postsecondary educators

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<sup>112</sup> Please refer to footnote 84.

and their experiences and expectations (of themselves, the programmes and the students) and also work that would examine the desire among high school students to pursue postsecondary education – what would encourage that desire and what would thwart it.

In chapter two, I touched on some of the historical material in relation to nursing in the Arctic and how Arctic nursing has been described in contemporary literature. While work exists that incorporates some of the extensive archival material<sup>113</sup> on early Arctic nursing (e.g., Copeland, 1960; Farrell, 2004; Farrell & Alivaktuk, 2005; Lange, 2010; Lange & Ezekiassen, 2004; Rutherford, 2008; Rønsager, 2002) work that documents Inuit nurses' contribution to early nursing in the Arctic and provides an analysis of how early Inuit nurses have affected nursing in the Arctic today, would provide a welcome appreciation for early Inuit nurses and nursing. Similarly, work that pulled together archival material describing the work and lives of early Southern nurses working in the Arctic would be valuable in an analysis of how this work has affected nurses and nursing in the Arctic today. Both would also be valuable contributions to the curriculum on the history of nursing that is taught in the Arctic nursing programmes.

### ***8.2 The Experience of Inuit Nurses and Students. A Tool to Advocate for Nursing, Nursing Students and Nurses in the Arctic***

Throughout this research, in the field periods, during transcription and translation, in the analysis and the write-up processes, when informally discussing the research with nurses in the Arctic and with friends and peers, and formally when presenting preliminary findings at conferences, I kept being struck by the strength, abilities, knowledge and qualities of the Inuit nurses and students. Still, as noted in chapter one and reiterated in chapter seven, the experiences of Inuit

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<sup>113</sup> As mentioned in chapter two, in Canada this material resides in the National Archives of Canada, the National Research Council Archives, the Alex Stevenson Collection, the Royal Ontario Museum, the Thomas Fisher Rare Book Library at the University of Toronto, the Glenbow Museum Archives in Calgary; in Denmark, at the Archives of the Royal Library and the Arctic Institute, as well in early periodicals such as *Meddelelser om Grønland* (Monographs on Greenland), "*Tidsskriftet Grønland*" (The Greenland Journal), and *Geografisk Tidsskrift* (The Journal of Geography).

students and nurses in their learning and practice are framed by colonialism. To help reduce the colonial frame and help recruit and retain Inuit nurses, I recommend an increased focus on several areas in relation to theoretical and practical education, post graduate education, collaboration between nurses in the Arctic, terminology and local nursing research, textual material, and support for the currently ongoing restructuring of the educational systems in the Arctic. I will start with a discussion on the need to acknowledge Inuit nurses' knowledge and abilities.

### ***8.2.1 Acknowledging Inuit nurses' knowledge and abilities***

As stated in chapter seven, Inuit nurses and students (along with other Inuit health care professionals) are one of the greatest assets the Arctic health care systems have. They possess *linguistic* and *cultural capital* that allows them to provide culturally relevant and appropriate care in a language and manner understandable and acceptable to Inuit populations. Unfortunately, because the Arctic health care systems have been largely governed by Southerners who are still a majority, and perhaps also because an "*Inuit habitus*" has prevented most Inuit from objecting, their knowledge and abilities have not been valued to the degree they deserve.

Inuit nurses' knowledge and abilities need recognition generally, and need to be acknowledged and valued in ways other than linguistically and culturally when serving as interpreters and cultural brokers in specific situations. As stated by one Inuit nurse, "*I was used as a cultural broker by my Southern colleagues and that may be extra difficult in the area of psychiatry... having to convey cultural things that are not described in books*" (T25:89).

Inuit nurses have knowledge about what nursing is in an Arctic setting and where Arctic nursing differs from Southern nursing. Inuit nurses know about Inuit concepts of health, disease and the body and where differences may exist between Southern and Inuit ways. Inuit nurses are able to communicate as nurses and approach, interview, provide information to, and advise Inuit patients in ways that fit their culture or *habitus*. Inuit nurses have knowledge about Inuit communication. Apart from being extremely valuable for Inuit patients and

therefore for the health care system, all these abilities and all this knowledge is valuable for the Southern colleagues they work with and for prospective colleagues they might work with in the future. It is important that this knowledge and the knowledge of other Inuit health professionals be used. For it to be used it may need to be documented either in the form of audiovisual or textual material, although this will certainly capture some aspects of it imperfectly. A focus on Inuit nurses' knowledge and abilities would in essence help 'decolonize' the Arctic health care systems.

### ***8.2.2 Cross Arctic nursing collaboration***

Forming Inuit nursing groups and prioritising that these groups be given time to meet would be extremely valuable. Such meetings might be used to discuss: a) what Inuit or Arctic nursing is; b) nursing actions, initiatives and approaches that work particularly well in Arctic settings and why they work; c) Inuit language health care, nursing, and medical terminology. Nurses who have a particular interest in developing the field of Inuit nursing both practically and theoretically should be encouraged and supported to do so. Perhaps Arctic College in Nunavut and the new Institute for Nursing and Health Research in Greenland might seek and secure funding to provide possibilities for graduate study to such nurses.

The Inuit nursing field is small in Greenland and even smaller in Nunavut and there is strength in numbers; therefore, Inuit nurses might benefit from forming liaisons with other Arctic nurses. I am aware that there are differences between Arctic settings and Arctic peoples; at the same time, however, Canadian and Greenlandic Inuit nurses share enough similarities in knowledge and abilities and similarities in professional challenges that I imagine that they would benefit from collaboration in developing Inuit nursing theory. A forum where Inuit nursing is discussed and celebrated may strengthen the voice of Inuit nurses and help promote Inuit nursing, again aiding in decolonizing the nursing field in the Arctic.

### ***8.2.3 Local, health, nursing, and medical terminology and texts***

One ability that many nurses and students felt they needed was knowledge of local health care, nursing and medical terminology. One medical terminology book exists in both Greenlandic/Danish and Inuktitut/English. While some used them, some nurses and students did not know they existed and many of those who did found them lacking. Virtually all also lamented the fact that they did not learn the local terminology, for example as part of their anatomy and physiology courses, and called for this to be a possibility. The possibility of having transparencies with the local terms to add to anatomy and physiology charts that display the Danish/English/Latin terms came up in several conversations and was thought to be a viable alternative to creating textbooks in the local languages. Such charts might be constructed as a collaboration between the departments of health and language in both regions, perhaps also involving the institutes for language and culture and nursing and health research at the University of Greenland and the programs of nursing and language and culture at Nunavut Arctic College.

Texts that address particular aspects of nursing as they play out in the Arctic were also sought after. This may be addressed by nursing research executed in the Arctic by Inuit nurses doing graduate work, as suggested above, and by the Institute of Nursing and Health Research in Nuuk and the nursing program at Nunavut Arctic College in Iqaluit engaging local nurses in research on nursing both as a field and as an action.

### ***8.2.4 Nursing leader courses***

Arctic nurses face challenges beyond being recognized as the assets they are and having their knowledge and abilities recognized too. Due to a shortage of nurses and high turnover of nurses who do not call the Arctic home, Inuit nurses are often pushed into leadership positions before they are properly prepared for them. Knowing that Inuit nurses are the ones who stay in the Arctic and are therefore preferable in nurse in charge positions, it would be beneficial to offer postgraduate courses or diplomas to neophyte nurses in the Arctic that would

prepare those who have a desire to pursue that route. It would also be helpful to team new leaders up with a mentor, even one who is in another institution in another town, this may decrease the risk of burnout which several Inuit nurses in leadership positions had suffered. That nurses need to travel to the south to take courses may work as an obstacle as many have family responsibilities where they live and work. It may also be beneficial to allow a leadership position to be shared by two neophytes, such that they have the possibility to stay connected to their co-workers as well as share the responsibilities as a leader.

### ***8.2.5 Student mentors***

Because of a lack of nurses and high turnover of non-Inuit nurses, Inuit nursing students face the challenge of not always having nursing mentors or having nursing mentors who are not available because of shift and call work; students often feel “alone” in their practicum. One solution to this challenge might be to allow a nurse who is situated in another location to be a backup mentor, perhaps with this nurse serving as a backup mentor to several students. Face to face communication between students and mentor might take place over an Internet connection with real time audio and video possibility (similar to Skype). For such an arrangement to work the nurse who mentors multiple students would need to have completed the student mentor course and would also need a reduction in ‘ward’ hours. Planning one particular day of the week where students would have planned ward time while in practicum and where the student mentor was accessible would facilitate easy and continuous communication. Setting up an electronic discussion forum for students and mentors might be a way to overcome some of the feelings of academic isolation experienced by nursing students when in practicum.

### ***8.2.6 Arctic elementary and secondary education***

Arctic nurses and students are among an elite few Inuit who possess the linguistic and cultural *capital* required to excel in the Southern framed educational systems that have prevailed in the Arctic during their elementary, secondary and post

secondary education. These systems appear to persist as there continues to be many more Southern than Inuit teachers employed in all of these places. This is not a problem for the nurses themselves or for the health care system in which they are employed. It is of concern, however, that only Inuit who possess a great amount of Southern *capital* are able to excel in the educational systems, although others may have both the desire and ability to pursue post secondary education. In the current schooling systems they may not have the right linguistic and cultural *capital* to do so.

As Hansen (2007) argues in a Greenlandic context, and which I believe is also valid in the Canadian Arctic, the ways in which teaching is structured in the current educational system is fundamentally different than the learning habitus of most Inuit students. Although Hansen sees the need for restructuring he has difficulty envisioning how this might work. T. Berger (2006) similarly argues for a restructuring of Nunavut's educational system because of linguistic and cultural differences between Inuit students and the system, recommending a system that is bilingual and bicultural.

In both Greenland and Nunavut restructuring of the educational systems are currently underway. Only time will tell what the outcome will be and what restructured educational systems will mean for prospective nursing students, some of whom may not be able to enter the programmes currently because their *linguistic and cultural capital* is not the sort that the educational system demands.

### **8.2.7 Final thoughts**

The title of the report on Aboriginal nurses in Canada "Against the odds" (Gregory & Barsky, 2007) I think is very apt in relation to Greenlandic and Canadian Inuit nurses. Inuit nurses are educated and practice in educational and health care systems that are dominated by cultures and languages different from local culture and language, their learning and working experiences are colonially framed, and their knowledge and abilities are not recognized to the extent that they deserve. Although there have been Inuit nurses in Greenland since the early 1900s and in Nunavut since the 1960s, the field of Inuit nursing is still in its

infancy. Inuit nurses and the field of Inuit nursing would benefit from being celebrated and further documented and developed. Inuit nurses and students should be instrumental and supported in this endeavour. Doing so would signal a desired move towards respecting Inuit abilities in health care generally and in nursing specifically. This would inevitably improve patient care and increase work satisfaction for Inuit nurses and likely over time also Southern nurses. It would also be a move towards mental decolonisation as recommended by Lyngé (2006). As stated, Inuit nurses provide strength and unique knowledge and abilities to the Arctic healthcare systems. They and their knowledge and abilities should be recognized, supported and embraced.

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## Appendix A

### Information about research and content form in Danish

**At vide hvad der tæller som viden : Hvordan Inuit og grønlandere der er sygeplejersker og sygeplejestuderende oplever og negotierer deres roller I Vestlige uddannelses og sundheds systemer.**

Kære Sygeplejerske/ sygeplejestuderende,

Dette er en invitation til at deltage i studiet:

**At vide hvad der tæller som viden : Hvordan Inuit og grønlandere der er sygeplejersker og sygeplejestuderende oplever og negotierer deres roller I Vestlige uddannelses og sundheds systemer.**

Jeg er PhD studerede ved afdelingen for Antropologi på University of Alberta. Jeg er også sygeplejerske og har arbejdet i Danmark og i Nunavut hvor jeg også har undervist medicinske tolke gennem Arctic College og udført forskning til en kandidat uddannelse i antropologi. Kandidat uddannelsen tog jeg gennem Københavns universitet. Derudover er jeg affilieret med antropologiafdelingen på Lakehead University i Thunder Bay, Canada hvor jeg underviser med fokus på kultur, politik og historie i relation til sundhed og sygdom.

**Projekt beskrivelse:** Studiet vil undersøge hvordan 1) Canadiske inuit og grønlandere der er sygeplejersker og sygeplejestuderende oplever den pædagogik, epistemologi (de måder vi opnår viden på og hvad der tæller som viden for os) og ontologi (vores opfattelse af verden og vores plads i den) der eksisterer på deres uddannelses og arbejdssted og: 2) hvordan inuit and grønlandere der er sygeplejersker og sygepleje-studerende negotierer deres roller i uddannelses og sundhedssystemer der i vid udstrækning er udviklet og ledet af danskere/ eurocanadiere ifølge dansk/eurocanadisk doktrin og kultur hvor hovedsproget er dansk/ engelsk.

**Formål med projektet:** *En undersøgelse af og indsigt i inuit sygeplejerskers og sygeplejestuderendes oplevelse af deres uddannelse og arbejdssted og den pædagogik, epistemologi og ontologi der hersker disse steder vil fremhæve eventuelle forskelle og ligheder der er mellem Inuit og danske/ eurocanadiske tilgange i sundheds og sygdomsspørgsmål hvilket kan bruges i fremtidige beslutninger om sundhedsvæsenets og sundhedsuddannelsernes struktur. Det kan også belyse hvilke forhold (personlige, samfundsmæssige og uddannelsesspecifikke mm.) der medvirker til at nogle studerende vælger og gennemfører uddannelsen til sygeplejerske og at andre vælger men ikke gennemfører den. Den Canadiske organisation "The National Aboriginal Health Organization" opfordrede i 2004 til at en undersøgelse af denne art blev udført og det samme gjorde Tine Curtis der udførte en PhD om kommunikation mellem læge og patient i den tolkede konsultation i Grønland i 2001. På grund af ligheder indenfor områder som sundhed og uddannelse vil dette studie have teoretisk og politisk relevans både for inuitter, grønlandere og andre oprindelige folk.*

**Interviews:** Projektet vil blive udført blandt andet ved interviews. Hvis den der interviewes indvilliger vil interviewet blive båndoptaget. I modsat tilfælde vil interviewereren tage notater. Efter interviewet beslutter den interviewede og interviewereren sammen om et eventuelt opfølgende interview skal udføres.

**Interview Emner:** De emner der vil blive dækket under interviewet inkluderer:

-Demografisk data (den interviewedes alder, tidligere karriere/arbejds erfaring og højest opnåede uddannelse, familiemedlemmers alder, højest opnåede uddannelse og arbejds erfaring, sprog talt i barndomshjem og nuværende hjem, forældres, bedsteforældres og eventuelle partners nationalitet, hvor voksede den interviewede op og med hvem)

- Den interviewedes minder om tidligere skolegang (Hvad husker du mest fra din folkeskoletid? Hvile fag ku du bedst lide? Var der nogle fag du ikke kunne lide? Var der fag du savnede? Hvilke(t) sprog blev du hovedsageligt undervist i? Hvilken nationalitet havde dine lærere? Hvilke faktorer gjorde skolegangen lettere/sværere?)
- Den interviewedes oplevelse af at være sygeplejestuderende (Fortæl mig det første der falder dig in om at være sygeplejestuderende. Er der aspekter af uddannelsen du finder specielt spændende, er specielt glad for? Er der aspekter af uddannelsen du finder specielt udfordrende eller er mindre glad for? Hvordan tror du du lærer bedst? Hvilke undervisningsmetoder bliver mest brugt i sygeplejeuddannelsen? Hvilket sprog foretrækker du at blive uddannet i? Hvilket sprog bruges mest i sygeplejeuddannelsen? Er der faktorer på sygeplejeskolen, i selve uddannelsen, personlige eller i samfundet der har gjort/gør det specielt muligt for dig at uddanne dig? At uddanne dig specielt til sygeplejerske? Er der faktorer der gør det specielt svært? Vil det gøre nogen forskel for dig om du bliver uddannet af en grønlander/dansker? Tror du Grønlandere og danskere underviser på samme måde? Hvis ikke, hvilke forskelle har du lagt mærke til? Betyder det noget for dig? Er der nogen forskel i den måde du vil vælge at undervise dine patienter i sundheds og sygdomsrelaterede emner på? Hvis ja, hvad dirigerer valget? Tror du generelt set at danske og grønlandske sygeplejersker plejer og underviser deres patienter på samme måde? Hvis nej, hvilke forskelle har du lagt mærke til?)

**Risiko ved at deltage i projektet:** Der er ingen risiko forbundet ved at deltage i projektet.

**At trække sig ud:** Deltagelse er helt frivillig. De, der vælger at deltage i projektet, kan trække sig ud på hvilket som helst tidspunkt uden at skulle angive en årsag og uden nogen form for straf.

**Honorar:** Alle der indvilliger i et interview modtager 100 kr. Den interviewede beholder honoraret også hvis han/hun beslutter sig for at trække sig ud af projektet.

**Anonymitet konfidentialitet og data opbevaring:** Deltagere i projektet forsikres anonymitet og konfidentialitet. Det sker ved at :

- deltageres navne eller andre kendetegnende karakteristika vil ikke blive brugt i rapporter eller andre publikationer og ej heller nævnes i diskussioner eller præsentationer af projektets udkomme.
- deltageres hjemland og etnicitet vil kun blive nævnt hvis betydelige forskelle findes mellem Grønland og Nunavut og i så tilfælde vil disse blive fremhævet som forskelle grupperne imellem.
- båndoptagelser og felt noter vil blive sikkert opbevaret af Helle Møller i 7 år og ingen andre vil have tilgang til det rå data..

**Forsknings Resultater:** Forskningsresultater vil blive delt med deltagerne og offentliggjort på følgende måde:

- et resume af resultaterne på dansk, grønlandsk, engelsk eller inuktitut vil blive sendt til alle deltagere, begge sygeplejerskoler og sundheds og uddannelses ministerierne i Nunavut og Grønland og præsentationer af forskningens udkomme vil givet ved institutionerne efter ønske.
- en disputats vil blive skrevet baseret på projektet. Denne disputats vil være offentligt tilgængelig og en kopi på engelsk vil blive givet til begge sygeplejerskoler.
- derudover vil der blive skrevet artikler baseret på forskningens udkomme. Disse vil blive udgivet i akademiske tidsskrifter og præsentationer vil blive givet ved akademiske konferencer.

**Forskningen udføres af:**

Helle Møller  
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 Department of Anthropology, HM Tory Building 13-15,  
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Email: [helle@ualberta.ca](mailto:helle@ualberta.ca). Telefon i Canada: (001) 807 983 2333, i Grønland: til 21/09: 32 11 93 Fra 22/09 til 22/10: 31 41 39 Fra 22/10-12/12 32 11 93.

Jeg, \_\_\_\_\_, er blevet fuldt ud informeret om studiet:  
deltagers navn

**At vide hvad der tæller som viden: Hvordan inuit og grønlandere der er sygeplejersker og sygeplejestuderende oplever og negotierer deres roller I Vestlige uddannelses- og sundheds-systemer.** Jeg forstår formålet med studiet og indvilliger i at blive interviewet til studiet. Jeg forstår også at min identitet vil forblive beskyttet, at interviewet er konfidentielt og at jeg kan trække mig ud af projektet på hvilket som helst tidspunkt uden nogen form for repressalier.

_____	_____	Jeg indvilliger i at interviewet bliver båndoptaget (slå cirkel om dit svar)
Deltagers underskrift	Dato	Ja          Nej

#### **Observation af studerende og sygeplejersker på deres arbejdsplads:**

*Som en del af studiet vil jeg gerne følge nogle sygeplejersker og sygeplejestuderende på deres arbejdsplads. Jeg har ikke brug for adgang til patient journaler ej heller specifik viden om patient forhold. Fokus er på sygeplejerskens/ den studerendes oplevelser.*

*Observationer vil fokusere på sygeplejersken/ den sygeplejestuderende i hans hendes arbejde når de giver information til og modtager information fra kolleger inklusive andre studerende, sygeplejersker, fysio- og ergoterapeuter, diætister, læger mm. og, givet at patienterne sanktionerer min tilstedeværelse, sygeplejerskens/ den studerendes interaktion med patienterne.*

*Den studerede/sygeplejersken vil spørge de patienter der er i deres pleje om de er komfortable med at jeg er tilstede for at observere sygeplejersken/ den studerede i hans/hendes arbejde som led i studiet om inuit sygeplejestuderende og sygeplejerskers oplevelser på/af deres uddannelses og arbejdssted.*

*De personer jeg følger vil modtage et resume af mine observationer. Og, jeg vil bruge den tid den individuelle sygeplejerske/studerende skønner nødvendig for at diskutere dagen og de oplevelser den studerende/sygeplejersken havde under min tilstedeværelse.*

*Ingen andre vil have adgang til notater gjort under observationerne eller den efterfølgende samtale.*

#### **Observationer bliver gjort af :**

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Jeg, \_\_\_\_\_, er blevet fuldt ud informeret om studiet:  
deltagers navn

At vide hvad der tæller som viden: **Hvordan inuit og grønlandere der er sygeplejersker og sygeplejestuderende oplever og negotierer deres roller i Vestlige uddannelses- og sundheds-systemer.** Jeg forstår formålet med studiet og indvilliger i at blive fulgt og observeret en dag på min arbejdsplads/ mit praktiksted. Jeg forstår også at min identitet vil forblive beskyttet, at den opfølgende samtale er konfidentielt og at jeg kan trække mig ud af projektet på hvilket som helst tidspunkt uden nogen form for repressalier.

Jeg indvilliger I at den opfølgende samtale bliver båndoptaget:      Ja      Nej

\_\_\_\_\_  
Deltagers underskrift

\_\_\_\_\_  
Dato

## Appendix B

### Introduction letter and questionnaire sent to students who have opted out of the education.

#### Kære tidligere sygeplejestuderende

*Vil du besvare et spørgeskema om hvordan det var for dig at være sygepleje-studerende i et dansk uddannelsessystem og sundhedsvæsen?*

Jeg, Helle Møller, er sygeplejerske uddannet både i Danmark og Canada, jeg er også PhD studerende ved University of Alberta i Canada.

Mit PhD studie undersøger hvordan Grønlandere og Canadiske Inuit der er sygeplejersker og sygeplejestuderende oplever at blive uddannet i et henholdsvis dansk og eurocanadisk uddannelses og sundhedssystem på et sprog der for de flestes vedkommende er anderledes end deres og deres patienters modersmål og i en kultur der ligeledes ofte er forskellig fra deres og deres patienters.

*Jeg laver undersøgelsen fordi der både i Grønland og i Nunavut, Canada er mangel på sygeplejersker. Der er blevet oprettet en sygeplejerskole (en i Iqaluit og en i Nuuk) for at prøve at råde bod på den mangel.*

Hvis skolerne skal kunne støtte de studerede bedst muligt så flere bliver uddannet er det vigtigt at vide noget om hvilke faktorer (personlige, samfundsmæssige, uddannelsesmæssige, politiske, historiske og meget andet) der får de studerende til at vælge uddannelsen og gøre den færdig - eller medvirker til at de stopper uddannelsen før de er færdige.

Indtil nu er 50 sygeplejersker og sygeplejestuderende blevet interviewet eller har udfyldt et spørgeskema; 34 af dem er fra Grønland og 16 af dem fra Arktisk Canada. For at få et billede af hvad der kan være medvirkende til at studerende vælger uddannelsen fra, er det vigtigt at høre fra dem der har stoppet uddannelsen. Derfor denne henvendelse til dig og andre der er stoppet med uddannelsen fra år 1999 hvor en ny uddannelses ordning trådte i kraft.

De spørgsmål der er i spørgeskemaet, der medfølger dette brev, har de nuværende studerende og færdige sygeplejersker også besvaret, udover dem der handler om hvordan dit forløb i sygeplejeuddannelsen har været.

Det er kun mig der vil have adgang til de besvarede spørgeskemaer, mens resultaterne fra spørgeskema undersøgelsen vil blive delt med de ansatte på Peqqisanermik Iliniarfik/ Center for Sundhedsuddannelser.

Således vil spørgeskemaerne dels indgå sammen med det øvrige materiale: interviews, spørgeskemaer og observationer der er foretaget siden 2007 i Grønland og Nunavut i forbindelse med PhD projektet, og dels vil spørgeskemaerne blive bearbejdet som en selvstændig undersøgelse af hvad der ligger til grund for at studerende ved sygeplejestudiet på PI afbryder uddannelsen.

Hvis du vil vide mere om projektet er du velkommen til at skrive en e-mail eller ringe til mig (mail adresse og telefonnumre er herunder).

Eller, hvis du vil besvare det spørgeskema der følger med og putte det i den store frankererede kuvert vil det være dejligt. Din besvarelse vil være anonym og du skal derfor ikke skrive afsender adresse på. Den anden kuvert indeholder et lille kort hvor du kan skrive dit navn, post adresse og eventuelt mail adresse som du kan sende til mig hvis du gerne vil have resultaterne fra undersøgelsen tilsendt.

Mange hilsner Helle Møller.

e-mail: [helle@ualberta.ca](mailto:helle@ualberta.ca)

Telefon til 24 september, 2008: 31 42 17

Telefon i DK fra 26 september til 18 november, 2008: 35 85 22 01

Eller, telefon i Canada fra den 19 November, 2008: 001-807 983 2333

Ring modtager betaler hvis du ringer til Danmark eller Canada.

### Spørgeskema til tidligere sygepleje studerende ved PI

#### Spørgsmål til sygeplejeuddannelses forløb:

1. Hvad fik dig til at vælge at gå ind i sygeplejeuddannelsen? (sæt X ved det mest passende)

- |  |                          |
|--|--------------------------|
| 1. mor eller far har en sundhedsuddannelse (sygeplejerske, sundhedshjælper, læge eller andet)  | <input type="checkbox"/> |
| 2. har tidligere selv arbejdet i sundhedsvæsenet (ufaglært, sundhedshjælper, tolk eller andet) | <input type="checkbox"/> |
| 3. egen interesse i faget  | <input type="checkbox"/> |
| 4. opfordret af skole lærer(e)   | <input type="checkbox"/> |
| 5. opfordret af familie medlem(mer)  | <input type="checkbox"/> |
| 6. første valg af uddannelse ikke mulig i Grønland   | <input type="checkbox"/> |
| 7. Andet (kort beskrivelse)  | <input type="checkbox"/> |

2. Hvilket år startede du på uddannelsen?

Hvilket år stoppede du uddannelsen?

3. Hvilket semester var du på da du stoppede?

4. Hvis dit uddannelses forløb var forlænget, hvad var årsagen? (sæt X ved det mest passende)

- |   |                          |
|---|--------------------------|
| 1. barsel                                   | <input type="checkbox"/> |
| 2. sygdom                                   | <input type="checkbox"/> |
| 3. familie forhold                          | <input type="checkbox"/> |
| 4. bestod ikke en eksamen/praktik           | <input type="checkbox"/> |
| 5. Andet (Hvad? Du må gerne bruge bagsiden) | <input type="checkbox"/> |

5. Hvordan oplevede du det at være sygeplejestuderende på PI? (Du må gerne bruge bagsiden)

6. Hvad var årsagen til at du stoppede på uddannelsen ? (Du må gerne sætte mere end et X)

1. uddannelsen ikke som forventet
2. barsel
3. sygdom
4. familie forhold
5. bestod ikke en eksamen/praktik
6. for svært at gennemføre på dansk
7. Andet (Hvad? Du må gerne bruge bagsiden)

7. Kunne noget have fået dig til at fortsætte uddannelsen? Hvis ja hvad? (Du må gerne bruge bagsiden)

8. Kunne du tænke dig at starte på uddannelsen igen? (sæt X ved det mest passende)

Ja  Nej

9. Hvad laver du nu?

1. under anden uddannelse  hvilken?
2. færdiguddannet med anden uddannelse  hvilken
3. er i arbejde som ufaglært  som?
4. søger arbejde  som?
5. er ikke i arbejde og søger ikke  fordi?

10. Kunne du tænke dig at lave noget andet end det du laver nu?

Ja  Nej  hvis ja, hvad?

### Spørgsmål til skole uddannelses forløb:

11. Hvor gik du i folkeskole?

12. Hvilket sprog blev du hovedsageligt undervist på i folkeskolen?

Grønlandsk  Dansk

13. Hvilket sprog snakkede du og dine klassekammerater hovedsageligt sammen?

Grønlandsk  Dansk

14. Hvor gik du i gymnasiet eller HTX

? \_\_\_\_\_

15. Hvilket sprog blev du hovedsageligt undervist på der?

Grønlandsk  Dansk

16. Hvilket sprog snakkede du og dine klassekammerater hovedsageligt sammen?

Grønlandsk  Dansk

### Baggrundsspørgsmål:



## Appendix C

### Information about the research and Consent form in English

Dear Nurse/ Nursing Student,

I am inviting you to take part in the PhD research study: **Knowing what counts as knowledge: How Inuit and Greenlandic nurses and nursing students experience and negotiate their roles in Western education and health care settings.**

**Project Description** This anthropological research project examines how Canadian and Greenlandic Inuit who are nursing students and practicing nurses experience and describe the pedagogy, ways of knowing and world views that exists within their places of education and practice, and, how they negotiate their roles in educational and health systems developed and governed by Danes or Euro-Canadians, according to Danish and Euro-Canadian doctrine and culture, where the teaching language is Danish/English.

**Methodology** The research will be carried out using anthropological methods including face to face or telephone interviews, which will be audio-taped with the permission of the interviewee, otherwise the researcher will take notes.

**Risk at partaking in the project** There is no risk associated with partaking in the project.

**Withdrawing:** Participation is completely voluntary. Those who choose to participate in the project can at any time withdraw from the project without any form of penalty.

**Honoraarium:** All who choose to partake will receive \$20 as an acknowledgement of their time. The participant will keep the \$ 20 also if she/he chooses to withdraw from the project.

**Conditions for release of audio-taped interviews.**

Audio-tapes will be safely stored by the researcher under lock for a period of seven years. Only the researcher will have access to these and they cannot be released to use by anyone else unless the interviewee has been asked specifically and given his or her permission.

**Research Results:** Research results will be shared in the following ways:

A summary of the results in Danish, Greenlandic, English or Inuktitut will be sent to any participant who requests it as well as to both nursing schools and to the ministries of health and education in Nunavut and Greenland. A doctoral dissertation will be written based on the study. This dissertation will be available publicly and a copy in English will be given to both nursing schools. Articles based on the research may be published in scholarly journals, and presentations made at scholarly conferences.

**Researcher Information** The research is being conducted by:

Helle Moeller

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"I \_\_\_\_\_ have been fully informed of the objectives of the project being conducted. I understand these objectives and consent to being interviewed for the project. I understand that steps will be undertaken to ensure that this interview will remain confidential unless I consent to being identified. I also understand that, if I wish to withdraw from the study, I may do so without any repercussions."

\_\_\_\_\_  
Signature of the participant

\_\_\_\_\_  
Date

I consent to the audio-taping of the interview (please circle)

Yes      No



15. You prefer to be taught in: Inuktitut, English Other \_\_\_\_\_
16. Childhood home's most used language? Inuktitut, English Other \_\_\_\_\_
17. Current home's most used language? Inuktitut, English Other \_\_\_\_\_
18. Where did you attend primary school?
19. What do you remember best about your primary school; the way you were taught, your teachers what you felt about being in school, about learning? Are there things you remember as particularly exiting/ nice, challenging/difficult?
20. Which language were you mostly taught in in primary school?  
English Inuktitut Other; Which? \_\_\_\_\_
21. Which language did you and your classmates speak together?  
English Inuktitut Other; Which? \_\_\_\_\_
22. What do you remember best about your high school: the way you were taught, your teachers what you felt about being in school, about learning? Are there things you remember as particularly exiting/ nice, challenging/difficult?
23. Which language were you mostly taught in in Highschool?  
English Inuktitut Other; Which? \_\_\_\_\_
24. Which language did you and your classmates speak together?  
English Inuktitut Other; Which? \_\_\_\_\_
25. What made you choose to go to nursing school?
26. If you think about the topics you have been taught and the teaching methods that have been used during your nursing education, what do you think have functioned really well for you?
27. If you think about the topics you have been taught and the teaching methods that have been used during your nursing education, what do you think have functioned less well for you or have been difficult?
28. Which language were/are you mostly taught in as a nursing student?  
English Inuktitut Other; Which? \_\_\_\_\_
29. Which language did/are you and your classmates speak(ing) together?  
English Inuktitut Other; Which? \_\_\_\_\_

30. Which factors in the education, your personal life, society have made it possible for particularly you to attend nursing school/ graduate? (for example: Support from parents or other family members, your own stubbornness, financial support, good English abilities, good academic abilities all together/ good teachers in primary/high school, well grounded in own language culture, there could be many other factors too)
31. Have there been factors that have made it more difficult? (for example: that you have children, finances, that English is not your first language, that your partner is not a student, that it is difficult to study at home because of space, that you are away from your home community and family, that most of your teachers do not speak Inuktitut, there could be many other factors too)
32. Do you think it would work best for you to be taught by an Inuit or Southern teacher? Why?
33. How has it been for you to be in practicum both professional and collegial? (what has functioned well/ less well and why; what has been exiting/challenging and why; what would you like to do more of and why; what would you like to do less of and why)?
34. Would you like to be hired in the place(s) where you have had your practicum? Why/ why not?
35. In your experience is there any difference between the way that Inuit and Southerners practice nursing or approach the patients? If yes what are they?
36. What would it mean for you if your colleagues were mostly Inuit? and, What would it mean for you if your colleagues were mostly Southerners?
37. Can you imagine that the nursing education with time will become Inuit and Inuktitut only?