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Communication culturellement sécuritaire et pouvoir de la langue dans les soins infirmiers de l'Arctique

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Résumé de l'article

Au Nunavut et au Groenland, la formation du personnel infirmier et les soins de santé ont été élaborés, et sont en grande partie régis, par les normes, la culture et la langue des Euro-Canadiens et des Danois. La majeure partie des enseignants et des professionnels en soins de santé du Groenland est constituée de Danois danophones, et au Nunavut, par de nombreux Euro-canadiens anglophones du sud du Canada. Cela n'est pas anodin pour les Inuit groenlandais et canadiens qui étudient pour devenir infirmiers ou infirmières, non plus que pour les patients canadiens ou groenlandais qui reçoivent des soins infirmiers et dont la langue maternelle, pour leur grande majorité, est l'inuktitut ou le groenlandais. À partir essentiellement de données recueillies lors d'entrevues avec des infirmiers/infirmières et des étudiants en sciences infirmières, tant groenlandais que canadiens, entre 2007 et 2010, je discute des façons dont la langue, en tant qu'habitus, peut soit soutenir soit entraver la sécurité culturelle dans les domaines des soins, des lieux de travail et de l'enseignement. J'avance que les étudiants infirmiers/infirmières groenlandais et canadiens, puisqu'ils ont une double culture, ont une valeur inestimable pour les systèmes de soins de santé dans l'Arctique, en tant que personnel soignant et en tant que négociateurs d'habitus culturellement sécuritaires. De plus, les professionnels de la santé de l'extérieur du Groenland et du Canada pourraient bénéficier des connaissances de leurs homologues groenlandais et canadiens.

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Helle Møller*

RÉSUMÉ

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Au Nunavut et au Groenland, la formation du personnel infirmier et les soins de santé ont été élaborés, et sont en grande partie régis, par les normes, la culture et la langue des Euro-Canadiens et des Danois. La majeure partie des enseignants et des professionnels en soins de santé du Groenland est constituée de Danois danophones, et au Nunavut, par de nombreux Euro-canadiens anglophones du sud du Canada. Cela n'est pas anodin pour les Inuit groenlandais et canadiens qui étudient pour devenir infirmiers ou infirmières, non plus que pour les patients canadiens ou groenlandais qui reçoivent des soins infirmiers et dont la langue maternelle, pour leur grande majorité, est l'inuktitut ou le groenlandais. À partir essentiellement de données recueillies lors d'entrevues avec des infirmiers/infirmières et des étudiants en sciences infirmières, tant groenlandais que canadiens, entre 2007 et 2010, je discute des façons dont la langue, en tant qu'habitus, peut soit soutenir soit entraver la sécurité culturelle dans les domaines des soins, des lieux de travail et de l'enseignement. J'avance que les étudiants infirmiers/infirmières groenlandais et canadiens, puisqu'ils ont une double culture, ont une valeur inestimable pour les systèmes de soins de santé dans l'Arctique, en tant que personnel soignant et en tant que négociateurs d'habitus culturellement sécuritaires. De plus, les professionnels de la santé de l'extérieur du Groenland et du Canada pourraient bénéficier des connaissances de leurs homologues groenlandais et canadiens.

ABSTRACT

Culturally safe communication and the power of language in Arctic nursing

Nursing education and healthcare in Nunavut and Greenland have been developed, and to a large degree governed, by Danish and Euro-Canadian norms, culture, and language. Teachers and healthcare professionals are mostly Danish-speaking Danes in Greenland and English-speaking Euro-Canadians from southern Canada in Nunavut. This is not trivial for Greenlandic and Canadian Inuit nursing students or nurses, or for Canadian and Greenlandic Inuit healthcare recipients, the majority of whom speak Greenlandic or Inuktitut as their mother tongue. Drawing primarily on data from interviews with Canadian and Greenlandic Inuit nurses and nursing students between 2007 and 2010,

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I discuss the ways in which language as habitus may work to support or impede culturally safe care, workplaces, and education. I argue that the double-cultured Greenlandic and Canadian Inuit nurses and nursing students are invaluable to Arctic healthcare systems as culturally safe healthcare providers and habitus brokers. Furthermore, healthcare professionals from outside Greenland and Nunavut can advantageously learn from their Greenlandic and Canadian Inuit counterparts.

Introduction

Nursing educational programs were established respectively in Nuuk (Greenland) in 1994 and in Iqaluit (Nunavut, Canada) in 1999. Both were launched with the aim of addressing serious recruitment and retention issues and having "homegrown" nurses who could provide culturally appropriate care in the local languages (Lange 2014; McClusky 1999). Today, a Bachelor of Science in Nursing can be earned at the Institute for Nursing and Health Science at Ilisimatusarfik/University of Greenland and through a program jointly offered by Nunavut Arctic College and Dalhousie University. Despite the location of the programs, students learn and practise in settings developed, and to a large degree governed, by Danish and Euro-Canadian norms, culture, and language.

Different histories and cultures exist both within and between Greenland and Nunavut, and in the past their governments have initiated programs with the aim of helping non-Inuit to learn local languages and become sensitive to local cultures, and both governments have agreed to do so in the future (Auditor General of Canada 2017; Quist 2016). Though a good beginning, learning a local language and becoming culturally sensitive is often not enough. This is true for both Nunavut and Greenland. While Inuit nursing students and nurses are bilingual and "double cultured" (Møller 2011), and the language most often spoken between Inuit nurses and healthcare users remains an Inuit language, more than half of the nurses in the Greenlandic healthcare system and 90% of those in Nunavut do not speak an Inuit language. Although nurses who have been in or have returned to Nunavut and Greenland often master some of the local language, the dominant means of communication in the healthcare systems remain English and Danish.

With the introduction of Greenlandic self-government the Prime Minister at the time, Kuupik Kleist, stressed that the Greenlandic language is a key part of Greenlandic identity (Kleist 2009: 2). The Government of Nunavut expressed a similar sentiment in 2011 when it wrote to the Office of the United Nations High Commissioner for Human Rights that the Inuit language "links each Inuk with his or her past, present and future identity" (Government of Nunavut 2011: 2). While there are diverging positions on the importance of language to identity (Dorais 1995; Government of Nunavut 2015; May 2003), the view that a strong connection exists between Inuit language and identity is largely shared by the Greenlandic and Canadian Inuit populations (Brody 1991; Gad 2009; Langgård 2003).

Cultural identity is one way of looking at identity; ethnic identity or ethnicity is another (Dorais 1995). Dorais (1995: 294) defines "people's attitudes and practices toward language" as cultural and "the political role played" by the Inuit languages in Greenland and Nunavut as ethnic. He further defines cultural identity "as the basic consciousness of one's own group's specificity amongst other peoples, in terms of living habits, customs, language, values, etc." and ethnic identity "as a way to gain access to, or be alienated from, some economic, political or cultural resources" (ibid.) and, I would add, power. In concert, cultural and ethnic identity bear resemblance to Bourdieu's (1980) concept of habitus.

Habitus, Bourdieu (1980) posits, is a system of socialized norms or tendencies that govern action and thought and which are continually contested, affirmed, and transferred from one generation to the next. As such, habitus "produces individual and collective practices" and guarantees a consistency and "correctness" of practices over time "more reliable than all formal rules and explicit norms" (ibid.: 54). Bourdieu employs the concept of habitus "principally in order to explore inequalities in power between dominant and subordinate groups" and argues that "the individual and collective habitus of the former is invariably constituted as *cultural capital*—that is, recognised as socially valuable—whereas the habitus of the latter is not" (May 2003: 109, emphasis in original). Rather, it is often associated with something negative and non-progressive by the dominant group (Lukes 1997).

When conversation takes place between individuals belonging to various fields as envisioned by Bourdieu, be they lawyers, various academics, nurses, or medical doctors, a certain choice of words and phrases, of communicating, or of using the language is implicitly expected, even required, in order to be understood, accepted, and comfortable. This shared way of communicating affords the speakers *linguistic capital*. Linguistic capital can be "measured in relation to a specific linguistic market where often unrecognized power relations are at play" (Bourdieu in Johnson 1993: 7). If two people who interact are not members of the same field or fields, or if they share membership of a professional but not cultural field, even if they share the same mother tongue or speak the same language fluently, they may not understand, or be understood by, their interlocutor.

For Inuit nurses and nursing students, linguistic capital includes the ability to speak and understand a southern language and to speak and understand the language of nursing or the healthcare field. It also includes the ability to switch to an Inuit language and *act* in it when caring for an Inuk patient—an ability that makes it more possible to provide culturally safe care (Møller 2011). Language is also action, as it includes the nonverbal communication of body language (i.e., gestures, facial expressions, looks, pauses, and silences).

Irving Goffman (1981: 2) posits that these "movements, looks, and vocal sounds we make as an unintended by-product of speaking and listening," through our lives become a specialized part of our behavior. We perform them "right where *others in our gestural community* would also" (Goffman 1981: 2,

emphasis added). The others of "our gestural community" are generally those with whom we share more habitus. Bourdieu (1986) posits that although habitus is largely unchangeable, it is transferrable and learnable. Like Goffman (1981), I understand habitus as being similar to identity, of which it is part, and as being more plastic than unchangeable. Once gestural conventions are established in a community, newcomers can acquire them (ibid.: 3). Gestures can be offered as part of verbal speech but can also be used in silence. Similarly, silence can be "an important part of communication" (Gudykunst 1998: 173). It carries meaning in and of itself, and it is used as a means to shape speech and to organize social relationships (Kivik 1998).

Understanding the habitus of the people we care for and the historical and colonial context of that habitus, whether in the form of verbal, body, or gestural language or silence, can help provide culturally safe care, work environments, and education (Brascoupé and Waters 2009). Maori nurses in New Zealand/Aotearoa developed the concept of cultural safety as a response to the agony Maori people went through during colonization and the mainstream healthcare system's ethnocentric inability to appropriately address their needs (Ramsden 2002, 2015). In cultural safety, the culture is plastic and politically charged (Woods 2010). It is not about a people's "habits or customs" (Ramsden 2002); rather, it is a "complex network of meanings enmeshed within historical, social, economic, and political processes" (Anderson and Reimer-Kirkham 1999: 63). Cultural safety shifts the focus from the "Other" (here the Greenlandic/Canadian Inuk patient or nurse) to the healthcare provider (here Euro-Canadian/Danish) (Browne and Varcoe 2006; Ramsden 2002) and transfers the power to define the meaning of cultural safe care from the provider to the client (Ramsden 2002). Summarized by the National Aboriginal Health Organization (2008: 3), "Cultural safety moves beyond the concept of cultural sensitivity to analyzing power imbalances, institutional discrimination, colonization and colonial relationships as they apply to healthcare."

Being able to converse in one's mother tongue is one aspect of cultural safety, especially if the patient is in a vulnerable position, such as needing healthcare (Brascoupé and Waters 2009). When nursing care is delivered with an absence of "cultural respect," "when elements such as language, the role of traditional medicine and/or healers, religious belief systems and practices, and birthing and death rituals are ignored or suppressed," a person's cultural identity and self-esteem may be compromised and lack of trust is the outcome (Woods 2010: 721). "Without trust, […] and without the preservation of self-esteem or prestige, patients' well-being will be diminished" (ibid.).

In this paper, I will discuss the ways in which language as habitus may work to support or impede culturally safe care, workplaces, and education. In doing so, I will present and analyze data from interviews I conducted with Canadian and Greenlandic Inuit nurses and nursing students between 2007 and 2010 for my doctoral research.

Methodology

An important principle of cultural safety is that healthcare providers and researchers situate themselves and are continuously self-reflective about how their preconceived assumptions, stereotypes, beliefs, and location affect their practice and the power dynamics that are part of their clinical/research encounters (Browne and Varcoe 2006). I am Danish, educated as a nurse and anthropologist in Denmark and Canada, and currently an associate professor at Lakehead University. Between 1997 and 2001, I lived and worked as a community health and tuberculosis nurse and consultant in Nunavut: two years in Cape Dorset, and shorter periods in Igloolik, Pangnirtung, and Iqaluit. I have conducted master's research (Møller 2005) in two Nunavut communities and doctoral research in three communities in Nunavut and four in Greenland, and taught courses for the medical interpreter program in Nunavut and for the nursing program in Nuuk between 2002 and 2010. Over shorter periods between 2010 and 2013, I worked with and interviewed Greenlandic nurses in Nuuk for a book about nurses and nursing in Greenland (Møller 2014). Living and working in Nunavut and Greenland has made me acutely aware of the ways in which healthcare and educational systems, and my different roles in them, have been shaped by histories of colonization, and how these histories have afforded me unearned privilege and power, which I must acknowledge (see Møller 2011).

My doctoral research employed ethnographic methods, including participant observation and in-depth semi-structured interviews. I interviewed 11 students and 13 nurses in Greenland, and 6 students and 11 nurses in Nunavut. I received written responses to open-ended questionnaires (containing the same questions as the interview schedule) from 7 students and 2 nurses in Greenland. The option of a written response encouraged more nurses and students to participate. The interview schedule included a few questions on interviewee background: where the interviewee grew up, family make-up, and schooling. I also asked interviewees to tell me their stories about and experiences with learning and being taught at home, in elementary school, in high school, and in nursing school, and any other post-nursing-school learning and teaching they might have been involved in. Interviews took between one hour and two and a half hours, and some people were interviewed twice. All interviews were transcribed verbatim and sent back to each interviewee for acceptance.

Altogether, I observed more than 120 instructional hours from one semester of each program, thus covering most levels of nursing education. I observed some students in their places of practice in Greenland, but could not obtain permission to do so in Nunavut. In addition, I was privileged to be included in the social lives of teachers, students, and nurses. I also conversed with community members and healthcare workers and professionals socially and casually in different forums. I took field notes in classes, after following students in their practicum and after spending social/casual time in the communities. In my field notes, I focused on verbal and nonverbal language use and on

conversations about health and healthcare, schooling and education, and teaching and learning. Data for my doctoral work also included a review of government reports, other gray literature, and articles in local papers plus the online and in-paper comments these generated.

I used the qualitative software program Atlas-ti to manage and code the interviews and field notes. Themes were generated and condensed over numerous readings and iterations of all the data. This paper has its starting point in one of the themes—the importance of language—albeit in a re-analyzed format. I draw here primarily on the data shared by the 50 nurses and students through interviews or written responses. For ease of reading and to protect the identity of quoted interviewees I will, unless differentiation is important, use the term Inuit to denote Greenlanders and Canadian Inuit, Southerners to denote Danes and Euro-Canadians, southern language to denote English and Danish, and Inuit language to denote Inuktitut and Greenlandic. I have also made these substitutions in any interviewee quotes used.

Linguistic habitus and cultural safety in Nunavut and Greenland

Nurses and students from Nunavut and Greenland found it challenging that the vast majority of southern healthcare practitioners did not speak an Inuit language during patient care, in the work environment, and when sharing the workload. Some felt that it would benefit Inuit patients if all healthcare practitioners spoke an Inuit language, while also acknowledging that such proficiency would likely be neither feasible nor enough. Culturally safe care requires that healthcare providers know about Inuit history, colonial and otherwise, and be able to reflect on and challenge the power relations inherent in the client-provider interaction (Ramsden 2002). As one nurse put it: "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 […] [and] lots of misunderstandings occur" (T20: 219).

When I asked a nurse what she meant when she talked about Inuit identity, she said: "Inuit identity is being Inuit, having the Inuit language, being part of the Inuit culture—what can I say?" (T29: 297). While not using those exact terms, Inuit nurses and students interviewed between 2007 and 2010 and several of the Greenlandic nurses contributing chapters to the book *Greenlandic Nurses Narrate* (Møller 2014) felt that healthcare practitioners who share or know the linguistic habitus, identity, and background of their clients are better equipped to provide them with culturally safe care. As one nurse said when caring for Inuit patients, she does so in

> their own culture, their own language […]. 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 (T41: 683).

Southern nurses who did not speak the Inuit language were thus reluctant to speak to Inuit patients. When they attempted and realized that the person could not speak a southern language, they seemed to interpret this inability, according to some Inuit, as a sign of lower intelligence. As one noted: "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). Southerners might also miss relevant information or misunderstand/misinterpret the information given. One Inuk nurse recounted an interaction between an Inuk patient and a southern nurse that led the latter to describe the patient as "a poor record-keeper" because she was unable to understand what he was telling her. The Inuk nurse helped the southern nurse and found when conversing with the patient, in an Inuit language, that he was articulate and able to describe his condition in great detail. If the southern nurse had provided culturally safe care, she would have recognized that her habitus and unilingualism were getting in the way of her understanding the patient and that the responsibility for sharing the same language did not lie with the patient. As Ramsden (2002) and Woods (2010) would have put it, the nurse should have shifted the focus from the patient to herself.

Many other examples were given where patients had not been understood by a southern nurse, or the nurse had been unable to make herself understood to the patient who was consequently deprived of needed care or medication. As stressed by one nurse, "it is the patients that suffer when they are not understood" (T29:354). This may explain, as noted by many interviewees, why Inuit patients prefer to be cared for by Inuit nurses: "The patients that we have, that speak an Inuit language only, they prefer to speak with an Inuk […]. It makes it possible to speak about everyday things […] about the patient's day to day life […]. I do not think that you as readily have that intimate conversation with the presence of an interpreter […]" (T19: 244). Indeed, many nurses and students mentioned the gratitude that Inuit patients expressed when they were able to speak their own language and share stories from home—and in some instances the pain of being separated from loved ones. Sharing linguistic habitus with Inuit patients aids Inuit nurses in providing culturally safe care. It also makes them the chosen care providers for many Inuit patients and a needed cultural broker for their colleagues.

Linguistic capital and a culturally safe work environment

Having a bilingual healthcare system is challenging to Inuit patients and healthcare professionals alike. It also greatly affects the working conditions of Inuit nurses and students. Many nurses related experiences of "double work"

because of their being bilingual while working with unilingual colleagues who did not speak the language of many of their patients. As one 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).

Another nurse related: "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).

Some southern nurses would directly ask Inuit nurses to take responsibility for unilingual patients, as recounted by Inuit nurses: "Some will say to me, 'You are an Inuk. You try to talk to the patient'" (T24: 86), and "It was difficult being only two Inuit nurses because the southern nurses push you, saying, 'but, you speak the language, can't you just […]?'" (T31: 137). Southern nurses who want to support a culturally safe workplace might reflect on what their habitus, in the form of decreased linguistic capital or unilingualism, means for Inuit nurses. Rather than ask the Inuk nurse to take over, the unilingual nurse could ask the Inuk nurse or an interpreter to see the patient with her so that she could learn from her bilingual Inuk colleague. This would show cultural respect and could be interpreted as an attempt to provide culturally safe care. Unfortunately, some Inuit nurses have, in casual conversations, related experiences with southern nurses who refused to take directions or learn from Inuit, an indication that they did not believe Inuit could be more knowledgeable than someone from a modern hospital in the South. It is understandable, then, that it may be a relief to Inuit nurses when they are able to work with other Inuit nurses, as one nurse said:

> I have been lucky in that I have worked at a place where there was more healthcare staff that spoke an Inuit language. My experience there 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 experiences, when asked directly whether it would make a difference to them if they worked with Inuit or southern nurses, everyone said "no." They all said that as long as the nurse was capable and respectful, it did not matter what her or his ethnic background was. The "no" may have to be seen in the light of me being Southern and it being said in a recorded interview. When nurses or students shared an experience that was not very positive, it would often be done outside the formal interview and in the form of a story. While

doing research on sociocultural experiences with tuberculosis in Nunavut, I found that although some might share negative experiences with Southerners in casual conversations, interviewees would rarely say anything negative about Southerners, be they healthcare professionals or not, during formal interviews (Møller 2005). Bryld (1998) described similar experiences when Greenlanders had been interviewed about their being sent to Denmark to be raised in foster care. That the "no" was said in conjunction with "as long as the nurse was respectful" has significance if respectful is equivalent to "culturally respectful." Such respect would have to meet a higher standard and could include providing care in the recipient's preferred language, as discussed by Woods (2010).

Linguistic capital and culturally safe learning

Similar to the nurses, the nursing students rarely said anything negative about southern nursing teachers, although several noted the differences in teaching between Inuit and non-Inuit teachers. One said that an Inuk teaches "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" (T6: 211). I asked her what she meant when she said "Inuk." She replied: "Someone who speaks the Inuit language as her mother tongue and knows the culture" (T6: 213). When asked directly, about 24% preferred Inuit teachers, about 40% preferred southern teachers, and about 36% said it did not matter. Again, me being a Southerner may have biased the answers towards preference for southern teachers, although other mechanisms also may have played a role. The nursing students may have developed a pro-White bias through their schooling experience, an outcome of an early and abrupt shift from learning in their mother tongue to learning in a dominant language (Bougie et al. 2003). Close family and other social connections to Southerners may have been an influence, or they may have internalized the mistrust in Inuit competence that had been historically conveyed, and still is, by many Southerners (Møller 2011).

The main reasons given for preferring a southern teacher were that the literature was in a southern language and that participants were used to being taught in a southern language. Some preferred Inuit teachers mainly because such teaching provided 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). Being unable to discuss experiences in an Inuit language can be damaging.

Recent statistics show a decreasing percentage of Canadian Inuit who describe themselves as fluent in Inuktitut and who choose to speak Inuktitut at home (Statistics Canada 2006), a fact that Mary Simon (2008), the previous President of Inuit Tapiriit Kanatami (ITK), lamented and felt to be detrimental

to Inuit health. This was also the sentiment shared at the circumpolar Inuugatta: Inuit Language Conference (Government of Nunavut 2015). Not all agree. The current ITK president Nathan Obed,[1] who is learning but does not yet speak Inuktitut fluently, has said that "language alone couldn't determine his identity"; he noted, rather, that historically you were an Inuk "if you believed you were Inuk, if you lived like an Inuk, and if your community accepted you as an Inuk" (Obed in Madwar 2015: para. 2).

Most Inuit nurses and students were quite pragmatic when they discussed the presence and domination of southern languages in the healthcare field. Rather than either abrogating or appropriating[2] the dominant colonizing language, it appears that Inuit nurses and students have generally retained their mother tongue. They use it to discuss and describe emotional and social relations when conversing with other Inuit, while having also acquired the colonizing language, which they use in their academic and professional spheres. This does not imply that such diglossia is always easy. Many nursing students and nurses felt they performed in two parallel worlds when at work, in their practicum places, or at school.

Some southern mentors asked Inuit students to conduct their conversations with Inuit patients in a southern language while using an interpreter so that they, the mentors, could understand and evaluate the patients. This speaks to the power relations (Bourdieu 1986) at play where one language, and what that language symbolizes, affords more *capital* than another. Such power relations, according to Thiong'O (1986), might alienate the speaker of the lower-status language from him or herself. In a similar situation, a culturally safe mentor might reflect on how the involvement of an interpreter could affect the interaction between the Inuk student and the healthcare recipient and allow the student to relate the conversation to the mentor afterwards (trusting that he or she would do so accurately). Or the mentor could consider the possibility of taping conversations in the Inuit language between the students and the healthcare recipients and afterwards having interpreters translate the conversation if more details were needed. Linguistic power differentials were observed and referred to me in other contexts, such as groups of Inuit nurses chatting in an Inuit language who felt they had to switch to a southern language whenever a southern healthcare professional came into the room. While talking about nursing theory and how to translate it into an Inuit language, one nurse said:

1. Nathan Obed was born and grew up in Nain, Nunatsiavut, where relatively few speak an Inuit language. In 2006, about 25% were able to converse in Inuktitut in Nunatsiavut, while 90% could in Nunavut (Statistics Canada 2006).

2. Abrogating is a refusal to employ the dominant language at all, or a refusal to adhere to the imperial standard of a "normative" or "correct" usage (Ashcroft et al. 2002: 37). Appropriating is the process of adopting and utilizing the dominant language as a tool to "express widely differing cultural experiences" (ibid.: 38-39).

> 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).

A nurse who thought it was easier to express emotions in her mother tongue explained: "When I speak a southern language I talk about something I have learned through school […] 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). Similar sentiments were voiced by the nurses who were contributing chapters to *Greenlandic Nurses Narrate* (Møller 2014). In other words, Inuit nurses understand, relate to, and employ what they have learned in the language they have learned it. As theorized by Ricoeur (2001) in another context, when Inuit nurses and students use and think with a language, they do so with the knowledge tied to the world of that language. This in theory means they are able to relate to and communicate with Inuit patients in a culturally safe manner—it becomes more complicated, however, when they also want to offer explanations and education about anatomy, physiology, illness, and disease. Many lack the Inuit language vocabulary to do so, since they were educated in a southern language. Most participants noted that having an Inuit language course in medical and healthcare terminology as part of their nursing education would have been a great benefit, and they recommended such courses even at the price of prolonging the programs by three to six months.

Body language and the language of silence

Greenlandic and Canadian Inuit nurses and community members stressed that body language carries great weight in Inuit communication. Not mastering or not being aware of this aspect of communication plays a part in recurring misunderstandings and misinterpretations that take place between southern healthcare providers and Inuit patients (Møller 2011; Quist 2016). 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).

Another nurse said she had made a note of informing southern staff, when they came to the Arctic, about this particular trait of some Inuit in order to make sure that the patients would be cared for in the best way: "I told them that an Inuk patient might not ask for pain medication even if he needs it […] 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 Inuk patient" (T32: 318). It was also commented that some of the southern nurses who had been in the North for longer periods learned to notice the body language of, for example, pain: "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). These nurses have learned to recognize various Inuit embodied habitus and are better at providing their patients with safe care— another reason for explicitly sharing this knowledge.

Reliance on body language, perhaps coupled with ability to learn well by observing and doing (Skifte 2014), may be why a nurse reported that some Inuit patients assume doctors can diagnose without hearing from 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). Health care may be influenced by the habitus of some particularly older Inuit who are humble and have been raised to avoid making special demands or expressing distinct wishes. This inhibition may be compounded by a colonial history where Inuit have not been heard or respected (Inutiq 2015; Quist 2016), and where their cultural habits (e.g., food choices) have been looked down upon (Møller 2011).

While some Inuit are not verbally expressive, they may express themselves using facial expressions, body language, and indirect requests. Some Inuit patients may thus be communicating what they feel without verbalizing. Some healthcare professionals do not share the habitus of their Inuit patients or are unfamiliar with gestures that would allow them to comprehend the message. When we share habitus, we may more easily provide culturally safe care, as exemplified in the following statements: "It is not always that my patients need to say anything. By looking at them one can see how they feel" (T20: 193); and "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?" (T29: 310). Several nurses talked about experiences with healthcare professionals who were unaware of, or unable to interpret or notice, their patients' body language. As one nurse said: "When I work with other Inuit nurses and we are caring for an elder, there's a lot of nonverbal communication that is going on,

whereas if I'm working with a Southerner, the nonverbal 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).

As noted by Ramsden (2002), if healthcare providers want to provide safe care, patients need to know that providers can safely be approached. Specifically, providers need to know about themselves, their own habitus, and their own history, including their body language and how these affect their interactions. As an example, an Inuk nurse described the bodily and facial reactions of a southern nurse in a room where a patient had been provided with fresh ptarmigan by family members. When in season it is traditionally eaten raw.

> 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).

Many Inuit, perhaps particularly older ones, connect the eating of food from the land to Inuit identity. When disgust is expressed facially and bodily for some Inuit food, this kind of response may universalize southern experiences and habitus as the norm while denigrating and rendering invisible Inuit perspectives and stereotyping the Inuit as the "Other" (Lukes 1997; May 2003). If healthcare providers are conscious of their habitus and know that they would have trouble enjoying a particular food, they could use body language, gestures, and verbal language to celebrate a patient's ability to access and consume the food that he or she enjoys. This may be especially so if they have taken the time to learn that eating "Inuit food"—food from the land (or sea)—is for some Inuit connected to preventing sickness and maintaining and restoring health (Borré 1991; Togeby 2004).

Body language also had importance in interaction between Inuit teachers and students. One teacher used body language as a means to get a particular student to participate in class without verbally confronting the student, and a student related how an Inuk mentor's body language informed her about whether she was on the right track during a practical exam. An Inuk nursing student has linguistic capital in the form of a southern language, and with this capital she can verbally make herself understood and can verbally understand her southern mentor. She also has the embodied cultural capital of body language, which she can draw on with her Inuk mentor and healthcare recipients, but it is generally of no value with her southern mentor.

Knowing when to speak, when not to, and about what

"Traditional Inuit held silence and respect as twin virtues" and due to this culturally ingrained value many Inuit are soft-spoken and may see people who speak comparatively louder, faster, and at length as "aggressive" (Qitsualik 1998: para. 2) or in some instances as less intelligent (Freeman 1978). In addition, silence has been described as having healing properties, and silent acceptance of what is perceived to be unchangeable is a way to decrease stress and anxiety (Minor 1992). Thus, it is easy to understand how not sharing the same verbal or body language can hinder proper communication; so too may not knowing the meaning of silence, or not "knowing when to speak and when not to" (T24:149). As a 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, saying that doing so would silence the elder "because he'll think that you know everything that there is to know, so they shut themselves off from saying something" (T40: 818).

If an elder does not speak when someone asks many questions, there may be several reasons: a feeling that he or she is not given the respect deserved; a belief that asking many questions is rude; intimidation in the face of authority (as doctors, nurses, and Southerners generally may be seen); acceptance of illness (which may be chronic or terminal); and unwillingness to discuss it in order to keep from getting anxious or stressed. The history of colonization might be another reason why an elder falls silent when barraged with questions (Møller 2005). If a patient says only "what is necessary" or uses nonverbal expressions to show how he or she is feeling, an Inuk nurse can, as one nurse expressed: "by listening only, without saying anything and just listening, catch other signals that a non-Inuk would be unable to. By listening, looking, observing […] everything will seem recognizable to her" (T30: 375).

Another nurse related an experience with a young woman who for the first time in her life had left her small northern community to take her sick baby to the hospital in a larger city. When the young woman enters the ward:

> 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 (T26: 169).

After guidance from an Inuk colleague, the southern nurse tries again. She meets the young woman where she is; she tries to convey to her that she has an interest in her, her family, her parents, her siblings, and where she comes from, and a connection is established. Cultural safety becomes possible when the southern nurse shows an interest in the young woman as a person, rather than "*attacking her*" with questions about "nursing knowledge," "big words" and "big movement," all of which are unfamiliar to the young woman in her culture (T26: 169). Many nurses and students noted that meeting Inuit with a smile and a light tone of voice, and, if linguistically possible, initiating conversations about their family, home life, home environment, and what they like to do, creates a comfortable and relaxed atmosphere. According to Inuit nurses and students, initially focusing on what is known and comfortable, rather than having a serious talk about disease and what should be done, creates a space where nurse and patient can meet on more equal terms and where the nurse is not seen as someone who sets herself above the patient. This is another important aspect of cultural safety.

In *Decolonizing the Mind,* Ngugi wa Thiong'o (1986: 15-16) argued: "Language carries culture and culture carries […] the entire body of values by which we come to perceive ourselves and our place in the world." Many Inuit nurses and nursing students agree (Møller 2011). Thiong'o (1986: 9) also emphasized that language has been "the most important vehicle through which [colonial] power fascinated and held the soul prisoner" (square brackets in original). By accepting a language one also accepts its values; the question of language is thus important to colonial and postcolonial experiences. This has been the case with Canadian Inuit and Greenlanders (Berger 2006; Gad 2009; Møller 2011).

Conclusion

Providing and receiving health care across ethnicities, cultures, and languages—particularly in colonial healthcare systems—is complex. Without providers having the necessary linguistic, cultural, and historical knowledge, the recipients may not receive culturally safe care, and health outcomes may ultimately be compromised (Inutiq 2015; Quist 2016). Health care providers must be willing to reflect on their own backgrounds, on those of the people in their care, and on the power relations at play in the clinical encounter. "The impact of a single good doctor or nurse who builds respect, equality and trust into the relationship is not enough if the underlying policies and structures are culturally unsafe" (Brascoupé and Waters 2009: 7). Culturally safe behaviour, knowledge, and power transfer must be institutionalized.

Most Inuit nurses and nursing students are double-cultured; they are comfortable in both Inuit and southern languages and cultures—they have overall been able to enter the nursing programs and succeed in the educational systems in the Arctic, as discussed elsewhere (Møller 2013). This is what helps them to provide culturally safe care— linguistically, orally, and through appropriate use of speech and silence in the clinical encounter. This is also what makes them able to function as habitus brokers between Inuit healthcare recipients and southern healthcare providers. However, because Inuit nurses and students are needed to perform as habitus brokers, and because they have to learn and practise in a southern rather than Inuit language, there is a demonstrable power inequality between southern and Inuit healthcare professionals and in the healthcare institutions overall. This power inequality tends to skew the workload in favour of southern nurses and may adversely affect recipient satisfaction and outcomes. Future research should focus on several points: how Inuit recipients perceive culturally safe healthcare and nursing practice, and the importance of Inuit language use; how southern healthcare workers perceive the ethical challenge of incorporating Inuit knowledge as a means to improve health, well-being, and wellness in their practice; and how southern nurses perceive the supports and tools they need in order to feel that they can provide Inuit with culturally safe care.

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