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SENSIBILITY: *a* NEW FOCUS IN SÁMI HEALTH CARE EDUCATION

RANDI NYMO

Department of Health and Nursing Science, Narvik University College, Box 385, N-8505 Narvik, Norway

■ Abstract

Colonialism has had significant bodily impacts on Indigenous peoples through medicine. Excluded from the German race, Sámi have been burdened by mainstream prejudices which perpetuate myths about Sámi having poor genetic material and, as a consequence, having an inferior culture and language. This offensive burden and subsequent humiliation has particular implications for the Sámi who come into contact with the health system as patients. Ethnic identity is connected with taboos, not only for patients, but also for Sámi and non-Sámi treaters. According to common knowledge Sáminess should not be a theme. In spite of intense assimilation, many Sámi understand illness as something caused of powers in nature or influenced by other people. The result can be a feeling of bodily chaos. Not understanding the meanings of the signs shown by the patients may bring health workers to interpret expressions of culture as signs of disease. Sámi patients can be diagnosed as suffering from delusions. Sometimes they are visited by traditional healers in faith to restore bodily cosmos. What's more, the patient trying to hide her Sámi origin can be considered as dishonest. Sensing this staff may discharge her from hospital earlier and spoil her chances to get proper treatment. Health educators have specific responsibilities to make students aware of the diversity of patient's culture and view of life. Within thought of body phenomenology the experiencing body is both subject and object. Messages are filtered by a cultural framework and the persons in interaction impact on each other. Face-to-face with the patients you can sense their vulnerability and decide to meet them as objects for your therapy activities or as individuals.

■ Introduction

Sápmi (Sámiland) is the Sub-Arctic area of the Scandinavian countries and the Kola Peninsula of Russia (North Calotte). The Sámi are the aborigines here and live in four countries: Norway, Sweden, Finland and Russia, though formally recognised only in Norway. The borders between these nations mean limitations on contact among the Sámi; in particular the Russian border was completely closed during the Soviet period (until 1990). The contact problem has been reinforced by the assimilation policies which have aimed at forcing the Sámi to live just like the other inhabitants in the various countries. However, our culture and worldview differ from our respective mainstream societies and from those of neighbouring Western countries, and our cultural differences have led to limited success of the assimilation programmes. Sámi, whose spiritual succour derives from animism and who look upon humans as part of the Nature that made them, resist Western influences.

Hence, culture, language and ways of doing things have meaning for the organisation of our daily lives and are also expressed by illness conditions. In this article, I will discuss cultural encounters in health care systems and argue that sensibility in caring is important simply because of the vulnerability of Sámi patients. To be precise, what I mean is that while all patients are vulnerable, the particular cultural vulnerabilities experienced by the Sámi is my focus here.

■ A historical review and myself placed

I am a Norwegian Sámi and will focus on Sámi living in Norway. The landscape of north Norway is special. The coastline has many fjords providing rich opportunities for food-securing subsistence activities. The peculiar life mode of fisherperson-farmer peasants has been based on the husband taking his boat to wherever there were fish, or going hunting, while his wife and children farmed and picked wild berries and the like. The little farm kept cows, calves, sheep, goats and hens. Norway has also been the Summerland for reindeer from Sweden from before the border was drawn in 1751, but state regulations, such as border closures from the middle of the nineteenth century and pasture conventions throughout the twentieth century, have limited this transhumance. When reindeer husbandry was hindered by poor grazing and mining (e.g., iron ore from the late nineteenth century), many herders

had to find another way to earn a living. They had experienced the richness of the coast and many, my ancestors included, moved to this land. It was not without problems as, in many areas, the coastal rim was occupied by Norwegians also seeking land. Some Sámi, however, were already established on the coast, and are now distinguished as coastal Sámi.

My ancestors had to settle in the woodland zone between the coast and the mountains, clearing small farms and living as multi-resource-utilising peasants. The areas are (in Norwegian) called *markebygd* (woodland rural district). They are rural agricultural areas in the woodland below the mountains with a dominant Sámi population, typical for parts of the counties of Nordland and Troms in Norway. These woodland rural district areas have a clear majority of Sámi peasants who traditionally have a multi-resource economy. My Sámi heritage is from such a *markebygd*. The *markebygd* is considered a Norwegianisation area as Norwegian has replaced Sámi as the dominant everyday tongue, and many Sámi apparently identify themselves with the Norwegian majority culture.

I have now presented two groups of settled Sámi, the coastal Sámi in north Norway and the woodland peasant Sámi, these are simply two groups among several more distinct groups of Sámi. There are also the Lule Sámi, named after a river and its valley in Sweden where they had their Winterland before settling in part of northern Nordland in Norway. The southern Sámi inhabit the area from Saltfjellet in Nordland to Hedmark in southeast Norway and form the southernmost group. Another small group is the "skolt" Sámi living in the east of inner Finnmark, the northernmost county of Norway. Last but not least, there are two groups of Sámi, both reindeer herders and peasant farmers, inhabiting the inland plateau in Finnmark. Most Norwegians have imagined that being real Sámi in cultural terms means to live in Finnmark and own reindeer. The landscape and geography of Norway have shaped many groups of Sámi, according to their way of living decided by Nature.

■ Sámi worldview

The traditional Sámi worldview is tied to the pre-Christian religion, which saw the world as consisting of three spheres, upper, middle and lower, interconnected through a *Tree of life* (Hansen, 1994). Nature is animated; rocks, mountains, lakes and trees are thought to be spirited, certainly if they have characteristic shapes. Sociologically and culturally, the Sámi population contrasts clearly with neighbouring peoples in the North Calotte area. Within our local communities we are connected through common traditions, genealogical ties, religious ties and social networks. Solidarity is also mediated beyond the frames of the local society and community (Hansen, 1994). The contrasts are not shown in daily life, but reveal

themselves in given situations, like the experience Ola Omma had in connection with Tromsø's application to host the Winter Olympic Games. A spectacular downhill piste was planned from the mountain top, and the status Tromsdalstind has had for the Sámi was actualised for 81 year old Ola Omma from Jokkmokk in Sweden. He was one of those who used to pray to the mountain for fortune and health when driving his reindeer between the summer and winter pastures. He says they drove their herd round the mountain and greeted the mountain when they reached their summer settlement. It was also a custom to allow the herd to graze at the foot of the mountain for three days before they left the area (Omma, 2004). This shows that there are still Sámi who believe in the power of natural features.

The religious historian Mircea Eliade (1969) wrote about the contradictions of *chaos* and *cosmos* in traditional societies and what they mean for people. He used examples from known and unknown phenomena in the life of a human being and how they influence the way traditional people live. A Holy Pole plays both a cosmological role and connects the people with the Divine sphere (Eliade, 1969, p. 23). I think chaos and cosmos can reflect two opposite states, mirroring how a Sámi feels when he or she gets ill, and also preventing illness, as with Omma's explanation. Because of our worldview, we do not easily hand over our bodies to medicine, and the Norwegianisation policy, which started in the mid-1800s and lasted for a hundred years, made us especially vulnerable. These two factors play roles when we encounter Western public health services. But first I will say something about the hardships of Norwegianisation.

■ The Norwegianisation of the Sámi

The Sámi were a minority and together with people of Finnish origin we were considered a foreign culture in northern Norway. In 1905, Norway withdrew from its union with Sweden and became independent. Programmes to build up a separate Norwegian nationality had already started in the mid-1800s. Norwegianisation was implemented through legislation. Speaking the Sámi language was forbidden in schools and other public places, and the Sámi folk music, joik, was also forbidden. Sámi dared to chant the joik almost only when they were drunk and accordingly the joik was identified with drunkenness by non-Sámi people. Moreover, Christianity, which was forced on the Sámi, considered drunkenness very sinful. Thus, chanting joiks was viewed in the same sinful frame as drunkenness by non-Sámi people. To the outside world, it was necessary to be comprehended as a pure Christian. The Norwegian nation believed it had good reasons for promoting assimilation. Science had been established and standards for normalities were set. The Germanic race was standardised as the best, with the

Sámi as the worst, or at least close to the worst. Racism dawned in Europe and spread to other continents. Social Darwinism programmes started under the pretext that primitive people needed the “important white man” to take care of them (Christensen, 1997). Moreover, due to the standard belief that culture and society cannot be more developed than the people are, the Sámi, with their bodies, culture, worldview and language, were placed on a lower rung of the social ladder than Finns and Norwegians. The burdens of a century of humiliation certainly had ramifications when programmes to vitalise Sámi culture and language started towards the end of the twentieth century. It also has consequences for Sámi when they become patients in Norwegian hospitals, as I have mentioned.

■ The experienced body and the intention of consciousness

The Norwegianisation of the Sámi can be reflected in several theoretical frames. For me as a Sámi nurse who has been caring for the bodies of patients it is natural to handle within the philosophy of Body Phenomenology. Note, in Norway, a Sámi nurse is one the public can have expectations of. The experiencing body is seen both as a subject and an object. For a nurse, the patient’s body is an object for many nursing activities. But the patient is really a subject, a fellow being.

Merleau-Ponty (1994) claims that we live with our bodies in a mutual world. Consciousness and thought belong to the body, just as much as to the extended body. With their bodies, human beings take part in each other’s existence. The experienced life is expressed through behaviour and attitudes. Existence is more than thinking. We are bodily present in the world, and all our experiences are woven together. We are culture-bearers. Messages from one to another are filtered by a cultural framework and the persons in interaction impact on each other. Therefore, *sensibility* is to be aware of the individual patient, his or her way of doing things and de-emphasise the technological and academic competence expressed through the encounters.

The Sámi are patients at risk like other Indigenous peoples can be, because of the historical legacy of their respective Indigenous identities and cultures being considered lesser than the dominant other. The Maori nursing educationalist Irihapeti Ramsden (1993) has launched the concept of cultural safety in nursing education in New Zealand. That means that a student has to walk steps to learn to be a culturally safe nurse. First step is cultural sensitivity meaning that the nurse understands that patients are different. The next step is cultural awareness, to interpret the patients as unique individuals rather than just being part of a collective. Students start to reflect on who they are themselves, what kind of embodied history they are bearing, and how they influence others (Ramsden, 1993). The steps to be culturally safe

practitioners as Ramsden has described is, so far I see, a way to develop sensibility. Bodies in interaction are the foundation of understanding and explaining of different phenomena. Face-to-face with each other you can sense the other’s vulnerability or power. Although we live in a mutual world, our experience is different. Consciousness plays a part in “choosing” one’s own individual actions in different circumstances. We can think that our body “prescribes” actions from its habitus (Bourdieu, 1996). “Habitus” can be explained as forms or programmes where bodily experience is inscribed as methods for operations.

Merleau-Ponty (1994) says that actions can be automatic or reflexive. Consciousness can overrule the immediate prescription of the habitus or the automatic, reflexive actions and suggest another way to act. Let me illustrate that overruling:

- 1) *consciousness* opens and becomes aware of the kind of influence it is exposed to.
- 2) *consciousness* plays a passive role and does not know what kind of influence it is exposed to and does not act, or overrule the prescription for action.
- 3) sometimes and suddenly, *consciousness* awakens because of its exposure to phenomena that influence it. Reflection starts because the subject (ego) and the object (the world, the surroundings) meet each other and shape understanding (Nortvedt & Grimen, 2004).

The theory of the intention of consciousness was formed by Edmund Husserl (1992). Husserl tried to understand how consciousness forms activities to give meaning and understanding, two important aspects in building relations between people. The body also makes intentional movements (Merleau-Ponty, 1994), which have meanings. As Ramsden (1993) has found, a nurse has to work to be culturally safe in her nursing. Practising within sensibility means to do reflections and interpretations, and challenges a nurse and other health personnel to have an active consciousness. You have to make turns in your mind. Reflection starts when thoughts affect consciousness. Reflection is held up by sensibility, when you learn to reflect you open your mind to be a participant and not only a spectator (Skjervheim, 1996). In caring for patients it means that any pain, distaste, bad position in bed, fear and vulnerability demand action to make the situation better for the patient. It alarms you almost like signs as low blood pressure, bad respiration or cardiovascular attack. The point is that health personnel who have developed sensibility are working side-by-side the patients in all interactions. When ethnic identity is phenomena, they are expected to be attentive. Another clue emerges when we discuss sensibility. That is to be professional, to balance nearness and distance. As a professional you need to know where the patient’s

problems start and where they end, you must not confuse your own feelings with the patient's feelings.

■ The professionals shape meanings within their context

The miracle of consciousness makes us understand our surroundings (Nortvedt & Grimen, 2004). A chair is not only a collection of pieces of wood, but just a chair. We love and hate. We often love somebody who is kind and lovely and fear somebody whose behaviour frightens us. The existence of a human being in this world is linked to a meaningful whole, as Heidegger deduced from Husserl (Heidegger, 1993). The human being, through their perception, is given access to objects and to others in the world. We meet the Other with our bodies, with our inscribed experience from life. Something in the Other goes right to our heart, beats within us and provokes feelings. Reality with the Other can be something we are familiar with. If the Others are strangers to us, it will be harder to accept their way of doing things. Perhaps we have learnt something about the culture of the stranger and "know" exactly how he or she is. We start to categorise. The medicinal frame has educated its people to use categories to provide meaning and understanding for the complex situations ill people put the professionals into. It shapes meaning and gives control.

Ramsden (1993, p. 6) points out that nurses think that they require a sort of cultural checklist. The diversity within cultures does not allow such a model, because the differences between conservative and liberal, age and youth, urban and rural, rich and poor and gender interaction (Ramsden, 1993). When the patient does not fit into the categories, what then? This happens, for example, when the professional has learnt about Sámi culture and meets the *markebygd* person who does not fit into his or her understanding. Perhaps the patient's condition does not fit into the diagnostic system either? Then the professional may record in the journal: *Case socialises and behaves just like the others from that place*. This has been written about many *markebygd* persons in health care system encounters.

■ Vulnerable *markebygd* persons as patients

Our Sámi bodies have gained experience from the Norwegianisation and our way of living is entered in our bodily registers. The choices related to ethnic identity made by generations of Sámi in Norway are either real choices or the outcome of *que sera, sera*. Sámi bodies carry experience, in good or bad ways, of cultural ceremonies where the Sámi language is included. They are just like other bodies, carrying good and bad experiences. Experience that is entered persists and requires action. An example can illustrate possible consequences of the oppression. When the Sámi language is displayed publicly, for example on road signs, it recalls memories of the position it had

during the Norwegianisation period. Sámi resisted that initiative (Bjørklund, 2000). In my Master's thesis (Nymo, 2003), I analysed and tried to see the resistance against Sámi place names among the Sámi themselves as an expression of vulnerability. Sámi bear the inflicted shame of Western culture. Kari Martinsen says that shame is culturally determined and a powerful culture has authority to inflict shame upon others (Martinsen, 2006, p.15). Sámi health personnel from Norwegianisation areas often bear the same shame and hide their Sámi origin. They are not culturally safe when facing Sámi patients. They uphold their image by specialised knowledge, and Sámi as patients can threaten their established position.

Here is an example to support how it can be expressed. In my surroundings a mother, I give her the name Anna, was sent with her 2 year old daughter to a hospital in southern Norway to correct a scar created by fire. The daughter's name was an old fashioned Sámi name, like her great-grandmother's. Anna used Sámi language to her little child, and that was another indication showing Sáminess. Before going to the south, Anna got a call from one of her childhood neighbours who told her that she was a nurse at the hospital in the ward they were going to visit. She had observed the name on the lists of incoming patients and there was also a file notification that the little child was learning Sámi as mother tongue. During the telephone call she sought to clarify with Anna that she would prefer not to be recognised as a known Sámi should they meet at the hospital. Anna was shocked. When this happened it was a burden for Anna, but today she can reflect over the incident. In her mind there was no doubt why she got that call – the nurse would not be revealed as a Sámi. We can sense how successful the oppression has been. Now, when there are political grounds for uplifting the culture and language, the resistance comes from the oppressed. And many still are afraid to be recognised as Sámi. That is perhaps unexpected, at any rate an attitude to wonder at. Encounters in health care between Sámi from *markebygds* and nurses can cause unsuspected bodily reactions. The patients may seem vague and it may be difficult to make a diagnosis, which therefore results in descriptions like "he or she acts just like the others" from that woodland rural district.

To understand this assertion, two concepts, illness and disease (Kleinmann, 1980) have to be introduced. Illness means the feeling a person has for his state of health, a feeling that something is wrong. Disease means the medical perspective of illness and has to be given a diagnosis. If the doctor cannot find anything wrong, he cannot present a diagnosis; consequently, the person does not have a disease. The worldview and culture have meanings for interpreting states of health. It is not unusual for a Sámi to feel that an illness is caused by sand brought from a cemetery. It creates chaos in his body and a medicine man

or shaman is fetched to take away the illness. Stein Mathisen (2000) writes about understanding illness in traditional medicine as a break in relations. This brings imbalance, firstly with regard to supernatural forces; secondly with regard to other people; and thirdly in the body. The body is interpreted as a micro cosmos. A shaman possessed knowledge, magical powers, to bring things into balance. He used his magic drum to seek connections between the illness and the forces. The figures on the drum had meaning and the pointer on the drum led to the figure through which the imbalance and illness had arisen. The shaman used a special form of drumming.

Nowadays, in modern societies, the traditional shaman does not exist, but there are many "light" versions *læsare* (readers, blowers) living in every Sámi society. They do their healing by reading rituals, possibly through prayer, and end the rituals by blowing with their mouths on the painful part of the body. If the pain is located in an extremity, often a woollen thread is then wound around it. Other methods are bloodletting and cupping (to remove bad liquids from the body). My uncle practised that in the 1970s (Nymo, 2003). The local doctor tried to seek out the man doing this, to report it as a crime, but the people in the district remained silent and protected my uncle so the doctor could not find out who the medicine man was. The condition of illness reaches further than any diagnosis or evidence of disease can perceive. Illness sometimes means chaos. Sometimes it is necessary to be in a chaotic condition before reaching cosmos. In their ways of living, Sámi have learnt to bear situations of discomfort and situations of being unwell.

■ Encounters

Western medicine claims to be able help, assist, cure or prevent all manner of health problems. The Sámi, including *markebygd* persons, have taken on the concept that modern medicine and health care can have all the answers to all their problems. They therefore have expectations. However, after some visits to the doctor, they feel medicine cannot answer all their questions and they still ought to have their own way to treat illnesses. Landscapes and areas where Sámi live influence the way they seek traditional medicine when they become ill. Some communities have good, accepted *læsare* (reader) who perform rituals. In some places, it is common to visit holy mountains (*bassi várri*); on the plateaus, lakes (*bassi jávri*) have a holy status in giving help. There are holy places in my Sámi surroundings, and we also use *læsare*. Myrvoll (2000) says that as long as there is a need for *læsare*, somebody using their knowledge, recruitment will take place. Two of my respondents told me that they combined treatments. An 80 year old woman from a *markebygd* said she

dared to hand her body over to the surgeon because she trusted in God and she knew that He overruled the doctor. During our conversation, she said she had recently been to a family event (a confirmation) in another place in north Norway and there she met her main doctor. She laughed and asked me: "Now you perhaps don't understand what I mean?" "Since I come from a *markebygd* I understand very well", I replied. She called him *læsar*, her main doctor. However, we cannot easily understand her "glorification" of the health care doctors a few moments earlier.

The other respondent is a 60 year old man who had suffered symptoms from a chronic disease since childhood. He said he had good contact with the health care system for his problem. However, he once had a painful operation on his leg, and then he had to organise contact with a *læsar*. He used his sister and another relative as intermediaries because his wife who is Norwegian, a non-Sámi, did not believe in *læsar* knowledge. But he tells that his wife has certainly become more receptive to traditional treatment as time has passed. The respondent means *læsing* works because traditional knowledge enthrones the relationship to the *læsar*, and that gives a feeling of well-being. He continues his argument saying that after surgery as a rule you have pain. Analgesic in big doses is not the first preference. You may become sick from analgesic and sometimes can get stomach afflictions. This has often been in interaction with health care systems and means that this system seems loose with tablets. He started to wonder about the traditional treatment he was used to as child. He says: "I started to ask myself why can't *læsing* work when I am adult?" In his mind, a difference came into being. He emphasises that making up Western medicine with traditional treatment has worked for him and his wife, suggesting that a dual approach combining the two systems of knowledge and practice is a way to go.

We can see that encounters between patients and health care systems are devoid of cultural phenomena (Eriksen & Sørheim, 2000). Medicine based on Western evidence, that seeks control over diagnostics and treatment, has not fully won through in the *markebygds* even though traditional medicine has been forbidden in health care systems. It has been considered horrifying, and Sámi have concealed their use of traditional "operations". Most feel shame if public health servants hint that old Sámi medical treatment may have been used. Moreover, when the patient continues to be vague and it seems difficult to make a diagnosis, public health servants often wonder whether he or she is using private healing. This is a non-communicated matter. Many Sámi, especially those who believe in traditional treatment, are therefore particularly vulnerable in encounters with health care. Now there is some measure of acceptance

for alternative and complementary medicine, and a National Centre for it has been set up at the University of Tromsø.

■ How can the nurse offer optimal nursing?

Above all, a nurse must have general nursing knowledge, and must know how to apply this knowledge in health care settings. A nurse may traverse across the components of knowledge, scientific knowledge and knowledge based on experiential learning (Benner, 1984). *Holistic* is a well-known concept in the nursing paradigm. Caring for patients in a holistic way and treating them as fellow beings means, for instance, being aware of their culture and their ways of doing things. Just like the Maori have their *Kaupapa Maori*, the Sámi from woodland rural districts have their *vuogi mielde bargat* (way of doing things). *Kaupapa Maori* literally means the Maori way or agenda (Henry & Pene, 1999, p. 2). An expert can allow more of the patient's way of doing things than a novice. To be an expert requires good, updated knowledge and the ability to reflect over one's own nursing practice. Learning to reflect as part of everyday work will develop consciousness in working with relationships. Nurses learn to recognise their own prejudices, and this is an important part of one's professional knowledge. The purpose is to be aware of their own bodily knowledge and understand that re-examination may be necessary. This means that nurses working in institutions where *markebygd* persons are patients should reflect on their own attitudes, prejudices and stigmas, and how their own nursing practice can be improved by understanding or at least relating to other ways. Ramsden argues that conscious or unconscious behaviours of those who have power to define service policies may cause those from other cultures to feel powerless, anger and humiliation often resulting in avoidance of the service (Ramsden, 1993, p. 7).

■ Sensibility is necessary in caring

As a teacher of nursing I argue that sensibility is a necessary component of nursing knowledge. The nurse ought to see with the eyes of the heart (Martinsen, 2006). Martinsen draws parallels to the Bible where heart means the soul of a man and represents his life force (Martinsen, 2006, p. 77). Seeing with the heart is to be present and ethical in nursing practice. I would say it means to approach the patient with bodily knowledge and get away from academic exploration when searching for signs to label the patient. It means to open a new way of meeting the body and not consider it merely an object therapy and care. The patient's body is also a subject carrying meaning and experience, which will be expressed in given situations. Theories of body phenomenology hold that the body should be accepted as an active

part in expressing a personal meaning (Merleau-Ponty, 1994). Attitude means bodily carriage. Sensibility includes taking warnings from the face of a patient through those many encounters where impressions are made and conclusions are drawn. My fieldwork included making observations at health gatherings for elderly in the boroughs of Evenes and Skånland. The gatherings had programmes that included reading in the Sámi language and lecturing on diseases. One participant said: "I come here because we get up-to-date knowledge about diseases presented in an understandable way, and I participate in a setting that uses a language I can understand and use. I was robbed of my Sáminess as a child and youngster, and this is a gap within me".

This illustrates how a person from a *markebygd* can think and feel. She has a need for knowledge, and is feeling a lack in her identity. The health care setting is a setting where her feelings about who she is are affected. I suggest that being aware of such factors may benefit health care. In a body phenomenological approach to health problems and old age we cannot ignore the person's life experience. The participant at the health gathering had her opinion of the gathering, others will have theirs. Nurses must learn to reflect so that they can meet the demands of their important caring role. To be a good nurse, is to be a nurse who practices sensibility.

■ Final remarks

As a Sámi nurse and teacher in nursing education, I have tried to remember that in encounters with the health care system patients have their own life experiences registered bodily. Their own culture and native tongue are phenomena that are registered and they provoke feelings in given situations. If the person has been exposed to cultural shame during their life, there is much vulnerability. Sámi who have experienced their culture, worldview, language and ways of doing things as shameful, form a particularly vulnerable and high risk group of patients. Many have learnt to hide their origin and hope to be seen as Norwegians. When they become ill or are aging, their cultural way of doing things becomes more apparent. Their vulnerability is expressed at a time when they are very dependent on others, particularly nurses and other health personnel to become their fuller selves again. It is very important that everybody in the health care system becomes more knowledgeable and expert with caring across cultures. Health personnel have power because they are owners of specialised knowledge. Patients are in need of their service and they usually cannot obtain these particular services from elsewhere. All patients are in need and therefore in a vulnerable position, and if the nursing service is provided by people from a culture seen as superior to that of the patient's culture, it leads to non-healthy interactions.

I have argued that good relations are necessary for the feeling of well-being for patients, as well as safety to get the best from scientific and technological knowledge. The education programmes for health personnel have to emphasise inter-human conditions as a way to be safe in treatment and care. The education process may alert students to their behaviour as a way to develop sensibility and be culturally safe in practising. For patients from *markebygds*, as an Indigenous group, it also concerns staying in the hospital. If their cultural needs are not taken care of, they may discharge and go home to their own treatment systems and thereby miss the chance for the benefits that are available through Western medicine. Practising cultural safety in nursing will also allow some traditional treatment to be used in mainstream health care settings. In culturally safe health care settings, health care personnel will not feel threatened by traditional treatment, in turn this can enable Western medicine to develop into a more inclusive discipline by accepting its own limitations and by accepting the possibilities of other health and well-being knowledges.

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■ About the author

Randi Nymo is Sámi from northern Norway, raised in a local Sámi community with the unclear ethnic identity and partial language shift from Sámi to Norwegian. Randi graduated as a trained nurse in 1975 and is a specialist in intensive and psychiatric care. She is an approved supervisor in nurse service education and is also trained in public administration and multicultural understanding, and has a Masters degree in Health Science. Randi is currently an Assistant Professor in nursing and a Research Fellow at Narvik University College as well as a PhD candidate at the University of Tromsø, Faculty of Medicine. The main objective of Randi's PhD research is to develop a deeper understanding of how Sámi patients in marginal Sámi areas compose their total system of caring based on elements of traditional systems and public systems.