# 'THAT'S HOW I SAW IT ANYWAYS': FOUCAULDIAN GENEALOGY TOWARD UNDERSTANDING AN HISTORICAL OUTBREAK OF AMEBIASIS IN LOON LAKE

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#### **ABSTRACT**

This thesis explores the utility of the conflated term "colonial medicine" by drawing on events during an historical outbreak of amebic dysentery that occurred on several Indian Reservations near Loon Lake, Saskatchewan, during the 1960s and '70s, including a series of government-sponsored drug trials conducted to stem the outbreak. Largely devoid of the racialized notions characterizing primary documents used by previous scholars of 'colonial medicine', the medical journal articles, government memorandums, and letters written by physicians in connection with the outbreak and trials reveal their immersion in 'la clinique', or an anatomo-clinical discourse similar to what theorist Michel Foucault described in *Birth of the Clinic*. Conversely, conversations with Loon Lake area community members on the subjects of the outbreak and trials reveal their multiplex and nuanced reactions to medical and colonial discourses. Arguably, then, when writing about past events, historians should weigh 'medicine' and colonial discourse separately.

Essential methodological consideration was given to the Foucauldian concept of 'disinterring' popular knowledge. Drawing on Foucault's edited works Power/Knowledge and I, Pierre Riviére, the subjugated knowledges of Aboriginal community members, physicians, sanitation workers, and government employees gleaned through interviews and text are contrasted as per his example in these works with the false functionalism of 'scientificity'. Moreover, when considered in tandem, these subjugated knowledges illustrate a 'structural violence', following anthropologist Paul Farmer's methodology for describing such phenomena in Pathologies of Power. Overarchingly, they obscure the paradigmatic dichotomies ('doctor'/'patient', 'patient'/the healthy person, 'colonizer'/'colonized', 'oppressor'/'oppressed') espoused in medical, colonial, and even post-colonial discourses. This understanding forces the reflexive recognition that—if we accept rhetorician Christopher Bracken's assertion in Magical Criticism there is a recourse to savage philosophy within academia—what we say as historians has consequence beyond discourse, possibly creating new 'subjects' in a Foucauldian, disciplined society.

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## CHAPTER ONE: ORWELLIAN 'DOUBLETHINK' AND THE DRUG TRIALS OF LOON LAKE

'Cause I kinda find him [her treating physician]—he was kinda really rough [...] That part is—it's a *memory* that will always stay with me [...] I was surprised that nurse wasn't doing anything, she was just standing there, like she would—she would *look* at him [...] But oh, I suffered there. And him, just—just telling me not to move.

—Doris Crookedneck, interview by author, 11 June 2008<sup>1</sup>

Michel Foucault opened Birth of the Clinic by stating "[t]his book is about space, about language, and about death; it is about the act of seeing, the gaze."<sup>2</sup> This thesis is about space, language, death, and conversely, *life*—and 'gaze', though in a somewhat different sense. Immediately, the above excerpt from an interview with northern-Saskatchewan First Nations woman Doris Crookedneck directs our line of sight from herself-as-a-child's eyes-to a nurse-to a doctor—in a reversal of Foucault's supposed "unprejudiced gaze" of the doctor toward patients.<sup>3</sup> But the interaction is more complex. To explain, in *Magical Criticism* rhetorician Christopher Bracken ironically discussed Herbert Spencer's account of how 'savage' minds experience mimesis citing his 1893 *Principles of Sociology*, arguing Spencer described a young lady's troubles sleeping as if she were actually present detailing them to him, projecting her "living presence" like the savages he derides. Elsewhere, he described the phenomena Spencer pinpoints (and then despite himself enacts) as the representative difference between stating, "I saw them" and "I dreamed that I saw them." We-you, the reader, and myself, thesis author and interview transcriber/interpreter—are projecting, or picturing forth in Bracken's terms, Crookedneck projecting her child-self looking at her nurse look at her doctor. So, this thesis is about so-called "forbidden possibilities of discourse," or 'savagery' as "the living reservoir of living language," as well as redefined 'gaze' (emphasis added).

<sup>&</sup>lt;sup>1</sup> Doris Crookedneck, interview by author, 11 June 2008, compact disc copy, University of Saskatchewan.

<sup>&</sup>lt;sup>2</sup> Michel Foucault, *The Birth of the Clinic: An Archaeology of Medical Perception*, trans. A. M. Sheridan (New York: Routledge Classics, 2003), ix.

<sup>&</sup>lt;sup>3</sup> Ibid., 241.

<sup>&</sup>lt;sup>4</sup> Christopher Bracken, *Magical Criticism: A Recourse of Savage Philosophy* (Chicago: The University of Chicago Press, Ltd., 2007), 172.

<sup>&</sup>lt;sup>5</sup> Ibid., 173, 174.

<sup>&</sup>lt;sup>6</sup> Ibid., 1, 13.

\* \* \*

In 1939, Dr. Max J. Miller published the results of a survey he had conducted to determine the incidence of human intestinal parasitic infections for three differing populations in Saskatoon, Saskatchewan.<sup>7</sup> Of the 254 hospitalized and non-hospitalized clinical cases, healthy persons (students), and orphanage 'inmates' whose stools he examined, he found that ninety-seven, or 38.2 percent, were positive for protozoan infection. Among other things, he concluded that: 1) infection incidence was considerably higher among the institutionalized group than the general population; 2) *E. histolytica* infection, specifically, occurred in 0.96 percent of the general group versus 23.4 percent of the institutionalized—although he was sure these numbers approximated one another more closely in reality than the survey had indicated; and 3) *E. histolytica*'s presence in Saskatoon suggested the possibility it could be found throughout Canada.<sup>8</sup> In addition, Miller reasoned these groups' infection followed from several possible factors:

[*E. histolytica*] Cysts gain access to the body through food and water. Water becomes contaminated through sewage pollution. Food is contaminated mainly by infected food handlers, the use of human excreta as fertilizer, and the transmission of cysts from fæces to food by flies. This last method may very likely be responsible for the transmission of amæbiasis<sup>9</sup> in western Canada, especially on farms where flies are usually very numerous and have access to the outdoor privies as well as to the food.<sup>10</sup>

Later, in 1965, another doctor, R. D. P. Eaton, described an outbreak of amebiasis on northwest Saskatchewan reserves (see Appendix A: A.1). Given that fifty-five of the 178 stool samples he collected exhibited either cysts or trophozoites<sup>11</sup> upon first testing, and that multiple tests are generally conducted to determine true rates of infection, Eaton estimated "quite possibly more than two-thirds of the Indian population...studied were infested<sup>12</sup> with *Entamoeba* 

<sup>&</sup>lt;sup>7</sup> Max J. Miller, "The Intestinal Protozoa of Man in Saskatchewan," *The Canadian Medical Association Journal* (August, 1939): 120-4.

<sup>&</sup>lt;sup>8</sup> Miller drew this conclusion additionally by referencing works published on intestinal infection in Montreal

<sup>&</sup>lt;sup>9</sup> Amebiasis is the clinical term for infection by the ameba *E. histolytica*, especially as causing dysentery.

<sup>&</sup>lt;sup>10</sup> Miller. "The Intestinal Protozoa." 123.

<sup>&</sup>lt;sup>11</sup> Trophozoites are protozoa in the feeding stage of their life cycle, as opposed to their reproductive or encysted stages.

<sup>&</sup>lt;sup>12</sup> Eaton's choice of words here is interesting.

histolytica."<sup>13</sup> This approximation was contrasted with the one to two percent carrier rate of *E. histolytica* in Canada, and noteworthy in his eyes because while the "causative organism of amoebic dysentery has been known for many years to be demonstrable in the intestine of man, in all parts of the world," it was not frequently cited "as a cause of pathogenicity...in the more northerly part of the American continent."<sup>14</sup> Eaton also speculated regarding disease transmission, and his remarks reflect his just having completed a mass anti-amebic therapy program on three neighbouring reserves:

The fact that such mass therapy is at best a stop-gap measure, is of course, well appreciated. The primary attack must be made along the normal lines of environmental sanitation and to this end, fact-finding surveys have already been made by Indian Affairs Branch and Indian and Northern Health Services working hand in hand to determine the sanitary needs of the affected populations. It is obvious, as indeed it has been all along, that our people live in conditions of considerable overcrowding, poor water supply, non-existent sewage disposal and gross lack of basic knowledge of sanitation.

Estimates have been made and expenditures requisitioned for some improvements in the sanitary environment...An even longer project on which we are making but small beginnings will be the education of the Indian people to the need for and use of such improved sanitary facilities and to the necessity of their maintaining a sanitary environment for the successful eradication of enteric and parasitic disease. These are difficult problems.<sup>15</sup>

Miller's and Eaton's perceptions, or 'gaze', of the medical scenarios before them differ at once both minimally and largely as Foucault found with his inspiring physicians Pomme and Bayle.<sup>16</sup> On the one hand, one could argue Eaton's piece simply constitutes a later point on a developmental continuum than Miller's concerning medical knowledge about intestinal parasites

<sup>&</sup>lt;sup>13</sup> R. D. P. Eaton, "Amoebiasis in Saskatchewan," *Canadian Journal of Public Health* 56(November, 1965): 484.

<sup>&</sup>lt;sup>14</sup> Ibid., 483.

<sup>&</sup>lt;sup>15</sup> Ibid., 485.

<sup>&</sup>lt;sup>16</sup> In order to explain what he meant by 'gaze', Foucault contrasted two doctors'-Pomme and Bayle's-pathological descriptors. Each was chosen as representative of physicians in their respective eras. When assessing the difference in language used by these men Foucault argued, "[f]or us, it is total, because each of Bayle's words, with its qualitative precision, directs our gaze into a world of constant visibility, while Pomme, lacking any perceptual base, speaks to us in the language of fantasy. But by what fundamental experience can we establish such an obvious difference below the level of our certainties, in that region from which they emerge? How can we be sure that an eighteenth-century doctor did not see what he saw, but that it needed several decades before the fantastic figures were dissipated to reveal, in the space they vacated, the shapes of things as they really are?" Foucault, *Birth of the Clinic*, x.

and their presence in North America. Where Miller hypothesized *E. histolytica* was distributed among Canadians at an approximately one percent rate, Eaton took such things for granted. Similarly, both doctors contrasted infection rates among so-called 'institutionalized' and 'general' groups (in Eaton's case, reserve residents make up the institutionalized). On the other hand, Miller's explanation for the transmission of amebiasis among western Canadians deviates from Eaton's thoughts respecting the prevalence of *E. histolytica* on reserves: while flies are blamed in the first instance, and human behaviour is largely left by the wayside, reserve resident's "need for...improved sanitary facilities" and "education" regarding "the necessity of their maintaining a sanitary environment" is discussed in the second (emphasis added). The attitude embodied in these latter comments typifies a patriarchal humanitarianism associated with colonial agendas. However, the distinction between Miller's and Eaton's perspectives is perhaps better drawn out when the former's remarks relative to the commonality of intestinal infection among asylum inmates are considered:

[H]eavier incidence and intensity of infections in the orphan asylum may be expected because of the lower level of sanitation in this group. This is dependent in part on the low age-level of the group and in part on the concentration of people in a limited space, both factors being characteristic of such institutions.<sup>17</sup>

The conditions of the orphans' existence are discussed as a point of fact, whereas "our people['s]" situation posed "problems"—to borrow Eaton's terms. The question driving this thesis is: how did a colonial attitude enter into a parasitological discussion in the first place?

\* \* \*

Crookedneck hurriedly followed me into the office where we had our interview. She had been told I was a visiting student interested in an outbreak of amebiasis that occurred in Loon Lake during the '60s and '70s, as well as a related drug (metronidazole) trial conducted by a Dr. Frank Scott and others. The proud, middle-aged woman did not remember either the outbreak or trial themselves, both because she was quite young at the time, and because she was from the less affected <sup>19</sup> neighbouring community of Ministikwan; rather, she had sought me out on a busy

<sup>&</sup>lt;sup>17</sup> Miller, "The Intestinal Protozoa," 122.

<sup>&</sup>lt;sup>18</sup> See note 15.

<sup>&</sup>lt;sup>19</sup> Max J. Miller, Frank Scott, and Edward Foster, "An Evaluation of Immunological Indicators for Amebic Disease Prevalence," *American Journal of Tropical Medicine and Hygiene* (January, 1973); and Max. J. Miller, Frank Scott, and Edward F. Foster, "Community Control of Amebic

day (she was about to pick up her child from school) to tell me about a negative experience she had had with Scott in childhood. With audible frustration in her voice, she laid out a chain of events: her inner ear had begun hurting during the course of the school day, so she went to the designated classroom where Scott saw his patients weekly; he examined her ear with a pair of tweezers while she screamed in pain and a nurse looked on unaffectedly; after that, her memory fades. When she became pregnant with her first child, her ear started to hurt again, and the problem persisted over successive pregnancies. She eventually saw a specialist when she noticed she was hard of hearing; this doctor reported she had an irreparable hole in her eardrum. At that point, she linked the trauma of her childhood with her pain and hearing loss in adulthood—a connection she felt I should be made aware of.<sup>20</sup>

Crookedneck's perception of Scott and the medical profession more broadly was complicated, bordering contradictory. With reference to Scott, she said "[h]e was really kind of a barbaric doctor [...] I kinda...you can sense the way he was too, like he was just like...uh, I don't know, the way he looks—no sympathy?"<sup>21</sup> When asked if she thought he was racist, she, like other Aboriginal informants from the Loon Lake area, responded affirmatively. Yet, when questioned as to whether she felt he was typical of his profession she responded thoughtfully, "[it's] just him [...] yeah, just him," and added

I used to be scared of him, too, and my mom used to take me to him, when I used to—I remember I had a toothache and he pulled it out in the office [...] But it is just—it's the...it's the ear part where he, uh, damaged my—he must have damaged it! And—and I just...and I get really, um, [angry] when I get those attacks, it's just real bad, real sharp pains in my ear [...] That's the only thing, I always wanted to talk to somebody about that <sup>22</sup>

Although she explicitly acknowledged Scott harmed her just once, and in the process tacitly admitted to his having given her acceptable medical care on other occasions—while pegging him as a racist-it was what she regarded and remembered as his method of practicing medicine that disturbed her. And despite the fact that she singled him out from others in his field, she

Disease by Periodic Mass Treatment with Metronidazole," *American Journal of Tropical* Medicine and Hygiene (January, 1972).

<sup>&</sup>lt;sup>20</sup> Crookedneck, interview.

<sup>&</sup>lt;sup>21</sup> Ibid.

<sup>&</sup>lt;sup>22</sup> Ibid. I have inserted the word 'angry', here, because whereas Crookedneck did not use the term in this instance, she did at other points in our discussion.

intimated misgivings about 'western'<sup>23</sup> medical practitioners throughout our interview. It troubled her, for example, that the attending nurse did not intervene on her behalf, as she had audibly and visibly struggled. Over the fifteen minutes we spent together, she also repeatedly observed her frustration that various doctors could or would not treat her ear commenting, "I thought they *would* fix it, and it always bothered me."<sup>24</sup> Additionally, her urgent need to speak with me about her childhood experiences was driven by a deep-seated anger towards Scott, which she, at one point, admitted to.

Crookedneck's 'gaze' or means of discussing Scott, and obliquely today's western medical praxis, also represents a wider Aboriginal community perspective on such matters, albeit in an individually nuanced way. Her voice wholly jars, moreover, when contrasted with the clinical if sometimes-colonial perspective provided by Miller and Eaton in a manner (again) reminiscent of the sharp perceptual difference between Pomme and Bayle.<sup>25</sup> Thus, this thesis comprises three distinct 'gazes' of the abovementioned dysentery outbreak and connected drug trial that took place in and around Loon Lake in the '60s and '70s. These gazes are reflected in two overarching research questions: 1) how and why did a colonialist discourse intersect with a clinical and positivist discussion of enteric disease, and 2) how does an Aboriginal outlook on the outbreak and trial obscure those characterizations? *My analysis and presentation is, for reasons I will clarify, unavoidably Orwellian doublethink—"the act of holding two* [or in this case, three] *contradictory beliefs in one's mind simultaneously and accepting both* [/all] *of them."* As such, it directly challenges certain historical conceptions of western medicine when

<sup>&</sup>lt;sup>23</sup> I have placed the term 'western' in quotation marks as that category represents a wide variety of both general epistemological standpoints as well as individual conceptions of medicine; it should be understood in the plural.

<sup>&</sup>lt;sup>24</sup> Crookedneck, interview.

<sup>&</sup>lt;sup>25</sup> See note 16 above.

<sup>&</sup>lt;sup>26</sup> 'Doublethink' is a now-widely used term from George Orwell's 1949 dystopian novel, *Nineteen Eighty-Four*. For a better explanation of its meaning, the passage cited fully reads "*Doublethink* means the power of holding two contradictory beliefs in one's mind simultaneously, and accepting both of them...To tell deliberate lies while genuinely believing in them, to forget any fact that has become inconvenient, and then, when it becomes necessary again, to draw it back from oblivion for just so long as it is needed, to deny the existence of objective reality and all the while to take into account of the reality which one denies—all this is indispensably necessary. Even in using the word *doublethink* it is necessary to exercise *doublethink*. For by using the word one admits that one is tampering with reality; by a fresh act of *doublethink* one erases this knowledge; and so on indefinitely, with the lie always one step

practiced in colonial contexts, in a manner that reminds us "discursive forces have more-than-discursive consequences," or academics have inherent responsibility when relaying narrative. It is therefore both a case and study of 'contact', if 'contact' is defined as "a series of moments that occurs repeatedly, and yet somewhat distinctively each time people speak across cultures." For when these four distinct, culturally bound perceptions of events are taken in tandem—the clinical, the colonialist, the Aboriginal, and the historian's—'contact' occurs. Not only that, 'contact' transpires in a manner accentuating the fluctuating and circulating nature of power in colonial settings. But before we can debate this last point, I invite my readers to consider exactly what those historians have argued.

\* \* \*

Historian Mary-Ellen Kelm quoted a Nisga'a man as stating "[w]hen we talk about the poor health of our people, [we] remember it all began with the white man."<sup>29</sup> The viewpoint here expressed aptly summarized Kelm's own understanding, as she claimed that both the past and current poor health of Aboriginal Canadians was and is indicative of cross-cultural relations and the colonial dynamic. Specifically, she labeled British Columbian Natives' bodies as sites of struggle for early twentieth-century Canadian colonial projects in her 1998 publication *Colonizing Bodies: Aboriginal Health and Healing in British Columbia, 1900-50.* For Kelm, the alarming rates of disease faced by Aboriginal people (for example, she attributes 38.5 percent of all Aboriginal deaths in British Columbia during 1935 to infectious disease, and 43.7 percent to the same cause in 1940) resulted as much from governmental policy and practice as from the pathogens themselves. Furthermore, she suggested the provision of medical services—or lack

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ahead of the truth [emphasis is original]." The term has a negative connotation in its original context referring to the State's manipulation of its populace through propaganda; here, I use it in a positive light solely for purposes of illustration in order to demonstrate the necessity of analyze the plurality of discourses important to the Loon Lake outbreak. George Orwell, *Nineteen Eighty-Four* (London: Penguin Books, 2003), 244.

<sup>&</sup>lt;sup>27</sup> Bracken, Magical Criticism, 206.

<sup>&</sup>lt;sup>28</sup> Keith Thor Carlson, "Reflections on Indigenous History and Memory: Reconstructing and Reconsidering Contact," in *Myth and Memory: Stories of Indigenous European Contact*, ed. John Lutz (Vancouver: UBC Press, 2007), 54. Carlson had referred to the 'contact' between Natives and Newcomers; I am too, but as with my use of Foucault's 'gaze' only in a sense.

<sup>&</sup>lt;sup>29</sup> Mary-Ellen Kelm, *Colonizing Bodies: Aboriginal Health and Healing in British Columbia* 1900-50 (Vancouver: UBC Press, 1998), xv.

thereof–to Native people by federal planners arose from notions of racial superiority, corresponding humanitarianism, assimilative goals, and efforts to isolate contagion.<sup>30</sup>

In an earlier work, historian and subaltern studies expert David Arnold examined state medicine in a colonial environment. Endeavoring to complete "a study of a colonizing process, rather than a history of Western medicine in India" via his book *Colonizing the Body: State Medicine and Epidemic Disease in Nineteenth-Century India*, Arnold put forward the idea that medical interventionism comprised a key point of engagement and/or conflict between British officialdom and its Indian subjects.<sup>31</sup> In tracing the history of epidemic disease (smallpox, cholera, and plague) in colonial India, he found questions of "[w]ho speaks for the body of the people?" informed both political and social actions on each side of the colonial equation.<sup>32</sup> Indians were both drawn to and repulsed by western medicine's 'reading' of the body, and their multifarious responses to that discourse and practice, according to Arnold, spoke not only to medicine's authoritativeness (he described it as "too powerful, too authoritative", but also to heterogeneity within Indian society. Western medicine in India itself was not simply transference of metropolitan medicine to the colony, but rather a local adaptation—'colonial science'. In either case, "the corporality of colonialism in India" took prominence, as opposed to its typically discussed 'psychological' nature.<sup>34</sup>

Both Kelm and Arnold found, as I have, inspiration in Foucault's works. For her part, Kelm noted Foucault's insistence on the epistemological creation of bodies stimulated successive scholarship, her efforts included. She summarized his writings (*Discipline and Punish*, *Birth of the Clinic*, *Madness and Civilization*, and the third volume of the *History of Sexuality*) as establishing, in the first case, how power relations formulated discursive boundaries for knowledge about bodies, and secondly, how discourses constitute bodies to produce or reproduce everyday expressions of power. She also embraced (but then later seemingly rejected it through an overview of Megan Vaughan's *Curing Their Ills*) Foucault's argument that knowledge about bodies in medicine, biology, psychiatry, etc. generated means for control while stimulating

<sup>&</sup>lt;sup>30</sup> Ibid., xv, xix, 7, 100.

<sup>&</sup>lt;sup>31</sup> David Arnold, *Colonizing the Body: State Medicine and Epidemic Disease in Nineteenth-Century India* (Berkeley: University of California Press, 1993), 7.

<sup>&</sup>lt;sup>32</sup> Ibid., 10.

<sup>&</sup>lt;sup>33</sup> Ibid.

<sup>&</sup>lt;sup>34</sup> Ibid., 8. To clarify, Arnold referred to other scholars' discussion of colonialism as a "psychological state."

individualization and promoting self-repression by way of participation in disciplinary systems. Beyond this scope, but not far from the Foucauldian paradigm, Kelm commented on the scholarly importance of structural anthropologist Mary Douglas's description of the body as a 'natural' symbol for society, as well as anthropologists John and Jean Comaroff's analysis of Europeans' pathologizing African bodies to justify colonialism, as colonialism, in turn, caused Africans' sickness.<sup>35</sup> From these cues Kelm reaffirmed that bodies, and particularly Aboriginal bodies in her case, were socially constructed entities in the eyes and practice of physicians and/or the (Canadian) state. <sup>36</sup>

Arnold likewise noted that readers would find Foucault's ideas "inscribed, however artlessly, in [his] pages." That said, as is already apparent given my description of his work above, he admittedly concentrated in a manner he says Foucault warned against on a state-centered system of knowledge (colonial medicine) rather than more diffuse mechanisms of knowledge and power. Also evident in my summary above, Arnold placed greater emphasis than Foucault on opposing conceptions of the body underlining it as a site of *contestation* versus appropriation. More important to this discussion, he pointed to the similarities between phenomena he analyzed under the umbrella of colonialism and events and processes that occurred in Britain, France, or the United States at the same time. As he says,

[t]here is indeed, a sense in which all modern medicine is engaged in a colonizing process. The history of medicine in European and North American societies over the past two hundred years has been a history of growing intervention and a quest for monopolistic rights over the body. It can be seen in the increasing professionalization of medicine and the exclusion of 'folk' practitioners, in the close and often symbiotic relationship between medicine and the modern state, in the far-reaching claims made by medical science for its ability to prevent, control, and even eradicate human diseases. It has aptly been said that the position of medicine today is 'akin to that of state religions yesterday'. 40

Here Arnold, in his engagement with Foucault has perhaps inflated the definition of colonialism past utility. However, in so doing and via other aspects of his study, he avoided that pitfall of too-narrowly focusing on state-based knowledge systems. Kelm, though using a neater

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<sup>&</sup>lt;sup>35</sup> Kelm, *Colonizing Bodies*, 220-1.

<sup>&</sup>lt;sup>36</sup> Ibid., xvii.

<sup>&</sup>lt;sup>37</sup> Arnold, *Colonizing the Body*, 7.

<sup>&</sup>lt;sup>38</sup> Although I do not think this jeopardized his argument.

<sup>&</sup>lt;sup>39</sup> Arnold, *Colonizing the Body*, 8-9, 10.

<sup>&</sup>lt;sup>40</sup> Ibid., 9.

explanation for colonialism,<sup>41</sup> lost sight of some of the complexities inherent in that process due to her close attention to the state. The issue raised by these authors' analytical methods is how to sort out what, precisely, is colonial about western medicine?

In her introduction, Kelm argued she used the term colonization to draw linkages between the Canadian experience and imperialism's practices, policies, and discourses. She then added, "Canadian government officials, medical practitioners, and elements of settler society never forgot their part in expanding the frontiers of Anglo-European ascendancy."<sup>42</sup> But later she suggests at least some medical practitioners did 'forget' that goal. When describing the 'on the ground' administration of Indian Health Services (IHS) in British Columbia during her period of study Kelm stated, "the Department of Indian Affairs had to rely on a pool of medical staff who had their own reasons for living on the periphery of mainstream white society...and as such did not necessarily share the department's colonizing zeal." She went on to explain that for many doctors department contracts comprised one among several sources of income: business-oriented physicians frequently neglected their Native patients in favour of white charges who paid, other doctors simply took no interest in their practices among Aboriginal people, and so on. 44 She concluded by saying "men like [these] were reluctant, even disinterested, colonizers. Their interest lay in creating a settler society that could supersede the First Nations' place in the province, rather than in practicing a medicine that could incorporate them into a new society."<sup>45</sup> Considering these comments I am left asking, what about these physicians' interests in medicine as a profession or subject of study? Were they bent exclusively on creating "cultural vestiges of...viable settler communities"?<sup>46</sup> Or more probable, were their aspirations and/or reasons for practicing medicine less superficial than Kelm suggests. Arnold

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<sup>&</sup>lt;sup>41</sup> Kelm defined colonialism as "geographical incursion, sociocultural dislocation, the establishment of external political control and economic dispossession, the provision of low-level social services, and finally, the creation of ideological formulations around race and skin colour, which position the colonizers at a higher evolutionary level than the colonized." She credits James Frideres with having outlined this process, which he dubbed 'internal colonialism', because, he argued, Canada had perpetuated this within its boundaries. See Kelm, *Colonizing Bodies*, xviii; and James S. Frideres, *Native Peoples in Canada: Contemporary Conflicts*, 3rd ed. (Scarborough, Ont.: Prentice Hall Canada Inc., 1988).

<sup>42</sup> Kelm, Colonizing Bodies, xix.

<sup>&</sup>lt;sup>43</sup> Ibid., 129.

<sup>&</sup>lt;sup>44</sup> Ibid., 133-4.

<sup>45</sup> Ibid., 135.

<sup>46</sup> Ibid.

made a point of reminding his readers that East India Company surgeons "were state servants quite as much as they were scientists" <sup>47</sup>; Kelm seemingly overlooked these Indian Affairs doctors' associations with science, despite Arnold's remark that medicine was "too powerful, too authoritative."

The previously mentioned examples of 'gaze' (the clinician's, Aboriginal patient's, historian's) further exemplify the risk scholars face of either too loosely defining colonialism or showing over-concern with the state. For instance, although the above passage by Eaton discloses his immersion in a state-culture promoting a colonialist agenda, it constitutes one of few examples among medical journal articles on the outbreak and trial where that type of rhetoric is evident—and Eaton authored or co-authored several of these pieces. Overwhelmingly these articles situated doctors' constructed knowledge about patients' bodies in this case as general in nature, i.e. non-racialized. Their discussions centered on E. histolytica's pathology, immunological indicators for amebic disease prevalence, and the clinical components of the trial; the passages cited from and summary of Miller's work are more representative than the selection from Eaton, and incidentally he (Miller) was also involved in management of the Loon Lake outbreak over twenty-years later. In fact, Miller's connection to the outbreak and trial speaks to another important aspect of this whole affair: most of the doctors and nurses involved, including Miller, were not formal employees of the state—that is to say, they were not employed by Indian Affairs or the Medical Services Branch of the Department of National Health and Welfare. So while these physicians manipulated, consciously or not, racial inequity in Canadian society towards their research ends, they primarily wrote about it with assumed scholarly detachment due to their varied affiliations, assumptions, and motives. Crookedneck's case is no less confounding. How much of her expressed concern had to do with colonization in a traditional sense<sup>48</sup> and how much related to a broader, though 'western', medical culture?

Stripping away her identity as an Aboriginal woman from Ministikwan, her having approached me given her tentative knowledge of my study, and her singling Scott out as a racist, her voice could be that of any patient who felt their doctor had damaged their hearing, or nurse had neglected his/her duty. This is a something of an oversimplification, however, as Crookedneck and I met strictly *because* she was an Aboriginal woman from a community that

<sup>&</sup>lt;sup>47</sup> Arnold, *Colonizing the Body*, 26.

was experimented on (Ministikwan served as the control) due to a structural-inequity-related illness. So the outbreak and trial are not simply state matters, or colonization in Kelm's or Frideres's sense, <sup>49</sup> nor are they well described by Arnold's 'colonialism writ large'.

What these 'gazes' provide are points of access, or windows, into the larger discourses that inform them; stated differently, they are instances of perception that precipitate out of discourse(s)—in this case, *either* a colonialist *or* a medical discourse (or in Crookedneck's scenario, as a reaction to those discourses). And to wholly appreciate the complexity of interaction surrounding the outbreak and affiliated drug trial, 'gaze', as noted earlier, must be placed center-stage so as not to boil western medical praxis or colonialism and their separate discourses into one another. That is the means to comprehend 'colonial medicine': as a multiplex of power relations implied by discourses-in-the-plural and implicit in individuals' understandings. For how else are we to sort out this garbled mess—Eaton speaking mostly clinically about his patients yet being employed by IHS and discussing sanitation with a colonialist bent, Miller's involvement as an academic in a government-sponsored but largely unsupervised drug trial on Indian reserves, Crookedneck's layered responses to doctors' treatments of her ear—unless we are prepared to see people as channels for flows of power.<sup>50</sup> To expand on what was argued previously, the 'contact' observable here is one where individuals touch discourses, is discernible via 'gaze', and is manifest in power relations.

This 'contact', moreover, is generative as the original quote by Carlson suggests (as a refresher, he asserted 'contact' occurred "repeatedly...yet distinctively" (b. As my earlier comments about Crookedneck implied, our meeting was triggered by her individuation as a subject of *both medical and colonial discourses*. More to the point, I traveled to the Loon Lake area to speak with people previously distinguished through discourse and praxis from others in the social body. Just as Foucault argued children, patients, madmen, and criminals are set apart

<sup>&</sup>lt;sup>49</sup> Ibid.

<sup>&</sup>lt;sup>50</sup> Here I am borrowing Foucault's conception of disciplinary power as opposed to traditional liberal or Marxist theories of power. Critically, Foucault argued in a disciplinary society (which characterizes 'modern', Western society) power is never localized to, or held by a person or persons like wealth but should be analyzed as functioning "in the form of a chain." Individuals in this conception experience push and pull, or are simultaneously in a position to both undergo and exercise power. Michel Foucault, *Power/Knowledge: Selected Interviews and Other Writings* 1972-1977, trans. C. Gordon (London: Harvester Press, 1980), 98.

<sup>&</sup>lt;sup>51</sup> Again, Carlson, "Reflections," 54.

in a disciplinary society from adults, the physically and mentally well, and non-delinquents, <sup>52</sup> Loon Lake area residents were/are individualized as *Aboriginal* (people)/*patients*; or, Crookedneck and I conversed because, in my assessment, individuals are not the "*vis-à-vis* of power" but, "one of its prime effects." I am implicated in 'contact' in so far as I, as well as Kelm and Arnold in their works, added to the original matrix of events and processes by inserting a history as a discourse into the fold–individuating subjects in an alternate way—whereas Crookedneck is involved as she sought me out thirty years after the fact to *contest* (notice my use of Arnold's wording here) instances of power directly affecting her.

This last comment brings me to additional aspect of this thesis. Crookedneck repeated, at various moments in our conversation, that she "always wanted to talk to somebody about that [her ear incident]." She expressed mixed views on western medical practice as she distinguished Scott, who she described as 'barbaric', from other practitioners while still holding reservations about them. Her nuanced reaction, I will argue, was to 'modern' medicine's 'subtraction' of the patient from medical encounters. Thirty years later she and others are *able* to speak up/out because we are in a period of transition between 'modern' and 'postmodern' medical praxes. <sup>54</sup> Not only that, others in her community rejected 'modern' medicine at the time of the trial by relying on traditional knowledge of health and healing. Power is therefore generative in another sense: merger of discourses prompts individuation of subjects in multiple ways *as well as* multiplex responses and/or *resistances* over time.

Now let's turn to a chapter-by-chapter breakdown of discussion. Chapter Two, 'Shit Happens in Medicine', provides an overview of the dysentery outbreak from a clinician's perspective, while philosophically landing in an ongoing debate in medical historiography on the side Foucault espouses in *Birth of the Clinic*. Instead of damning a particular medical practice (or another), what matters is "that which systematizes [it] from the outset." That might seem an odd stance to take, but reproducing-in-brief a structural analysis of 'anatomo-clinical'

<sup>&</sup>lt;sup>52</sup> Michel Foucault, *Discipline and Punish: The Birth of the Prison*, trans. Alan Sheridan (London: Allen Lane, 1977), 193. See also Alex McHoul and Wendy Grace, *A Foucault Primer: Discourse, Power and the Subject* (Victoria: University of Melbourne Press, 1993), 57-76.
<sup>53</sup> Foucault, *Power/Knowledge*, 98.

This argument is based on Leigh E. Rich et al., "The Afterbirth of the Clinic: A Foucauldian Perspective on "House M.D." And American Medicine in the 21st Century," *Perspectives in Biology and Medicine* 51, no. 2 (Spring, 2008).

<sup>&</sup>lt;sup>55</sup> Foucault, *Birth of the Clinic*, xxii.

discourse (Foucault's terminology) effectively proves it cannot be sandwiched into another discursive form or made its subsidiary, as Kelm (and to a minimal extent, Arnold) would have it. This Chapter's "strange discourse"—'strange' because it is "based neither on the present consciousness of physicians, nor even on a repetition of what they may have said"-focuses on a "visible invisible," or projected subterranean disease mapping plotted by clinicians on patients' bodies over and above race, age, class, gender, and so on; important to Foucault's original conception of 'gaze' are the principles of 'Tissual Communication', 'Tissual Impermeability', 'Penetration by Boring', the specificity of 'Attack on the Tissues', and 'Alteration of Alteration<sup>56</sup>; we will attempt to see as dysentery trial physicians saw. For these same principles of 'gaze' tie into wide-sweeping cases of experimentation during this era far beyond Loon Lake; among later listed examples where minority groups were used, consider the 1954 poliomyelitis field trials funded by the National Foundation for Infantile Paralysis (or the famous 'March of Dimes') where 623,972 United States school-children were injected with vaccine or placebo regardless of their race, class, sex, etc.<sup>57</sup> 'Modern' medicine has its own cross to bear, quite apart from any (Kelm's) colonial legacy. Lastly, Foucault directly questioned the unending play of signifier and signified in an (our) 'age of criticism' in his opening chapter to Birth of the Clinic, a dynamic hinted at in the above comments on 'strange discourse', which I simultaneously attempt to avoid in this Chapter but manipulate throughout the thesis overall. Asking "is it inevitable that we should know of no other function for speech...than that of commentary?" Foucault observed 'commentary' in our time rests on the postulate that questioning what discourse intends to say definitively admits to an excess of signified over signifier; speech ('parole' according to Sheridan, Birth of the Clinic's the translator) is an act of translation whereby the signifier both reveals and conceals, leaving the signified with a ever burgeoning cache of meaning; each assumes autonomy, and commentary occupies the space between their separate significations. (Note the similarities between this line of reasoning involving complex imaginativeness and Bracken's discussion of Spencer, above.) He proposes the operational rule "[t]he meaning of the statement [should] be defined not by the treasure of intentions that it might contain...but by the difference that articulates it upon other real or

<sup>&</sup>lt;sup>56</sup> Ibid., xvii, 183-8.

<sup>&</sup>lt;sup>57</sup> See Marcia Meldrum, "'A Calculated Risk': The Salk Polio Vaccine Field Trials of 1954," *British Medical Association Journal* 317(31 October 1998).

possible statements, which are contemporary to it or to which it is opposed in the linear series of time." As opposed to debating the 'truth' of 'modern' or 'post-modern' medical discourse—finding implied meaning (i.e. colonialism) in medical praxis, or unearthing deeper meaning than past or present clinicians were and/or are aware of—we will treat each as 'discourse-objects' looking for the differences articulating one 'serious speech act' from another in linear time. <sup>59</sup> That way, we can discern why some contemporary physicians questioned the ethics of the trials at Loon Lake and others did not.

Chapter Three, 'That's How I Saw It Anyways', relates Loon Lake and Ministikwan residents' 'gaze' of their past experimental use to mitigate twin appropriations: the 'subject'creating effect of racially-based, binary discursive modes ('colonizer'/colonized', 'oppressor'/'oppressed', Aboriginal/non-Aboriginal); and the dismissal of patient experience from medicine, another discourse perpetuating dichotomy (doctor/patient, or patient/non-patient from a clinician's perspective). Two philosophical influences underpin this Chapter. The first is the Foucauldian concept of 'disinterring' popular knowledge: subjugated knowledges of psychiatric patients, the ill, doctors or nurses counteracts the false, functionalist coherence presented by 'scientificity'. The stated aim of Foucault's 'genealogies' was to combine (what I call 'doublethink') erudite knowledge and local memory towards the historical understanding of conflict within society for tactical use today. <sup>60</sup> The second is medical anthropologist Paul Farmer's stratagem to expose structural violence via biographical example after repeated biographical example to create a composite image in the reader's mind of what that might be. My overarching aspiration, imbedded in my argument, is that Loon Lake and Ministikwan residents be permitted to speak for themselves, and a recognition that, as Jesuit scholar Michele DeCerteau argued elsewhere, when they do what they say defies discourse(s). 61

<sup>&</sup>lt;sup>58</sup> Foucault, *Birth of the Clinic*, xvii-xix.

<sup>&</sup>lt;sup>59</sup> Dreyfus and Rabinow define 'serious speech acts' as what experts say when they speak as experts; Hubert L. Dreyfus and Paul Rabinow, *Michel Foucault: Beyond Structuralism and Hermeneutics*, 2nd ed. (Chicago: University of Chicago Press, 1983), xxiv. For further discussion 'commentary' in the *Birth of the Clinic*, see ibid., xxiii-xxiv.

<sup>&</sup>lt;sup>60</sup> Foucault, *Power/Knowledge*, 82-3.

<sup>&</sup>lt;sup>61</sup> For a discussion on the difficulty of acceding to the 'discourse' of another, see Jesuit scholar Michel de Certeau's chapter on cases of possession among Loudun nuns between 1632-8, further discussed in Chapter Three. Michel de Certeau, *The Writing of History*, trans. Tom Conley (New York: Columbia University Press, 1988), 244-68.

Chapter Four, 'But We Have to Learn to Use Them', expands on claims made in the current Chapter. When introducing their ideas (above), I questioned Arnold and Kelm's conflation of 'colonialism' and 'medicine,' but in Chapter Four I posit that a deeper underlying difficulty facing historians is the question of how we use language. Too often it is employed without regard to the ramifications of concept formation, or more specifically, 'subject creation'. Kelm had no trouble accusing "government officials, medical practitioners, and elements of settler society" of perpetuating imperialism; but what about her inclusion and participation in that same system through her activities as a scholar? Here I am not referring to "geographical incursion," "economic dispossession," "provision of low-level social services," or "ideological formulations around race and skin colour," positioning "colonizers at a higher evolutionary level than the colonized," although I am in part discussing disciplinary systems as a 'great race equalizer' in terms of bringing into play mechanisms of power causing "sociocultural dislocation" and "external political control." Rather, my principal objective is suggesting that in our society, as Foucault acknowledged (excuse the repetition), children are more individualized than adults, patients more than the physically and mentally healthy, criminals/delinquents over non-delinquents, 63 to which I add 'Aboriginal' over 'non-Aboriginal'. It is my contention that Kelm, linked as she was (is) to a university or "theoretical-commercial institution," branded according to (racial) binary mode the abnormal individual instantiating whether done consciously or not-a whole set of disciplinary mechanisms or techniques to measure, supervise, create, or alter him/her.<sup>64</sup> Otherwise phrased, in Aboriginal history as a discipline, the Aboriginal person is more individualized than the scholar of 'Aboriginal' history, creating a power dynamic not unlike the doctor to their patient, or colonizer/colonized relationship. Fundamentally the problem arises in Kelm's case due to her disregard for Foucault's identified five methodological cautions from "Lecture Two: 14 January 1976," despite her supposed adherence to a Foucauldian conception of power. Deeper still, Kelm's work (and I am guilty of this as well) reveals that despite efforts to the contrary it is difficult to be aware of one's apriorism. Dualistic terms have consequences in terms of how people constitute themselves, and are constituted by others, as 'subjects'. Returning to our discussion of

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<sup>&</sup>lt;sup>62</sup> Kelm, Colonizing Bodies, xviii.

<sup>&</sup>lt;sup>63</sup> Foucault, *Power/Knowledge*, 84; Foucault, *Discipline and Punish*, 193.

<sup>&</sup>lt;sup>64</sup> Foucault, *Discipline and Punish*, 199-200.

'commentary', Foucault evoked Nietchze's assessment that the meaning of words—whether "reasonable or senseless, demonstrative or poetic"—looms overhead, drawing us ever forward to their rearticulation, renascence. Chapter Four deductively reasons towards *two*, separate accounts of dysentery outbreak events; by the end, I have 'doublethought' historical events twice over from—a 'modern' medical perspective, an Aboriginal community member's perspective, a post-colonial framework, and a disciplined bodies perspective.

For clarity then, my main arguments are as follows:

- 1) The drug trials associated with the dysentery outbreak at Loon Lake and its surrounding area link to widespread human experimentation during the early to mid-twentieth century. Contemporary censure of the ethics of those trials reflects a shift in medical discourse and praxis post-1960 (from 'modern' to 'post-modern'). A concerted effort to understand 'la clinique' (Foucault's term, comprising clinical medicine and the teaching hospital)<sup>66</sup> reveals it is a discourse in its own right apart from any race-based ideology.
- 2) Loon Lake and Ministikwan residents' perspectives on their experimental use in the dysentery outbreak in and of themselves critique power/knowledge in a Foucauldian 'genealogical' conception (which is what this thesis is).
- 3) Drawing on the above, I suggest academics like Kelm risk perpetuating/creating a racial binary tied to disciplinary power; she individualized the excluded using a set of disciplinary procedures to mark them.<sup>67</sup> 'Post-colonial' studies complete with their 'colonizer/colonized' labels (can) objectify, or constitute as 'subjects', the very people they seek to 'liberate'.

<sup>&</sup>lt;sup>65</sup> Foucault, *Birth of the Clinic*, xvii.

<sup>&</sup>lt;sup>66</sup> See the translator's note, ibid., vii. From the French, Sheridan (the translator) argues 'la clinique' roughly translates to the odd-sounding 'clinic'; both terms are used interchangeably throughout this thesis.

<sup>&</sup>lt;sup>67</sup> Foucault, *Power/Knowledge*, 83; Foucault, *Discipline and Punish*, 199.

### CHAPTER TWO: 'SHIT HAPPENS IN MEDICINE'

[S]o I said to the nurses, 'I want a fresh specimen from this patient, in the lab, nine o'clock tomorrow morning.' So the following morning I took Gene over to the hospital, and we went into the lab, and I said, 'There's a specimen. I looked at one yesterday that was positive.' He took less than a minute to confirm that yes, this was a case of amebic dysentery—it was not just a case of whether we had amebic dysentery, but how much. <sup>68</sup>

Lastly and this is perhaps my most serious criticism, I do not agree with Dr Millers [sic] approach to the problem as nothing more than an interesting scientific situation, which should be pumped for all the information it can give regardless of the well-being of the people. Perhaps his comment that he 'did not worry too much about a few deaths' underlies his whole outlook. This is a spurious 'scientific approach' that I cannot condone, and I am unable to work in association with any project which has such a basis of operations... Efforts at eradication of disease and death from amoebic infection have been held up for three years already in the name of 'scientific investigation'. They should be held up no longer. Science can be served equally well by careful observation of the results of eradicative efforts made sincerely in the interests of the population at risk. <sup>69</sup>

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In a 1968 special edition of the *Canadian Medical Association Journal* (CMAJ), Miller, Drs. W. H. Mathews, and D. F. Moore detailed several 'Indian' patients' deaths from dysentery. 'P.B.', a seventy-three-year-old treated with streptomycin, chloramphenicol, and chlortetracycline for atypical ulcerative colitis, died four weeks after admission to University Hospital, Saskatoon. Necropsy indicated his "primary ulcerative process [was] complicated by a marked, super-added, suppurative inflammation." Or, as the doctors elaborated,

[t]here was extensive necrosis of tissue through all layers of the colonic wall, with the formation of pools of necrotic debris and pus and infiltration by many polymorphonuclear leukocytes. These changes extended to the subserosal fat, and here also there was diffuse infiltration of polymorphs as well as a chronic inflammatory reaction both beneath and on the serosal surfaces. An extensive perforation was obvious [see Appendix B: B.1].

<sup>&</sup>lt;sup>68</sup> Frank Scott, interview by author, 25 June 2008, compact disc copy, University of Saskatchewan.

<sup>&</sup>lt;sup>69</sup> Library and Archives Canada [hereafter LAC], RG 29, vol. 2967, file 851-4-046, part 3, R. D. P. Eaton to O. Schaefer, Northern Medical Research Unit, 16 May 1970, 2.

Eighty-three-year-old 'W.C.' received only minor treatment, as he died a day following initial admission. In line with his distended stomach and swollen ankles—unusual symptoms for an amebiasis case—postmortem analysis of his bowel showed

marked edema of all bowel layers with infiltration by eosinophils, lymphocytes and plasma cells. The ulcers involved mainly the mucosa and submucosa, and their bases were made up of necrotic debris resting on an edematous submucosa. Amebic trophozoites were scattered throughout ...

'M.M.', a sixty-four-year-old, underwent extensive treatment with sulfonamides, chloramphenicol, emetine hydrochloride, diiodohydroxyquinoline, and oxytetracycline but died days after entering University Hospital. Permission for autopsy was refused, but biopsy revealed that despite her suffering fifty-one weeks of symptomatic diarrhea, "[t]here was little evidence of tissue reaction, and the amebae were commonly present in tissues in clusters. The mucous membrane overlay an abnormal submucosa characterized by fibrous reaction and dense inflammatory infiltration."

What is striking about these descriptions, given Kelm's arguments as discussed in Chapter One, is how little patients' race, age, or class is reflected in the writings of these physicians. Rather patients were paradoxically described, as a reading of Foucault might expect one to anticipate, externally in comparison to what they suffered from; alternately put, the medical 'reading' took them into account only to put them in "parentheses." Their *disease* was what was important to doctors, mapped as it was on patients' bodies, "caus[ing] lesions that [became] visible under autopsy, trigger[ing] off, at one point or another, the interplay of symptoms, caus[ing] reactions, and thus mov[ing] towards a [final] fatal...outcome." As he concluded, "[w]e are dealing here with those complex, derived figures by means of which the essence of the disease, with its structure of a picture, is articulated upon the thick, dense volume of the organism and becomes *embodied* within it." Miller, Mathews, and Moore traced,

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<sup>&</sup>lt;sup>70</sup> Max J. Miller, W. H. Mathews, and D. F. Moore, "Amebiasis in Northern Saskatchewan: Pathological Aspects," *Canadian Medical Association Journal* 99(October 12, 1968): 696-8.
<sup>71</sup> Foucault, *Birth of the Clinic*, 7. Rich et al. suggest when Foucault used the term "parentheses," he was referencing Edmund Husserl's phenomenology, which attempted to understand things in and of themselves (similar to medical 'gaze') and 'bracket' phenomena to separate one's preconceptions and perception from the 'reality' of the bracketed. Rich et al.,

<sup>&</sup>quot;The Afterbirth," 223.

72 Foucault, *Birth of the Clinic*, 9.

second-hand, <sup>73</sup> invasive amebiasis's movement "through... the colonic wall" as necrosis "extended to the subserosal fat," "infiltration by eosinophils, lymphocytes and plasma cells," and amebas' "presen[ce] in tissues in clusters" (emphasis added). <sup>74</sup> The chapter's opening citations further reveal physicians' perceptual biases towards disease, or broadly, their immersion in 'modern' medical/anatomo-clinical discourse—what Foucault termed a 'language of rationality', a transformational event in the connection between words and things, and man/woman to his-/herself. <sup>75</sup> Scott (mentioned in the introduction) found dysentery not at his patient's bedside but the 'lab', <sup>76</sup> and even Eaton, writer of the second strongly worded excerpt, phrased his objections in the discourse: 'science' could be "served equally well" via "careful observation," <sup>77</sup> maintaining a 'modern ethic' to eradicate disease. <sup>78</sup>

However, Eaton's concerns additionally flag that transition from 'modern' to 'post-modern' medicine spoken about in the introduction: a reflexive reformulation of clinical discourse given the 'no holds barred' legacy of 'big science'. Scott's recollection of a forty-

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<sup>&</sup>lt;sup>73</sup> While never stated in their article, it is highly unlikely that Miller and Mathews (professors at McGill University), and possibly Moore as well (faculty member, and later Dean of the Faculty of Medicine at the University of Saskatchewan), either treated or conducted the post-mortems for these patients. They probably accessed hospital records for research.

<sup>&</sup>lt;sup>74</sup> Miller, Mathews, and Moore, "Amebiasis: Pathological Aspects," 696-8.

<sup>&</sup>lt;sup>75</sup> Foucault, *Birth of the Clinic*, xvi. A timing issue is present here: as implied in note 16 above, Foucault focused on a transformation in medical discourse over the eighteenth to nineteenth centuries in post-revolution France; however, Rich et al. suggest the transition from 'premodern' to 'modern' medicine occurred later in United States, which I feel holds true for Canada as well. See Rich et al., "The Afterbirth," 221.

<sup>&</sup>lt;sup>76</sup> Rich et al. argue that most of modern medicine's doctoring occurs either in the diagnosis room or laboratory; see Rich et al., "The Afterbirth," 224. Admittedly their stance was based on Paul Starr's discussion of how detached technologies (microscopes, X-rays, chemical and bacteriological tests, electrocardiographs, etc.) enhance physicians' supposed objectivity insofar as the diagnostic process is removed from the presence of the patient to 'backstage' areas where several doctors can examine data at once; Paul Starr, *The Social Transformation of American Medicine* (New York: Basic Books, Inc., 1982), 136-7.

<sup>&</sup>lt;sup>77</sup> RG 29, Eaton to Schaefer, 16 May 1970, 2.

<sup>&</sup>lt;sup>78</sup> Rich et al. use this phrasing. Rich et al., "The Afterbirth," 221.

<sup>&</sup>lt;sup>79</sup> Alvin M. Weinburg coined this term referring to post-WWII expansions in scientific research involving extensive budgets, large laboratories, and when extended to medical settings, human experimentation. It is worth quoting the following descriptive passage, here, to better understand what Weinburg was driving at: "When history looks at the twentieth century, she will see science and technology as its theme; she will find in the monuments of Big Science—the huge rockets, the high-energy accelerators, the high flux research reactors—symbols of our time just as surely as she finds in Notre Dame a symbol of the Middle Ages. She might even see analogies between

year-old discussion with 'Gene' rings out with a self-assured linguistic footing revelatory of Foucault's thesis concerning the inseparability of the articulation of anatomo-clinical language and its object, between 'saying' and 'seeing'—he speaks with clarity imbued by the (supposed) restraint of 'modern' medical discourse from theory, systems, or philosophy. 80 Miller, Mathews, and Moore observed 'P.B.', 'W.C.', and 'M.M.' like "stars or a laboratory experiment," testifying in "open up a few corpses" fashion to disease vitality while distinguishing "legitimate" clinical 'signs' (as opposed to symptoms) of disease from "bastard" they acted precipitately from a priori 'gaze' ostensibly unburdened by language. Together, Scott's and Miller, Mathews, and Moore's collective brashness represents the sort of "interesting scientific situation" Eaton balked at. Rich et al. sketch a "science of inhumanity," listing battleships, tanks, high altitude bombers, as well as compulsory sterilization and Nazi experimentation among modernism's archive. 83 In opposition to the "single, 'objective' narrative of modernity," they pit post-1960s changes in medical praxis (publication of Henry K. Beecher's "Ethics and Clinical Research," the 1976 decision In the Matter of Karen Ann Quinlan, 84 etc.) to demonstrate the proliferation of stakeholders (patients, families, administrators, health insurers, pharmaceutical companies) in the medical encounter beyond but not exclusive of 'modern' physicians<sup>85</sup> (contrasting Miller

our motivations for building these tools of giant science and the motivations of the church builders and pyramid builders. We build our monuments in the name of scientific truth, they build theirs in the name of religious truth..." Alvin M. Weinberg, "Impact of Large-Scale Science on the United States," *Science* 134, no. 3473 (1961): 161.

<sup>&</sup>lt;sup>80</sup> Foucault, *Birth of the Clinic*, xii, xxi. Foucault explained the "*restraint*" of anatomo-clinical discourse—or its rejection of theory, systems, and philosophy—reflects the "non-verbal conditions on the basis of which it can speak: the common structure that carves up and articulates what is seen and what can be said" (emphasis in original).

<sup>&</sup>lt;sup>81</sup> To expand, Foucault discussed necropsy as a central component of the 'clinic'. Two things are important here: first, anatomo-clinical method triangulated death, life, and disease making the latter "exhaustively legible" against the former and detached from a "metaphysic of evil"—death became a perceptual apex from which to view the "truth"/*life* of disease, or to spatialize and individualize the pathological course; second, given that, autopsy was a key component to 'modern' medical education. It is worth noting all words and phrases in quotation marks in the main text body are extracted from primary documents written by past clinicians (specifically Sournia, Frier, and Bichat), whom Foucault cites. Ibid., xvi, 8, 152-80, 194-5, 243.

<sup>&</sup>lt;sup>82</sup> RG 29, Eaton to Schaefer, 16 May 1970, 2.

<sup>&</sup>lt;sup>83</sup> Rich et al., "The Afterbirth," 228.

<sup>&</sup>lt;sup>84</sup> Rich et al. explain that the decision allowed the parents of a woman in a vegetative state to disable her ventilator.

<sup>85</sup> Rich et al., "The Afterbirth," 228-9.

specifically, Eaton asked for efforts "*sincerely* in the interests of the population at risk" [emphasis added]). 86

But before leaving this discussion of 'modern' medicine's 'glory day'-remembering Arnold's "too powerful, too authoritative" admonishment-let us first more deeply consider its implications.

\* \* \*

Unlike Miller, Mathews, and Moore, the provincial public health authority initially thought 'P.B.'s' death was worth only cursory notice when it occurred in July 1959. Despite report of the diagnosis<sup>87</sup> as well as post-mortem confirmation, the Saskatchewan Department of Public Health declined further investigation of the possibility of widespread infection.<sup>88</sup> Meanwhile, other local reserve residents developed amebic disease: a two-year-old child died from amebic colitis with perforation in August 1960, though this went unrecognized until years later; 'P.B.'s' thirty-two-year-old son survived amebiasis in 1961 after a defunctioning ileostomy and antiamebic therapy with emetine hydrochloride and diiodohydroxyquinoline; this man's wife and another woman from Ministikwan suffered amebic colitis in the subsequent month; and a forty-year-old man from Onion Lake endured amebic liver abscess twice that year, and was treated with oxytetracycline, chloroquine, as well as two open drainages of pus.<sup>89</sup> The Department finally took notice when Scott identified approximately another dozen cases from his local family practice. However, missives simply directed him to send samples to the Communicable Disease Center (CDC) in Atlanta, Georgia, telling Scott "this is impossible" as amebiasis should not exist so far North.<sup>90</sup>

Scott, in turn, was annoyed by their close-mindedness on the matter. He had spent time in the British army in Malaysia, as well as maintained a family practice in Lagos, Nigeria, and had no doubt about what he was observing. His on-the-spot examination of patients' stools

<sup>&</sup>lt;sup>86</sup> RG 29, Eaton to Schaefer, 16 May 1970, 2.

<sup>&</sup>lt;sup>87</sup> Saskatchewan's Department of Public Health labeled dysentery a reportable disease; Frank Scott, interview by author, 21 May 2008, field notes, University of Saskatchewan; Scott, interview, 25 June.

<sup>88</sup> Eaton, "Amoebiasis," 483.

<sup>&</sup>lt;sup>89</sup> R. D. P. Eaton, "Amebiasis in Northern Saskatchewan: Epidemiological Considerations," *Canadian Medical Association Journal* 99(October, 1968): 706. Scott likened the consistency of these drainages to anchovy sauce: "a filthy dirty brown liquid." Scott, interview, 25 June. <sup>90</sup> Ibid.

revealed "ameba moving freely with engulfed red [blood] cells...amebic dysentery," and so when members of the public health department claimed amebiasis did *not* exist in northerly climates he argued, "the climate in my gut, right now, was exactly the same as it was when I lived in the tropics. And number two: the first well-documented case of amebic dysentery was from Archangel in the Soviet Arctic." He was further perturbed when he discovered the 'expert' he was sending his sera to had no better means of assessing samples than he did; instead, the CDC's Dr. George R. Healey asked Scott to send him matched blood and fecal specimens so he could prove an *experimental* technique he was in the process of developing. Needless to say the CDC eventually confirmed his diagnoses, and with that information Dr. Herman Dillenberg—an epidemiologist with the Department of Public Health—sent Dr. Eugene Meerovitch<sup>93</sup> (McGill University), as well as Eaton, to reserves to perform stool surveys.

Meerovitch and Eaton originally planned to visit Loon Lake, Ministikwan, and Bighead, where twelve of a now fifteen confirmed cases of human amebiasis originated, but alternately accessed members of all three reserves collecting specimens at a five-day Sun Dance held near Loon Lake in August, 1964. In a published report on their findings, the doctors skimmed over difficulties experienced collecting samples at a religious function<sup>95</sup> to concentrate instead on methods for collection:

[S]pecimens were collected in waxed-paper containers and placed as soon as possible in MIF fixative in one-ounce plastic, screw-capped vials and emulsified...The name, age, place of residence, and any history of diarrheal disease were taken from each person providing a specimen...

<sup>&</sup>lt;sup>91</sup> Ibid. Notably these comments are devoid of the racialized notions of health/'bodies' Kelm critiques.

<sup>&</sup>lt;sup>92</sup> Scott, interview, 21 May and Scott, interview, 25 June. Healey apparently went so far as to acknowledge Scott in one of his publications for sending him samples.

<sup>93</sup> Meerovitch is the 'Gene' referred to in the chapter's opening quote.

<sup>&</sup>lt;sup>94</sup> Eaton, "Amoebiasis," 483.

<sup>&</sup>lt;sup>95</sup> Meerovitch and Eaton's exact phrasing was "some difficulty was experienced before a certain measure of cooperation was obtained from the people...enhanced by the religious and social nature of the occasion." E. Meerovitch and R. D. P. Eaton, "Outbreak of Amebiasis among Indians in Northwestern Saskatchewan, Canada," *American Journal of Tropical Medicine and Hygiene* 14(1965): 719. Contrastingly, Scott observed people responded "perfectly reasonably," adding the ease with which specimens were obtained throughout the outbreak was "strange"; Scott, interview, 25 June. These perspectives further contrast at least some Aboriginal community members' views on these events (see Appendix C: C.1).

Fecal specimens were further emulsified [when they arrived at the Institute of Parasitology at McGill], strained through gauze and examined directly and after a concentration procedure based on the formalin-ether method. Concentration was very effective for protozoal cysts and in most cases also for trophozoites. Permanently stained preparations were made from only a few specimens because it was seen that temporary iodine-stained wet mounts were adequate for making diagnosis.

Results indicated 124, or nearly seventy percent, of the 178 people tested had feces-transmitted intestinal parasites. *Entamoeba coli* infected sixty-nine or 38.8 percent of people, comprising the most frequently encountered parasite, whereas *E. histolytica* infected fifty-five or 30.9 percent of cases. In the latter scenario, thirty peoples' samples revealed cysts, thirteen peoples' showed trophozoites, while twelve indicated both. Notably, eight specimens "appeared to be dysenteric, with blood and mucus, and occasionally with hematophagic \*\*P. histolytica\*\* trophozoites." Other encountered parasites included *Endolimax nana*, *Giardia lamblia*, *Entamoeba hartmanni*, and *Chilomastix mesnili*. Meerovitch and Eaton broke down parasitological distribution by residence and age (see Appendix B: B.2 and B.3). In addition to the strain's virulence: two more people died from amebic dysentery immediately after the survey's completion, plus they suspected one victim contracted his ailment during the Sun Dance. They conjectured that although they found just eight dysenteric stools, "there were probably more unformed stools, because amebic trophozoites were seen in 32 specimens." \*\*98\*\*

Consequently, Eaton ran an anti-amebic therapy program<sup>99</sup> from October to December 1964, as "[h]ealth care for all reservation Indians [was] the responsibility of the Indian Health Service." Intending to treat "every individual—man, woman and child—on affected reserves," his team (comprising two public health nurses, a regional sanitarian, and Indian community health workers) realistically treated around 700 of a known 720-to-730 reserve residents via three separate and consecutive treatment schedules. Going door-to-door at Ministikwan (labeled "the reserve most likely to give whole-hearted cooperation)"), Bighead, and Loon Lake, his team

<sup>&</sup>lt;sup>96</sup> Ibid., 719-21. Scott maintained that cysts are not enough to determine amebiasis, but only mark people as carriers. Instead, bloody stools and/or trophozoite-laced stools confirms amebiasis. Scott, interview, 21 May.

<sup>&</sup>lt;sup>97</sup> Or blood-fed; see Scott's description, page 22-3 above.

<sup>98</sup> Meerovitch and Eaton, "Outbreak of Amebiasis," 720-1.

<sup>&</sup>lt;sup>99</sup> As discussed in Chapter One; Eaton, "Amoebiasis," 484-5.

<sup>&</sup>lt;sup>100</sup> Miller, Scott, and Foster, "An Evaluation," 331. Breakdown of health care to Aboriginal peoples at that time varied; private physicians and local facilities provided most treatment needs, however the IHS dealt with preventative health measures.

ran vital statistics and prescribed either Furamide or Mexaform (with children receiving paromomycin sulfate) to the 700. 101

The overall result of these short-term treatment programs "was to stop the apparent development of amebic dysentery for about three months, after which new cases started to appear." This, as well as research conducted by Sivasankran et al., 102 prompted Eaton to attempt continuous therapy of Loon Lake and Minsitikwan residents between November 1966 and March 1967 using Furamide. In a memo to Saskatchewan's Regional Director, Eaton discussed the '66 campaign aftermath as ineffective because Furamide failed to treat ameba infecting non-intraluminal enteric tissue, and patient compliance was an issue. Therefore, in 1967 "all attempts at continuous control by drug therapy [were] stopped." In a later report, he further listed deficiencies of each drug used: not only were Paramomycin, Mexaform, and Furamide ineffective for either single-dose or longer-term treatments, they caused intolerable and increased side effects. Scott summarized, "really, in the beginning there was no good treatment for, uh, amebic dysentery. And we tried the standard [...] chloroquine, and what have you, which didn't do very much." And we tried the standard [...] chloroquine, and what have you, which didn't

Medical Services personnel also had concerns about their hired consultant. Contracted in both 1949 and '52 by IHS to conduct cursory surveys on several reserves, <sup>106</sup> Miller was again conversationally approached by Drs. G. Graham-Cumming and H. A. Procter in April 1965 to submit his opinion on "highlights of the outbreak." His pursuant "interest in the amoebiasis

<sup>&</sup>lt;sup>101</sup> Eaton, "Amoebiasis," 484-5.

<sup>&</sup>lt;sup>102</sup> M. P. Sivasankran, et al., "Chemoprophylaxsis of Amebiasis with Entamide Furaote," *British Medical Association Journal* 1((April 2) 1966); Eaton, "Amebiasis: Epidemiological Considerations," 709.

<sup>&</sup>lt;sup>103</sup> LAC, RG 29, vol. 2967, file 851-4-046, part 3, R. D. P. Eaton, memorandum to Director, Prairie Region, February 1970, 1.

<sup>&</sup>lt;sup>104</sup> LAC, RG 29, vol. 2967, file 851-4-046, part 3, R. D. P. Eaton, Northern Medical Research Unit, memorandum to Regional Director, Saskatchewan Region, "Maintenance of Anti-Amoebic Measures in the Amoebiasis Area," 17 December 1971, 2-3.

<sup>&</sup>lt;sup>105</sup> Scott, interview, 25 June.

<sup>&</sup>lt;sup>106</sup> LAC, RG 29, vol. 2967, file 851-4-046, part 1, Max J. Miller, memorandum, "On the Loon Lake Amoebiasis Outbreak," n.d., 1.

 $<sup>^{107}</sup>$  LAC, RG 29, vol. 2967, file 851-4-046, part 1, G. Graham Cumming, Advisor, Public Health to Max Miller, 20 April 1965.

problem over the years,"<sup>108</sup> as well as promised "resources" and available laboratory space at his employers (at that time, the Institute of Parasitology),<sup>109</sup> resulted in his eventual agreement to perform "serological service" in connection with the anti-amebiasis program at a rate of \$17,500 annually. <sup>110</sup> By January 1970, his infrequent and lackluster progress reports grated.

It is realized that Dr. Max Miller is supposed to be the consultant on this project. He has visited the area once or twice a year and when he does visit, he does not even discuss the situation with Dr. Gompf or Dr. Waldron, whose responsibility it is to ensure that the disease is kept under control. We have received no reports from Dr. Miller and I understand this department is reimbursing him for 'consultant' services at the rate of about \$18,000 per annum...

It is realized that Dr. Miller may be conducting some research with respect to Amoebiasis of which we are not aware... 111

His "brief" progress report submitted February 1970 solved little: Dr. O. J. Rath panned it as "not very informative," adding "[i]t was obvious that Dr. Miller is interested only in research and preparing articles for medical journals."

In that report, Miller outlined activities over the questionable period (September to December 1969), particularly "the successful treatment trial for amebic disease with Metronidazole (Flagyl)." In the subsequent article, published January 5, 1970 in the *Journal of the American Medical Association*, Miller and Scott described the treatment of five "proved" amebic ulcerative colitis cases with 250 milligrams metronidazole, three times daily, for ten, or

<sup>109</sup> LAC, RG 29, vol. 2967, file 851-4-046, part 1, K. G. Davey, Director, Institute of Parasitology to H. A. Procter, Director, Indian and Northern Health Services, 9 June 1965, 1-2. The School of Public Health and Tropical Medicine at Tulane University, New Orleans, LA, later employed Miller.

<sup>&</sup>lt;sup>108</sup> LAC, RG 29, vol. 2967, file 851-4-046, part 1, Max J. Miller to H. Proctor, Medical Services, 10 May 1965.

LAC RG 29, vol. 2967, file 851-4-046, part 1, The Honorable Treasury Board, memorandum to Department of National Health and Welfare, "Authority To Enter Into Agreement," 20 December 1965.

<sup>&</sup>lt;sup>111</sup> LAC, RG 29, vol. 2967, file 851-4-046, part 3, O. J. Rath, Regional Director, Prairie Region, memorandum to Director General, Medical Services, "Amoebiasis–Saskatchewan," 23 January 1970.

LAC, RG 29, vol. 2967, file 851-4-046, part 3, O. J. Rath, Regional Director, Prairie Region to Director General, Medical Services, "Amoebiasis—North Battleford Area," 12 February 1970.
 LAC, RG 29, vol. 2967, file 851-4-046, part 3, Max J. Miller, memorandum to J. H. Wiebe, Director General of Medical Services, "Amebiasis Project: Progress Report Sept. 1st-Dec. 31st 1969," 21 January 1970.

in one case fourteen, days. Each person was asymptomatic within days. By way of illustration, Cases 3 and 4, forty-eight and thirteen-year-old females respectively, had bloody mucoid diarrhea for ten plus days, as well as "very active bowel sounds"; by the forty-eight hour mark, both patients "were free of complaints." Case 6, a blind, fifty-year-old man diagnosed with amebic ulcerative colitis the previous month, and whose sigmoidoscopy revealed "an annular friable mass at 5 cm" and "[n]umerous erythrophagic amebae...in scrapings from the ulcers," saw his ameboma shrink within six days; on

the 11<sup>th</sup> day it was represented only by a slight rim. Treatment in this case was continued for 14 days, by which time the ameboma was no longer detectable. A sigmoidoscopic examination four days later showed a healthy bowel wall; the ameboma had resolved completely, and there was no evidence of ulceration.

Except for a "transient skin interruption" (Case 1, an eighteen-month-old child), patients experienced no adverse reactions. Singularly, Case 2 delivered a healthy baby to term without trouble.<sup>114</sup>

Medical Services staff still had concerns. Dr. John Gompf told Eaton he worried about the lack of control program, and "was dissatisfied with the amount of interest showed by Dr. Miller himself." Miller had not seen him since the previous summer, and Gompf only expected his return the next. In an unsent letter dated April 20, 1970, Medical Services Director Dr. J. H. Wiebe, who had formerly supported Miller's efforts, and continued to do so after a clarifying phone conversation, wrote:

[w]e have been under considerable pressure for the past two months to do more to combat amoebiasis in the Loon Lake area.

Dr. Eaton is anxious to get into the act and presumably would resume prophylactic treatment of amoebiasis on a mass basis. The Regional Director is recommending such a course of action...<sup>117</sup>

Wiebe presumably decided not to mail his letter after learning that Miller had announced plans, in a progress report dated January/March 1970, to conduct chemo-prophylactic study at

<sup>115</sup> LAC, RG 29, vol. 2967, file 851-4-046, part 3, R. D. P. Eaton, Northern Medical Research Unit, memorandum to Director, Prairie Region, "Amoebiasis–Saskatchewan," 19 January 1970. <sup>116</sup> No relation to author.

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<sup>&</sup>lt;sup>114</sup> Frank Scott and Max Miller, "Trials with Metronidazole in Amebic Dysentery," *Journal of the American Medical Association* 211, no. 1 (January 5, 1970): 118-20.

<sup>&</sup>lt;sup>117</sup> LAC, RG 29, vol. 2967, file 851-4-046, part 3, J. H. Wiebe, Director General, Medical Services Branch, to Max Miller, 20 April 1970.

Loon Lake using metronidazole. A preliminary meeting held May 5 at the Cavalier Hotel, Saskatoon, and attended by Waldron, Gompf, and others to discuss Miller's project, rankled Eaton. In addition to his objections to using reserves for controls, he argued:

Dr. Miller says that he does not believe that eradication of <u>E. Histolytica</u> is possible, and that this treatment schedule is aimed only at elimination of overt disease. On a world wide basis I would agree with his opinion at present, but not in the restricted situation that we have in [Loon Lake]...if Dr. Miller wishes only to suppress the disease and ignore the carrier status completely, this is tantamount to sweeping the dirt under the rug and is in complete defiance of all the concepts of public health...

Dr. Miller proposes to use for his 'study', the supplies of metronidazole that have been supplied at considerably reduced cost by Poulenc Ltd. [the manufacturer] on the basis of a therapeutic approach that I have worked out in cooperation with May and Baker...for licensing purposes of the drug, and their investigational research programme. To now divert these supplies to other purposes amounts to a breach of contract. 118

Regardless, two years later Miller, Scott, and IHS sanitarian Edward F. Foster published "Community Control of Amebic Disease by Periodic Mass Treatment with Metronidazole." Remarking on their capacity to "carry out certain types of field studies in Indians with a greater degree of control than in a general population," they declared "[g]ood results" treating approximately 350 Loon Lake reserve residents using metronidazole for twelve months. When in previous years cases ranged from nine to twenty-eight, with twenty-seven and twenty-eight cases in the last two consecutive twelve-month periods, Miller, Scott, and Foster observed a seven-fold reduction to just four cases in the treatment period. Contrastingly, the authors noted that in Ministikwan, which "did not receive prophylactic treatment [to serve] as controls for the study," nine, six, and six cases were reported between August 1968 and July 1971. Dosage was set to two grams monthly for the first three months for adults weighing over 110 pounds, and later reduced to 1.5 grams bi-monthly<sup>119</sup> given community objections<sup>120</sup>; those weighing less received proportionally lowered amounts (approximately forty-three milligrams per kilogram of body weight). Infants and pre-school children took medication in both water or sugar-syrup solutions, and also received decreased amounts (by half) part way through given high incidences

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<sup>&</sup>lt;sup>118</sup> RG 29, Eaton to Schaefer, 16 May 1970, 1-2.

<sup>&</sup>lt;sup>119</sup> Max. J. Miller, Frank Scott, and Edward F. Foster, "Community Control of Amebic Disease by Periodic Mass Treatment with Metronidazole," *American Journal of Tropical Medicine and Hygiene* 21, no. 4 (1972): 400-1.

<sup>&</sup>lt;sup>120</sup> Scott, interview, 21 May and Scott, interview, 25 June.

of vomiting. Public health workers administered drugs on a house-to-house basis, while school children received doses in-class. Of the four dysentery cases that occurred during Miller's study, three out of four patients went untreated. A young adult male who missed the first treatment became ill shortly thereafter, an elderly female who refused treatment during the third distribution was dysenteric four months later, and a dysenteric six-month-old child vomited the drug at four months old. Only in the fourth case was treatment provided, where a 2.5-year-old child contracted amebic disease six weeks following drug administration. <sup>121</sup>

\* \* \*

With this last trial in 1971, the amebic dysentery outbreak in the Loon Lake area was effectively controlled. Research physicians had sketched a blueprint for what would become today's dosing regimen: currently, adults with invasive colitis due to E. Histolytica infection receive 500 to 750 mg metronidazole three times daily for seven to ten days, followed by a luminal agent (including Paromomycin, diiodohydroxyquin or diloxanide furoate) to eliminate intraluminal cysts. 122 Asymptomatic patients (or carriers) with E. Histolytica infection are treated solely with the intraluminal agent. Moreover, they had help 'discover' (if that term can be used, considering they did not personally synthesize the drug, but rather extended its use beyond the original application for patients with trichomoniasis and other sexually-transmitted infections) the penicillin-equivalent for treatment of anaerobic infection–metronidazole has since gained broad use as an antibacterial and antiprotozoal agent. The trials reported in "Trials with Metronidazole" and "Community Control of Amebic Disease" highlight the changes in dosage dependent on the applied context (symptomatic versus carrier patients). In addition, they represent the second and third published clinical trials of metronidazole for treatment of amebiasis to that point in time, with the first conducted on Durban workers (alternately called "Africans" and "African males" in missives) in South Africa—a 'race' parallelism that we can no longer ignore. 123

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<sup>&</sup>lt;sup>121</sup> Miller, Scott, and Foster, "Community Control," 401-2.

<sup>&</sup>lt;sup>122</sup> It is worth noting that a ten-day course of metronidazole often eliminates intraluminal infection, however use of the second agent is preferable.

<sup>&</sup>lt;sup>123</sup> See Eric J. Baines, "Metronidazole: Its Past, Present, and Future," *Journal of Antimicrobial Chemotherapy* 4, no. Suppl. C (1978). For a direct example of racist remarks relating to the Durban trial, see the following excerpt from Baines's letter to Eaton: "[t]he outstanding important question, apart from the feasibility of administering second and third consecutive doses, is that of the patient's tolerance. The Durban workers have had no real problem with this

Kelm and others would argue at this juncture that 'race' is an essential paradigm to this discussion, as it is no coincidence that reserve populations, or mining communities in South Africa, served as ideal control subjects to test metronidazole's effectiveness in treating amebic infection over members of the general population. But the narrative above smacks of the 'flex' of 'big science': infants, children, and pregnant women served as test subjects, as with other cases of human experimentation at the time; a religious function was interrupted for sample gathering, an act intolerable by today's pharmaceutical and university ethics boards' criteria; and so on. Regarded in this light, it is important to consider the following excerpt about race, all the more relevant to our discussion because it refers to one of the numerous trials associated with the Loon Lake outbreak we have yet to examine, and involves the intentional harm of patients by inciting a welt on the skin for the purpose of creating an (proven unsuccessful and importantly, non-therapeutic) epidemiological screening tool for amebiasis—an exemplar of Rich et al.'s "science of inhumanity."

The high pre-skin test IHA titer of the object MR was due to the presence of an amebic liver abscess; although the abscess was drained and the patient was treated, his antibody titer was still high 7 months later. In all but one (JB-1) of the remaining eight cases there occurred a significant rise in the IHA titer following the skin test...We suggest that an intradermal injection of histolyticin into a subject with a latent low-grade amebic infection and a low antibody titer will raise the titer, and that this might lead to confusion in the interpretation of the titer as related to disease. 125

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at any time during the past three years but it must be noted that they have been dealing entirely with Africans who seem to be able to tolerate large doses of various chemotherapeutic agents..." LAC, RG 29, vol. 2967, file 851-4-046, part 3, Eric J. Baines, New Products Manager, May and Baker Ltd., to R.D.P. Eaton, Northern Medical Research Unit, 8 January 1970. It is worth noting that within said letter, Baines mentions various experiments with metronidazole on the mentally ill, "mentally retarded," and army personnel in Pakistan and India.

Rich et al., "The Afterbirth," 228.

<sup>&</sup>lt;sup>125</sup> E. Meerovitch and F. Scott, "Skin Tests and Hemagglutinating Antibody Titers in Amebiasis Patients," *The Journal of Parasitology* 59, no. 6 (1973): 1134-5.

Table 2.1\*

IHA titers and skin test reactions in subjects from an amebiasis-endemic area

Reciprocal of IHA titer

Object	Age (yrs)	Pre-skin test	Post-skin test	Interval between serum samples (days)	Skin Test
DJ	6	128	512	17	+
JB-1	71	8	16	14	-
TB	80	256	4096	17	+
RM	50	64	1024	14	+
MD	36	8	128	16	+
JB-2	10	32	256	19	+
AM	10	64	512	15	+
MR	56	4096	4096	7 mos.	+
DC	20	128	512	27	+

Compare this to Eaton's gibe "[p]erhaps...he 'did not worry too much about a few deaths'" to what historian James Jones called the first professional objection to the Tuskegee Syphilis Experiment, known as the longest non-therapeutic human experiment and contemporary to the Loon Lake outbreak.

I am utterly astounded by the fact that physicians allow patients with a potentially fatal disease to remain untreated when effective therapy is available. I assume you feel that the information which is extracted from observations of this untreated group is worth their sacrifice. If this is the case, then I suggest that [...] those physicians associated with it need to reevaluate their moral judgments in this regard. 127

The three passages contrastingly layered as such reveal a redistribution of medical knowledge. Commenting on the earlier transition from an "old[er] clinical theme" to 'modern' or anatomo-clinical method, Foucault remarked

[n]onetheless the rejuvenation of medical perception, the way colours and things came to life under the illuminating gaze of the first clinicians is no mere myth. At the beginning of the nineteenth century, doctors described what for centuries had remained below the threshold of the visible and expressible... 129

What had changed was the configuration underpinning language: "the relation of situation and attitude to what is speaking and what is spoken about [emphasis added]." Jones, for his part, reveled at the *Atlanta Constitution*'s "eloquent" assessment of "moral astigmatism" in the Tuskegee Study "that saw these black sufferers simply as subjects in a study, not as human

<sup>&</sup>lt;sup>126</sup> RG 29, Eaton to Schaefer, 16 May 1970, 2.

<sup>&</sup>lt;sup>127</sup> Irwin J. Schatz to Donald H. Rockwell, 11 June 1965, in James H. Jones, *Bad Blood: The Tuskegee Syphilis Experiment*, New and expanded ed. (Toronto: Maxwell Macmillan Canada, 1993), 190.

<sup>\*</sup>Source: Data from Meerovitch and Scott, "Skin Tests," 1135.

<sup>&</sup>lt;sup>128</sup> Foucault, *Birth of the Clinic*, xx.

<sup>129</sup> Ibid., xiii.

<sup>&</sup>lt;sup>130</sup> Ibid., xi.

beings"<sup>131</sup>—howls from an 'age of criticism' (mentioned in Chapter One) bent on unending creation of commentary on discourse<sup>132</sup>; that is not my (prescriptive) intent.<sup>133</sup> Instead, let's assume "no remainder, nothing in excess of what has been said, but only the fact of its historical appearance."<sup>134</sup> Bask in Bichat's "brightness [in] death"—or the illumination of an anatomoclinical, death-centric perspective.<sup>135</sup>

Foucault observed "[t]he exact superposition of the 'body' of the disease and the body of the sick man is no more than a historical, temporary datum." But just how "self-evident" is that superposition? Would we, as readers, notice the absence of a person or persons in the following sentence despite our start-of-chapter discussion of 'P.B.', 'W.C.', and 'M.M.': "[t]he correlation between the skin test and indirect hemagglutination (IHA) test for amebiasis has been examined by Maddison, [et al.]?" (Although we may have noticed the awkward turn of phrase "the object MR.") The space of an individual's body and the space for disease are, according to Foucault, two associated 'structures' derived from a process of mapping disease onto the body following anatamo-clinical post-mortems. Consider several superficial examples from the discussion above: "the first well-documented case of amebic dysentery was from Archangel in the Soviet Arctic"; "[r]esults of examinations of 178 fecal specimens broken down according to place of residence...[/]age groups" (Appendix B: B.2 and B.3); "really, in the beginning there was no good treatment for, uh, amebic dysentery"; "Dr. Miller says that he does not believe that

<sup>&</sup>lt;sup>131</sup> Jones, *Bad Blood*, 14.

<sup>&</sup>lt;sup>132</sup> Foucault, *Birth of the Clinic*, xvii. Again, Foucault sought to disengage himself from 'commentary' whereby "deeper meaning" is continually sought from speech with the assumption signified exists in excess of signifier; see Foucault, *The Birth of the Clinic*, xvii-iii and Dreyfus and Rabinow, *Beyond Structuralism*, xvii-xxvii.

<sup>&</sup>lt;sup>133</sup> Mentioned in Chapter One, Foucault's exact phrasing was: "I should like to make it plain once and for all that this...has not been written in favour of one kind of medicine as against another kind of medicine, or against medicine and in favour of an absence of medicine"; Foucault, *Birth of the Clinic*, xxii.

<sup>134</sup> Ibid., xix.

<sup>&</sup>lt;sup>135</sup> Ibid., 180. Foucault's wording, here, inverts Bichat's (supposed founder of the 'clinic') from *Anatomie Générale*: "[f]or twenty years, from morning to night, you have taken notes at patients' bedsides on affections of the heart, the lungs, and the gastric viscera, and all is confusion for you in the symptoms which, refusing to yield up their meaning, offer you a succession of incoherent phenomena. Open up a few corpses: you will dissipate at once the darkness that observation alone could not dissipate."

Foucault argued we have just begun to detach ourselves from the self-evidence of the perceptual overlay of a pathological configuration over a sick person's body. Ibid., 2. <sup>137</sup> Ibid., 194.

eradication of <u>E. Histolytica</u> is possible, and that this treatment schedule is aimed only at elimination of overt disease."<sup>138</sup> The perceived abstinence in anatomo-clinical discourse from a theoretical structure or guiding philosophy (mentioned above) results in patients' grammatical repudiation—amebiasis lives in the Arctic, feces assumes owners' ages, and "treatment [is]...aimed at...disease."

This linguistic peculiarity<sup>139</sup>—or the (unacknowledged) *embodiment* of disease—should be recognized not merely as a haphazard substitution of nouns or even metaphor, but as the first 'theme' in Foucault's clinical 'inventory' at the base of which is 'gaze' proper, or a mode of perception. Moreover, it cannot be so easily dismissed, as Kelm or Jones would have it; the following few demonstrated 'Principles' of that 'theme' from publications arising from the Loon Lake outbreak typify a much larger archive. Principles 1) and 2) of his 'visible invisible', <sup>141</sup> the "Principle of Tissual Communication" and the "Principle of Tissual Impermeability" horizontally track pathological courses along isomorphic tissue (along the plane of the tissue as opposed to through it). The "Principle of Penetration by Boring" [Principle 3)], limits these two given lengths of affliction. Inflammation and fibroplasia from the quote below are encompassed by Principle 4), or the "Specificity of the Mode of Attack on the Tissues," where organisms either produce tissue usually localized elsewhere (i.e. fibrous reaction) or create new tissue (i.e. inflammation) when under duress. Each membrane has a particular type of alteration

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<sup>&</sup>lt;sup>138</sup> Again, see Scott, interview, 25 June; Meerovitch and Eaton, "Outbreak of Amebiasis": 720; RG 29, Eaton to Schaefer, 16 May 1970, 1.

<sup>&</sup>lt;sup>139</sup> Foucault, *Birth of the Clinic*, 207. To expand, "the extraordinary beauty of the text links, in a single moment, the internal work of a language in pursuit of perception with all the strength of its stylistic originality, and the conquest of a hitherto unperceived pathological individuality..." Ibid., 208.

<sup>140</sup> Ibid., xx-xxi.

<sup>&</sup>lt;sup>141</sup> Foucault suggests the concept of a 'visible invisible' "organizes anatomo-pathological perception": "[i]t is a question of the *visible* that the living individuality, the intersection of symptoms, the organic depth, in fact, and for a time, render invisible, before the sovereign resumption of the anatomical gaze." Reversed, or in Bichat's words, anatomists' goals are reached "when the opaque envelopes that cover our parts are no more for their practised eyes than a transparent veil revealing the whole and the relations between the parts" See ibid., 204, 209

<sup>142</sup> Foucault, *Birth of the Clinic*, 183-4.

<sup>&</sup>lt;sup>143</sup> Ibid., 185.

<sup>&</sup>lt;sup>144</sup> Ibid., 185-7.

(mucous membranes produce polyps; serous membranes, edema). So to jointly exemplify these four principles we have:

[again] [t]here was extensive necrosis of tissue through all layers of the colonic wall, with the formation of pools of necrotic debris and pus and infiltration by many polymorphonuclear leukocytes [Principle 3)]. These changes extended to the subserosal fat, and here also there was diffuse infiltration of polymorphs [Principles 1) and 2)] as well as a chronic inflammatory reaction both beneath and on the serosal surfaces [Principle 4)]...[see fig. 2.1]; [or]

[t]he mucous membrane overlay an abnormal submucosa characterized by fibrous reaction and dense inflammatory infiltration [Principles 3) and 4)]. 145



Fig. 2.1. Three separate images showing tissual penetration in 'P.B.'s' bowel wall. (Original caption included.) (Image from Miller, Mathews, and Moore, "Amebiasis: Pathological Aspects," 697.)

The "Principle of Alteration of Alteration"<sup>146</sup> [Principle 5)] completes our cartographic rules for the pathological course: chronicity causes afflictions to take over one another and/or links disorders together. Foucault provides the example that inflammation of the lungs and catarrh taken together do not make up tuberculosis, though they incite its development<sup>147</sup>; or, from "Amebiasis: Pathological Aspects,"

[again, pertaining to 'P.B.'] [r]adiological investigation showed that the entire colon was markedly irregular, particularly in the region of the splenic flexure where the mucosal pattern was almost entirely absent, and the appearance of the bowel suggested marked edema of its wall with irregular haustra and possible pseudopolypi. A diagnosis of atypical ulcerative colitis was made. 148

<sup>&</sup>lt;sup>145</sup> Miller, Mathews, and Moore, "Amebiasis: Pathological Aspects," 697-8.

<sup>&</sup>lt;sup>146</sup> Foucault, *Birth of the Clinic*, 187.

<sup>147</sup> Ibid.

<sup>&</sup>lt;sup>148</sup> Miller, Mathews, and Moore, "Amebiasis: Pathological Aspects," 696.

The above citation is the 'clinic' in full form: a projected pathology (or predicted outcome) radiologically charted (tracing an already dotted-out image in the clinician's mind) on a living corpse (as a reminder, diagnoses are made from death-bearing perception). Clinical practitioners, then, "[q]uestion the body" by sight, ear, or touch, in search of a hidden, unfolding geography of the wake of disease. 150 So in the following quote, the amount of antibody present in a person's blood either shows if they are infected, or represents a corrupt sample: "[w]ould the antibody titer be indicative of the state of infection, or would it be influenced by the previous intradermal injection of histolyticin?" <sup>151</sup> Apodictic 'signs' sought through this trinity of sight/touch/hearing ('gaze' is a semiological reading from sensory triangulation) trump mere 'symptoms'-the body's generalized responses to a variety of stimulae<sup>152</sup>: "very active bowel sounds," "slight rim[s]," and bloody mucoid diarrhea 153 make amebiasis highly probable, but only individual serodiagnosis or IHA tests designate it without error. <sup>154</sup> This formed the basis of Scott's debate with the Department of Public Health: his 'sign' for amebic dysentery comprised "ameba moving freely with engulfed red [blood] cells" or "typical erythrophagic trophozoites of Entamoeba histolytica in stools" 156 as opposed to that IHA test. Simply put, clinical method privileges everyday vision by rights over artificially enhanced vision (e.g. with the use of a microscope or any other imaging tool)<sup>157</sup>; hence, the idea of a skin test "capable of surprising...lesion[s]" indicative of internal (hidden) manifestations of disease<sup>158</sup>:

the antigen reaction had to be at least twice the size of the saline control, and in general a wheal under 12 mm. in the long axis was not considered as positive unless it was notably turgid, showed pseudopod formation and was surrounded by a well-marked zone of erythema. In about 75% of positives the wheal was at least 14 mm in the long axis. Areas of erythema ranged from 15 to 60 mm across [fig. 2.2]. 159

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<sup>&</sup>lt;sup>149</sup> Foucault, Birth of the Clinic, 200.

<sup>&</sup>lt;sup>150</sup> Ibid., 196-9, 200.

<sup>&</sup>lt;sup>151</sup> See note 125 above.

<sup>&</sup>lt;sup>152</sup> Foucault, *The Birth of the Clinic*, 197, 200, 202.

<sup>&</sup>lt;sup>153</sup> See page 27 (note 114) above.

Foucault, Birth of the Clinic, 197.

<sup>155</sup> Scott, interview, 25 June.

<sup>156</sup> Scott and Miller, "Trials," 119.

<sup>&</sup>lt;sup>157</sup> Foucault, Birth of the Clinic, 205.

<sup>158</sup> Ibid 200

<sup>&</sup>lt;sup>159</sup> Max J. Miller and Frank Scott, "The Intradermal Reaction in Amebiasis," *Canadian Medical Association Journal* 103(August 1, 1970): 254.

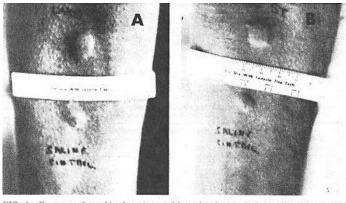


FIG. 1.—Forearm of amebic dysentery subject showing typical intradermal reaction. The characteristic wheal with pseudopods is seen at the site of injection above the ruler and the saline control below. (A) shows the reaction at five minutes and (B) at 15 minutes after injection.

Fig. 2.2. Photograph of typical wheals resulting from intradermal injections to the forearm. (Original caption included.) (Photograph from Miller and Scott, "Intradermal Reaction," 254.)

But "[m]iracles are not so easy to come by" 160; Meerovitch and Scott summarize "that an intradermal injection of histolyticin into a subject with a latent low-grade amebic infection and a low antibody titer will raise the titer, and that this might lead to confusion in the interpretation of the titer as related to disease." <sup>161</sup> Notably, the language deployed is conceptually eons away from 'race'. In plain language, the skin test was ineffective because fleeting pathological projections, or ephemeral symptoms mark the quest for *ideal* disease (or imposed meaning). In anatomo-clinical method (as opposed to its relation, 'clinical' method)<sup>162</sup>—the highest extension of 'gaze' proper-it is better to keep death as the conceptual link revealing the 'truth' of disease: "open up a few corpses" to bypass that "succession of incoherent phenomena" offered by borborygmus or wheals. 163 Foucault's second and third 'inventory themes'—a distinct distribution of corporal space and anatamo-clinical 'signs' versus 'symptoms'-require a normative linear series of morbid events. 164 'M.M.' died six days after hospital admission or

<sup>&</sup>lt;sup>160</sup> Foucault, Birth of the Clinic, xvi. Foucault chose this phrasing to critique (among other things) assumptions that medical discourse takes on the general form of scientific investigation; I use it tongue-in-cheek.

<sup>&</sup>lt;sup>161</sup> Meerovitch and Scott, "Skin Tests," 1135.

<sup>&</sup>lt;sup>162</sup> Foucault details several incarnations of medical discourse in *Birth of the Clinic*, some of which were contemporary to one another and methodologically combined comprise 'la clinque': classificatory medicine, clinical medicine, anatamo-clinical medicine.

<sup>&</sup>lt;sup>163</sup> Foucault, Birth of the Clinic, 180, 194.

<sup>&</sup>lt;sup>164</sup> For 'clinic'-al themes, see ibid., xx-i.; for a complete discussion of the linear series of morbid events, see pages 172-6.

fifty-one weeks after symptomatic onset, 'W.C.' "died a day following initial admission" both patients' conditions "deteriorated rapidly" prior to death. Deterioration', however, contrasts pathology (in this case, amebic ulcerative colitis):

[once more,] [m] *icroscopic study* revealed marked edema of all bowel layers with infiltration by eosinophils, lymphocytes and plasma cells. The ulcers involved mainly the mucosa and submucosa, and their bases were made up of necrotic debris resting on an edematous submucosa. Amebic trophozoites were scattered throughout...;

[t]here was little evidence of tissue reaction, and the amebae were commonly present in tissues in clusters. The mucous membrane overlay an abnormal submucosa characterized by fibrous reaction and dense inflammatory infiltration.<sup>167</sup>

Death is the spontaneous experiment that allows the anatomo-clinician to comparatively delineate non-variable from accidental phenomena 168—so contrasting his fellows, 'P.B.',

was admitted... four weeks after he had developed colicky abdominal pain and bloody diarrhea (10 to 12 motions per day). He was dehydrated and had obviously lost considerable weight... Sigmoidoscopic examination to 15 cm. showed an inflamed mucosa, but no ulceration or bleeding was seen. The erythrocyte sedimentation rate (ESR) was 85 mm. in one hour, and total serum proteins were 5.9 g, per 100 ml.–2.2 g. albumin and 3.7 g. globulin... Four weeks after admission there was no evidence of improvement; he still suffered from recurring lower abdominal cramps and frequent bloody (tomato soup) stools, and had lost 16 more pounds. Sigmoidoscopy at this time again showed no evidence of ulceration, but the walls of the bowel were covered with a mucoid bloody slime... A perforation of the ascending colon occurred and at an emergency operation the entire colon down to the proximal portion of the sigmoid was resected. His condition deteriorated in the following week and he died 10 weeks after the onset of his illness [emphasis added]. 169

Or, as Scott observed, "shit happens in medicine." 170

From our 'strange' discourse<sup>171</sup> we "recognize the operation of the clinic and the principle of its entire discourse" in just 'P.B.'s' case report, as simply Foucault did in the

<sup>167</sup> Ibid., 696-8.

<sup>168</sup> Foucault, *Birth of the Clinic*, 176. Because death may occur at anytime in the pathological calendar, and has its own fixed mechanisms, one can "reconstitute, by means of this opening onto time, the evolution of a whole morbid series": time of death "may slide along the entire length of the morbid evolution; and as this death loses its opaque character, it becomes, paradoxically...the instrument by which the duration of the disease can be integrated with the immobile space of the dissected body."

<sup>&</sup>lt;sup>165</sup> Again, see Miller, Mathews, and Moore, "Amebiasis: Pathological Aspects," 697-8.

<sup>&</sup>lt;sup>166</sup> Ibid.

<sup>&</sup>lt;sup>169</sup> Miller, Mathews, and Moore, "Amebiasis: Pathological Aspects," 696.

<sup>&</sup>lt;sup>170</sup> Frank Scott, personal conversation with author, June 2008.

questions "What is the matter with you?" versus "Where does it hurt?" the quest for his 'pathological seat' 173 via sigmoidoscopy, the eventual resection of his colon; 'space', 'language', 'death'. 174 Let's widen the lens. From 'P.B.'s' vantage, several things peculiar to our outbreak materialize: why Miller, Mathews, and Moore sought to discuss 'P.B.', 'W.C.', and 'M.M.'s' deaths at all between four and nine years after-the-fact in a special edition of the CMAJ; why "specimens were collected in waxed-paper containers," emulsified, and then sent to McGill; why the CDC's Healey, McGill's Meerovitch, and Miller, first from McGill and then Tulane University, got involved; Miller's alleged interest solely "in research and preparing articles for medical journals." 175 La clinique—"constantly praised for its empiricism, the modesty of its attention, and the care with which it silently lets things surface to [an] observing gaze", 176-is institutionalized "collective, homogenous space" as much as anything else: organized hospital field, defined patient status within society, a relationship between public assistance and medical experience, help and knowledge. <sup>177</sup> So, from 'P.B.'s' vantage: Miller, Mathews, and Moore detailed 'P.B.', 'W.C.', and 'M.M's' deaths in a special edition CMAJ because the relationship between defined patient status within society, help, and 'knowledge', in the Foucauldian sense, demands exposition of their diseased corpses in an academic forum for past, present, and future doctors to understand the pathological calendar of amebiasis; specimens were sent to McGill, serum to the CDC, and Meerovitch and Miller became involved due to institutionalized, organized hospital field, or academic hierarchy; and Miller's interest solely in research and journal articles is to be expected given the relationship between public assistance or medical aid, and medical experience or sought expertise. There is no reason to immortalize the deaths of

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<sup>&</sup>lt;sup>171</sup> Again, Foucault argued his discourse on the 'clinic' was "strange" because it was not based on "the present consciousness of clinicians, nor even on a repetition of what they once might have said" (see page 14, note 56; Chapter One). Foucault, *Birth of the Clinic*, xvii.

<sup>&</sup>lt;sup>172</sup> Foucault suggests the difference between eighteenth and nineteenth-century medicine was articulated in the "minute but decisive change" in doctors' dialogues with patients as summarized in these two questions. Ibid., xxi.

<sup>173</sup> Read: the localized temporal and spatial starting point for disease. See ibid., 172.

<sup>&</sup>lt;sup>174</sup> These terms extend the quote used on page 1 of Chapter One; the full citation reads, "[t]his book is about space, about language, and about death; it is about the act of seeing, the gaze." ibid., ix.

<sup>&</sup>lt;sup>175</sup> Miller, Mathews, and Moore, "Amebiasis: Pathological Aspects," 696-8; Meerovitch and Eaton, "Outbreak of Amebiasis," 720; RG 29, Rath to Director General, 12 February 1970. <sup>176</sup> Foucault, *Birth of the Clinic*, xxi.

<sup>&</sup>lt;sup>177</sup> See ibid., 21-2, 242.

these patients in medical journals, or send stool samples from the knowledgeable local physician to research centres across North America, or to be more interested in amebiasis as opposed to the patient's experience outside of a 'clinique-al' frame of reference. For Miller, Mathews, Moore, Healey and Meerovitch—whose 'gaze' demanded unconditional, experiential servitude—the "descriptive formula" was the "revealing gesture": they "show[ed] by saying what one sees" in classrooms, in journal articles. Teaching hospitals facilitated, above all, "medicine [...] given and accepted as positive" and positive is to be taken literally because for the clinician death is not wholly negative "Dear Gene[,] I am sorry to have raised your hopes (?) unnecessarily. Permission for autopsy [...] was not given I find..."

Again, "shit happens in medicine"; the so-called 'age of Bichat' <sup>181</sup> is fading. Rich et al. compare the 'modern' clinician to Marx's languishing workman, a "crippled monstrosity" wearing disheveled street clothes, addicted to opiates in Holmesian fashion, walking with a cane: a hero, but a tragic, anachronistic hero. <sup>182</sup> That descriptor may be less than appropriate, because beyond grating exemplars ("the object MR"), the perceptual superposition of the 'body' of the sick man and the *life* of his disease are 'structures' still so interminably associated for us (at least in western society), 'post-modern' medicine has yet to disengage from that 'language of rationality', the aforementioned dramatic change in man/woman's relationship to his-/herself, and of language to its object. <sup>183</sup> Eaton's expressed disagreement with ongoing research inquiry surrounding the dysentery outbreak at Loon Lake is *just* phrased with 'science' being served 'equally well' by observation, while Foucault's applied Principles to 'P.B.', 'W.C.', and 'M.M's' case report and the results of indirect hemoglutenation skin test map a corporeal disease geography as discursively ('clinique'-ally) fresh today as it ever was. The 'no holds barred' legacy of 'big science' is precisely that: in addition to the archaic use of a racially segregated community for experimental purposes, children and pregnant women were viable 'subjects' in

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<sup>&</sup>lt;sup>178</sup> Ibid., 242.

<sup>&</sup>lt;sup>179</sup> Discussed above; Foucault observed when "death became the concrete a priori of medical experience" it was detached from a metaphysical of evil and "*embodied* in the *living bodies* of individuals": ibid., 243.

<sup>&</sup>lt;sup>180</sup> LAC, RG 29, vol. 2967, file 851-4-046, part 1, R. D. P. Eaton to Eugene Meerovitch, 23 December 1965.

<sup>&</sup>lt;sup>181</sup> Foucault, *Birth of the Clinic*, 150.

<sup>182</sup> Rich et al., "The Afterbirth," 227.

<sup>&</sup>lt;sup>183</sup> Foucault, *Birth of the Clinic*, xvi.

that "science of inhumanity"—to borrow Jones's phrasing once more, all were viewed "simply as subjects in a study, not as *human beings* [emphasis added]." Anatomo-clinical method parenthesizes patients so far as to trace disease to its cellular and molecular trajectory. Kelm's mistake was to forget that, dismissing an entire discourse out-of-hand.

## CHAPTER THREE: 'THAT'S HOW I SAW IT ANYWAYS'

I had one case where this abscess ruptured through the dome of the liver, into the lung, into the chest cavity, and the patient was spitting up blood. And he was so convinced he had TB, he hid in the bush for a long time, uh, 'cause he didn't want to go to the sanitorium [...] Uh, eventually I got my hands on him, checked him over, found out what the problem was, and shipped him down to University Hospital to have this thing dealt with surgically [...] It was basically, you had to go in, clean out the chest cavity, clean out the, the abscess, and close the hole joining the abdominal and thoracic cavities. Uh, it was the second case I'd seen, and it was the first of it they'd seen in Saskatoon.<sup>184</sup>

At the centre of the above example epitomizing the 'visible invisible' of 'modern' medicine-or the 'anatomo-clinical' method just discussed-is a person running scared, alone in the bush. Chapter Three showcases Aboriginal and/or patients' 'gazes' of their experiences with the medical community. My intent in this chapter (borrowing from Arnold<sup>185</sup>) is to mitigate two 'appropriations': 1) 'subject' creating (in the Foucauldian sense), racially-based binary discursive modes (i.e. 'colonizer'/'colonized', 'oppressor'/'oppressed', Aboriginal/non-Aboriginal); and 2) the absence or dismissal of 'patient' experience from positive medicine (a discourse that itself espouses dichotomy, i.e. doctor/patient). 186 I pay particular attention to Farmer's method for avoiding a succinct but inaccurate definition of 'structural violence', Foucault's motives for unearthing 'popular knowledge' (e.g. I, Pierre), and Jesuit historian and philosopher de Certeau's premises for accepting the discourse of another (what he called 'writing alterity') outlined in *The Writing of History*. My conclusion–given what Loon Lake and Ministikwan residents' said in conversation about their experiences in the dysentery outbreak, as well as their broader interactions with health professionals—is that their 'gaze' defies dichotomous discursive modes. Argumentatively, while these ideas are a kernel in Chapter Three, by Chapter Four they come to full fruition. Let's turn to what the man-in-the-bush has to say about his 'subject'-ivity.

BETTY AND RITA'S STORIES

<sup>&</sup>lt;sup>184</sup> Scott, interview, 25 June.

<sup>&</sup>lt;sup>185</sup> See page 9 (note 39) above.

<sup>&</sup>lt;sup>186</sup> Foucault, *Birth of the Clinic*, 243.

On a lukewarm afternoon in June 2008, I met with Betty and Rita Mitsuing at the Makwa Sahgaiehcan (Loon Lake) Band office to discuss their relatives' deaths from dysentery. The familial resemblance between them was obvious: both took the same thoughtful pauses between sentences. Betty who works in Justice, spoke passionately about the issues at hand; Rita, a Health Committee elder, spoke softly but firmly. Taking the lead, Betty recounted that her aunt, Peepees Runningaround, died in either 1972 or '3 from complications associated with amebic infection. Initially admitted to Meadow Lake Hospital, she was transferred to Saskatoon due to the severity of her illness. When asked how her family dealt with the death, Betty responded that Peepees's daughters as well as grandchildren were greatly affected; the two girls lost both parents at a young age. Rita recalled that her mother-in-law's mother, Peepun (meaning 'Winter'), died from severe diarrhea mid-outbreak. Like many "old people," Peepun resisted going to visit the hospital and declined medical aid. On another occasion, Peepun's family intervened and drove her to hospital: although acute vomiting and diarrhea gained her immediate admittance to St. Walburg's facilities, she was first turned away from Loon Lake Hospital as staff argued nothing was wrong with her. Some medical personnel, Rita felt, "didn't really care about Native people."

Conversation quickly turned to reserve residents' experiences with health professionals, particularly in light of Betty's difficulties securing possible interviews for me. Responses on hearing my topic of research inevitably included reference to "that horse doctor [Scott]" who administered "big pills that—they were made for horses," and community perception that this medication, "ma[de] them sick, more sick"—listed symptoms included nausea and worsened diarrhea. When asked whether or not people knew what the pills were for, Betty responded, "[n]o—nope, people don't even ask what kind of medication they were given." Rita said her sister-in-law knew of a ten or eleven year old Ministikwan girl who gave birth and subsequently was unable to conceive; suspicion was she had been sterilized by having her tubes tied. Both Betty and Rita recalled local First Nations attempts to have disliked medical personnel fired as perception was they "damag[ed] the community." At a certain point, Betty reaffirmed outright, "St. Walburg was a better place to take our people, 'cause the doctor there was respectful."

Issues of respect also permeated our discussion of reserve sanitation mid-outbreak. Scott overzealously placed aerial photos of the reserve's most uncleanly yards in the newspaper to spur

a complacent public health body to act; *his* actions significantly angered 'the community'. As Betty frustratedly commented,

[w]e had our own, uh, uh...sanitation—you—they used to call them sanitation, uh, worker? Uh, now they're called garbage—garbage pickers, garbage men? [...] Yep, yeah we had our own. And yeah, we had our grounds, that nuisance grounds? They—they—they were, uh, they had—you know they made those big long holes [...] dugouts for the garbage to be put in? So that's what we had [...] Maybe it was some of the—some of the yards that he took pictures of, not the whole community.

Conversely, both Betty and Rita appreciated Foster's monthly IHS personal hygiene and sanitation workshops.

LW: So, did—'cause I—I thought that was, um, interesting in the sense that—so Health Canada [sic] comes in and they do these sanitation—

BM: Mmhmm—

LW: —things—

BM: —yeah.

LW: —it's kind of—I don't know, to me, I'd be like, 'You're in *my* house, don't tell me about'—right?

BM: [laughter] No, we used to have the workshops on, uh—

LW: Okay.

BM: —at the old band office, and that, uh, resort, 'cause we used to work the resort, and Eddy Foster used to come in—

LW: Okay.

BM: —for personal hygiene, for sanitation, yep.

LW: So that—that—

BM: Mmhmm.

LW: —people didn't find him offensive?

BM: No, no.

LW: And they didn't mind those workshops?

BM: No...hmm.

LW: Did they find them helpful, or?

BM: Yes, yeah.

LW: Okay.

BM: We *loved* him, I think the people...he's nice.

However helpful, Betty and Rita had their own interpretation of the outbreak's source.

After speculating "maybe the water [...] contamination of water," Betty added:

'[c]ause it's not poor sanitation. If you'd come around our houses long time ago there was wood flooring, and our log houses too—before that time, uh...uh, we used to have—our houses were so clean that you wouldn't even see a dust on the floor.

Rita suggested water was hauled from either the lake or canyon, proving problematic for one or two reasons—as Betty stated, people lived too close to the lake (contaminating it), and livestock roamed freely near water sources.

Our entire conversation crystallized with Betty and Rita's final remarks. Following some hesitation, Rita stated,

[t]hey [Scott and his wife Penny Davis, M.D.] gave me one of the b—one of the boy[s], my niece's boy, Christopher. 'Cause he was sick, he had seizure when he was four months old...seizures. That was in '88. And he just about died on those seizures. He had them four times, I think. And they sent him to Saskatoon; when he was brought back no—they couldn't find a place for him. They told me that—Dr. Scott told me that 'he'll be a vegetable all his life', 'cause he wasn't talking or walking, just lays in the crib. So they asked me if I could take him, and I got a lot of kids at that time, but they were all big, and, uh, they told me that he'll never be like those other kids? He'll be a vegetable rest of his life. They asked me if I could keep him, so I told them 'I'll think about it'. And be—just before they leave, they phone—they got me and told me to go pick [up] Christopher. So I got him. I raised him, and now he's walking and he's talking [...] Yep, that's what they told me when he was a baby. His name is Christopher.

Cuing to a possible latent message, I asked if she sought traditional help for him. Pithily, she responded, "[a]nd we have a salt lake way up west here. I went and give him a bath there. And it was summer...that's where he—he's walking now."

Silence ensued, and Betty recounted an incident from her youth where she visited the hospital after an evening of drinking. Despite showing up of her own accord, the on-call doctor accused her of over-dosing. Fuming, she recollected:

I didn't even take any pills. He thought I over—I O.D.'ed; I didn't even O.D.'ed, I didn't even take any pills. Then when I got up, I was ready—he—he told me to go home, and just—I was there for overnight, 'cause I wasn't feeling good. So he told me, 'Next time you wanna commit suicide, just put a rifle in your mouth'. That's what he told me [...] Yep, and I didn't even try to commit suicide [...] It just *drives* me. <sup>187</sup>

\* \* \*

Betty and Rita's emotional, and sometimes staggering account typified the conversations I had with Loon Lake residents: discussion tacked seemingly aimlessly from topic to topic (from foggy memories of the dysentery outbreak to liked sanitation workshops to personal trauma). The ways Loon Lake area residents construct knowledge ('gaze') about the dysentery outbreak

<sup>&</sup>lt;sup>187</sup> Betty Mitsuing and Rita Mitsuing, interview by author, 11 June 2008, compact disc copy, University of Saskatchewan.

stands in contradistinction to 'traditional' academic models, and are not readily assumed within the literature; typically, the manner in which these types of accounts are dealt with is to extract pithy sound bites and incorporate them into a larger narrative espousing a theoretical framework. For example, in her chapter, "'My People are Sick. My Young Men are Angry': The Impact of Colonization on Aboriginal Diet and Nutrition" in *Colonizing Bodies*, Kelm intersperses short quotations from interviews among larger paragraphs built on ethnographic literature and medical journal articles. 188 Stories like Betty's and Rita's are rarely told in-full (the bulk ending up on the cutting room floor), for their contradictory nature, fragmentary elements, and readilyapparent active construction between probing interviewer and a ready informant belies whatever "theoretical political avant garde" du jour, or 'scientificity'. 189

Farmer discussed a similar phenomenon when describing a gender sensitivity workshop gone awry in Pathologies of Power: Health, Human Rights and the New War on the Poor. Crammed in schoolchildren's desks, twenty or so Huehuetenango locals (mostly women) coloured pictures under surveillance by Guatemala City facilitators. The lesson kept veering off track, as adult pupils depicted violence or death as opposed to sought-after gender issues within indigenous communities. One jean-clad instructor pressured a participant when she recounted that at the age of ten, and after her mother's death, she assumed care of her siblings:

Facilitator (expectantly): 'So your father treated you differently because you were a girl'?

Respondent (matter-of-factly): 'No, not really. He loved us all the same' [italics in original].

Farmer viewed the exercise as demeaning: locals victimized by previous decades of violence were expected to kowtow before big-city/U.S. university agenda, sporting the 'right' answers to posed questions. 190 Keith Thor Carlson and Kristina Fagan observe as much in their introduction to Call Me Hank: A Stó: lõ Man's Reflections on Logging, Living and Growing Old arguing, "many non-Aboriginal people think that they know, even before they have listened, what

<sup>&</sup>lt;sup>188</sup> See Kelm, *Colonizing Bodies*, 24-5. <sup>189</sup> Foucault, *Power/Knowledge*, 85.

<sup>&</sup>lt;sup>190</sup> Paul Farmer, Pathologies of Power: Health, Human Rights, and the New War on the Poor (Berkeley: University of California Press, 2005), 3-4.

Aboriginal people will say. They assume that there is an 'Aboriginal perspective'." My line of questioning toward Foster's IHS workshops unfortunately substantiates their concern; whereas I pursuantly queried as to whether or not classes seemed patronizing, Betty and Rita "matter-offactly" denied it (emphasis added). 192 These observations prompt the question, 'what am I, or other academics, doing (there)'?

Farmer self-delineated his role as "scratch[ing] at [a] surface silence," with 'silence' referring to the un-voiced or "stoic" (although Farmer debates using that term) suffering endured by the poor. Alternately, one can 'bear witness', to borrow his terminology, by simply observing that silence, avoiding an anthropologist's urge to 'scratch'. Whatever route taken, Farmer hesitated over writing on the condition of the oppressed as, quoting anthropologist Philippe Bourgois, "everything you say about them will be used against them." <sup>193</sup> Instead he adopts a unique methodology, according to Amartya Sen (a Nobel prize-winning economist), using biographical accounts to delineate 'structural violence' rather than giving the typical epigrammatic definition; terse explanations can create a false exactitude. 194 His procedure mimics the way children learn language, with a "teach[er] pointing to the objects, directing...attention to them, and at the same time uttering a word; for instance the word 'slab' as he points to that shape." 195 Via these means, Farmer hoped to communicate the concerns of the 'oppressed' without "self-interested...rooting." <sup>196</sup>

Foucault comparatively aimed for what he called "a return of knowledge"." By that he partly meant 'disinterring' popular knowledge or savior des gens, which is far from general or commonsense understanding. (He also meant uncovering historical contents disguised by systemization or functionalist coherence, but that is less important here.) "Naïve," "lowranking," and otherwise labeled "disqualified," 'subjugated knowledges' of psychiatric patients, ill people, nurses, or doctors parallel and are marginal to scientificity; they are local

<sup>191</sup> Henry Pennier, 'Call Me Hank': A Stó:Lô Man's Reflections on Logging, Living, and Growing Old, ed. Keith Thor Carlson and Christina Fagan, 2nd ed. (Toronto: University of Toronto Press, Inc., 2009), xv.

<sup>&</sup>lt;sup>192</sup> See note 190.

<sup>&</sup>lt;sup>193</sup> Farmer, *Pathologies of Power*, 25-6.

<sup>194</sup> Sen in ibid., xiii-iv.

<sup>&</sup>lt;sup>195</sup> Lugwig Wittgenstein quoted by Sen in ibid., xiii.

<sup>&</sup>lt;sup>196</sup> Ibid., 26.

peculiarities: unsuitably differential.<sup>197</sup> But when the prisoner–another ostensibly unfit knowledge source–begins to speak he/she possesses "an individual theory of prisons, the penal system, and justice. It is this form of discourse which ultimately matters, a discourse against power…and not a theory *about* delinquency." Differently put, popular knowledges in and of themselves critique power/knowledges, and therefore best speak for themselves. <sup>199</sup>

These comments on method tentatively sketch a rationale for incorporating stories like Betty's and Rita's beyond potentially misleading excerpts, which I enumerate below.

1) I "[am] dealing with" a community, to borrow Freestone's unfortunate phrasing, <sup>200</sup> largely unaware of its own involvement with the metronidazole trial. Echoing Betty's sentiment "[n]o—nope, people don't even ask what kind of medication they were given," some Loon Lake reserve members remembered 'pills' but were incognizant to their actual purpose. When pushed for more information regarding pill distribution or colouring, informants had limited knowledge; Betty, for example, recalled Scott issuing "those pills" from his pharmacy, whereas public health nurses overwhelmingly took charge in the trial. <sup>201</sup> Ministikwan's use as a control was unheard of: Rita flatly responded "[n]o" when questioned, while Betty answered "[w]hy would he [Scott] be just trying them on [...] here and not—because he—he flies into Ministikwan, maybe he did that [there] too?" Others (perhaps too young) simply knew nothing, either concerning the trial or the outbreak itself. Many, and by that I mean both those in-the-know and unwitting, in addition to referencing "that horse doctor" shrugged or grimaced at my topic as if saying 'how typical' with passing remark on their use as 'guinea pigs.'

That is not to suggest Loon Lake and Ministikwan reserve residents were unknowledgeable—quite the opposite, actually. Those who remembered the outbreak (if not the drug trial) contextualized it relative to Aboriginal/patient involvement with 'modern'/'post-modern' medical systems: that is, they effortlessly and fluidly characterized it with reference to their participation as Aboriginal and/or patient subjects *over time*. It is the conversational

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<sup>&</sup>lt;sup>197</sup> Foucault, *Power/Knowledge*, 81-2, 86.

<sup>&</sup>lt;sup>198</sup> Foucault cited in McHoul and Grace, A Foucault Primer, 19.

<sup>&</sup>lt;sup>199</sup> I.e. Academics need not speak in their place.

<sup>&</sup>lt;sup>200</sup> Al Freestone, "Environmental Sanitation on Indian Reserves," *Canadian Journal of Public Health* 59(January, 1968): 25.

<sup>&</sup>lt;sup>201</sup> Of course, Scott and other local doctors prescribed metronidazole for individual patients in the course of their practice.

<sup>&</sup>lt;sup>202</sup> Mitsuing and Mitsuing, interview.

equivalent of what anthropologist Kirin Narayan argued against the paradigmatic dichotomy between 'native' and 'non-native' anthropologists—they had "shifting identifications amid a field of interpenetrating communities [or in this case, colonial and/or 'modern'/'post-modern' medical discourse] and power relations:"

For instance, Betty discussed her aunt's illness and death in terms of patient understanding; Rita linked her mother-in-law's mother's experience to racism; yet both nodded along *in congruency* throughout that part of conversation. Similarly—except in a blurred way reminiscent of Crookedneck's mixed feelings—utterances about "that horse doctor"/"guinea pigs" simultaneously reveal patient malcontent toward anatomo-clinical-'gaze' and underlying sentiments toward Aboriginal peoples' use in experiments. Moreover, not only were Betty and Rita's relatives' deaths interpreted reflexively regarding past and present (Betty described Peepees's daughters' current experiences; Rita, Peepun's past medical encounters), they were contextualized relative to other interactions with health professionals—again, both historically and now. So Peepun's disdain for medical attention *links to* and *informs* Christopher's story, just as Betty was/is "driv[en]" by scuttled care (vis-à-vis perceived overdosing).

2) Farmer used "oppressed" when discussing the poor, aligning himself with liberation theologist Gustavo Gutiérrez and educational theorist Paulo Freire. Freire's *Pedagogy of the Oppressed*, quoted by Farmer, responds to or extends psychiatrist and philosopher Frantz Fanon's arguments on anti-colonial education in *Wretched of the Earth*. Both Freire and Fanon set-up distinct dichotomies, with either 'oppressor'/'oppressed' or 'colonizer'/'colonized' as categorical labels; the following passages delineate their comparative perspectives.

[W]hile both humanization and dehumanization are real alternatives, only the first is the people's vocation. This vocation is constantly negated, yet it is affirmed by that very negation. It is thwarted by injustice, exploitation, oppression, and the violence of the oppressors; it is affirmed by the yearning of the oppressed for freedom and justice, and by their struggle to recover their lost humanity.<sup>204</sup>

The colonial world is a world divided into compartments. It is probably unnecessary to recall the existence of native quarters and European quarters, of schools for natives and schools for Europeans; in the same way we need not recall apartheid in South Africa. Yet if we examine closely this system of compartments, we will at least be able to reveal

<sup>204</sup> Paulo Freire, *Pedagogy of the Oppressed*, trans. Myra Bergman Ramos, 30th Anniversary ed. (New York: Continuum, 2007), 43-4.

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<sup>&</sup>lt;sup>203</sup> Kirin Narayan, "How Native Is a "Native" Anthropologist?," *American Anthropologist* 95, no. 3 (Sep., 1993): 671.

the lines of force it implies. This approach to the colonial world, its ordering and its geographical layout will allow us to mark out the lines on which a decolonized society will be reorganized.<sup>205</sup>

So 'oppressed' carries ample 'post-colonial' baggage.

I 'hesitate' (much like Farmer) applying that terminology here. As already noted, this thesis espouses a Foucauldian power that is not localizable but operates with individuals as links on netted chains, simultaneously experiencing push-pull, tolerating and/or exercising it.<sup>206</sup> This position was partially arrived at considering Farmer's distaste (re. the workshop), and Carlson and Fagan's warning, but more importantly, in light of interviewees' own descriptions. Peepun's *family* drove her to hospital, Betty admitted *herself* to the local ER, and reserve residents *voluntarily* attended Foster's workshops: i.e. they were/are "vehicles of power, not its points of application." Or, as Kelm put it crediting Foucault (again, cited above), but with alternate emphasis, power/knowledge encourages self-repression through participation in disciplinary systems (recall Arnold's "too powerful, too authoritative" medicine). The difference in nuance between this and Farmer's predecessors' (Freire and Fanon's) perspectives, again referencing Pomme and Bayle, is "both tiny and total" is de-'compartmentalized'. And while 'injustice', 'exploitation', and 'oppression' typify Betty, Rita, and other Loon Lake and Ministikwan reserve residents' experiences, they were and/or are far from 'power'-less.

3) Part of individuals' navigating the effects of power involves their multiplex resistance to dovetailed discourses. Rita's comments on Christopher's rehabilitation directly address Arnold's question, "Who speaks for the body of the people?" with soft-spoken but firm accolade for traditional health knowledge. Much as Kevin Washbrook argued concerning metaphorical ways Stó:lõ people discussed medicinal plants, Rita and other reserve residents'

<sup>208</sup> Kelm, Colonizing Bodies, 220; Arnold, Colonizing the Body, 10.

<sup>&</sup>lt;sup>205</sup> Frantz Fanon, *The Wretched of the Earth*, trans. Constance Farrington (New York: Grove Press, Inc., 1963), 37-8.

Previously cited on page 12 (note 50) above; Foucault, *Power/Knowledge*, 98.

<sup>&</sup>lt;sup>207</sup> Ibid

Foucault, *Birth of the Clinic*, x. In the interest of self-preservation (and toward that 'tiny' and 'total' difference), further elucidating Foucault's conception of power seems pertinent. To him, power was not an individual or class's "consolidated and homogenous domination over others," nor "that which makes the difference between those who exclusively possess and retain it, and those who do not have it and submit"; instead, it was something that circulates. See, again, Foucault, *Power/Knowledge*, 98.

<sup>&</sup>lt;sup>210</sup> Arnold, *Colonizing the Body*, 10.

cure stories affirm traditional knowledge over inefficacious and ignorant 'White' medical knowledge. That tendency, of course, emphasizes continuity between their culture's self-sufficient past and current-state as embodied in their elders' wisdom.<sup>211</sup> That Rita told Christopher's story last should not suggest its place of importance; rather, her measured delivery and sudden overstep of Betty's stride in conversation isolate it as her ultimate import: 'contestation versus appropriation'.<sup>212</sup>

These reasons—complex and rambling as they are—respond to my initial question of 'what am I doing (there)'?: point blank, I am 'scratching at surface silence' aiming to 'disinter' popular knowledge; I hope to do so without 'self-interested rooting' or subject individuation in harmful ways; alternately put, by giving example after repeated example, much like Sen's teacher identifying objects for his/her tutee, I hope to create a composite image in the reader's mind of Loon Lake and Ministikwan reserve residents' 'gaze'. And in order to achieve that-mindful of Farmer's annoyance as well as Carlson and Fagan's caution-my subjects should speak for themselves, i.e. I should observe and report. Betty and Rita's interview 'jars' 213 on its own and in totality, as the pliancy with which they contextualize the dysentery outbreak, jumping without chronology or logical coherence yet perfectly on thematic point, off-sets whatever clinical or colonial 'gazes' already discussed. The next two interviews read similarly, as partial retellings (insofar as they represent my impressions) of conversations with informants. Like Betty's and Rita's accounts, they are simultaneously fragmentary and reflexive recollections of individuals' broader interactions with health professionals spurred by confirmation that their community was used in past experiments. Those relationships were voluntarily engaged in, revealing Loon Lake area residents ready participation in disciplinary systems and multifarious responses to separate discourses. Foucault observed we should cease viewing power as exclusionary, concealing, repressive, abstracting, censorial, or any other gamut of negative descriptors based on outcome when instead it shapes our horizon, producing reality.<sup>214</sup>

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## **ALEX'S STORY**

<sup>&</sup>lt;sup>211</sup> Kevin Washbrook, "Plants and Medicine: Talking about Power in Stó:lõ Society" [10 June 1994] Document 000390, Stó:lõ Nation Archives, Chilliwack, B.C.

<sup>&</sup>lt;sup>212</sup> Again, see Arnold, *Colonizing the Body*, 10.

<sup>&</sup>lt;sup>213</sup> See comments on Crookedneck above, page 6.

<sup>&</sup>lt;sup>214</sup> Foucault, *Discipline and Punish*, 194.

Barefoot, Alexander welcomed me to her home with a broad grin.<sup>215</sup> She stepped lightly, had long black-brown hair with flecks of grey, and slim ankles. As with other interviewees, I meet her not knowing what to expect (and still trying to keep my expectations in check); as it turned out, we discussed her overarching experiences with the medical community as opposed to the dysentery outbreak. Furiously, I jotted down details as they related to her life's events: "[t]his is who I am," she said, by which I understood her medical experiences and biography inextricably linked.

At the age of sixteen or seventeen (she was uncertain about her exact age), Alex experienced racist behaviour from a doctor for the first time. Despite immediately perceiving this, she remarked, "What could I do?" as her remote location prevented her from seeing another physician. As she was in-and-out of hospital from excessive vomiting due to alcoholism, <sup>216</sup> their meeting's circumstances accentuated miscommunication. Other patients experienced similar troubles–disgustedly, she recalled how her grandmother was treated when hospitalized.

Alex regretted her inability to conceive. During the period of her life where she routinely drank (she is a recovered alcoholic), Alex underwent a D and C.<sup>217</sup> Visibly upset, she recalled going "into the operating room," feeling surrounded, and was unclear about her understanding of the procedure in advance; derisively, she said, "I didn't want to go back there anymore [i.e. the hospital]." At twenty-two, and after achieving sobriety, Alex became interested in parenting. She remembered visiting the new local doctor, traveling to Saskatoon for tests, and finally being told there was "no hope of [her] having a child"—her tubes were blocked. The local doctor disagreed with the city-specialist, arguing perhaps "they could reverse it"; however, all plans proved fruitless as Alex relocated out-of-province to follow a love interest.

While off reserve, she continued pursuing means to conceive. In conjunction with new physicians, Alex tried various fertility procedures to no avail. Finally, her appointment for the reversal procedure (see above) was set—but her common-law spouse broke his arm, so they moved to retain his employment, and her surgery was nixed.

<sup>&</sup>lt;sup>215</sup> This particular informant chose to retain anonymity; all identifying information related to her case has been changed.

<sup>&</sup>lt;sup>216</sup> It is worth noting acute vomiting results from alcohol consumption while taking metronidazole.

<sup>&</sup>lt;sup>217</sup> D and C is the abbreviation for dilatation and curettage, a procedure where the cervix is dilated in order to scrape (curette) material from inside the uterus. It is generally performed to remove uterine cysts or following a miscarriage.

Life moved on: Alex finished school, returned to the Loon Lake area, met a new love-interest, and adopted two children. At one point, she underwent an emergency appendectomy: with horror, she recalled waking up to hear her doctor explain to her husband how he removed her right fallopian tube—as well as her appendix—due to a cyst; remorsefully, she observed "they didn't even give me a chance." Since that time, she "felt like part of [her] was missing":

How would you feel if someone were to take part of your body without your consent? I just felt so angry, really angry. I needed to talk to someone [...] Being an Indian, sometimes you feel you are being taken advantage of [...] I was stuck [...] Today is the first time I talked about it.

She envied other women able to get pregnant–for her, it appears a foundational experience.

Several other medical incidents left Alex angry. Her cousin's tubes were forcibly tied, "so she never had a chance to...[have children]." Later she developed cancer (presumably of her reproductive system) and Alex felt the two events connected. Her sister's copper I.U.D. dislodged, and was replaced, twice; afterwards, both women blamed her inability to conceive on its use and reinsertion. Growing up, Alex said life was tough: on one occasion, she took six doctor-prescribed pills at once to blind herself to "what [she] was seeing [at] home." Fever and illness ensued, so her worried father took her to hospital—when she responded in silence to the doctor's questions (due to nausea), he stormed off. Returning home, her father gave her liquids and Tylenol (her aunt also "doctored her" with a little beer mixed with water, which helped). Alex said "one of the things [she] wanted to tell [me] about" was her mother's "passing." Her mother lost the ability to walk prior to her death from a benign spinal tumor, in addition to having diabetes and rheumatoid arthritis (her ill-health precipitated Alex's move back home). On and off, Alex took her mother to traditional healers. Just before her mother died, she was transferred from the local hospital to Saskatoon. Following her mother's arrival, admissions personnel promptly sent her back home via medical taxi: she vomited black the entire trip. Livid, the local doctor made several phone calls, and an ambulance took her to North Battleford instead. She died en-route (apparently, just as the ambulance pulled up). Her family declined autopsy, as her mother argued before death she, "never wanted the doctors cutting her up anymore."

Summing up, Alex said, "when they [doctors] see a person so sick, they just want to get rid of them": it is a matter of "poke here, poke there, and out you go." She suggested physicians

"get paid alot to see a patient," and that "when they see a Native patient, its just a few minutes, [but] its the same amount [what doctors are paid]."<sup>218</sup>

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## ISABELLE'S STORY

Isabelle Ben, her niece, Dion Fineblanket and I sat around Isabelle's kitchen table. We talked casually over cups of coffee, laughing at one another's jokes. In the next room, Isabelle's preteen granddaughter danced in socked-feet while playing Guitar Hero; it provided comic relief during our forty-minute discussion.

Isabelle remembered sickness in the Loon Lake area during the '60s and '70s, but admitted she was elsewhere at the time. Many children were ill. Dion agreed his grandmother lost seven children to "that sickness" (the type of illness referred by this point was unclear<sup>219</sup>), and acknowledged she struggled to cope because she was eighty-five-years old. Isabelle lost two out of three boys due to sickness; she noted both died in Loon Lake hospital.

In the past when children were sick, Isabelle said "the government" simply took them without explanation. Dion explained, "like say if they had TB [...], and the kids will leave the—the—the reserve, and sometimes they'll get adopted out. And that's what happened to alot of—alot of kids in our community [...] Without permission, without asking, because of the sickness." Isabelle's niece recalled her trauma when hospitalized in Saskatoon for smallpox: she was doused in medicinal liquids that burned her skin. With pause, Isabelle noted sometimes stories balloon into 'fish stories'—she was trying her best to recall things accurately.

When asked about other medical experiences, Isabelle described her granddaughter's death: her worried daughter, Edna, took her coughing baby to hospital twice; nothing was done on either occasion (apparently the doctor "just sent them away...sent them back home"); and the infant died from what they could only guess was pneumonia. Isabelle recounted the pressure young women faced to use birth control—as Dion surmised, certain health professionals "wouldn't let people have more kids [...] would stop [them] from pregnancy, and stuff like that." He added that in his experience, if a patient was sent to Saskatoon, as opposed to treated locally, they were often saved—the opposite held true if they stayed nearby. Isabelle agreed with his

<sup>218</sup> Interview with Loon Lake area community member, interview by author, 16 June 2008, compact disc copy, University of Saskatchewan.

Conversation moved quickly between Cree and English, and I was therefore uncertain as to whether "that sickness" referred to dysentery or smallpox, which was also discussed.

assessment, and with reference to Scott both concluded, "[m]ostly Native people, he was hard on. Dr. Scott."

Contrastingly, traditional healers "knew more about how to heal people." Women gave birth at home instead of in hospital, as "the older people knew what to do." With laughter, Isabelle described the effects of a traditional laxative her mother administered—she and her siblings rushed to the designated spot their mother chose outside mid-winter, as their family did not have an outhouse. Her niece recalled a time when her diarrhea was so bad she "couldn't eat, just dr[ank] water." After a trip via horse team to the local medicine woman, she concluded smiling, "Indian medicine, it was great for me!" Now, however, Isabelle and Dion admitted many so-called traditional healers used their skills for personal gain, at bingo events, and so on; before they took precedence over 'western' doctors, but presently "[p]eople are taking advantage of it."

Isabelle commented on other cultural losses. Traditional naming had waned, while youth had lost their sense of self and respect toward elders. Dion expanded,

because...white is different from Native. It's always been like that, and—and then—and then, you can't—a Native person can't become white [...] He still has to keep the values, the tradition, because our—our greatest respect is the nature of this land, and our elders, and then we respect them; but today, kids are different, they don't—they don't follow that anymore. They are more of, uh, gangster style [...] rapper style, stuff like that

Isabelle added today's method of schooling fosters negative depictions of Native children portrayed by the media; in the past, parents taught children at home lessening bullying. Although life was tough as people lived in sod homes lacking windows or flooring, illness was infrequent—people wore moccasins, snared rabbits, and were "more healthier [sic]." Elderly people walked upright without using canes. Whereas present day additives in food (particularly, growth hormones in beef and chicken) cause "all kinds of sickness," traditional diets staved off illness; Isabelle and Dion joked about ice cream and pop, but Dion noted seriously, "today, it's—you get running water, you live the 'white'—kinda 'white' way, or [...] that white style, or—that's—and it's—you get sick—like, seems like it's—you get sicker now: Native people are getting sicker and sicker."

Two observations grounded these examples like bookends. On the one hand, both Isabelle and Dion remarked on smallpox-laced blankets distributed by Royal Canadian Mounted

Police (R.C.M.P.) in conjunction with Treaty settlements (before launching into the topic, Dion joked hesitantly "I sound like I'm racist"). On the other hand, Isabelle's description when asked what sickness meant to her directly contradicts 'modern' medical definition: in explanation, I observed doctors often link sickness to symptoms, while she said (bonding with patient experience), 'it's a suffering stage'—"kwâtakihtawin." Later, their polarity deafens; crosscultural interaction directly transmitted disease, but understanding between cultures of what that meant diverged.

With her granddaughter now silent, Isabelle remarked she was happy I came.<sup>220</sup>

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As he carefully maneuvered my car along the rutted road from Ministikwan to Loon Lake, Dion broke the silence that lingered between us following my interview with his longtime friend, Sidney Chief. He remarked he was struck by his friend's wisdom beyond his years: his clarity, and keen insight over our forty-five minute discussion. I agreed, echoing sentiments I had expressed to Chief himself at the close of our conversation, that he answered more questions than I had knowledge to ask. I added I thought his would be my last interview—the last in a series because Chief had singlehandedly unified, in a beautifully convoluted whole, themes or ideas that seemed disparate in my mind from each of the other interviews. We spoke solemnly, the way people speak in theatres as the end credits roll after a particularly moving film, or in the hushed tones people assume as an orchestra begins to tune. (At least those are my points of comparison; feel free to draw your own.) When sitting to write this chapter, I poured through the anthropological literature looking for an explanation of that experience; the closest was 'saturation', but I ultimately rejected it on grounds I am not sure I will ever find peoples' stories redundant; I cannot regard our conversation in the context of 'saturation's' smug boredom, for that was not my experience.

Later, I read Foucault's 1975 dossier titled, *I, Pierre Rivière, Having Slaughtered My Mother, My Sister, and My Brother...A Case of Parricide in the 19<sup>th</sup> Century,* which chronicled (as the title indicates) everything written in connection with Pierre Rivière, and his premeditated murder of his family. Foucault's purpose for publication was to draw a map of the confrontation of discourses surrounding that case, as the cantonal judge, prosecutor, presiding judge, Minister

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<sup>&</sup>lt;sup>220</sup> Isabelle Ben, interview by author, 13 June 2008, compact disc copy, University of Saskatchewan.

of Justice, medical practitioners, villagers, and the murderer himself appeared to be speaking at cross purposes: "a battle among discourses and through discourses." He argued the dossier's coherence eschewed outdated academic methods of textual analysis, as it was neither a composite work nor legal document. He also suggested Rivière's memoir, which assumed a central position holding the various subsidiary texts together—and whose astonishing beauty, or "singular strangeness," proved the impetus to publish at all—be left as is. He and fellow book contributors were unwilling to superimpose their texts on his, due to its legacy of taking four corpses with it, and because if it were interpreted along juridical, criminological, psychiatric or psychoanalytic lines, they would be guilty of imposing the very power relations whose reductiveness they had hoped to show in the first place."

Since its publication scholars have alternately labeled *I, Pierre* 'memoir', 'archive', a 'dossier' (the term I adopted), "typically French excited sentimentality," due to its alterity; one reviewer dismissed it as adding little to criminology as the editor (Foucault) argued "the unusual degree of documentation in this otherwise undistinguished case justified...publication of these materials." Therein lies the problem: many academics do not accept alterity as 'discourse'. By way of illustration, while urban educationist Carol Tennessen accepted the principle that 'signs' are not trustworthy substitutes for 'real' objects (based on Foucault's argument in *The Order of Things* that the 'age of resemblance' between 'words' and 'things' has waned), she would only go so far as to say the disparate accounts of *I, Pierre* belie 'truth'—not that Rivière's version *is* 'truth'. As de Certeau summarized in connection with his work on possession

<sup>&</sup>lt;sup>221</sup> Michel Foucault, ed. *I, Pierre Rivière, Having Slaughterd My Mother, My Sister, and My Brother...: A Case of Parricide in the 19th Century* (Lincoln: University of Nebraska,1975), x. <sup>222</sup> Ibid., xi.

<sup>&</sup>lt;sup>223</sup> Ibid., x, 199.

<sup>&</sup>lt;sup>224</sup> Ibid., xiii.

<sup>&</sup>lt;sup>225</sup> Richard L. Bowler, *Library Journal* 100, no. 7 (April 1975): 684; Duncan Macdiarmid, *Journal of Analytical Psychology* 23, no. 4 (October 1978): 378. See also Jean-Marie Alliume, "The Riviére Beast, or the Unfinished Trial of the Creature Who Tortured Birds and Frogs," *October* 24(Spring 1983); Egon Bittner, "I, Pierre Rivière, Having Slaughtered My Mother, My Sister, and My Brother: A Case of Parricide in the 19th Century," *American Journal of Sociology* 82, no. 1 (July 1976); Denis Hollier, "The Word of God: "I Am Dead"," *October* 44(Spring 1988); Patricia O'Brien, "Crime and Punishment as a Historical Problem," *Journal of Social History* 11, no. 4 (1978).

<sup>&</sup>lt;sup>226</sup> Carol Tennessen, "Nothing but the Truth: The Case of Pierre Rivière," *University of Toronto Quarterly* 57, no. 2 (Winter 1987): 290-1.

among Loudun nuns, the difficulty lies in the relationship between the ethnographical tale and whatever 'other society' it claims to give voice to: demonological, theological, and medical discourses assume the identical position "I know what you are saying better than you"-or more cynically, "My knowledge can position itself in the place whence you speak"—over accounts by the possessed woman, primitive, and patient.<sup>227</sup>

This chapter assumes the premise that "there is no discourse of the other, only an alteration of the same."<sup>228</sup> Equivalent to Foucault's motive for publishing *I, Pierre*, <sup>229</sup> I seek to expose the medical, and to a lesser extent juridical, mechanisms (better yet, disciplinary mechanisms) surrounding Crookedneck's, Betty's and Rita's, Alex's, Isabelle's, and by extension Dion's, and Chief's recounted experiences by textually positioning them adjacent to accepted 'discourse' (plural): medical texts, government publications or documentation, secondary sources (Colonizing Bodies, Colonizing the Body), as well as this text. This is parcel to the thesis's overall 'genealogical' project, to demonstrate in what ways specific modes or mechanisms gave birth to mankind as the object of scientific discourse(s)/knowledge. <sup>230</sup> Like Foucault admitted in connection with his work in *Discipline and Punish*. I am not the first to work in this direction; however, to my knowledge, I am the first to envelope 'post-colonial' studies among disciplinary techniques (power/knowledge).<sup>231</sup> To do so, as stated above and I will now restate, I tried my best to let 'subjects' speak for themselves. A problem arises, though, in terms of my positioning as thesis 'author', or in relation to those conversations that I was a part of.

With the above interviews I recounted my impressions of conversations, and could be accused of, to quote Donaldo Macedo's introduction to Friere's Pedagogy of the Oppressed, adopting a 'language of clarity': "a pernicious mechanism used by academic liberals who suffocate discourses different from their own."<sup>232</sup> It is *citation*, and as de Certeau argued about ethnographic texts and travel literature, 'savages' (or in his case, possessed women) are cited to bolster texts' accreditation through a literary and, by extension, juridical fashion by discourse

<sup>&</sup>lt;sup>227</sup> de Certeau, *The Writing of History*, 250.

<sup>&</sup>lt;sup>228</sup> Ibid., 265.

<sup>&</sup>lt;sup>229</sup> Foucault, *Power/Knowledge*, 49.

<sup>&</sup>lt;sup>230</sup> Foucault, *Discipline and Punish*, 24.

<sup>&</sup>lt;sup>232</sup> See Freire, *Pedagogy of the Oppressed*, 20.

that displaces them, "saying about these unknowing people what they do not even know about themselves". He expands, stating 'citation' as a literary technique could be understood in the purview of citation before a tribunal, as it sets—at its heart—discourse in a position of judgment over the 'other' it (allegedly) articulates. Later he answers his own posed question as to whether it was his ambition to hear better than past scholars what these possessed women betray as 'other' ("what...authorizes me, today, to suppose that I can speak the other better than all of them?"):

Today an analysis that might show how a text (the one I am writing) relates to demoniac speech in the seventeenth century would perhaps be a way of relating the question without risk of falling into folklore or scientism. This would be tantamount to thinking the strange remark that Freud picked up from Goethe, 'So muss den doch die Hexe dran'—we must therefore resort to the sorceress...<sup>235</sup>

So I direct the reader's attention to the transcript of my conversation with Chief found in Appendix C.1. This was done solely due to page length restrictions on Master's theses. That way I cannot be criticized for speaking for Chief, rather than letting him speak for himself.

If we accept Chief's text as 'discourse', we must accept groundwork done by de Certeau's in "Discourse Disturbed: The Sorcerer's Speech" (*The Writing of History*). <sup>236</sup> His primary concern was situating the possessed woman's claim, 'Je est un autre', or that her discourse was spoken by another at the time of possession. De Certeau acknowledged an analogous distinction between what the demonic or possessed woman states and demonological treatises to the discourses of madmen and psychiatry: as he stated, equating the possessed woman's speech to knowledge of possession is as implausible as equating the 'mad'-man or woman's expressed thought to psychiatry and psychoanalytic knowledge. <sup>237</sup> Simultaneously, he did not view the possessed woman's discourse as readily exhumed from under the varying interpretations of medical or religious discourse (a lower level of discourse, "intact, to be unearthed"), or their antitheses, polarities in an inverse relation ("[t]he possessed woman's speech is established relative to the discourse that awaits her in *that* place...just as the language of the crazed woman in the hospital is only what has been prepared for her on the psychiatric

<sup>&</sup>lt;sup>233</sup> de Certeau, *The Writing of History*, 250.

<sup>&</sup>lt;sup>234</sup> Ibid., 251.

<sup>&</sup>lt;sup>235</sup> Ibid., 254-5.

<sup>&</sup>lt;sup>236</sup> See ibid., 244-68.

<sup>&</sup>lt;sup>237</sup> Ibid., 246-8, 255.

stage").<sup>238</sup> Instead, he maintains the demonic woman's claim, 'Je est un autre' is a transgression of religious laws of language, written into that language by a *modus loquendi* (style of practice).<sup>239</sup> For example, when urged by the exorcist to fix her name according to the postulate I=x, with x designating a definitive name (the exorcist's goal was to extort a proper name from the possessed woman to pigeonhole her in demonological repertoire), she answers first, "I am Asmodeus" (I = Asmodeus), and then,

I = Isacaron

I = Leviathan

I = Aman

I = Balam

I = Behemoth

in heterogeneous identifications.<sup>240</sup> Her response compares to Chief's answer when queried about the medication that Scott and/or the public health nurses distributed:

LW: —do you have any memories of either Dr. Scott, or the medication he used to give out, or the medication, say, nurses would give out?

SC: At school—when we went to school, we had these pills given to us everyday.

LW: Okay.

SC: We had, uh, milk and, uh, crackers and whatnot, but we—there was pills there that we had to take. It was a...prerequisite, so to speak.

LW: Right.

SC: And when we went to school we were in the hands of the, uh, teachers, and I don't know these—um, not superintendent, but they were a...kinda like a, they were, uh, our parents for the day—

LW: Right.

SC: —so...So when we had to go to school we had to follow their, uh, rules. So when we took the—we took the pills, we had to take the pills. But they were, like you said, uh...In my years, that I can remember, there was, uh, times that I seen, uh, like, I don't know how you say it, uh...what is that, uh, word, where there were a whole box full of needles and...shots given to us, eh?

LW: Okay...

SC: On Treaty days! I remember, uh, some Treaty days, uh, I don't now how many—how old I was—

LW: Yeah.

SC: —but you had to have this shot!

DF: Right here, that forearm, right here.

SC: Yeah! I remember I had to have that.

LW: Did they ever tell you what they were for, or?

<sup>&</sup>lt;sup>238</sup> Ibid., 248.

<sup>&</sup>lt;sup>239</sup> Ibid., 250.

<sup>&</sup>lt;sup>240</sup> Ibid., 256.

SC: No. I was too young to remember anything like that.

DF: It was x-rays and give us shots.

SC: Yeah. And when—

LW: On Treaty days...

SC: —we went to the, uh—we went to the Treaty day. And back then our people knew that in order for the treaties to continue we had to go to these, uh, to take the, uh—

DF: Needles and stuff.

SC: Needles and stuff, and whatnot. That was a requirement. There was a cop there, there was an RCMP there in a Mountie outfit, and he was there, dressed in, in his uniform, shaking peoples hands after they'd been shot with the needles and whatnot, eh? And there was strange looking pills back then too, eh—like I don't know, they were black little, like little beads—

LW: Yeah.

SC: —and you had to take those. I don't know what they were...

LW: On Treaty days you had to take them?

SC: On Treaty days we had—took em, yeah.<sup>241</sup>

Treaty adherent/patient/non-delinquent (due to the presence of police at the Treaty day celebration). As de Certeau similarly maintained, this plurality of identifications denies localization without rejecting the larger discursive code (in his case, demonological; in ours, pedagogical/medical/colonial/juridical).<sup>242</sup> The *name* is "a space of play."<sup>243</sup> Elsewhere, Chief's text could be published as the centerpiece of a 'dossier' surrounded by the medical texts, government missives, and ethnographic detail chronicled in this thesis, much like *I, Pierre*, however controversial it may be. The 'astonishing beauty' of his text is that it articulates a 'microphysics' of disciplinary power offsetting Crookedneck's, Betty's and Rita's, Alex's, and Isabelle's and Dion's separate accounts as "element[s] in the genealogy of the modern 'soul'" (to borrow Foucault's terminology).<sup>244</sup> Their 'gaze' allows the reader to associatively learn the geography of what Farmer calls 'structural violence', like Sen's teacher pointing out 'slab'-like objects. When Chief and other Loon Lake and Ministikwan residents extort the play between the stable, discursive *place* language/power/knowledge would direct them to, and "the evanescent plurality of places" the colonized/patient/student, etc. could occupy discursively in a disciplinary society (to combine de Certeau and Foucault's postulates), they

Chief varyingly identifies himself according to the postulates I = student/patient, I = student, I =

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<sup>&</sup>lt;sup>241</sup> Sidney Chief, interview by author, 14 June 2008, compact disc copy, University of Saskatchewan

Saskatchewan. <sup>242</sup> de Certeau, *The Writing of History*, 256.

<sup>&</sup>lt;sup>243</sup> Ibid., 260.

<sup>&</sup>lt;sup>244</sup> Foucault, *Discipline and Punish*, 29.

participate in "discourse undone" 245: they deny paradigmatic dichotomies— 'oppressor'/'oppressed', Aboriginal/non-Aboriginal, patient/non-patient. In essence, they invite us to free a man (the man-in-the-bush?) who "is already in himself the effect of a subjection much more profound than himself. A 'soul' inhabits him that brings him into existence...the soul is the prison of the body."<sup>246</sup> Which forms the core of the next chapter.

<sup>&</sup>lt;sup>245</sup> de Certeau, *The Writing of History*, 253, 266. <sup>246</sup> Foucault, *Discipline and Punish*, 30.

## CHAPTER FOUR: 'BUT WE HAVE TO LEARN TO USE THEM'247

The diffuse nature of Chief's 'gaze'-with its fleeting references to medical, colonial, pedagogical, and juridical codes-evokes Foucault concerns about the fragmentary nature of his work expressed at the close of his career; dismissively in a 1976 lecture he remarked that his histories of the penal procedure, the institutionalization of psychiatry, sophistry, Greek money, the medieval Inquisition, infantile sexuality, etc. retreaded the same thematic ground, marking ticking time. That theme situated the modern 'soul' as the correlation of 'power' as opposed to the effect of Christian theology, which is produced on and in connection to the body by a 'technology' exercised on "those punished"—or specifically, on the trained, supervised, corrected, madmen, delinquents, children, "the colonized," and so on. Chief's (and, indeed, other Loon Lake area residents') heterogeneous identifications invite us to further test the utility of the term 'colonial medicine', in conjunction with revelations from Chapter Two (i.e. that 'medicine' cannot be discursively subsumed). To do so, our discussion will centre on another 'gaze'—the "dubious" science of sanitation, or the hygienic practices included in the discipline of public health—in addition to medicine, colonialism or race-based rhetoric, pedagogy, and the judicial system. Sanitation was selected because it was important to doctors and federal government

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Excerpted from a letter as follows: "[i]f we require people to live in crowded circumstances, out of reach of the cleansing effects of the open air existence, then we must make possible by the provision of at least minimal services...[Sanitary] habits are impossible to acquire if the taps on which people had learned to rely are close(d?), the wash-tubs locked up and the showers put out of commission...In some way it must be brought home to the inhabitants of [Loon Lake] that they, and they alone are responsible for cleanliness and maintenance...None of the foregoing is new. Apart from the arrival on the scene of the drug Metronidazole, our weapons are the same as they have always been, simply application of normally accepted principles of public health. But we have to learn to use them." LAC, RG 29, vol. 2967, file 851-4-046, part 3, R. D. P. Eaton, memorandum to Director General of Medical Services, "Amoebiasis–Eradication or Control," 22 September 1970.

Foucault, *Power/Knowledge*, 78-9.

<sup>&</sup>lt;sup>249</sup> Foucault, *Discipline and Punish*, 29.

<sup>&</sup>lt;sup>250</sup> With reference to Nietzsche, Foucault argued the best way to pay tribute to another academic's thought was to stretch to the point of protestation; it is in this spirit that I address Kelm and Arnold's work. Foucault, *Power/Knowledge*, 54.

When setting out to discuss the political status of science in western society, Foucault focused on what he called 'dubious' sciences including medicine and psychiatry, as opposed to say,

employees affiliated with the Loon Lake trial, as identified in Chapter One. To emphasize the constructive nature of history as a discipline—and particularly 'colonial medical' histories—Chapter Four is framed as a remedial exercise by applying Foucault's five methodological precautions outlined in his 1976 lecture to our study of sanitation. From that, along with previously presented argumentation, it is apparent that historians perpetuate a certain disciplinary power/knowledge over the contemporary 'soul', marking the 'excluded' with the procedures of individualization.<sup>252</sup>

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Prior to launching into the abovementioned discussion of Foucault's methodological cautions, I would direct the reader's attention to several excerpts located in Appendix D (D.1, D.2, D.3, D.4). They are lengthy, and will be referred to intermittently throughout the upcoming argument in addition to exemplars from Foucault's Discipline and Punish. The first citation is from a 1968 article published in the Canadian Journal of Public Health, written by sanitarian Al Freestone. It chronicles his experience administering sanitation programming on Saskatchewan Indian Reserves. The second is a memorandum by Public Health Inspector M. A. Butler regarding a sanitation workshop held in Driftpile, Alberta in October 1967. Notably, these first excerpts illustrate day-to-day handling of Medical Services sanitation initiatives among First Nations, both in their respective provinces and when considered in tandem, on an interprovincial scale. The third (1970) outlines the duties and responsibilities for the position of Public Service Nursing Counsellor, wherein a nurse provided (occupational) health counseling for Department of National Health and Welfare employees; importantly, this was an internal position as opposed to one specific to reserve populations. The fourth excerpt is from a report on the feasibility of using hospital statistics to identify environmental effects on the health of 'on-reserve' Indians. As will be demonstrated below, it exemplifies trending towards epidemiology, or the use of statistical analyses to examine health populations. The last illustration (D.5) was taken from the booklet "Canadian Indian Homes," and should be weighed along side a second image from the same publication, part of a discussion on architectural 'power' below.

theoretical physics or organic chemistry. For more information see, ibid., 109; Dreyfus and Rabinow, *Beyond Structuralism*, xxiv.

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<sup>&</sup>lt;sup>252</sup> Foucault. *Discipline and Punish*, 199.

Foucault's first methodological caution was avoiding analyzing power in legitimated (regulated), central locations in favor of *peripheral power*, regional and local capillaries characterized by their comparative illegality or less-legal quality: where manifestations of power surpass 'rules of right', investing themselves in tools of possibly violent material intervention, techniques, and/or institutions. <sup>253</sup> For example (discussed in Chapter Two above), Eaton's, Rath's, and others' indignation at Miller's singular research drive exemplifies a centralist bucking against periphery control. Freestone, who identified himself as "the first public health inspector in the Federal Service in the Saskatchewan Region," self-styled his terms of employment: "I was not an officer, I was not primarily an inspector. To myself I was a person who was going to attempt to teach environmental control. Hence I became a sanitarian." (Only later, following "five years and some definite decisions...by the provincial body" did he accept the original title.) Rites of passage 'firsts' interspersed his discussion ("my first task," "[o]ur first workshop"), while attendance concerns lend an ad hoc quality to the Fort Qu'Appelle workshop: "[w]e had been told by many people who were working with the Indian people 'no one would come'. With this in mind we began asking for additional delegates hoping to wind up with at least 20."254 The Driftpile workshop was abjectly local—or immediate relation with its object/the target audience<sup>255</sup>—"[a]t this point the women stayed in the health centre to carry out their program and the men joined the Public health Inspector in the garage to take part in the actual construction of items..."; "the people are tired of talk and more talk and prefer getting action": "[a]s these two projects were completed a look of accomplishment, willingness and enthusiasm could be discerned on the faces of the men doing the actual work."<sup>256</sup> Thus, we return to earlier affections re. 'state-based knowledge systems'. 257

Foucault's second methodological concern was to avoid analyzing the conscious intentions or decisions of historical/present-day actors, or consideration of power from its own frame of reference (he mentioned the "labyrinthine and unanswerable question: 'Who then has power and what has he in mind?""), in favor of continual processes dictating gesture, altering

<sup>&</sup>lt;sup>253</sup> Foucault, *Power/Knowledge*, 88, 96, 97. <sup>254</sup> Freestone, "Environmental Sanitation," 26.

<sup>&</sup>lt;sup>255</sup> Foucault, *Power/Knowledge*, 97.

<sup>&</sup>lt;sup>256</sup> Butler to Area Director, "Sanitation Workshop," 2.

<sup>&</sup>lt;sup>257</sup> See page 12 (note 49) above.

behaviour, 'subject'-ing our bodies: grasp the materiality of subjection.<sup>258</sup> Freestone's 'problems', like Eaton's, invite scrutiny along Kelm's trajectory about racist, early-twentieth century Euro-Canadian attitudes about 'changing' Aboriginal bodies to help them cope with 'civilization'.<sup>259</sup>

Then you look at the other problems. You are dealing with an ethnic group whose culture is much different from our own. You are dealing with people of a low income group. You are dealing with people of a low-educational standard. You are dealing with people who, because of their culture, do not particularly care about tomorrow. They think mostly of today—tomorrow will take care of itself. You are dealing with people who feel they have been cheated and many of whom distrust the white man.<sup>260</sup>

Reading that, it's difficult not to shudder–or at least it's hard for some (a visceral response like Jones's disgust at the Tuskegee trial).<sup>261</sup> But within that glib exterior lies a full-space/"hollow" in which language finds support: "where the loquacious gaze with which the doctor observes *the poisonous heart of things* is born and communes with itself," in the latter case (emphasis added).<sup>262</sup>

For this *rehearsal*<sup>263</sup> we have to delve deeper (perhaps wider?) to discover the sheer procedural humility<sup>264</sup> of Freestone's "environmental control," Eaton's "education of the Indian people", hierarchical observation, normalizing judgment, and their amalgamation, examination. House Plans 1 through 6 articulate internal, detailed control over would-be occupants—to transform their behaviour, make them knowable—bring the effects of power not just past their thresholds but to the very physicality of their homes. Scott described logistical necessities before federally funded housing would be granted historically:

<sup>&</sup>lt;sup>258</sup> Foucault, *Power/Knowledge*, 97.

<sup>&</sup>lt;sup>259</sup> Kelm, *Colonizing Bodies*, xv-i.

<sup>&</sup>lt;sup>260</sup> Freestone, "Environmental Sanitation," 25.

<sup>&</sup>lt;sup>261</sup> Jones, *Bad Blood*, 14.

<sup>&</sup>lt;sup>262</sup> Foucault, *Birth of the Clinic*, xii.

<sup>&</sup>lt;sup>263</sup> Foucault described exercise as "the only truly important ceremony" among disciplinary methods; and so, we will exercise throughout this Chapter. Foucault, *Discipline and Punish*, 137, 161-2.

<sup>&</sup>lt;sup>264</sup> Ibid., 170. Foucault contrastingly argued power in a disciplinary society operated through humble, if suspiciously calculated procedures as opposed to ostentatious rituals associated with sovereign power.

<sup>&</sup>lt;sup>265</sup> Freestone, "Environmental Sanitation," 25; Eaton, "Amoebiasis," 485.

<sup>&</sup>lt;sup>266</sup> Concepts outlined in Foucault, *Discipline and Punish*, 170-94.

<sup>&</sup>lt;sup>267</sup> Ibid., 172.

FS: But, then because of the outcry from this first paper, the town got sewer and water, the reserve was offered sewer and water provided they would line up as a village—LW: Right.

FS: —close to, close to Loon Lake. Alot of them at that time were living close to Loon Lake—just literally, just the opposite side of the mythical railway.

LW: Right.

FS: Now the housing lots on the reserve were going to be two hundred feet by two hundred feet.

LW: Mmhmm.

FS: And you only had to build on alternate lots. In town, the lot was a hundred feet by fifty—

LW: Okay.

FS: —so, uh, by conver—comparison to what the Indian village would have been like, uh, the town itself was going to be very crowded—

LW: Right.

FS: —and was very crowded [laughter]. I mean fifty by a hundred is a, sort of, standard city lot. Uh, if you have a lot that's really, four hundred by two hundred, it's a really large lot.

LW: Yeah.

FS: But they wouldn't. 268

The exact measurement of the required living arrangements is not unlike Foucault's description of a military camp, the model for 'correct training'/coercion via observation whose underlying principle informed urban development (working-class housing, hospitals, prisons, schools) "for a long time": on parade grounds, tents were positioned two feet from one another; tents of junior officers separated from arms-depots by ten-feet; tents of subalterns opposite the alleys of their companies; tents of captains opposite fifty-one feet company streets; and so on, until *observation was continuously if discreetly enacted* (over men deemed all the more dangerous because they were armed). Loon Lake reserve residents should line up their houses opposite the town in precisely measured, two-hundred-by-two-hundred foot lots. Compare that to "Canadian Indian Homes"—innocuous enough with its provisions for "log construction, if this type of construction is desired," future additions and "inclusion of electricity, running water, etc.," "constructive criticism and suggestions from field officers, Band Councils and individual Indians" —with its addendum "Sanitation for Indian Homes," and a diagram from the Central Mortgage and

<sup>269</sup> Foucault, *Discipline and Punish*, 171.

<sup>&</sup>lt;sup>268</sup> Scott, interview, 25 June.

<sup>&</sup>lt;sup>270</sup> LAC, RG 10-C-VI, vol. 11580, file "Department of Citizenship and Immigration–Indian Affairs Branch–Canadian Indian Homes," Canada, Department of Citizenship and Immigration, "Canadian Indian Homes" (Ottawa: Department of Citizenship and Immigration, 1957), 1-2.

Housing Corporation's manual "Choosing a House Design." The authors identify "highlights of sanitation" categorized under several headings:

### Highlights of Sanitation:

It is useful to organize one's thinking with respect to sanitation under a number of headings and sub-headings. This assists the health worker in making a systematic approach to the inspection of existing conditions and in making recommendation for improvement. The following headings and sub-headings are suggested:

- A. Type of House:
  - a) Foundation
  - b) Floors
  - c) Walls
  - d) Number of Rooms
  - e) Floor area
  - f) Window area
  - g) Privacy
- B. Lighting:
  - a) Natural
  - b) Artificial
  - c) Electricity
- C. Heating:
  - a) Usual winter temperature indoors
  - b) Ventilation
  - c) Humidity
- D. Water Supply:
  - a) Source
  - b) Availability inside
  - c) Availability outside
  - d) Protection
  - e) Potability
  - f) Bacterial quality [...]<sup>271</sup>

<sup>&</sup>lt;sup>271</sup> LAC, RG 10-C-VI, vol. 11580, file "Department of Citizenship and Immigration–Indian Affairs Branch–Canadian Indian Homes," John S. Willis, "Sanitation for Indian Homes," 1-2.

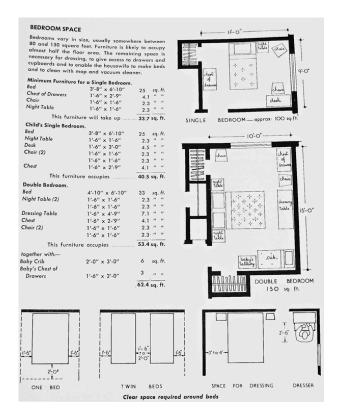


Fig. 4.1. Bedroom floor plan from "Choosing a House Design." Notice the exact placement of beds, bedside tables, and other furniture in feet-inches, with a total accounting of occupied square-footage. [LAC, RG 10-C-VI, vol. 11580, file "Department of Citizenship and Immigration—Indian Affairs Branch—Canadian Indian Homes," Canada, Central Mortgage and Housing Corporation, "Choosing a House Design" (Ottawa: Central Mortgage and Housing Corporation, 1957), 13.]

Foucault observed, "stones can make people docile and knowable"; 'sanitary' living involved an accounting of natural versus artificial lighting, privacy, exact placement of furniture in feet-inches, in addition to water potability and ventilation. In *Discipline and Punish*, Foucault described the structures of seventeenth century hospital buildings as instruments of medical action to better observe patients—determining their treatment ("progressive objectification")—and isolate them preventing spread of infection ("subtle partitioning of individual behaviour"). Hundreds of years later, Chief described the isolation he felt as a boy in hospital:

SC: I was always hospitalized. I—I—I—I seen alot of kids from Loon Lake, I seen alot of kids from Bighead, people from here [Ministikwan], for the *littlest* things, they kept you for two weeks. For some—uh, today, if you have a broken leg, you go home, right? LW: Yeah. They cast you and then—

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<sup>&</sup>lt;sup>272</sup> Foucault, *Discipline and Punish*, 172.

<sup>&</sup>lt;sup>273</sup> Ibid., 172-3.

SC: But back then, you did a whole *month* in the hospital for a broken leg! I, uh...you know, like, uh, diarrhea...fevers...I was there for fourteen, fifteen days. I can remember, I'm not saying it was fourteen, fifteen days, but I, I remember days and days out that you were there, and so lonely that you're—you're—you're put in a room, and Dr. Scott'd tell you, "I'll check you out," you weren't allowed to go home...And mom—my parents came to pick me up and, "No, it's not time for him to go home. He needs to be here for a while." I don't' know why—I felt healthy at those times.

LW: Yeah.

SC: I was okay, I was willing to go home, I was happy to go home; but *no*, I was supposed to stay there for another four days—five days—you know? I didn't know back then what five days, four days meant, but today I remember those words, like—

LW: Right.

SC: —what he meant. Today—I don't, you know, like—one week, two weeks, I can remember that.

LW: Hmm.

SC: But why would a person have to be there when he's okay?<sup>274</sup>

Welcome the "establish[ed]...individual in his irreducible quality,"<sup>275</sup> to borrow Foucault's phrasing: a 'penality of the norm' both compared and differentiated, hierarchized, imposed uniformity towards the mean, brought exclusion; each *subject* (Chief in the above example) in a "punishable, punishing universality."<sup>276</sup> All spectrum of non-conforming was subject to 'micro-penality'–light physical punishment, minor deprivations, petty humiliation–in schools, the army, the workshop; any psychological, gestural, or physical tool/technique (coldness, indifference, questioning, physical isolation) could be used by the teacher/drill-sergeant/supervisor to make the child/individual feel their offence.<sup>277</sup> Scott's fervor to prompt public outcry (see Chapter Three) caused humiliation for Loon Lake residents:

We had our own, uh, uh...sanitation—you—they used to call them sanitation, uh, worker? Uh, now they're called garbage—garbage pickers, garbage men? [...] Yep, yeah we had our own. And yeah, we had our grounds, that nuisance grounds? They—they—they were, uh, they had—you know they made those big long holes [...] dugouts for the garbage to be put in? So that's what we had [...] Maybe it was some of the—some of the yards that he took pictures of, not the whole community.<sup>278</sup>

Pressure to comply (achieve normalcy) in hierarchized penality revealed a plethora of individual differences in a corresponding micro-economy of debts-rewards/'gratification-punishment'.

<sup>275</sup> Foucault, *Birth of the Clinic*, xv.

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<sup>&</sup>lt;sup>274</sup> Chief, interview.

<sup>&</sup>lt;sup>276</sup> Foucault, *Discipline and Punish*, 178, 183.

<sup>&</sup>lt;sup>277</sup> Ibid., 178-9.

<sup>&</sup>lt;sup>278</sup> Mitsuing and Mitsuing, interview.

Foucault outlined varying gradations (silver, red silk and silver, red wool, brown wool) of 'epaulette' and/or punishments (arrest, imprisonment, confinement to the cage or kneeling, wearing a sackcloth, solitary confinement) given to military students at the *École Militaire* following their designation into separate classes (first class, second class, '*les médiocres*', the 'bad' class).<sup>279</sup> The description below from a medical journal article on the outbreak at Loon Lake shows similar ranking, in this case according to 'most' or 'least' "primitive" housing:



Fig. 4.2. Photograph of an ideal (Indian) home at Red Peasant Reserve, Battleford Agency, Saskatchewan. Original caption reads "[i]nterior of house in I-25 showing a very clean and tidy living room and kitchen. November, 1958 (1560)." (Canada. Health and Welfare Canada Collection. Accession number 1983-120 NPC. Box 05131)

The Loon Lake Reserve...is housed in 35 small frame dwellings. None of the houses has any form of plumbing but the majority have a privy. Water is obtained from a well, from the nearby lake, or in a few cases, from the tank truck which serves the village. The litter, the dilapidated houses and the lack of almost any form of employment lend an air of despairing poverty.

The Ministikwan Reserve has a population of 250 Indians. The houses, while of similar construction to those at Loon Lake, are farther apart and on the whole, better maintained; some families grow vegetables or keep livestock, and most of the men work as laborers on nearby farms.

Conditions on the Bighead Reserve...are perhaps the most primitive. While there are houses on the Reserve, many of the population live in tents or teepees in the summer months. Hunting and trapping are practically the only occupations. <sup>280</sup>

Silver dollar prizes in hundred-dollar, fifty-dollar, and twenty-five-dollar increments were awarded for 'best' "Home Improvement." This culture of 'gratification-punishment'

<sup>280</sup> Meerovitch and Eaton, "Outbreak of Amebiasis," 719.

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<sup>&</sup>lt;sup>279</sup> Foucault, *Discipline and Punish*, 178, 180, 181-2, 184.

inevitably found Chief mimicking the posture of Foucault's isolated, prostrate man (nearly kneeling, like the second class's punishment at the École Militaire<sup>282</sup>; see figure 4.3):

LW: Or how, like, how—cause this is one thing that really baffles me, like, if you're at a treaty day and—or say you're in school and the nurse says you have to take this pill, like, what happens if you don't take it?

DF: [Muffled] They'd force you.

LW: Like it's—it—it—to me, like, how does that make you feel as a person, like, I don't...I know I wouldn't feel very good—

SC: No!

LW: —if I was being forced!

SC: No! You had no rights, so to speak—

LW: Yeah.

SC: —because when I went to school there was a boundary there, once you entered that boundary, you were in the hands, in the mercy of the teachers. And your parents were not in the picture, they had no say! They had—they couldn't do anything about it. So they left their kids go to school and...that—it's their responsibility to school. So when you went to school...you had to sing 'O Canada', and you had to...I think there was a time you even had to *pray*. 'God Save the Queen' and 'God s—' all this, blah, blah, blah—and 'Dominion of Canada', I remember 'Dominion of Canada', we were called a 'Dominion of Canada'—

LW: Yeah.

SC: —I don't know, there, there was a time, a pic—

LW: A time when...

SC: —a connection there, eh? In the Dominion of Canada I think they were calling it, and we had to pray at the time, it was, uh, again, a prerequisite, that you had to be...so he had no...uh, I saw guys standing in a corner because they didn't want to—they didn't want to say, or didn't want to take the pill, or didn't want to sing, or couldn't...or couldn't! So they were made to stand in the corner and...I remember holding books one time, I don't know why...I had, uh, I don't know what they were called, er, Webster's dictionary on the one side, and I don't what the other—geo—Geography, on the other side. And they were heavy, after a while they were so heavy that, uh, I didn't want to go through that again.

LW: Yeah.

SC: But its not—not the pain that I was embarrassed about, it was being put through that in front of my classmates.

LW: Yeah.

SC: You know, you—you're classmates looking at you being put through, [laughter] going through trail and [laughter] execution at the same time.<sup>283</sup>

<sup>&</sup>lt;sup>281</sup> LAC, RG 29, vol. 2967, file 851-4-046, part 3, Max J. Miller to J. H. Wiebe, Director General, Medical Services Branch, "Amebiasis Project (Progress Report, September 1-November 30, 1970" 4 December 1970, 3.

<sup>&</sup>lt;sup>282</sup> Foucault, *Discipline and Punish*, 181.

<sup>&</sup>lt;sup>283</sup> Chief, interview.

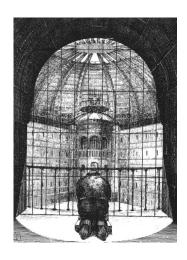


Fig. 4.3. Sketch of a prisoner from *Plan for a Penitentiary* by N. Harou-Romain (c.1840). Original caption reads, "[a] prisoner, in his cell, kneeling at prayer before the central inspection tower." Image from Foucault, *Discipline and Punish*.

But those are just petty machinations delimiting abnormality (outliers, the 'bad', <sup>284</sup> Bighead Reserve in Meerovitch and Eaton's configuration). Instead, *examination* (mentioned above) is the keystone of procedures of discipline, manifesting subjection of the objectified and objectification of the subjected, in what Foucault called a ritualistic and (questionably) scientific registration of individual difference. <sup>285</sup> To illustrate, we have "Table and picture." Foucault described the epistemological thaw resulting from hospitals' conversions to 'examining' apparatuses: in 1687, an 'expectant' physician called on only seriously sick patients in the afternoon; by the eighteenth century, the visit's two-hour duration and its timing were set, even on Easter Sunday; and by 1771, a resident physician visited patients at night as well as between visits from an outside physician. The patient is perpetually examined <sup>287</sup>—need we revisit Chief's childhood two-week hospitalization? Or the battery of stool-surveys/samples, treatment schedules delivered door-to-door or in hospital, and sometimes hourly observation of Cases 1 through 6 above (Chapter Two)? All, of course, neatly fixed in masses of documents, a meticulous archive of diurnally catalogued bowel movements, micturition, nausea, anorexia—"bodies and days." In seventeenth century hospitals, the specification of kept registers; their

<sup>284</sup> Foucault, *Discipline and Punish*, 181, 183, 194.

<sup>&</sup>lt;sup>285</sup> Ibid., 184-5, 192.

<sup>&</sup>lt;sup>286</sup> Foucault, *Birth of the Clinic*, 5.

<sup>&</sup>lt;sup>287</sup> Foucault, *Discipline and Punish*, 185-6.

<sup>&</sup>lt;sup>288</sup> Chief, interview.

<sup>&</sup>lt;sup>289</sup> Scott and Miller, "Trials," 118-20.

modes of transcription from form to form; their circulation in rounding; their handoff from doctors to administrators, and ultimately, to centralizing bodies solidified individuals as analyzable objects in disciplinary writing.<sup>290</sup> Table 4.1\* is merely the time-honoured extension of that process.

Table 4.1\*

IHA titers and skin test reactions in subjects from an amebiasis-endemic area

Reciprocal of IHA titer

		1			
Object	Age (yrs)	Pre-skin test	Post-skin test	Interval between serum samples (days)	Skin Test
DJ	6	128	512	17	+
JB-1	71	8	16	14	-
TB	80	256	4096	17	+
RM	50	64	1024	14	+
MD	36	8	128	16	+
JB-2	10	32	256	19	+
AM	10	64	512	15	+
MR	56	4096	4096	7 mos.	+
DC	20	128	512	27	+

Whether one agrees or not (and by saying that, it should be apparent I do not), Hacking's remarks seem pertinent:

[i]t is certainly not true that most of the applications of the new statistical knowledge were evil. One may suspect the ideology of the great Victorian social reformers and still grant that their great fight for sanitation, backed by statistical enquiries, was the most important single amelioration of the epoch. Without it most of you would not exist, for your great-great...-grandparents would never have lived to puberty. Statistical data *do have a certain superficial neutrality between ideologies* (emphasis added).<sup>291</sup>

This innovation—"good medical 'discipline'" (document accrual and seriation; the establishment of comparative fields to classify, categorize, fix averages or norms)—included means to retrieve individual 'data' (an individual) integrated into cumulative systems (the general register) while each datum from individual exams affected overall calculations. Series of *codes* transcribed individual features by means of homogenization<sup>292</sup>:

# Specific Objectives

Within the time frame of the study:

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<sup>&</sup>lt;sup>290</sup> Foucault, *Discipline and Punish*, 189, 190.

<sup>\*</sup> Source: Data from Meerovitch and Scott, "Skin Tests," 1135.

<sup>&</sup>lt;sup>291</sup> Ian Hacking, "How Should We Do the History of Statistics?," in *The Foucault Effect: Studies in Governmentality*, ed. Graham Burchell, Colin Gordon, and Peter Miller (Chicago: University of Chicago Press, 1991), 183-4.

<sup>&</sup>lt;sup>292</sup> Foucault, *Discipline and Punish*, 189, 190.

- 1. to analyse data relating to hospital admissions by *diagnostic code*, prepared by Statistics Canada, 1970-75 inclusive, for the registered Indian population of Saskatchewan.
- 2. to correlate hospital morbidity of Indians living on reservations with environmental data obtained from the environmental and community profiles of Medical Services, Department of National Health and Welfare.
- 3. to compare hospital morbidity of Indians living on reservations with that of Indians living off reservations and the total Saskatchewan population.
- 4. to draw conclusions concerning the association of specific environmental factors with specific reasons for hospital admission, especially the conclusions which indicate a need for special program emphasis [...]

Table 9. On-Reserve Indians as a % of Saskatchewan Population (1973); On-Reserve Indian Hospital Admission as a % of Total Hospital Admissions (1971-75); by Age Group and *CDL Codes 092, 093, 094, 095* 

Table 10. Number of Hospital Admissions Per 1000 Populations (1971-75)—On-Reserve Indian and Total Saskatchewan Populations by Age Group and *CDL Codes 180, 178, 171-177+179+181, All Conditions* (emphasis added) [...]<sup>293</sup>

Enter the "calculable man," or deviance defined: Foucault observed to analyze the normal, healthy, law-abiding citizen we pit foils of his/her inner childishness, secret madness, dreamt criminal activity.<sup>294</sup> He elicited the commemorative medal of Louis XIV's first military review (15 March 1666) to signify the transition to scientifico-disciplinary mechanisms of individuality, from historic-ritual mechanisms (formerly in Western society, individualization was greatest among higher echelons/monarchs—the 'memorable man' was memorable because written accounts, visual reproductions, and ritual designated him as such in an 'economy of visibility').<sup>295</sup> The king is pictured commanding the parade (ostensibly, an exam) holding a stick, with ranks of soldiers on his left full-face, holding rifles in their right arms vertically to shoulder height, right leg forward, left foot turned out; underfoot, a rectangle is depicted on the ground to guide them in the upcoming exercise: it is *disciplined* pomp and circumstance.<sup>296</sup> The same militaristic ceremony hauntingly characterized Chief's description of injections received on Treaty Day.

SC: —so...So when we had to go to school we had to follow their, uh, rules. So when we took the—we took the pills, we had to take the pills. But they were, like you said, uh...In my years, that I can remember, there was, uh, times that I seen, uh, like, I don't

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<sup>&</sup>lt;sup>293</sup> Dennis and Pearson, "The Effect of the Living Environment," 3, 5.

<sup>&</sup>lt;sup>294</sup> Foucault, *Discipline and Punish*, 193.

<sup>&</sup>lt;sup>295</sup> Ibid., 187-9, 192-3.

<sup>&</sup>lt;sup>296</sup> Ibid., 188.

know how you say it, uh...what is that, uh, word, where there were a whole box full of needles and...shots given to us, eh?

LW: Okay...

SC: On Treaty days! I remember, uh, some Treaty days, uh, I don't now how many—how old I was—

LW: Yeah.

SC: —but you had to have this shot!

DF: Right here, that forearm, right here.

SC: Yeah! I remember I had to have that.

LW: Did they ever tell you what they were for, or?

SC: No. I was too young to remember anything like that.

DF: It was x-rays and give us shots.

SC: Yeah. And when—

LW: On Treaty days...

SC: —we went to the, uh—we went to the Treaty day. And back then our people knew that in order for the treaties to continue we had to go to these, uh, to take the, uh—

DF: Needles and stuff.

SC: Needles and stuff, and whatnot. That was a requirement. There was a cop there, there was an RCMP there in a Mountie outfit, and he was there, dressed in, in his uniform, shaking peoples hands after they'd been shot with the needles and whatnot, eh? And there was strange looking pills back then too, eh—like I don't know, they were black little, like little beads—

LW: Yeah.

SC: —and you had to take those. I don't know what they were...

LW: On Treaty days you had to take them?

SC: On Treaty days we had—took em, yeah. 297

Foucault argued the major effect of Panopticism is that individuals, themselves, are the bearers of the power situations they get caught up in.<sup>298</sup> No doubt the astute reader has already noted the similarity between this observation and arguments presented in Chapter Three (Peepun's family took her to hospital, Betty admitted herself to the emergency room, and reserve residents choose to attend Foster's workshops<sup>299</sup>). Part one of our third, belabored methodological precaution seems an old hack: power should not be understood as one person's consolidated domination over a group or class; power is circulatory, not localizable, never held like a commodity or wealth; power is employed through "net-like organization" (recall my earlier description of a netted chain); individuals are not points of application but rather vehicles

<sup>298</sup> Foucault, *Discipline and Punish*, 201.

<sup>&</sup>lt;sup>297</sup> Chief, interview.

<sup>&</sup>lt;sup>299</sup> As discussed in Chapter Three; Mitsuing and Mitsuing, interview.

of power.<sup>300</sup> They say impositions are the best way of advancing one's progress by correcting past offences–perhaps "[t]o punish is to exercise" (which is what you, the reader, and I are currently doing)? <sup>301</sup> The morning of the Fort Qu'Appelle workshop opened with thirty-six delegates; by day two, there were forty-eight.

It was a problem solving session. What was their problem on the reserve as they saw it? The group leaders came up with the same problems I have mentioned, lack of water supplies, lack of waste disposal, and poor housing.

The theme for the week was 'self-help'. They recognized the problem—what could *they* do to help solve it?<sup>302</sup>

Comparatively, at the Driftpile event: "[a] minimum of time was given to lecturing [...] I might mention at this time that I feel the people are tired of talk and more talk and prefer getting action; "[t]his group of men enjoyed working with their hands [...] [g]uidance only was required"; [a]s these two projects were completed a look of *accomplishment*, *willingness and enthusiasm could be discerned on the faces of the men doing the actual work* [emphasis added]." Such is the work of a dispersed, automatic power, a network of relations that functions not only from top to bottom but bottom to top and laterally: "supervisors, perpetually supervised." In Bentham's *Panopticon* all that was needed was to put a supervisor in a central tower and shut in varying cells, say, a madman, patient, criminal, worker, schoolboy; through backlighting, the supervisor observed the silhouetted activity of those in the peripheral cells like cages, "like so many small theatres," wherein each person was perfectly individualized in constant visibility. It was above all a mechanism of spatial unities to transform behavior. Which is, again, reminiscent of the necessitated rows of two-hundred-by-two-hundred foot housing lots before sewage/water was granted. And anyone can operate the machine.

<sup>300</sup> Foucault, Power/Knowledge, 98.

<sup>&</sup>lt;sup>301</sup> Foucault, *Discipline and Punish*, 179, 180.

<sup>&</sup>lt;sup>302</sup> Freestone, "Environmental Sanitation," 26.

<sup>&</sup>lt;sup>303</sup> Butler to Area Director, "Sanitation Workshop," 2.

Foucault, *Discipline and Punish*, 176, 177.

<sup>&</sup>lt;sup>305</sup> Ibid., 200.

<sup>&</sup>lt;sup>306</sup> Scott, interview, 25 June.

<sup>&</sup>lt;sup>307</sup> Foucault, *Discipline and Punish*, 202.

Part two is almost second nature: certain gestures, desires, bodies, behaviours, discourses are constituted by power as individuals<sup>308</sup>; we met our 'calculable man'.<sup>309</sup>

Foucault's fourth methodological caution provides an interesting challenge to readers. He cautions against *deductions* of power, starting at a perceived centre with the aim of discovering the extent to which power permeates and reproduces itself down to the base elements of society; rather, researchers should conduct 'ascending analysis', working from (seemingly) insignificant societal mechanisms with specific histories and trajectories up to determine how global mechanisms invest, colonize, utilize, involute, transform, displace, or extend them. <sup>310</sup> In a review of Colonizing Bodies that appeared in a 2000 edition of The American Historical Review, Bracken critiqued Kelm for "consistently elid[ing] the distinction between what was and what was said"; ignoring Foucault's claim that the body is an artifact of discourse; "fail[ing] to adopt a critical stance toward the colonial archive supplying the bulk of her 'data'," "twenty years after the publication of Edward Said's *Orientalism* (1978)"; falling back "into the very discourse she begins...critiquing" through a "ghoulish survey of causes of death, population growth and decline, mortality rates, and hospital admissions."<sup>311</sup> But there is a bigger issue with her work. As an exemplar, Foucault outlined descending analyses of bourgeois repression of infantile sexuality from Wilhelm Reich and others: from the seventeenth and eighteenth centuries onwards, all forms of expenditure beyond industrial productivity were banned, repressed, etc. But the opposite argument is easily made, by appealing to the same principle (i.e. dominance of the bourgeois class) that in an ideally executed capitalist system the workforce should be infinite, and therefore sexual precociousness and training encouraged. Foucault made similar claims about the internment of the mad-throwing them to the dogs makes more sense in an industrialist system. Summarily, he argued these deductions are unendingly possible, simultaneously right and wrong, and primarily glib because one can unvaryingly rationalize the opposite viewpoint.<sup>312</sup> Elsewhere he refers to the problem as the "inhibiting effect of global, totalitarian theories"; the chink in our fundamental understanding of existence exposed by fragmentary, discontinuous researches (discussed in the introduction to the Chapter, above); for although Marxism and

<sup>&</sup>lt;sup>308</sup> Foucault, *Power/Knowledge*, 98.

<sup>&</sup>lt;sup>309</sup> Foucault, *Discipline and Punish*, 193.

Foucault, *Power/Knowledge*, 99.

<sup>&</sup>lt;sup>311</sup> Christopher Bracken, *American Historical Review* 105, no. 2 (April, 2000): 534.

<sup>&</sup>lt;sup>312</sup> Foucault, *Power/Knowledge*, 99-100.

psychoanalysis, for example, provided useful tools for local research, they are given to the point that their internal, theoretical unity is curtailed or-if you will-thrown by the wayside, caricatured, theatricalised.<sup>313</sup> So let's pose a question: what else are Kelm's comments about "disinterested colonizers" besides deduction? Shall we revisit:

Men like [these] were reluctant, even disinterested colonizers. Their interest lay in creating a settler society that could supercede the First Nations' place in the province, rather then in practicing a medicine that could incorporate them into a new society. Yet this colonial medicine did work to create the cultural vestiges of more stable, economically viable settler communities that could boast to investors, resource companies, government spenders, and settlers alike that they too had the amenities of 'modern' life 314

Men always colonizing (true and not)-bourgeois interest as the starting point for analyses as opposed to 'mechanisms' bypassing color lines. You are smiling now because you see the mess I have made of Freestone's remarks above; whatever 'problems' he had "with an ethnic group whose culture is much different from our own [emphasis added]," whatever their income or "educational standard," however much the 'Savage' whittled time away "not particularly caring about tomorrow" in an endlessly new and repeated subset of the 'tale of two sorts, 315 Butler proposed the non-Aboriginal Public Service nurse should:

foster in employees the knowledge to promote their own and their families' good health. Subjects which may be involved in such activities include personal health and hygiene, emotional health, problem drinking, nutrition and food budgeting, recreation, home and family problems, maternal and child health, job adjustment and vocational guidance, excessive absenteeism and work environment[...]

<sup>&</sup>lt;sup>313</sup> Ibid., 80, 81.

<sup>314</sup> Kelm, *Colonizing Bodies*, 135.

<sup>&</sup>lt;sup>315</sup> Freestone, "Environmental Sanitation," 25; Bracken, Magical Criticism, 22-53. Drawing from Marx's interpretation of Adam Smith's *The Wealth of Nations*, Bracken argues the 'tale of two sorts' contrasts two incompatible modes of time: future-oriented time, characterized by industry and frugality, "is the temporal mode of civilization," whereas now-time, inciting instantaneous expenditure and improvidence, "is the mode of 'wild-life' or savagery. It is an ethnocentric/moralistic (if not directly racist) tale: "[s]avage nations, though they accumulate without cease, are nonetheless guilty of the sin of waste, notably waste of life," while civilized nations, though supporting the unemployed-for-whatever-reason, "perform a scarcity of toil yet enjoy a surplus of stock." Marx argues such "insipid childishness" is recited all the time, though seems to belong to no time at all; Bracken adds that it means the 'tale of two sorts' belongs to one of the sorts it describes: the tale exceeds the limits of its context just like 'savage' economy exceeds thrift and foresight. See ibid., 24, 26, 28, 30.

The nurse participates, where required, in the local administration of environmental health programs and may advise management concerning the need for supervision or control of occupational or environmental hazards which may come to her attention. She is concerned with the general medical supervision of sanitary conditions[...]<sup>316</sup>

Which brings us to our fifth and last methodological precaution. Foucault granted the possibility that major mechanisms of power are accompanied by ideological productions—he conceded there is (likely) an ideology of education, the monarchy, parliamentary democracy, etc. But, he warned what took place was beyond (both more and less than) ideological, and instead the creation of apparatuses of knowledge, methods/techniques of observation, registration, research and investigation, control.<sup>317</sup> In *Discipline and Punish* he described two distinct utopias, two alternate political dreams of our society: 1) the leper's exile-enclosure towards a pure community and 2) the plague-stricken town's strict partitioning in a disciplined society, the perfectly governed city back-ridden by disciplinary writing, superfluous hierarchical observation/surveillance, as discussed above; at the base of disciplinary projects, the image of the plague equates to chaos, while the leper marks the necessity for exclusion, to severe human contact. 318 They are not mutually incompatible. Rather, from the nineteenth century on the strategy was to treat the 'leper' as 'plague victim', projecting scrupulous, tactical partitioning onto spaces symbolically filled with 'lepers', though actually occupied by madmen, beggars, vagabonds, etc.; "individualize the excluded, but use the procedures of individualization to mark the excluded." Authorities exercising individual control—in psychiatric asylums, penitentiaries, reformatories, hospitals, and schools—operated according to a double mode: binary division (insane/sane, delinquent/non-delinquent, patient/healthy-person, abnormal/normal), and coercive assignment (who is he, where should he go, how should we characterize him, how should we recognize him, etc.). In conclusion, he acknowledged,

[t]he constant division between the normal and abnormal, to which every individual is subjected, brings us back to our own time, by applying the binary branding and exile of the leper to quite different objects; the existence of a whole set of techniques and institutions for measuring, supervising, and correcting the abnormal brings into play the disciplinary mechanisms to which the fear of the plague gave rise. All the mechanisms of

Roy to Webb, "The Role of the Public Service Nursing Counsellor," 1.

<sup>&</sup>lt;sup>317</sup> Foucault, *Power/Knowledge*, 102.

<sup>&</sup>lt;sup>318</sup> Foucault, *Discipline and Punish*, 198-9.

power which, even today, are disposed around the abnormal individual, to brand him, and to alter him, are composed of those two forms from which they distantly derive.<sup>319</sup>

So I pose the question: are 'post-colonial' studies a 'science', in something of a reversal of Arnold's colonialism-writ-large?<sup>320</sup> Ideological productions, granted, but consider the implications of our genealogical 'exercise' on Kelm's piece, tied as it is to the function and parameters of 'scientific' discourse in our society, embodied in the university or, really, any educational apparatus—'theoretical-commercial institutions'—like, to borrow Foucault's exemplars again, psychoanalysis or Marxism?<sup>321</sup> Bracken singularly suggested that *Colonizing* Bodies showed "what white audiences continue to want to know about First Nations in 'Canada' is how they fall ill and how they die.",<sup>322</sup> (Was that the specter leading me forward during those interviews?) Foucault elucidates a second, less obvious, follow-up: before we can determine whether or not something (in his case, Marxism or psychoanalysis) is comparable to a scientific practice in terms of its functioning, construction, etc.—draw the formal analogy—surely we should question what we wish to gain by adopting the power assumed to go along with scientific discourse?<sup>323</sup> Hidden in an apriorism like Kelm's is a discourse operating via the duality just detailed, whereby racial binary (aboriginal/non-aboriginal) is folded onto the kind of 'centralized theoretical productions' disciplinary powers bring into play: "individualize the excluded, but use the procedures of individualization to mark the excluded [emphasis added]."324

\* \* \*

At the close of this exercise, it seems the most pertinent way to move forward would be to summarily answer the research questions posed in Chapter One: namely, how or why did a colonialist discourse transect a clinical and positivist discussion of an amebiasis outbreak in Loon Lake and its surrounding area; and, how do local reserve residents' perspectives on the outbreak and its connected drug trials obscure colonial and/or medical discourses? Our discussion will be loosely organized under headings derived from my opening comments on 'space', 'language', and 'death'; 'gaze' will be referred to intermittently throughout.

<sup>&</sup>lt;sup>319</sup> Ibid., 198, 199, 200.

<sup>&</sup>lt;sup>320</sup> Discussed in Chapter One; Arnold, Colonizing the Body, 9.

<sup>&</sup>lt;sup>321</sup> Foucault, *Power/Knowledge*, 84.

<sup>&</sup>lt;sup>322</sup> Bracken: 534.

<sup>&</sup>lt;sup>323</sup> Foucault, *Power/Knowledge*, 84.

<sup>&</sup>lt;sup>324</sup> Ibid., 81, 83; Foucault, *Discipline and Punish*, 199.

#### **DEATH**

From our examination of 'serious speech acts' in Chapter Two, distinguishing 'modern' from 'post-modern' medical 'gaze' in linear time, it became apparent that in an effort to maintain "theoretical unity" Kelm glossed over a discourse—'la clinique'—so pervasive we have yet to disentangle ourselves from it in 'western' society, and which manifests itself along flows of power (in this case, race-based inequity) toward the singular aim of objectifying patients.

I took my promise to avoid damning one type of medical practice or another seriously in Chapter Two, and that particularly meant the death-bearing, death-centric perspective espoused by 'modern'/'post-modern' clinicians resulting in oxymoronic statements to the effect that Eaton could announce to Meerovitch his hopes would be dashed because permission for autopsy was refused. 326 I refrained from engaging in Jones' 'howls' of 'criticism', pronouncing my definitive 'commentary' on the ethics of those trials because, quite frankly, could I-did it show 'moral astigmatism' to have Ministikwan serve as a control while Loon Lake went treated, considering the potential efficacy of the drug was unknown, considering Loon Lake community members were already tiring of the battery of trials, considering the number of clinical cases and deaths to that point was grave? (And I should now note the Loon Lake trials are *just* related to the Tuskegee Experiment ethically.) Am I so qualified? (Insert the plethora of clichéd phrases/maxims that come to mind: 'hindsight is twenty-twenty', 'people in glass houses should not throw stones', 'let he who is without sin...', etc.) Instead, my interest lay elsewhere, as Foucault's did in Birth of the Clinic but in connection to our Loon Lake case: in determining the unspoken parameters that systematized physicians language/discourse from the outset; what could be seen versus what was said; more fundamentally, understanding language at the level where 'things' and 'words', 'seeing' and 'saving' were inseparable<sup>327</sup>; mapping flows of power that determined gesture, governed behaviour, produced bodies, and importantly, constituted the 'subject' as an 'object' of knowledge. This was not an arbitrary decision.

We already observed, to Bracken's credit, that *Colonizing Bodies* showed that what 'white' audiences continue to want to know about First Nations is how they fall sick and die<sup>328</sup>; we discussed the perpetuation of dualistic discursive modes regarding the 'Aboriginal' person-

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Foucault, Power/Knowledge, 81.

<sup>&</sup>lt;sup>326</sup> RG 29, Eaton to Meerovitch, 23 December 1965.

<sup>&</sup>lt;sup>327</sup> Foucault, Birth of the Clinic, xii, xxi.

<sup>&</sup>lt;sup>328</sup> Bracken: 534.

patient. That street goes two ways, if my reader will permit me to conduct the sort of ascending-descending analysis Foucault did with Reich's arguments on bourgeois repression of infantile sexuality. As discussed in Chapter One, and readdressed in the current Chapter, through the elision of the term 'colonial medicine', and the individualization of the 'aboriginal'/'colonized'/'patient', we—or better yet Kelm, and other scholars who reason along this vein—created the correlating *always colonizing* 'doctor': a new 'subject' in the enduring creation of discourse on discourses, against whom all the procedural forces to mark 'the excluded' can be (and have been) brought to bear. If we are honest with ourselves about the type of ideological or theoretical stamp applied through that act, it can be said that this denotes a clash of discourses—earlier I remarked that Kelm subsumed medicine in colonial discourse, but she further pitted 'post-colonial' history as a discourse over medicine in a power-play. To rephrase Bracken's assessment, perhaps what we continue to want to know about physicians in a historical context like the outbreak at Loon Lake, and its subsequent drugs trials, is how they make mistakes, how their "interest lay in creating a settler society that could supersede First Nations." 329

The precipitate of the 'gaze' of physicians affiliated with the drugs trials at Loon Lake and its neighboring area—whether federally-employed, the 'man-on-the-spot', or researchers linked to a university and receiving grant funding—draws either from a colonialist or a 'modern' (anatomo-clinical)/'post-modern' medical discourse, as already stated. But importantly, studies like what Kelm, Arnold, and I have produced reopen events like the dysentery outbreak at Loon Lake to discourses again and transform them, branding their actors for good or ill as 'subjects'. By meticulously investigating the unacknowledged, unspoken structure underpinning anatomo-clinical language, where the line between what is seen and what could be said is blurred in the wake of a death-bearing perspective, we have elicited our own blurred lines, or *a priori* as historians.

#### **SPACE**

The flip-side of the *always colonizing* 'doctor' as the 'subject' of a discourse like Kelm's is, of course, the *always colonized* 'patient'. If, in their most 'reluctant, disinterested' moments physicians practicing in rural Canada among First Nations "never forgot their part in expanding

<sup>329</sup> Kelm, Colonizing Bodies, 135.

the frontiers of Anglo-European ascendancy," 330 then correspondingly in their most interested moments in receiving 'western' medical care-from our examples, Peepun's family objecting to her expressed demand and driving her to hospital, Betty walking herself through local emergency room doors, reserve members' keen interest in Foster's sanitation workshops—'Aboriginal' persons/'patients' repetitively and actively participated in that as well. Is it fair to assess a tenor eleven-year-old Ministikwan girl with having done so when she showed up to hospital to deliver her baby, or Alex for continuing to pursue fertility options/treatment in light of a primary diagnosis of infertility, or an entire community for sharing the opinion St. Walburg was a better option for 'their people'? Chief reported his family 'willingly' took medication while others did not; Betty and her extended family sought hospital treatment while Rita bathed Christopher in a natural salt lake: does that make those 'others' or Rita better 'Indians' over, say, the boy (Chief) who stayed-up nights listening to Elders' stories 'round the campfire-'Black Skin, White Masks' and all that business?<sup>331</sup> The incipient message of a discourse like Kelm's (or even Kevin Washbrook's regarding Stó:16 dietary practice) is the *only* way an Aboriginal person can 'contest', to borrow Arnold's phrasing, 332 is by drawing on a traditional archive of Aboriginal knowledge, never by telling someone, as Betty did, that her doctor treated her poorly, or by questioning whether involuntary sterilization was in actuality performed, or by scowling at the (re-)discovery that one's community was experimentally used, or by remarking that physicians 'get paid a lot to see a patient' but their attitude is to shuffle Native patients through<sup>333</sup>; that is all 'appropriation'. The 'full space' in which discursives like this find support denies members of an Aboriginal community like Loon Lake or Ministikwan the capacity to make informed (perhaps 'adult' would too strongly reprimand scholars working with gusto in this *avant-garde*) choices from options available to them on the discourse-horizon of their society toward health and healing.

Which is the equivalent observation to Freire's remark that all tries to soften the 'oppressors' power by deferring to the weaknesses of the 'oppressed' manifest as a false

<sup>330</sup> Ibid., xix.

<sup>&</sup>lt;sup>331</sup> Mitsuing and Mitsuing, interview; Loon Lake area community member, interview; Chief,

<sup>&</sup>lt;sup>332</sup> Arnold, *Colonizing the Body*, 10.

<sup>333</sup> Mitsuing and Mitsuing, interview; Loon Lake area community member, interview.

Foucault, Birth of the Clinic, xii.

generosity without the dualism it infers.<sup>335</sup> Chapters Three and Four placed 'local criticism' above a 'theoretical-political *avant-garde*' to map the complexity of a type of 'structural violence'. Chief and other Loon Lake and Minstikwan reserve members' 'gaze', as well as letters and official publications roughly lumped under the domain of public health (and topically on sanitation), obscure colonial, medical, and, by extension, post-colonial discourses through an inherent ambiguity countering *placement* (stasis) within/by their bridled discursive codes; as already stated, they eschew paradigmatic dichotomies ('oppressor'/'oppressed', 'colonizer'/'colonized', Aboriginal/non-Aboriginal, *abnormal*/normal). Freire also observed it was "the great humanistic and historical task" of the 'oppressed' to liberate themselves and the 'oppressor'<sup>336</sup>: could it be we have argumentatively arrived there with some hairsplitting, or lack thereof?

#### **LANGUAGE**

This last statement, rift as it is with contradiction, points to the stated goal of this thesis to 'doublethink' events associated with the historical outbreak of dysentery at Loon Lake and in its surrounding area. The reader no doubt noticed I conveniently 'forgot' facts when they inconvenienced me–e.g., in Chapter Two, I drew the comparison between the metronidazole trails at Loon Lake and contemporary Tuskegee Syphilis Experiment to incite a discussion on the so-called 'science of inhumanity', while in the current Chapter I dismissively comment they are not *so* related; on the one hand, I held Eaton up as the paragon of 'post-modernist' medical discourse using his phrase 'perhaps he did not worry too much about a few deaths', '337 then on the other, repeatedly hearken back to his letter to Meerovitch on dashed, and decidedly 'modernist' hopes for a post-mortem '338'; in Chapter Three, I say Loon Lake and Ministikwan community members had limited knowledge about the 1960s and '70s drug campaigns, then turn around and say, 'but they have in-depth knowledge of those trials'; I analyzed Freestone's remarks on 'dealing with an ethnic group whose culture is different than our own' as indicative of early twentieth century racist attitudes about 'changing' Aboriginal bodies before ultimately characterizing his actions as evidence of a disciplined society. More duplicitously, I

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<sup>&</sup>lt;sup>335</sup> Freire, *Pedagogy of the Oppressed*, 44.

<sup>336</sup> Ibid

<sup>&</sup>lt;sup>337</sup> RG 29, Eaton to Schaefer, 16 May 1970, 2

<sup>&</sup>lt;sup>338</sup> RG 29, Eaton to Meerovitch, 23 December 1965.

<sup>&</sup>lt;sup>339</sup> Freestone, "Environmental Sanitation," 25.

avoid definitive 'commentary' on the historical actions of doctors associated with the Loon Lake trials, selected just snippets to 'comment' on from an abundance of stories by Loon Lake/Ministikwan residents, then continuously and unrelentingly infer deeper meaning in Kelm's statements than her signifiers suggest. 'Doublethinking' comprises this: telling intentional lies while simultaneously believing them, denying objective reality though accounting for it in the final reckoning, necessarily placing the lie one step ahead of the truth to use the word 'doublethink' in the first place. Stated abstractly as such, my reader may object saying, 'this is all too relativistic'. But each and every day we put into play superabundance of discourse-proper, folding codes into day-to-day conversation, 'subject'-ing and 'object'-ing others and ourselves without limit; practically speaking, we did not struggle to accept analyzed cross-sections of resected colons alongside Betty's account of her anger at accused suicide, or Alex's upset at an unexpected salpingectomy, or Chief's contextualization of the purpose behind the Sun Dance where stool samples were taken because human beings are capable of complex, contradictory, and non-linear thought. In writing the history of the present we have to move the conversation past discourse that would divide us from our-(true) selves.

If the 'soul' Foucault described is at once the result of a certain 'correlative of power over the body', or the "prison of the body," then perhaps what is most evident for us is the truth behind Bracken's assertion that in the history of ideas there has been a *ricorso* to 'savage' philosophy—i.e. that "discursive forces have more than discursive consequences." Let's return to the image of Crookedneck picturing her childhood-self in her mind's eye looking at her nurse look at her doctor: it is *ekphrasis*, or a picture painted in words that "addresses its audience from within the borders of a text." The 'meaning' that has taken shape that hangs over us, "awaiting in the darkness for us to attain awareness before emerging into the light of day," is that perhaps we are still haunted by a perverse specter not unlike Bracken's cited description from the novel *Solaris* of a "giant Negress" with "rolling gait" and yellow grass skirt. Earlier I

<sup>&</sup>lt;sup>340</sup> Orwell, Nineteen Eighty-Four, 244.

Foucault, Discipline and Punish, 29, 30.

<sup>&</sup>lt;sup>342</sup> Bracken, *Magical Criticism*, 14, 206. Bracken borrows the Latin '*ricorso*' (recourse) from Giambattista Vico's *The New Science of Giambattista Vico*.

<sup>&</sup>lt;sup>343</sup> Ibid.. 5.

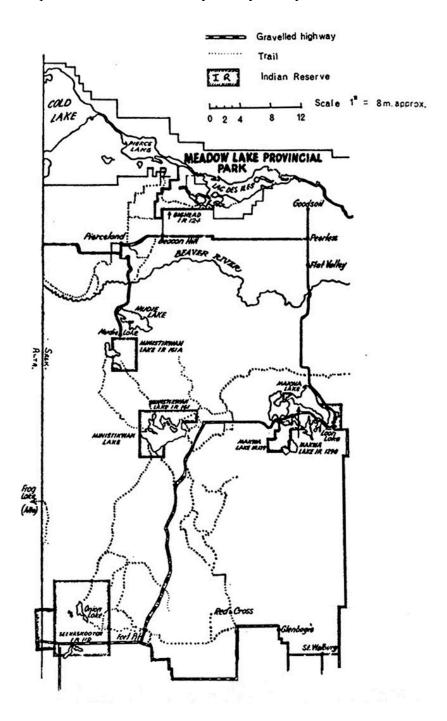
<sup>&</sup>lt;sup>344</sup> Foucault, *Birth of the Clinic*, xvii. See also my comments on Foucault's discussion of Nietzche (Chapter One).

<sup>345</sup> Bracken, Magical Criticism, 208.

stated this thesis is about "the *living* reservoir of *living* language" (emphasis added)<sup>346</sup>; Chief's foiled image to Crookedneck's ekphrasis sees himself through a child's eyes dropping the dictionary and geography textbook, not wanting "to go through that again." 347 But 'we have to learn to use' that.

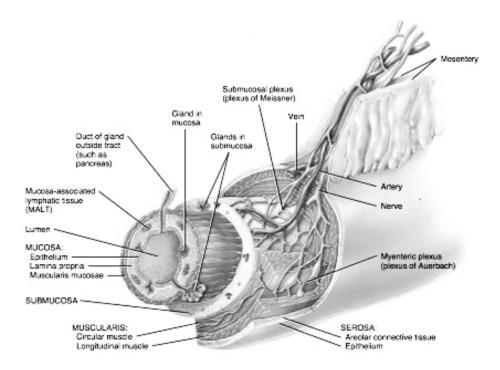
<sup>&</sup>lt;sup>346</sup> Ibid., 13. <sup>347</sup> Chief, interview.

APPENDIX A: Map of the Areas Affected by the Dysentery Outbreak



A.1. Map of area showing the location of Indian reserves affected by the dysentery outbreak. Note: Loon Lake is alternately called Makwa Lake, with 'mâkwa' translating to 'loon' from Cree. Image from Eaton, "Amebiasis: Epidemiological Considerations," 706.

APPENDIX B: Figure of the Small Bowel Wall, and Original Tables from Meerovitch and Eaton's "Outbreak of Amebiasis"



B.1. Layers of the small bowel wall. Importantly, this illustrates the respective locations of the mucosa, submucosa, and serosa (or serosal wall). Image from Tortora and Derrickson, Principles of Anatomy and Physiology, 1006.

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 ${\rm B.2}^{\star}$  Results of examinations of 178 fecal specimens broken down according to place of residence

Reserves	No. exam	Infected		I	Entamoeba	histolytica	ı	Entamoeba hartmanni				Cysts of							
		No.	%	No. spec. with		Total Cases		No. spec. with		Total cases		Entamoeba coli		Endolimax nana		Giardia lamblia		Chilomastix mesnili	
				Cysts	Troph s	No.	%	Cysts	Trophs	No.	%	No.	%	No.	%	No.	%	No.	%
Loon Lake	91	61	67.9	15	14	23	25.3	3	3	4	4.4	35	38.5	17	18.7	13	14.3	7	7.7
Ministikwan	75	53	70.7	22	9	25	33.3	4	3	5	6.7	28	37.3	16	21.3	9	12	1	1.3
Bighead	12	10	83.3	5	2	7	58.3	2	1	2	16.7	6	50	1	8.3	0	0	0	0
Totals	178	124	69.7	42	25	55	30.9	9	7	11	6.2	69	38.8	34	19.1	22	12.3	8	4.5

 $$\mathrm{B.3}^{*}$$  Results of examinations of 178 fecal specimens broken down according to age groups

		Infe	Infected		Entamoeba histolytica				Entamoeba hartmanni					Cysts of							
Age groups (years)	No. exam	No.	%	No. spec. with		Total Cases		No. spec. with		Total cases		Entamoeba coli		Endolimax nana		Giardia lamblia		Chilomastix mesnili			
				Cysts	Trophs	No.	%	Cysts	Trophs	No.	%	No.	%	No.	%	No.	%	No.	%		
0-4	57	34	59.6	11	13	19	33.3	0	2	2	2.5	14	24.6	6	10.5	9	15.8	2	3.5		
5–9	51	40	78.4	14	5	16	31.4	2	1	2	3.9	23	45.1	17	33.3	9	17.6	0	0.0		
10–19	24	19	79.2	8	1	8	33.3	2	1	2	8.3	13	54.2	4	16.7	2	8.3	2	8.3		
20+	46	31	67.4	9	6	12	26.1	5	3	5	10.9	19	41.3	7	15.2	2	4.3	4	8.7		
Totals	178	124	69.7	42	25	55	30.9	9	7	11	6.2	16	38.8	34	19.1	22	12.3	8	4.5		

<sup>\*</sup>Source: Data from Meerovitch and Eaton, "Outbreak of Amebiasis": 720.

## APPENDIX C: Transcript of Sidney Chief's Interview

C. 1. Date: Monday, July 14<sup>th</sup>, 2008

Interviewee: Sidney Chief Interviewer: Lesley Wiebe

Location: Ministikwan, Sidney Chief's home

Lesley Wiebe: Well...alright.

Sidney Chief: Dion might wanna say a prayer? Naw, I'm just kidding! [laughter] LW: Ok, so, do you...I guess, how—maybe we should start with a little background information?

SC: Yeah.

LW: About you? SC: Yeah, go ahead.

LW: Just say who you are and, for the record—oh, and first I should say it's Lesley Wiebe and I'm interviewing Sidney Chief and the date is the...14<sup>th</sup>?

SC: Mmhmm. LW: —of July.

SC: Yes. My name is Sidney Chief. I am from Island Lake First Nations [sic], otherwise known as Ministikwin. I was born in, uh, on the reserve here, uh, in 1959. Uh, February 23. Is that it?

LW: Uh, yep, that's good.

SC: Okay. Hope that you can—that's clear.

LW: —Oh it should be.

SC: Sometimes it's a little bit...Yeah, okay.

LW: Yeah, it's...I got a—I've got it set on the—the—so it picks the most sound that—possible.

Yeah. [laughter] SC: Mmm, okay.

LW: So, first of all I guess I should ask, um, do you have any recollection of the dysentery outbreak?

SC: What is that?

LW: It's, um, you get pretty rampant diarrhea.

SC: Oh, I remember...long ago, I can remember a young person—being a young person, I don't know maybe five...four...and we were in a—we were in a Sundance...and there were nurses—and this is a sacred event by the way: Sundance. And what they—what happened is, uh, they were giving boxes to people, little—little...like those margarine things.

LW: Okay.

SC: And they were giving people to go to the bathroom with those things. And, uh, people were shy! But, they needed, uh, information, and they need—they required—

LW: Huh.

SC: —and they were—everybody was, uh, having, uh, diarrhea problems. And there was, uh, supposedly a medication for that as well.

LW: Yeah.

SC: But you had to go and see your own physician.

LW: Okay.

SC: So, I—that's all I remember.

LW: That's—that's good though. With the Sundance, like, 'cause it is a sacred event—

SC: Mmhmm.

LW: —do you remember people being concerned, like, about the fact that nurses were

there...doing this?

SC: Well...

LW: Like was that invasive, or?

SC: Because it was sacred event. At—those days it was very sacred.

LW: Yeah.

SC: Not like today: people come and go.

LW: Okay.

SC: Like it was, uh, an exhibition or something, but back then the elders were very rigid with their, uh—they weren't allowed to come and go as they pleased.

LW: Mmhmm.

SC: Even the Native people weren't allowed to even drink in the premises.

LW: Right.

SC: So, but, people were talking amongst themselves that there was an epidemic at the time.

LW: Yeah.

SC: I can remember, you know, maybe there—like it was, it's like—vividly like a dream?

LW: Mmhmm.

S: But I remember yeah, we were—everybody was having problems, and we wanted to participate in this event!

LW: Right.

SC: And it was like, uh, it wasn't very nice. [laughter]

LW: So, were people, was the Sundance held because everybody was sick?

SC: No, uh, a Sundance, I don't wanna go into detail but—

LW: Yeah.

SC: —a sun—a Sundance is, uh, predetermined.

LW: Okay.

SC: I was set up by somebody that needed to...to deal with these issues—

LW: Okay.

SC: —and when, when they did it was pre—setup ahead of time—

LW: Yeah.

SC: —like it had nothing to do with, uh—it's part of life.

LW: Yeah.

SC: It's part of tradition—

LW: Okay.

SC: —that they have it. And it's, uh—there's always somebody that had it—

LW: Yeah.

SC: —different people...and it's odd that people knew what was happening.

LW: Hmm.

SC: It was like a moccasin telegraph, everybody knew.

LW: Right.

SC: You know.

LW: Hmm...hmm. And so the nurses they came and they had people—they just said, "Can you please"—

SC: Yeah.

LW: —"go to the bathroom in this"—

SC: Yeah, yeah, yeah!

LW: —"and then we'll take it and look at it," is that what they said?

SC: Yeah, they were giving containers and what not.

LW: Okay.

SC: A part of, uh, maybe, maybe I'm—could be thinking of a—a different, uh, outbreak.

LW: Mmhmm.

SC: I think there was a time even that we had, uh, issues of worms.

LW: Okay.

SC: I think there were time too we had, uh, what do you call those things, uh, they come out of a bum?! [laughter]

LW: Yeah, yeah, yeah!

SC: I don't know.

LW: It's the worms that little kids get sometimes right?

SC: Yeah, but I think back then too they were talking about tapeworms.

LW: Okay.

SC: And diet consisted of fats back then—

LW: Mmhmm.

SC: —and, uh, today…like I told you before, diabetes was rampant today, but back then everybody was, uh, uh, traditional foods.

LW: Yeah.

SC: But then we had also had fats, whatnot, were being introduced into, uh, modern cross-cultural foods, so to speak—

LW: Right.

SC: —so that too may have had a play in it but we had—people were suffering from, may—I don't know if they were, what kind of worms they were, but they were giving people medication for that as well.

LW: Hmm.

SC: I remember that part too.

LW: Hmm.

SC: And it was also—I think that's when the governments knew that people would come together—

LW: Yeah.

SC: —was in the Sundance—

LW: Yeah.

SC: —and that's when they, uh, sent their nurses in.

LW: Right.

SC: I have that in my head that maybe that's why they sent—

LW: The nurses—

SC: —that's the only time that big gatherings were taking place.

LW: Yeah.

SC: And every reserve had that function—

LW: Right.

SC: —every reserve had every summer a gathering somewhere.

LW: Hmm.

SC: One month it would be in Mudie Lake, Ministikwin, Waterhen, Loon Lake, Joseph Bighead, even the bigger reserves like Thunderchild and Onion Lake.

LW: Hmm.

SC: But I think these people here, amongst themselves, were isolated and had their own, uh, uh, I don't know how you'd call it but a kind of uh, uh, work together—

LW: Hmm.

SC: —as a, uh...cause it—I think at one time they had all belonged to one—

LW: Mmhmm.

SC: —community. One major, uh, point where they all located.

LW: Okay.

SC: But anyway when they had the Sundances, they all seemed to know what months to have it—

LW: Hmm.

SC: —and, uh, the people that were setting them up knew when—who was setting up a Sundance so they didn't, uh, infringe on, or step on other peoples toes, so to speak.

LW: Okay.

SC: Yeah.

LW: Okay.

SC: So they knew. I don't know how, but they knew.

LW: Hmm, hmm. So, with the medication, do you remember was that something that everybody had to take, or did you just take it if you were sick, or?

SC: Well...[laughter] I think my family—I think they—they were willing—

LW: Okay.

SC: —because they, they knew—they knew they had to take it.

LW: Hmm.

SC: I don't know about other families but I think there—there's always a case where there's one that's not willing?

LW: Right.

SC: But we—I think my family were willing.

LW: What would make somebody willing or not willing?

SC: At the time, people were cautious about white people.

LW: Yeah.

SC: They were always cautious about white people—

LW: Mmhmm.

SC: —and their doings. Coming and goings. They were all cautious.

LW: Yeah.

SC: Uh, anytime you see a white man, it was tension among the herd. [laughter]

LW: Yep! [laughter] Yeah.

SC: So, yeah, like until...in that...those people left, and everything was back to normal. That's how I saw it anyways.

LW: Right. Hmm. So, um, I guess. If—was there a perception that, like, 'cause, you know there was sort of this dysentery outbreak, and there was medication *they* were giving out—the nurses—were there—was there perception that this would be *helpful* among, like, some people obviously thought it would be helpful and took it, and others, did they go to traditional healing methods, or?

SC: Yeah, uh...that I'm saying is because not too many people were allowed to practice traditional healing it was, uh, like, uh, bootlegging—

LW: Okay.

SC: —type of method, where you weren't allowed to be practicing herbs and medicines, eh, like, uh, traditional, traditionally every band had an—uh, a few people that were practicing—LW: Okay.

SC: —healing and they, uh, interworked with other communities how to deal with, uh, problems. Like midwifes for instance, *per se*, you know they had—they knew how to deal with, uh, uh, bringing up children.

LW: Right.

SC: So with, uh, traditional healing in, like you say, some people *had*. But they were very, uh, secretive about it.

LW: Okav.

SC: They weren't, uh—you didn't wanna let people know that you were a—a medicine man—

LW: Right.

SC: —or a medicine woman.

LW: Okay.

SC: I don't know if, uh, they were fearing that if they said some—anything about it that there was a law against it. But I think, uh, when treaties were made there was, uh, alot of things banned—

LW: Yeah.

SC: —from our people in, like I said, uh, there was a period of time when you couldn't, uh, share medicines with other communities. 'Cause not all the medicine that we have here grow over there.

LW: Oh-

SC: In other different communities, right.

LW: —okay.

SC: But back before the treaties everybody knew to go to a certain point in a district, or community, that had these plants. So they were always sharing...and trading—

LW: Yeah.

SC: —but when the treaty's made that stopped.

LW: Right.

SC: The only time they came together was in the Sundance.

LW: Hmm.

SC: That, I, I don't know...if, uh...But I remember when I was a kid, Sundance was allowed—

LW: Yeah.

SC: —and that's when, uh, I think that was—it was banned and you could go to different communities. But before that I think they weren't allowed to go anywhere.

LW: Hmm.

SC: I think before my time.

LW: Right.

SC: I think there's an emphasis on that in a point because another time when I was a young man, I think it wasn't allowed. But before my time they weren't allowed to go anywhere.

LW: Right. Hmm. So...with the, um, like I'm trying to draw out the connection between this sort of incident, the dysentery outbreak, with the rampant diarrhea, and then the medicine chest clause.

SC: Oh! Okay.

LW: 'Cause I, uh—I see on the one hand that, like—okay, so—

SC: Well, the medicine chest clause. When they signed the treaty, it was understood that the white man would help people when they were, er, sick—

LW: Yeah.

SC: —they would come out and...help the people with any illnesses and what not. But, we still—I had some of the best, uh, medicines—

LW: Mmhmm.

SC: —unlike, uh, the pills and what not that they had. Plus, we had to go somewhere far just to, uh, get medication—get hospitalized somewhere far, whereas traditionally you could be healed at home. But yeah, we, we, there was an understanding there. There was no, uh...But like I said again, people *were* cautious about the white man.

LW: Yeah.

SC: We—we—we had to, I mean—

LW: Yeah, definitely.

SC: —that's how I see it, I mean I don't understand, uh, my in—uh, interest in—is it? Yeah, everything we talk about is treaties…but because of the, uh, outbreak—I don't know how it played?

LW: Yeah.

SC: You know how the role played.

LW: Yeah.

SC: Like I said, again, my family were willing, but they—that's the only re—*alternative*. There was no other alternative—

LW: Yeah.

SC: —but to go with, uh, white man's medicine. [laughter]

LW: Yeah. Yeah. So do you think that, um, 'cause I know some lawyers have said that the medicine chest clause, like everytime it's—I've done a bit of work on it, um, looking at legal cases involving it—

SC: Mmhmm.

LW: —and they would sort of say, "Well, it just means, like a first aid kit"—

SC: Mmhmm.

LW: —whereas, at least from the preliminary research I've done, alot of Aboriginal people are like, "No, it's supposed to change over time, and it's supposed to develop." Do you...have anything—any opinions on that, or?

SC: Okay, uh, yeah I know what you're trying to say. Back then when they were making the—the—uh, the—uh, the treaties and the oral concept of, uh, the medicine chest is that, okay, today maybe we, uh, required—they didn't have hospitalization and all that—

LW: Yeah.

SC: —there were not too many hospitals back then, but that's what they were saying.

LW: Yeah.

SC: And medicine—in—in native people were strong back then, they didn't have, uh, diabetes as rampant as we have today, there was no AIDS, there was no gonarrhea, there was no, uh, smallpox, chicken pox, I can go on and on. We were free of all of those things, eh? But they always had—like even gallstones, I don't think they even had gallstones back then.

LW: What are call stones?

SC: Gallstones?

LW: Yeah.

SC: You don—you don't know what gallst—? They're the—those little things that go in your, uh, because you had too much, uh...I don't even—

Dion Fineblanket: Grease.

SC: Huh? DF: Grease. SC: Yeah, uh...

DF: It's too much fatty food. SC: Yeah, you get gallstones.

LW: Oh, gallstones! [laughter] Okay! [laughter]

SC: Yeah, sorry! [laughter]

LW: Okay, I got it, I got it. [laughter] I'm a little slow!

SC: No, no, it's okay. [laughter] DF: I'm not here! [laughter]

LW: Dion knows me, I'm kind of spinny, right? [laughter]

SC: No, I understand. Yeah, I mean, I may have not said it right. But yeah—yeah, those were never around, eh? We never had that problem, but today...But back then they were wise. They were almost you can say like, uh—uh...philosophers, almost—

LW: Yeah.

SC: —they were philosophical people. They, they knew things, they saw things, and they always predicted how things were gonna be. That's how I saw the elders of long ago. 'Cause they seen things be—before it hadn't ever happened. They even predicted what's happening today. They *knew*. So when, when they made the oral treaty, uh, the—the oral understanding of it they knew they wanted that emphasized, that—yeah, if, uh, the white man want to make a treaty and they said, "We'll take care of your needs," well, what were they thinking when they said that? You know, they were saying, "Yeah, if you have cancer, we'll hospitalize, we'll take care of it."

LW: Hmm.

SC: You know. Even uh, burials and cemeteries and the whole nine yards. They dealt with it. That's the *concept*. That's what they were saying. They—they, uh—I don't know how, uh, the government probably didn't see it *that* way, but I, uh, that's how I saw it even from where I stand.

LW: Yeah.

SC: That that's what they were saying.

LW: Yeah.

SC: Maybe the white man wasn't philosophical back then, I don't know! [laughter]

LW: Yeah, yep.

SC: But they weren't, uh, thinking 100 years down the road, I don't know, but our people were.

LW: Right.

SC: Because if you're gonna sell land, you obviously are worried about alot of things.

LW: Yeah.

SC: I mean, uh...or lend your land to somebody, you're gonna, you, you wanna see things to the letter.

LW: Yeah.

SC: And I think that's what they were saying. Yeah, medicine chest meant needles, uh, penicillin, hospitalization, the whole nine yards. That's what it means. But then at the same token, you know, we had or own—

LW: Yeah.

SC: —and I think what they were saying, we could practice our own—along with yours.

LW: Right.

SC: If my medicine's not good enough maybe yours is—

LW: Right.

SC: —you know. Or if your medicine's not good enough we'll use ours, you know.

LW: Hmm.

SC: It, um—it's like, uh, two nations coming together—they needed to...But I don't think the white man say it that way.

LW: Yeah.

SC: But our elders did—they wanted, "Let's live side by side," and yet that's not taking place. That never took place.

LW: Yeah.

SC: Right off the bat we were prisoners of war [laughter]. I don't want to say that, but that's what—

LW: No, definitely!

SC: —the, the mentality was, hey, that, uh, you weren't allowed to go anywhere, you weren't allowed to practice this, you weren't allowed to do that. You're just like a little person, you know. Your parents telling you, "Go to your room," you know—

LW: Yeah.

SC: —that's how it looks. I'm not angered by it anymore, but I used to be very angry with the white man. But now, today, I'm not.

LW: Understandable if you were, for sure.

SC: [laughter] No I, uh, I grew out of that stage.

LW: Hmm...hmm. So do you have any memories of, um, like alot of people...they—they won't quite remember the dysentery outbreak but they remember Dr. Scott, and they remember getting pills—

SC: Yeah.

LW: —do you have any memories of either Dr. Scott, or the medication he used to give out, or the medication, say, nurses would give out?

SC: At school—when we went to school, we had these pills given to us everyday.

LW: Okay.

SC: We had, uh, milk and, uh, crackers and whatnot, but we—there was pills there that we had to take. It was a...prerequisite, so to speak.

LW: Right.

SC: And when we went to school we were in the hands of the, uh, teachers, and I don't know these—um, not superintendent, but they were a...kinda like a, they were, uh, our parents for the day—

LW: Right.

SC: —so...So when we had to go to school we had to follow their, uh, rules. So when we took the—we took the pills, we had to take the pills. But they were, like you said, uh...In my years, that I can remember, there was, uh, times that I seen, uh, like, I don't know how you say it,

uh...what is that, uh, word, where there were a whole box full of needles and...shots given to us, eh?

LW: Okay...

SC: On Treaty days! I remember, uh, some Treaty days, uh, I don't now how many—how old I was—

LW: Yeah.

SC: —but you had to have this shot!

DF: Right here, that forearm, right here.

SC: Yeah! I remember I had to have that.

LW: Did they ever tell you what they were for, or?

SC: No. I was too young to remember anything like that.

DF: It was x-rays and give us shots.

SC: Yeah. And when—

LW: On Treaty days...

SC: —we went to the, uh—we went to the Treaty day. And back then our people knew that in order for the treaties to continue we had to go to these, uh, to take the, uh—

DF: Needles and stuff.

SC: Needles and stuff, and whatnot. That was a requirement. There was a cop there, there was an RCMP there in a Mountie outfit, and he was there, dressed in, in his uniform, shaking peoples hands after they'd been shot with the needles and whatnot, eh? And there was strange looking pills back then too, eh—like I don't know, they were black little, like little beads—

LW: Yeah.

SC: —and you had to take those. I don't know what they were...

LW: On Treaty days you had to take them?

SC: On Treaty days we had—took em, yeah. And like I said there were times at Sundances that we had to take some medication as well.

LW: Hmm.

SC: Even to this day I'm always—

LW: And were the nurses and them, did they show up and the s—Sundances to give them to you, or?

SC: They were allowed to come and go.

LW: Okav.

SC: But they weren't there for the two day, uh, event.

LW: Right.

SC: But they were there when they were left.

LW: Hmm.

SC: But they weren't allowed to be roaming around too much, but they just come and go.

LW: Right.

SC: And I think that they—they left and picked up.

LW: Right.

SC: They had people working with them that were within the, um, group, the—the gathering,

uh... Sundance whatnot. Uh, that's all I can remember, but I remember stories from our elders, eh.

LW: Yeah.

SC: And there's, uh, sometimes there's sacred events that take place that you can't share—

LW: Mmhmm.

SC: —but this, I think its okay to share this. In a Sundance, there's always fires kept burning all night.

LW: Okay.

SC: They weren't allowed to go out. So they needed young people to go in and—make those, uh, chop wood, gather wood, make the fire all wood. And young people were always allowed—told to go to bed at, at, before sun, sun up.

LW: Yeah.

SC: But privileges were given to the guys that were helping with the Sundance...

LW: Okay.

SC: So I was one of those key players that could stay up—

LW: Right.

SC: —and go and, uh, chop wood, and sit by the fire wood, and drum with the elders, and drink tea with the elders, and smoke pipe with the elders, that pipe was going around, I'd sing with them and...But the part that I wanted to share—

LW: Yeah.

SC: —is the part that there was story telling then. There was sharing then. And these were *elders*, you know, like uh, how you say, uh, respected people were sitting in, uh, fires, and they were sharing about uh, their uh—their uh, perspective?—or their point of view of the treaties and the things that went on.

LW: Yeah.

SC: And alot of things used to make you upset, [you] know, hearing that the white man did this, the white man did their, like the chickenpox, and the smallpox that—

LW: Yeah.

SC: —that came through when the treaties were signed. Supposedly as a gift they gave you blankets, and those blankets were not [laughter] new! They were infected with, uh, *diseases* that the white man—that the people that had gone to war in the United States or overseas that were wearing these, uh, blankets. And they were never probably even *washed*, and they give them to the people: diseased blankets. And those, uh, th—th—I can always remember that, when the treaties were signed, what were their—what was their, uh, plan? When they made a treaty and gave them a gift?

LW: Yeah.

SC: And that gift was not honorable, it was, uh—kill you!

LW: Yeah.

SC: And how were the people supposed to live with that and *love* it, when their intentions were not good?

LW: Yeah.

SC: To this day! Uh, uh...and even to jump forty years, fifty years, to have, uh, lands taken away from you, on top of that.

LW: Yeah.

SC: It—it—it taint—it—it paints a great picture of what was transpiring. They were not here to be friendly! [laughter]

LW: Yeah.

SC: No it wasn't—the, er, the medicine chest as well. It wasn't, uh, today you can, uh, contracts can be broken. But the white man—the Indian people, if you said you were gonna be in Bighead tomorrow—

LW: Mmhmm.

SC: —remember this Dion, if you said you were gonna be in Bighead tomorrow, you're gonna be there tomorrow at two o'clock [laughter]. Their *word* was like, uh...uh, uh, written to the letter, was a contract that cannot be broken. Your word is honorable.

LW: Right.

SC: If you broke that word—I don't believe Dion's gonna be here at two o'clock tomorrow, so I'm not gonna wait around [laughter]. But if I knew Dion was honorable and kept his word...So people, when they said something, they meant it—

LW: Yeah.

SC: —they didn't toy around, so that—that concept has to be understood as well.

LW: Yeah.

SC: So when the treaties were made, they weren't fooling around. They were—

LW: Yeah!

SC: —really business, eh?

LW: Yeah.

SC: So to me...I don't understand how people can turn back on their words.

LW: Yeah!

SC: You know—

LW: Or how, like, how—cause this is one thing that really baffles me, like, if you're at a treaty day and—or say you're in school and the nurse says you have to take this pill, like, what happens if you don't take it?

DF: [Muffled] They'd force you.

LW: Like it's—it—it—to me, like, how does that make you feel as a person, like, I don't...I know I wouldn't feel very good—

SC: No!

LW: —if I was being forced!

SC: No! You had no rights, so to speak—

LW: Yeah.

SC: —because when I went to school there was a boundary there, once you entered that boundary, you were in the hands, in the mercy of the teachers. And your parents were not in the picture, they had no say! They had—they couldn't do anything about it. So they left their kids go to school and...that—it's their responsibility to school. So when you went to school...you had to sing 'O Canada', and you had to...I think there was a time you even had to *pray*. 'God Save the Queen' and 'God s—' all this, blah, blah, blah—and 'Dominion of Canada', I remember 'Dominion of Canada', we were called a 'Dominion of Canada'—

LW: Yeah.

SC: —I don't know, there, there was a time, a pic—

LW: A time when...

SC: —a connection there, eh? In the Dominion of Canada I think they were calling it, and we had to pray at the time, it was, uh, again, a prerequisite, that you had to be...so he had no...uh, I saw guys standing in a corner because they didn't want to—they didn't want to say, or didn't want to take the pill, or didn't want to sing, or couldn't...or couldn't! So they were made to stand in the corner and...I remember holding books one time, I don't know why...I had, uh, I don't know what they were called, er, Webster's dictionary on the one side, and I don't what the other—geo—Geography, on the other side. And they were heavy, after a while they were so heavy that, uh, I didn't want to go through that again.

LW: Yeah.

SC: But its not—not the pain that I was embarrassed about, it was being put through that in front of my classmates.

LW: Yeah.

SC: You know, you—you're classmates looking at you being put through, [laughter] going through trail and [laughter] execution at the same time.

LW: Yeah.

SC: Yeah, they were, uh, today it's a whole different ball game, you see kids playing, you go to school, you'll see kids smoking!

LW: Yeah.

SC: Back in my time you—I could be able to walk if I smoked in school. My butt would be just purple, just, from those span—they had a letter [sic] that long, and it was that thick—that wide, just on your [SC gestures], yep—

LW: Oh my goodness.

SC: Er...uh, disciplinary tactics they had, eh? Was—today they could be doing nine months for—

LW: Yeah.

SC: —touching a kid like that. And they were allowed to do that!

LW: Yeah.

SC: Whip the tar out of you. [laughter] The—you smoke em, get the tar whipped out of you! [laughter] Yeah, but they made us just pray and everything, right? And I think that's why alotta times, uh, after school you don't want to pray no more, you don't want to go to church no more, you did your prayers already.

LW: Yeah.

SC: As if we didn't pray in the mornings when we got up. As if we didn't pray when we would go to bed. But when we went to school we'd have to do it again. [SC pounds his fist on the table] How many times a day do you have to pray? You know, those are the things that, uh, they never look at.

LW: Yeah.

SC: [sigh] Human rights violations everyday, like left and right.

LW: Yeah. Hmm.

SC: Alot of times I don't speak of my personal experiences but a collection of people's experiences, because it relates. And I heard my parents, I heard my uncles, my aunties, experience those things.

LW: Yeah.

SC: And when you have, like I said before, ten people saying it, there's gotta be some truth to it.

LW: Yeah. Hmm. [phone rings]

SC: Go ahead—it—it—it's just in my head. [laughter]

DF: I'll answer that phone. Where's the phone?

SC: It's in my head, it's not—[laughter] Ringing in my head!

DF: Almost sleeping, I can't answer it.

SC: [laughter] Maybe you're dreaming it then, that's why! [laughter]

LW: Well you've answered all my questions already so unless you want to add—

SC: Really?!

LW: Yeah, like this has been amazing! Very good!

SC: Oh!

LW: Oh! Unless you have memories of Dr. Scott, specifically...

SC: Oh jeez, I—you know, I don't know if they keep records at the hospital...When I was a little boy, I as always at the doctor's off-when, I was always in hospitalized [sic].

LW: Okay.

SC: I was always hospitalized. I—I—I seen alot of kids from Loon Lake, I seen alot of kids from Bighead, people from here [Ministikwan], for the *littlest* things, they kept you for two weeks. For some—uh, today, if you have a broken leg, you go home, right?

LW: Yeah. They cast you and then—

SC: But back then, you did a whole *month* in the hospital for a broken leg! I, uh...you know, like, uh, diarrhea...fevers...I was there for fourteen, fifteen days. I can remember, I'm not saying it was fourteen, fifteen days, but I, I remember days and days out that you were there, and so lonely that you're—you're—you're put in a room, and Dr. Scott'd tell you, "I'll check you out," you weren't allowed to go home...And mom—my parents came to pick me up and, "No, it's not time for him to go home. He needs to be here for a while." I don't' know why—I felt healthy at those times.

LW: Yeah.

SC: I was okay, I was willing to go home, I was happy to go home; but *no*, I was supposed to stay there for another four days—five days—you know? I didn't know back then what five days, four days meant, but today I remember those words, like—

LW: Right.

SC: —what he meant. Today—I don't, you know, like—one week, two weeks, I can remember that.

LW: Hmm.

SC: But why would a person have to be there when he's *okay*?

LW: Yeah.

SC: You kinda get the impression, uh—uh, feeling that maybe...they were doing experiments on you or something? That's what I always feel today, and you know, like, uh, er, uh...When you take, uh, psychology, I think there's a—a thing where you practice when—without their knowledge?

LW: Yeah.

SC: They make you do things. Test you out. See how you come out of it.

LW: Yeah.

SC: But also, I think alot of times, I think that's what the, uh, the doctors were doing to Native people is, uh, practicing—using, uh, why they sent a guy that's, uh, practicing to our First Nations area, and they send the best doctors to the cities. They send a guy, like, there, there—the doctors here don't seem to have that—that, uh, experience as the city people.

LW: Hmm.

SC: Like, for instance, my gallstones. I was suffering for a year and a half—

LW: Yeah.

SC: Sometimes I'd—panic attacks and stuff like that—

LW. Mmhmm

SC: —and then there was a guy that was just transferred to Meadow Lake. And I went, seen that guy and, uh, he was, he happened to be there on, uh, on a weekend: standby? And he said, "How long have you had this?" I says, "Been suffering with this for a year and a half." He says, "What do you go through?" and he's telling me all this, and then says, "My God! You have to have a operation right away," he said. And sure enough I was taken to Humboldt. That was the only opening, in *all* the province of Saskatchewan—he phoned everywhere. And he put me

through, uh, what they call, uh, ... What is that thing where they give a woman when there's pregnant there?

LW: Oh, ultrasound.

SC: Ultrasound. I was kinda shy because I didn't wanna talk about being put through an ultrasound. [laughter] But yeah, you don't talk about some things, eh?

LW: Yeah.

SC: Because of the way people are today. [laughter] So anyway, I was sent to Humboldt. [laughter] And, uh, yeah the next day I had surgery. And, uh, for two weeks I was in critical—LW: Wow.

SC: —because that gallstone was this big. [SC gestures] And it—if you ever check into that, what they are, young people would come in, when I was in Humboldt, I'd sit there, and I'd see a young person with his parents comin' in—white people, they'd bring there kid in. They'd come in the morning, he goes home at night. That's how simple the operation is. How come [SC pounds fist on table] it didn't take long [sic] for them to know...what it was? And my gallstones were that big. [SC gestures]

DF: Hmm.

SC: And gallstones are about this much—[SC gestures]

LW: Yeah.

SC: —real small. And alot of our people here are suffering. [SC pounds his fist on the table] And I always mad about the doctors that—they *don't* give First Nations priority. They don't give you, that—a white man comes in and a Native person comes in: they give priority to the white person, and they give you, uh, like it was just...emergency. You needed to have that medical problem taken care of, but if you were a First Nations, "I don't know [if] I can fit you in, you know, or I can fit you in with a specialist. Six months later, you're still suffering, but if you were a white man, you be out of the problem within a couple days.

LW: Yeah.

SC: And that's how it is right now, it is, that's how it is today.

LW: Yeah.

SC: It just, it just, that's—we see that all the time.

LW: Yeah.

SC: And alot of people don't even—it doesn't phase on them, 'cause they never go through it. They're not going through the problems, so they don't worry about it. What doesn't bother you, doesn't affect you. But if you've been going through it, you go suffering through it, then you see it and you know, *why*?

LW: Yeah.

SC: That's the only time you say, is when you're going through something. Land issues, I can talk about treaties and everything, and I can tell you, *why*? It's, uh...it's *so*...I don't even know—there any words for that. Forked tongue about it, eh? It's not...I guess I can—that's all I can say, I mean, I—

LW: Yeah.

SC: —there's no words to it. [SC pounds his fist on the table]

LW: Yeah.

SC: The treaties that were made here, just to make a closing comment—

LW: Yeah.

SC: —is that, let's say back in 1905, there were a group of people living here—just to give you a point—the treaty, the people here were kinda worried that there were treaties being made, and

how this was going to effect us, so the elders here said 'Hey, come and talk to us about this, come and tell us what your people are up to: making these treaties an why are you doing this.' So anyway, they—they put a six mile around the reserve here, six mile boundary—

LW: Mmhmm.

SC: —that nothing was to be, it was kind of like a caveat, you—do you know what a caveat is? LW: Yeah, yeah.

SC: Okay, so [inaudible] around it, and nothing was to be tampered with for a period of time until there was an investigation done. So there were people doing research—these were the three books that I put before you. So the amount of people that they had here were two hundred and fifty people, like, I heard that there were about as many people as Onion Lake back here before the treaties that died of small pox, sick—sleeping sickness, and they died of, uh, there was a fire that come through here, and that was before the treaties. And I think there was, uh, uh, a treaty made by Hudson [sic] Bay with our First Nations people—that's why they were farmers before the treaties, they were already making deals with the governments—

LW: Hmm.

SC: —so when the treaties were made there was a whole different, uh, but anyway, uh, what was my...oh yeah, two hundred and fifty people were found to be living within these areas. So they did, uh, according to the treaty one square mile for a family of five. So ten—six miles by ten miles. So from Whelan, I think, to Beaver River, which is about ten miles—

DF: Mmhmm.

SC: —and six miles wide. So then that's what was given in the treaty; the treaty was already signed, done deal. Six months later, the governments came back and said they, uh, they wanted to, uh, put Loon Lake at Loon Lake, and Joseph Bighead at Joseph Bighead.

LW: Hmm.

SC: But our people didn't want to sign the treaty; they said, 'No, we have already made the treaty. We had to smoke pipe with you before; we can't smoke the pipe again with you'—LW: Yeah.

SC: I—I don't know if I expressed that when you smoke a pipe once, that's good enough. That's, uh—

DF: It's a done deal.

SC: Yeah—

LW: It's binding.

SC: —you can't smoke the pipe again, especially how sacred it was back then. So when the—when the treaties made and they smoked a pipe, he says, "Six miles by ten miles." So within the period of time later they wanted to renegotiate, I mean, uh, make the—a new treaty. Loon Lake was given, uh, a parcel of land; Joseph Bighead was given a portion of land, and the man that signed the treaty for Island Lake First Nations was called Jumbo, he was from, uh, Joseph Bighead. Then he went to sign the treaty at Joseph Bighead! So he signed the treaty *twice*. And how does that look to the treaties, to the government. There were surveyors and superintendents back then that said don't do it, don't sign the treaty, uh, don't renew—don't—but they did it anyways. So after that, that's when I told you there was a period of time you weren't allowed to go anywhere—

LW: Mmhmm.

SC: It was, uh, uh, Loon Lake had their place, Joseph Bighead had their place, Ministikwan had their place. Then—then what happened again is to give them welfare, give them supposedly family allowance, and give 'em all this treaties and all that, they took a portion of the land out of

that portion that they gave you. So out of that they gave it to homesteaders so they can, uh, home—so that they could give you that welfare.

LW: Hmm.

SC: And that's the point they never emphasize with the government. You know all these taxpayers, they're always grumping and complaining that our tax dollars are going to the First Nations and it doesn't—you know, it's not being used properly, when the government didn't tell them, "We took their land—

LW: Yeah.

SC: —we took some more land so—so we can give them them this deal"—

LW: Yeah!

SC: —we made a deal about that. They never said it, openly. It's, uh—it was just like, uh, put behind the back burner. And *again*, three times, they took some land from our First Nations right here in Ministikwan, and we have paper work.

LW: Hmm.

SC: Uh, and see, to this day our First Nations are, right now on our reserve itself—

LW: Yeah.

SC: —we don't expect them to do, we're just so...they don't believe.

LW: Yeah.

SC: Even when I tell them that "When the treaties were broken we can go back and fight for our treaty rights," people don't believe it.

LW: Hmm.

SC: It's right there, openly. It's...

LW: Yeah.

SC: So that's my closing comments, so—and yet we have to continue trying to be open minded, and try to be, uh, nice, you know!

LW: Yeah.

SC: Try to be Christian, in this day and age after all that.

LW: Yeah.

SC: So there! [laughter]

LW: Well thank you so much—

SC: Okay!

LW: —I really appreciate it!

DF: Hi, hi Sidney!

SC: Mmhmm.

# APPENDIX D: Government Approaches to Teaching Sanitation or Hygienic Practices

D.1. Excerpt from Al Freestone, "Environmental Sanitation on Indian Reserves," *Canadian Journal of Public Health* 59 (January, 1968):

On joining the Department it seemed that none of the titles being used in the Service would fit—I was not an officer, I was not primarily an inspector. To myself I was a person who was going to attempt to teach environmental control. Hence, I became a sanitarian[...]

My first task was to look at general conditions on the Indian reserves. We have some 83 reserves with 31,000 people. Saskatchewan contains 12 health regions plus the Northern Administrative District and our Service has people in all parts of Saskatchewan.

How do you go about developing a sanitation program over such a vast area? Well, first you realize that it is not possible to work in all reserves in such a large territory. Then you look at the other problems. You are dealing with an ethnic group whose culture is much different from our own. You are dealing with people of a low income group. You are dealing with people of a low-educational standard. You are dealing with people who, because of their culture, do not particularly care about tomorrow. They think mostly of today—tomorrow will take care of itself. You are dealing with people who feel they have been cheated and many of whom distrust the white man. This is one of the toughest problems we have in the field[...]

Our first workshop was held in Fort Qu'Appelle in 1962. It was led by our advisor in health education in Ottawa.

With the co-operation of the chief and council and the nurses in the area 28 delegates were selected to attend this first Saskatchewan Indian Sanitation Workshop. We had been told by many people who were working with the Indian people 'no one would come'. With this in mind we began asking for additional delegates hoping to wind up with at least 20. The morning the workshop opened we had 36, and by the second day, some of them being on Indian time, we had 48 delegates. It was a problem solving session. What was their problem on the reserve as they saw it? The group leaders came up with the same problems I have mentioned, lack of water supplies, lack of waste disposal, and poor housing.

The theme for the week was 'self-help'. They recognized the problem—what could *they* do to help solve it? <sup>348</sup>

D.2. Excerpt from a memorandum by M. A. Butler to the Area Director for the Northern Alberta area on the "Sanitation Workshop at Driftpile, Alberta–October 25, 1967":

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<sup>&</sup>lt;sup>348</sup> Al Freestone, "Environmental Sanitation on Indian Reserves," *Canadian Journal of Public Health* 59(January, 1968): 25.

At this point the women stayed in the health centre to carry out their program and the men joined the Public Health Inspector in the garage to take part in the actual construction of items generally need by every family of the area. A minimum of time was given to lecturing, except for an explanation of the projects undertaken, with reasons why, how, and the health benefits to be derived by the families. I might mention at this time that I feel the people are tired of talk and more talk and prefer getting action. This group of men enjoyed working with their hands. Guidance only was required. A type of incinerator was constructed from an oil drum; a drum was made into a rather nice looking water barrel; painted inside and out with aluminum paint, fitted with a cover and fawcett. The simplest of tools, that anyone could obtain at little cost, were used, e.g. chisel, hammer, file and punch. In some areas tools are scarce[...]

As these two projects were completed a look of accomplishment, willingness and enthusiasm could be discerned on the faces of the men doing the actual work.<sup>349</sup>

D.3. Excerpt from a memorandum by L. C. Roy to M. L. Webb on "The Role of the Public Service Nursing Counsellor," dated May 22, 1970:

The Public Service Nursing Counsellor fulfills a key role in the operation of the Public Service Health Program. Her prime function is to undertake an active program of health counselling designed to foster in employees the knowledge to promote their own and their families' good health. Subjects which may be involved in such activities include personal health and hygiene, emotional health, problem drinking, nutrition and food budgeting, recreation, home and family problems, maternal and child health, job adjustment and vocational guidance, excessive absenteeism and work environment[...]

The nurse participates, where required, in the local administration of environmental health programs and may advise management concerning the need for supervision or control of occupational or environmental hazards which may come to her attention. She is concerned with the general medical supervision of sanitary conditions, including provision of advice and instruction to employees in proper food handling techniques. She is also prepared to participate in the activities of local safety committees.<sup>350</sup>

D.4. Excerpt from C. A. R. Dennis and B. L. Pearson, "The Effect of the Living Environment on the Health of Saskatchewan Indians":

<u>Specific Objectives</u>
Within the time frame of the study:

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<sup>&</sup>lt;sup>349</sup> LAC, RG 29, vol. 3, file 851-5-5, M. A. Butler, Public Health Inspector, Northern Alberta Area, memorandum to Area Director, Northern Alberta Area, "Sanitation Workshop at Driftpile, Alberta–October 25, 1967," 1 November 1967, 2.

<sup>&</sup>lt;sup>350</sup> LAC, RG 29, vol. 2, file 853-1-1, L. C. Roy, Health, Safety and Physical Working Conditions Group, to M. L. Webb, Deputy Director General, "The Role of the Public Service Nursing Counsellor," 22 May 1970, 1.

- 5. to analyse data relating to hospital admissions by diagnostic code, prepared by Statistics Canada, 1970-75 inclusive, for the registered Indian population of Saskatchewan.
- 6. to correlate hospital morbidity of Indians living on reservations with environmental data obtained from the environmental and community profiles of Medical Services, Department of National Health and Welfare.
- 7. to compare hospital morbidity of Indians living on reservations with that of Indians living off reservations and the total Saskatchewan population.
- 3. to draw conclusions concerning the association of specific environmental factors with specific reasons for hospital admission, especially the conclusions which indicate a need for special program emphasis [...]

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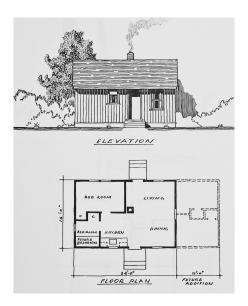
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<sup>&</sup>lt;sup>351</sup> LAC, RG 29, vol. 1, file 851-5-X300, C. A. R. Dennis and B. L. Pearson, "The Effect of the Living Environment on the Health of Saskatchewan Indians," 3, 5.



D.5. House Plan 1, of a possible six, from the "Canadian Indian Homes" booklet by Indian Affairs Branch. Engineering and Construction Division writers described it as a step, "within the limitations of the housing budget and personal contributions, to include or make provision for accepted standards in Indian Housing," particularly "insulation, safety type chimneys, basic kitchen cabinets, storm doors, windows and screens and provision for at least basic sanitation facilities." [LAC, RG 10-C-VI, vol. 11580, file "Department of Citizenship and Immigration—Indian Affairs Branch—Canadian Indian Homes," Canada, Department of Citizenship and Immigration, "Canadian Indian Homes" (Ottawa: Department of Citizenship and Immigration, 1957).]

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