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Care for the 'Racially Careless': Indian Hospitals in the Canadian West, 1920–1950s

Abstract: *In the 1930s, sanatorium directors and medical bureaucrats warned of the threat to Canadian society of 'Indian tuberculosis.' Long-standing government policy aimed to isolate Aboriginal people on reserves and in residential schools, while their access to medical care was limited by government parsimony and community prejudice. Characterized as 'racially careless' concerning their own health, Aboriginal bodies were seen as a menace to their neighbours and a danger to the nation. By the 1940s state-run racially segregated Indian hospitals institutionalized Aboriginal people who were not welcome in provincial sanatoria or in the modernizing community hospitals. The opening of the Charles Camsell Indian Hospital in Edmonton in 1946, one of the first acts of the newly created department of National Health and Welfare, was a very public demonstration of the state's commitment to define and promote 'national health' by isolating and institutionalizing Aboriginal people.*

Keywords: hospital, Aboriginal health, colonialism, tuberculosis, First Nations, sanatorium, national health, welfare state

Résumé : *Au cours des années trente, les directeurs de sanatoriums et les bureaucrates de la santé ont alerté la société canadienne des dangers que représente la 'tuberculose indienne'. Les politiques gouvernementales de longue date visaient à isoler les Autochtones sur les réserves et dans des pensionnats, tandis que la parcimonie du gouvernement et l'existence de préjuges dans la collectivité limitaient leur accès aux soins médicaux. Caractérisés comme une 'race négligente' en ce qui a trait à leur propre santé, les peuples autochtones étaient vus comme une menace pour leurs voisins et un danger pour la nation. Rendu aux années quarante, des hôpitaux dirigés par l'État et uniquement pour les Indiens ont institutionnalisé les Autochtones qui n'étaient pas les bienvenus dans les sanatoriums provinciaux ni dans les hôpitaux communautaires en cours de modernisation. L'ouverture de l'hôpital indien Charles Camsell d'Edmonton en 1946, l'une des premières initiatives du ministère nouvellement créé de la Santé nationale et du Bien-être social fut une démonstration très publique de l'engagement de l'État à définir et à promouvoir la 'santé nationale' en isolant et en institutionnalisant les Autochtones.*

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Mots clés : hôpital, santé des autochtones, colonialisme, tuberculose, Premières nations, sanatorium, santé nationale, État providence

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> It is the avowed intention ... to eliminat[e] any discrimination between those Canadian citizens of Indian status and other citizens of Canada ... To this end the regulations contain compulsory provisions to be used when necessary.
> – Indian Health Regulations sec. 72 Indian Act, order-in-council, P.C. 193–1129, 17 July 1953

On a hot August morning in 1946, war hero and governor general Field Marshall Viscount Alexander of Tunis officially opened the rambling Charles Camsell Indian Hospital in Edmonton.[1] For forty years, from 1945 to 1985, the Hospital treated Aboriginal people (First Nations and Inuit) from the West and North. Owned and managed by the newly established Department of National Health and Welfare's Indian Health Services (IHS), it was part of a larger expansion that by 1960 saw twenty-two racially segregated institutions.[2] Many, like the converted 500-bed Camsell Hospital, were decommissioned military barracks, others were renovated residential schools, an acknowledgment of the government's deadly education policy. This is not a patient's perspective of the hospitals; indeed, that would be a far different story of resistance and accommodation, where the hospitals came to serve community needs. But they did not begin that way. This paper instead asks how a putative liberal democracy comes to rationalize and justify coerced and racially segregated hospitals. I focus here on Western Canada where colonialism played out on Aboriginal bodies in particular ways, and where the medical and

1 Camsell was deputy minister of mines and resources, the administrative home of Indian Affairs at the time. The hospital admitted patients in late 1945 before the official opening in 1946.

2 *Indian* is used here to reflect contemporary usage. Much of the history of Indian hospitals has been written by those directly involved: Donna Dryden, Elva Taylor, Rena Beer, Ron Bergmann, and Margaret Cogill, *The Camsell Mosaic* (Edmonton: Charles Camsell History Committee, 1985); P.E. Moore, 'No Longer Captain: A History of Tuberculosis and Its Control amongst Canadian Indians,' *Canadian Medical Association Journal* 84 (May 1961): 1012–16; G.J. Wherrett, *Miracle of the Empty Beds: A History of Tuberculosis in Canada* (Toronto: University of Toronto Press, 1977). For critical perspectives, see Laurie Meijer Drees, 'Reserve Hospitals in Southern Alberta, 1890 to 1930,' *Native Studies Review* 9, no. 1 (1993–4): 93–110; Pat Sandiford Grygier, *A Long Way from Home: The Tuberculosis Epidemic among the Inuit* (Montreal and Kingston: McGill-Queen's University Press, 1994); T. Kue Young, *Health Care and Cultural Change: The Indian Experience in the Central Subarctic* (University of Toronto Press, 1988).

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bureaucratic discourse of the threat of 'Indian tuberculosis' was most strident.

I locate Indian hospitals in the broader colonial project of racial exclusion and segregation. Scholars note how Western medicine is implicated in colonialism, occupying what David Arnold calls a central place in the 'ideological as well as the technological processes' of colonial rule.[3] Canada's colonial policies and practices – sociocultural disruption and economic dispossession – shaped Aboriginal ill-health while rudimentary Euro-Canadian medicine attempted to confine illness on reserves, marking Aboriginal bodies as fundamentally weak and diseased.[4] Never a stable category, colonialism is a shifting and flexible dialectic encounter creating identities for both colonizer and colonized. The characterization of Aboriginal communities as unrepentantly backward and roundly infected reinforced the superiority of white colonizers, justifying further isolation and repression. But isolation of the ill in mission hospitals or in Indian wards of community hospitals could no longer contain what an increasingly shrill medical and bureaucratic discourse identified as the threat of rampant 'Indian tuberculosis.'[5] I argue that the Indian hospitals emerge as Canada was consciously defining national health, or a normal white citizenship.[6] The danger to the nation's health from what Dr David Stewart, superintendent of Manitoba's Ninette sanatorium, called the 'racial carelessness and ignorance' of First Nations 'soaked with tuberculosis' could no longer be left to well-meaning missionaries and apathetic Indian

3 David Arnold, 'Medicine and Colonialism,' in *Companion Encyclopedia of the History of Medicine*, ed. W.F. Bynum and Roy Porter (London: Routledge, 1993), 2:1411. See also David Arnold, ed., *Imperial Medicine and Indigenous Societies* (Manchester: Manchester University Press, 1988); Roy MacLeod and Milton Lewis, eds., *Disease, Medicine, and Empire* (London: Routledge, 1988); Randall M. Packard, *White Plague, Black Labor: Tuberculosis and the Political Economy of Health and Disease in South Africa* (Berkeley: University of California Press, 1989); Megan Vaughan, *Curing Their Ills: Colonial Power and African Illness* (Palo Alto: Stanford University Press, 1991).

4 Mary-Ellen Kelm, *Colonizing Bodies: Aboriginal Health and Healing in British Columbia, 1900–50* (Vancouver: University of British Columbia Press, 1998); Maureen Lux, *Medicine That Walks* (Toronto: University of Toronto Press, 2001).

5 North American medical literature pathologized the 'discursive Indian'; by the 1930s the focus shifted to the threat Aboriginal contagion posed to society. Mary-Ellen Kelm, 'Diagnosing the Discursive Indian: Medicine, Gender, and the "Dying Race,"' *Ethnohistory* 52, no. 2 (2005): 373, 378.

6 Warwick Anderson examines how science and medicine defined race, health, and bodily reform in the larger project of white citizenship and national destiny, in *The Cultivation of Whiteness: Science, Health, and Racial Destiny in Australia* (New York: Basic Books, 2003).

agents. Worse, according to Stewart, racial carelessness was compounding as Aboriginal populations were actually increasing and 'mingling with the general population,' despite grave predictions of a dying race.[7] Steadily falling tuberculosis rates in non-Aboriginal Canada reassured the state and its ally, the Canadian Tuberculosis Association (CTA), that sanatorium treatment might conquer the 'white plague.'[8] And as the CTA urged, the state must include Aboriginal people in its calculations of national health, if only to keep them properly isolated. State-run Indian hospitals also acknowledged community prejudices that demanded segregated health care, ensuring that modernizing hospitals were increasingly white hospitals. The colour line in modern health care, starkly drawn and carefully maintained by informal coercion and the legal compulsion of the Indian Health Regulations, also recalibrated the colonial binary. Unchecked Indian tuberculosis justified coercive institutionalization, which conjured an increasingly robust national health guarded by a vigilant state. The high state drama of the Charles Camsell Hospital's opening ceremony demonstrated the state's commitment to a strategy of Aboriginal isolation and exclusion in pursuit of white national health and welfare.

In Canada, with its hegemonic liberalism that celebrated inclusivity and individual autonomy, exclusion and coercion seem an uneasy fit. But at liberalism's core rests what theorist Uday S. Mehta calls the 'thicker set of social credentials that constitute the real bases' of

7 Quoted in 'House of Commons Discusses Estimates for Indian Affairs Branch,' *Bulletin of the Canadian Tuberculosis Association* 15, no. 4 (June 1937): 4; D.A. Stewart, *The Social Ramifications of Tuberculosis* (Winnipeg: Veterans Press, n.d.), 6, box 10, RG10-30-A-1, Archives of Ontario.

8 Tuberculosis today is understood as an infectious disease caused by *Mycobacterium tuberculosis*. Spread through droplet infection, it affects the lungs most commonly but can involve almost any organ of the body. Symptoms include fatigue, lethargy, and weight loss that progress to coughing sputum and blood, and shortness of breath. It has a variable incubation period, and factors such as the quality of nutrition and crowding determine whether the disease develops. William D. Johnston, 'Tuberculosis,' in *The Cambridge World History of Human Diseases*, ed. Kenneth Kiple (Cambridge: Cambridge University Press, 1993), 1059–61. The causes for tuberculosis decline in the Western world are not clear, but improvements in personal hygiene, increased prosperity, and improved sanitation, housing, and workplaces all had an impact. For Britain, see Linda Bryder, *Below the Magic Mountain* (Oxford: Clarendon, 1988), 2; Thomas McKeown, *The Modern Rise of Population* (London: Arnold, 1976), 92; F.B. Smith, *The Retreat of Tuberculosis, 1850–1950* (London: Croom Helm, 1988), 1. For the United States, see Rene Dubos and Jean Dubos, *The White Plague: Tuberculosis, Man and Society* (Boston: Little, Brown, 1952), 185.

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citizenship.[9] The social credentials – race, ethnicity, gender, class – defined the individual and marked those to be excluded, Aboriginal people foremost.[10] The liberal view of the individual as one whose body and mind were his or hers alone stood in sharp contrast to Aboriginal world views that positioned themselves as but one part of the larger circle of life, where individual wellness required community support and collective rites for its restoration, and where the value of goods was realized by giving them away.[11] Their legal status as wards of the state presumed the absence of rational citizenship and the inability to acquire it without fundamental social, cultural, and political change. Indeed, as Adele Perry argues, the liberal order and 'the nation that defined it would find its own unique ways of rendering some people outsiders and, in the process, making itself.'[12] Since Michel Foucault's famous 'carceral archipelago,' scholars have become aware of the continuities among institutions of isolation – asylums, prisons, sanatoria, Indian reserves, and residential schools – where experts attend to those requiring reform or cure.[13] This 'collusion of knowledge and power' created institutions that 'consolidated administrative authority, bureaucratic regulation,' and colonial control.[14] Canada's liberalism, simultaneously 'a utopian project of individual liberation *and* one of colonialism and subordination,' cultivated its

9 Uday S. Mehta, 'Liberal Strategies of Exclusion,' in *Tensions of Empire: Colonial Cultures in a Bourgeois World*, ed. Frederick Cooper and Ann Laura Stoler (Berkeley: University of California Press, 1997), 61.

10 Ian McKay, 'Canada as a Long Liberal Revolution,' in *Debating the Canadian Liberal Revolution*, ed. Jean-Francois Constant and Michel Ducharme (Toronto: University of Toronto Press, 2009), 351.

11 For an overview of medical traditions in Aboriginal cultures, see James Waldrum, D. Ann Herring, and T. Kue Young, *Aboriginal Health in Canada* (Toronto: University of Toronto Press, 2006), chap. 5.

12 Adele Perry, 'Women, Racialized People, and the Making of the Liberal Order in Northern North America,' in *Debating the Canadian Liberal Revolution*, ed. Jean-Francois Constant and Michel Ducharme (Toronto: University of Toronto Press, 2009), 285.

13 Alison Bashford and Carolyn Strange, 'Isolation and Exclusion in the Modern World,' *Isolation: Places and Practices of Exclusion*, ed. Bashford and Strange, 1–19 (London: Routledge, 2003); Michel Foucault, *Discipline and Punish: The Birth of the Prison*, trans. A. Sheridan, 2nd ed. (New York: Vintage, 1975); Michel Foucault, *Madness and Civilization: A History of Insanity in the Age of Reason* (New York: Vintage, 1984); Renisa Mawani, 'Legal Geographies of Aboriginal Segregation in British Columbia,' in Bashford and Strange, 173–90.

14 Colin Jones and Roy Porter, eds., 'Introduction,' in *Reassessing Foucault: Power, Medicine and the Body*, 1–2 (London: Routledge, 1994).

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core of normal healthy white citizenship by marginalizing and excluding Aboriginal bodies.[15]

TRANSFORMING HOSPITALS

Canada's liberal governance attempted to subordinate and contain Aboriginal conceptions of the world and society, and from the 1880s schooling would accomplish this goal. In fact, residential schools, 'pre-eminent laboratories of liberalism,' played a significant role in the spread of disease from school to home.[16] Christian missionaries established rudimentary hospitals in conjunction with schools in the late nineteenth century so that ill children might remain on the school rolls and eligible for government subsidies.[17] In the church-run residential and reserve schools, children suffered from the diseases that prey on the ill-fed and poorly housed, especially tuberculosis. For example, at the Anglican Tsuu T'ina (Sarcee) reserve school outside of Calgary, physicians examined students in 1907, 1908, and 1909, when they reported that every child in the school suffered from some form of tuberculosis.[18] Another inspection in 1921 found dirty floors and windows, and bed linens 'stained with blood and puss [sic] marks old and recent.'[19] Finally, the long-neglected school was fitted out with new sleeping porches and deemed a 'hospital' with F.T. Murray in the dual role of physician and Indian agent. Meanwhile the whole reserve became a 'hospital area,' with movement off reserve restricted while Calgarians were warned of the nearby threat of contagion.[20] While it

15 McKay, 'Canada as a Long Liberal Revolution,' 397.

16 Ian McKay, 'The Liberal Order Framework,' *Canadian Historical Review* 81, no. 4 (Dec. 2000): 637. On schools and disease, see especially P.H. Bryce, *The Story of a National Crime: Being an Appeal for Justice to the Indians of Canada* (Ottawa: Hope, 1922); J.R. Miller, *Shingwauk's Vision* (Toronto: University of Toronto Press, 1996); John Milloy, *A National Crime: The Canadian Government and the Residential School System, 1879–1986* (Winnipeg: University of Manitoba Press, 1999).

17 The largest mission hospitals were in Alberta at the Kainai (Blood) and Siksika (Blackfoot) reserves. In 1923 the Siksika controlled their hospital as a non-denominational institution until 1947 when IHS took control.

18 Lafferty to McLean, Dec. 1908, file 140, 754-1, vol. 3957, RG10, Library and Archives Canada (LAC).

19 Quoted in Elizabeth Churchill, 'Tsuu T'ina: A History of a First Nations Community, 1890–1940' (PhD diss., University of Calgary, 2000), 396.

20 Ibid., 393–4.

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seems clear that infection crossed racial and reserve boundaries, the direction of that spread was not clear.

At the same time, a 1927 survey in British Columbia implicated the schools in the spread of tuberculosis infection in children. Researchers found a clear link between bone and gland infection in residential school children and the raw milk used in the schools. They concluded that the infection could not have come from home, since few reserve families used cow's milk, but the Department of Indian Affairs (DIA) suppressed the report.[21] The fate of the Tsuu T'ina seemed sealed when government anthropologist Diamond Jenness arrived that summer to document the last gasp of a 'dying race.'[22] The Tsuu T'ina experience was not representative of all schools, but the differences were in degree not in kind.[23] The expedient of ignoring the ill or confining them to mission hospitals or schools rather than admitting them to local hospitals was dictated by the department's uppermost concern for economy in all things. But there were other considerations that influenced the form and place of medical treatment for Aboriginal people in the Canadian West.

North American hospital history emphasizes the expansion and transformation of the hospital in the late nineteenth and early twentieth centuries from almshouse to medical marketplace. In Canada, before 1890, hospitals, financed by charity and government, housed the sick poor while their social betters convalesced in the comforts of home. But by the 1920s hospitals began to attract patients who demanded, and would pay for, the benefits that medicine seemed to promise: relatively safe and effective surgery, professional nursing, and technological innovations such as X-ray.[24] Care for the poor was kept well separate from the paying patients as the modernizing

21 H.W. Hill, 'The Epidemiology of Tuberculosis amongst British Columbia Interior Indians,' 31, file 33, 'Indians – BC,' I75, MG28, Canadian Tuberculosis Association, LAC; 'Conference on Tuberculosis among Indians in Canada, Ottawa, 1937,' 37, file II(a), I75, MG28, LAC; Bryce, *Story of a National Crime.*

22 Diamond Jenness, *The Sarcee Indians of Alberta*, bulletin no. 90 (Canada: National Museum of Canada, 1938).

23 Bryce, *Story of a National Crime.*

24 On these transformations in Canada, see, for example, David Gagan and Rosemary Gagan, *For Patients of Moderate Means: A Social History of the Voluntary Public General Hospital in Canada, 1890–1950* (Montreal and Kingston: McGill-Queen's University Press, 2002). In the United States, see Charles Rosenberg, *The Care of Strangers: The Rise of America's Hospital System* (New York: Basic Books, 1987); David Rosner, *A Once Charitable Enterprise: Hospitals and Health Care in Brooklyn and New York, 1885–1915* (New York: Cambridge University Press, 1982).

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hospital actively shaped class inequality within and beyond the hospital. The transformed hospital also reflected and constructed racial inequality.[25] State-funded and racially segregated Indian hospitals need to be understood within this larger context of the modernizing hospital.

In the West, racialized minorities were commonly treated in segregated hospitals and wards. Chinese and Japanese patients, in the early twentieth century, suffered in Vancouver General Hospital's basement 'Ward H' alongside 'dirty indigent cases,' those with particularly loathsome terminal illnesses.[26] Chinese tuberculosis patients in the 1940s were relegated to Vancouver's St Joseph's Oriental Hospital. Patients complained about the constant traffic noise from the railway lines on one side of the hospital, and the stench from the cannery on the other; there was little nursing care; and the Catholic missionaries actively proselytized dying patients. Many in the Chinese community avoided X-ray clinics for fear of being confined at St Joseph's. As community advocates noted, 'Some have declared emphatically that they would rather die than go to St Joseph's Hospital.' Public health nurse J.B. Peters also urged, 'When the Chinese were given the same type of facilities for treatment as occidental races they would cooperate in the same way.'[27] Patients and their supporters who resisted such hospital care were deemed 'racially indifferent' to health care and a danger to the community, further recommending their incarceration and segregation.

Community hospitals throughout the West and North also maintained 'Indian wards' and segregated annexes. Even hospitals that relied for their financial survival on DIA funds maintained strict racial separation. The Bella Coola Hospital on British Columbia's West Coast received funds from the department for construction and equipment, but its Indian ward consisted of one bed and a chair, with neither

25 Mark Cortiula, 'Social Class and Health Care in a Community Institution: The Case of Hamilton City Hospital,' *Canadian Bulletin of Medical History* 6 (1989): 133–45; Gagan and Gagan, *Patients of Moderate Means*, 39–40; James Wishart, 'Class Difference and the Reformation of Ontario Public Hospitals, 1900–1935,' *Labour / Le Travail* 48 (2001): 27–61. For an American example, see Vanessa Northington Gamble, *Making a Place for Ourselves: The Black Hospital Movement, 1920–1945* (New York: Oxford University Press, 1995).

26 Gagan and Gagan, *Patients of Moderate Means*, 166–7.

27 Andrew Lam, Esther Fung, et al., Chinese Christian Youth Conference Committee, to W.H. Hatfield, director Division of TB Control, 5 Apr. 1946; J.B. Peters to deputy provincial health officer, 3 Sept. 1946, file 5, box 2, GR 129, British Columbia Archives (hereafter BCA).

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chimney nor fire.[28] Bella Coola was no exception in British Columbia.[29] Private and voluntary hospitals also observed a strict colour line. At Pine Falls, Manitoba, in the 1930s the Manitoba Pulp and Paper Company's hospital refused to treat local people, even though the company physician was under contract to attend First Nations patients. Because employees objected to 'meeting Indians' in the hospital, the company built, at government expense, an annex for the exclusive use of First Nations patients.[30] The St Boniface Sanatorium, owned by the Grey Nuns at St Vital Manitoba, maintained a separate Indian building.[31] At Cardston, Alberta, the Blood Indian Hospital literally sat across the street from the local municipal hospital. Segregation likewise defined territorial hospitals after the Second World War when the privately owned hospital at Mayo, Yukon, simply refused to admit First Nations patients until the government built an Indian ward.[32] From its opening in 1948 the Yellowknife hospital confined Aboriginal patients to its ten-bed Indian wing with a separate entrance and waiting room.[33] The rationales for segregation reflected community prejudices that were rarely questioned by the DIA.

Ongoing and unrelieved suffering prompted the Indian agent at Battleford in central Saskatchewan to suggest an Indian hospital because the community hospital was over-crowded: 'And besides, the presence of Indians is sometimes objected to on other grounds.'[34] Sixteen years later the new agent, citing increased public criticism of the government, repeated the plea noting that 'several have died in filth and misery because there was no possible place to care for them and local hospitals would not take them.'[35] The next year, in 1924, the

28 Memorandum, A. Forget, accountant, Department of Indian Affairs, 26 Feb. 1917, pt 1, file 811-2, vol. 2728, RG29, LAC; Kelm, *Colonizing Bodies*, 136–7.

29 E. Martin, BC minister of health, to J.W. Monteith, minister of National Health, 25 Oct. 1961, 'At one time it was a practice in some hospitals in BC to maintain Indian wards to which Indian patients were assigned exclusively.' File 10, box 5, GR679, BCA.

30 W.H. Carter to Thomas Murphy, 4 Feb. 1933, pt 1, file 822-1-X200, vol. 2775, RG29, LAC; H. McGill to Dr Bissett, 24 Mar. 1938, pt 2, file 822-1-X200, vol. 2775, RG29, LAC.

31 J.D. Adamson to J. McEachern, 15 July 1939, pt 1, file 800-1-D297, vol. 2590, RG29, LAC.

32 Ken Coates, *Best Left as Indians; Native–White Relations in the Yukon Territory, 1840–1973* (Montreal and Kingston: McGill-Queen's University Press, 1991), 95.

33 Stanton to chairman, 27 Mar. 1950, file 41-5-9, vol. 878, RG22, LAC.

34 Inspector Chisholm, Battleford Agency, 10 Dec. 1906 to Feb. 1907, pt 1, file 831-1-D353, vol. 2795, RG29, LAC.

35 S.L. Macdonald to secretary DIA, 31 July 1923, pt 1, file 831-1-D353, vol. 2795, RG29, LAC.

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department considered building an Indian wing at the local Notre Dame Hospital and the Sisters of Providence would charge the government $2.50 per day for care. But hospital superintendent Sister Justinian demanded a separate Indian building with its entrance at the rear of the property instead of an Indian wing.[36] In the meantime Anglican Bishop George Lloyd objected to the DIA 'handing all our Anglican Indians ... over to the tender mercies of a Roman Catholic institution at the time of sickness.'[37] The plans for hospital care in Battleford were shelved for another twenty years until 1947 when IHS opened the North Battleford Indian Hospital in decommissioned military buildings. Denominational turf wars and concerns for economy limited institutional health care in the interwar period.

While Aboriginal patients were relegated to indigent wards or Indian wings and subjected to community prejudice, the DIA accepted the situation since its financial commitment was predictable and easily controlled. Departmental physicians, under strict supervision lest they provide too many services, could do little more than recommend hospital care for their patients; ultimately bureaucrats and bookkeepers determined who was admitted to hospital and for how long, with a keen eye to the bottom line. But First Nations actively advocated for better care. Elders recall that a delegation from Pasqua reserve in southern Saskatchewan travelled to Ottawa in 1928 (covertly circumventing the travel and fund-raising restrictions of the Indian Act) to protest their exclusion from community hospitals. A 1923 petition from the British Columbia Indian Anti-Tuberculosis League likewise demanded improved care.[38] In the 1920s Indian Commissioner William Graham also agitated for hospital care, arguing that a departmental hospital with fifty to sixty beds with minimal staff could be maintained for less than half the per diem cost they were currently paying to local institutions. How those savings might be accomplished was left to the imagination. Graham also stressed that 60 per cent of costs could be paid by the bands themselves. Despite departmental assertions that its parsimony was justified because hospital care relied on public funds, half the hospital costs from 1922 to 1924 were

36 Joseph Guy, OMI, to D.C. Scott, 1 Dec. 1924; S.L. Macdonald to D.C. Scott, 15 Apr. 1926, pt 1, file 831-1-D353, vol. 2795, RG29, LAC.

37 G.E. Lloyd, bishop, Diocese of Saskatchewan, to D.C. Scott, 30 July 1926, pt 1, file 831-1-D353, vol. 2795, RG29, LAC.

38 Interview with Andrew and Rosabel (Ryder) Gordon, Pasqua First Nation, 14 July 2000; Gordon's father, Andrew Gordon Sr, led the delegation that included First World War veterans Abel Watech and Harry Ball; Petition, 30 Oct. 1923, file 600,023, vol. 4093, RG10, LAC.

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actually paid by First Nations for their own care. In reply to Graham's plea that he was faced every week with people 'actually suffering and some of them dying for want of care,' Deputy Minister D.C. Scott replied that the 'present system is adequate' and 'it is quite impossible to obtain money for these pressing demands.'[39]

Hospital care, constrained by a state parsimony that extended to the management of First Nations' *own* funds, and relegated to basement wards and Indian annexes, did little to convince Aboriginal people of the benefits of Western biomedicine. Indeed, many chose to remain under the care of their own healers, despite the legal and extra-legal repression that circumscribed their practice. Given the reception they might receive in community hospitals, the decision to remain at home was likely prudent. As the government doctor at Battleford noted, 'Notwithstanding the discomforts they endure [at home] they seem to prefer the association of their own people to the comforts which an institution would provide.' Finding the attitude incomprehensible, the physician was convinced that Aboriginal people posed a threat to the community and advised the use of force to 'break up this custom among the Indians.'[40] The construction of First Nations as carelessly indifferent to their own health and a danger to others recommended increasingly coercive practices. Indian hospitals might thus serve the social imperative to 'break up Indian customs,' while reserving community hospitals for white patients.

Government fiscal policy also worked to maintain the colour line in community and voluntary hospitals, especially its practice of paying somewhat less than the 'indigent rate,' or the rate paid by municipalities for the care of the poor. Defending the practice, bureaucrats argued that hospitals padded each bill to cover delinquent accounts, but since the department always paid its bills eventually, hospitals should discount the rates charged for government patients. Not surprisingly, hospital administrators disagreed.

In Alberta the issue became particularly acrimonious with the manager of the Calgary Hospitals Board asking why the government expected Alberta communities to subsidize First Nations' care: 'Each Indian patient admitted and paid for by the government on the basis of $3.00 flat rate per day prohibits, during the period of his or her hospitalization, the admission of some civilian patient who likely

39 Scott to Graham, 1 Dec. 1925; Graham to Scott, 1 Feb. 1926, file 495,800, vol. 4084, RG10, LAC.

40 H.C. Norquay, to assistant deputy and secretary, Department of Indian Affairs, 30 July 1923, pt 1, file 831-1-D353, vol. 2795, RG29, LAC.

would pay the full rates charged.' Accordingly, he recommended that the 'Calgary Hospitals Board adopt a policy of refusing to admit Indian patients.'[41] The 846-bed Calgary General Hospital had treated only about eight First Nations patients in the previous six months.[42] Dr Percy Moore, IHS director, and never one to underestimate his own authority, threatened that since the city's Calgary Stampede profited by First Nations participation, 'this [Indian Health] Service will, in future, pay no accounts incurred by Indians due to injury when competing in stampede activities.'[43]

Smaller community hospitals in Alberta also benefited in their efforts to attract and maintain paying patients. Dr E.L. Stone, IHS regional superintendent in Alberta in 1950, warned that Alberta hospitals 'have practically ceased to accept a sick Indian except in the most emergent circumstances, and for the shortest possible time.' Moreover, the hospitals 'are overcrowded by patients from their own municipalities and for whose care they can depend on full rates.'[44] State policy clearly aided hospitals' efforts to devote bed space to the right patient, the paying patient.

The Tsuu T'ina by the early 1950s improved their economic circumstances by developing the reserve's oil and gas resources, and given their experience with the boarding school on the reserve, they were anxious to access medical care. By 1955 the government reached an accommodation with the Calgary hospitals and agreed to pay a per diem rate of $12.75. This escalating rate reflects the soaring costs of hospital care in the 1950s, and not primarily as bureaucrats suspected, an attempt by hospitals to gouge the government. Nevertheless, a gap remained and the Tsuu T'ina continued to subsidize hospital costs. Meanwhile reserve living conditions – especially housing – deteriorated, and as the supervisor of Indian agencies noted, there was little logic in using their funds to pay hospital bills when they required so many necessities 'before we can conclude that the people are not experiencing a substandard existence.'[45] Despite devoting precious funds, Tsuu T'ina patients found themselves in the indigent

41 J. Barnes to H.A. Proctor, IHS, 30 Sept 1948; Barnes and J.D. Heaslip to chairman and members, Calgary Hospitals Board, 12 Jan. 1949, pt 1, file 851-1-X400, vol. 2936, RG29, LAC.
42 Barnes and J.D. Heaslip to chairman and members, Calgary Hospitals Board, 12 Jan. 1949.
43 Moore to Barnes, 1 Apr. 1949, pt 1, file 851-1-X400, vol. 2936, RG29, LAC.
44 Stone to director IHS, 5 Jan. 1950, pt 1, file 851-1-X400, vol. 2936, RG29, LAC.
45 R.F. Battle, regional supervisor, to director, Indian Affairs Branch, 8 Dec. 1955, pt 1, file 851-1-X400, vol. 2936, RG29, LAC.

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ward. The modernizing hospital with patients anxious to purchase its services saw no need to take up valuable beds and offend middle-class sensibilities by admitting Aboriginal patients. Moreover, the state's minimal commitment to First Nations health care actively cultivated an image of the people as unworthy of care and a burden on the community. Modern hospitals with the state's aid produced and reproduced racialized lines of exclusion; it became normal and natural that effective health care was reserved for white citizens.[46] At the same time, growing public criticism of government policy that left disease, especially tuberculosis, untreated and a threat to the nation recommended the establishment of government-run Indian hospitals.

THE SANATORIUM CURE

While voluntary and community hospitals reluctantly admitted First Nations patients, tuberculosis sanatoria in the West rarely contemplated the idea. Established in the optimism that tuberculosis could be cured through 'open air' treatment, bed rest, and nourishing food, sanatoria emerged as the most popular, indeed the singular, approach to the disease.[47] Fashioned after European spas with chalet-style architecture in bucolic settings far removed from urban populations, provincial sanatoria, although founded prior to the First World War by volunteer groups, increasingly relied on public funds. Treatment relied on extended stays that focused on improvement and regulation of the self, where the 'soul of the citizen' came under scrutiny.[48] Confinement created healthy, self-governing citizens who, as Alison Bashford argues, were 'released back into the community, as part of this new cultivation of the hygienic self.'[49] The disciplinary function

46 Lindsay Granshaw makes a similar point in reference to British hospitals, in 'The Hospital,' *Companion Encyclopaedia of the History of Medicine*, ed. W.F. Bynam and Roy Porter (London: Routledge, 1993), 2:1193.

47 Historians continue to debate the role of sanatorium treatment in the decline of tuberculosis. Barbara Bates, *Bargaining for Life: A Social History of Tuberculosis, 1876–1938* (Philadelphia: University of Pennsylvania Press, 1992); Amy Fairchild and Gerald Oppenheimer, 'Public Health Nihilism vs Pragmatism: History, Politics and the Control of Tuberculosis,' *American Journal of Public Health* 88, no. 7 (1998): 1105–17; Sheila Rothman, *Living in the Shadow of Death: Tuberculosis and the Social Experience of Illness in American History* (New York: Basic Books, 1994).

48 Bashford and Strange, *Isolation*, 135.

49 Alison Bashford, *Imperial Hygiene: A Critical History of Colonialism, Nationalism and Public Health* (London: Palgrave, 2004), 62, 70–1.

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of the sanatorium emerged more clearly as tuberculosis became associated with the working classes and the poor. But the 'cure' in the 1920s was not medicine or surgery but 'an idea: a way of life ... the development of faithful endeavour, helpfulness, earnestness, good humour, kindliness and forbearance.'[50] Armed with these attributes of safe and healthy citizenship, the cured could leave the institution as self-governing individuals knowing they no longer posed a risk to their families or community.

Antimicrobials developed in the late 1940s made tuberculosis much more manageable, but institutional treatment remained necessary for those who could not be trusted to follow the long course of chemotherapy. As Dr Wherrett of the CTA advised in a Department of Labour radio series *Canada at Work*, the sanatorium experience not only restored health but improved workers: 'It's a smart secretary too who sees that she doesn't lose her shorthand or let her typing slip. Should she happen to be weak on spelling she can use the months in hospital to become a better speller – a joy to any boss.'[51] The medical discourse of improvement through confinement is obvious and clearly directed at those who through ignorance or social position had not yet acquired the knowledge and understanding to be rational healthy citizens.

Aboriginal people, wards of the state and deemed insufficiently educated to benefit from training in rational citizenship, were not as a rule accepted for treatment in provincial sanatoria in the West.[52] Saskatchewan was the exception, with three public sanatoria by 1930 and more than seven hundred beds. In the south, the Fort Qu'Appelle Sanatorium reserved its more than three hundred beds for whites, but for a time maintained a forty-bed Indian wing in order to repay debts to the federal government. Further north, the Prince Albert Sanatorium provided a few beds in the late 1930s for deserving First Nations who were judged by Indian agents or local physicians as worthy of care and 'advanced' enough to benefit from treatment. But social, not medical, criteria determined who might receive care: young residential school students whose families demonstrated progress along the path to assimilation.

50 Quoted in C. Stuart Houston, *R.G. Ferguson: Crusader against Tuberculosis* (Toronto: Dundurn, 1991), 51.

51 Dr. Wherrett, 'Back to Work after a Bout of Tuberculosis,' *Canada at Work* (broadcast N-537, 5 Dec. 1954), 3, file 10, vol. 21, Canadian Tuberculosis Association, I75, MG28, LAC.

52 Houston, *R.G. Ferguson*, 92; Kelm, *Colonizing Bodies*, 122; Lux, *Medicine That Walks*, 197, 215.

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When sixteen-year-old Mary (not her real name) was returned to her father from the Onion Lake residential school in May 1937 after suffering hemorrhages for a year, he requested that she receive sanatorium treatment. The government's Dr Norquay flatly refused, claiming that Mary's older sister, who also contracted tuberculosis at school and was treated at the sanatorium, upon her return to the reserve became 'very intimate with a young man ... [who] was permitted to occupy the same bed with the daughter.' Moreover, her father made no effort to force the young couple to marry until she became pregnant, which 'greatly lessened her chances of a permanent cure.' Clearly the sanatorium cure was wasted and her father was to blame. Mary was therefore refused treatment, although the doctor approved a $5 ration voucher, but when Norquay discovered that her father spent it all on fresh fruit, 'which would necessitate the rest of the family participating if the fruit was not allowed to spoil,' he warned that 'this sort of foolishness would result in the withdrawal of such favours.'[53] Desperate, Mary's father engaged a lawyer to press Norquay's superiors, arguing, 'The child was well when she went to the school and contracted the disease there ... They [parents] know that there is care for sick white children and believe the same care should be afforded to Indian children.' Not until a local newspaper publicized Mary's case did the Indian branch director, Harold McGill, authorize sanatorium treatment for a 'a limited number of tuberculous Indians,' but only Mary was admitted.[54] Physicians' authority over Aboriginal bodies that refused to adopt middle-class notions of sexual propriety and acceptable gender roles exposed medicine's collusion in Canada's colonizing project. But as Mary's plight revealed, demands for care and resistance to exclusion made it more difficult to keep disease isolated in schools and on reserves.

MAKING INDIAN HOSPITALS

The extent of tuberculosis on reserves, however, remained the subject of much speculation. Manitoba's Dr David Stewart claimed that in the western provinces the 'death rate among Indians [is] ten to twenty times as great as that among white people, and over 30 percent of

53 Norquay to Stone, 28 Sept. 1937, pt 1a, file 851-1-A671, vol. 2915, RG29, LAC.

54 F.R. Conroy, barrister and solicitor North Battleford, to DIA Ottawa and Department of Public Health, Regina, 20 Sept 1937; Director of Indian Affairs to S.L. Macdonald, Indian agent, 23 Oct. 1937, pt 1a, file 851-1-A671, vol. 2915, RG29, LAC.

the total deaths from tuberculosis occur among the Indians, who comprise less than three percent of the total population.'[55] In a more candid moment he admitted that since so few First Nations were attended by physicians, 'there is some doubt about the accuracy of death causes of Indians ... and there is the strong tendency to put down an Indian as dying of tuberculosis. The poor fellow scarcely is allowed to die of anything else.' Moreover, the statistical picture of Indian tuberculosis, however faulty, also illustrated a satisfying decline in the white death rate. As Stewart explained, the official death rate for Manitoba for 1932 per 100,000, 'if Indian deaths were dropped ... would become 40, and if the half-breed deaths were dropped, a non-Indian rate of 34/100,000 would emerge.' Stewart's statistics became considerably muddled when he conceded that 'half-breed deaths' were an estimate because they were counted in the census 'according to the white racial mixture, as French, Scotch or English.'[56] A more complete knowledge of tuberculosis would have to await the bureaucratic regulation that the Indian hospitals afforded, but the threat of Indian tuberculosis was clear.

Increased medical surveillance began with a CTA- and government-sponsored 1926 survey in British Columbia that for two years X-rayed, examined, and gave advice to First Nations, with no offer of treatment. This desire to create a detailed 'colonizing archive,' while refusing treatment, caused considerable outrage in First Nations communities.[57] Physician bureaucrats found that case-finding on reserves with no chance of treatment, 'only irritate[s] the tuberculosis and public health authorities and the Indians.' An attempted repeat tuberculosis survey on a Manitoba reserve faced the ire of the community. 'The chief and councilors nearly kicked us off the reserve. It took us three or four days to convince them to let us bring our x-ray machine ... because we had not done anything about it the first time.'[58] Coercion succeeded when tuberculosis survey crews travelled with treaty parties who simply refused to pay annuities until the people submitted to an X-ray.[59] Knowledge of the 'Indian problem,' frustrated by limited

55 D.A. Stewart, 'The Red Man and the White Plague' [1936], 4, file VII.27, A638, Lung Association, Saskatchewan Archives Board (hereafter SAB).

56 D.A. Stewart, Manitoba Sanatorium Board, to R.A. Wardle, 22 Jan. 1934, file VII.27, A638, SAB.

57 Kelm, *Colonizing Bodies*, 120.

58 'Conference on Tuberculosis,' 1; 'Advisory Committee for the Control and Prevention of Tuberculosis among the Indians, May 1945,' 129, file 36, II(a), I75, MG28, LAC.

59 Bruce Norton, 'Northern Manitoba Treaty Party, 1949,' *Manitoba History* 39 (Spring 2000): 15–24, Dryden et al., *Camsell Mosaic*, 133.

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access to reserve communities, increasingly focused on the much more accessible residential schoolchildren and First Nations infants.

In 1933 Dr Ferguson, director of Saskatchewan's Fort Qu'Appelle Sanatorium, began an experimental trial of the highly controversial tuberculosis vaccine BCG (bacillus-Calmette-Guerin) on First Nations infants. He lived at the sanatorium, which was literally surrounded by reserves and the threat of First Nations contagion. With funding from the CTA and the National Research Council, Ferguson's trial showed that BCG provided some resistance to the disease and, more to the point, prevented its spread. But Ferguson's trial required infants to be born in hospital and never exposed to the disease (unvaccinated controls were born on the reserves), so in 1936 (the Depression notwithstanding) the government built the fifty-bed Fort Qu'Appelle Indian Hospital, across the lake from the provincial sanatorium.[60] Despite the trial's apparent success against tuberculosis, 12 per cent of the infants died before their first birthday, and seven years into the trial 105 children, or 17 per cent, were dead from pneumonia and gastrointestinal disease.[61] Overcrowded housing, poor nutrition, and unclean water, or poverty, posed the greatest threat to children, but unlike tuberculosis, it did not spread to white communities. The new Indian hospital, a dour three-storey brick building shared none of the sanatorium architectural style with sleeping porches and expansive grounds, resembling instead a small school. And while general hospitals rarely admitted tuberculosis patients for fear of cross infection, the Fort Qu'Appelle Indian Hospital kept tuberculosis patients on the third floor, with maternity, medical, and pediatric patients on the second floor. The hospital's rationale, to remove First Nations from Ferguson's sanatorium and making space for white patients, and to provide maternity facilities for his BCG vaccine trial presumed that Aboriginal patients could all be isolated together, that tuberculosis was a threat to the white community only.

The CTA, representing sanatorium directors, like Ferguson and Stewart, was the most powerful voice for racially segregated treatment.

60 The next year DIA was made a branch of Mines and Resources with a much reduced budget, and hospital patients were discharged. McGill to Agents, 14 Jan. 1937, file 311-T7-16, vol. 1225, RG29, LAC.

61 R.G. Ferguson, *Tuberculosis among the Indians of the Great Canadian Plains* (rpr.; London: Adlard, 1928); Ferguson and Simes, 'BCG Vaccination of Indian Infants in Saskatchewan,' *Tubercle* 30, no. 1 (1949): 5–11; M.K. Lux, 'Perfect Subjects: Race, Tuberculosis and the Qu'Appelle BCG Vaccine Trial,' *Canadian Bulletin of Medical History* 15, no. 2 (1998): 289. From 1933 to 1945 Ferguson vaccinated 306 infants and studied 303 unvaccinated controls.

FIGURE 1 Built in 1936, the fifty-bed Fort Qu'Appelle Indian Hospital sat across Echo Lake from Saskatchewan's provincial sanatorium. The site of Dr Ferguson's BCG experiment on Aboriginal infants, it replaced the aging cottage hospital at the File Hills Colony on the nearby Peepeekisis Reserve. Accession no. R96-472, Saskatchewan Archives.

Established in 1901 by elites concerned with the economic impact of tuberculosis, the CTA, in the collusion of knowledge and power, exerted considerable influence on government policy. In a letter to the Manitoba premier, Stewart called the First Nations 'dangerous neighbours' and a 'menace ... to the health of ordinary citizens' and an 'uncontrolled nuisance.'[62] At its 1935 annual meeting the CTA devoted a session to 'Indian tuberculosis' and sent resolutions to the prime minister and minister of health, warning of the 'menace of uncontrolled tuberculosis on Indian reserves to the surrounding white population,' demanding more government action. The CTA continued to press the point, noting in 1937 that the 'opinion has been expressed in some quarters that there is a higher incidence of the disease in communities adjacent to Indian reserves.'[63] Physician and Liberal member of Parliament J.J. McCann put the CTA's position before the House during the 1937 debate on estimates of the Indian Affairs branch. Quoting from Stewart's pamphlet, 'The Red Man and the

62 Stewart to Premier Bracken, 14 Nov. 1934, file 311-T7–16, vol. 1225, RG29, LAC.
63 Wherrett, *Miracle*, 110, 112–13.

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White Plague,' McCann reminded MPs that falling white tuberculosis rates meant virtuous families, like their own, with healthy unexposed children were particularly vulnerable to 'outside infection ... a spark in dry grass.'[64]

In June 1937 the CTA formed a joint committee of federal and provincial bureaucrats and sanatorium directors that met in Ottawa to consider how best to control the threat of Indian tuberculosis, with the paltry $50,000 the Indian branch had at its disposal. Dr E.L. Stone, at this time superintendent of medical services for Indian Affairs, opened the meeting by drawing a bold red line across the map of Canada from west to east that separated 'those [Indians] to the south who are, generally speaking, in contact with and a menace to white populations, from those to the north, who ... are not.'[65] Approximately 75,000 (of a total First Nations population of about 115,000) lived in this 'contact zone,' representing just 0.6 per cent of the Canadian population of slightly more than 11 million. Despite their small number, Stone emphasized the threat: 'Roughly two Indians out of three, are shown to be in contact with white people.' Of the population in the 'white contact areas,' 9,000 were students living in sixty residential schools, but as Ferguson of Saskatchewan noted, the experience of the Tsuu T'ina reserve showed that schools were easily turned into sanatoria. He added that, despite criticisms of residential schools, 'for the purpose of cleaning up tuberculosis among the children they are a wonderful institution.' The irony that the schools, so clearly implicated in the spread of the disease, would now be the solution, seemed lost on Ferguson. But, as Dr Alexander, medical superintendent at Six Nations reserve near Brantford argued, adults were a greater threat. 'I know of at least three families to whom an Indian maid has conveyed infection to the children.' Lapsing into a telling military metaphor, Aboriginal people were 'an enemy in our midst, and while we have few guns trained on them there is no reason why we cannot attack them with such weapons as we have.'[66]

The committee recommended dividing the funds among the provinces on the basis of a simple calculation of the number of 'Indians in contact with white people ("in south") ... and the probable amount of Tuberculosis among them.'[67] Seventy per cent ($35,000) went to the four western provinces to establish 'preventoria' in the

64 'House of Commons Discusses Estimates for Indian Affairs Branch,' *Bulletin of the Canadian Tuberculosis Association* 15, no. 4 (1937): 3–4.

65 'Conference on Tuberculosis,' 11.

66 Ibid., 13, 57–8, 73, 89.

67 Ibid., memorandum, E.L. Stone to director, 29 June 1937.

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schools that segregated children with 'minimal lesions,' and to pay the churches to provide sickly children with extra food and 'one or two years better care than the rest.'[68] Keeping infected and healthy children in the same institution likely only slowed the spread of disease within the schools, but it might limit the spread from school to reserve, which, as Stone confided to his director, posed a larger problem: 'It would be hard to prove that the Residential Schools, as a group, are not agencies for the spread of tuberculosis.'[69] Stone assured Director McGill that he could keep ordinary medical costs to $10 per capita, or half the cost for white people, but more funds would be needed for medical officers and Indian tuberculosis sanatoria. Before it adjourned, the conference also established an Indian advisory committee, essentially the management committee of the CTA, to keep the problem of Indian tuberculosis before the government and public.

The Indian advisory committee recommended dramatically increased parliamentary appropriations for tuberculosis surveys in schools and reserves and an aggressive Indian hospital construction program. The CTA made clear that past efforts to ameliorate the predisposing causes of tuberculosis – diet and housing – only clouded the real problem that tuberculosis is a communicable disease, in the same way that 'leprosy, typhoid fever, or smallpox are communicable diseases.' Comparisons to historically frightening diseases emphasized the danger for those who remained complacent and implied the coercive measures that such diseases prompted. 'Polluted with tuberculosis,' Aboriginal people required a system of surveillance by medical personnel, as well as 'training, supervision, treatment or segregation.' Admitting that there was little understanding of the extent of disease on reserves, the CTA suggested that the elderly and 'hopeless cases' should be segregated on reserves under the care of nurses, if any could be hired. But the foundation of control efforts would be confinement in special tuberculosis institutions of 'young Indians ... [and] hopeful cases that can be cured, intelligent Indians whose education and sanitary habits will have some effect in raising the standards of the Indian generally.' Such deserving 'hopeful cases' might be trained in healthy citizenship.[70] Nothing less than an expansion of racially

68 Ibid., 14. 'Preventoria' were intended to prevent illness rather than treat it, and provide a middle-class home life for children of the tubercular indigent. Cynthia Connolly, *Saving Sickly Children: The Tuberculosis Preventorium in American Life, 1909–1970* (New Jersey: Rutgers University Press, 2008), 2.

69 Memorandum, E.L. Stone to director, 29 June 1937, file 36, II(a), I75, MG28, LAC.

70 'Outline of Tuberculosis Control for the Indian Population of Canada, 1937,' file 31, II(a), I75, MG28, LAC.

segregated institutions like Fort Qu'Appelle Indian Hospital would suffice, well removed from white sanatoria.

Naturally, the next Indian hospital to open was in Manitoba, home to the minister responsible for the Indian branch, Thomas Crerar. In 1939 the Anglicans gladly sold its Dynevor Hospital, near Selkirk, to the Indian branch. The aging structure, built in the 1870s as a rectory for St Peter's parish and converted to an infirmary in the 1890s, became a fifty-bed Indian hospital managed for the government by the Manitoba Sanatorium board.[71] Friends of the government ensured that the hospital received international attention, with the *New York Times* congratulating the government for its 'steady progress' in the provision of hospitals for 'sick Indians at a cost less than that of admitting them to public institutions.'[72] The Dynevor Indian Hospital had its critics, however. Dr J.D. Adamson of the St Boniface Sanatorium in nearby St Vital, which recently added twenty beds to its Indian building in anticipation of much-needed revenue from government patients, claimed that the Dynevor Indian Hospital would mean an 'enormous over-supply of beds.' But, explained Dr E.L. Ross of the Manitoba Sanatorium board, Dynevor was not intended to be a 'fully equipped sanatorium,' but an inexpensive alternative providing rest and nursing care, well removed from white populations. Indeed, Dynevor made do without an X-ray machine when renovation costs exceeded the Indian branch budget.[73]

High death rates, the grim reality of tuberculosis treatment in any sanatorium, threatened to tarnish Dynevor's image, so the dead were buried across the Red River at St Peter's Parish.[74] In its first year the hospital admitted sixty-seven tuberculosis patients, nearly half of which were children removed from schools. The most common treatment at Dynevor was pneumothorax 'refills.' Pneumothorax, or therapeutic lung collapse, was an extension of rest therapy surgically induced, but the lung naturally re-inflated so a 'refill' of gas injected

71 John McEachern to H.W. McGill, 25 Sept. 1939, pt 1, file 800-1-D297, vol. 2590, RG29, LAC.

72 'Hospitals Developed for Canadian Indians,' *New York Times*, 7 Jan. 1940.

73 St Boniface Sanatorium was established in 1931 by the Catholic Grey Nuns. J.D. Adamson to J. McEachern, 15 July 1939; H. McGill, 'Memorandum for the Deputy Minister,' 15 Sept 1939, pt 1, file 800-1-D297, vol. 2590, RG29, LAC.

74 Northwood to P.E. Moore, 3 Apr. 1940, pt 1, file 800-1-D297, vol. 2590, RG29, LAC. Northwood decried the Indian Affairs policy of limiting burial costs to $25 when the government allowed $100 for military burials.

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FIGURE 2 Dating from the 1870s, the building in the centre was originally the rectory of St Peter's Parish, near Selkirk, Manitoba. Converted to an infirmary in the 1890s, the building was sold to the Indian branch in 1939 and opened as the Dynevor Indian Hospital managed by the Manitoba Sanatorium board. Rupert's Land 150, Archives of Manitoba.

into the pleural space maintained the lung collapse.[75] In its first year alone Dynevor performed more than three hundred pneumothorax refills.[76] By its fifth year, 29 per cent of Dynevor's patients were dead, and another 12 per cent were 'unimproved.'[77] The efficacy of pneumothorax, the mainstay of surgical treatment in Canadian sanatoria in the 1930s and 1940s, is impossible to judge, but of the First World War veterans treated at the Central Alberta Sanatorium in

75 Johnston, 'Tuberculosis,' 1065. Other forms of collapse therapy included thoracoplasty (the surgical removal of several ribs to collapse the lung), and phrenic nerve crush (to paralyze the diaphragm).

76 'Report of the Resident Physician of Dynevor Indian Hospital,' 31 Dec. 1940, pt 1, file 800-1-D297, vol. 2590, RG29, LAC.

77 'Report of the Dynevor Indian Hospital for the Year 1945,' pt 2, file 800-1-D297, vol. 2591, RG29, LAC. Of the remaining patients, 27 per cent were well enough to work, 22 per cent at school, and 9 per cent well at home.

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Calgary, only half of the pneumothorax patients lived, and fewer than one third improved.[78] Besides surgery, or often because of it, bed rest was strictly enforced. As in all sanatoria, some patients resisted the enforced idleness, strict routines, or the prospect of surgery, but Dynevor's physician suggested that 'the philosophy of the Indian' made the problem more acute.[79] Police forcibly returned patients who 'ran away' (left against medical advice) under the authority of the clumsy and time-consuming provincial Communicable Disease Control Act.[80] While all sanatoria faced recalcitrant patients, since much of the therapy was concerned with cultivating the proper attitudes of the hygienic self, patients were not held against their will. But Indian hospitals were different; as we shall see, the Indian Act was subsequently amended to force medical examination and treatment.

In British Columbia in the 1930s there were no sanatorium beds for Aboriginal people, but, warned Dr W.H. Hatfield, head of the tuberculosis program, the threat was worse because they were not confined to reserves, but 'free Indians' mixing with the white population, causing alarm.[81] In 1941 the Indian branch opened the Coqualeetza Indian Hospital near Chilliwack, British Columbia.[82] Founded as a Methodist mission school in 1889, it expanded in 1924 when the DIA built a larger 200-student residential school. The children's health deteriorated by 1932, when an inspection found so much tuberculosis that the missionaries built a small preventorium for the most ill rather than send them home.[83] By 1938 the missionaries could no longer manage the school and turned it over to the government. In September 1941 the 185-bed hospital opened with six girls transferred from the preventorium. A 1948 fire destroyed much of the building; remarkably, no one was killed, but conditions were far from ideal for the ninety-eight patients who remained in the undamaged wing, or for the twenty-two patients in 'the converted hen house, known as the preventorium,' rotting and in immediate danger

78 Katherine McCuaig, *The Weariness, the Fever, and the Fret: The Campaign against Tuberculosis in Canada, 1900–1950* (Montreal and Kingston: McGill-Queen's University Press, 1999), 71–2; Darlene Zdunich, 'Tuberculosis and World War One Veterans' (MA thesis, University of Calgary, 1984), 102.

79 Report 31 Dec. 1940, pt 1, file 800-1-D297, vol. 2590, RG29, LAC.

80 Report 1945, pt 2, file 800-1-D297, vol. 2591, RG29, LAC.

81 'Meeting of the Indian Advisory Committee, March 10, 1938,' file 31 'Indians,' II(a), I75, MG28, LAC.

82 *Coqualeetza* is the Sto:lo word for place of cleansing or purification, 'The Coqualeetza Story, 1886–1956,' pt 1, file 8001-D528, vol. 2596, RG29, LAC.

83 Ibid., 8.

of collapse.[84] At war's end when responsibility for health care transferred to the newly formed department of National Health and Welfare, parliamentary appropriations for institutionalization increased considerably.

Post-war expansion of Indian hospitals began with the Charles Camsell Indian Hospital in Edmonton, the centrepiece of IHS in the West. Like most of the Indian hospitals, it was a borrowed building. Built in 1913 as a Jesuit college for boys, in 1942 the three-storey brick building became the headquarters of the American military's Northwest Command, when they added large California redwood frame buildings eventually covering three city blocks.[85] When the Americans withdrew in 1944, the Canadian army bought the sprawling complex but by 1945 deemed it redundant and turned it over to IHS for use as an Indian hospital.[86] Local protests erupted almost immediately. Petitions from veterans groups, the mayor, local politicians, and the hospital's neighbours demanded the redwood buildings be used to relieve the local housing shortage, while the hospital itself should be reserved for veterans. 'Tubercular Indians' posed a particularly dangerous threat.[87] A mass public meeting in late November attracted more than three hundred citizens and one RCMP confidential informant.[88]

To reassure Edmontonians, the government clarified its rationales for segregation and isolation: the hospital would treat all conditions, not just tuberculosis, 'and thus relieve the public wards of the Edmonton hospitals from treating Indians in these institutions.' Moreover, the grounds would be fenced and patients completely confined in the institution, noting that it was better to have 'these people under treatment than to have tuberculous Indians wandering about the streets of Edmonton ... spreading the disease.'[89] Minister of National Health and Welfare Brooke Claxton also reminded citizens

84 Moore to deputy minister of national health, 7 June 1950, pt 1, file 8001-D528, vol. 2596, RG29, LAC.

85 K.S. Coates and W.R. Morrison, *The Alaska Highway in World War II: The U.S. Army of Occupation in Canada's Northwest* (Toronto: University of Toronto Press, 1992); Shelagh D. Grant, *Sovereignty or Security? Government Policy in the Canadian North, 1936–1950* (Vancouver: UBC Press, 1988), 123.

86 Dryden, *Camsell Mosaic*, 8–9.

87 Mayor Fry to MacKenzie, 4 Oct. 1945; petition to prime minister, 13 Oct. 1945, pt 1, file 800-1-D479, vol. 2592, RG29, LAC.

88 H. Darling, RCMP 'K' Division, 26 Nov. 1945, pt 1, file 800-1-D479, vol. 2592, RG29, LAC.

89 J. Allison Glen to mayor, 24 Oct. 1945 pt 1, file 800-1-D479, vol. 2592, RG29, LAC.

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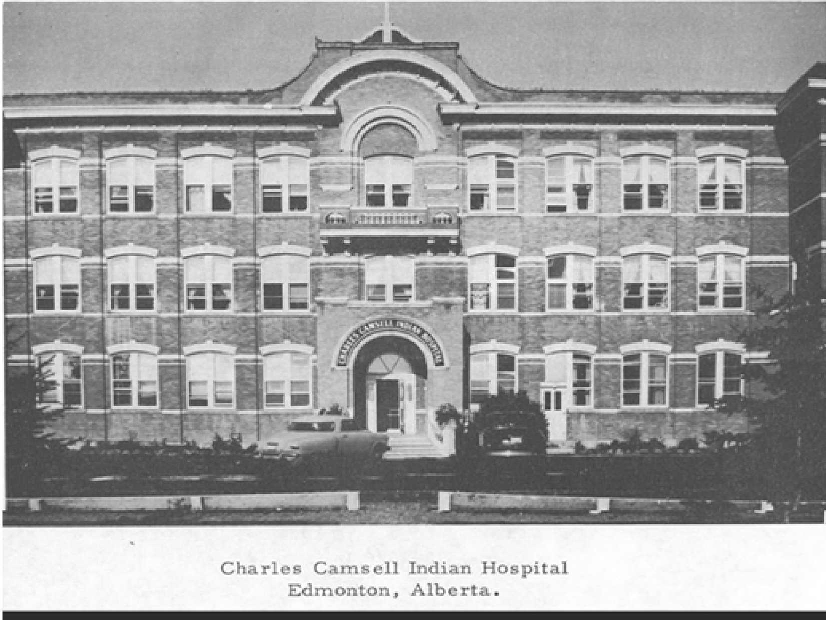

FIGURE 3 Built in 1913 as a Jesuit college for boys, in 1942 the building became the headquarters of the American military's Northwest Command until 1944, when the Canadian army bought the property for use as a military hospital. Deemed redundant the following year, the army turned it over to IHS for use as an Indian hospital. Donna Dryden, Elva Taylor, Rena Beer, Ron Bergmann, and Margaret Cogill, *The Camsell Mosaic* (Edmonton: Charles Camsell History Committee, 1985).

of the hundreds of jobs the hospital would bring, and that 'tuberculous Indians who are not in hospital are a danger to the community.'[90] IHS quickly transferred the fourteen Aboriginal patients in Edmonton hospitals and admitted patients from outlying denominational hospitals to the Charles Camsell.

The new Indian hospital treated all medical conditions, not just the 'Indian tuberculosis' that prompted its creation. The city's hospitals would be reserved for white citizens. In its first full year of operation, 69 per cent of admissions were for some form of tuberculosis; in 1947 tuberculosis admissions dropped to 40 per cent, and the

90 'Hon. Brooke Claxton' n.d., ca. November 1945, pt 1, file 800-1-D479, vol. 2592, RG29, LAC.

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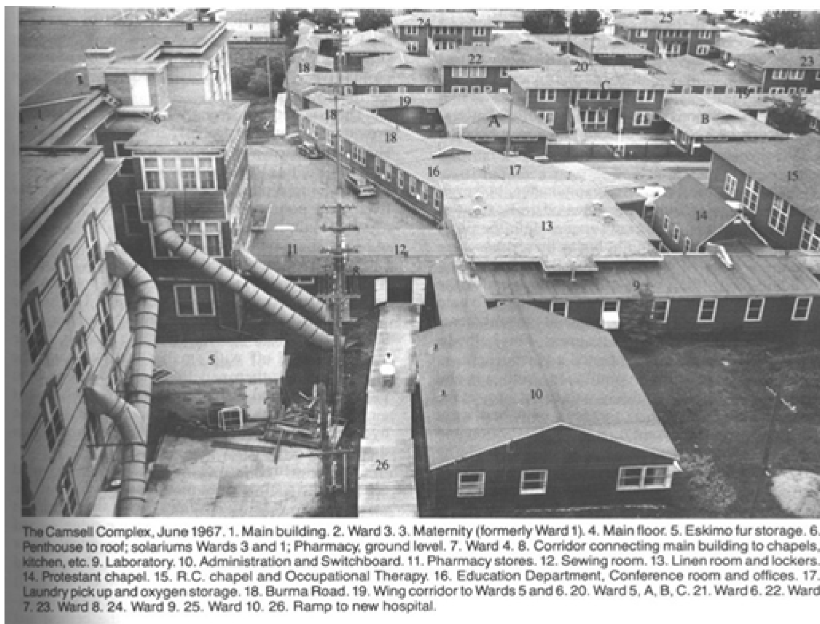

The Camsell Complex, June 1967. 1. Main building. 2. Ward 3. 3. Maternity (formerly Ward 1). 4. Main floor. 5. Eskimo fur storage. 6. Penthouse to roof; solariums Wards 3 and 1; Pharmacy, ground level. 7. Ward 4. 8. Corridor connecting main building to chapels, kitchen, etc. 9. Laboratory. 10. Administration and Switchboard. 11. Pharmacy stores. 12. Sewing room. 13. Linen room and lockers. 14. Protestant chapel. 15. R.C. chapel and Occupational Therapy. 16. Education Department, Conference room and offices. 17. Laundry pick up and oxygen storage. 18. Burma Road. 19. Wing corridor to Wards 5 and 6. 20. Ward 5, A, B, C. 21. Ward 6. 22. Ward 7. 23. Ward 8. 24. Ward 9. 25. Ward 10. 26. Ramp to new hospital.

FIGURE 4 The rear of the hospital complex reveals the crude conditions in the makeshift institution, where fire was a constant concern. For more than twenty years the building served as the centrepiece of Indian Health Service until it was demolished in 1967 and replaced by a new building on an adjacent site. Donna Dryden, Elva Taylor, Rena Beer, Ron Bergmann, and Margaret Cogill, *The Camsell Mosaic* (Edmonton: Charles Camsell History Committee, 1985). Reprinted with permission of Alberta Health Services.

following year tuberculosis counted for only 36 per cent of admissions.[91] Tuberculosis admissions increased as X-ray surveys fanned out across the West and North in the 1950s. Like the Fort Qu'Appelle Indian Hospital, the Charles Camsell Hospital established maternity and medical wards alongside tuberculosis wards. But the large dormitory wards of an army hospital were completely inappropriate for a combined tuberculosis/general hospital treating men, women, and children. Necessary renovations, delayed in the rush to admit patients, created dangerous cross infections. As Camsell's medical superintendent and chest surgeon Herbert Meltzer anxiously noted, children

91 File 33, box 2, accession 73.315, Charles Camsell Hospital records, Central Alberta (Baker) sanatorium, Public Archives of Alberta.

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admitted for other medical conditions contracted tuberculosis in the hospital.[92] The social, financial, and political utility of the hospital often trumped medical considerations.

Nevertheless, institutionalization continued apace, and it was a mass project. The extent of disease on reserves was still a matter of conjecture, but with post-war institutional expansion turning decommissioned military barracks into Indian hospitals across the West, IHS quickly expanded its surveillance.[93] Percy Moore later boasted that IHS screened 95 per cent of the total Indian population: 'At one point I had nearly half of them in the hospitals.'[94] And with institutions at its disposal, IHS stepped up compulsory measures. The Indian Act, amended in 1953 by the Indian Health Regulations, eased the detention and incarceration of the dangerous. Exposing the limits of Canada's liberalism, the Regulations' intent was to 'eliminat[e] any discrimination between those Canadian citizens of Indian status and other citizens of Canada' by applying all provincial public health laws to status Indians. But in order 'to protect and promote the health of the Indians,' the regulations contained compulsory provisions.[95] Thus, an Indian who 'suspects himself to be infected with an infectious disease' must be treated by a doctor. Violators faced a $100 fine, three months' imprisonment, or both. The regulations included Forms A, B, and C authorizing (respectively) compulsory medical examination and treatment, apprehension and detention, and the forced return of patients to hospital. And though the new regulations recognized that 'some Indians object strongly to having the police called in to force them to undergo examination and treatment … it is necessary to take compulsory action.'[96] Some chose to resist by isolating themselves from family and community in the bush rather than in hospital; arrest warrants were issued nevertheless. For example, in Saskatchewan, bureaucrats complained that First Nations who should be institutionalized 'are hiding in the bush, even though a warrant has been issued for their apprehension … Right now there is an old lady 77 years old who is hiding herself somewhere in the bush

92 Meltzer to Moore, 16 Jan. 1947, pt 1, file 831-1-D479, vol. 2796, RG29, LAC.

93 In the west, redundant military institutions at Miller Bay and Nanaimo in British Columbia, North Battleford in Saskatchewan, and Clearwater Lake in Manitoba became Indian hospitals in the 1940s.

94 Charlotte Gray, 'Profile: Percy Moore,' *Canadian Medical Association Journal* 126 (Feb. 1982): 416.

95 'Circular Letter to All Superintendents,' Indian Health Regulations, sec. 72 Indian Act, order-in-council, P.C. 193-1129, 17 July 1953, 1. The Regulations targeted all infectious disease, but made special mention of tuberculosis and venereal disease.

96 Indian Health Regulations, sec. 6, 18, 8.

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to avoid the RCMP.'[97] The Indian Health Regulations codified the fears, real or imagined, of the threat posed by the careless infected.

Not surprisingly, coercion continued inside the Indian hospitals where bed rest (augmented by surgery and chemotherapy) remained the core of tuberculosis treatment. Rambunctious children had both legs set in plaster casts with a bar connecting the legs, making movement impossible. When misbehaviour continued, they were fitted with full body casts. Staff jokingly referred to the condition as 'castitis.' Adult patients had their pajamas and robes taken away, forcing them to remain in bed to avoid humiliation.[98] One of the few Aboriginal professionals to work in the Camsell hospital, nurse Steinhauer-Anderson described the patient experience: 'Most of the patients demonstrated that sense of despairing resignation so evident at a residential school … Gaols seem to elicit somewhat the same response from native people familiar with such institutions.'[99] Linking these sites of isolation and discipline, she pointed to a persistent reality in the lives of many Aboriginal people.

CONCLUSION

Excluded from the modernizing hospital by the needs of the health-seeking middle class, and deemed incapable of benefiting from the sanatorium cure, Aboriginal bodies became the careless infected and a threat to the community. Demands for care from First Nations communities only increased their isolation on reserves and in mission schools. Indian hospitals as sites of confinement and control worked to isolate disease and continue the state's assmilationist agenda by other means. Colonialism's racialized lines of exclusion, tended by medicine and a vigilant state, also traced the contours of white national health. Just as the systematic marginalization and dispossession of First Nations sat at the core of nineteenth- and early-twentieth-century Canadian state formation, their isolation and segregation was fundamental to the emerging welfare state.

97 T.J. Orford, to G.D. Barnett, 13 Oct. 1961, file VIII.48, A638, SAB.
98 Dryden, et al., *Camsell Mosaic*, 29, 95.
99 Kathleen Steinhauer-Anderson quoted in ibid., 101.