Reserve Hospitals and Medical Officers: Health Care and Indian Peoples in Southern Alberta, 1890s-1930

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ABSTRACT. Between the 1890s and 1930 the Department of Indian Affairs became increasingly involved in Indian health. With the aim of revealing aspects of the Department's Indian health administration in this early period, this article describes the creation and workings of two hospitals on Indian reserves in southern Alberta. In this period, the federal government took two main steps in dealing with Indian peoples' health: it built hospitals on reserves, and it created a system of medical officers to staff these facilities. Before World War II, the health care system had a number of characteristics: firstly, it was a system initially operated by missionaries and later taken over by the Department of Indian Affairs; secondly, it was an extensive and decentralized system; thirdly, the health care services delivered by the system were firmly rooted in Canadian middle-class reformist values and represented an attempt to have these values applied to Indian communities; lastly, it appears that Indian peoples in southern Alberta were reluctant to use the facilities and services made available to them. Contrary to the idea that prior to World War II the federal government refused to take responsibility for Indian health in Canada, the development of an Indian health policy and system had already taken place gradually. This article strives to illustrate the link between federal Indian health care and the ideology of social reform operating in Canada between the 1890s and 1930.

SOMMAIRE. Entre 1890 et 1930 le Département des Affaires Indiennes s'intéressa de plus en plus à la santé des autochtones. Dans le but d'éclaircir cet aspect de l'administration des Affaires Indiennes, le présent article décrit la création et le fonctionnement de deux hôpitaux dans des réserves du sud de l'Alberta. A l'époque, le gouvernement fédéral prit deux mesures principales concernant la santé des autochtones: la construction d'hôpitaux sur les réserves, et la création d'un personnel médical pour assurer les soins. Avant la deuxième guerre mondiale le système médical possédait les caractéristiques suivantes: a) il s'agissait d'un système d'abord administré par les missionnaires, puis repris par le Department des Affaires Indiennes; b) ce système était à la fois extensif et décentralisé; c) les services médicaux ainsi fournis étaient ancrés dans les valeurs réformistes de la classe moyenne canadienne et tentaient d'appliquer ces valeurs aux communautés autochtones; et d) les Indiens du sud de l'Alberta semblent avoir hésité à utiliser les installations et les services qui leur étaient offerts. Contrairement à l'opinion qu'avant la deuxième guerre mondiale le gouvernement fédéral se refusait à prendre en charge la santé des autochtones, il est clair qu'une politique et un système de soins médicaux s'étaient déjà développés petit à petit. Le présent article tente de décrire la relation entre le système médical indien du gouvernement fédéral et l'idéologie de réforme sociale qui prévalait entre 1890 et 1930.

Introduction

Between the 1890s and 1930 health care on two southern Alberta Indian reserves became increasingly institutionalized and structured under the guidance and auspices of the federal Department of Indian Affairs. Contrary to the generalization that "prior to the 1940s, the federal government refused to take any responsibility for the high rates of mortality and morbidity among their Native 'wards',"[1] the development of facilities and the corps of attendant health care staff in western Canada indicates that Indian Affairs did seek to involve itself in Indian health matters, if only

1 Corrine Hodgson, "The Social and Political Implications of Tuberculosis Among Native Canadians," *Review of Canadian Sociology and Anthropology* 19, no. 4 (1982): 509.

Figure 1. Location of Blackfoot and Blood reserves in southern Alberta.

gradually. In addition, the development of facilities and services reveals the nature of federal attitudes towards Indian health in the pre-World War II era.

The purpose of this article is to describe the health care services delivered to the Blood (Kainai First Nation) and Blackfoot (Siksika First Nation) Reserves in southern Alberta via federal hospitals and physicians (see Figure 1). By discussing the nature of these services as revealed by various government records, hospital records and the records kept by the attendant physicians, this article will show how the Department of Indian Affairs was involved in Indian health prior to 1930. Before World War II, federal initiatives in Indian health care included taking over mission-founded hospitals and operating a decentralized health care system. The nature of federal involvement in Indian peoples' health also suggests that these dealings were firmly rooted in the social values of the day. Specifically, it seems they were very much influenced by and were also a product of a

self-styled social movement identified by historian Mariana Valverde as the "social purity movement" that swept Canadian society in this same period.[2]

The Blood and Blackfoot Reserves were selected for this discussion because of their general similarities. Both reserves are located in southern Alberta away from large urban centres, and people from these reserve communities have been historically related through their adhesion to Treaty Seven. Both the Blood and Blackfoot Reserve economies were based in agriculture, and both communities suffered from tuberculosis and other epidemics that swept the southern areas of the province in the early decades of the twentieth century. Obviously, the two reserves also had distinct differences; however, federal response to Indian health care needs in these communities was remarkably consistent between the 1890s and 1930. Ultimately, it is hoped that knowledge of early federal health care initiatives on these two reserves will make a preliminary contribution to an understanding of historical federal Indian health policy.

Though this article is concerned with the federal Indian health care system, it is clear that this system is but part of a complex history. How did Indian peoples perceive the health care system set up to serve their communities? How did they respond to it? What was the state of Indian peoples' health in this period? These questions must be addressed if the nature of federal Indian health policy is to be fully understood. Answers to these questions must also be sought outside the standard government documentary sources. Oral histories would most likely yield more information on Indian peoples' perceptions of health and health care in their own communities. Government records do indicate, indirectly, how some members of the southern Alberta reserve communities viewed the federally provided health care; however, this information is limited. Until more research can be undertaken into Indian peoples' historical views of health care, this article will limit its focus to one aspect of Indian health care: the federal initiatives taken to attend to Indian peoples' health, and the attitudes they reflected.

To date, the history of Canadian government in Indian peoples' health care has rarely been analyzed or described.[3] Existing literature concerned with Indian health in Canada focusses either largely on current issues, or on the historic effects of disease epidemics on Amerindian populations. Writings dealing with the historic effects of European diseases on Native

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2 See Mariana Valverde, *The Age of Light, Soap and Water: Moral Reform in English Canada, 1885-1925* (Toronto: McClelland and Stewart, 1991).

3 Existing writings on the subject of Canadian federal Indian health policy are limited, older, and include the following main works: G. Graham-Cumming, "Health of the Original Canadians, 1867-1967," *Medical Services Journal of Canada* 23, no. 2 (1967): 115-66; C.R. Maundrell, "Indian Health, 1867-1940" (M.A. thesis, Queen's University, 1941); R.F. Badgley, "Social Policy and Indian Health Services in Canada," *Anthropological Quarterly* 46, no. 3 (1973): 150-59. See also Jim Waldram, T. Kue Young and D. Anne Herring, *Aboriginal Health in Canada: Historical, Cultural and Epidemiological Perspectives* (Toronto: University of Toronto Press, 1995).

populations address many issues, ranging from Native peoples' response to new diseases introduced through trade and missionizing to the role of the fur trade in spreading epidemics such as smallpox.[4] By contrast, little research has been done on health care services for Indian peoples in the early modern period of Canadian history. Survey works of Indian-white relations in Canada tend to focus on Treaty Six and the medicine chest clause, providing little insight into the involvement of the Canadian government in Indian health.[5] Similarly, more specific works on Indian health are scarce. Recent research pertaining to Indian health in the Canadian government era includes the works of Hodgson (1989), Haden (1990) and Lux (1992).[6] Though these three works each have a highly specific focus, as a group they fail to identify the existence of a consistent government approach or national level policy for Indian health care in the era before World War II.

Perhaps the best work related to the Department of Indian Affairs health policy is Sally Weaver's investigation of medicine and politics on the Six Nations Reserve.[7] Through a description of health services on this reserve between the 1850s and the 1950s, she identifies important issues in the

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4 A sample of prominent works in this category include Bruce Trigger, *Natives and Newcomers* (Montreal: McGill-Queen's Press, 1985); Arthur Ray, *Indians in the Fur Trade* (Toronto: University of Toronto Press, 1974); and more recently, Jody Decker, "Tracing Historical Diffusion Patterns," *Native Studies Review* 4, nos. 1 and 2 (1988): 1-24. A great deal of literature exists on the subject of early North American disease epidemics resulting from Native-European contact.

5 See J.R. Miller's *Skyscrapers Hide the Heavens* (Toronto: University of Toronto Press, 1989) and Olive P. Dickason, *Canada's First Nations* (Toronto: McClelland and Stewart, 1992). Both works barely mention health care, except in the context of the fur trade and then of Treaty 6.

6 See C. Hodgson "The Social and Political Implications of Tuberculosis Among Native Canadians," *Review of Canadian Sociology and Anthropology* 19, no. 4 (1982): 502-12; Maureen Lux, "Prairie Indians and the 1918 Influenza Epidemic," *Native Studies Review* 8, no. 1 (1992): 23-33; Joanne Hader, "The Effects of Tuberculosis on the Indians of Saskatchewan" (M.A. thesis, University of Saskatchewan, 1989). Of the three, Hader's research on the effects of tuberculosis on the Indian population of Saskatchewan provides the most extensive survey of federal Indian health policy. Her discussion includes a brief outline of the gradual expansion of federal health services available to Indian peoples, and the pressures exerted by tuberculosis and the various tuberculosis associations on the Department of Indian Affairs to increase its involvement in Indian health. Though her survey of early policy touches on many important points, her assertion that between the 1880s and the 1920s "no organized health services existed for the Indians" and that until the 1940s federal health services emphasized medical relief rather than comprehensive services is misleading. Her analysis of policy ignores the establishment of facilities in Ontario and Alberta, as well as the work of local physicians in addressing the medical needs of Indian peoples across Canada. Hader's work is incomplete in its discussion of the services available to Indian peoples before the 1930s, and only through further specific research into early Department facilities, services and employees, can federal Indian health policy be more precisely understood.

7 Sally Weaver, *Medicine and Politics* (Ottawa: National Museums of Canada, 1972) and "Smallpox or Chickenpox," *Ethnohistory* 18, no. 4 (Fall 1971): 361-78.

history of federal Indian health policy, including the nature of federal financial support for Indian health care, the nature of facilities built on the reserve for Indian health care, and issues pertaining to staff operating the facility. In addition, Weaver's work deals with Indian reaction to the federally sponsored Indian health care system. Interestingly, the health care initiatives taken by the federal government on the Six Nations Reserve have much in common with those initiatives taken in southern Alberta. Weaver's discussions of health care on the Six Nations Reserve are important to this article because they provide additional specific examples of the complex relationship that evolved between Indian peoples and the federal government in this matter. This article seeks to expand on Weaver's research by providing additional specific, local examples of federal Indian health care so that an understanding of national Indian health policy might eventually be generated.

Historian David Gagan has recently made the point that the aim of the social history of medicine is understanding society's historical response to disease, "especially in relation to those in need of health care and those who provide it." In his view, this interaction represents a microcosm of modern society.[8] This idea is particularly applicable to the present study of Indian reserve hospitals. The history of the hospitals built on the two southern Alberta reserves is just such a story of interaction between those providing and those needing health care. Furthermore, the response of the federal government and missionaries to Indian peoples' health was also firmly rooted in the social values of the day, and in this way functioned as a microcosm of modern society. The history of Indian health care is very much linked to trends within Euro-Canadian society, rather than an exception to them.

In addition to utilizing the work of Canadian social historians to understand the history of reserve hospitals, this research borrows from the discipline of medical anthropology. Specifically, this paper makes use of an idea developed by such medical anthropologists as Byron J. Good: that the way the illness is expressed is linked inextricably to the fundamental values of a society. This perspective holds that symptoms of an illness are part of a symbolic system which reflects "deep cultural associations ... that appear to members of a society simply as part of nature or an invariant social world."[9] Since according to this perspective, diseases are expressed in a culturally specific way, treatments also reflect deep cultural associations and can appear as "natural and invariant" as the diseases. In this way, health care is invariably linked to social values. An analysis of the Department of Indian Affairs health policy in southern Alberta reveals indeed that the health care encouraged and sanctioned by the Department reflected values

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8 David Gagan, "For 'Patients of Moderate Means': The Transformation of Ontario's Public General Hospitals, 1880-1950," *Canadian Historical Review* 70, no. 2 (1989): 151.

9 Ibid., 55.

emphasized in the larger, non-Indian Canadian society between 1890 and 1930.

Canadian federal Indian health care emphasized values embodied by the "social purity movement." Historian Mariana Valverde has described the period between 1885 and 1925 as the "age of light, soap and water," when a self-styled social reform movement swept Canada with an aim to "raise the moral tone" of the nation.[10] The reformers associated with this movement, mostly middle-class professionals and charity workers, were eager to instill in the next generation of citizens their ideals of morality, and to "purify" Canadian society. Purification was to be both moral *and* physical. This mission was part of the reformers' greater effort to conserve, preserve and shape human life in Canada:[11] the idea was to create a Canadian society of health citizens, both physically and intellectually.[12] Reformers saw themselves as contributing to the building of a great nation; their desire was to prevent national decline by intervening in the lives of individuals or ethnic groups (especially Indian peoples) perceived to be falling morally and socially behind the rest of Canadian middle-class society.[13] Not surprisingly, physicians were often leaders of social purity and reform activities.[14]

The social reformers associated with the purity movement stressed certain values through their actions: they believed in the importance of a scientific approach to moral and physical reform; they emphasized the importance of women and children to society;[15] and most importantly they saw physical and moral health as inseparable. To the reformers, disease, dirt and degradation were all related.[16] Only by eliminating dirt could immorality and poverty be addressed. To combat one was to combat the other, and without physical cleanliness, moral reform could not occur. For example, it was firmly held that clean water and milk were necessary for mothers to be able to raise their children as Christian Canadians.

The reform of Canadian social values was to be primarily the task of

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10 Valverde, *The Age of Light, Soap and Water*, 17.

11 Ibid., 24.

12 Ramsay Cook, *The Regenerators* (Toronto: University of Toronto Press, 1985) describes the rise of social reform movements in Canada as part of the secularization of the sacred, the decline of orthodox religion. Valverde has taken her analysis of the social reform movement even further, and has made a connection between the reformers' desire to regenerate society on a spiritual level and the desire to improve health conditions in Canadian society.

13 Valverde, *The Age of Light, Soap and Water*, 27, 114, and 17.

14 Ibid., 47.

15 Ibid., 19; see also Katherine McCuaig, "'From Social Reform to Social Service.' The Changing Role of Volunteers: The Anti-Tuberculosis Campaign, 1900-1930," *Canadian Historical Review* 61 , no. 4 (1980): 484.

16 Valverde, *The Age of Light, Soap and Water*, 46.

philanthropists, not the state, although increasingly the state came to be seen as the only institution capable of exercising enough power to direct society along the lines encouraging social purity.[17] Consequently, these values came to influence the Department of Indian Affairs and led to an Indian health care system that emphasized many of the concepts originally promoted by the social purity movement: conservation of life; interventionism in the lives of those requiring reform; emphasis placed on moral and physical purity; and attention focussed on women and children.

Rather than revealing that "Indian health was never a high priority for Indian Affairs," this article shows, through a description of Indian Affairs health care in southern Alberta that Indian health certainly received attention; however this attention was clearly linked to a larger social movement operating in this era.[18] Social reformers in this era targeted the poor and the rural for reform, and Indian peoples were included in their agenda through the Department of Indian Affairs.

The Blood Reserve Hospital

The Blood "Indian" hospital was originally established in 1893 as a small cottage hospital run by the Grey Nuns, who provided funds for the first building.[19] In return for creating the hospital, the Department of Indian Affairs agreed to provide the salaries of the nursing Sisters, as well as to cover other operating costs. This idea of the federal government contributing funds to a private institution was very much in keeping with the philosophy of philanthropy operating in Canadian society in that decade. At the turn of the century, whole-scale government intervention into social issues was deemed inappropriate, although the government was seen as having a role in social reform and improvement.

By 1894 this new hospital, officially opened by the Superintendent-General of Indian Affairs, had seen forty-nine Indian patients and was viewed as a great asset to the Department.[20] By 1928 the hospital had increased its capacity to thirty-five beds, the cost of the extensions to the facility having been provided by the Department over the years.[21]

The existence and expansion of this federally supported hospital run by the Catholic Church was not without controversy in the early decades of its operation. The rival Anglican mission on the reserve periodically accused

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17 Ibid., 26.

18 Lux, "Prairie Indians," 27.

19 Glenbow Archives (GA), M742, f. 56, Harold Wigmore McGill Papers (hereafter McGill Papers).

20 Canada, House of Commons, *Sessional Papers*, Annual Report of the Department of Indian Affairs, No. 14, 1895, p. 88-89.

21 GA, McGill Papers, memo McGill to the Superintendent-General of Indian Affairs.

the Catholics of influencing the Anglican patients in the hospital and, as a precaution, worked actively to develop infirmaries in their Anglican Indian residential schools to care for their own students. By 1913, St. Paul's Anglican residential school had built a separate hospital building next to its school, exclusively for its students.[22] There continued to be demands made throughout these early years for the establishment of a "Protestant" hospital. However, this suggestion was never entertained by the Department of Indian Affairs, which viewed the existing Blood Indian hospital as a nonsectarian institution available equally to all reserve residents.[23]

Since the Blood Indian hospital was a relatively large institution in the Cardston community, it quickly became a significant part of the local economy, and supplying the hospital became a much sought-after privilege. Until at least 1913, the supplying of goods and services to the hospital occurred through patronage appointments, involving everything from drug supplies to the appointing of the attending medical officer.[24]

By 1928 the now aging hospital was deemed to be "beyond repair," and a new and larger building was erected on the reserve at Cardston. Again, the Anglican Church renewed its calls for a second hospital or the establishment of the new institution as a lay hospital. The Department responded to these calls by, on the one hand, retaining the services of the Grey Nuns, while on the other hand establishing a policy neutralizing denominationalism. It ordered that there be no insignia in any part of the new building open to the patients or the public, that no chaplain be kept in the facility, and that the Indian agent have the sole right of calling a clergyman to a dying patient.[25] This problem of denominational competition for access to the sick and dying was not unique to the Blood Reserve and had a strong influence on the development of hospital facilities. It seems the competition was one factor that encouraged the federal government to increase its control over the Blood Indian hospital, and to begin its operation of nondenominational public institutions.[26] By the 1930s, the Department policy was to treat all departmental hospitals as nonsectarian, even though they may have been church founded.[27]

Shortly after the new Blood hospital began operations, the Atterton photography studio of Cardston was commissioned, probably by the federal

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22 Laurie Meijer Drees, "Reserve Hospitals in Southern Alberta, 1890 to 1930," *Native Studies Review* 9, no. 1 (1993-94): 95.

23 GA, McGill Papers, memo McGill to Superintendent-General of Indian Affairs.

24 GA, M1788, f. 99, Blood Indian Agency Records, Indian agent to druggist A.D. Ferguson, 15 April 1913.

25 GA, McGill Papers, McGill to Superintendent-General of Indian Affairs, memo, 24 January 1936.

26 Ibid.

27 Ibid.

Figure 2. Blood Indian hospital, exterior view (ND-27-4, Glenbow Archives). The classical design of the new federally funded Blood Indian hospital reflected the fashion of the day. The verandahs on each end of the hospital were for the treatment of tubercular patients.

government, to photograph the facility inside and out. The photographs show that the hospital was a fully modern facility, with the newest developments in hospital design, including an "hygienic" brick structure, high ceilings to give tubercular hospital patients adequate air space (1,000 cubic feet were recommended at the time), smaller wards with fewer patients, modern sterilizing equipment, a separate dispensary, a dietary room, heavy linoleum on the floors, smooth plastered walls and, finally, large windows and prominent verandahs. All of these features were considered mandatory elements in the only treatment believed at the time to cure tuberculosis: access to adequate food, fresh air and sunlight.[28] Since the cause and nature of tuberculosis were still debated in the 1920s, a great deal of emphasis was placed by physicians on the physical design and working of treatment facilities, and the reserve hospitals proved to be no exception to this rule. Not only was the facility medically advanced, but the classical exterior design also marked it as being in vogue for the 1920s.[29] Interestingly, the Blood Indian hospital was built only a year after Lady Willingdon Hospital was built on the Six Nations Reserve in Ontario. The architecture of both hospitals was surprisingly similar.[30]

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28 Meijer Drees, "Reserve Hospitals," 95.

29 Ibid.

30 Weaver, *Medicine and Politics*, has photos of the Lady Willingdon Hospital on p. 71. The Six Nations hospital design appears remarkably close to that of the Blood Indian hospital.

Figure 3. Blood Indian hospital, interior view (ND-27-6, Glenbow Archives). The interior of the hospital reflected new hygiene practices of the time: high ceilings, plaster walls, and linoleum floors were new developments in hospital construction aimed at combatting the spread of tuberculosis.

The architecture of the reserve hospitals not only reflected medical perceptions of the day, but also deeper non-Indian perceptions of Indian peoples. In his discussion of the development of Ontario's public general hospitals, David Gagan has identified how, after the turn of the century, hospitals underwent radical transformation. According to his findings, hospitals around the time of World War I came to be characterized by a growing preponderance of private and semiprivate wards, rather than public wards, as the middle classes came to view hospitals as preferred places of treatment.[31] Reserve hospitals, in contrast, were still being constructed after World War I with large dormitory-style wards which in non-Indian communities would have been perceived as suitable only for indigents. As a result, it seems that the reserve hospitals, though technologically advanced through their basic floor plans, reflected Euro-Canadian perceptions that Indian peoples were of a lower class and would require less differentiated care.

The expansion of the Blood Indian hospital in 1928 was in keeping with the ever-evolving, greater expansion of federal involvement in Indian health care across Canada between the 1890s and 1930.[32] In this period the Department increased its commitment both in terms of staff and facilities.

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31 Gagan, "For 'Patients of Moderate Means'," 152.

32 See also Weaver, *Medicine and Politics*. Note that the Six Nations hospital was also built in this period.

More doctors and health care officials were drafted into the Department of Indian Affairs, and a series of new reserve hospitals were built in the West. In 1896, for example, the Department employed six medical officers in the West; by 1904, the Department listed twenty-six medical officers on its employee rosters in western Canada; and it employed ninety-seven by 1927.[33] The position of medical superintendent for the Department of Indian Affairs was created in 1904 to give direction to the new health staff. In addition to its growing corps of medical officers, the Department also employed increasing numbers of nurses, including the nursing Sisters of the Blood Indian hospital. Hospitals built on the Prairies in this period included the Blood Indian hospital, the Blackfoot hospital, the Peigan hospital, and the Stoney hospital.

Between the 1890s and 1930, the Department's financial commitment to Indian health care also expanded in response to a variety of factors, including public pressure, as well as the perception that diseases such as tuberculosis might spread from the Native to the non-Native community.[34] In the West, medical expenses were limited in 1895 to salaries of the few medical officers and nurses, and to providing incidental supplies to the small mission hospitals. In contrast, by 1929 the annual medical expenditures exceeded the allotted grant for that year; the total expended for the western territories alone was $330,625.21. The over-expenditure that year exceeded $15,000.[35]

Just as expenditures on Indian health increased within the Department of Indian Affairs, so did mention of health in the Department annual reports. In the 1890s departmental annual reports only briefly mentioned health issues; but by 1926 the report of the Superintendent General of Indian Affairs remarked extensively on Native health. It even went so far as to state explicitly that

> Epidemic conditions of disease are dangerous, no matter where they originate. The *White population has a vital interest* in the expenditure for the prevention of tuberculosis ... and for treatment of venereal diseases. This expenditure is upon the increase, as the fact becomes clear that the diseases among Indians must be dealt with *by modern scientific methods* ... Among the many important duties of the department those associated with the *conservation* of the health of Indians must take a prominent place... . [emphasis mine][36]

These comments not only indicate that Indian health had become an increasing concern for the federal government, but their terminology links

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33 See Canada, House of Commons, *Sessional Papers*, Annual Report for the Department of Indian Affairs, 1896, No. 14, pp. 8-12; 1905, No. 27, pp. 165-66; 1929, p. 11.

34 This perception was not based on empirical evidence in the form of health statistics.

35 Canada, House of Commons, *Sessional Papers*, Annual Report of the Department of Indian Affairs, 1930, p. 93.

36 Ibid., 1926, p. 8.

concern with Indian health to the reform sentiments of the same period. Firstly, the concern with Indian health reflected a more general trend in Canadian society regarding public health. As early as the 1880s and into the 1920s, social reformers felt that all social issues, including health, could be unified into one macroproblem: "conserving life."[37] Even after the Great War, these reformers viewed public health as a key national resource to be conserved, much like fish, wildlife and manpower.[38] Conservation of resources, in turn, would contribute to Canada's program of nation building.[39] As a result of this mindset, as much as the health of immigrants was monitored following the War in the interests of national wealth, so Indian health was also to be conserved.[40] Grappling with Indian health in a "scientific" manner was also very much in keeping with reform ideals. Maximizing rational calculation in the delivery of health care, and eliminating pity: this was seen as the best way to reform society's ills.[41] Finally, these comments acknowledge that it was felt the white population stood to gain from the prevention of disease in Indian communities: these diseases might spread to white communities. Overall, Indian health was a matter of public health.

In addition to viewing health in terms of "scientific" and "conservation" terms, in the first decades after the turn of the century health and hygiene were also seen as moral issues. To neglect a community's health was to neglect its further moral development in the eyes of the social reformers of the day.[42] The connection between morality and health was certainly emphasized in the care of Indian health. Indian health was seen as problematic and lagging behind that of non-Indians, primarily because Indian people lacked the necessary moral development. In the opinion of Chief Medical Officer P.H. Bryce in 1905, Indian peoples' "difference in moral development, with its accompanying lagging behind in material advancement" was the prime reason for the poor state of their general health.[43] Indian health could best be improved through the "intellectual advancement" of these people.[44] Ultimately, federal support for the Blood Indian hospital, and the

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37 Valverde, *The Age of Light, Soap and Water*, 24 and 27.

38 P.H. Bryce, *The Story of a National Crime* (Ottawa: James Hope and Sons, 1922), 8.

39 Valverde, *The Age of Light, Soap and Water*, 24.

40 When discussing the inspection of immigrant health, federal employees reported, "The potentialities of this work can only be properly appreciated after one has given the subject thoughtful consideration in respect to its immediate and future bearings from a national point of view. *The movement is not one of expediency for the Motherland or Canada, but a distinct economic gain* to both countries..." (emphasis mine). Canada, House of Commons, *Sessional Papers*, Annual Report of the Department of Immigration and Colonization, 1925, p. 72.

41 Valverde, *The Age of Light, Soap and Water*, 19.

42 Ibid., 27-33. Valverde points out how moral reform was vital to nation building, and that improving hygiene was part of the program of improving the morality of communities.

43 Canada, House of Commons, *Sessional Papers*, Annual Report of the Department of Indian Affairs, 1906, Report of the Chief Medical Officer, p. 276.

44 Ibid., p. 277.

increase in its size resulted from this kind of social reform mentality. The idea of "improving" Indian peoples through health care permeated federal Indian health policy at this time and encouraged the government to extend its commitment to Indian health.

An extended commitment to Indian health care also forced the Department of Indian Affairs to increasingly monitor and justify its expenditures. The Department had always been a cost-conscious institution and health care costs became a prominent issue, particularly in the late 1920s and into the 1930s. During these years the Depression undermined the funds available at a time when the Department had just completed one of its greatest expansions in health care, the building of the Blood and other prairie reserve hospitals.

The correspondence relating to the activities of the Blood hospital between 1928 and 1931 clearly reflects the Department's concern with Indian health care costs as well as the Department's goal of creating a decentralized health care system for Indian peoples. At this time, health care regulations and expenditures became the responsibility of the local Indian agent. It was departmental policy, with the building of the new Blood hospital, that the Indian agent "acting under the instructions from the Department, shall be responsible for the conduct of the institution ... all business being done through the Agent's office."[45] As a result, it became the agent's role to control health care at the local level and to ensure that health care costs were kept down. On the Blood Reserve in the 1920s and 1930s, this agent was J.E. Pugh.

Pugh's struggle to keep expenditures low surfaced regularly in his correspondence with the medical officers, other health care officials, and the Department. Every decision to send an individual off reserve for treatment had to be justified to the Department, as did the use of physicians or hospital facilities other than those of the Department. When, in 1931, an individual was hospitalized and treated in Lethbridge rather than on the reserve, the Department was quick to remind Pugh that,

> the Department has been at an expense to provide a very excellent hospital for the care of the Blood Indians and that this emergency might well have been taken care of in that hospital if the woman had made proper plans. It would be advisable for you to lose no opportunity to impress on the Indians that they should use their own hospital.[46]

Though it paid for outside services, the Department did not take into account the fact that some Indian people were unwilling to use the Blood hospital, as was the case for this woman.[47]

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45 GA, McGill Papers, 22 March 1928; GA, Blood Indian Agency Papers, M1788, f. 155?, D.C. Scott to Sister Superior, Blood Indian Hospital.

46 Ibid., M1788, f. 156, Department of Indian Affairs to Agent Pugh, letter 28-103, 3 February 1931.

47 Ibid., M1788, f. 156, Agent Pugh to Department of Indian Affairs, 10 February, 1931.

In another instance, Pugh took the initiative to save the Department some expense when a patient of the Blood Reserve succumbed to tuberculosis in the Central Sanatorium in Calgary. Pugh felt it was more economical to have the body placed in a Calgary cemetery than to have it sent back to the reserve. In his words: "I made these arrangements, as the more economical one, requesting Armstrong's [funeral home] to keep the costs at a minimum, consistent with decency."[48]

It was up to Pugh to ensure that all actions and expenses associated with Indian health care were kept within set departmental limits and he regularly made suggestions to the Department on "how we could get efficiency in treatment at our own hospital, and avoid sending our patients away."[49] The Department had established rates for medical services rendered; however, these tended to be low, and this sometimes made it difficult for both Pugh and the medical officer to find individual health specialists, including dentists and optometrists, to attend a patient. On occasion the medical officer recommended a particular treatment only to find that no one would treat an Indian at those low departmental rates.[50] Health care professionals called in from "outside" the Department to treat an Indian patient openly complained to Indian Agent Pugh that the departmental rates did not allow for proper treatments. In one instance, an eye, ear, nose and throat specialist wrote to Pugh about the authorization of glasses for a Blood individual:

> I would like to point out to you that it is practically impossible to fill a prescription and do the examination for this amount ... I am anxious to do this work and cooperate with your Department in every way and I am willing to do it as reasonably as possible, but I believe the Department should be notified.[51]

Clearly the Department of Indian Affairs did not always provide enough funds for the adequate treatment of Indian patients, and not all physicians were willing to treat Indian patients for low rates.

The records for the Blood Indian hospital reveal more than just the financial aspects of the Department of Indian Affairs health policies and practices. The records for the later years, the 1920s and 1930s, reveal some aspects of life for patients in the hospital such as diet, bedding, and clothing, which distinctly reflect some of the values underlying the federal Indian health policy. Food, clothing and bedding also played a central role in hospital life for the patients because most patients stayed for extended periods. The average stay for an individual in hospital in the early 1930s was twenty-four or twenty-five days in winter, and fifteen days in summer.[52]

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48 Ibid.

49 Ibid., M1788, f. 154-56, Agent Pugh to Secretary, Department of Indian Affairs, 21 November 1931.

50 Ibid., M1788, f. 155, Agent Pugh to W.M. Graham, Indian Commissioner, 13 June 1931.

51 Ibid., M1788, f. 154, Dr. Shore to Pugh, 19 August 1931.

52 Ibid., M1788, f. 154 and 156, monthly hospital records, February and July 1931.

The supply records for the hospital in the year 1931 suggest that the hospital menu was varied. Food orders for the hospital included strawberries, raspberries, peaches, pears, tomatoes, apples and grapes.[53] Other items regularly ordered included potatoes, vegetables and beef. Cod-liver oil was another staple of the hospital diet, as it was in hospitals across the country. The Department encouraged, at this time, what it considered "the judicious use of Cod Liver Oil by Indians," and two teaspoonfuls were to be administered to adults after each meal. A "very palatable" preparation of cod-liver oil and malt would only be supplied to patients who could not be given plain oil.[54] The oil and menu were part of the pervading contemporary ideology in the treatment for tuberculosis: provide the patient with a clean environment and a rich diet.

The dry goods ordered for the Blood hospital by the nursing Sisters are also revealing of the reformist values the health care system was attempting to inculcate in its Indian patients. Based on the orders placed by the hospital staff, it appears that the patients were provided with clothing by the nuns. Young girls dressed in chintz smocks, slippers, bloomers, vests, hose and at night, fancy nightgowns. For the girls, not all clothes were ordered as it seems that the Sisters sewed house dresses and bathrobes for their charges. Boys and men, in turn, wore twill pants or cotton suits, jerseys, hose and slippers, and pajamas at night. Bedridden patients were placed in beds appointed with crochet bedspreads, woolen blankets and eiderdown quilts.[55] It is important to note that part of the aim of providing Indian patients with clothing was to encourage the patients to improve their lives materially. The Department advocated teaching Indian peoples not only better hygiene, but also better housekeeping, and generally felt that "by such simple *instruction in the art of living*, coupled with the care given by the Indian agents and medical attendants, the *health of the Indian people is being materially improved* (emphasis mine)."[56] Obviously, in the eyes of the Department, health and homemaking were inextricably linked. Indian peoples' moral well-being was clearly perceived to be tied to their physical health and in this way the hospitals played a role in educating and reforming Indian peoples along these lines. In this way, the actions of the Department of Indian Affairs in the realm of Indian health were in line with the ideas of progressive reformers of the day.

Despite their non-Indian perspective, the government records of the Blood Indian hospital do indicate that Indian peoples on the Blood Reserve were not all equally interested in the types of treatments offered by the

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53 Ibid., M1788, f. 155, orders to Department of Indian Affairs from hospital staff.

54 Ibid., M1788, f. 154, see Circular, Department of Indian Affairs, 24 August 1931.

55 Ibid., M1788, f. 155, Sister Mary of the Visitation to Pugh, 16 June 1931.

56 Canada, House of Commons, *Sessional Papers*, Annual Report of the Department of Indian Affairs, 1922, No. 27, p. 15.

hospital and its staff. Older reserve residents could not be persuaded to have vaccinations (against smallpox) and they were accordingly passed up by health officials. In fact, many chose to continue with their own healing and medical traditions rather than risk the new services offered by the hospital and government.[57] This reticence to use the hospital on the part of some reserve residents was openly recognized by the agent: "due as I have stated ... to intolerance to our Hospital."[58]

The Blackfoot Reserve Hospital

The history of the Blackfoot Reserve hospital echoes many of the same themes outlined for the Blood hospital, supporting the idea that the federal government approached Indian health care in Alberta in a uniform manner. As in the early history of the Blood Indian hospital, the missions played a central role in the founding of the Blackfoot hospital, the federal government gradually increased its involvement in Indian health care on the Blackfoot Reserve after the turn of the century, and like the Blood Indian hospital, the Blackfoot hospital facility was modified in the 1920s. The Indian agent for the Blackfoot also played an important role in making suggestions for Indian peoples' health care in the community he oversaw. As on the Blood Reserve, Indian peoples in the community were also reticent to use the Blackfoot hospital. However, in contrast to the Blood hospital, the Blackfoot facility was modified using the band's own trust fund money, and the Blackfoot band council was involved in hiring a physician to operate the hospital. Both the role of the Indian agent and the initiatives taken by the Blackfoot band council indicate, once again, that it was the strategy of the Department of Indian Affairs to administer a decentralized health care system where Indian health questions were handled locally.

Like the Blood hospital, the Blackfoot hospital was founded in the early 1890s as a joint venture between church and state. On the Blackfoot Reserve, until 1896, a federally appointed medical officer merely visited the reserve on a monthly basis. However, by 1895 a new, small hospital was built at the north end of the reserve by the Church of England. It opened its doors officially the following year.[59] The Women's Auxiliary of the Church of England missions in eastern Canada provided the bedding, furniture and $46.00 for cupboards and other fittings. The federal government, in turn,

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57 GA, Blood Indian Agency Papers, M1788, f. 156, Agent Pugh to Department of Indian Affairs, 10 February 1931.

58 Ibid.

59 Canada, House of Commons, *Sessional Papers*, Annual Report of the Department of Indian Affairs, No. 14, 1894, p. 85. The number of beds of this small hospital are not mentioned. Photos indicate that it was a small house.

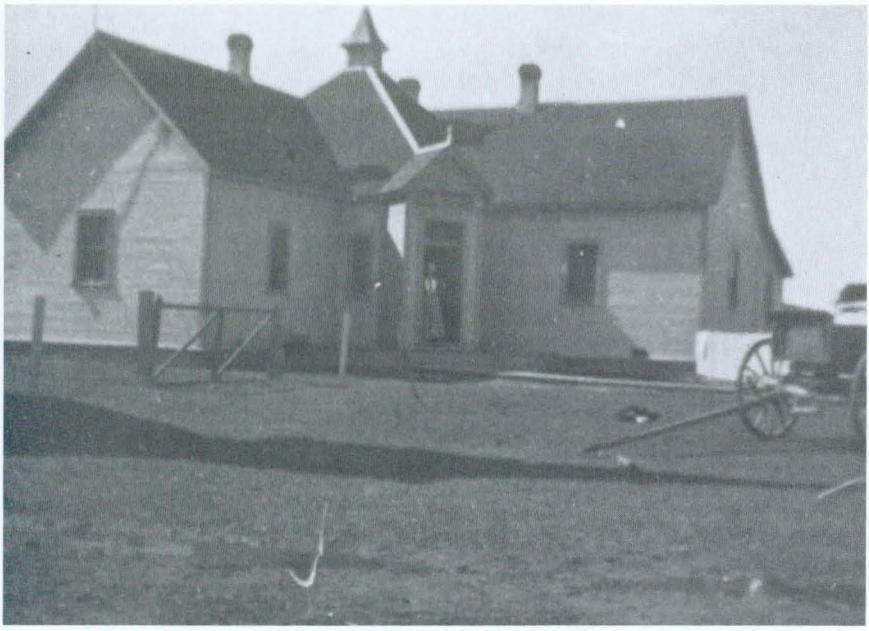

Figure 4. Blackfoot Anglican hospital, exterior view (NA-2294-31, Glenbow Archives). The mission hospital was a small facility, attended by a nurse, pictured here in the doorway.

financed the interior plastering and masonry work.[60] The idea of opening a hospital on the reserve was greeted with optimism in the government reports which claimed: "it will be of great assistance to the doctor in the treatment of serious cases."[61] Mainly, the hospital was seen as a facility useful for the isolation of contagious cases.[62] In its early years it lacked the same kind of staff that ran the Blood hospital, which had a local physician and a federally salaried nursing staff. The Blackfoot hospital, with its two tiny wards, was attended by only a nurse and a doctor working under the auspices of the Anglican Church. The government physician made monthly visits from Calgary and worked separately from the hospital.[63]

The small Blackfoot Anglican hospital operated relatively independently until 1923, when the federal government became involved and allowed Blackfoot band funds to be taken out of trust for the building of a new thirty-five-bed hospital to replace the tiny Anglican facility. This

60 National Archives of Canada (NA), RG 10, Vol. 1153, no file, December 1896, Agent Baker to the Department of Indian Affairs. Glenbow Archives microfilm reel T-1470.

61 Canada, House of Commons, *Sessional Papers*, Annual Report of the Department of Indian Affairs, No. 14, 1896, p. 137.

62 Ibid., No. 14, 1897, p. 152.

63 NA, RG 10, Vol. 1153, no file, December 1896. Glenbow Archives microfilm reel T-1470.

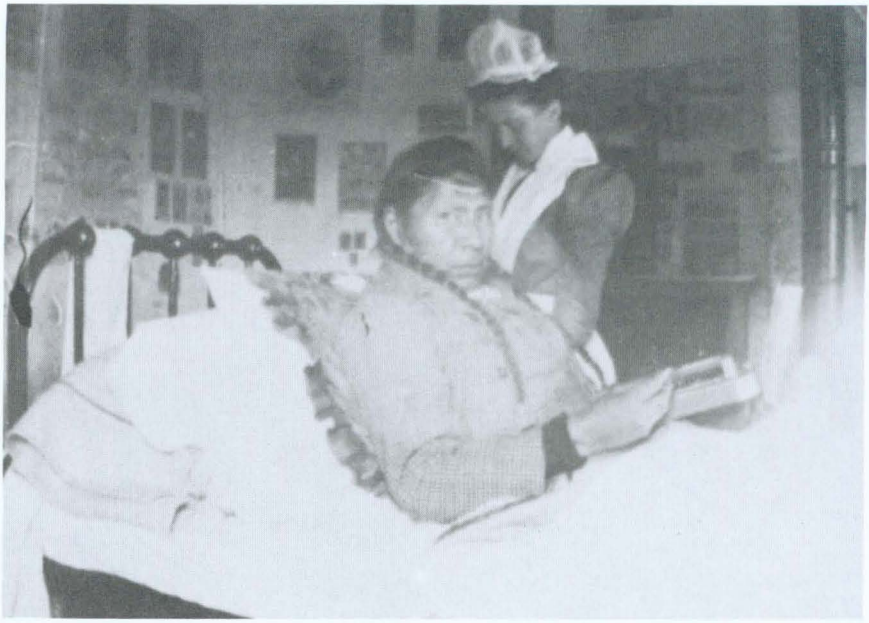

Figure 5. Interior of the Blackfoot Anglican hospital (NA-2294-32, Glenbow Archives). The mission hospital was staffed by a member of the Anglican church, who wasn't necessarily professionally trained in nursing. Note the woodburning stove, and pictures on the walls. The patient, Jack Black Horse, appears to be wearing his own clothing.

government-supported expansion seems to have been derived from the same general concern with Indian health that led to the expansion of the Blood hospital in the same period. As has been indicated, "conserving" Indian health was a recognized issue at this time; however, since the federal government saw itself as under no legal obligation to provide health services to Indian peoples, as health care was not explicitly a treaty right for those bands adhering to Treaty Seven, the federal government allowed band trust funds to be used to supplement its own contribution to the building.[64] In this way, the federal government encouraged local initiatives in Indian health care despite its increased involvement in this field. Weaver's analysis of health care on the Six Nations Reserve points to a similar trend there in the late 1920s, when band funds were used to build the new Lady Willingdon Hospital on the reserve, and pay part of the attending medical officer's salary.[65]

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64 Maundrell, "Indian Health," 79. Maundrell, writing in 1941, recognizes this practice of using band funds to supplement government funding of health care as common at the time. The federal contribution to the building of the Blackfoot hospital was $40,000. See also Glenbow Library clipping file "Blackfoot Indian," *Albertan*, September 5, n.d.

65 Sally M. Weaver, "Health, Culture and Dilemma: A Study of the Non-Conservative Iroquois, Six Nations Reserve, Ontario" (Ph.D. dissertation, University of Toronto, 1967), 146.

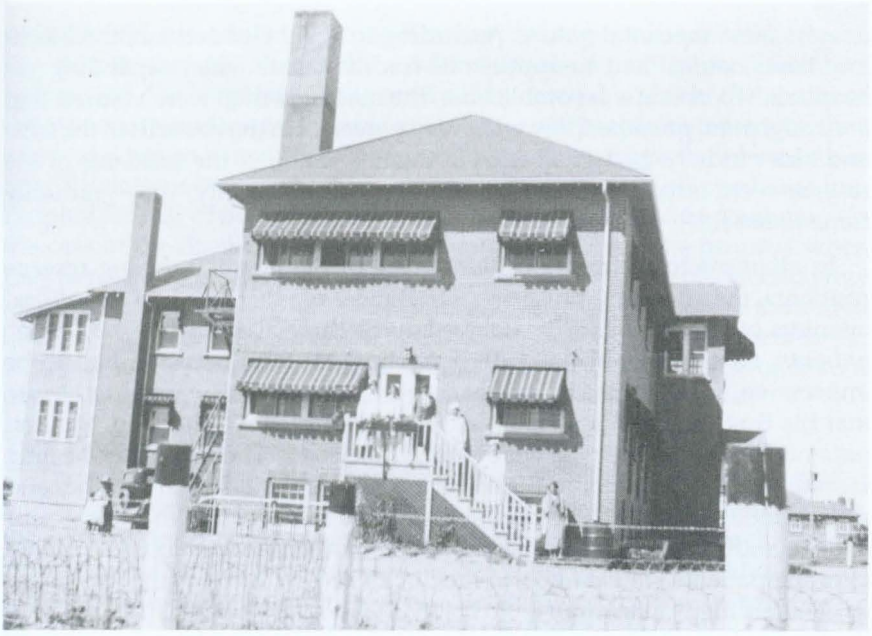

Figure 6. New Blackfoot hospital, built using trust funds (NA-4716-6, Glenbow Archives). The new Blackfoot hospital was a fully modern facility at the time it was built. It had a full-time attending physician.

The new hospital was built in 1923 on the recommendation of the Indian agent George Gooderham. As a local newspaper reported, the new hospital had two stories with a full basement, "and when finished there will be few buildings in the Bow Valley to compare with it in architectural beauty."[66] The architectural style of the new building was much like the Blood hospital, including large windows, brick structure, two storeys and segregated open wards.[67] Money for the building was derived from the sale of Blackfoot Reserve lands to the Canadian Pacific Railway in 1910. The band council voted in favour of using the funds, held in trust by the Department of Indian Affairs, for a hospital and permanent physician in 1922.[68] The facility opened its doors in 1924, though a physician was not permanently appointed by the band until 1927.[69]

Agent Gooderham's accounts of the Blackfoot hospital reveal indirectly how Indian people viewed the facility. Since little is known of Indian peoples' response to these facilities, his observations are worth noting

66 Glenbow Library clipping file, "Blackfoot Indians - Health and Hygiene," *Albertan*, n.d.

67 Ibid.

68 GA, M 4738, Box 1, f. 3, George Gooderham Papers (hereafter Gooderham Papers), "The Hospital."

69 Ibid.

despite their anecdotal nature. According to agent Gooderham, the Blackfoot band council had to appease its traditionalists when expanding the hospital: "To obtain a favorable vote, the medicine men were assured that they might still practice. They were very powerful in the councils of the tribe and older Indians had great faith in them."[70] Though the residents of the reserve were initially skeptical of the new health facility, they gradually came to use it.

In attempts to secure a positive image of the hospital among reserve residents, the attending physician, Dr. Bowles of Gleichen, had the official opening of the new facility delayed until there were a few "suitable" patients. Of the opening, Gooderham claimed, "this occasion had to be impressive," and according to his accounts, the doctor wanted to ensure that his first treatments were a guaranteed success. To that end, the first patients in the new hospital were carefully selected. Their dramatic healing would better convince the Blackfoot people of the hospital's value, and during their treatment "No one was allowed to visit and what the doctor and his staff were doing for these patients was a well kept secret."[71] Only after the patients were cured did the doctor open the hospital doors for all to view his medical triumphs. To curious visitors the patients testified that the hospital was "a fine place: good food, comfortable beds and no pain."[72] According to Gooderham, the visitors "hurried away to spread the news, and the next day the doctor was besieged by Indians who wanted operations ... the surgeon was accepted and the hospital off to a good start."[73]

Interestingly, Gooderham hastened to add, "the medicine men had lost round one," a statement that alludes to the important role traditional medicine continued to play in the community at the time.[74] The hospital was acknowledged to be valuable for operations; however, "ordinary" patients who needed "rest, good food and medicine" continued to go to the community healers.[75] According to Gooderham, the old people believed in the traditional healers and feared them: "while many of the younger Indians did not have such faith in the medicine man, their elders still made the decisions and kept them away from the hospital."[76]

Indian people of the Blackfoot community, like those of the Blood, continued to value their own unique healing practices and did not automatically endorse or utilize the new non-Indian system of care. Traditional

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70 Ibid.

71 Ibid., "The Hospital," p. 1.

72 Ibid., p. 2.

73 Ibid.

74 Ibid., p. 3.

75 Ibid.

76 Ibid.

medicine continued to operate and occupy an important place in reserve life, despite the arrival of "fully modern" Western medical facilities.[77] As late as 1940, the hospitals were perceived by many Indians of the southern Alberta communities as "houses of death" — if people became sick they often "did not go to hospital," because "when old folks go they never come out."[78] Relatives, in turn, were known not to press their loved ones to go into hospital for fear of being suspected of being unwilling to care for them.[79] In the case of the Blackfoot hospital, patients at times left the hospital when they perceived the physician could not help them. Even the physicians were aware of this common course of events and released patients to their own healers.[80] Weaver's investigation of the hospital and medical officers on the Six Nations Reserve identifies a similar reticence on the part of Indian people to use newly established hospital facilities on the reserve.[81]

Two Medical Officers of the Blood and Blackfoot Reserves, 1930s

Though reserve hospitals were central to the health care system created by the Department of Indian Affairs for Indian people in southern Alberta, the medical staff employed by the Department to work in these facilities also played an extremely important role in determining the type of health care offered to reserve communities. A brief examination of two contemporary physicians working as medical officers on the Blackfoot and Blood Reserves, Dr. Frances Evelyn Windsor and Dr. John Knox Mulloy, respectively, provides additional insight into the reform-oriented health policy the Department of Indian Affairs promoted in southern Alberta prior to 1930.

Windsor's work with women and children, and Mulloy's focus on tuberculosis prevention reflected values clearly related to the "social purity movement." Like many social reformers of her time, Windsor sought to purify the lives of Indian women and children through direct intervention, just as Mulloy was interested in the health of Indian school children. Both of these physicians were concerned with more than just the physical health of their patients: they saw a direct connection between the physical condition of Indian people and their moral state.

Physicians were hired by the Department as reserve "medical officers." In the 1890s, medical officers were generally hired on a part-time basis, and by 1892 southern Alberta had two of the original six medical officers hired by Indian Affairs. In 1929, the northwest region had ninety-seven medical officers, the highest number for any region in Canada.[82]

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77 See accounts in GA, M8078, Hanks Papers, which discuss the persistence of traditional medicine on the Blackfoot Reserve.

78 Ibid., Box 301, f. 15, pp. 7 and 10.

79 Ibid.

80 Ibid., Box 301, f. 15, p. 10.

81 Weaver, "Smallpox or Chickenpox," 364-65; Weaver, *Medicine and Politics*, 73-77.

82 Canada, House of Commons, *Sessional Papers*, Annual Report of the Department of Indian Affairs, 1929, p. 11.

It is of interest that this growing corps of medical officers was to treat an Indian population for which few health statistics existed. In Canada generally, it was not until 1931 that statistics began to be collected for health care institutions.[83] In addition, the compilation of Indian deaths by cause began only in 1926, making it necessary to estimate for the early years the recorded deaths from diseases such as tuberculosis, smallpox, and influenza.[84] As a result, federal Indian health care was based to a large extent on what Indian agents recommended as solutions to local problems, and what the Department judged Indian people required, rather than on an intimate knowledge of the state of Indian health. Thus, the dramatic increase in the number of medical officers following World War I can in part be attributed to the federal government's increased concern with public health and to the application of these health principles to Indian people.

Though the Blood Reserve had a full-time medical officer much earlier, the Blackfoot Reserve was serviced until 1927 by a series of part-time medical officers who either travelled to the reserve on a monthly basis from Calgary or else lived in nearby Gleichen. The use of part-time medical officers was not an unusual practice in treating Indian peoples, it seems, as the Six Nations Reserve was also serviced by part-time doctors until the turn of the century.[85] For the Blackfoot, however, it was not until 1928 that the first full-time physician was appointed to serve the reserve and in that year the physician appointed by the band was Dr. Frances Evelyn Windsor.

The appointment of Dr. Windsor as physician to the Blackfoot population was remarkable for a number of reasons. Firstly, a female physician appears to have been an unprecedented occurrence in the federal Indian health care system. Secondly, Dr. Windsor was hired and paid by the Band itself, and her appointment was exclusively to the Blackfoot — though her position was officially with the federal civil service. Finally, Dr. Windsor was well educated and her approach to health care was in keeping with the values and concerns of contemporary social reformers.

Dr. Windsor, like other medical officers working in southern Alberta, was a highly educated individual — a 1908 University of Toronto graduate who had interned at Johns Hopkins in Baltimore, the Women's Medical College of Pennsylvania, and the Hospital for Women in Detroit.[86] In 1911 she and her classmate, Rosamond Leacock, moved to Calgary with their chaperone to establish a small practice specializing in women and children. This practice reflected the emphasis of social reformers, who saw women

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83 Canada, Annual Report of Tuberculosis Institutions, 1937, Ottawa: 1939, p. 5.

84 Canada, Dominion Bureau of Statistics, *Special Report on Mortality in Canada*, 1921-32, Ottawa: 1935, pp. 4-5.

85 Weaver, "Health, Culture and Dilemma," 101.

86 Internships for women were difficult to get in Canada and as a result Dr. Windsor chose to intern in the United States, according to her daughter, Mrs. Joan Fellows (personal communication, Calgary, August 1994).

and children as the "future of the nation."[87] Windsor, however, remained in Calgary only briefly and soon joined the Canadian Forces overseas to serve as a physician to the troops in World War I.

It was not until 1927 that Windsor returned to Calgary. At the time, she was newly separated from her husband and in need of steady employment, which she quickly found as temporary physician for the Blackfoot Reserve. A year later the Blackfoot band council accepted Windsor as the reserve's full-time physician. The band hired Windsor not only because of her availability (and presumably her abilities given her training), but also because it felt the need of a female physician to care for the women of the reserve.[88] According to Windsor's daughter, the Blackfoot men were reticent to send their wives to a male physician.[89] Since Windsor was particularly interested in maternity cases and women's and children's health issues, she was considered appropriate for the position.

Indian agent Gooderham approached her about assuming the position of reserve medical officer, and she agreed to take it.[90] For the federal government, the fact that Windsor was a war veteran made her particularly attractive, since following World War I the policy of the Civil Service Commission gave hiring preference to "those having overseas service in the Great War."[91] In addition, the government encouraged her appointment since band funds were being used to pay for her position. The annual report of the Deputy Superintendent General of Indian Affairs for 1929 stated:

> Changes in medical personnel at the Blackfoot reserve presented an opportunity for the appointment of a woman physician. This was in the nature of an experiment, but the results have been most encouraging. The Indian women and children are taking advantage of her services much more freely than they did of those of the very capable male physician who formerly gave attendance. The outcome of this innovation is being watched with great interest.[92]

Though Windsor's appointment was considered unusual, it was in keeping with the reform trends operating in middle-class society at the time.

Dr. Windsor's activities among the Blackfoot are in some ways better documented than the activities of the other physicians, partly because she

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87 Valverde, *The Age of Light, Soap and Water*, 19.

88 Carlotta Hacker, *The Indomitable Lady Doctors* (Toronto: Clark, Irwin and Co. Ltd., 1974), 192; personal communication, Mrs. Joan Fellows, Calgary, August 1994.

89 Personal communication, Mrs. Joan Fellows, Calgary, August 1994.

90 GA, Gooderham Papers, M4738, Box 2, f. 8.

91 GA, McGill Papers, M742, f. 36, McGill to Rev. F. Marcotte, Ottawa, 1 April 1935; in 1908 the Civil Service Amendment Act led to the discontinuation of patronage appointments to government positions.

92 Canada, House of Commons, *Sessional Papers*, Annual Report of the Department of Indian Affairs, 1929, p. 13.

was in full-time attendance on the reserve. Previous medical officers had tended to reside in either Calgary, or just off the reserve in Gleichen. A closer look at Windsor's work reveals her own medical ideas, the care offered Indian peoples through the federal Indian health system, and how Indian peoples responded to this care.

As indicated, Windsor was particularly interested in and committed to the maternity activities of the hospital.[93] One of her first priorities on the reserve was establishing a baby clinic at the hospital. The purpose of the clinic was to instruct and advise Indian mothers on the care of their babies, and before new mothers left the hospital each was given a complete layette and instructed in the use of the clothing.[94] To further encourage new mothers to follow the methods of baby care devised by Windsor, baby contests and shows with medals and money prizes were held in which many mothers eagerly participated.[95]

This aspect of Windsor's work was very much in keeping with medical programs of the day. One of the impacts of World War I on western Canadian society was the generation of an intense interest in "making the world a better place, particularly for the children."[96] According to historians Nancy Sheehan and Katherine McCuaig, in the years immediately following World War I, rural communities came to be viewed as sources of regeneration for Canadian society.[97] Country life enthusiasts and child-savers at this time believed that a clean, wholesome rural environment was the best way to conserve and enhance child life.[98] Promoters of this ideology were inspired by the Red Cross, which had served the health of the military populations so effectively during the War, and had drawn attention to the concept of public health care. Reformers interested in the regenerating potential of rural life, and particularly the place of children in country life, began to use the Junior Red Cross — the youth arm of the Canadian Red Cross — to improve the life of rural children. Indian communities on reserves were not exempt from the ideology of this reforming movement. In 1924 and 1925, the Department of Indian Affairs cooperated with the Junior Red Cross in the promotion of better health for Indian children[99] by

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93 GA, Gooderham Papers, Box 2, f. 8, essay entitled "Doctors to the Indians whom I have known"; personal communication, Mrs. Joan Fellows, Calgary, October 1994.

94 GA, Gooderham Papers, ibid.

95 Ibid. The Glenbow photo archives also contains a photo, PA-32-1, of the baby contest in 1926.

96 Nancy M. Sheehan, "The Junior Red Cross Movement in Saskatchewan, 1919-1929," in David C. Jones and Ian MacPherson, eds., *Building Beyond the Homestead* (Calgary: University of Calgary Press, 1985), 68.

97 Ibid. and McCuaig, "From Social Reform to Social Service," 491.

98 Sheehan, "Junior Red Cross Movement," 68.

99 Canada, House of Commons, *Sessional Papers*, Annual Report of the Department of Indian Affairs, No. 27, 1924, p. 14.

implementing a program of personal hygiene and sanitation through rural and Indian residential schools, as well as Indian hospitals. Windsor's focus on caring for children and women was thus very much in keeping with this reformist thinking. In this sense, the type of health care delivered to Indian peoples by the Department of Indian Affairs through the medical officers reflected the general hopes and optimism of middle-class Canadian society, rather than an attitude of indifference.[100]

The idea that Indian peoples were included in the reformist programs of post-World War I Canadian society does not imply that the older colonial-segregationist and racialist ideologies had stopped operating. In fact, it appears that the two ideologies, reformist and racialist, existed side-by-side. On the Blackfoot Reserve, for example, Dr. Windsor promoted a reformist health program with baby care and x-rays, while at the same time she viewed Indian people as a separate group with whom she did not want to associate. Windsor, as late as the 1930s, believed that "Whites and Indians should not mix" and "should keep their place"; but she did allow her son to play with a Blackfoot friend on the reserve.[101] Similarly, although the Blackfoot hospital and its physician operated under progressive assumptions that health care should be available to all people, Indian people included, the nursing staff at the Blackfoot hospital had a similar contradictory view of the Blackfoot patients: they admired Blackfoot patients for their stoicism and sophisticated notions of death, while at the same time perceiving them to be "just like animals."[102]

Dr. John Knox Mulloy was officially appointed medical officer for the Blood agency on 29 October 1929, though he had been working among the Blood people from his practice in Cardston prior to that time.[103] Mulloy, like the other medical officers, was from eastern Canada and studied medicine both at the new University of Alberta medical school and later at McGill, following his military service in World War I.[104] Again, Mulloy's appointment reflected the Civil Service Commission's preference for veterans. Like Windsor, Mulloy was a medical officer who resided near the Indian community he serviced and had a long-term relationship lasting over eighteen years with that community, even though his position was only part-time. On the Blood Reserve, Mulloy became one of the first physicians to work in the new hospital.

As medical officer, Mulloy's work reflected the same progressive attitudes

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100 See Hodgson, "Social and Political Implications," 503, 509.

101 GA, Hanks Papers, M8078, box 301, f. 15.

102 Ibid., f. 14, Account of Nurse Pesquot, nurse to the Blackfoot hospital.

103 NA, RG 10, Vol. 1544, no file, C-14839, Department of Indian Affairs, F.H. Paget, chief accountant to Blood Agent Pugh, October 1929. Glenbow Archives microfilm reel.

104 See the community history, *Chief Mountain Country: A History of Cardston and District* (Cardston: Cardston and District Historical Society, 1987), 380-81.

that inspired many health professionals following World War I. One of the concerns was controlling the high incidence of tuberculosis on the reserves. Mulloy personally petitioned the Department of Indian Affairs to install an x-ray machine in the Blood hospital for the purpose of tuberculosis detection.[105] In the years he was medical officer, Mulloy also used his connection with Dr. Baker, medical superintendent of the Central Alberta Sanitorium in Calgary, to have tubercular patients transferred from the reserve to the Sanitorium for extended treatments in a period when the Department of Indian Affairs, in its chronically under-financed state, discouraged expenditure on off-reserve treatments.[106] Mulloy travelled off the reserve to northern Native communities to further his tuberculosis research, and pioneered an immunization program for the reserve.[107] Ultimately, Mulloy was made an honorary chief by the Blood band council in recognition of his contributions to the health of that community. Despite his active and lengthy involvement in Indian health care, however, Mulloy rarely associated with Indian peoples in Cardston and kept himself at a socially acceptable distance from his charges, much like Dr. Windsor.

Conclusions

Ultimately, the nature of hospital facilities and the work of the two medical officers on the Blood and Blackfoot Reserves reveal aspects of federal Indian health care policy for southern Alberta between the 1890s and 1930. Overall, it seems it was federal policy until the 1920s to allow missions to operate health care services on reserves; it was not until the 1920s in Alberta that the role of missionaries in Indian health care was reduced and the government's role increased. It is also apparent that the Department of Indian Affairs emphasized economy: expenditures on Indian health in southern Alberta had to be carefully monitored and justified since involvement in health care was not yet an accepted government role. The health care system devised by Indian Affairs up to World War II was also a decentralized system. Agents were deemed responsible for local expenditures, and doctors were also given the freedom to initiate programs as long as they did not incur unnecessary expenses. Indian band councils were also encouraged to undertake their own health care initiatives, using trust fund monies.

This study suggests themes in federal Indian health policy for southern Alberta very similar to those identified by Weaver for the Six Nations Reserve. These themes include the early importance of missionaries in

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105 GA, Blood Indian Agency Papers, M1788, f. 154-56, Agent Pugh to Dr. J.K. Mulloy, 15 September 1931.

106 Ibid., M1788, f. 154; personal communication with Dr. Bill Mulloy, son of Dr. J.K. Mulloy, August 1994; see also Hodgson, "Social and Political Implications," 505.

107 Glenbow Library clipping file, "Dr. J.K. Mulloy," *Calgary Herald*, 1969.

Indian health care, the reticence of Indian people to use hospitals, the influence of the medical officers and Indian agent on the exact nature and extent of local health care services, the role of the band government in reserve health services, and the significance of new hospital facilities built by the federal government in the 1920s.[108] Correspondences between Weaver's findings and the material presented here suggest there existed a consistent national-level federal Indian health policy before 1930.

The health care system operated by the Department of Indian Affairs in southern Alberta between the 1890s and 1930 was founded on, and informed by, values promoted in non-Native society. The health policy that emerged for the region emphasized many of the values of the social purity movement: conservation of life, interventionism in the lives of those requiring reform, placing emphasis on moral and physical purity, and focussing attention on women and children. These ideals were prominent in Canadian middle-class society at the time, and were not necessarily devised by bureaucrats in Ottawa for specific and exclusive application to Indian peoples.

Based on the annual reports of the Department and hospital records, Indian Affairs emphasized first and foremost the "scientific" conservation of Indian peoples' health and life. Not only was the idea of "conserving life" openly stated in the annual reports, but the idea was also reflected in the early inclusion of crude population statistics into the annual Indian Agent reports. These early statistics were not reliable enough to allow for any effective policy or program planning, but did reflect the Department's concern with life and death on the reserves.

The health care extended to Indian peoples in southern Alberta placed great emphasis on the idea of purity: among other issues, the records emphasize that houses were regularly white-washed; refuse on reserves was conscientiously burned; the hospital provided new clothing to its patients and newborns; the medical officers were responsible for reserve sanitation; and nursing matrons on the reserves and in the hospitals were to teach Indian women and children the basics of homemaking and moral living, both seen as important to overall health. All of these characteristics of the health care system created by the Department reflected an obsession with the principles of purity and hygiene, mental and physical.

Finally, in administering to Indian health, the Department emphasized the principle of interventionism. The placement of Indian people in hospital facilities as "patients," separate from their families and isolated from the activities of the reserve community, was viewed as necessary and positive. In hospital, the sick could be remade and regenerated using the latest and proper scientific techniques and once recovered, they could be redirected to live cleaner and purer lives. Children born in hospital were to be brought up

108 Weaver, *Medicine and Politics*, 38-79.

using the latest scientific techniques, in the hope that this new generation would better survive and contribute to the rural regeneration of Canada. Indian women were to be taught by visiting instructors how to keep themselves and their homes clean and healthy as part of their health supervision.

In conclusion, the actions of the Department of Indian Affairs and its employees involved in Indian health clearly reflect the federal government's emphasis on definite contemporary social reform goals and values, as well as its attempts to implement these values among its Indian charges through hospitals and physicians. Federal Indian health care initiatives were built on complex views of race, class and a sense of nationalism. It should be noted, however, that Indian health was not revolutionized by the federal system. Indian peoples made selective use of the health facilities and services provided by the government, but also continued with their own healing practices.

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