

**A Time to Heal:
Medical Missions and Indigenous Medico-Spiritual
Cosmologies on the Central Coast of British Columbia,
1897-1914**

by

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Abstract

In the late 1890s, the Methodist Church of Canada established medical missions among the two largest Indigenous settlements of the Central Coast: the Heiltsuk village of Bella Bella, and the Nuxalk village of Bella Coola. These medical missions emphasized the provision of biomedical care as an evangelization strategy, since the Methodists believed that God's grace and power manifested through their integrated medico-spiritual work. Although missionaries attempted to impose Euro-Canadian notions of health and healing, their assimilatory efforts resulted in an unexpected outcome. Rather than abandoning Indigenous healing, the Heiltsuk and Nuxalkmc recognized the limitations of biomedicine but also its advantages, and thus incorporated biomedical care into their cultural beliefs and practices. This thesis examines the convergence of Euro-Canadian and Indigenous healing systems and how it resulted in the emergence of medical pluralism, and considers how this reciprocal process of exchange affected both missionaries and Indigenous peoples.

Keywords: Methodist medical missions; Indigenous healing; medical pluralism; British Columbia; Heiltsuk; Nuxalk

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Preface

About noon of the following day the chief was still lying in the same position when he saw a large snake with horns on each side of the head, approaching. It put out its tongue as it was approaching the dying chief. The snake went right up to his stomach and crawled across him. Then it went into the woods. The chief did not move nor did he look about, for he was too weak. After a little while he heard the voice of a man who said, *Q!ōmÉna'küla*, my friend, I am glad that you were not frightened when I passed over your body in the form of a snake. Now I come to call you to my house. Arise and come." The chief arose from his bed and went to where the snake man was standing, for now his sickness had almost left his body. The snake man instructed him what to do before entering his house. He wanted him to imitate everything that he would see in the house. He said, "In front of the house is a spring of hot water on the right hand side facing the house, and from the left hand side cold water is running into it. This is the water of life. You must bathe four times in this water and dive, then you will be well and strong again and we will go into my house."

"The Chief Who Became a Shaman," *Bella Bella Tales*

To every thing there is a season, and a time to every purpose under the heaven: A time to be born, and a time to die; a time to plant, and a time to pluck up that which is planted; A time to kill, and a time to heal; a time to break down, and a time to build up; A time to weep, and a time to laugh; a time to mourn, and a time to dance; A time to cast away stones, and a time to gather stones together; a time to embrace, and a time to refrain from embracing; A time to get, and a time to lose; a time to keep, and a time to cast away; A time to rend, and a time to sew; a time to keep silence, and a time to speak; A time to love, and a time to hate; a time of war, and a time of peace.

Ecclesiastes 3:1-8, *The Holy Bible, King James Version*

Introductory Image

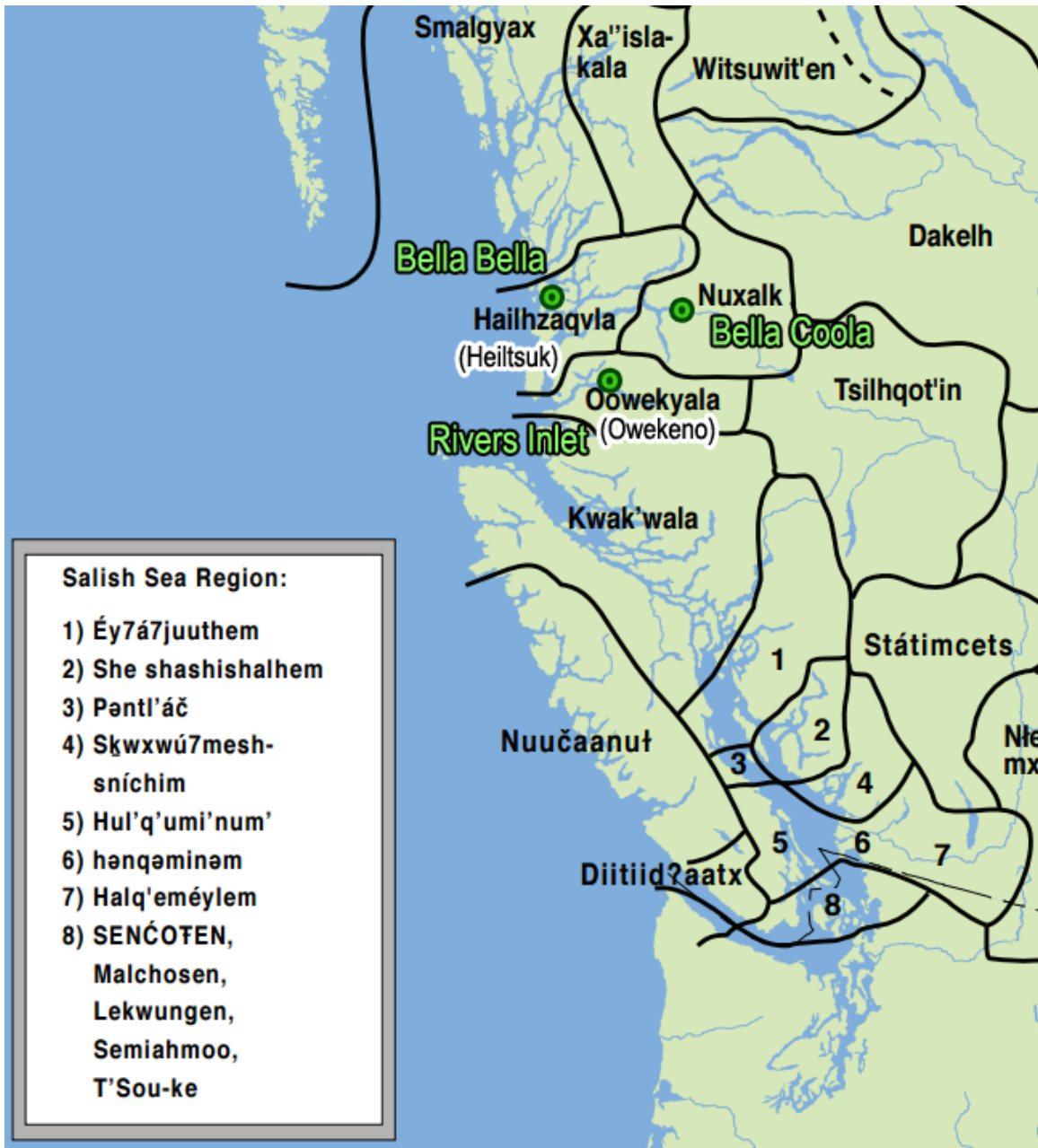


Figure 1. Map of Indigenous Linguistic Regions in Western British Columbia

Image used with permission from the Museum of Anthropology, University of British Columbia

Introduction

Nestled in an inlet surrounded by sharp peaks and towering conifers, the Bella Coola Valley was the ancestral home of the Nuxalkmc.¹ A new year—1907—had dawned upon the valley, bringing with it the steady rains of winter. It was January, but the dreary skies belied the bustle of activity unfolding at the main Bella Coola village. After a summer of fishing and itinerant labour in salmon canneries along the coast, the Nuxalkmc returned home, storing food and engaging in winter ceremonials. Through potlatches and dances, kinship bonds and communal identities were negotiated and affirmed, as they had been for innumerable generations. Although banned under the *Indian Act* amendment of 1884, potlatches continued in spite of government repression and the presence of Christian missionaries, who became a fixture on the Northwest Coast by the end of the nineteenth century.² Bella Coola was where the Nuxalkmc moved between two worlds: the resource extraction economy which formed the basis of settler-colonial British Columbia, and the lifeways of their ancestors.

The year began uneventfully on the Central Coast, although damp conditions tended to aggravate cases of chronic illness.³ One day, a woman complained of having a pain in her side, and requested an “Indian doctor” to come and examine her.⁴ After a

¹ During the turn of the twentieth century, Nuxalkmc was a plural noun which specifically referred to the “Nuxalk people” from the Bella Coola Valley. Other Nuxalk-language speakers of the surrounding region generally identified with their village, rather than collectively as a Nuxalk Nation. “Nuxalk” is used as an adjective or singular noun; ie. Nuxalk beliefs, Nuxalk woman. For a discussion of Nuxalk terms and identities, see Jennifer Kramer, *Switchbacks: Art, Ownership, and Nuxalk National Identity* (Vancouver: University of British Columbia Press, 2006), 24-25.

² Peggy Brock, *The Many Voyages of Arthur Wellington Clah: A Tsimshian Man on the Pacific Northwest Coast* (Vancouver: University of British Columbia Press, 2011), 192.

³ R.W. Large, “Bella Bella,” *The Missionary Outlook* 21, no. 9 (September 1902): 199.

⁴ I use the term “Indian doctor” because it reflects Dr. Spencer’s original verbiage. After hearing about the case, Dr. Spencer remarked that the patient was treated by an “Indian doctor,” rather than a “medicine man” or “shaman.” See J.C. Spencer, “Letter from Rev. J.C. Spencer, 18 January 1907,” *Missionary Bulletin* 3, no. 4 (Dec-Mar 1907): 796.

lengthy demonstration in front of the patient and family members, the Indian doctor proceeded to suck and extract a worm, approximately two inches in length, from her abdomen. To the onlookers present, no one could see how the medicine man performed the deed, since there were no surgical excisions visible on the patient's body.⁵

The patient's husband appeared to be unconvinced about the efficacy of the medicine man's intervention, since he sought a Euro-Canadian medical missionary, J.C. Spencer, for further assistance. Intrigued by what had transpired, Dr. Spencer recounted the patient's story in a letter to the *Missionary Bulletin* journal:

This feat would puzzle white surgeons. After the Indian doctor extracted the worm the husband came to me asking that I do what I could for his wife, and knowing that the Indian doctor was still practicing on her, I told him I did not like to interfere. This displeased him very much.⁶

Although this case is briefly mentioned amidst an otherwise mundane narrative of life in Bella Coola, its brevity belies the magnitude of its implications. The fact that a medical missionary knew his Indigenous parishioners were engaging in "pagan" practices, but refused to intervene, elicits many questions about the positioning of missionaries as colonial and assimilatory agents. The actions of the Indigenous family is equally revealing and surprising. The patient's husband distrusted the Indian doctor, even though the doctor was an "honored member of the tribe," and decided to consult Dr. Spencer for a second opinion. The patient herself and other family members, however, expressed "satisfaction" with the Indian doctor's help.⁷ While the Nuxalkmc often turned to medicine men in cases of severe illness, and attributed the causation and treatment of some illnesses to spiritual forces, individual adherence to these beliefs varied. Since the 1830s, the Nuxalkmc developed regular contact with Hudsons' Bay Company (HBC) traders, and would have been exposed to Euro-Canadian health practices during their interactions. The HBC established Fort McLoughlin on the territory of the Heiltsuk, a neighbouring Indigenous group who had longstanding social and political ties with the Nuxalkmc. Scottish doctor

⁵ Spencer, "Letter from Rev. J.C. Spencer," 18 January 1907," 795.

⁶ Spencer, "Letter from Rev. J.C. Spencer," 18 January 1907," 797.

⁷ Spencer, "Letter from Rev. J.C. Spencer," 18 January 1907," 796.

William Tolmie served at Fort McLoughlin intermittently in the 1830s, and documented his treatment of patients and interactions with Indigenous locals.⁸ In 1867, the HBC opened another trading post at Bella Coola itself, which was later acquired in 1885 by an English settler named John Clayton.⁹ The arrival of Christian medical missionaries in the late nineteenth century further amplified the interchange of cultural knowledge and practices. This thesis will examine these moments of encounter and convergence between medical missionaries and Indigenous peoples, and consider their historiographical significance and implications.

The concept of medical missions can be traced back to the earliest days of Christianity, as the healing power and public ministry of Jesus was recounted in the Gospel of John and other books of the New Testament.¹⁰ The first missions to Indigenous peoples in Canada, begun by Catholic orders in the seventeenth century, have been the subject of extensive research and analysis. Monographs such as Allan Greer's *Mohawk Saint* and Carol Blackburn's *Harvest of Souls* both present ethnohistorical analyses of Indigenous-Jesuit relations in eastern Canada. While these works established many precedents for ethnohistorical scholarship, they focus primarily on the spiritual aspects of missionization and their corresponding influence on Indigenous culture and identity.¹¹ Blackburn notes that some Wyandot (Huron) people considered epidemics to be a sign of Jesuit sorcery, but does not elaborate on Indigenous conceptions of the body-soul unit or the spiritual causation of physical ailments.¹² In most studies on Indigenous-missionary relations in early colonial Canada, health and healing tend to be subsumed as a secondary topic or chapter within a larger work.

⁸ His observations are published in William Tolmie, *The Journals of William Fraser Tolmie: Physician and Fur Trader* (Vancouver: Mitchell Press, 1963).

⁹ John Barker and Douglas Cole in T.F. McIlwraith, "Introduction," in *At Home with the Bella Coola Indians: T.F. McIlwraith's Field Letters, 1922-24*, eds. John Barker and Douglas Cole (Vancouver: University of British Columbia Press, 2003), 11.

¹⁰ *The Holy Bible*, King James Version (New York: Oxford Edition, 1769); King James Bible Online, 2017, accessed 25 April 2017, <http://www.kingjamesbibleonline.org/>.

¹¹ Carole Blackburn, *Harvest of Souls: The Jesuit Missions and Colonialism in North America, 1632-1650* (Montreal and Kingston: McGill-Queen's University Press, 2004); Allan Greer, *Mohawk Saint: Catherine Tekakwitha and the Jesuits* (New York: Oxford University Press, 2005).

¹² Blackburn, *Harvest of Souls*, 106.

Despite its minor standing in historical scholarship, healing work was a critical part of early Christian missions in Canada, which were operated by various Catholic orders prior to the Reformation. The Jesuits, Grey Nuns, and Ursulines established hospitals, although most missionaries from the seventeenth century did not receive any formal medical training. While Catholic missions attempted to enforce their ideals of proper health and healing, Indigenous cultures already had entrenched healing modalities in place. Furthermore, what is commonly associated with “Western medicine”—such as surgery, germ theory, and the scientific method—was still in its embryonic stages and would take several more centuries to develop.¹³ Seventeenth-century Catholic views on medicine were unexpectedly similar to those of the cultures they tried to convert; in fact, missionaries sometimes appropriated and utilized Indigenous herbal knowledge from various parts of the world, such as “Jesuit’s bark,” which was an anti-malarial compound made from cinchona trees in Peru.¹⁴ However, Catholic orders in this era could not implement a formal medical mission programme, due to theological debates over clergy performing surgical excisions on the human body.¹⁵

By the mid-nineteenth century, the scientific and socio-political climate had greatly shifted following the Protestant Reformation and the Enlightenment. These changes stimulated the emergence of formal medical missions, which started with German Protestant groups, then spread into Britain and its colonies. Christoffer Grundmann describes the second half of the century as “a time of epoch-making discoveries,” citing scientific advancements such as anaesthesia in 1846 and Joseph Lister’s contributions to asepsis and surgical hygiene in 1867.¹⁶ Robert Koch made significant progress in the field of germ theory, after he discovered the bacterial origins of two infamous diseases: tuberculosis in 1882 and cholera in 1883.¹⁷ After Pasteur and Koch, scientists finally

¹³ Christoffer H. Grundmann, *Sent to Heal!: Emergence and Development of Medical Missions* (Lanham, M.D.: University Press of America, 2005), 45.

¹⁴ Manuchair Ebadi, *Pharmacodynamic Basis of Herbal Medicine*, 2nd ed. (Boca Raton, F.L.: CRC Press, 2007), 245, 279.

¹⁵ Grundmann, *Sent to Heal!*, 23.

¹⁶ Grundmann, *Sent to Heal!*, 45.

¹⁷ Grundmann, *Sent to Heal!*, 46. The scientific name for tubercular bacterium is *Mycobacterium tuberculosis* and cholera is *Vibrio comma*.

understood germ theory and the aetiology of various communicable diseases, but it would take another fifty years until they developed effective therapies to treat them. Likewise, missionaries were no longer itinerant healers who improvised on the job; with the increasing professionalization of medical expertise, mission doctors now possessed degrees from medical schools. Dr. William Lockhart, who trained at Guy's Hospital in London, became the first medical missionary in the British colonies upon his deployment to southern China in 1839.¹⁸

Similarly in Canada, many medical missionaries graduated from Toronto Medical School, Queen's, or McGill.¹⁹ Dr. Spencer, who began his mission career at Kispiox under the supervision of Thomas Crosby, took a leave of absence to enrol at Stanford University's medical school before coming to Bella Coola in 1899.²⁰ As most missionaries had Anglo-Canadian identities, persons who were outside of their white racial construct were pathologized as innately unhealthy—both bodily and spiritually—and targeted as prospective converts to Christianity.²¹ While the scourge of Indigenous “superstition” was a common refrain in missionary parlance, “Indian work” constituted a minor part of the overall missionary enterprise. Overseas fields in China and India, due to their exoticized appeal, drew more applicants and public interest. While the Anglicans were the first denomination to establish an Indigenous medical mission in British Columbia, the Methodists soon became the dominant face of Protestant evangelism.²² At the peak of Protestant evangelism in the late nineteenth century, the Methodist Church fervently

¹⁸ G.H. Choa, *"Heal the Sick" Was Their Motto: The Protestant Medical Missionaries in China*. (Hong Kong: The Chinese University Press, 1990), 24.

¹⁹ The academic backgrounds of B.C. medical missionaries can be found in Bob Burrows, *Healing in the Wilderness: A History of the United Church Mission Hospitals* (Madeira Park, B.C.: Harbour Publishing, 2004).

²⁰ R. Geddes Large, *Drums and Scalpel: From Native Healer to Physician on the North Pacific Coast* (Vancouver: Mitchell Press Limited, 1968), 88.

²¹ For an overview of colonial discourses around Indigenous bodies and health, refer to Mary-ellen Kelm, *Colonizing Bodies: Aboriginal Health and Healing in British Columbia, 1900-1950* (Vancouver: University of British Columbia Press, 1998), 62.

²² The first Anglican medical missionary in British Columbia was Robert Tomlinson, who was best known for his work at the Kincolith mission on Nisga'a lands. He arrived in British Columbia in 1867. A biographical overview can be found in George Tomlinson and Judith Young, *Challenge the Wilderness: A Family Saga of Robert and Alice Tomlinson, Pioneer Medical Missionaries* (Seattle: Northwest Wilderness Books, 1993).

established mission fields across Canada, and published their endeavours in journals with equal zeal.²³

Late-nineteenth-century Methodists did not view their joint biomedical and missionary endeavours as paradoxical or mutually irreconcilable. In their perspective, biomedical science and Christian evangelism were complementary and integral to their divinely inspired mission. Medical missionaries conceived of Jesus Christ as the “Great Physician” and sought to cure the unconverted of their “soul-sickness.”²⁴ Rather than viewing the material and spiritual worlds as separate, they believed healing the sick body would also heal and save the afflicted soul. When missionaries sought to “bring the Sun of righteousness” to Indigenous peoples, they were confronted by belief systems which resembled their own.²⁵ Like many of his Indigenous patients, the scientific and spiritual worlds converged in Dr. Spencer’s pluralistic conception of healing.

As much as medical missionaries tried to supplant Indigenous beliefs, the congruity between Euro-Canadian and Indigenous ontologies resulted in their convergence and syncretization. Their convergent nature mutually reinforced each side, allowing for both hybridity and the simultaneous co-existence of settler and Indigenous ontologies. While missionaries hoped that convergence would result in assimilation, it in fact bolstered Indigenous healing practices by cultivating an ontological space for medical pluralism.²⁶ Indigenous peoples could observe and experiment with Euro-Canadian medicine within their own cultural understandings, and gained access to a greater array of therapeutic options.

²³ The Methodist Church published regional and national periodicals relating to theology and missionary operations, which were widely disseminated to church members. These periodicals include *The Missionary Outlook*, *Missionary Bulletin*, and *Western Methodist Recorder*. See Neil Semple, *The Lord’s Dominion: The History of Canadian Methodism* (Montreal and Kingston: McGill-Queen’s University Press, 1996), 207.

²⁴ A.E. Bolton. “Letter from Port Simpson, B.C., 20 October 1893,” *The Missionary Outlook* 13, no. 12 (December 1893): 182.

²⁵ Spencer, “Letter from Rev. J.C. Spencer, 18 January 1907,” 798.

²⁶ The concept of “medical pluralism” is presented in Kelm, *Colonizing Bodies: Aboriginal Health and Healing in British Columbia, 1900-1950*, 129. Kelm defines medical pluralism as “a continued acceptance of indigenous medicine alongside an ongoing struggle led by Native people to strip the overlays of cultural superiority from the provision of non-Native medicine.”

Medical missionaries, while outwardly rejecting Indigenous beliefs, were also affected by this process of convergence. Dr. Spencer declined to treat the female patient with abdominal pain, since he did not want to interfere with the “Indian doctor,” after recognizing that this sort of illness was beyond his ontological understanding. Furthermore, Dr. Spencer’s account reveals how missionaries became unintentional archivists of Indigenous knowledge, as settler curiosity prompted them to observe and write about their observations. Through letters in the *Missionary Bulletin* and other church periodicals, missionaries exposed the existence of Indigenous healing to their mainstream Euro-Canadian readership, by documenting the use of pharmacological plants, medicine men, and beliefs on the causation and treatment of various ailments. Even if missionary observations were often superficial, they still brought Indigenous practices into settler knowledge and discourse.

Thus, my thesis will examine the history of medical missionization and Indigenous peoples through the lens of convergence. I argue that the convergence of Euro-Canadian and Indigenous ontologies resulted in the emergence of medical pluralism. Within this system of medical pluralism, Indigenous peoples could access and maintain control over a greater range of therapeutic choices, and also resist missionary interference over their bodily and spiritual well-being. Specifically, I will focus on the interchange between Euro-Canadian and Nuxalk and Heiltsuk medico-spiritual cosmologies; the concept of “medico-spiritual cosmology” is integral to my interpretation of convergence and will be explained later. The Nuxalkmc and Heiltsuk peoples, the two largest Indigenous cultures of the Central Coast at the turn of the twentieth century, were targeted as prime candidates for missionization. Situating my analysis between 1897 and 1914, I identify this period as the nascent era of Methodist medical missions on the Central Coast. The first medical missionary, Dr. J.A. Jackson, arrived at the Heiltsuk village of Bella Bella in 1897, and his presence set in motion the process of medico-spiritual convergence.²⁷

Medical missionization is integral to the wider scholarship on the history of colonialism in Canada, since missionaries often acted in tandem with secular government

²⁷ At the time of Dr. Jackson’s arrival, Bella Bella was still located at ‘Qélc, which is the site of Fort McLoughlin. This location is known as Old Bella Bella. Starting in 1898, the Heiltsuk began moving to a new village site down the strait. In their language they called the location “Waglisla,” but to the missionaries it became New Bella Bella.

interests. Nonetheless, it is critical to emphasize that missionaries and state officials should not be viewed as a homogenous entity, nor labelled using the dichotomy of Euro-Canadian as “colonizer” versus Indigenous peoples as the “colonized.” The colonizer-colonized dichotomy has been a major framework in Indigenous Canadian historiography, but it is problematic for a number of reasons. Firstly, it assumes that missionization is aligned with colonialism and imperialism, but these processes are not necessarily integrated. Robin Fisher’s *Contact and Conflict*, which is considered a pioneering work on Indigenous history in British Columbia, presents a methodical critique of the missionary enterprise. He contends that missionaries were agents of settler-colonialism, who “deliberately and consciously thought out plans of acculturation.”²⁸ To the contrary, evidence suggests that colonial interchanges were much more nuanced, which will be demonstrated in my analysis.

Outside of Canadian historiography, anthropologists John and Jean Comaroff articulate an argument similar to Fisher’s view of missionaries. Writing in the context of South Africa, the Comaroffs emphasize the primacy of missionary power.²⁹ They frame the colonial dynamic using a military metaphor, where the missionary is viewed as a “footsoldier” of imperialist and colonialist agendas. Furthermore, they argue that missionization is essentially a form of ontological hegemony, which “colonizes the consciousness” of Indigenous peoples. Not only did missionization try to convert Indigenous peoples to Christianity, it was also a civilizing project designed to assimilate them into colonial cultural systems and worldviews. However, their argument over-emphasizes the polarity between Euro-Canadian and Indigenous lives when the contrary was true: Indigenous Christians and mixed-blood peoples lived between boundaries of identity, and even staunch white Methodists such as Dr. Spencer found himself—even if unwillingly—enfolded into the lifeways of Indigenous communities.

While missionary ambitions to convert often intersected with government agendas to assimilate, they did not always act in concurrence. Blackburn’s *Harvest of Souls*, which

²⁸ Robin Fisher, *Contact and Conflict: Indian-European Relations in British Columbia, 1774-1890* (Vancouver: University of British Columbia Press, 1977), 119.

²⁹ Jean Comaroff and John L. Comaroff, “The Colonization of Consciousness in South Africa,” *Economy and Society* 18, no. 3 (1989): 267.

examines Huron-Jesuit relations, makes a distinction between religious and secular forces of colonialism, by arguing that their actions were driven by different economic and socio-political agendas. In British Columbia, where most of the province is not under First Nation treaties, missionaries have often supported Indigenous struggles for land and resource rights against government interests.³⁰ I am not arguing that missionaries should be absolved of complicity in grievous historical injustices, such as residential schools, but it is important to emphasize that colonialist agents varied greatly in their relations with Indigenous peoples. While church and state sometimes colluded in their assimilatory agendas, they were just as likely to be in discordance. Thus, the colonizer-colonized dichotomy is inherently limiting, given that the colonizers did not share a cohesive colonial vision, and it reduces Indigenous peoples into a single category of identity.

The colonial vision that medical missionaries held was rooted in paternalism and evangelistic optimism, but their hopes were mired in ideological and pragmatic challenges. In British Columbia, difficulties with staff recruitment and retention was compounded by a rural mission field spanning thousands of kilometres, where the amenities of Euro-Canadian infrastructure was still in its infancy. It was also one of the most diverse mission fields in Canada, as the land was home to Indigenous peoples from seven linguistic and cultural groups. Beneath their outward paternalism, however, Protestant missionary rhetoric derided the paganism of the unconverted, especially the use of *nuscaakstatim* or *dásgíú* in Indigenous healing.³¹

Although medical work represented a significant part of the missionary programme, academic scholarship has been limited in several aspects. Existing literature tend to be popular histories written for a general audience, usually by former missionaries or authors affiliated with church organizations. The most comprehensive history of

³⁰ Lynn A. Blake, "Oblate Missionaries and the 'Indian Land Question'," *BC Studies* no. 119 (Autumn 1998): 27-44.

³¹ *Nuscaakstatim* is the Nuxalk word "a spell has been placed on him, he is bewitched," as defined in H.F. Nater, *A Concise Nuxalk English Dictionary* (Ottawa: Canadian Museum of Civilization, 1990), 107. *Dásgíú* is the Heiltsuk word for "witchcraft," as noted by anthropologist Ronald Olson, quoted in Michael Harkin, *The Heiltsuks: Dialogues of Culture and History on the Northwest Coast* (Lincoln: University of Nebraska Press, 1997), 82. The same word is used to denote a "witch doctor," as defined by John C. Rath, *A Practical Heiltsuk-English Dictionary with a Grammatical Introduction* (Ottawa: National Museums of Canada, 1981), 221.

Methodist and United Church medical missions in British Columbia, *Healing in the Wilderness*, is written by Bob Burrows, who is a retired mission-boat captain.³² As is the case with *Healing in the Wilderness* and other non-academic works, the monograph is mainly a chronological overview of key persons and events. Critical analysis is rarely presented, and Indigenous perspectives are hidden beneath the missionary narrative. In fact, most academic monographs on Canadian medical missions do not examine Canada at all; the majority of them focus on China, whose large non-Christian population attracted an immense amount of missionary interest. These monographs include Sonya Grypma's *Healing Henan: Canadian Nurses at the North China Mission* and Rosemary Gagan's *A Sensitive Independence: Canadian Methodist Women Missionaries in Canada and the Orient*.³³

Through my research, I hope to address the historiographical shortfall on domestic medical missions, particularly the "Indian fields" in British Columbia. I focus on the Central Coast, a region which is well-documented in archaeological scholarship by Nancy Turner, Dana Lepofsky, and others, but not often studied through a historical methodology.³⁴ The most notable ethnohistorical contribution is Michael Harkin's *The Heiltsuks: Dialogues of Culture and History on the Northwest Coast*. Published in 1997, *The Heiltsuks* is a seminal text in the study of Indigenous responses to Christianity, and one of the few studies situated within the cultural context of the Central Coast. Harkin articulates that the Indigenous body is a powerful site of spiritual power, transformation, and contestation. In contrast to Robin Fisher, Harkin contends that the Heiltsuk were not subjugated by

³² Bob Burrows, *Healing in the Wilderness: A History of the United Church Mission Hospitals*, 14.

³³ Sonya Grypma, *Healing Henan: Canadian Nurses at the North China Mission, 1888-1947* (Vancouver: University of British Columbia Press, 2008); Rosemary Gagan, *A Sensitive Independence: Canadian Methodist Women Missionaries in Canada and the Orient, 1881-1925* (Montreal and Kingston: McGill-Queen's University Press, 1992).

³⁴ Turner has published extensively on Indigenous ethnobotany; monographs include Nancy J. Turner, *Ancient Pathways, Ancestral Knowledge: Ethnobotany and Ecological Wisdom of Indigenous Peoples of Northwestern North America* (Montreal and Kingston: McGill-Queen's University Press, 2014). Lepofsky is known for her community-based scholarship with the Heiltsuk and other peoples of the Central Coast, where she studies Indigenous clam gardens and food resource management. Turner and Lepofsky have collaborated on numerous publications, and served as guest editors of a special issue of *BC Studies: Ethnobotany in British Columbia: Plants and People in a Changing World*, special issue, *BC Studies* 179 (Autumn 2013).

missionization, nor was colonial hegemony totalizing in its power. Instead, Harkin believes that Heiltsuk responses to colonial agents were “dialogic,” as there were numerous instances of both overt and subtle resistance.³⁵ Likewise, Harkin’s arguments follow the historiographical tradition established by James Axtell in the 1980s, who argues that conversion and acceptance of Christianity should not be viewed as an act of surrender or “defeat” for Indigenous cultures.³⁶ Rather, Indigenous peoples found ways to reconcile and indigenize Christianity into existing cosmologies and cultural practices.

After Harkin, Susan Neylan, Nicholas May, and Sergei Kan have made more recent contributions to the history of Indigenous-Christian encounter on the North Coast. Nicholas May’s doctoral work on the Nisga’a focuses on their response to Anglican Christianity.³⁷ Susan Neylan’s *The Heavens Are Changing*, which examines Tsimshian responses to missionaries and indigenization of Christianity, has been a critical influence on my own work. While *The Heavens are Changing* presents a well-rounded critique of the socio-cultural impacts of missionization, its discussions of health and healing are limited. Likewise, Sergei Kan’s *Memory Eternal: Tlingit Culture and Russian Orthodox Christianity through Two Centuries* addresses similar issues in Alaska, although it is comparatively different from other monographs due to its focus on Orthodox Christianity. Brett Christophers’ *Positioning the Missionary: John Booth Good and the Colonial Confluence of Cultures* considers the Nlaka’pamux of interior B.C. as active agents of missionization, as they sought conversion to Anglicanism rather than were compelled out of economic or political necessity. Like Blackburn in *Harvest of Souls*, Christophers emphasizes the difference between missionary agendas and secular imperialism.³⁸ While most of the scholarship has been produced by settler scholars, Indigenous historians such

³⁵ Michael Harkin, *The Heiltsuks*, 98-99.

³⁶ James Axtell, “Some Thoughts on the Ethnohistory of Missions,” *Ethnohistory* 29, no. 1 (Winter 1982): 35-41.

³⁷ Nicholas May, “Feasting on the AAM of Heaven: The Christianization of the Nisga’a, 1860-1920” (PhD diss., University of Toronto, 2013).

³⁸ Susan Neylan, *The Heavens are Changing: Nineteenth-Century Protestant Missions and Tsimshian Christianity* (Montreal and Kingston: McGill-Queen’s University Press, 2003); Sergei Kan, *Memory Eternal: Tlingit Culture and Russian Orthodox Christianity through Two Centuries* (Seattle: University of Washington Press, 1999); Brett Christophers, *Positioning the Missionary: John Booth Good and the Confluence of Cultures in Nineteenth Century British Columbia* (Vancouver: University of British Columbia Press, 1998).

as Mary Jane McCallum (Munsee Delaware) and Winona Wheeler (Fisher River Cree) work to decolonize the history of colonial encounter. McCallum studies the effects of medical encounter on Indigenous health and hospitals, while Wheeler has worked on missionary encounter through the experience of Askenootow (Charles Pratt), an Anglican Cree/Métis catechist from the Prairies.³⁹

Following historiographic standards set by Harkin and others, I wish to expand on how scholars conceptualize the effects of medical missionization. My analysis will integrate physical and spiritual considerations into one unit of historiographical analysis, rather than address them as separate categories; *The Heiltsuks*, as an example, divides “Bodies” and “Souls” into different chapters. Drawing on the research of medical sociologist Nicholas Jewson, I adopt his term *medical cosmology* to denote the ontological, spiritual, and material ways in which a culture conceives of health and illness. While “medical paradigm” is a more commonly-known expression, it is predominantly rooted in a scientific model, rather than humanistic.⁴⁰ Instead of employing Jewson’s term in its original verbiage, I will use “medico-spiritual cosmology.” The concept of “medico-religious” is already established in the historiography of Indigenous-Christian relations, although scholars such as Allan Greer and James Axtell assign it different meanings.⁴¹ I contend that “medico-spiritual” is a more inclusive term, because *religious* denotes a specific theological dogma, whereas *spirituality* is arguably more self-experiential.

In this thesis, I explore how convergence is central to understanding the relations

³⁹ Mary Jane McCallum, “The Last Frontier: Isolation and Aboriginal Health,” *Canadian Bulletin of Medical History* 22, no.1 (2005): 103-20; Winona Wheeler, “The Journals and Voices of a Church of England Native Catechist: Askenootow (Charles Pratt), 1851-1884,” in *Reading Beyond Words: Native History in Text and Context*, eds. Jennifer Brown and Elizabeth Vibert (Peterborough, O.N.: Broadview Press, 1996), 304-29.

⁴⁰ D. Greaves, “Reflections on a New Medical Cosmology,” *Journal of Medical Ethics* 28, no. 2 (April 2002): 81-82.

⁴¹ Greer uses “medico-religious” to define the medical culture of Catholic France, which utilized saints and divine intercessions for healing, and explains how it influenced Jesuit relations with Kanien’kehá:ka (Mohawk people); Greer, *Mohawk Saint*, 162-63. While Methodism was considerably different in theology from Catholicism, Methodist missionaries shared similar beliefs with their Jesuit counterparts. Axtell uses “medico-religious” to denote a shaman’s function and power in Indigenous societies, which often attribute physical sickness to a metaphysical origin; Axtell, “The Invasion Within: The Contest of Cultures in Colonial North America,” in *The European and the Indian: Essays in the Ethnohistory of Colonial North America* (New York: Oxford University Press, 1981), 71.

between medical missionaries and the Nuxalkmc and Heiltsuk. Chapter 1 discusses the cultural context in which a Methodist medico-spiritual cosmology evolved, and how historical processes led to its convergence with Indigenous counterparts on the Central Coast. In Chapter 2, I analyze how the convergence of these cosmologies influenced the everyday lives of Nuxalkmc and Heiltsuk and produced a system of medical pluralism. Indigenous concepts of medico-spiritual knowledge and power will be addressed by focusing on the relations between Indigenous patients, medicine men, and Euro-Canadian doctors. Chapter 3 identifies how medical pluralism influenced the mission hospital, and how medical missionaries were affected by convergence. Drawing on research by Kelm, McCallum, Lux, and Harkin, I consider how the hospital space functions within medical colonialism.

Although conceived as a space of bodily control, the mission hospital could not wholly regulate Indigenous patients' autonomy and therapeutic choices. Beyond the hospital space, missionary control was tempered by practical problems such as understaffing, as well as Indigenous peoples actively resisting surveillance of their healing practices. Furthermore, the process of convergence went both ways—Indigenous peoples adopted Euro-Canadian health practices, and so did missionaries who enlisted Indigenous assistants, furnishings, and food to treat hospitalized patients, many of whom were non-Indigenous. To conclude, I contend that the operations of medical missions begin to shift around 1914, which is the temporal end-point of my thesis, when government entities increasingly take over the funding and operation of colonial health care. The violent displacement of children to residential schools further compromised the knowledge and practice of Indigenous medicine alongside Euro-Canadian models.

In terms of primary sources, I am selective in my approach due to space and practical limitations. I am less concerned with the bureaucratic aspects of medical colonialism, since the ramifications of Aboriginal health policy in Western Canada have been explored in significant depth by Kelm and Lux, so I wish to expand the dialogue in a direction that is less state-centric.⁴² As such, I will not elaborate on the relations between the Nuxalkmc, Heiltsuk, and the Department of Indian Affairs (DIA), although I will provide

⁴² Maureen Lux, *Medicine That Walks: Disease, Medicine, and Canadian Plains Native People, 1880-1940* (Toronto: University of Toronto Press, 2001); Kelm, "Colonizing Bodies."

a brief overview of DIA involvement in Indigenous governance and health care. Given that my archival sources were produced by and written for a Euro-Canadian perspective, I am aware of their limitations in a work about Nuxalk and Heiltsuk cultures. Most of my sources are missionary letters, which were published in periodicals such as the *Missionary Bulletin* and *The Missionary Outlook* for church members. Missionaries wrote hundreds of letters with the aim of soliciting donations and drawing public interest, so they included detailed observations about the daily happenings of Indigenous life and practices. The abundance of these letters makes them a valuable tool for historians, but nonetheless, missionaries tended to present a sterilized and essentialist narrative.

Since Indigenous peoples often shielded their medico-spiritual knowledge from missionary surveillance, I use ethnographies to supplement my church sources. Euro-Canadian ethnographers, including Thomas McIlwraith and Harlan Smith, developed close relationships with several informants, including Joshua Moody and Captain Schooner.⁴³ However, early-twentieth-century ethnographies are problematic; they tended to present a reductionist view of Indigeneity, in which only “pagan” and “pre-modern” practices are deemed authentic and worthy of study. Ethnographies are also doubly mediated, given that they represent the experiences of specific Indigenous individuals, and are filtered again through the Euro-Canadian scholars’ perspectives. Some informants did not have access to protected knowledge from secret societies, and certain medicinal remedies were owned and used by particular families. Furthermore, ethnographies document Indigenous beliefs in a written manner, which are detached from their oral, performative, and experiential contexts.

I recognize that the immaterial nature of medico-spiritual cosmologies do not translate well to linear text. While oral histories are often employed in ethnohistorical scholarship, and commonly expected in postcolonial research paradigms, I did not conduct oral history interviews. My sources are exclusively archival, comprising letters, ethnographies, government records, and photographs, with the exception of a few oral history interviews recorded and transcribed in the 1970s. The main reason that I am not

⁴³ The most well-known of these ethnographies would be T.F. McIlwraith, *The Bella Coola Indians*, intro. John Barker, reprint of 1948 edition (Toronto: University of Toronto Press: 1992). It is a two-volume study produced in collaboration with Nuxalk consultants such as Joshua Moody and Captain Schooner.

using an oral history methodology is because of temporal distance. My period of study precedes the living memory of peoples in the twenty-first century. Memories—both embodied and cognitive—are transferable across generations, although the methodological implications of memory scholarship are beyond the purview of my thesis. Instead of oral history, my historiographical contribution will be interdisciplinary and informed by medical anthropology, ethnohistorical scholarship, and a literary approach to source interpretation. Rather presenting a quantitative analysis of hospital admissions and funding, which is commonly found in studies of medical colonialism, I focus on missionary letters and ethnographic narratives, and pay close attention to silences, use of figurative devices, and diction.

Furthermore, Euro-Canadian primary sources are not entirely devoid of Indigenous voices. As James Clifford and John Barker argue, ethnographies are collaborative texts, since they are not created in an ontological vacuum. Missionary letters and narratives are also the product of authors responding to actions and beliefs of their subjects. Borrowing a term from cultural theorist Mikhail Bakhtin, Michael Harkin argues that such texts exhibit “heteroglossia,” meaning that they are layered with different levels of voices.⁴⁴ While the ethnographer or missionary ultimately shapes the final organization of their text, the consciousness of Indigenous cosmologies permeate through the written word. By mediating the past and the present, I hope this thesis will allow these layered voices to surface, and illuminate what has been hidden, but not lost, through the course of history.

⁴⁴ Harkin, *The Heiltsuks*, 157.

Chapter 1.

Heavenly Bodies: The Convergence of Medico-spiritual Cosmologies

Our world is called A'nēkô'ôl, or Qenki'lst, that is, "the land below." It is an island swimming in the boundless ocean. In the far east a giant is sitting with legs apart, who is called Alēp!ālxtnaix. He holds a long stone bar in his outstretched hands. The earth is fastened to this stone bar by means of two stone ropes. Sometimes he gets tired, and moves his hands to take better hold of the stone bar. Then we have an earthquake...

Nuxalk creation story⁴⁵

The homeland of the Nuxalkmc and Heiltsuk lies atop the intersection of three major tectonic plates, and it is one of the most active convergent boundaries in the world. This state of flux is reflected in the geography, as the land is marked by sharp mountain peaks and carved into valleys and fjords by glaciers. Bella Coola, the home of the Nuxalkmc, is located by the mouth of the Bella Coola River in North Bentinck Arm. Further downstream at the junction between the mainland and ocean, a sea-faring traveller would find the village of Bella Bella, where most of the Heiltsuk resided at the turn of the twentieth century.⁴⁶

While scholars in Euro-Canadian academia would apply a geological understanding of landscapes, the Nuxalkmc have their own theory of earth's origins. In a Nuxalk creation story, their homeland is akin to a sort of "middle earth," nested between multiple layers of existence. Earth floats as an island suspended atop the ocean via stones, held by a giant, whose movements can cause earth tremors and epidemics. In the Euro-Canadian version of history, the Central Coast had been inhabited for at least 10,000

⁴⁵ Franz Boas, "The Mythology of the Bella Coola Indians," *Publications of the Jesup North Pacific Expedition* 2, no.1 (November 1898): 37.

⁴⁶ Refer to the map of Nuxalk and Heiltsuk cultural subgroups and territories in Martha Black, *Bella Bella: A Season of Heiltsuk Art* (Toronto: Royal Ontario Museum, 1997), 4-5.

years, when much of North America was still embedded under a continental glacier.⁴⁷ I use the term “Central Coast” to denote this region’s locality at the coastal midpoint of British Columbia, spanning approximately 240 km in length from Douglas Channel in the north to Rivers Inlet in the south, and 150 km inland from the Pacific Ocean. Once established on this territory, the Nuxalkmc and Heiltsuk’s ancestors would have converged with and adopted the traditions and beliefs of neighbouring peoples. Generations of Indigenous cultural interchange preceded the arrival of European newcomers, since the Central Coast was a meeting place between two different linguistic groups, the Wakashan and the Salishan. Differences between these groups emerged as early as the first century C.E., based on modes of subsistence and kinship organization.⁴⁸

Although Wakashan and Salishan languages developed in close proximity, they are in fact separate language families.⁴⁹ The Nuxalk language is Salishan and an isolate surrounded by Wakashan speakers, which include the Heiltsuk people, who call their language Hailhzaqvla. The Heiltsuk live at the northernmost extent of Wakashan territory, and are comparatively small in population to the Nuu-chah-nulth and Kwakwaka'wakw on Vancouver Island.⁵⁰ Likewise, the Nuxalkmc also resided at the northern reach of Salishan territory. While the Nuxalkmc and Heiltsuk maintained amicable relations through trade and intermarriage, warfare was not unusual due to conflicts over resources, land, or interpersonal conflicts. They simultaneously fought each other and united to raid distant tribes, including the Haida and Tsimshian. For the most part, Nuxalk and Heiltsuk societies did not revolve around a central authority figure nor did they enact strict social

⁴⁷ Philip Hobler, “Prehistory of the Central Coast of British Columbia,” in *Handbook of North American Indians: Northwest Coast*, ed. Wayne Suttles, vol. 7 (Washington, D.C.: Smithsonian Institution, 1990), 298.

⁴⁸ Hobler, “Prehistory of the Central Coast of British Columbia,” 298. Wakashan culture tended to be matrilineal and the Salishan was bilateral. Due to the relatively inland location of Bella Coola, many Nuxalk women married Dakelhne (Carrier men), who were from the Central Interior and an Athapaskan-speaking group. The Dakelhne were more patrilocal than the coastal groups.

⁴⁹ Dean R. Snow, *Archaeology of Native North America* (New York: Routledge, 2016), 281.

⁵⁰ Early European traders on the British Columbia coast made extensive records of their encounters with the Nootka (Nuu-chah-nulth) and Kwakiutl (Kwakwaka'wakw), including John R. Jewitt’s dramatic recounting of his life in Nootka Sound, where he lived for two years as a slave of Chief Maquinna.

stratification.⁵¹ Given the heterogeneity of the Central Coast, cultural alliances were not entrenched and were constantly reshaped by shifting socio-political circumstances.

While scholars today often identify Indigenous peoples by their nation, such as “Nuxalk First Nation,” it is important to note these affiliations are relatively recent developments. The idea of a pan-tribal identity developed in the post-contact period when various kinship groups, which had their own village sites, began to assemble at trading posts or mission settlements. They sometimes congregated due to economic incentives, such as working in canneries, or to strengthen their population in the wake of epidemics. Prior to the 1920s, Nuxalk peoples identified with their specific village rather than as a collective nation. *Nuxalkmc* specifically referred to the Indigenous people of the Bella Coola Valley, while the extended Nuxalk culture had four distinct groups: Nuxalkmc, Taliyumc, Kwalhnm, and SutsImc.⁵² In the Nuxalk language, Bella Coola village was called *Q’umk’wts*. It was originally one of four smaller ancestral villages that consolidated in the late nineteenth century, so “Bella Coola” was commonly used to refer to the whole settlement.⁵³ Although the name’s origin is uncertain, Euro-Canadian traders likely anglicized *belwxela*, which is the Heiltsuk term for Nuxalk speakers.⁵⁴ Unlike the Nuxalkmc, the five Heiltsuk tribes had coalesced their communal identity by the early twentieth century, although Heiltsuk subgroups such as the Xai’xais of Klemtu retained some distinction.⁵⁵ Traders probably modified the word *bilballa* into “Bella Bella,” and it became an umbrella term for the Heiltsuk people, homeland, and main village site.

Contact with Euro-Canadian missionaries certainly accelerated the pace of cultural interchange, but it was not unprecedented given the region’s dynamic history. Alexander Mackenzie, a Scottish trader from the North West Company (NWC), encountered the

⁵¹ Barker and Cole, “Introduction,” in *At Home with the Bella Coola Indians*, 10.

⁵² Kramer, *Switchbacks: Art, Ownership, and Nuxalk National Identity*, 25.

⁵³ Clayton Mack, *Bella Coola Man: More Stories of Clayton Mack*, ed. Harvey Thomassen (Madeira Park, B.C.: Harbour Publishing, 1994), 103, 110.

⁵⁴ Some Nuxalk people today attribute the origin of “Bella Coola” to a corruption of the Spanish or Latin word for “beautiful valley,” as cited in Kramer, *Switchbacks: Art, Ownership, and Nuxalk National Identity*, 24.

⁵⁵ The majority of the Heiltsuk population resided at Old Bella Bella around the 1890s. Black, *Bella Bella: A Season of Heiltsuk Art*, 10.

Nuxalkmc and Heiltsuk in the summer of 1793, a few weeks after George Vancouver's first contact. It was Mackenzie who probably introduced the earliest instance of Euro-Canadian health care to the Nuxalkmc; he gave Turlington's Balsam, a patent medicine which purportedly cured a range of ailments, to a chief stricken by a severe skin ulcer. The Balsam had little effect, so Nuxalk medicine men treated the patient by performing a ritual and scarifying the ulcer with a surgical implement.⁵⁶ Along with medicine, the early contact period signified another crucial change in the material lives of Indigenous peoples; namely, access to European metal implements and trade goods such as woven cloth, which reconfigured potlatch alliances and economic networks of the coast.⁵⁷ While material manifestations of contact are the most apparent to historians, changes at the ontological scale were also occurring, especially in the way Indigenous peoples used language to understand and communicate their worldviews. Due to the diversity of the region, Chinook Jargon developed as the *lingua franca* for both Indigenous peoples and European traders, and was extensively adopted by missionaries in subsequent decades. By the end of the eighteenth century, the forces of convergence had already been set in motion, and change was stirring within the cosmos of the Central Coast.

Traders brought not only material goods, but biological agents in the form of communicable diseases, and laid the groundwork for future colonial contestations. While it is difficult to determine exact mortality rates, both Indigenous oral histories and missionary accounts suggest that smallpox deaths resulted in population declines of 27 to 83 percent, a figure which varied along the coast of British Columbia.⁵⁸ The entire Nuxalk culture likely lost 46 percent of its population, and the Heiltsuk, 34 percent during the smallpox epidemic in the 1830s.⁵⁹ The pre-contact Nuxalk population of the 1790s was estimated at 2,910, and fell to 402 by 1868.⁶⁰ According to a DIA census for 1897, the year

⁵⁶ James Waldram, D. Ann Herring, and T. Kue Young, *Aboriginal Health in Canada: Historical, Cultural, and Epidemiological Perspectives*, 2nd ed. (Toronto: University of Toronto Press, 1995), 158.

⁵⁷ Black, *Bella Bella: A Season of Heiltsuk Art*, 19.

⁵⁸ Robert Thomas Boyd, *The Coming of the Spirit of Pestilence: Introduced Infectious Diseases and Population Decline among Northwest Indians, 1774-1874* (Vancouver: University of British Columbia Press, 1999), 223.

⁵⁹ Boyd, *The Coming of the Spirit of Pestilence*, 227.

⁶⁰ Barker and Cole in McIlwraith, *At Home with the Bella Coola Indians*, 11.

when Methodist medical missionaries first arrived, the Nuxalk population dropped even lower to 213, while the Heiltsuk of Bella Bella was 285.⁶¹ In addition to smallpox, venereal disease, tuberculosis, and viral fevers also joined the disease pool. Moreover, the immediate toll of mortalities was further compounded by long-term impacts, including malnutrition, intertribal violence from political instability, and loss of culture and families.

This backdrop of epidemics, and its biological and socio-political legacies, prompted the HBC to offer Euro-Canadian medical care. In Western Canada, there are numerous instances of traders providing food, blankets, and emergency and long-term medical care to Indigenous patients.⁶² The company forts stocked medicine chests and surgical implements, and employed trained medical doctors such as John McLoughlin and William Tolmie. The company also established quarantine measures to protect the healthy from the spread of disease. On the Central Coast, Dr. William Tolmie served intermittently at Fort McLoughlin (Old Bella Bella) in the 1830s, and made observations of Heiltsuk life in his journal. In an entry from 24 March 1835, Dr. Tolmie treated a patient (perhaps a white trader) with laryngitis, who was lodging at the house of an Indigenous person.⁶³ In 1837, Dr. McLoughlin spearheaded an initiative to protect Indigenous peoples against smallpox, and sent cowpox vaccines to Fort McLoughlin with the hope that “the Indians will allow themselves to be vaccinated.”⁶⁴ In addition to medical care, the HBC forts provided Christian teachings and services to the local population. At Fort Nisqually, which was established in 1833 near present-day Olympia, Washington, the Sunday services attracted a noticeable number of Indigenous peoples. One of the traders recognized the importance of reconciling Christian beliefs with Indigenous dancing and other spiritual

⁶¹ Prior to 1904, Indian Agent reports and the DIA censuses described the Nuxalkmc as part of the “Tallion Nation,” which was an anglicized variant of “Taliyumc.” The Taliyumc band had a different identity from the Nuxalkmc and mostly resided at the village of Talyu, which was about 37 km south of Bella Coola in South Bentinck Arm. In 1897, Talyu had 42 residents, while Bella Coola had 213. It is not known why the DIA considered Bella Coola to be part of Tallion Nation, rather than vice versa, since the Nuxalkmc were the most populous of the Nuxalk-speaking peoples. Refer to Canada, Department of Indian Affairs, *Annual Report of the Department of Indian Affairs, for the year ended 30th June 1897* (Ottawa: Queen's Printer, 1898), 361.

⁶² Waldram, Herring, and Young, *Aboriginal Health in Canada*, 157-159.

⁶³ Philip Hobler, “Old Bella Bella, Genesis and Exodus,” *Urban History Review* 28, no. 2 (March 2000): 8.

⁶⁴ Hobler, “Old Bella Bella, Genesis and Exodus,” 8.

expressions.⁶⁵ In the period between 1793 and 1897, the HBC laid the foundation for Indigenous peoples' encounters with Euro-Canadian health and spiritual practices.

The Methodist medical missions transformed the HBC's services into a more cohesive and regimented programme, which accelerated the process of medico-spiritual convergence. Roving missionaries had already worked on the Central Coast since 1880, but the Methodists did not send a permanent medical missionary until 1897. As the Heiltsuk had the largest post-epidemic population, and was already exposed to Christian concepts from the early missionaries, Bella Bella was earmarked for a medical mission and hospital. By the time Dr. J.A. Jackson arrived in Bella Bella in 1897, and Spencer at Bella Coola in 1899, the peak of smallpox had already passed, as the last major epidemic struck in 1862-63. Nonetheless, Jackson and Spencer would likely have witnessed smallpox scars lingering on the bodies of Indigenous survivors, who were elders bearing the psychological and spiritual wounds of cultural loss. These scars not only documented the epidemiological history of the Central Coast, but it also showed the embodied legacies of colonial encounter.

Before examining the arrival of missionaries on the Central Coast, we need to go back to 1793 and consider developments a continent and ocean away. In England, the populace was sparked by a current of spiritual reform and change. Historians of religion describe this era as the Second Great Awakening, a Protestant revival movement which established the antecedents of evangelical reform movements and global missionization in the late nineteenth century.⁶⁶ Beginning in the 1730s, the Protestant sphere of Western Europe and Euro-America saw an intense wave of religious upheaval, as adherents of the Church of England became increasingly critical of the Church's emphasis on hierarchy, ritual, and sacraments. Such doctrines, they argued, hindered the individual's faith and relationship to God. Unlike the previous Protestant revolutions of the Puritans and

⁶⁵ Robert H. Ruby and John A. Brown, *John Slocum and the Indian Shaker Church* (Norman, OK: University of Oklahoma Press, 1996), 15.

⁶⁶ The term "awakening" was popularized by historian William McLoughlin from Brown University, who first used it in 1980. See McLoughlin, *Revivals, Awakenings, and Reform: An Essay on Religion and Social Change in America, 1607-1977* (Chicago: University of Chicago Press, 1980).

Presbyterians, the Great Awakening of the 1730s emphasized universal salvation regardless of gender, class, race, or spiritual pre-election. The most prominent branch of this religious movement became known as Methodism, named for its insistence on spiritual discipline and "methods" based on four foundations of authority: Scripture, tradition, reason, and experience.⁶⁷

This era of spiritual awakening unfolded alongside major scientific and intellectual breakthroughs. Western European medical care, which for centuries had been based on "bedside medicine," shifted towards the hospital model.⁶⁸ Under this new biomedical framework, the provision of health care became centralized and professionalized within a hospital setting. The innovation of nitrous oxide and ether for anaesthesia in the 1840s, as well as principles of antiseptics, allowed for more invasive surgeries. In the 1870s, the development of germ theory in disease transmission paved the way for immunology. By 1890, vaccines existed for cholera, anthrax, rabies, tetanus, diphtheria, and cowpox, although tuberculosis—the infamous "consumption" of the Victorian era—did not have an effective vaccine until 1921.⁶⁹ Furthermore, antibiotics and most modern pharmaceutical drugs were not invented until the 1930s. In 1895, the invention of medical x-rays increased diagnostic accuracy, although Bella Bella Hospital did not obtain an x-ray machine until the 1920s.⁷⁰ Even though mission hospitals were often situated far away from urban centres, staff strove to modernize the facilities as best as they could. Within ten years of opening, Bella Bella Hospital expanded to include a surgical ward, a dispensary for out-patients, and quarantine and tubercular cottages.

While it seems unusual for devout Christians to be champions and purveyors of biomedical science, late nineteenth-century Protestants held a more holistic understanding of the body than the historiography suggests. Canadian historians of

⁶⁷ Semple, *The Lord's Dominion*, 16.

⁶⁸ L.S. Jacyna, "The Localization of Disease," in *Medicine Transformed: Health, Disease and Society in Europe: 1800-1930*, ed. Deborah Brunton (Manchester: The Open University, 2004), 2-3.

⁶⁹ The first effective tuberculosis vaccine was BCG (Bacille Calmette-Guerin); see Lux, *Medicine That Walks: Disease, Medicine, and Canadian Plains Native People*, 202.

⁷⁰ George E. Darby, "A Visit to Bella Bella Hospital with Dr. Darby as Guide, 14 January 1920," *Missionary Bulletin* 16, no. 2 (April-June 1920): 212.

medicine, including Wendy Mitchinson and Michael Bliss, have generally approached their research from a biomedical perspective, focusing on scientific developments and their socio-political implications.⁷¹ Jacalyn Duffin is one of the few medical historians who have addressed the intersection of religion, particularly in *Medical Saints: Cosmas and Damian in a Postmodern World* and *Medical Miracles: Doctors, Saints and Healing in the Modern World*, but these works are not specific to a Canadian or Indigenous context.⁷² Furthermore, Duffin's work focuses on Catholicism, which has a strong tradition of divine healing through miracles and saintly intercessions.

In contrast to Catholicism, mainline Protestantism is not generally associated with miraculous or spiritual healing. Pamela Klassen challenges these stereotypes by drawing on examples of "supernatural" medicine performed and sought by mainline Protestants in Canada, such as healing through radio wave energy and group prayer. In *Spirits of Protestantism*, Klassen argues that Victorian-era notions of healing reflected a form of "supernatural liberalism."⁷³ By liberal Protestants, Klassen is referring to mainline denominations such as Anglicans and Methodists, as opposed to evangelical Pentecostal and Charismatic churches. Likewise, liberal Protestants viewed the union of science and religion as an "antidote to the ravages of materialistic science as well as to non-Christian superstitions."⁷⁴ The concept of medical missions have their origins within this liberal Protestant worldview. Even though Euro-Canadian biomedicine is considered to be based on "science" and "the scientific method," spiritual and scientific understandings of bodily

⁷¹ Mitchinson's research often presents a feminist analysis of biomedicine, especially the provision of gynecological and obstetrics care in the nineteenth and early twentieth centuries. See Wendy Mitchinson, *Body Failure: Medical Views of Women, 1900-1950* (Toronto: University of Toronto Press, 2013) and Mitchinson, *The Nature of Their Bodies: Women and Their Doctors in Victorian Canada* (Toronto: University of Toronto Press, 1991). Bliss has written extensively about the modernization of biomedicine and biomedical technologies, as well as Frederick Banting, William Osler, and other influential physicians. See Michael Bliss, *The Making of Modern Medicine: Turning Points in the Treatment of Disease* (Chicago: University of Chicago Press, 2010) and Bliss, *William Osler: A Life in Medicine* (Toronto: University of Toronto Press, 2000).

⁷² Jacalyn Duffin, *Medical Saints: Cosmas and Damian in a Postmodern World* (New York: Oxford University Press, 2013); Duffin, *Medical Miracles: Doctors, Saints and Healing in the Modern World* (New York: Oxford University Press, 2008).

⁷³ Pamela E. Klassen, *Spirits of Protestantism: Medicine, Healing, and Liberal Christianity* (Berkeley and Los Angeles: University of California Press, 2011).

⁷⁴ R. Fletcher Moorshead quoted in Klassen, *Spirits of Protestantism*, 91.

wellness have co-existed throughout different periods in history, and continue to exist in various manifestations.

Unlike other major Protestant denominations, late nineteenth-century Methodism is difficult to locate on the evangelical to mainline spectrum. While Methodism is rooted in an evangelical tradition, with its emphasis on conversion, revivals, mission work, and Scripture as the “inspired word of God,” it was neither fundamentalist or Adventist.⁷⁵ Neither did Methodists believe in spiritual gifts, such as divine healing or prophecy, which was a hallmark of Pentecostalist churches. While Klassen shows that some liberal Protestants experimented with energy waves or “faith cures,” the Methodist Church discouraged the use of non-biomedical healing. Medical missionaries defined faith cures as “a cure said to be wrought in answer to the prayer of faith to the exclusion of all medical advice and appliances.”⁷⁶ They opposed faith cures, not due to its associations with quackery, but because it was unscriptural on theological grounds. Firstly, faith healing dictated that “the atonement [of Christ] provides for immediate immunity from all the natural disabilities of sin” in the present life, while Methodists believed redemption of the body from all disease and death would happen at Resurrection. Secondly, Methodists took issue with faith healing’s “disparagement of all those remedies which God, through the laboratory of nature has provided for the mitigation of pain, and the correcting of the disorders to which our bodies are liable.”⁷⁷ Faith healing’s opposition to biomedicine was viewed as an affront to God, as Methodists believed medical science was a physical manifestation of divine blessing and power.

Methodist medical work was borne out of both tradition and innovation; it was concurrently informed by the tradition of Jesus' healing ministry, and the latest advancements in biomedical science. Missionaries did not view science and religion to be inherently contradictory; biomedicine helped to cure the body, and a robust body was a

⁷⁵ Semple, *The Lord's Dominion*, 392. The theology of “Christian fundamentalism” is beyond the scope of this thesis, but at its most basic definition, fundamentalist churches believe the Bible is the literal word of God. *Adventists* refer to churches that believe in the imminent return of Jesus Christ to earth, otherwise known as the “Second Coming.”

⁷⁶ Author unknown, “The Faith Cure,” *The Missionary Outlook* 23, no. 10 (October 1904): 220.

⁷⁷ Author unknown, “Field Notes,” *The Missionary Outlook* 23, no. 11 (November 1904): 244.

microcosmic representation for a spiritually whole society. In a cosmology where divine and biomedical power melded, Klassen describes liberal Protestants as "heirs and benefactors of scientific method while they simultaneously dwell in a universe permeated with divinity."⁷⁸ Likewise, she argues that liberal Protestants played a key role in the development of biomedicine in the early twentieth century, particularly in university medical education and professionalization of the health field.

Despite Methodism's prominence in late nineteenth-century Protestantism, it initially had difficulty gaining popular traction. In Anglo-Protestant Canada, the Church of England held longstanding influence in the socio-political sphere, as it was the establishment church of many colonies in British North America.⁷⁹ Peter Doll notes the longstanding influence of Anglicanism on British foreign policy and identity, which he describes as "Imperial Anglicanism."⁸⁰ With minimal separation of church and state, political elites often had strong Anglican connections. One example was the Family Compact, an oligarchy which controlled much of Upper Canada's government in the early nineteenth century, led by Bishop John Strachan. The Church also wielded power through landholding grants established by the Constitution Act of 1791, namely the Clergy Reserves, which was vaguely granted to "Protestant clergy," but interpreted as solely reserved for Anglicans. Increasingly by the mid-nineteenth century, the colonial government began to secularize and nationalize Anglican holdings, as other Protestant denominations demanded their share of land and financial resources. During the mid-nineteenth century, Methodist leaders rose in prominence when they publically engaged in a war of words with Strachan, who was criticized for provoking hostilities against the Methodist Church.⁸¹

Methodism would come to define the fundamental socio-political ideology of white,

⁷⁸ Klassen, *Spirits of Protestantism*, 17.

⁷⁹ I use the term "Anglicans" in reference to adherents of the Anglican Communion, although in Canada, this Protestant denomination was officially known as the Church of England until 1955.

⁸⁰ Peter M. Doll, *Revolution, Religion, and National Identity: Imperial Anglicanism in British, 1745-1795* (Cranbury, N.J.: Associated University Presses, 2000), 13-14.

⁸¹ Egerton Ryerson, *The Story of My Life*, ed. J. George Hodgins (Toronto: William Briggs, 1883), 103.

middle-class Canadians in the late nineteenth century. Neil Semple argues that settler Canada was founded as a "Christian model for the entire world," and its chief colonizers inspired by the Methodists' focus on spiritual fellowship, personal and moral development, and social reform.⁸² However, Methodism originated from a starkly different past; its early associations with working-class peoples, open-air preaching, and fervent evangelization led to accusations of fanaticism by High Church adherents. Over time, Methodist doctrine and belief became more mainstream, evolving to form the basis of liberal Protestantism espoused by middle-class professionals and community leaders. Given its emphasis on intellectual development and social welfare, it is not surprising that Methodist culture encouraged the development of educated health-care professionals. It soon became the most popular mainline Protestant church; in the Dominion Census of 1881, over 740,000 out of approximately 4.3 million Canadians identified as Methodist, exceeding Anglicans and Presbyterians.⁸³ In 1839, Rev. George Cookman described Methodism as "above all, a revival of the missionary spirit," and a conviction that "goes forth aggressively under the eternal promise to the conquest of the world."⁸⁴ Thus, Methodism was simultaneously mainline and evangelical, forging a spiritual consciousness rooted in both reason and experience, and a spiritual outlook propounding change through proselytization and conversion.

In the competition for Indigenous souls, Methodist missions were a relative latecomer in Canada, compared to the Catholics who established Sulpician and Jesuit missions in the mid-seventeenth century. Anglican-Episcopalian missions had served among the Haudenosaunee (Iroquois) since the early eighteenth century and, together with Catholics, they spread westward onto the Prairies and demarcated their fields with mission villages and schools.⁸⁵ Although the Methodists had worked among the Mi'kmaq

⁸² Semple, *The Lord's Dominion*, 3.

⁸³ Methodist Church (Canada) General Conference, *Centennial of Canadian Methodism* (Toronto: William Briggs, 1891), 334; population figures from Canada, Library and Archives Canada, "1881 Census," last modified 28 September 2016, last accessed 25 April 2017, <http://www.bac-lac.gc.ca/eng/census/1881/pages/about-census.aspx>.

⁸⁴ Cookman quoted in *The Missionary Outlook* 22, no. 3 (April 1903): 96.

⁸⁵ Owanah Anderson, "Anglican mission among the Mohawk," *Three Centuries of Mission: The United Society for the Propagation of the Gospel, 1701-2000* (London: Continuum, 2000), 235.

and Beothuk in Atlantic Canada since the end of the War of 1812, their spiritual influence was largely overshadowed; in their early years, Methodists often worked as sub-contractors to Anglican missionary societies.⁸⁶ It would take until the turn of the twentieth century, with the Third Great Awakening and rise of the Social Gospel movement, before Methodist missions became a dominant force in Canada, and specifically in British Columbia. As the competition for mission fields was fierce in eastern Canada, Methodists focused their efforts on the Northwest Coast, which was the "last frontier" in the Euro-Canadian imagination. It is this reason that coastal British Columbia has a high number of Methodist-run residential schools, including Coqualeetza, Port Simpson, and Alberni.⁸⁷

Though the missionary enterprise in Canada predated the existence of Methodism by more than a century, Methodists arguably created the first "modern mission," utilizing both men and women field workers who were spiritually moderate, often university-educated, and middle class. The stereotype of a black-robed ascetic missionary was no longer the norm; Methodist workers were encouraged to have families and immerse themselves in their mission communities. They preached in the local language or lingua franca of Chinook, fished and hunted with locals, organized Christmas dinners and pageants, played "Santa" and hid trinkets in stockings, made clothes at sewing bees, and provided entertainment on magic lanterns. In addition, the media-savvy Methodists propagated their extensive public-relations machine, which is evident in their numerous missionary magazines, fundraising campaigns, promotional photographs of smartly dressed missionaries with wives and children, and young adult groups such as the Epworth League.⁸⁸

In addition to their innovative approach to public relations, the Methodists were equally modern in their engagement with science, technology, and medicine. They viewed good health as a critical component in spiritual and moral elevation, so medical work was made an integral part of missional labours. Concepts such as cleanliness, hygiene, and

⁸⁶ Semple, *The Lord's Dominion*, 152.

⁸⁷ John S. Milloy, *A National Crime: The Canadian Government and the Residential School System* (Winnipeg: University of Manitoba Press, 1999).

⁸⁸ Dr. Large's son, R. Geddes Large, gives a detailed recounting of mission life in Large, *Drums and Scalpel*, 1-22.

bodily regulation greatly informed the Social Gospel movement; likewise, Mariana Valverde frames this era as the “age of light, soap, and water.”⁸⁹ Missionary societies and lay associations turned to the Bible to justify the importance of medical missions, emphasizing Scriptural examples of healing ministries and depicting Jesus Christ as “the Great Physician.”⁹⁰ Horace Wrinch, who was posted for many years at Hazelton, B.C., noted the tradition of medical evangelization by citing Matthew 4:23: “And Jesus went about all Galilee, teaching in their synagogues, and preaching the gospel of the kingdom, and healing all manner of sickness and all manner of disease among the people.”⁹¹ In numerous tracts published in *The Missionary Outlook*, Wrinch justified the importance of medical missionary work by depicting Christ, first and foremost, as a Healer, adding that “the itinerating medical missionary is copying very closely the life of the Master.” By describing Christ as a Healer, rather than Saviour, Wrinch suggests that medical work is critical for successful evangelization, and it would—by extension—save the soul as well.

Among Indigenous mission fields, medical services have long been an integral part of missionary work, as Indigenous bodies were deemed to be inherently sickly by the pathologizing colonial gaze. However, most missionaries had no professional training in medicine, relying on folk knowledge, utilization of local pharmacology, and trial and error. Thomas Crosby and his crew traveled the coast providing smallpox inoculations, but none were certified doctors.⁹² In coastal British Columbia, the Anglican’s Church Missionary Society (CMS) was the first religious organization to hire a medical missionary, Robert Tomlinson. Originally from Ireland, Tomlinson trained at the Adelaide Hospital in Dublin and was ordained a deacon before deploying to Canada in 1867.⁹³ Although Tomlinson never received full priesthood, the CMS was in dire need of a medical missionary, due to the rampage of disease in northern British Columbia. Tomlinson went to assist William

⁸⁹ Valverde, *The Age of Light, Soap, and Water: Moral Reform in English Canada, 1885-1925* (Toronto: University of Toronto Press, 1991).

⁹⁰ Heather D. Curtis, *Faith in the Great Physician: Suffering and Divine Healing in American Culture, 1860-1900* (Baltimore: Johns Hopkins University Press, 2007).

⁹¹ Horace Wrinch, “Go Heal the Sick,” *The Missionary Outlook* 22, no. 9 (September 1903): 203.

⁹² Thomas Crosby, *Among the An-ko-me-nums or Flathead Tribes of Indians of the Pacific Coast* (Toronto: William Briggs, 1907), 171.

⁹³ Tomlinson, *Challenge the Wilderness*, 4-5.

Duncan at Metlakatla, and later became head of the Kincolith mission in Nisga'a territory. While the CMS certainly had professional doctors on its roster, they did not publicize medical work to the same extent as Methodists.⁹⁴ In their periodicals, the Methodists promoted their utilization of the latest scientific tools and technologies, including anaesthesia and abdominal surgery, and foregrounded a biomedical modality of health care in conjunction with spiritual healing.

Buoyed with scientific and spiritual optimism, the Methodists turned their attention to regions outside of Anglican and Catholic oversight. After epidemics in the 1830s and 1860s, along with the shift to wage labour at forts and canneries, the Heiltsuk began restructuring their community. In the 1880s, families started to settle around Fort McLoughlin, which the Heiltsuk called 'Qélc. Euro-Canadians called this site "Bella Bella," and it became the largest Heiltsuk village. The 1880s also marked a significant year for spiritual convergence: Bella Bella Jack became the first Heiltsuk to convert to Christianity, and adopted the baptismal name of Arthur Ebbstone. Other Heiltsuk soon followed his lead. Charles Tate, the first permanent missionary at Bella Bella, noted the shift in Heiltsuk culture, dramatically stating that it was his "privilege to witness some of the grandest transformation scenes that have ever taken place on this coast."⁹⁵ After the early 1880s, Bella Bella and Bella Coola were served by a series of missionaries, none of whom left substantial records.

More than a decade passed before the Methodists committed to a permanent medical missionary, Dr. Jackson. Plagued by ill health, Jackson only worked for a year before retiring. His successor, Richard Large, was a prolific writer who documented his decade-long tenure in great detail. After serving for a short period at the Japanese hospital in Steveston, B.C., Large arrived on the Central Coast in December 1898. He was a

⁹⁴ In addition to the *Missionary Bulletin* and *The Missionary Outlook*, the Methodist Church was a key publisher of religious and secular works across Canada. The *Missionary Bulletin* was in publication from 1903 to 1921, and *The Missionary Outlook* from 1881 to 1925. Emphasizing the importance of education and intellectual development, the Methodist Church operated various publishing houses and book rooms. In comparison, most of the CMS operations were documented in annual reports, which were not published for public circulation.

⁹⁵ Black, *Bella Bella: A Season of Heiltsuk Art*, 30. Charles Tate was not a medical missionary, but he was the first permanent one and worked in Bella Bella from 1880 to 1884.

twenty-five-year-old fresh out of Trinity Medical School and a surgery residency at Toronto General Hospital.⁹⁶ Under Large, Bella Bella's field expanded into Bella Coola and Rivers Inlet, and saw the establishment of two mission hospitals. In the following year, Large was joined by Spencer, who took over the post at Bella Coola.

Although Large had no experience working in Indigenous missions, Bella Bella appeared to be the perfect fit for a new recruit. In the 1897 DIA report, all 298 Heiltsuk at Bella Bella identified as Christian, so it seemed that the Methodists' evangelizing ambitions had already been achieved.⁹⁷ But even if all Heiltsuk now identified as Christians, it did not mean that they abandoned Indigenous healing and other practices deemed "uncivilized" by missionaries. The missionaries believed that Indigenous peoples needed continual guidance in order to become fully civilized, and to prevent backsliding. The establishment of the medical mission, however, had little effect on curtailing Heiltsuk practices; instead, the similarity between Methodist and Heiltsuk medico-spiritual cosmologies reinforced the continuance of Heiltsuk culture. Due to their convergent ontology, practices, and discourse, the Heiltsuk could readily adopt and integrate a Methodist cosmology into existing cultural systems. As Large would discover, convergence was reciprocal, and he soon became enfolded into this sphere of medical pluralism. Like the active geological zone which laid underneath Bella Bella, this convergence of cosmologies would bring seismic changes for both sides.

* * *

When Dr. Large arrived in December 1898, the Heiltsuk were busily constructing their new town site at Waglisla. The Heiltsuk had returned to their winter homes after a summer of fishing and migrant labour. Several years earlier, most Heiltsuk lived at 'Qélc, but a winter storm damaged several houses and made villagers question the safety of their residence. Land was also becoming scarce and the community was divided by political conflicts between the chiefs. Furthermore, Dr. Jackson, who recently quit due to ill health, had urged his parishioners to move to Waglisla and build single-family homes.

⁹⁶ Black, *Bella Bella: A Season of Heiltsuk Art*, 138.

⁹⁷ Canada, Department of Indian Affairs, *Annual Report of the Department of Indian Affairs, for the year ended 30th June 1897* (Ottawa: Queen's Printer, 1898), 361.

It was a subtle tactic in the missionary's assimilatory agenda, which sought to impose Euro-Canadian notions of the nuclear family and private property. After some rough years, the Heiltsuk decided to start anew, and moved their settlement down the strait. There, they erected Waglisla, which meant "river delta" in the Heiltsuk language, and the village became known to Euro-Canadians as "New Bella Bella." It would soon become the largest Indigenous village of the Central Coast, comprising 74 dwelling-houses by the end of 1899 and a population around 300.⁹⁸ Given its central location at the junction of seafaring routes, Waglisla became an important stop for migrant workers seeking supplies and assistance.



Figure 2. The village front, Bella Bella [1910]

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Approaching Waglisla by boat, the rocky shoreline was dotted with rows of low-lying buildings, situated against a dense backdrop of hemlock and cedar trees. The Heiltsuk depended on these forests for constructing houses and the waterfront; as a community largely serviced by marine trade and transport, good harborage was a key

⁹⁸ Canada, Department of Indian Affairs, *Annual Report of the Department of Indian Affairs, for the year ended 30th June 1899* (Ottawa: Queen's Printer, 1899), 263.

necessity. In 1903, the BC provincial government loaned a steam-pile driver for the construction of a new wharf and sent two white workers to operate it, but the Heiltsuk voluntarily provided most of the demanding, physical labour.⁹⁹ Heiltsuk shopkeepers donated food to workers, while the village council purchased bolts and nails. With this community effort, the Heiltsuk managed to complete the wharf in about two weeks. Behind the new wharf stood single family houses with gabled roofs, painted white with dark trimming around sidings and window frames, built in the latest Euro-Canadian style.¹⁰⁰ While gabled houses and wharves may have been an architectural import, their construction was nevertheless created by Heiltsuk hands, which embodied generations of wood-working knowledge.

Despite being hundreds of kilometres from the urban centres of Victoria and Vancouver, Waglisla was not lacking in material comforts and "progress" by Euro-Canadian standards. Dr. Large approved of what he saw in the village. It had a school-house funded and supplied with a teacher by the DIA.¹⁰¹ The people of Bella Bella wore collared shirts and blouses trimmed with lace and ribbon, rather than cedar bark blankets. There was a recreation hall, shops stocked with imported goods—selling snacks such as popcorn, chewing gum, and soda water, toys for children, and haberdashery—and a main boulevard of six-metre-wide planks illuminated by oil lamps during the night.¹⁰² By 1910, with a population of approximately three hundred residents, Waglisla's market economy was entrenched in a Euro-Canadian system of wage labour and monetary goods. The majority of Heiltsuk left Waglisla to work in summer canneries at Rivers Inlet, and returned home in the fall and winter. Increasingly though, lifeways became less transitory, as some Heiltsuk adopted professions and business to retain capital within the village, which prompted them to reside year-round. These jobs included carpenters, a banker, woodcarvers, a lighthouse keeper, and boat builders, as well as a steam sawmill and

⁹⁹ R.W. Large, "Letter from Richard W. Large, November 1903," *Missionary Bulletin* 1, no.4 (March 1904): 413.

¹⁰⁰ R.W. Large, "Souvenir of Bella Bella, BC," Prince Rupert Presbytery: Bella Bella U.C., vol. 2, Vancouver: United Church of Canada, British Columbia Conference Archives.

¹⁰¹ Canada, Department of Indian Affairs, *Annual Report of the Department of Indian Affairs, for the year ended 30th June 1899* (Ottawa: Queen's Printer, 1899), G-141.

¹⁰² Black, *Bella Bella: A Season of Heiltsuk Art*, 35.

grocery shops.¹⁰³

Outwardly, the vestiges of Bella Bella's Indigenous identity appeared to be rapidly vanishing. The spatial orientation of buildings, with single-family dwellings and merchant businesses replacing lineage longhouses, demarcated Waglisla as a Euro-Canadian space. The outward appearance, however, belied the fact that Heiltsuk cultural practices permeated in spite of missionary surveillance. At 'Qélc, "old Bella Bella," the Heiltsuk buried their deceased with granite tombstones alongside wooden grave houses. After moving to Waglisla, missionary pressure discouraged the use of grave houses and other monumental buildings, but the Heiltsuk continued to maintain their funerary edifices at 'Qélc.¹⁰⁴ The persistence of Indigenous funerary practices alongside Christian beliefs is one manifestation of convergence, which transformed Heiltsuk lives and, it would appear, afterlives as well. Chapter 2 will examine these convergent practices in greater detail.

Bella Bella may have been the most modernized village on the Central Coast by 1898, but it lacked a crucial feature: the hospital. From Dr. Jackson, Dr. Large and his wife Isabella inherited the monumental task of expanding the medical mission and establishing a hospital that would provide health services to the surrounding community, and to fulfill the Methodists' vision of salvation through medico-spiritual healing. The mission's duty was to assist anyone regardless of race or religion, so it assisted many non-Indigenous people, including Japanese, Chinese, and white labourers. Given the mobility of both the Indigenous and non-Indigenous population, Dr. Large was tasked with founding a summer hospital in the cannery town of Rivers Inlet. Along with providing church services and pastoral care, Large also served as the community's justice of the peace and wrote regularly to church periodicals. Dr. Raynor, the medical missionary who replaced Large while he was on furlough in 1907, remarked on the overwhelming rigour of the job: "I felt somewhat discouraged the first week or two, owing to the fact that besides the medical work I had to prepare two talks and the Sunday School lesson for Sunday, and a talk for the Thursday evening prayer-meeting. Not having been used to such work, I found it very

¹⁰³ Black, *Bella Bella: A Season of Heiltsuk Art*, 35-36.

¹⁰⁴ Large, "Souvenir of Bella Bella, BC," 10.

hard at first.”¹⁰⁵ This demanding lifestyle was typical of medical missionaries, whose work would not have been possible without the unpaid labour from their wives, nurses, and Indigenous assistants.

* * *

About 100 kilometres away from Waglisla up the inlet of North Bentinck Arm, the Nuxalkmc lived at the mouth of the Bella Coola River. From the shoreline, the village of Bella Coola resembled Waglisla, with the exception that it was spatially smaller and lacked the amenities of nascent capitalism, such as merchant shops. The Nuxalkmc adopted an agricultural economy rather than rely on wage labour, since their fertile land suited the growth of potato crops. Compared to the 74 dwelling-houses in Waglisla, Bella Coola had 32, and a population around 205.¹⁰⁶ The Indian Agent, C. Todd, noted that many houses were built in the “modern style and comfortable,” and they were conveniently connected by wooden boardwalks. Even though many houses were “modern,” Nuxalk architecture reflected a distinctly syncretic style. At Bella Coola, longhouses with house posts and totem poles could be found as late as 1920, and even modernized houses displayed family crests above the front doorway. Deceased Indigenous converts were buried with white crosses, right beside traditional grave houses entombing their ancestors and the unconverted. One grave box, resting upon a thunderbird or eagle totem, was surrounded by a decorative white-picket fence, which was clearly an Euro-Canadian import.¹⁰⁷

¹⁰⁵ W. Raynor, “Letter from W. Raynor, 11 August 1907,” *Missionary Bulletin* 4, no. 2 (September 1907): 545.

¹⁰⁶ Canada, Department of Indian Affairs, *Annual Report of the Department of Indian Affairs, for the year ended 30th June 1899* (Ottawa: Queen’s Printer, 1899), 264.

¹⁰⁷ Although Harlan Smith took the majority of his photographs in 1920, the village landscape retained much of the same characteristics as the late 1900s-1910s. See photos in Harlan I. Smith, *The Bella Coola Valley: Harlan I Smith's Fieldwork Photographs, 1920-1924*, ed. Leslie H. Tepper (Ottawa: Canadian Museum of Civilization, 1991), 23.



Figure 3. Bella Coola Indian Village Of Noohalk [189-]

Image G-00958 courtesy of the Royal BC Museum and Archives. Image used with permission.

The Nuxalkmc were not the only residents of the Bella Coola Valley. Since 1894, they had allowed Norwegian settlers to farmstead on their territory and establish the village of Hagensborg about 13 km inland. The Nuxalk were hospitable hosts, but as settler Milo Fougner remembered, generally kept to themselves.¹⁰⁸ Community relations, for the most part, was cordial and respectful. The settlers' children played with their Indigenous neighbours, and learned to speak some of the local language. Annie Levelton, a settler who grew up in Hagensborg, remarked that "the Indians were surprisingly very good to

¹⁰⁸ Milo was the son of Iver Fougner, who worked as the Indian Agent for Bella Coola Agency starting in 1910.

us. They could have resented us pretty badly but they were awfully good to us.”¹⁰⁹ Given that the Norwegian settlers were all Lutherans and had their own church and missionary, the Methodist missions had minimal involvement in their affairs.¹¹⁰

Large, however, provided health care to the Norwegian settlers through his responsibilities as provincial Medical Health Officer and director of Bella Bella Hospital. The Methodist Church had little interest in funding a separate hospital at Bella Coola, a situation which disappointed Dr. Spencer: “The prospects for a hospital in Bella Coola are not promising, and as we send out worst cases to Bella Bella we have concluded we would be doing the right thing to send some supplies to Dr. Large.”¹¹¹ At Large’s request, Dr. Spencer sometimes travelled to the Bella Bella Hospital to assist in major operations, an arduous journey that required voyage by steamer and canoe. For the most part, Dr. Spencer had to make do with the lack of a hospital at Bella Coola and travelled to patients’ homes to provide care.

The Norwegian settlers travelled to Bella Bella Hospital, the sole hospital on the coast between Port Simpson and Vancouver, for severe illness or cases requiring surgery.¹¹² During an outbreak of scarlet fever in December 1905, Large joined Spencer in Bella Coola to inspect the situation and gave consultations to patients.¹¹³ By 1910, the Norwegian settlement expanded enough that they took control of their own health care services. The settlers spearheaded the construction of the Bella Coola Hospital, and upon its completion in 1910, was operated by a board of Hagensborg residents and the provincial government.¹¹⁴ The Bella Coola Hospital functioned as a secular institution,

¹⁰⁹ Milo Fougner, Annie Levelton, and Ted Levelton, “Into a Wild Country: Norwegians at Bella Coola,” ed. Gordon Fish, *Sound Heritage: Voices from British Columbia* (Vancouver: Douglas & McIntyre, 1984), 52.

¹¹⁰ J.C. Spencer, “Letter from Rev. J.C. Spencer, 15 April 1907,” *Missionary Bulletin* 4, no. 1 (June 1907): 224-25.

¹¹¹ Canada, Department of Indian Affairs, *Annual Report of the Department of Indian Affairs, for the year ended 30th June 1899* (Ottawa: Queen’s Printer, 1899), 264.

¹¹² Bella Bella Hospital operated in conjunction with the summer hospital at Rivers Inlet, which usually opened in June to late August of each year.

¹¹³ R.W. Large, “Letter from Richard W. Large, 18 January 1906,” *Missionary Bulletin* 3, no. 2 (Dec-Mar 1906): 253.

¹¹⁴ Grant Thomas Edwards, *Bella Coola General Hospital III*, unpublished typescript (Vancouver: United Church of Canada, British Columbia Conference Archives, 1980), 5.

unlike the Bella Bella and Rivers Inlet Hospitals which was originally founded and operated under the Methodist mission programme.

Although the Nuxalkmc lived alongside the Norwegian Lutherans, their interactions had minimal influence on Nuxalk religious beliefs. In the 1897 DIA report, 65 percent of the Nuxalkmc still identified as pagan, with the rest professing to be Methodist.¹¹⁵ William Pierce, a Tsimshian Methodist missionary, had attempted to evangelize the Nuxalkmc back in 1883, but his evangelizing efforts did not appear to be well-received. Indian Agent Todd remarked that “they cared but little for religious matters,” a situation which spurred the Methodists to action.¹¹⁶ Dr. Large was already overwhelmed with Bella Bella, but Bella Coola needed its own medical mission. In 1899, Dr. Spencer arrived to relieve Large of his duties, and to focus on transforming the Nuxalkmc into model Methodists.

The missionaries believed their aid would guide Indigenous peoples toward full civilization, but their paternalistic ambitions were often thwarted by Indigenous agency. Far from needing the assistance of an outsider, the Nuxalkmc and Heiltsuk already had their own roster of 5-6 chiefs. While chiefs in some Indigenous communities were elected or appointed under the *Indian Act*, the Central Coast chiefs held hereditary titles divided into first and second chieftainships. The first chiefs were recognized as tribal leaders, while the second chiefs acted as family headships. These hereditary chiefs, however, were largely cultural figureheads rather than possessing tangible political clout. The Indian Agent appointed a Council of Chiefs from the roster, and granted them “the power of fining members of the tribe guilty of gambling, drinking, fighting and immorality.”¹¹⁷ Though it may seem the Council—by acting as arbiters of Euro-Canadian law and standards of respectability—colluded against their own people, they in fact used their power to resist colonial intrusion. In Chapter 2, I will examine one case involving a public health ordinance, where the Council co-opted the “white man’s law” and turned it against the white man himself.

¹¹⁵ Canada, Department of Indian Affairs, *Annual Report of the Department of Indian Affairs, for the year ended 30th June 1897* (Ottawa: Queen’s Printer, 1898), 361.

¹¹⁶ J.C. Spencer, “Letter from Rev. J.C. Spencer, 16 July 1905,” *Missionary Bulletin* 3, no. 1 (Sep-Dec 1905): 120.

¹¹⁷ R.W. Large, “Letter from Richard W. Large, Fall 1902,” *Missionary Bulletin* 1, no. 1 (March 1903): 83.

Though the DIA attempted to monitor and regulate the activities of Indigenous communities, their direct influence on Nuxalk and Heiltsuk affairs was subdued. Both communities fell under the oversight of Indian agents from the Northwest Agency, and from 1910 onwards, the Bella Coola Agency. The DIA's involvement was mainly monetary: they hired teachers for the local schools, funded public infrastructure projects, and reimbursed the mission hospitals for care and treatment of Indigenous patients. The DIA also paid salaries to Large and Spencer to serve as Medical Officers, and by extension, serve as enforcers of the *Indian Act* and assimilatory policies. Missionary letters, however, reveal the contrary; I will later discuss how Large and Spencer often declined to stop potlatches and other prohibited forms of cultural expression, and accepted their Indigenous parishioners' use of medicine men. Moreover, the Bella Bella and Bella Coola letters made few references to the activities of Indian Agents, which suggest that missionized villages were largely delegated to church oversight.

Relatively shielded from government interference, the medical missions implemented their own vision for transforming Bella Bella and Bella Coola into fully modernized villages. Recognizing that infrastructure was a key component in civilizing Indigenous peoples, Large and Spencer prioritized the establishment of hospitals and churches, despite difficulties in obtaining sufficient funding, staffing, and supplies. Their main goal, however, was to establish first their medico-spiritual authority, and then to educate Indigenous peoples about the proper path to bodily and spiritual salvation. But as Large and Spencer would discover, they had far more to learn from the Nuxalkmc and Heiltsuk than they realized.

Chapter 2.

Bedside Manners: The Emergence and Practice of Medical Pluralism

It was a winter night in Waglisla, but one family had no time for rest. Their young boy, who was visiting the village from China Hat, had fallen quite ill.¹¹⁸ Family members called on Dr. Large, who diagnosed the boy with pleurisy, but he was unable to provide adequate treatment. As the boy's illness persisted, family members turned to the local medicine man, Owekeno Charley, for assistance. After examining the patient, Charley sucked and bit down on the boy's chest, drawing forth blood and two foreign objects. Although the boy was exhausted from the invasiveness of the procedure, family members deemed it to be effective. The boy received a follow-up visit from Dr. Large several days later, but the family was reluctant to reveal Charley's involvement, due to their desire to shield Indigenous healing practices from missionary scrutiny. Nonetheless, Dr. Large observed a large red blotch on the boy's chest, and after some questioning, the family admitted to Charley's intervention and presented the expelled objects as evidence.¹¹⁹

Upstaged by the Indigenous medicine man, an indignant Dr. Large sought revenge in his letters to the *Missionary Bulletin*, where he demeaned Charley as "mentally deficient" and mocked his "vacant stare" and "dirty and ill-fitting" clothes.¹²⁰ Despite attempts to deride Indigenous healers, the missionaries could not suppress the medicine man's power and influence, even among the Christianized Heiltsuk. Owekeno Charley and the boy patient illustrate the medically pluralistic culture which emerged in Waglisla at the turn of the twentieth century. By calling on both the medical missionary and medicine man for assistance, the patient's family made therapeutic decisions wrought by the convergence of Euro-Canadian and Indigenous cosmologies.

¹¹⁸ Pleurisy is inflammation of the pleural cavity and membrane surrounding the lung, often caused by viral infections. Symptoms include sharp chest pain while breathing, constant dull ache, and coughing.

¹¹⁹ R.W. Large, "Letter from Rev. Richard W. Large, 25 March 1908," *Missionary Bulletin* 5, no.1 (June 1908): 17.

¹²⁰ Large, "Letter from Rev. Richard W. Large, 25 March 1908," 18-19.

This chapter will examine how convergence influenced patients' therapeutic choices and outcomes, and how it led to the emergence of medical pluralism. My analysis will explore healing practices in the everyday life of Indigenous households, from disease prevention during pregnancy, to care of infirm family members, to preparation of funerary rites and the afterlife. First, I observe how Nuxalk and Heiltsuk informants represented their conceptions of illness and healing in ethnographic studies, and discuss how these beliefs manifested in their medico-spiritual practices. I consider the roles of Indigenous healers and patients, as well as the use of pharmaceutical plants and substances, and the integration of medical missionaries into the therapeutic process. I will then analyze missionary accounts which revealed the limits of colonial power in curtailing Indigenous therapeutic agency. Chapter 3 will continue these ethnohistorical discussions by moving from the domestic sphere of Nuxalk and Heiltsuk homes to the surveilled space of the mission hospital. In the next chapter, I will consider the ways in which medical missionaries engaged in medical pluralism, and how medico-spiritual convergence affected the operations of the mission hospital.

Although the Nuxalkmc and Heiltsuk both integrated aspects of Euro-Canadian healing alongside Indigenous ones, they differed in their approach. The Nuxalkmc were fairly open about their engagement with medical pluralism, while the Heiltsuk were more covert. Dr. J.C. Spencer—the Methodist medical missionary at Bella Coola—was aware that his patients routinely consulted medicine men, unlike the Heiltsuk who shielded their interactions with Indigenous healers from their missionary, Dr. R.W. Large. In the *Missionary Bulletin*, Large complained that the Heiltsuk summoned healers late at night to avoid detection, while Spencer recounted several cases where patients informed him about their use of medicine men.¹²¹ Perhaps this discrepancy in behaviour could be explained by personality differences; Dr. Spencer may have been more permissive than Dr. Large, and had a more tolerant attitude toward Indigenous healers. Alternatively, cultural and socio-political influences were at play. Starting in 1880, the Methodists consistently maintained a dedicated missionary—the first being Charles Tate—at Bella Bella, instead of using itinerant ministers.¹²² With the advent of a permanent mission,

¹²¹ Large, "Letter from Rev. Richard W. Large, 25 March 1908," 18.

¹²² Black, *Bella Bella: A Season of Heiltsuk Art*, 138.

Michael Harkin contends that “the general ethos of [Bella Bella] village increasingly came to be dominated by the discipline of the Methodist mission,” which may have compelled the Heiltsuk to hide Indigenous practices as a defence against missionary surveillance and accusations of backsliding.¹²³ By 1897, when the medical mission was formally established, all Heiltsuk professed to be Christian.

On the other hand, the presence of the Methodist mission was more subdued in Bella Coola, which resulted in the Nuxalkmc retaining a pagan majority until 1909.¹²⁴ Even though many were not Christian, the Nuxalkmc donated \$188.00 toward a new church in 1902, and designated six acres of their land for mission purposes.¹²⁵ Despite their contributions, the Nuxalkmc still openly maintained Indigenous forms of cultural expression, which is evident in the totem poles and family crests adorning Bella Coola homes. The houses of Waglisla, in contrast, lacked these displays. In Bella Coola, Dr. Spencer noted that a “clever wood carver and silversmith” made “considerable money doing work for the heathen dancers,” by fashioning headdresses, masks, and whistles. Although Dr. Spencer was displeased with these “heathen practices,” he did not attempt to stop them. Furthermore, Dr. Spencer was fully aware of the Nuxalkmc’s fall and winter ceremonials, noting that “since the middle of October almost every night there has been some heathen dance or feast.”¹²⁶ Despite their ceremonials being an open secret, the Nuxalkmc often held them in remote locations to avoid missionary scrutiny.

I mention the Nuxalkmc and Heiltsuk’s engagement with Christianity for a key reason: their different approaches affected their relationship with Euro-Canadian observers, which in turn influence how my sources can be utilized and interpreted. In this chapter, my discussions of Indigenous healing draw heavily from McIlwraith and Smith, who collaborated with Nuxalk informants to produce a sizeable corpus of ethnographic research. McIlwraith’s *Bella Coola Indians*, field letters, and articles comprehensively address a wide range of medico-spiritual topics, from usage of medicinal herbs to the role

¹²³ Harkin, *The Heiltsuks*, 113.

¹²⁴ Canada, Department of Indian Affairs, *Report of the Department of Indian Affairs, for the fiscal year ended 31st March 1909* (Ottawa: Queen’s Printer, 1910), 38.

¹²⁵ J.C. Spencer, “Untitled Letter, November 1902,” *Missionary Bulletin* 1, no. 1 (March 1903): 94.

¹²⁶ J.C. Spencer, “Letter from J.C. Spencer, 7 November 1904,” *Missionary Bulletin* 2, no. 3 (March 1905): 596.

of medicine men. Harlan Smith's "Materia Medica of the Bella Coola," a compendium of Nuxalk pharmacological substances, was produced with assistance from Joshua Moody and Captain Schooner. Moody and Schooner were both full-blood Nuxalkmc, but their opposing attitudes toward Christianity symbolized the highly pluralistic nature of Nuxalk society. Moody was a devout Christian, although McIlwraith rued that he "has an unpleasant habit of comparing Indian theology with parts of the Old Testament, about which he knows more than I."¹²⁷ Captain Schooner, in Smith's parlance, was a "pagan gentleman."¹²⁸ While Moody exemplified a model Christian through his study of the Bible, Smith nevertheless considered him "a Bellacoola scientist" due to his command of Indigenous medicinal knowledge.¹²⁹ Both a Nuxalk scientist and a Christian believer, Moody embodied how the convergence of Indigenous and Euro-Canadian cosmologies manifested in the everyday lives of the Nuxalkmc.

In contrast to the Nuxalkmc, few ethnographers focused on Heiltsuk healing at the turn of the twentieth century. While most missionaries attempted to assimilate their Indigenous parishioners, the ethnographer sought to study Indigenous cultures in their "original, uncontaminated" form.¹³⁰ As a result, the Christianized Heiltsuk were not targets for ethnographic study, while the predominantly pagan Nuxalkmc—who were less "Westernized" in McIlwraith and Smith's view—attracted the attention of scholars. Despite their close relationships with Indigenous informants, the racial biases of Euro-Canadian scholars are evident in their attitude toward Christianized Indigenous cultures, which they considered to be "inauthentic." Due to these limitations, my discussion of Heiltsuk healing relies on missionary accounts, which made amateur ethnographic observations, but lack the depth and collaborative nature of professional ethnographies. For this reason, I depend on cross-referencing Dr. Large's letters with McIlwraith and Smith's research, and look for any similarities between Nuxalk and Heiltsuk practices. Given the two peoples'

¹²⁷ McIlwraith, *At Home with the Bella Coola Indians*, 34.

¹²⁸ Harlan I. Smith, "Sympathetic Magic and Witchcraft among the Bellacoola," *American Anthropologist*, New Series 27, no. 1 (Jan-Mar 1925): 117.

¹²⁹ Harlan I. Smith, "Materia Medica of the Bella Coola and Neighbouring Tribes of British Columbia," National Museum of Canada, Annual Report 1927, reprint of the 1927 edition, Bisbee, A.Z.: Southwest School of Botanical Medicine, accessed 25 April 2017, http://www.swsbm.com/Ethnobotany/Bella_Coola_Materia_Medica.pdf, 2.

¹³⁰ McIlwraith, *The Bella Coola Indians*, vol. 1, 525.

long history of cultural exchange, there is a high degree of overlap in their medico-spiritual cosmologies. Wherever possible, I have identified whether a practice is specifically Nuxalk, Heiltsuk, or common among Indigenous cultures of the Central Coast. I have already discussed how ethnographic writings are doubly mediated and often several steps removed from the source; they are accounts witnessed or heard by an informant, recounted to the ethnographer, then edited by other Euro-Canadian writers if published. Missionary sources, in some cases, are closer in distance to their subjects, as they are witnessed and told directly by the missionary observer.

Having established the usage and limitations of my sources, I will begin my discussion of Indigenous medico-spiritual cosmologies by returning to Owekeno Charley and Dr. Large's depiction of him. In missionary discourse, the medicine man embodied the worst depravity of Indigenous "heathenism," due to their ability to summon *dásgíú* for both positive and negative effects.¹³¹ Unlike medicine men, medical missionaries could not directly commune with or utilize supernatural forces, which rendered them ineffective for treating illnesses caused by *dásgíú*. Missionary anxieties over their loss of authority were reflected in narratives of "showdowns" between missionaries and medicine men. Kim Greenwell notes that missionary writings depicted medicine men as "spectacles of savagery," by using animal imagery to emphasize their dangerous and untamed nature.¹³² Susan Neylan contends that while "showdown" narratives can be exaggerated, they are still valuable for understanding how the menacing medicine man loomed large in missionary imaginations.¹³³

Before discussing the work of medicine men, I will first consider how Indigenous cosmologies account for the aetiology and nature of different illnesses. The Nuxalkmc, and similarly the Heiltsuk, regarded "all things as swayed by the supernatural: success

¹³¹ *Dásgíú* is the Heiltsuk word for "witchcraft," as noted by anthropologist Ronald Olson, quoted in Michael Harkin, *The Heiltsuks: Dialogues of Culture and History on the Northwest Coast*, 82. The same word is used to denote a "witch doctor," as defined by John C. Rath, *A Practical Heiltsuk-English Dictionary with a Grammatical Introduction*, 221.

¹³² Kim Greenwell, "Picturing 'Civilization': Missionary Narratives and the Margins of Mimicry," *BC Studies* no. 135 (Autumn 2002): 21.

¹³³ Neylan quoted in Greenwell, "Picturing 'Civilization': Missionary Narratives and the Margins of Mimicry," 21.

and failure, births and death, health or disease.”¹³⁴ These powers live on a different cosmological plane than human existence, so ordinary mortals could not directly commune with them. McIlwraith observes that “it is true that they are faced at all times with diverse forces, but they know how to deal with them in prayer, by sacrifice, by magic, and by what might be regarded as embryonic science.”¹³⁵ Depending on the nature of the illness, patients may opt for self-treatment with pharmaceutical plants or substances. If the illness became severe, or if the patient fell ill from *nuscaakstatim*, family members would seek the medicine man for medico-spiritual assistance.¹³⁶

In Heiltsuk culture, compensation for the medicine man’s services were given in advance and usually rendered in the form of gifts; this gift-giving stems from the Indigenous practice of social reciprocity, which is most evident in the potlatch system. Missionaries viewed gift-giving with disdain, partly because it was antithetical to Euro-Canadian notions of economic exchange, and because it supposedly encouraged avarice. Owekeno Charley’s patients usually provided a good meal or old clothes as compensation, and occasionally gave money as well.¹³⁷ Dr. Large argued that medicine men were motivated by greed, since “the larger the fee the harder he worked.”¹³⁸ In critical cases of illness, family members piled “fresh gifts” before the medicine man to “cause him to exert his power to the utmost, and to do him justice he was often more exhausted than the patient when through with his single-handed wrestling with the powers of evil.”¹³⁹ If a patient should die, Nuxalk medicine men would return the fee. It is not known whether the

¹³⁴ McIlwraith, “Observations on the Medical Lore of the Bella Coola Indians, British Columbia,” in *At Home with the Bella Coola Indians*, eds. John Barker and Douglas Cole (Vancouver: University of British Columbia Press, 2003), 173.

¹³⁵ McIlwraith, “Observations on the Medical Lore of the Bella Coola Indians, British Columbia,” 173.

¹³⁶ *Nuscaakstatim* is the Nuxalk word for “a spell has been placed on him, he is bewitched,” as defined in H.F. Nater, *A Concise Nuxalk English Dictionary*, 107. The root syllable *sc* in the Nuxalk language means “bad,” so words with this root usually refer to a negative entity, such as *scm*, “to be gravely ill,” and *scak*, “witch.”

¹³⁷ Large, “Letter from Rev. Richard W. Large, 25 March 1908,” 21.

¹³⁸ R.W. Large, “Untitled Letter, 20 February 1909,” *Missionary Bulletin* 5, no. 4 (March 1909): 696.

¹³⁹ Large, “Untitled Letter, 20 February 1909,” 696-97.

Heiltsuk did the same.¹⁴⁰

Missionary opinions of the medicine man's power, for the most part, were ambivalent and contradictory. Likewise, some Indigenous peoples were ambivalent toward medicine men as well; in the Introduction, I mentioned how the husband of a Nuxalk patient doubted the medicine man's work, and went to ask Dr. Spencer for advice. Dr. Large accused medicine men of using "artifice and deception" and "sleight-of-hand" to purge foreign objects from patients, and claimed that patients sometimes discovered their trickery.¹⁴¹ In regards to Charley, Dr. Large assured readers that "belief in his curative powers is very slight, and all serious cases come to me."¹⁴² Both Large and Spencer claimed that Indigenous belief in the medicine man's power was on the decline, especially among younger peoples, who were supposedly more accepting of Euro-Canadian practices. Yet, Dr. Large could not effectively treat the boy with pleurisy, and as the illness became serious, the family brought in Charley for healing. This chapter will demonstrate that the appearance of decline was deceiving, since Indigenous peoples actively shielded their healers and healing practices from missionary surveillance.

It is ironic that Euro-Canadians denounced Indigenous healing for its supernatural elements, yet medical missionaries believed—through their faith in "true Christian science"—a peculiarly similar form of medico-spiritual hybridity.¹⁴³ Likewise, some medicine men converted and adopted a syncretic identity as Indigenous-Christian healers. From Edward S. Curtis' *The Kwakiutl*, it is known that the Kwagu't (Kwakwaka'wakw) of central Vancouver Island held Heiltsuk medicine men in high esteem. The "greatest" one was named Késina, who was notably a "Christian Indian." Késina died in the 1860s, but subsequent Heiltsuk medicine men—including Owekeno Charley—were nominally Christian as well. Harkin argues that "this syncretism is striking but not surprising... In the

¹⁴⁰ J.C. Spencer, "An Introduction to the Medical Work in British Columbia," *The Missionary Outlook* 20, no. 9 (September 1901): 202.

¹⁴¹ Large, "Untitled Letter, 20 February 1909," 697, 699.

¹⁴² Large, "Letter from Rev. Richard W. Large, 25 March 1908," 22.

¹⁴³ A.E. Bolton, "The Indian Work, British Columbia Conference," *Annual Report of the Missionary Society of the Methodist Church of Canada, 1897-98* (Toronto: Methodist Missionary Conference Office), xlvii.

face of their failure to treat the new diseases, it is logical that Christianity would be included among outside powers sought.”¹⁴⁴ I agree with his argument, although I am inclined to suggest that some medicine men may have converted to Christianity for more pragmatic reasons, such as political benefits or to avoid rousing missionary suspicions.

Given that medicine men tried to elude missionary surveillance, eyewitness accounts of their work are notably sparse in Large and Spencer’s letters. Furthermore, the letters rarely mentioned medicine men by name, which suggest that community members and healers themselves shielded their identities. In 1903, one of Dr. Large’s letters mentioned “two old-time doctors” who treated the sick by casting stones and pieces of bone from their body, and also conversed with departed spirits.¹⁴⁵ Though unidentified, subsequent letters would reveal their names: the aforementioned Owekeno Charley and an elderly Heiltsuk named “Dr. Sam,” who died in 1906.¹⁴⁶ In an attempt to end their activities, Dr. Large told Charley and Sam to “stop misleading the people,” or otherwise they would be reported to the government. While Dr. Large appeared to be acquainted with only Charley and Sam, there were likely more practitioners at Waglisla and nearby communities. Missionaries noticed that many Heiltsuk bore scars from bloodletting or bites, an embodied sign that a large proportion of Indigenous patients continued to receive the medicine man’s treatment.¹⁴⁷

In the competition for souls and bodies, missionaries turned to colonial law for reinforcement. As missionaries often served as justices of the peace, they could threaten medicine men with arrest.¹⁴⁸ Such efforts, however, were largely futile as missionaries had almost no method of enforcing a jail sentence or monetary fine. In most cases, very few missionaries ever witnessed a medicine man actually treating a patient, or acquired evidence to prove it occurred. In Owekeno Charley’s case, the Heiltsuk invited Charley

¹⁴⁴ Harkin, *The Heiltsuks*, 110.

¹⁴⁵ R.W. Large, “Rivers Inlet Hospital, 12 June 1903,” *Missionary Bulletin* 1, no. 3 (June 1903): 227.

¹⁴⁶ R.W. Large, “Letter from Rev. Richard W. Large, 25 March 1908,” *Missionary Bulletin* 5, no. 1 (June 1908): 18.

¹⁴⁷ Large, *Drums and Scalpel*, 79.

¹⁴⁸ R.W. Large, “Letter from Rev. Richard W. Large, 18 January 1906,” *Missionary Bulletin* 3, no. 2 (Dec-Mar 1906): 254.

into their homes late at night or after Dr. Large's usual time for house calls, thereby allowing the medicine man to practice undetected. Exasperated by their secrecy, Dr. Large complained that "it has been difficult for me to catch him, as his patients screen him."¹⁴⁹ When Dr. Large expressed suspicion after attending to the boy with pleurisy, family members tried to conceal Charley's involvement.

Outside of Waglisa and Bella Coola, where missionary oversight was limited, most villages had at least a few medicine men.¹⁵⁰ Dr. Large noted that "as each Chief had his own doctor who assisted him, there was intense rivalry among them at times."¹⁵¹ Similar to the Nuxalkmc, Heiltsuk medicine men received their power "through being possessed with a spirit which enters them while voluntary wanderers on the mountain or in the forest."¹⁵² Dr. Large observed that "only certain of the higher families were eligible for such spirit possession." Owekeno Charley appeared to be an exception, given his impoverished background, but he was probably not constricted by Heiltsuk hierarchies due to his outsider status. According to Dr. Large, Charley had fallen out with his Owekeno tribe, and arrived destitute in Waglisa. Mission staff deemed him to be mentally deficient and physically disabled, but gave him odd jobs to keep him out of the Provincial Asylum. As Medical Officer of Bella Bella, Dr. Large could have easily confined Charley to the asylum, but perhaps he thought that Charley posed no real threat due to his physical and mental disabilities. The Heiltsuk, however, recognized Charley's medico-spiritual abilities and his status elevated to that of a medicine man. The Heiltsuk believed "his mental and bodily defects were valuable assets in the role of an Indian doctor—probably they resulted from his relations with the spirit world."¹⁵³ While Dr. Large dismissed Charley as a "spent force," the Heiltsuk saw his disability as a special ability, which allowed him to convene with higher spiritual powers.

In contrast to the dry humour and paternalistic tone that is typical of Dr. Large's letters, his crude vilification of Charley's appearance is particularly conspicuous. It reveals

¹⁴⁹ Large, "Letter from Rev. Richard W. Large, 25 March 1908," 18.

¹⁵⁰ Spencer, "An Introduction to the Medical Work in British Columbia," 202.

¹⁵¹ Large, *Drums and Scalpel*, 73.

¹⁵² Large, *Drums and Scalpel*, 79.

¹⁵³ Large, "Letter from Rev. Richard W. Large, 25 March 1908," 21.

Dr. Large's frustration and inability to deal with the medicine man's presence. Since Charley was disabled, Dr. Large conceded that "his helplessness and mental defect make one loath to use strong measures."¹⁵⁴ While he seemed compassionate, Dr. Large was actually more concerned about losing the support of the Heiltsuk if he took strong measures against Charley. If Charley was arrested, Dr. Large believed the Heiltsuk would interpret it "as a proof of our jealousy and unwillingness to leave the results of our work to fair comparisons." Yet, Dr. Large also worried that "were we to show special interest in him and provide for all his needs, this might be taken to mean that we were afraid of his opposition, and so paid him to cease practice." Trapped in a no-win situation and fearing that the Heiltsuk would turn against him, Dr. Large felt he had little choice but to tolerate Indigenous healers. Dr. Large's predicament demonstrates that, underneath the polished veneer of church propaganda, missionary power was often precarious and constrained by the opinions of Indigenous parishioners.

Although skeptical of medicine men, Dr. Large admitted that they performed "marvellous cures"—although whether he was being sincere or sarcastic is open to interpretation. Even if he meant to be sarcastic and dismissive, his detailed observations exposed his keen interest and curiosity about Indigenous healing. In one letter, he recalled hearing about a skirmish between some Heiltsuk and "Fort Ruperts," who were Kwakwaka'wakw people from Vancouver Island.¹⁵⁵ One Heiltsuk was stabbed in the back by a barbed spear, but managed to reach the village of a famous medicine man before falling unconscious. Because the barbs pierced deeply into the flesh, villagers were afraid to extract the spear for fear of endangering his life. The medicine man then came to the scene, and although unsure of his strength to remove the weapon, began treating the patient. The medicine man draped himself in a bark mat and sang and danced, using "his magic to such good effect that the spear head, snail like, barb by barb, glided from the wound and fell to the floor, without being once touched by the doctor."¹⁵⁶ Dr. Large surmised that the incident did actually transpire, but dismissed the medicine man's feats as hyperbole.

¹⁵⁴ Large, "Letter from Rev. Richard W. Large, 25 March 1908," 22.

¹⁵⁵ Large, "Untitled Letter, 20 February 1909," 698.

¹⁵⁶ Large, "Untitled Letter, 20 February 1909," 698.

In the same way that Dr. Large begrudgingly came to tolerate the work of medicine men, so too did Dr. Spencer. In June 1904, Dr. Spencer saw an ill man who responded favourably to treatment. After Dr. Spencer was called to Kimsquit, the patient had a relapse and decided he needed the assistance of a medicine man. Upon discovering the situation, Dr. Spencer became incensed and gave the patient an ultimatum, warning that “he must decide between us [doctors], as I did not care to treat him while the Indian doctor was practicing his conjuring methods.”¹⁵⁷ After the patient chose the medicine man, Dr. Spencer withdrew from the case in protest. Dr. Spencer remarked that “the poor fellow weakened and died,” which implied that the medicine man’s “conjuring methods” was ineffective and at fault.

However, Dr. Spencer had a change of heart three years later. As I have recounted in the Introduction, Dr. Spencer heard about a medicine man who extracted a worm from a female patient’s body, apparently without any surgical excisions. An intrigued Dr. Spencer, going against proper missionary protocol, did not attempt to intervene; instead, he recognized that such illness was beyond his scope of practice and deferred to the skill of the medicine man. It is worth emphasizing that it was the patient’s husband who had sought Dr. Spencer’s advice, while the patient herself preferred the medicine man.¹⁵⁸ The intersection of gender and racial dynamics may explain these differences in attitude. The female patient may have felt uncomfortable subjecting her body to Dr. Spencer’s gaze and touch, due to him being a non-Indigenous man and cultural outsider. These different choices demonstrate that, even within a particular Indigenous household, family members often held differing opinions over therapeutic decision-making. I will later examine how gender dynamics account for some of these differences.

While missionaries recognized the power of Indigenous healers, they attributed the medicine man’s efficacy to the placebo effect, since their ritual practices created “a mental state which is favourable to recovery.”¹⁵⁹ Dr. Large reminded his readers that Euro-Canadian medicine was not always as progressive as it deemed itself to be. He

¹⁵⁷ J.C. Spencer, “Letter from J.C. Spencer, August 1904,” *Missionary Bulletin* 2 (1904): 302.

¹⁵⁸ Spencer, “Letter from Rev. J.C. Spencer, 18 January 1907,” 797.

¹⁵⁹ Large, “Letter from Rev. Richard W. Large, 25 March 1908,” 22.

disparaged the popular use of patent medicine, which were over-the-counter tinctures with unverified health claims, as similar to the medicine man's "cure-all qualities." Large also remarked that "not so long ago England burned her witches, and that even America has a known Cotton Mather fighting witchcraft with the power of the church behind him."¹⁶⁰ Since Euro-Canadian society eventually abandoned the belief in witches, Dr. Large assured his readers that Indigenous peoples would also progress and become fully civilized with the missionary's guidance.

Despite their fixation with medicine man as medico-spiritual competitors, missionary anxieties were somewhat misplaced. Whereas Euro-Canadian medicine upheld the doctor's expertise above everyone else, the Nuxalkmc and Heiltsuk consulted medicine men as a last resort, only after physical treatments had been exhausted or if the illness was caused by *dásgíú*. The medicine man's role was often secondary to the patient's own participation in the healing process. A patient and relatives usually made diagnostic and therapeutic decisions themselves, by drawing upon generations of oral tradition and knowledge. Familial involvement was an integral part of Indigenous healing, as well as bearing witness to the treatment of sick relatives by medicine men. Minor surgery such as setting fractured limbs and removing boils could be done by family members. Patients could also seek curative comfort through immersion in hot springs or baths.¹⁶¹ At home, patients retained greater control over their therapeutic decision-making, whether it was access to healing herbs, or the services of a medicine man in severe cases. Dr. Large noted that "there are still many who prefer remaining in their own homes under many disadvantages rather than come to the 'sick-house' for treatment."¹⁶² Patients recognized that their autonomy could be comprised by missionary surveillance in the hospitals, so they attempted to remain home whenever possible.

Euro-Canadian and Indigenous medico-spiritual cosmologies differed in how their

¹⁶⁰ Cotton Mather was an influential American Puritan minister who supported the Salem Witch Trials in 1692. Large, "Untitled Letter, 20 February 1909," 712.

¹⁶¹ McIlwraith, "Observations on the Medical Lore of the Bella Coola Indians, British Columbia," 174.

¹⁶² R.W. Large, "The Indian Work, British Columbia Conference," *Annual Report of the Missionary Society of the Methodist Church of Canada, 1903-04* (Toronto: Methodist Missionary Conference Office), xii.

healers acquired curative power. Unlike the biomedical doctor, a medicine man gained expertise through supernatural endowment. In Euro-Canadian medicine, degrees, board certifications, and professional associations codified the doctor's expertise. His knowledge was acquired through scholarly learning and clinical practice. A medicine man, however, derived his knowledge through birth or personal experience. For the Nuxalkmc, he could be born possessing "powers that are a source of envy to their less fortunate tribesman—powers obtained from supernatural beings in dreams or in visions."¹⁶³ The supreme deity bestowed a supernatural element called *himanoas* on each person, in the back of the neck, at birth. The Nuxalkmc thought this body part formed the root of all mental activities. It corresponds to the biomedical belief that the nape connects the brain stem and spinal cord, and is the place where consciousness fuses with physical senses and reflexes. McIlwraith observed that "young men" with sensitive *himanoas*, whose personalities were thoughtful and reserved, were encouraged by families to develop commune with spirits, especially if their deceased relatives had been medicine men themselves.¹⁶⁴

Other medicine men acquired their power after experiencing serious illness. A supernatural woman, Tlitcaplixwanna, selected and restored certain people with healing power. Whether acquired by birth or through illness, the seat of spiritual power was directly embodied within the medicine man. One Nuxalk medicine man, who acquired his power in the 1890s, recalled his experience to McIlwraith. The medicine man had contracted a wasting disease, in which all his muscles and flesh atrophied within three months. Near death, Tlitcaplixwanna visited the man and casted power into this stomach, causing him to heave violently. This act of purging expelled the sickness, and he repeated Tlitcaplixwanna's words until it formed a song. From that point, the song was used as part of his healing practice.¹⁶⁵ Purging was an important healing technique because it embodied the elimination of disease, so patients would consume laxatives or induce vomiting to expel a foreign agent.

¹⁶³ McIlwraith, "Observations on the Medical Lore of the Bella Coola Indians, British Columbia," 174.

¹⁶⁴ McIlwraith also spelt it as "hichmanoas" in McIlwraith, *At Home with the Bella Coola Indians*, 34; McIlwraith, "Observations on the Medical Lore of the Bella Coola Indians, British Columbia," 172, 174-75.

¹⁶⁵ McIlwraith, "Observations on the Medical Lore of the Bella Coola Indians, British Columbia," 175-76.

Similarly, the medicine man's chief technique was to squeeze or suck the illness from the patient's body, and the illness would manifest in the form of a foreign substance or congealed blood; this was the procedure that Owekeno Charley performed on the sick boy. Other interventions included the use of songs, dancing, burning smoke, massage, or splashing water over the patient; rarely did medicine men make the patient take anything internally.¹⁶⁶ Along the Central Coast, it was common for some medicine men to specialize in surgical interventions, as Dr. Spencer observed:

In nearly every village is one or more [Indian doctor] who has a reputation as a surgeon. These men do more or less cutting operations. In case of a rheumatic pain, or a bruise with effusion of blood into a part, slits are made over the seat of pain, varying as the operator deems wise. They have but little knowledge of the blood vessels or nerves, in some cases these are cut, causing serious trouble. The writer has known an Indian to perform lithotomy on another, and remove several stones from the bladder.¹⁶⁷

Although Dr. Spencer claims medicine men lacked knowledge of the vascular and nervous systems, lithotomy was an invasive procedure involving surgical incision and extraction of urinary calculi.¹⁶⁸ These surgical interventions differed from utilizing supernatural force to remove foreign objects, since the latter was used when *dásgíú* or *nuscaakstatim* was suspected as the cause of illness. If a patient was incapacitated and near death, the Nuxalk medicine man would channel his energy and "the power is itself thrust into the sufferer who, thus endowed, begins to grunt and gurgle in the same way and casts out the evil; the power is then returned to the owner and the cure is complete."¹⁶⁹ It is important to note that Euro-Canadian observers would not have been permitted to witness many of these rituals, and thus relied on second-hand accounts from Indigenous informants, so my sources can only convey a superficial and truncated depiction of medicine men and their practices.

Missionaries saw medicine men as a threat not only because of their supernatural

¹⁶⁶ Spencer, "An Introduction to the Medical Work in British Columbia," 202.

¹⁶⁷ Spencer, "An Introduction to the Medical Work in British Columbia," 202.

¹⁶⁸ Calculi (plural of calculus) is the biomedical term for kidney, bladder, or gallbladder stones.

¹⁶⁹ McIlwraith, "Observations on the Medical Lore of the Bella Coola Indians, British Columbia," 176.

abilities, but because they embodied the greatest fear of the missionary enterprise, which Greenwell identifies as “the abject failure and rejection of their civilizing and Christianizing efforts.”¹⁷⁰ Since the ultimate goal of the missionary enterprise was assimilation, Greenwell argues that “the continuing power of medicine-men and shamans to define key cultural practices, particularly those surrounding the body, was viewed as a direct challenge to the missionary’s own incipient authority.” Although missionaries scorned Indigenous healing as “superstition,” the Methodists’ own medico-spiritual work was similarly supernatural in nature. The medicine man gained power through spiritual endowments, similar to how the medical missionary acquired his abilities through God’s will. Both believed their healing work could heal the body and simultaneously restore spiritual balance in the afflicted. This commensurability between medicine man and medical missionary made their work complementary, rather than in opposition with each other. It made the medical missionary’s role decipherable to Indigenous peoples, and provided them with opportunities to integrate Euro-Canadian practices into existing cultural systems. Indigenous peoples recognized that both medical missionary and medicine man possessed curative powers, but believed their abilities were suited for different ailments. The medicine man could treat *dásgiú* or utilize supernatural power as a last resort in near-death cases, while the medical missionary’s biomedical drugs and surgical technologies were more effective in other situations. As seen in Owekeno Charley’s case, the patient’s family called on Dr. Large for biomedical treatment, but when biomedical intervention failed, the family turned to supernatural aid.

Unlike many other aspects of Indigenous healing, the involvement of extended family and friends in patient convalescence was met with missionary approval. Dr. Spencer described the Nuxalkmc as “careful nurses” during one of his house calls, where he examined a boy stricken with typhoid fever for more than a week. His temperature had reached 105 degrees (40.6 Celsius), which caused the doctor “some anxiety.” Dr. Spencer explained that the situation was dangerous, but remarked that the patient’s friends “gave him the best possible care” and were “sponging him daily” with cool water to relieve the fever.¹⁷¹ The boy recovered to the surprise of his friends and family, who believed that

¹⁷⁰ Greenwell, “Picturing ‘Civilization’: Missionary Narratives and the Margins of Mimicry,” 21.

¹⁷¹ Spencer, “Letter from J.C. Spencer, August 1904,” 303.

could die, but their attentive care undoubtedly played a key role in his survival. In cases involving medicine men, family members sometimes participated in the singing of healing songs.¹⁷²

Given that missionary and ethnographic observers were nearly all male, it is important to account for the gendered nature of their writing. Social taboos would have prevented male Euro-Canadian observers from readily accessing the experiences of female healers, and the private space of the family home. It can be surmised that familial caregivers were predominantly women. Harkin notes that a few “female shamans” also existed in Heiltsuk society, but they were limited in number.¹⁷³ Most female healers were herbalists, who had limited supernatural power and could not enter altered psychic states. McIlwraith did not specify whether women could be born with strong *himanoas*, although he mentioned that the Nuxalkmc had “female shamans.” Most female shamans were past child-bearing age, but a few women of child-bearing age could attain the role if they observed absolute chastity, and were the last survivor of their family.¹⁷⁴ Given the androcentric perspective of Euro-Canadian sources, it is difficult to determine the extent to which female shamans existed and practiced following the establishment of medical missions. The Heiltsuk, like the Nuxalkmc, usually sought botanical remedies for regular ailments, which would fall under the scope of female herbalists.

The participation of women as knowledge keepers and healing practitioners was central in Nuxalk and Heiltsuk communities, but it received minimal attention in missionary discourse. Isabella Large and female nurses bore the gendered responsibility of educating and ministering to Indigenous women, such as hosting Ladies’ Aid groups. Isabella Large noted that Heiltsuk women “are most careful to keep alive the old heathen customs, particularly in regard to births, marriages, etc., and as they, unlike Indian women in the North-West, rule the house, in many families, at least, it is the more difficult for the men to

¹⁷² McIlwraith, “Observations on the Medical Lore of the Bella Coola Indians, British Columbia,” 176.

¹⁷³ Harkin, “Engendering Discipline: Discourse and Counterdiscourse in the Methodist-Heiltsuk Dialogue,” *Ethnohistory* 43 no.4 (Autumn 1996): 653.

¹⁷⁴ McIlwraith, *The Bella Coola Indians*, vol. 1, 574.

break away from these old customs.”¹⁷⁵ Given their control over the domestic space, women maintained and passed on familial knowledge of healing remedies, many of which could only be used by members of certain ancestral families. One Nuxalk remedy, used to treat blood conditions, involved the preparation of spruce saplings and water-lilies in a ritualized manner. Since this remedy belonged to a certain family, anyone who wished to use it had to “obtain the services of an owner to apply it, and recompense him for so doing.”¹⁷⁶ Smith noted that, among the Nuxalkmc, medicines were “largely family possessions known to a few individuals only, so that two families may have different remedies for the same specific complaint; but this is not the case among the other tribes.”¹⁷⁷

Given their role as keepers of healing knowledge, Heiltsuk women also took charge of caring for non-relatives as well. In the first quarter of 1905, the Bella Bella Hospital was “taxed beyond its accommodation,” resulting in “several patients having to be cared for in homes in the villages.”¹⁷⁸ Given that Bella Bella’s transient population was largely non-Indigenous labourers, many of these patients were white, Chinese, or Japanese. In the Indigenous domestic space, where women maintained control, healers and patients were unhindered by missionary surveillance. While Dr. Large made house calls to residential homes, and provided patients with biomedical drugs and therapies, it is worth speculating whether non-Indigenous patients received Heiltsuk healing from their hosts. Even if the hosts did not provide any formal treatment, the integration of Indigenous caregivers into the hospital system was still a form of medical pluralism, in which Heiltsuk modes of convalescent care melded with Euro-Canadian therapies.

Along with maintaining familial remedies and acting as caregivers, women and their bodies were a source of medico-spiritual power. The Nuxalkmc recognized that

¹⁷⁵ Isabella G. Large, “Letter from Mrs. R.W. Large, 3 March 1905,” *Missionary Bulletin* 2, no. 3 (March 1905): 591.

¹⁷⁶ McIlwraith, *The Bella Coola Indians*, vol. 1, 729.

¹⁷⁷ Smith, “Materia Medica of the Bella Coola,” 2. The other tribes he studied were Gitksan (Gitksan), Carrier (Dakelh), and Sikani (Sekani). The Dakelh and Sekani are Interior Athabaskan peoples. The Gitksan live inland along the Skeena watershed and are culturally related to the Tsimshian, but have close social and political ties with Athabaskan cultures.

¹⁷⁸ Large, “Letter from Mrs. R.W. Large, 3 March 1905,” 594.

menstrual blood and bloody discharge from childbirth contained potent forces, which could be dangerous to both humans and supernatural beings. Bloody discharge was also unclean, and the presence or smell of delivery blood in a household could cause death. At first menstruation, an adolescent girl had to retreat into the forest and clean herself in a secluded pool.¹⁷⁹ Similarly, women in labour constructed a temporary shelter in a nearby grove, and delivered the baby there.¹⁸⁰ In addition to female blood, both the Nuxalkmc and Heiltsuk were particularly concerned about the disposal of excrement and soiled personal effects. Dr. Large noted that an enemy might steal bodily fluids or clothing and place them in an “evil box,” which would result in *dásgiú* casted upon the victim.¹⁸¹ Bodily waste such as urine and excrement, while unclean, could be a powerful antidote against illness and supernatural forces. The Nuxalkmc warded off ghosts with urine sprinkled outside their home, while a remedy for a heart condition involved mixing one’s excrement with certain herbs, and then consuming it.¹⁸²

It is difficult to determine the extent in which Indigenous beliefs around female blood and waste disposal persisted under medical missionization. Due to the private and taboo nature of bodily waste and menstruation, male Euro-Canadian observers would not have been privy to such information. However, it is highly probable that these beliefs remained in place, which would explain why some Nuxalk and Heiltsuk patients preferred to stay home and ask the medical missionary to make a house call. They would rather compromise the privacy of their domestic space by having an outsider visit, instead of partaking in the conveniences of hospital care. In the hospital space, some Indigenous patients may have felt apprehensive that their improperly disposed bodily wastes could make them vulnerable to illnesses from *dásgiú*.

Likewise, medico-spiritual care and practices around childbirth were guarded from missionary surveillance. In the missionary records that I examined, there were no identifiable accounts of a doctor assisting with Indigenous childbirth. The first baby

¹⁷⁹ McIlwraith, *The Bella Coola Indians*, vol. 1, 370.

¹⁸⁰ McIlwraith, *The Bella Coola Indians*, vol. 1, 365.

¹⁸¹ Large, “Untitled Letter, 20 February 1909,” 699-701.

¹⁸² McIlwraith, *The Bella Coola Indians*, vol. 1, 729.

delivered at Bella Bella Hospital was in fact a Japanese girl, who was born in late May 1904.¹⁸³ This omission suggests that families deliberately chose to utilize Indigenous healing practices for pregnant women, rather than subject their bodies to medical intervention by cultural outsiders. During pregnancy, both parents observed prohibitions to ensure a safe delivery and healthy baby, including the avoidance of particular foods, negative emotions, or encounters with certain animals. For example, a Heiltsuk infant could suffer irregular breathing if either parent prenatally witnessed a dying animal gasping for breath. In a rather amusing instance of cultural convergence, Heiltsuk parents frowned upon the consumption of bottled soda water, a confection introduced by Euro-Canadian merchants. Dr. Large noted that soda water became a popular drink at feasts, but since bubbles could cause hiccups and gas, expectant parents abstained from consumption, lest it cause breathing difficulties in the baby.¹⁸⁴

Nuxalk taboos stipulated that no man should be present during childbirth, which would not be possible in a hospital setting with a medical missionary present.¹⁸⁵ The process of childbirth was imbued with dangerous supernatural power; among the Nuxalkmc, a spirit named Sxaiaxwax appears during childbirth, but the typically malevolent figure changes into a benign helper to assist with labour.¹⁸⁶ Indigenous mothers, aware that these supernatural forces existed outside the medico-spiritual cosmology of Euro-Canadian doctors, turned to midwives and family members who possessed knowledge of proper childbirth practices. Medical missionaries recorded instances of childbirth, but these accounts were told from hearsay. There is little evidence to suggest that Nuxalk and Heiltsuk women, except in cases of complications, attended a hospital to give birth. In Bella Coola, Dr. Spencer wrote about a baby who was delivered at home. After the birth, the father went to collect rocks and fresh-cut alder wood, which was soaked in the infant's bathwater to prevent illness.¹⁸⁷ Although Dr. Spencer knew about the birth, he did not intervene, since the family was well-equipped to ensure safe

¹⁸³ Large, *Drums and Scalpel*, 45.

¹⁸⁴ Large, "Untitled Letter, 20 February 1909," 704-05.

¹⁸⁵ For a more detailed overview of Nuxalk childbirth practices, see McIlwraith, *The Bella Coola Indians*, vol. 1, 362.

¹⁸⁶ McIlwraith, *The Bella Coola Indians*, vol. 1, 363.

¹⁸⁷ Spencer, "Letter from Rev. J.C. Spencer, 18 January 1907," 794.

delivery and provide neonatal care on their own.

In Bella Bella, Dr. Large documented one case where he examined a two-week-old infant, who developed spasms, a purple face, and laboured breathing. Dr. Large attended to the infant at the parents' home and prescribed medication. After returning to check up, the baby's condition had significantly improved. Rather than using his prescribed medications, however, Dr. Large noted the parents gave their child "dark fluid in a cup," which turned out to be dye from a purple balloon.¹⁸⁸ The Nuxalkmc and Heiltsuk believed that "like cures like," so healing methods often used the application of objects with congruent medico-spiritual meanings and values. For example, a Nuxalk father would cover his son with bear skin to raise a strong child. In the case of the two-week-old Heiltsuk infant, the mother had inflated and deflated a purple balloon to amuse the child. Seeing that the child turned purple during a spasm attack, the mother soaked the balloon and used the purple dye to wash the baby's face. To his surprise, Dr. Large noted the balloon treatment seemed effective and "the improvement was quite marked at once."¹⁸⁹ In a similar case, a mother treated her baby, who had a severe skin eruption, by rubbing mussel ashes on the baby's head. The mother had eaten large mussels during pregnancy, which she determined to be the cause of her baby's illness.¹⁹⁰ The purple balloon case is one example of an uneasy convergence, where an Euro-Canadian object that had no medico-spiritual power was adopted into the Heiltsuk cosmology and became a therapeutic agent.

Pharmaceutical remedies form the basis of Nuxalk and Heiltsuk healing, which utilized natural substances found in the environment, ranging from plants, invertebrates, to inorganic compounds. Crushed metals, such as fine copper particles, were scraped from a clean source and placed in sore eyes as a remedy.¹⁹¹ Saltwater was among the most commonly used pharmaceutical substance, since it was readily available along the coast. Both the Nuxalkmc and Heiltsuk used saltwater as an emetic to induce vomiting or

¹⁸⁸ R.W. Large, "Letter from Richard W. Large, 21 July 1905," *Missionary Bulletin* 3, no. 1 (Sep-Dec 1905): 114-15.

¹⁸⁹ Large, "Letter from Richard W. Large, 21 July 1905," 115.

¹⁹⁰ Large, "Letter from Richard W. Large, 21 July 1905," 115.

¹⁹¹ Smith, "Materia Medica of the Bella Coola," 36.

diarrhea, which was a purging remedy that was well-known among missionaries.¹⁹² Dr. Large noted that "in strong vigorous cases it acts very well," although the treatment was usually too harsh for children or weakened patients, but the Heiltsuk still had "great faith in the saltwater treatment."¹⁹³ The act of purging, which I have previously discussed, was used extensively by the Nuxalkmc and Heiltsuk to treat an array of conditions. Along with casting out illness, purges also purified the soul for war or hunting. Bathing thoroughly in the sea resulted in a similar effect, since the salt drew out contaminants through osmosis.¹⁹⁴

With the establishment of dispensaries and prescribed medications from mission doctors, Indigenous patients would have learned about Euro-Canadian pharmacological concepts, such as dosing. From Dr. Large's letters, it appeared that Heiltsuk patients adopted the concept of dosages into their therapeutic practices. Patients would drink several quarts of saltwater, up to ten in divided doses, followed by freshwater when the treatment cycle was complete. Indigenous peoples believed this process purged bile from the digestive system, in the same way that biomedical doctors treat bile duct obstructions to prevent the build up of blood toxins.¹⁹⁵ The use of saltwater dosages reflect how Euro-Canadian pharmacological practices converged with Indigenous beliefs of purgative healing.

Along with applying new methods to Indigenous healing, patients were equally willing to try Euro-Canadian medications. In Euro-Canadian medicine, castor oil and Epsom salts were commonly used as purgatives, similar to the Nuxalkmc and Heiltsuk's use of saltwater. Given their popularity, the dispensary at Bella Bella Hospital stocked Epsom salts and castor oil by the barrel. Dr. Large's son, Geddes Large, recalled an elderly Indigenous man who purchased a bag of salt and a bottle of oil. Geddes thought either compound would be sufficient for the man's condition, so he asked why the man wanted both. The elderly man swore by the efficacy of the combined salt and oil treatment

¹⁹² Smith, "Materia Medica of the Bella Coola," 37.

¹⁹³ Large, "Letter from Richard W. Large, November 1903," 416.

¹⁹⁴ Large, *Drums and Scalpel*, 52.

¹⁹⁵ Large, "Letter from Richard W. Large, November 1903," 416.

in clearing his digestive tract: "I take the bottle at night and next morning half the bag of salts. My! Lots of green stuff!"¹⁹⁶ Compared to seawater, Epsom salts could be easily stored and had a higher concentration, allowing its purgative properties to happen more forcefully. In this example of convergence, Indigenous patients substituted saltwater with Euro-Canadian equivalents, which had the same therapeutic action but worked more efficiently.

While Indigenous peoples developed effective remedies for illnesses endemic to their community, the introduction of Euro-Asiatic infectious diseases, such as smallpox, severely constrained their therapeutic capabilities. Dr. Spencer noted that medicine men had "no idea of taking care of patients with infectious disease, as smallpox, measles, etc. The prevailing afflictions among them are tuberculosis, rheumatism, grippe, afflictions of the heart, and specific diseases."¹⁹⁷ Since infectious diseases were foreign to their medico-spiritual cosmologies, Indigenous peoples sought the assistance of medical missionaries for "Euro-Canadian illnesses." Dr. Spencer remarked that "missionaries and storekeepers are constantly asked for medicine, which has led to each keeping more or less drugs on hand." Confounded by communicable infections, Indigenous patients knew that medical missionaries possessed the requisite knowledge and medico-spiritual power to fight this new biological threat. Dr. Large made a distinction between Indigenous and Euro-Canadian types of diseases; in one case, an elderly Indigenous man developed a severe infection in his eyes, which atrophied into scar tissue. According to Large, it was a "white man's disease," so the patient sought the medical missionary for help.¹⁹⁸ Since many of his people had successful operations, the patient requested Dr. Large to do the same, but the condition was so advanced that surgery was unfortunately futile.

Although they lacked immunity to many "Euro-Canadian diseases," the Nuxalkmc and Heiltsuk developed new medicinal methods to combat them. In particular, the Nuxalkmc discovered a workable treatment for tuberculosis, one of the deadliest

¹⁹⁶ Large, *Drums and Scalpel*, 51.

¹⁹⁷ Spencer, "An Introduction to the Medical Work in British Columbia," 202.

¹⁹⁸ R.W. Large, "Letter from Richard W. Large, 29 November 1907," *Missionary Bulletin* 4, no. 4 (March 1908): 949.

introduced diseases. According to Joshua Moody and Captain Schooner, the white fir or balsam fir, *Abies grandis*, was “said to have cured many cases of tuberculosis.”¹⁹⁹ The Nuxalkmc made a decoction from the bark of the root through boiling, then took it daily for tuberculosis or stomach ailments. Another treatment involved boiling leaves and stems of an unidentified fleshy plant, then drinking the concoction. The more plants used in the concoction, the more potent its effect. McIlwraith noted that this remedy was a “Nootka Indian’s” hereditary cure for a cough, but was found to be effective for tuberculosis. The knowledge of this remedy spread rapidly, “saving the lives of hundreds.” While Nuxalk culture had strict regulations around the use of hereditary remedies, pragmatic need trumped intellectual property rights; due to the dangers of tuberculosis, the Nuxalkmc stopped regarding the remedy as private and “have no hesitation in applying it whenever required.”²⁰⁰

Nuxalk and Heiltsuk pharmacology made significant use of plants, harvesting everything from seaweeds to coniferous trees. One botanical drug that was documented in both Nuxalk and Heiltsuk usage was the yellow water lily, or *Nuphar polysepala*. It was used as a universal pain reliever “in a magic way for pain in all parts of the body.”²⁰¹ The root was boiled for at least twelve hours, then the soup was taken internally as a blood tonic. According to Moody and Schooner, the Nuxalkmc used water lily for “consumption, rheumatism, heart disease, and gonorrhoea. Considered good for the blood.” Dr. Large observed a similar usage of water lily among the Heiltsuk; a female patient was “quite ill, she had been taking some Indian medicine. The roots of the water lily had been boiled in water for some hours and she had taken a cup full of the liquid.”²⁰² The patient’s husband, however, “threw the rest of the medicine out of doors” and placed more trust in Dr. Large’s expertise. This case is another example of an Indigenous woman preferring Indigenous medicine, due to women’s role as keepers of familial healing knowledge, while her husband was keener to try Euro-Canadian methods.

¹⁹⁹ Smith, “Materia Medica of the Bella Coola,” 7.

²⁰⁰ McIlwraith, *The Bella Coola Indians*, vol. 1, 731.

²⁰¹ Smith, “Materia Medica of the Bella Coola,” 17-18.

²⁰² R.W. Large, “Letter from Richard W. Large, 12 September 1903,” *Missionary Bulletin* 1, no. 3 (September 1903): 300.

While medical missionaries accepted the use of medicinal plants, substances that were deemed unpalatable by Euro-Canadian standards became a point of contention. The use of animal parts, while largely foreign to Euro-Canadian medical practices, was a common remedy for pains and sores. The Nuxalkmc flayed the giant slug open and bound it tightly over large cuts, while spittle insects could be pulverized and applied to wounds as well.²⁰³ Sea cucumbers were boiled in water to form a decoction, then taken internally for heartburn. Mountain goat fat was rendered with goose droppings, and the mixture could be given to babies for colds. A red squirrel could also be flayed through its underside and applied to groin ulcers.²⁰⁴ Despite their effectiveness, eating animals for medicinal purposes went against Euro-Canadian principles.

In one particular case, Dr. Large took issue with a patient eating frogs for therapeutic effects. The patient, who came from China Hat and was hospitalized for paralysis, complained that "as a result of eating the hospital food in the small quantities given, his stomach unfortunately became contracted."²⁰⁵ The patient believed his stomach problems were caused by "eating little food like a white man and from that time his inside get small." After being discharged home, the patient drank saltwater for five days to "wash his inside." Before drinking, he "took a frog and cut it up or grind it with stones and some water and took it for his medicine." Unfortunately, the home treatment did not help, aggravating his illness and preventing him from eating for two days. In a letter, the patient requested Dr. Large to prescribe medicine "to make his inside good and to make him eat," which the doctor agreed to do. However, Dr. Large warned that if the patient "continued to eat minced frog he would probably soon 'croak'."²⁰⁶ The word "croak" is onomatopoeia of frog sounds, but is also slang for "to die."

Dr. Large's comical warning against "death by frog" reveals key differences between Euro-Canadian and Indigenous understandings of illness. While a Euro-Canadian doctor considered raw amphibians to be entirely inedible, even harmful, the frog

²⁰³ Smith, "Materia Medica of the Bella Coola," 36.

²⁰⁴ Smith, "Materia Medica of the Bella Coola," 35-36.

²⁰⁵ Large, "Letter from Richard W. Large, November 1903," 415-16.

²⁰⁶ Large, "Letter from Richard W. Large, November 1903," 416.

had spiritual power in Heiltsuk healing. Frogs, being amphibious, represent a liminal state between different bodily and metaphysical forms.²⁰⁷ The Heiltsuk believed frogs embody both illness and healing, as well as fertility and feminine bodily cycles. For some situations, frogs signified a tangible form of impurity that needed to be purified from the body. Likewise, Large's patient consumed a raw frog as a form of embodied substitution, using the frog to represent the illness in his stomach. The patient then drank saltwater to purge the frog, an act which expelled illness from his body.

Although the patient was still suffering from paralysis, Dr. Large could not provide an effective remedy and discharged him from hospital. Unable to be healed by the Euro-Canadian doctor, the patient turned to Indigenous remedies. The patient took a jelly-fish, which was "placed between his shoulders in order that his blood might be more forcibly sent to his extremities."²⁰⁸ Dr. Large realized that "those of you who have seen a jelly-fish contracting and relaxing while seeking food will at once see the rationale of the treatment. The jelly-fish, brought in contact with the back of the patient, would augment the force of the heart's action." The patient supplemented the jelly-fish with fresh nettles applied to the throat, as a way of stimulating paralyzed muscles. However, Dr. Large claimed that the patient's condition did not improve, and there was no further record of whether or not the patient was re-admitted to hospital or sought treatment elsewhere.

Despite repeated warnings to abandon Indigenous remedies. Dr. Large documented numerous instances where the Heiltsuk used his services and Indigenous healing in tandem:

[They are] persuaded by heathen friends to revert to heathen rites and practices. When doing this, however, they generally continue taking our medicine, so as to get whatever good there may be in it. In such cases the native manipulator will claim credit for any improvement, and blame us on the other hand if there is none. We find it necessary, in order to combat this, to refuse to treat unless we first obtain a promise that they will not call in native doctors.²⁰⁹

²⁰⁷ Harkin, *The Heiltsuks*, 84.

²⁰⁸ Large, *Drums and Scalpel*, 52.

²⁰⁹ R.W. Large, "Bella Bella, September 1901," *Missionary Outlook* 20, no. 9 (September 1901): 204.

Even though missionaries tried to suppress the use of Indigenous remedies, they had limited efficacy in enforcing their rules. Medical pluralism was not only a matter of preference, but a necessity for many Indigenous patients. Euro-Canadian medicine could more effectively counteract communicable infections, such as typhoid fever and scarlet fever, which were introduced to Nuxalk and Heiltsuk communities. Euro-Canadian medicine also provided surgical methods, such as general anaesthesia, which allowed for more invasive interventions and alleviated the suffering of pain. Indigenous patients made therapeutic decisions based on the nature of their illness, and sought medico-spiritual assistance from both cosmologies to maximize their healing potential. Still, medical missionaries believed that their own cosmology was the sole path to bodily and spiritual salvation, and to becoming fully civilized.

As part of their civilizing agenda, medical missionaries tried to instil Euro-Canadian notions of hygiene among Indigenous peoples. Missionary writings described Indigenous homes as dark and unhygienic, adjectives which convey a sense of “grime” or “stain” afflicting Indigenous peoples, who needed Euro-Canadian guidance to scrub their bodies and souls clean.²¹⁰ As I have mentioned in Chapter 1, the DIA appointed a Council of Chiefs to regulate hygiene and moral behaviour at Waglisla. After learning about the biomedical model of tuberculosis transmission, which was spread airborne through respiratory droplets, the Council used this knowledge to enforce a “no-spitting” ordinance.²¹¹ Public sanitation was upheld through prominent “no-spitting” signs, which the council erected around the wharf and boardwalk, and any violators were issued a monetary fine.

While the Council of Chiefs appeared to be colluding against their own people by upholding colonial law, they in fact used the “white man’s law” to defend themselves against settler encroachment on their territory. In one instance, three white visitors to Bella Bella contemptuously disregarded the no-spitting ordinance, since “it was only an Indian village so they paid no attention to the signs.”²¹² To their surprise, villagers arrested the

²¹⁰ Large, “Bella Bella, September 1901,” 204.

²¹¹ Large, “Letter from Richard W. Large, Fall 1902,” 83.

²¹² F.C. Stephenson, *One Hundred Years of Canadian Methodist Missions, 1824-1924* (Toronto: The Missionary Society of the Methodist Church, 1925), 201.

white men and brought them before Council, where they paid a fine towards the Village Improvement Fund. The Council of Chiefs adopted Euro-Canadian standards of hygiene, and used these standards to police the behaviour of white encroachers on their territory. Thus, the Heiltsuk co-opted colonial tools of bodily regulation, and used the law to their advantage.

The Heiltsuk's openness to co-opting new ideas, rather than a boon to their assimilation into Euro-Canadian culture, sometimes proved to be a source of frustration for missionaries. In Dr. Large's view, some Indigenous peoples were perhaps too enthusiastic about Euro-Canadian medicine, to the point that they adopted pseudoscientific beliefs. Dr. Large himself admitted that "patent medicines, roots and witchcraft [are] our competitors"—by "roots," he was referring to Indigenous plant medicines.²¹³ While medical missionaries derided the use of supernatural power as unscientific, such sentiments were not confined solely to Indigenous healing. Around the turn of the twentieth century, biomedical doctors found their authority challenged by the rise of alternative medicines in Euro-Canadian society, such as homeopathy. From the medical missionary's perspective, the effectiveness and validity of medicines existed in a hierarchy, with biomedicine at the top, alternative medicines and Indigenous healing questionable in most situations, and patent medicine to be quackery. Even if missionaries were ambivalent about Indigenous healing and often attributed its effectiveness to the placebo effect, they still recognized its salience and importance in Indigenous communities.

Dr. Large found the use of patent medicines by Indigenous patients to be disconcerting, since he believed that their hyperbolic health claims deceived patients from seeking biomedical care. In one case, a new mother appeared to develop septicaemia following the death of her newborn, and suffered from a high fever. Although some friends promised to bring her to Bella Bella Hospital, she was instead sent to one of the canneries, where she had other friends. There, someone purchased and gave her patent medicine, but she died shortly afterwards. Dr. Large blamed her death on the friends' failure to bring her to the hospital; too many people, he argued, "pin their faith to patent medicines, and

²¹³ Large, "Letter from Richard W. Large, 12 September 1903," 300.

the missionary has to enter into competition with one or more of these rivals, and win confidence and retain it."²¹⁴ Indigenous patients who were unfamiliar with Euro-Canadian pharmaceuticals may have been misled by patent medicines, which were proprietary tinctures of various substances that claimed to be a panacea for a wide range of conditions, ranging from tuberculosis to neuralgia. Commercial manufacturers, who had little regard for clinical effectiveness and safety, made these over-the-counter drugs and often advertised them with exaggerated health claims to maximize sales.

Furthermore, Dr. Large's criticism against the use of medicinal "roots" belied the fact that common Euro-Canadian drugs were derived from plants, including digitalis and quinine. In many cases, Indigenous pharmacology used the same medicinal plants as the Euro-Canadian model. The shelf fungus, *Polyporus officinalis*, was used by the Nuxalkmc as a treatment for venereal disease. Fungus parts were ground and soaked in water, then consumed as a decoction.²¹⁵ According to Harlan Smith, both Euro-Canadian and Nuxalk pharmacology utilized the shelf fungus, and noted its "medicinal virtues have long been known in the old world." Smith wrote that an American pharmaceutical manufacturer named "Park, Davis, and Company" [sic] made a fluid extract from shelf fungus, which was used to treat night sweats from tuberculosis and also a cathartic in large doses.²¹⁶ Likewise, patent medicines often used the same botanical basis as clinical drugs, but with questionable efficacy and applications.

Regardless of the efficacy of patent medicines, the patients' willingness to experiment with them alongside Indigenous remedies, medicine men, and medical missionaries illustrates the salience of medical pluralism. Euro-Canadian medico-spiritual cosmologies not only co-existed with Indigenous ones, but hybridized as well. The Nuxalkmc developed remedies for "Euro-Canadian diseases," such as tuberculosis, which were introduced to their medico-spiritual cosmology. Likewise, the Nuxalkmc discovered

²¹⁴ Large, "Letter from Richard W. Large, 12 September 1903," 300.

²¹⁵ Smith, "Materia Medica of the Bella Coola," 33.

²¹⁶ Smith, "Materia Medica of the Bella Coola," 34. Smith made a spelling error on the company name; "Parke-Davis and Company," as it is officially known, was once the largest and oldest pharmaceutical drug manufacturer in the United States. It was founded in the 1860s and was absorbed by the Pfizer Corporation in 2000.

that drinking fresh blood from a toad could potentially treat smallpox, another introduced disease.²¹⁷ If these remedies did not work, patients sometimes made the decision to consult a medical missionary. If *dásgiú* was suspected as a cause of illness, Nuxalk and Heiltsuk patients often called on medicine men, who could harness supernatural forces for curative effects. Even medicine men themselves found it necessary to partake in medical pluralism. In one instance, an elderly medicine man sought Dr. Large's services when his own cures could not bring relief to himself.²¹⁸ This anecdote is only mentioned in passing without any further details, but it shows the extent in which convergence transformed all levels of Indigenous society.

Perhaps the most poignant example of medico-spiritual convergence occurred during the death of a female Nuxalk child, who entered the next world by passing through both Nuxalk and Methodist cosmologies. After suffering from illness, family members announced her death by firing rifle shots, which alerted friends to the situation and summoned them to the funeral. On the day of the funeral, Dr. Spencer went to the child's home to hold a service, where he found the family preparing for burial. A chief and several men entered carrying a coffin, and the child was put in with dresses, biscuits, butter, and sugar, all of which were Euro-Canadian trade goods. Dr. Spencer noted that "those present knew I wished to speak to them and they gave me the opportunity." He held a Methodist service by reading the 21st and 22nd chapters of Revelation, which told of the New Jerusalem. It was a place enlightened by the glory of God, where there was no more death, sorrow, or crying. The service ended with a song and prayer, and several onlookers thanked Dr. Spencer for "the words of comfort read and spoken."²¹⁹

After the Methodist service, family members carried the coffin to the grave, led by a man carrying a burning blanket at the front of the procession. While the grave was being dug, the uncle of the child burned the child's clothing on a small pyre until all items were destroyed. When the grave was deep enough, a man stepped forth with a fresh spruce bough, and swept the grave four times facing west, the direction of sunset. Each time he swept, the dirt and sand adhering to the bough was shaken off outside the grave. Finally,

²¹⁷ McIlwraith, *The Bella Coola Indians*, vol. 1, 731.

²¹⁸ Stephenson, *One Hundred Years of Canadian Methodist Missions*, 202.

²¹⁹ J.C. Spencer, "Untitled Letter, 3 March 1905," *Missionary Bulletin* 2, no. 3 (March 1905): 599.

the coffin was put into the grave and covered. The family ended the burial by placing a small board near the grave, and laid a kitchen clock upon it as an offering. Curious by what had transpired, Dr. Spencer asked a chief for an explanation. The burning blanket cleared the way of *nuscaakstatim* and protected the living from sickness and death, while the spruce bough was used to protect the man who dug the grave.²²⁰ The chief explained that burying and burning grave goods allowed them to reach the next world, since the spirit of the departed could use the spirit of the goods.

The passing of the child shows how medico-spiritual convergence transformed the everyday lives of the Nuxalkmc and Heiltsuk, from birth to death to the afterlife. In this chapter, I have examined Nuxalk and Heiltsuk understandings of illness, healing, and the role of patients and healers in the therapeutic process, and how their cosmologies were influenced by Euro-Canadian beliefs and practices. Most Indigenous health practitioners were not “medicine men,” but lay people who had knowledge of pharmacology, minor surgery, and convalescent care. This knowledge was often maintained and passed on through families, particularly by women. The patient and family played a key role in therapeutic care and decision-making, but patients sought outside assistance if they deemed it necessary. Patients sought either the medical missionaries’ biomedical power or the medicine man’s supernatural power, or both depending on the nature of their illness.

Although missionaries tried to suppress Indigenous healing and healers, they had little power to curtail the therapeutic agency of Indigenous patients. To elude missionary surveillance, patients purposely chose to remain home for treatment and shielded the activities of medicine men. Medical pluralism provided patients with access to more therapeutic options, as they could utilize different medico-spiritual powers and mechanisms, often in conjunction for the same illness. Through these pluralistic practices, patients could increase their chances of recovery. In turn, a healthy body also improved their spiritual wellbeing, which strengthened Nuxalk and Heiltsuk communities against the negative forces wrought by colonial intrusion. In the next chapter, I will examine how medical pluralism occurred in the mission hospital, and how medical missionaries were in turn affected by convergence.

²²⁰ Spencer, “Untitled Letter, 3 March 1905,” 600.

Chapter 3.

Doctor's Orders: The Mission Hospital as a Site of Convergence

On the 7th of November in 1902, Miss Kissack, a nurse of the Bella Bella Hospital, arose at dawn from her living quarters and began lighting six stoves to ward off the bitter chill. Writing to *The Missionary Outlook*, Miss Kissack admitted that "it takes a mighty effort to crawl out of a snug bed in the morning and get all these fires started," but the cold weather could not dampen her excitement.²²¹ Only ten days earlier, the Bella Bella Hospital finally opened after nearly three years of planning and construction. Just over a week after opening, the hospital had already served five in-patients, although there were barely any furnishings or equipment to be found. Miss Kissack quipped that "we look quite like a ten-cent lodging-house," since their shipment of white enamel bedsteads from Eastern Canada had been delayed. She lamented that the kitchen was missing supplies, and the dining room had no linen: "There are so many things that seem necessary, but which we cannot have for lack of means."

It was not an ideal situation for opening week, but staff members were accustomed to the transportation difficulties and funding limitations of working in a rural location. They would have to make do with help and supplies sourced locally. Due to a lack of bedsteads, the hospital staff resorted to treating "patients in regular Indian style, lying on mattresses on the floor."²²² Amidst the disarray, an Indigenous carpenter helped to build a bookcase for the nurse's sitting-room, and an Indigenous assistant performed much of the housekeeping. Miss Kissack conceded that "things that minister to the aesthetic are not to be thought of until the physical is well provided for," but she was grateful and happy for what little they had. Buoyed by their ambitious paternalism and optimism, the mission staff envisioned the hospital to be a place of transformative change, where the sickly bodies and souls of Indigenous patients could be made into healthy and civilized Christians. *The*

²²¹ Miss Kissack, "Indian Work, 7 November 1902," *The Missionary Outlook* 22, no. 1 (January 1903): 22.

²²² Miss Kissack, "Indian Work, 7 November 1902," 22.

Missionary Outlook assured readers that “at first there may be suspicion and prejudice as in the case of the evangelist, but let one or two be healed of their diseases and soon suspicion abates and prejudice is overcome.”²²³ Through the Bella Bella Hospital, many Indigenous patients came to appreciate and partake in the benefits of hospital care, such as anaesthetic surgery and biomedical drugs. But rather than abandoning Indigenous healing—as the missionaries had hoped—patients integrated hospital care into their existing communities of healers and healing practices.

This chapter will situate the Bella Bella Hospital as a site of convergence between Euro-Canadian and Nuxalk and Heiltsuk cosmologies, and consider the effects and implications of this exchange. The hospital not only served the residents of Bella Bella, but attracted patients from all over the Central Coast. I will also discuss the Rivers Inlet Hospital, which opened as a summer extension to serve migrant labourers at the cannery town. Through the hospital space, missionaries sought to control the therapeutic choices of patients, but they were constrained by staffing shortages and the seasonal mobility of Indigenous peoples. While Indigenous patients recognized and partook in the benefits of hospitals, such as antiseptic surgery, they continued to uphold Indigenous understandings of illness, healing, and convalescence alongside Euro-Canadian methods. Medical pluralism provided Indigenous patients with greater therapeutic autonomy and opportunities, but it affected mission staff as well. Due to funding and staffing constraints, missionaries found themselves increasingly reliant on Indigenous labour and supplies to sustain their work. Likewise, missionaries adopted medico-spiritual practices from the same peoples that they derided as “backward,” including the use of Indigenous foods in hospital meals and placing patients in Indigenous homes for long-term care. Thus, I will consider the reciprocal nature of convergence by examining the influence of Indigenous medico-spiritual cosmologies on missionary beliefs and practices.

To begin, I will discuss the origins and operations of the Bella Bella Hospital and Rivers Inlet Hospital, and situate them within the Methodist mission’s overarching agenda. Although the Bella Bella medical mission was established in 1897, it did not actually open a hospital until October 1902. Prior to the hospital’s opening, Dr. Large often had to treat

²²³ Author unknown, “Editorial: The Medical Missionary, August 1906,” *The Missionary Outlook* 25, no. 8 (1906): 171.

and house patients in his own lodgings at the mission house. After his arrival in Bella Bella, Dr. Large was tasked with planning and constructing the hospital, as well as expanding the summer clinic at Rivers Inlet, a cannery town about 80 km southeast of Waglisla.²²⁴ Since most of the Central Coast population—both Indigenous and non-Indigenous—worked around Rivers Inlet during the summer, the Methodists maintained a secondary hospital there to serve the migrant workers. The Rivers Inlet Hospital was originally founded in 1897 by Dr. Albert Bolton, who began working at Port Simpson in 1889 and was the first Methodist medical missionary in British Columbia.²²⁵ After Dr. Large took over the management of Rivers Inlet, he enlarged and furnished the building with a Provincial Government grant of \$600, while cannery employees donated \$450.²²⁶ A fire destroyed the hospital building in 1904, but it was quickly rebuilt and reopened the following year.

At Bella Bella, the mission hospital occupied a prominent position in the Waglisla villagescape, as it was one of the largest buildings. Based on photographs, the hospital's exteriors were painted either white or light beige, and the two-story building had three gabled roofs with a sidewalk and steps leading to the front entrance. Dr. Large wanted to plant grass seed around the front yard, as he was determined to transform the hospital into a space of Christian domesticity, but the waterlogged and rocky soil put a damper on his landscaping aspirations.²²⁷ He asked workers to line the interior with insulation, then paint and wallpaper the hallways and wards. When it opened in October 1902, it could accommodate seven or eight in-patients, had an operating room, and living quarters for the nurse. By 1907, the hospital had expanded to twelve beds, and was equipped with hot and cold water and a plumbing system. Near the shore, Dr. Large constructed an isolation ward for infectious cases, as well as a tent-cottage for tubercular patients.²²⁸ These facilities reduced and centralized the workload for hospital staff, as there were only one doctor, his wife if he was married, one or two nurses hired by the Woman's Missionary

²²⁴ 80 km away is “as the crow flies”; travel by boat would cover a greater distance.

²²⁵ Burrows, *Healing in the Wilderness*, 22.

²²⁶ R.W. Large, “The Indian Work: Report,” *Annual Report of the Missionary Society of the Methodist Church of Canada, 1901-1902* (Toronto: Methodist Missionary Conference Office): xxxix.

²²⁷ Large, “Letter from Richard W. Large, November 1903,” 413.

²²⁸ Large, “Letter from Richard W. Large, 29 November 1907,” 954.

Society, and a few Indigenous aides at any given time. In the 1901-1902 operating year, the small staff managed to assist with 2,500 house calls and patient visits at the two hospitals.²²⁹



Figure 4. Bella Bella Hospital [1909]

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The hospital space, and socio-political discourses around hospitals, have received significant attention from historians and cultural theorists. Foucault's concepts of bio-power and the clinic serve as the theoretical basis for many historiographical studies. By bio-power, Foucault refers to institutions of bodily discipline and regulation. These institutions are manifested in spaces such as hospitals and prisons, which are often extensions of institutional power and colonial hegemony. Maureen Lux and Mary Jane McCallum have examined how "Indian hospitals" function within the system of medical colonialism in Canada. Lux contends that these hospitals were used to limit the mobility of Indigenous populations, whose "racial carelessness" threatened the spread of diseases

²²⁹ Large, "The Indian Work: Report," *Annual Report of the Missionary Society of the Methodist Church of Canada, 1901-1902*, xl.

to settler populations.²³⁰ McCallum advances a similar argument by examining how discourses of isolation informed colonial approaches to Indigenous health care, and how isolation became a metonym for cultural difference.²³¹ The isolation of Indigenous bodies prevented the spread of diseases to the white population, but conversely, colonial health officials believed Indigenous peoples needed isolation to protect them from the corruptive influences of white society. The Bella Bella Mission's evangelizing strategy also employed isolation, but with a different rationale than the ones identified in Lux and McCallum's scholarship. Through isolation in the hospital, Indigenous peoples would be barred from accessing the "heathen" influences of medicine men and supernatural forces. Instead, they would be saved with biomedicine, which missionaries believed to be a direct manifestation of God's grace and healing power.

While the church is the most obvious manifestation of missionary power, the hospital was more integral to medical mission programme, since it was a space where bodies and souls coalesced into one unit for surveillance and assimilation. Rather than proffering Christian beliefs through preaching, the Methodists' dominant strategy was to introduce Euro-Canadian values of health care, wellbeing, and hygiene through the hospital space. Furthermore, they believed that church services were not sufficient in bringing patients closer to God. In *The Missionary Outlook*, its editors argued that "a hospital is naturally required to complete the work begun, and it is in the wards and regular daily services of the hospital that the Gospel is made plain."²³² As Dr. Large articulated: "The work done is medical and missionary, and our ideal should be, we believe, to make a perfect blending of both."²³³ From a medical missionary's viewpoint, medical work was inherently spiritual, and the hospital superseded the church's ability to gain converts: "There is no place equal in opportunities for personal work to the wards of the mission

²³⁰ Maureen K. Lux, "Care for the 'Racially Careless': Indian Hospitals in the Canadian West, 1920s-1950s," *The Canadian Historical Review* 91, no. 3 (September 2010): 410.

²³¹ McCallum, "The Last Frontier: Isolation and Aboriginal Health," 104.

²³² Author unknown, "The Need and Power of Medical Missions," *The Missionary Outlook* 23, no. 8 (August 1904): 180.

²³³ Large, "The Indian Work, British Columbia Conference," *Annual Report of the Missionary Society of the Methodist Church of Canada, 1903-04*, 64.

hospital.”²³⁴ Compared to the more abstract practice of reading or hearing Scripture, medical work manifested God’s word and power in tangible, material ways.

As Michael Harkin notes in *The Heiltsuks*, the hospital is a privileged space of medical control. It is where a patient is anatomized and objectified under the medical expert's clinical gaze, which Foucault terms as "tertiary spatialization."²³⁵ Thus, medicine is not a purely scientific or impartial institution, but mutually informs and intersects with colonial discourses of knowledge, bodily politics, and power. While Harkin’s work is critical to my own interpretation of Indigenous health care, his arguments on hospitals present a somewhat truncated explanation of colonial power dynamics. It is indisputable that Indigenous peoples faced a power imbalance due to the biological and socio-cultural legacies of epidemic diseases. But while missionaries occupied a position of power in the hospital space, the extent of their control was often constrained by Indigenous agency. As I will later demonstrate, patients sometimes disagreed with the mission doctor’s orders, and opted to leave the hospital in favour of Indigenous remedies. Furthermore, the hospitals had limited efficacy in curtailing Indigenous mobility; Indigenous peoples continued to maintain their seasonal rounds between the winter villages and summer fishing sites, which compelled missionaries to follow them and accommodate their migration schedules.

One factor that circumscribed missionary power was due to the mission’s reliance on Indigenous labour. Like most of the village’s infrastructure, the construction of the Bella Bella Hospital depended on Indigenous wood-crafting knowledge. In April 1902, most of the Heiltsuk men were away fishing and hunting, but Dr. Large managed to get a few helpers and had the hospital frame erected. After the June fur-seal hunt, the men returned home from Goose Island and freely donated their time to construction. On some days, as many as forty Heiltsuk worked on the hospital, and they almost completed the building in just ten days.²³⁶ The hospital staff then left for Rivers Inlet, and upon their return in late August, two or three of the most-skilled carpenters finished the interiors. The hospital

²³⁴ Dr. Kilborn quoted in C.H. Lawford, “Medical Missions,” *The Missionary Outlook* 22, no. 9 (September 1903): 204.

²³⁵ Foucault cited in Harkin, *The Heiltsuks*, 95.

²³⁶ Large, “Letter from Richard W. Large, Fall 1902,” 82.

finally opened on October 27th, 1902. In keeping with the Methodists' s

ocial gospel agenda, hospital staff accepted any patient regardless of ethnicity or religion, and treated many Indigenous patients who were not Nuxalkmc or Heiltsuk. While doctors rarely mentioned tribal affiliations except for "Interior Indian" or "southern Indian," it is very likely that the neighbouring Tsilhqot'in and Dakelh peoples comprised a large percentage of Indigenous patients.²³⁷ Lacking a mission hospital at Bella Coola, Dr. Spencer sent his cases to Waglisla if hospitalization or an operation was warranted. Patients of settler descent also utilized the Bella Bella Hospital; in 1906 for example, the hospital admitted 108 in-patients, comprising "65 Indians, 34 whites, 5 Japanese, and 4 Chinese."²³⁸ Bella Bella, along with Rivers Inlet in the summer, was the only permanent hospital between Port Simpson and Nanaimo, so it was situated at a critical location for migrants up and down the Central Coast.

Along with unpaid labour, the hospital's operations depended on financial contributions from Indigenous patients. Although many patients still preferred Indigenous healing practices, they recognized the benefits and value of Euro-Canadian health infrastructure for their communities. Most locals received minimal pay in the wage economy, usually from fishing, cannery labour, and work in the village sawmill, but they contributed what they could toward treatment and medication fees. In 1905, the hospital operated on a budget of around \$5000. The majority of finances were borne by federal and provincial grants, along with church funding through the Methodist General Board, Woman's Missionary Society, and Young People's Forward Movement for Missions. In 1910, Indigenous patients contributed \$800, half of which came from the Heiltsuk, toward the Bella Bella Hospital fund.²³⁹ This amount marked a significant change from a decade earlier. During the first year of Dr. Large's tenure in 1898, many Heiltsuk patients were reluctant to pay for medical costs, because they doubted the intentions of missionaries

²³⁷ Tsilhqot'in (Chilcotin) and Dakelh (Carrier) are both Interior Athabaskan speakers. They are culturally and linguistically different from Central Coast groups, but have a long history of intercultural relations. See Alan D. McMillan and Eldon Yellowhorn, *First Peoples in Canada* (Vancouver: Douglas & McIntyre, 2004): 184.

²³⁸ R.W. Large, "Letter from Richard W. Large, 12 February 1907," *Missionary Bulletin* 3, no. 4 (Dec-Mar 1907): 800.

²³⁹ Large, *Drums and Scalpel*, 58-59.

and were unfamiliar with Euro-Canadian health systems.²⁴⁰ Initially, the federal government provided missionaries with simple remedies to dispense, so patients did not have to pay any fees. When Dr. Large began paying for and dispensing his own medications, Heiltsuk patients believed their contributions went to Dr. Large's private fortune, rather than the community. When Dr. Large brought up the issue of fees at a Council meeting, the head chief picked up his hat and left in anger.²⁴¹

To assuage any misunderstandings over the disbursement of funds, the hospital gave each head of household a book, where treatment fees were entered and credited. The hospital also displayed a prominent sign of patient names, with their contributions publically listed. Even with these tactics, Dr. Large wrote in 1910 that "we have more of poor than of well-to-do patients and this will probably always be true but this makes the work none the less necessary and appreciated."²⁴² Impoverished patients were accepted on a pro-bono basis or paid what they could, although some patients gave generous donations exceeding the fee schedule. One family brought their boy to the hospital, where he underwent amputation of his right arm due to a gunpowder explosion. After the surgery and two-month stay, his parents decided to pay a substantial \$10 for his treatment, to express their gratitude and satisfaction at his recovery.²⁴³

Class dynamics often informed patients' therapeutic choices, since it is evident from missionary letters that chiefs did not frequently seek hospital care. As noted in Chapter 2, Dr. Large observed that chiefs from surrounding communities had their own medicine men, and elite families had hereditary access to particular medicinal remedies. On one occasion, Dr. Large saw the ill wife of a chief, who believed an "evil doctor" casted a stone into her body. The couple then decided "to call in an old-time doctor to see if he could not overthrow the work of the evil disposed doctor," but Dr. Large convinced them to try biomedical treatment.²⁴⁴ Dr. Large performed a small operation and found what he believed to be the true cause of the ailment, although he did not specify what he

²⁴⁰ Large, *Drums and Scalpel*, 46.

²⁴¹ R.W. Large, "Letter from Richard W. Large, 25 April 1910," *Missionary Bulletin* 6, no. 4 (June 1910): 914.

²⁴² Large, "Letter from Richard W. Large, 25 April 1910," 916.

²⁴³ Large, *Drums and Scalpel*, 20.

²⁴⁴ Large, *Drums and Scalpel*, 20-21.

discovered. He credited the operation for “relieving” the woman’s mind, which helped her make a slow recovery. Although the couple attributed the illness to *dásgíú*, Dr. Large was convinced it had an organic cause. He refused to acknowledge that a physical ailment might have supernatural origins; such an admission would persuade the Heiltsuk couple to call for a medicine man, since medical missionaries were usually incapable of treating *dásgíú*. Nonetheless, the wife recovered after surgery, so the chief believed that hospital treatment was effective and expressed satisfaction with Dr. Large’s help. In this case, it appears that surgery managed to counteract *dásgíú*, which suggests that biomedical power and supernatural power had fused through cosmological convergence.

A significant portion of Indigenous patients who sought assistance from Euro-Canadian hospitals were transient migrants, usually impoverished men who had limited social or kinship connections to the Nuxalkmc and Heiltsuk. In missionary letters, non-local patients were usually identified by the region of their origin, such as “southern Indian” or “Interior Indian.” The unfamiliar hospital space and lack of cultural support often took a severe emotional toll, as some patients cried from homesickness and isolation.²⁴⁵ The Rivers Inlet Hospital admitted a large proportion of summer labourers, many of whom came from non-Indigenous backgrounds. Patients at the summer hospital often sought aid for physical injuries rather than diseases, which reflected their employment as manual labourers, since broken bones were commonly sustained during workplace accidents. During the peak fishing season in 1903, the majority of in-patients (out of 35 total) at Rivers Inlet were white, prompting Dr. Large to remark that “there was not as much sickness among the Indians as usual.”²⁴⁶ The low hospitalization rate for Indigenous peoples suggest that many patients were treated privately at home, or that they were less likely to fall severely ill due to their use of Indigenous preventative remedies. Since the Nuxalkmc and Heiltsuk had access to familial remedies and the assistance of medicine men, they could forego hospital treatment unless they deemed it necessary.

The low hospitalization rate can also be attributed to the mobility of Indigenous peoples in the Central Coast. The Nuxalkmc and Heiltsuk frequently travelled to remote regions of their territory for fishing and hunting, so patients did not depend on Euro-

²⁴⁵ Large, “Rivers Inlet Hospital, 12 June 1903,” 228.

²⁴⁶ Large, “Letter from Richard W. Large, 12 September 1903,” 298.

Canadian health infrastructure for medical aid. At the turn of the twentieth century, the Nuxalkmc and Heiltsuk continued the seasonal lifeways of their ancestors, although the economic rationale for their migration increasingly began to change. The introduction of mercantile and industrial capitalism to the Central Coast shifted Indigenous economics from the trade and potlatch system to the Euro-Canadian wage economy. Fish processing, which exported canned fish to national and global markets, depended on the labour of Indigenous peoples and East Asian migrants. In the spring and summer, the majority of working-age Nuxalkmc and Heiltsuk travelled to Rivers Inlet, which was the largest cannery town on the Central Coast. There, Indigenous peoples fished and sold their harvests to canneries, then worked as fish processors or manual labourers for local businesses. The Rivers Inlet Hospital was built at the site of Wannock Cannery, which became part of the B.C. Packers Association in 1892.²⁴⁷

In response to this mobility, Dr. Large temporarily closed the Bella Bella Hospital from June to late August, and moved the mission staff southeast to Rivers Inlet.²⁴⁸ Staffing shortages prompted Dr. Large to hire local Indigenous peoples for nursing and housekeeping assistance, since his wife and one or two nurses could barely keep up with the workload. Even with employment in the hospitals, the assistants preferred to maintain Indigenous patterns of seasonal mobility. In summer, the assistants often left the hospital to join extended family working at the canneries and fishing and hunting grounds, and took opportunities to renew social bonds and kin relationships during their migration. Furthermore, the seasonal round allowed the Nuxalkmc and Heiltsuk to build social connections beyond the Central Coast, including Indigenous peoples from Vancouver Island, the Interior, and East Asian migrants.

It is unsurprising that Dr. Large took issue with his Indigenous employees' apparent lack of work ethic: "We have been disappointed in our Indian girl assistants. We have had three of them altogether during the last two years, but they generally wish to stop work

²⁴⁷ K. Mack Campbell, *Cannery Village: Company Town* (Victoria, B.C.: Trafford Publishing, 2004): 62.

²⁴⁸ Large, "Letter from Richard W. Large, 21 July 1905," 110.

just when they are most needed."²⁴⁹ In keeping with Euro-Canadian attitudes, Dr. Large believed that the "Indian" was innately restless and "does not take kindly to the confinement and routine of hospital work."²⁵⁰ However, he did appreciate the work of two Heiltsuk staff, a probationer nurse named Miss Grant and a custodial helper named Alfred Brown, who assisted with surgical cases. Brown had "learned to give the anaesthetic very well under the doctor's direction," while Miss Grant was "a welcome addition to our staff of white workers."²⁵¹ Hannah Edgar, who was the daughter of Rev. George Edgar, was a nursing assistant at Rivers Inlet Hospital and hailed from a family of Indigenous Christian ministers.²⁵² In Dr. Large's view, a good Heiltsuk employee was industrious and docile, and conformed to Euro-Canadian gender and racial hierarchies. Female Indigenous assistants were given the "rougher kitchen work," housekeeping, and basic nursing tasks, while the white nurse managed surgical cases.²⁵³ Despite their crucial role in hospital operations, missionary letters rarely referred to female Indigenous workers by name. Instead, they were usually called "Indian girls" or "girl assistants," which positioned them as subordinate to white staff members, who were always mentioned by name and formally addressed as "Dr." or "Miss."

The mobility of Indigenous societies curtailed the limits of missionary surveillance, which allowed the Nuxalkmc and Heiltsuk to maintain their autonomy and cultural practices. In *Authentic Indians*, Paige Raibmon contends that mobility was a critical factor in Indigenous survival under colonialism.²⁵⁴ Furthermore, the introduction of the wage economy did not weaken existing Indigenous economic structures; in many instances, it stimulated it. From 1900 to 1910, the growth of Indigenous businesses—such as the

²⁴⁹ Large, "Letter from Richard W. Large, 12 September 1903," 298.

²⁵⁰ Large, "Letter from Richard W. Large, 12 September 1903," 298.

²⁵¹ R.W. Large, "Our Medical Missions: Bella Bella and Rivers Inlet Hospitals," *Missionary Outlook* 22, no. 9 (September 1903): 202.

²⁵² Large, *Drums and Scalpel*, 53. The Edgar family hailed from Lax Kw'alaams (Port Simpson). George Edgar was born in 1854 on Gabriola Island, and grew up in Lax Kw'alaams. With Scottish and Tsimshian heritage, he was one of the first Indigenous ministers in the Methodist Church, working alongside William Pierce. Edgar began his service as teacher and lay preacher in 1877, and was ordained in 1909.

²⁵³ Large, "Our Medical Missions: Bella Bella and Rivers Inlet Hospitals," 202.

²⁵⁴ Paige Raibmon, *Authentic Indians: Episodes of Encounter from the Late-Nineteenth-Century Northwest Coast* (Durham: Duke University Press, 2005), 25-27.

sawmill—and skilled artisans meant that Waglisla could support a nascent capitalist economy. Monetary capital strengthened Indigenous trade networks by helping families purchase consumer goods, which in turn bolstered cultural survival through potlatches. Although potlatches were banned under the *Indian Act* amendment of 1884, missionaries had difficulty enforcing the law. In fall 1913, when A.E. Best served as a temporary missionary at Bella Coola, only one Nuxalk person showed up for Sunday morning service at the village church. By that year, 206 out of 222 Nuxalkmc professed to be Methodist, so their absence roused Best's suspicions. Concluding that his parishioners were holding a potlatch, the missionary and his wife canoed across the river and surprised the Nuxalkmc, who expressed guilt when discovered. However, Dr. Best made no attempt to dismiss the congregation, but decided to make the best of the situation and held Sunday service right in the assembly house.²⁵⁵

Although the ultimate goal of missionaries was to gain converts and make them into model Christians, it is important to note that the Methodists did not believe in overt proselytizing. Instead of relying on preaching or praying, they believed their God-given purpose could be attained through medico-spiritual work. While missionaries maintained conventional Protestant practices, such as holding Sunday service, leading prayer groups, and ministering to the dying and deceased, most of their attention and energy was consumed by the hospital. As the mission's workload continued to expand in the 1910s, the situation worsened to the point that Dr. Best, who was Dr. Large's successor, was compelled to hold evening Sunday services in the hospital reception room.²⁵⁶ The hospital even housed a portable miniature organ, so staff could play hymns around the wards and transport it to Rivers Inlet during the summer.²⁵⁷ Best's decision to host Sunday services in the hospital was not a deliberate evangelizing strategy, but a matter of necessity. His wife, Gertrude, lamented their staffing woes: "One doctor on the field cannot possibly do it, and at the same time be on hand at the hospital to treat all

²⁵⁵ A.E. Best, "Letters from Dr. and Mrs. A.E. Best, 14 January 1914," *Missionary Bulletin* 10, no. 2 (Mar-Jun 1914): 210-11.

²⁵⁶ Gertrude J. Best, "Letter from Mrs. A.E. Best, 15 June 1913," *Missionary Bulletin* 9, no. 4 (Sep-Dec 1913): 582.

²⁵⁷ Miss Alton, "Hospital Work at Bella Bella, December 1904," *The Missionary Outlook* 23, no. 12 (December 1904): 287.

patients who come in.”²⁵⁸ As the hospital became both chapel and sickroom, Best tried to liven up the situation a male singing quartet and orchestra comprised of Heiltsuk artists.

Due to chronic funding and staffing constraints, Methodist missionaries rarely insisted on holding services in a proper church setting. Like the hospital, the local school building served as an alternative chapel. By 1907, the Bella Bella Mission still used the school-house to hold church services, since their main church building needed repair, and there were no other buildings large enough to accommodate the growing local and migrant population.²⁵⁹ The mission finally acquired a fully equipped church in 1909, which was again built by Heiltsuk labour using lumber from the Waglisla sawmill.²⁶⁰ The locals donated about \$700 in cash towards its construction and maintenance, while the female mission staff and some Heiltsuk women furnished the interior. The church had an altar, carpeting and linoleum, a baptismal font, a pulpit Bible and hymn book, an organ, and a bell. Dr. Large elatedly announced its completion in the *Missionary Bulletin*: “We have now one of the best churches on the Coast Missions, well built, entirely by free Indian labor, and the giving of our substance and the labour of our hands has been a means of grace to us all.” While Dr. Large acknowledged the unpaid labour of the Heiltsuk, Indigenous peoples were rarely credited in missionary writings as being active contributors to mission operations. Missionary discourse emphasized the naivety and passiveness of Indigenous peoples, who needed moral guidance to protect them from the corrupting influence of alcohol and other vices.

The workload of the Bella Bella Hospital was extraordinarily intensive, as the small staff served both in-patients and out-patients, performed operations, provided medications in the dispensary, and went on house calls to Waglisla and the surrounding community. The hospital was capable of conducting invasive surgery under general anaesthesia and antiseptic conditions, including appendectomies and amputations. In one case, a mixed-blood deckhand on a cannery tug was severely injured in a workplace accident, which

²⁵⁸ Gertrude J. Best, “Letter from Mrs. A.E. Best,” 582.

²⁵⁹ W. Raynor, “Letter from W. Raynor, 11 August 1907,” 546.

²⁶⁰ Large, “Letter from Richard W. Large, 15 January 1909,” *Missionary Bulletin* 5, no. 4 (March 1909): 687-89.

severed his leg above the knee joint.²⁶¹ Ten hours had elapsed between the accident and the tug's arrival at Waglisla, so Dr. Large had little hope for the patient's survival as he performed the amputation. The deckhand unfortunately died four hours later, and although Dr. Large managed to hold prayer and comfort him before the operation, the missionary regretted that he could not save the patient. Previously, I mentioned an Indigenous boy whose right arm was damaged by a gunpowder explosion; in this case, Dr. Large successfully amputated the limb and the boy survived.²⁶² In addition to surgery, Dr. Large spent most of his time giving consultations to patients, and responding to letters requesting treatment and medications. At Rivers Inlet, one female patient wrote in search of "medican for Pains headake [sic]," because she had "rumitis," an archaic term for rheumatism.²⁶³ Dr. Large personally went to see the patient, but determined her condition was not severe and she soon recovered.

In critical cases, patients were too ill or endangered to travel to the hospital, so medical missionaries were prepared to provide emergency treatment in any situation. At Bella Coola, Dr. Spencer was called to assist with a Nuxalk man who cut himself badly with an axe. Since there was no time to dispatch the patient to Bella Bella Hospital, Dr. Spencer and some Nuxalk bystanders made a makeshift operating table from cedar boards. Four men carried in the patient and laid him on the table, while family members gathered to watch. Dr. Spencer applied an antiseptic solution and drawn together the gash, which was five inches long and quite deep. The bleeding was soon staunched, and the man made a good recovery. Dr. Spencer noted than in Nuxalk medicine, the wound would have been left open and allowed to crust over with pus and flesh. This technique, however, usually left the patient bedridden for weeks.²⁶⁴ Since Euro-Canadian medicine could minimize pain and infection more efficiently, the Nuxalkmc knew to call on Dr. Spencer in cases of severe wounds or blood loss.

Even though medical missionaries could perform operations, Euro-Canadian medicine still had its limitations at the turn of the twentieth century. In a case involving an

²⁶¹ Large, "Letter from Richard W. Large, 26 July 1904," *Missionary Bulletin* 2 (1904): 282.

²⁶² Large, "Rivers Inlet Hospital, 12 June 1903," 227-229.

²⁶³ Large, "Letter from Richard W. Large, November 1903," 415.

²⁶⁴ Spencer, "Letter from Rev. J.C. Spencer, 7 November 1904," 598-599.

unconscious young boy, Dr. Large determined that the cause of illness was due to brain pressure from a tumour, but he deemed it to be inoperable. Although the staff could not do much, Dr. Large was particularly interested in the case and asked the boy to remain hospitalized. Sensing that the Indigenous family was “suspicious of the staff,” the doctor permitted the father to stay with the boy. The next morning after breakfast, his parents gathered their son and left the hospital without any announcement. Dr. Large discovered that the parents “took him to their camp and made preparations for his death, which occurred three or four days later. They had concluded that we could not save him and therefore removed him.”²⁶⁵ Believing the boy's condition was beyond the capabilities of Euro-Canadian medicine, the parents chose end-of-life care within a culturally meaningful and private setting, rather than letting their son die in a hospital.

Although staff tried to make the hospital space as inviting as possible, many patients found the environment to be unfavourable. Indigenous patients, particularly those from distant communities, found the hospital space to be socially and culturally isolating. In one case, Dr. Large documented an “interior Indian” who came to the Rivers Inlet hospital for a broken thigh, presumably from an accident at a cannery. The patient had travelled one hundred miles for treatment, but staff reported that “it was hard for him, being so far away from his friends, and he often cried from homesickness.”²⁶⁶ After the cannery season ended, staff attempted to bring the patient back to Bella Bella, but he refused to proceed after a stopover at Bella Coola. He contended that “he would die if he went with us,” so the staff released him into the care of his friends. Like the boy with the brain tumour, the “interior Indian” also preferred to die in the care of his friends and decided to withdraw from treatment.

Thus, while many Indigenous patients sought hospital care, they did not always follow through with their course of treatment. Medical missionaries often considered Indigenous patients “difficult to manage,” but they failed to account for cultural differences toward healing. While Indigenous healing prioritized familial care and the central role of the patient in therapeutic decision-making, the Euro-Canadian model emphasized bodily

²⁶⁵ Large, “Rivers Inlet Hospital, 12 June 1903,” 228.

²⁶⁶ Large, “Rivers Inlet Hospital, 12 June 1903,” 228.

isolation in the hospital and the expertise of the professional. Though Euro-Canadian doctors tried to save patients from death wherever possible, some Indigenous patients accepted the inevitability of death and made a final decision to leave the hospital and die in the community. By returning home, patients could die in a culturally appropriate manner, especially if their family still adhered to Indigenous funerary customs. It also mitigated any potential unease toward the handling of their body after death, since the improper removal or theft of bodily parts could result in *dásgiú*. Similarly, some Indigenous patients were opposed to post-mortem examinations, although Dr. Large noted that others requested one. When the wife of Captain Carpenter, who was one of the Heiltsuk chiefs, became seriously ill, she was brought to Bella Bella Hospital for treatment. Dr. Large determined an operation was necessary, but her family decided she was too old, so Mrs. Carpenter was taken home to die. Dr. Large asked Captain Carpenter if he would like to know the cause of death via a post-mortem, but the chief refused, stating that: “it was enough to have his wife die once without killing her a second time.”²⁶⁷ As the wife of a chief, Mrs. Carpenter was laid to rest in a “fine grave house,” in a manner in keeping with her Indigenous identity and high-ranking status. The experience of the Carpenters, again, demonstrate how Indigenous patients strove to maintain their autonomy over therapeutic choices and end-of-life care.

At Rivers Inlet Hospital, Dr. Spencer faced a similar situation arising from patient disagreement over the cause and treatment of illness. While the mission at Bella Coola did not have its own hospital, Dr. Spencer travelled to Rivers Inlet during the summer to follow the Nuxalkmc’s seasonal migration. In the summer of 1899, he performed three operations under general anaesthesia, which all had good outcomes. However, one case involving a boy with typhoid fever was particularly worrisome, since a woman died several days earlier of a lung hemorrhage at the canneries.²⁶⁸ The boy’s illness was so advanced that he began bleeding from the bowels. One early morning, the nurse was awakened by the boy’s father, who panicked when he saw his son’s nose bleeding while asleep. The blood dropped down in the mouth and was expectorated, which reminded the father of the

²⁶⁷ R.W. Large, “Letter from Richard W. Large, 13 May 1905,” *Missionary Bulletin* 2, no. 4 (June 1905): 821-22.

²⁶⁸ J.C. Spencer, “Letter from Rev. J.C. Spencer, 25 August 1899,” *The Missionary Outlook* 19, no. 10 (October 1899): 223.

women who died of the lung hemorrhage. When the father went outside the hospital, he heard a dog run away, but misattributed the sound to an escaping medicine man. Believing the boy was afflicted with *dásgíú*, the family thought Dr. Spencer could no longer save him. Furthermore, the family's panic was compounded by cultural differences over food intake during convalescence. In Euro-Canadian medicine, the diets of typhoid patients had to be carefully regulated, which led to the family mistakenly believing that their boy was starved on purpose. Despite these conflicts, the family decided to persist with treatment, and the boy made a full recovery.

The fact that hospital staff had difficulty regulating the movements and actions of patients demonstrate the limits of missionary surveillance. Surveillance became reciprocal in the hospital; while patients were monitored by the missionary's gaze, Indigenous peoples simultaneously observed the practice of Euro-Canadian medicine and noted its benefits and limits. Medical pluralism provided patients with the opportunity to experiment with different therapeutic methods, maintain control over their health-care decisions, and bolster their chances of recovery. Furthermore, the mobility of the Nuxalkmc and Heiltsuk tested and constrained the institutional boundaries of the hospital. Instead of acting as the nexus of missionary power, the hospital could not wholly regulate Indigenous souls and bodies. The schedule of mission work and life was subsumed into the seasonal lifeways of the Nuxalkmc and Heiltsuk. Instead of Indigenous peoples following the lead of missionaries, as the Methodists hoped, it was the missionaries who had to follow and accommodate their parishioners. The Rivers Inlet Hospital was established to cater to this mobility, and even then, missionaries could not compel Indigenous patients to seek hospital treatment.

Along with institutional boundaries, cosmological boundaries between non-Indigenous and Indigenous peoples also stretched and intersected. Dr. Large noted a case where an Indigenous person from a neighbouring tribe attributed the local Indian Agent's illness and death to *dásgíú*. Dr. Large thought this situation was unusual, since Indigenous peoples generally believed that "white people, as a rule...to be different to themselves, and therefore immune" to supernatural forces. Nonetheless, the Indian Agent developed a carbuncle in the neck because he had ridiculed a medicine man's "evil box," and his disbelief towards its power resulted in death. The Agent's carbuncle was a physical

manifestation of *dásgíú*, since it signified that “a part of his clothing had been stolen” and placed in the evil box.²⁶⁹ Even though Indigenous peoples believed that white persons had different constitutions, it appeared that some supernatural forces could cross bodily and spiritual boundaries in exceptional circumstances. Through convergence, colonial agents were reciprocally enfolded into Indigenous cosmologies, in the same way that Indigenous peoples were affected by settler systems.

Like the Indian Agent, missionary lives were changed by convergence, no matter how they struggled to uphold Euro-Canadian beliefs and practices. As mentioned in this chapter’s introduction, chronic funding and staffing shortages forced medical missionaries to adapt and utilize Indigenous assistance and practices. When Bella Bella Hospital first opened, the delay in the delivery of hospital beds compelled staff to treat patients “in regular Indian style, lying on mattresses on the floor.”²⁷⁰ After the hospital faced a bed shortage and ran over capacity in 1905, some non-Indigenous patients were sent to local homes and cared for by the Heiltsuk. The mission staff also recognized the importance of varying hospital food to suit Indigenous dietary preferences, which would improve morale and help them heal more effectively. Euro-Canadian traders had already introduced potato and cabbage crops to Waglisla, but agriculture was limited due to poor soil conditions. Hospital staff concluded “it is best to give the Indian patients their own Indian diet,” so Heiltsuk fishers harvested seaweed, dried salmon, oolichan grease, and fish eggs for the patients.²⁷¹ Willie Hans, a Nuxalk chief who was a teenager in the 1920s, recalled drinking oolichan grease to build his strength while sick with typhoid fever.²⁷² Not only were marine-based foods more familiar to Indigenous patients, they also contained high amounts of nutrients and protein needed for recovery. Dr. Large recognized how pluralistic medico-spiritual practices could increase recovery rates, even if he was displeased with certain elements of Indigenous healing and remedies. He remarked that “while they may not have unwavering faith in these remedies for many years to come, many of them will wish to use

²⁶⁹ The “evil box” is missionary parlance for a box used by medicine men to hold personal effects or bodily waste, designed for the purpose of inflicting *dásgíú* upon something or someone. The term can be found in Large, “Untitled Letter, 20 February 1909,” 704.

²⁷⁰ Miss Kissack, “Indian Work, 7 November 1902,” 22.

²⁷¹ Miss Kissack, “Indian Work, 7 November 1902,” 22.

²⁷² Grant Thomas Edwards, “Oolachen Time in British Columbia,” *The Beaver* (Autumn 1978): 32.

them in conjunction with other means, to avoid taking chances on a cure."²⁷³

Convergence also affected how missionary discourses documented and represented Indigenous healing, especially the use of medicine men and supernatural power. While missionaries derided medicine men as "heathen," their writing in fact encouraged settler curiosity in Indigenous peoples. Although Isabella Large did not contribute regularly to the *Missionary Bulletin*, she occasionally wrote letters about life at Bella Bella. At one time, Euro-Canadian readers were particularly curious about the lives of Indigenous women, since they were largely ignored by male missionaries, so Mrs. Large complied with reader demand and wrote about the role of women in Heiltsuk society. She remarked that women "are much harder to reach than the men," since they "rule the house" and were responsible for maintaining important cultural customs, especially around births and marriages.²⁷⁴ To counteract this situation, the mission established a Ladies Aid group, which promoted Euro-Canadian standards of respectable womanhood. Mrs. Large encouraged Heiltsuk women to participate in Bible readings and religious exercises, and to fundraise for the church by sewing and selling their work. Even though they sought to convert and assimilate their parishioners, missionaries, ironically, became the archivists of Indigenous beliefs and practices, and introduced them into settler knowledge and discourse.

Likewise, convergence changed how Dr. Large thought of *dásgjú* and supernatural powers, which he initially considered to be superstition. Around 1908, he began to collect specimens of foreign objects expelled from patients, and documented his observations in the *Missionary Bulletin*. In one case, a young Indigenous woman came to Waglisla and sought hospital treatment for severe abdominal pain. She improved and was discharged, but once she returned home, the pain returned and she vomited blood along with a sewing needle. The Heiltsuk attributed her illness to *dásgjú*, but Dr. Large believed the wife was the victim of a conflict between her husband and the sawmill manager, who had her food doctored with a needle. Nevertheless, Dr. Large was fascinated with the needle, because he had only heard about foreign objects cast into bodies, but never actually seen one

²⁷³ Large, "Letter from Richard W. Large, 21 July 1905," 116.

²⁷⁴ Refer to the letter from Isabella G. Large, "Letter from Mrs. R.W. Large, 3 March 1905," 591.

caused by *dásgiú*. He noted: “In ten years’ experience among the Indians this is the only case where we have seen something tangible used to cause illness.”²⁷⁵ Although Dr. Large had previously seen the congealed blood and objects expelled by Owekeno Charley, as seen in his treatment of the boy with pleurisy, that particular case was not attributed to *dásgiú*. While he expressed disbelief in these forms of supernatural power, settler curiosity prompted Dr. Large to investigate further, and caused him to question whether his presumptions were valid.

In another situation, Dr. Large had his ego humbled by the Heiltsuk in a debate over the existence of supernatural power. He knew that some Heiltsuk medicine men, years before the arrival of medical missionaries, would perform post-mortem examinations on sudden deaths. These deaths were attributed to *dásgiú*, since bits of shell, bone, or metal would be found piercing the heart or other internal organ. The post-mortems were held in the presence of the elect, while the pierced organ would be shown to the general public.²⁷⁶ While this practice seemed to decline with the arrival of medical missions, the Heiltsuk still believed in the power of *dásgiú* and thought it could physically manifest as objects. During a public meeting with some Heiltsuk, Dr. Large brought up the issue of *dásgiú*. One of the villagers, William Brown, remembered an incident from his youth where the heart of a deceased chief was placed in the fire. The flame’s colour showed the presence of copper, and a piece of copper metal was indeed found in the heart. When Dr. Large suggested that the metal had been “probably put in after death to strengthen the belief in witchcraft among the common people,” the Heiltsuk responded with laughter, “partly at the explanation and partly at [his] incredulity.”²⁷⁷ The Heiltsuk’s laughter gently scolded Dr. Large for his attempt to discredit Brown’s story, and affirmed their conviction in the legitimacy of supernatural power. Heiltsuk did not find their Indigenous beliefs to be irreconcilable with Christian and Euro-Canadian ones; rather, they co-existed and mutually informed each other.

The co-existence and intersection of different cosmologies also affected the

²⁷⁵ Large, “Untitled Letter, 20 February 1909,” 692.

²⁷⁶ Large, “Untitled Letter, 20 February 1909,” 695.

²⁷⁷ Large, “Untitled Letter, 20 February 1909,” 696.

Nuxalkmc. By 1914, which is the end-point of my analysis, over 90 percent of Nuxalkmc identified as Christian, but their medico-spiritual cosmologies retained a distinctly Nuxalk way of relating to the supernatural world.²⁷⁸ McIlwraith noted that some men “converted in middle life carries all the fervour and realism of the old religion with him to the new, and feels thoroughly familiar with the atmosphere of the Old Testament. He continues to hear the voices of supernatural beings, and to interpret mental creatures as visions, but he ascribes them to the beings of the white man’s religion.”²⁷⁹ These converts had an innate sensitivity to the supernatural world, but they substituted their visions of Nuxalk spirits with Christian ones. Perhaps the most notable instance of this convergence can be seen in the interaction between a Nuxalk and Heiltsuk patient at Bella Bella Hospital, which I will recount below.

A devout Nuxalk Christian, who McIlwraith called “X,” was a patient at Bella Bella Hospital. In the same ward, he met a Heiltsuk boy whose illness did not respond well to treatment. When he asked the Heiltsuk about his condition, X seemed to have a premonition that the boy would be better by seven o’clock the next morning. The young man did indeed improve, but the medical missionary “foolishly”—according to X—gave the patient some medicine, which worsened his condition again. The boy grew sicker over the next nine days, until he felt he was near death and asked X for help:

“No,” replied X, “I am no doctor. But you will be all right. I see Holy Ghost, Holy Spirit, Baptism, and Believe-It [Faith?] by your bed. Repent and you will be saved.”

X added that the Bella Bella saw and repent before his death so that he has undoubtedly been saved.²⁸⁰

The lives of two Indigenous Christian patients, one Heiltsuk and one Nuxalk, intersected at Bella Bella Hospital. However, Euro-Canadian medicine failed to save the Heiltsuk patient, and he weakened until the point of death. In the final moments, X attempted to console the dying boy, rather than call the missionary, since X could already sense the presence of the Holy Ghost. The dying boy sensed its presence too and

²⁷⁸ Canada, Department of Indian Affairs, *Annual Report of the Department of Indian Affairs, for the year ended 31st March 1914* (Ottawa: Queen’s Printer, 1915), 4.

²⁷⁹ McIlwraith, *The Bella Coola Indians*, vol. 1, 515.

²⁸⁰ McIlwraith, *The Bella Coola Indians*, vol. 1, 516.

repented, and both Indigenous patients were comforted by the belief that he was saved. The story of X encapsulates the points and themes examined in this chapter, which considers how convergence occurred and manifested in the mission hospital. Not only did convergence bring Indigenous patients into contact with Euro-Canadian medicine, it also transcended and fused the cosmological boundaries between the Indigenous supernatural world and the Christian heavens.

In this chapter, I have explained how medico-spiritual convergence transformed the mission hospital and how it created opportunities for medical pluralism. Medical missionaries attempted to use hospitals as tools of medico-spiritual surveillance and segregation. In their evangelizing vision, Methodists believed the hospital could transform sickly Indigenous bodies and souls into healthy, civilized Christians. Despite their efforts, missionary power was often thwarted by the agency and mobility of their parishioners. Indigenous patients actively negotiated their own diagnostic and therapeutic decisions, by integrating hospital care and Euro-Canadian medicine alongside Indigenous healing practices. In the same way that convergence affected Indigenous cosmologies, it also affected the beliefs and practices of medical missionaries. Plagued by underfunding and understaffing, medical missionaries depended on the unpaid labour of Indigenous workers to construct village infrastructure, to care for patients, and to maintain the daily operations of the hospital. Furthermore, the cosmological boundaries between Indigenous peoples and Euro-Canadians became permeable, as supernatural forces crossed and affected either side. Convergence was reciprocal, and no mortal beings were left untouched by the supernatural forces stirring in the cosmos of the Central Coast.

Conclusion

Set in motion by the giant Alēp!ālxtnaix balancing the earth between his hands, the physical and spiritual landscape of the Central Coast had always been in a state of flux, with its continual flows of cosmological and cultural convergence throughout time. The arrival of medical missionaries marked a new epoch in this region's long history of interchange. Imbued with evangelical zeal and equipped with the latest biomedical innovations, mission doctors implemented their medico-spiritual project among Indigenous peoples. It was a project which was ideologically paternalistic and assimilative, driven by the Methodist Church's aim for Indigenous bodily renewal and spiritual transformation. Optimism fuelled the first decade of mission work, but the Methodists' evangelizing vision was soon confounded by chronic underfunding and understaffing.

From 1897 to 1914, the initial era of medical missionization offers a lens to understanding how convergence affected both Indigenous and Euro-Canadian medico-spiritual cosmologies. The interchange of Nuxalk and Heiltsuk ontologies with the Methodist one gave rise to medical pluralism, a cultural system where different beliefs and practices toward illness, healers, and healing co-existed and hybridized. While Indigenous peoples took advantage of medical pluralism, missionaries were pressured by their supporters and donors to resist any vestiges of hybridity. Bound by the civilizing agenda of church ideology, missionaries tried to assimilate and downplay the persistence of Indigenous healers and healing practices in their mission fields. Despite sustained efforts, the missionary enterprise was constrained by pragmatic limitations and contradictions. As Pamela Klassen observes, liberal Protestants "came to see the deep ironies of how their own projects of healing were complicit with the evils they sought to exorcise."²⁸¹ Missionaries, who proffered biomedicine as a civilizing antidote to Indigenous heathenism, held a medico-spiritual cosmology that was unquestionably imbued with supernatural influence.

Medical missionaries did not believe they could commune directly with the supernatural world, but they thought God's will manifested through their work, and that

²⁸¹ Klassen, *Spirits of Protestantism*, xii.

their earthly mission was divinely inspired by Biblical precedents. One Anglican bishop, Frederic Du Vernet of the Diocese of Caledonia, developed a healing practice based on radio waves. He believed radio waves channelled God's energies. Integrating theology, the supernatural, and science, Du Vernet's "spiritual radio" healing challenged conventional Protestant dogma. Most crucially, his beliefs were informed by the travelling spirits of the Nisga'a people and other Northwest Coast cultures he encountered.²⁸² While it can be argued that Du Vernet appropriated and distorted Indigenous spirituality, his convictions demonstrate the theological porosity of mainline Protestantism. It also shows the extent in which metaphysical beliefs infused the Anglo-Protestant world during the turn of the twentieth century. Du Vernet was not trained as a medical missionary, but his convictions overlap with his Methodist counterparts, especially their mutual belief that bodily healing would restore the spirit as well.

Despite calling Indigenous beliefs "heathen" and other disparaging terms, missionaries maintained a paternalistic approach towards Indigenous peoples, and believed their parishioners were capable of elevating their moral and cultural state. Missionaries also lobbied for legislation to protect them from corrupt secular influences, such as the alcohol trade and gambling. At times, the Methodists defended Indigenous interests against the DIA, whose secular power became increasingly dominant over missionary oversight. A group of missionaries asked the Dominion Government to amend the *Indian Act* and add a new clause, which would make suppliers of alcohol liable for Indigenous peoples who drank and committed violence. This resolution, along with a proposal to protect women cannery workers, was "consigned to the waste-paper basket" by DIA officials.²⁸³ Charles Tate lamented the strained relationship between church and state: "If the Government were in full sympathy with our work, and would employ only such men as are in sympathy with the work to fill the offices of Indian Agents, how much easier that work would be to the Indian missionary!"²⁸⁴

²⁸² Klassen, *Spirits of Protestantism*, xii.

²⁸³ Tate, "Letter from C.M. Tate, 20 January 1914," *Missionary Bulletin* 10, no. 2 (Mar-Jun 1914): 207.

²⁸⁴ Tate, "Letter from C.M. Tate, 20 January 1914," 208.

The burgeoning secularization of Indigenous health care signalled a major shift in the lives of the Nuxalkmc and Heiltsuk. Laurie Meijer Drees notes how the DIA bureaucracy expanded almost right after the establishment of medical missions on the Central Coast: “For example, in 1904 a new medical superintendent was appointed for Indian health, and medical personnel in the federal employ rose from twenty-six medical officers in 1904 to ninety-seven by 1927.”²⁸⁵ Similarly, Lux contends that state agents, in order to further their colonial agendas, were eager to supersede missionary control over Indigenous affairs: “The rise of expert and objective medical authority supplanted often-meddlesome Christian missionaries, and redefined what was commonly referred to as the ‘Indian problem,’ or the anxieties Canadians experienced by Aboriginal people’s continued legal and cultural differences.”²⁸⁶ The DIA replaced missionaries as the vanguard of Euro-Canadian encroachment, a change which shifted the power dynamic between Indigenous peoples and colonial agents. Government collusion—at both the provincial and federal level—with church entities became more bureaucratic, replacing the adaptable nature of missionization with state policies and regulations.

In some situations, the DIA flatly refused to provide any funding for mission hospitals, even in cases of severe epidemics. Between 1910 and 1913, an outbreak of tuberculosis at Bella Coola took a severe toll on the community, whose population had declined eightfold since the smallpox outbreaks in the 1830s. The town doctor, Dr. T.F. Cavanaugh, created a blueprint for an open-air sanatorium and sought Indian Agent Iver Fougner for assistance. After writing to his department, Fougner’s funding request was denied. Ottawa believed education was sufficient in stopping the epidemic: “There are no funds available...the Doctor should be able to do much in teaching the necessity of guarding against contagion...”²⁸⁷ The government’s refusal to provide funding, which likely contributed to deaths, is an example of insidious colonial neglect of Indigenous well-being.

²⁸⁵ Laurie Meijer Drees, *Healing Histories: Stories from Canada's Indian Hospitals* (Edmonton, A.B.: University of Alberta Press, 2013), 12-13.

²⁸⁶ Maureen Lux, *Separate Beds: A History of Indian Hospitals in Canada, 1920s-1980s* (Toronto: University of Toronto Press, 2016), 3.

²⁸⁷ Grant Thomas Edwards, “Bella Coola Indian and European Medicines,” *The Beaver* (Winter 1980): 8.

By 1914, the rising degree of government interference in mission villages constrained the ability of Indigenous peoples to resist colonial encroachment. The DIA's new superintendent, Duncan Campbell Scott, was a strong advocate of assimilation and shaped departmental policies to suit his vision.²⁸⁸ Indian Agents became the middle-men of brokering DIA funds and enforcing laws on the Central Coast, which was part of the Bella Coola Agency. The area's longstanding Indian Agent, Iver Fougner, was nevertheless an exception among his civil-service cohort. A Norwegian immigrant from Hagensborg, Fougner lived most of his adult life beside the Nuxalkmc and developed close relations with them. Fougner wrote a letter to Ottawa defending the Nuxalkmc's winter ceremonial dances, and chose not to interfere with their cultural practices.²⁸⁹ Around the same time, the government sought to settle the "Indian land question" and established the McKenna-McBride Commission, which recommended the reduction of reserve sizes and apprehended valuable land in many communities.²⁹⁰ Although changes were not implemented until the 1920s, these acts of territorial demarcation further eroded the land base which was vital to Indigenous identities and livelihoods.

Along with bureaucratization, health infrastructure was progressively secularized and shifted to state control. This was the case at Bella Coola Hospital, which was established after Norwegian settlers advocated for reliable health services from the provincial and federal governments. Dr. Spencer, the first medical missionary at Bella Coola, served for ten years before leaving his post in 1907. The Norwegian settlers established a hospital board in 1908, and by December 1910, the Bella Coola Hospital was completed.²⁹¹ The missionary who replaced Spencer, W.H. Gibson, was not a physician. From this point forward, medical care was delegated to secular doctors, who

²⁸⁸ Scott began his superintendent post in 1913, and is often thought to be the originator of "kill the Indian in the child." This is wrongly attributed, but Scott's policies reflected the same sentiment. The original remark was "Kill the Indian, save the man," uttered by Captain Richard Pratt. He founded the Carlisle Indian Industrial School in Pennsylvania in 1879, which was the first Indian boarding school operated by the U.S. government. For an overview of Scott's policies, see E. Brian Titley, *A Narrow Vision: Duncan Campbell Scott and the Administration of Indian Affairs in Canada* (Vancouver: University of British Columbia Press, 1986).

²⁸⁹ McIlwraith, *At Home with the Bella Coola Indians*, 185.

²⁹⁰ Paul Tennant, *Aboriginal Peoples and Politics: The Indian Land Question in British Columbia, 1849-1989* (Vancouver: University of British Columbia Press, 1990), 88.

²⁹¹ Edwards, *Bella Coola General Hospital III*, 5.

received funding either through the Provincial Health Officer, DIA, or the Bella Coola Hospital Authorities board. In 1910, Dr. Cavanaugh was hired by the DIA to provide biomedical care to the Nuxalkmc, with the expectation that he would also service the settler community.²⁹² However, Cavanaugh's personality was disliked by the settlers and the town newspaper harassed him to leave. It is not known whether the Nuxalkmc had a better opinion of him.

The Nuxalkmc welcomed the Bella Coola Hospital and contributed to its construction, but they had difficulty accessing biomedical care due to colonial politics. The hospital's operations were further marred by infighting between the Hospital Board and provincial and federal governments. During the Royal Commission on Indian Affairs in the Province of British Columbia, W.H. Gibson went to a hearing in August 1913 and reaffirmed the Bella Coola Mission's interest in medical affairs. He noted that "the Hospital has been built nearly five years now, but has not been made ready for the reception of patients. The Indians gave very freely of their time and labour in clearing the land."²⁹³ Although the hospital received DIA funds, the money and decision-making was controlled by the Hospital Board, which was dominated by Norwegian settlers. Since the Board prevented non-Norwegians from attending meetings or voting, an incensed Gibson demanded the Commission to prosecute the Board for misuse of public funds. The issue was settled in late 1913 with new board members and a new town doctor, W.E. Bavis.²⁹⁴ However, doctors did not last long in their posts, staying an average of two years, as many hospitals had difficulty finding reliable and qualified staff.²⁹⁵

The Methodist missions were confronted with another predicament: the optimism which had fueled the initial years of "Indian Work" rapidly declined due to inadequate staffing, high turnover rates, and chronic funding shortages. After leaving Waglisla in December 1910 and failing to secure a permanent successor, Dr. Large called on his brethren to accept his former post. He praised the Bella Bella Mission as "an opportunity

²⁹² Edwards, *Bella Coola General Hospital III*, 5-6.

²⁹³ Edwards, *Bella Coola General Hospital III*, 8.

²⁹⁴ Edwards, *Bella Coola General Hospital III*, 9.

²⁹⁵ Kelm, *Colonizing Bodies*, 131.

for the spending of life where it counts—equal to that to be found in some more distant field, even if the glamour and romance may not be so pronounced.”²⁹⁶ Dr. Large did not leave Bella Bella for an overseas post; rather, he transferred to Port Simpson to seek better education for his children. After some years of uncertainty, Dr. George Darby arrived on a temporary appointment in the summer of 1912, and became the permanent medical missionary in 1914.

I chose to end my analysis in 1914 for two key reasons. The first reason is that the Central Coast missions entered a new phase under Darby, who modernized and expanded the work to include marine mission boats and new biomedical innovations.²⁹⁷ The second reason is that broader socio-political changes palpably affected the Methodist Church’s evangelization strategy. The advent of World War I constrained the church’s resources in terms of funding, staffing, and public support. Personnel were needed both in Europe and domestic congregations to provide pastoral care, and overall, the war generated great disillusionment with Western society and the civilizing role of missionaries.²⁹⁸ Furthermore, missionaries turned their attention to the influx of non-British immigrants into Canada’s western provinces, and put Indigenous work on the backburner. The mainline Protestant denominations were theologically fractured into Methodists, Presbyterians, Congregationalists, and other regional churches, all of which were competing for trained staff, funding, and parishioners in settler communities. To streamline their operations, the churches began negotiating terms of union. The Methodists, most Presbyterians, and Congregationalists of Quebec and Ontario finally amalgamated into the United Church in 1925.²⁹⁹

Amidst these colonial contestations, many of the Nuxalkmc and Heiltsuk were determined to uphold many of their medico-spiritual beliefs and practices. Indigenous peoples strengthened their resolve to define medico-spiritual beliefs and practices on their own terms. Rather than being restrained by medical missionization, the peoples of the

²⁹⁶ R.W. Large, “Letter from Rev. R.W. Large, 7 May 1912,” *Missionary Bulletin* 8, no. 3 (Jun-Sep 1912): 1299.

²⁹⁷ Burrows, *Healing in the Wilderness*, 56-60.

²⁹⁸ Semple, *The Lord’s Dominion*, 322.

²⁹⁹ Semple, *The Lord’s Dominion*, 416.

Central Coast integrated aspects of Christianity and biomedicine into existing cosmologies. Likewise, the practice of medical pluralism defied the assimilatory agendas of missionaries, who were mandated by church leadership to curtail Indigenous healing and any other “heathen” beliefs. Missionaries, however, often lacked the material means to implement these agendas, and relied on Indigenous labour and financial contributions to maintain the medico-spiritual work. Through these exchanges, Indigenous peoples observed and partook in the benefits that medical missions offered, but also saw its limitations. Patients asserted control over the healing process and made therapeutic choices depending on the nature of their illness. While Euro-Canadian medicine was effective in many cases, Indigenous patients also incorporated botanical remedies and medicine men to maximize their healing potential. Even with the rise of government “Indian Hospitals,” which sought to isolate pathologized Indigenous bodies from settler society, medical pluralism continued to exist in various forms.³⁰⁰ The introduction of a new medico-spiritual cosmology, rather than diluting “traditional” beliefs, provided Indigenous peoples with an ontological space to forge new understandings of being and healing.

In response to the historiography on medical colonialism, I have discussed how medical missionization is commonly framed as a form of colonial surveillance over racialized bodies. I examined how Indigenous peoples asserted therapeutic agency over their health-care decisions, and specific ways in which they resisted missionary overtures to curtail Indigenous practices. It is not surprising that the Nuxalkmc and Heiltsuk resisted colonial intrusion, but I believe their particular expressions and methods of agency deserve close analysis. My discussion of agency responds to the scholarship of Neylan, May, Kan, and especially Harkin’s ethnohistorical work on the Heiltsuk. Harkin positions the Indigenous body as a site of “domination, resistance, and cultural transformation” in regards to housing, food, clothing, medicine, and other bodily practices. As Harkin has argued, the Heiltsuk resisted the medical missionary’s authority through “passive disagreement with certain medical techniques and a preference for traditional methods.”³⁰¹ While he briefly discusses acts of resistance, he does not consider instances where the Heiltsuk actively chose biomedical treatment over Indigenous medicine, or utilized both

³⁰⁰ See Chapter 8 of Kelm, *Colonizing Bodies*, for a discussion of medical pluralism in Indigenous communities from 1900 into the 1940s.

³⁰¹ Harkin, *The Heiltsuks*, 96.

methods. In this thesis, I presented several cases where patients specifically called on the medical missionary for assistance, or sought hospital care. Patients made therapeutic decisions and opted for treatment which they thought was best suited for the cause and nature of their ailment. Thus, Indigenous agency was not solely an expression of resistance to colonial authority, but also active acceptance and integration of settler systems. My discussion of Indigenous agency is informed by my conceptual framework of convergence, which emphasizes the nature of exchange and reciprocity between Indigenous and Euro-Canadian cosmologies.

Likewise, missionary beliefs and practices were also influenced by convergence as they lived and worked alongside their parishioners. Euro-Canadians witnessed the effects of supernatural powers on Indigenous patients and in exceptional situations—like the Waglisla Indian Agent—were affected by *dásgíú* themselves. Missionaries observed instances of Indigenous healers and healing, and documented their practice in settler discourse. They also came to accept that medical pluralism, even if it ran counter to their assimilatory agendas, was critical to maintaining the well-being of their Indigenous patients and communities. Ultimately, medical missionaries adopted a pragmatic attitude to their work. If medical pluralism helped Indigenous peoples become healthier physically, they would improve spiritually as well, and that wholeness brought them one step closer to God.

Given the limitations of my sources, it is difficult to quantify the extent and effectiveness of medical pluralism in increasing Indigenous health. There are no records that compare recovery rates between biomedical treatment, Indigenous treatment, and combined treatment, since many patients shielded their use of medicine men and considered some Indigenous remedies to be restricted intellectual property. Furthermore, certain medico-spiritual conditions, such as those caused by *dásgíú*, were rarely treatable by biomedical means. The purpose of my analysis is not to question whether medical pluralism was effective, but why and how the Nuxalkmc and Heiltsuk chose to engage in these practices. Medical pluralism was important to Indigenous peoples not because it caused a measurable improvement in recovery rates, but because it granted them access to a wider source of healing power and knowledge. Healing was integral to Nuxalk and Heiltsuk cultural identity, and rooted their sense of being and place in the world.

It is fitting that the root word for “Heiltsuk,” *hylh*, means “right, proper, well.” *Hylh* is the basis of another word, *hailikila*, which means “to heal,” or more specifically, the “ability to overcome an uncontrolled power.”³⁰² Whether that uncontrolled power is colonial conflict, epidemic diseases, or supernatural imbalance, the Heiltsuk’s identity is grounded in their medico-spiritual cosmology. The culture of the Nuxalkmc, similarly, is also one of healing and restoring cosmic balance. In the Preface, I provided an excerpt from “The Chief Who Became a Shaman,” a story from *Bella Bella Tales*. It recounts a supernatural snake man who saved a dying chief and gave him this advice:

In front of the house is a spring of hot water on the right hand side facing the house, and from the left hand side cold water is running into it. This is the water of life. You must bathe four times in this water and dive, then you will be well and strong again and we will go into my house.³⁰³

The chief, who overcame illness by entering the water of life, transformed into a powerful shaman. His experience can be interpreted as a metaphor of Indigenous healing and resistance against the malady of colonialism. For the Indigenous Christians who also learned from the Bible and were inspired by Ecclesiastes 3, they would know there was “a time for everything”; there was “a time to heal; a time to break down, and a time to build up.” To heal is to survive and be reborn—stronger and braver—into an uncertain, ever-changing world.

³⁰² Harkin, *The Heiltsuks*, 61.

³⁰³ Franz Boas, *Bella Bella Tales* (Millwood, N.Y.: Kraus Reprint, reprint edition, 1973), 162.

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