

**DISCOURSES AND PRACTICES OF ISOLATION IN THE
IMPLEMENTATION OF HEALTH CARE IN STE.
THERESE'S HOSPITAL, CHESTERFIELD INLET,
1929-1958**

by

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ABSTRACT

This thesis examines the mid-twentieth-century implementation of health care in Canada's Eastern Arctic by applying insights from a growing body of literature on space, medicine and colonialism to a specific case study, the history of Ste. Therese's Hospital in Chesterfield Inlet (Igluligaarjuk) from 1929 to 1958. Using records from Oblate missionaries, biomedical doctors and government employees, I argue that non-Inuit discourses framed the hospital as both an isolated and an isolating space, distant from "proper" health care conditions but still useful for separating bodies and diseases in familiar ways. In doing so, I argue that these discourses produced certain spatial relationships as either healthy or diseased, thus shaping medical practices in, around and through the hospital. This thesis identifies space as an important factor shaping health care provision, emphasizes the complexities of Northern colonial discourses, and negotiates the subtleties of isolation as a concept in Canadian Arctic medical history.

Keywords: Canadian Arctic; Chesterfield Inlet; hospital history; space; isolation; colonial medicine

Subject Terms: Medical care – Canada, Northern – History; Missionaries, Medical – Canada, Northern – History; Inuit – Health and hygiene – Canada, Northern – History; Inuit – Canada – Government Relations – History; Hospital architecture – North America – History

For my parents with love,
for believing in everything that this is,
and everything that I am.

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In Patricia Duncker's novel, *Hallucinating Foucault*, her graduate student protagonist discovers, "Writing a thesis is a lonely obsessive activity. You live inside your head, nowhere else." (4) Indeed, academic research and writing – and perhaps especially graduate work – can sometimes seem like an isolated and an isolating endeavour. However, no matter how much I lived in my head for the past two years, I cannot claim to have produced this thesis in any form of isolation as many people supported me in invaluable ways – intellectual and personal – through the process.

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INTRODUCTION

In 1924, the leader of the federal Opposition, Arthur Meighen, told Canadian Parliament, “The best policy we can adopt towards the Eskimos is to leave them alone. They are in a latitude where no-one will ever bother them.”¹ The government, he argued, could successfully claim Arctic territory without the expenditure necessary for the extension of state institutions into its difficult environment and with its scattered population. Although a member of the Opposition, Meighen’s attitude accurately reflected the government’s official “Eskimo policy” in this period, as it consistently denied any responsibility for implementing health care or other social services in the Arctic.² This matter became a jurisdictional debate between federal and provincial governments, as well as between various federal branches including the Department of Mines and Resources, the Department of the Interior, the Department of Indian Affairs, the Department of Justice and the Royal Northwest Mounted Police, the Department of External Affairs, the Northwest Territories and Yukon Branch, and the

¹ R. Quinn Duffy, *The Road to Nunavut: The Progress of the Eastern Arctic Inuit since the Second World War* (Montreal: McGill-Queen’s University Press, 1988), 5-6.

² The federal government sent Royal Northwest Mounted Police officers to claim sovereignty in the North instead, stationing them at posts where they could best “show the flag” in the face of international challenges rather than in areas where they could access local populations. Duffy, *The Road to Nunavut*, 4; and William R. Morrison, *Showing the Flag: The Mounted Police and Canadian Sovereignty in the North, 1894-1925* (Vancouver: University of British Columbia Press, 1985).

Northwest Territories Council.³ Ultimately, each of these branches argued that they did not have any statutory obligation to provide medical services for the Inuit.⁴

As such, by 1928 there were no hospitals in the entire 600 000-square-mile Canadian Eastern Arctic. Instead, missionaries, police regiments, fur traders, and whalers provided *ad hoc* health care services in the region, and healing remained largely in the hands of the Inuit.⁵ However, Inuit healers were increasingly facing new health problems in this period. New diseases like influenza and tuberculosis spread through Inuit communities at epidemic rates, and government administrators argued that the population was no longer reproducing at a sustainable pace.⁶ These health problems were clearly linked

³ For an explanation of how Northern administration was divided – and debated – among these branches, see Terry Cook, “Paper Trails: A Study in Northern Records and Northern Administration, 1898-1958,” in *For Purposes of Dominion: Essays in Honour of Morris Zaslow*, eds. Kenneth S. Coates and William R. Morrison (North York, Ont.: Captus University Publications, 1989), 13-36; Mark O. Dickerson, *Whose North? Political Change, Political Development, and Self-Government in the Northwest Territories* (Vancouver: University of British Columbia Press, 1992); and Duffy, *The Road to Nunavut*, 3-18.

⁴ Under the British North America Act of 1867, the federal government was responsible for Aboriginal health services, while the provinces were responsible for health care and hospitals. Eugene Vayda and Raisa B. Deber, “The Canadian Health Care System: A Developmental Overview,” in *Canadian Health Care and the State: A Century of Evolution*, ed. C. David Naylor (Montreal: McGill-Queen’s University Press, 1992), 125. However, the Act did not define the Inuit as either Indians or non-Indians, thus leaving in question whether the federal government should take responsibility for their health care (defining them as Indians) or whether provincial governments should (defining them as non-Indians). For thorough explorations of this debate, see Walter Vanast, “Hastening the Day of Extinction: Canada, Quebec, and the Medical Care of Ungava’s Inuit, 1867-1967,” *Etudes/Inuit/Studies* 15, 2 (1991): 55-84; Duffy, *The Road to Nunavut*, 7-11; Frank James Tester and Peter Kulchyski, *Tammarniit (Mistakes): Inuit Relocation in the Eastern Arctic, 1939-63* (Vancouver: University of British Columbia Press, 1994), 13-42; and James B. Waldram, D. Ann Herring, and T. Kue Young, *Aboriginal Health in Canada: Historical, Cultural, and Epidemiological Perspectives* (Toronto: University of Toronto Press, 1995), 167.

⁵ Waldram, Herring, and Young, *Aboriginal Health in Canada*, 122-140, 149-151, and 165-6.

⁶ Duffy, *The Road to Nunavut*, 74.

with the non-Inuit presence in the North.⁷ As Elizabeth Nutarakitlup, an Inuit elder from the Chesterfield Inlet area, explained in an interview in the 1990s,

No one was hardly ever sick. The only thing was when someone went to get provisions from a place where there were white people... That was the only time flus [*sic*] occurred. White people were the only flu causers.⁸

Non-Inuit observers also recognized such links. For example, Dr. Frederick Banting reported in the late 1920s, "Where there is no contact with white men the general health of the Eskimo is good."⁹ Where there was contact, by extension, the Inuit were experiencing devastating health conditions.

These conditions were also shaped by the fact that, by the 1920s, many Inuit had become wage labourers in the Northern fur trade. Shifts in diet

⁷ Many colonial medical historians have commented on the ways in which epidemic disease patterns were closely linked with the colonial process, both on a local and a global level. See, for example, Alfred W. Crosby Jr., *The Columbian Exchange: Biological and Cultural Consequences of 1492* (Westport, Conn.: Greenwood Press, 1972); Lenore Manderson, *Sickness and the State: Health and Illness in Colonial Malaya, 1870-1940* (Cambridge: Cambridge University Press, 1996); and Ken de Bevoise, *Agents of Apocalypse: Epidemic Disease in the Colonial Philippines* (Princeton: Princeton University Press, 1995).

⁸ Northwest Territories Archives (hereafter NWT), Department of Culture and Communications, Oral Traditions Programme, G92-056, Box 1, File 2, interview with Elizabeth Nutarakitlup. See also NWT, Department of Culture and Communications, Oral Traditions Programme, G92-056, Box 1, various interviews; NWT, Taloyoak Elders Project, N94-012, various interviews; and NWT, Wager Bay Oral History Project Interview Transcripts, N92-269, especially interview with Guy Amarok, 13 November 1991, 27-42.

⁹ NWT, Alexander Stevenson Fonds, N92-023, Box 49, File 5, Inuit Health Reports, Sir Frederick Banting, "Medical Investigations Among Eskimo." Frederick Banting is best known as the discoverer of insulin, but he also had Arctic experience. Banting first spent time in the North in 1927 while travelling with the Canadian Arctic Expedition. NWT, Leslie Livingstone Fonds, N87-019, File 2, newspaper clipping, "Ice-Buffered Beothuc Back from 7000-Mile Arctic Cruise"; and Lloyd Stevenson, *Sir Frederick Banting* (Toronto: Ryerson Press, 1946), 240. He publicly criticized the non-Inuit presence in the North for having a negative impact on Inuit health, causing a major scandal among Northern administrators. For details on this incident, see Michael Bliss, *Banting: A Biography* (Toronto: McClelland and Stewart, 1984), 173-75; Stephen Eaton Hume, *Frederick Banting: Hero, Healer, Artist* (Montreal: XYZ Publishing, 2001), 116; and Seale Harris, *Banting's Miracle: The Story of the Discoverer of Insulin* (Toronto: J. M. Dent & Sons, 1946), 162.

associated with the trade had a negative impact on their health. As Dr. Leslie Livingstone wrote in an undated diary entry from this period,

The foods of the white man at first to the Eskimo are a luxury but now in many localities essential where his employment is such that he is unable to hunt and unable to pursue his native food. Thus we see in those localities where they exist on imported foods a people degenerate both physically and mentally.¹⁰

In other words, a move to wage labour meant that the Inuit were increasingly reliant on foodstuffs provided at the trading post, primarily processed and canned foods, white flour, and sugar. Because of this change in diet, their immune systems weakened, and in years when the fur trade companies could not restock their posts due to transportation issues, starvation spread through local areas.¹¹

By late 1928, the Director of the Department of the Interior's Northwest Territories and Yukon Branch, Oswald Sterling Finnie, had received numerous letters criticizing his steadfast refusal to fund health care for the Inuit in the Eastern Arctic, despite these skyrocketing infection and mortality rates. As historian Mark Dickerson writes, "This health care policy, at least what existed of it, was one of the more contentious issues facing Northern administrators."¹² In one such complaint, Arsene Turquetil, then Oblate missionary and Apostolic Prefect of Hudson Bay, told Finnie, "Up to this day, we have been... issuing medicines to Eskimo patients, but... proper care and attendance... require

¹⁰ NWTA, Leslie Livingstone Fonds, N87-019, File 2, excerpt from diary, "Eskimo and Food." Leslie Livingstone was another doctor with extensive Arctic experience, having spent more than twenty-five years stationed at various hospitals across the region. See Dudley Copland, *Livingstone of the Arctic* (Ottawa: n. p., 1967) for biographical details.

¹¹ See, for example, Duffy, *The Road to Nunavut*, 76, and 81-86; and Vanast, "Hastening the Day of Extinction."

¹² Dickerson, *Whose North?*, 45. See also Richard Diubaldo, *The Government of Canada and the Inuit, 1900-1967* (Ottawa: Indian and Northern Affairs Canada, 1985), 101.

hospital and nurses.”¹³ Turquetil was determined to build a hospital in Chesterfield Inlet (Igluligaarjuk), on the west coast of Hudson Bay, but argued that, without government funding and support, missionaries could not be expected to provide such services in the North.

Finnie had previously rejected calls for hospital services from missionaries, fur traders, and others, but in January 1929, he responded positively to Turquetil’s assertive letter of the previous month. Since the Oblates had asked only for a standard monthly grant relative to the number of patients admitted to the hospital, Finnie replied, “The Department approves of the erection of this hospital and will be very glad to give the customary grant on receipt of the hospital returns.”¹⁴ Although it is unclear exactly why Finnie changed his mind at this point, a 1981 retrospective on mission medicine in the Eastern Arctic, jointly presented by the Oblates and the Grey Nuns (Sisters of St. Nicolet), claimed,

Bishop Turquetil encountered many administrative difficulties. Visiting doctors, and health officials in Ottawa, were not in favour of a hospital in the North, and only supported the concept of visiting doctors... But the action taken by the Churches and fear of public attention compelled the Government into providing [support to his proposal].¹⁵

Whatever the precise reason, Turquetil was finally in possession of government support for a hospital in the Eastern Arctic. The Oblates stationed in Chesterfield

¹³ Library and Archives Canada (hereafter LAC), Northern Affairs Program, RG 85, vol. 193, file 1, R. C. Hospital at Chesterfield Inlet Returns, letter from A. Turquetil to O. S. Finnie, 23 December 1928.

¹⁴ LAC, Northern Affairs Program, RG 85, vol. 193, file 1, R. C. Hospital at Chesterfield Inlet Returns, letter from O. S. Finnie to A. Turquetil, 18 January 1929.

¹⁵ NWTA, Department of Health and Social Services, G99-044, File 1, “Who Is My Neighbour?” Slide Presentation. See also NWTA, Hopital Ste.-Therese, N92-159.

Inlet began construction that summer, and on 3 October 1931, Ste. Therese's Hospital officially opened its doors. The hospital was formally a part of the Oblate missionary settlement, staffed primarily by Grey Nuns who worked as nurses. However, the Northwest Territories and Yukon Branch also partly funded the hospital, and when the government could find the money and a willing individual, they also hired a biomedical doctor to assist the nuns. The hospital remained open from 1931 until 1958. In that final year, its doctor died in a plane crash and the government declined to replace him, instead moving towards funding smaller nursing stations in more communities.¹⁶

The history of Ste. Therese's Hospital provides a fruitful opportunity for exploring complexities in the implementation of health care in the mid-twentieth-century Canadian Eastern Arctic that have hitherto remained understudied in the literature. Arctic medical history has, as a field, developed in fits and starts over the past twenty years. Scholars have increasingly turned to Northern medical history over this period with an eye to finding the historical causes for contemporary health problems among the Inuit.¹⁷ In some ways, the basic historiographic trends parallel those of Canadian Aboriginal medical history more generally.¹⁸ However, work on Arctic medicine also developed from early

¹⁶ LAC, Northern Affairs Program, RG 85, vols. 193 and 194; NWTA, Department of Health and Social Services, G99-044, File 1, "Who Is My Neighbour?" Slide Presentation; "Twenty-Five Years at Chesterfield Hospital," *Eskimo* 40 (June 1956): 3-19; and Waldram, Herring, and Young, *Aboriginal Health in Canada*, 172.

¹⁷ See, for example, T. Kue Young, *Health Care and Cultural Change: The Indian Experience in the Central Subarctic* (Toronto: University of Toronto Press, 1988).

¹⁸ For an overview of this literature, see Peter L. Twohig, "Aboriginal Health in Canada," *Acadiensis* 32, 1 (2002): 140-48.

interdisciplinary work on Northern or Inuit history, mostly written by anthropologists, archaeologists, epidemiologists, and historical demographers, and sometimes even explorers and Arctic adventurers.¹⁹ Grounded in this literature, the historical work in this field took off dramatically in the early 1990s, primarily spurred by Walter Vanast. In a series of articles, he called attention to the harmful effects of government policies and government inaction in the Eastern and Central Arctic during the late nineteenth and early twentieth centuries.²⁰ However, Arctic historians have not just focused on government health care policies, as some works have also considered the role of missionaries, including medical missionaries, in the Canadian Arctic.²¹ In the second half of the 1990s, some Arctic medical historians turned to the relationship between health care and government relocation schemes, especially the mid-twentieth-century Southern hospitalization programs for Inuit tuberculosis patients. In doing so, the literature began to focus on Inuit experiences with

¹⁹ Shelagh Grant, "Inuit History in the Next Millennium: Challenges and Rewards," in *Northern Visions: New Perspectives on the North in Canadian History*, eds. Kerry Abel and Ken S. Coates (Peterborough: Broadview Press, 2001), 94-95. There are a number of broadly-scoped bibliographies which provide detailed lists of these early works including for example, Robert Fortuine, *Health of the Eskimos: A Bibliography, 1857-1967* (Hanover, NH: Dartmouth College Libraries, 1968).

²⁰ Walter Vanast, "The Death of Jennie Kanajuq: Tuberculosis, Religious Competition and Cultural Conflict in Coppermine, 1929-1931," *Etudes/Inuit/Studies* 15, 1 (1991): 75-104; Walter Vanast, "'Ignorant of Any Rational Method': European Assessments of Indigenous Healing Practices in the North American Arctic," *Canadian Bulletin of Medical History* 9, 1 (1992): 57-69; and Vanast, "Hastening the Day of Extinction."

²¹ For example, Walter Vanast, "Arctic Bodies, Frontier Souls: Missionaries and Medical Care in the Canadian North, 1896-1926" (Ph.D. diss., University of Wisconsin-Madison, 1996); and Cornelius H. W. Remie and Jarich Oosten, "The Birth of a Catholic Inuit Community: The Transition to Christianity in Pelly Bay, Nunavut, 1931-1950," *Etudes/Inuit/Studies* 26, 1 (2002): 109-41. Vanast's work focuses on medical missionaries in the Western Arctic, while Remie and Oosten situate medical mission work within the larger context of missionary activity in the Eastern Arctic.

biomedical health care systems.²² More recent work in the field has become clearly influenced by the broader literature on colonial medical history, deconstructing concepts like race, colonialism, science, medicine, and disease in local Arctic contexts.²³

With this understanding of the basic trends in Arctic medical historiography, I use this thesis to present a more complicated and “tangled”²⁴ medical history of the Canadian Eastern Arctic. In doing so, I do not focus on broad generalizations of policy, like the earlier works, nor do I consider the various interests in question – missionary, government, and biomedical – in isolation from one another. Rather, I take the history of Ste. Therese’s Hospital as a case study for understanding the ways in which these three interest groups implemented and understood health care in a local context in the mid-twentieth-century Eastern Arctic. While I discuss what I call missionary, doctor, and government discourses on the hospital, I also acknowledge that these varied by individual and by context, and were by no means monolithic, static, or identical. As such, throughout this thesis I highlight instances where their discourses

²² For example, Pat Sandiford Grygier, *A Long Way from Home: The Tuberculosis Epidemic among the Inuit* (Montreal: McGill-Queen’s University Press, 1994); Tester and Kulchyski, *Tammarniit*; and Frank James Tester, Paule McNicoll and Peter Irniq, “‘Writing for Our Lives’: The Language of Homesickness, Self-Esteem and the Inuit TB ‘Epidemic,’” *Etudes/Inuit/Studies* 25 (2001): 121-40.

²³ For example, Patricia Jasen, “Race, Culture and Colonization of Childbirth in Northern Canada,” *Social History of Medicine* 10, 3 (1997): 383-400; and Frank James Tester and Paule McNicoll, “‘Why Don’t They Get It?’ Talk of Medicine as Science. St. Luke’s Hospital, Panniqtuuq, Baffin Island,” *Social History of Medicine* 19, 1 (2006): 87-106.

²⁴ Ann Laura Stoler, *Carnal Knowledge and Imperial Power: Race and the Intimate in Colonial Rule* (Berkeley: University of California Press, 2002), 3.

clashed in order to highlight the complexities of this relationship.²⁵ That said, despite their often-dramatic differences in priorities, goals, intentions, and beliefs, their discussions about isolation and the hospital are remarkably similar and uncontested during this period.

I am particularly interested in how missionary, doctor, and government discourses on the hospital framed it as both an isolated and an isolating space, distant from what they saw as “proper” health care conditions but still useful for separating bodies and diseases in familiar ways. In this thesis then, I argue that the implementation of health care in Ste. Therese’s Hospital was shaped by non-Inuit discourses on isolation that defined the relationship between space, bodies, medicine, and disease in particular ways. In doing so, I focus specifically on how missionary, doctor, and government discourses produced certain spatial relationships as either healthy or diseased, thus shaping medical practices in, around, and through the hospital.

There is a wealth of historical sources on Ste. Therese’s Hospital, and health care in the Eastern Arctic more generally. By focusing on missionary, doctor, and government correspondence, I necessarily lose sight of other aspects of the hospital’s history that could be both illuminating and important.

²⁵ To this end, Kerry Abel has argued that, in the Mackenzie District of the Canadian North, missionaries and government officials did not present “united action,” even if they were part of a larger colonizing force in the region. In doing so, she highlights the hesitations, frustrations, confusions that were an intimate part of the non-Inuit presence in the Western Arctic and sub-Arctic. Kerry Abel, “‘Matters are Growing Worse’: Government and the Mackenzie Missions, 1870-1921,” in *For Purposes of Dominion: Essays in Honour of Morris Zaslow*, eds. Kenneth S. Coates and William R. Morrison (North York, Ont.: Captus University Publications, 1989), 73.

While I can gain an understanding of the interactions between these three parties, many of the records produced by one group in isolation from the others remain understudied, as do Inuit perspectives on and receptions of the hospital. I have chosen not focus on the role of the Oblates and Grey Nuns in isolation from government administrators and doctors, as Vanast has done so in similar works in this area.²⁶ Instead, I mostly use correspondence between Oblate and government administrators, although I have also used some records produced for those within the missionary community. In addition, a study of Inuit experiences with and conceptions of the hospital was simply not within the scope of this work, although the field could also use a better understanding of Inuit receptions of hospitals, mission medicine, and biomedicine in the Eastern Arctic. Rather, I use sources that best illustrate how the three primary parties that administered health care in the hospital – missionaries, doctors, and government employees – viewed and negotiated its objectives, purposes, roles, and relationships with surrounding spaces and bodies. These sources primarily include hospital reports and correspondence, although photographs, published memoirs and biographies, documentary films, and government publications also reveal much about the hospital's history. Together, these sources contribute to a fuller understanding of how missionaries, doctors, and government employees imagined the hospital, and reveal the primary role of space – and more specifically, isolation as a particular relationship among spaces and bodies – within such discourses.

²⁶ Vanast, "Arctic Bodies, Frontier Souls."

In the following chapters, I explore this relationship between space, isolation, and health care in Ste. Therese's Hospital through a number of different lenses. First, in Chapter 1, I review the theoretical literature on space, hospitals, and colonial medicine in order to introduce how these overlap in and inform my project. This will provide the necessary background and theory for the rest of my thesis. Chapter 2 explores how missionaries, doctors, and government employees framed Ste. Therese's Hospital as an isolated space, distant both from Southern Canada and from other communities in the Eastern Arctic. In this sense, isolation became both a positive and a negative factor in shaping health care in Ste. Therese's Hospital. Missionaries, doctors, and government employees simultaneously celebrated and struggled against isolation, seeing it as hampering both the spread of infectious diseases and the 'proper' health care provision for those who were infected. Chapter 3 expands on these insights from Chapter 2, while taking the concept of isolation in another direction. In this chapter, I examine the hospital as an isolating space rather than an isolated one, focusing on how missionary, doctor, and government correspondence on Ste. Therese's Hospital framed it as a space through which to isolate bodies and diseases in order to prevent or cure disease. More specifically, I consider the discourses that defined Inuit bodies, practices, and spaces as diseased and thus necessitating isolation in the hospital. In doing so, I argue that the hospital worked to control the movements of bodies and pathogens according to a complex interplay of medical, racial, and colonial discourses.

1. SPACE AND THE HOSPITAL: THEORY AND LITERATURE

Dr. Joseph Palmer Moody was still less than one year into his three-year term at Ste. Therese's Hospital in early 1947, when he received an urgent message that two Inuit men had disappeared from their camp at Fullerton Point, approximately ninety miles away. In his 1995 memoirs on his time in Canada's Eastern Arctic, Moody remembered his fearful response to the situation:

The two Eskimos were carriers of a dangerous and contagious disease! Frightened by their own illness, they had left their camp and were fleeing aimlessly from pains they couldn't understand. They must not be allowed to roam around the countryside endangering the health of that entire section of the arctic.²⁷

By linking the physical location of the Inuit with his biomedical knowledge of health and disease, Moody framed the situation as one of necessary containment – of illness and of bodies – within a particular space. Hoping to prevent an epidemic, he immediately launched a search, risking his life by flying through a severe Arctic blizzard in order to find the two men and bring them back to his hospital for treatment. This response reflects a larger colonial attempt to medicalize and regulate Inuit behaviour, achieved by discursively and physically containing indigenous responses to new diseases, new healing systems, and new conceptualizations of health and the body. For Moody, any Inuit attempt to

²⁷ Joseph P. Moody, *Medicine Man to the Inuit: A Young Doctor's Adventures among the Eskimos* (Denver: Arctic Memories, 1995), 83.

circumvent such regulations had to be stopped; especially when involving deadly illness, “aimless” movement could not be allowed.

This complex relationship between disease, space, colonial power, competing knowledge systems, and the hospital forms the heart of this work. Historians have increasingly focused on space and bodies as fundamental aspects of medical history, and particularly of colonial medical history. In doing so, some have conceptualized the hospital as a space in and through which such histories played out. Responding to this literature, I emphasize the importance of spaces in the implementation of health care in Chesterfield Inlet, seeing hospital discourses and practices as inherently and explicitly embodied and spatial. In this chapter, then, I introduce my conceptualization of space. After doing this, I explain how I frame the hospital as a particular kind of space – one that regulated relationships between places, bodies, and diseases. In doing so, I outline the literature on hospital histories, and especially that on colonial and mission hospitals, illustrating how my thesis both contributes to and moves beyond the trends in this field of study.

Theorizing Space

In this thesis, I use the concept of space as a lens through which to examine the implementation of colonial medicine in Chesterfield Inlet, with a particular focus on how missionaries, doctors, and administrators conceptualized, produced, and manipulated spaces for and through health care. In other words, while ideas about colonial power and knowledge underpin this thesis, as in other works of Arctic medical history, my focus is on adding a spatial element to these

histories. I aim to do so because this is an aspect which has remained absent from the field despite increasing attention to space in the broader colonial medical literature.

In this respect, I am influenced by literature that has grown from the so-called “spatial turn” that consolidated in the social sciences and humanities in the 1990s. Geographer Edward Soja describes the spatial turn as follows:

[It] reflects the growing interest in the power of space and spatial thinking as a way of interpreting not just the contemporary world, but of dealing with critical questions of all kinds... Increasing attention is being given to the problems of the city, urban and regional issues, to locality, to the body, to place, to the relationships between the local and the global, to boundaries, to borders, to what can most broadly be described as the spatiality of human life.²⁸

For the most part, this literature moves away from the assumption that space is a “practico-inert container of action,”²⁹ rather suggesting that it is socially produced in complex ways, or as Kate Darian-Smith, Liz Gunner and Sarah Nuttall argue, that it is a “multidimensional entity with social and cultural as well as territorial dimensions.”³⁰ In conceptualizing space for this project, I am particularly influenced by the work of social anthropologist Henrietta Moore, who

²⁸ Edward Soja, “Afterword: Symposium on Surveying Law and Borders,” *Stanford Law Review* 48, 5 (1996): 1423. Heavily influenced by poststructuralist geography, this critical concern with space has since become a transdisciplinary area of study. Jonathan Murdoch, *Post-Structuralist Geography: A Guide to Relational Space* (London: Sage, 2006); Soja, “Afterword”; and Edward Soja, *Postmodern Geographies: The Reassertion of Space in Critical Social Theory* (London: Verso, 1989).

²⁹ M. Crang and N. Thrift, eds., *Thinking Space* (London: Routledge, 2000). Quoted in Sara Mills, *Gender and Colonial Space* (Manchester: Manchester University Press, 2005), 23. See also Murdoch, *Post-Structuralist Geography*, 19. For other summaries of this conception of space-as-social-production, see Kate Darian-Smith, Liz Gunner and Sarah Nuttall, “Introduction,” in *Text, Theory, Space: Land, Literature and History in South Africa and Australia* (London: Routledge, 1996); Tim Unwin, “A Waste of Space? Towards a Critique of the Social Production of Space,” *Transactions of the Institute of British Geographers* 25, 1 (2000): 11-29.

³⁰ Darian-Smith, Gunner, and Nuttall, “Introduction,” 2.

suggests that space is the product of both cultural codes and practical activities.³¹ Working from Moore, then, my primary conception of space integrates the influence of social discourses, functional requirements, and physical conditions, viewing space as historically produced out of a dialogue between social and cultural dimensions and physical (topological or built) environments. Thus, physical spaces or entities – for example, the Arctic, the hospital, or the body – are “read” or inscribed with meaning through discourse, while at the same time those discourses are influenced by the physical conditions they encounter.

While I consider space as the product of an interplay between the social and the physical, I also emphasize the extent to which it is interwoven with the workings of power relations. Influenced by Michel Foucault’s linking of power, knowledge, practice, and space,³² scholars after the spatial turn have increasingly seen space as socially produced through and in relation to power. As Soja argues, “We must be insistently aware of how... relations of power and discipline are inscribed into the apparently innocent spatiality of social life.”³³ Literary theorist Sara Mills argues that scholars should do this by considering how particular configurations of spatiality are normalized historically through

³¹ Henrietta L. Moore, *Space, Text and Gender: An Anthropological Study of the Marakwet of Kenya* (Cambridge: Cambridge University Press, 1986), 191. Quoted in Mills, *Gender and Colonial Space*, 25.

³² See, for example, Michel Foucault, “Space, Knowledge, and Power,” in *Michel Foucault: Power*, ed. James D. Faubion (New York: The New Press, 1994): 349-64. For a summary of Foucault’s influence in poststructuralist geography, see Murdoch, *Post-Structuralist Geography*, 48. For a recent collection on Foucault’s influence in geography and spatial studies more broadly, see Jeremy W. Crampton and Stuart Elden, eds., *Space, Knowledge, and Power: Foucault and Geography* (Aldershot, Hants, England: Ashgate, 2007).

³³ Quoted in Mills, *Gender and Colonial Space*, 25.

discourse and practice.³⁴ While this normalization of spatial forms is not a simple or finished process in any context, colonial settings gave rise to particularly complex relationships between space and power. This was in part because such contexts challenged colonizers' perceptions of space by presenting different social, cultural and physical conditions than those to which they were accustomed, while at the same time providing opportunities for various people to assert, negotiate, and challenge power.³⁵ Indeed, while Bernard Smith observed that Europeans interpreted conditions in the Pacific on familiar terms,³⁶ individuals involved in colonial projects always discovered spaces – and conceptions of spaces – that challenged these familiar terms, and thus their ability to interpret solely or wholly through them.

Thus, my conception of space leads me to ask in this project: How are particular perceptions and organizations of space the product of social relations and physical environments? How were these organizations of space inscribed with meanings, and how were these meanings maintained through social interaction?³⁷ I approach these questions specifically through an analysis of various productions of and discourses on isolation in the hospital context. In this sense, I view the hospital as a particular kind of space, a built environment inscribed with socially- and culturally-produced meanings. In the colonial Arctic

³⁴ Mills, *Gender and Colonial Space*, 1.

³⁵ The colonial project was necessarily and inherently a spatial project. As Mills highlights, "Colonialism is predicated on the use of force to appropriate land and resources... This... is one of the key elements in colonialism and it is inevitable that it has an impact on spatial relations." Mills, *Gender and Colonial Space*, 5.

³⁶ Quoted in Darian-Smith, Gunner, and Nuttall, "Introduction," 4.

³⁷ See Moore, *Space, Text and Gender*; and Mills, *Gender and Colonial Space*, 74.

setting, this space was saturated in power relations that defined the relationships between doctors and patients, Inuit and non-Inuit, and healthy and diseased.

Hospital Histories

This project applies this concept of space to the history of Ste. Therese's Hospital in Chesterfield Inlet. In doing so, it contributes, in part, to a specific body of literature in medical history known as hospital history. Hospital histories are often popularized works, written by doctors as celebratory pieces about a particular institution.³⁸ Over the past two decades, however, academic historians have also turned to the hospital – both individual institutions and the hospital more generally – to explain more complex historical questions. According to Lindsay Granshaw, many now see the hospital as a “microcosm of society,”³⁹ illuminating trends from the larger historical context. As a result, the sub-genre of hospital histories has become more diverse and theoretical, as scholars now often include power and knowledge in their analyses, explore differing forms and conceptions of medicine, use new sources,⁴⁰ emphasize the patients' experiences as well as those of the hospital staff,⁴¹ and critically consider the

³⁸ Lindsay Granshaw, “Introduction,” in *The Hospital in History*, eds. Lindsay Granshaw and Roy Porter (London: Routledge, 1989), 1 and n. 3, 12-13.

³⁹ Granshaw, “Introduction,” 4.

⁴⁰ Annmarie Adams and Kevin Schwartzman argue that hospital histories should expand into new historical records as well as in new theoretical directions, showing the potential value of images and technology in writing the history of hospitals. As they say, the photograph is “an inventory of medical material culture that may tell us something distinct from textual medical history.” Annmarie Adams and Kevin Schwartzman, “Pneumothorax Then and Now,” *Space and Culture* 8, 4 (November 2005): 436.

⁴¹ Roy Porter, “The Patient's View: Doing Medical History from Below,” *Theory and Society* 14, 2 (March 1985): 175-98.

hospital's practices, intentions, and interests.⁴² As such, while academic historians sometimes criticize earlier hospital histories as parochial and amateur, the genre now offers many possibilities for critical historical analysis, both within medical history and within a broader historical context. Indeed, as Guenter Risse suggests, "The hospital history is cultural, social, and medical history."⁴³

Although some Canadian historians were beginning to turn to hospital histories in the 1980s, the field was somewhat slow to develop in Canada.⁴⁴ By 1990, though, Jim Connor argued that change was coming; while there had been no "synthetic study of 'the hospital,'" nor any "sophisticated analysis of a specific institution," Connor identified several studies in progress that were seeking to understand change and space in Canadian hospitals, and to situate them in larger social and cultural contexts.⁴⁵ In the past decade, Annmarie Adams has been particularly prolific and influential in the Canadian field, arguing for a number of different medical contexts that discourses on health and disease were

⁴² John R. Guy, "Of the Writing of Hospital Histories There is No End," *Bulletin of the History of Medicine* 59 (1985): 415-20; and Kenneth M. Ludmerer, "Writing the History of Hospitals," *Bulletin of the History of Medicine* 56 (1982): 106-09.

⁴³ Guenter B. Risse, *Mending Bodies, Saving Souls: A History of Hospitals* (Oxford: Oxford University Press, 1999), 4.

⁴⁴ See, for example, Barbara L. Craig, "The Canadian Hospital in History and Archives," *Archivaria* 21 (Winter 1985-86): 52-67; and S. E. D. Shortt, "The Canadian Hospital in the Nineteenth Century: A Historiographic Lament," *Journal of Canadian Studies* 18 (Winter 1983-44): 3-14.

⁴⁵ J. T. H. Connor, "Hospital History in Canada and the United States," *Canadian Bulletin of Medical History* 7 (1990): 94.

closely linked with architecture and space.⁴⁶ Similarly, historians of asylums, both in Canada and elsewhere, have increasingly emphasized the importance of architecture and physical spaces in historical treatments of madness.⁴⁷

An examination of this recent literature reveals that many historians now conceptualize the hospital as a particular kind of space that brings together its physical (built) aspects and conceptual or discursive understandings of the hospital, disease, medicine, and bodies. In the Canadian context, most of these historians have done so with a focus on architecture and architects, arguing that discourses on health and health care start long before the doctor-patient relationship.⁴⁸ To this end, Risse argues generally, hospitals' functions are closely linked with, and perhaps even determine, their internal spatial organizations.⁴⁹ He then goes on to outline a chronology of shifts in hospital

⁴⁶ For example, Annmarie Adams and Thomas Schlich, "Design for Control: Surgery, Science, and Space at the Royal Victoria Hospital, Montreal, 1893-1956," *Medical History* 50 (2006): 303-324; Annmarie Adams, "Borrowed Buildings: Canada's Temporary Hospitals During World War I," *Canadian Bulletin of Medical History* 16 (1999): 25-48; Annmarie Adams and David Theodore, "Designing for 'the Little Convalescents': Children's Hospitals in Toronto and Montreal, 1875-2006," *Canadian Bulletin of Medical History* 19 (2002): 201-243; Adams and Schwarzman, "Pneumothorax Then and Now"; and Annmarie Adams, "Modernism and Medicine: The Hospitals of Stevens and Lee, 1916-1932," *The Journal of the Society of Architectural Historians* 58, 1 (March 1999): 42-61. For similar theoretical arguments outside the Canadian context, see Lindsay Prior, "The Architecture of the Hospital: A Study of Spatial Organization and Medical Knowledge," *The British Journal of Sociology* 39, 1 (March 1988): 87.

⁴⁷ For example, M. Donnelly, *Managing the Mind* (London: Tavistock, 1983); J. Taylor, *Hospital and Asylum Architecture in England, 1840-1914* (London: Mansell, 1991); Barry Edginton, "The Well-Ordered Body: The Quest for Sanity through Nineteenth-Century Asylum Architecture," *Canadian Bulletin of Medical History* 11 (1994): 375-86; Barry Edginton, "The Design of Moral Architecture at The York Retreat," *Journal of Design History* 16, 2 (2003): 103-116; and Leslie Topp, James E. Moran and Jonathan Andrews, eds., *Madness, Architecture and the Built Environment: Psychiatric Spaces in Historical Context* (London: Routledge, 2007).

⁴⁸ For example, Adams, "Modernism and Medicine"; and Edginton, "The Design of Moral Architecture." It seems that Adams at least sees herself as an architectural historian rather than a medical historian, and her focus throughout her work is first and foremost on physical features of buildings.

⁴⁹ Risse, *Mending Bodies, Saving Souls*, 6.

architecture theories. First, he suggests that hospitals prior to the eighteenth century were “architectural landmarks, their monumental exteriors as expressions of religious piety and sources of civic pride.” He then argues that eighteenth-century hospitals were overcrowded and thus promoted cross-infections and high death rates, while twentieth-century hospitals were “gleaming high-rise buildings and home-like interiors proclaimed a vision of asepsis, professionalism, and comfort.”⁵⁰ Risse’s chronology is over-simplistic, but other hospital historians have made use of individual and comparative case studies to demonstrate some of the ways in which hospital architecture did change in response to shifting disease transmission theories and discourses on health, disease, space, and society.⁵¹

Barry Edginton’s work on asylum architecture clearly illustrates how some scholars link architectural social theory with hospital histories in order to understand how the physical design of health institutions produced, and were produced by, discourses on health, healing, and disease. As Alan Lipman outlines, architectural social theory suggests that physical spaces influence social behaviour within those spaces.⁵² Working from Lipman, Edginton asks how people of the past imbued architecture with the ability to heal. More

⁵⁰ Risse, *Mending Bodies, Saving Souls*, 5.

⁵¹ For example, Adams demonstrates that, following the First World War and developing from Canadian experiences in temporary hospitals during the war, hospitals were domestic and familiar despite a push to sanitize and standardize the institution, and that they were increasingly accessible to the Canadian public. Adams, “Borrowed Buildings,” 42. Jeanne Kisacky also illustrates links between changing disease theories and changing architectural features in the New York Hospital. Jeanne Kisacky, “Restructuring Isolation: Hospital Architecture, Medicine, and Disease Prevention,” *Bulletin of the History of Medicine* 79 (2005): 1-49.

⁵² Alan Lipman, “The Architectural Belief System and Social Behaviour,” *British Journal of Sociology* 20, 2 (1969): 190. Quoted in Edginton, “The Design of Moral Architecture,” 104.

specifically, he questions how the asylum's physical aspects were part of its medical discourses, and vice versa.⁵³ In this sense, he pushes historians to think about how "ideas and images of sanity" – and health or normality more broadly – "became embodied in the physicality of brick and deal."⁵⁴

While some hospital historians have examined architectural designs, many have also maintained a focus on bodies – particularly patients' bodies – as part of an institution's spatial history. For example, in his article, "The Well-Ordered Body," Edginton demonstrates the ways in which discourses on 'insane' bodies worked in dialogue with discourses on asylum spaces, producing a relationship that was seen (by architects and doctors) as healing and healthy.⁵⁵ Annmarie Adams and Kevin Schwartzman have also illustrated the potential in juxtaposing images and imaginings of body spaces and hospital spaces in historical analysis.⁵⁶ In other words, historians have argued that there can be a fruitful overlap between spatial analysis and hospital histories, in terms of both architectural designs and bodies as they were produced in relation to discourses on health, disease, and healing.

By comparing the histories of different institutions, it becomes clear that no "monolithic 'hospital' emerges."⁵⁷ Rather, the individual, the local, and the specific become important in such microhistorical work. Indeed, Risse writes,

⁵³ Edginton, "The Design of Moral Architecture," 103.

⁵⁴ Edginton, "The Design of Moral Architecture," 105.

⁵⁵ Edginton, "The Well-Ordered Body."

⁵⁶ Adams and Schwartzman, "Pneumothorax Then and Now."

⁵⁷ Granshaw, "Introduction," 4.

To depict the evolution of the hospital in broad strokes is to present a lifeless universe. The generic hospital is an abstraction. In reality, there are only particular hospitals, each with its unique name, patrons and mission, buildings, staff, and patients.⁵⁸

Considering such arguments, I have chosen to focus specifically on Ste.

Therese's Hospital in this study, while implying neither that it is representative of health care across the entire Eastern Arctic region, nor that it is a remarkable or unique case in Arctic medical history. Rather, I use the history of Ste. Therese's as a case study from which to draw broader conclusions about health care in the region without losing sight of the locality and specificity of Chesterfield Inlet.

Colonial and Mission Hospitals

While providing insightful overviews of hospital historiography, both Granshaw and Risse also reproduce some of the key limitations in the genre.⁵⁹ For example, both conceptualize the hospital as a Western phenomenon, focusing primarily on English, Italian, and modern American hospitals. In doing so, they do not take into account the ways in which hospitals functioned around the world – and through time – as colonial and local institutions. By viewing hospitals, and medicine more generally, without a cross-cultural or global perspective, Granshaw and Risse obscure the rich and complex history of colonial hospitals. In other words, while both reviews develop a complex picture of how the hospital changed over time within a European context, they do not engage with how the institution was developed, transplanted, and received in colonial settings. This reflects a larger trend in the field, for despite a rich

⁵⁸ Risse, *Mending Bodies, Saving Souls*, 4.

⁵⁹ Granshaw, "Introduction"; and Risse, *Mending Bodies, Saving Souls*.

literature on colonial and imperial medical history, hospital histories from colonial contexts are comparatively rare. While historians have largely overlooked the histories of specific hospitals in colonial settings, these institutions offer the opportunity to complicate existing understandings of both the hospital and colonial medicine. In many contexts, hospitals were central institutions in colonial history since health care – and the accompanying re-conceptualizations of health, disease, and the body – were at the forefront of colonizing efforts.⁶⁰

The mid-twentieth-century Canadian Arctic was not part of any of the European empires, and as such is often disconnected from the literature on colonial medicine. Nonetheless, the relationship between Southern Canada and the Arctic was essentially a colonial relationship, as the government administered the North as a territory without representation while trying to exploit its resources and change Inuit lifestyles and worldviews.⁶¹ As such, I argue here that the region can serve as an excellent case study in colonial medical history, especially since it is a different environment and context than is generally examined in the field. A study of Ste. Therese's Hospital reveals the value of and potential for analyses of a specific hospital to colonial medical history, while complicating ideas about space, isolation, colonialism, and medicine in the North. Ste. Therese's Hospital also provides a useful case study for examining the interplay between different colonial interests in a medical setting. Unlike many of the institutions analyzed by hospital historians, Ste. Therese's was jointly

⁶⁰ See Waldram, Herring, and Young, *Aboriginal Health in Canada*, 169-70.

⁶¹ For an early application of the term "colonialism" to the North, see Robert Paine, "The Nursery Game: Colonizers and Colonized in the Canadian Arctic," *Etudes/Inuit/Studies* 1, 1 (1977): 5-32.

administered by the Canadian federal government, biomedical doctors, and Catholic missionaries. A study of the interactions between these interests complicates representations of colonial medical interests as either mission- or government-based.

Colonial medical historians have increasingly turned the history of medical missions in the past two decades. According to this literature, mission medicine was relatively slow to develop, with approximately only thirteen European medical missionaries stationed around the world in 1852.⁶² Catholic medical missionaries were particularly late on the scene. Norman Etherington suggests that this was because canon law had traditionally forbidden clergy to practice medicine.⁶³ However, Michael Worboys argues that this may have been more a matter of the contrasts between a Protestant “instrumentalist” stance on conversions and the Catholic “fundamentalist” one.⁶⁴ Regardless, by the late nineteenth century, medical care has become a part of standard missionary activity in many regions around the world.⁶⁵ For many European colonial contexts, indigenous people first encountered modern Western medicine through

⁶² Christopher P. Williams, “Healing and Evangelism: The Place of Medicine in Later Victorian Protestant Missionary Thinking,” in *The Church and Healing*, ed. William J. Shiels (London: Blackwell, 1982), 271.

⁶³ Norman Etherington, “Education and Medicine,” in *Missions and Empire: The Oxford History of the British Empire Companion Series*, ed. Norman Etherington (Oxford: Oxford University Press, 2005), 279.

⁶⁴ Michael Worboys, “The Colonial World as Mission and Mandate: Leprosy and Empire, 1900-1940,” *Osiris* 2, 15 (2001): 209. For more on missionary societies’ early scepticism about medical work, see Williams, “Healing and Evangelism,” 272.

⁶⁵ Worboys, “The Colonial World as Mission and Mandate,” 209. For some possible reasons for this expansion, including the professionalization of medical work in England, see Williams, “Healing and Evangelism,” 273.

Christian missionaries.⁶⁶ The existing literature on mission medicine identifies five primary aims: to continue the work of Christ the Healer, to facilitate conversions in colonial contexts, to demonstrate the superiority of Western rational, scientific thought, to protect missionaries from colonial diseases, and to represent values like time, discipline, and restraint.⁶⁷ Charles Good argues that these medically related conversions were more effective, since indigenous people tended to resist European medicine less than they did Christian religions.⁶⁸ However, I would suggest that these characterizations are limited simplifications of medical mission history, since values and practices would have been shaped by missionary denomination, indigenous group, period, individual, and local context. In addition, the existing literature on mission medicine is

⁶⁶ Worboys, "The Colonial World as Mission and Mandate," 208. See also Michael Worboys, "The Spread of Western Medicine," in *Western Medicine: An Illustrated History*, ed. Irvine I. Loudon (Oxford: Oxford University Press, 1997), 249-63; and Charles M. Good, "Pioneer Medical Missions in Colonial Africa," *Social Science and Medicine* 32 (1991): 1-10. In at least some contexts, this may have been because colonial governments tended not to provide adequate medical care, particularly for local indigenous people. For a clear example, see Sean Hawkins, "To Pray or Not to Pray: Politics, Medicine, and Conversion among the LoDagaa of Northern Ghana, 1929-1939," *Canadian Journal of African Studies* 31, 1 (1997): 66; and Good, "Pioneer Medical Missions in Colonial Africa," 1.

⁶⁷ Terence O. Ranger, "Godly Medicine: The Ambiguities of Medical Mission in Southeast Tanzania, 1900-1945," in *The Social Basis of Health and Healing in Africa*, eds. Steven Feierman and John M. Janzen (Berkeley: University of California Press, 1992), 258; Worboys, "The Colonial World as Mission and Mandate," 209; and Williams, "Healing and Evangelism," 274-85.

⁶⁸ Good, "Pioneer Medical Missions in Colonial Africa," 1. See also Hawkins, "To Pray or Not to Pray," 65. To an extent, Reverend Morice's biography of Bishop Turquetil makes similar claims in the Arctic context, as he suggests that the Oblates had great difficulty converting local Inuit communities until the hospital was built. Adrian G. Morice, *Thawing Out the Eskimo*, trans. Mary T. Loughlin (Boston: The Society for the Propagation of the Faith, 1943), for example, 193 and 199.

generally limited to studies in Asia, Africa, and India.⁶⁹ As I will demonstrate in the following chapters, there was also medical missionary activity in the Canadian Eastern Arctic as the two hospitals built in the early 1930s – Ste. Therese’s and St. Luke’s – were Catholic (Oblate) and Anglican, respectively. By studying Ste. Therese’s Hospital, I will question how these characterizations of mission medicine played out in a very different context.

A number of scholars have argued that mission medicine differed from biomedicine in a number of fundamental and important ways.⁷⁰ According to their positions, biomedicine developed from a movement towards modernization and rationalization in Europe, and focused on separating bodies from larger contexts, utilizing scientific technologies to treat germs, and producing specialized knowledge. As such, it was concerned primarily with curing physical bodies through scientific discourses and pathogenic disease theories.⁷¹ In contrast, most scholars argue that mission medicine was concerned with both healing bodies and saving souls, and in the face of deadly disease or epidemics, missionaries prioritized rapid conversions.⁷² According to Etherington, the goals and values of mission medicine contrasted with those of biomedicine, as it was

⁶⁹ For example, Worboys, “The Colonial World as Mission and Mandate,” 209. See also Good, “Pioneer Medical Missions in Colonial Africa”; Michael Gelfand, *Godly Medicine in Zimbabwe* (Harare: Memba Press, 1988); and Megan Vaughan, *Curing Their Ills: Colonial Power and African Illness* (Stanford: Stanford University Press, 1991). In 2002, the University of Warwick hosted a conference on mission medicine, but limited the papers to subjects in Africa and Asia. See David Hardiman, “Conference Report: Medical Missions in Asia and Africa,” *Wellcome History* 21 (October 2002): 14, <http://www.wellcome.ac.uk/assets/WTD006091.pdf>.

⁷⁰ For example, Worboys, “The Colonial World as Mission and Mandate”; Etherington, “Education and Medicine”; and Vaughan, *Curing Their Ills*.

⁷¹ See Soma Hewa, “Physicians, the Medical Profession, and Medical Practice,” in *Health, Illness, and Health Care in Canada*, eds. B. Singh Bolaria and Harley D. Dickinson (Scarborough: Nelson Thomson, 2002) for a very basic overview of the development and features of biomedicine.

⁷² For example, Etherington, “Education and Medicine,” 276-77.

more focused on evangelism than on philanthropy, on the supernatural and miraculous than on the scientific and rational, and on sin than on pathogenic disease.⁷³ Megan Vaughan has explored the relationship between missionary and state medical personnel in the colonial African context. In doing so, she concludes that their approaches and discourses differed in some clear ways, particularly since missionaries were concerned with their patients as individuals, while civil doctors were more concerned with “disease agents, vectors, and populations.”⁷⁴

Some historians have argued that this perceived divergence in “theory and practice” between mission and biomedicine has resulted in a corresponding split in the historiography, with medical missionaries neglected in the larger literature on medicine.⁷⁵ This thesis in part addresses this gap, considering the close links between mission medicine and biomedicine in the Eastern Arctic. While I have not accessed sources that provide enough information about the religious or spiritual aspect of medical mission work in Chesterfield Inlet, I have found a wealth of records that examine this relationship between missionaries, doctors, and government administrators. An analysis of these, I argue, reveals that Ste. Therese’s Hospital was a space where various medical discourses converged –

⁷³ Etherington, “Education and Medicine,” 275-76.

⁷⁴ Vaughan, *Curing Their Ills*, 60. See also Worboys, “The Colonial World as Mission and Mandate,” 210.

⁷⁵ Etherington, *Education and Medicine*, 277; and Worboys, “The Colonial World as Mission and Mandate,” 207-208, 217. More specifically, Worboys, argues that colonial medical history has largely focused on “disease-control-centred medical science and technology,” thereby challenging the dominance of imperial tropical medicine in the literature. Instead, he argues that mission medicine was an integral part of colonial medicine. Indeed, he suggests that “the themes of Christian caring, medical humanism, colonial development, and welfare policy” became closely linked in the implementation of colonial mission medicine. Worboys, “The Colonial Medicine as Mission and Mandate,” 207.

Inuit, mission medical, government, and biomedical – in a complex negotiation that played out on the ground in specific, local ways. In this project, I recognize the role of mission medicine and religion in the functioning of Ste. Therese’s Hospital, but also emphasize that it was a federal government-funded institution staffed by biomedical doctors rather than mission doctors. As such, various parties sometimes hotly debated the role of religion and the goals of health care within the hospital, producing and contesting various discourses on bodies and health. However, I also argue that the frequently drawn divisions between these parties are less clear in practice, at least in the Eastern Arctic context; my analysis suggests that, in fact, missionary, biomedical, and government perceptions of health, healing and disease were often remarkably similar.

Conclusion

Seventeen years ago, Charles Good called for scholars to examine the history of medical missions in terms of their relation to varying conceptions of space.⁷⁶ In some senses, this project responds to this call by incorporating a spatial analysis into a history of Ste. Therese’s Hospital in Chesterfield Inlet, although I take his specific theoretical questions in new directions. In this chapter, I have outlined the basic theories and bodies of literature in which I situate my project. First, I introduced my conceptualization of space, allowing for an exploration of how the hospital regulated spatial relationships between places, bodies, and diseases. Then I reviewed the literature on hospital histories, particularly within the context of colonial and mission medicine. In doing so, I

⁷⁶ Good, “Pioneer Medical Missions in Colonial Africa,” 6.

suggested that the history of Ste. Therese's Hospital can be located at the intersections between spatial analyses, hospital histories, and the study of colonial and mission medicine, fields that have not yet come together in coherent historical analyses, especially in the Canadian Arctic context. This positioning allows me to draw broader conclusions about all three fields of study.

In the following chapters, I move onto a more detailed analysis of the history of Ste. Therese's Hospital in Chesterfield Inlet, examining discourses on isolation through the theoretical lenses presented in this chapter. First, I explore how missionary, doctor, government discourses on Ste. Therese's produced it as an isolated space, thus shaping the implementation of health care in the hospital by defining the relationship between disease, medicine, and bodies in particular ways.

2. THE HOSPITAL AS AN ISOLATED SPACE

The non-Inuit historical record on Ste. Therese's Hospital is saturated with references or responses to unfamiliar conditions in the Eastern Arctic.

Missionaries, doctors, and government administrators framed these conditions as both "natural" (climate, environment, and terrain) and "social" (transportation and communication infrastructure, limited medical staff, and a scattered and mobile Inuit population). A 1958 draft paper on the Eskimo Health Worker Programme expresses non-Inuit concerns with these conditions perhaps most clearly, reading:

A close look at the difficulties of geography, of transportation, and of communications in the North, quickly leads to the conclusion that the problems to be overcome are not so much those of public health or medicine per se, as of logistics. It is not a difficult matter to have a nurse give an injection of penicillin or a dose of diphtheria toxoid to an Eskimo or to have an x-ray technician make a film of chest, once they are on the spot. It is the business of getting them there at the right time with the facilities they need that presents the major problem. The climate and terrain of our Canadian Northland make communication at best difficult and sometimes impossible. These natural difficulties, combined with our limited staff and the scattered distribution of the people of nomadic habit with whom we are dealing, present an almost insurmountable problem to our service in the North.⁷⁷

This "almost insurmountable problem" had been central to discussions on health care in the Canadian Eastern Arctic for decades as non-Inuit parties claimed that the implementation of health care in the region could only be partial, tentative,

⁷⁷ LAC, Northern Affairs Program, RG 85, vol. 365, file 252-5/170, Draft paper re Eskimo Health Worker Programme, July 1958. Quoted in Duffy, *The Road to Nunavut*, 57.

and sporadic because of logistical problems that quite simply stretched a small budget too thin.⁷⁸ The existing health care in Ste. Therese's Hospital was shaped by these concerns, as hospital staff and administrators found themselves far from familiar facilities, specialists, equipment, and infrastructure.⁷⁹

Missionaries, doctors, and government employees frequently expressed these anxieties in the language of isolation. They saw the natural and social challenges of the Eastern Arctic as converging in the concept of isolation, and thus imagined the hospital as an isolated space. In this chapter, I use this idea of isolation as a theoretical lens through which to examine the implementation of health care in Ste. Therese's Hospital. More specifically, I explore how missionary, doctor, and government discourses framed Ste. Therese's as isolated in complicated and sometimes contradictory ways, seeing the hospital's isolation as simultaneously a positive and a negative factor in health care. In order to do so, I first introduce my theorization of isolation as used in this chapter. Then I examine how missionary, doctor, and government employees grounded their conceptions of the hospital in particular ideas about disease transmission, medicine, and space, and thus in particular ideas about isolation. I then analyze

⁷⁸ See, for example, Duffy, *The Road to Nunavut*, 56; Tester and Kulchyski, *Tammarniit*, 16-20; and correspondence from R. A. Gibson in LAC, Northern Affairs Program, RG 85, vols. 193 and 194.

⁷⁹ Another example of this language can be found in the Northwest Territories Administration files on Inuit Health: "In analysing the medical service requirements for the Eskimo inhabiting the Eastern and Western Arctic, due considerations must be given to the nomadic characteristics of these natives, the extensive area over which they are domiciled, the small population in the settlements, and the difficulties and high cost of communication and transportation. When these various factors are taken into consideration it becomes obvious that the providing of a medical service adequate to meet all requirements in the Northwest Territories must necessarily involve considerable expenditure." N.W.T.A., Alexander Stevenson Fonds, N92-023, Box 49, File 5, Inuit Health Reports, 1944-1969, "Synopsis of Arrangements Made by the Northwest Territories Administration for the Medical Care of Eskimos."

the place of Ste. Therese's Hospital in such discourses, emphasizing how these non-Inuit interests framed it as an isolated space. In part, I do this by exploring how missionaries, doctors, and government employees saw the hospital's isolation as a negative factor, or a challenge, in implementing "proper" health care in the Canadian Eastern Arctic. At the same time, I demonstrate how they also embraced the hospital's isolation as a positive factor, reducing the spread of disease and making heroes out of health care providers. Finally, I consider how the implementation of health care served to "tame" this isolation, shifting its sense of distance and remoteness. In approaching the chapter in such a way, I also explore the ways in which non-Inuit commentators saw "isolated" Inuit camps as positive and negative factors in disease transmission in the North, as they compared them implicitly and explicitly to non-Inuit spaces like the hospital. Ultimately, this chapter demonstrates how missionary, doctor, and government discourses produced the hospital as an isolated space that both hampered and facilitated "proper" health care delivery in the Eastern Arctic. This complex and often-contradictory conceptualization allowed hospital administrators to manipulate the hospital space, thus producing particular forms of isolation in order to prevent or cure illness; I will explore this process in the following chapter.

Theorizing the Isolated Space

In this chapter, I use the concept of "isolation" to signify the relationship imagined by missionaries, doctors, and government employees between the hospital and its surrounding space. Historian Mary Jane McCallum has used isolation in a similar way, arguing that medical and public health journals

between 1910 and 1970 conceived and used “isolation” as a “vague geographical description,” tending to be defined by inaccessibility, scattered populations, and social landscapes that differed dramatically from those familiar to the “dominant cultures.”⁸⁰ Working in part from McCallum, I see isolation as a multi-dimensional concept encompassing both physical and discursive aspects. In this way, a place is seen as isolated in part because of its physical surroundings, environment, and infrastructure, but at the same time it cannot be understood as isolated without a socially-produced conception of what I call “centres of civilization.” In other words, the very idea of isolation is a comparative one; if the North is seen as isolated, it is always isolated *in comparison to* somewhere else. Without an idea of Southern Canada as un-isolated (the centre of their imaginings), missionaries, doctors, and government employees could not produce the Eastern Arctic as an isolated space. In a sense then, locating isolation depended on locating civilization for these non-Inuit commentators.

Used in this way, isolation might be seen as a factor of distance, as the Arctic was seen as isolated in part because it was distant from the South. In incorporating the idea of distance into this chapter, I respond to Bill Waiser’s 2001 essay, “A Very Long Journey: Distance and Northern History.” In this exploration of distance and Northern history, Waiser suggests, “Although distance is regularly mentioned in historical studies, it... has enjoyed limited use

⁸⁰ Mary Jane McCallum, “This Last Frontier: Isolation and Aboriginal Health,” *Canadian Bulletin of Medical History* 22, 1 (2005): 105.

as an analytical tool.”⁸¹ Despite – or rather because of – this relative lack of attention, he argues that using distance, remoteness or isolation as central concepts, historians will be able to understand better the patterns and nature of Northern history.⁸² Considering Waiser’s arguments, I suggest that an understanding of health care in the Canadian Eastern Arctic benefits from an exploration of the role of distance in shaping its implementation. Most of the existing literature on health care in the Arctic has focused on government policy, without considering how distance and isolation shaped the actual implementation of such policies on the ground in specific, local contexts.⁸³ As such, a better understanding of the implications of distance and isolation, and space more generally, has much to offer this field of study, especially since the historical record is saturated with explicit references – both positive and negative – to these concepts.

Relatively little work has been done specifically theorizing the concept of isolation as I am using it here, but since it is so closely related to conceptions of distance, I will now examine the existing literature on the latter term. Scholars in Australia and New Zealand completed much of the early theorizing of distance in

⁸¹ Bill Waiser, “A Very Long Journey: Distance and Northern History,” in *Northern Visions: New Perspectives on the North in Canadian History*, eds. Kerry Abel and Ken S. Coates (Peterborough: Broadview Press, 2001), 39.

⁸² Waiser, “A Very Long Journey,” 41.

⁸³ As Shelagh Grant argues of Inuit historiography more generally, “While there is ample information on government policy initiatives, or the lack thereof, the *manner and degree to which they were implemented* can only be determined by a more rigorous examination.” Grant, “Inuit History in the Next Millennium,” 99. My emphasis. Ken Coates identified a similar problem in the literature on the Yukon Territory. See Ken S. Coates, *Best Left as Indians: Native-White Relations in the Yukon Territory, 1840-1973* (Montreal: McGill-Queen’s University Press, 1991), 159.

history, with several major studies published in the 1960s.⁸⁴ One of the most influential of these, Geoffrey Blainey's *The Tyranny of Distance*, emphasizes the importance of both physical and conceptual distance in Australia's history.⁸⁵ Blainey does not just use distance as a concept of physical or geographical space, but also emphasizes the importance of how Australians understood the meanings of such spaces.⁸⁶ This stress on the meanings layered onto landscapes is essential to my conception of distance and isolation in this chapter for, as I have already mentioned, I see space as a dialogue between physical characteristics and socially produced concepts. In other words, distance and isolation are "both a physical reality and a state of mind."⁸⁷ In this way, then, I argue that non-Inuit commentators framed Ste. Therese's Hospital as distant not just because of its physical separation from the South (due to sheer miles, limited transportation and communication infrastructures, and seasonal, climatic and geographic challenges), but also because they were faced with a cultural and geographic landscape that was conceptually distant from spaces familiar to them.⁸⁸

⁸⁴ Keith Sinclair, ed., *Distance Looks Our Way: The Effects of Remoteness on New Zealand* (Auckland: University of Auckland, 1961); and Geoffrey Blainey, *The Tyranny of Distance: How Distance Shaped Australia's History* (Melbourne: Macmillan, 1968).

⁸⁵ Blainey, *The Tyranny of Distance*.

⁸⁶ Waiser, "A Very Long Journey," 40.

⁸⁷ Waiser, "A Very Long Journey," 38.

⁸⁸ This was, in a sense, a self-fulfilling conception; as non-Inuit observers framed Chesterfield Inlet as distant, they were also able to maintain a continued identification with Southern Canada – the familiar space – and thus the North continued to appear unfamiliar. For a similar argument in an analysis of Canadian literature, see W. H. New, *Land Sliding: Imagining Space, Presence, and Power in Canadian Writing* (Toronto: University of Toronto Press, 1997), especially 71 and 143.

It is important to recognize that conceptualizations of distance and isolation in the North were not static, uniform, or value-less. Rather, the historical record on Ste. Therese's Hospital is characterized by shifting and contested conceptualizations of both terms, each of which was thoroughly implicated in power relations in the Eastern Arctic. The idea that Chesterfield Inlet was an isolated place was closely linked with colonial power relations that placed civilization in the South and devalued Inuit conceptions of the landscape.⁸⁹ By viewing the North as a distant isolated space, missionaries, doctors, and government employees denied Inuit space, and the history and practices that produced it. This becomes evident when examining the ways in which missionaries, doctors, and government employees conceptualized isolation, the places with which they compared the Arctic and Chesterfield Inlet, and the extent to which they incorporated or rejected Inuit conceptions of the landscape.⁹⁰ At the same time, power relations were also important to how isolation was "tamed" through the colonial process, particularly with the imposition of new communities, infrastructure and buildings, transportation and communication systems, and technologies onto the Arctic space.

Much of the existing literature that uses distance as a conceptual tool focuses on the latter point, the historical struggle to tame distance, suggesting

⁸⁹ McCallum, "This Last Frontier," 109.

⁹⁰ Valerie Alia argues that colonial power worked to shift Inuit identity by interfering with their naming systems. See Valerie Alia, *Names, Numbers, and Northern Policy: Inuit, Project Surname, and the Politics of Identity* (Halifax: Fernwood, 1994). I would suggest that this idea also extends to changing conceptions of landscapes – and distances – as colonialism imposed new ideas about what counted as a 'place' to be named, what social and cultural references were contained within the name chosen, how it related to other named places around it, and how it obliterated Inuit names for the land.

that people of the past saw distance as a negative factor that pushed them to attempt to overcome it. For example, Blainey's work emphasizes distance's "tyranny," examining the "taming of distance" in Australia's history. Similarly, Cole Harris has focused on the "struggle with distance," arguing that colonizers in British Columbia tried to reduce distances in order to gain control of the land.⁹¹ However, in this chapter, I will look at the non-Inuit relationship with isolation in Chesterfield Inlet as more complicated than a struggle to tame distance. Rather, I will argue that non-Inuit conceptualizations of distance and isolation were simultaneously positive and negative: while they struggled against distance in implementing familiar health care systems, missionaries, doctors, government employees and others also saw it as a positive factor that both glorified their role in the North and helped prevent the spread of disease among the Inuit. In other words, while the implementation of health care was inextricably linked with a form of "taming" distance through colonialism, non-Inuit interests also bemoaned the negative consequences of such a process. At the same time, it is also valuable to recognize that distances "fought back" against non-Inuit struggles to tame it in the Eastern Arctic. The region's isolation necessarily challenged, and indeed diluted to an extent, surveillance and colonial power in the Arctic, while non-Inuit interests sought technological advances to combat this trend.

⁹¹ Cole Harris, "The Struggle with Distance," in *The Resettlement of British Columbia: Essays on Colonialism and Geographical Change* (Vancouver: University of British Columbia Press, 1997), 161.

Locating Chesterfield Inlet as Isolated

In 1912, Arsene Turquetil established the first Catholic mission in the Eastern Arctic, locating it near the opening of Chesterfield Inlet into Hudson Bay.⁹² In doing so, he founded the beginnings of the community that would host Ste. Therese's Hospital nineteen years later. In order to understand how distance and isolation shaped the implementation of health care in that hospital, it is first important to examine how missionaries, doctors, and government employees actually conceptualized Chesterfield Inlet as a distant and isolated place. The mid-twentieth-century non-Inuit historical record on Ste. Therese's Hospital framed it as a very different place from the metropole of Southern Canada. Perhaps more importantly than this, missionaries, doctors, and government employees did not just conceptualize it as a distinct region, but saw it more specifically as a *distant* region because their centres of conceptualization were in the South. Indeed, non-Inuit observers almost uniformly described communities in the Eastern Arctic as distant and remote, located a long physical and conceptual distance from Southern Canada. In other words, the spaces encountered in the Eastern Arctic were not only difficult to access from the South due to geography, climate, and limited transportation infrastructure, but they were also unfamiliar and difficult for Southerners to understand. As such, I want to emphasize that when I discuss Chesterfield Inlet as isolated, I see this as a

⁹² NwTA, Department of Health and Social Services, G99-044, File 1, "Who Is My Neighbour?" Slide Presentation. See also Morice, *Thawing Out the Eskimo*, 82; and "Twenty-Five Years at Chesterfield Hospital," 3. Turquetil established the mission in reaction to the expansion of Anglican missionary activity in the region. Remie and Oosten, "The Birth of a Catholic Inuit Community," 113.

fundamentally non-Inuit conceptualization of space that is grounded in colonial power relations that placed “civilization” in the South.

In Reverend Morice’s 1943 biography of Bishop Turquetil, *Thawing Out the Eskimo*, he describes Chesterfield Inlet as follows:

[It], like the whole extent of shore of the inland sea that is called Hudson’s Bay and the territory for three hundred miles around, is a dismal solitude without a foot of arable land: in summer a barren soil bristling with sharp stones and devoid of any trace of vegetation, and during the ten months of winter a desert of snow and ice.⁹³

Consistently invoking this imagery depicting the Arctic as the Barren Lands, Morice’s writing was typical of many “adventure” narratives that both bemoaned and celebrated Northern isolation.⁹⁴ In terms of medical services, though, hospital administrators usually invoked this sense of isolation when they observed that Arctic communities had limited access to health care. For example, as the doctors from the 1945 Eastern Arctic Patrol reported, the region contained only “remote communities whose contact with medical advice and treatment is limited to a few hours each year.”⁹⁵ Similarly, as Dr. George Hooper wrote in 1946, the hospitals were “widely separated” and “only look after a very small section of the country.”⁹⁶ Regarding Ste. Therese’s Hospital more

⁹³ Morice, *Thawing Out the Eskimo*, 84.

⁹⁴ For example, Morice, *Thawing Out the Eskimo*, 151. See also Louis-Edmond Hamelin, “Barren Grounds – Terres Stériles Géographie et Terminologie,” in *For Purposes of Dominion: Essays in Honour of Morris Zaslow*, eds. Kenneth S. Coates and William R. Morrison (North York, Ont.: Captus University Publications, 1989), 201-210; and Peter Davidson, *The Idea of North* (London: Reaktion Books, 2005), 188-89.

⁹⁵ LAC, Northern Affairs Program, RG 85, vol. 834, file 7387, reel T13334, Drs. McCarthy and Laidlaw, Joint Eastern Arctic Patrol Report, 28 September 1945.

⁹⁶ LAC, Northern Affairs Program, RG 85, vol. 834, file 7387, reel T13334, Dr. George Hooper, Report of the 1946 Patrol Trip, 31 May 1947.

specifically, Dr. Joseph Moody's 1977 documentary film, *Arctic Doctor*, describes him as "the lone medical doctor for thousands of Inuit people, scattered over a vast area of 600 000 square miles in the remote Canadian Eastern Arctic."⁹⁷ Moody then furthers this image, calling Chesterfield a "barren place," and saying, "People travelled for days to reach my station, and when necessary, I travelled by dog-team, canoe and small aircraft, a total of 50 000 miles."⁹⁸ This attitude was not just one held by biomedical doctors, as the Grey Nuns stationed in Ste. Therese's Hospital also explained that their work "means accepting willingly a certain degree of isolation."⁹⁹ As these examples show, health care providers working in the Eastern Arctic saw their task as located in a fundamentally remote place, giving them the responsibility to struggle against such remoteness in an effort to provide medical care across such a territory.

However, while non-Inuit observers saw the community as remote when implicitly or explicitly compared to the South, they also framed Chesterfield Inlet as far more accessible than other communities in the Eastern Arctic. This was in part because it was located along one of the only corridors of transportation and communication that extended into the Eastern Arctic from the South. This corridor passed through Chesterfield Inlet due to its proximity to Hudson Bay and Baffin Island, as well as its positioning along the Eastern Arctic Patrol shipping routes. In addition, Chesterfield Inlet served as a microcosm of mid-twentieth-century Euro-Canadian interests in the Arctic since it had:

⁹⁷ LAC, Joseph Palmer Moody Collection, Accession 1987-0264, *Arctic Doctor*, 1977.

⁹⁸ LAC, Joseph Palmer Moody Collection, Accession 1987-0264, *Arctic Doctor*, 1977.

⁹⁹ NWTA, Department of Health and Social Services, G99-044, File 1, "Who is My Neighbour?" Slide Presentation.

a number of government officers, including the R.C.M. Police, wireless station operators, also a number of other white persons, including missionaries, traders, etc. Chesterfield is also used as a base by the Air Force and by two mining companies operating in that district during the summer months.¹⁰⁰

While the Chesterfield area had not been a traditional stopping ground for the Inuit, they had moved into the area with the establishment of the Hudson's Bay post in 1912 and maintained a frequent – although not permanent – presence in the area throughout this period.¹⁰¹ Because of this convergence of interests in Chesterfield Inlet, many non-Inuit observers saw it as a good place for a hospital, even more accessible than St. Luke's Hospital in Pangnirtung, on Baffin Island. At the same time, this positioning also meant that health care in Ste. Therese's sometimes suffered. As Bishop Turquetil acquiesced to Gibson in 1942, it made more sense to have a doctor at Pangnirtung than Chesterfield because:

There is no other way to provide the hospital there with a Doctor, whereas in case of necessity, you could send a doctor to Chesterfield by plane, easily enough, or by dog-team, in winter, if you can obtain a doctor for Chesterfield.¹⁰²

In short, I suggest that non-Inuit observers situated Chesterfield Inlet in an “in-between” space in the Eastern Arctic. They saw it as fundamentally isolated because it was located in the North, distant from the South, and characterized by unfamiliar conditions, but also as less isolated than other Arctic communities or Inuit camps because it was located along transportation routes and

¹⁰⁰ LAC, Northern Affairs Program, RG 9, vol. 810, file 6815, reel T13313, unsigned memo to R. A. Gibson, 22 August 1931.

¹⁰¹ NWTA, Wager Bay Oral History Project Interview Transcripts, N92-259, interviews with Leonie Sammurtok and Mary Nuvak, 14 November 1991.

¹⁰² LAC, Northern Affairs Program, RG 85, vol. 194, file 2, R. C. Hospital at Chesterfield Inlet, letter from A. Turquetil to R. A. Gibson, 18 August 1942.

communication lines, and had more non-Inuit people than other areas of the Eastern Arctic. As such, this “in-between” status brought Chesterfield Inlet into the reach of Southern health care and yet it was still remote enough to be isolated.

This sense of distance and isolation profoundly shaped the administration of Ste. Therese’s Hospital, and often led to miscommunications and conflicts between the various non-Inuit parties involved. On a basic level, the federal departments responsible for the hospital, and Bishop Turquetil, who oversaw the hospital administration on the part of the Oblate mission, were primarily based in Southern Canada, and as such they often found it difficult to develop, implement, or negotiate policy for the Eastern Arctic from a distance. As such, individuals stationed in Chesterfield Inlet often made decisions without any knowledge of administration policies, and sometimes even intentionally contravened them. Indeed, as Cornelius Remie and Jarich Oosten explain in relation to Turquetil’s management of Oblate missions,

The vast distances of the Arctic implied that it was not easy to control what was happening at the mission posts, and missionaries in remote missions often had to improvise or follow their own judgement in dealing with difficult and controversial issues.¹⁰³

Similarly, in the civil administration of the hospital, medical officers acted essentially as unofficial mediators between the local community and the government, reporting on conditions and translating policy into practice.

¹⁰³ Remie and Oosten, “The Birth of a Catholic Inuit Community,” 118.

However, these doctors were not bound to government policy but sometimes had different perspectives on particular matters.

This was complicated by the fact that doctors had many, and often contradictory, roles in the North. Even their so-called “medical” tasks were more diverse than those dealt with by doctors in Southern Canada; they were general practitioners, dentists, surgeons, maternity doctors, and nutritionists. When he first arrived in Chesterfield Inlet, Joseph Moody had just finished medical school and did not have specialist training or experience in any of these areas.¹⁰⁴ As a result, the medical care he provided his Inuit patients must have been, at times, tentative, and perhaps even wrong or ineffective. In addition to these diverse medical tasks, the federal government also hired doctors to work as certified justices of the peace and coroners, and they took on many other official and unofficial roles in the community as well. Indeed, the Civil Service's 1930 call for applications for the position of Medical Officer at Chesterfield Inlet listed the M.O.'s duties as follows:

To be responsible for the general health and welfare of the Eskimos in an assigned area of Arctic Canada; to make patrols by dog team and by boat to native settlements; to diagnose cases and prescribe treatment; to fit eye glasses, extract teeth, perform operations and instruct those engaged in treating and caring for the Eskimo; to instruct the natives on matters pertaining to hygiene and sanitation and to enforce the regulations respecting same; to instruct natives on game and other laws and to impress upon them the importance of game conservation; to keep the Director informed on all matters affecting the life, customs and conditions of the Eskimo; and to perform other related work as required.¹⁰⁵

¹⁰⁴ Moody, *Medicine Man to the Inuit*, 4-5.

¹⁰⁵ LAC, Northern Affairs Program, RG 9, vol. 810, file 6815, reel T-13313, Dr. D. S. Bruce – Medical Officer, “Civil Service Positions,” 24 March 1930.

As one newspaper article reported, the position was essentially “medical officer of health and supervisor of hygiene and a million and one other things.”¹⁰⁶ In short, because the government could not – or chose not – to afford to hire numerous agents to work in isolated communities in the Arctic, doctors took on a number of roles in the community. Although there are few clear examples of conflicts of interest arising from these diverse positions, certainly doctors were less able to focus on their “medical” tasks when called away to rule on game laws. At the same time, these roles brought doctors into collusion or conflict with Hudson’s Bay Company employees and police officers in the region, who also had stakes in game conservation and law enforcement.¹⁰⁷

These conditions produced the hospital as a space in which various discourses on colonialism, health, disease, medicine, and bodies converged in complicated and often contested ways, often without reference or control from administrators in the South. For example, there is clear evidence that biomedical doctors frequently clashed with missionaries in hospital administration. In 1947, Dr. Joseph Moody reported serious problems with the local Oblates and Grey Nuns, apparently stemming from a struggle for power, a conflict in medical and spiritual practices, or simply a personal dislike. The government report outlined some of his grievances:

Dr. Moody had... complaints to the effect that treatments which he prescribed were sometimes not given by the nurse, that at certain

¹⁰⁶ NwTA, Leslie Livingstone Fonds, N87-019, File 2, newspaper clipping, Robinson MacLean, “Easy if You Know Him: But Mrs. L. D. Livingstone, Once Mabel Anderson of Campbellford, Found It Unusual Adventure At First.”

¹⁰⁷ See LAC, Northern Affairs Program, RG 85, vols. 193 and 194, correspondence from HBC and NWMP employees.

hours while working with patients in the hospital he would be abandoned by the staff while they attended devotional services, and finally that the Mission actively warned the natives to have nothing to do with him. This latter move was carried to the point where he could not get a native maid or man to work for him and the natives instead of using the path by his house across the settlement climbed over the rocks along the shore to avoid contact with him.¹⁰⁸

In another such case, Dr. Thomas Melling expressed frustration with the missionaries, as he felt they undermined his authority during an influenza epidemic in 1937. He wrote to Northwest Territories and Yukon Branch administrator, R. A. Gibson, as follows:

I placed in hospital only those that warranted special care, in accordance with my observations. But at present the Mission authorities here are admitting patients at will, without consulting me, or, informing me regarding their action... I admit that one or two required hospital care and I would have admitted them had I been called, but the first indication of their illness was that I had when visiting the hospital and found that they were already in bed. I have even visited the hospital numerous times daily only to find that new natives had been admitted without calling me.¹⁰⁹

Melling's fears about the ramifications of this became clear when he then continued,

As a consequence of this, the natives will be calling the Mission for medical assistance rather than the Medical Officer... I informed them that I could not sign the monthly hospital statement for patients admitted to the wards by anyone other than myself, except in cases of emergency.¹¹⁰

¹⁰⁸ LAC, Northern Affairs Program, RG 85, vol. 1002, file 16498, reel T13986, Medical Health Officer, Chesterfield, Dr. J. P. Moody, confidential letter from Wright to Gibson, 22 August 1947.

¹⁰⁹ LAC, Northern Affairs Program, RG 85, vol. 193, file 1A, R. C. Hospital at Chesterfield Inlet Returns, T. Melling to R. A. Gibson, 27 April 1937.

¹¹⁰ LAC, Northern Affairs Program, RG 85, vol. 193, file 1A, R. C. Hospital at Chesterfield Inlet Returns, T. Melling to R. A. Gibson, 27 April 1937.

He writes, "I then asked for an explanation and was told that it was obligatory with them in line with their missionary duties."¹¹¹ Although only Melling's perspective on this incident is available in these records, his correspondence reveals the presence of some tensions between the goals of missionary medicine, government policy, and biomedicine. As for Gibson and other budget-minded officials in the South, they could do little but trust doctors like Melling and Moody to act in the government's best interest.

During the years when no doctors were assigned to the Chesterfield post, the government particularly suffered from a lack of communication and first-hand knowledge of the conditions there. For example, in early 1944 Gibson received word that the Oblates might have been admitting patients to the hospital that did not require overnight care. He wrote,

This is an extremely difficult problem to deal with at long range, particularly when we have no doctor at the point and when last year even the Eastern Arctic Patrol with the Government doctor on board was unable to call at Chesterfield.¹¹²

In order to deal with such conditions, government representatives in Ottawa balanced various interests against each other. In this case, Gibson relied primarily on the local police officer, who, "as a rule, knows local conditions very well." In doing so, however, he recognized that "the nurses are likely to know more about the condition of the individual patients than the police officer." Nonetheless, Gibson decided to rely on police reports because "the police officer

¹¹¹ LAC, Northern Affairs Program, RG 85, vol. 193, file 1A, R. C. Hospital at Chesterfield Inlet Returns, T. Melling to R. A. Gibson, 27 April 1937.

¹¹² LAC, Northern Affairs Program, RG 85, vol. 194, file 2, R. C. Hospital at Chesterfield Inlet, letter from R. A. Gibson to Plourde, 1 February 1944.

should have an excellent perspective on local conditions” and would help limit the number of in-patients treated, whereas he suggested that missionaries or nurses were too invested in the grant money they received per patient to be objective about the matter.¹¹³ In this case, then, distances between Southern Canada and the hospital shaped health care in a basic way, as administrators struggled to “know” and run the hospital from afar. However, as the rest of this chapter will demonstrate, the concepts of distance and isolation influenced the implementation of health care in Chesterfield Inlet in much more complicated and sometimes contradictory ways as well.

“Plus an Indomitable Spirit”: Isolation, Masculinity, and the Hero Doctor

While many works of colonial medical history emphasize the extent to which colonialism involved an attempt to recreate familiar systems and spaces in unfamiliar territories, non-Inuit interests in Arctic health care actually embraced some elements of isolation. For example, the doctors stationed in Chesterfield Inlet were heralded in the historical record, and heralded themselves, as heroes who overcame dangerous and unfamiliar environments in order to bring civilization and health care to an uncivilized people. The isolation of Chesterfield Inlet was an integral part of the “hero doctor” motif found in the media, autobiographies, and government correspondence. Other scholars have identified this trend in similar contexts, including Mary Jane McCallum in her

¹¹³ LAC, Northern Affairs Program, RG 85, vol. 194, file 2, R. C. Hospital at Chesterfield Inlet, letter from R. A. Gibson to Plourde, 1 February 1944. This undoubtedly would have exacerbated tensions between local missionaries and police officers. See LAC, Royal Northwest Mounted Police, RG 18, vol. 516, file 615-16, Chesterfield Inlet, alleged interference with work of Roman Catholic Missionaries.

study of isolation in Canadian Aboriginal health research and Megan Vaughan in her study of colonial African medical history.¹¹⁴ As McCallum suggests,

Like the jungles of deepest Africa to the Boy Scout, the snow-capped peaks of Mount Everest to the manly mountaineer, or the Wild West to the American pioneer, isolation was the imperial backdrop to the courageous, adventuresome medical professional whose character and determination was what prepared them for the tasks of conquest and colonization.¹¹⁵

Similarly, the literature on Ste. Therese's Hospital and Northern doctors clearly reflects these elements, and in all cases emphasizes the strength of character needed to overcome the isolation inherent in their work. For example, the Department of National Health and Welfare's publication, *Canada's Health and Welfare*, celebrated:

The hardship, the romance and the pioneering spirit always linked with the efforts of Indian Health Services. Canoe, riverboat, dog team and snowshoes combine with motor, train and plane, plus an indomitable spirit, to bring health to Canada's first inhabitants.¹¹⁶

While McCallum demonstrates the links between isolation and the "hero doctor" image, I argue here that these discourses were also productions of a particular form of masculinity: white, colonizer, brave, knowledgeable, humanitarian. Discourses on the isolated hospital consistently reproduced this idealized form of "hero doctor" masculinity, as doctors' temperament became a central concern in their ability to survive and flourish in such conditions. Government officials explicitly sought this particular type of man for Northern positions. For example,

¹¹⁴ McCallum, "This Last Frontier"; and Vaughan, *Curing Their Ills*. See also Waldram, Herring, and Young, *Aboriginal Health in Canada*, 166-7; and Tester and Kulchyski, *Tammarniit*, 47-8.

¹¹⁵ McCallum, "This Last Frontier," 116.

¹¹⁶ LAC, Department of National Health and Welfare, RG 85, vol. 269, file 1003/20, part 1, Newsletters, "Indian and Eskimo Health," *Canada's Health and Welfare*, special supplement no. 18.

the candidate's temperament was clearly one of the most important factors in the hiring of Donald Sinclair Bruce for the Chesterfield Medical Officer position in 1930. The Civil Service of Canada job description – used throughout this period for all Chesterfield Medical Officer openings – required that candidates be “physically and temperamentally suited for life in the Arctic,” as well as having “administrative and supervisory ability, tact and good judgement.”¹¹⁷ Bruce's references similarly focused on his temperamental suitability for Arctic work.

Major Burwash, for instance, wrote:

He is fully qualified to stand the rougher side of northern life... [He] is familiar with modes of travel by water, dog sled and air, and he is no stranger to severe climatic conditions. He is temperamentally suited for northern work.¹¹⁸

Similarly, Guy Blanchet wrote Finnie to confirm:

Dr. Bruce is unusually well qualified to take charge of a northern medical post, both temperamentally and from his past experience in northern Manitoba, which has developed his resourcefulness in meeting unusual situations.¹¹⁹

As this one case study suggests, hospital administrators were very concerned with the temperament of doctors in Chesterfield Inlet, suggesting that the specific conditions and “unusual situations” of the community – particularly its isolation – required a particular kind of man.

¹¹⁷ LAC, Northern Affairs Program, RG 9, vol. 810, file 6815, reel T13313, Dr. D.S. Bruce – Medical Officer, “Medical Officer, NWT, Civil Service Positions,” 24 March 1930.

¹¹⁸ LAC, Northern Affairs Program, RG 9, vol. 810, file 6815, reel T13313, Dr. D.S. Bruce – Medical Officer, memorandum from Major Burwash to O. S. Finnie regarding application of Dr. DS Bruce, 15 April 1930.

¹¹⁹ LAC, Northern Affairs Program, RG 9, vol. 810, file 6815, reel T13313, Dr. D.S. Bruce – Medical Officer, memorandum from G. Blanchet to O. S. Finnie regarding Dr. Bruce, 15 April 1930.

Similarly, other commentaries on Arctic doctors reminded a Southern public that these men were models of ingenuity, humanitarianism, bravery, and strength. They emphasized that isolation and distance meant doctors could not always perform their medical work in the hospital, but rather had to go to their patients wherever they were and adapt to unusual conditions. To this end, Southern newspapers celebrated Dr. Leslie Livingstone because he:

[did] his work whenever it was most convenient, often successfully performing the most delicate operations under conditions not recommended in any medical textbook... [with] no operating room, nothing sterile, and probably a lack of some unnecessary instruments.¹²⁰

He once even performed surgery in the saloon of the *Arctic*, one of the annual patrol ships sent by the Canadian government.¹²¹ One magazine claimed that such work outside the hospital “[required] the utmost skill as well as courage and self-confidence,”¹²² while another suggested, “In addition to medical knowledge, it requires a lot of native ingenuity to be a travelling doctor in the north.”¹²³

Besides this type of ingenuity, humanitarianism and sacrifice were also key features of a “hero doctor.” For example, one newspaper article called Livingstone a “doctor of mercy for people living on the limits of human civilization.” The article then continued,

¹²⁰ NwTA, Leslie Livingstone Fonds, N87-019, File 2, newspaper clipping, “Dr. L. D. Livingstone is Physician to the Arctic.”

¹²¹ NwTA, Leslie Livingstone Fonds, N87-019, File 2, newspaper clipping, “Dr. L. D. Livingstone is Physician to the Arctic.”

¹²² NwTA, Leslie Livingstone Fonds, N87-019, File 2, magazine clipping, “Canada’s Arctic Doctors,” *Onward Around the World with a Camera*, 2 January 1938.

¹²³ NwTA, Leslie Livingstone Fonds, N87-019, File 2, newspaper clipping, L. I. Weeks, “A Physician to the Arctic: The Story of an Epic Figure in the Life of Canada’s Northland,” *The Canadian Doctor* (December 1936): 17-20.

If anybody thinks the days of heroes is over, they may well give some consideration to this fearless Polar physician who has cut himself from all civilization's comforts and friendly associations, on purpose to help the lonely people of the Far North.¹²⁴

Another article reported, quite simply, "Arctic doctors have big hearts."¹²⁵

Because of these characteristics, commentators expected that Arctic doctors, despite the hardships of their position, were truly committed to the work. As a magazine special reminded readers, "It is doubtful if any of Canada's arctic doctors would exchange their jobs for those of the most famous city specialists."¹²⁶

In outlining the character of a heroic Arctic doctor, Southern commentators often drew parallels between the Arctic and the African or tropical context, suggesting that both landscapes were wild and uncivilized, thus demanding a sense of adventure. For example, Paul Hoystradt wrote of Livingstone,

It isn't likely many physicians would... take over his practice. He's the only doctor in an extremely large area and a good deal of the time he has to go to his 'cases' by dog team. When winter's snow turns the Arctic into a great white Sahara... he can't hop in a car and dash off on his rounds.¹²⁷

Livingstone even promoted such links by declaring that he and David Livingstone were actually distant relatives.¹²⁸

¹²⁴ NWTA, Leslie Livingstone Fonds, N87-019, File 2, newspaper clipping, Paul Hoystradt, "Livingstone has been found," 17 May 1942.

¹²⁵ NWTA, Leslie Livingstone Fonds, N87-019, File 2, unidentified newspaper clipping.

¹²⁶ NWTA, Leslie Livingstone Fonds, N87-019, File 2, newspaper clipping, "Canada's Arctic Doctors," *Onward Around the World with a Camera*, 2 January 1938.

¹²⁷ NWTA, Leslie Livingstone Fonds, N87-019, File 2, newspaper clipping, Paul Hoystradt, "Livingstone has been found," 17 May 1942.

¹²⁸ NWTA, Leslie Livingstone Fonds, N87-019, File 2, genealogical papers. See also Leslie Livingstone, "Twenty-Five Years Amongst the Eskimos," speech to the Empire Club, 25 October 1945, <http://www.empireclubfoundation.com/details.asp?SpeechID=629&FT=yes>.

At times then, doctors embraced isolation as a strategy for achieving and demonstrating a heroic masculinity, even celebrating this in self-promoting private correspondence, public autobiographies, documentaries, articles, and films.¹²⁹ However, they also sometimes saw isolation as a threat to their sanity, and by extension their masculinity. For example, an article in the Department of National Health and Welfare newsletter in July 1949 reads,

Because of the conditions of service, married couples interested in living and working in the north are particularly sought after. Most of the northern settlements are isolated for varying periods of the year. It is felt, therefore, that married couples would be better suited for employment in the north than single persons. In spite of the many ways in which northern living has been made more enjoyable in recent years, hardships and difficulties still exist and home life assumes a greater importance than in more populous areas.¹³⁰

In this way, they struggled to “tame” the hospital’s isolation by reproducing familiar and “civilized” gender and family contexts, in order to maintain sanity and ease of living.¹³¹

The Mobility of Disease: Distance, Contagion, and Settlement

While in some contexts non-Inuit health care providers celebrated isolation as a factor shaping and promoting a particular form of masculinity, they were

¹²⁹ For example, Joseph Palmer Moody’s experiences in the Arctic are chronicled in a number of sources including Joseph P. Moody, *Arctic Doctor: An Account of Strange Adventures among the Eskimos* (New York: Dodd Mead, 1955); Moody, *Medicine Man to the Inuit*, and documentary films for the Canadian Broadcasting Corporation, including LAC, Joseph Palmer Moody Collection, Accession 1987-0264, *Arctic Doctor*, 1977. For similar records on Leslie Livingstone, see NWT, Leslie Livingstone Fonds, N87-019, Files 1-2; and Copland, *Livingstone of the Arctic*.

¹³⁰ LAC, Department of National Health and Welfare, RG 85, vol. 269, file 1 [1003-20], Newsletters, *Canada’s Health and Welfare*, 5 July 1949.

¹³¹ This source may also implicitly reflect a fear of sexual improprieties on the part of Arctic doctors. However, I have found no other evidence to suggest that this was a concern.

more ambivalent about the meaning and implications of isolation in the North when they considered the relationship between disease transmission and space. In Southern Canada, the federal government had adopted schemes of centralization in order to settle Aboriginal people in confined physical spaces like reserves, supposedly increasing the effectiveness of government surveillance tactics. Here, it was argued, medical professionals could “do much to improve the health status of the Indians, many of whom were [previously] living in scattered areas under most primitive conditions.”¹³² This also served to separate Aboriginal bodies – seen as inherently diseased – from white bodies, thus protecting local non-Aboriginal communities from epidemics.¹³³

The early and mid-twentieth century saw a heated debate among missionaries, doctors, and government employees (with individual parties sometimes simultaneously taking opposing sides) about the ideal places for Inuit bodies in order to reduce disease incidence in the North. Some argued that the Inuit, like indigenous people in Southern Canada, should settle in permanent, “civilized” towns in close contact with missions, schools, and hospitals. According to this line of thinking, such settlements would cancel out the negative influences of tents and igloos, replacing unhygienic “Inuit” practices with “proper” and “civilized” ways of living, thus reducing the spread of disease. At the same time, this would bring the Inuit into the reach of health care systems. In contrast,

¹³² Quoted in McCallum, “This Last Frontier,” 111.

¹³³ Warwick Anderson, “Postcolonial Histories of Medicine,” in *Locating Medical History: The Stories and Their Meanings*, eds. Frank Huisman and John Harley Warner (Baltimore: The Johns Hopkins University Press, 2004), 293; and Mary-ellen Kelm, *Colonizing Bodies: Aboriginal Health and Healing in British Columbia, 1900-50* (Vancouver: UBC Press, 1998), 106.

others argued that towns and settlements were also places that made the Inuit sick, as indicated by the annual “ship’s flu” that spread at epidemic rates each time a ship from the South contacted an Arctic community. From this position, isolation – both internal (distances between Arctic communities) and external (distances between the Arctic and the South) – appeared to be an important factor in reducing the spread of epidemic diseases, as the Inuit were scattered across the land rather than overcrowded in close proximity to contagions.

Those supporting the latter position argued that the Inuit contracted – and contracted – more diseases as more non-Inuit people came through the area in transient and mobile ways. This argument resonates with experiences in other colonial contexts, as scholars have observed the connections between disease rates and the increased movement of people and pathogens associated with colonialism.¹³⁴ To this end, the Eastern Arctic Patrol papers suggest that, without contact with non-Inuit people, “the topography of the Arctic divides Eskimos into groups which cannot easily come into contact with one another. Disease in one group is therefore not readily transmitted to the next.”¹³⁵ This meant, as Dr. Joseph Elie Maltais contended in 1951, “The more isolated the Eskimo population the hardier it is.”¹³⁶ In response to this common association between a non-Inuit presence and Inuit infection rates, Dr. Frederick Banting argued,

¹³⁴ Hawkins, “To Pray or Not to Pray,” 68.

¹³⁵ N.W.T.A., Alexander Stevenson Fonds, N92-023, Box 39, File 3, Eastern Arctic Patrol, “Standing Orders for Personnel, Eastern Arctic Summer Surveys,” 1955.

¹³⁶ N.W.T.A., Alexander Stevenson Fonds, N92-023, Box 15, File 4, General Meeting on Eskimo Affairs, Dr. Joseph Elie Maltais, Medical Officer’s Report, C.G.S. *N.B. McLean* Patrol in the Hudson Strait, 1951.

Rigid steps should be taken to prevent introduction [of new diseases]... as natives have no knowledge of sanitation and no racial immunity. Everyone entering the Arctic should be examined for communicable diseases.¹³⁷

With this latter suggestion, Banting illustrated one of the ways that non-Inuit commentators hoped to limit disease rates among the Inuit of the Eastern Arctic. Isolation should be maintained as much as possible in order to keep infection rates under control.

However, other proposals did not just rely on regulating non-Inuit bodies, movements, and practices. Instead, this debate quickly became one more about the comparative merits of spatial arrangements – especially igloos, tents and permanent settlements – than about the regulation of non-Inuit movements.¹³⁸

The non-Inuit historical record frequently condemned igloos and tents as unsanitary and disease causing. For example, Turquetil wrote in 1933,

A whole camp stricken with the ailment, at a time when Eskimos live either inside a wet, melting snow-house, the roof of which has already been taken off, or else in a tent put up on top of melting snow and ice. Hence a common cough will soon degenerate into a pneumonia, tonsillitis will be accompanied by dysentery, mumps will be operated upon by natives with disastrous consequences. Too many were dying every year, or left in a weakened condition very much like consumption.¹³⁹

At the same time, federal government administrators argued that even when the Inuit settled in permanent villages, they were living in 'shacks' rather than 'proper'

¹³⁷ NWT Archives, Alexander Stevenson Fonds, N92-023, Box 49, File 5, Inuit Health Reports, Sir Frederick Banting, "Medical Investigations Among Eskimo."

¹³⁸ For example, NWT Archives, Alexander Stevenson Fonds, N92-023, Box 15, File 1, Agenda of Matters to be Discussed at a General Meeting on Eskimo Affairs, 19 May 1952.

¹³⁹ LAC, Northern Affairs Program, RG 85, vol. 193, file 1, R.C. Hospital at Chesterfield Returns, letter from A. Turquetil to H. E. Hume regarding the appointment of a doctor at Chesterfield Inlet, 21 January 1933.

houses, which did little to improve their health situation.¹⁴⁰ To this end, the minutes from the General Meeting on Eskimo Affairs in 1952 read,

Igloos and tents versus permanent dwellings: Permanent buildings ["shacks"] are not yet of any use to the Eskimos. They have no means of heating them. They are cold, damp... and dirty. They are absolutely unhygienic and regular germ breeding places... [On the other hand, there is a] natural need of man for a permanent home, his weariness at having to rebuild his igloo every so often, and his feeling of insecurity in a tent.¹⁴¹

Those at this General Meeting also linked the matter closely with other factors, particularly the impact of wage labour and dietary changes on Inuit health. For example, the final report continues,

The debility of the Eskimos' physique brought on by the progressive change from the only diet suitable for the country – meat and fat – to the insufficient vitaminless regime of the White Man. To this must be added the substitution of woollen and cotton clothes for fur, and sometimes, too, the abandoning of snowhouses for dirty, damp, shacks.¹⁴²

In response to such changes in Inuit lifestyles, representatives at the General Meeting concluded,

Eskimos should be encouraged and helped to live off the land and to follow their traditional way of life. Surveys have shown that where natives subsisted on the produce of the land they were less subject to disease... Dependence on supplies of white man's food and poor game conditions in some areas and the delay in the

¹⁴⁰ Dickerson, *Whose North?*, 74.

¹⁴¹ NWTA, Alexander Stevenson Fonds, N92-023, Box 15, File 4, "Suggestions re: Matters to be Discussed at the General Meeting to be Held May 19th, 1952."

¹⁴² NWTA, Alexander Stevenson Fonds, N92-023, Box 15, File 4, "Suggestions re: Matters to be Discussed at the General Meeting to be Held May 19th, 1952."

isolation and removal to hospital of active cases were contributory causes to the present condition [of high disease rates].¹⁴³

In other words, proponents of this position argued that the Inuit were healthier on the land, eating their own food and remaining isolated and scattered.¹⁴⁴ Tents and igloos retained an ambivalent role in this discourse, sometimes seen as harmful, sometimes framed as better than the alternative.

While the report from the 1952 General Meeting on Eskimo Affairs most clearly illustrates this position, these discourses are also present elsewhere in the historical record. For example, in a report on his 1955 air patrol through the Chesterfield region, R. A. J. Phillips suggested that there were serious problems among the Inuit who had already settled somewhat permanently in the community:

[The] First [major problem] is the establishment of a large group of Eskimos attracted to the mission. As a consequence, it was said, the Eskimos are not going far from the camp to tend trap lines or to hunt caribou, even though the sources of food and fur were plentiful a relatively short distance away... Superintendent Larson suggested that the problems at Chesterfield – or at least its economic problems – could be solved if the Eskimos lived in the settlement in decent houses and the hunters and trappers would absent themselves for sufficient time each year to carry out their

¹⁴³ NWTA, Alexander Stevenson Fonds, N92-023, Box 15, File 4, General Meeting on Eskimo Affairs, Department of Resources and Development, Editorial and Information Division release, 21 May 1952.

¹⁴⁴ This position is, in part, reflective of the broader 'best left as Indians' policy that dominated government policy in the North during this period. Coates, *Best Left as Indians*, 163 and 185. Coates argues here that government administrators in the Yukon thought that hunting, trapping and "traditional" lifestyles offered "the best prospects" for Aboriginal people through the territory. Richard Diubaldo explores the counter-argument to this position in the post-Second World War period, arguing that a number of factors resulted in a shift from a "best left as Indians"-type policy to a "you can't keep the native native"-type policy. See Richard J. Diubaldo, "You Can't Keep the Native Native," in *For Purposes of Dominion: Essays in Honour of Morris Zaslow*, eds. Kenneth S. Coates and William R. Morrison (North York, Ont.: Captus University Publications, 1989), 171-88.

work while leaving their families behind. At present... those living permanently in the settlement do not tend to seek far for game.¹⁴⁵

As such, Phillips argued that the Inuit could balance the benefits and drawbacks of permanent settlement by staying on the land to hunt, and returning the community the rest of the time.

Other sources suggest that this debate was linked with other – sometimes more pragmatic – concerns. David Damas has argued that, prior to the Second World War, the government and the Hudson’s Bay Company fostered a positive relationship in order to keep the “Inuit economy and conditions of life... to those of a fur trade and hunting emphasis” on the land.¹⁴⁶ In the post-war period of increased involvement in health care, the government moved away from HBC interests towards a permanent settlement scheme. However, as the Assistant Chief of the Arctic Division, J. Cantley, reported in 1956:

The situation that has developed at Chesterfield Inlet... where the people have congregated in and around the settlement, is one that should be carefully considered. These people are not being materially affected by the DEW [Distance Early Warning] line or other forms of employment. However, if the people are to continue to live in close proximity to the settlement, other means will have to be devised to provide them with a living. At the present time they are living largely on relief and family allowances.¹⁴⁷

In other words, even if a continued move into permanent settlements might serve as an aid to ‘civilizing’ the Inuit, it also led to serious economic challenges for the

¹⁴⁵ NWTA, Alexander Stevenson Fonds, N92-023, Box 39, File 4, Air Patrols and Inspections, Report of a Trip to the Central Arctic, R. A. J. Phillips, 21 April 1955.

¹⁴⁶ David Damas, “Shifting Relations in the Administration of Inuit: The Hudson’s Bay Company and the Canadian Government,” *Etudes/Inuit/Studies* 17, 2 (1993): 23. See also Tester and Kulchyski, *Tammarniit*, 54.

¹⁴⁷ NWTA, Alexander Stevenson Fonds, N92-023, Box 39, File 5, Air Patrols and Inspections, memorandum from J. Cantley to Mr. J. P. Richards, *Arctic Trip*, 12 March 1956.

community, and by extension, the federal government's welfare division.

Government administrators remained somewhat ambivalent about the benefits of such a move.

Health and disease played a central role in the non-Inuit discussions of the best place for Inuit bodies. By extension, non-Inuit commentators often referred to the place of Ste. Therese's hospital in such conditions. Perhaps not surprisingly, the hospital played a contradictory role in this complicated debate. On one hand, as RCMP Inspector H. A. Larsen wrote, many people thought Ste. Therese's was little more than a "disease [trap]... unfit for human habitation."¹⁴⁸ The hospital brought Inuit bodies into closer contact with contagions that they would not otherwise encounter on the land. On the other hand, Ste. Therese's offered possibilities for bringing them into closer contact with "proper" health care to cure such diseases, while separating them from "traditional" diseased spaces.¹⁴⁹ Ultimately, these conflicts reflected the contradictions in the larger non-Inuit debate on health, disease, and settlement in the Eastern Arctic; isolation simultaneously hampered the spread of diseases and the treatment of them.

¹⁴⁸ LAC, Northern Affairs Program, RG 85, vol. 1234, file 251-1, part 2, letter from H.A. Larsen, 30 October 1951. Quoted in Duffy, *The Road to Nunavut*, 57; and Waldram, Herring, and Young, *Aboriginal Health in Canada*, 172.

¹⁴⁹ This latter debate about the role of the hospital in isolating bodies will be explored further in the section, "A Benefit to the People: Isolating Inuit Patients from an Unhealthy Culture," in the following chapter.

Isolation as Diluting Colonial Power

Colonialism in the Eastern Arctic was also contradictory, complex, and shaped by non-Inuit perceptions of isolation. Ste. Therese's Hospital provides a useful case study for exploring this relationship between colonialism and isolation. In some ways, the hospital represented a colonial presence in the "isolated" Arctic landscape through its reorganization of space, knowledge and power. However, at the same time, isolation worked to dilute the colonial power symbolized by the building, allowing for multiple interpretations of the relationship between space, isolation, colonialism, and the hospital.

Part of the colonial process in the Eastern Arctic relied on the separation of the Inuit from familiar cultural and environmental landscapes and practices.¹⁵⁰ As the previous section demonstrated, non-Inuit commentators debated the how, when, and how much such separation should occur, but their presence in the Arctic necessarily resulted in dramatic changes to Inuit lifestyles anyways. Rhoda Kaujak Katsak, who grew up during mid-twentieth century attempts by the Canadian government to settle and assimilate the Inuit in new spaces, remembered her experience of "coming off the land" in a way that emphasizes the production of new power relations and new knowledge systems:

It was very difficult for me to learn when I was a child that there are other races, like the Qallunaat, who have the power, who have the authority... When I came off the land, the people with any type of authority were Qallunaat... The nurses, they taught us that we weren't supposed to have lice in our hair. We had never thought that lice in our hair was necessarily a bad thing! When I got to town that very first day, they found lice in my hair, they took me to the

¹⁵⁰ For an exploration of the links between imperialism and space, see Good, "Pioneer Medical Missions in Colonial Africa," 5.

nursing station and cut my long hair off. The nurses, they also taught us to take pills when we were sick, those sorts of things.¹⁵¹

The hospital, and the biomedical “knowledge” it entailed, was a part of this larger re-spatialization of the Eastern Arctic landscape, bringing the Inuit into closer contact with new colonial power relations and new conceptions of health, disease, and the body.¹⁵² Indeed, Ste. Therese’s symbolized the development of colonial medical, religious, and educational spaces in which the Inuit, as previously semi-nomadic communities, were relocated and confined in specific, if occasionally tentative, ways.

The hospital was a commanding physical and symbolic imposition on an Inuit cultural landscape, signifying colonial and medical knowledge, power, and permanence. Non-Inuit interests asserted this image in spite of, or perhaps because of, the uncertain and uneven presence of colonial medicine in the North.¹⁵³ In part, the hospital symbolized colonial power through the physical characteristics of the building itself. As Frank Tester and Paule McNicoll argue,

There is a remarkable difference between Inuit buildings and those of the *Qallunaat*. *Qallunaat* buildings are permanent, imposing and impenetrable... Inuit structures – tents, igloos, *qarmaqs* – are, by comparison, temporary, unimposing and can be penetrated physically and vocally with relative ease. The *Qallunaat* structure

¹⁵¹ Nancy Wachowich et al., *Saqiyuq: Stories from the Lives of Three Inuit Women* (Montreal: McGill-Queen’s University Press, 199), 194-95.

¹⁵² David Arnold argues that medicine was, in fact, an integral part of colonialism, with its focus on the colonized body, scientific, rational thought, power/knowledge, and the state. Indeed, he even suggests that there is “a sense in which all modern medicine is engaged in a colonizing process” with its discourses of intervention, “monopolistic rights over the body,” and professionalization. It is also important to remember here, though, that medicine was a critical part – but only one part – of the colonizing process. As he writes, “medicine did not stand alone but occupied a place within a more expansive ideological order and a wider empirical domain.” David Arnold, *Colonizing the Body: State Medicine and Epidemic Disease in Nineteenth-Century India* (Berkeley: University of California Press, 1993), 8-9.

¹⁵³ Tester and McNicoll, “Why Don’t They Get It,” 91.

announces clearly, 'We are here!': not only here, but, 'Here to stay!'¹⁵⁴

In addition, both Joseph Moody's descriptions and historical photographs show the hospital was by far the largest building in the settlement, dominating the otherwise flat horizon.¹⁵⁵ The hospital's lighted cross, intended to guide mariners off the shore, only added to the physical and visual dominance of the building on an otherwise flat landscape;¹⁵⁶ both in the dark and the light, Ste. Therese's asserted a commanding presence in the Chesterfield Inlet area.

However, when the concept of isolation is added to this analysis, we can illuminate this idea of colonial power in new ways as it appears much more tentative, partial, and diluted. Because Chesterfield Inlet – and the hospital more particularly – was not in close proximity to most, or even many, of the Inuit supposedly being colonized, the building's colonial power was immediately challenged by the inability of doctors and missionaries to attract Inuit patients into the building. Ste. Therese's Hospital was supposed to provide medical care for all of the Inuit living across 300 000 square miles, but most of its "patients" had never seen the building, let alone entered it, so its symbolic (visual) presence was already in question.

The Inuit did not just challenge the building's power because they were physically distant or isolated from it, however. The historical record also

¹⁵⁴ Tester and McNicoll, "Why Don't They Get It," 95-96. See *Inuit tents pitched at Chesterfield Inlet with hospital Ste. Therese in background*, 1947, LAC, PA-210318.

¹⁵⁵ For example, Moody, *Medicine Man to the Inuit*, 24; *Chesterfield Inlet Looking North East*, 193-?, LAC, A2875-46; and *Catholic Mission Hospital of St. Therese, Chesterfield Inlet maintains 30 beds, 7 nurses, one of them an Inuk*, 1952, LAC, PA-173132.

¹⁵⁶ Moody, *Medicine Man to the Inuit*, 24.

suggests some of these ways in which the Inuit actively resisted or challenged the hospital's symbolic power, sometimes mobilizing isolation and distance as tools against the institution.¹⁵⁷ In particular, there are a number of examples where the Inuit refused to be treated in the hospital, or to conform to its demands on their behaviour. Many Inuit seem to have avoided the hospital because of their belief that they should avoid places where people have died, while others would only enter once the hospital had already established an Inuit population.¹⁵⁸

For example, the returns from the Chesterfield Inlet Hospital read:

Not all Eskimo patients will agree to come to the hospital, for a while they will have to understand that it is the best thing to do for their own benefit.¹⁵⁹

Similarly, Dr. Joseph Elie Maltais reported in 1951,

I brought to civilization only three (3) Eskimos suffering from easily curable diseases as, when an Eskimo dies in the hospital, his relatives have a very poor opinion of us. This is the reason why it is difficult to persuade them to come to our medical centres for treatment.¹⁶⁰

¹⁵⁷ Alison Bashford and Carolyn Strange, "Isolation and Exclusion in the Modern World: An Introductory Essay," in *Isolation: Places and Practices of Exclusion*, eds. Carolyn Strange and Alison Bashford (London: Routledge, 2003), 12.

¹⁵⁸ Franz Boas, "The Central Eskimo," in *Smithsonian Institution Bureau of Ethnography* (Washington: General Printing Office, 1888), in Tester and McNicoll, "Why Don't They Get It?," 97; John Bennett and Susan Rowley, eds. *Uqaluraiit: An Oral History of Nunavut* (Montreal: McGill-Queen's University Press, 2004), 224; and LAC, Northern Affairs Program, RG 85, vol. 193, file 1, letter from A. Turquetil to Turner, 12 October 1934, and letter from A. Turquetil to O. S. Finnie, 3 June 1929.

¹⁵⁹ LAC, Northern Affairs Program, RG 85, vol. 193, File 1, letter from A. Turquetil to O. S. Finnie, 3 June 1929. Quoted in Tester and McNicoll, "Why Don't They Get It?," 95.

¹⁶⁰ N.W.T.A., Alexander Stevenson Fonds, N92-023, Box 15, File 4, General Meeting on Eskimo Affairs, Dr. Joseph Elie Maltais, Medical Officer's Report, C.G.S. *N.B. McLean* Patrol in the Hudson Strait, 1951.

Providing an example with more detail about Inuit responses to the hospital, Dr. Melling's 1937 report on Ste. Therese's describes the responses of the Pugvik family to hospitalization:

Brought here from the east coast of the Hudson Bay by the 'Nascopie.' Consists of a nine year old boy unable to walk due to flexer spasm of the thigh muscles and loss of power in the extensor muscles, this allegedly due to infantile paralysis, the boy's father, Pugvik, reputed to have been insane but which seems doubtful, and the grandfather, who is senile and in poor health, due to cardiac degeneration. This group refuses to cooperate in any way with the hospital staff at present. Hence it is impossible for me to institute any treatment on the boy. I was able to have the old man in bed for a few days but after trying every available room for natives, including the basement, he decided that he would be better outside. They are constantly arguing about religion, deriding the natives hereabouts, and breaking hospital regulations, it became necessary to threaten them with arrest. Perhaps, if there remains no influence other than ours, at a later date I may be able to have them cooperate more fully.¹⁶¹

On another occasion, doctors tried to transfer two patients from Chesterfield to The Pas for "operation and treatment," but as an administrator in the Northwest Territories Branch, H. Hume, summarized, "The patients were averse to leaving their own country, and either one or both were in such a serious condition that it was very doubtful whether any permanent relief could be hoped for."¹⁶² The doctors' hopelessness and the patients' refusal to leave combined to allow them to remain in "their own country." In other words, Inuit patients sometimes rejected the hospital, and the colonial power and knowledge, and the separation from familiar cultural landscapes that it entailed.

¹⁶¹ LAC, Northern Affairs Program, RG 85, vol. 193, file 1A, R. C. Hospital at Chesterfield Inlet Returns, Dr. Melling's Report on Hospitalization for August, 7 October 1937.

¹⁶² LAC, Northern Affairs Program, RG 9, vol. 810, file 6815, reel T13313, letter from H. Hume to R. Rowatt, 18 March 1932.

Hospital administrators were thus faced with the task of convincing Inuit patients that the care provided in Ste. Therese's was more effective than their own healing strategies. In doing so, they grappled with the reasons why the Inuit refused treatment in the hospital. In 1955, Northern Service Officer Jameson Bond suggested that the Inuit rejected health care programs because such programs failed to account for varying cultural understandings of disease and health:

In the past, well intended and technically competent people have attempted to introduce modern health practices in communities which, up to that time, had viewed public health as something determined by the control of supernatural forces... The failure on the part of the persons carrying out such a technical programme to recognize the basic difference between two concepts of the etiology of disease and institute special measures for its prevention, resulted in frustration, or at least slow progress.

He then proposed a solution involving not so much the incorporation of Inuit conceptions of disease, but rather the cooption of Inuit individuals:

My own field experience in the north demonstrated quite forcibly to me the value of gaining the active interest and support of an Eskimo in the community, who is oriented towards western culture (the white man's way of life) and particularly if this person is influential in the community, it is not long before the other people of the group will follow the example of this influential person.¹⁶³

Whether or not health care providers chose to take Bond's recommendations, it was clear to them that biomedical discourses alone were not sufficient for attracting patients for a number of reasons. Indeed, Moody recognized that the Inuit did not receive his medical "knowledge" as such, instead saying that many

¹⁶³ NWTA, Alexander Stevenson Fonds, N92-023, Box 49, File 4, Inuit Health – General, memorandum from Jameson Bond, Northern Service Officer, to Mr. Silvertz regarding the Eskimo Public Health Program, 2 December 1955.

of them “had more faith in their own witch doctors than in the Kabloona [non-Inuit] medicine man.”¹⁶⁴ In response, he had to shift his expectations and explanations in order to attract or force patients into the hospital. In short, the hospital was not always accepted as a symbol of colonial power, permanence, and knowledge; rather, it faced a variety of challenges to this assertion. Inuit rejections of Ste. Therese’s Hospital were aided by isolation since they could more easily avoid the building, and doctors and missionaries often could do nothing in the face of such challenges.

Recognizing these limitations, missionaries, doctors, and government employees moved towards a “struggle” with isolation, aiming to “tame” it and turn the Eastern Arctic into a more familiar and “civilized” space. As Cole Harris argues, “the conquest of distance” was a “central motor of colonization, enabling an immigrant society to impose its ways.”¹⁶⁵ If non-Inuit health care providers could tame distance and isolation, they could better impose the colonial power and knowledge systems onto a previously Inuit landscape. In the following sections then, I explore how non-Inuit commentators saw the hospital as playing an important role in taming isolation and distance, thus allowing for a more effective imposition of familiar health care systems and increasing colonial control and civilization in the region. In particular, I focus on ways in which these health care providers attempted to work with or beyond the hospital’s isolation in order to shift the spatial relationships between bodies, disease, and medicine in the Eastern Arctic.

¹⁶⁴ Moody, *Medicine Man to the Inuit*, 24.

¹⁶⁵ Harris, “The Struggle with Distance,” 161.

Roving Physicians and a Three-Storey Hospital

In 1929, when Ste. Therese's Hospital was in its early planning stages, Bishop Turquetil wrote to Oswald Finnie, Director of the Northwest Territories and Yukon Branch, to give him an update on the hospital's progress. In this letter, Turquetil asserted, "a hospital would no doubt help saving the lives of some patients whom it is very hard to attend to in a proper way, under snow-houses or tents."¹⁶⁶ While the idea of 'proper' health care provision was never simple or uncontested, this letter suggests that the medical missionaries stationed in Chesterfield Inlet had previously found it difficult to care for the Inuit without familiar facilities and equipment. The hospital was thus framed as a space facilitating the saving of Inuit lives, in direct and explicit contrast to conditions in the Arctic which were seen as disease-causing and inconducive to 'proper' or familiar medical practices.

In the context of such concerns about the disconnects between the Arctic and 'proper' medical practice, the implementation of health care in Chesterfield Inlet was tentative, shifting, and adaptive to Northern conditions. In addition, the recognition that the Inuit sometimes rejected the hospital space meant that health care providers needed a more flexible medical service in the North, which would somehow negotiate Inuit concerns, local conditions, and the non-Inuit emphasis on 'proper' health care delivery. As a result, the specifics of the Arctic as a space – and particularly its sense of distance and isolation – shaped the implementation of health care as it responded to Inuit demands and local conditions.

¹⁶⁶ LAC, Northern Affairs Program, RG 85, vol. 193, file 1, R.C. Hospital at Chesterfield Returns, letter from Turquetil to Finnie, 3 June 1929.

In response to the limitations that Arctic conditions posed for 'proper' medical services in the hospital, some non-Inuit observers called for a unique medical service that would reflect the unique demands of the region and its population by negotiating with the Arctic space in new ways. For example, in the late 1920s, when the Oblates and the Northwest Territories Branch were drawing up plans for the Chesterfield Inlet hospital, two prominent Canadian doctors – both with Arctic experience – spoke out against the proposed building. Dr. Frederick Banting and Dr. Leslie Livingstone both argued that the hospital model was inappropriate for the North, with its geographic and climatic conditions and its scattered population. Rather, they saw the need for a particularly “Northern” medical service, with “roving physicians” who would service the Eastern Arctic with flexible, mobile service focused on the doctors going to the patients in scattered communities rather than the patients coming to the doctors in the hospital. In essence, Banting’s reports suggested that the “proposed hospital... would be a waste of money, as it could be reached by only a few natives. Favours a travelling medical officer who would visit settlements.”¹⁶⁷

However, Turquetil and the Northwest Territories Branch rejected the “roving physician” concept. Indeed, they do not appear to have even seriously considered it, as the debate is largely absent from the hospital’s planning records. This may have been because missionary and civil medical services across Canada and around the world were generally based in a central location like a hospital. As a result, the key figures involved in planning Ste. Therese’s

¹⁶⁷ NWTA, Alexander Stevenson Fonds, N92-023, Box 49, File 5, Inuit Health Reports, Sir Frederick Banting, “Medical Investigations Among Eskimo.”

may have seen the hospital as the best model for providing familiar and 'proper' health care that would contribute rather than take away from larger colonial and missionary goals.

Regardless of the reasons for building the hospital, Ste. Therese's did not actually preclude the existence of "roving" style medical care. Some non-Inuit observers argued,

The Eskimo is a primitive and also a man of one land – taken away from it and from his own, he seems to disintegrate, lose interests – something snaps inside him that greatly impairs – if not preventing his recovery.¹⁶⁸

Because of such attitudes, doctors and others continued to envision a version of the original "roving physician" concept in which they would be stationed at centres like Chesterfield Inlet, but would service remote communities with mobile care throughout the region.¹⁶⁹ For example, Dr. George Hooper argued in 1947, "The present two hospitals [in Chesterfield and Pangnirtung]... could be used as centres where the Medical Officer can make his headquarters for a local survey."¹⁷⁰ In this way, they could access more patients who would be otherwise isolated from the hospital, and treat them in contexts in which they were more comfortable.

Such proposals played out in practice as doctors, missionaries and government employees sometimes shifted their health care practices in response

¹⁶⁸ NWT, Alexander Stevenson Fonds, N92-023, Box 15, File 4, "Suggestions re: Matters to be Discussed at the General Meeting to be Held May 19th, 1952."

¹⁶⁹ LAC, Northern Affairs Program, RG 85, vol. 834, file 7387, reel T13334, Dennis Jordan, 1945 Eastern Arctic Patrol Medical Report.

¹⁷⁰ LAC, Northern Affairs Program, RG 85, vol. 834, file 7387, reel T13334, George Hooper, Report of the 1946 Patrol Trip, 31 May 1947.

to local conditions by taking medical services *to* the Inuit. As Joseph Moody wrote in reference to the 1949 polio epidemic, “We had to treat many of them in their igloos. They preferred it... They wanted to isolate themselves from the whites as much as possible.”¹⁷¹ In this way, he framed the Inuit as mobilizing the concept of isolation in their own way, seeking to separate themselves from diseased spaces and demanding to stay in familiar surroundings. Like in this case, doctors continued to ‘rove’ around the Arctic, using the hospital merely as a base for their work; their duties included regular patrols and emergency trips by any transportation means possible, usually dog team, boat or airplane.¹⁷² They also made use of the existing communication networks, passing messages by word-of-mouth and telegraph systems in order to facilitate their medical care.¹⁷³

The Eastern Arctic Patrol was an important part of this mobile health care strategy to ‘tame’ distances and isolation in the North. Travel across land or sea was dependant on seasons and weather conditions, and as such, it was often difficult for non-Inuit health care providers to access patients on a regular basis. However, the Eastern Arctic Patrol ships opened up a regular corridor of transportation and communication through the region, as the federal government sent ships each summer to patrol the area, provide health care to local inhabitants, and conduct Arctic research.¹⁷⁴ As Cole Harris points out, corridors

¹⁷¹ Moody, *Medicine Man to the Inuit*, 124.

¹⁷² For example, LAC, Joseph Palmer Moody Collection, Accession 1987-0264, *Arctic Doctor*, 1977.

¹⁷³ For example, LAC, Northern Affairs Program, RG 85, vol. 193, file 1, memorandum from H. Hume to Rowatt, 20 April 1933; and Morice, *Taming the Eskimo*, 207-8.

¹⁷⁴ For more about the Eastern Arctic Patrol, see Grygier, *A Long Way from Home*, 86-103; LAC, Northern Affairs Program, RG 85, vol. 834, file 7387, Medical Health Officers reports, Eastern Arctic Patrol; and NWTA, Alexander Stevenson Fonds, N92-023, Eastern Arctic Patrol files.

of transportation and communication such as these allowed for the partial taming of distance, providing opportunities for local strategies to reach the spaces between the main corridors of settlement. In other words, by acting as “capillaries,”¹⁷⁵ corridors like the Eastern Arctic Patrol routes opened up the possibility of connecting Ste. Therese’s Hospital with the “outside,” more specifically with the South, as well as with other Arctic communities.

These strategies suggest that non-Inuit health care providers sought to develop a more flexible medical system in Chesterfield Inlet, one that would take into account the specific needs and possibilities of a distant and isolated landscape. In doing so, they maintained their emphasis on “proper” and familiar health care delivery, and debated the extent to which they should adapt to local conditions. By working either in Ste. Therese’s Hospital or on the Eastern Arctic Patrol ships, missionaries and doctors took their services to Inuit communities, thus working to “tame” the distances involved in Northern health care. However, as one “roving” doctor aboard the *SS Ungava* reported in 1932, “It should be understood that none of the native camps or hunting villages of the Eskimos were seen, only the Police Trading Company posts.”¹⁷⁶ In order to do effectively struggle against distance and isolation, and provide services that were even vaguely “proper” and familiar, non-Inuit health care providers required improvements in personnel levels, and transportation and communication technologies in the Eastern Arctic.

¹⁷⁵ Harris, “The Struggle with Distance.”

¹⁷⁶ Quoted in Dickerson, *Whose North?*, 48.

The Expansion of Services and the Reduction of Isolation

Since distance and isolation were factors in medical and government conceptions of Inuit health and health care, the development of transportation and communication systems in the North played a key role in reconfiguring its spatial relations with Southern Canada, bringing the North within the reach of the “civilized” South, and facilitating the prevention and curing of disease among the Inuit.¹⁷⁷ Indeed, as Daniel Headrick has argued, technological advances – including those in transportation, medicine, warfare, and communication – allowed for, and even stimulated, the penetration and colonization of new areas.¹⁷⁸ Working from this insight, I use this section to demonstrate how non-Inuit health care providers sought to “tame” the hospital’s isolation by expanding transportation, communication, and personnel into the region, even as they debated the health consequences of such a process.

In response to the perceived isolation of the Eastern Arctic, medical professionals and government employees consistently called for the extension of services into the region. As Dr. George Hooper reported in 1946, “Of course there are a great many areas which have never been surveyed from a medical standpoint and with the present set-up never will be.”¹⁷⁹ Without increased

¹⁷⁷ McCallum, “This Last Frontier,” 110.

¹⁷⁸ Daniel R. Headrick, *The Tools of Empire: Technology and European Imperialism in the Nineteenth Century* (Oxford: Oxford University Press, 1981). Other scholars have also demonstrated the complex ways in which changing technologies shifted historical understandings of space and distance, allowing people to imagine and claim new territories. See, for example, Marshall McLuhan, *Understanding Media: The Extensions of Man* (New York: McGraw-Hill, 1966); and Stephen Kern, “Distance,” in *The Culture of Time and Space, 1880-1918* (Cambridge, Mass: Harvard University Press, 1983): 211-240.

¹⁷⁹ LAC, Northern Affairs Program, RG 85, vol. 834, file 7387, reel T13334, George Hooper, Report of 1946 Patrol Trip, 31 May 1947.

services, doctors like Hooper contended, they were unable to provide any kind of adequate or “proper” care.

A key part of the expansion of medical services into the North was to come with an increase in medical personnel stationed in places like Chesterfield Inlet. Doctors stationed in the North consistently called for more support throughout this period, demanding that colleagues be located nearby so they could consult on medical matters and share responsibility for care in the expansive territory. For example, Dennis Jordan wrote in his 1945 Eastern Arctic Patrol Medical Report, “In the Eastern Arctic the scattered population, the geographic and climatic conditions demand a much larger medical and nursing personnel than at present exists.”¹⁸⁰ Similarly, Dr. Orford, the Medical Officer at Pangnirtung in 1940, reported to the Northwest Territories Council:

There is a great deal of medical health work to be done. In his opinion, the service is just in its babyhood and must be extended a great deal to cover the entire eastern Arctic in future, if possible. One man at Pangnirtung cannot hope to cover the entire population.¹⁸¹

With this proposed increase in medical personnel, doctors envisioned a version of the original “roving physician” concept where they would be stationed at centres like Chesterfield Inlet, but would service remote communities more

¹⁸⁰ LAC, Northern Affairs Program, RG 85, vol. 834, file 7387, reel T13334, Dennis Jordan, 1945 Eastern Arctic Patrol Medical Report.

¹⁸¹ LAC, Northern Affairs Program, RG 85, vol. 196, file 550/170, part 2, St. Luke’s (Anglican) Hospital at Pangnirtung Returns, “Report of Dr. Orford, Medical Officer, Pangnirtung,” Extract from the Minutes of the 118th Session of the Northwest Territories Council, 1 November 1940. This is during a period of several years when there was no medical officer stationed in Chesterfield.

effectively by sharing the burden caused by difficult transportation and scattered populations. As Jordan continued,

Having a doctor at Chesterfield and one at Pangnirtung and none in between is totally inadequate. If the staff were increased, the doctors could make patrols and visit camps, such as in the same manner as the Mounted Police. In other words, a doctor could be located at the same posts at which there is a detachment of RCMP and be 'on call,' cover the territory for purposes of inoculation, hygiene, sanitation, etc.¹⁸²

The following year, Hooper argued a similar point, suggesting, "The present two hospitals... could be used as centres where the Medical Officer can make his headquarters for a local survey."¹⁸³

In addition to calls for increased biomedical personnel, technology was another integral aspect of this colonial expansion into the Arctic space, pushing doctors, missionaries, the government, and the Inuit to reconceptualize isolation, and to traverse distances in new or different ways. Of all the technological changes to health care in the North, transportation advances were particularly important in decreasing isolation and increasing medical access into remote places. As Drs. McCarthy and Laidlaw recognized in 1945, "Such additions [of personnel] would be ineffectual without improved transport services."¹⁸⁴

Chesterfield Inlet would be an intermediate point along corridors of transportation, connected to the South via the Eastern Arctic Patrol ships, while

¹⁸² LAC, Northern Affairs Program, RG 85, vol. 834, file 7387, reel T13334, Dennis Jordan, 1945 Eastern Arctic Patrol Medical Report.

¹⁸³ LAC, Northern Affairs Program, RG 85, vol. 834, file 7387, reel T13334, George Hooper, Report of the 1946 Patrol Trip, 31 May 1947.

¹⁸⁴ LAC, Northern Affairs Program, RG 85, vol. 834, file 7387, reel T13334, Drs. McCarthy and Laidlaw, Joint Eastern Arctic Patrol Report, 28 September 1945.

capillaries would also connect it with smaller, more remote communities in the region.

The airplane was the major advance in transportation technology during this period, essentially changing the nature of health care in the Eastern Arctic and shifting non-Inuit conceptions of space and isolation. Non-Inuit commentators celebrated the possibilities the technology offered for medical care in the North. As Northwest Territories administrator Roy Gibson reported in 1945,

Dr. McCarthy is a great believer in the use of aeroplanes and thinks that if suitable planes and experienced pilots are provided there should be little difficulty in visiting most of the places where there is likely to be trouble. In any event, he believes that a system can be worked out whereby sick people will be brought to places which can be visited regularly by plane.¹⁸⁵

Similarly, Dr. Hooper reported the following year,

Transportation has and always will be a big question, but I still consider the aeroplane will continue to be used in an increasing amount. There are times when weather conditions will prohibit its use and also there will be places where they cannot go.... Nevertheless, their sphere of usefulness will increase... The present system of isolated Medical Officers is not a good one... Transportation can be done by whatever means are the most favourable... The aeroplane will be of great value.¹⁸⁶

These celebratory assessments of the airplane were not value-free, but were also an intimate part of the colonial process in the North, and more specifically part of the colonizing element of medical work in the region. The airplane shifted

¹⁸⁵ LAC, Northern Affairs Program, RG 85, vol. 834, file 7387, reel T13334, letter from R. A. Gibson to H. Moore, 12 September 1945.

¹⁸⁶ LAC, Northern Affairs Program, RG 85, vol. 834, file 7387, reel T13334, George Hooper, Report of the 1946 Patrol Trip, 31 May 1947.

understandings of the landscape, changing how people – Inuit and non-Inuit – could interact with the land. They were loud, thereby penetrating not just visual space but aural as well, and allowed contact with ‘remote’ communities or camps quickly and easily. The airplane might also be seen as a symbol of colonial dominance, especially as the Inuit were often forced to enter and use such unfamiliar technology in order to access medical care.¹⁸⁷

By the mid-1940s, most doctors and government employees were putting their hopes in the airplane as the best means of reaching isolated areas. They had previously used boats – most notably with the Eastern Arctic Patrol ships, but also from the hospitals into other communities – as well as dog sleds in winter. This, of course, had kept medical patrols limited seasonally and along the routes of water systems. As Joseph Moody explained in his 1977 documentary, *Arctic Doctor*, “The break-up of ice in the summer makes travel to the more remote areas possible.”¹⁸⁸ In 1945, Drs. McCarthy and Laidlaw argued that the North needed a more comprehensive medical survey and servicing, but

With the mode of travelling which has obtained hitherto, difficulties encountered in an attempt to carry out a large scale survey would be almost insurmountable. On the other hand, by using an aeroplane and a large motor boat, a physician and technician with portable equipment might be able to go over the whole field during the summer months.¹⁸⁹

¹⁸⁷ For one Inuk’s response to the airplane, see Saimaiyuk, “Life as a TB Patient,” 20-21. As Joseph Moody explained, airplane crashes did not help boost Inuit confidence in the new technology. Moody, *Medicine Man to the Inuit*, 147-48.

¹⁸⁸ LAC, Joseph Palmer Moody Collection, Accession 1987-0264, *Arctic Doctor*, 1977.

¹⁸⁹ LAC, Northern Affairs Program, RG 85, vol. 834, file 7387, reel T13334, Drs. McCarthy and Laidlaw, Joint Eastern Arctic Patrol Report, 28 September 1945.

Dr. H. W. Lewis took this argument a step further two years later, suggesting that making the Eastern Arctic Patrol by water necessitated a “great waste of man-days.” He wrote,

Through force of circumstance this year both the Hudson’s Bay Company and the Royal Canadian Mounted Police made partial and successful patrols in the Eastern Arctic by Air transport, thus saving much time and servicing posts that could not be reached by the available ship... It is considered that this department with the Northwest Territories Administration Branch should together make a careful study of the possibility of using air facilities for complete patrol coverage of the Eastern Arctic.¹⁹⁰

Within five years, the Department of National Health and Welfare’s publication, *Canada’s Health and Welfare*, reported, “Doctors and nurses are within flying distance of most areas, even those within the Arctic circle.”¹⁹¹ Non-Inuit commentators clearly described these advances in transportation in terms of isolation, for example proclaiming, “The rapid development of long-range air travel broke down the isolation of the Arctic.”¹⁹²

Of course, geographic and climatic conditions in the North sometimes complicated flying; this was not simply a matter of transplanting infrastructure, equipment and personnel from the South, but was also about developing new techniques that were designed specifically for the North, or that responded

¹⁹⁰ LAC, Northern Affairs Program, RG 85, vol. 834, file 7387, reel T13334, Dr. H. W. Lewis, Regional Superintendent for the Eastern Arctic, Medical Report from the Eastern Arctic Patrol, *SS North Pioneer*, 2 October 1947.

¹⁹¹ LAC, Department of National Health and Welfare, RG 85, vol. 269, file 1003/20, part 1, Newsletters, “Indian and Eskimo Health,” *Canada’s Health and Welfare*, special supplement no. 18.

¹⁹² NWT, Alexander Stevenson Fonds, N92-023, Box 38, File 3, Eastern Arctic Patrol, “Notes for Lecture to Lions Club, Ottawa: 1954 Eastern Arctic Patrol,” 23 November 1954.

specifically to Northern conditions. In this respect, the 1945 Eastern Arctic Patrol doctors wrote,

It is understood that some thought has been given by those in authority toward making adequate use of the aeroplane as a means of keeping in a much more intimate touch with the areas concerned. At Lake Harbour we met eight sergeants of the American Armed Services... They stated that it was comparatively easy to maintain ice runways in winter and water stretches in summer for the accommodation of visiting planes. After the Americans established themselves at Churchill, thousands of flights by amphibian aircraft were made from there far into the North. Is it unreasonable to suggest that attempts should be made to carry, in similar fashion, that aid which is so essential to the health and prosperity of our fellow citizens?¹⁹³

Seasonal or weather conditions were important factors to consider, and they could limit the system of flying patients out of or doctors into communities. As Bishop Turquetil pointed out, "In the middle of winter a pilot would not know where to land."¹⁹⁴ However, these difficulties were increasingly conquered with the development of more effective technologies for the North throughout the twentieth century, including signal stations and weather forecasting, thus further taming isolation in the region by adapting to local conditions.¹⁹⁵

Many non-Inuit observers discussed the airplane in language that invoked images of the North as an isolated and barren wasteland, while the airplane was the technology with which to conquer such territories. For example, one Southern Canadian newspaper described how "the sick are taken out on regular

¹⁹³ LAC, Northern Affairs Program, RG 85, vol. 834, file 7387, reel T13334, Drs. McCarthy and Laidlaw, Joint Eastern Arctic Patrol Report, 28 September 1945.

¹⁹⁴ LAC, Northern Affairs Program, RG 9, vol. 810, file 6815, reel T13313, Dr. D. S. Bruce, Medical Officer, Chesterfield, Notes of Interview with Bishop Turquetil, 19 January 1933.

¹⁹⁵ NWTA, Alexander Stevenson Fonds, N92-023, Box 49, File 5, Inuit Health Reports, "Eskimo Health Services," *Encyclopedia Arctica*, 10.

runs into isolated posts,” when “planes are turned into flying ambulances... [and] pilots fly more warily than ever over the vast uninhabited stretches of lake and bush and rock.”¹⁹⁶ Other newspaper articles celebrated the advantages of the airplane over the primitive, albeit exotic, dogsleds, as it was more effectively able to reduce distance and isolation in the North:

Hardly visible in the raging blizzard which swept in from the Atlantic, a plane stood out on the ice... Its skis were buried deep in the drifting snow, and its pilot was watching the skies with the hope that the heavy snow would soon stop. On the shore, a dog sled stood in readiness for the pilot’s signal... The doctor... had said that only an operation would save the woman’s life... By land or over sea ice the trip by dog team would have taken weeks. Less than four hours after taking off, Pilot W. E. Wardle landed his ship on its skis at the Quebec airport, taxied it alongside an ambulance, and a few minutes later the sick woman was in a hospital.¹⁹⁷

However, transportation became, at other times, a balancing act between old and new technologies: the airplane and the dog. As Dr. J. A. Urquhart wrote, it was:

often necessary to fly for considerable distances and bring in severe injuries or emergency sicknesses. The winter flying is difficult due to very short days and adverse weather conditions, with poor visibility. It also has the disadvantage of being point to point, while with dogs one can travel regardless of the light and usually regardless of the weather conditions, and at the same time with the dogs one visits every family en route. The airplane is invaluable for long distances and where time is a factor. The dogs, however, come into their own when one is making a patrol and wishes to make first-hand observations of the people as a whole, whether sick or well.¹⁹⁸

In other words, both had their benefits and drawbacks for the Arctic environment.

While dogs conquered distances in some senses, bringing doctors into closer

¹⁹⁶ NwTA, Leslie Livingstone Fonds, N87-019, File 2, unidentified newspaper clipping.

¹⁹⁷ NwTA, Leslie Livingstone Fonds, N87-019, File 2, unidentified newspaper clipping.

¹⁹⁸ NwTA, Alexander Stevenson Fonds, N92-023, Box 49, File 5, Inuit Health Reports, J. A. Urquhart, “Most Northerly Practice in Canada.”

contact with individuals and moving across the land in any conditions, airplanes could travel much faster and further, allowing doctors to target particular locations in the case of medical emergencies.

While advances and increases in non-Inuit transportation systems improved access to health services in the North, advances in communications were also important to this process. In particular, radio and telegraph stations found in many Northern communities were essential to the Canadian government's health care policy for the Inuit. Government health care provision relied on the interaction between communication and transportation systems to make "remote" communities accessible to doctors. In this way, as Dr. Maltais summarized in 1953, "The whites could... contact civilization with the help of the large governmental stations and ask for help in case of emergency and thus facilitate evacuation by plane." He then continued, proposing, "Valuable help could be given to the sick Eskimos through a grant to amateur radio stations where the sick often take refuge."¹⁹⁹ This system of radioing for help, and either bringing in a doctor or evacuating patients by plane, was the official policy in Chesterfield Inlet in the many years between 1931 and 1958 when there was no doctor appointed to the community. The Northwest Territories and Yukon Branch and Bishop Turquetil officially negotiated this arrangement upon the government's decision to recall Donald Bruce as Medical Officer at Chesterfield

¹⁹⁹ LAC, Northern Affairs Program, RG 85, vol. 834, file 7387, reel T13334, Joseph Elie Maltais, Medical Officer's Report, C.G.S. *N.B. McLean* Patrol in the Hudson Strait, 1953.

in 1932, and re-implemented it whenever the hospital was without a doctor.²⁰⁰

As these examples suggest, the expansion of medical services into the Eastern Arctic was largely dependent on the “taming” of distance and isolation through changes to, and the interplay between, personnel, transportation, and communication in the North.

By the 1950s, shifts in personnel, transportation, and communication had transformed the provision of health care in the Canadian Eastern Arctic. While doctors and other health care providers still faced challenges from “improper” or unfamiliar conditions, non-Inuit observers argued that hospitals and doctors were no longer as isolated. Rather, as one Southern newspaper article celebrated,

Medical aid has come to the isolated settlements of the Canadian sub-Arctic and Arctic, where spaces are vast and the population is small, where the snow hems in the people nearly ten months of the year. Within the past few years hospitals have been established, x-ray equipment and surgical apparatus are available, doctors and nurses have been appointed to various outposts. Where there is no doctor, aeroplanes often carry the patient to medical aid, or the nearest radio station makes contact with Ottawa, where doctors are becoming accustomed to handling operations and giving directions to patients thousands of miles distant.²⁰¹

Non-Inuit health care providers were thus in much closer contact with “civilized” and specialist care in Southern Canada, and were able to mobilize new technologies to reach new areas and to incorporate new patients into their medical system.

²⁰⁰ See, for example, LAC, Northern Affairs Program, RG 9, vol. 810, file 6815, reel T13313, Dr. D. S. Bruce, Medical Officer, Chesterfield, letter from A. Turquetil to H. E. Hume regarding postponed appointment of a doctor at the hospital of Chesterfield, 11 March 1932.

²⁰¹ NwTA, Leslie Livingstone Fonds, N87-019, File 2, unidentified newspaper clipping.

Conclusion

In this chapter, I have argued that non-Inuit commentators saw Ste. Therese's Hospital as an isolated space, but that the meanings associated with this were ambivalent, contested, and often contradictory. Missionaries, doctors, and government administrators encountered unfamiliar conditions in the Eastern Arctic, and struggled to understand them, live in them, or change them. Health care serves as a fruitful case study for exploring this process, as familiar medical equipment and facilities were not available in the North, and thus health care providers had to adjust to local conditions in various ways. This process was a colonizing one that depended on particular characterizations of the North as uncivilized and unhealthy; ultimately, missionaries, doctors, and government employees framed the hospital as a way to shift the relationships between Inuit bodies and disease. At the same time, doctors embraced isolation as a celebration of a particular form of masculinity, and as a possible strategy for "naturally" reducing the spread of contagious diseases. However, health care providers and policy-makers also struggled against isolation as hampering the provision of familiar and "proper" medicine in the North, and thus as diluting the impact of the hospital as a colonizing and healing institution. In response, they developed flexible medical services – a variant of the "roving physician" concept – in order to adapt to isolation and distances in the Eastern Arctic. They also worked to increase transportation, communication, and personnel in order to reduce distances and facilitate ease of access. As Alexander Stevenson explained to Ottawa's Lions Club in 1954, these changes meant, "The Eskimos

could no longer be treated as an isolated group, but that steps would have to be taken to prepare them to take their place in a changing Arctic and eventually to be assimilated into the Canadian economy."²⁰² With changes to technology and health care in the North came changes to Southern understandings of the Inuit's role in Canada.

²⁰² NWTA, Alexander Stevenson Fonds, N92-023, Box 38, File 3, Eastern Arctic Patrol, "Notes for Lecture to Lions Club, Ottawa: 1954 Eastern Arctic Patrol," 23 November 1954.

3. RE-PLACING DISEASED BODIES AND DISEASED SPACES: MEDICAL AND SOCIAL ISOLATION PRACTICES IN THE HOSPITAL

Throughout the early history of Ste. Therese's Hospital, non-Inuit commentators framed it, on a basic level, as a space through which to isolate bodies and diseases in order to prevent or cure illness. It is this conceptualization of the hospital that forms the heart of this chapter, as I consider the practices and discourses that defined Inuit bodies as diseased and thus necessitating isolation in Ste. Therese's Hospital. In doing so, I argue that Ste. Therese's worked to control the movements of bodies and pathogens according to a complex interplay of medical, racial and colonial discourses. I do this in three primary ways: by showing how the hospital was designed and intended as a space to prevent the spread of disease through the isolation of bodies and pathogens; by tracing the discourses that produced Inuit spaces and cultures as diseased, and by demonstrating the ways in which the hospital was intended to isolate the Inuit from these in order to prevent further spread; and finally by examining the ways in which the hospital building itself was designed around internal concepts of isolation that separated bodies from one another based on simultaneously-articulated medical, social and racial discourses. In this chapter, then, I argue that missionaries, doctors, and government employees designed and used Ste. Therese's Hospital in such a way as to shift the relationship between the Inuit and their surroundings in order to prevent or cure illness. In

other words, the hospital's spatial characteristics, in dialogue with the social, worked to control the movements of bodies and pathogens according to contemporary discourses on disease, race, and colonialism.

Theorizing Isolation and the Hospital

While the previous chapter examined Ste. Therese's Hospital in terms of its distance and isolation from the South, this chapter takes the concept of 'isolation' in different theoretical directions. Here, I use it to indicate a particular kind of spatial practice produced through, legitimated by, and resisted in discourses. In her 2005 study of hospital architecture and isolation practices, Jeanne Kisacky offers a conceptual framework for understanding 'isolation' as an interplay between social and spatial practices in a medical context. On a basic level, hospital isolation practices essentially work to keep 'things' separate from one another in order to prevent or cure disease. As such, Kisacky argues, historical studies of such practices require an understanding of their spatial and material elements.²⁰³ This framework informs my work in this chapter. At the same time, my use of the concept of 'isolation' also depends on a number of more complex questions that accompany this basic formula. In particular, I probe the historical contexts of such practices in Ste. Therese's Hospital, including the particular forms isolation takes in different conditions, the various justifications given for them, the multiple and conflicting responses to them, and the ways all these change over time.

²⁰³ Kisacky, "Restructuring Isolation," 2.

Many historians have analyzed practices of isolation – both in the hospital and in other settings – as inextricably linked with power. For example, in the introduction to their edited collection *Isolation: Places and Practices of Exclusion*, Alison Bashford and Carolyn Strange argue that isolation practices are imbued with particular configurations of power, regardless of whether they claim to punish, cure, or protect those being segregated.²⁰⁴ In this respect, even though hospitals justify isolation practices based on goals of curing and prevention, Bashford and Strange maintain that hospitals also developed as an integral part of the modern state's "ambition to track, know and manage populations."²⁰⁵

The idea that isolation practices in the hospital are spatial manifestations of power relations has been strongly influenced by the work of Michel Foucault. According to Foucault, "space is fundamental in any exercise of power."²⁰⁶ In terms of the hospital more specifically, he suggests that the development of a post-Enlightenment European conceptualization of medicine and illness was closely connected with the workings of space, power, and knowledge production in several ways. On one level, illness – particularly epidemic disease – was seen increasingly as a spatial problem, as particular city and building designs encouraged the movement of pathogens from one body to another.²⁰⁷ However, Foucault also frames space and disease as interacting with power in a much more complex manner as well. In this respect, his conception of space is dually

²⁰⁴ Bashford and Strange, "Isolation and Exclusion in the Modern World," 2-3.

²⁰⁵ Bashford and Strange, "Isolation and Exclusion in the Modern World," 4.

²⁰⁶ Michel Foucault, interview in *The Foucault Reader*, ed. Paul Rabinow (New York: Pantheon Books, 1984), 252.

²⁰⁷ Foucault, "Space, Knowledge, and Power," 352. See also Ian Buchanan and Gregg Lambert, "Introduction," in *Deleuze and Space*, eds. Ian Buchanan and Gregg Lambert (Toronto: University of Toronto Press, 2005), 3.

focused, examining the interplay between the body as a “spatial form defined by bodies of knowledge like medicine” and disciplinary spaces that “confer command over such bodies.”²⁰⁸ According to Foucault, the interactions between these spaces worked to bring bodies into contact with comprehensive medicalizing discourses.²⁰⁹ With this, disciplinary institutions like hospitals played a key role in ordering space in order to facilitate and further the official production of knowledge about bodies. While I only partially apply Foucault’s frameworks to the specifics of a colonial Eastern Arctic setting,²¹⁰ my basic conceptualization of isolation takes inspiration from this theoretical literature, considering it as both a spatial and a social practice, articulated through particular configurations of power in the hospital setting.

Disease, Isolation, and the Role of the Hospital

For centuries, the hospital, as a general form, has been conceptualized as a space for reducing the spread of disease through various isolation practices.²¹¹ While this basic tenet has remained fairly consistent through the institution’s history, Jeanne Kisacky demonstrates that it has taken specific manifestations over time. Her focus is primarily on shifting architectural designs in response to

²⁰⁸ Felix Driver, “Bodies in Space: Foucault’s Account of Disciplinary Power,” in *Reassessing Foucault: Power, Medicine, and the Body*, eds. Colin Jones and Roy Porter (London: Routledge, 1994), 113. For Foucault’s dual examination of the production of the body as spatial form and the development of the hospital as disciplinary space, see Michel Foucault, *The Birth of the Clinic: An Archaeology of Medical Perception*, trans. A. M. Sheridan Smith (New York: Vintage, 1994).

²⁰⁹ Michel Foucault, “The Birth of Social Medicine,” in *Michel Foucault: Power*, ed. James D. Faubion (New York: The New Press, 1994), 135.

²¹⁰ For some theoretical explorations of the applicability of Foucauldian thought to colonial settings, see Ann Laura Stoler, *Race and the Education of Desire: Foucault’s History of Sexuality and the Colonial Order of Things* (Durham: Duke University Press, 1995); and Vaughan, *Curing Their Ills*.

²¹¹ Bashford and Strange, “Isolation and Exclusion in the Modern World,” 4.

new disease theories that changed ideas about the relationship between bodies, diseases, and space. According to Kisacky, in the nineteenth century, prevalent medical discourses emphasized the potential for environments to actually cause diseases. As such, hospital architecture in this period was primarily designed to promote air circulation and to provide complete isolation facilities. Around the turn of the twentieth century, however, disease theory shifted to redefine the role of air, physical surroundings and space on contagion. Newly developed germ theories suggested that physical spaces could not, in fact, cause diseases, but rather that diseases spread by the uncontrolled movement of bodies and pathogens.²¹² In these shifting discourses, then, “scientific sample-taking and laboratory analysis” were increasingly important for identifying diseases.²¹³ As such, twentieth-century hospital architecture continued to offer possibilities for isolation, but these depended more on the social management of people rather than the spatial isolation of contagious diseases.

In other words, by the time Ste. Therese’s Hospital was completed in 1931, other hospitals in North America were based on a particular idea of isolation that had shifted from previous centuries. While the separation of the unhealthy from the healthy continued through and within hospital buildings, the definitions and understandings of these had changed dramatically.²¹⁴ Ste. Therese’s Hospital differed, of course, in a number of ways from Kisacky’s New York Hospital and others of this period. However, the historical documents

²¹² Kisacky, "Restructuring Isolation," 40.

²¹³ Kisacky, "Restructuring Isolation," 42.

²¹⁴ Kisacky, "Restructuring Isolation," 46.

relating to the Chesterfield hospital still clearly suggest the importance of isolation in the hospital's architecture and practices, even while local conditions shaped the specific manifestations of such discourses on isolation.

Begun in 1929 and completed in 1931, Ste. Therese's Hospital was "of wooden construction, steam heated, electrically lighted, equipped with X-Ray, iron lung, etc. and staffed by conscientious and qualified nurses."²¹⁵ Its primary intended purpose, as reflected in non-Inuit correspondence, was to prevent the spread of disease among local Inuit communities by confining bodies and pathogens in regulated ways. In order for this to happen, health care providers and administrators first had to conceptualize disease as a contagion that could be contained through isolation. Indeed, annual hospital reports from Oblate missionaries and government-employed doctors framed isolation tactics as extremely effective in preventing the spread of disease. For example, as Turquetil described in 1942,

On the 22nd of August, 5 people from Southampton Island were examined by Dr. McKee on account of their showing signs of scabies. The Doctor ordered them back to Southampton to avoid the spreading of the disease among Chesterfield people. But early in September, 4 others were brought in, they were in the well advanced stage of scabies. The doctor had foreseen that, and given orders to isolate them thoroughly, it was done, and they all recovered pretty soon.²¹⁶

²¹⁵ LAC, Northern Affairs Program, RG 85, vol. 194, file 2, R.C. Hospital at Chesterfield, "Precis for the Northwest Territories Council: Chesterfield Hospital and Industrial Home," 26 November 1943.

²¹⁶ LAC, Northern Affairs Program, RG 85, vol. 194, file 2, R.C. Hospital at Chesterfield, letter from A. Turquetil to R. A. Gibson, 12 October 1942.

Similarly, in August 1936 there was a bout of the ‘yearly epidemics’ – usually identified as a cold or influenza that came with the ships from the South – and over half of the hospital beds were full. According to Turquetil, “the doctor was contemplating to establish the ‘quarantine’ all around, as the cases were pretty serious.”²¹⁷ In other words, doctors stationed at Ste. Therese’s were actively promoting a form of isolation in order to prevent the spread of disease and cure existing illnesses.

Epidemic disease was a particular problem – and thus a particular fear – in the mid-twentieth-century Eastern Arctic. Whenever doctors isolated patients in order to prevent the spread of illnesses, they were explicitly concerned that they were dealing with the beginning of a new epidemic. As such, correspondence on the hospital repeatedly framed it as a space that facilitated isolation practices, thus preventing the start of epidemics and helping to end those that had already begun. In particular, non-Inuit observers credited Ste. Therese’s Hospital with saving countless Inuit lives because of its ability to curb the spread of epidemics that previously had run rampant through the population, as Turner wrote in 1935:

At the time the hospital was completed – September 1931 – an epidemic broke out but due to the facilities then available no deaths occurred. However, if the hospital had not been in existence an epidemic of this nature would have run rampant and, no doubt, resulted in the death of many.²¹⁸

²¹⁷ LAC, Northern Affairs Program, RG 85, vol. 193, file 1A, R.C. Hospital at Chesterfield Returns, letter from A. Turquetil to Deputy Minister of Interior, 1 December 1936.

²¹⁸ LAC, Northern Affairs Program, RG 85, vol. 193, file 1, R.C. Hospital at Chesterfield Returns, memorandum from Turner to R. A. Gibson regarding Chesterfield Hospital, 8 July 1935.

Similarly, in July 1942 Turquetil submitted the hospital reports from the first four months of the year, summarizing that they had dealt with the 'yearly epidemics' particularly well that year:

They [the hospital returns] show no epidemics affected the natives in any serious way. A slight touch of influenza sent 6 people to hospital at the same time, but none of them stayed more than three days there. Apparently, the disease was taken care of on the right time, cured promptly and prevented from spreading among the population.²¹⁹

Architectural design is often a fundamental aspect of isolation practices.²²⁰

In the case of Ste. Therese's, missionaries, doctors, and government employees saw the particularly large size of the hospital as an essential element of its ability to isolate and cure patients in the case of epidemics. For example, Turquetil explained in 1934:

We realize... that a hospital of 4 or 5 beds for emergencies would not be much of a help in case of epidemics that claim so many lives if not properly attended to in a proper hospital. You will remember that my intention in putting up this hospital was to save the lives of the young people, in case of yearly epidemics, and this is why I put up a large building, the more so because it was the only one for the whole Western section of Hudson's Bay, with a population of nearly 2000 people. True enough, the upkeep of a large hospital will cost a lot more, and for instance, should be the same proportion of these last four months apply to the whole year, it would be very hard to meet the expenses at the end, but we want to be and keep ready to save a good number of lives in case of epidemics, which are so frequent, and to avoid contagion in the few cases of tuberculosis.²²¹

²¹⁹ LAC, Northern Affairs Program, RG 85, vol. 194, file 2, R.C. Hospital at Chesterfield, A. Turquetil to R. A. Gibson, submission of hospital and Industrial Home monthly reports from January-April, 6 July 1942.

²²⁰ Kisacky, "Restructuring Isolation," 2.

²²¹ LAC, Northern Affairs Program, RG 85, vol. 193, file 1, R.C. Hospital at Chesterfield Returns, A. Turquetil to Turner, report and return for August-November 1933, 11 April 1934.

At other times, 'travelling doctors' had to regulate and quarantine Inuit bodies without the use of the hospital. For example, during one chickenpox epidemic near Chesterfield Inlet, Leslie Livingstone found it "impossible to keep the nomads from visiting each other and in ten days the disease spread throughout the camp." However, he eventually managed to check the epidemic through the use of isolation within and of the camp, spurring a newspaper to celebrate his work: "In other days it would have spread to other camps but the fur-clad physician put that camp under rigid quarantine for five weeks and so checked the epidemic."²²²

However, usually doctors were able to use the hospital building itself. During the mid-twentieth century, hospitals were commonly seen as spaces facilitating the isolation of pathogens in order to cure and prevent infection.²²³ Ste. Therese's Hospital was similar in this respect, as correspondence on the hospital frequently invoked the building's potential for isolating contagious diseases. The hospital's annual report for 1933 sums up these discourses, as Turquetil asserted its ability to save lives through isolation practices:

Our hospital was a necessity to save Eskimo lives: out of a population of 60 to 65 at or around and close by the post, epidemics were killing nearly four young people average, every year. This hospital has proved very useful: not one young patient died of epidemics, since it was opened, (two seasons now) and I am very anxious to be able to keep it up.²²⁴

²²² NWTA, Leslie Livingstone Fonds, N87-019, File 2, newspaper clipping, Thomas Wayling, "Fur-Clad Physician."

²²³ For example, Kisacky, "Restructuring Isolation," 48.

²²⁴ LAC, Northern Affairs Program, RG 85, vol. 193, file 1, R.C. Hospital at Chesterfield Returns, letter from A. Turquetil to H. E. Hume, 6 February 1933.

By emphasizing that no deaths occurred from any of these epidemics, such reports justified the building of the hospital, and the expense involved in maintaining it, especially because of its size. However, these reports also highlight the role that the hospital space played in isolating contagious diseases that previously would have run unchecked through the Inuit population. Ultimately, the goals of treatment in Ste. Therese's Hospital were framed as curative and preventative throughout this period, aimed most particularly at curbing the spread of epidemic diseases through isolation.

“A Benefit to the People”: Isolating Inuit Patients from an Unhealthy Culture

In her 2001 study of Plains Aboriginal medical history, Maureen Lux argues that social categories like gender, class, and race have historically framed discourses on health, disease, and medicine, especially in colonial settings.²²⁵ In *Colonizing Bodies*, Mary-Ellen Kelm argues that the medical care historically provided to Aboriginal people by the government and missionaries was intimately linked with colonialism, even as it was framed as a humanitarian project.²²⁶ At the heart of this colonial relationship was the idea that indigenous people were inferior, and the widespread and devastating impact of disease on Aboriginal communities was taken as biological 'proofs' of this.²²⁷ However, this attitude was not directed simply at the physical health of Aboriginal bodies, but was also

²²⁵ Maureen K. Lux, *Medicine That Walks: Disease, Medicine, and Canadian Plains Native People, 1880-1940* (Toronto: University of Toronto Press, 2001), 5.

²²⁶ Kelm, *Colonizing Bodies*, 100.

²²⁷ Lux, *Medicine That Walks*, 6 and 9.

aimed at the culture as a whole.²²⁸ This section of my thesis responds in part to this literature by exploring the ways in which discourses on race and culture, and theories of disease transmission shaped the isolation practices in Ste. Therese's, and more importantly how these were intertwined with one another. While non-Inuit observers saw Ste. Therese's Hospital in part as a space for isolating epidemics and preventing the spread of disease, discourses on the hospital also expressed concerns with the relationship between Inuit cultural spaces and the health of Inuit people. Indeed, correspondence on the hospital tended to frame Inuit culture as quite literally diseased, both in the sense that traditional lifestyles were seen as facilitating the spread of illness through unhealthy practices (the pathologization of Inuit culture), and in the sense that Inuit bodies were seen as susceptible, weak and inherently diseased (the racialization of Inuit bodies). As such, historical documentation on the hospital emphasized its potential for separating Inuit individuals from such a diseased lifestyle, thereby limiting the spread of contagions.

In general, non-Inuit discourses worked to discredit Inuit lifestyles and healing practices, characterizing them as uncivilized, ineffective, and even harmful to overall health. For example, reports from the Canadian Arctic Expedition from 1927 reported that the Inuit frequently suffered from "seal poisoning," which was "a malady developed in handling seal meat."²²⁹

Missionaries blamed famines and illness in Inuit communities on traditional

²²⁸ To this end, Kelm suggests, "Indigenous healing and ceremonial, indeed the whole of the culture, was seen as sick and in need of remedial influences under the conditions of contact." Kelm, *Colonizing Bodies*, 102.

²²⁹ NWT, Leslie Livingstone Fonds, N87-019, File 2, newspaper clipping, "Ice-Buffered Beothuc Back from 7000-Mile Arctic Cruise."

“taboos” and belief systems, while of course implicitly or explicitly promoting the rationality and practicality of Christianity. For example, Reverend Morice claimed,

The taboo against hunting caribou when the hunter already had some seal meat in the house had sometimes the effect of postponing the hunt until the annual migration of the caribou was over, the animals were out of reach and the family faced starvation. Another taboo forbade the making of winter clothes until it was possible to build the igloo on fresh-water ice, and often in the meantime the cold caused serious illness, for the first onset of winter brings a penetrating wet cold. When an Eskimo died, a taboo required that everything belonging to him... should be destroyed. Added to the tyranny of the taboos was the hardship of having to make burdensome offerings to the dead or to the inexorable spirits that lived at the bottom of the sea.²³⁰

In addition, non-Inuit observers identified some Inuit relationships as incestuous, arguing that these were primary reasons why their bodies were weak and diseased. For example, George Binney’s health education book, *The Eskimo Book of Knowledge*, has an entire chapter devoted to explaining the evils of incest. As he says, some marriages “produce strong children,” while others – the incestuous ones – “produce weak children.”²³¹ Continuing, he writes,

When a man and his wife are of the same stock, then their children only have in their bodies a single strength, so that they are likely to be weaker than the children of parents who are of different blood.²³²

Reverend Morice celebrated the impact that missionary activity in the Chesterfield Inlet area had on such practices, writing,

²³⁰ Morice, *Thawing Out the Eskimo*, 200-201.

²³¹ George Binney, *The Eskimo Book of Knowledge* (London: Hudson’s Bay Company, 1931), 126.

²³² Binney, *The Eskimo Book of Knowledge*, 128.

The clan spirit is being superseded by the Christian idea of the family. As a direct result marriages between near relatives are becoming a thing of the past, and with them sterility and rickets.²³³

In essence, non-Inuit commentators argued that the Inuit knew nothing about hygiene and sanitation, and actively created hardship and ill health for themselves.²³⁴ Quite simply, the report from the 1952 General Meeting on Eskimo Affairs concluded, "Their way of life in common... has helped a lot in spreading the contagion."²³⁵ It was therefore up to non-Inuit people to "educate" them, or physically separate them from such practices in order to prevent or cure disease.²³⁶

Inuit healing practices were particularly central in these discourses that linked disease rates with culture. For example, Dr. Livingstone reported in 1938, "If an Eskimo child falls sick... the mother's only attempt at remedy is to feed it. In fact, whatever happens to an Eskimo they give him things to eat."²³⁷ In contrast, he framed his own biomedical expertise as being the "proper" way to treat such illnesses. Similarly, Dr. Lewis criticized Inuit responses to tuberculosis, suggesting that their "high morbidity and mortality rate" was linked

²³³ Morice, *Thawing Out the Eskimo*, 199.

²³⁴ LAC, Northern Affairs Program, vol. 193, file 1, R.C. Hospital at Chesterfield Returns, letter from A. Turquetil to Turner, 11 April 1934.

²³⁵ NWT, Alexander Stevenson Fonds, N92-023, Box 15, File 4, "Suggestions re: Matters to be Discussed at the General Meeting to be Held May 19th, 1952."

²³⁶ There were several publications disseminated among Inuit communities in an attempt to "educate" about sanitation, hygiene, disease, and healthy living. See, for example, Binney, *The Eskimo Book of Knowledge*; Canada, Bureau of Northwest Territories and Yukon Affairs, Lands, Parks and Forests Branch, Department of Mines and Resources, *The Book of Wisdom for Eskimo* (Ottawa, 1947); and Frank Tester, Paule McNicoll and Peter Kulchyksi, "Arctic Absterion: The Book of Wisdom for Eskimo, Modernism and Inuit Assimilation," *Etudes/Inuit/Studies* 23, 1-2 (1999): 199-220.

²³⁷ Quoted in NWT, Leslie Livingstone Fonds, N87-019, File 2, magazine clipping, "Canada's Arctic Doctors," *Onward Around the World with a Camera*, 2 January 1938.

with the fact that they made “no attempt made to treat or segregate open cases.”²³⁸ Again, these statements set up an implicit comparison between erroneous or absent Inuit healing practices and rational, active biomedical treatment. These criticisms did not just come from doctors, however. Southern newspapers frequently reported stories such as this:

An Eskimo has but one cure for a swelling or similar ailment; to thrust a knife in. When the knife has been used in the hunting and not cleaned afterward, the remedy is worse than the disease.²³⁹

In addition, missionaries bemoaned what they saw as Inuit “despair” in the face of disease, suggesting that patients would rather commit suicide than treat the problem.²⁴⁰ In short, non-Inuit discourses generally suggested that Inuit cultural practices were diseased and disease causing, and that their healing practices did little to combat this.

While non-Inuit commentators framed Inuit cultural and healing practices as diseased, they also saw the spatial conditions in which Inuit people lived on the land as particularly conducive to the spread of contagious diseases. Indeed, tents and igloos became almost synonymous with disease in much of the correspondence on Ste. Therese’s Hospital. In contrast, non-Inuit discourses framed the hospital as the antidote to such conditions; by isolating patients from the unhealthy conditions in which they lived, the hospital was seen as both curing the already sick (bodies and cultures), and preventing the spread of contagious disease which otherwise would run rampant through Inuit communities. For

²³⁸ Quoted in Duffy, *The Road to Nunavut*, 69.

²³⁹ NWT, Leslie Livingstone Fonds, N87-019, File 2, magazine clipping, “Canada’s Arctic Doctors,” *Onward Around the World with a Camera*, 2 January 1938.

²⁴⁰ For example, Morice, *Thawing Out the Eskimo*, 193 and 200.

example, Dr. Heinbecker suggested in 1931, "Living in tents or igloos makes treatment of TB difficult, as they keep infecting one another. Could best be segregated and treated in hospitals."²⁴¹ Similarly, in 1933 Bishop Turquetil wrote,

To help preserving the Eskimo race, it was necessary to put up a hospital, and it is necessary to keep on operating it. For, every year, between seasons, epidemics occur, which, though of a rather benign nature, do kill too many young people, owing to the lack of proper lodging and attendance.²⁴²

Again, the hospital building provided the solution to such problems of "proper lodging and attendance," allowing for effective isolation and treatment of cases.

Turquetil continued in the same letter,

Not so when and where patients can go to the hospital. Last summer, we had up to twenty-nine patients at a time: not one died, most of them recovered perfectly within a few days, only those who had been weakened either by previous attacks, or by not being able to come to the hospital as soon as they felt sick, had to be kept for a longer period.²⁴³

In this way, he framed the hospital as a space in which Inuit patients could be cured by being separated from diseased environments and ineffective healing practices.

²⁴¹ NWTA, Alexander Stevenson Fonds, N92-023, Box 49, File 5, Inuit Health Reports, Dr. Heinbecker, "Medical Investigation Among Eskimo," 11 June 1931.

²⁴² LAC, Northern Affairs Program, RG 85, vol. 193, file 1, R.C. Hospital at Chesterfield Returns, letter from A. Turquetil to H. E. Hume regarding the appointment of a doctor at Chesterfield Inlet, 21 January 1933.

²⁴³ LAC, Northern Affairs Program, RG 85, vol. 193, file 1, R.C. Hospital at Chesterfield Returns, letter from A. Turquetil to H. E. Hume regarding the appointment of a doctor at Chesterfield Inlet, 21 January 1933. These ideas were also reflected in Archibald Fleming's correspondence on the Anglican hospitals in the Eastern Arctic in this period, suggesting relative agreement across denominations as well. For example, he wrote that hospitals were best since "at that time the Eskimo were pagan, and often made it very difficult for the Missionaries to treat the patients properly in their tents and snow huts." Quoted in Waldram, Herring, and Young, *Aboriginal Health in Canada*, 165.

Missionaries, doctors, and government employees did not just view the hospital as a way to protect sick patients from an unhealthy environment, but they also framed it as a way to protect other Inuit people from the dangers of their lifestyle; by isolating the diseased individuals, the hospital was able to transform Inuit camps into healthier places. For example, the 1952 General Meeting on Eskimo Affairs reported, "The stricken must be hospitalized as much as for the protection of the others as for their own welfare."²⁴⁴ Similarly, in 1934 Turquetil wrote,

Not only were they better looked after and cared for in the hospital than it would have been possible in the Eskimo camps, but also and specially that their admission into the hospital eliminated the danger of contagion among other children, who would partake the same bed, clothing, drinking cups and so forth, if these had been left in the camps.²⁴⁵

In a similar letter, he argued that the hospital had an important function for isolating contagions, even if biomedical doctors and Grey Nun nurses could do little to treat the patients themselves:

Two orphans, one from Eskimo Point, the other from Repulse Bay are suffering from tuberculosis, and I am told that there is little hope for their recovery, but it seems plain to me that the admission of such patients is a benefit to the people, as they would be a danger of contamination for members of their family if kept with and by their people who know nothing about hygienic cautions in such cases.²⁴⁶

In the latter letter's accompanying report, Turquetil added, "There is little hope for their recovery, but it seems plain to me that the admission of such patients is a

²⁴⁴ NWTA, Alexander Stevenson Fonds, N92-023, Box 15, File 4, "Suggestions re: Matters to be Discussed at the General Meeting to be Held May 19th, 1952."

²⁴⁵ LAC, Northern Affairs Program, RG 85, vol. 193, File 1, R.C. Hospital at Chesterfield Returns, letter from A. Turquetil to Turner, 12 October 1934.

²⁴⁶ LAC, Northern Affairs Program, vol. 193, file 1, R.C. Hospital at Chesterfield Returns, letter from A. Turquetil to Turner, 11 April 1934.

benefit to the people” because it would prevent the inevitable spread of disease within a culture that knew “nothing about hygienic cautions.”²⁴⁷ As these examples demonstrate, the conceptualizations of Ste. Therese’s Hospital produced by Turquetil and federal government employees were not simply about the building’s ability to isolate cases and prevent the spread of contagious disease. Rather, this concept was simultaneously imbricated with the expression of inherent judgments of Inuit culture and practices. Non-Inuit observers framed Inuit living conditions as unhygienic and ultimately the cause of outbreaks of disease on the land.

Ste. Therese’s was an unusually large hospital, especially considering the scattered and small population of the Chesterfield Inlet area. In 1936, Bishop Turquetil wrote, “I do not know of any other [hospital] of the same proportions... 40x60, with basement, and two stories, and accommodation for forty patients.”²⁴⁸ He justified the hospital’s unusually large size along two main lines:

1) We needed accommodation for all patients during epidemics. I could not stand any longer loosing [*sic*] 4, 5, 6 young people every year for the lack of proper attendance and accommodation. A hospital with four or five beds for emergency cases might have proved somewhat useful, but would have been a mere show during yearly epidemics. 2) We needed a place to take charge of ‘old, impotent (temporarily or permanently) of any age, during the periodic starvations, in order to eradicate the custom of killing baby girls at birth, and so to save the race as the Government is anxious to do by all means.²⁴⁹

²⁴⁷ LAC, Northern Affairs Program, RG 85, vol. 193, file 1, R.C. Hospital at Chesterfield Returns, A. Turquetil to Turner, report and returns for August-November 1933, 11 April 1934.

²⁴⁸ LAC, Northern Affairs Program, RG 85, vol. 193, file 1A, R.C. Hospital at Chesterfield Returns, letter from A. Turquetil to the Deputy Minister of Interior, 1 December 1936.

²⁴⁹ LAC, Northern Affairs Program, RG 85, vol. 193, file 1A, R.C. Hospital at Chesterfield Returns, letter from A. Turquetil to the Deputy Minister of Interior, 1 December 1936.

In both lines of reasoning, then, Turquetil conceptualized the large hospital as saving Inuit lives, and by extension, the 'race'. However, this dual preventative purpose was not merely conceptualized as a medical process, but it also aimed to reorient Inuit cultural practices (or stereotypes thereof) by preventing the killing of baby girls at birth.²⁵⁰ In this sense, the issue was not always about disease in a strictly 'medical' sense, but was also about the framing of Inuit practices as unhealthy or wrong. As such, non-Inuit discourses often conceptualized the hospital as a vehicle to prevent deaths in a whole variety of medical and socio-cultural ways.

During the winter of 1932-1933, Chesterfield Inlet became the centre of a varicella (chicken pox) epidemic among the Inuit population. In his 20 April 1933 report to government administrator H. E. Hume, Turquetil wrote,

Apparently... this sickness was brought in into the camp by outsiders, but nobody could tell exactly wherefrom, as natives come from all quarters. Out of a population of about a hundred persons at or around Chesterfield, nearly 75 took sick. 34 patients were received in the hospital. Only two old ladies died of it [both of whom are also listed as having previous medical problems]... Together with the chicken pox, dysentery set in, one child of 4 years died: that was the only death among young people. All others were saved. They had up to 38 patients at a time, in the hospital.²⁵¹

²⁵⁰ The idea that the Inuit killed baby girls was one of the more common to appear in ethnographic and travel writing from the late nineteenth and early twentieth centuries. It has continued to be a contentious issue. For example, Morice, *Thawing Out the Eskimo*, 199; Stacey B. Day, *Tuluak and Amaulik: Dialogues on Death and Mourning with the Inuit Eskimo of Point Barrow and Wainwright, Alaska* (Minneapolis: Bell Museum of Pathobiology, 1973), for example 20-21, and 39-40.

²⁵¹ LAC, Northern Affairs Program, RG 85, vol. 193, file 1, R.C. Hospital at Chesterfield Returns, A. Turquetil to H. E. Hume, summary report, 20 April 1933.

Under epidemic conditions, the individual isolation of patients was impossible, even in such a large hospital. However, as Turquetil describes, the fathers and nuns working in the hospital still focused on controlling the epidemic by separating the ill from unhealthy conditions on the land when possible, ventilating rooms to promote air circulation, and overall educating the sick on 'proper' practices to prevent and cure:

For a while they were a little crowded, as two upstairs rooms were not yet finished, nor ready for use, but the father and sisters could not leave patients highly fevered in their iglus without fuel to heat them, nor without any assistance. The two fathers and the brother at the mission gave a hand to the sisters, distributing meals for patients, washing dishes, ventilating the rooms, etc, besides spending much time comforting and encouraging the patients during the first week of the illness, when they felt so poor, owing to high fever. Besides that, the epidemics broke in the camps all around. Father Ducharme visited them. He states that in most cases, pneumonia also set in, owing to the wet conditions of the iglu, and also owing to the fact that fevered patients, not knowing any better, would lay outside to feel cooler. Therefore, those patients who could not come to the hospital kept sick for a long time, many recovered somewhat and took sick again, finally many were left alive but in a much weakened condition. The nurse, Rev. Sister Heroux, went also and visited patients in the camps close by, that is not more than a day distance from the hospital.²⁵²

An analysis of Turquetil's report on this epidemic demonstrates the role of isolation – internal and external – in the running of Ste. Therese's Hospital, and the fears and realities of secondary infections during epidemics of contagious diseases. It also gives a sense of the basic steps taken by hospital staff during outbreaks of disease, with ventilation and comfort being key parts of the medical missionaries' work. The rationale that Inuit spaces were 'diseased' (medically

²⁵² LAC, Northern Affairs Program, RG 85, vol. 193, file 1, R.C. Hospital at Chesterfield Returns, A. Turquetil to H. E. Hume, summary report, 20 April 1933.

and socially) and that Inuit healing practices simply made diseases worse becomes very apparent, with the hospital as a safe place to isolate and cure both unhealthy bodies and cultures.

However, this was neither a simple nor a uniform characterization. Indeed, as I explored in the previous chapter, non-Inuit individuals and groups frequently cited contradictory causes of disease, pressuring Inuit families both to move off the land and to stay on it. While the hospital worked as a space in which to “cure” diseased bodies and unhealthy cultural practices, it also brought patients into closer contact with pathogens. At the same time, non-Inuit commentators disagreed about the importance of isolating Inuit patients from familiar places and people in order to heal bodies. For example, RCMP Inspector H.A. Larsen observed in 1951,

The effect on these people when being taken from their native surroundings and friends is not good... The period of recovery and convalescence might be much shorter if the Eskimos went under treatment in the environment to which they belong.²⁵³

Similarly, Dr. Moody, the Oblates, and the Grey Nuns appeared to have clashed over the best treatment for Inuit tuberculosis patients. From Moody's perspective at least, the conflict arose over different theories on medical care and isolation.

A government summary report of the conflict reads,

²⁵³ LAC, Northern Affairs Program, RG 85, vol. 1234, file 251-1, part 2, letter from H.A. Larsen, 30 October 1951. Quoted in Duffy, *The Road to Nunavut*, 57. Of course, this recognition did not prevent the implementation of the Southern hospitalization program for Inuit patients in the post-Second World War period. Indeed, Larsen was probably compelled to make this observation *because* Inuit patients were being taken out of familiar environments for health care purposes on a regular basis. For more on the Southern hospitalization program and other health care initiatives that separated Inuit patients from familiar settings, see, for example, Grygier, *A Long Way from Home*; Tester, McNicoll, and Irniqu, “Writing for Our Lives”; and Sarah and Simon Saimaiyuk, “Life as a TB Patient in the South,” *Inuktitut* 71 (1990): 20-24.

Briefly the trouble seems to have started early last fall when Dr. Moody tried to change some of the hospital procedures along more modern lines. Apparently some of the T.B. cases were allowed to visit around the hospital and industrial home and native visitors were allowed in to see them at will. Further as the hospital only has seven beds for natives many of the TB cases were quarantined in tents outside the hospital. These tents were also open to visitors at will and in some cases the family including small children lived in the same tent with the sick person. Dr. Moody felt that under these conditions the hospital was doing more to spread the disease than to treat it. His attempt to have the Mission segregate the TB cases were not favourably received it being claimed that the natives were accustomed to visiting their sick relatives at will and they would not understand any change.²⁵⁴

It is clear, then, that at least some non-Inuit people saw some benefits to Inuit cultural practices and spaces, suggesting that they perhaps facilitated the healing process in ways that the hospital could not. However, even as these people contested ideas about the diseased nature of Inuit culture and spaces, they continue to sustain the underlying assumptions in such attitudes. Particular spaces were conducive to disease transmission or to medical care, and it was up to non-Inuit health care providers to determine the best locations for Inuit bodies in order to keep them healthy.

Internal Segregation: The Medical and the Social

While Ste. Therese's Hospital was oriented towards these forms of isolation, other practices of internal segregation were also literally built into the architecture and running of the hospital as patients were physically separated from one another within the building. Jeanne Kisacky emphasizes that hospital

²⁵⁴ LAC, Northern Affairs Program, RG 85, vol. 1002, file 16498, reel T13986, Medical Health Officer, Chesterfield, Dr. J. P. Moody, confidential letter from Wright to Gibson, 22 August 1947.

practices have historically isolated patients based on both social characteristics and those of their diseases.²⁵⁵ Making a similar argument, Annmarie Adams uses a case study of temporary hospitals in Canada during the First World War to illustrate how they categorized their patients according to class, gender, and disease, thus working to “separate and segregate before healing.”²⁵⁶ An examination of the internal structure and practices within the hospital reveal that Ste. Therese’s, like these other institutions, produced gendered and racialized bodies through a variety of isolation tactics within the building itself.

In Chesterfield Inlet, the hospital building was physically divided into sections, separating particular functions of the space from one another. In his 1995 memoirs, *Medicine Man to the Inuit*, Joseph Moody describes how the hospital was internally divided:

Downstairs it had facilities for old and crippled Eskimos. Upstairs I found an adequate dispensary and examining room, X-ray equipment, a developing room, a small laboratory, a surgery and space for about fourteen Eskimo patients. A small separate cubicle could be used for white patients.²⁵⁷

Like biomedicine itself, which was occupied with separating the body into distinct parts and systems, the hospital was based on the separation, even the isolation, of distinct activities and categories of people. The patients (bodies, or their constituent parts and fluids) moved through a series of stages within the building

²⁵⁵ Kisacky, "Restructuring Isolation," 47.

²⁵⁶ Adams, "Borrowed Buildings," 44.

²⁵⁷ Moody, *Medicine Man to the Inuit*, 23.

in specific ways.²⁵⁸ This movement was dependent on the classification – by the doctor – of their bodies and pathologies. These “internal lines of isolation”²⁵⁹ could separate men from women, children from adults, and patients by category of disease, ultimately becoming the spatial manifestations of biomedical and social discourses that worked to redefine knowledge, healing and the body. In the case of Ste. Therese’s, this was not merely a “medical” process, but also a racializing one, as the patients’ bodies were identified as “Eskimo” or “white,” and isolated from one another accordingly.²⁶⁰ At the same time, this was also a gendering process, as women and men were housed in separate rooms.²⁶¹ In this sense, patients were segregated in ways similar to hospitals in the South, sometimes even disregarding the medical afflictions that caused them to be hospitalized in the first place.

Other social conditions were also medicalized and segregated in the hospital setting. For example, the admission of patients to the hospital for whom “nothing” could be done – biomedically, at least – led to the creation of the industrial home for “aged and infirm” Inuit in 1937. This concern for the welfare of such individuals appears to have grown from two strands of thought about the

²⁵⁸ This similar in some respects to the yaws screening buildings described by Vaughan in the African context, through which African bodies were moved and defined in regimented ways. Vaughan, *Curing Their Ills*, 49-52.

²⁵⁹ Bashford and Strange, "Isolation and Exclusion in the Modern World," 11.

²⁶⁰ While less space was taken in the non-Inuit historical record for defining and racializing white bodies, their treatment in the hospital appears to have differed from that of Inuit patients – not just because they had a separate room. They were usually treated for less serious medical issues, rarely requiring overnight stays, and dental work was one of the most common reasons for coming to the hospital. See LAC, Northern Affairs Program, RG 85, vols. 193 and 194, R.C. Hospital at Chesterfield Returns, monthly reports.

²⁶¹ For visual evidence of the segregation of patients according to gender, see LAC, Northern Affairs Program, RG 85, vol. 193, file 1, R.C. Hospital at Chesterfield Returns, photographs included with letter from A. Turquetil to H. E. Hume, 20 April 1933.

Inuit. First, ethnographic and travel writing from the preceding century was saturated with references to the abandonment and killing of elders, orphans, and otherwise 'weak' individuals.²⁶² Second, non-Inuit commentators on the industrial home hoped to aid Inuit hunters on the land by "relieving" them of the duty of caring for weaker family members.²⁶³ The industrial home was housed in the same building as the hospital, but government administrators repeatedly specified that inmates and patients should be separated from one another. For example, Roy Gibson wrote to Turquetil outlining the conditions under which they had created the industrial home, including the following:

It will be necessary to segregate those admitted to the industrial home from the regular hospital patients. Reverend Father Plourde felt you would either divide the hospital building or assign one of the floors, preferably the upper one, for the inmates of the industrial home.²⁶⁴

In the case of the Chesterfield industrial home, then, missionaries, doctors, and government administrators medicalized the 'aged and destitute' as requiring space in the hospital, but kept them separate from other cases.

As these examples suggest, the internal organization of the hospital produced a space that was organized in a very particular way according to biomedical and social conceptions of bodies. Another important element in

²⁶² For example, Boas, *The Eskimo of Baffin Land and Hudson Bay*, 117. This has continued to be a contentious issue. See, for example, McGrath, "Inuit Write About Illness," 30; and Day, *Tuluak and Amaulik*, 20-21 and 39-40.

²⁶³ LAC, Northern Affairs Program, RG 85, vol. 193, file 1A, R.C. Hospital at Chesterfield Returns, R. A. Gibson to A. Turquetil, 6 July 1938.

²⁶⁴ LAC, Northern Affairs Program, RG 85, vol. 193, file 1A, R.C. Hospital at Chesterfield Returns, letter from R. A. Gibson to A. Turquetil, 25 May 1937. See also LAC, Northern Affairs Program, RG 85, vol. 193, file 1A, R.C. Hospital at Chesterfield Returns, letter from R. A. Gibson to A. Turquetil, 26 October 1937.

defining and racializing these bodies was in laboratory research on “the diseases of the Eskimo,” conducted in Ste. Therese’s Hospital by the Department of Indian Affairs, the Department of National Health and Welfare, and individual doctors.²⁶⁵ Research was also a fundamental part of the Eastern Arctic Patrol doctors’ work, with projects conducted on topics such as blood types, diet and nutritional deficiencies.²⁶⁶ These research objectives influenced social and spatial practices in the hospital setting. For example, in 1939, Dr. Thomas Melling wrote Gibson asking for laboratory space in the hospital so that he could pursue such questions, saying,

I would call your attention to our correspondence of recent date relative to preparation of material for presentation in Canadian Medical Journal. This organization, and also representations of the Department of Pensions and National Health, asked that a general paper be presented concerning diseases of the Eskimo. Clinically this is possible but I would hesitate to do so without first having gained laboratory knowledge of the cases to be presented. Therefore, to comply with this request is impossible because of lack of laboratory facilities at Chesterfield. Indeterminate illnesses have been met with at Chesterfield, but until such time as laboratory knowledge becomes available there will be only slow progress in treatment. Hence space in the hospital should be set aside for laboratory purposes, the fitting and construction of this should be under the supervision of the medical man, and the required chemical reagents, stains and equipment should be supplied.²⁶⁷

²⁶⁵ Some of these were diseases recognizable to non-Inuit observers, like influenza and tuberculosis, but were particularly influencing Inuit populations. Others were ‘culturally-bound’, like *pibloktoq* (Arctic hysteria), which were attributed to psychoanalysis, environment, nutrition, and cultural or social factors, as Lyle Dick has shown. Lyle Dick, “Pibloktoq (Arctic Hysteria): A Construction of European-Inuit Relations?,” *Arctic Anthropology* 32, 92 (1995):1-42. See also James B. Waldram, *Revenge of the Windigo: Construction of the Mind and Mental Health of North American Aboriginal People* (Toronto: University of Toronto Press, 2004), 195-99.

²⁶⁶ LAC, Northern Affairs Program, RG 85, vol. 834, file 7387, reel T1334, Medical Health Officers Reports, Eastern Arctic Patrol, part 2.

²⁶⁷ LAC, Northern Affairs Program, RG 85, vol. 193, file 1A, R.C. Hospital at Chesterfield Returns, memorandum from T. Melling to R. A. Gibson regarding hospital equipment, 3 October 1939.

Bishop Turquetil, however, received this idea more cautiously. Writing Gibson in 1940, he argued that space concerns simply did not allow for medical research, since it would be less beneficial to the Inuit patients than actual medical treatment. Laboratory work was simply another pursuit, not an integral part of the hospital itself, according to Turquetil:

We might find one room in the hospital, and this room would be occupied by scientific instruments. But I should consult the staff and the doctor at the Hospital, before I give a definite answer... But I am sure that we could not accommodate any scientist, not even a single one, without causing the building meant to be a hospital, become anything but hospital.²⁶⁸

Nonetheless, by the time of Joseph Moody's tenure in Chesterfield in the late 1940s, there was laboratory space in the hospital.²⁶⁹

The research conducted in this laboratory was spurred by lingering concerns that the Inuit were a 'vanishing race,' due to the notion that either their bodies or their lifestyles were particularly susceptible to disease.²⁷⁰ Turquetil, doctors, and various government agencies raised this idea repeatedly in correspondence, often accompanied by demands for further research into how to deal with the specific diseases and health concerns faced in the Arctic. Epidemics were particular triggers for research, with some scientists suggesting, for example, that a diet of egg powder had been the primary cause of the polio

²⁶⁸ LAC, Northern Affairs Program, RG 85, vol. 193, file 1A, R.C. Hospital at Chesterfield Returns, letter from A. Turquetil to R. A. Gibson, 19 February 1940.

²⁶⁹ Moody, *Medicine Man to the Inuit*, 23.

²⁷⁰ For a general exploration of the links between race, science and medicine, see Waltraud Ernst and Bernard Harris, eds., *Race, Science and Medicine, 1700-1960* (London: Routledge, 1999). For an exploration of similar discourses in the Canadian setting, see Mary-Ellen Kelm, "Diagnosing the Discursive Indian: Medicine, Gender, and the 'Dying Race,'" *Ethnohistory* 52, 2 (Spring 2005): 371-406.

epidemic that hit Chesterfield in 1948 and 1949.²⁷¹ Unlike some other colonial contexts, there does not appear to have been research conducted on white bodies in the Arctic setting.²⁷² Instead, Northern research sought, in part, to limit future epidemics in the region, with an eye to understanding the unique characteristics of Inuit bodies in order to prevent disease. Indeed, in the aftermath of the polio epidemic, medical researchers reported, “Much useful scientific information has... been gathered on the spread and behaviour of epidemics of communicable diseases amongst primitive people.”²⁷³ Using this information, researchers questioned whether the apparent Inuit susceptibility to disease was a part of traditional lifestyles, a ‘natural’ result of ‘civilizing’ them, or a matter of inherent weakness in their racially different bodies. At the same time,

²⁷¹ Dr. Patton put forward the main proposal to this end, sparking debate among Indian Health Services, the Northern Administration & Lands Branch, a Welfare Teacher stationed on Southampton Island, the Hudson’s Bay Company, and the Chief Epidemiology Division of the Department of National Health and Welfare. Most tried to discredit Patton’s research, but suggested further samples should be collected and experiments performed on humans and monkeys. LAC, Northern Affairs Program, RG 85, vol. 855, file 8012, reel T13352, Chesterfield District Medical Reports, egg powder file.

²⁷² For explorations of colonial laboratory research on white bodies, see especially Warwick Anderson, “‘Where Every Prospect Pleases and Only Man is Vile’: Laboratory Medicine as Colonial Discourse,” *Critical Inquiry* 18 (Spring 1992): 506-529; and Warwick Anderson, *The Cultivation of Whiteness: Science, Health and Racial Destiny in Australia* (New York: Basic Books, 2003). There are several factors that may at least partially account for the lack of research on white bodies in the Arctic. For example, colonizers tended to find themselves susceptible to “local” diseases – often associated with foreign environments – in the earlier colonial period, and particularly in tropical regions. Anderson, “Postcolonial Histories of Medicine,” 293; Julyan G. Peard, *Race, Place, and Medicine: The Idea of the Tropics in Nineteenth-Century Brazilian Medicine* (Durham: Duke University Press, 1999); Warwick Anderson, *Colonial Pathologies: American Tropical Medicine, Race, and Hygiene in the Philippines* (Durham: Duke University Press, 2006); and Mark Harrison, “‘The Tender Frame of Man’: Disease, Climate, and Racial Difference in India and the West Indies, 1760-1860,” *Bulletin of the History of Medicine* 70 (1996): 68-93. These discourses that linked the environment, climate, race, and disease may simply have seemed less relevant in the twentieth-century Canadian Arctic, where white bodies were more susceptible to cold and perhaps a form of environment-induced madness than pathogenic disease. See Davidson, *The Idea of North*, 191 for more on this latter point.

²⁷³ NWTA, Alexander Stevenson Fonds, N92-023, Box 49, File 4, Inuit Health – General, letter from R. A. Gibson to Honorary Secretary-Treasurer of the Professional Institute of the Civil Service of Canada, 31 January 1950.

researchers also questioned whether the Inuit had 'natural' (racial) immunity to some diseases. In 1937, for example, newspapers in Southern Canada reported:

The hope of the medical world that there was one race immune from cancer, the Eskimo, has vanished with the report reaching the Department of Mines and Resources that a native from Lake Harbour on Baffin Island has been found to be afflicted with the disease... Each year doctors in the Eastern Arctic expedition examine hundreds of natives. This year they examined 700. Never before have these examinations revealed cancer.²⁷⁴

In short, research conducted in Ste. Therese's Hospital not only required space within the building, but it also shaped biomedical and government knowledge about Inuit bodies and their relationships to disease.

Each of these examples – the defining and isolating of bodies, the separation of social ills from medical ills in the industrial home, and the production of laboratory research in the hospital – demonstrates the ways in which the spatial divisions within the hospital were reflections of social and medical discourses articulated through one another. As Bashford and Strange argue more generally,

Practices of isolation – especially penal and medical isolation – involved the arrangement of bodies-in-space and the regulation of contact between them. The placement of differently gendered, sexualised and racialised embodied individuals *vis-à-vis* each other became a policy obsession in the modern era.²⁷⁵

²⁷⁴ NWTA, Leslie Livingstone Fonds, N87-019, File 2, newspaper clipping, "Banting Says Cure of Cancer Problem Won't Come by Chance; Discoverer of Insulin Asserts After 35 Years of Research, Only Three Treatments are of Proven Value," 14 December 1937.

²⁷⁵ Bashford and Strange, "Isolation and Exclusion in the Modern World," 12.

In the case of Ste. Therese's, the practices of isolation and the physical arrangement of space in the hospital building produced gendered and racialized bodies through intertwined medical and social discourses.

Conclusion

In this chapter, I have argued that non-Inuit discourses on Ste. Therese's Hospital emphasized the importance and value of isolation practices that defined and controlled Inuit bodies in particular ways. First, I suggested that missionaries, doctors, and government employees conceptualized the hospital as a space for isolating bodies and pathogens in order to prevent the spread of contagious disease. I then traced the discourses that pathologized Inuit culture as diseased and Inuit healing practices as ineffective, demonstrating the ways in which non-Inuit administrators intended the hospital to isolate diseased bodies from these diseased cultures in order to prevent further spread. Finally, I examined the ways in which the hospital building itself was designed around internal concepts of isolation that defined and physically separated bodies from one another based on simultaneously articulated medical, social and racial discourses.

CONCLUSION

In November 1945, federal responsibility for health care in the Canadian Arctic was transferred from the Department of Mines and Resources to the Department of National Health and Welfare. Six months later, on 13 May 1946, the Minister of National Health and Welfare, Brooke Claxton, told the House of Commons that Inuit health had been:

a matter of serious concern to the government for some time... I may say that we had a conference here on February 8 of this year which was attended by some of the prominent doctors who have made the trip to the far north in recent years... We have had their assistance in drawing up plans for dealing with the exceedingly difficult problems of the Eskimo and we hope to be able to do something further to extend the service that they have already been given in that field where there are some 7,700 Eskimos scattered over a territory of nearly 700,000 square miles.²⁷⁶

However, these plans to improve health care services in the Canadian Arctic did not prove to be very effective. In 1954, nine years after National Health and Welfare took over responsibility for Inuit health care, an official memo claimed, "Medical and health services in the Yukon and Northwest Territories often fall seriously below the standards generally acceptable in Canada."²⁷⁷ Despite the help of prominent doctors, the federal government was still struggling with the "exceedingly difficult problems" of Inuit health care provision in the Canadian Arctic.

²⁷⁶ Canada, House of Commons, *Debates*, 13 May 1946. Quoted in Duffy, *The Road to Nunavut*, 55-56.

²⁷⁷ LAC, Northern Affairs Program, RG 85, vol. 333, file 1009-3, part 5, "Memo re Northern Health Services." Quoted in Grant, "Inuit History in the Next Millennium," 99.

Today, successive federal governments continue to name health care as a political priority, but Canada's Inuit communities still grapple with major health problems. In 2003, Health Canada reported that levels of tuberculosis, HIV, type 2 diabetes and other diseases are significantly higher in Inuit communities than in the rest of the country. In 2007, the national Inuit organization, Inuit Tapiriit Kanatami (ITK), published a statistical profile on the Canadian Inuit population, reporting that tuberculosis rates were almost fourteen times higher than the rate for all Canadians, suicide rates were more than eleven times higher than the Canadian average, and infant mortality rates were about four times higher than for all Canadians.²⁷⁸ Mothers encounter contaminants in the Arctic environment on such high levels that they cannot safely breastfeed their children. At the same time, Canadian Arctic communities face a shortage of trained health care professionals, high turnover rates, and difficulties accessing even the most basic of nursing stations.²⁷⁹

On 19 April 2007, the Canadian Federal Health Minister Tony Clement announced that his department would be opening a new office in Ottawa to address "the unique health challenges Inuit face across the country, from epidemics to health-care access in remote communities." ITK president Mary Simon embraced the announcement, saying that the Inuit have been "receiving

²⁷⁸ The category "all Canadians" retains the original phrasing. It is unclear exactly who constitutes "all Canadians"; the report does not clarify whether the rates for "all Canadians" include Inuit statistics or whether it only includes non-Inuit statistics.

²⁷⁹ Health Canada, "A Statistical Profile of the Health of First Nations in Canada," 2003, http://www.hc-sc-gc.ca/fnih-spni/pubs/gen/2003_stat_profil/index_e.html; Marla Cone, *Silent Snow: The Snow Poisoning of the Arctic* (New York: Grove Press, 2005); and Inuit Tapiriit Kanatami, "Inuit Statistical Profile," 2007, http://www.itk.ca/publications/StatisticalProfile_Inuit2007.pdf.

health services that are really geared towards southern people,” and Ottawa has of yet failed to recognize their “unique health issues.”²⁸⁰ As James Waldram, Ann Herring and Kue Young suggest in their seminal work, *Aboriginal Health in Canada*, these present-day health problems among Aboriginal communities, and the resulting discrepancy between Aboriginal and non-Aboriginal health statuses in Canada, are rooted in historical processes and conditions. As such, Waldram, Herring and Young call for scholars to examine the historical underpinnings of the relationship between Aboriginal people, the government, and the health care system in order to understand and improve contemporary conditions.²⁸¹

In this thesis, I have begun to explore the historical roots of these contemporary conditions. Initially, I was particularly interested in historical discourses of “unique health issues” in the North, reproduced by Clement and Simon in 2007. More specifically, I wanted to examine how health care providers imagined particular problems as being “Northern,” attempted to solve them with Southern-developed policies, and then shifted such policies on the ground in response to Northern conditions. In this respect, I expected to find sources that described a health care policy developed in the South with little understanding of the specific and unique needs of the North, or on the other hand, sources that described a health care policy that was particularly concerned with the unique requirements of a Northern climate, geography and population.

²⁸⁰ Canadian Broadcasting Corporation, “Inuit Health Office to Open in Ottawa: Clement,” 19 April 2007, <http://www.cbc.ca/canada/north/story/2007/04/19/inuit-health.html>.

²⁸¹ Waldram, Herring, and Young, *Aboriginal Health in Canada*, ix.

However, when I began my analysis, it became clear that the history of Ste. Therese's Hospital was a more complex negotiation of space, disease, medicine, bodies, and colonialism. This was not simply a matter of implementing foreign policies and shifting according to local conditions. Instead, I began to focus on the complex ways in which discourses on isolation shaped health care in Ste. Therese's Hospital by defining the relationship between space, bodies, medicine, and disease in particular ways, as a way through which to approach larger questions about colonial medicine in the North. In doing so, I examined how non-Inuit discourses produced particular relationships between bodies and spaces as healthy or diseased, thus shaping how health care providers understood the hospital's isolated location and allowing their discourses on isolation to shape medical practices in the hospital. More specifically, I did so using missionary, doctor, and government discourses on the hospital in order to demonstrate how they framed it as both an isolated and an isolating space.

Non-Inuit commentators on the hospital framed it as an isolated place from "proper" or familiar contexts in Southern Canada, but they saw this as simultaneously a positive and a negative factor in preventing and curing disease in the Eastern Arctic. In some contexts, doctors embraced isolation as a celebration of a particular form of masculinity, and while others celebrated it as a possible strategy for "naturally" reducing the spread of contagious diseases. At the same time, health care providers and policy-makers struggled against isolation as hampering the provision of "proper" medicine in the North, and as diluting the impact of the hospital as a colonizing institution. In response, health

care providers developed flexible and mobile medical services in order to adapt to isolation and distances in the Eastern Arctic. They also worked to increase transportation, communication, and personnel in order to “tame” distances and increase ease of access to Northern communities.

At the same time as they saw the hospital as isolated, missionaries, doctors, and government administrators also framed Ste. Therese’s as a space in and through which to isolate bodies and diseases. The hospital’s design and function served to isolate pathogens according to contemporary disease theories, thereby preventing the spread of contagious diseases that had previously ravaged local Inuit populations. In addition, non-Inuit discourses also functioned to pathologize Inuit culture and racialize Inuit bodies, producing both as diseased and thus necessitating isolation in a controlled medical environment. Indeed, Ste. Therese’s Hospital was designed around internal concepts of isolation that defined and physically separated bodies from one another based on simultaneously articulated medical, social and racial discourses.

There remain some potentially fruitful avenues for analysis in this area. A better exploration of how the Inuit shaped, received, and reworked non-Inuit discourses on the hospital would provide another important dimension to this topic. This may also allow for a better overall understanding of the complex negotiations between various parties involved in health care in the North. To this end, rather than perpetuating the categories I established in this paper, more research might reveal that the negotiations between various individuals and groups were more complicated than I have suggested, and indeed illustrate

some reasons why their interests overlapped in many contexts. In addition, a comparison of hospital experiences and discourses on isolation in Arctic hospitals like Ste. Therese's and Southern hospitals that serviced Inuit populations may reveal more complexities about the concept of isolation, particularly in regards to how Inuit patients understood space and isolation in comparison to the non-Inuit interests I have examined here.²⁸²

That said, this thesis does work to present a new conceptualization of health care in the Eastern Arctic that re-inserts space as an important factor shaping health care provision, emphasizes the complexities and limitations of colonial discourses in the North, and negotiates the subtleties of isolation as a concept in medical and colonial history in the Eastern Arctic. In doing so, I suggest that Ste. Therese's Hospital illuminates some patterns in Arctic medical history, but also demonstrates the importance and value of considering local contexts. This work is by no means exhaustive, but it does point to some new ways of analysing colonial medical history and the history of the Canadian Arctic. A renewed focus on space, perhaps with recognition of the subtleties of spatial relations encapsulated in concepts like distance and isolation, can reveal new aspects of colonial medical history, thus complicating the existing literature and providing new openings for further research.

²⁸² For some primary and secondary sources that reveal Inuit responses to Southern hospitals as "isolated" places, see NWT, Simeonie Amagoalik, N93-018, "1962 Simeonie Eskimo from Resolute Bay Charles Camsell Hospital Edmonton Alberta"; Tester, McNicoll and Irniq, "Writing for Our Lives"; Saimaiyuk and Saimaiyuk, "Life as a TB Patient in the South"; and Robin McGrath, "Inuit Write About Illness: Standing on Thin Ice," *Arctic Medical Research* 50 (1991): 30-36. More generally, Minnie Aodla Freeman's autobiography illustrates the profound ways in which she, as an Inuk, saw Southern Canada was isolated and isolating from familiar contexts. Minnie Aodla Freeman, *Life Among the Qallunaat* (Edmonton: Hurtig Publishers, 1978).

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