
Canadian Bulletin of Medical History / Bulletin canadien d'histoire de la médecine is published by the Canadian Society for the History of Medicine and is available online at: http://www.cbmh.ca/index.php/cbmh/index.

This article is available at: http://www.cbmh.ca/index.php/cbmh/article/view/502/501.
Nursing and Native Peoples in Northern Saskatchewan: 1930s-1950s

LAURIE MEIJER DREES
LESLEY McBAIN

Abstract. The aim of this research is to investigate the role of nurses in northern Saskatchewan Aboriginal communities in Canada between 1930 and the 1950s. During and after the war, the federal government began sharing its responsibilities for delivering health services to Indian communities with a growing system of provincial Public Health nursing stations. In northern Saskatchewan, interaction between Aboriginal peoples and the state health care system occurred primarily through provincial Public Health nurses permanently stationed at these outpost clinics. What was the role of nurses in these communities? How did federal Indian health policy influence nurses’ behaviour? Based on the record available for Saskatchewan, it appears the outpost clinics delivered standard nursing care. It also appears that the federal government was eager to devolve its responsibilities for Indian health care to the province, and that its tenuous commitment to providing health care caused confusion in the treatment of patients.

Resume. Cette recherche a pour objectif d’appréhender le rôle des infirmières dans les communautés autochtones du nord de la Saskatchewan au Canada entre 1930 et les années 1950. Pendant et après la guerre, le gouvernement fédéral a commencé à partager ses responsabilités quant aux services de santé destinés aux communautés amérindiennes, avec les postes avancés d’infirmière du système provincial de santé publique. Dans la partie nord de la Saskatchewan, c’est généralement à travers les infirmières de ces cliniques permanentes que les autochtones ont été en contact avec le système de santé publique de l’État. Quel rôle ont-elles joué dans ces communautés? Comment les politiques fédérales de santé concernant les Amérindiens ont-elles influencé le comportement de ces infirmières? Selon les données disponibles pour la Saskatchewan, il apparaît que les cliniques offraient des services infirmiers usuels. Il apparaît également que le gouvernement fédéral entendaient déléguer aux provinces ses
responsabilités dans les services de santé pour les Amérindiens, et que son peu d'empressement à leur fournir des soins de santé a causé une certaine confusion dans le traitement des patients.

INTRODUCTION

In its annual report of 1948-49, the federal Indian Health Services Division of the Department of National Health and Welfare reported that, "In several provinces the provincial health nursing service extends to native groups, a most happy arrangement which wipes out any feeling of distinction between racial groups." A short statement, it belied the less than obvious co-operation between the federal and provincial governments in addressing issues related to Native health care, and implementing Indian health care services. One of the areas where provincial and federal co-operation in providing Indian health services was most clear, was in the delivery of nursing services to Indian populations in remote areas of Canada. Beginning in the 1930s, northern Saskatchewan nursing outposts became the avenue through which, for at least 30 years, Native health care was provided.

Although scholars researching Indian health have focused on the role and workings of federal Indian hospitals, and federally appointed Indian Affairs Medical Officers, the workings of provincially run nursing operations in Native communities has largely been ignored. The purpose of this paper is to outline and analyze the workings of the nursing outposts in northern Saskatchewan between 1930 and 1954, an era that witnessed tremendous expansion of health services available to Canadians generally, but also to Aboriginal peoples. What was the structure of Indian health care policy during the interwar and immediate postwar years? How did the outposts work, and what was the role of the nurses in these outpost stations? How did federal Indian health policy influence actions of the nurses? These questions are significant because it was nurses, rather than doctors who, in Canada's remote communities, had the most intense and long-term contact with their Aboriginal patients. This discussion focuses on the outposts at Cumberland House, Buffalo Narrows, Lac La Ronge, Snake Lake (Pinehouse), and Uranium City.

Sources for this investigation derive primarily from the personal papers of the nursing staff who worked in the outpost hospitals, the annual reports of the Indian Health Services Division of the Department of National Health and Welfare, and the Public Health Division of the provincial ministry of Health and Welfare. In addition, preliminary oral interviews conducted with former nursing staff, Native and non-Native, serve to further deepen our understanding of the workings and influence of these nursing outposts at mid-century. These interviews were conducted
in 1999 and 2000 with five former provincial nursing station employees. One of these was a nurse's aide.

EXISTING LITERATURE

To date, the existing literature on Indian health lacks extensive analysis or description of specific Indian Affairs health policies or programs. Instead, analyses of Indian Affairs policies appear to focus on the involvement of the department in Indian education, self-government and land use. Despite the lack of in-depth investigations into the history of government delivery of health services to Indian peoples, there are several older works which serve as the basis for present and future research into historical Indian health services. Specific investigations into the role of nurses in the delivery of Indian health care have yet to be completed and this paper marks initial research in this direction.

Two landmark works informing much of the current writing on historical Indian health services are C. Richard Maundrell's thesis, "Indian Health, 1867-1940" (1941), and G. Graham-Cumming's article, "Health of the Original Canadians, 1867-1967" (1967). Both works outline the history of federal government involvement in Indian health services, and focus on the influence of tuberculosis and other epidemic diseases on the nature of Indian health services. The role of the provinces in delivering health care to Aboriginal Canadians is not a consideration in these works.

Waldram, Young and Herring have completed the most prominent survey of federal Indian Affairs' involvement in First Nations' health. In their work, the authors provide general but clear outlines of the federal health services for Status Indian people. They also investigate how the federally employed Indian medical officers viewed their Native patients. The role of provincial nursing services is not covered in their work. Given that nurses in the field generally spent much more time directly involved with Aboriginal peoples, this research emphasizes that the question of how nurses viewed Native patients is equally significant. Furthermore, the role of the province in delivering health care services to Indian peoples is also raised by this limited investigation.

To date, nursing history literature has not specifically addressed the role of nurses in Canada's Native communities. Newer histories of nursing, however, are probing the social history of the profession and considering the influence of factors such as race, class and gender on nursing work. For example, Kathryn McPherson's exploration of Canadian nursing in the twentieth century seeks to "re-examine nursing's past by using the tools of social history to probe the everyday lives of 'ordinary' nurses at work." According to McPherson, research into how nurses fit into the evolving class structures of the twentieth cen-
tury, how gender shaped nurses' lives, and how social relations between nurses and patients were influenced by racial perceptions, should be pursued. McPherson's work also identifies categories of nurses work at mid-century, providing a context for the daily activities of outpost nursing staff. Taking McPherson's views as a point of departure, this paper investigates the particular nature of relations between non-Aboriginal nurses and their Aboriginal patients at selected nursing outposts in northern Saskatchewan from the perspective of the nurses. It also seeks to compare the nursing work at the outposts with standard nursing practices of the day. Nursing at these stations was unique because it involved non-Native nurses treating Native charges in an age when cross-cultural training for nurses was not en vogue. It also involved nursing work in a geographic location where non-Natives were in the minority.

There are many lines of inquiry pertaining to the relations between nurses and Aboriginal peoples that can—and should—be pursued. However, this paper deals only with nurses' work and nurses' attitudes towards Aboriginal peoples in northern Saskatchewan. Native perceptions of nurses and public health programs are equally important. Knowledge of these Aboriginal perspectives would provide much needed insight into the actual workings of Indian health services. The historic place of Aboriginal healing traditions within a government-controlled health care system is also an area that requires investigation.

This paper refers to Aboriginal communities composed of both Status and non-Status Indian peoples, and uses the term "Indian" to better reflect the historical terminology as well as the administrative language of the time period under discussion. Status Indian peoples were, and are, First Nations registered under Canada's Indian Act and fall under the care and administration of Canada's federal Department of Indian Affairs. In Canada, all Treaty Indians are Status.

FEDERAL INDIAN HEALTH SERVICES AND INDIAN HEALTH POLICY

According to Waldram, et al., Indian health services resulted from the work of Dr. Peter H. Bryce, who was appointed in 1904 as the first federal official responsible for Status Indian health. Bryce was committed to improving services to First Nations communities, despite Indian Affairs' fixation on economizing expenditures on Indian administration between 1904 and the 1920s. He single-handedly contributed to the gradual expansion of such services to include providing Indian peoples with access to Medical Officers, the creation of specially designated Indian hospitals on reserves, and efforts to improve health conditions in Indian residential schools. Bryce was not popular with his superiors in the Indian Affairs department, and his efforts to change the administration of Indian health
were continually undermined during his career. Bryce was, however, successful in seeing government implement an idea he had promoted: the creation of nursing support at the community level. In 1922, a mobile nurse-visitor program was implemented, in which Medical Officers were assisted by nurses. Subsequently, the first full-fledged nursing station operated by Indian Affairs was opened in 1930 on Manitoba's Fischer River reserve. Bryce retired in 1921, but his ideas left a mark on the evolution and expansion of Indian health services.

From these early beginnings, health care services for Indian communities continued to expand in the immediate postwar years through the 1950s. Up to World War II, the Department of Indian Affairs attempted to manage and care for registered Indian peoples' health using specially appointed Medical Officers, nursing staff, Indian hospitals and the assistance of missionaries. Between 1900 and 1945 the civil service in this field increased from comprising a mere handful of individuals, to an army of employees including 27 full-time Medical Officers, 700 consulting physicians, 16 full-service hospitals, and 24 full-time Field nurses. Noteworthy is that most of this growth took place between 1935 and 1945 in the face of tremendous government fiscal restraint. In November 1945, federal commitment to "improving" Aboriginal health was solidified when Indian health services were removed from under the control of the Department of Indian Affairs and subsumed under the newly created Department of National Health and Welfare as a separate division: Indian Health Services. At this time Indian health formally became an issue of national interest. In 1945-46, the number of Indian people who fell under the administration of this new division, according to a 1944 census, numbered 125,686.

The goal of the new Division was clear from the start. Indian Health Services, under direction of the new Department of National Health and Welfare, aimed first and foremost "to provide a complete health service for these [Status Indian and Inuit] peoples," based on a moral, rather than legal, imperative. More directly, "Canada's Indian Health Service... has arisen, not from legislative obligation, but rather as a moral undertaking to succor the less fortunate and to raise the standard of health generally."5

A second explicitly stated goal of the Indian Health Service was to "improve assimilation" of Indian peoples by supporting provisions against ill-health and thereby eventually encouraging their economic independence.6 The assimilationist attitude, and lack of interest in traditional Aboriginal health practices, lasted through the 1960s. Beyond an economic interest in improving Aboriginal health, Indian Health Services viewed its work as corrective: "It is not as if we were merely trying to replace ignorance with correct attitudes and knowledge. We
are trying to introduce new attitudes and practices to people who already have strong feelings and traditions about sickness and its treatment, however erroneous these may be."

Third, Indian Health Services were committed to building facilities supporting Indian health care, such as hospitals and nursing stations. This was accomplished through the building of new facilities for Indian communities, or through the takeover of Department of National Defence hospitals after the war, such as the Charles Camse1l Hospital, and the Fort Qu’appelle hospital. Hospitals were considered central care facilities while the nursing station, or "field unit" was viewed as a health centre that would allow a nurse to spread "her influence into the homes, schools and community life," thus "driving home the fundamentals of good health habits...." Between 1946 and 1952, the number of federally employed nurses working in field units grew from 27 to 103. Many of the hospitals, and posts for nurses in the field were located in rural and remote settings, in keeping with the nature of reserve communities. In 1946, the only federally operated hospital for Status Indian people in Saskatchewan was located in the south of the province (Fort Qu’appelle hospital). Only a handful of the 17 federal Indian hospitals existing in 1946 were located in the middle or far north, and most were on southern reserves or regions.

Last, the federal body responsible for Indian health sought to share the expense of caring for First Nations by encouraging a loose network of support services offered by Provincial health departments, Royal Canadian Mounted Police, the Department of Natural Resources, Department of Transport, as well as Indian bands themselves. In fact, some Indian bands were assisted in using their own trust monies to purchase health services. The federal branch viewed this sharing of responsibility as advantageous and non-discriminatory. As it stated in 1948, "In several provinces, the provincial health nursing service extends to native groups, a most happy arrangement which wipes out any feeling of distinction between racial groups." Thus, although the federal government provided services and facilities, it also relied heavily on those same services offered at the provincial level. In 1948, the federal government operated 20 hospitals and 18 nursing stations, but "Over and above the facilities operated by the Indian Health Services, arrangements are made for the treatment of persons of native Status at several hundreds of general and special hospitals...." It was implicit that Indian Health Services should embrace every opportunity to integrate its activities with those communities adjacent to Indian communities. Despite the assertion that provincial and federal authorities work together in treating Aboriginal patients, the nature of the agreements to "share" were vague and appeared to imply simply cost reimbursement by the
federal government to the provincial agencies for expenses incurred by Status Indian patients.

Federal commitment to caring for Indian health was never solid. The Indian Health Services was seen as a temporary solution meant to address a changing social and public health situation. The federal government was eager to make clear that this temporary service would eventually transfer back to the hands of the communities, stating in 1952:

The health service for Indians and Eskimos has evolved to augment the care normally provided by the home, the community and the provincial agencies.... It [Indian Health Services] stands ready to hand back the charge to the home, the com-
munity and the province when these agencies exhibit the will and the resources to take over. . . . \(^{13}\)

The Department of National Health and Welfare never actively pursued encouraging provincial takeover of Indian health care, but support for federal facilities and services was not always forthcoming between 1945 and the late 1950s. As a result, the role of the provinces, such as Saskatchewan, in providing formal health care to Indian peoples, was significant.

**NURSING AND INDIAN PEOPLES IN NORTHERN SASKATCHEWAN**

The province of Saskatchewan became involved in Indian health care as a result of Indian Health Services' policy of sharing responsibility with other jurisdictions. The Saskatchewan Department of Public Health, specifically its "Division of Public Health Nursing," became the administrative arm of the province dealing directly with Indian patients through its provincial nursing stations. From the early 1900s to the 1930s, the provincial nursing stations were run in southern locations only, such as Melfort, Outlook, Wilkie, Kerrobert, Swift Current and Rosthern, all overseen from the head office in Regina.\(^{14}\) It was around 1929 that Saskatchewan public health nurses began dealing with northern and Aboriginal patients (Status and non-Status) through the nursing station in Cumberland House. This nursing station was also the first to provide bedside care, an exception at the time. Subsequently, during and after World War II, the number of provincial nursing stations providing health education and bedside care in Aboriginal communities across the Saskatchewan north increased noticeably. Some of these stations, such as Goldfields and Uranium City, were created in response to a growing non-Native population at mining sites in the north. Others were located at old mission sites or in larger Native communities. Nursing stations were opened in northern communities as follows:

- Cumberland House: c. 1929
- Green Lake: 1940
- Meadow Lake: 1941
- Buffalo Narrows: 1947-48
- Stony Rapids: 1948
- Snake Lake: 1948
- Sandy Bay: 1948
- Lac La Ronge: 1951
- Goldfields: 1951
- Uranium City: 1952

By establishing these nursing outposts in its remote northern regions, the Saskatchewan provincial government and its public health nurses played an increasingly significant role in Indian Health Services' work
in an area inaccessible by road and only inconsistently connected to urban centres via air service. Provincial public health nurses also became direct and primary care-givers to Aboriginal communities as the main representatives of a state-directed health care system. At the Cumberland House station, formal and direct involvement with Status Indian patients was initiated in 1941 when the provincial government negotiated specific arrangements with the Department of Indian Affairs whereby the Cumberland House public health nurse would dispense drugs to Status Indian peoples. Before this date, it seems provincial nurses dealt with Status patients on an ad-hoc basis, treating whomever they felt required care.15 Provincial involvement in the treatment of registered Indian patients increased from that year forward. Aboriginal peoples served by this system included Métis, non-Status and Status Indian peoples. In 1950, the Saskatchewan Department of Public Health estimated the population in its Northern Administration district included 3,500 Metis, 2,500 non-Native, and 3,400 “Indian” people.16

What services did these stations provide? What role did the nurses have in Aboriginal communities? And finally, what were nurses’ attitudes towards their Aboriginal patients?

A brief overview of the provincially employed nursing staff of the outposts between 1930 and the late 1950s indicates that many of the nurses held professional accreditation, and were encouraged to seek upgrading for their skills. In 1944, for example, several public health nurses (from a staff of less than 20) were allowed leave to pursue graduate studies in Public Health Nursing, and in 1945 more staff nurses were taking advanced courses in obstetrical techniques in New York City, McGill University in Montreal, and University of British Columbia in Vancouver.17 By 1951 half of the 90 public health nurses in Saskatchewan were registered nurses, and financial assistance was made available for increased training through federal and provincial grants.18 Despite growing opportunities for women in the nursing field in the postwar decades, recruitment of new nursing staff became problematic in the 1950s as many single young women married and stopped pursuing their careers. For example, in 1946, public nurses numbered 56, while in 1954-55, the Department reported having 105 individuals on staff; by the mid-1950s recruitment of nurses, especially for the northern district, slowed as resignations almost equalled the number of new recruits. In response, the province actively sought new staff in the United Kingdom. The building of nursing outposts also slowed in these same years; construction of nursing outposts appeared to peak in the late 1950s, after which the expansion of services slowed dramatically.

The Saskatchewan Provincial Archives houses extensive correspondence between nurses employed in northern nursing posts, and their
supervisors from this time period. Based on these letters, a great deal of insight can be gained into the daily work of the nurses, their attitudes toward their situation, and the challenges they faced.

From the 1930s, the intention of the Public Health Nursing service was to provide communities with health education:

The public health nurse is essentially a health teacher. As such she has become a recognized asset in the modern public health programme, which is fundamentally educational. Her close contact with the school, the home and the community gives her unlimited opportunities for health instruction.19

In contrast to the role of provincial public health nurses in the south, bedside care also was emphasized in the northern nursing outposts because of the dearth of hospital facilities; beside care was not a normal duty of the southern-based public health nurses. Originally, nurses were informed by the Deputy Minister of Public Health that, “apart from obstetrical work, most of the work centring on the outposts will be that type of work ordinarily carried on by public health nurses …” and this instruction was given to nurses at the Buffalo Narrows outpost when it was taken over by the province in 1947.20 The nursing supervisor for the northern administration district instructed her nurses that “no amount of red tape should interfere with your good work there. We are counting on it being a good demonstration of a link-up between bedside nursing and community health.”21

For northern public health nurses, the health care program consisted primarily of obstetrical and pediatric work, including birthing, well baby clinics, immunization of children and adults, eye and teeth clinics, and basic hygiene instruction for adults and children alike. Clinics were held either in the outpost hospital or out in the field, in schools or bush communities, depending on the need. Regularly scheduled classes (usually offered on a weekly basis) existed at the hospital or a local residential school, reflecting the need to educate communities on public health issues. For example, at Buffalo Narrows, Miss Mary Lyons reported in 1948 that she had launched a Home Nursing Class and that

There are 5 members taking it, and two of these are going into northern areas where there will be no doctor or nurse, so it is very interesting to teach them. It is wonderful having the hospital and equipment to use for demonstrating. I am teaching Mon. and Thur. nights. Last lesson was communicable diseases and I finished by setting up our single ward as an isolation unit and carried out a complete technique. …22

Well baby clinics represented another opportunity for nurses to instruct and socialize their charges, and at these clinics mothers were shown “proper” baby care. Nurse Lyons was surprised at the interest and skill of the Native mothers who attended her clinic, writing to her supervisor:
Last Wednesday I held a Well Baby Clinic. There were eleven babies checked. ... The scales were a delight to the mothers as most of them had never seen baby scales and I surely enjoyed using them. ... I was able to talk on baby feeding and then give them written instruction. The mothers seemed interested. ... Every baby showed evidence of good care—I mean by this that the mothers were doing their best according to their own mode of living. ...  

In addition to their educational programs, the nurses were also involved in bedside care in their simple clinics. The outpost hospitals were characteristically small, consisting of a nurse’s residence, a kitchen, a ward of two to five beds, and a nursery. At Buffalo Narrows, the small hospital made a positive first impression to Nurse Glenny, who upon seeing the facility for the first time reported, “I think this hospital is a lovely little place, especially the nurses sitting room and bedrooms and kitchen.” The Cumberland House community improved its tiny outpost hospital in 1941 to consist of a new peeled log house with four beds and a furnace. Not all hospitals were alike, however. In contrast to the others, the Uranium City hospital was a foundationless dwelling without storm windows or even insulation. Nurse Augener, stationed there in 1954 complained “the rain comes in by the windows and through the roof. The nights are very cold already and without the oilstove going this little shack was like an icebox....” 

Bedside care ranged from treating short-term influenza, whooping cough, fish poisoning, pleurisy and tuberculosis-related conditions. Longer-term care patients included new mothers recovering from childbirth, and those with less acute conditions such as broken limbs. In unusual cases, patients could stay for weeks. All acute care patients were flown out of the north to Prince Albert beginning in 1946, using the first organized air ambulance service in North America: Saskatchewan Department of Public Health’s air ambulance.

Sometimes the responsibilities of bedside care mitigated the giving of educational lectures and demonstrations. Nurse Pierce at Stoney Rapids found herself tied to her hospital duties when her small ward contained patients: “My public health work here is going to have to wait for a while but I hope I can get something done after these two patients come and go.” Nurse Lyons at Buffalo Narrows also complained, “In order to get this Public Health work done I do feel I need some one to do night duty at the hospital in fact if we keep always having patients plus out patients I think I’ll have to ask for a helper as 24 hr. duty just seems too much to take.” Feeling caught between bedside duties and the need for home visits and public education was a common complaint in the correspondence of many of these nurses working in northern Saskatchewan. Hospitalization of ill patients was officially allowed only if provincially available hospitalization insurance was held by that person; otherwise individuals coming to the outpost risked being turned
away, although most nurses appeared generous in making concessions on this point.

As a heavy bedside nursing workload drained nurses’ time for public health work, their daily existence also required work beyond that of an urban-based nurse practitioner. Their daily existence depended on their ability to heat the outpost, work in the outpost garden to ensure a supply of fresh vegetables for themselves, maintain the outpost accounts, operate the local radio, and generally supervise the building maintenance and medical supply stocks. Canning meat, soap-making, and evening sewing “meetings” were other regular activities. From Snake Lake, Nurse Enid Broome confessed, “I had no idea of the work involved in a community this size. As you probably know I operate the departmental radio and along with the household duties find every minute is accounted for.”

Garden work seemed to offer some rewards, and from the Buffalo Narrows gardens came blueberries and other delights:

We have been busy canning carrots as our rows need thinning... They taste very good. I did some blueberries packed dry and sprinkled with some sugar. They are delicious... our garden is rejuvenating—the cucumbers etc. were slightly touched with frost... lots of growth now will make the cauliflower and cabbage worth taking in. The flowers are really holding out well...

The long hours of sunlight in the northern regions undoubtedly helped the harvest. Gardening and the cultivation of vegetables was not only for the nurses’ consumption but also to serve as an example to the local Native population and inculcate the idea that local country foods were not sufficient for a healthy diet.

Nutrition counselling was a high priority for public health nurses in this time period, and both the provincial and federal Indian Health Services nurses were eager to direct Aboriginal communities to change their eating patterns. After the war, a concerted attempt was made by governments to have community gardens established on Indian reserves and to teach Indian children in schools and hospitals about “nutrition.” Clearly, the gardens at the outpost hospitals contributed to this kind of education. As Nurse Broome at the Snake Lake hospital explained to her supervisor, “We try to sell them [Natives] food combinations and try to tell them how to prepare same. It is almost impossible to change their diets although lately we have sold more cheese, vegetables and fruit...”

Much like the gardening initiatives, programs were also offered through the hospital to encourage what was considered the “proper” socialization of these remote northern communities. Nurse Lyons explained that at Buffalo Narrows, “… hospital staff are sponsoring a Novelty dance... there is to be a full programme of novelty, modern and old-time dances with a floor manager in attendance... We have
put this dance on so that the young people here who seldom get out of B.N. will have a dance that is different to the usual ones..."34 Miss Lyons even took it upon herself to sponsor classes in her Buffalo Narrows outpost to teach young girls cooking and sewing, and her mission was clear: "In my estimation, our biggest contribution to Public Health in this district is training the women and girls how to use their leisure time profitably."35 Given her numerous commitments, it is understandable that Miss Lyons occasionally commented on her exhaustion: "Everything is fine up here, but very busy. If this rush keeps up I'll be completely crippled."36

Overall, provincial nurses' work in northern Saskatchewan fit the standards and expectations of nursing practice for the day, although public health nurses clearly took on a much expanded role for themselves in their remote setting. Like their southern-based sisters, public health nurses in the north exercised skills that formed the foundation of all nurses' work. In this way, their work in the north was little adapted to the unique geographic and cultural nature of their situation. In her history of Canadian nursing, Kathryn McPherson identifies the standard categories of nurses' work between 1900 and 1942. Nurses across Canada in this time period characteristically were responsible for the practical work of preparing patients for treatment by doctors, administering medications, maintaining wards and their equipment, administrative tasks, diagnostic tests, and all the tasks associated with bedside care.37 Northern nurses in Saskatchewan also generally carried out these standard duties. In addition, they carried out their public health duties, requiring home visits and educational seminars aimed at preventing disease at the community level through a concerted plan of changing social patterns in favour of non-Native standards of living.

Even at the conceptual level, nursing practice in the north also reflected the trend in the profession emphasizing scientific management. Based on the correspondence of nurses in the northern outposts, it is evident that they emphasized a systematic and time-managed approach in their dealings with patients. Clinics were regularly scheduled affairs, and treatments were clearly routinized. Everything from tonsillectomies to immunizations were carried out in a rigid fashion almost resembling industrial assembly line practice. Visiting hours were strictly controlled, as was the movement of patients within the clinics, as reflected in one Stony Rapids nurse's desire for a waiting room in her outpost, to keep new patients confined to one area.38 By routinizing their work to such a degree, the nurses were able to best control their work and their patients within the outpost, thereby exercising and clearly indicating their own authority over the rituals of healing they performed. As one nurse
LAURIE MEIJER DREES and LESLEY McBAIN

noted of her schedule: "I thought having regular days would eliminate the stragglers who make extra work at the busy time."39

Similarly, the routines in the outpost hospitals across Saskatchewan's north also reveal the nurses' desire to instill notions of conformity and discipline into their patients. Clinics of all kinds held at the outposts, ranging from baby clinics to the taking of school children's weights, happened on a fixed schedule and as group activities, emphasizing the idea that people should be treated, as well as behave, similarly. Classes and lectures on public health functioned on a similar assumption—that health and healthy living were social concepts, not concepts based on the sensibilities or sensitivities of individuals. Since the nurses also spent little of their social time within the Aboriginal communities they served, their norms for treatment and acceptable behaviour were little influenced by local ideas of health and wellness. These ideas in nursing practice were accepted as standard in non-Native communities, as McPherson points out; however, one wonders how the Aboriginal population viewed such impersonal clinical approaches.

What was obviously unique about nursing service in northern Saskatchewan was the cross-cultural contact that occurred within the outpost. Due to their remote location the workload for northern nurses was not only quantitatively heavier, but also qualitatively different from the southern public health nurses. It is clear that language and cultural barriers presented hurdles to nurses who sought to change Native lifestyles by instructing them in child care, health, and social issues. Nurses did not speak, and were not taught, Indigenous languages before leaving for their posting. Even more significantly, they were not specifically prepared to deal with cross-cultural contact and communication issues that might confront them in their dealings with a predominantly Aboriginal population in the middle-north. As a result, nurses encountered difficulty in delivering their message. Sometimes family members were able to act as interpreters between patient and nurse, but in other cases verbal communication was not an option. The nurse posted at Stony Rapids in 1948, for example, knew her ability to nurse was limited without facility in the local language. Writing to her supervisor, she stated:

Another problem that is coming to light now is an interpreter for my office calls. So far some of the local women have come up and some times they had to come up three or four times in an afternoon [to translate]. They are getting tired of this and one woman has started to charge for coming up. I am told that it will be worse this summer. I am wondering if I shouldn't try to get a maid that talks Chipeweyan. I have written to Mr. Stewart, Indian Agent at Fort Chipeweyan asking if he would know of a good reliable maid who talks Chipeweyan.40

Others found that language barriers interfered not only with direct treatment, but with public health instruction. Nurse Broome at Snake
Lake found that “the natives get very little out of a planned lecture or demonstration but have had wonderful results ... of allowing them to visit in our home. They are very observant and follow our habits readily.” At the Lac la Ronge outpost in the 1940s, in turn, the cook acted as translator when Cree-speaking patients were brought in for treatment. There, the nurse could communicate with her Cree-speaking patients using only hand signals. Interestingly, the language barrier did not feature as a major issue in the minds of many nurses, and apparently they assumed their actions were more significant than their words. The authority of the nurse was not questioned by patients in the presence of the nurse, and nurses themselves did not question their own authority, even under such circumstances when direct communication was not possible. Only a few nurses reported on language issues in correspondence with their supervisor.

Nurses' attitudes towards their Aboriginal patients varied just as their sensitivity to language did. For example, on the one hand Buffalo Narrows nurse Helen Janzen was eager to assert her authority over her Native patients, and reported “I do not find the natives here too easy to work with. They are very demanding, and especially when there is a new nurse. We are beginning to understand each other and they are not quite as saucy as they were at first.” Miss Lyons, like other nurses, was confident of her superior knowledge, writing to her supervisor: “These women have very little idea of child health,” although she later did concede “… that mothers were doing their best according to their own mode of living. ... I feel the conditions are not so appalling but that they can be improved through time.” On the other hand, some nurses enjoyed their contact with the northern population. Nurse Augener, who operated the Buffalo Narrows outpost between 1953 and 1954, was enthusiastic about her experiences: “I like my work here. The people are friendly and helpful,” and later, “… the longer I am here, and the more I get to know the people the better I like it.”

Nurses and doctors seemed to exercise authority over their Aboriginal patients when they deemed it fit. Parental consent forms, for example, were not considered necessary by the supervising doctor when dental treatment was given to children in Buffalo Narrows. However, despite their ideals, the medical staff were not always successful in controlling the actions of their charges. There are also accounts of patients leaving or escaping from hospital care against the wishes of the doctors and nurses. In the Buffalo Narrows hospital, when a Treaty Indian patient was transferred to the Ile-a-la-Crosse hospital against her wishes, she arranged for her own return. According to the nurse’s report, the woman “had her husband go down to Ile-a-la-Crosse and there he stole enough gas out of Dr. Lavoie’s speedboat to bring her back to Buffalo
Narrows, and she had her baby here." In another case, a difficult tuberculosis patient was taken home by parents against the will of the nurse, who lamented, "All my labour lost. Guess one gets used to that in the north." People attending the hospital also attempted to integrate the facility into their own healing regimes, by secretly slipping their family members (who were in hospital) home-made treatments and country foods, to the displeasure of the doctors and nurses. As Nurse Aylsworth reported "I do think that a large number of the people are becoming more reasonable. With a few exceptions... Dr. Lavoie has told me since that he often finds patients at Ile-a-la-Crosse who have brought their own home-made remedies to take along with what the hospital might have to offer...." At the Uranium City hospital, one nurse recalled how a child was brought caribou meat by his parents without the knowledge of the nursing staff. Nurses hoped that eventually such practices would cease as people became more reasonable and received "proper" instruction in nutrition and health practices. Native healers did not appear to ever have been formally invited into these facilities.

The prevailing attitude of superiority and the social distance some nurses felt from the communities they served was enhanced by the fact that few nurses appear to have involved themselves in the social life of their community. This social isolation of nursing staff could also have been related to the fact that most were unmarried during their terms of service in the north, and that their service hours were long. Betty Lou Simpson, nursing in Uranium City in the 1950s recalled how the nurses in that community "had our own society" that centred around the hospital located outside of town on what was then known as "hospital hill." Nurses at the Uranium City hospital socialized extensively with each other, and only occasionally with other non-Native workers in the town.

The work of nurses in the outpost hospitals of northern Saskatchewan was influenced directly by federal Indian health policy. Specifically, the federal policy of sharing health care of registered Indian peoples with the provinces created difficulties for the nurses in the field who were frequently confused about where their treatment responsibilities lay. Although the provincial nursing stations were to treat all patients in possession of hospitalization insurance, as well as those able and willing to pay the rate of about four dollars per day, all registered Indian peoples were to be treated free of charge. In regions where federal Indian Health Services were lacking, it was anticipated that provincial public health nurses would step in and provide care to registered Indians. The provincial health authorities were reimbursed for services delivered to Treaty Indians on a piece-by-piece basis, and the
I.H.S. would also provide drugs to the provincial service.\textsuperscript{52} Theoretically such arrangements appeared clear-cut; however, in practice Indian Health Services did not support the provincial efforts well, and nurses were often left wondering who would pay for the drugs and services Treaty Indian peoples required, as the nurses struggled with their account books and limited medical supplies. The issue was further complicated by the fact that Aboriginal communities were often a mixture of Status and non-Status individuals, making rules about treatment distinctions problematic. From Snake Lake in 1951 Nurse Broome wrote:

I made a 60 mile canoe trip to Fish River to see a number of ill children. I had a note from one of the natives there asking me to come in and see the children. I hesitated in authorizing a charter so made the canoe trip as there were several families living along that route I wanted to visit. The majority were treaty Indians. What can I do about the expenses?\textsuperscript{53}

Much like Nurse Broome, another complained from Stony Rapids to her supervisor in Regina: “There were no medicines from Indian Affairs on the boat this time, so what do we do now? Do we get all from the Department of Public Health?” and “My limited supply of drugs is a great handicap. However there are more treaty Indians to serve and the treaty supply at The Hudson’s Bay is a life saver…. The supplies throughout the hospital in general are not sufficient.”\textsuperscript{54} Conversely, Indian Health Services did little to support non-Status peoples’ health when it did visit communities in northern Saskatchewan. This frustrated the provincial public health nurses as they worked so hard to treat communities and families as a whole, irrespective of their legal status. Nurse Shannon from Uranium City reported her frustration with such jurisdictional wrangling at the expense of a health programme:

The Treaty party has come and gone. The results were disappointing from my point of view. The Treaty Indians turned out for [tuberculosis] xray to a man, ninety-one in all. So also did large numbers of metis and white, all of whom were turned away. This was extremely disconcerting, since I had been telling them for weeks to be sure to report for xray when the party came around.

When I asked the reason for this attitude since, as I pointed out, they had always been willing on previous years to take all comers, I was told that the provinces had never paid for work done by Indian Health Services, therefore, they had precise instructions to do only the Treaty Indians.

I feel that all our recent work on B.C.G. is incomplete without the followup xray, and it would seem that until the various departments come to an agreement, there is little encouragement for field personnel to put forth the efforts they have done in the past.\textsuperscript{55}

Despite these difficulties, it appears the nurses improvised and did their best to treat all who came to them. Patients were encouraged to
take up insurance, but seriously ill patients without means were still admitted. From the perspective of the front-line worker, the public health nurse, Indian Health Services’ practice of separating Treaty and non-Treaty for care was not effective.

Lastly, after giving consideration to the roles and actions of public health nurses in the lives of Aboriginal peoples in Saskatchewan’s north, it is important to note the place of Aboriginal peoples in that same health care system. Between the 1930s and the 1950s, it appears that Native peoples had very little involvement in this health system, except as patients. The records indicate the nursing staff were overwhelmingly Euro-Canadian or English, university educated, middle-class and unmarried. On rare occasions, however, Native people were employed as nurse’s aides, assistants or translators at the outpost hospitals. Muriel Innis, for example, worked as a nurse’s aide in the Lac La Ronge outpost hospital as a young woman, starting in June 1949. Following the death of her mother, her father moved his small family from Bangor in southern Saskatchewan to Lac La Ronge in order to become the foreman of the local fish processing plant. Innis’ father placed her in service at the local hospital, where she worked for over two years.

Innis recalled many incidents reflective of the general role and attitude of the public health nurses in outpost hospitals at this time. As an aide, Innis helped the nurse with her patients, taking on jobs ranging from preparing linens and bandages, and sterilizing equipment, to watching the outpost while the nurse was away. Innis recollected how the nurses at the La Ronge outpost had difficulty communicating with the Cree-speaking patients who came to the hospital for treatment, and that in such cases the hospital cook, a local woman, was used as a translator. She also remembered how the small hospital functioned primarily to assist women in the community, particularly in childbirth and child care, and that male patients were rare. In addition, during her years at the La Ronge institution, Innis pointed out how Treaty money was at times linked to medical care: for Treaty Indian people, receiving Treaty payment was tied to taking medicine for tuberculosis, a disease which was often monitored by the nurses on Treaty day. Finally, she recalled how the nurses she worked under did their best to re-educate the Native mothers in the hospital away from the use of moss bags and to the use of cloth diapers: “the moms did it until they got home and then switched back to moss—they never questioned the nurse... it was the way things were.” Innis herself felt the nurses with whom she worked were very dedicated but she noted these women never really integrated themselves into the local community, as their workload was heavy and time-consuming. Following her work in La Ronge, Innis transferred to the federal Indian hospital at Prince Rupert to continue her nursing aide work.
Nursing and Native Peoples in Northern Saskatchewan: 1930s-1950s

Native nurses were not employed in the Saskatchewan health system until after 1954, when Jean Cuthand Goodwill became the first Aboriginal woman in Canada to complete her nursing training. Goodwill graduated from the Holy Family School of Nursing in Prince Albert, Saskatchewan, nursed at Lac La Ronge, and later in Bermuda. Although Goodwill was aware of the difficulty of changing Aboriginal communities through a foreign system of health care, especially in remote northern regions, she also felt sympathy for non-Native nurses working in the outlying communities. In an article published in the Canadian Nurse (1984), she recalled, "the one thing that cannot change, at least until the people are ready to make that change, is the traditional ways and customs of the indigenous people who live in the north." She also added how she was amazed at how well the non-native nurses, with their high ideals, their curiosity, determination and strong sense of responsibility, managed to cope with the adversity they encountered in this setting. To some extent the scenery, terrain, serenity and silence comforted the nurses trying to deal with the devastation that resulted from imposition of another way of life on Canada's Aboriginal people.

Comparing Goodwill's views and those of the nurses reflected in this body of records, it is clear Goodwill was sensitive to the traditions of Aboriginal peoples in a way that the non-Native nurses were not. Goodwill hoped that nurses of Native ancestry could reinforce the healing traditions and beliefs of Aboriginal peoples while at the same time making available the best that modern nursing could offer to Aboriginal communities. This bicultural view of health care for Aboriginal peoples was not one expressed by nurses working within Saskatchewan's public health care system in the northern region between 1930 and the 1950s.

CONCLUSIONS

This paper has attempted to take a social history approach to the work of provincial nurses in northern Saskatchewan between 1930 and the 1950s. It was in this era that nursing care expanded dramatically in the province, just as the Department of National Health and Welfare Division of Indian Health Services began to increase its interest in offering nursing care to Indian peoples. Based on the records of the Indian Health Service, the Saskatchewan Department of Public Health, the correspondence between outpost nurses and their supervisors in these years, and personal memories of those who worked in the outposts, a clearer picture of nurses' work in northern Saskatchewan can be derived. The picture that emerges is that during this time period, young
unmarried female nurses worked in isolation from their peers, as well as in isolation from the people they served, in small hospitals across the province’s remote north. As representatives of a new system of public health, these nurses were empowered to educate the northern population on health issues, engage in pediatric and obstetrical work, and give general bedside care as needed. The length of a nurse’s career in this region was generally two to three years. Nurses treated non-Aboriginal and Aboriginal patients alike, whether Treaty or non-Treaty. Based on their recollections and correspondence, the work was intense but generally interesting to these women, and few of them appeared to view their work with Aboriginal peoples as qualitatively different than with non-Aboriginal patients.

Overall, it seems that nursing work in Saskatchewan’s north, with a population that was predominantly Aboriginal, was not uniquely adapted to meet the needs or wants of its client base. Despite the official disregard for the unique cultural features of northern Aboriginal communities, nurses who worked in the outpost clinics did at times express a sensitivity to, and take notice of, the unique conditions under which they worked. Only some nurses sought to better understand their charges, with the help of interpreters or by adapting their work to the local demands.

To what extent the Native peoples valued the formal health care system introduced into their communities in this time period is an important question that requires further research. It is evident that most Aboriginal people had only a limited role in this system, and only after 1954 did Aboriginal people enter into this system as nurses. Prior to that date, they were merely objects to be re-educated and remodelled through interaction with the system and its representatives. In Saskatchewan’s north, health care was about more than individual health—it also involved attempts by nurses to alter local social behaviour, and change lifestyle patterns, from eating to leisure activities.

Finally, investigation of nursing work in northern Saskatchewan also reveals that jurisdiction over First Nations health in Canada has been historically changeable and not always readily discernible. In the time period investigated here, the Departments of Indian Affairs and National Health and Welfare accepted some degree of temporary responsibility for the health of registered Indian peoples, but not for Aboriginal peoples generally. The record shows that the federal government was also eager to devolve its work to the provinces, and its policy of “sharing” the work of Indian Health Services with provincial public health workers did at times interfere with health care service delivery to Indian peoples. The nature of the agreements between province and the federal government on the extent and nature of care to be delivered to
Status Indian people is not always clear, particularly if the nurses' accounts of their work are considered. For provincial nurses working in the field, the lines between Status and non-Status patients also were not always clear, and care was given to most who required it. More research needs to be conducted to clearly establish the effects of these vague arrangements on Aboriginal health care.

NOTES


9 DNHW, *1946/47*, p. 32; and *1952/53*, p. 34.


12 DNHW, *1948/49*, p. 107. See also "Indian and Northern Health Services."


14 In Saskatchewan both cottage and Red Cross hospitals operated in the province prior to the establishment of public health nursing stations. Starting in approximately 1900, Cottage Hospitals were established to help people in sparsely settled areas. Lady Minto, wife of the Governor General, helped raise funds to establish and maintain Cottage Hospitals in the NWT and other areas. The Victoria Order of Nurses provided both money to build, and the nurses to staff the Cottage hospitals in the province. The Red Cross Society was organized in Saskatchewan in 1913, and by 1930 had 17 Outpost Hospitals in operation. The hospitals were originally designed for the Soldier Settlement areas created after World War I, but they were adapted for other areas as their need became apparent. The last Outpost Hospital operated by the Red Cross closed in 1959. See Marguerite E. Robinson, *The First Fifty Years* (Regina: Saskatchewan Registered Nurses' Association, 1967), p. 16, and 103-4).

15 Dorothy Gallagher, Interview, North Battleford, June 2000. Mrs. Gallagher worked as an early provincial health nurse in northern Alberta in the 1920s, and she recalled that although federal authorities did offer some health care to Status Indian peoples, she was sometimes unclear as to whether patients were registered or not, and that this did not stop her from delivering the primary care she offered. It seems the distinction between Status and non-Status patients became more significant in the 1950s, although more research on the jurisdictional wrangling between province and federal government in this area is certainly required.

16 Saskatchewan Archives (SA), Department of Public Health, Nursing Services Division (DPH, NSD), PH5,IIIB, File 57, Statement of deaths from tuberculosis for year 1950.


20 SA, DPH, NSD, PH5, IIIB, File 1, Buffalo Narrows, 1947-1954, C.F.W. Hames, Deputy Minister of Public Health to F.W.G. Miles, Commissioner Canadian Red Cross, 7 November 1947.
21 SA, DPH, NSD, PH5, IIIB, File 1, Miss E. Smith to Miss M. Lyons, 26 August 1947.
23 SA, DPH, NSD, PH5, IIIB, File 3, Miss M. Lyons to Miss E. Smith, 17 August 1947.
26 Ben McIntyre, Uranium City—The Last Boom Town (Mill Bay: Driftwood Publishing, 1993), p. 126; and SA, DPH, NSD, PH5, IIIB, File 54, Uranium City, Miss C. Augener to Miss M. Edwards, no date. When the eight-bed Uranium City outpost hospital burned in May 1955, the patients were simply moved to the home, and bed, of the Public Health nurse and her husband.
27 SA; DPH, NSD, PH5, IIIB, File 3, Buffalo Narrows, Miss M. Lyons to Miss E. Smith, 31 August 1948.
29 SA, PH5, IIIB, File 44, Stoney Rapids, Myrtle Pierce to Miss E. Smith, Director of Nursing Services, 25 April 1948.
30 SA, DPH, NSD, PH5, IIIB, File 3, Buffalo Narrows, Miss M. Lyons to Miss E. Smith, 31 August 1948.
31 SA, DPH, NSD, PH5, PH5, IIIB, File 44, Snake Lake, Miss E. Broome to Miss E. Smith, 4 January 1951.
32 SA, DPH, NSD, PH5, IIIB, File 3, Buffalo Narrows, Miss M. Lyons to Miss E. Smith, 31 August 1948.
33 SA, DPH, NSD, PH5, IIIB, File 44, Snake Lake, Miss E. Broome to Miss E. Smith, 4 January 1951.
34 SA, DPH, NSD, PH5, IIIB, File 3, Buffalo Narrows, Miss M. Lyons to Miss E. Smith, 3 March 1948.
35 SA, DPH, NSD, PH5, IIIB, Miss Lyons to Dr. Totton, Buffalo Narrows, 20 April 1949.
36 SA, DPH, NSD, PH5, IIIB, Buffalo Narrows, Miss M. Lyons to Miss E. Smith, 18 April 1948.
37 McPherson, Bedside Matters, p. 78-81.
38 SA, DPH, NSD, PH5, IIIB, File 50, Stony Rapids, Miss M. Pierce to Miss E. Smith, 25 April 1948.
39 SA, DPH, NSD, PH5, IIIB, File 3, Buffalo Narrows, Mary Lyons to Miss E. Smith, 19 January 1948.
40 SA, DPH, NSD, PH5, IIIB, File 5, Miss M. Pierce to Miss E. Smith, 25 April 1948.
41 SA, DPH, NSD, PH5, IIIB, File 44, Snake Lake, Miss E. Broome to Miss E. Smith, 4 January 1951.
42 Muriel Innis, Interview, 1 May 1999, Saskatoon, SK.
43 Innis interview. The authority of nurses over their patients was also confirmed by Betty Lou Simpson in interview, 5 August 1999, Saskatoon, SK.
44 SA, DPH, NSD, PH5, IIIB, File 1, Stony Rapids, Miss H. Janzen to Miss M. Edwards, 11 August 1954.
45 SA, DPH, NSD, PH5, IIIB, File 3, Buffalo Narrows, Miss M. Lyons to Miss E. Smith, 18 August 1947.
46 SA, DPH, NSD, PH5, IIIB, File 5, Buffalo Narrows, Miss A. Augener to Miss E. Smith, 30 September 1953; and Miss Augener to Miss E. Smith, 4 November 1953.
47 SA, DPH, NSD, PH5, IIIB, File 2, Buffalo Narrows, Miss M. Lyons to Miss E. Smith, 5 October 1949.
48 SA, DPH, NSD, PH5, IIIB, File 3, Buffalo Narrows, Miss M. Lyons to Miss E. Smith, 30 November 1949.
Nursing and Native Peoples in Northern Saskatchewan: 1930s-1950s

49 SA, DPH, NSD, PH5, IIIB, File 2, Buffalo Narrows, Miss G. Aylsworth to Miss E. Smith, 8 October 1952.

50 Betty Lou Simpson, Interview, 5 August 1999, Saskatoon, SK.

51 Simpson interview; and Jean Graham, Interview, 3 June 1999, Saskatoon, SK.

52 SA, DPH, NSD, PH5 correspondence contains payment submissions for various treatments of Treaty Indians.

53 SA, DPH, NSD, PH5, IIIB, File 44, Snake Lake, Miss E. Broome to Miss E. Smith, 12 September 1951.

54 SA, DPH, NSD, PH5, IIIB, File 50, Stony Rapids, Miss M. Pierce to Miss E. Smith, 28 January 1948.

55 SA, DPH, NSD, PH5, IIIB, File 26, Goldfields, Mrs. R. Shannon to Miss M. Edwards, 26 June 1954.

56 Muriel Innis, Interview, 1 May 1999, Saskatoon, SK.

57 Robinson, First Fifty Years, p. 201.