Health and the Health Care Delivery System:
The Micmac in Nova Scotia

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Abstract

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This thesis examines the history of medical care and the development of the health care delivery system among the Micmac in Nova Scotia during the nineteenth and twentieth centuries. It examines the relationship of the medical profession to the state and, through this examination, the relationship of the Micmac to the state. This thesis examines a broad range of topics, including the struggle of medical orthodoxy to professionalize, the role of the Micmac in this struggle and the role of the state and philanthropic capitalism in advancing the status of orthodoxy. The thesis then examines the response of the medical profession to later challenges to its authority.

These interrelationships grow out of an analysis of varied source materials. Petitions reveal much about the extent and nature of nineteenth century medical attendance. At the same time, these petitions offer numerous insights into the dynamics within the medical marketplace. Tremendous use is made of government reports and publications because of the pervasive concern with the role of the state. As well, newspaper accounts have been utilized to give voice to some of the arguments presented and add colour.

This thesis makes a contribution to our collective understanding of the medical profession in Nova Scotia and adds another dimension to the history of the Micmac and their relationship with the state. In doing so, it demonstrates how change within the medical profession and the provision of medical care to the Micmac was a negotiated process and how the Micmac were active participants in their own history.

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Introduction

Perhaps no other field of historical inquiry has shown the growth and diversity in the past decade as that of medical history. A late comer to the realm of social history, the "new social history of medicine"[1] investigates the nexus at which the private world - the traditional concern of social historians which includes the history of the family, childhood and other such pursuits - and the public world intersect. David Gagan recently wrote that the "social history of medicine seeks to understand society's historical response to disease, especially in relation to the interaction between those in need of health care and those who provided it, as a microcosm, perhaps even a paradigm, of modern society."[2] The history of medicine, Sir William Osler is said to have observed, "is the history of mankind". Therefore "virtually all human activity has some implication for the social history of medicine".[3] It is this perspective that lies at the foundation of the body of scholarship that has been generated in the area of medical history.

Given the large scope of inquiry that could be placed under the rubric of medical history, it is not surprising that there are several neglected areas, including questions pertaining to medical research, the medical care provided to prisoners or members of the military, or other such topics.[4] One other such area is the provision of medical care to native peoples. This thesis, it is hoped, will further our understanding of medical history in Canada and in Nova Scotia. Through an

examination of the historical provision of medical services to the Micmac in Nova Scotia, the interface between the social history of medicine and native history may be illuminated. This analysis of medical care in Micmac communities will integrate various approaches and orientations in the writing of medical history - amateur, profession-centered, disease-centered, biographical and patient-centered. In doing so, it will situate medical care for Micmac squarely within the constructs of medical professionalization and bureaucratization. This thesis, then, will investigate two seperate, though not unrelated themes - the relationship of the state to the medical profession and, through an analysis of medical care, the relationship of the state to the Micmac. It is hoped that this work will further our understanding of the medical profession, while illuminating many of the modern concerns the contemporary Micmac have with respect to health care delivery.

The new social history of medicine had the benefit of a large corpus of published material on a variety of aspects of medical history, produced largely by the medical profession itself. It has been "an historiographic cliché" Sam Shortt has written "that medical history is traditionally written by doctors, about doctors, and for doctors."[5] This kind of medical history has traditionally focused on the role that prominent doctors, or the entire medical profession, played in discovering or applying medical and scientific innovations, thereby advancing the curative power of medicine. This Whiggish approach has characteristically held that such developments were part of a natural evolution, an argument that has been criticized with the entry of the professional historian

into the realm of medical history.[6] Yet, these earlier works should neither be discarded nor ignored, and the efforts of those dedicated individuals who generated these studies should be given due recognition for producing a "solid foundation of research",[7] rather than condemned for a "lack of methodological sophistication".[8] The subject matter of both genres of medical history - 'professional' and 'amateur' - has, after all, remained largely the same. Histories of medical legislation, institutions such as the hospital and biographies of practitioners are to be found in both approaches. Yet the difference lies in the social historian's concern with the process of change.

It is this process that is illuminated in Chapter II and Chapter III of this thesis. How did medical practitioners transform themselves from a diverse group, rife with sectarianism and competing amongst themselves into a more or less cohesive profession, with a virtual monopoly on formal medical care? This achievement is even more remarkable when one considers that this was accomplished in the absence of an effective therapeutic arsenal, a question ignored by the amateur historian. By creating the hospital, medical schools and medical societies, and redefining orthodoxy around these institutions, rather than therapeutics, the regular practitioner emerged preeminent.[9]

Then there is the question of the relationship between the profession and the state. Various petitions to the Nova Scotia House of Assembly and the sessional papers of the Dominion of Canada illustrate that there was a de facto recognition of orthodox practitioners as

preeminent by the colonial administrators of Nova Scotia. It has long been recognized that the role of the state in the public health movement had served to further the professional aspirations of regular medical practitioners, but it would appear that this very relationship emerged considerable earlier, albeit in a much more tenuous form. Yet, one should not imbue this process, or any of this thesis, with notions of conspiracy or social control for, as Stephen Nissenbaum points out in his investigation of the health reformer Sylvester Graham, it "is not historical to equate the consequences of a new ideology with the intentions that led people to devise or adopt it."[10] Similarly, simply because the end result of the formation of medical societies, reconstitution of hospitals and reform of medical education was a self-governing profession with a monopoly, none of these developments should be viewed as leading unalterably to that point. Such a view is deterministic and ahistorical.

The fourth chapter is primarily concerned with the creation and evolution of the Indian health service, operated by the Medical Services Branch of the Department of National Health and Welfare. The evolution of this vast government bureaucracy, as well as that of Indian Affairs, was syptomatic of a broader trend in bureaucracies, including medicine, toward specialization, departmentalization and compartmentalization. Continuing the theme first encountered in Chapter III, the declining importance of the 'country doctor', medicine became increasingly depersonalized and faceless. Physicians become a part of a larger complex of health care workers, and had to defend their interests against those of

a rationalizing bureaucracy. This is best illustrated through physicians' tenacious defence of payment on a fee-for-service basis. That medicine served a hegemonic function for the ruling class, a theme articulated in the third chapter, is further illustrated in Chapter IV through an examination of the Indian health service's main preoccupation, namely vaccination.

One important focus of this thesis, then, is the individual practitioner and the institutions he or she utilized - medical schools, hospitals and medical societies. Another focus must be the patient, described by Wendy Mitchinson as "the missing half of the dynamic of medicine".[11] While reconstruction of individual patient biographies is clearly beyond the scope of this thesis, attention is given to the role of the Micmac community in promoting and maintaining health. While petitions and accounts revealed much about the extent and nature of medical attendance, it was not possible to ascertain the quality of that care, save for inference. In lieu of this, attention has been given to changes within the Micmac community, and the implications these changes had for the health status of the Micmac. Thus, in Chapter I, the reader is introduced to the changes wrought by colonization - changes which included rapid depopulation at the hands of disease, war and dietary change. At the same time, a brief summation of traditional health care is offered, together with contemporary evaluations of the herbal pharmacopeia's efficacy. Later in the work, notably in the last chapter, consideration is given to contemporary Micmac perceptions of what constitues health, perceptions which are

firmly rooted in Micmac culture. It was in 1774, in a paper read before the American Philosophical Society, that Benjamin Rush noted the interrelationships between economics, politics and disease,[12] a viewpoint which has been recast in recent years and given the title 'whole health'. Such a perception is not foreign to the Micmac community and is at the root of much of the dissatisfaction with the modern health care delivery system. Furthermore, and in keeping with Rush's comments, consideration will be given throughout to questions pertaining to the Micmac economy and social world.

Chapter V, in addition to examining native perceptions of illness and health, focuses attention upon indigenous efforts at improving health, through involvement in the health care delivery system. The increasing participation of Micmac bands, political organizations and individuals in the health care delivery process, at both the administration and delivery levels, will be documented and then juxtaposed with questions pertaining to medical professionalization, authority and bureaucratization. Moreover, the policies of the federal government - the variety of programs and policies initiated during the period - will also be given due consideration. In recent years, the lack of progress in many areas of native health has been noted and commented upon by scholars and medical bureaucrats alike. A new school of thought believes that a lack of native power in the health care system is at the root of this poor progress. As Micmac communities increasingly participate in the health care system, questions pertaining to the power of the medical profession necessarily emerge.

In the final analysis, then, this thesis sets out to document the history of medicine among the Micmac and practiced within their communities by white practitioners. It is a history which attempts to unite divergent themes in a coherent fashion. It is by no means comprehensive. Questions pertaining to mental health, for example, are virtually ignored. Similarly, detailing the alternative methods of cure utilized in Micmac communities was a task too large to be included in this work. It is fully recognized that the scope of this work is limited, given the large proportion of medical care and health maintenance that occurs beyond the parameters of orthodox medicine, notably in the home. This very large and very important component of health maintenance, as well as the interaction between this care and 'formal' medical care, remains to be illuminated, as do numerous other considerations. Despite these limitations, a clear picture of medicine in Micmac communities does emerge. Many of the arguments of other historians regarding therapeutic effectiveness, professionalization and bureaucratization may find further illustration herein. Yet, this work is more than an adjunct to the previous historical and sociological wisdom. It demonstrates the fluidity of the boundaries between questions of ethnicity and medical professionalization. Moreover, the analysis of the data adds to the earlier medical history of the region by illuminating the role of the state in inadvertently aiding the process of medical professionalization. The end result, while flawed, throws light upon the history of medicine among the Micmac, the interaction between orthodox and native medicine, and the role of the state in the professionalization process.

Endnotes

1. Samuel Shortt, "The New Social History of Medicine: Some Implications for Research" in Archivaria No. 10 (Summer 1980), p. 5.

2. David Gagan, "For 'Patients of Modern Means': The Transformation of Ontario's General Hospitals, 1880-1950" In Canadian Historical Review Vol. LXX, No. 2 (June 1989), p. 151.

3. Shortt, op. cit., p. 10.

4. Samuel E.D. Shortt, "Antiquarians and Amateurs: Reflections on the Writing of Medical History in Canada" in Samuel E.D. Shortt, ed., Medicine in Canadian Society: Historical Perspectives. Montreal: McGill-Queen's University Press, 1981, p. 8.

5. Shortt, "The New Social History of Medicine", p. 5.

6. Wendy Mitchinson and Janice Dickin McGinnis, Essays in the History of Canadian Medicine. Toronto: McClelland and Stewart, 1988, p. 13.

7. Ibid., p. 7.

8. S.E.D. Shortt, "The Canadian Hospital in the Nineteenth Century: An Historiographic Lament" in Journal of Canadian Studies Vol. 1, No. 4 (Winter 1983-1984), p. 4.

9. This is not to suggest that the importance of therapeutics diminished. John Harley Warner argues that, quite the contrary, therapeutics continued to be fundemental to professional self-identity, even if defective. See Warner, The Therapeutic Perspective. Cambridge: Harvard University Press, 1986, p.p. 4, 258-264. Notwithstanding this argument, a redefinition of the profession around medical licensing, medical societies and medical education does occur, thereby establishing different criteria, other than therapeutics, on which to differentiate orthodoxy from its' competitors.

10. Stephen Nissenbaum, Sex, Diet, and Debility in Jacksonian America: Sylvester Graham and Health Reform. Westport: Greenwood Press, 1980, p.p. x, ix.

11. Wendy Mitchinson, "The Health of Medical History" in Acadiensis Vol. XX, No. 1 (Autumn 1990), p. 254.

12. George Rosen, "Political Order and Human Health in Jeffersonian Thought" in George Rosen, From Medical Police to Social Medicine: Essays on the History of Health Care. New York: Science History Publications, 1974, p. 247.

Chapter I - The Aboriginal World and European Intrusion

Prior to the presence of European fishing vessels off the Nova Scotian coast, the aboriginal inhabitants of this land prospered and a sophisticated and functional cultural system ensured a quality of life. An economic system characterized by seasonal migrations exploited a wide variety of terrestrial and marine resources. Yet, the romantic image of the native person in harmony with nature is, at best, questionable. Aboriginal life for the Micmac was not without hardship. The resource exploitation pattern, though highly adapted and sophisticated, could not prevent food shortages, especially through the lean winter months. Similarly, the pre-contact Micmac did not lead a disease-free existence and an elaborate herbal pharmacopeia played a significant role in maintaining physical health, while shamanism maintained the mental health of the Micmac.

Increasingly, however, the aboriginal world came under attack by European intrusion. Long before colonization occured in the early seventeenth century, the economic system of the Micmac was disrupted, as trade between the Micmac and European fishermen became increasingly frequent. After the sixteenth century, economic patterns were altered to the detriment of the aboriginal diet. Moreover, new diseases or strains of diseases were introduced to an unprotected population. These two factors combined to account for a significant portion of a dramatic population decline, which began before colonization. A brief outline of the literature surrounding population estimates for the Micmac and an outline of traditional economic pursuits is provided

as a backdrop to later themes of European intrusion, disease, dietary change, traditional health care, colonization and subsequent hostilities. The end result of European colonization, from an administrative point of view, was the founding of a fledgling Indian bureaucracy.

Through an examination of the aboriginal economy, European intrusion and the resultant depopulation, as well as traditional health care, one may begin to understand the profound impact of the European presence in the New World. Furthermore, insight into the aboriginal health maintenance system may be gained. While it is impossible to deal fully with these themes, it is important to recognize the sophistication of Micmac culture, and its adaptation to the local environment. What follows is a cursory treatment of the aboriginal world and early colonization, but it is nonetheless important, for it establishes context for subsequent discussions.

I - The Aboriginal Population

Nova Scotia has long been inhabited. Archaeological evidence from the Debert site near Truro suggests that it may have been settled as early as 10,600 years ago.[1] There are competing theories as to whether or not these early inhabitants were the direct ancestors of the historic Micmac. The most commonly held theory is that the Micmac were the last of a series of aboriginal peoples to come to Nova Scotia. It is, however, recognized that a people with a similar technology to that of the historic Micmac have been present in the region since at least A.D. 1200.[2] How numerous were the Micmac prior to European contact? If one is to understand the depopulation that occured during the six-

teenth, seventeenth and eighteenth centuries, an estimate would be useful. The difficulty is that it is impossible to arrive at a precise figure. Nonetheless, a review of the literature on this issue may be beneficial.

The first historic population estimate for the Micmac is that of the Jesuit priest, Pierre Biard, who estimated a population of between 3000 and 3500.[3] Yet, this is clearly a post-contact estimate and a dubious one at that. Trade had been conducted between the Micmac and European fishermen for at least a century, resulting in a variety of changes, including the introduction of new diseases and dietary change. Virginia P. Miller has put forth an aboriginal population estimate of 35,000. This figure was calculated using the Dobyn ratio of a 20:1 depopulation rate for each individual alive at the population nadir. Using Biard's 3500 estimate as the nadir figure, an aboriginal population of 70,000 is arrived at. Miller compromises by using a population reduction factor of only 10:1, thereby arriving at the 35,000 figure.[4] Yet, this figure is for the entire Micmac population. Using criteria established elsewhere by the author[5], one can derive the Nova Scotia population. Nova Scotia constituted roughly forty-six percent of all Micmac territory. Assuming equal distribution throughout the Micmac territory, a figure of 16,100 Micmac in Nova Scotia is calculated. In another study utilizing similar criteria, Miller offers the reader a figure of 26,000 Micmac in Nova Scotia.[6]

What other figures have been put forth for the aboriginal population? Bernard Hoffman, in his doctoral dissertation, argued that a

pre-contact population of 6000 Micmac would not be unreasonable, though he has more recently conceded that this figure is too low.[7] Snow has utilized a ratio of 12.3 persons per one hundred square kilometers to arrive at an estimate of 12,000 Micmac.[8] Harold F. McGee has suggested a population of 35,000.[9] All of these figures are for the entire Micmac population, not just that portion inhabiting Nova Scotia. While it is clear that no concensus exists, it would not be unreasonable, for the purpose of reference, to suggest a population of 20,000.

This population had a geographic range consisting of the major portion of what are now the Maritime provinces as well as the Gaspé peninsula. This was the Micmac homeland - Megumage[10] to its inhabitants. The Nova Scotia portion of this area contained all or part of six relatively independent socio-political units.[11] These areas were held together through common interests, a common language and a range of other ties. Also, they shared a similar, though not identical, resource exploitation pattern.

II - The Micmac Economy

The Micmac economy was one of subsistence. Their economic strategy was hunting-gathering and, as one would expect, intricately associated with the sea. The Micmac invested a great deal of time exploiting marine resources and a significant portion of their diet came from the sea. It has been suggested that as much as ninety percent of their diet came from the sea,[12] which provided sustenance for ten months of the year.[13] A new interpretation has been put forth that emphasizes the

terrestrial component of the economy. Hoffman's ninety percent marine diet estimate has been refined somewhat by David Sanger, who emphasizes that this could only apply to the Micmac surrounding the resource-rich Bay of Fundy, yet even here it would remain a high estimate.[15] As the debate over the significance of the marine diet reveals, the Micmac economy was seasonal, and exploitation patterns were adjusted accordingly. It would be useful to reconstruct the economic year, to gain insight into the aboriginal diet and as a reference point for the changes that accompanied the European presence in the region.[16]

Spring brought the Micmac to the coast. They would move to the numerous bays, estuaries, coves and river mouths around the region. Here, they gathered in villages, living in nuclear and extended family units. They would prepare their weirs in an effort to catch smelt, herring, gaspareau, salmon or sturgeon, which ran in the spring and summer. The numerous shellfish resources were also collected, and hooks and leisters employed to take large fish and lobster. Marine resources were undoubtedly a strong element of the spring and summer diet, but other resource bases were exploited. Migratory birds such as loons, herons, geese and auks were hunted in the spring. Indigenous birds, including the black duck, gulls and owls were hunted in vast quantities, and together with their eggs and nestlings, were an important source of food. Hunters used a variety of weapons to take these birds, including snares, clubs and bows and arrows. Ground nuts and berries were collected, and these were often dried and stored for the leaner winter months. Land animals such as beaver, moose, bear and caribou were hunted sporadically, although they were not a significant

portion of the spring and summer diet. These were seasons of plenty - there were no food shortages and no starvation.

During the fall, birds remained plentiful as they paused on their southward migration. However, the fall meant a more restricted resource base. When late summer arrived, the Micmac began to move away from the coast to the provincial interior. The move provided the opportunity to catch eels in great numbers, as the Micmac retreated from the coast along river banks. The eels were eaten fresh as well as being smoked for winter consumption.

The arrival of winter brought a greater preoccupation with land animals. "Our Indians have...no occupation more honorable than hunting"[17] wrote Chrétien LeClerq, but the prestige associated with hunting surely predated the European presence. An early description states the Micmac's "chief preoccupation is the Chase; They must engage in it or die." Furthermore, the moose was "one of the finest prizes an Indian can secure".[18] Moose hunting was a prominent feature of the winter economic strategy and was mentioned in nearly all of our seventeenth century descriptions of the Micmac, including Lescarbot, Denys and Dièreville. Caribou were also present, but were seemingly not an important food staple, probably due to their affinity for more remote or barren areas. Hunting these large land animals was a major enterprise, but not the only one. Seals were taken in large numbers during the winter whelping season. As well, the Micmac consumed their stores of dried and smoked foodstuffs. LeClerq described the winter "as a time of involuntary penitence and very rigorous fasting" which

exposed the Micmac "to the danger of dying from hunger."[19] While LeClerq's commentary comes after the Micmac economic strategy was disrupted by the European traders, it is likely that winter in the aboriginal world was difficult. The availability of food fluctuated, in contrast to the abundance of the warmer seasons. Winter, even a good one, was a time to anxiously await spring.

Economic activity was carried out by both sexes. Ellice Gonzalez[20] rejects the commonly held notion of a strict sexual division of labour. She argues, for example, that hunting, often thought of as the domain of males, was in fact a cooperative activity, indicating a greater degree of interdependency. Gonzalez concludes that women occupied a dominant role in the pre-contact Micmac economy. Gonzalez's work is provocative, but the point should not be lost that survival necessarily depended on the cooperation of the sexes and their interdependent activities.

III - European Intrusion

The Micmac economic cycle was disrupted and changed with the arrival of the Europeans. Recent archaeological excavations at L'Anse aux Meadows, on the north coast of Newfoundland, have yielded firm evidence of a Norse presence in the eleventh century.[21] In the early seventeenth century, the settlement at Port Royal was founded. Between these two extremes came the group of Europeans that had the most significant and extended period of contact with the native peoples of the east coast - the fishermen.

Basque, Norman and a range of other European fishermen frequented the rich grounds off Nova Scotia since at least 1500.[22] These ships established regular contact with the Micmac, largely facilitated through a mid-century change in the European fishing strategy. Prior to the mid-sixteenth century, the predominant fishing stategy was the 'wet' or 'green' fishery. This method involved salting the fish on board the ship, which meant going ashore only for repairs and supplies. This method had weaknesses, however, for it required large amounts of salt and the fish was not ideally preserved and therefore had to be marketed quickly.[23]

About mid-century, the wet fishery was supplanted by the 'dry' fishing strategy.[24] This methodology overcame the difficulty of preservation and the expense of salt. The fish, once caught, were lightly salted and then sun-dried. This necessarily involved going ashore for extended periods of time. This method was also more practical because more fish could be caught and transported, thereby rationalizing shipping. This transition to the dry fishery increased the contact between the Micmac and the Europeans. The contact changed from intermittant association to periods of extended interaction lasting the whole fishing season. This longer period of seasonal acquaintance led to trading between the two groups. The Micmac began to trade furs and handcrafts for European iron goods, such as knives, and foodstuffs. Yet, perhaps the most profound result of sixteenth century European contact was not the economic disruption, but the drastic population decline. Harold McGee has suggested that the population may have been reduced from 35,000 people to 5000.[25]

IV - Disease

What were the causes of such a profound decimation? Calvin Martin has described the native peoples of North America as "immunologically virgin",[26] which he attributed to the Arctic cold, which acted as a 'germ filter'. This operated as the ancestors of native peoples crossed the Bering land bridge. Martin was alluding to the fact that over several millenia, native peoples lived in the absence of Old World afflictions, and therefore lost their immunological defense. This is not to suggest that they lived in the absence of disease, merely the absence of European strains.

Nicholas Denys wrote, in fact, that the Micmac "were not subject to diseases, and knew nothing of fevers."[27] Yet, they were familiar with such afflictions and developed a large and complex pharmacopeia to deal with them. But they were not European or Old World diseases. Measles, scarlet fever, tuberculosis, chickenpox, smallpox, typhoid, typhus and venereal diseases have long been described as European introductions. Paleopathological studies reveal a somewhat different picture however. Through analysis of preserved coprolites and bones, as well as native materia medica, evidence has been found of polio, syphillis, hepatitis, non-pulmonary tuberculosis, arthritis and a range of other afflictions.[28] Examples abound of potential threats to native health, and one such example is tularemia. This is a disease common in rodents, such as the beaver, which can be transmitted to humans, where it manifests plague-like symtoms. Tularemia may be contracted through eating infected meat or simply handling infected hides. It is, therefore, not inconceivable that this might have been

an affliction that the Micmac had to endure.[29] Nevertheless, Europeans introduced new, more virile strains of diseases, if not entirely new diseases in every case, for which the native person had no immunological defence. This is not to suggest that aboriginal peoples were, in some way, biological inferior. Clearly they were not, for their immune system was highly effective in combating diseases to which they had been exposed. But they lacked an effective immunological defence against these new introductions.

How significant was the role of disease in depopulation? None of the early European chroniclers mention epidemics. Nevertheless, epidemic disease surely exacted a heavy toll during the sixteenth century. But in order to understand depopulation as it probably occured, attention must be given to factors other than disease, notably diet.

V - Dietary Change

Virginia Miller suggests that "the principal cause of Micmac decline...<was> dietary change resulting in endemic diseases, with perhaps some local incidences of European diseases taking their toll".[31] In discussing the Micmac economy, it was noted that there was a heavy dependence on meat (The nutritional values of some foodstuffs are given in Appendix A). The Micmac had few, if any, general food taboos,[32] though it has been suggested that females bearing young were not eaten.[33] Young hunters were not allowed to eat certain foods for spiritual reasons. For example, the porcupine was not consumed by young hunters because of its slowness which, it was feared, would impair the hunter's ability.[34] Beyond such restrictions, the Micmac ate what they wanted,

when they were hungry. As long as there was food, nobody went hungry, for the economy was a redistributive one.

However, food availability depended upon the maintenance of the seasonal economic cycle. But as contact with European fishermen became commonplace and trade frequently conducted, the seasonal exploitation pattern was disrupted.[35] Food commodities received by the Micmac were often of poor quality. Dried goods, hardtack, corn, prunes, wheat flour and peas were some of the articles received. Pierre Biard wrote that the Micmac complained "that the merchandise is often counterfeited and adulterated" or perhaps "spoiled and sold to them."[36] More significant to the Micmac diet, however, was the fact that these items did not compensate for the disrupted aboriginal diet. Trade, then, brought about a cultural change. Summers formerly spent gathering and preserving food were now occupied by the demands of trade. Moreover, more time was devoted to gathering the primary means of exchange - furs. The end result was that no native food stores were procured for the long interim months. This necessarily weakened the physical condition of the Micmac, thereby increasing the susceptibility to endemic disease, as well as those of European origin.

It would seem plausible that together, dietary change and the introduction of European diseases combined to facilitate the depopulation that began in the sixteenth century and continued for at least two centuries thereafter. This was apparently recognized by the Micmac, for Biard wrote that they were "astonished and often complain that, since the French mingle with and carry on trade with them, they

are dying fast and the population is thinning out."[37] Micmac medicine could not deal with a weakened and sick populace on such a large scale. Hence, the population was reduced to perhaps one-tenth of its former size. Never before had the population been so ravaged and traditional medicine so helpless.

VI - Traditional Health Care

There are, generally, three types of traditional Indian medicine: (1) the internal, which made use of various herbal preparations; (2) the structural, which utilized mechanical means for bone setting, stitching wounds, etc., and (3) the psychological, utilizing ritual or shamanistic behaviours.[38] All of these were present in aboriginal Micmac society. Ill health, moreover, was explained in one of three ways.[39] First, there were those afflictions which arose on a cause and effect basis. If such a cause was absent, illness was explained in either psychological or supernatural terms. The former were associated with unfulfilled desires.[40] Supernatural afflictions may be caused by sorcery, the presence of a foreign substance in the body placed there by a shaman or the presence of an illness-causing spirit essence.[41] Given this context, it should be no surprise to learn that health was maintained through a bifurcated medical system. Herbalists and shamans played discrete, though not unrelated, roles in maintaining the health of the community. Recourse was had to the shaman in the event of psychological or supernatural illness, or for more serious ailments. The many herbal remedies were prepared by the 'makers of medicine' - the herbalist.

Early European travellers noted that the Micmac had a tremendous arsenal of remedies. Lescarbot wrote that "the Indians...possessed a knowledge of medicine and surgery that was in some ways the equal of our own. In their application of the medicinal properties of the vegetable kingdom the Indians were probably superior to the French physicians. They had remedies for each and every occasion".[42] Indeed they did, for R. Frank Chandler has recently isolated 128 different plants used in the treatment of approximately seventy afflictions,[43] though some may be of European origin. This medical tradition contained remedies which served as emetics, purgatives, astringents, expectorants, abortifacients and emenagogues.

The Micmac believed that nature provided cures for natural illnesses in plants. Most of the herbal remedies utilized a single herb, but compound remedies were not infrequent. The herbs were chosen by way of the doctrine of signatures - that like cured like. Hence, one finds red plants used in association with blood or bleeding, yellow ones for conditions such as jaundice, and so forth.[44] But one should not underestimate the value of these remedies, for many contained real therapeutic value. These remedies, moreover, were not guarded secrets and the herbalists were not conspicuous in appearance and had no special powers. Laurie Lacey has suggested that this probably accounts for their persistence even after the Micmac conversion to Christianity, whereas the shaman faced an assault on his legitimacy.[45] Herbalists, who could be either men or women, were adept at preparing their nostrums and had an extensive knowledge of the plant and animal world.

It has been the persistence of the herbalist until the present day that has provided us with a knowledge of some of these remedies (See Appendix B). Among those ingredients of proven therapeutic value are yarrow (Achilla millefolium) and tansy (Tanacetum vulgare). Yarrow was a familiar part of many cultures traditional pharmaceutical arsenal. The Micmac used it primarily for external injuries - bruises, sprains and swelling. Yarrow has a significant presence of a volatile oil, which acts as a counter-irritant through rapid evaporation, in addition to exhibiting analgesic and perhaps anti-inflammatory properties.[46] Another herb used in traditional Micmac medicine was tansy, which also exhibits some therapeutic properties.[47] This was used primarily as an abortifacient and as a diuretic. This perrenial herb contains a sufficiently high level of thujone to induce abortion. Tansy persisted in materia medica for many centuries, appearing in the United States Pharmacopeia continuously between 1820 and 1905.[48]

Other remedies also possessed certain properties that would provide real relief to the recipient of the preparation. Tannin, for example, is present in numerous plants, including the balsam fir, spruce, pine, juniper and alder trees, and exhibits astringent properties. The balsam fir shall serve as an example of how a medicine could be prepared. Parts of the fir were chewed by the herbalist and the juice generated was spat into the wound. The chewed remains were then applied to the wound in the form of a poultice and the underbark was used as a dressing.[49] Other plants were utilized for their antiseptic properties. Spruce, pine, juniper and alder all contain oleoresins, a known antiseptic.[50] Volatile oils, as previously mentioned, provide relief

through rapid evaporation and are found in many plants as well. Finally, infection could be combated with plants that contain methyl salicylate or alkaloids, such as the wintergreen oil found in birch bark or bloodroot, respectively.[51] Both of these chemical components have antibacterial properties, though they are mild.

It should, then, be abundantly clear that traditional Micmac medicine consisted of more than a vast array of placebos. In fact, in many instances they were based on sound physiological foundations.[52] The fact that over two hundred native Indian drugs have been listed at various times in pharmaceutical publications is testimony to their real therapeutic value, or the perception of that value. Moreover, as late as the 1960s, nearly one-half of all prescriptions filled contained an active natural ingredient.[53]

In addition to illness, the Micmac had to endure frequent cuts, wounds, broken bones and sprains that were the result of a hunting-gathering lifestyle. Dièreville wrote of how a bone was reset:[54]

> the bones are reset evenly, and large pads of soft fine moss are made, which are saturated with their Turpentine, and wrapped around the broken limb; outside of that is placed a piece of Birch bark, which readily conforms to the shape of the part; splints are not forgotten, and, to hold all this secure, they use long strips of thinner bark which make suitable bandages.

Wounds were treated in two primary ways. Lescarbot wrote that an individual would "lick and suck them <the wounds>, using a beaver's kidney, of which they put a slice upon the wound, and so it heals itself."[55] Sutures were also utilized, and were made of either inner tree bark or deer tendons.[56]

The sweatbath must have been a familiar feature or Micmac life, for it is mentioned by all of the early French authors. Dièreville wrote that when "they are very weary and overwhelmed by lassitude and sluggishness...they cure themselves by profuse sweating."[57] The sweat bath, according to Lescarbot, was used to "ward off sickness."[58] These comments would seemingly support Laurie Lacey's suggestion that the sweathouse "was an important part of Micmac preventative medicine."[59] But could the sweatbath have been of ritual significance to the Micmac? To draw once again on Lescarbot, who wrote "by the frequent use of the sweatbath, say once a month, they protect themselves, driving out all the cold and evil humours which they may possibly have collected."[60] Such a regular use may be indicative of some kind of purification rite associated with the sweatbath. Hoffman also suggests the possibility of a ritual significance to sweatbaths,[61] but conclusions such as this should only be regarded as tentative.

There were, of course, other cultural features of Micmac society that had a direct influence on physiological health, and consideration shoud be given to some of these. There were, for example, many cultural features related to pregnancy, childbirth and newborns. During pregnancy, sexual relations between husband and wife ceased, for it was considered harmful to the unborn child.[61] The process of childbirth was assisted by a midwife. Dièreville relates the process of childbirth to us, saying that when "the wife is in labour and believes that delivery is at hand, she leaves the Wigwam and goes some distance into the Forest with a Squaw to assist her and the business is soon over." In appreciation and for payment the "Mother gives the Woman,

who has delivered the Child, the knife with which the cord has been cut, and that is her only recompense."[62] If complications arose during labour, childbirth was artificially induced. The expectant mother had her hands bound to a pole, while the midwife massaged her sides and then pressed hard in an effort to expel the baby.[63]

Following birth, the newborn was immediately washed in a stream. The child was also given animal grease or oil as its first nourishment. Dièreville tells us that the baby "is forced to swallow this, after which he gets only his mother's milk until he is strong enough to live as others do."[64] Lescarbot mentions the use of grease or oil as well, though not the swallowing of it. Bernard G. Hoffman could find no rationale for this custom.[65] However, Calvin Martin may shed some light on this custom. Martin cites Frank Speck as writing that "the hunter resorts to drinking bear's grease to nourish his 'great man'." Martin then suggests that the custom of giving a newborn grease or oil may have served the same purpose - to begin to nourish the infant's soul-spirit.[66]

Newborns were breast-fed for extended periods of time, perhaps as long as three years. There was apparently no forced weaning. Ruth and Wilson Wallis make two statements on the issue of breastfeeding, saying that if a nursing mother became pregnant, the nursing baby was "weaned at once". At another point in the same article, however, it is stated that "if a mother of a nursing child became pregnant, she produced an abortion by means of a secret native drug."[67] Dièreville supports the latter of these two suggestions:[68]

> ...those yet unborn
> Are not favoured, and a Mother who,
> Still with a Nursling at her breast,
> Conceives again, will without fear
> Of God or man a potion drink so that
> She may abort; she cannot, so she says
> With her own body nourish two at once,
> Nor, roaming in the Forest, carry both

Denys also supports this, saying that abortions were induced "because they cannot nourish two children at the same time".[69] No criteria was established by the Wallis' regarding whether an abortion was induced or a nursing child was weaned, but it would seem probable that age was the determining factor. If the nursing child was near the weaning age, then no abortion was necessary. However, if the nursing child was unable to be weaned, then an abortion was likely induced. In this way the mother ensured the proper nourishment of the child at the breast and, hence, his or her health.

There were, of course, other cultural adaptations that preserved the health of the populace. Lescarbot relates to us that the Micmac had " a superstition that they will not eat mussels; for this they can give no reason...Yet when in our company seeing us eat them they did the like".[70] One can conclude from this that there was no taboo against the consumption of mussels. Perhaps this reluctance to eat mussels stemmed from incidences of food poisoning - a common result of consuming bivalve mollusks. Cases of paralytic shellfish poisoning, for example, cause acute intoxication at the hands of a powerful neurotoxin. Its symptoms are severe - paresthesias of the face lips, mouth and limbs, diarrhea, nausea and vomiting. Severe cases, which are rare, are characterized by paralysis or muscle weakness, faltering respiration or

death. The symptoms of paralytic shellfish poisoning, then, may have been severe enough to generate a fear of mussels, if not a prohibition.

When herbal preparations failed to restore health or when illness was deemed to be of psychological or supernatural origin, the shaman was summoned. The shaman was an important personage in the Micmac community, offering predictions regarding the hunt, war, or other concerns. However, his most important shamanistic role was that of healer. All of the European chroniclers contain references to the ceremonies surrounding illnesses. Laurie Lacey informs us that the shaman, who was always a man, acquired his ability in one of five ways: (1) through inheritance; (2) through a dream; (3) through receiving a gift of power from a shaman; (4) through acquiring a plant containing a power spirit or (5) through receiving a gift of power from a spirit helper.[71] Biard describes the shaman as one "whose office is the same as that of our Priests and our Physicians" who were "well versed in tricks and impositions".[72] Lescarbot was equally critical of the shaman, saying they "know well how to win credit from the common people; for by their impostures they live and make themselves necessary, playing the part of physicians and surgeons".[73]

The early writers offer descriptions of the shaman's attempts to rid the patient of a particular affliction. Dièreville writes:[74]

> The Juggler in contortions writhes
> With vile grimaces, so appalling that
> The Demon should himself be terrified...
> The Band listen to all he has to say,
> With close attention, and they have no doubt
> That what the Demon has foretold, shall be.

Denys offers an extended account of the shaman's ritual curing:[75]

> They were men who had some cunning more than the others, and made them believe all they wished, and passed for their physicians. These fellows came there to see the sick man, and asked of him where his ill was. After being well informed in all, they promised health, by blowing on him... They danced with such fury that they emitted foam as big as the fists on both sides of the mouth. During this performance they approached the patient from time to time, and at the place where he had declared he felt the most pain, they placed the mouth upon it...This lasted sometimes seven to eight days, and finally they made a pretence of drawing something from his body...and often in fact the man got well through imagination. And if the patients did not grow well, they found some other excuse.

Lescarbot offers a somewhat different description of the shaman's activity, writing "they fix in a pit a staff, to which they tie a cord, and putting their head into this pit, they make invocations or conjurations...When the devil is come, this master Autmoin makes them believe that he holds him tied by his cord".[76] What emerges from these descriptions of shamanistic ritual is the remarkable confidence the Micmac community had in the shaman's ability, which must have been a powerful psychological agent in the healing process. Moreover, it was a ceremonialism that was consistent with the broader Micmac belief system, such as their notions of disease causation. It was, then, a therapy which reinforced cultural patterns and beliefs, as well as offering community members a powerful psychological healing process.

Shamans were a visible manifestation of native beliefs and were therefore ridiculed and discredited by those engaged in missionary activity, notably the Jesuits.[77] The end result was that "between the early 1800s and the first quarter of the twentieth century, the insti-

tution of shamanism disappeared as a culturally acceptable and valid part of Micmac Indian life."[78] Ultimately, the shaman's ceremonial role would be replaced by the Catholic priest and his medical role by the Western doctor, in contrast to the herbalist, who has endured until the present day.

VII - Colonization

Casual trade between Micmac and European throughout the sixteenth century, and the accompanying changes it brought to the aboriginal world, was accelerated through the seventeenth century, which brought early attempts at colonization. It was France that first established a solid claim to the region, though John Cabot provided England with a nominal claim. Pierre de Gua, Sieur De Monts was granted a monopoly over the area between the fortieth and forty-sixth parallel, on the premise that he could develop a highly profitable fur trade. Furthermore, King Henry IV granted the charter on condition that De Monts assume responsibility for establishing colonies there.[79] De Monts, together with Champlain, first settled St. Croix Island in 1604, but when this failed, the colony was relocated to Port Royal.[80] The latter site was chosen partly because of the nature of the native people encountered, a point to which we will return. Simply stated, the two groups - French and Micmac - were not in competition with one another for either land or resources.

De Monts returned to France in 1607, but his efforts were not lost. The Sieur de Poutrincourt reestablished the colony at Port Royal in 1610.[81] This marked the beginning of a continuous French presence in the region which endures to this day. A large proportion of the credit

for the perseverance and success of the colony must be placed with the settlers who's "common aim was the creation of a self-supporting community." Furthermore, from the beginning, "the majority of those that came to Acadie wanted to establish a new homeland rather than a trading station, or a base for further exploration".[82]

Poutrincourt, however, did not establish the colony with ease, and his efforts serve as a microcosm of the greater circumstances in which he lived, especially the tumultuous political and religious structures of seventeenth century France. The original expedition of 1604 was comprised of both Catholics and Protestants, though it was under Protestant leadership. De Monts and Poutrincourt did business with politicians and financiers of both faiths, an extraordinary tolerance in the highly divisive religious circumstances of France in the 1600s. Catholics and Protestants were divided and these divisions created a web of entanglements that extended into the political and mercantile community.[83]

Following the assassination of the French King Henry IV in 1610, his widow, Marie de Medici, turned to the zealous Jesuit order for both comfort and advice. This greatly concerned the merchant investors of La Rochelle. They threatened to withdraw their backing of Poutrincourt if the Jesuits became too influential in the colony, which would have effectively ruined Poutrincourt financially and ended any hope of reestablishing the colony at Port Royal. A resolution came in 1613, when the Jesuits encouraged the French government to grant Acadia, except for Poutrincourt's lands around Port Royal, to the Marquise

of Guerchville.[94]

The experience of Poutrincourt in the tangled network of France's religious quarrels served not only to illustrate the circumstances in which Poutrincourt maneuvered, but also the fact that Acadia was subjected to various forms of manipulation from different quarters. Another example of this external manipulation may be found in the geography of Acadia. In fact, from the beginning, Acadia, due largely to its strategic location between New England and New France, "was subjected to divergent policies that turned it into a pawn on the great chessboard of imperialistic policies."[85] Furthermore, "the area was the scene of frequent devastation".[86] One such devastation came at the hands of the Virginian Samuel Argall, who destroyed the Jesuit settlement at Saint Saveur and sacked and burned Port Royal in July 1613.[87] This marked the beginning of a fourteen-year period of neglect for Acadia. The French government focused her colonial efforts on the colony of Canada instead, long the jewel in the crown of New France. While it is true that Acadia was left with little or no support, there remained a continued and strong French presence in Acadia. French missionaries continued their activities, trading companies continued to exploit Acadia and fishing vessels frequented Acadian harbours during the summer months.[88]

Interest in the colony was not renewed until 1627, when England and France entered into renewed hostilities. This resulted in a brief period, between 1628 and 1632, which saw the English and Scots dominate Acadia.[89] This, however, was ended by the Treaty of St.

Germain-en-Laye, which restored Acadia to the French and marked the beginning of a period of renewed interest in the North American colonies. The embodiment of this interest was Richelieu's Company of 100 Associates. The task of reestablishing French dominance in Acadia was given to Isaac de Razilly. The governor founded a colony at the mouth of the Le Héve River.[90] De Razilly has been attributed with the "first serious attempt to colonize Acadia."[91] It was de Razilly who brought the skilled dyke builders to Acadia. This enabled farming to take place on the fertile marshlands, as well as the added advantage of enabling the settlers to harvest salt, which could then be utilized in the drying of fish to be shipped to Europe.[92] Thus began a settlement pattern and a lifestyle that has come to be associated with the Acadian people.

By the 1650s, the Acadian people were firmly established in the region. Their settlements were usually found along "dyked tidal marsh portions of rivers and streams",[93] a settlement pattern which endured until the 1750s. An explanation has been put forth concerning this geographic distribution and land use. It has been suggested that many Acadians originated from the western coastal region of France, where the geography of the land was similar to that of the colony.[94] This argument is suspect, however, and it is more likely that there were professional dyke builders in the colony. Regardless, once firmly established, the Acadians founded many more settlements and had "by the end of the seventeenth century spread up the Annapolis River... their villages ringed by the Cobequid Bay form Windsor (Pisiquid) to Truro (Cobequid), and stretched on to the Tantramar Marshes".[95] The

Acadians persevered, proliferated and, in the process, developed a unique culture, one that was largely shaped by their unique circumstances - a strategic location, a diversified economy and a wavering imperial interest. Acadia, due to its strategic location, was often subjected to the machinations of competing colonial powers - France and England - and was often subjected to frequent policy changes and devastation. These factors combined to shape a unique culture - one that was neither French nor English. Furthermore, the resulting insecurity of the colony probably led to the necessity of a high degree of self-sufficiency.

This self-sufficiency was undoubtedly aided by the amicable relationship between the settlers and the Micmac. Francis Parkman's oft-quoted dictum that "Spanish civilization crushed the Indian; English civilization scorned and neglected him; French civilization embraced and cherished him"[96] does contain some truth. Equally important as the European treatment and perceptions of native peoples were the actions and thoughts of the Indians themselves. While Alfred Goldsworthy Bailey wrote, quite rightly, that the "subjective standpoint cannot be eliminated" in reconstructing the earliest perceptions of Europeans by the Micmac, he does argue that "French opinion of Micmac shortcomings was balanced by Micmac apprehension of the vices and frailties of the French." Similarly, Cornelius Jaenan argues that "Amerindian evaluation of French culture and civilization was often as unflattering as was the low regard of Frenchmen for Amerindian culture."[97]

Jaenan further argues that this was a period of non-directed acculturation, writing that while the "French regarded their own culture as infinitely superior...It would be a fundemental error to assume that the Amerindians entertained or accepted such a comparative evaluation".[98] The Micmac, who had a successful resource exploitation strategy and vibrant culture, also maintained a significant military role for, as John G. Reid has argued, as late as 1630 "the northeastern maritime region remained Indian territory...European colonization had made only the faintest of imprints upon the land."[99] Moreover, the settlement pattern of the Acadians - in small marshland communities of little value to the non-agricultural Micmac - was conducive to fostering good relations with the Micmac. Colonization, like earlier trade relationships, did not disrupt the traditional economic base of the Micmac, though it did alter their pursuits.[100]

The harmonious relationship between French settlers and Micmac Indians came to occupy a more significant role in the latter part of the seventeenth century. To again cite Reid, who has provided readers with a convincing analysis of the interrelationships between Euro-Americans and northeastern aboriginals, the amicable relations between French and Micmac came "to assume increasing importance from the European point of view in the years following 1675." Moreover, the "framework of French-Indian contacts in the later seventeenth century...was sufficient to prevent any rupture of the relationships that had existed in the formative years...French-Indian relations were able to proceed on a basis of mutual respect and cooperation."[101]

Yet there was another colonial power, England, that had a vested interest in Acadia. The colony's strategic location between the colonies of New France and New England, and the potential for overland invasions via the Chaudiere and Kennebec rivers, respectively, made it a significant piece of colonial real estate. It was France that had successfully colonized the area. They managed to missionize the Micmac, enjoyed a prosperous trading relationship and, in the process, forged a valuable alliance. With the War of the Spanish Succession (1701-1714), Acadia's position became precarious. The end result for the New World, the 1713 Treaty of Utrecht, was ambiguous at best with respect to Acadia. England gained control of most of Acadia, though France retained control of Ile St-Jean and Ile Royale.[102] Section fifteen of the Treaty outlines provisions regarding the Micmac.[103] It reads:

> XV. The subjects of France inhabiting Canada, and others, shall hereafter give no hinderance or molestation to the five nations or Cantons of Indians, subject to the Dominion of Great Britain, nor to the other natives of America who are freinds of the same. In like manner the subjects of Great Britain shall behave themselves peaceably towards the Americans who are subjects or friends to France; and on both sides they shall enjoy full liberty of going and coming on account of trade.

The Micmac were recognized as a distinct people by the treaty and were free to pursue trading activities and social relations with either the French or the English. The alliance between French and Micmac, therefore, could be maintained.

British contact with the Micmac began long before the cession of Acadia. The New Scotland settlement enjoyed good relations with the Micmac.[104] However, the development of a British policy toward the Micmac began only with the treaty. At the time of the cession, Brit-

ish policy had as its only aim the maintenance of peace in the face of two potentially hostile groups. Neither the Acadians nor the Micmac saw the arrangement, that is, British control, as permanent. They were simply awaiting the restoration of French power. Peace was guaranteed only while the defeated recouped and readied themselves to strike again. The Micmac, though small in number, were of great concern to the British due to their close relationship with the French. The change from French to British rule did not mean a corresponding change in Micmac allegiance. In the ensuing half century, particularly between 1715 and the final fall of Louisbourg in 1757, there were periodic conflicts between the Micmac and the British.

VIII - Hostilities

The Micmac were subjected to French propaganda surrounding the Treaty of Utrecht. As one study notes, "when the French informed the Indians that they were not mentioned in the Treaty of Utrecht, they considered themselves an independent people and not the subjects of Britain."[105] Such propaganda reinforced Micmac hostility towards the British and perpetuated their affinity to the French. Hostilities between the Micmac and British were intense between 1710 and 1730, and after a ten year respite, flared once again,[106] prompted by the War of the Austrian Succession. This war ended in 1748 with the Treaty of Aix-la-Chapelle. However, the treaty resolved little[107] and did not end the conflict in Nova Scotia.

There were attacks by the Micmac on the settlements at Halifax and Canso in the late summer of 1749. On 18 September, 1749, Governor

Cornwallis read a letter before the Council in which he expressed his concern over a Micmac attack on the village at Minas where three Englishmen and seven Micmac were killed. Cornwallis continued, "it was known that Leutre <sic> the Priest had been some time with Indians, & it being highly probable that he is there on purpose to excite them to War".[108] A week earlier, on 11 September, 1749, Cornwallis had said "if the Indians do begin <hostilities>, we ought never to make peace with them again" and "root them out entirely."[109] Hostilities and continued raids occured throughout September, culminating in a Micmac declaration, as L.F.S. Upton has written, that "the land belonged to the Micmacs and they would not abandon it without a fight. Unless the English abandoned Halifax there would be war".[110] After an attack on a sawmill on Halifax harbour, the Council responded swiftly, though it stopped short of declaring war because to do so "would be in some sort to own them a freepeople, whereas they ought to be looked on as Rebels to his Majesty's Government".[111] Instead, the Council unanimously approved the following:

> That His Excellency gave orders to the commanding officers at Annapolis Royal, Minas, to all others within the Province, to annoy, distress & destroy the Indians every where.
> That a premium be promised of ten Guineas for every Indian killed or taken Prisoner.
> That another Independent Company be raised...not exceeding one hundred men...who shall have the same pay and provisions as the troops have & the reward of ten Guineas for every Indian they shall take or destroy.

Virginia Miller, in her work on population decline, notes that this policy did not meet with much success, even though the bounty was raised to the handsome sum of £50 the following June. Miller has

concluded that "only a single bounty was ever collected", though such sanctioned hostility likely exacted a greater toll in terms of Micmac deaths.[112]

English expansion prompted Micmac resistence, as they attempted to settle areas of traditional importance to the Micmac - areas around Halifax Harbour, Chezzetcook, Lunenburg and Mahone Bay. Here, as Upton has noted, "the newcomers found cleared land, for the sites had long been used by the Indians."[113] The trouble and fear of the Micmac inhibited the expansion of British settlement in Nova Scotia, illustrated by the Council minutes for 10 August 1752:[114]

> His Excellency also informed the Council that he had His Majesty's Instructions to settle the foreign Protestants in such a place as he should judge most suitable and desired the opinion of the Council whether (in light of the advanced season of the year and present unsettled Condition of the province in respect of the Indians) it is advisable to settle them this year in any place distant from the settlements already made.

It is clear that a hesitantcy remained despite of the ostensible peace concluded in 1752.[115] Similarly, though Cornwallis rescinded the earlier bounties and forbade "all persons to molest, injure or commit any kind of hostility against any of the aforesaid Indians"[116] such official proclamations did little to end hostilities. There was a case of a Samuel Cleveland, apparently killed by Micmacs at Jeddore.[117] An interesting case involved John Connor and James Crace, who appeared in Halifax Harbour on 15 April, 1753 in a Micmac canoe carrying with them six Micmac scalps. The next day, they related to the Council a story of native treachery. After living some time with a number of Micmacs, Connor and Grace were told by an informant that they were to

be killed. As a result, the two men[118]

> took this opportunity to endeavor by destroying the Indians, to make their Escape. That accordingly, they first killed the Woman and Boy and then secured the Arms and ammunition of the Indians and waited for their return when they rushed upon them and killed them with Guns and Axes at their landing

The men claimed that the Micmac had seized their ship and that they were the sole survivors of the crew. Upton, however, refutes this story. Instead, the men had apparently robbed the Indians of their Government-issue supplies. They had been "taken in and cared for by friendly Indians whom they murdered for the scalp money."[119] Such instances are indicative of the suspicion that reigned between some whites and Micmac, despite government overtures of peace and mutual habitation.

The peace concluded in 1752, the Articles of Peace and Friendship Renewed, lasted little more than two years, and fear of hostilities continued until the capture of Louisbourg and the fall of Beausejour in 1755. Miller argues that the bounty was reinstated in 1756 and "individual Englishmen continued to hunt and kill Micmac people ...these companies did not keep records of how many Micmac were killed...<but there is> some indication that it was a considerable number."[120] Despite the collapse of the French strongholds and the deportation of the Acadians, the Micmac continued their struggle. In December, 1758, Lunenburg was raided and there were sporadic conflicts through 1759. Lasting peace, and the psychological relief it must have provided to the settlers, finally came in 1760, when a peace treaty was concluded between Chief Michael Augustine of the Richebucto

Indians and Nova Scotia governor Charles Lawrence,[121] Treaties were later concluded with other Micmac tribes. This treaty brought an era of native policy to an end. Prior to this, the Micmac and French 'problem' had been indistinguishable. The sole purpose of British policy was the maintenance of peace. It was a period which saw the Micmac oppose British rule and defend their lands. Only with the collapse of French power did Micmac resistence end, thereby setting the stage for the emergence of a settler economy and a new focus for British policy.

IX - Administration

The settler economy had to be precipitated by the regulation of land. It was this consideration that gave rise to the Royal Proclamation of 1763.[122] This document established hunting grounds for the Micmac and confirmed hunting rights. Perhaps most important, the Royal Proclamation outlined the procedure for the acquisition of these lands. Thus, it established the active role of the Crown as the protector of the Micmac, especially in land matters. The Government also made its first attempts at regulating trade with the Micmac. The treaty of 1760 forbid the Indians to "Traffic, Barter, or Exchange a Commodity in any manner, but with such person or the Managers of such Truck-houses". Despite earlier promises of the construction of truckhouses, the government appeared more serious and on 8 February, 1760, appointed Benjamin Gerrish, a native of New England, to act as "Agent or Commisary on behalf of the Publick <sic> for carrying on a Commerce with the several Tribes of Indians inhabiting this Province and its

environs".[123] The Lieutenant Governor, in a message to the Assembly, wrote of "the necessity of a Law to prevent such pernicious practices from a private Commerce with these people". Following Lawrence's directions the House considered "a Bill to prevent Clandestine Trade with His Indians", which was assented to on 29 March, 1760.[124] The truckhouse system, however, was plagued by its complexity and the heavy debts incurred. In 1764, the Board of Trade in London drafted a new scheme, but the system "had collapsed of its own accord in Nova Scotia."[125] The new plan essentially deregulated the trade with the Micmac, and all Indians under British administration, though in Nova Scotia it was still only to be conducted at specified locations.

X - Conclusion

With the collapse of the truckhouse system, the office in charge of Indians, the Agent for Indian Commerce, became irrelevant and was replaced by a new office, the Superintendent of Indian Affairs. In 1768, jurisdiction over Indians was transferred from the British government to the colonies,[127] thus ending the period of imperial administration and initiating the era of colonial administration that was to last a century. Within a century and a half, the Micmac had witnessed the end of their profitable and amicable relationship with the French, a relationship that was replaced by British administration.

Colonization had indeed brought a great many changes to the Micmac, but colonization marked the second European intrusion, for change began in the sixteenth century. The agents of this change were not the great

explorers or the colonizers, but the fishermen and the trade they conducted. It was a period of non-directed acculturation, and there is no evidence of a dominant-subordinate relationship, beyond that of the Jesuits with respect to religion. But contact with the Europeans did change Micmac life in some dramatic respects. The introduction of new strains of disease, or entirely new diseases, coupled with dietary change and losses due to hostilities, combined for a drastic population decline. Moreover, the position of the shaman, an important component of both spiritual and mental health of the Micmac, hence the aboriginal health maintenance system, was undermined. However, Micmac confidence in their herbalists endured, as did the herbalist, probably due to their inconspicuous place in the Micmac community and the fact that they posed no threat to the missionary ideology. What emerges, then, is a society that is vastly changed, but retains its own notions of health and methods of health maintenance. These notions, however, would largely be ignored or scorned by the orthodox medical practitioner who, under the British administration, would become the chief providers of medical care. Orthodoxy was involved in its own struggle - the struggle to professionalize and secure public legitimacy.

Appendix A

Nutrient Value of Selected Foods
(for 90g serving)

	Energy (kj)	Fat (g)	Carbohydrates (g)	Protein (g)	Iron (mg)	Vitamin A (RE)	Vitamin C (mg)
Deer (fresh, roasted)	757	5	0	27	2.0	0	0
Moose (cooked)	661	3	0	31	3.0	47	0
Rabbit (wild, stewed)	812	9	0	26	1.4	0	0
Duck (wild, raw, flesh only)	469	1	0	19	3.0	-	0
Liver (deer, cooked)	862	10	5	24	8.0	14,432	24
Cod (dried, salted)	490	tr	0	26	3.2	0	0
Eel (raw)	879	16	0	14	0.6	435	-
Herring (broiled or baked)	907	14	tr	21	1.3	47	3
Salmon (smoked)	662	8	0	19	1.3	8	-

tr - trace amounts
- - lack of reliable data, though believed to be present

kj - kilojoules
g - grams
mg - milligrams
RE - retinol equivalent

Source: Canada. Health and Welfare Canada. Native Foods and Nutrition: An Illustrated Reference Source. Ottawa: Supply and Services, 1985.

Appendix B

Some Afflictions and Herbal Cures

Affliction	Natural Ingredients
Bruises	Balsam fir, yarrow, lilies
Burns	Balsam fir
Chancre	Burdock roots, beech
Cholera	Calamus, cow parsnip
Colds	Tea of hemlock bark, tea of white pine, balsam fir, yarrow, maple, sweet flag, angelica, spikenard, Indian turnip, tamarack, white pine, Labrador tea, poplar
Colic	Balsam fir
Consumption	Spikenard, mountain holly, juniper, tamarack
Cough	White maple, maple, sweet-grass, angelica, spikenard, wild turnip, avens, black spruce
Cramps	Alder, Indian ginger
Diabetes	Golden thread
Diarrhea	Blackberry, balsam fir, chokecherry, red oak, raspberry
Diptheria	Alder
Fatigue	Spikenard
Fever	Ground hemlock, alder, lilies, club moss, raspberry
Fractures	Balsam fir
Gonorrhea	Balsam fir, maple, spikenard

Appendix B (Cont'd)

Affliction	Natural Ingredients
Gonorrhea	blackroot, cleavers vine, tamarack, wintergreen
Laxative	Balsam fir
Pleurisy	Calamus, cow parsnip
Rheumatism	Yellow birch, animal grease bayberry, sweet fern, juniper
Scurvy	Bearberry, Indian tea tree, white pine
Smallpox	Compound tea of princess pine, black cherry bark, wild turnip and honey
Sprains	Yarrow, juniper, lambkill, sweet fern
Swelling	Lambkill, lilies, juniper, yarrow, sweet fern, cedar
Ulcers	Juniper, goldenthread
Wounds	Balsam fir, spikenard, juniper, white spruce, white pine

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Chapter II - 'among us, yet not of us': The Early Nineteenth Century

In February, 1847, Dr. Edward Jennings recounted in a petition to the Lieutenant Governor his experience in treating some Micmac near Dartmouth. His description is of interest because it contains many of the elements that were characteristic of the medical community and their struggles, as well as the situation of the Micmac during the early nineteenth century. Jennings wrote that a "number of the natives were successively attacked & died having no medicine administered - Save the decoction of some astringent barks, which certainly hastened the fatal termination. The first proper medical attention rendered was by Dr. Richardson". It is evident from Jennings' description that he viewed traditional remedies, obviously still in use, with suspicion, but on what did he base such an evaluation? In describing the disease, which was likely infectious hepatitis, Jennings continued that "despair and distress were pictured in the countenances of all and it was evident that fear was the chief exciting cause of the disease." Jennings believed "that a combination of Atmospheric circumstances, owing to the variableness of the weather and assisted by local causes of Effluvia filth, poverty and its concomitant a deficiency of warm clothing and proper nourishing diet will account for the Phenomena." Medicine still lacked an adequate explanation of disease, as well as treatments. To the ravaged Micmac population, Jennings and Richardson could offer only "brisk purgatives. In some cases of great debility...powders of Quinine, Calomel &...Nitrate of Bismuth were administered...At the same time

securing a free evacuation of the bowels...These powders corrected the Nausea". To those who were recovering, the doctors offered "Wine, beef tea and occasionally brandy". The traditional arsenal of medical therapeutics was clearly in use, but a subtle change was occuring, for bloodletting "was not resorted to in any case nor do I think it could with safety -- Leeches might have been used with advantage."[1]

Jenning's description illustrates some of the salient features of the care provided to the Micmac during the early nineteenth century. The provincial Indian affairs bureaucracy, the object of Jennings' petition, emerged in the 1820s and came to play a significant role in many aspects of native life, including health care. Also characteristic of the early nineteenth century was medical orthodoxy's struggle to professionalize, and the resultant redefinition of professionalism that emerged based upon medical schools, societies and hospitals.[2] These themes intersect in the Micmac community. The relationship between the state and regular practitioners began to emerge, though admittedly it remained tenuous. Not until the public health movement, when regular practitioners received the sanction of the state, and the power and prestige that accompanied that sanction, did this relationship become secure. Nevertheless, a semblance of this later development may be seen in the nineteenth century Indian reserve.

An analysis of the interrelationships between practitioners, Micmac communities and the fledgling government bureaucracy will also reveal something about the nature of those doctors servicing native communities. Competition in the medical marketplace between orthodox

practitioners, sectarians and patent medicine peddlars, yet another hallmark of the nineteenth century, did not extend into Micmac communities. It was, however, a major obstacle for the regular profession in their struggle to gain preeminence in the medical marketplace. Perhaps it was this competition that led Jennings to summarily dismiss the validity of native remedies.

Through an analysis of the early nineteenth century, the antecedents of the redefinition of professionalism and professional reform and the conditions that spawned these changes can be identified. The results of these early efforts, or lack thereof, can be illustrated through an examination of the middle decades of the century. How did these attempts at reform, such as medical licensing, affect the health care provided to the Micmac? What about the quality of this care? What did the diseases encountered by doctors, and endured by the Micmac, reveal about the socioeconomic condition of the Micmac? To what extent did orthodoxy utilize the emerging bureaucracy to advance their own professionalism?

The medical care the Micmac received cannot be viewed apart from the broader socioeconomic context of the communities and the changes taking place within these over time. It was with pessimism that Abraham Gesner observed in 1848 that the[3]

> scattered remnant of this once brave and patriotic people is now utterly degraded and overwhelmed in misery. They have been supplanted by civilized inhabitants, and in return for the lands of which they were the rightful owners, they have received loathsome diseases,alcoholic drinks, the destruction of their game and threatened extermination.

The resultant destitution of many Micmac placed an extraordinary burden on the provincial coffers. A large portion of the burden derived from doctor's petitions for remuneration. The extent and nature of this attendance, and the demand by the government for greater accountability intersected with the development of bureaucratic responses to the plight of native people and their 'ideal' relationship to the larger social system.

M.H. Perley, in an 1843 report, described the native inhabitants of New Brunswick as a people "among us, yet not of us".[4] The Micmac did not fit the emerging role of the agricultural settler - they remained a distinct entity within the province, and in Nova Scotia as well. Despite government efforts, the Micmac had not been integrated into the dominant white economy. A review of the early forays into Indian administration, beginning with the Joint Committee of the Assembly and Council, appointed in 1800, will serve as an adequate starting point. The Joint Committee inaugurated a policy that would come to fruition in the later decades of the century - a policy of systematic settlement and the attempted creation of self-supporting agricultural communities. As well, the Joint Committee can be viewed, to a certain extent, as an early step toward erecting the larger bureaucracy which would evolve over the next half century and come to pay a significant proportion of its budget for medical attendance.

I - Early Indian Administration

While the government of Nova Scotia retained the Superintendency for Indian Affairs in 1783, it did little beside issuing licenses

for land to some Micmac, and was allowed to lapse in 1784. Military considerations, however, brought Indian affairs to the forefront once again in 1793, with the outbreak of the third Anglo-French war.[5] In 1797, the desperate situation of the Micmac prompted the British government to offer an imperial grant of £200. A flowering of interest occured at the turn of the century, which culminated in the appointment of a committee to investigate the state of the Micmac. Spawned by the Assembly's protest aginst the classification of native peoples as indigent poor,[6] the Committee report, tabled on 15 April 1800[7] contained three recommendations: (1) the government should offer incentives to induce Micmac to settle on the land and support themselves through agriculture; (2) the establishment of a grant to relieve distressed Micmac, and (3) further study of the problem.[8] Another task, a component of the first but one worth mentioning, was that lands were to be surveyed, with an eye toward inducing the Micmac to settle. Government relief was to be restricted only to those who would settle and George Monk suggested "withholding all publick Assistance from those who would not comply". The Council and Assembly even approved "a sum not exceeding £350" to be expended "for the relief of the Indians in their present distress".[9] Between December, 1800 and 12 June, 1803, the government expended £530.2s.8d., though "many parts of the Country which has been much burthened <sic> with Indians having received little or no assistance from that fund."[10] Interest soon lapsed, however, as the Legislative Council failed to approve a grant of £200 for the following year,[11] and lands were never surveyed.

A resurgence of interest in the administration of Indian affairs, perhaps rekindled by fear of Micmac collusion during the Anglo-American crisis, occured in 1807. Monk wrote that the Micmac "Expect the province will be invaded and it appears generally to be their intention, in case of such an event, to remain neuter until they can form an Opinion...and then (in their own words) "to join the strongest party"".[12] The memory of Micmac military strength was not far buried in the minds of the colonial administrators, though this strength was clearly in decline. In response to the perceived military threat, Monk created twelve Indian districts in the province, each with a correspondent to oversee and report on the condition of the native inhabitants.[13]

Monk also noted that it was becoming increasingly difficult for the Micmac to continue with traditional economic pursuits, as Nova Scotia had "no back Country for the Aborigines to retreat to". Furthermore, "they must resort to other means, or suffer for want. Those means would probably be obtained by encouraging them to become Stationary" and become farmers.[14] The suggestion to farm also found a home in the North American Indian Institution, established in Halifax in 1814.[15] Despite a lull in the provincial economy in 1817, optimism reigned in early 1819, and Lieutenant Governor Dalhousie noted in an address to Council that "succeeding years of abundant crops have...dispelled the clouds that hung over us, and I have had the satisfaction to observe the increasing prosperity in all parts of the Province."[16] Yet, growing prosperity did not extend beyond the white community, and a letter to the editor of the Novascotian in March 1828[27] noted this:

> it should be borne in mind by ue <sic> that while we are rejoicing at our elevation...there is a portion of the population proportionally depressed- a body of people whose hearts cannot be gladdened, for their interests are not advanced by it, as they behold the rough forest turned into the fruitful field...in the columns of the Nova Scotian, the pitiable state of the aborigines of this Province ought to have a place...Relief, however... does not and cannot benefit them as a people.

The alternative to relief, of course, was "to convert them into useful tillers of the earth."

The author of the above letter, who, incidentally, signed it 'Micmac', reflected the government's thinking. The government took heart in finding that "two settlements of Indians have been made, one at the Shubenacadie consisting of twelve families, and one at Gold River near Chester...Improvements to a considerable extent have been made in each of those Settlements, and a quantity of Grain and Potatoes raised in the last session."[18] At the Council meeting held on 22 December, 1819, the Lieutenant Governor expressed his optimism that many Micmac could now be induced to settle and take up agriculture. Dalhousie proposed setting aside reserved lands, which were not to exceed one thousand acres, in each county. On 8 May, 1820, the surveyor general provided Council with a description of these lands. Reserves in Cape Breton, outside of Nova Scotia's jurisdiction in 1820, were roughly surveyed in the 1830s.[19] Nevertheless, agriculture enjoyed only minimal success, and Sir James Kempt noted in 1827 that a great deal was left to do. Meanwhile, "the sufferings of the Indians were much greater then <sic> was commonly recognized, and many of them were now disposed to settle."[20] One aspect of their suffering, undoubtedly tied

to the decline of traditional economic pursuits and proximity to white settlers and immigrants was disease.

II - Disease in the Early Nineteenth Century

The Joint Committee of the Assembly and Council, appointed in 1800 to alleviate the suffering of the Micmac wrote that "the Native Indians of the Province, who from Age, Sickness or other Inability to procure their own subsistence may, during the ensuing Winter be in danger of starving".[21] Sickness was a feature of not only Micmac life, but that of the entire colony, and figured prominently in the colony's administration during periods of widespread infection. Trading vessels, often the vehicle for the introduction of disease were viewed with a degree of foreboding. "It remains for me to recommend" said Lieutenant Governor John Wentworth to the Assembly in 1799, "that you will take into your Consideration, the existing danger of having Yellow Fever, or other infectious Distemper, brought into the Province, for want of proper Regulations".[22] Quarantines and inspection were the means by which it was hoped that the introduction of disease could be slowed. In 1800, for example, the account of the Health Officer for Halifax was in excess of £120 for inspecting vessels arriving from the United States or the West Indies.[23] Other accounts were not so large: Lunenburg's Health Officer received £5.10s, Liverpool's £24.15s and Shelburne's £27.10s.[24] Contagious disease figured prominently in the mortality statistics of the province throughout the nineteenth century, and was, therefore, a very real threat to the colonial population, especially those in a weakened state.

One of the most feared diseases of the early nineteenth century must surely have been smallpox, which was widespread throughout Nova Scotia from 1800 to 1802. Simeon Perkins noted in his diary that the "people are Alarmed, & wish to have them <those infected> removed."[25] Virginia P. Miller has suggested that smallpox was introduced at Pictou by Scottish immigrants, but clearly it had taken hold in the province prior to November, 1801.[26] Reports of smallpox among the Micmac came from throughout the province: Halifax, Liverpool, St. Margaret's Bay, Guysborough County, Pictou and Antigonish all reporting incidences.[27] One result of smallpox among the Micmac was the migration it spawned, thereby possibly facilitating the spread of the disease.[28] The migration response to disease also had consequences for the provision of relief. One inhabitant of St. Margaret's Bay noted that "Old Phillip the Indian and his...Family have Ben <sic> Back in the woods all this winter on account of the Small Pox and without any Provisions or Gun".[29] The Overseers of the Poor for Shelburne petitioned the House of Assembly in February, 1801, stating:[30]

> We beg leave to inform you that there are a number of them in the vicinity of this Town (suppose Twenty families at least) some of whom are in a very distressed situation, and have applyed <sic> to us for relief and that we find a the number of these ...is likely to increase considerably, being by their fear of this Small-pox driven from both Halifax & Liverpool - and therefore think it our duty to request you will have the Goodness, as early as possible...to obtain for them some relief.

The provision of relief was rendered more difficult, on the one hand, by the withdrawal of many Micmac away from white communities and, on the other, by taxing the resources of local Overseers of the Poor, who then had to petition the Assembly for reimbursement. Finally, the

Joint Committee for Indian Affairs noted that smallpox, "having driven the Indians away from their usual places of Resort have rendered it impossible for the joint Committee fully to complete the object of the Legislature in their appointment",[31] which was, of course, an investigation of the conditions of the Micmac.

Vaccination was one method, beyond the appointment of Health Officers, that the government utilized in an attempt to control the spread of smallpox, and the Micmac were encouraged to receive this protection.[32] Miller, however, writes that "the Indians dislike and avoidance of vaccinations doubtless contributed to the smallpox mortality."[33] Conflicting evidence exists on this point, however, and such a view becomes a matter of interpretation. In 1801, for example, "fourteen families chiefly from Antigonish" descended upon Guysborough, apparently because in Antigonish, the people were "inoculating for the small pox".[34] Does this indicate a fear of inoculation or a fear of the disease? The evidence would seem to support the latter. Dr. J. Bolman received £30 for vaccinating Micmac in 1815[35] and in 1830, Dr. Thomas Jeans of Cape Breton found "the Indian population particularly solicitous to be guarded from the contagion of small pox so frequently introduced into this Island by the Emigrant ships."[35] It should also be noted that vaccination was not restricted to the Micmac population, for in 1828 some one thousand and sixty-two persons were vaccinated in the Pictou area.[36]

Smallpox continued to make periodic appearances throughout the province and was often the lethal byproduct of trade and emigration.

It occured among thirty-eight emigrants in Halifax during the summer of 1818,[37] was introduced to the Micmac around Sydney by a brig from Aberdeen in 1826[38] and occured among Irish immigrants in Halifax in 1831.[39] Yet, in the 1830s, the fear of cholera eclipsed that of smallpox and gave rise to another policy, quarantine. During the middle part of the nineteenth century, cholera swept across Europe and made appearances in British North America in 1832, 1834, 1849 and 1854.[40] The fear gripped Halifax, and the Assembly appointed a committee "for the prevention of the Cholera in the Town".[41] In 1832, "An Act to prevent the spreading of contagious diseases, and for the performance of Quarantine" was given assent.[42] Cholera and quarantine were intertwined in the Nova Scotian context, and Kenneth G. Pryke had provided a convincing synthesis of cholera, quarantine, theories of contagion and public perceptions of disease and those afflicted.[43] What is of particular interest to this analysis are the latter two considerations. First, Pryke notes that quarantine was based on a theory of contagion which theorized that disease could be spread through direct or indirect contact. This theory, and the quarantine policy it spawned were, however, being critically examined in the United States and Great Britain during the 1830s, largely by those who looked toward the unsanitary conditions in which people lived. Miasmatic theory believed that the causative agents of disease existed in the atmosphere and were bred in the waste of the urban environment. Moreover, disease was associated with immorality or degeneracy in the Victorian mind. Thus, it was with the utmost confidence that a traveller could write of the New Brunswick Micmac that "their diseases are multiplied through the

prevailing habits of idleness and drunkenness".[44] These notions of the spread of disease and the constitution of those afflicted had popular support, which was reflected among medical practitioners of the early nineteenth century.

III - Practitioners

"Tuesday, Feb. 17th - ...They are all under the Care of Mr. Alexander Stevenson, School Master. He has some Knowledge of the Practice but is not a professed Physician."[45] Written during the smallpox outbreak of 1801, this simple comment reveals that medical care was not yet institutionalized in hospitals, medical schools or medical societies. The first efforts to regulate the profession and the increasing role of education which occured in the early nineteenth century were the antecedents to a much larger reform of medical practice which came to its fruition late in the century. In 1784, there were thirty-five practitioners in the province, only one of whom was a graduate of a university or college. Apprenticeship was the norm, and the other thirty-four practitioners were products of either the civilian or military apprenticeship systems. By 1854, Nova Scotia enjoyed the services of 122 physicians, seventy of whom received formal medical education.[46] North America had only four institutions offering degrees in medicine - Dartmouth, Harvard, the University of Pennsylvania and the Medical School of King's College, in New York City - prior to 1800,[47] so the Nova Scotian pattern was not an unfamiliar one.

Yet the quality of care offered to the residents of the province was sufficiently low to foster petitions to the legislature in 1819 to restrict the profession. One of these, from the "subscibers, Heads of Families in the Town of Halifax", signed by eighty-one men, stated that they "have long been aware of the defective state of the Medical Profession in this Town, and Province, and that your Petitioners and their Families are thereby subjected, to frequent and serious danger, from the conduct of persons in the Medical Art, and, of whose qualifications, your Petitioners have no criterion whereby to judge."[48] This petition was followed, five days later, on 27 February, 1819, by a petition from the emerging medical elite. These practitioners, led by Dr. Samuel Head and all four of whom were graduates of either Edinburgh's or London's medical schools, were seeking regulation or restriction to, first, enhance the status of medicine which "suffers disgrace from the conduct of ignorant pretenders" and, second, enhance their financial rewards, which "the heavy expense of their education entitles them to". The petition further states[49]

> That your Memorialists in the Prosecution of their Practice have with regret witnessed the serious and even fatal consequences to arise from the conduct of persons uneducated in the Profession and therefore incompetent either to judge of the nature of diseases or to prescibe medicines, which are frequently dangerous in their operation unless administered with due skill

With their concoctions of powerful emetics, purgatives and widespread use of calomel, the treatment was often as distressing, and potentially dangerous, as the illness, But these treatments were utilized not only by quacks and irregulars, but by those university-trained practitioners as well. In fact, given a lack of a distinguishing

therapeutic arsenal or theory of disease, there was little basis to distinguish one practitioner from another. Despite this reality, the physicians' petition went on to say "that Laws have been enacted in the mother country and by different Legislatures of the Sister colonies of Canada and New Brunswick...for the exclusion of persons from the Practice of Physic have not been duly qualified by a regular medical education". Formal medical education was becoming the criteria by which to judge ability, and was becoming increasingly common among practitioners. In the first half of the nineteenth century alone, over eight thousand university trained and educated men entered into practice in Great Britain.[50]

Samuel Head's petition was read in the House of Assembly on 27 February, 1819[51] and a bill was presented in a matter of weeks. The bill was read a second time, before being deferred for consideration.[52] A similar bill was introduced into the House 20 January 1824.[53] It was not until 15 March, 1826 that "A Bill to regulate the practice of Physic and Surgery" was passed,[54] and the "Act to exclude ignorant and unskilled Persons from Medicine" was passed and was assented to in 1828.[55] This latter bill was primarily concerned with the contractual relationship between patient and provider - the recovery of fees for services rendered. The measure, however, was introduced at a time when some American states were rescinding similar legislation.[56] The Nova Scotia bill was amended the following year, so that persons engaged in practice prior to 1821 were exempted. But was it truly humanitarianism, which the petition emphasized and which was reiterated by D.A.

Campbell in his Presidential Address to the Nova Scotia Medical Society sixty years later when he said "the professional leaders of that period foresaw danger looming up and determined to raise a barrier against the inflow to our ranks of an undesireable element",[57] that spawned this legislation? By raising such a barrier, practitioners were also enhancing their own position in the community. Halifax, where the petitioners resided, had an abundance of doctors - 21 in all in 1815, or one for every five hundred residents.[58] Thus, any emphasis on humanitarianism should be tempered, for at the same time, such legislation enhanced the status of medical doctors, while concurrently eliminating or resticting competition.

This debate aside, the act found opposition amidst the public. Petitioners in Wilmot requested the legislature "amend the Act...as to protect such practitioners as may have been found respectable and useful."[59] Ninety-one inhabitants of Bridgetown, while supporting the Act, wrote that[60]

> a number of skillful practitioners of medicine, who have not obtained diplomas, have long practiced in many of the new settlements, have become familiar with many local diseases, are acquainted with the habits and constitutions of the inhabitants, and from their excellent moral deportment and their usefulness are highly esteemed and respected.

The amendment of 1829 addressed not only these concerns, but the reality of the Nova Scotian situation as well. By 1830, Nova Scotia had some 76 physicians, eighteen of whom practiced in Halifax.[61] Of the seventy-six, only twelve had university medical degrees - six of them from the University of Edinburgh and two from the New York

College of Physicians and Surgeons.[62] One of those who held a medical degree was Dr. Edward Carritt. The native of Lincolnshire, England had graduated from Edinburgh in 1826, and had come to Nova Scotia that same year, and he established his practice in Halifax.[63] In February, 1832, he petitioned the Assembly, asking that "the Poor House in Halifax may be open to the visits of Medical Men generally and their pupils, to serve as a Medical School."[64] The Committee to which the petition was referred recommended the establishment of a hospital, but failing this[65]

> it is every way desireable that the Province should be rendered independent of other countries in regard to all the Professions...This can only be furnished be well-regulated Institutions for the sick, open to Instructions in Medical Science...In the mean time...the Poor House should be opened to all the regular Medical Practitioners in Town and their Students

The struggle to professionalize was clearly underway, though it would not fully manifest itself for another two decades. Licensing and education were two components of this early preliminary effort. Consideration will now be given to how these early changes, in the first decades of the nineteenth century, altered or influenced the medical care the Micmac received.

IV - Doctors and Disease: The 1840s

In July 1841, George Edward Jean reported on the condition of the Micmac inhabitants of Richmond County. The six elderly inhabitants, between the ages of 62 and 80, were afflicted with a degree of infirmity, four being described as "blind" or "nearly blind",

the other two were described as simply "becoming infirm". One eighteen year old female was described "with a broken back" though she could "with difficulty walk". Most, however, were described as either "strong and healthy" or "feeble", "infirm" or "sickly".[66] Disease had taken its toll and the Micmac continued to be plagued by a variety of illnesses. Tuberculosis was reported among the Micmac for the first time at Bear River in 1841, with the notation that "many have died off with consumption."[67] Hereafter, tuberculosis became a regular occurance in Micmac communities, particularly among the elderly. Typhus fever and smallpox were widespread enough in Pictou that a total of £197.15s.5d was expended in connection with these diseases. Throughout the province that same year accounts were submitted attesting to the vaccination of 8312 poor persons in every region of the province, at a rate of 2s.6d per vaccine. Not every account was paid in full, the usual allowance being two-thirds of the total. The total cost of providing these vaccines was in excess of £743.[68] Vaccination of the poor was often extended to the native community during 1842 and 1843.[69] If doctors were not vaccinating the Micmac for the prevention of disease, they were administering medical attendance in response to it. Doctors attended miscellaneous fevers, the majority of which went unidentified, and then petitioned the Assembly for remuneration, with charges ranging from £2 upwards to over one hundred pounds.[70]

William Anderson, Secretary of the Pictou Board of Health, at the urging of Father Hugh O'Reilly, dispatched Health Officers in June 1846 to an encampment of Micmac. The officials[71]

> visited upwards of twenty Wigwams, & that there

> they found ten individuals affected with a very severe form of Fever, which the Indians informed them had devastated the encampment...Yesterday Dr. Johnston reported that there were then sixteen cases of Fever...on visiting them this afternoon, he found, one dead, about thirty prostrated with the Fever, and about twelve more complaining of premonitory symptoms

Some weeks later, Anderson noted that the "number of sick and severity of the disease, has varied with weather during the prevalence of rain the sick list exceeded Forty" but a spell of fine weather reduced the number of sick to thirty and "the Health Officers do not anticipate more than one fatal case".[72] Six months later the Health Board found "the general health and condition on the whole much improved...and complete restoration to health of the great proportion of those attacked...so far as the Board is acquainted, there is no disease among the survivors".[73] It would appear that the Board's efforts met with some success. Yet the effort was, in part, to protect the white residents. The Pictou County Board of Health stated as much, in declaring "a malignant Fever, had been for some time past prevalent among the Indians and which, it was feared might spread among the white population. On receiving this information the Board immediately directed the Health Officer to visit the encampment".[74] The disease, which went unidentified, may have been infectious hepatitis, which was widespread throughout mainland Micmac communities during 1846 and 1847.[75]

It is equally probable that it was infectious hepatitis that Dr. Jennings and Dr. Richardson encountered in Dartmouth during 1847. Infectious hepatitis, or hepatitis A, thrives in areas of poor san-

itation and overcrowding, and is spread by infected persons before they become clinically ill, during the incubation period. Viral hepatitis, both types A and B, require supportive care - rest, fluids, and nutrition - to allow the body's recuperative powers to combat the disease. In the case of Drs. Jennings and Richardson, discussed in the introduction to this chapter, the treatment offered was "brisk purgatives" while also "securing a free evacuation of the bowels".[76] Such treatment was in opposition to the supportive care required. The doctors also endeavoured to erect a temporary hospital which may have aided their efforts, but the fact that the disease spreads during incubation mitigates against this. By February, the disease had run its course, but not before Dr. Richardson became infected and ill, "for which one or two blisters were applied." Alas, even doctors could not escape their own remedies.[77]

The provision of medical attendance was, however, in a somewhat dubious position with respect to compensation. This issue was raised in correspondence in 1842 with then Indian Commissioner Joseph Howe. James Dawson wrote Howe "wishing to know whether the terms of the present Indian Grant permitted you to apply any part to medical aid" because the Micmac near Pictou were "labouring at present under dangerous diseases, and the overseers of the Poor refuse them any aid."[78] Howe's response was that the "act contemplates no expenditure for medical attendance, and in general the Indians are better Doctors than the Whites". Given the example of transient paupers, Howe wrote "if one Doctor is put upon the Indian Civil list another must be and...

the cost would be enormous."[79] The physicians represented the other side of the argument, and this is exemplified by the 1844 petition of Dr. Ebenezer Annan of Liverpool:[80]

> your petitioner has, for the last Eight Months, rendered his professional services to the various Indian families in and about Liverpool - that he did so, at the first, solely with a charitable object; but that now, your Petitioner finds, that unless some provision be made to indemnify him for his outlay of Medicines, he will be unable to render them further assistance.

Annan's attendance was deemed to have "been useful", and in Howe's opinion he, together with a Reverend Garraty, "have fair claims to some compensation."[81] Yet, as the cost of medical attendance rose throughout the 1840s, the legislature became more reluctant to pay the submissions. Edward Jennings, for example, submitted an account totalling £120, of which £90 was for medical attendance. The legislature honored most of the other £30 of charges - £11 for medicines, another £0.15s for medicines left with the Indians, £8 for travel expenses and horse hire and £9.15s for miscellaneous charges. Yet, it paid only £55 of the £90 for the actual medical attendance, bringing the total payment to £85. Jennings complained, saying his "attendance was...For thirty four days a total sacrifice of my private practice...its average value is £2 a day. This year it must have realized more, an unusual degree of sickness Existing." Moreover, he seemed genuinely hurt and offended, saying his "professional character which hitherto has been unimpeached, was attacked. I have been represented as an extortioner and this circulated amongst my friends in the City and Country."[82] Disease had become frequent and the cost of medical care prohibitive. In the 1850s, the legislature would demand

greater accountability, but before examining this change, the broader context in which disease and doctors apparently flourished should be examined.

V - The Micmac at Mid-Century

From the time that Paul Pemmenwick petitioned the Assembly in 1783 to "occupy a Track of Land...on the River called Stewyack...for Hunting & Fishing as Customary",[83] the provision of land was becoming intricately associated with government policy. But while Pemmenwick petitioned for land on which he could continue to pursue traditional economic pursuits, the government was looking toward agriculture. In 1801, Joshua Frost forwarded a request for land on behalf of seven Micmac who, owing to the disruption "in their Fishing and hunting by the white people" wished to secure access to the Salmon River for fishing.[84] In 1835, after the establishment of reserves, another petition, this one from Liverpool, laments that "your petitioner is one among a Number of Indians comprising not less than Twenty families who obtain a precarious subsistence by Hunting".[85] With the traditional economy in decline, agriculture was put forth by the government as a means to foster self-sufficiency, hence control of relief payments, and integrate the Micmac into the colonial economy.

Dr. Edward Jennings succinctly echoed these sentiments in February, 1847 when he wrote that to "contribute small sums yearly must produce degeneracy as it favors idle habits. To civilize & make them independent might be slowly accomplished by affording them the means of cultivating the land & by appointing a man in each district to direct their atten-

tion to agricultural pursuits".[86] In fact, agriculture had made some marginal gains among the Micmac, notably at Bear River where, by 1836, "most of the settlers have made profitable clearings upon their lots".[87] Nevertheless, by 1847 Abraham Gesner still recorded that the "chief occupations of the Indians are hunting, fishing and basketmaking" - traditional economic pursuits adapted to their new position in the colonial economy. Gesner, however, described them as "a discouraged and spirit-broken people." He accounts for this because of dislocation from their land, even that which was reserved for them, the declining fisheries and white occupation of the best fishing shores and the scarcity of game due to human encroachment and over-hunting. "These united causes have operated fearfully and at last reduced the whole tribe to the extreme of misery and wretchedness."[88] Proximity to white settlers wreaked havoc with hunting and fishing, but so too did it inhibit agriculture.

White encroachment on reserved lands appears to have become a considerable problem by the 1830s, prompting a public notice, dated 1 May 1837, to declare under the title "Notice to Trespassers on Indians Reserves", that all persons were "to abstain from extending their clearings, or cutting of wood of any kind on the said Indian Reserve at Wagmatcook, or any other Indian Reserve." For those who did not desist from the practice, prosecution was threatened.[89] In 1845 Edmund M. Dodd and H.W. Crawley wrote that the Micmac resreved lands in Cape Breton "are eagerly coveted by the Scotch Presbyterian settlers...They are by no means disposed to leave the abor-

igines a resting place in the Island of Cape Breton."[90] Encroachment was occuring on the mainland as well, Gesner noting that in 1849 that "I found it necessary to pay two visits to...Shubenacadie, one to Cumberland and one to St. Margaret's Bay to settle a dispute in reference to land".[91] If encroachment was a real obstacle toward fostering agriculture among the Micmac, it was aggravated by a provincial potato blight which occured between 1846 and 1848. When crops failed, it affected not only those Micmac who had taken up farming, and who sold potatoes for goods, but also those who sold goods or services to local farmers, in exchange for food.[92] At Kejimkujik, Gesner observed in 1849, "clearings have been enlarged, and the roads that approach the lake improved but the general calamity of failure of crops has checked the progress of the little colony".[93] The dream of an agricultural Micmac had failed to be realized, despite the concerted efforts of colonial officials. That they had failed would become increasingly important throughout the 1850s, as the Micmac were subjected to endemic disease and periodic outbreaks of epidemic disease.

VI - Doctors, Disease and Medical Attendance: The 1850s

In his report to the Assembly for 1847, Abraham Gesner solemnly noted that nearly "the whole Micmac population are now vagrants who wander from place to place and door to door, seeking alms...Necessity often compels them to consume putrid and unwholesome food". Gesner continued:[94]

> Exposed to the inclemency of the weather, and destitute of the proper diet and treatment re-

> quired by contagious diseases, numbers are swept off annually by complaints unknown to them in their original state.
>
> During my tour of inspection, I prescibed for several cases of hopeless consumption. The venereal disease, the scourge of vice contracted by the visits of the dissolute to the towns is by no means rare...Infant mortality is very great. Intemperance also has done its fatal work.

Disease was indeed common among the Micmac with no less than sixty different practitioners in every area of the province attending the Micmac between 1845 and 1866.[95] The vast majority of this attendance was for various unidentified ailments, though petitions exist for the treatment of typhus in two cases, smallpox in three, three incidences of tuberculosis, three for injury, two for measles, and one each for tooth extraction, venereal disease and rheumatic fever. The historical record is sufficiently complete to allow a profile of the period to be compiled, a profile which reveals the nature and extent of medical attendance and the response of the legislature to the increasing cost.

Medical attendance by practitioners accounted for only a small portion of the total expenses incurred for relief in 1844, amounting to only £35.3s.3d of an expenditure of £333.[96] This is not to suggest that this was the only attendance rendered, nor that the entire account was for medicines and attendance, as practitioners often played a significant role in distributing relief supplies, such as blankets. By 1847, the accounts of doctors totalled £350.19s.7d, well over one third of the £813.13s.11d expended to relieve Micmac "during severe illness". Fourteen physicians, all of whom were from the mainland, rendered services, in contrast to the five who were active during 1844.[97] This

particular year, 1847, as previously demonstrated, was characterized by widespread outbreaks of infectious hepatitis. Nevertheless, costs were increasing at a sufficient rate by the end of the decade to bring forth the suggestion that,[98]

> To prevent abuses creeping into this branch of the public service, your Committee are of opinion that it is necessary to impose restictions upon these Grants and recommend the passage of a Resolution by the House granting compensation to any Medical practitioners for Medicines supplied to, or attendance, sick Indians, unless the services are performed by direction of Overseers of the Poor, or one of the Indian Commissioners

This was not the first suggestion of restricting the activity of practitioners. Two years prior, the Assembly raised the spectre of accountability, when it wondered whether "the nature of the disease really demanded the lavish expenditure which has occured...or whether the Medical Bills rendered to the Government are not, in some cases, much higher than they ought to be". These, however, were "questions which your Committee have no means of deciding."[99] The charges, which came from both the Overseers of the Poor and individual practitioners, sought remuneration from the annual Indian grant,[100] and were usually payed in full until 1850, when a House Resolution passed, giving the Assembly some semblance of control.

This control quickly manifested itself. The accounts for 1851 record the petitions of four practitioners, only two of whom - Dr. Howard Hooper of Newport and Dr. Alexander McDonald of Antigonish, received remuneration.[101] The petitions of Drs. Willobiske and Forbes, both of Liverpool, were "not certified in the manner prescibed by the

Resolution of the House last year - and it does not appear that the services were rendered under any authority recognized by that resolution".[102] As such, the Committee did not recommend any grant until such time as the appropriate certificates were forwarded. Forbes did, however, receive compensation for services a year later.[103] In instances where the physician was authorized according to the Resolution to perform services, such as Benjamin D. Fraser of Windsor, payment was usually in full.[104] In cases where it was not authorized, the Assembly used its discretion. The petition of Henry D. Ruggles of Weymouth is typical:[105]

> during the month of August last year your petitioner was sent for in great haste to attend upon a female Indian a distance of 8 miles from his residence who had met with a compound fracture of the arm and a dislocation of the wrist...Also your Petitioner has since attended upon several female Indians labouring under complaints incident to the female sex.

Dr. Ruggles, in an attempt to justify his attendance, wrote that the "exigency of the cases not admitting of time to procure a special order from the Magistrates...immediately proceeded to the respective camps of the impaired and sick". The Committee did not accept the doctor's explanation and did not recommend any grant.[106]

Most doctors, however, apparently adhered to the committee's regulations. Accounts for 1853 reveal that doctors received £27.8s.9d and all but one received remuneration. But the cost of medical attendance remained high, and it was noted that petitions[107]

> come in annually from medical gentlemen resident in different parts of the province. These bills in the aggregate, amount to a large sum, which is drawn directly or indirectly from the only source

> by which these people are aided in their farming. It is therefore extremely desireable that such charges should not be made, or if they are made, that they should be audited and paid by several counties where the Indians reside.

This suggestion would be implemented a few years later. The House Resolution of 1850 agreed to pay medical attendance providing it was authorized by an Indian Commissioner or the local Overseers of the Poor. A Resolution passed in April 1857 rectified what had become "a very large expense" by providing a "reasonable check."[108] The Assembly declared that medical bills would not be paid except in cases of surgery or accouchement. It further restricted the activities of local Overseers of the Poor, in that relief efforts would have to be paid fully by the Overseers, and then the Assembly would refund one-half of the charges.[109] In the interim, however, accounts continued coming in: £38.9s.1d in 1855, £29.16s.7d in 1856, £39.6s.5 1/2d in 1957 and £73.5s.9d in 1858.[110] There was no systematic fee structure in place for the remuneration of practitioners. Dr. Edward Jennings complained in 1854 that young practitioners, or those with low standards "who value their time at a low figure may be satisfied with a small compensation which in fact would be no compensation but rather a loss to the Physician having a large practice."[111] Jennings raised an interesting point with respect to the personalities and qualifications of those in practice among the Micmac, one worthy of investigation.

In a petition dated 3 March, 1854, Dr. Henry Shaw of Kentville wrote that the "Indians & Indian affairs seen to me are infinite nuisances, & although I have had several applications to visit sick

Indians, lately I have refused".[112] Despite Shaw's frustration and displeasure, most did not refuse. Whether or not the petitioners were motivated by the potential for money is debateable, given the protests of men such as Jennings and Shaw. Whatever the motivation, doctors continued to provide treatment for a range of ailments.

On February 8 1861, Dr. Charles Aitken petitioned the House for remuneration for services rendered, to the modest sum of £1.6s.3d, adding that for "many services" he "never made any charge - that he has always gone to their relief when required, and oftentime at great inconvenience."[113] Two years earlier, Aitken had petitioned for payment for treating a Micmac with rheumatic fever and for performing surgery, on the same person, on a wounded wrist.[114] Aitken received his medical education through an apprenticeship in Newfoundland, and formal education at Harvard, and later was to serve as a coroner for the County of Lunenburg.[115] Another coroner was Dr. Edward L. Brown who, in 1846, was "the oldest medical Practitioner in this section of the County."[116] In 1854, Brown was active among the Micmac near Gaspereau treating miscellaneous disorders, notably measles.[117]

Typhus fever appeared in Cumberland County at least twice in five years. Dr. Charles Bent, apparently a graduate of the University of Pennsylvania, treated seven Micmac for the fever in 1848.[118] Dr. Charles Tupper paid seven visits to a young Micmac child afflicted with typhus in April 1853, but the child died. Tupper, a graduate of the University of Edinburgh and member of the Royal College of Surgeons at Edinburgh, had a distinguished medical career, serving as the

Canadian Medical Association's first president.[119]

Tuberculosis became increasingly common among the native population of Nova Scotia through the 1850s. Indian Commissioner James McLeod solemnly wrote that "Consumption I regret to state has of late become very prevalent among these poor people Several fatal cases occured during the past season and many more are now suffering from the same cause".[120] While McLeod was writing primarily about Cape Breton, Dr. Charles Creed's petition offers evidence of "pulmonary consumption" in a "Camp in the Woods at a distance of two miles from the Town" of Pugwash. For services rendered and medicines administered, Dr. Creed submitted a bill for £3.6s.9d for treatment between 27 March and 11 April, 1857, a total of six visits. Creed, a member of the Royal College of Surgery, London, received only £2.6s.9d and therefore petitioned the House once again on 17 March, 1860.[121]

It is not insignificant that typhus, rheumatic fever and tuberculosis were becoming increasingly prevalent among the Micmac, as all three of these diseases are associated with living conditions and the general health of the population. Typhus is an acute infectious disease caused by the parasitic microorganism Rickettsia and is usually transmitted by ticks, fleas, mites and lice. Typhus generally occurs in areas where people are suffering from hunger and disease, and living in overcrowded, cold areas. Damp, cold conditions also allow rheumatic fever to thrive. Finally, malnutrition, poor health and crowded, unsanitary living conditions also increases a person's susceptibility to tuberculosis.

Smallpox occured along the Eastern Shore during the winter of 1860 and 1861. William Chearnley authorized attendance, and his call was answered by Dr. Thomas Henley, who submitted an account totalling £9 for medical services and relief supplies. He attended their illness for five weeks, during which time at least nine people died, judging from the account of George Grant, who submitted a bill for £1.16s for coffins which cost four shillings each,[122] though an eyewitness counted only five deaths.[123] By January, 1861 the disease had run its course - fifteen had contracted the disease but recovered, twelve had died and three, all of whom were vaccinated, escaped infection. One third of those who died were women, ranging in age from seventeen months to forty years old. The age distribution of the male victims was three months to seventy-eight years.[124]

One final disease should be mentioned, called the "scourge of so many North American Native groups"[125] - veneral disease. Gesner had declared that such afflictions were "by no means rare"[126] but information is scant in early nineteenth century records and where evidence does exist, it simply mentions the affliction. The petition of Henry D. Ruggles is typical, mentioning only that he visited a female who was "labouring under a disease termed Uteritis."[127] Other references include a man with inflamed testicles and a woman suffering from "clap or pox".[128]

Finally, something should be said of the rest of the physicians who were practicing among the Micmac. The majority were prominent either in their own communities or in the province. Many, including

Thomas O. Geddes, George M. Johnston, Charles Aitken, Alexander Lane, Robert Leslie, James Forbes, Alexander McDonald, Edward Jennings, Charles Creed, Henrie Shaw and Charles Tupper, were active in the provincial medical society.[129] Many of these were members of either the Royal Colleges of Edinburgh or London. While their education cannot reveal anything about the quality of care that they provided, they were at least familiar with the latest medical techniques and theories of orthodoxy. Sebra Crooker of Liverpool was active among the Micmac, but never appears on the medical society lists.[130] Yet it does appear that this man, originally from Maine, was held in high esteem. Dr. James Forbes offered an endorsement of Crooker, writing that "I have known the petitioner...for the last sixteen years, during which time he has been practicing in this country & has obtained the favourable opinion of a large majority of the people."[131] The petition of eighty-six residents in support of licensing Crooker lends further credence to Forbes' endorsement.[132]

Perhaps of more interest is the petition of Peter Paul Toney Babey, a person who claimed to be an Indian physician, describing himself as a "Physician, Chemist and Alchemist" who "from his youth has turned his attention to the nature of plants, herbs and the various roots of the Country possessing medicinal qualities." Babey held out his herbal preparations as medicine "which renovate the system...and have a tendency to prolong life" in contrast to the medicines used by white practitioners, who utilized "minerals and noxious Medicines calculated to destroy life." Babey concludes by stating that "your

Petitioner has deserved for many years back...compensation" such as "the white men who pretend to give any assistance to the poor Indian receives".[133] It would appear that Babey had some knowledge of traditional herbal remedies, though he preferred to term his endeavours "scientific pursuits", perhaps couching his petition in the language of the emerging medical elite. Nevertheless, it does offer further evidence that some Micmac retained a knowledge of traditional herbal remedies. Moreover, that pharmacopeia, or the application of it, was not static, as we have already seen in its use in combating infectious hepatitis in Dartmouth in 1847.[134] Babey's petition was greeted only with ridicule, however, as recorded in the following exchange:[135]

> Hon. Provincial Secretary would move that the Indian be standing physician to the house. (Laughter.)
> Mr Marshall - That might do very well, provided we know what party he belongs to.
> Hon. Pro. Secretary - As he comes under the auspices of the learned member from Kings, our side will have to be careful. - (Laughter.)

Such derision and laughter, however, masked the reality of the state of medical orthodoxy, whose own therapeutics would be challenged and derided by sectarians within the medical community. Lacking adequate organization, licensing or therapeutics, orthodoxy was still struggling to achieve preeminence within the medical community.

VII - The Struggle to Professionalize

When Peter Babey emphasized his herbal preparations over those of orthodox practitioners, he was reflecting a much broader competition that was rife within the medical community. Prior to the middle of the

nineteenth century, doctors in Nova Scotia enjoyed only a marginal status. Deprived of an effective therapeutic arsenal, the orthodox practitioner had to compete with the patent medicine peddler, irregular practitioners and quacks in the medical marketplace. Babey emphasized the herbal over the mineral, as did Samuel Thomson, founder of the Thomsonian movement. Thomson began selling "Family Rights" to his system in 1806 which, for twenty dollars, entitled purchasers to the sixteen page booklet "Family Botanic Medicine" and enrolled them in the Friendly Botanic Society. The book contained various preparations but left out the key ingredients, which were filled in by Thomsonian agents only after a pledge of secrecy. Thomson claimed that by 1840 three million people had adopted botanic medicine, based on the sale of some 100,000 Family Rights.[136] It would appear that Thomson was following in the tradition of writers such as William Buchan, who's 1769 Domestic Medicine met with tremendous success. But there was a difference, for Buchan and his heirs, among them Anthony Benezet, who Americanized Buchan in 1826, advocated the use of domestic medicine only if a physician could not be consulted.[137] Buchan's work, therefore, did not challenge the value of medical attendance and it often took its place alongside William Cullen's Practice of Physic, a standard text of the day, in many practitioners' libraries, including Nova Scotia's Dr. Michael Head.[138] Thomsonians, in contrast, rallyed under the cry "Every man his own physician" which found tremendous support in Jacksonian America. So too did the self-medication that Thomson advocated, as the harsh treatments of orthodoxy, characterized by strong purgatives, bleedings

and doses of calomel, were coming under increasing criticism.[139]

The popularity of the Thomsonian movement began to wane through the 1840s, primarily due to internal divisions, but was only to be replaced by homeopathy. Formulated late in the eighteenth century by a German, Samuel Hahnemann, homeopathy was predicated on two principles, the law of infinitesimals and the law of similars. The latter of these held that medicines which produced the symptoms of a disease in a healthy person, could cure that disease in a sick person, while the law of infinitesimals held that the smaller the dose, the more efficacious the result. It first appeared in North America in 1825, and provided yet another alternative to the rigorous therapies offered by both Thomsonians and orthodoxy. But homeopathy was dominated by regularly-trained physicians who had no desire to democratize medicine,[140] or 'make every man his own physician', but rather sought to callenge orthodoxy's endeavours to achieve preeminence in the medical marketplace.

John Harley Warner, in his brilliant study of therapeutics in America, asserts that sectarianism was symptomatic of the declining status and power of medical orthodoxy. Thus, the struggle to professionalize was concerned with securing markets through gaining public confidence and the restriction of entry into the marketplace. Warner identifies some of the indices of this struggle, including the formation of medical societies, the rise of new professional journals and the pursuit of higher public profiles for physicians.[141] Paul Starr, in The Social Transformation of American Medicine demonstrates the

role of structural change in facilitating the process of professionalization, and its accompanying role in the extension of the orthodox practitioner's hegemony.[142] Consideration will be given to this process through an examination of the hospital as the institutional expression of orthodoxy's authority, the changing nature of medical therapeutics, and the combined role of the medical school, medical society and government legislation.

VIII - Hospitals

Doctors had long recognized the value of hospitals in enhancing their position in the community. A general hospital, it was believed, would enhance the treatment available not only to the poor, but to all classes. At the same time, it would relieve the practitioner of the burden of providing charitable care to the indigent poor.[143] The Maritime Medical News put forth a romantic description of practitioners at mid-century saying that many "metaphorically speaking, existed, they could not live. They often wanted for the common comforts of life, with hundreds of pounds on their books".[144] Charity was a feature of physician care and doubtless there were those who were not well off. Starr makes the point that there was disparity among physicians and "that distance was so great that doctors cannot be said to have belonged to a single social class."[145] A general hospital would recast the institutional expression of the medical community. It would create "an institution of medical science rather than of social welfare, its reorganization along the lines of a business rather than a charity, and its reorientation to professionals and their patients rather than to

patrons and the poor."[146] Nevertheless, when a number of physicians petitioned for the founding of a public hospital with a visiting dispensary they argued that it would facilitate "providing for the care and cure of poor and destitute sick persons".[147]

The first institution under consideration is the Halifax Visiting Dispensary. First opened in June 1855 on Brunswick Street, the Dispensary was concerned with treating the 'deserving poor', it admitted 503 patients, attended another 129 in their own home and filled some three thousand prescriptions.[148] By 1887, the Dispensary treated 3780 patients and filled some 13,333 prescriptions.[149] But, as Colin Howell has demonstrated for the period May 1855 to April 1865, the Dispensary served less than four hundred cases per month.[150] This leads one to conclude that alternative treatments were being utilized. Often, these alternative treatments involved self-treatment with patent medicines. These preparations had been on the market since early in the eighteenth century,[151] and were often advertised in the colonial press. Patent medicine peddlers were "the nemesis of the physicians. They mimicked, distorted, derided, and undercut the authority of the profession."[152] An advertisement in the Acadian Recorder was typical, announcing a "new discovery being a positive method of self-cure, affording instant and magical relief to sufferers who may have been deaf for 40 or 50 years by means of a compound medicated vapour applied to the external ear."[153] A second alternative was a visit to one of the numerous practitioners of quackery or miracle doctors located in the city. The advertisement of Dr. John Fox is characteristic, declaring that he "is familiar with all the modern

improvements...among which are the simple and successful treatment of Dyspepsia. The Sulphur Fume Bath in Chronic cases". Moreover, Fox promised "the destruction of CANCERS without the knife".[154] For those who were too ill for self-treatment or required long-term hospitalization, the only alternative was the Halifax Poor's Asylum.

These institutions were class based, in that they serviced the area's indigent poor. They were, however, regarded with suspicion and fear by those they were designed to serve.[155] Neither were they amenable to the advancement of the profession, which depended upon the large-scale participation of the middle and upper classes, many of whom received treatment in their own homes from their personal physicians.[156] To foster large-scale, multi-class participation, a general hospital was required.

The first general hospital to open its doors in the Maritimes was the Halifax City Hospital. Established in 1859, the hospital suffered from financial problems, forcing the city to abandon operations. It was reopened, however, as the City and Provincial Hospital in 1867. These Institutions, like the Halifax Visiting Dispensary and Poor's Asylum, still serviced mainly the indigent poor.[157] Sickness was equated with sin in the Victorian mind, just as physical health was "a direct means of personal evaluation", an evaluation of a person's fitness morally and spiritually.[158] In other words, there existed a prevalent moral interpretation of disease and those afflicted. Intemperance and immodesty took their place alongside notions of pythogenesis - that disease was generated by filth - and diet in this view.[159] Nevertheless, the estab-

lishment of a hospital did allow doctors the opportunity for therapeutic experimentation. Yet medical therapeutics were undergoing change, and this change played a central role in the attempt to secure public confidence, and the subsequent redefinition of orthodoxy's professionalism.

IX - Therapeutics

Associated with middle and upper class reluctance to enter hospitals was therapeutic ineffectiveness. John Harley Warner views therapeutics as central to defining not only the profession, but professional authority and legitimacy as well, saying, because "medical therapeutics was so central to what defined a regular practitioner - and to what set the orthodox practitioner apart from the sectarian - it was closely linked to professional identity."[160] Implicit in this analysis is the fact that a lack of therapeutic effectiveness stands in opposition to professionalization. It was therapeutic weakness which various sectarians exploited, thereby undermining medical orthodoxy. Howell has convincingly applied this to the Maritime context, arguing that therapeutic ineffectiveness fostered "lingering public suspicion" and the "continuation of "unprofessional" forms of medical treatment."[161] The struggle of the medical community to professionalize was closely associated with the attempt to devleop scientific therapeutics - a process aided by the various sectarians who helped "to lay the cultural foundations of modern medical practice - a predominantly secular view of sickness rather than the religio-maoralistic view that sickness equalled sin.[162] Failing

the emergence of 'scientific' therapeutics, a new definition of professionalism was put forth, one that was not associated with therapeutics.

Early nineteenth century therapeutics were dominated by a belief in heroic therapy. Sickness was caused by an imbalance in the fluids of the body. As a result, interventionist treatments such as venesection, blistering or leeching were common, in an attempt to restore the body's natural equilibrium.[163] Reaction against such therapies began in the 1850s, while the 1860s and 1870s brought a belief in clinical experimentation and the healing power of nature. This manifested itself in an 1850 petition in support of botanic medicine, signed by 161 men, which said as many who "have tryed the medicine have found by personal experience in the Reformed Practice of Bottanic <sic> Medicine Superior healing virtues, to any other remedial agents". Moreover, the petition requested self-regulation, asking the "Province to diplomatise all such to practice in said system of Bottanic <sic> Medicine as shall produce a certificate of having passed the examination of a Regular Board of Bottanic <sic> Physicians".[164] The Petition was referred to Committee after being read in the House, which decided that under existing legislation, botanic practitioners could apply "to the Lieut. Governor to appoint a Board of competent persons to examine the Botanic Practitioners, and, if found qualified, to license them to Practice Medicine and Surgery, on the same footing as other Practitioners, and to compel payment for their services, which is the only disability to which they are now subject".[165] This of course masks the reality that botanic practitioners

had little chance of securing licensure from a Board dominated by orthodox practitioners struggling to professionalize. It does reveal, however, that orthodoxy, in a legalistic sense, had not yet secured its position as the only legitimate provider of medical care.

Botanic practitioners were not the first to attempt to gain government sanction for their activities in the medical marketplace. Joaquin Martin DeSardina apparently enjoyed some experience operating a vapour bath and "attended regular courses of lectures and for three years was a superintendent of the Bath in Edinburgh." DeSardina had every confidence in the bath's ability to "cure...malignant fevers." Upon his arrival in the New World, he found no baths, depite their seeming popularity among "many of the principal inhabitants of Halifax." This petitioner-entrepreneur established a bath in Halifax in 1820 and later in Windsor and Liverpool, and he claimed "many important cures have been effected and he has been in the habit at the differert establishments of administering them to the Poor gratis." What is of particular interest is that DeSardina suggests that he "is the only person in this province who rightly understands the proper treatment of Invalids who require the Baths and particularly the method of administering the vegetable, Sulphur, Mecurial and mineral baths". As such, DeSardina goes on to suggest that if "unskilled persons", that is, persons other than DeSardina, established similar baths, the health of the provincial population could be threatened.[166] Attempts to restrict access, hence competition, were themselves not resticted to the orthodox profession.

Another petition, more akin to that of the botanic petitioners, came in 1837 from Henry Green. The petition reads, in part[167]

> That the present law of this Province protects no person practicing in any branch of the medical art, except regularly educated medical men. That there are some diseases to which human nature is subject that the best informed doctors with all their skill and education cannot cure - among which...Cancers are the most formidable... That Memorialist is acquainted with the means of preparing a salve that has both healing and purifying properties; and is so powerful that it will effectively eradicate and cure <these diseases.>

He also affixed four testimonials to his petition, the earliest dating from 1818. It is interesting to note, however, that these appear to be copies and not original documents. In 1840, after requesting money to reveal his cure, a House Committee concluded "that if he really is in possession of such a secret, (of which, however, they have had no proof, except his own assertion), it will sufficiently recommend itself to the public."[168] The Committee did not recommend payment, but petitions like this and the consideration given to them are indicative of the competing alternatives to the therapeutics of regular doctors.

In a more general sense, drug therapy, too, began to be called into question, largely replaced by galvanic therapy and hydrotherapy.[169] The use of electricity and water marked a change from the depletive therapies encountered earlier, to stimulative therapies. More significantly, it marked the uncertainty of orthodox therapeutics and the adoption of some of their competitors techniques. The transition from depletive to stimulative therapy amounted to little, for neither had any therapeutic value. This also accounts for the persistence of quacks

and miracle doctors, as well as patent medicines. The therapeutic uncertainty during the 1850s through to the 1880s did pose a potential threat to the orthodox profession. Nevertheless, the strength of sectarians, and the weakening distinction between orthodox and sectarian therapeutics caused many regular practitioners to rethink the adequacy of their own therapeutics and the process of therapeutic change.[170] More disturbing, however, was the wholesale adoption by orthodox practitioners of their competitor's techniques, and that some "leading physicians called into question whether medicine had any effective therapies to offer...The failure of self-confidence and growth of therapeutic dissension within the profession further contributed to its weakness."[171]

The case of Dr. Frederick W. Morris may serve as an illustration. Morris had been a Vice President of the Halifax Medical Society and was the resident physician at the Halifax Visiting Dispensary. Yet, in 1861, Morris began to advocate the use of a Micmac remedy in combating smallpox. One such endorsement appeared in the 29 April, 1861 issue of the Novascotian, in which Morris declared that "I have no hesitation...from what I now know of the medicine, in recommending all persons who are at all anxious in this matter, to provide themselves with the remedy with all haste." This public endorsement went a good deal further, however, with Morris writing:

> I can with confidence assure the public, from the astonishing influences of the remedy I have already seen, that I have not the least misgivings as to its efficacy. I do not believe it will ever fail to cure, if given at any period of the

> disease up to the third or fourth day of the eruption, or as long as there is any power of of reaction in the system.
> In the language of the Micmac, "it kills the disease." It is of so mild a nature that the smallest infant may take it with perfect safety.

Such public endorsements earned Morris the scorn of his peers, and he was expelled from the medical society. He was, however, allowed to retain his position at the Visiting Dispenary, on the proviso that he discontinue prescribing the remedy.[172]

At the meeting of the Nova Scotia Medical Society held on 6 May, 1861, the members present, with Morris alone dissenting, passed the following resolutions:[173]

> Resolved...that Dr. Morris has not had any reliable data upon which to found any opinion in favour of its value as a remedial agent.
> Resolved that a copy of the foregoing resolution be published in two or more of the morning papers.

Morris' endorsement of the smallpox remedy, moreover, while not costing him his position at the Dispensary, did cause difficulties at that institution. There were a number of resignations from the Board of Medical Governors, including Drs. Hume, Black, Parker, Gilpin and Forest. Moreover, the Dispensary required Morris to sign a letter which read, in part, "I hereby pledge myself to refrain in future from the use of such remedies and such publications, whilst an officer of the Institution." It would appear that the orthodox profession was not as concerned with the actions of Dr. Morris, as with the public perceptions of those actions, evidenced through the publication of Morris' recanting. Moreover, underlying these condemnations of Morris was the "unspoken fear that regular practitioners offered less to their patients than their competitors."[174]

The relationship between Frederick Morris and John Thomas Lane, the supplier of Morris' remedy, was a lengthy one. Lane was a keen marketer of his product, the so-called Indian Liniment. Testimonials were frequently published in the Novascotian, attesting to the value of this preparation, which apparently offered relief to those suffering from sore throats, arthritis and other ailments. These testimonials appeared both before and after Morris' endorsement, though the last one appeared on 6 May, 1861, the day Morris was reprimanded by the Medical Society.[175] Lane and Morris, moreover, would have to defend their actions before a coroner's inquest into the death of Mary Ann Cope. By 3 June, 1861, Lane, who described himself as "Medicine Man to the MicMac Tribe", was publishing testimonials recounting the efficacy of his smallpox remedy.[176] It was this 'remedy' that led Lane and Morris to the inquest into the death of a Micmac child, Mary Ann Cope who died, according to the Coroner's jury, "from the Effects of small pox for want of proper attendance".[177]

The inquiry, which focused on the efficacy of Lane's smallpox remedy and the nature of the attendance rendered, was, however, primarily concerned with the perceptions of the public. The jury did find that young Mary Ann Cope died "from the effect of small pox, <and> for want of proper attendance to keep her from taking cold, while the deceased was laboring under the disease of small pox", which emphasized that smallpox, and not iatrogenesis, was responsible for the death. After the decision, Edward Jennings, the Coroner, addressed the jury, saying the "decision will clearly show to the public that

had the deceased been under the care and treatment of a medical man, there exists every probability that life would have been saved."[178] Thus even in tragedy, orthodoxy found a method, through the Coroner's Inquiry, of deflecting potential criticism away from the emerging profession, while concurrently extending orthodoxy's hegemony through equating good medical care with regular practitioners, even in the absence of a sound therapeutic base.

Popular resistence to orthodox medicine has often been portrayed as a fear or hostility to modernity and science.[179] Yet, scientific discovery further undermined traditional therapeutics, rather than enhancing them. Advances were being made in science, but therapeutics remained largely static, and the gulf between knowledge and application grew wider.[180] The theoretical principles which distinguished the orthodox profession from its competitors crumbled in the face of the discoveries of Lister and Koch, and the increasing adoption of germ theory. Treatments that were disease-specific, in fact, had no legitimacy within orthodoxy and were associated with quackery. Thus, orthodoxy held that disease could be caused in a variety of ways and therefore, the treatment given was not uniform - two people with the same disease or affliction may require opposite treatments, based on socioeconomic, geographic, occupational or ethnic considerations. Hence, most antebellum doctors in the United States could assert with confidence that blacks required distinctive treatments.[181] But the discoveries of science resulted in a new emphasis being placed on clinical inquiry, largely carried out in hospitals, to distinguish the regular practi-

tioner from his competitor in the medical marketplace.

Therapeutic ineffectiveness continued to plague the profession into this century. Meetings of the Provincial Medical Board in 1908 illustrate the sensitivity of the profession with respect to therapeutics. In April, the Board passed a bylaw dealing with the erasure of practitioners "on account of infamous professional conduct."[182] But despite continued therapeutic ineffectiveness, the orthodox practitioner emerged preeminent in the health care field. The question that has to be posed is how this was accomplished. The key lies in how the orthodox profession defined its professionalism, given the uncertainty surrounding therapeutics. Professionalism became increasingly wedded to such institutions as the hospital, the medical school and the medical society.

X - Medical Schools and Medical Societies

Paul Starr has succinctly outlined the emerging definition of medical professionalism:[183]

> The boundaries defining the medical profession might have been drawn on any of three lines: graduates versus nongraduates of medical schools; members versus nonmembers of medical societies; licenses versus unlicensed practitioners...Eventually the boundaries would be drawn so that education and licensure coincided.

Thus, to understand the new definition of professionalism, one must consider the role of medical education, medical societies and government legislation.

The Halifax Medical Society was founded in 1854. The Society was

aptly named, for it was dominated by an elite group of Halifax practitioners. In fact, only one of the Society's executive officiers was from outside the city. Thus, the Society not only promoted the interests and hegemony of orthodoxy,[184] but extended the hegemony of the Halifax elite over the rest of the profession in Nova Scotia.[185] The Society had three primary objectives: (1) the enhancement of professional and scientific standards in medical therapeutics and medical practice; (2) to lobby the legislature for more expedient payment for services rendered and (3) the promotion of a more positive public image. The objectives of the Society were closely associated with the scientific medicine movement. Medical societies also provided a forum for discussion of such topics as therapeutics, licensing or payment, and therefore fostered a collective spirit. In 1861, the Halifax Medical Society was renamed the Nova Scotia Medical Society. In 1869 a group of Halifax practitioners founded the Halifax Clinical Society in an effort to improve therapeutic effectiveness and surgical techniques.[186]

A letter read before the New Brunswick Medical Society declared "the organizations known as Medical Societies exist not only for the advancement of the sciences...but also, for the benefit of the physician himself."[187] Implicit in this comment is that medical societies had not only a utilitarian role but a hegemonic one as well. The leaders of the Halifax Medical Society played a central role in gaining hospital privileges at the City and Provincial Hospital. Moreover, this same elite played a prominent role in the Dalhousie Faculty of Medicine and the Halifax Medical College.

The Dalhousie Faculty of Medicine was founded in 1868, though between 1875 and 1911 medical education was carried out at the Halifax Medical College. During this period, the College's relationship with Dalhousie was ambiguous, though in 1885 it was described as being "affiliated" with Dalhousie. Another description states that after 1889 the College was "fully Affiliated".[188] Two reports offer some clues as to why the Faculty of Medicine was established in 1868. The first, dated 20 August, 1868 was a request for funding, which read in part:[189]

> That your petitioners have ascertained that from sixty to seventy-five students leave the Maritime Provinces yearly to receive a medical education ...that to remedy this pressing want your petitioners were appointed a Faculty of Medicine... to carry out their plans successively an Act of the province in furtherance of their objects and the grant of a small sum to meet the necessary outlay...are indispensably requisite.

The petitioners included the leading physicians in Halifax, among them Drs. Alexander P. Reid, James Ross, Edward Farrell and Archibald Lawson.

Another request for funding, prompted by a cut in financing from $1000 per year to $800, was received by the province in March 1879. In it, the registrar of the Halifax Medical College, Dr. J.F. Black, explicitly stated the objectives of local medical education, which were "to keep our medical students at home and cause them to spend the money necessary for the education in the country...and also raise the standard of medical education in this part of the Dominion." Furthermore, provincial funding was necessary because "receipts from students are comparatively small and the expenses are heavy".[190]

Medical education served two purposes. First, there was a concern about overcrowding in the medical marketplace. Education was seen as a tool through which access to the medical marketplace could be restricted. But doctors viewed education as more than a way to enhance their economic position and status. They had a genuine concern with improving the quality of medical education, stemming from their dedication to social and professional reform. The criteria for graduation was impressive (See Table 2.1). It included daily visits to the Halifax Visiting Dispenary, to become "practically acquainted with less severe forms of disease".[191] Medical education may have increased the standards of new practitioners entering the marketplace, but what of those already in practice, who may not have received any formal education, or whose education was gained at an institution of dubious quality? There had been a proliferation of proprietary medical schools in the United States beginning about 1790, and, "as early as the late 1830s, the uncontrolled proliferation of medical schools was a matter of great concern" to the regularly educated practitioners.[192]

By 1851, Nova Scotia had legislation concerning quarantine, boards of health, infectious diseases, rabid animals and health inspectors, in addition to the act regarding medical practitioners.[193] By 1856, the Act of 1828 was expanded to provide for registration of medical practitioners. Ironically, this Act was passed at the very time that similar legislation was being repealed in the United States.[194] Practitioners had long recognized the value of restricting access to the medical profession. Two petitions were presented in 1837 requesting

Table 2.1

Courses Offered at the Halifax Medical College
1876-1877

Course	Description	Instuctor
I Medicine	Theory and Clinical	Dr. A.P. Reid
II Surgery	Theory and Clinical	Drs. Farrell and Lawson
III Obstetrics	Including Midwifery	Drs. Slayter and Woodill
IV Chemistry		Professor George Lawson
-Practical Chemistry		Professor Waddell
V Physiology		Dr. John Sommers
VI Materia Medica	Medicinal Plants and Drugs	Dr. John F. Black
VII Anatomy	"illustrated by the fresh subject"	Dr. George Sinclair
VIII Medical Jurisprudence		Dr. D.A. Campbell and Mr. Henry
IX Practical Anatomy		Dr. D.A. Campbell
X Clinical Medicine		Drs. Reid and Black
XI Clinical Surgery		Dr. Farrell
XII Botany		N/A
XIII Practical Pharmacy		Prof. C.E. Puttner

Requirements for Graduation 1876-1877

1. Four Years of Lectures
2. Twelve Months of Practical Work at Provincial and City Hospital or another approved institution
3. Three Months Practical Work Dispensing Drugs
4. Thesis

Source: Halifax Medical College Annual Announcement 1876-1877

a more efficient law to regulate entry into the medical marketplace.[195] The 1856 Act prohibited unregistered persons from receiving provincial appointments, established a fine of five pounds and prohibited unregistered persons from recovering fees for services rendered.[196]

An Anatomy Act was passed in June, 1869 which facilitated investigation of cadavers, in the hope of developing more 'scientific' medicine. In terms of restricting access, the Act of 1872, "An Act to Regulate the Qualifications of Practitioners in Medicine and Surgery" established the Provincial Medical Board to ascertain the quality of education and training of a licensure candidate. This Act, which granted the profession the right to self-determination, read that the duties of the Board were to "regulate the study of Medicine, Surgery and Midwifery" and to "examine all degrees, diplomas, licenses, and other credentials presented".[197] This act marked the first time that registration in Nova Scotia was tied to the quality of a candidate's credentials, as determined by the orthodox practitioner and was the fruition of the professionalization process.

XI - Conclusion

L.F.S. Upton, in writing that "the disgraceful state of affairs" within the administration of Nova Scotia's Indian affairs "had not come about due to the Indians themselves, but to the increasing claims that Overseers of the Poor were making against the Indian grant...the largest sum, year after year, was for medical fees",[198] attaches a great deal of significance to the provision of medical care. The growth

in medical attendance was undoubtedly tied to the decline of the traditional economy and the marginal position of the Micmac within the colonial economy. But it was equally tied to the growing number of practitioners in the province and the struggle for professionalization. Most of the physicians that were active during the first half of the nineteenth century among the Micmac received regular medical education and were prominent in their communities. Thus, even before the 1856 Act that restricted provincial appointments to registered physicians, there was a tacit acceptance on the part of the government that orthodox practitioners would receive these appointments. Perhaps the care offered the Micmac, like the public health programs that characterized the early twentieth century, offered medical orthodoxy official sanction and, hence, increased prestige and power. The attitude of the government, moreover, was reflected in the derision with which petitions from irregulars or sectarians, such as Henry Green or Peter Babey, were greeted.

The petition of Peter Babey is also indicative of the continued presence of traditional herbalists in Micmac communities, which attests to the resilience of Micmac culture. The continued use of traditional remedies also finds support in the experience of Dr. Frederick Morris, who advocated the use of a Micmac remedial agent in treating smallpox and Dr. Edward Jennings, who encountered the apparent use of a traditional remedy in treating infectious hepatitis during an outbreak in 1847 in Dartmouth. Laurie Lacey makes no mention of a plant remedy for this disease, though Jennings is quite clear that a bark was used.

Given the number of general remedies that comprised the traditional pharmacopeia it could be that this was a traditional remedy used in a traditional fashion.[199] Nevertheless, one cannot exclude the possibility that this marked an adaptation of native medicine to a new disease, perhaps attesting to the resiliency of these medicines. Another aspect of the traditional role in maintaining health which does not survive in the historical record, but which undoubtedly existed, is the role of the commmunity. The predominant amount of medical care occurs in the house and this was probably the case in native communities. Thus, the extent and nature of traditional health care strategies cannot be determined with any degree of certainty.

As bills for attendance by white practitioners began to mount, the government answered with attempts to restrict the services rendered and demand a greater degree of accountability. Yet, the individual nature of medical care and the lack of a standardized fee structure inhibited the effecetiveness of these measures. There appears to have been no suggestion of retaining physicians on the provincial payroll, which would have been contrary to the professionalization process, since one of the hallmarks of a profession is independence from the subordination of the labour market and compensation on a fee-for-service basis. The problem of remuneration for medical attendance continued to plague the federal government after Confederation, with doctors expecting full compensation and the federal government lacking an adequate mechanism within the new federal bureaucracy to pay physicians.

Endnotes

1. Public Archives of Nova Scotia (hereafter PANS) MG15 Vol. 4 #19.

2. John Harley Warner, The Therapeutic Perspective. Cambridge: Harvard University Press, 1986.

3. Nova Scotia Jouurnals of the Legislative Assembly (hereafter JLA) 1848 Appendix No. 24, p. 118.

4. "M.H. Perley's Report on the Indians of New Brunswick" in Harold F. McGee, ed., The Native Peoples of Atlantic Canada: A History of Indo-European Relations. Ottawa: Carleton University Press, p. 83.

5. L.F.S. Upton, Micmacs and Colonists: Indian-White Relations in the Maritimes, 1713-1867. Vancouver: University of British Columbia Press, 1979, p.p. 82-83.

6. L.F.S. Upton, "Indian Policy in Colonial Nova Scotia 1783-1871" in The Acadiensis Reader: Volume One Atlantic Canada Before Confederation. P.A. Buckner and David Frank, eds. Fredericton: Acadiensis Press, 1985, p. 95.

7. PANS RG1 Vol. 430 #33 1/2 and JLA 15 April, 1800.

8. Elizabeth Ann Hutton, "Indian Affairs in Nova Scotia, 1760-1834" in McGee, op. cit., p.p. 73-74.

9. PANS RC1 Vol. 218P 1 May, 1801.

10. JLA 27 June 1803 and 29 June 1803.

11. JLA 1 July, 4 July, 6 July, 7 July 1803 and PANS RG 1 Vol. 218S 6 July and 7 July, 1803.

12. PANS RC1 Vol. 430 #145 Monk to Prevost.

13. Ibid. The twelve districts were Canso, Antigonish, Pictou, Cumberland, Minas Basin, Cobequid, Annapolis, St. Mary's Bay (Digby), Shelburne, Liverpool, Chester and Halifax.

14. Ibid.

15. Upton, "Indian Policy in Colonial Nova Scotia 1783-1871", p. 98.

16. PANS RC1 Vol. 218KK 11 February, 1819.

17. Novascotian 6 March, 1828.

18. JLA 3 April, 1819.

19. Hutton, op. cit., p. 77; Upton, Micmacs and Colonists, p.p. 87, 88; Upton, "Indian Policy in Colonial Nova Scotia 1783-1871", p.p. 99, 103.

20. Upton, Micmacs and Colonists, p. 87.

21. PANS RG1 Vol. 430 #34.

22. JLA 11 June 1799.

23. PANS RG1 Vol. 430 #54 15 April 1800.

24. PANS RG1 Vol. 218P 18 April 1800.

25. Charles Bruce Fergusson, ed., The Diary of Simeon Perkins 1797-1803. Toronto: The Champlain Society, 1967, p. 269.

26. Virginia P. Miller, "The Decline of Nova Scotia Micmac Population" in Culture Vol. 2 No. 3 (1982), p.p. 112-113 and PANS RG1 Vol. 430 #88.

27. PANS RG1 Vol. 430 #52, #58, #72 1/2 and #88.

28. Ibid. and JLA 13 July 1801.

29. PANS RG1 Vol. 430 #58.

30. PANS RG1 Vol. 430 #52.

31. PANS RG1 Vol. 430 #72 1/2.

32. Smallpox has three strains, variola major (true smallpox), variola minor (a milder form) and variola vaccinae (cowpox). Infection by any one provides temporary protection against all others.

33. Miller, op. cit., p. 113.

34. PANS RG1 Vol. 430 #72 1/2.

35. PANS RG5 Series P Vol. 42 #1.

36. PANS RG5 Series P Vol. 41 #91.

37. JLA 27 February 1819. and 1 April 1819.

38. PANS RG5 Series P Vol. 41 #59.

39. PANS RG5 Series P Vol. 42 #38 and JLA 9 April 1832.

40. Geoffrey Bilson, "Canadian Doctors and the Cholera" in S.E.D. Shortt, ed., Medicine in Canadian Society: Historical Perspectives. Montreal: McGill-Queen's University Press, 1981, p. 115.

41. JLA 16 December 1834 and Appendix No. 7.

42. JLA 5 April 1832.

43. Kenneth G. Pryke, "Poor Relief and Health Care in Halifax, 1827-1849" in Wendy Mitchinson and Janice Dickin McGinnis, eds, Essays in the History of Canadian Medicine. Toronto: McClelland and Stewart, 1988, p.p. 47-51.

44. John West, A Journal of A Mission to the Indians of the British Provinces, of New Brunswick, and Nova Scotia, and the Mohawks, On the Ouse, or Grand River, Upper Canada. London: L.B. Seely and Son, 1827, p. 236.

45. Fergusson, op. cit., p. 284.

46. Allan E. Marble, "A History of Medicine in Nova Scotia, 1784-1854" in Collections of the Royal Nova Scotia Historical Society, Vol. 41 (1982), p.p. 75, 91.

47. Ibid., p. 76.

48. PANS RG5 Series P Misc. A #41.

49. PANS RG5 Series P Vol. 1 #50.

50. Bruce Haley, The Healthy Body and Victorian Culture. Cambridge: Harvard University Press, 1978, p. 5.

51. JLA 27 February 1819.

52. JLA 18 March, 19 March, 23 March 1819.

53. JLA 21 January, 16 February, 25 February 1824.

54. JLA 24 February, 25 February, 13 March, 15 March 1826.

55. Marble, op. cit., p. 82.

56. Pryke, op. cit., p. 42.

57. Maritime Medical News July 1889, p. 96.

58. Marble, op. cit., p.p. 81-82.

59. PANS RG5 Series P Vol. 3 #75 31 January 1829.

60. PANS RG5 Series P Vol. 3 #76 January 1829.

61. Marble, op. cit., p. 83.

62. Robert Mathieson, Health, Disease and Medicine in a Nineteenth Century Highland Emigrant Community. Unpublished M.A. Thesis, University of Guelph, 1989, p. 49.

63. Maritime Medical News January 1889, p. 49.

64. JLA 9 February 1832.

65. JLA 1832 Appendix No. 49, p. 58.

66. PANS RG5 Series P Vol. 8a #14A.

67. PANS RG1 Vol. 431 #20.

68. JLA 1843 Appendix No. 55.

69. PANS RG5 Series P Vol. 44 #46 and #69.

70. Charles Tupper of Amherst received £2.10s for attending a wounded Micmac in 1846, Greggs Joseph Farish £3.5s for attendance in Yarmouth County during 1846 and Edward Jennings, £101.15s for attendance during an epidemic in 1846. PANS RG5 Series P Vol. 83 #16 and #101 and PANS RG1 Vol. 431 #40.

71. PANS RG1 Vol. 431 #41 27 June 1846.

72. PANS MG15 Vol. 3 #99 14 July 1846.

73. PANS MG15 Vol. 4 #6 16 January 1847.

74. PANS RG5 Series P Vol. 45 #9.

75. Miller, op. cit., p. 113.

76. PANS MG15 Vol. 4 #19.

77. PANS MG15 Vol. 4 #16.

78. PANS RG1 Vol. 432 29 September 1842, Dawson to Howe.

79. PANS RG1 Vol. 432 1 October 1842, Howe to Dawson.

80. PANS RG5 Series P Vol. 44 #45.

81. JLA 1844 Appendix No. 50. Dr Annan's name is spelled incorrectly in the Journal, though there is little doubt that the Dr. 'Annau' mentioned is, in fact, Dr. Annan.

82. PANS RG1 Vol. 431 #43 1 April 1847.

83. PANS RG1 Vol. 430 #23 1/2

84. PANS RG1 Vol. 430 #71 Frost to Wentworth.

85. PANS RG1 Vol. 431 #16.

86. PANS MG15 Vol. 4 #18.

87. PANS RG1 Vol. 431 #22.

88. PANS MG15 Vol. 4 #1.

89. PANS RG1 Vol. 431 #36. Encroachment is further mentioned in documents 37-39.

90. JLA Appendix No. 16.

91. PANS MG15 Vol. 4 #77. Report on Indian Affairs 1849. For a complete treatment of white encroachment during this period, see Harold F. McGee, "White Encroachment on Micmac Reserved Lands in Nova Scotia 1830-1867" in Man in the Northeast Vol. 8 (1974), p.p. 57-64.

92. PANS MG15 Vol. 4 #60 14 February 1848 and MG15 Vol. 4 #77, Report on Indian Affairs 1849.

93. PANS MG15 Vol. 4 #77, Report on Indian Affairs 1849.

94. JLA 1848 Appendix No. 24, p.p. 119, 117.

95. This addition is based upon data recorded in the JLA, PANS RG5 Series P, MG15 Vol. 4a, 5, 6 and RG1 Vol. 431.

96. JLA 10 April 1845. The account was as follows: Dr. Benjamin Page (Amherst) £7; Dr. Charles Tupper (Amherst) £3; Dr. Ebenezer Annan (Liverpool) £13.4s.9d; Dr. Edward L. Brown (Horton) £3; Dr. William Slocomb (Lunenburg) £7.18s.6d. The addition of medical accounts is my own.

97. JLA 1847 Appendix No. 57, p. 247. The addition of medical accounts is my own.

98. JLA 1849 Appendix No. 88, p. 498.

99. JLA 1847 Appendix No. 57, p. 246.

100. Upton, "Indian Policy in Colonial Nova Scotia 1783-1871", p. 108.

101. JLA 1851 29 January, 12 February, 14 February for presentation of the petitions and Appendix No. 91, p.p. 281-282 for payments rendered. Hooper and McDonald received £3.10s.

102. JLA 1851 Appendix No. 91, p. 282.

103. JLA 1852 Appendix No. 45, p. 310.

104. PANS MC15 Vol. 4a #119, JLA 1852 11 February and Appendix No. 45, p. 310.

105. PANS MC15 Vol. 4a 11 February 1852.

106. JLA 1852 Appendix No. 45, p. 310.

107. JLA 1852 Appendix No. 32, part 2, p. 274.

108. JLA 29 April 1857.

109. Ibid.

110. JLA 1854/55 Appendix No. 29, p. 164; JLA 1856 Appendix No. 63, p. 236; JLA 1857 Appendix No. 63, p. 378 and JLA 1858 Appendix No. 68, p. 435. The additions are my own.

111. PANS MG15 Vol. 5 #31 15 March 1854.

112. PANS MG15 Vol. 5 #30 3 March 1854.

113. PANS RG1 Vol. 431 #116 8 February 1861.

114. PANS RG5 Series P Vol. 49 #30 10 February 1859.

115. Mather Byles DesBrisay, History of the County of Lunenburg. Belleville: Mika Studio, 1972 (1895), p. 124 and PANS RG3 Vol. 1 #198 25 June 1864.

116. PANS RG5 Series GP Vol. 10 #73 3 April 1846.

117. PANS MG15 Vol. 5 #34a 29 April 1854.

118. PANS RG5 Series P Vol. 45 #128 23 January 1849. On the petition Bent signed his credentials, indicating he was a graduate of the University of Pennsylvania, a claim he maintained in a Halifax Morning Chronicle advertisement, 31 May 1853.

119. PANS MG15 Vol. 5 #35 9 February 1854 and David Allison, History of Nova Scotia, Vol. III. Halifax: A.W. Bowen & Co., 1916, p.p. 26, 27-28.

120. PANS MG15 Vol. 5 #1 12 January 1853.

121. PANS MG15 Vol. 6 #47 16 February 1858; PANS RG5 Series P Vol. 49 #82 17 March 1860 and Charles Tremaine Harrington, A General History of the Harrington, DeWolfe and Tremaine Families. Newton, Mass.: The Graphic Press, 1938, p. 15.

122. PANS RG1 Vol. 431 #123 21 December 1860.

123. PANS RG1 Vol. 431 #113 24 December 1860.

124. PANS MG15 Vol. 6 #63 4 January 1861.

125. Miller, op. cit., p. 113.

126. JLA 1848 Appendix No. 24 p. 117.

127. PANS MG15 Vol. 6 #42 11 February 1858.

128. Miller, op. cit., p. 113.

129. Belcher's Farmer's Almanack 1857 p. 110.

130. The Medical Society membership lists were published in Belcher's Farmer's Almanack, and were consulted for the years 1857-1866.

131. PANS RG1 Series GP Vol. 3 #134 28 January 1858.

132. PANS RG1 Series GP Vol. 3 #135 December 1857. The issue of licensing is discussed later in the chapter.

133. PANS MG15 Vol. 4a #126 19 February 1852.

134. PANS MG15 Vol. 4 #19.

135. Novascotian 1 March 1852.

136. Ronald L. Numbers, "Do-It-Yourself the Sectarian Way" in Guenter B. Risse, et. al., eds. Medicine Without Doctors: Home Health Care in American History. New York: Science History Publications, 1977, p.p. 49-50.

137. John B. Blake, "From Buchan to Fishbein: The Literature of Domestic Medicine" in Risse, op. cit., p.p. 12, 15-16.

138. Upon his death in 1805, Head left a library of 144 works. Allan E. Marble, ""He usefully exercised the medical profession": The Career of Michael Head in Eighteenth Century Nova Scotia" in Nova Scotia Historical Review Vol. 8, No. 2 (1988), p.p. 52-53.

139. Blake, op. cit., p. 55.

140. Blake, op. cit., p.p. 57-58, 59.

141. Warner, op. cit., p.p. 38, 39.

142. Paul Starr, The Social Transformation of American Medicine. New York: Basic Books, 1982, p.p. 229-231.

143. Pryke, op. cit., p. 39.

144. Maritime Medical News January 1889, p. 59.

145. Starr, op. cit., p.p. 81, 84.

146. Starr, op. cit., p.p. 147-48.

147. Pans RG5 Series P Vol. 44 #154 29 January 1846.

148. Halifax Visiting Dispensary Society Annual Report 1855. PANS MC3 Vol. 179.

149. Minutes of the Halifax Visiting Dispensary Society . PANS MG3 Vol. 179.

150. Colin D. Howell, A Century of Care. Halifax: The Victoria General Hospital, 1988, p. 16.

151. James Harvey Young, "Patent Medicines and the Self-Help Syndrome" in Risse, op. cit., p.p. 97-98.

152. Starr, op. cit., p. 128.

153. Acadian Recorder 15 January 1859.

154. British Colonist 7 September 1852.

155. Pryke, op. cit., p. 41.

156. Howell, op. cit., p.p. 16-17.

157. Howell, op. cit., p.p. 9-14.

158. Haley, op. cit., p. 225.

159. Bilson, op. cit., p. 124.

160. Warner, op. cit., p. 7.

161. Colin D. Howell, "Reform and the Monopolistic Impulse: The Professionalization of Medicine in the Maritimes" in Acadiensis Vol. II No. 1 (Autumn 1981), p.p. 6-7.

162. Starr, op. cit., p.p. 36-37.

163. Colin D. Howell and Michael Smith, "Orthodox Medicine and the Health Reform Movement in the Maritimes, 1850-1885" in Acadiensis Vol. XVIII No. 2 (Spring 1989), p. 56.

164. PANS RG5 Series P Vol. 46 #41 2 February 1850.

165. JLA 1850 2 February and Appendix No. 59, p. 195.

166. PANS RG5 Series P Vol. 3 #84 25 February 1829.

167. PANS RG5 Series P Vol. 6 #76 8 February 1837.

168. JLA 1840 30 January and Appendix No. 10, p. 81.

169. Howell and Smith, op. cit., p. 56.

170. Warner, op. cit., p.p. 176-178.

171. Starr, op. cit., p. 31.

172. Novascotian 29 April 1861; Colin D. Howell, "Elite Doctors and the Development of Scientific Medicine: The Halifax Medical Establishment and 19th Century Medical Professionalism" in Charles G. Roland, ed., Health, Disease and Medicine Essays in Canadian History. McMaster: The Hannah Institute for the History of Medicine, 1984, p. 105 and Howell and Smith, op. cit., p. 55.

173. PANS RG1 Vol. 431 #129 8 May 1861.

174. Minutes of the Halifax Visiting Dispenary Society. PANS MG3 Vol. 179 8 July 1861; Howell, "Elite Doctors and the Development of Scientific Medicine", p. 106.

175. Testimonials may be found in the following issues of the Novascotian: 18 February 1861, p. 4, 22 April 1861, p. 7, 29 April 1861, p. 7 and 6 May 1861, p. 4. Morris defended his relationship with Lane in Novascotian 10 June 1861, p. 6.

176. Lane's description of himself may be found in Novascotian 22 July, 1861, p.p. 2-3 and the advertisement of the testimonials in Novascotian 3 June 1861, p. 6.

177. PANS RG41 Series C Vol. 33 #1. Coroners Inquest re: Mary Ann Cope. The proceedings of the Inquest were published in Novascotian 22 July 1861, p.p. 2-3.

178. Novascotian 22 July 1861, p. 3.

179. Starr, op. cit., p. 56.

180. Warner, op. cit., p. 236.

181. Warner, op. cit., p.p. 62-65.

182. Minutes of the Provincial Medical Board, 15 April 1908. PANS RG 83 Vol. 1.

183. Starr, op. cit., p. 46.

184. Kathryn M. McPherson, Nurses and Nursing in Early Twentieth Century Halifax. Unpublished M.A. Thesis, Dalhousie University, 1982, p. 15.

185. Howell, Elite Doctors and the Development of Scientific Medicine", p. 107.

186. Howell and Smith, op. cit., p. 62.

187. Maritime Medical News September 1890, p. 69.

188. Halifax Mail Star 14 September 1968.

189. PANS MG17 Vol. 19 #17.

190. PANS MG100 Vol. 124 #16.

191. Halifax Medical College Annual Announcement 1876-77, p. 9.

192. James H. Cassedy, "Why Self-Help? Americans Alone With their Diseases 1800-1850" in Risse, op. cit., p. 35.

193. Revised Statutes of Nova Scotia 1851.

194. E. Richard Brown, Rockefeller Medicine Men: Medicine and Capitalism in America. Berkeley: University of California Press, 1979, p. 63.

195. JLA 21 February 1837. Petitions of James Dawson and James Chipman.

196. Revised Statutes of Nova Scotia 1857.

197. Revised Statutes of Nova Scotia 1873.

198. Upton, "Indian Policy in Colonial Nova Scotia 1783-1871", p. 111.

199. Laurie Lacey, Micmac Indian Medicine: A Traditional Way of Health. Antigonish: Formac Publishers, 1977, p.p. 21-38.

Chapter III - The Micmac in Canada: Medical Specialization and Bureaucratization

The latter half of the nineteenth century was characterized by a continuing concern with contagious diseases, notably smallpox and tuberculosis, as well as the role of the physician as the primary provider of medical care. The physician, however, became a component, though the preeminent one, of a much larger structure comprised of hospitals, nurses, related health care workers, and federal and provincial health bureaucracies. Medicine underwent a transformation during the period 1867 to 1940, from the individual 'country doctor' form that was dominant until the late nineteenth century, to a bureaucratized form, a development not unrelated to the emergence of industrial capitalism, with its scientific management style that treated workers as individual components of a larger structure.

Industrial capitalism, and its support of the medical reform movement which created the medical care system, was also influential within Nova Scotia's Micmac communities. Many Micmac participated in manufacturing and construction jobs, though never fully integrated into the dominant economy owing to their continued pursuit of more traditional enterprises such as hunting and fishing. The medical care which the Micmac received was also susceptible to the effects of industrial capitalism and the specialized and bureaucratized medical system it helped to create manifested itself in the introduction of new personnel into the delivery process, such as nurses. What is most striking is how these apparently divergent concerns were

wedded. Disease was often attributed to the nomadic lifestyle required for continued participation in the pursuit of game and the sale of handcrafts. Settlement on the reserves, conversely, would not only improve health, but also facilitate greater participation in the industrial economy by undermining occupational pluralism. Thus, the goal of industrial capitalism - to integrate the Micmac into the dominant economy - and that of the medical profession - to improve health - became united in the Indian reserve. How they were wedded is a theme explored in this chapter through an examination of the profession, philanthopists and the health care the Micmac received.

The reform of medical education, technological innovation and the departmentalization of the hospital were all characteristic of the last decades of the nineteenth and first decades of the twentieth centuries. The participation of American philanthropists, embodied by Abraham Flexner, in the reform process was significant, though the initial impetus came from within the medical community. Health care delivery was reconstituted through the efforts of reformers, philanthropists and physicians alike, from a process solely concerned with the physician to one that encompassed doctors, nurses, related workers, hospitals. laboratories, social reformers and government bureaucrats. Though bureaucrats had always played a role in the affairs of the Micmac and in health, this relationship was redefined by the British North America Act. An examination of this redefinition and its implications will serve as an adequate starting point to understanding the relationships which evolved.

I - The National Context

With Confederation in 1867 came a new distribution of powers between Ottawa and the provinces. Chapter VI, section 91 of the British North America Act lists those matters which fell within the federal government's jurisdiction, and "Indians and Land reserved for the Indians" became the exclusive domain of Ottawa.[1] Health, however, was first and foremost a provincial responsibility according to articles 92 (16), 92 (13) and 92 (7). Nevertheless, the federal government did retain certain responsibilities under 19 (27), including the care of sick mariners, the health of immigrants, quarantine and native peoples.[2] These federal responsibilities were assigned to the Department of Agriculture, though its activity was minimal. During its initial year, the Department was primarily concerned with cholera, though in subsequent years it operated a Marine and Emigrant hospital at Quebec City.[3]

The statutory relationship between Indians and the federal government also began to take shape. On 22 May, 1868, "An Act Providing for the Organisation of the Department of Secretary of State of Canada, and for the Management of Indian and Ordinance Lands" was given assent.[4] The act essentially outlined who could exploit native lands and their resources. In 1869, "An Act for the Gradual Enfranchisement of Indians, and Better Management of Indian Affairs, and to Extend the provisions of Act 31 Victoria Cap. 42" allowed for, among other things, the development of band government.[5] Furthermore, federal agents were appointed to monitor Indian reserves and submit regular

reports. The first Indian Act was passed in 1876 and defined who, in the eyes of the law, was an Indian and who was not. It also defined the band council's very limited powers in relation to both the federal and the provincial governments. The 1876 Indian Act also consolidated previous laws and expanded upon them.

Cumulatively, these measures represented a substantial increase in state interest in Indian affairs. These same measures also established the administrative and legal framework that led to government involvement of all aspects of native life. Nevertheless, the new administrative structure was not without its weaknesses. As early as 1869, this was recognized by the federal government:[6]

> In Nova Scotia as well as New Brunswick, the Land Reserve Funds are so small in amount that nothing entitled to the name of revenues is derived from them; and the Parliamentary Annual Grants in the one of $1,300 and in the other $1,200 are hardly sufficient to relieve the pressing wants of the more indigent people, furnish medical attendance to the sick, and some clothing and blankets to those who most require them

Nova Scotia's government was not silent on the issue of administrative ineffectiveness. In 1870, the Committee on Indian Affairs reported that "the Indians have, in their opinion, been much neglected since confederation, owing to the overseers of the poor considering them a charge on the Dominion, and the Dominion not fully recognising their claims." To correct this jurisdictional dispute, the Committee declared it "the duty of the overseers of the poor to attend to their <Micmac> immediate wants and to forward their accounts to the department", which maintained the status quo while maintaining services.

Bills for attendance continued to come in as physicians tried to contend with widespread contagious disease and other ailments.

II - Doctors, Disease and Micmac

The Medical Society of Nova Scotia offered the following mortality statistics for the province during 1860:

Total Deaths	4679
Epidemic, Endemic and Contagious Disease	1592
Diseases of the Nervous System	284
Diseases of the Circulatory and Respiratory Organs	1359
Diseases of the Digestive Organs	371
Diseases of the Urinary and Generative Organs	58
Violent and Accidental Deaths	175
Diseases of Sight and Hearing Organs	4
Not Specified	452
Uncertain	384

The petition also added that the "great increase in the mortality of 1860 as compared with the Census of 1857 when it reached but 2802 is very striking and seems mainly to be attributable to the great fatality of Diptheria."[8] Diptheria, accounting for 1003 deaths and, indeed, all contagious disease figured prominently in the mortality statistics for the province (For reference purposes, some data on the incidence and mortality of selected diseases is appended to the chapter). Similarly, it was contagious disease in Micmac communities that exacted the heaviest toll and attracted the most attention, reflecting the historical importance of these diseases, not the least of which was smallpox.

As late as 1901, the Maritime Medical News wrote that an "outbreak of small pox at Digby and Kentville, localities not far distant

from and in easy communication with Halifax, aroused the City Health Board into activity. Late in March, a wholesale vaccination of the inhabitants was ordered."[9] A similar response to the dread disease, described as "so fatal to the Indian people" by the News, could be found within the fledgling Indian bureaucracy. In 1872, William Spraggs, the Deputy Superintendent for Indian Affairs, wrote that when smallpox appeared "in the vicinity of their reserves", the department responded with "the immediate adoption of precautionary measures, by resorting without delay to vaccination".[10] The vaccination response was so strong that in 1873, a bill proposing general vaccination was introduced into the Nova Scotian legislature, though it did not pass.[11]

Yet, providing vaccinations to the Micmac was a task dependent upon the cooperation between practitioner and Micmac, and did not always meet with success. In 1882, Halifax County Indian agent D.C. O'Connor wrote:[12]

> The Department wished me to have the Indians of the county vaccinated this past year. I regret to say the Indians could not be brought together as the physician requested, to have it done. The old ones refused to submit to the operation at all. Another medical man refused to have anything to do in the matter as he thought the remuneration totally inadequate.

The federal government was often criticized for its low payments for services rendered. An editorial in the profession's Maritime Medical News criticized the Department of Marine and Fisheries, saying that physicians "are occasionally called upon to treat sick mariners and furnish the bills to the Department...where they undergo examination, and if not approved...are clipped and cut down." What really raised

the ire of the profession was that the department failed to honor its own fee schedule, which the editorial condemned as "very dishonourable".[13] Examining the Halifax County example, it would appear that fees were at the root of the problem. The first physician, who went unidentified, wanted the Micmac to congregate at one location, where the vaccines would then be administered. Had payment been adequate, such a demand would not have been necessary, for the travel involved would have been a prosperous venture. The outright refusal of the second physician was based entirely upon the poor remuneration. Finally, the Micmac, by their refusal to gather at the appointed location, inhibited the vaccination process.[14] Vaccination, however, did not always meet with failure in Micmac communities. Dr. Muir, agent for Colchester County, vaccinated the Indians in his district with apparent success in the autumn of 1886.[15]

Some twenty years later, smallpox continued to appear periodically throughout the province and elicited a strikingly similar response. The Department of Public Health recorded an "extended epidemic" of smallpox in the counties of Digby, Yarmouth, Lunenburg, Cumberland, Colchester, Pictou and Inverness, in addition to "a few scattering cases in Halifax and Cape Breton."[16] Yet, smallpox can erupt in extremely localized areas. For example, in 1907, Dr. M.D. Morrison recorded that the Micmac community of Pictou Landing was unaffected, whereas in nearby New Glasgow there were thirteen reported cases and in the town of Pictou, the Stanley Hotel was under quarantine.[17] In fact, the Micmac residents of Pictou County escaped 1907 unscathed by smallpox. The local agent noted that the disease "which

has been spreading in different sections of the county, spared the Micmac tribe." Typically, the response of Indian Affairs to the threat of smallpox was vaccination.[18]

Vaccines and smallpox outbreaks were often accompanied by an increased appropriation. In 1908, smallpox finally came to the residents of Pictou Landing, as well as Bedford and Indianbrook. This led Frank Oliver, Minister of the Interior and Superintendent General of Indian Affairs, to say that in Nova Scotia the "appropriations for medical attendance and relief have been altogether inadequate, chiefly due to the outbreaks of smallpox". Some thirty people were afflicted at Pictou Landing, and at Indianbrook, five families had the disease.[19] The following year, smallpox was even more widespread among Nova Scotia's Indians. Daniel Chisholm, agent for Halifax County, wrote that a "great deal of sickness prevailed during the past year, including a mild form of smallpox, which, due to the strict measures taken, is now about stamped out." Mild forms of smallpox were also recorded in New Germany, and Hants and Pictou Counties. In the latter, the "settlements of Indians at Pictou Landing, Pine Tree and Loch Broom were quarantined from the beginning of January to the middle of April. All the Indians had the disease except three or four families. Two deaths resulted from it. They have all now fully recovered." Smallpox occured again the following year in Halifax and Kings Counties and was, once again, described as being mild.[20] In 1911, the disease struck Eskasoni where there were "no deaths from the disease, and all necessary precautions were taken to prevent its spread, such as general vaccination

and isolation of those infected."[21] Quarantine and vaccination of Micmac were the mainstays of both federal authorities and physicians throughout the period for combating smallpox.

Diptheria, so prominent in the mortality statistics for 1860, was handled somewhat differently than was smallpox, but still fell well within the established parameters of the profession. The Indian agent for Cape Breton County reported in 1883 that[22]

> I regret to have to report that diptheria has lately appeared among the children at Eskasoni. So far three deaths have occured...As soon as the sickness became known among them, I lost no time in bringing the matter to the notice of the attending physician. Measures were at once devised to prevent the spread of the disease.

These measures were primarily concerned with sanitation and quarantine of the houses and camps afflicted. The school at Eskasoni was even closed to prevent the spread of diptheria. The following year these measures were given due credit for the fact that diptheria had "entirely disappeared from their village."[23]

Diptheria came to occupy a prominent position among provincial health officials during the 1890s. Dr. Edward Farrell, reporting on the International Health Congress wrote that[24]

> In Nova Scotia diptheria has been by far the most prevalent and most fatal of the germ diseases...isolation and disinfection, if carried out effectively, will in a short time rid a community of this dread disease, or at least will so speedily lesson the number and malignancy of the cases...This was proved in our own city <Halifax> during the prevalence of a severe type of diptheria in 1889-90.

That same year, Dr. J.W. Morrison wrote in the Maritime Medical News that the

> physician who states that he has never lost a case of diptheria has never had an extensive practice... To-day throughout the civilized world diptheria is considered to be the most dreaded of all diseases, chiefly because, to the laity, it has been surrounded by such a veil of mystery, which unfortunately the profession heretofore has been powerless to effectually remove.

Nevertheless, this pessimism was tempered by a confidence in the "modern treatment of diptheria" which was based "upon the clearly demonstrated fact that it is a germ disease, specific and local, due to direct local infection."[25] Diptheria antitoxin and quarantine became extensively utilized within the public health bureaucracies, including the Indian health bureaucracy,[26] which bolstered the profession's confidence. Germ diseases, such as diptheria, could be identified through laboratory means and dealt with by physicians, which enhanced their status and fuelled their, and the public's, growing faith in science.

But some maladies defied scientific solutions. As diptheria was gaining prominence through the 1890s, so too was just such a disease - influenza. William Chisholm wrote that "last winter the Indians suffered very much from the prevailing epidemic "la grippe", and its effect upon them is even now painfully noticeable in the form of coughs, hemorrhage of the lungs and such pulmonary complaints."[27] During the winter of 1891 and spring of 1892, influenza was reported among the Micmac of Richmond County, sometimes with fatal results. The local agent reported that influenza

> has been epidemic among the Indians, as well as among the white people, in this part of the country. The services of two physicians were required for a time to render needed medical aid to the plague-stricken people...a number of children and three or four adults succumbed to the disease.

Influenza remained endemic within reserve communities, occuring in Yarmouth and Antigonish in 1892, Hants, Antigonish, Digby and Inverness during 1897 and at Milton and Shubenacadie and in Colchester throughout 1899.[28] The Micmac shared with the rest of the Nova Scotia population the Spanish flu epidemic of 1918. That disease, which swept the world, accounted for 1769 deaths in Nova Scotia to September 30, 1919 (See Appendix B). The Micmac, however, did not suffer to the extent of the surrounding population. As one Indian bureaucrat noted, the Indians "of Nova Scotia in common with those in all other parts of the Dominion suffered severely during the past year from the epidemic of influenza...The percentage of deaths...among the Indians in this province, however, was not as high as in the case of the white population."[29] Whereas some native peoples payed a terrific price, such as those in the United States,[30] the Micmac escaped the epidemic's worst results. The flu did break out in erratic patterns, owing to the return of troops and troop movements overland, but the relative isolation of many reserve communities may have impeded its spread among the Micmac.

Influenza of all varieties often occured in conjunction with other ailments. In 1891, while the adult population was combating the flu, children were experiencing the ravages of whooping cough. The local agent for Bear River wrote that the "Indians suffered from much

sickness the past winter and spring. the children with whooping cough, the adults with la grippe; in consequence there were ten deaths, all young, except two."[31] At Millbrook during 1900, the children also labored under whooping cough, which caused "many deaths among the young".[32] In 1933, it was prevalent throughout Nova Scotia along with measles, which prompted the following:[33]

> Measles and whooping cough...have been very prevalent, and have caused a good many deaths among young children...It is difficult to prevent their spread, there is no acknowledged specific remedy, and recovery depends largely on the ability of the mother to give adequate nursing care. The standard in this respect is lower among Indians than among white people, and the children suffer accordingly.

Medicine had no solutions to the threat of whooping cough and measles, and therefore the Indian bureaucracy was content to rest partial blame at the feet of the Micmac. Patient care for the former is primarily supportive - the patient requires a proper diet with food given in small amounts, though frequently, and bed rest as long as the fever persists. This was clearly within the means of most Micmac families. Nevertheless, the whooping cough patient is highly susceptible to various secondary infections, which cannot be controlled without the use of antibiotics, to which neither Micmac nor doctor had access. Moreover, the explanation belies the fact that even today, whooping cough, which most often occurs in children under ten, with half of the cases being children under five, remains fatal, especially if infants are involved. Supportive care simply would not have been enough to ward off the most tragic results of whooping cough.

Measles is more conducive to supportive care, but this is compli-

cated by the fact that serious complications may arise if the patient is exposed to a secondary infection. Moreover, the areas where patients are cared for should be well ventilated and warm, difficult conditions to muster in areas and communities in the midst of a depression and characterized by a high degree of illness. Measles had, of course, occured in Micmac communities previously, but without tragic results. At Whycocomagh in 1882, there was a measles outbreak and the familiar migration response, discussed in the previous chapter.[34] Measles epidemics occured in Cumberland County in 1891, in Cape Breton County during 1889, in Colchester in 1893 and again in 1902, all of which were without serious consequence.[35] Measles also erupted at Whycocomagh in the spring of 1905, which prompted the closure of the reserve school. Four children died during the epidemic, though not all from measles. Smallpox was present near both Malagawatch and Whycocomagh, and one resident nearly died of tuberculosis, providing the kind of circumstance measles required to claim lives.[36]

In addition to the ailments previously discussed, there were isolated and periodic outbreaks of scarlet fever, German measles, pneumonia and chickenpox.[37] D.C. O'Connor, the agent for Halifax, noted that one Micmac woman died from alcohol-related illness,[38] though this did not appear to be a problem on the reserves. Venereal disease among the Micmac went completely unmentioned in the departmental reports for the period under consideration. None of these ailments, nor smallpox, influenza, whooping cough or measles, however, attracted the attention or caused the misery that tuberculosis did.

"My attention was called to one very sad case about the middle and coldest part of the year. The family in question lives in Bridgewater, besides four other camps"[39] wrote Indian agent E.J. McCarthy in early 1881. He continued,

> When I arrived at the spot, I found the father and mother in the last stages of consumption, without fire, food or clothing. They told me they had been in that state for three days and nights...By the means of speedy aid from the Department, together with the help solicited from kind, charitable friends, I was soon able to administer amply to their wants. Both have since become victims to this disease.

Tuberculosis, more than any other malady, attracted the attention of physicians, bureaucrats and social reformers, for although Koch had isolated the tubercle bacillis in 1882, there was no adequate treatment until the 1920s. This lack of an effective treatment, such as a vaccine or antitoxin, or the successful use of quarantine, mitigated against the physician achieving preeminence within the early anti-tuberculosis movement and hence, tuberculosis "fitted in ideally with the prewar urban social reform movement."[40] Sheila Penney has argued that tuberculosis "simply did not fit the patterns of early scientific medicine".[41] Medicine was becoming institutionalized and a greater emphasis was being placed upon the individual and bacteriological explanations of disease, but tuberculosis remained outside these structures until the 1920s.

Prior to the twentieth century, moreover, these explanations of tuberculosis held little sway with the public. Some attributed tuberculosis to immorality, miasmata or other such explanations, and most believed that it was hereditary.[42] Thus, in 1884, the comments of

Roderick McDonald, Indian agent for Pictou, that tuberculosis "is the prevailing disease among the Indians; owing to the fact of its being hereditary in some families"[43] would not be out of place. McDonald also cited a lack of proper diet and clothing, as well as exposure to the damp and cold as contributing factors. Conversely, Dr. D.H. Muir of Colchester County noted a decrease in the incidence of "pulmonary disease" in 1885, which he attributed to "a warm, dry summer".[44] Environmental explanations such as these were given an added twist by the fact that the Micmac were a distinct people. Thus, an agent for Cape Breton County noted[45]

> Consumption is the most fatal ailment to which they are subject; each succeeding generation seems to be more liable to the disease. Of the six deaths reported...four were from consumption. This degeneracy of the race I attribute to the scarcity of those articles of food which are most congenial to the tastes and constitutions of the Indians, such as the deer, and a variety of other game now almost extinct.

Similarly, William C. Chisholm, agent for Antigonish and Guysborough, noted that the Micmac in his district were not "as hardy and robust as they once were, as is evident from the fact that lung diseases are becoming every year more common among them. This is due, no doubt to the many privations they endure."[46] Beyond these hereditary, environmental and economic explanations, one final contributing factor was mentioned during the 1880s. Roderick McDonald cited the "want of proper attendance" in 1884, while that same year, Freeman McDormand, writing of Bear River, mentioned the inadequacy of medical care, writing that the "annual grant for the relief of sick and aged Indians has been expended as judiciously as possible, considering the disproportion between the amount and the number requiring assistance."[47]

Two years later, McDormand noted that eighteen deaths occured, many of whom were adults, and stated that the "suffering and privation following in the train of so much sickness" was aggravated "when there is no provision made in time of health for such an emergency."[48] Together, these commentators pointed to the inadequacy of relief and medical care, including preventive measures.

But whether adequate medical care could have actually prevented the spread of tuberculosis and the resultant death it spawned, is highly questionable. Though Koch had isolated the bacillus, thereby "irrefutably proving that the disease...was indeed contagious, and thus preventable and theoretically curable",[49] the medical profession was not entirely convinced. Thus, at the July 1889 meeting of the Nova Scotia Medical Society, Dr. J.C. DeWitt of Halifax "expressed the opinion that the tubercle bacilli were a sequel and not the cause of tubercular disease. He believed they were nearer the mark who regard this disease as a neurosis".[50] Such comments at the session, ironically entitled 'The Progress of Medicine', clearly illustrates that new ideas were sometimes slow to gain acceptance within the profession, marking a continuation of a theme encountered in the previous chapter of slow and irregular, as opposed to linear, therapeutic change. By 1894, Dr. P. Robertson Inches of St. John wrote that[51]

> while the disease is thus infectious, that is, communicated from those suffering from it to the well, it is certain that many are more liable to incur the disease than others, being predisposed to it by inheritance, and especially by unhealthy conditions of living, dampness of locality and dwellings, poor food, above all by overcrowding the most deadly - prebreathed air.

Thus, Dr. Inches represents an interim position, for while recognizing the bacteriological component as illuminated by Koch, he had a continuing faith in the heritability of a predisposition to the disease, while at the same time recognizing socio-economic factors contributing to exposure. This latter consideration allowed for the widespread public participation characteristic of the early decades of the anti-tuberculosis movement. Thus, while Sheila Penney argues that the notion of heritability "was another potent factor in the 'lassitude' of the general public" for "if heritable, there was simply nothing to be done but accept ones's fate",[52] there was, conversely, a powerful response by social reformers aimed at sanitary reform and preventive education.

Preventive education was not unfamiliar within the Indian Affairs bureaucracy. As early as 1902 one agent in Cape Breton commented that the "department did much last year in circulating amongst the Indians literature showing the great danger of contagion and the precautions necessary to arrest its progress; but it is hard to get them to realize the danger." J.D. McLeod, agent for Pictou, added that the "government's efforts in educating the Indians in hygienic laws, to be observed in cases of consumption will no doubt be beneficial."[53] In 1909, Donald McPherson of Inverness County commented that it "ought to prove beneficial if the medical attendants gave the people little talks on sanitation. The agents could read to the Indians the pamphlets of the Anti-Tuberculosis League."[54] The first such league was established in Nova Scotia in 1905 and by 1908, the Canadian Tuberculosis League sponsored an expansion of the movement in the province.[55] In 1912, the Anti-Tuberculosis Leagues of Cape Breton published a work entitled

Consumption: Its Cause, Prevention and Cure. It was distributed free of charge (26,000 copies in all) to residents of Capé Breton and included brief summaries in Italian, French, Gaelic and Micmac, in an apparent effort to reach as many people as possible. The work was the culmination of a joint effort by physicians, St. Francis Xavier University and lay people.[56] But the Micmac themselves played an active role in the preventative education movement, as acknowledged by John Cameron, who reported in 1915 that the "active measures taken by the department for the prevention of consumption is having the desired effect, and the disease is being slowly wiped out. The Indians, too, are doing everything in their power to wipe out this disease."[57]

Yet, despite the important role of social reformers in the pre-war decades of the twentieth century, the medical profession offered solutions of its own, the most obvious manifestation of this being the sanitorium. In 1900, the Nova Scotia legislature passed "an Act to Establish a Sanatorium and to aid in the Treatment and Care of persons suffering from Tubercular Disease of the Lungs".[58] About a year earlier, the Victoria General Hospital's Medical Board unanimously passed a resolution to "draw the attention of the local government to the inadequacy of the present provision for the cure and treatment of consumptives in that institution, and to the danger to other patients arising from their presence in the general wards of the hospital."[59] In fact, between 1892 and 1897, tuberculosis accounted for 28.3 percent of all deaths at the Victoria General.[60] The V.G. was not unique in its lack of treatment facilities for tuberculous patients, as hospitals throughout Canada lacked treatment

facilities, some even refusing admission.[61] Nova Scotia attempted to correct this situation with a sanatorium, which was built with provincial funds and opened in 1904. Here the medical profession could practice institutionalized and scientific medicine and therefore enhance the status of the profession. Nevertheless, without the benefit of x-rays and pneumothorax, treatment remained largely ineffectual. A contemporary account described the Kentville sanatorium thusly:[62]

> the method of treatment consists of open air and rational diet, the house is constructed for this end, all bedrooms opening directly on verandas twelve feet wide, and within easy reach of sun rooms. By night the beds are rolled outside, and there the patient sleeps until the weather becomes too inclement.

By the 1920s sanatoria were transformed "from glorified summer camps to hospital-like institutions". The bacteriological approach to tuberculosis came to the forefront, and with it came a technological orientation, complete with patient histories, physicals, x-rays, tuberculin testing, collapse therapy, and the possible use of a vaccine, B.C.G., which was tested in Quebec in 1925.[63]

III - Health Care Delivery

Just as the medical treatment of tuberculosis became more bureaucratized and institutionalized, so too did the medical care the Micmac received. By 1928-1929, doctors were making use of local sanatoria and hospitals in the provision of care, and there was a public health nurse active in Nova Scotia.[64] The stability of the 'country doctor', dominant throughout the nineteenth century, was being transformed and often elicited reactions from physicians, Micmac and government bureaucracy alike.

Between 1875 and 1891, no less than 109 practitioners provided medical care to the Micmac in all areas of the province. The medical expenditures by the federal government associated with this care is presented in Tables 3.1 and 3.2, in which totals are given for the individual districts as well as by year. Though fluctuations do occur, there is, generally, an increase in the amount expended over time, which is due to increased services, increased population, and, perhaps, more illness, or at least better detection. Far and away the greatest expenditure by district was in District 1B, which encompassed the counties of Digby and Yarmouth until 1889, when Yarmouth became an independent district. Moreover, for the years 1889 to 1891, the medical expenditures in Digby alone totalled $1019.43. Yet, the County did not have a disproportionate share of the Micmac population, nor did it appear to labour under an excessive amount of disease, which raises questions with respect to the equality of services throughout the province and accountability.

As early as 1880, there was an attempt to rationalize the growing expense of medical care, though it did occur in the unlikely area of Kings County, where expenditures were traditionally moderate. Nevertheless, agent J.E. Beckwith, demonstrating his fiscal restraint reported that he "had given the Indians to understand that they must not expect any assistance during the summer". Yet, even Beckwith wavered in his resolve, for he made "provisions for a married daughter brought home sick to her father, so as to be near the doctor. Having satisfied myself that it would be a lingering disease...I gave an order to the doctor to make one visit, but that, thereafter, they

Table 3.1A

Administrative Districts of Nova Scotia
(1875-1878)

District No. 1 - Counties of Annapolis, Digby, Yarmouth, Shelburne
District No. 2 - Counties of Kings, Queens, Lunenburg
District No. 3 - Counties of Halifax, Hants, Colchester, Cumberland
District No. 4 - County of Pictou
District No. 5 - Counties of Antigonish and Guysborough
District No. 6 - County of Richmond
District No. 7 - Counties of Inverness and Victoria
District No. 8 - County of Cape Breton

Table 3.1B

Medical Expenditures (1875-1878)

	1875	1876	1877	1878	TOTALS
District No. 1	$87.80	-	$54.10	$78.65	$220.55
District No. 2	41.00	232.50	311.60	9.22	594.32
District No. 3	-	68.75	117.99	68.83	255.57
District No. 4	62.50	-	2.50	-	65.00
District No. 5	72.28	75.57	99.86	164.43	412.14
District No. 6	92.50	-	25.48	-	117.98
District No. 7	36.61	35.41	9.40	-	80.52
District No. 8	45.00	-	-	16.18	61.18
TOTALS	437.69	411.33	620.93	337.31	1807.26

Source: Sessional Papers 1876 No. 9 Return D(1); 1877 No. 11 Return C(1); 1878 No. 10 Return C(2) and 1879 No. 7 Return C(2).

Table 3.2A

Administrative Districts of Nova Scotia
(1879-1891)

District No. 1 - Counties of Annapolis, Digby and Yarmouth
District No. 1A - Annapolis County
District No. 1B - Counties of Digby and Yarmouth
District No. 2 - Kings County
District No. 3 - Queens County
District No. 4 - Lunenburg County
District No. 5 - Halifax County
District No. 6 - Counties of Hants and Colchester
District No. 6A - Hants County
District No. 6B - Colchester County
District No. 7 - Cumberland County
District No. 8 - Pictou County
District No. 9 - Annapolis and Guysborough
District No. 10 - Richmond County
District No. 11 - Inverness County
District No. 12 - Victoria County
District No. 13 - Cape Breton County
District No. 14 - Yarmouth County
District No. 15 - Shelburne County
X - denotes district not in existence

Table 3.2B

Medical Expenditures (1879-1891)

	1879	1880	1881	1882	1883	1884	1885	1886	1887	1888	1889	1890	1891	TOTALS
District No. 1	59.52	73.53	60.05	133.25	X	X	X	X	X	X	X	X	X	326.35
District No. 1A	X	X	X	X	-	15.00	102.93	60.00	80.95	121.85	66.50	50.50	39.95	546.78
District No. 1B	X	X	X	X	56.60	227.75	194.95	230.55	331.95	272.90	167.50	601.08	250.85	2344.13
District No. 2	31.04	15.54	12.00	14.50	23.90	31.50	45.70	15.70	42.25	18.70	46.00	87.35	46.00	430.18
District No. 3	23.10	-	22.05	-	19.95	29.00*	70.40*	55.20*	177.65*	58.35	104.20*	69.20	37.00	864.92*
District No. 4	13.50	11.50	85.62	-	-					63.00		12.60	12.60	
District No. 5	-	76.50	5.00	25.00	-	15.25	15.25	103.80	125.50	135.85	82.85	193.30	314.50	1077.55

* Districts 3 and 4 together

Table 3.2B (Cont'd)

	1879	1880	1881	1882	1883	1884	1885	1886	1887	1888	1889	1890	1891	TOTALS
District No. 6	-	31.20	X	X	X	X	X	X	X	X	X	X	X	31.20
District No. 6A	X	X	32.70	35.94	69.76	-	13.75	65.65	39.75	38.25	90.60	82.10	53.75	522.25
District No. 6B	X	X	38.20	21.00	27.50	35.00	42.00	75.10	45.00	109.50	51.00	90.75	97.05	632.10
District No. 7	19.00	25.00	25.20	17.43	23.00	51.25	9.75	118.25	62.00	33.25	105.10	201.25	107.35	797.83
District No. 8	25.40	36.75	-	34.91	52.00	-	84.00	67.00	63.00	42.00	42.00	62.25	50.00	559.31
District No. 9	53.56	47.50	35.07	7.25	44.32	32.62	110.50	67.95	55.30	155.02	112.70	234.90	120.75	1077.44
District No. 10	-	12.00	-	6.80	65.80	-	46.25	26.50	132.10	22.00	84.75	59.70	138.30	594.20
District No. 11	60.75	28.98	23.50	21.00	6.75	59.50	31.00	34.39	19.50	53.75	27.25	54.50	54.50	475.37
District No. 12	63.20	73.15	-	47.40	55.65	63.60	55.20	80.70	31.80	77.13	132.35	112.85	168.60	961.63
District No. 13	41.75	48.00	52.50	41.83	157.09	50.10	102.85	100.00	92.30	244.35	107.25	178.87	100.00	1316.89
District No. 14	X	X	X	X	X	X	X	X	X	X	23.75	74.90	5.25	103.90
District No. 15	X	X	X	X	X	X	X	X	X	X	X	X	68.45	68.45
TOTALS	390.83	479.65	391.89	406.31	602.32	595.32	924.53	1100.79	1299.05	1445.9	1243.9	2175.1	1664.9	12,720.48

Sources: Sessional Papers 1880 No. 4 Return C.2; 1880-81 No. 14 Return C.2; 1882 No. 6 Return C.2; 1883 No. 5 Return C.1; 1884 No. 4 Return C.1; 1885 No. 3 Return C.1; 1886 No. 4 Return C.1; 1887 No. 6 Return C.1; 1888 No. 15 Return C.1; 1889 No. 16 Return C.1; 1890 No. 12 Return B.1; 1891 No. 18; 1892 No. 14 Return A(2).

must depend upon their own nursing."[65] Rationalization in Beckwith's view had little to do with making physicians accountable, but was solely concerned with decreasing Micmac utilization of physician services. Robert Borden took a somewhat different approach to rationalization when he suggested that "if more money were expended in giving these unfortunate people blankets, flour potatoes, food, &c., it is possible that less money would be required for medical attendance and medicines."[66] Borden's suggestion implied that money was being misallocated - that prevention would be cheaper than cure and was, therefore, a critique of the emerging sickness-treatment system.

Physicians, however, also came under scrutiny. The member for Cape Breton, H.F. McDougall, raised the spectre of accountability in the House of Commons in 1900 when he questioned the increased expenditure and asked "Why is that?...Is it not due to the fact that there is greater license in the way medical men are allowed to make their charges?"[67] Yet the following year, 1901, responsibility for excessive expenditures was once again shifted from the physician to the Micmac people. Charles E. Kaubach, representing Lunenburg, asked whether[68]

> it is an established rule that physicians in the district shall be employed, then the rule on principle has been broken in the case of reserves in Lunenburg, because physicians living miles outside the district have been employed, and in consequence of which the bills are very greatly increased. If the government desire economy, we have lots of first-class physicians in the district

The Minister of the Interior, Clifford Sifton, replied and, in doing so, illustrated a return to Beckwith's strategy advanced in 1880.

Sifton stated

> we have two doctors who attend the Indians, at a salary of $75 a year each; Dr. Marsh, who resides at Bridgewater and Dr. Kelly, at Chester. I doubt if any economy would result from employing others and paying them fees. We have a constant struggle to keep down the cost of medical attendance in the maritime provinces, because the Indians themselves desire a doctor very often when there is nothing the matter with them, and if we gave them the least encouragement, the medical bill would run up to a high figure. Therefore, we endeavor to employ men whose judgement can be relied on not to attend the Indians except in cases of necessity.

Sifton was suggesting that the best way to control medical expenditures was to render doctors inaccessible. Moreover, Sifton believed that the doctors themselves could play a role in minimizing expenditures by providing care only when absolutely necessary. Either way, the end result for the Micmac was a reduction in the availability of service and, hence, the efficacy of care, especially early detections.

There was some debate as to whether or not making doctors less accessible was, in fact, conducive to fiscal restraint. The debate was continued by Charles E. McManus, agent for Halifax County, who, in opposition to Sifton, argued in 1904 that some Micmac "live at a great distance from the nearest physician, and so, in cases of repeated visits, the medical accounts are brought to a high figure."[69] The discrepency stems from different viewpoints, particularly salary versus fee-for-service payments. Thus, while McManus recognized that government expenditures were based, at least partly, on fee-for-service, Sifton preferred to view physicians as salaried officials. Payments had long been based on a formula which, in 1895, included

an allowance for travel as well as a fee for office consultations. Nothing, however, was paid for attendance per se, unless a surgical procedure was required. Payment was adjusted in 1896 from fifty cents per mile to thirty-five cents, and there was even the suggestion of "paying for the medical attendance by salaries instead of fees."[70] It was essentially the same procedure utilized by the provincial government from 1857 to Confederation. Nevertheless, physicians were, by 1903, paid a base salary according to their workload, though there was special allowances made in the event of difficult circumstances, such as epidemics.[71] Thus, in some respects, payment was still based upon services rendered. This was acknowledged by Duncan S. Scott, the Deputy Superintendent General of Indian Affairs, who wrote that the "system of medical relief conducted by the department gives the Indians the benefit of the services of qualified practitioners, who are paid either by salary or upon accounts rendered."[72]

Nevertheless, physicians became only a part of a larger complex of related health care workers and institutions. Thus, the 1913 statement of Dr. P.H. Bryce, Chief Medical Officer for Indian Affairs, that "the small bands distributed through the maritime provinces" received only "partial medical attention" contrasts sharply with the 1915 statements of Duncan Scott, who believed that the health bureaucracy's "force of doctors, nurses and hospitals is constantly employed in treating sick Indians".[73] There were clearly discrepencies in the care native peoples received and realms that required special attention, such as the care of the elderly and the strain this placed on

limited resources.[74] Yet, the utilization of hospitals and nurses represented a marked change in the health care delivery system, though it was a change that had parallels throughout Canadian medicine.

The department developed a new policy in 1922 that was to improve not only medical care, but preventative services as well. The program, which began in western Canada, utilized travelling public health nurses "whose duty it is to inspect the Indian schools and to go about among the homes on the reserves giving assistance and advice. These nurses work in co-operation with the Indian Agents and departmental medical attendants".[75] By 1927, there was a nurse operative among the Nova Scotia Micmac in addition to the four in the Prarie Provinces and, indeed, by 1928, there was at least one in every area of the Dominion, except Prince Edward Island and the Yukon.[76] But the nurses role was clearly considered supportive, and subordinate, to that of the physician. By the late 1920s, there were seven full-time physicians employed by the Department and over 250 part-time practitioners.

The fees these part-time practitioners received were standardized in 1928-29. This move toward a fee schedule, while ostensibly made to rationalize the emerging bureaucracy, also allowed the physicians in the service of Indian Affairs "to compensate for the unreliable nature of private sector fees."[77] Moreover, there was a planned expansion of public health nursing "which is considered to present great possibilities for improvement of health conditions."[78] Matrons and dispensers came into use in 1928 in the four western provinces and the Northwest

Territories, which attests to the growing specialization of health care workers symptomatic of the period. Moreover, in fiscal year 1928-29, the Department developed a "Public Health Regulation" which defined the responsibilities of the various health care workers and reinforced the emerging hierarchy. The regulations essentially allowed for the application of provincial health regulations to Indian reserves in the event of outbreaks of communicable disease.[79]

Thus, a transition was occuring within the Indian Affairs bureaucracy, which saw the end of the 'country doctor', though physicians remained the dominant providers of care and preeminent within the new bureaucratically managed health care delivery system. Field matrons, dispensers and nurses were added to the department, whose policy in April 1929 was "to extend the service rather than reduce the cost."[80] In fact, departmental expenditures gradually increased through the 1920s (see Table 3.3). Nevertheless, the cost per capita for Canada's Indians hovered around the ten dollar mark through the 1930s, significantly below the amount expended by private and public sources for the entire Canadian population, which remained close to thirty dollars per capita.[81] The depression, however, mitigated against the expansion of medical care services, as noted in the Departmental report for 1932:[82]

> 'During the year under review economic conditions have prevented any general extension of health activities...It has not been financially possible to extend the effort of combatting tuberculosis, nor, indeed, to maintain it at its former standard. The department has been compelled to limit admissions of tuberculous Indians to sanatoria and hospitals, and it must be anticipated

that this will result in an increased spread of the disease.

Table 3.3

Medical Expenditures on Micmac Indians (Nova Scotia)

Fiscal Year	Amount	Total as a Percentage of Total Expenditure
1916-17	6498.97	25.4%
1917-18	6783.52	24.0%
1918-19	6211.31	25.6%
1919-20	7395.16	26.1%
1920-21	12,176.59	26.4%
1930-31	26,715.33	28.1%
1931-32	28,107.99	32.7%
1932-33	33,716.87	23.1%
1933-34	34,085.13	22.8%
1934-35	33,141.38	24.0%

Source: Sessional Papers 1916-17 - 1920-21 and Department of Indian Affairs Annual Report 1931-1935.

This reduction of services did not, however, appear to have any tangible adverse effect upon the health of the Micmac. Physicians were required to accept less than their usual fees for services rendered.[83] But during the Depression, with the great increase in patients who could not afford to pay, in addition to those who delayed seeking medical attendance,[84] a decreased payment still acted to stabilize physicians declining revenues. This was consistent with the dominant ideology within the profession, which had opposed any

notion of health insurance through the 1920s when incomes were rising at an unprecedented rate, but which had, in the midst of the Depression, tacitly accepted state health insurance.[85]

IV - The Micmac Context

The Depression also had a profound effect on the socio-economic position of the Micmac in Nova Scotia. Contrary to the government assertion that "the change for the worse in their economic position is relatively less marked than among the white population",[86] which appears to be a variation on the stale argument that the Depression did not effect the Maritimes as hard as the rest of the Maritimes, the Micmac did feel its effects in a number of significant ways. Industrial expansion in Nova Scotia had increased Micmac opportunities for wage labour in the period after 1868, which heretofore existed only in the realm of agriculture.[87] This opportunity allowed the Micmac to make some inroads into the industrial-based economy, including jobs in manufacturing areas along with related fields and, with the twentieth century, work in construction. This participation in the industrial economy was not without its difficulties. Micmac participation in the non-Indian economy was, at best, marginal. There was little stable, year-round employment for the Micmac. As Jean Guillemin has noted[88]

> as early as the turn of the century, and probably before that time, Micmac men worked building railroads, in lumber camps, on river drives, and in crop harvesting in Canada and the northern part of the United States. Forays out to the industrial centers of New England also began at the

> same time, and the Micmac, along with other Indians across the country, were continuously being integrated into industrial society as "cheap labor".

The Micmac were not, however, completely subordinated to the status of wage labourers. There were some opportunities for self-employment in the expanding industrial economy, and farming continued throughout the period. The handcraft economy likewise continued though it was, as were all Micmac endeavours, susceptible to changes in provincial prosperity. As one Indian agent noted in 1886 "distress and hard times for the farmers have prevailed here generally for the past year, making Indian wares unsaleable, and forcing them to wander more than usual from place to place, in order to eke out an honest subsistence."[89] But this was, largely, a period of self-sufficiency for the Micmac as they managed to gain a tenuous foothold in the predominant economy through wage-labour and self-employment, and supplemented these pursuits with agriculture, the sale of handcraft goods, as well as hunting and fishing.

Oftentimes there were links drawn by Indian Affairs officials between the prevalence of disease and the more traditional economic pursuits of the Micmac, namely, hunting, fishing, and the pursuit of the handcraft trade. Thus, in 1882, J.E. Beckwith noted that in Kings County, the sale of handcraft goods allowed the Micmac only "to eke out a scanty living" which was aggravated by the fact that the "game is all gone." The tentative nature of this existence, Beckwith argued, meant that when disease struck, "destitution and starvation stares them in the face."[90] Joseph Chisholm also drew a

connection between a traditional way of life and the prevalence of disease or general health status, when he declared that "there has been some suffering among the nomad portion of them from chronic diseases".[91] Donald McPherson took a somewhat different tack in 1904 when, writing of Inverness County, he associated the Indians low economic position with tuberculosis, saying "because of poverty, and its common attendant, lack of cleanliness, proper precautions are not taken to prevent the disease germs of this scourge taking hold of new victims."[92] Similarly, twelve years later, the agent for Cumberland County noted "there are still to be found the usual number suffering from tuberculosis due to their mode of living."[93] The following year, 1917, John Campbell, agent for Victoria County, commented that the "health of the members of this band has been fairly good; however, the nomadic habits of one family brought scarletina to the reserve, which caused the death of two children and the discomfiture of many others".[94] These would all appear to be examples of the dominant ideology at work. Like their predecessors, the Nova Scotian administrators, the federal government's Indian policy promoted the establishment of a sedentary and agricultural native population. The continuation of more traditional pursuits and the form of occupational pluralism that resulted not only mitigated against this, but also against integration into the industrial economy as inexpensive wage labor. Disease, so the argument would go, was facilitated by the nomadic behaviour necessary for traditional economic pursuits; therefore settlement on reserves would reduce the likelihood of disease. At the same time, of course, settlement on a reserve would also

facilitate greater participation in the dominant economy.

But the fact remained that Micmac culture continued to be vibrant and necessary. The Micmac began to lose their marginal foothold in the industrial economy with the downturns and depressions of the 1920s and 1930s. Thus, when Clara Dennis, a Nova Scotia author and journalist, visited Whycocomagh in 1928, she was told that the residents subsisted largely on hunting and fishing because "no day work can be got." Dennis also recorded that men and women continued to make baskets, barrel hoops and axe handles. Deer, muskrat, mink and fox were hunted, though the informant observed that there were "too many after them" and that there would "soon be no fox."[95]

While the Micmac retained their economic traditions in the face of a concerted effort on the part of Indian Affairs administrators, they also faced a more subtle challenge from a professionalizing body of practitioners. Dara Culhane Speck has argued that "one of the major obstacles to the development of the medical profession's exclusive jurisdiction over the human body was the knowledge and skill in the practice of folk medicine possessed by many non-professionals".[96] This is perhaps stated too strongly, for even today it is estimated that seventy to ninety percent of health care is carried out in the social sphere, which does not include nonprofessional healers,[97] and this reality has not diminished the social or professional status of doctors. It is, however, true that physicians looked upon traditional remedies with disdain. But the Micmac evidently maintained their use of traditional remedies. Clara Dennis

recorded many of these preparations, all of which were firmly rooted in Micmac tradition. She records that some of the population consulted a medicine man during illness and that he had "many testimonial<s> of people he cured with flue <sic>." Dennis also noted remedies for colds, indigestion and other ailments.[98] Of particular interest is the fact that the Micmac appeared to have continued to practice a form of preventative medicine. They "make medicine & go through ceremony" Dennis wrote in her notebook, "to dry <drive?> out the evil spirit before they take it...medicine is taken 2 times a year spring and fall. Everyone took it."[99] There are two very important elements contained in Dennis' description. First, the fact that residents of Whycocomagh still partook in a preventative medicine ritual attests to the resiliency and strength of their beliefs. Second, it is obvious that some Micmac retained their traditional beliefs of disease causation. Medicine men not only stand as a symbol of the continued presence of indigenous beliefs, but also played a role in perpetuating another portion of Micmac heritage. One informant told Clara Dennis that when he "was a boy the Chief medicine man would gather the children - boys and girls into his camp & tell the stories." Undoubtedly, the oral transmission of legends and stories was not restricted to 'medicine men' and the informant quickly added that a number of "old people would be there also to see if he told them correctly."[100]

Beyond their own cultural traditions, the Micmac were also active participants in the delivery of health care by the Indian administration. The praise given the Micmac in 1915 for their efforts

in the prevention of tuberculosis has already been mentioned, but they also, at least in one instance, took it upon themselves to petition the federal government with respect to an individual practitioner. On 14 June, 1897, a petition from the residents of Salmon River was read in the House of Commons.[101] It read that the residents

> desire to bring to your notice the gross injustice of being coerced by the Indian agent here of employing a physician who is objectionable to us. We deplore the prospect of being denied the services of our old physician, Dr. J.A. MacDonald, who has treated us for years successively, in whose generosity, ability and skill we have the most implicit confidence, and for whom we entertain every feeling of respect.

Dr. MacDonald had been employed in the district since 1884 and the reasons for his replacement by Dr. Bisset were only explained by Richard Dobell, Minister of the Interior, as part of "steps... taken for the purpose of reducing the cost" of medical care provided to Nova Scotia's native population.[102] The replacement of Dr. MacDonald was merely a side effect of the emerging concern for a bureaucratically-managed, rational health care system, in which it mattered little who was providing care as long as somebody was. Medicine, too, was being transformed to a specialized, bureaucratized and scientifically managed profession.

V - Continued Professional Struggles and Physician Preeminence

A recent article in Saturday Night entitled "The Professionals" remarked that modern professionals - lawyers, university professors and doctors - "keep their numbers down so that the value of those professing remains as high as possible, and they fight off pretenders to the fold."[103] As demonstrated in the last chapter, one of the most

effective means available was to increase the standard of medical education and tie this to licensure. Nevertheless, concerns over limiting numbers and fighting off 'pretenders to the fold' were not the sole motivation behind this reform for, as Colin Howell has argued, physicians at the forefront of educational reform "felt a professional and social obligation to improve the quality of medical care."[104]

A 1938 article in the Dalhousie Medical Journal contains a letter in which the author, Dr. D. MacKintosh, recounts the early days of medical education in Halifax. Dr. MacKintosh wrote that "at the time" there was "great difficulty in procuring subjects for dissection, and we had to steal the bodies."[105] In fact, scientific research had made tremendous advances in bacteriology with the discovery of the origins of tuberculosis, diptheria, typhoid, syphilis and gonorrhoea in the 1880s and there was a hope, or rather a confidence, that science would offer the cures as well,[106] but the state of medical education in Halifax lagged somewhat behind. From the outset, the education of potential doctors was limited and consisted largely of lectures, accompanying the professor-practitioner on trips through local hospital wards, and the clinical lecture where students watched and discussed the care of an ambulatory patient.[107] Even the Anatomy Act of 1869, which ended the necessity of bodysnatching and allowed lectures to be 'illustrated by the fresh subject', failed to fill the absence of practical clinical training for the student, for the school suffered from a chronic shortage of cadavers until the 1890s owing to the strict regulations governing the procurement of bodies. This is

not to imply that developments in bacteriology, physiology and other areas went unnoticed by the medical profession or the faculty.

Halifax practitioner John Stewart has worked under Lister in 1875 as a dresser and in 1876 as a clerk, before returning to Nova Scotia to preach the gospel of antisepsis.[109] Listerism was, however, greeted in the Maritimes with anxiety, resulting in "especially widespread confusion and disagreement among doctors". Support for Listerism and germ theory grew nonetheless, and by the middle of the 1880s there was little opposition within the Maritime medical profession to either.[110] Nevertheless, the acceptance of Listerism and germ theory was fraught with difficulties, not the least of which was the therapeutic uncertainty discussed in the last chapter.

One manifestation of the tenuous nature of orthodox therapeutics was the debate over whether patients should have been subjected to repeated doses of drugs and experimented upon by the practicing physician, or whether such experimentation should have been conducted in a laboratory, where physiologists could have conducted experiments and drew conclusions from the use of lab animals.[111] The debate was as divisive and strenuous as that surrounding antisepsis and germ theory, with some physicians arguing against laboratory experimentation and in favor of what had always been the foundation of medicine, clinical experience.[112] Nevertheless, John Harley Warner has offered a persuasive argument that the "scientific basis of therapeutic practice increasingly came to mean laboratory experimentation...making therapeutics more rational by basing it on laboratory experimentation

meant making it more scientific." This was not unrelated to the continued therapeutic ineffectiveness of medicine, which continued despite the advances of bacteriology. Warner continues that by entering the laboratory "these physicians hoped to accelerate the process of therapeutics by linking it to that of physiology."[113]

Thus, it should come as little surprise to learn that those physicians in the vanguard of medical education reform and therapeutic change - Drs. D.A. Campbell, Alexander P. Reid and William H. Hattie - were the very same physicians involved in creating laboratory facilities in Halifax. Though the origins are obscure, equipment for a clinical laboratory was apparently obtained in 1894.[114] Though lacking even basic equipment such as an incubator to culture bacteria which, incidentally, was compensated for by requiring interns to carry the culture tubes in their pockets overnight, the medical profession had begun to recognize the value of laboratories. Dr. Andrew Halliday wrote to Dr. Reid in January 1901, expressing interest in the post of provincial pathologist and bacteriologist "because I like the scientific side of medicine much better than the clinical & (2) because I am not physicially strong enough for country practice."[115] Not only was laboratory science becoming accepted, but it was diverging, a process indicative of the increasing specialization of medicine, into diagnostic and preventative services.[116] Moreover, the public was coming to expect "more modern aids to diagnosis and treatment" according to St. John practitioner William Warwick in a 1908 article entitled "The Laboratory and the General Practitioner".[117] He continued, saying the

> more intelligent of our patients will come to expect these methods to be used, and no doubt be glad to pay for their use...and we must impress our patients with the fact that these methods are essential and necessary. The result will be that the standard of medical and surgical knowledge will be raised to a higher level and so, many patients may be prevented from hurrying off to New York, Boston or Montreal

This is truly a remarkable declaration of first, why laboratories must be utilized and second, how that utilization would increase the prestige, authority and income of the whole profession. Warwick's statement of purpose is much more clear than later articles, such as Dr. Fraser Harris' 'From the Vague to the Concrete in Science and Medicine' in which Harris, of Dalhousie University, merely extolled the virtue of science and scientific medicine, while assuming that better science equalled better medicine.[118] This is in marked contrast to earlier phases of the scientific medicine movement which resulted largely in "heightened professional rivalry and continued public suspicion."[119]

Further technological innovations and diagnostic techniques completed the emergence of scientific medicine. The middle of the nineteenth century brought the stethoscope, opthalmoscope and the laryngoscope. Following these innovations were the microscope, first used at the Halifax Medical College in 1872-73 though they were not common at other medical schools on the continent until the 1890s,[121] and the x-ray machine, first acquired by the Victoria General in 1897, though it suffered from mechanical problems.[122] Bacteriological and chemical tests allowed for the detection of disease causing agents, and this aspect was greatly assisted by the construction of

a modern pathology laboratory, which opened in 1914.[123] Scientific research had become "the ideology of professional reform and uplift"[124] and at the same time was being institutionalized in Canada's universities, which required educational reform.[125]

Just as the universities had to undergo structural reform to accomodate the institutionalization of scientific research, so too did medicine undergo a transformation. Whereas laboratories, x-ray machines and other such innovations were the progeny of the scientific medicine movement, their incorporation into the hospital framework was symptomatic of the increasing specialization, departmentalization and bureaucratization of hospitals and medicine. In 1895 the provincial government opened the Victoria General's private wards, which had previously been open only to the medical staff, to all registered practitioners,[126] thereby making the hospital the focus of a great proportion of medical care. This medical care, moreover, was increasingly being divided into discrete units. While in 1887 the Victoria General had only the departments of medicine and surgery, in the decades that followed an opthalmic department was established, as were wards for children, people with infectious diseases and a gynecological department. In addition, new positions were created including that of gynecologist and anaesthetist.[127] The V.G. had clearly embarked on the journey of specialization, modernization and reform.

Concurrently, medical education was undergoing reform, a reform which was similarly based on the ideology of science and specialization

and modeled after Johns Hopkins medical school. That school utilized full-time instructors and researchers who were salaried at levels sufficient enough to compensate for the loss of private practice. Hopkins was essentially modeled on German medical schools and its faculty was largely trained in these schools.[128] It was these German institutions that progressive reformer Abraham Flexner greatly admired, an admiration he carried with him when he set out, with the support of the Carnegie Foundation, to investigate the state of medical education in the United States and Canada. Flexner's report severely criticized the medical schools at Queen's, Laval, Western Ontario, and Halifax, and change followed almost immediately. Yet, if the Flexner Report acted as a catalyst to change, it was a catalyst which accelerated, not initiated, the reform of medical education. In 1907, the American Medical Association, for example, had conducted its own investigation of medical education and reported on the inadequacies identified. The result was that by the time of the Flexner Report, there had already been a decrease of almost twenty-five percent in the number of medical schools.[129] Similarly, the reform process had already begun at the Halifax Medical College which, through the 1890s, added a new laboratory, attempted to give students more opportunities for clinical experience and made significant changes to its curriculum to incorporate the ever-increasing body of scientific knowledge.[130] Nevertheless, Flexner's report did facilitate the demise of the Halifax Medical College and its reabsorbtion by Dalhousie, after more than two decades of relative independence.[131] The takeover by Dalhousie also allowed the Provincial Medical Board to continue recognizing the

degrees granted, as the Education Committee reported that it did "not feel called upon to take any steps by way of restricting the recognition at present accorded to certificates issued by the College or by the Medical Faculty of Dalhousie."[132]

The great American philanthopists continued their involvement in the areas of health and education through the 1920s and 1930s.[133] In May 1920, Dalhousie Medical School was the recipient of half a million dollars from the Rockefeller Foundation and received a similar grant from the Carnegie Corporation. Together, these grants facilitated the construction of the Public Health Centre and Medical Science Building, financed the purchase of a new laboratory equipment and provided for an endowment.[134] The reasons for the philanthropists' support for the reform of medical education were varied. First, by elevating the standard of health care the poor and working classes received, a potential breeding ground of class conflict, and its accompanying demands for more costly structural reforms, was defused, which also served to legitimize the existing social order. Second, by elevating the prestige and incomes of physicians, the ruling class was, in fact, bolstering its own membership, hence, its position vis-a-vis the rest of the social order. Third, scientific medicine, by deemphasizing the structural or class inequalities pertaining to health through a reductionist, bacteriological explanation of disease, helped to justify the prevailing capitalist social structure.[135] Thus, the participation of philanthropic capitalists served to reinforce the existing social order and maintain the status quo. Nevertheless, this

is not to suggest that corporate capitalism "personally exercised control over the development of medicine through the foundations they established",[136] which is the argument Paul Starr used as a critique of E. Richard Brown. Such criticism fails to recognize that first, medical reform, which was necessary to the profession to secure their position, was costly and required the participation, through money, of the philanthropists. Second, the class interests of the two groups, both of whom were elites, coalesced, thereby facilitating, not control by the capitalists, but cooperation between the two groups to satisfy their individual agendas.

Analogies can be found within the public health movement in Nova Scotia. This had "immeasurable positive effects on the lives of Canadian children"[137] and benefitted the medical profession, who were desirous of a provincial department of health, the creation of which was supported, in part, by the Rockefeller Foundation.[138] Nova Scotia had a history of public health, passing "An Act in Relation to the Public Health" in 1888.[139] It was amended in 1893 and 1900, and in 1904 legislation abolished the Provincial Board of Health and replaced it by a Department of Public Health. The federal government was also increasing its activity in the sphere of health, though sometimes its efforts were frustrated by local practitioners. On receiving a circular from the Department of Agriculture regarding preventable diseases and tuberculosis in 1889, the Maritime Medical News remarked that the "practitioner who sits down seriously to grapple with the six questions propounded will find them a good exercise...it appears

to us a momentous undertaking for a busy practitioner".[140] By the 1890s there was considerable interest in the realm of public health and sanitary reform, an interest that manifested itself in the reports from Nova Scotia's Indian agents.

Beginning in the 1890s, the mention of sanitation or sanitary improvement is not infrequent and comments such as those of Bear River's Indian agent in 1894 are typical, when he says that "there have been few deaths...owing in great measure to medical attendance supplied, and the sanitary measures introduced by the Department."[141] Sanitation figured prominently in the reserve health maintenance strategy of the federal government and reports from Nova Scotia had a subsection entitled 'Health and Sanitary Condition' or something very similar. Roderick McDonald, writing of Micmac in Pictou County, drew attention to the cleanliness of the reserves, reporting that "their houses and camps are sufficiently ventilated to give them all the pure air they require...their houses are kept clean and their water supply is, as a rule too far away from their dwellings to be contaminated by any impurities."[142] In fact, in 1903, Alonzo Wallace of Hants County, went so far as to suggest that the "health of the Indians, with the exception of those who will persist in roving around, has been fairly good...and could they be kept on the reserve ...they would be much more healthy".[143] On the reserve Wallace thought "they would observe sanitary regulations required by the department", which would appear to be a justification, or at least an effort at legitimizing the dominant ideology that Indians belonged on reserves.

Thus, two ideological tenets became linked - that of sanitary reform and the dominant ideology of reserves that was pervasive within the Indian Affairs bureaucracy. There was not, however, complete agreement on the notion that reserves were conducive to sanitary reform. A.J. Boyd, the Nova Scotian Superintendent for Indian Affairs, attributed the prevalent disease among the Micmac to an economic component - the poor living conditions - and a cultural component - the distribution of a deceased person's goods.[144]

This last point emphasizes a critical component of the sanitation strategy, namely that it required the active participation of community members in order to be a success. This was acknowledged by the Montreal Health Survey Committee in a 1927 report when it stated that "community action must be taken to protect the individuals who make up the community."[145] Thus, blame for failures in the realm of sanitation could easily be shifted from the profession to the community, as the agent for Cumberland County did when, in 1925, he wrote that "there has been more sickness than usual, due in some cases to their sanitary conditions. I have in every way tried to show them how important it is to keep both person and surroundings clean; but, unless they are watched, they fall back into their old habits and customs."[146] Despite this recognition of the primary role of the community in the success or failure of sanitary improvements, the medical profession wanted to guide the sanitation strategy[147] as well as secure its hegemony over those who worked within it.

The success of the public health movement also depended upon utilizing "inexpensive, skilled personnel to deliver their message of preventive medicine...and thus employed trained nurses as their agents in the community."[148] The opportunity to work in public health, like that of the field nurse employed by the Department of Indian Affairs, removed some of the constraints placed on nurses working in more familiar environments such as hospitals. Field nurses were not employed by an individual physician or patient, and thus enjoyed greater autonomy and freedom in decision making and action.[149] In keeping with the increased specialization of the early twentieth century, Dalhousie established a course in public health nursing with the aid of the Rockefeller Foundation, the Red Cross and the Massachusettes - Halifax Relief Commission.[150] Physicians looked upon all nursing with a degree of apprehension, for they feared that the professionalization of nursing would greatly undermine their own efforts to achieve preeminence within the medical community, which necessitated the subordination of allied health care workers. Physicians emphasized the limited education of nurses while stressing "her decorum, her personality and her subordination to the doctor",[151] perhaps embodied in the 1892 Report on Humane Institutions which recommended that the nurses residence should have "at least one good piano" to make it "more enjoyable, more homelike, and its influences more refining".[152]

Rather than attempting to subordinate midwives, as they did with nurses, the medical profession simply adopted the process of delivering babies into their own workload. Their success was remarkable, all

but eradicating midwifery in Nova Scotia by World War II.[153] But this transition also meant the introduction of new technology into the paturition process, as well as childbirth's move from the private sphere into the public domain.

Dr. D.S. Muir, in an 1898 article, acknowledges this transition with reference to the Micmac. He wrote:[154]

> how many die during, after or from their confinement, and how often is a medical man called to deliver a squaw with forceps? I have yet to learn of such a circumstance. Puerperal convulsions and puerperal infections of all kinds are very rare with the Mic-Mac Indian. This is true also all over the world with the aborigines, and why is it so? Pardon me gentlemen, if I say chiefly because they are severely left alone.

Muir is making the case for natural childbirth, adding that chloroform or other anaesthetics allowed instruments such as midwifery forceps to be utilized, thereby speeding up delivery and making obstetrics more profitable. Contrasting popular medical texts of this period illustrates this transformation. The first work, published in 1865 declares that the expectant mother should "resist the temptation to a feeling of haste. Nature will often proceed more evenly, and more speedily, if allowed to take her own time. A hurry to get through is a great obstacle to succ delivery".[155] Another work, published in 1890, asks whether it is "possible to avoid the throes of labour and have children without suffering? This is a question which science answers in the affirmative...Of late years chloroform and ether have been employed to lessen or annul the pains of children" though the work does suggest that "where the pains are readily borne,

they are not required."[156] The use of forceps, considered a surgical tool and hence, within the domain of doctors as opposed to midwives, was also criticized by Dr. Muir. An examination of the obstetric case histories of Dr. W. Bruce Almon illustrates how prevalent the use of forceps was. The first time Dr. Almon recorded their use was during the birth of a female child in Jollimore, outside Halifax, on 11 March, 1901. Between that date and 30 August, 1913, Dr. Almon attended some 302 births. Of these, forceps were applied by Almon or a consulting physician in no less than 53 cases or 17.5 percent. They were most often applied when Almon described labour as "tedious", as in the case of twenty-one year old Eliza, whose case history bears the notation "tedious labor terminated by forceps at 9 P.M. after 30 hours" or fifteen and a half year old S.A.H., who was in "labor over 30 hours" before forceps were applied. Forceps were often used in conjunction with anaesthetics, but this was not without its hazards. Almon noted on 19 November, 1906, that one of his patients "nearly died from chloroform".[157]

Concurrently, birth was being transformed from a private to a public event.[158] As a private event, the expectant woman was attended by neighboring women, family members and a midwife. Birth was considered a natural process that did not, in normal circumstances, require a large degree of interference or 'maintenance'. To facilitate the transformation from midwife to physician, doctors pathologized the labour process, which necessarily entailed the active intervention of doctors. With respect to the sex of the obstetricians, an early

description stated that "a female physician should deal with female patients".[159] Thus, the profession did not distinguish with respect to sex, but regarded the introduction of "obstetric surgeons instead of uneducated midwives" as a great advance in the medical art."[160]

VI - A Sensitive Profession

Not unrelated to the subordination of nursing, the elimination of midwifery and the struggles against sectarianism was the condemnation of osteopathy as another of the nineteenth century's "fads and fooleries".[161] The 1899 editorial treated osteopathy with derision, declaring "the cures that these osteopaths are making are marvellous. By the laying of hands dislocated bones are restored to their proper position and function, and the lame and the halt are made to walk. Truly this is an age of miracles." There was no room in the profession for pretenders to the fold, even if their therapeutic techniques had some validity. Hence, osteopaths and chiropractors were lumped in the same category with Christian scientists, faith healers and other sectarians and excluded from orthodox medicine, if not from the medical marketplace. The profession also still had to contend with dubious local competitors, such as the proprietors of Murphy's Gold Care Institute. An 1896 petition reveals that the Institute was opened "for the purpose of administering the Murphy Gold Cure for Drunkenness, and the Tobacco and Morphine habits".[162] Medical practitioners responded to the Institute's request for funding from the provincial government by saying their "attention has been attracted by the circumstance that the number of relapsing cases becomes greater every day and that the

number of permanent cures is no larger than that obtained by other remedial measures, moral and physical."[163]

The orthodox practitioners did not succeed in entirely eliminating all forms of alternative cure. For example, the Provincial Medical Board minutes for 17 July, 1912 record "that no fee had been paid Dr. Read for examination of the homeopathic candidate. On motion it was decided to pay Dr. Read the usual fee allowed any examiner for one candidate that is $6.25."[164] Dr. H.H. Read, a McGill graduate, was long a homeopathic practitioner in Halifax, and was a registered examiner appointed under the Medical Act of Canada. It is significant that Read was the homeopathic examiner, and took his place beside examiners in clinical medicine, therapeutics and hygiene, anatomy, clinical surgery and other orthodox subdisciplines. The transformation to scientific medicine and the redefinition of orthodoxy discussed in the previous chapter, allowed homeopaths to be absorbed into the regular profession without challenging or undermining its authority.

The profession was less concerned about homeopaths than it was about the credentials and licensure of practitioners within the province. When Dr. J.M. Roy requested to be registered in 1907 his credentials, which included an M.D. diploma from Tufts College (1894), a Certificate of Registration from the Massachusettes Board of Registration in Medicine (1894), as well as one from the Vermont State Medical Society and a membership in the Canadian Association for Opticians, "were of course of no particular value as regards qualifying Roy for for registration or for examination".[166] Another case surrounded a

Dr. Sutherland, who was practicing in the River Hebert area without a license in 1908.[167] In the summer of 1908, Dr. Ira Everett Dyas was was erased from the Medical Register by the Board. There was some concern among Board members that Dr. Dyas had falsified the results of a physiology exam taken in 1898-99.[168] Dr. Anthony Ivan Mader, in 1915, faced erasure under the "infamous professional conduct" bylaw for violation of "professional confidence" when he exposed, during court proceedings, that he had treated a patient for gonorrhoea. A letter from the Board states that though the "Board had a very unpleasant duty to perform...it owed it to the profession to see to it that...professional secrets are not divulged".[169]

The profession had a keen interest in maintaining its high standards, which not only served to protect the patients, but ensured a continuation of patients' confidence in the profession. Advertising was a somewhat different case, concerned with fostering feelings of corporate solidarity among members of the profession by prohibiting advertising. Hence, in a letter entitled "Whither are We Drifting?" an anonymous doctor complained of the unprofessional conduct of some of the faculty at the Halifax Medical College in 1891. The author wrote that "some of these very men have had their praises sounded in the public press in such a way that it is impossible to believe that they did not have something to do with these notices".[170] Similarly, Dr. W.T. Morris MacKinnon was criticized for the publicity he received over special methods of treatment "which certainly seemed to place him in the position of violating in a very glaring way the ethics of the

profession"[171] which banned advertising, thereby reducing competition among practitioners and generating professional solidarity.

If the profession had a prohibition against advertising, patent medicine peddlars certainly did not. As early as 1874 a bill to regulate the sale of drugs and medicines was introduced into the legislature, though it did not pass.[172] The disdain practitioners held for patent medicine peddlars was evident from an editorial which characterized them as "parasites".[173] Another bill was introduced aimed at regulating the patent medicine trade in 1906 and though it had the support of practitioners,[174] it set off alarm bells in Halifax newspapers, who not only derived significant revenues from the advertisements of these goods but saw that it "promoted...the interests of the medical profession at the expense of the people." The Acadian Recorder declared that the proposed legislation "practically forced" people requiring medicine "to consult a doctor" while the Halifax Herald declared "it would be a public injury" and that "the public have their own opinions".[175] The Herald was correct, for in a letter to the editor, the author linked the sale of patent medicine to the dominance and the ineffectiveness of the regular profession, saying "everyone knows what has caused the immense sale of patent medicines is the failure of the ordinary physicians' presciptions and consequently the people have been compelled to go elsewhere for relief."[176] By the 1920s, the patent medicine question was no longer a concern to the profession as the federal government was testing preparations under the Proprietary or Patent Medicine Act in Department of Health

laboratories. Thus, laboratories, which the profession had been so instrumental in creating, were utilized to secure the position and status of orthodoxy. The medical profession had become specialized, departmentalized and bureaucratized and, together with provincial and federal health departments, had largely assumed its modern shape.

VII - Conclusion

Health personnel, progressive reformers, government bureaucrats, industrial capitalists and the Micmac people all helped to shape the health care delivery system that emerged during the period following Confederation. The process of change was a negotiated one and not merely the result of one interest group successfully asserting its own interests to shape the fledgling Indian health bureaucracy. Thus, while philanthopists may have sponsored various medical reforms, the success and shape of those reforms depended largely upon the participation of physicians. Similarly, while physicians were successful in subordinating nurses and eradicating midwifery, their early attempts to regulate the patent medicine trade met with a hostile reaction from the media and the public. In the first instances physicians were able to present their own interests as the interests of all. The public accepted the argument that nurses and midwives lacked the education to perform duties that could and should be done by doctors. Nevertheless venues remained for nurses to maintain a semblance of independence, notably in public health nursing, but the example of the field nurses employed by the Department of Indian Affairs may also serve as an illustration. Conversely, in their efforts to regulate the patent

medicine trade, the public asserted its interests, to the detriment of the profession, by denying the latter the sole privilege of dispensing all medicine. The Micmac too played an active role in shaping their own history. The maintenance of their own cultural traditions, and the occupational pluralism that resulted, mitigated against the full participation in, and subordination to, the industrial economy. Moreover, they were not completely dependent on the medical profession for health care, evident through their retention of indigenous notions of disease and medicine.

Finally, ideology played a role in shaping the way in which the many variables discussed throughout the chapter interacted. Thus, the federal government's concern with establishing a sedentary, agricultural Micmac population was consistently reinforced by the way in which physicians and agents regarded disease. Thus, contagious disease was often associated with the pursuit of the traditional economy, whereas reserves, later in the period, were seen to be conducive to sanitary reform. The government would, in 1942, announce a policy of centralization, which was once again tied to health care, with its promise of improved medical care through creating economies of scale.

Appendix A
Incidence and Mortality for
Selected Diseases (Nova Scotia)

Fiscal Year Ending Sept. 30		Consumption*	Smallpox	Influenza	Typhoid Fever	Diptheria	Scarlet Fever	Measles	Whooping Cough
1898	Cases	747	N/A	902	213	156	91	692	187
	Deaths	214	N/A	19	8	21	1	18	1
1899	Cases	722	N/A	375	179	107	84	212	95
	Deaths	171	N/A	17	6	10	6	6	1
1900	Cases	149	10	759	185	47	192	1543	163
	Deaths	44	1	4	-	8	6	54	6
1901	Cases	340	81	654	266	66	191	205	369
	Deaths	126	-	2	35	8	12	10	5
1902-3	Cases	279	45	1567	216	72	222	179	15
	Deaths	94	1	10	28	17	14	1	-
1903-4	Cases	913	435	1650	563	213	252	404	544
	Deaths	229	5	11	48	21	12	3	-
1904-5	Cases	1588	22	1470	249	163	105	365	46
	Deaths	158	-	15	26	30	7	14	-
1905-6	Cases	1684	16	1468	275	N/A	257	415	60
	Deaths	232	-	35	24	N/A	9	16	2
1906-7	Cases	1850	1830	1680	249	N/A	291	455	156
	Deaths	410	5	66	20	N/A	12	17	15
1907-8	Cases	1885	1740	1792	260	N/A	317	471	160
	Deaths	501	3	76	22	N/A	12	18	16

Source: Journal of the Legislative Assembly. Board of Health and Department of Public Health Annual Reports 1899-1909.

* After 1900 tuberculosis statistics are for tuberculosis of the lungs only.

Appendix B
Selected Mortality Statistics
(Nova Scotia)

	Consumption	Smallpox	Influenza	Typhoid Fever	Diptheria	Scarlet Fever	Measles	Whooping Cough
1908-09	922	2	82	86	178	59	20	56
1909-10	859	7	73	74	99	34	10	74
1910-11	968	4	101	58	95	42	139	64
1911-12	794	-	61	58	110(b)	45	5	59
1912-13	794	4	58	58	118(b)	49	17	113
1913-14	779	-	48	86	90	30	82	28
1914-15	655	-	79	59	80	15	48	71
1916-17°	768	1	75	57	133(b)	7	51	109
1917-18	603	2	94	31	122(b)	5	51	58
1918-19	778	6	1769	39	96(b)	6	42	26
1919-20	651	5	210	46	53(b)	8	25	131
1921*	579(a)	-	70	30	63	10	29	95
1922	562	-	119	20	45	8	9	85
1923	241	-	68	16	12	16	27	48
1924	550	-	91	27	25	33	24	88
1925	500	-	224	19	23	22	6	35
1930	237	-	55	5	31	16	5	48
1935	416	-	142	7	11	9	14	48
1940	316	-	254	2	21	2	15	53

Source: Journal of the Legislative Assembly. Vital Statistics 1910-1912; Health Report 1915; Vital Statistics 1915, 1916, 1918-21, 1923, 1924-27, 1932, 1937, 1942.

° no data available for 1915-16.
* data is for the calender year after 1921.
(a) after 1921 data is for tuberculosis of the respiratory system only.
(b) diptheria statistics also includes croup.

Appendix C
Tuberculosis Mortality Per 100,000 Population (N.S., N.B., P.E.I. and Canada)

	Prince Edward Island	Nova Scotia	New Brunswick	Canada
1921	144	134	106	88
1922	126	134	108	86
1923	107	126	113	87
1924	116	129	107	84
1925	100	113	103	81
1926	103	125	105	84
1927	83	125	103	81
1928	114	111	101	81
1929	85	101	94	78
1930	117	107	97	80
1931	77	102	83	74
1932	99	100	79	69

Source: Douglas O. Baldwin, "Volunteers in Action: The Establishment of Government Health Care on Prince Edward Island, 1900-1931" in Acadiensis Vol. XIX, No. 2 (Spring 1990), p. 131.

Endnotes

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11. JLA 1873 18 March, 9 April, 21 April, 30 April.

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13. MMN March 1889, p. 66. See also p. 70.

14. The reasons for this refusal must have been complex and may have included such considerations as interfering with their livelihood, illness, misunderstanding, or simple refusal stemming from a lack of a perceived need. No evidence could was uncovered to substantiate or repudiate any of these reasons.

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21 Sessional Papers (No. 27) 1912, p. 68. Smallpox was also noted in Antigonish County (p.p. 67-68) and Cumberland County, where the two cases were described as "very Severe" (p. 71). A milder form occured in Halifax County (p. 73).

22. Sessional Papers (No. 5) 1883, p. 30.

23. Sessional Papers (No. 4) 1884, p. 40.

24. JLA 1892, Appendix No. 25, p. 5. For information on the diptheria outbreak in Halifax see JLA 1890, Appendix No. 15, p.p. 2-3.

25. MMN February 1893, p. 19.

26. For an example among the Micmac, see Sessional Papers (No. 27) 1915, p. 34.

27. Sessional Papers (No. 18) 1891, p. 29.

28. Sessional Papers (No. 14) 1892, p.p. 39, 43; Sessional Papers (No. 14) 1898, p. 61; Sessional Papers (No. 14) 1899, p.p. 59, 61, 63; Sessional Papers (No. 14) 1900, p.p. 66, 68, 71.

29. Sessional Papers (No. 27) 1920, p. 46.

30. 4th Estate 22 September 1976, p.p. 4-5. Some four percent of American native people died from Spanish flu.

31. Sessional Papers (No. 14) 1892, p. 39.

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The 'Cultural Gap of Centuries': Micmac Health 1942-1968

A century of medical reform came to fruition during the period 1942 to 1968, a period which, for the Micmac, was dominated by the related themes of centralization and welfare dependency. The power of physicians was consolidated and the hospital emerged as a bureaucratically managed, specialized institution. Medical technology and the widespread use of new drugs, such as penicillin, enhanced public confidence in physicians and ensured their preeminence. Doctors moreover, fought the state throughout the period over the issue of medical care insurance, succeeding in defending fee-for-service payment, so that health insurance in Canada became a system of social welfare, as opposed to one of socialized medicine. The state, in capitulating to the physician lobby, served to reinforce the latter's professional legitimacy and status. Disease continued to be defined through biological, rather than social terms. By defining illness through bacterial infection, the social conditions which breed prevalent disease are reduced to secondary considerations, thereby deflecting criticism away from the inherent inequalities of the prevailing social structure.

The immediate post-war period also saw the federal bureaucratic empire assume its modern shape. Indians have always enjoyed, or endured, depending on your perspective, a statutory relationship with the federal government. This manifested itself first in the Indian Act of 1876 and the creation of the Department of Indian Affairs.

The Department was created in 1880, after being a branch within the Secretary of State (1868-1873) and the Department of the Interior (1874-1879). It was again relegated to branch status in 1934, this time under the Department of Mines and Resources, passing to Citizenship and Immigration in 1950. Finally, on 1 April, 1966, Indian Affairs was reestablished as an independent department and the bureaucratic framework of the present day emerged in its entirety. So too did the Indian health service, which was administered by Indian Affairs until 1945, when the Department of National Health and Welfare assumed responsibility for it. The Atlantic Zone, or Region as it was later called, of Medical Services was also created in 1960, though it underwent refinement throughout the 1960s. Finally, the welfare state emerged, complete with Old Age Security, Old Age Assistance, Family and Mothers' Allowances and welfare. Cumulatively, these programs provided an elaborate income support program, and Nova Scotia Micmac were eligible for all of these at one time or another. In fact, the dramatic growth of these support programs provided at least part of the impetus to centralize Nova Scotia's reserve population.

I - Centralization

The depressions of the 1920s and 1930s saw the Micmac lose their marginal foothold in the industrial economy, and there was an accompanying rise in welfare payments and related expenses. For the first time, the federal government was prepared to alleviate the worst suffering, and the desperate situation of the Micmac led to an increased

frequency of welfare payments on a large scale, and a heightened government involvement in Micmac affairs. But supplying the Micmac with relief became a strain on federal government resources and it became increasingly concerned about these costs. It was these concerns that prompted the Indian Affairs Branch of the Department of Mines and Resources to commission a report in 1941 into the administration of the Nova Scotia reserves. The report, by W.S. Arneil, resulted in the federal government's decision to centralize Nova Scotia's forty reserves.[1]

Arneil's report argued that by consolidating the scattered Micmac reserves at Eskasoni and Shubenacadie, on Cape Breton Island and the mainland respectively, the increasing costs of administration could be slowed. This would be achieved through creating economies of scale. Centralization would allow the reserves to employ full-time medical professionals and allow the development of hospitals and health programs. Furthermore, a consolidated native population would allow cooperative buying, and therefore save the federal government money in the form of income support. Finally, money would be saved through rationalizing the administrative bureaucracy. At Confederation, the federal government adopted the expansive Nova Scotian administration of reserve communities, complete with nineteen Indian agents and agencies.[2] Centralization would provide the opportunity to close the agencies of Yarmouth, Digby, Shelburne, Lunenburg, Annapolis, Kings, Queens, Hants County (Windsor), Halifax, Cumberland, Colchester, Pictou, Antigonish-Guysborough, Richmond, Inverness,

Victoria and Cape Breton (Sydney). The entire Micmac population was to be administered through the agencies at Shubenacadie and Eskasoni. This came to pass at the beginning of the 1943 fiscal year,[3] and survives as one enduring legacy of centralization. The report also argued that a centralized population would foster the development of local industry, thereby providing more employment opportunities.

The language of the report is of interest, as the following illustrates:[4]

> with supervision and spiritual care, a vast reduction in the number of illegitimate cases resulting from the cohabitation of very young girls with coloured laborers and transient whites...One is forced to the conclusion that the processes of the Nova Scotian Indian at this stage in his development is likely to be determined by his willingness to accept the spiritual guidance extended to him by his church

There are two important elements in this passage. First, it illustrates the paternalistic and moralistic elements contained not only within the Report, but the bureaucracy as well. Arneil thought that proper moral and spiritual guidance would alleviate many of the problems which, in his view, were the result of improper behaviour. Secondly, the passages add another dimension to the centralization policy. It is not enough to consider the policy as merely an economic decision, for there appears to have been a genuine concern among bureaucrats for the welfare of the Micmac. Centralization, then, was a decision based on economic rationalization and a more general concern with reform. This is not to suggest that this reform was in the best interests of those it was directed at, for the reform impulse was constantly

shaped through the relations of power, a theme explored throughout this chapter.

One contemporary newspaper viewed the centralization scheme as a "reward", for the Micmac "fought valiantly in the Great War" and for those who were "fighting in the ranks at this time."[5] But such a policy had been recommended in 1925 and again in 1935, the latter coming from the Director of Medical Services.[6] Nevertheless, Lisa Patterson has argued that the war facilitated the implementation of the policy. The relocation scheme was authorized by a federal Order in Council (P.C. 33/2570) on 2 April, 1942, which was retroactive to March 1, 1942. It authorized the centralization of Nova Scotia's reserves, in addition to the relocation of Prince Edward Island's 275 Micmac residents, located on five reserves, to Lennox Island.[7] The Nova Scotian program was no small task, for the Micmac numbered some 2165 and were scattered among seventeen counties. Those located on the mainland, south of Pictou County, were to be relocated to Shubenacadie's MicMac Reserve, whereas the Micmac residents of the other counties were to be moved to Eskasoni, except the residents of Pictou County, who were to have their choice.

Centralization immediately experienced difficulties in its implementation, the first of which was trying to accommodate those who were scheduled to move. Housing was not completed at an appropriate rate because of poor roads, labour shortages, poor equipment and ill weather. By the early months of 1944, only ten houses were completed at each reserve.[8] A second difficulty concerned the unwillingness of the

people to move. Patterson has collected many oral accounts of this reluctance, as well as some of the coercive threats used to induce people to move, including threats if the elimination of services at other reserves. An interesting case of this reluctance occured at Millbrook, near Truro. The Micmac inhabitants there, only a few miles away from Shubenacadie, were unwilling to move because many thought the employment prospects were better in the Truro area. By 1946, only a dozen families had relocated to Shubenacadie, while thirty-two remained at Millbrook.[9] In another example, a white resident of the town of Pictou, A.W. Harris, appealed to the federal government in 1942 to abandon the policy, for it would disrupt the employment many residents had secured at the shipyards.[10]

Amidst divided native opinion and problems in construction, the scheme progressed only slowly. The population at Eskasoni, which was 257 when centralization began, had only been bolstered, by the addition of forty-one families, to 435 by May 1947.[11] Yet, faith in the program continued. The Sydney Post-Record stated that the program, "the first social experiment of its kind in Canada", was concerned with the "transformation of the Indian village of Eskasoni, C.B., into a model community".[12] The Halifax Herald echoed these reports, viewing the goal of centralization as improving "the situation of Indians especially with regard to spiritual advice, education, health, housing and employment".[13] The Indian Affairs Branch, in its unwavering enthusiasm for the program, declared in 1947 that, within five years, the Micmac would "be enjoying a raised standard of living, their tuber-

culosis death-rate decreased, and they will be on their way to self-dependence."[14]

II - The Indian Health Bureaucracy

Reserve life had always been characterized by a degree of dependence on Indian administration. In fact, in 1800 there was the suggestion of withholding "publick assistance" from those who could not be induced to settle on a reserve.[15] Thus, government and reserves have had a long connection with one another. A century later, in 1901, this connection was largely reiterated in the House of Commons, when it was declared that "if the government exercised pressure to keep them <Micmac> on the reserve the government would thereby incur a moral responsibility to provide for their support", because it was recognized that the Micmac continued to gain their livelihood through a kind of occupational pluralism, a portion of which depended upon mobility.[16] Another comment deals specifically with accessibility to doctors, noting there was a "constant struggle to keep down the cost of medical attendance in the maritime provinces, because the Indians themselves desire a doctor very often when there is nothing the matter with them, and if we gave them the least encouragement, the medical bill would run up a high figure."[17] The solution seemed obvious - hire doctors who were removed from their patient population, thereby rendering them inaccessible to those with minor afflictions.[18]

Arguments in favour of making medical care less accessible were largely silenced through the expansion of the Indian health bureau-

cracy during the 1940s. The Indian health service underwent an expansion under the Department of Mines and Resources, which continued after its transfer to the Department of National Health and Welfare in 1945. It was also in that year, upon the administrative change, that Indian and Inuit health services were merged, thereby facilitating the coordination of all native health services. An Atlantic Zone of the Medical Services Branch (MSB) of Health and Welfare, the governing bureaucracy of aboriginal health services, dealing primarily with the Maritimes, though Newfoundland and Labrador were included later, was created in 1960, and assumed its modern shape in the mid-1960s.

The expansion of health services was not facilitated through legislation, but rather out of "moral obligation". Nearly every report makes it a point to declare that there existed no legal precedent for the provision of health care to native peoples, and the 1956 Report is typical:[19]

> it must be emphasized that the Indian is not entitled by law to free medical care...nor has the State even assumed the responsibility of providing free medical attention to all, irrespective of their legal status or ability to pay. On the other hand, the government votes a certain amount of money to be spent each year for the provision of basic health and treatment services to the Indians and Eskimos. This is done on humanitarian grounds, for the isolation of many of these people is such that even the most primitive facilities would not otherwise be available.

In fact, the only treaty in which health matters are mentioned was concluded between the Wood and Plain Cree groups and the Crown on August 23 and 28, and on Sepember 9, 1876, in what was to become the

Province of Saskatchewan. This is the only time the government recognized anything beyond a moral obligation when it came to health care. This care was, furthermore, only to be provided in the recipient-patient met three criteria: (1) the person had to be an Indian as defined by the Indian Act; (2) they must be following the "Indian way of life", which by then, it is interesting to note, was defined by residence on a reservation, or living off reserve for less than one year, and; (3) the patient must be unable to pay for the required care him or herself.[20]

With respect to payment, it should be noted that the vast majority of physicians were employed by the department on a fee-for-service basis. As an example, in 1950, the Department of National Health and Welfare received bills "regularly" from 1250 physicians, 125 dentists and 600 hospitals. These were men and women who remained in private practice, as did the 64 physicians who were employed on a part-time basis by the Indian health service.[21] Thus, doctors did not allow themselves to be subordinated to the status of employees, but tenaciously held to their independence. This was entirely consistent with the professional ideology of the day, articulated by the Canadian Medical Association's executive committee which, at the annual meeting in 1941, rejected any medical insurance scheme in which practitioners would be "employed, directed and paid by the State on a salary basis."[22]

Attracting sufficient personnel to provide care to the Micmac and Indian populations was a difficult task. Initially in the period

under consideration, the bureaucracy had to contend with the war, in which many physicians had enlisted. The resultant shortage of medical personnel necessitated scaling down the activities of the Indian health service and making alternative arrangements.[23] Moreover, personnel shortages continued after the war, though physicians in private practice assumed many of the cases.[24] Centralization, among other promises, was to enhance the quality of care the Micmac received. Besides infrastructural changes, discussed below, larger reserves were to facilitate the full-time attendance of health care workers. By 1947 at Eskasoni, one registered nurse was employed as was a nursing aide. A resident physician was to be secured when the reserve population reached one thousand persons,[25] but as already demonstrated, the population was only 435. The plan, if enacted, would have compared favourably with the national doctor-population ratio, which was 1:968 in 1948.[26] When one considers the location of the reserves, the 1:1000 ratio is even more impressive, given the traditional urban bias of physicians' practices. Evidence bears this out, for in 1961, Halifax had just a quarter of the provincial population, but contained 47.9 percent of practicing physicians.[27]

The problem of adequate physician care was exacerbated by the continued migration of the Micmac to the United States, in pursuit of seasonal work. The first reference to this problem in the departmental reports came in 1960, which coincided with the creation of Medical Services Branch (MSB) Atlantic Zone, and this probably accounts for its mention. The problem was twofold. First, there was the more

obvious concern for the health of the returning workers, who were largely employed picking potatoes and blueberries. Farm workers were subjected to poor living conditions and, as a result, were susceptible to a variety of infections and parasitic infestations.[28] The second concern was that some Micmac established residence in the United States, and therefore did not meet the residence requirements on which the provision of care depended. Often, this fact was not disclosed until after care had been received, hence doctors could not recover fees for services they may have provided. This was not a particularly common problem in Nova Scotia as it was largely localized to the areas adjacent to the United States border, particularly in New Brunswick. Yet, an example from this area will serve to illustrate the fragility of the relationships on which MSB depended.

In 1967, the problem of residence and payment for services rendered came to a head, largely centered on the Maliseet reserve at Tobique, New Brunswick, just 18 miles from the Maine border. Many of the residents of the reserve resided in the United States for extended periods of time and were therefore ineligible to receive treatment. Exacerbating this problem was the fact that the schedule of fees payed by MSB was considerably less than those outlined by the New Brunswick Medical Society.[29] These two factors combined to bring about a withdrawal of physician services in the area that lasted over a year.[30] The difficulty surrounding fee schedules also caused friction with the New Brunswick Dental Society and the medical societies of Nova Scotia and Prince Edward Island.[31] There were more general com-

plaints about the speed with which physicans received their remuneration, in addition to the level of their payment.[32] Unable to secure salaried physicians in the face of the powerful medical lobby and the failure of contract revisions left MSB in an unenviable position, and the issue was not to be fully resolved until the department adopted medical society fee schedules.

Yet, if it was difficult to secure physicians, so too was it difficult to procure adequate nursing staff, and this was perhaps more critical. The field nurse was usually the first health care worker a Micmac contacted in the event of illness or injury, or more general inquiries. The problem of pay scales, which were well below those of non-federal positions, continued to cause recruitment problems. Field nurses arranged physician treatment or offered treatment themselves. As one report noted, the nurse became "the key person in control of general diseases as well as the communicable diseases and our native population has become very dependent on the nurses' services especially in areas remote from a doctors office."[33]

Given the significant role of the field nurse, it follows that the nursing station became the most apparent manifestation of MSB. In fact, the department offered a variety of treatment facilities to Canada's native peoples. The largest of these units was the departmental hospital. In 1950, some 6500 native persons were treated in these institutions,[34] but no such hospital was located in Atlantic Canada, despite a 1936 recommendation to establish such a unit. In fact, Lisa Patterson points to the failure to act upon this suggestion,

and the subsequent public outcry about the state of Indian health, as providing part of the impetus to centralize Nova Scotia's reserves.[35] The next institution was the health centre, which was an office, usually situated in a house, and staffed by a nurse. The nurse provided what care she (for they were predominantly women) could, but was primarily concerned with public health, health education and vaccinating the population. If beds were added to this basic structure, it was termed a nursing station. Here, the nurse was usually assisted by a practical assistant, and together they treated minor accidents, childhood illnesses and maternity cases. Finally, the last departmental unit was the clinic, which was staffed by one or two doctors, aided by one or two nurses.[36] Throughout the 1950s, MSB operated, at one time or another, one clinic, one nursing station and one health centre, or two health centres and a clinic in Nova Scotia. The health centre at Eskasoni was upgraded to a nursing station in 1959.[37]

What kind of illnesses were being treated and what activities were being carried out at these facilities? These can be grouped into several broad categories, including communicable diseases, immunization programs, tuberculosis control, maternal health and specialty services. For the purpose of clarity each of these will be considered independently.

III - Communicable Disease

> Reduced to its simplest terms the question which the Service is trying to answer is how to overcome

> the difficulties inherent in arranging a modern health service for 2,000 small groups, often isolated...The problem is further complicated by the comparatively high incidence of illness found amongst the native peoples. Most striking at first glance is the prevalence of those communicable diseases which always follow in the train of poor sanitation and inadequate housing.

This comment reveals what is described as "the cultural gap of centuries"[38] with respect to native living conditions and native health. Eskasoni was a typical reserve, with its residents living in "squalor and disease",[39] before centralization. Improved housing was one of the central goals of the policy. Agency buildings, such as schools, houses for non-native bureaucrats and other such buildings were all completed by 1948 and had water systems and electricity.[40] However, if one looks to the Membertou Reserve at Sydney a different picture emerges. Membertou, of course, was not included under centralization, but it was without adequate water and sewer a decade later, which commanded only the passing comment that "most of the home owners have already made arrangements <in 1959> to install plumbing in their homes."[41]

Centralization failed to correct this basic lack of sanitation and perhaps hindered development through concentrating funds at Eskasoni and Shubenacadie. But another difficulty stemming from the legacy of centralization was welfare dependency. The war had provided somewhat of a boom, as many Micmac found opportunities as wage labourers. Moreover, construction of homes, associated with centralization, at Eskasoni and Shubenacadie provided many opportunities, as did work at the sawmill which provided the lumber. Yet, these were temporary

measures which had largely disappeared by 1948, when "steady employment was at a low ebb."[42] By 1950, employment opportunities were especially poor at Shubenacadie and Eskasoni, whereas better, though sporadic, opportunities existed at places such as Millbrook and Membertou.[43]

Poor housing and poverty breed a high prevalence of communicable disease. A three year period in the mid-1960s reveals the picture of this incidence in Nova Scotia (See Table 4.1). Rubeola, or measles, was particularly prevalent among Micmac reserves in 1966.[44] Notable gains were made during 1967 against this affliction, but there was an outbreak of mumps, or endemic parotitis, on the mainland. Infectious hepatitis and whooping cough (pertussis) remained at a low incidence. Shigellosis, a bacterial infection resulting in dysentery, made a fairly significant impact upon the population of Eskasoni during 1966, and may be suggestive of the poor sanitary conditions on the reserve, for it remains prevalent today in areas of endemic poverty and poor sanitation.[45] This brief examination of the incidence of communicable disease leads one to ponder an apparent contradiction. Common infectious diseases are apparently in decline, yet the appearance of shiggellosis suggests that a more critical look is needed. This apparent discrepancy is likely the result of two things: first, the success of an extensive immunization campaign, aimed largely at children and, second, the failure of Indian Affairs to address the community or social causes of disease. The presence of the shigella bacteria was likely due to the poor sewage facilities and the poor water supply. The fact that

it was apparently restricted to the one reserve lends further credence to this suggestion. With adequate sewer and water supplies this disease is extremely uncommon and is therefore a preventable disease, not through vaccination but through infrastructural expenditures, a more costly approach to health care.

Table 4.1 - Reported Cases of Communicable Diseases (1965-1967)

	Shubenacadie Agency			Eskasoni Agency		
	1965	1966	1967	1965	1966	1967
Rubeola	-	134	-	31	128	9
Rubella	7	59	-	-	-	-
Varicella	4	41	31	10	20	54
Pertussis	3	-	-	-	-	-
Hepatitis	-	1	-	-	3	-
Epidemic Parotitis	-	3	18	-	3	2

Source: Health and Welfare Canada. Indian and Northern Health Medical Services Atlantic Region Annual Review, 1965-1967.

IV - Immunization

A more common, and less expensive, response to the threat of disease was a large-scale immunization program. The most common vaccines given to children throughout the 1940s were those that offered protection against whooping cough, smallpox, diptheria and typhoid, though other vaccines were used in the face of widespread outbreaks of other, less common diseases.[46] The Salk vaccine against polio was introduced to native populations for the first time in

Table 4.2 - Immunizations
(1965-1968)

	Shubenacadie Agency				Eskasoni Agency			
Vaccine	1965	1966	1967	1968	1965	1966	1967	1968
Diptheria-Tetanus-Polio	60	28	-	-	382	45	-	-
Diptheria-Tetanus-Pertussis	-	2	144	56	-	-	33	187
Smallpox	46	140	165	42	442	69	57	329
Polio (Sabin)	44	-	-	-	-	10	26	-
Polio (Salk)	-	1	-	-	-	-	-	-
Measles	-	-	-	-	-	-	-	123
Quadruple	141	152	296	192	227	236	263	125

Source: Health and Welfare Canada. Indian and Northern Health Medical Services Atlantic Region Annual Review, 1965-1968.

1955, and was administered by the provincial authorities. The most frequent vaccines utilized in the period were the triple diptheria, whooping cough and tetanus antigen.[47] By 1966 among the vaccines administered were the diptheria-tetanus-polio, the diptheria-tetanus-pertussis, smallpox, Sabin and Salk polio vaccines and the quadruple, which was the most frequently given vaccine and protected the recipient against diptheria, pertussis, tetanus and polio. In 1968, provincial authorities in Nova Scotia made the measle vaccine available, and in that year 123 shots were given to provincial Micmac, all of whom were located within the Eskasoni Agency - Eskasoni, Whycocomagh. Membertou, Middle River and Chapel Island. The figures for vaccination are provided in Table 4.2. Many of these vaccines were administered under the auspices of the Nova Scotia Department of Health, prompting the

suggestion by Dr. L.D. Hirtle that the tuberculosis program, and others, be entirely transferred to the province, perhaps foreshadowing the climate that would give rise to the Statement of the Government of Canada on Indian Policy, commonly known as the White Paper, that was announced in 1969. Nevertheless, provincial authorities played a significant role in the vaccination program, as they also did, as Hirtle's comments suggest, in the control of tuberculosis among the Micmac population.

V - Tuberculosis

So dreaded was tuberculosis that, in 1938, the Canadian Tuberculosis Association warned that "Indians are a menace to the White people in their respective provinces, and Indian reserves are a source of infection from which adjacent White settlements have been contaminated."[49] Tuberculosis mortality is presented in Table 4.3. Tuberculosis, even when one recognizes that statistical variations are wide when dealing with a small population, was a major threat to aboriginal people. It was this fact that precipitated the introduction of a large-scale B.C.G. vaccination program, as well as a comprehensive survey utilizing x-rays and follow-ups. The bacille Calmette Guerin (B.C.G.) vaccine was first utilized in the mid-1940s at the Quebec reserves of Mistassini, Obedjiwan, Manowan, Weymontaching and Waswanipi in the Abitibi region. These were the first large populations to receive B.C.G. in any significant number.[50] The B.C.G. does provide some protection against T.B. but cannot, by itself, control the disease.

Table 4.3 - Tuberculosis

A. Comparative Death Rates (per 100,000 pop.)

	Indians	Non-Indians
1946	579.1	41.9
1947	549.1	41.9
1948	488.5	32.5
1949	399.6	26.7
1950	298.8	22.0
1951	262.2	20.7
1952	167.5	14.7
1953	100.0	11.4
1954	60.2	9.8

B. Incidence of T.B. (Nova Scotia)

	New Cases				Reactivations				Deaths			
Reserve	1965	1966	1967	1968	1965	1966	1967	1968	1965	1966	1967	1968
Shubenacadie	1	1	-	-	-	-	-	-	-	-	-	-
Pictou Landing	-	-	-	-	-	-	-	-	-	-	-	-
Afton	-	3	-	-	-	-	-	-	-	-	-	-
Millbrook	-	-	-	-	-	1	-	-	-	-	-	-
Bear River	-	-	-	-	-	-	-	-	-	-	-	-
Eskasoni	-	1	-	2	-	3	2	2	-	1*	-	-
Membertou	-	2	-	-	-	-	-	-	-	-	-	-
Middle River	2	2	-	5	2	4	-	-	-	-	-	-
Whycocomagh	2	2	1	-	2	4	1	-	-	-	-	-
Chapel Island	-	-	-	-	-	2	-	-	-	-	-	-
TOTALS	5	11	1	7	4	14	3	3	-	1*	-	-

*attributed to T.B. related complications

Source: Health and Welfare Canada. Indian and Northern Medical Services Atlantic Region Annual Review, 1965-1968 and Department of National Health and Welfare Annual Report 1956.

Nevertheless, the vaccination program was warmly received by MSB and was soon expanded into Saskatchewan and, in 1949, throughout the country. By 1956, efforts were being made to immunize every newborn Indian child.[51] However, tuberculosis remained a significant problem throughout the 1950s, accounting for 57% of Indian patient days in 1956.[52]

Reliable statistics for Nova Scotia begin only in 1965, and these data are presented in Table 4.3, part B. It may be of interest to note that of the seven new cases found in 1968, five were under the age of twenty, four of these under the age of ten, perhaps indicating the imperfection of the prevention program. Such a suggestion, however, is only tentative, because of the imperfect protection provided by B.C.G. vaccination. Nevertheless, much of the credit for the effort against tuberculosis must go to the provincial health department, which carried out the program among the more isolated mainland populations as well as the entire Micmac population of Cape Breton Island. Tuberculosis continued to be a concern until the mid-1970s, but now appears to be nearly eradicated, with only one case, occuring in a person aged 65 to 74, reported in the Atlantic Region in 1988.[53]

VI - Maternal Health

Like tuberculosis, maternal health became a focus of attention in the post-war era but endures as a major concern to the present day. A common theme in the reports of the 1940s and 1950s was the rapid

expansion of the native population at a rate appreciably higher than that of the general population. This rate varied between 25 to 50 births per thousand, yielding a net population increase of about 1.5 percent per thousand in 1949, even when one takes into account both the high death rates and enfranchisements.[54] The maternal health program in Nova Scotia was characterized by an extensive program of pre-natal and post-partum visits, in addition to the operation of well-baby clinics, in which nurses taught new mothers 'essentials' with respect to infant care, including nutrition, carried out immunization programs and provided infants with medical check-ups. These clinics are an illustration of the intrusion of child-care workers into the realm of motherhood, as well as the unquestioning faith in professionals. As the mother's role came to be scrutinized and shaped by health care workers, doctors and nurses extended the mandate of professionals into the earliest years of life. At the same time, their professionalism was contrasted with the 'amateurish' mother. This was not a feature unique to Micmac women, for all mothers had to contend with challenges from professionals, be they doctors, nurses, social workers or teachers, in the socialization of their children. Nor was it a feature unique to health care, but clearly belongs to the broader framework of the intrusion of institutions into private life, which served to undermine women's prestige and authority.

VII - Specialty Services

Health education was the aim of much of the maternal health program, but a more generalized departmental focus on raising health consciousness was also a characteristic of the post-war period. This largely consisted of instructive lectures, pamphlets, posters, films and booklets. The latter seemed to enjoy a particular popularity and included "Good Health for Canada's Indians" and a publication entitled "The Book of Wisdom" for Inuit, both of which had several printings.

Health education was but one of the specialty services available to people of native status. Another was, of course, dental care, which in Nova Scotia largely meant restorative dentistry and introducing preventive dental care to children.[56] Mental illness appears to have been relatively uncommon, or it went undiagnosed by the various health care workers.[57] The federal government initiated a public health sanitarian service in areas in which it was responsible for health in 1966. The program was conducted on Indian reserves, where it consisted largely of more courses, this time regarding general sanitation and hygienic living.[58] Perhaps more ominous were the increasingly frequent references to the use of alcohol. The 1951 Indian Act permitted natives to drink in public places pursuant with provincial regulations, and was again amended in 1956 to allow natives to consume alcohol on reserves. In 1960, the increased use of alcohol, the "more than modest use" was noted and was considered a "problem which could stand more attention."[59] By 1965, reference was being made to "alcoholism"

and by 1967, the use of alcohol among teenagers was becoming a major concern.[60] This increased and problematic use of alcohol, or at least the increasing frequency with which reference is made to alcohol consumption, seems to point to the deteriorating condition of reserve life, though the absence of such commentary earlier may stem from the illegality surrounding alcohol use.

VIII - Mortality

Brief consideration should be given to the most obvious manifestation of ill health, namely mortality. During the 1950s, the leading causes of mortality among Canadian Indians, in no particular order, were acute respiratory infections, tuberculosis, accidents, neoplasms and chronic heart disease. More general causes included diseases of infancy, vascular lesions of the central nervous system and, when taken together, gastroenteritis, colitis and dysentery.[61] There was some variation on this general pattern in the Atlantic Region, and the leading causes here are presented in Table 4.4. What immediately becomes apparent is the prevalence of diseases of the circulatory system, including heart disease, diseases of the arteries and hypertension and the dramatic mortality attributed to accidents, violence and poisoning. Within this category are such tragedies as car accidents, drowning, exposure, accidental burns, falls and overdoses. Even more tragic was the fact that, in 1967, five of the sixteen victims were under the age of five, and half were under ten years old.[62] Diseases of the circulatory system are largely attributable to poor diet, obesity, smoking and alcohol consumption and are, therefore, largely

Table 4.4 - Leading Causes of Mortality
Among Nova Scotia Micmac 1965-1968

Cause	1965		1966		1967		1968	
	M	F	M	F	M	F	M	F
Infective and Parasitic Diseases	-	-	-	-	2	-	-	-
Neoplasms	4	1	-	3	3	2	1	2
Diseases of the Nervous System and Sense Organs	1	-	4	2	3	2	-	-
Diseases of the Circulatory System	6	2	10	8	8	4	12	6
Diseases of the Respiratory System	4	4	1	1	2	1	1	2
Diseases of the Digestive System	-	-	3	-	1	1	-	1
Congenital Malformation	1	-	1	1	1	1	1	-
Diseases of Infancy	1	-	2	1	2	2	1	-
Ill-defined and Senility	2	-	3	4	3	1	-	-
Accidents, Poisoning and Violence	2	-	5	2	10	6	8	4

Source: Health and Welfare Canada. Indian and Northern Health Medical Services Atlantic Region Annual Reviews, 1965-1968.

the result of lifestyle. Accidental death, while never preventable, may be reduced through a range of measures, especially if they were alcohol related.

IX - Provincial Context

Many of the health problems which afflicted the Micmac population were not restricted to them and consideration should be given to the provincial population. The general problem of promoting and maintaining

health in a rural setting cannot be fully explored here, but some data is presented to establish a broader context and facilitate some comparison with the Micmac. Communicable disease, tuberculosis and well-baby clinics were a feature of not only reserve life, but life in many communities throughout Nova Scotia.

Communicable diseases (See Table 4.5 Parts A-H), particularly the diseases of childhood, namely chickenpox, mumps and measles, occur sporadically and dramatically in all of the Department of Public Health divisions (See Table 4.5, Prefatory Note and Parts A, B and C). No county seems to have been spared, though Halifax County, including Dartmouth, generally had lower reported incidences. Thus, in 1951 epidemic parotitis (mumps) was widespread across the province, but in Halifax County there were relatively fewer reported cases. The counties of Colchester and Cumberland also reported low incidences, however. It would appear, then, that the incidence was not related to the urban or rural nature of a given county, but to more fortuitous considerations. That same year, 1951, also saw a notable outbreak of measles, particularly on Cape Breton Island and in the Fundy Health Division.

Yet, these diseases did not enjoy either the attention or the dread that accompanied polio. According to the Department of Public Health Report for 1942 (See Table 4.5 D), only ten cases of all types of polio were reported that year. Unlike statistics for other diseases, this is probably an accurate reflection of the actual incidence, given

the serious nature of the disease. Polio reached its peak during the 1952-53 fiscal year, with 191 cases reported throughout the province. By 1957, the reported incidence had dropped to seventeen cases, largely due to the introduction of the Salk vaccine. While no data could be obtained on where the incidences occured or whether or not the person afflicted had been immunized, the case of the Northumberland Division in 1956 may provide some clues. Five of the eight cases of polio reported occured in a rural, unnamed part of Antigonish County, where there was no immunization program in operation. This is perhaps significant for two reasons. First, it lends credence to the value of the Salk vaccine. Second, and more important, it may suggest something about the difficulty of providing adequate preventative care in rural settings. Such a suggestion should only be regarded as tentative and difficult to validate or dismiss given the lack of data for units smaller than the departmental divisions. What is clear, however, is that the Department of Health, as in the case of Indian health services, initiated and maintained a widespread immunization program against communicable disease, utilizing both primary and reinforcing vaccines. These programs, it should be noted, were not without effect, as the cases of polio and diptheria (See Table 4.5, Part E) clearly illustrate. By the 1950s, diptheria was a rare occurrence and by 1957, no cases were reported.

By the 1960s, the Department of Public Health compiled tables on some areas of concern for communicable diseases (See Table 4.6). It is interesting to note that of those afflictions deserving of comment in

these reports, only hepatitis and whooping cough appear in the MSB reports (See Table 4.1). While the late 1960s brought no large epidemics of communicable disease, such as measles or German measles, among the general population, both of the Indian health agencies had to contend with them in 1966. Thus, while the thrust of the two health bureaucracies, within the larger context of communicable diseases, was different in that the diseases focused upon were different, the means were the same - widespread vaccination programs aimed largely at school-aged children.

Consideration should also be given to mortality among the Nova Scotia population. Tuberculosis death rates are presented in Table 4.7, death rates for selected communicable diseases in Table 4.8 and selected causes of mortality in Table 4.9. These have been presented to demonstrate trends over the period and to facilitate comparison with the Micmac population, the data for which has been presented in Tables 4.3 and 4.4.

Tuberculosis was characterized by a dramatic decline through the period 1942-1949, and fell to only 4.5 deaths per 100,000 population by 1960. It may be of interest to note which counties had the highest and lowest death rates through the period. No clear trends emerged, but it was found that when the three highest rates for each year were identified, the same counties were represented. Over the eight years examined in succession (1942-1949), Antigonish ranked among the three highest five times (1942, 1943, 1947-1949), Cape Breton twice (1945, 1948),

Digby once (1946), Guysborough twice (1944, 1945), Halifax twice (1942, 1943), Kings twice (1942, 1943), Richmond three times (1945, 1946, 1949), Shelburne three times (1944, 1946, 1947) and Yarmouth on four occasions (1944, 1947-1949). Thus, nine of the counties accounted for the highest rates, and these represented all geographical areas of the province. A similar pattern was found with the three lowest rates each year, and it is interesting to note that only Digby and Shelburne had rates among the highest three and the lowest three. Only Inverness and Pictou counties were not among the highest or lowest in any year. A final point of interest may be that the average Nova Scotia rate throughout the 1940s was consistently and significantly higher than the Canadain average, presented in Table 4.3.

With respect to mortality, it should be recalled that the leading causes among reserve Micmac were diseases of the circulatory system, and accidents, poisoning and violence (See Table 4.4). For the same period, the two leading causes of mortality in Nova Scotia were neoplasms and diseases of the circulatory system in each year, continuing a trend that began in 1944 (See Table 4.8). Though it would be desireable to analyze more disease-specific information, such as hypertension versus arteriosclerosis, the MSB reports use only the broadest classifications. Nevertheless, many of the leading causes of mortality were shared by natives and non-natives, though deaths attributable to accidents, poisoning and violence were much more prominent among the Micmac.

If the period under consideration witnessed the creation of the Indian health bureaucracy, so too did the Canadian and provincial health bureaucracies emerge. The Nova Scotia Department of Health underwent numerous reorganizations, eventually assuming its modern shape (See prefatory note to Table 4.5). Health considerations became compartmentalized and specialized with the creation of such divisions as Consultation Services, Laboratory Services and Mental Health Services. Also created was the medicare system, out of a combination of federal and provincial legislation. These developments were all reflected within the Indian health services provided by Medical Services Branch.

X - Conclusion

It is an irony that on 6 May, 1968, a large number of Micmac joined in protest on the Eskasoni Reserve demanding improved housing, sewer facilities and medical supplies. Sewage from the 187 houses flowed into open ditches, as only the government's administration buildings were connected to a sewer system. Moreover, the houses that were, in May 1968, under construction, were being built without plumbing.[63] An editorial comment on the protest foreshadowed a significant attempt to change Indian policy that would come in 1969, when the writer declared if "the Indian wishes equality with the white man he must be willing to accept the disadvantages of a white man".[64] Although the poor living conditions, and the protest they spawned, may lead one to believe that little had changed throughout the period,

there were significant and enduring changes.

First, Indian Affairs assumed its modern shape after passing through the Departments of Mines and Resources and Citizenship and Immigration, finally being reestablished as an independent department on 1 April, 1966. So too did the Indian health service, which became a Directorate under the Department of National Health and Welfare in 1945, and the Atlantic Zone was established to service the needs of native peoples in Atlantic Canada in 1960. Administrative changes occured as well, with the Indian Act of 1951, the creation of formal bands and band councils in Nova Scotia in 1958 and the granting of the franchise in 1960. It was a dynamic period for medicine as well, with the passage of the Hospital Insurance and Diagnostic Services Act (1957) and the Medical Care Insurance Act (1966), neither of which excluded native persons and which, together with provincial legislation, constitute Canada's medicare system.

Yet, the health care system that emerged did not take its cues from some amorphous humanitarian impulse. Medical reform was shaped by its participants and, by implication, the physicians who emerged preeminent succeeded in presenting their interests as the interests of all. One obvious manifestation of this was the refusal of doctors to become salaried employees of Medical Services, and their tenacious defence of the fee-for-service method of payment, through which they maintained a key feature of their professional ideology - their autonomy. Moreover, the focus of much of MSB's activity, immunization,

failed to address the social causes of disease rooted in the inequalities of poverty and unemployment and their manifestations, namely, poor living conditions and inadequate nutrition. Preventive vaccinations may serve to limit the incidence of disease, but they are also cheaper than major infrastructural changes, which often address the cause of disease, rather than its prevention, such as sewer and water systems, and thereby serve to deflect criticism away from inequalities and, concurrently, legitimize existing relations.

Finally, one must consider the role of the Micmac in shaping these changes. Throughout the period, one can state with relative confidence, the Micmac continued their use of traditional herbal remedies, discussed in previous chapters. This use, while not mentioned in government reports, had been documented by Wilson and Ruth Wallis during their fieldwork in the mid-1950s.[65] The retention of these traditional remedies allowed the Micmac a degree of independence from health care workers, and ultimately it was the Micmac who decided when 'professional' help was required. Moreover, their reluctance to relocate to Shubenacadie and Eskasoni must have played a role in the eventual abandonment of the centralization policy. The retention of their cultural values attests to the active role of the Micmac in shaping their own history. The institutions that emerged during this period shoud be viewed as arising out of a complex process of negotiation, a process which continued, perhaps even accelerated in the decades that followed.

Table 5.5 - Reported Incidences of Selected Communicable Diseases

Prefatory Note

The follwing notes appear on Appendices A - H:

a. Includes Dartmouth.
b. Beginning in 1948, Guysborough was in the Northumberland Division.
c. Counties of Pictou, Annapolis and Kings only.
d. Not including Digby County.
dd. Includes only the Counties of Annapolis, Kings and Hants.
e. Includes Digby County.
f. Digby, Yarmouth and Shelburne Counties.
g. Divided into two units at the end of the 1951 fiscal year.
h. Cobequid Division was created in 1948 and consisted of Cumberland and Colchester Counties.
i. Created in 1948, consisting of Lunenburg and Queens Counties.

1. The 1951 fiscal year was 16 months, from November 1949 to March 1951.
2. N/A indicates that the data was not mentioned in the Department of Public Health Annual Report, from which the data has been taken, or that it has been grouped in a larger category.

Appendix A

Reported Incidence of Chickenpox
Nova Scotia 1943-1957

	1943	1944	1945	1946	1947	1948	1949	1951[1]	1952-53	1954	1955	1956	1957
Atlantic Division (Halifax Co.)	11	0	0	11	7	4[a]	14	12	7	33	87	N/A[2]	36
Atlantic Division (Guysborough Co.)[b]	1	0	17	1	0								
Northumberland Division	46	17	0	12	23	16[c]	53	41	N/A	N/A	7	38	57
Fundy Health Division	112	163	140	127	120[d]	314[dd]	254	208	114	N/A	N/A	N/A	N/A
Western Health Division	67	20	N/A	30	73[e]	N/A[f]	31	126	N/A	N/A	N/A	124	38
Cape Breton Island[g]	N/A	N/A	N/A	N/A	N/A	890	N/A	674					
Cape Breton North									N/A	N/A	N/A	N/A	N/A
Cape Breton South									N/A	388	N/A	N/A	N/A
Cobequid Division[h]						21	25	24	N/A	N/A	N/A	N/A	N/A
Lunenburg-Queens Division[i]						N/A	5	26	N/A	N/A	N/A	N/A	N/A

Appendix B

Reported Incidence of Mumps
Nova Scotia 1943-1957

	1943	1944	1945	1946	1947	1948	1949	1951[1]	1952-53	1954	1955	1956	1957
Atlantic Division (Halifax Co.)	0	N/A	0	0	1	11[a]	0	38	0	4	9	N/A[2]	9
Atlantic Division (Guysborough Co.)[b]	33	0	0	0	0								
Northumberland Division	133	4	1	1	N/A	47[c]	40	112	N/A	N/A	36	42	3
Fundy Health Division	749	191	3	1	20[d]	50[dd]	259	450	N/A	290	55	N/A	N/A
Western Health Division	81	16	N/A	N/A	2[e]	103[f]	87	163	N/A	N/A	N/A	12	47
Cape Breton Island[g]	2600	41	N/A	N/A	N/A	316	N/A	558					
Cape Breton North									N/A	N/A	N/A	N/A	N/A
Cape Breton South									N/A	N/A	N/A	N/A	N/A
Cobequid Division[h]						0	208	3	N/A	N/A	N/A	N/A	N/A
Lunenburg-Queens Division[i]						N/A	1	65	N/A	N/A	N/A	N/A	N/A

Appendix C

Reported Incidence of Measles
Nova Scotia 1943-1957

	1943	1944	1945	1946	1947	1948	1949	1951[1]	1952-53	1954	1955	1956	1957
Atlantic Division (Halifax Co.)	0	0	11	17	2	1[a]	65	0	5	11	95	43	25
Atlantic Division (Guysborough Co.)[b]	6	0	0	45	0								
Northumberland Division	172	11	0	113	153	N/A[2c]	226	20	N/A	N/A	0	25	240
Fundy Health Division	234	98	9	444	648[d]	482[dd]	184	203	970	N/A	253	176	61
Western Health Division	237	16	N/A	25	331[e]	18[f]	220	24	N/A	N/A	N/A	54	50
Cape Breton Island[g]	1000	1000	N/A	N/A	N/A	N/A	N/A	382					
Cape Breton North									2000	N/A	N/A	N/A	N/A
Cape Breton South									626	806	N/A	N/A	N/A
Cobequid Division[h]						72	N/A	18	N/A	N/A	N/A	N/A	N/A
Lunenburg-Queens Division[i]						N/A	165	47	N/A	68	N/A	31	N/A

Appendix D

Reported Incidence of Polio (All Types)
Nova Scotia 1943-1957

	1943	1944	1945	1946	1947	1948	1949	1951[1]	1952-53	1954	1955	1956	1957
Atlantic Division (Halifax Co.)	N/A[2]	N/A	N/A	7	4	3[a]	9	1	10	N/A	15	53	4
Atlantic Division (Guysborough Co.)[b]	N/A	N/A	N/A	N/A	2								
Northumberland Division	1*	1	2	5	8	4[c]	7	2	13	N/A	28	8°	1
Fundy Health Division	0	4	7	19	9[d]	7[dd]	15	0	52	6	10	10	2
Western Health Division	3	4	4	3	5[e]	2[f]	7	0	40	2	0	0	2
Cape Breton Island[g]	6	6	N/A	N/A	10	2	6	5					
Cape Breton North									6	20	18	7	1
Cape Breton South									5	4	3	2	6
Cobequid Division[h]						1	2	2	51	N/A	N/A	16	1
Lunenburg-Queens Division[i]						4	7	1	14	1	1	5	0

* A Micmac

° Five of these cases occured in a rural area of Antigonish County where there was no immunization program.

Appendix E

Reported Incidence of Diptheria
Nova Scotia 1943-1957

	1943	1944	1945	1946	1947	1948	1949	1951[1]	1952-53	1954	1955	1956	1957
Atlantic Division (Halifax Co.)	123	39	9	18	4	0[a]	4	N/A[2]	0	3	0	0	0
Atlantic Division (Guysborough Co.)[b]	8	0	0	2	0								
Northumberland Division	106	21	26	15	16	1[c]	0	0	N/A	0	0	N/A	N/A
Fundy Health Division	65	115	46	24	9[d]	5[dd]	0	2	0	0	1	0	0
Western Health Division	16	11	2	18	2[e]	1[f]	1	0	0	0	0	0	0
Cape Breton Island[g]	26	69	110	68	18	13	6	3					
Cape Breton North									0	0	0	0	0
Cape Breton South									2	0	1	N/A	N/A
Cobequid Division[h]						N/A	0	0	0	0	0	0	0
Lunenburg-Queens Division[i]						0	1	6	0	0	N/A	N/A	0

Appendix F

Reported Incidence of Whooping Cough
Nova Scotia 1943-1957

	1943	1944	1945	1946	1947	1948	1949	1951[1]	1952-53	1954	1955	1956	1957
Atlantic Division (Halifax Co.)	N/A[2]	N/A	N/A	5	1	0[a]	1	48	1	N/A	3	N/A	2
Atlantic Division (Guysborough Co.)[b]	N/A	N/A	N/A	3	0								
Northumberland Division	34	39	13	7	0	1[c]	36	104	N/A	N/A	20	12	0
Fundy Health Division	49	233	164	53	107[d]	2[dd]	6	137	69	38	86	N/A	0
Western Health Division	114	8	87	170	0[e]	2[f]	16	113	N/A	N/A	N/A	15	46
Cape Breton Island[g]	200	627	N/A	N/A	N/A	571	533	20					
Cape Breton North									N/A	444	N/A	79	36
Cape Breton South									N/A	192	N/A	N/A	48
Cobequid Division[h]						20	0	4	N/A	N/A	N/A	N/A	N/A
Lunenburg-Queens Division[i]						0	0	30	N/A	148	N/A	12	0

Appendix G

Reported Incidence of German Measles
Nova Scotia 1943-1957

	1943	1944	1945	1946	1947	1948	1949	1951[1]	1952-53	1954	1955	1956	1957
Atlantic Division (Halifax Co.)	0	0	0	1	2	0[a]	4	43	3	2	11	N/A[2]	N/A
Atlantic Division (Guysborough Co.)[b]	0	0	0	4	0								
Northumberland Division	12	1	5	16	N/A	N/A[c]	2	10	N/A	N/A	0	150	9
Fundy Health Division	13	78	42	4	6[d]	2[dd]	N/A	92	N/A	N/A	N/A	N/A	N/A
Western Health Division	N/A	N/A	N/A	N/A	N/A[e]	N/A[f]	N/A	59	N/A	N/A	N/A	57	19
Cape Breton Island[g]	N/A	N/A	N/A	N/A	N/A	N/A	N/A	691					
Cape Breton North									N/A	N/A	N/A	N/A	N/A
Cape Breton South									N/A	N/A	N/A	N/A	N/A
Cobequid Division[h]						0	N/A	9	N/A	N/A	N/A	N/A	N/A
Lunenburg-Queens Division[i]						N/A	N/A	67	N/A	N/A	N/A	12	N/A

Appendix H

Reported Incidence of Scarlet Fever
Nova Scotia 1943-1957

	1943	1944	1945	1946	1947	1948	1949	1951[1]	1952-53	1954	1955	1956	1957
Atlantic Division (Halifax Co.)	24	9	4	11	4	6[a]	8	7	0	5	4	3	13
Atlantic Division (Guysborough Co.)[b]	22	0	0	0	0								
Northumberland Division	63	27	11	1	5	2[c]	6	15	N/A[2]	N/A	3	1	3
Fundy Health Division	64	121	93	63	36[d]	31[dd]	44	26	6	3	13	12	3
Western Health Division	51	66	22	30	10[e]	14[f]	51	21	8	2	N/A	1	14
Cape Breton Island[g]	126	148	63	237	N/A	43	22	19		"			
Cape Breton North									N/A	N/A	N/A	N/A	26
Cape Breton South									N/A	N/A	N/A	0	666
Cobequid Division[h]						2	33	0	N/A	N/A	8	N/A	N/A
Lunenburg-Queens Division[i]						11	8	1	4	0	5	N/A	5

Table 4.6

Reported Incidence of Selected
Communicable Diseases (Nova Scotia 1965-1968)

	1965	1966	1967	1968
Diptheria	0	0	0	0
Dysentery (Bacillary)	12	3	16	1
Infectious Hepatitis	384	288	397	229
Whooping Cough	80	38	506	59
Poliomyelitis	0	0	0	0
Scarlet Fever and Stepto-coccal Sore Throat	1339	1399	979	1097

Table 4.7

Tuberculosis Death Rates (All Types)
(per 100,000)

	1942	1943	1944	1945	1946	1947	1948	1949	1955	1960
Annapolis	33.9	39.6	56.5	39.6	22.6	16.9	28.3	28.3	4.3	0.0
Antigonish	161.2	284.5	56.9	75.9	85.3	113.7	85.3	56.9	15.9	14.3
Cape Breton	67.7	81.3	68.6	84.0	92.1	63.2	55.1	38.8	8.9	6.9
Colchester	23.2	29.9	56.4	39.8	26.5	26.5	36.5	10.0	6.2	5.4
Cumberland	65.9	60.8	53.2	55.7	60.7	40.5	27.9	7.6	10.1	2.5
Digby	51.4	25.7	71.9	56.5	102.7	56.4	35.9	41.1	5.0	5.1
Guysborough	38.8	38.8	116.4	84.1	71.1	58.2	32.3	45.3	14.5	14.9
Halifax	79.9	84.8	66.9	44.9	63.5	44.8	46.5	39.1	7.3	4.0
Hants	36.3	31.8	36.3	54.5	36.3	58.9	13.6	9.1	4.2	7.7
Inverness	58.3	87.5	58.3	63.2	72.9	58.3	48.6	34.2	5.7	5.5
Kings	197.1	210.9	41.5	55.3	31.1	38.0	34.6	20.7	0.0	2.4
Lunenburg	36.4	24.3	45.5	36.5	48.5	36.4	36.4	21.2	0.0	2.9
Pictou	49.0	39.2	53.4	58.9	66.0	63.7	39.2	34.3	13.2	0.0
Queens	33.3	16.6	8.3	33.3	66.5	49.8	41.6	24.9	15.7	0.0
Richmond	55.3	46.1	46.1	92.1	110.5	73.7	46.1	55.3	0.0	0.0
Shelburne	15.1	37.7	120.7	83.0	98.1	83.0	45.3	30.2	13.5	13.5
Victoria	12.5	37.4	37.4	50.0	24.9	62.2	0.0	0.0	0.0	0.0
Yarmouth	53.5	80.3	84.8	49.1	71.3	84.7	62.4	53.5	0.0	0.0
TOTAL	65.6	72.2	58.3	54.3	62.4	49.75	38.89	28.5	7.2	4.5

Table 4.8

Deaths from Selected
Communicable Diseases

	Whooping Cough	Diptheria	Scarlet Fever	Measles	Polio	T.B.
1942	39	63	10	3	17	379
1943	13	56	5	5	1	417
1944	26	26	1	1	1	357
1945	27	17	2	1	1	388
1946	8	12	3	9	2	382
1947	77	13	1	14	7	309
1948	4	1	0	4	4	247
1949	8	1	11	23	13	184
1950	20	1	0	5	1	176
1951	8	1	0	0	23	126
1952	1	1	0	9	7	94
1953	6	1	0	2	6	72
1954	7	1	1	7	7	75
1955	3	0	0	5	1	48
1956	1	0	0	7	1	44
1957	2	1	1	3	0	45
1958	4	0	0	9	0	36
1959	2	0	0	3	0	28
1960	3	0	0	0	1	33
1961	1	0	0	1	2	28
1962	2	0	0	6	0	28
1963	0	0	0	2	0	29
1964	0	0	0	4	0	29
1965	0	0	0	2	0	26
1966	0	0	0	3	0	20
1967	0	0	0	0	0	33
1968	1	0	0	5	0	27

Source: Dept. of Public Health. Maternal and Child Health Communicable Disease Division Annual Report, 1968.

Table 4.9

Selected Causes of Mortality
(Nova Scotia)

Table 4.9A

	1942	1943	1944	1945	1946	1947	1948	1949	1955	1960
Infective and Parasitic Diseases	715	726	633	505	578	453	561	170	80	65
Congenital Malformation	82	100	-	79	128	111	102	61	105	133
Accidents	255	290	380	303	401	368	422	182	380	413
Heart Disease	1081	1142	1319	1250	1360	1453	1611	1787	1722	1935
Maternal	40	54	-	24	28	20	19	7	13	4
Neoplasms	673	727	769	790	787	880	877	421	964	1035
Senility	106	-	-	182	172	149	134	33	48	31
Diseases of Respiratory System	479	484	485	402	405	366	380	178	344	289
Diseases of Digestive System	348	227	251	258	219	216	197	125	171	200
Diseases of Early Infancy	87	52	-	315	328	360	300	31	285	296

Source: Dept. of Public Health Annual Reports and Annual Reports of the Registrar General (Vital Statistics).

Table 4.9B

	1965	1966	1967	1968
Infective and Parasitic Diseases	50	43	57	52
Neoplasms	1152	1139	1198	1151
Diseases of Nervous System and Sense Organs	855	897	879	858
Diseases of Circulatory System	2339	2557	2656	2701
Diseases of Respiratory System	306	357	344	442
Diseases of Digestive System	203	195	204	187
Congenital Malformation	104	107	85	74
Diseases of Infancy	219	210	192	164
Senility	23	25	15	12
Accidents, Violence and Poisoning	500	568	600	534

Source: Dept. of Public Health Annual Reports.

Endnotes

1. See Lisa Patterson, "Centralization in Nova Scotia: An Adventure in Canadian Indian Policy". A paper presented at the annual meeting of the Canadian Historical Association, Learned Studies Conference, University of Manitoba, June 1986.

2. Lisa Patterson, Indian Affairs and the Nova Scotia Centralization Policy. Unpublished M.A. Thesis, Dalhousie University, 1985, p. 2.

3. Canada. Department of Mines and Resources Annual Report 1943, p. 159.

4. W.S. Arneil, Investigation Report on Indian Reserves and Indian Administration, Province of Nova Scotia. Ottawa: Department of Mines and Resources, 1941, p.p. 3, 9.

5. Eastern Chronicle (New Glasgow) April 9, 1942, p. 4.

6. Patterson, Indian Affairs and the Nova Scotia Centralization Policy, p.p. 27, 34.

7. Ibid., p. 56.

8. Ibid., p. 73.

9. Ibid., p. 82.

10. Eastern Chronicle March 17, 1942, p. 8.

11. Sydney Post-Record May 8, 1947, p. 10.

12. Ibid.

13. Halifax Herald October 8, 1947.

14. Sydney Post-Record May 8, 1947, p. 10.

15. Public Archives of Nova Scotia RG1 Vol. 430 #33 1/2.

16. Canada. Debates of the House of Commons (hereafter Debates) 1905, p. 6515.

17. Canada. Debates, 1901, p. 2759.

18. Patterson, Indian Affairs and the Nova Scotia Centralization Policy, p. 19.

19. Canada. Department of National Health and Welfare Annual Report 1956, p. 84.

20. Canada. Department of National Health and Welfare Annual Report 1957, p.p. 76-77.

21. Canada. Department of National Health and Welfare Annual Report 1950, p. 80.

22. Cited in David Naylor, Private Practice, Public Payment: Canadian Medicine and the Politics of Health Insurance, 1911-1966. Montreal: McGill-Queen's University Press, 1986.

23. Canada. Department of Mines and Resources Annual Report 1941, p. 165.

24. Canada. Department of Mines and Resources Annual Report 1947, p. 223.

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26. Stanislaw Judek. Royal Commission on Health Services: Medical Manpower in Canada. Ottawa: Supply and Services, 1964, p. 8.

27. Bernard R. Blishen. Doctors and Doctrines: The Ideology of Medical Care in Canada. Toronto: University of Toronto Press, 1969, p. 6.

28. Canada. Health and Welfare Canada. Indian and Northern Health Services (Medical Services Branch) Atlantic Region Annual Report 1967, p. 19. (Hereafter cited as MSB Annual Report).

29. Ibid., p. 18.

30. MSB Annual Report 1968, p. 8.

31. MSB Annual Report 1967, p. 18.

32. MSB Annual Report 1960, p. 5.

33. MSB Annual Report 1965, p. 13.

34. Canada. Department of National Health and Welfare Annual Report 1950, p. 81.

35. Patterson, Indian Affairs and the Nova Scotia Centralization Policy, p.p. 45-46.

36. Canada. Department of National Health and Welfare Annual Report 1955, p. 79.

37. See the Department of National Health and Welfare Annual Reports for the entire 1950s.

38. Canada. Department of National Health Welfare Annual Report 1956, p. 87.

39. Sydney Post-Record May 8, 1947.

40. See Department of Mines and Resources Annual Report 1947, p. 214 for Eskasoni and Annual Report 1948, p. 213 for Shubenacadie.

41. Canada. Department of Citizenship and Immigration Annual Report 1959-1960, p. 87.

42. Canada. Department of Mines and Resources Annual Report 1948, p. 212.

43. Canada. Department of Citizenship and Immigration Annual Report 1950, p. 61.

44. MSB Annual Report 1965, p. 15.

45. MSB Annual Report 1967.

46. Canada. Department of Mines and Resources Annual Report 1947, p. 223 and Department of National Health and Welfare Annual Report 1949, p. 106.

47. Canada. Department of National Health and Welfare Annual Report 1956, p. 88.

48. MSB Annual Report 1968, p. 8.

49. Canadian Tuberculosis Association, "The Tuberculosis Problem in Canada" prepared for the Royal Commission on Dominion-Provincial Relations, Ottawa, 1938.

50. Canada. Department of Mines and Resources Annual Report 1947, p. 223.

51. Canada. Department of National Health and Welfare Annual Report 1956, p. 88.

52. Canada. Department of National Health and Welfare Annual Report 1957, p. 79.

53. MSB Annual Report 1988, p. 35.

54. Canada. Department of National Health and Welfare Annual Report 1953, p. 33.

55. Canada. Department of National Health and Welfare Annual Report 1952, p. 49.

56. MSB Annual Report 1960, p. 4 and MSB Annual Report 1965, p. 18.

57. MSB Annual Report 1960, p. 4.

58. MSB Annual Report 1966, p. 17.

59. MSB Annual Report 1960, p. 4.

60. MSB Annual Report 1965, p. 23 and MSB Annual Report 1967, p. 19.

61. Canada. Department of National Health and Welfare Annual Report 1960, p. 29.

62. MSB Annual Report 1967.

63. Cape Breton Post May 7, 1968, p. 3.

64. Cape Breton Post May 7, 1968, p. 4.

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Chapter V - The Just Society Reconsidered

In the period 1942 to 1968, we have seen how a century of medical reform and bureaucratization came to its fruition, as well as the emergence of the federal bureaucratic empire that governs Indian health services. Accompanying these changes was a significant improvement in the health status of Indian people, including the Micmac. Common infectious diseases, such as measles and whooping cough, were in decline, as was the incidence of new and reactivated cases of tuberculosis. Specialty services aimed at improving maternal health, pre and post natal counselling and health education programs were also initiated. Cumulatively, then, many of the hallmarks of the Indian health care delivery system had emerged in the post-war decades, and were simply redefined after 1969. Yet, if the previous period was characterized by a real improvement in the health status of the Micmac, the 1970s and 1980s saw not continuing improvement, but rather stagnation. It has been argued, reiterated later in the chapter, that this stagnation is primarily, though not exclusively, the result of native people's alienation from the health care delivery peocess, at both the administrative and service levels. Moreover, even where native people have made significant inroads, such as the Community Health Representative program, they have remained dependent upon, and subordinate to, non-natives.

The focus of this chapter, then, will not be on the physician, who remained the paramount figure in health care delivery, but rather

on the native community and its members, and the respective efforts of each. It will examine the increasing role of Micmac bands, political organizations and individuals in the delivery process, and consider the implications of this involvement on the health care system. Furthermore, the chapter will examine contemporary indigenous beliefs about medical care, and its goals, in an effort to come to terms with continued Micmac frustration over the perception of poor health. Efforts at achieving a new understanding of what constitutes health, an understanding which would incorporate the Micmac perspective, will then be placed in the broader analytical context of apparent challenges to the medical monopoly and hierarchy.

If further improvements in Micmac health and their perceptions thereof are dependent upon a process of empowerment, consideration must be given to the policy directions of the federal government, the presence of which is as pervasive as ever in Micmac communities, including health services. Through an examination of these changes, and the Micmac reaction to them, one can begin to understand the desire for heightened Micmac participation. Yet, in the case of the Micmac, this desire is continually tempered by a concern over the erosion of services, a concern that can be traced to the government's 1969 Statement on Indian Policy and its long-standing attitude that health care is provided to native people out of moral obligation, an attitude unaltered by the introduction of medicare legislation.

I - Hospital and Medical Insurance

The federal government has always maintained that it had no legal precedent for the provision of health services to the Indian population of Canada (See Chapter IV, p.p. 190). The Department of National Health and Welfare expressed this sentiment in 1969, declaring that there was "no specific legal obligation to provide health services to Indians. However, the federal government has over the years felt morally obliged to do so. This would not necessarily involve providing services directly but would involve seeing to it that Indians did have ready access to health care services." Thus, Medical Services Branch (MSB) viewed itself as taking a supervisory role in the provision and delivery of health services. The report continues:[1]

> Consequently the branch attempts wherever possible to enlist the services of any available practitioner, hospital, health unit or other locally available facility. Physicians' and dentists' and other paramedical practitioners' services are extensively hired on a fee-for-service basis...Provincial health units accept a variety of arrangements, some a partial payment others a sharing of staff and facilities...The indigenous peoples are strongly urged and frequently assisted financially to enlist themselves under provincial medical care insurance.

Medicare, which became effective in Nova Scotia on 1 April, 1969, together with previously enacted hospital insurance plans offered Canadian citizens insurance against the cost of physicians' services, hospital and diagnostic services. Under the terms of the financing agreements between the provinces and the federal government, the benefits of these programs had to be extended to all provincial citizens, including Indians. But the programs did not relieve the federal government of its "obligations to the health of Canadians in areas where federal legislation or custom establish that federally conducted services are required."[2] In

other words, it did not alter the federal relationship with Indians with respect to health care delivery.[3]

However, because the federal government viewed the provision of health services as arising out of moral obligation rather than legal precedent, medicare, which was to be administered by the provinces, could be seen as an erosion of federal services. We have seen how the Nova Scotia Department of Health administered the measle vaccination program in Micmac communities initiated in 1968 (See Chapter IV p.p. 199). This excursion into Indian health services was followed by Dr. L.D. Hirtle's suggestion[4]

> that serious consideration be given to the advisability of "phasing" out these activities <pertaining to tuberculosis control and treatment> to the provincial authorities as they show their willingness to take over the whole provincial population and the Indians become more and more integrated in school and domestic life with the whites.

These sentiments were reiterated the following year in a report that also noted that tuberculosis control was at a low ebb. In fact, to "maintain a high degree of protection we need now B.C.G. vaccinate newborn babies only", a marked reduction in MSB's efforts in this area. Thus, while the T.B. programme was still important, it could be integrated with the provincial service with little opposition. The province, after all, operated the chest clinics and sanatoria. By 1970-71, Medical Services had abandoned its x-ray survey programme of reserve communities, content to let the province perform this, though it was noted that the surveys were conducted "not as extensively as was performed by Medical Services".[5]

The transfer of the tuberculosis program was of minor concern and extracted no reaction from the Micmac community. The fact that it seemed to go largely unnoticed and unchallenged was perhaps the result of its being overshadowed by the far more sweeping 1969 Statement of the Government of Canada on Indian Policy.[6] The Statement is of significance here not only because it exemplifies the effects of an entrenched bureaucracy and the ruling liberal ideology, but because it came to occupy a significant position in the collective conscience of the Micmac, and often colored native responses to policy endeavors.

II - The 1969 Statement

When Pierre Trudeau came to occupy the office of Prime Minister, he brought with him a well articulated liberal ideology, embodied in his Pierre Elliot Trudeau: Federalism and the French Canadians. It was this ideology that would be applied to shaping the approach to, and outcome of, Indian policy. Lester B. Pearson's Indian Affairs department had come under increasing public criticism throughout 1967, though it had initiated a program, under Arthur Laing, to revise the Indian Act. However, both the public and native peoples were dissatisfied by the lack of progress - a dissatisfaction inherited by Trudeau.[7] Trudeau's personal philosophy was surely a potent force in shaping Indian policy. In dealing with the issue of French Canadians, Trudeau firmly refuted any suggestion of special status and this same philosophy was applied to Indian policy. Culture, in Trudeau's view, could only be made stronger if special advantages were withdrawn -

advantages such as the Indian Act. This was a social Darwinist approach to culture which argued that competition would enhance cultural vitality. It was this philosophy that led Trudeau to write that "I am against any policy based on race or nationalism."[8] The Indian Act was erected upon just such a policy. Furthermore, the collectivism embodied in the 1951 Indian Act was antithecal to the prevailing liberal ideology, present under Pearson but more pronounced under Trudeau, which emphasized individualism, freedom and equality. The difficulty with such an ideology is that it fails to recognize that one's opportunities are influenced by a variety of mitigating factors - poverty, education and racism to name but a few.

It was, nonetheless, this ideology that was applied to Indian Affairs and Indian policy, both of which had been ineffective for some time. This ineffectiveness was partly the result of instability in the Government. Between 1957 and 1963, the Conservatives held power, and the Liberals from 1963 to 1968. Minority governments dominated the 1960s, electoral results yielding a divided house bewteen 1962 and 1968. During this same period, Indian Affairs had eight ministers, six of whom held office for a year or less. This left civil servants with little or no political direction, resulting in a further entrenchment of the bureaucracy an an accompanying resistance to change. In an era of political instability, the civil service was remarkably stable taking "the form of 'the old guard'...a small group of senior men who had been in Indian Affairs for over two decades".[9]

When the liberals were returned to power in 1968, Trudeau appointed two ministers to the department - Jean Chrétien as Minister for Indian Affairs and Robert K. Andras as Minister Without Portfolio. These Ministers inherited the Regional Advisory Councils, which had been established in 1965 and had met some fifty times by the end of the 1967-68 fiscal year. In July 1968 the consultation meetings came to the Atlantic Region. Eleven band representatives from Nova Scotia attended the meeting, in addition to the five Nova Scotia Micmac members of the Regional Advisory Council. The meeting reflected some of the concerns of the Micmac people. During a discussion about delegating more authority to local band councils, the issue of abolishing Indian Affairs became a topic. A representative of a New Brunswick band was concerned that abolition would mean that there would be no representation for native people in Ottawa. The delegate was assured by co-chairman Labillois that "there was no indication that the Department would be abolished".[10]

While it is unclear whether the new policy direction had begun to take shape at the time Jean Chrétien spoke to those assembled, it is clear that by mid-January 1969, the Minister had begun to advocate the transfer of delivery services to the provinces. Chrétien believed in essentially the same ideological tenets as Trudeau. As a result, he saw the issue as a dichotomy - either native peoples should keep their special rights or they should opt for equality. Perhaps J.S. Erskine put it best when he poignantly wrote, in 1959, that the "Micmac is faced with the unenviable choice of going out into the white man's world where he may find a future but must lose his past, or of

remaining in the reserve where he may keep his past but will have no future."[11] By February, cabinet had approved a policy that embraced full 'non-discriminatory' participation of Canada's native peoples in the larger society. The five-step program that accompanied this contained the essential elements of the Statement that would follow. On June 25, 1969, Chrétien announced the government's Statement to the House. Although commonly referred to as the White Paper, it was not presented as such. Neither was it put forth as a proposal. Thus, the Statement's significance was immediately shrouded in ambiguity.

There was not, however, any ambiguity as to its content. The first pages set the tone for what followed:

> to be a Canadian Indian is to be someone different in another way. It is to be someone apart - apart in the law, apart in the provision of government services and, too often, apart in social contacts ...The government believes that its policies must lead to the full, free and non-discriminatory participation of the Indian people in Canadian society. Such a goal requires a break with the past. It requires that the Indian people's role of dependence be replaced by a role of equal status, opportunity and responsibility.

The Statement goes on to state that "Canada cannot seek the just society and keep discriminatory legislation on its statute books."[12] This sentence summarizes what is evident in the former - that the 1969 Statement was a tangible manifestation of the ruling liberal ideology. The 'just society' was to be erected upon this mantle, with its utopian notions of individualism and freedom.

To achieve legal equality necessarily meant dismantling two and a half centuries of Indian policy. This document sought to accomplish

this through six steps: (1) the removal of the constitutional and legal basis of discrimination; (2) that there be a recognition of the native contribution to Canadian life; (3) that native peoples receive the same services as other Canadians through the same channels; (4) those most in need would be given the most help; (5) a recognition of lawful obligations and; (6) Indian control of Indian land.[13] It was essentially a policy of termination - native citizens would become provincial citizens. As Sally Weaver wrote, the "fusion of the liberal ideology with Trudeau's own views against special rights for ethnic groups...made termination the central theme in the new policy."[14]

What was the reaction to the new policy? On June 25, 1969 one member of the House of Commons declared "I hope the decision of liquidating Indian Affairs at the federal level will benefit the Indians so that they may become real Canadians". Another member cynically stated that since "the policy...is based on the concept that white is right, is the Prime Minister considering withdrawing sanctions against Rhodesia?"[15] The Leader of the Opposition, Robert Stanfield, was less flamboyant but no less critical, arguing that equality could not be created by "declaring your intention for achieving that state of equlity. Equality for the Indian people of Canada requires far more than a transfer of jurisdiction to the provinces." This was a recognition of the shortcomings of the application of liberal ideology, perhaps best illustrated by a second comment, when he noted that "for those who live in the less wealthy provinces, <equality becomes> a much more distant goal."[16] Equality in the law did not necessarily translate into equality of opportunity, a fact readily recognized by native people.

What was the reaction of members of the House of Commons from Nova Scotia, many of whom had Micmac constituents? Did these members (See Table 5.1) reflect any concern over the 1969 Statement and the implications it had for their Micmac constituents? If these members were vocal opponents or critics of the policy, it went unrecorded in the Hansard. Neither is their opposition present in the Halifax Mail Star. Perhaps foreshadowing this silence was a debate in the House on 19 June, 1969, less than a week before Chrétien's announcement. The debate concerned, among other things, the Standing Committee on Indian Affairs and changes to the Indian Act. Near the end of the debate, the Progressive Conservative member for South Western Nova, Louis Comeau, rose to speak. He began a long speech, but one which had nothing to do with Indian Affairs or his Micmac constituents. Rather, Comeau spoke on the establishment and implications of national parks. The remaining nine members from Nova Scotia, all of whom were P.C.'s except Allan MacEachen and therefore potential critics of the Statement, were silent.[17]

But what of the Micmac reaction to the Statement? The day after the announcement, then Nova Scotia Human Rights Coordinator Martin Schiff stated that "the Indians make no secret about the fact that they are unhappy about the Indian Act and the Department of Indian Affairs"[18] a restatement of the sentiments articulated at the consultation meetings. More significant in terms of the Micmac reaction were the comments of Chief Roy Gould of Membertou. Displaying a caution that was characteristic of early native reaction to the Statement, he said he would not comment, but did suggest "that he thought the provincial government could not handle the situation <of delivering services> alone and would

Table 5.1

Members of Paliament from Nova Scotia
28th Parliament

Name	Constituency	Party Affiliation
Coats, Robert	Cumberland-Colchester North	P.C.
Comeau, Louis	South Western Nova	P.C.
Crouse, Lloyd	South Shore	P.C.
Forrestall, Michael	Dartmouth-Halifax East	P.C.
MacEachen, Allan J.	Cape Breton Highlands-Canso	Lib.*
MacEwan, H. Russell	Central Nova	P.C.
MacInnis, Donald	Cape Breton-East Richmond	P.C.
McCleave, Robert	Halifax-East Hants	P.C.
Muir, Robert	Cape Breton-The Sydneys	P.C.
Nowlan, Patrick J.	Annapolis Valley	P.C.
Stanfield, Robert	Halifax	P.C.°

* Minister of Manpower and Immigration

° Leader of the Opposition

require federal assistance."[19]

Over five months passed in the Mail Star with no recorded comment on the Statement by a member of the Micmac community. On 8 December, in an article entitled 'Indian Seeking Same Services as Others Get', Greg Johnson and Joe Marshall, welfare officers at Shubenacadie and Eskasoni, respectively, emphatically stated that the Micmac did want provincial services extended to them. This was not, however, an endorsement of the Statement, but rather the concept of 'citizen-plus'. This concept was put forth in the Hawthorne Report, a study conducted between 1963 and 1967 but subsequently ignored, which advocated that the special status of native people not only be maintained, but enhanced. This was, in fact, what came to be in the realm of health care delivery, to be examined later. That Johnson and Marshall were advocating the citizen-plus concept was underlined by the comments of Chief Gould, who said at "least on the reserve they have some land and a home", clearly not the statement of one looking forward to the abolition of the Indian Affairs bureaucracy.[20]

The fact that the Micmac response was not recorded in the local media may stem from the fact that in Nova Scotia, Indians were still largely a politically unorganized minority. There was still no cohesive voice speaking for the Micmac people but the political process of policy formation did provide the impetus for political organization. At the first organizational meeting of the Union of Nova Scotia Indians (UNSI), one reason cited for the need to organize was the lack of "legal representation at the Ottawa Indian Act Conference from the Province of

Nova Scotia."[21] At the following meeting, held after the 25 June announcement, Peter Christmas said at "no greater time do we need to strive for total unity, provincially and nationally. A unified voice is a must to express a unified approval or disapproval of any Bill from any government".[22] These same minutes, however, contain no direct reference to the recent developments in Indian policy. This may be indicative of a cautious approach with respect to the Statement, but such a conclusion should only be regarded as tentative.

Another possibility as to the absence of the Micmac reaction in the Halifax press may be the low level of priority given, and interest in, native affairs. If this was the case, what of coverage in the alternative media? To gain this perspective, two prominent publications were consulted, the Mysterious East and the 4th Estate. The January 1970 issue of the former contained an interview with then president of the UNSI, Noel Doucette. In the interview, Doucette attributed the formation of the Union to developments within the Indian Affairs bureaucracy. When questioned about militantcy within the reserve communities, Doucette replied, "there's no open hostility on the reserves, and I hope there won't be." Furthermore, on the question of the possibility of hostility, he said not "in the eastern part of Canada, I don't believe - at least in Nova Scotia and the Maritime provinces."[23] The Micmac, it would appear, did not respond to the 1969 Statement by adopting a militant posture, but rather opted for political organization.

The 4th Estate was consulted in its' entirety between June 1969 and October 1970. An editorial on 24 July, 1969 said the Statement "caught Nova Scotia Indians by surprise." This article, and one on 21

August, cite a lack of concensus within the native community as to the major issues facing the Micmac. The impetus to organize politically was because "the federal government is scared to death in other provinces ...so Indians in Nova Scotia - just because they are Indians - also became involved."[24] Implicit in this last comment is the fact that the Micmac were a small, and politically unorganized, minority. They could neither mobilize nor exert the influence to the extent that their counterparts in Western counterparts could, because they lacked organization and sheer numbers.

Finally, consideration must be given to the comments found in the Micmac News. An excerpt from the UNSI brief to the Committee on the Constitution of Canada submitted on 21 October, 1970, and reprinted in the Micmac News in January 1971, stated that the "white paper was totally rejected by the Indian people across Canada" and that further changes "must be decided by the Indian people for the Indian people." Also, in a column entitled 'Questions and Answers' which appeared in November 1970, the following was published as an answer as to the reaction of the Micmac to the White Paper: "The Indians of Nova Scotia in general did not accept nor did they accept <sic> the White Paper Policy. The Union of Nova Scotia Indians are presently investigating all aspects where it would involve the Indian people before any decisions are made."[25] In the final analysis, it is difficult to come to terms with the Micmac reaction to the Statement of the Government of Canada on Indian Policy, 1969. The evidence examined does not indicate that the Micmac response was angry or militant, but rather it appears that a cautious posture was adopted. The sources consulted may reflect a subtle bias against native issues, stemming from a lack of political

power in the form of population or political organization. Moreover, the ambiguity of the document may have contributed to this posture, because of its promise of equality.

Ultimately, the policy was withdrawn. By 1970, with native organizations, the media and the public all criticizing the policy, Trudeau announced that the government would not proceed with implementation. By the spring of 1971, Jean Chrétien formally withdrew the policy. The dénouement was unsensational, but in subsequent years the White Paper was elevated to the status of a symbol for native people - a symbol which represented all that was wrong with Indian Affairs, and the spectre of this symbol would be raised again in matters pertaining to health care delivery.

III - Health Care Delivery: The Early 1970s

It is ironic that the Medical Services Branch annual report for 1970-71 notes Atlantic Region's[26]

> fortunate position in an area of relatively high population density, and where most provincial health services available to the general public are available to the Indian population. In fact, when one adds the additional services - Dental, Opthalmic, drugs, appliances provided to the needy Indian by Medical Services, the total services available to the Indian population surpasses what is provided residents of the provinces of similar socio-economic status.

While debate on the White Paper was intensifying, MSB was acknowledging a de facto, if not de jure, implementation of the citizen-plus manifesto contained in the Hawthorne Report. Liaison with provincial health departments, to eliminate "duplication of effort" or "hiatus"[27] became the norm, and we have already seen MSB's willingness to utilize provincial

manpower and expertise in the provision of some services. The provincial health departments were also given due credit for providing "extensive service" to smaller reserve communities, as well as nutrition education. Finally, for those Micmac enrolled in schools, health services were provided by public health nurses working for the province.[28] Agreements were concluded through the 1972 fiscal year with Nova Scotia's Pharmaceutical Association, Optometrists Association and the Association of Dispensing Opticians for the payment of prescription drugs and the provision of eyewear. These agreements supplemented and enhanced basic medical coverage and services provided under the provincial plan.[29]

Early in 1970, there was also a move toward encouraging more native involvement in the health care delivery system. In July 1970 three applicants were chosen for training as Community Health Workers. Their duties when they returned to their communities were many, and included: (1) educating community members as to the services available and encouraging their use; (2) fostering improvement of sanitary conditions and health habits; (3) education of medical staff in native customs so that teaching could be more effective; (4) fostering collective attitudes toward resolution of health problems; (5) organizing and working with local health committees; (6) teaching and demonstrating health techniques, and; (7) acting as interpreters.[30] The program enjoyed some success, and was deemed to be a "worthwhile community motivating force" largely due to the "infectious enthusiasm" of the workers. By 1972 there was a worker at Eskasoni and Shubenacadie, while Membertou and Barra Head shared one, as did Afton and Pictou Landing. Nevertheless, the program was described by MSB as only

working "fairly satisfactory" in 1973. A special problem was noted at Afton and Pictou Landing "where our nurse makes only occasional contact and is therefore unable to give supervision and guidance to the program". As a result, "the value of the work done by the Community Health Representative is probably less than the potential."[31]

The Community Health Representative was one of the earliest positions in the health care delivery system filled by native people and, as a result, they faced high expectations. Moreover, these expectations came from both their own communities and those they served, and other individuals directly involved in health care delivery. This could have been a potential source of strain and conflict. However, in Nova Scotia, it was another native worker, the Liaison Officer, who became the focal point of such conflict.

Agreements were concluded with the UNSI in July 1970 for MSB to provide financial assistance toward the establishment of a Liaison Officer program. The UNSI, together with its counterpart in New Brunswick, appointed people to the position. There was, however, "an attitude being displayed which appeared to be anti-department" in the early going. Breakdown in communication was not uncommon and an interesting example of this occured in New Brunswick following the introduction of medicare. The Indians of New Brunswick refused to register for the benefits of medicare, considering themselves instead a "federal responsibility" - a position undoubtedly entrenched by the developments surrounding the White Paper. Clearly, in the period following the White Paper, native peoples were sensitive about what they perceived to be a transfer of services to the provinces. Nevertheless, a compromise was arrived at,

which allowed Indians access to the benefits through the use of their band numbers. By the end of the 1970 fiscal year, the Liaison Officer program was described by MSB as "mutually satisfactory" and plans were announced for an "augmented program".[32]

The Medical Liaison officers were to report to the UNSI, maintain liaison between MSB and UNSI, MSB and the reserve population and MSB and other bureaucratic agencies, such as Indian Affairs.[33] Nova Scotia had, by 1972, two Liaison workers - Roselita Herney and Eleanor Johnston. But, in Johnston's view, the mainland population was being "neglected" due to the heavy workload on Cape Breton and the sometimes difficult travelling conditions.[34] Despite the expansion of the program from its inception - by 1971 there were 15 liaison officers throughout Canada - the program was discontinued in 1973, with ineffectiveness being cited as the chief reason.[35]

Nevertheless, the Micmac had made some inroads by the early 1970s into the administration and delivery of health services. The CHR program was thriving, as was a Summer Student program. Whereas in 1969, MSB Atlantic could note only that native people were employed on a "casual part-time basis" as handy-men and maids, by 1971 there were four CHRs (three of these in training), and two liaison officers. The following year three Indian high school students were employed as aides to the CHRs.[36] Corresponding with these developments was an increased interest by band governments in administering the medical transportation program. As early as March 1971, bands at Tobique, Burnt Church and Lennox Island, in the other two Maritime provinces, were administering their transportation programs.[37] The Unions also operated pro-

grams aimed at alcohol and drug abuse. With ever-increasing band involvement, liaison remained remarkably good, though one annual report did note that although MSB was "prepared to give advice and guidance on all matters relating to health...there seems to be a growing resistance to accepting advice from non-Indians."[38]

Until 1975, there was little direct Micmac involvement in the administration of health care delivery, save for the medical transportation program[39] and the growing participation of the CHR's at the delivery level. That same year, 1975, the landmark James Bay Agreement was signed between the Cree, the province of Quebec and the federal government. Interestingly enough, one stipulation of the agreement, imposed by Quebec, was that the Cree forsake their special relationship with Ottawa in matters pertaining to health services. The Cree were to have control over their own health care, though it would now be considered a provincial matter. One author has noted that, historically, Indians "have been generally unwilling to put their health care in the hands of provincial authorities who they fear may fail to recognize their special stauts <sic>" and that, when the Cree did just this, they were "criticized...by other Indian groups."[40] The James Bay Agreement created a northern Quebec region, in which the Cree Regional Board of Health and Social Services was responsible for administering all health programs, including public health, and health facilities in the region.[41]

IV - Administration and Delivery 1977-1980

If James Bay was supposed to provide the impetus for further transfers or negotiations, it did not. In fact, as the optimism and economic prosperity of the 1960s yielded to the stagnation of the 1970s, the federal government became concerned about the costs associated not only with Indian health care, but all health care. This manifested itself in a variety of ways. In March 1976 the Micmac News reported that Medical Services had expressed some concern over the costs associated with providing health services to non-status Indians. Dr. Ian F. MacCaw, the Regional Zone Director, stated that the department would no longer honor non-status Indians' requests for payment. MacCaw stated that MSB was expressing "the sentiments of registered Indians in recognizing the differences between those holding status and those who have chosen to disclaim their heritage". This was a reaffirmation of the legislative distinction between status and non-status Indians, and MSB's perceived responsibilities to only the former.[42] Moreover, the department would no longer provide services already provided by the province, a restatement of the policy of avoiding duplication or hiatus encountered earlier. Nonetheless, the Micmac Chiefs condemned the policy, saying "this is not acceptable as the Federal government has certain responsibilities to the Indian people"[43] undoubtedly fearing an erosion of service and their status.

Native peoples, despite the precedent of James Bay Agreement, still did not have any great influence over the direction or implementation of Indian health policy. This prompted the National Indian Brotherhood to pass an Executive Council Resolution on 7 October, 1977,

calling for more native involvement in the development of policy and an end to the federal government's unilateral approach. To foster the meaningful participation of native people, the NIB struck a National Commission Inquiry on Indian Health, which was to identify "positions, concerns and priorities of Indian people across Canada" and arrive at a comprehensive statement.[44] National Health and Welfare noted that a "new trend is being established to encourage Indian bands to take over total or partial responsibility for health services."[45]

The government statement marked a dramatic change in the approach to fostering native health, in theory if not in application. It amounts to a de facto recognition that significant progress in native health could only be made if Indians became more involved in the planning and delivery of health services. The progress made from 1945 to the late 1960s in elevating the standard of native health was not sustained in the 1970s. Thus, in 1978, the UNSI expressed its displeasure with the standard of medical services, despite the fact that, in general, the Maritime Indian population enjoyed a standard of health close to their non-Indian counterparts.[46] It would appear that while, in general, the level of health was improving within native communities, there remained continued dissatisfaction. Many explanations have been put forth to explain this lack of continued progress. Some have argued that the poor level of Indian health was the result of inadequate funding or misallocation of funds, high levels of unemployment and the resultant low levels of income, social problems arising out of a neglect of traditional native problems or a scattered and remote population. While each of these explanations undoubtedly are important in

determining the level of native health, it has been more recently recognized that progress in advancing the level of health in native communities is dependent upon increasing the level of native participation in the planning, administering, operating and delivery aspects of health services and, thereby increasing their power.[47] Rather than increased native involvement in the health care delivery system, management and proposals respecting health services continued to be made in the absence of native participation. MSB Atlantic attempted, in 1978, to transfer the administration of drug accounts to Blue Cross of Atlantic Canada. The transfer was concluded after "several months of negotiations" between Blue Cross and MSB, negotiations which did not include native representatives. Implementation and operation were, however, short lived, as the native response to the transfer was decidedly negative.[48] Incidences such as this illustrate the extent of the exclusion of native people from policy formation.

Equally important in the termination of the Blue Cross scheme were the restrictive measures imposed by the Liberal régime, under the direction of the Minister of National Health and Welfare, Monique Bégin. In September 1978, Bégin had declared that health benefits should be provided only to indigent Indians. In a press release issued on 21 December, Health and Welfare stated that funds for health services "which come from the Canadian taxpayer, are made available to those treaty Indian people most in need, rather than to provide to fully-employed treaty Indian people services which are not available to other employed Canadians."[49] This was tantamount to a rejection of the citizen-plus policy direction that had characterized Indian Health Services through-

out the 1970s, and prompted New Democrat Member of Parliament Lorne Nystrom to question "the transfer of Indian health care the provinces".[50] The guidelines applied to non-insured services such as ambulance transportation, optometric and dental services, as well as prescription drugs. The position of the federal government strained the relationship between MSB and Indian communities in Nova Scotia, and resulted in a "curtailment of services" due to inadequte funding.[51] The level of medical services on the reserves became a focal point for native leaders in Nova Scotia, who vented their anger at regional officials during a two day meeting in June 1979.[52] At the same time, the National Indian Brotherhood released a summary position paper calling for a "guaranteed universal Indian health care package encompassing curative medical services as a leading priority and establishment of long term educational, preventive, environmental and community development programs". According to the NIB's National Commission Inquiry on Indian Health, these programs were essential "as a vital part of an Indian health care system".[53]

The NIB and Micmac representatives were articulating a health care strategy that would offer native communities a comprehensive health strategy and health services, a position in opposition to the restictive guidelines that had been imposed by National Health and Welfare in the summer of 1978. These positions, moreover, were an outgrowth of a six month moratorium imposed by Bégin on the cutbacks, to allow time for consultation with native communities, a process described by Maritime Chiefs as filled with "confrontation and racism."[54] The consultation gave rise to a new policy directive, announced in September 1979

which stated

> that the traditional relationship of the Indian people to the federal government must be strengthened by opening up communication with the Indian people and by encouraging their greater involvement in the planning budgeting and delivery of health programs.

Moreover, the policy reinstated the status of non-insured services, allowing for their provision "on the basis of professional medical or dental judgement or by other fair and comparable Canadian standards."[55] The policy called for greater native participation by encouraging band governments to administer some health services, described by Monique Bégin as a policy of "devolution".[56] The announcement of the Indian health policy had a favourable effect in the wake of the restrictive measures imposed beforehand, an effect which "helped to restore better relationships with all concerned."[57] Nevertheless, the policy met with a degree of opposition. In the area of medical transportation, for example, the Cape Breton bands, as well as Shubenacadie and Afton, refused to negotiate any terms other than the open-ended contract in use, where MSB fully compensated the bands for expenses incurred, thereby ensuring that no decrease in service would occur.[58]

The change of policy embodied in the 1979 Indian health policy had few tangible results at the community level, as a 1984 article in the Micmac News noted, when it said "there has not been a significant improvement in Indian health since implementation of the federal Indian Health Policy of 1979 and the subsequent spending of millions of dollars for health services."[59] In 1980, the UNSI commissioned a study to determine the status of Micmac health, the causes of poor and recommend solutions. The project made recommendations in line

with the 1979 policy, namely, that bands become responsible for the health care delivery system. But the recommendations went further, for bands were not to be merely the administrators, but were to assume complete control.[60] MSB had had little success in elevating the standards of native health to those enjoyed by their provincial counterparts. In Nova Scotia, the life expectantcy for a Micmac Indian was 48 years, compared to 76 years for non-Indians and rates of disease and other health indicators were significantly higher among the Micmac: heart disorders 47 per cent higher; stomach problems 72% higher; liver disorders 38% higher; obesity 87% higher and diabetes 16% higher. Moreover, convalesence for a Micmac patient was 30% longer, indicative of lower standrads of sanitation, housing and nutrition that the Micmac had to endure. This was recognized by the Barkhow report when the author noted that "major health problems stem from social problems."[61]

V - Infant Health

Efforts at improving health through addressing social problems or the social roots of health problems often met with success. An example of this may be found in the pre-natal classes sponsored by National Health and Welfare. A 1967 study found that babies born to mothers who had attended pre-natal classes enjoyed substantially lower mortality rates than those who's mothers did not. The infant mortality rates "among the infants of Indian women receiving good pre-natal care and following nursing advice was at the rate of 3%, not much in excess of the national rate, whereas among the children of mothers not receiving care or following advice it was over 10%."[62]

The Lalonde Report reiterated this sentiment in the mid-1970s, saying "it is generally conceded that early pre-natal care, along with early identification of high-risk pregnancies, is the principal means by which the infant mortality rate can be further lowered."[63] The socialization of child rearing, accomplished through intsitutions such as the school, social workers and child care experts,[64] was extended to the pre-natal period, while concurrently fostering confidence in the ability of health care workers to improve health status.

In the early 1970s, the infant mortality rate among the Micmac in Nova Scotia compared favourably to that of the Nova Scotia rate. In 1971-72 there was but one death in 177 live births, a rate of 5.6 per 1000 live births, compared with a rate of 19.6 for the entire population of Nova Scotia. The following year it was noted that the Micmac "continue to experience neonatal, postnatal, and infant death rates lower than those reported for the province of Nova Scotia."[65] This is not to suggest that there were not problem areas with respect to infant health. Stillbirths were a problem, as were perinatal deaths.[66] In fact, when one examines the number of neonatal (eight to twenty-eight days) and infant (twenty-nine days to one year) deaths, the data for which is presented in Table 5.2A, what emerges is a remarkable stability throughout the period under consideration. Of the forty-four deaths between 1972-73 and 1986, the two leading causes of death were crib death, which accounted for sixteen and congenital anomalies, responsible for fifteen deaths. The other causes, in order, were pneumonia (4), immature fetus or prematurity (3), burns (2), asphyxiation (1), poisoning (1) and diabetes (1).[67]

Table 5.2A
Neonatal and Child Deaths

Year	Neonatal	Infant
1970	1	1
1970-71	4	3
1971-72	0	1
1972-73	1	0
1974	1	4
1975	2	3
1976	0	4
1977	1	1
1978	1	1
1979	0	1
1980	0	1
1981	2	0
1982	3	0
1983	3	2
1984	2	2
1985	2	0
1986	6	2

Source: MSB Atlantic Region Annual Reports 1970 to 1986.

In analyzing the data, it was found that crib death, or Sudden Infant Death Syndrome (SIDS), and congenital anomalies were leading causes of mortality among all Canadian Indians.[68] It should be noted that there is a relationship between infant mortality and not only adult mortality, but adult behavioral patterns as well. Thus, in areas where the frequency of cigarette smoking is elevated, as it is among the Micmac, one often finds respiratory disorders more prevalent among children. In addition, parental smoking has been shown to be a risk factor in creating an elevated risk of SIDS. The first part of the premise, that infant mortality is related to adult mortality

is supported by the elevated level of accident mortality among Micmac infants. It folows that if adults are dying more frequently from fires, car accidents, or other such tragedies than their non-native counterparts, so too will native children.[69] Finally, the consistency of the number of infant and neonatal deaths supports the contention that health gains made through the 1960s have not been improved upon. By using the raw numbers, this consistency is demonstrated, as rates are misleading because of the small population. In 1985, for example, the total infant mortality rate was 7.19 per 1000, but that year there were but two neonatal deaths. The previous year, there had been four deaths and the following year eight, for rates or 16.26 and 25.64 respectively. In 1986, the rate for Canada's native population was 17.2, more than twice that of the Canadian rate of 7.9.[70]

The number of infant deaths remained relatively constant despite the fact that pre-natal classes and "personal instuction" had been offered by MSB, though attendance was generally conceded to be "generally disappointing".[71] These deaths also occur in spite of a sophisticated indigenous attitude toward pregnancy. Jeanne Guillemin has documented these attitudes among the Micmac near Boston. Guillemin wrote[72]

> Long before a Micmac woman goes to a clinic for prenatal care, she is involved in her own private rituals for ensuring the health of the baby. She is encouraged to eat for her infant as well as herself and to be very attentive to her personal food preferences, denying herself nothing, even a new and unusual craving, because in being sensitive to her body, she is doing the best by her baby.

Eleanor D. Glor has recently demonstrated the success of pre- and post-natal counselling when indigenous practices and attitudes, such as those outlined above, are wedded to more orthodox counselling, such as that provided by MSB. The program, which included prenatal counselling, coaching during labor and post-natal education, was operated by the Regina Native Women's Association (RNWA) and was available to all native women, including those without status. The program enjoyed great success in reaching and counselling high-risk pregnancies, demonstrating "that a Native, community based, para-professional program" could indeed lower the risk of complications before, during and after childbirth through providing information and altering behavioural patterns. At the same time RNWA operated a variety of other projects, including a home for battered women, a housing program and a refuge for homeless girls. These projects are typical of a wholistic approach to health, characteristic of native people, and were not without an impact on the pre- and post-natal counselling program, as these auxilliary programs referred five women to the counselling program.[73]

One focus of the RNWA program was to decrease the incidence of low birth weights, a condition intimately connected with an elevated incidence of handicap and infant mortality. Low birth weight, defined by MSB as below the 2500 gram level, is related to smoking, prepregnancy weight, low weight gain during pregnancy, marital status, maternal youth, particularly if the mother is under sixteen, the gestational age of the fetus and primigravidity.[74] In its 1986 annual report, MSB Atlantic Region noted "an increase in low birth weight infants to 17 from 7 in 1985 and 4 in 1984. This may be a trend and bears watching so that

appropriate interventions may be taken."[75] Despite this concern, however, the population that MSB serves has always demonstrated fluctuations in the incidence of low birth weight. Thus, in 1982 there were sixteen, but in 1983 only two, a range for which there exists no adequate explanation, save for fortune (See Table 5.2B).

Another focus of the RNWA project was an attempt to increase the number of new mothers who breastfeed. The shift away from breastfeeding to bottlefeeding among native people took place following World War II, a fact not unrelated to fecundity.[76] Not unexpectedly, the native population of Atlantic Canada demonstrated a low level of breastfeeding. In fact, the National Database on Breastfeeding indicated that, in 1983, the native population of Atlantic Canada had the lowest incidence and duration of breastfeeding in the nation. It is interesting to note that the non-native population of this same region also ranked lowest among non-natives. In 1984, this situation was described as a "major disaster", though the following year, MSB noted with optimism that "there appears to have been a significant improvement in the numbers of infants being fed at the breast."[77] It would appear that this optimism was misplaced, for in 1986 the region's native [illegible]ion still had the lowest rates of breastfeeding in the country.[78] Part of the problem, which also illustrates the woeful lack of coordination among government departments, was the Department of Indian Affairs provision of formula to new mothers. This was recognized by MSB as an influence on infant feeding patterns as early as 1983, but it was not until 1986 that Indian Affairs restuctured its program to provide assistance to breastfeeding mothers. Nevertheless, only thirty-five

out of 312 new mothers that year breastfed, a disappointing 11.2 percent.[79]

Table 5.2B
Low Birth Weights

Year	Number	Rate per 100
1978	3	1.47
1979	4	1.61
1980	10	5.00
1981	7	3.19
1982	16	5.92
1983	2	0.85
1984	4	1.60
1985	7	2.51
1986	17	5.44

Source: MSB Atlantic Region Annual Reports 1978 to 1986.

VI - Substance Abuse

In each case where a MSB report notes its efforts at encouraging breastfeeding to six months of age, it was careful to note that such encouragement always excluded "cases where the mother is a known drug or alcohol abuser."[80] A recent report on studies conducted in native communities in British Columbia and the Yukon illustrates the enormity of the problem of maternal substance abuse. The report found that as many as twenty percent of native children bore the effects of maternal alcohol use and abuse, while other studies have estimated about five percent.[81] Alcohol abuse also creates or contributes to a variety of health problems, including peptic ulcers, acute and chronic gastritis, pneumonia, chronic bronchitis, heart and vascular disorders and some cancers, notably those affecting the upper respiratory and digestive

tracts.[82] The tragedy of substance abuse has often been focused upon, but no chapter on health could be complete without some analysis. In keeping with the theme of this chapter, however, emphasis will be placed on indigenous efforts in combating the problem.

Efforts aimed at alcohol and drug abuse were among some of the earliest to involve native participation. In 1971-72 an agreement was concluded between the Department of National Health and Welfare and the UNSI to develop program proposals, the end result of which was the creation of an alcoholism counselling pilot project, comprised of six counsellors.[83] By the mid-1970s, the program had expanded to include two facilities, one in Shubenacadie, opened in November 1973, and another in Sydney, opened in March 1974.[84] On 1 April, 1975, the National Native Alcohol Abuse program was inaugerated to provide assistance to existing programs while developing others.[85] In 1978, efforts were made toward developing a core of native para-professional workers, through a formal training program conducted at St. Francis Xavier University. The program was to foster increased skills in identifying problems, and develop counselling, education and follow-up skills. At the same time, it was thought that a formal training program would create a cadre of native paraprofessionals, who would then provide stability to the program, by decreasing the likelihood of staff turnover.[86] It is important to note that the program was essentially non-medical in its orientation, focusing rather on the triumvirate of counselling, treatment and prevention.[87] The non-medical aspect of the problem and potential solutions, was noted a decade earlier, in 1971, by Dr. M.S. Verick, a physician in Sydney who dealt

with local members of the Micmac community. Dr. Verick felt that the problem of substance abuse was "so large and so complex that he would reduce his personal effectiveness if he attempted to do more than treat the medical aspect of the problem".[88]

The National Native Alcohol and Drug Abuse Program (NNADAP), created in 1982 with a budget of $154 million over five years, did not change the tacit non-medical orientation of earlier programs. It did, however, provide the Micmac bands in Nova Scotia with funding to develop the fifteen bed Mi'kmaw Lodge Treatment Centre in Eskasoni, which opened four years later.[89] The objective of the NNADAP was "to support Indian and Inuit people and their communities in establishing and operating programs aimed at arresting and offsetting high levels of alcohol, drug and solvent abuse among their populations".[90] The program replaced the pilot project National Native Alcohol Abuse Program and assumed responsibility for the 275 community programs already in operation. In 1982-83 an enhanced program was initiated that was to run for five years and receive funding amounting to $194 million. By 1985, there were more than 340 projects in operation throughout Canada under the auspices of the NNADAP.[91]

In Nova Scotia, the Native Alcohol and Drug Abuse Counselling Association (NADACA) of Nova Scotia supervised alcohol and drug abuse programs in fifteen Micmac communities. Counsellors worked with community steering committees and residents to ensure that the programs were relevant and effective. In addition, communities established Alcoholics Anonymous, Alanon and Alateen groups and held community workshops in an effort to reach those residents in need.[92]

NADACA was also the group responsible for managing, on behalf of the thirteen Nova Scotia bands, the Mi'kmaw Lodge Treatment Centre, the only such treatment centre east of the Ontario border in 1986. The Centre offered those suffering from drug and alcohol abuse a thirty-five day program offered in-house.[93] The facility aimed at offering people enrolled in the program a wholistic approach to achieving and maintaining sobriety, through addressing physical, mental, spiritual and emotional concerns, according to one treatment director at the Lodge, Charles Gould.[94] The realization of a native treatment centre, which utilized a multi-lateral or wholistic approach to sobriety was exactly what many Micmac leaders had been calling for. Joseph Denny, the Executive Director of NADACA identified the problem in 1985 as a

> very complex one...involving physiological, social, cultural, political and economic dimensions. The condition of being an Indian and also an alcoholic in this society are economically, politically, socially, psychologically very different from those under which the rest of the people in this country live.

Denny, while advancing the argument for culturally appropriate care on the one hand nevertheless condemned the program as "nothing more than token treatment by the government of Canada."[95] In a similar vein, Micmac spiritual leader Noel Knockwood advocated the creation of "our own rehabilitation centre", which could provide a more wholistic approach to treatment, thereby providing "a more sophisticated and meaningful program" of treatment.[96] With the opening of the Mi'kmaw Lodge, and the Eagle Nest Recovery House, which recently opened in Shubenacadie,[97] it would appear that more culturally appropriate care is now available.

It should be noted that alcohol abuse is but one component of the broader issue of substance abuse. Another aspect of this is the abuse of prescription drugs, long an area of concern within native communities, as well as the Indian health bureaucracy. An article entitled 'Doctors and Pills', which appeared in the Micmac News in August 1971, raised some concern over the "availability of drugs among Indian reserves". The article continues that the "increase is shown where young people either receive high doses or obtain them through persons (adults) that receive them. There are too many pills being given out." The explanation offered for this over-prescibing was "that doctors are more than willing to get rid of their patients simply by prescibing a drug...No real consultation is carried out by doctors on most cases."[98] The problem apparently continued throughout the 1970s, though it went unremarked upon in either the Micmac News or the annual reports of MSB, until 1979. In that year, Dr. Ian MacCaw criticized doctors who were prescibing "unusually high quantities of medication", notably psycho-pharmachological drugs such as valium.[99] Another article from the Micmac News put the situation in the following terms[100]

> The abuse of presciption drugs has increased on some reserves which indicates a good portion of Indians are using the prescription drugs for non-medical purposes, especially drugs such as valium, librium...antidepressant drugs and diet pills... Names of several doctors, believed to overprescribe were submitted a couple of years ago to the N.S. Medical Board, and nothing has become of that.

It is unclear as to who submitted the names of those doctors, but it is apparent that Medical Services was aware of the situation, noting "an identifiable number of physicians who either from naivety

clinical irresponsibility issue prescriptions on request to Indian patients". Yet, in the same breath that they were reprimanding these physicians, MSB articulated a whole explanation on the abuse of prescription drugs, an explanation which largely shifted the blame in the direction of the client population. Thus, MSB describes a "pathological" search by natives, especially native males, for "some form of psychologic release". Moreover, the right to freedom of choice with respect to physician care is targeted as a contributing factor, as is access to a multiplicity of pharmacies and the inability of MSB to monitor drug use and abuse. The final contributing factor identified by MSB was "a client population who have been educated to demand their rights to unlimited access to physician services and prescription drugs at no cost."[101] The ultimate responsibility for proper drug use undoubtedly rests with the recipient patient, but this should not absolve physicians of their responsibility with respect to the frquency of prescription and dosage. In fact, between 1982-83 and 1984-85, the average number of prescriptions received by native people in Atlantic Canada rose from 8.98 per year to 9.39, yet there was no apparent rise in illness requiring medications.[102]

No account of substance abuse would be complete without reference to the problem of solvent abuse. One edition of the Micmac News noted, in 1971, that there were "five cases of peptic ulcer diseases (stomach ulcers)...identified in children under nine years of age and four of them at least were reported to have at some time sniffed gas", the apparent cause of the disorder. These cases, all of which occured in Cape Breton, were part of what Dr. M.S. Verick described as a

general and marked increase in the use of gasoline and glue sniffing, as well as alcohol and drug abuse.[103] A powerful and haunting account of the physiological and social repercussions of solvent abuse appeared in the letter to the editor column of the January 1982 Micmac News. In it, the author, 'Shubenacadie Ex-sniffer' wrote[104]

> When I sniffed I was ignored by almost everyone I saw on the reserve except for the sniffers. I dropped out of school on account of the stuff. I used to steal the stuff from hardware stores...I've seen girls as young as 10 years old do the stuff!
> You get a slow memory from this stuff. You lose your speech, you talk slower and stutter a lot - look foolish and lose your parents and friends. Nobody likes to hire a sniffer. You are a loner when you sniff.

The drug of choice for this ex-sniffer was a can of glue, such as contact cement or other such preparations. While no reliable statistics are available on the extent of solvent abuse in the Maritimes are available, it appears to have been a problem. One survey of Inuvik conducted in 1988 found that one in five children, both native and non-native, between the ages of twelve and eighteen had used solvents at least once.[105] A most moving and graphic account of solvent abuse among the Grassy Narrows Ojibwa has been provided by Anastasia Shkilnyk.[106] There is no evidence to support an assertion that solvent abuse was widespread within Micmac communities, yet because it is often a child's first introduction toward a pattern of drug abuse, since solvents are cheap and widely available, it is an important consideration.

VII - Suicide

It has been estimated recently that between 68 and 72 percent of native teenagers in Nova Scotia use drugs and alcohol,[107] and this is

often advanced as evidence indicative of poor mental health and self-esteem, conditions not unrelated to high levels of suicide. It should be pointed out that this analysis was recently confirmed by the Confederacy of Mainland Micmac (CMM), and amounts to more than simply perpetuating new native stereotypes. The CMM's Health Needs Assessment Survey found that key respondents, that is those involved in the administration and delivery of health services, identified the following health concerns: all mentioned alcohol and drug abuse and high unemployemnt, all except respondents from Bear River identified a lack of resources for youth, and all except respondents from Bear River and Horton were concerned about mental and emotional illness.[108] Dr. Phillip May, of the University of New Mexico, has suggested that suicide rates are higher among those in a state of cultural anomie - those "who haven't made a committment to either society",[109] which may manifest itself in the data presented from the key respondents. Data for the number of suicides, method and sex distribution, as well as a percentage of total deaths is presented in Table 5.3. In 1982, the suicide rate for status Indians in Atlantic Canada was 40.7 per 100,000, compared with 12.2 per 100,000 for all of Canada. The average rate per 100,000 among native people in Atlantic Canada was 43 per between 1984 and 1988.[110] Between 1983 and 1985, as a rough point of comparison, Indians in Canada endured a suicide rate of 34 per 100,000, more than twice that of the national rate for the same period, which was 14 per 100,000. For Indians between the ages of twenty and twenty-four, the rate was a staggering 171 per 100,000.[111] Even more astronomical was the rate on a "Nova Scotia reserve known for its spurts of suicidal tendencies" which had a rate of 188 per 100,000

Table 5.3
Suicides (1977-1986)

Year	Total	Male	Female	Method
1977	1	1	-	Unidentified
1978	5	4	1	Firearms (2), Overdose (3)
1979	4	3	1	Firearms (1), Overdose (1), Unidentified (2)
1980	0	0	0	
1981	5	5	0	Firearms (1), Unidentified (3)
1982	5	5	0	Firearms (3), Overdose (1), Unidentified (1)
1983	0	0	0	
1984	5	4	1	Firearms (1), Overdose (4)
1985	4	3	1	Firearms (1), Motor Vehicle (1), Unidentified (2)
1986	3	3	0	Firearms (3)

Source: MSB Atlantic Region Annual Reports 1977-1986

calculated over the period 1978 to 1988.[112] The rash of suicides at Indianbrook and the "alarming" rate of suicide among the Micmac in general prompted residents to initiate a suicide awareness program, an endeavor that received the unanimous support of the Native Council of Nova Scotia. As part of this effort, Stephen Michael, a Royal Canadian Mounted Police officer at Indianbrook, related his own experiences with alcohol and drugs, which he believed to be the trigger factor leading to many of the suicides. Michael also identified other factors, including "the dwindling away of the Micmac culture, the lack of respect for reserve elders, unemployment and a low self esteem."[113] Talks such as this, which address the community and social component of suicide may begin to offer a solution to the

high rates of suicide, something that MSB, with its policy of referring people who had attepted suicide to Provincial Mental Health Clinics, could never accomplish for, as a recent report noted, "Indian people rarely avail themselves of mental health services outside their community."[114]

VIII - Indigenous Attitudes Towards Health

Throughout this chapter, the examination has focused upon indigenous efforts at fostering health in Micmac communities, efforts which, at times, addressed broader social issues. Stanley Johnson, the co-ordinator for the Nova Scotia Community Based Health Project, felt in 1984 that raising Indian health standards was dependent upon the triumvirate of community development, the health care system of Canada and a continuing relationship between native people and the federal governemnt.[115] Indeed there is a strong relationship between issues of community development and health concerns. A recent report on health in the Sioux Lookout Zone in Ontario noted some "of the illnesses that plague native children - otitis media, gastroenteritis, streptococal infection, pneumonia and influenza - could be prevented with better living conditions".[116] A recent letter from Alan Knockwood to the Canadian Mortgage and Housing Corporation's publication Perspective articulated the problem of housing on Nova Scotia's reserves in 1990, noting that there exists "an enormous housing problem on all reserves." Knockwood continues, using his own community as an illustration, writing that "Indianbrook is located 70km outside Halifax. Our population is about 1200...Our current housing list, that is, families waiting for adequate housing, is 250+. This often means

that families who need housing will wait 5 to 15 years or longer, often living in overcrowded or inadequate housing".[117] Yet, important as these infrastructural considerations may be in determining health, it is with interest that we note that the authors of the Sioux Lookout Zone study wrote that "the greatest single problem facing the aboriginal people in the Sioux Lookout Zone - and putting pressure on the health care system - is the breakdown of the traditional, extended family unit, the loss of cultural and spiritual values and the resulting decline in mental health".[118]

Noel Knockwood, the Micmac spiritual leader, recently expressed a similar sentiment, saying that "traditional native spirituality" is needed to overcome problems such as family violence, alcoholism and the alienation and dissatisfaction of Micmac youth, which are rife within Micmac communities. "One of the ways we can deal with these things", Knockwood continued, "is to reintroduce native rituals and sacred ceremonies such as the sacred peace pipe ceremony, or the purification ritual of the sweat ceremony".[119] Similarly, Gabe Marshall, an addictions counsellor, has noted that fellow Micmac "must be attuned to ourselves, our families, our religion, our environment and our Creator. We must find value in all these things before we are free of the chemical (dependency)".[120] Marshall was articulating what is, essentially, a restatement of traditional native values and attitudes.

Similarly, the Confederacy of Mainland Micmac recently defined health as "a never-ending interaction between physical, emotional, spiritual and environmental factors".[121] Given this comprehensive

definition of health it should come as no surprise to learn that Micmac medicine practices, indeed their whole approach to illness is equally comprehensive, embodied in the catchphrase 'wholistic health'. As Noel Knockwood has said, "Indian medicine practices do not treat symptoms alone, but work on the cause of the illness. Indians do not seperate the body and soul (spirit)...Our physical health cannot be complete without our spirits, body and mind for one cannot be without the other. Let us not deny the ancient spiritual teachings, beliefs, and practices of our beloved native ancestors."[122] Thus, the traditional native medicine man will not only utilize herbal medicines, discussed in Chapter One, but will also attempt to cleanse the spirit of the afflicted individual through psychic healing and the therapeutic touch - the laying of hands.

The Micmac concern for fostering spiritual well-being as part of the healing process is intimately associated with their notions of disease and causation. Not all Micmac enthusiastically endorse germ theory as the only explanation of disease. Just as physical strength is often seen as a sign of a special endowment of, or access to, spiritual power, illness or sickliness is considered part of the afflicted individual's constitution - "an endemic aspect of his (or her) personality" as Jeanne Guillemin has commented.[123] Thus, for those young members of the Micmac community who are frequented by illness[125]

> the predisposition to sickness is noticed and remarked upon...The child who tires easily is described as having thin blood and has to submit both to the potions of modern medicine and those of the old women who are concerned about him. The child who lacks an appetite, the child who tends to get colds and earaches gets the same double treatment. The closer a sickly child gets to adolescence, the

> more fatalistic the attitude of his caretakers become. If their ministrations have not made him or her a robust energetic member of the family by the age of ten or eleven, the possibility of a transformation is usually abandoned.

In addition to this notion of predisposition - that illness is part of an individual's physical and spiritual constitution - many Micmac also believe that extraneous spiritual energy, such as anger, can induce ill health or accidents. Given that the residual anger left over from an encounter between people may cause illness in one or the other, sickness then becomes not only a matter of physiology or spirituality, but becomes firmly rooted in the social sector. Therefore, explanations of illness must ultimately include suppositions and knowledge of human inter-relations. Thus, as Gullemin writes, women, as the chief providers of informal medical care, receive "cultural license to approach the problem of illness, her own and others', with speculations about the specific motivations behind the fact of sickness: are there bad feelings in the kin group of the sick person, is there an old enemy who has reappeared on the scene; is the sick person, for a lack of spirit, ready to die?"[126]

Traditional Micmac beliefs, then, go beyond the modern medical concern for the individual, and parts of the individual, in the classic 'body as machine' analogy. This analogy has often been condemned. Ivan Illich wrote that such a view reduces the patient "to an object being repaired". Lynn Payer has suggested that

> it was an extreme application of the machine (and business) metaphor that prompted the U.S. Labor Department to announce in December 1985 that it was drafting a proposal whereby civilian federal employees would not be compensated for losing

> certain body parts such as sex organs, breasts, kidneys, or lungs in the line of duty. Officials believed...that these organs were not necessary for the production of income.

Such an approach to the body is totally foreign to Micmac culture, which was concerned with the physical, spiritual, emotional and social components of disease and illness. When Noel Knockwood called for more education in traditional native values and beliefs, he meant for the community, not for individuals. Only by addressing the ills of the community, on which individual health depends, can better health be fostered. As an example of this, Knockwood cited the example of British Columbia's Alkali reserve where, after a reintroduction of traditional native spiritualism, the problem of alcoholism was eradicated.[127] Thus, while the focus of modern medicine is essentially reductionist, that of the Micmac perspective is expansive.

There exists, then, a gap between Micmac expectations of the health care system and what it can provide. Health care delivery simply does not incorporate herbal medicines or psychic healing with the dominant Western pharmacology and medical practices. Given the fundemental difference between Micmac perceptions of health - which includes community and spiritual health - and those of health care professionals, who are largely concerned only with physiological health, frustration and disappointment are bound to ensue. Complaints about Medical Services being "insensitive" to the health needs of the Micmac are not uncommon. This frustration, of course, extends beyond the realm of health care and the health care bureaucracy. Anastasia Shkilnyk recorded an illustration of this from an Ojibwa Indian:[129]

> You white people, you divide everything up. If we

> have a family problem, we now have to go to six different government agencies: one for getting a job, one for getting welfare, one for taking care of children, one for curing and medicine, and so on. And no one place exists to help the family as a whole.

Hence, one must be careful not to impose an analysis upon the Micmac people of Nova Scotia. While the statistical data presented thus far, and the comments of Shkilnyk's informant indicate, there has been considerable improvement in the services offered native people and their overall health status since the Second World War, the perception remains within native communities that they are afflicted with an excess of disease and health problems.[150] The fragmentary approach of the various government bureaucracies combined with MSB's concern for physiological health do not alleviate these frustrations, but rather enhance them. The Micmac look to the health care delivery system, perhaps as they would have looked toward their own pharmacopeia and spiritual leaders, as offering solutions in helping them achieve health, as defined by them. When the health care delivery system fails in this objective, frustration ensues. Culturally sensitive health care, which would necessarily be more wholistic, is something not yet achieved, as there has been little blending of the two health care systems - the informal Micmac system, with its cultural tenets and herbal pharmacopeia and the formal system, embodied by MSB, and incorporating elements of the broader health care system.

IX - Challenging the Medical Monopoly?

It is important to recognize that health care systems are also cultural systems, not only in the informal system but the formal as well. The vast majority of health care is carried out in the former

by unlicensed people in homes or communities. Kenneth Davidson, based on research conducted in the late 1960s in an unidentified northeastern town in Nova Scotia, wrote that most people in the lowest socioeconomic group "will initially try to deny their illnesses for long periods of time, engage in self diagnosis and use home or patent remedies to prevent transition into a deviant role <i.e. the patient role> and avoid costly treatment by medical personnel."[131] This was a different pattern exhibited than that found among other socioeconomic groups, perhaps demonstrating not only a cultural basis, but a class one as well.

To return, though, to a consideration of the formal health care system, the central focus here, it too has cultural components. We have seen how the medical profession has largely succeeded in excluding alternative practitioners from the medical marketplace, first turning toward their closest competitors - homeopaths, eclectics and the like - and later toward practitioners such as osteopaths, chiropractors and midwives. The very process of professionalization that excluded these sectarians, however, did not yield the same results everywhere. Hence, one may still encounter midwives practicing in Quebec. In France, homeopathy is a vibrant and accepted part of 'orthodox' medicine. A 1978 survey found that no less than six thousand physicians utiliized homeopathic remedies, half of these exclusively, and fifty-five percent of pharmacists occasionally prescribed homeopathic remedies. Moreover, the stature of homeopathy is not merely a remnant of imperfect professionalization or an earlier age, for the pharmacists predicted an increase in the utilization of these remedies.[132]

In Nova Scotia, indeed Canada, there has been an increasing trend toward utilizing alternative forms of care and treatment as well. The recent Report of the Nova Scotia Royal Commission on Health Care has noted that "studies in Canada and the United States estimate that between 40 and 90 per cent of primary physicians could safely be delegated to nurses who have been appropriately trained to have initial contact with patients without physician supervision."[133] But alternatives go far beyond simply allowing health care providers more responsibilities, and include expanding the very definition of who can provide health care to include those hitherto excluded from government insurance schemes. Recently proposed legislative changes in Ontario would place practitioners such as massage therapists, osteopaths, chiropractors and other providers of non-prescription treatments under the same legislative rubrics as doctors dentists and nurses. Nevertheless, diagnosis, prescribing and dispensing presciptions, performing surgery, setting fractures, administrating inhalations and injections, and managing labor and childbirth would continue to be the exclusive domain of persons registered under the appropriate governing body.[134]

Such legislative changes, while significant, still recognize the paramount position of physicians within the health care hierarchy and therefore are not a serious threat to their monopoly. Rather, they do pose a threat to some groups, such as naturopaths. The proposed legislation in Ontario would allow osteopaths and chriopractors to conduct spinal manipulation and would forbid naturopaths to diagnose disease. These two key tenets of naturopathy would be licensed to other practitioners, thereby threatening naturopathy's continued existence.

Naturopaths, self-governing since 1925 under the Drugless Practitioners Act, and the Ontario Naturopathic Association looked toward this supposedly progressive legislation with only great foreboding, fearing an end to their discipline.[135] There are no statistics kept on the number of visits Canadians make to alternative practitioners each year but there has been greater recognition of the role of alternative practitioners in the health care delivery system. It would seem that this legislation was a recognition of that role, but aims not to include them, but rather to submit them to the control of medical orthodoxy.

There is one final point that is worth noting briefly as an example which exists neither entirely in the formal or the informal medical system in Nova Scotia, the example of midwifery. Though it remains illegal in Nova Scotia, there remains two acknowledged practicing midwives in the province, though there may be more. One of these, Charlene MacLellan has "caught" over forty babies during the past eight years.[136] MacLellan also feels that, in time, midwives will be allowed access to hospitals for the purpose of delivery. The Medical Services Branch annual report for 1985 noted a "pre-planned (by the parent) home birth attended by a traditional midwife" as "the first such for several years." The report went on to note that it was "a poor choice by the mother who had to receive multiple transfusions in the hospital, although no problems ensued for the infant."[137] With its sterling record of maternal health, MSB was quick to disassociate itself from this event, as evidenced by its paranthetical remarks and the critical comments regarding the aftermath.

X - Mortality

While MSB did have a sterling record with respect to maternal health, with no maternal deaths from 1968 to 1986 there were, and continue to be, areas of grave concern with respect to mortality (Selected mortality statistics may be found in Table 5.4 for the Micmac. Comparative data for the province as a whole is in Table 5.5). Recently published data from Statistics Canada graphically illustrates this problem. Between 1983 and 1986, the annual death rate for Canada's reserve population was nine per 1000, one and a half times the rate for Canada as a whole, which was 6.6. Most frightening, however, was the statistic that Indians were three times more likely to die before reaching age thirty-five than other Canadians.[138] One should, however, be careful in applying these statistics to the context of Nova Scotia's Micmac population, or that of Atlantic Canada's native peoples. One study of mortality on Canadian reserves, analyzing data for the period 1977 to 1982 found that between ages twenty and twenty-nine, the age-specific mortality rates were 2.8 times the Canadian rates for men and 3.5 for women. Between ages 50 and 70,"age-specific rates for men were similar to those for Canada as a whole, while rates among women were elevated".[139] This pattern was true for all provinces except for Prince Edward Island, which was excluded because of its small population, and Nova Scotia, where mortality rates among Indians were consistently and significantly lower. The authors concluded that the "low rates in Nova Scotia may have been due to a genuine decrease in risk. However, in light of the findings for the rest of the country, it is more likely that the decrease is an artifact resulting from the incorrect residency coding of

death certificates."[140] Mortality rates are, however, suspect at the best of times, especially in areas where the native population is in close proximity to urban centres. This leads not only to the incorrect coding of death certificates, but other problems as well. Urban centres may draw the native population away from the reserve community, though individuals may return to the community in the latter stages of life. Thus, in 1984 the death rate for Atlantic Region's native people's was a respectable 6.78 per 1000, if the on-reserve population is used to calculate the figure. This figure, which compares quite favourably to the average rate for Canada between 1983 and 1986 (6.6/1000) and most favourably to the national Indian rate for the same period (9.0/1000), is, however, markedly reduced if the total native population is used, which yields a modest crude death rate of 5.1 per 1000. The rate, it would appear, is either artificially high or low.[141]

The question of a reduced risk in Atlantic Region, then, still has to be conclusively, or at least convincingly, redressed. What is clear, however, is that the leading causes of mortality in Atlantic Region are sometimes at variance with the corresponding national indicators. Between 1980 and 1984, the leading causes of mortality among the total Indian population served by MSB were: accidents, injury and poisoning (33.6%), diseases of the circulatory system (23.3%), neoplasms (9.5%) and diseases of the respiratory system (8.7%).[142] For the same period in Atlantic Region, the leading causes of mortality were: diseases of the circulatory system (41.3%), accidents, poisoning and violence (23.9%), neoplasms (16.4%), and diseases of the respiratory system (3.9%), which cumulatively accounted for 85.5 percent of all deaths in the region.[143]

Table 5.4

Selected Causes of Mortality -
Indian Population of Atlantic Region

	1970-71		1971-72		1972-73		1974		1975		1976		1977	
	M	F	M	F	M	F	M	F	M	F	M	F	M	F
Infective and Parasitic Diseases											4	1		
Neoplasms	1	4	2	1	4		7	2	3	2	5		8	1
Allergic, Endocrine System, Metabolic and Nutritional Diseases		1							2	1			1	
Diseases of the Blood and Blood Forming Organs	1					1								
Mental, Psychoneurotic and Personality Disorders														
Diseases of Nervous System and Sense Organs							1		1					
Diseases of Circulatory System	10	14	12	6	5	5	14	8	9	7	18	11	15	5
Diseases of Respiratory System	3	1	3		2	1	3	4	2	2	4	2	3	2
Diseases of Digestive System	1	1	2		1	1	4	4	1	2			1	
Diseases of Genital Urinary Tract			1		1		1		1	2		1		2
Congenital Malformations	2	1			1		1				1	1	1	
Diseases of Early Infancy	2				1				2					
Accidents, Poisoning and Violence	8	1	15	3	12	6	15	8	5	4	11	2	16	4

Table 5.4 (Cont'd)

	1978		1979		1980		1981		1982		1983		1984		1985		1986	
	M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F
Infective and Parasitic Diseases							1											2
Neoplasms	2	1	5	7	3	5	4	4	8	8	2	5	5	6	4	10	6	6
Allergic, Endocrine System, Metabolic and Nutritional Diseases	4	1	1			2					1				1			2
Diseases of the Blood and Blood Forming Organs																		
Mental, Psychoneurotic and Personality Disorders					1													
Diseases of Nervous System and Sense Organs								1										
Diseases of Circulatory System	18	6	8	15	8	16	17	6	18	6	12	13	17	13	8	14	10	10
Diseases of Respiratory System	1	1	1	2	2	1	2		1		1	3	2		3	3	1	2
Diseases of Digestive System	1		4	4	6			2	1	2	2	1	1		2	1	3	2
Diseases of Genital Urinary Tract	1	1	2	1		1	1	1			2		1		1			1
Congenital Malformations								2	1	1	3	1	1	1	1			
Diseases of Early Infancy																		
Accidents, Poisoning and Violence	11	7	24	3	21	6	12		8		7	3	8	8	13	4	8	1

Table 5.5
Selected Causes of Motality -
(Nova Scotia)

	1969		1970		1971		1972		1973		1974	
	M	F	M	F	M	F	M	F	M	F	M	F
Infective and Parasitic Diseases	40	18	32	23	38	21	28	10	23	17	25	18
Neoplasms	659	577	747	595	675	575	752	607	761	634	779	606
Diseases of the Circulatory System	1974	1453	1968	1463	2001	1465	2074	1525	1995	1507	1988	1445
Diseases of the Respiratory System	273	176	320	167	273	142	280	167	308	163	311	205
Diseases of the Digestive System	123	97	104	91	110	88	138	77	153	80	144	84
Diseases of the Genito-Urinary Tract	53	33	64	42	22	9	77	43	78	31	71	57
Congenital Malformations	57	38	38	39	43	41	38	43	45	31	39	34
Diseases of Early Infancy	82	44	76	51	80	45	45	34	44	42	37	37
Accidents, Poisoning and Violence*	459	142	419	141	439	145	434	157	508	147	473	177
Suicide	67	9	63	10	62	7	73	20	73	16	73	14

* includes suicide

Source: Vital Statistics 1969-1974

Table 5.5 (Cont'd)

	1975		1976		1977		1978		1979		1980	
	M	F	M	F	M	F	M	F	M	F	M	F
Infective and Parasitic Diseases	22	24	30	23	25	20	29	21	23	11	24	22
Neoplasms	788	619	790	638	890	668	841	714	887	708	929	743
Diseases of the Circulatory System	1897	1446	1972	1574	2045	1491	1901	1426	1874	1462	1798	1514
Diseases of the Respiratory System	305	174	312	189	294	199	312	162	249	183	319	203
Diseases of the Digestive System	146	110	115	85	122	83	119	112	157	113	157	111
Diseases of the Genito-Urinary Tract	73	33	57	59	61	43	70	46	71	37	66	63
Congenital Malformation	37	34	37	42	43	25	32	29	32	33	32	30
Diseases of Early Infancy	55	30	37	24	32	20	44	24	46	23	28	20
Accidents, Poisoning and Violence*	443	141	434	144	385	127	448	145	428	133	388	137
Suicide	73	12	71	15	75	19	81	24	89	17	87	10

*includes suicides

Table 5.5 (Cont'd)

	1981		1982		1983		1984		1985	
	M	F	M	F	M	F	M	F	M	F
Infective and Parasitic Diseases	21	20	19	28	38	30	25	22	39	28
Neoplasms	913	691	911	748	959	756	974	821	1000	862
Diseases of the Circulatory System	1807	1483	1797	1411	1783	1421	1643	1466	1757	1468
Diseases of the Respiratory System	337	202	337	199	385	231	337	218	386	245
Diseases of the Digestive System	140	114	122	148	143	128	133	145	145	132
Diseases of the Genito-Urinary Tract	70	75	66	68	59	53	62	63	72	85
Congenital Malformations	34	23	30	28	30	28	23	24	26	28
Diseases of Early Infancy	43	30	20	14	28	15	20	22	15	22
Accidents, Poisoning and Violence*	369	123	389	141	368	127	313	126	340	136
Suicides	76	16	82	22	90	14	75	11	90	16

* includes suicides

For the entire population of Canada during the same period, the ranking was as follows: diseases of the circulatory system (44.5%), neoplams (25.8%), accidents, injury and poisoning (8.0%) and diseases of the respiratory system (7.3%).[144]

The trend within Atlantic Region of an elevated risk of cardiovascular disease, when compared to their counterparts on other Canadian reserve communities, was a trend throughout the period under consideration. In 1969, the annual report noted that diseases of the respiratory system "accounted for a disturbingly high proportion of the total."[145] By 1984, however, there was an attempt by MSB to dispell the 'myth' of "the "serious" problem of deaths from cardiovascular deaths". In that year, such deaths accounted for 46.2% of the total recorded deaths. Yet the report said "in point of fact the majority of these deaths occured at a moderately advanced age and reflect a lower incidence of deaths from other causes."[146] Despite the fact that, as a percentage, cardiovascular disease marginally increased - 46.2% in 1984 compared with 43.2% in 1969 - it no longer seemed to elicit the concern of MSB.[147]

Consistent concern has been demonstrated with respect to the high rates of mortality attributable to accidents, injury and poisoning. In 1971-72 these causes accounted for forty percent of reported deaths, though by the 1980s this percentage was markedly reduced. It was generally recognized that these deaths were associated with the high level of substance abuse within native communities by both the communities themselves and MSB. It has been estimated that three-quarters of all deaths in this category were the result of alcohol useage or "alcohol

related problems."[148] One author has noted that the "most significant differences between mortality on Indian reserves and that experienced by Canadians as a whole were the much higher Indian mortality rates for accidents/poisonings and violence on reserves."[149] Given the perceived association between substance abuse and this type of death, does one find a decrease in the rates as native people began to exert their influence in the area of treatment of substance abuse? While there appears to be no direct correlation, there is a general trend toward the decreasing prominence of this cause of mortality (See Table 5.5). This is not to suggest that this is the only factor, but there is surely a relationship between the two variables. As native people begin to assert their control over the problem of substance abuse, they are also confronting a leading cause of mortality.

Table 5.5
Accidents, Poisoning, Violence
As a Percentage of Total Deaths

Year	Total Accidents, etc.	Total Deaths	Accidents as a %
1970-71	9	51	17.6%
1971-72	18	45	40.0%
1972-73	18	41	43.9%
1974	23	76	30.3%
1975	9	47	19.1%
1976	13	63	20.6%
1977	20	60	33.3%
1978	18	58	31.0%
1979	27	77	35.1%
1980	27	75	36.0%
1981	12	53	22.6%
1982	8	55	14.5%
1983	10	57	17.5%

Table 5.5 (cont'd)

Year	Total Accidents, etc.	Total Deaths	Accidents As a %
1984	16	65	24.6%
1985	17	66	25.8%
1986	9	60	15.0%

Source: MSB Atlantic Region Annual Reports 1970-71 to 1986

XI - Towards a New Strategy?

The World Health Organization has defined health promotion as "a process of enabling people to increase control over, and to improve their health" and, as noted by a recent editorial in the Canadian Journal of Public Health, "it is this concept of empowerment that also defines the essence of the transfer of control of health services to native people."[150] The 1979 Indian Health Policy had three central objectives: community development, strengthening the relationship between native people and the federal government and the maintenance of the active role of the federal government in the provision of health services to Indians. Yet, it was also a statement of intention by the federal government, in that it was committed to encouraging and promoting native involvement in the administration and delivery of health services- the "devolution" discussed earlier. Thus, as a 1984 Micmac News article noted, "the thrust toward Indian self-determination and self-control over the past decade has jettisoned health care into the political arena".[151] In this section, recent changes in the administration and delivery of health services will be considered, with a special focus on the involvement of native people in this process.

It was with a hint of pride that the national review of MSB activities for 1982 and 1983 noted that "the delivery of frontline health services is involving, to an even greater extent, local personnel such as Community Health Representatives. The majority are band employees, paid from funds channeled through agreements made between Medical Services and individual bands." The report went on to note, however, "that success in involving Native people is not limited to recruiting Community Health Representatives" as the twenty-two percent of MSB's total staff were native people.[152] Nevertheless, this total was sufficiently modest to prompt Monique Bégin, Minister for National Health and Welfare, to announce an initiative to develop more native health workers. At the time of the announcement, Bégin noted that only thirty-eight people of native ancestry were employed by MSB as executives and delivery personnel. The Minister also commented that there were fewer than two hundred health workers in all of Canada.[153] Apparently native people had actually lost ground in the area of delivery, for Paul Grescoe noted that at the time the Registered Nurses of Indian Ancestry Association was formed in 1977, there were 221 Indian nurses alone in Canada. Grescoe also noted that that same year, 1977, the "best guess is that there are only one Inuit and nine Indian doctors in the country" and adds, with derision, that "Medical Services couldn't even make a guess, which is a telling indication of how it has divorced itself from any encouragement of native Canadians to study medicine."[154] To remedy the deplorable state of native involvement as outlined by Bégin, if not Grescoe, the government approved an Indian and Inuit Health Professional Career Development Program, which

had some one hundred students enrolled in five institutions by 1985-86.[155]

Concurrent with the development of the Career Development Program was the formation of the First Interim Micmac Indian Health Commission, formed in November 1984. The Commission was given the mandate of fostering interest in native health and health issues. It also initiated a campaign throughout Nova Scotia to seek "input from native people on the reserves with respect to the improvement of the present health services and the eventual takeover of the services by native people" in an effort to arrive at policy decisions regarding the "eventual takeover of Indian Health Services by the Native people".[156] Yet, despite the fact that Dr. Lyall Black, the assistant deputy minister of Health and Welfare, assured Micmac delegates at a conference entitled 'Indian Control of Indian Health...Progress Through Involvement' held in April 1985, that his department was committed to the transfer of health services, there remained apprehension within the native communities. A preliminary report presented at the conference by the Director of Community Health for the UNSI, Peter Stevens, found that within communities there existed a "fear that Ottawa would provide insufficient funds for an Indian controlled health system as well as a belief that real decision making authority would remain in the hands of the federal government."[157] It was likely this apprehension that led MSB to comment upon the "negative" response from the UNSI regarding transfer.[158]

The federal government was, however, committed to transfer. In the fall of 1985 Jake Epp, the Minister responsible for Indian Health Ser-

vices, "approved the mission of Medical Services Branch to: (a) effect transfer of control of health services to Indian communities at a pace to be determined by the communities themselves; and (b) enhance existing programs for Indian and Inuit communities."[159] By late summer, 1986, there was a change of tone within Micmac communities. "The need to assume control of Indian Health has been expressed and supported by many of our community people as well as the health committees in Nova Scotia" reported the Micmac News. However, this enthusiasm was tempered by "severe logistical problems which include the lack of human and financial resources within the Bands" and "the governments failure to provide legislative guarantee as well as the appropriate funding formula".[160] By January 1987 all bands in Nova Scotia were rejecting transfer, unless these issues were resolved.[161]

XII - Conclusion

Throughout this chapter, we have seen an increasing participation by native people in the areas of delivery, planning and administering Indian health services. But what impact does this increasing community involvement have on the medical marketplace and the medical profession? We have encountered the use of the term 'devolution' to characterize developments in health services during the 1980s, but are these developments indicative, as Morton Warner has argued, of "a reversal in the professionalization and bureaucratization of medicine and health services"? Moreover, will the community participation that will ensue from the transfer process "be disruptive to health professional and bureaucratic modes of operation and bring about demands upon political

structures for increased democracy"? Finally, will the transfer process and other forms of participation by the community result in "an accelerated reduction in the power of the medical profession"?[162]

Soon after physicians achieved a position of preeminence within the medical hierarchy in the 1930s, that position was challenged and physicians "found themselves in a struggle with hospitals, insurance companies, medical schools, foundations, government health agencies, and other groups with an interest in a more rationalized health system" wrote E. Richard Brown.[163] This challenge came not from below - from allied health workers such as nurses or community programs - but rather from their peers, who had little interest in challenging the status quo of the medical marketplace but rather wanted only to carve out their own spheres of influence and, hence, profitability. Community participation, as demonstrated through the example of the Micmac, does not entail a wholesale restructuring of the medical bureaucracy either, but rather aims to gain access to it. Efforts are directed at increasing native participation at the delivery level, most recently through programs such as the National Native Access Program to Nursing and the Micmac Professional Health Careers Project, and at the administrative level. Through incorporating native people and native interests into the existing structure, these programs serve a hegemonic function. Moreover, funding arrangements still have to be negotiated with the federal government and, even after transfer, bands still have to "maintain a dual responsibility to the federal government and their communities"[164] which will serve as an inhibiting factor.

Similarly, the recognition of the need for more culturally sensitive and appropriate care has been incorporated, to a limited extent, into the existing structure. The most obvious success, substance abuse programs, are essentially non-medical in orientation and therefore pose no real threat to the power of physicians or the medical bureaucracy. Traditional native medicine, with its emphasis on a wholistic approach could be viewed as such a challenge, but more likely should be seen as an adjunct to orthodox medical care. Moreover, it has been argued that community health facilities, those much sought after bastions of medical authority and orthodoxy, play a role not only in enhancing that status and profile of orthodoxy, but also serve to "discredit, destroy or coopt the prevailing folkways."[165]

In the final analysis, then, it would seem that community based programs and indigenous beliefs do not pose a threat to the status quo but rather are being incorporated into the existing structure and thereby reinforce the existing relations. This is not to suggest that these endeavours are not wothwhile, clearly they are. Native operated and staffed programs have made significant gains in educating the reserve populations about substance abuse and treating its effects. What remains to be seen is whether these community endeavours can succeed where MSB has failed, namely, in further elevating the status of Micmac health. What is clear is that the foundation for empowerment of the Micmac community with respect to health care has been layed, the basis from which further change can be initiated.

Endnotes

1. Canada. Department of National Health and Welfare Annual Report 1969, p.p. 117, 102-103.

2. Canada. Department of National Health and Welfare Annual Report 1977-78, p. 11.

3. The history of medical, hospital and diagnostic services legislation will not be dealt with fully, except as it pertained to the Micmac. It is a long and complex history, that can trace its modern roots to 1919, though there are earlier examples. See A.D. Kelly, "Health Insurance in New France" in Bulletin of the History of Medicine Vol. 38 (1954), David Naylor, Private Practice, Public Payment: Canadian Medicine and the Politics of Health Insurance, 1911-1966. Montreal: McGill-Queens University Press, 1986 and Malcolm G. Taylor, Health Insurance and Canadian Public Policy, Montreal: McGill-Queens University press, 1978.

4. Canada. Health and Welfare Canada. Indian and Northern Health Services (Medical Services Branch) Atlantic Region Annual Report 1968, p. 3. (Hereafter cited as MSB Annual Report). L.D. Hirtle was the Regional Director of Atlantic Region when he made the statement.

5. MSB Annual Report 1969, p. 3 and MSB Annual Report 1970-71, p. 5. It should be noted that no new T.B. cases had been detected by x-ray for several years, even during years of mass survey.

6. Canada. Indian and Northern Affairs. Statement of the Government of Canada on Indian Policy, 1969. Ottawa: Department of Indian Affairs, 1969.

7. Events leading up to the White Paper and the document itself have been dealt with more extensively in my "Government Policy and the Micmac of Nova Scotia: 1969-1971". An unpublished manuscript prepared for Atlantic Canada Studies Seminar: Culture of Atlantic Canada. November 28, 1989.

8. Pierre Elliot Trudeau, Pierre Elliot Trudeau: Federalism and the French Canadians. Toronto: Macmillan, 1968, quoted on the back cover.

9. Sally M. Weaver, Making Canadian Indian Policy. Toronto: University of Toronto Press, p.p. 23, 45-46.

10. Canada. Indian and Northern Affairs. Annual Report 1967-68, p. 61. The names of those Micmac in attendance may be found in Indian and Northern Affairs, Report of the Indian Act Consultation Meeting, Moncton, New Brunswick July 29-31, 1968. Ottawa: Queen's Printer, 1968. See also page 5 of the report.

11. J.S. Erskine, "Their Crowded Hour: The Micmac Cycle" in Dalhousie Review, Vol. 38, No. 4 (Winter 1959), p. 452.

12. Canada, Statement of the Government of Canada on Indian Policy, 1969, p.p. 3, 5, 8.

13. Ibid., p.p. 6-12.

14. Weaver, op. cit., p. 197.

15. Canada. Debates of the House of Commons (hereafter Debates) June 25, 1969, p. 10585 and July 4, 1969, p. 10842.

16. Canada. Debates July 11, 1969, p. 11131-32.

17. The entire debate may be found in Debates June 19, 1969, p.p. 10410-10444. Comeau's speech is on p.p. 10441-10443. The Mail Star was consulted for six months following the announcement for potential reaction from Nova Scotia's Members of Parliament.

18. Mail Star June 26, 1969, p. 35.

19. Ibid.

20. Mail Star December 8, 1969, p. 35 for the comments of Johnson, Marshall and Gould. For the concept of 'citizen-plus' see Harry B. Hawthorne, A Survey of Contemporary Indians of Canada: Economic, Political, Educational Needs and Policies. Vol. 1. Ottawa: Queen's Printer, 1966-67, p. 45.

21. Union of Nova Scotia Indians. Minutes of Organizational Meeting May 13, 1969. Public Archives of Nova Scotia Library, p. 1.

22. Union of Nova Scotia Indians. Minutes of Organizational Meeting July 11-13, 1969, p. 6.

23. The Mysterious East, January 1970, p. 9.

24. 4th Estate, July 24, 1969, p. 4 and August 21, 1969, p. 3.

25. Micmac News January 1971, p. 8 and November 1970, p. 3.

26. MSB Annual Report 1970-71, p.p. 3-4.

27. Canada. Department of National Helath and Welfare Annual Report 1970, p. 104.

28. MSB Annual Report 1974, p. 5.

29. MSB Annual Report 1972-73, Appendix K, p.p. 7-8.

30. Micmac News November 1971.

31. MSB Annual Report 1971-72, p. 6 and Annual Report 1972-73, p.p. 8-9, Appendix K, p. 7.

32. MSB Annual Report 1970-71, p. 4.

33. Micmac News October 1971, p. 3.

34. Micmac News April 1972, p. 19.

35. Canada. Department of National Health and Welfare Annual Report 1971, p. 56, MSB Annual Report 1972-73 Appendix K, p. 7 and MSB Annual Report 1979 Appendix A, p. 2.

36. MSB Annual Report 1969, p. 2 and Annual Report 1972-73, p. 3.

37. MSB Annual Report 1970-71, p. 4.

38. MSB Annual Report 1972-73, p. 7.

39. Only four bands administered their own transportation services and none of these were in Nova Scotia. In addition, it should be noted that the Lennox Island Band did hore its own registered nurse on a half-time basis, a program that did enjoy some success. See MSB Annual Report 1974, p. 9.

40. Michael E.K. Moffatt, "Land Settlements and Health Care: The Case of the James Bay Cree" in Canadian Journal of Public Health Vol. 78 (July/August 1987), p. 223.

41. Ibid., p.p. 224-225.

42. Micmac News March 1976, p. 1.

43. Micmac News December 1976, p. 13.

44. Richard N. Nuttall, "The Development of Indian Boards of Health in Alberta" in Canadian Journal of Public Health Vol. 73 (September/ October 1982), p. 301.

45. Canada. Department of National Health and Welfare Annual Report 1977-78, p. 13.

46. Micmac News March 1978, p. 5.

47. Nuttall, op. cit., p. 301.

48. MSB Annual Report 1978, p. 2.

49. The press release is quoted in Dara Culhane Speck, An Error in Judgement: The Politics of Medical Care in an Indian/White Community. Vancouver: Talonbooks, 1987, p.p. 200-201.

50. Canada. Debates November 16, 1978, p. 1183.

51. MSB Annual Report 1979, p. 6.

52. Micmac News June 1979, p. 4.

53. Micmac News June 1979, p. 6.

54. Micmac News February 1979, p. 5.

55. Canada. National Health and Welfare Medical Services Annual Review 1981, p. 17.

56. Monique Bégin, Medicare: Canada's Right to Health. Montreal: Optimum Publishing International, 1984, p.p. 38-39.

57. MSB Annual Report 1979, p. 6.

58. Ibid., Appendix A, p. 5.

59. Micmac News January 1984, p. 4.

60. Micmac News July 1980, p. 23, August 1980, p. 1 and February 1981, p. 1.

61. Micmac News June 1980, p. 20, and February 1981, p. 1.

62. Canada. Department of National Health and Welfare Annual Report 1967, p. 128.

63. Marc Lalonde, A New Perspective on the Health of Canadians. Ottawa: Department of Health and Welfare, 1974, p. 14.

64. Christopher Lasch, Haven in a Heartless World: The Family Besieged. New York: Basic Books, 1979, p.p. xx, xxi.

65. MSB Annual Report 1971-72, p. 7 and Annual Report 1972-73, p. 10.

66. MSB Annual Report 1974, p. 8 and Annual Report 1975, p.p. 8-9.

67. MSB Annual Reports 1972-73 through 1986. No data could be obtained as to the cause of infant mortality for the earlier reports.

68. Canada. Health and Welfare Canada. Health Status of Canadian Indians and Inuit Update 1987. Ottawa: Indian and Northern Health Services, 1988, p. 12.

69. H.I. Morrison, Yang Mao, Robert Semenciw and Donald Wigle, "Infant Mortality on Canadian Indian Reserves 1976-1983" in Canadian Journal of Public Health Vol. 77 (July/August 1986), p. 272.

70. Globe and Mail December 22, 1989, p. A10.

71. MSB Annual Report 1984, p. 2.

72. Jeanne Guillemin, Urban Renegades: The Cultural Strategy of American Indians. New York: Columbia University Press, 1975, p. 221.

73. Eleanor D. Glor, "Impacts of a Prenatal Program for Native Women" in Canadian Journal of Public Health Vol. 78 (July/August 1987), p.p. 250, 253.

74. Ibid., p. 249.

75. MSB Annual Report 1986, p. 5.

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93. MSB Annual Report 1986, p. iv and Micmac News June 1986, p. 2. See also Micmac News July 1986, p. 7. The band at Millbrook decided to administer its own program.

94. Micmac News April 1988, p. 19.

95. Micmac News January 1985, p. 5.

96. Micmac News April 1985, p. 25. The issue of native approaches to health maintenance is dealt with more fully later in the chapter.

97. Micmac News February 1990, p. 36.

98. Micmac News August 1971, p. 6.

99. Micmac News June 1979, p. 4.

100. Micmac News January 1985, p. 5.

101. MSB Annual Report 1984, p.p. 5-6.

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103. Micmac News July 1971, p. 2 and August 1971, p. 1.

104. Micmac News January 1982, p. 2.

105. Globe and Mail February 20, 1990, p. A3.

106. Shkilnyk, op. cit.

107. Daily News May 25, 1990, p. 5.

108. Confederacy of Mainland Micmac. Community Health Needs Assessment Study. Copyright pending, 1989, p. 55. The Confederacy consisted of the bands of Afton, Bear River, Millbrook, Pictou Landing and Shubenacadie at the time of the survey.

109. Micmac News October 1988, p. 20.

110. Daily News May 25, 1990, p. 5.

111. Globe and Mail December 22, 1989, p. A10.

112. Micmac News October 1988, p. 19. While the reserve went unidentified in the article, it is likely that it was the Indianbrook reserve, which had four suicides between 1986 and 1988 according to the Micmac News July 1988, p. 39. Moreover, in a recent article in the Daily News (May 25 1990, p. 5.), RCMP Special Constable Joe Michael, himself a Micmac, recounted seeing ten suicides on the reserve during his eleven year tenure with the Stewiacke RCMP. See also Micmac News June 1988, p. 22.

113. Micmac News July 1988, p. 39.

114. MSB Annual Report 1983, p.p. 22-23.

115. Micmac News January 1984, p. 4.

116. Edward Scott, Wally McKay and Harry Bain. From Here to There: Steps Along the Way. Achieving Health for All in the Sioux Lookout Zone. The Report of the Scott-McKay-Bain Health Panel, 1989, p.p. 14-15.

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118. Scott, et. al., op. cit., p.p. 13-14.

119. Mail Star June 24, 1989, p. 9. See also Mail Star August 5, 1989.

120. Mail Star December 3, 1988, p. 74.

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122. Noel Knockwood, Native Spirituality Information Kit. Unpublished manuscript prepared for Corrections Canada, 1989. See also Noel Knockwood, Indian Health. Unpublished manuscript prepared for a national workshop on native health, Quebec City, April 1987.

123. Guillemin, op. cit., p. 103, 252-253.

124. Ibid., p.p. 252-253.

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127. Mail Star December 3, 1988, Lynn Payer, Medicine and Culture: Varieties of Treatment in the United States, England, West Germany, and France. London: Penguin Books, 1988, p. 149 and Ivan Illich, Medical Nemesis: The Expropriation of Health. Cuernauaca: Center for Intercultural Documentation, 1974, p. 84.

128. See for example Micmac News December 1988, p. 12.

129. Shkilnyk, op. cit., p. 103.

130. My thanks must go to Terry Knockwood, Health Liaison Officer for the Confederacy of Mainland Micmac, who offered her insights on this difference between Micmac perceptions and those of MSB. Ms. Knockwood was interviewed October 30, 1989. Noel Knockwood offered his insights on this matter during an interview conducted on September 5, 1990 and I am indebted. Finally, Donald Julien and Bill Wicken, in numerous informal conversations in the Public Archives helped to shape these thoughts in ways that they, nor I, will ever know, and are to be thanked.

131. Kenneth R. Davidson, "Conceptions of Illness and Health Practices in a Nova Scotia Community" in David Coburn, et. al., Health and Canadian Society: Sociological Perspectives. Toronto: Fitzhenry and Whiteside Ltd., 1981, p. 91.

132. Payer, op. cit., p. 65.

133. Nova Scotia. The Report of The Nova Scotia Royal Commission on Health Care: Towards A New Strategy (Summary). Halifax, 1989, p. 48.

134. Globe and Mail January 27, 1989, p. A3 and Chronicle-Herald March 14, 1990, p. C1.

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137. MSB Annual Report 1985, p. 7.

138. Globe and Mail December 22, 1989, p. A10.

139. Yang Mao, et. al., "Mortality on Canadian Indian Reserves 1977-1982" in Canadian Journal of Public Health Vol. 77 (July/August 1986), p. 265.

140. Ibid., p. 267.

141. MSB Annual Report 1984, p. 6.

142. Canada. Health and Welfare Canada. Health Status of Canadian Indians and Inuit Update 1987. Ottawa: Indian and Northern Health Services, 1988, p. 13.

143. These calculations were based upon data drawn from Table 5.4. For reference purposes, the total number of deaths in Atlantic Region for the period 1980-84, inclusive, was 305.

144. Canada. Health and Welfare Canada. Health Status of Canadian Indians and Inuit Update 1987. Ottawa: Indian and Northern Health Services, 1988, p. 14.

145. MSB Annual Report 1969, p. 5. Cardiovascular disease in 1969 accounted for 16 of 37 deaths, or 43.2%.

146. MSB Annual Report 1984, p. 7.

147. The two statements made by MSB are not mutually exclusive and may not be contradictory. It may well be that, in 1969, those dying from cardiovascular disease were younger, and the concern contained within the report well-placed. However, no data could be obtained from MSB regarding the age-distribution of cardiovascular mortality in the respective years.

148. Micmac News January 1985, p. 5. Early comments from MSB may be found in the reports for 1971-72 (p. 7), 1972-73 (p. 11) and 1974 (p. 8) and, indeed, throughout the rest of the reports.

149. Mao, et. al., op. cit., p. 267.

150. B. Postl, Michael Moffatt and Peter Sarafield, "Epidemiology and Interventions for Native Canadians" in Canadian Journal of Public Health Vol. 78 (July/August 1987), p. 220.

151. Micmac News January 1984, p. 4.

152. Canada. Department of National Health and Welfare. Medical Services Annual Review 1982 and 1983. Ottawa: Supply and Services, 1985, p. 6.

153. Micmac News May 1984.

154. Grescoe, op. cit., p. 122

155. Micmac News September 1984, p. 8. Canada. Department of National Health and Welfare Annual Report 1985-86, p. 20.

156. Micmac News December (B) 1984, p. 20. See also Micmac News December 1984, p. 10.

157. Micmac News April 1985, p. 21.

158. MSB Annual Report 1985, p. iv.

159. Canada. Department of National Health and Welfare Annual Report 1985-86, p. 18.

160. Micmac News August 1986, p. 10.

161. Micmac News January 1987, p. 3 and MSB Annual Report 1986, p.p. iv, 4.

162. Morton Warner, "The Rise of Community Participation: Its Impact on Health Professionals and the Health Bureaucracy" in David Coburn, et. al., Health and Canadian Society: Sociological Perspectives. Toronto: Fitzhenry and Whiteside Limited, 1981, p.p. 355, 361.

163. E. Richard Brown, Rockefeller Medicine Men: Medicine and Capitalism in America. Berkeley: University of California Press, 1979, p. 6.

164. Micmac News January 1988, p. 12.

165. John Ehrenreich and Barbara Ehrenreich, "Medicine and Social Control" in John Ehrenreich, ed., The Cultural Crisis of Modern Medicine. New York: Monthly Review Press, 1978, p. 68.

Conclusion

The history of medicine, disease and health care delivery among the Micmac in Nova Scotia yields a number of insights into our understanding of the medical profession and medical professionalization, while concurrently documenting the participation of the Micmac in shaping their own history. In this thesis, two themes were examined. The primary theme was the relationship between the state and the medical profession, while the secondary theme, investigated via an examination of medical care, was the relationship of the state to the Micmac. Throughout, consideration has been given to the process of change, in an effort to illustrate how change was a negotiated process.

One obvious example of the negotiated process of change comes from the struggle of the medical community to professionalize. Through an examination of various petitions and government reports from the middle decades of the nineteenth century, it was revealed that many of the physicians active in Micmac communities were generally prominent in their own communities and within the profession itself. Thus, even before the Act of 1828 was expanded in 1856 to provide for registration of practitioners and prohibiting unlicensed practitioners from securing provincial appointments, there was a de facto recognition by the colonial government of Nova Scotia of the preeminence of medical orthodoxy. Yet, this sanction was not without consequences for the colonial government or for the administration of Indian affairs. The accounts submitted by physicians severely taxed the Indian budget during the 1840s and 1850s, prompting the colonial government

to seek greater accountability. The first attempt at rationalizing this expense was the government's decision to pay only for authorized attendance and, second, the government's later refusal to pay for services other than surgery or accouchment. Nevertheless, the colonial government offered medical orthodoxy official sanction and, hence, increased power and prestige at a time when regular practitioners were still competing with sectarians, patent medicine peddlers and quacks in the medical marketplace.

Examples of this competition abound in the historical record and include petitions in support of botanic practitioners, therapeutic baths and the numerous advertisements for miracle doctors and patent medicines. Of particular interest to this analysis were those instances that illustrated the uncertainty of medical therapeutics and the fluidity of cultural boundaries. In 1852, for example, Peter Babey tried to use this therapeutic uncertainty to further his own ends. Babey sought remuneration for his services to members of the Micmac community, citing his beneficial herbal preparations and contrasting them with the potentially harmful and rigorous remedies of white practitioners. Equally instructive was the wholesale adoption of a Micmac remedy for smallpox by Dr. Frederick W. Morris. In 1861 Morris, a former Vice President of the Halifax Medical Society and the resident physician at the Halifax Visiting Dispensary, publicly advocated the efficacy of the remedy, for which he was expelled from the Nova Scotia Medical Society.

This last example serves to illustrate not only the therapeutic uncertainty of the mid-nineteenth century, but the struggle to profession-

alize as well. How did the medical profession emerge from a fractured and diverse group of individual practitioners, into a full-fledged profession with a virtual monopoly? Through creating and utilizing medical societies, medical education, hospitals and licensure, medical orthodoxy secured its preeminence within the medical marketplace. Medical orthodoxy turned first toward its closest competitors, the various sectarian practitioners, and eliminated them from the marketplace. Through tying licensure, hence the right to practice and recover fees, to education, regular practitioners secured their position as the only legitimate providers of medical care. Yet, this process was an ongoing concern - one not limited to sectarians. The operation of a modern, 'scientific' hospital, for example, required a trained and capable nursing staff, but such a corps of workers posed a potential threat to the preeminence of physicians. As a result, the physician lobby deemphasized the skill level of nurses, while emphasizing their limited education and the womanly need to nurture. In this way, physicians successfully subordinated nurses.

But opportunities remained for nurses to maintain a degree of independence within the health care delivery system, particularly in the realms of the public health nurse and the Indian Health bureaucracy. In these positions, nurses were relatively free physician supervision and had the opportunity to exercise their authority. The Indian health service, the origins of which may be traced to the 1870s, though government-provided medical care began much earlier, employed public health nurses, together with field matrons and dispensers. These allied health

care workers are also indicative of the expanding Indian health service as well as the bureaucratization of health care. The country doctor, the sole provider of medical care through much of the nineteenth century, had his role altered by this expanding bureaucracy, for the practitioner was no longer the sole provider of health care. But unlike allied health care workers, the physician would not be subordinated to a wage. Despite various attempts at rationalization, the dominant form of payment remained fee-for-service, one of the hallmarks of a profession. Physicians have historically defended this autonomy with tenacity, exemplified in this century be debates over health insurance. Though the interest of the medical profession in various health insurance schemes vacillated, the defence of fee-for-service payment was constant.

The twentieth century brought the emergence of the modern health service and Indian Affairs bureaucracies, both of which assumed their present configuration in the 1960s. But if one theme of this century was bureaucratization, another was surely departmentalization and specialization. Maternal health programs, dental health services and mental health clinics were manifestations of these trends in Nova Scotia's Micmac communities. The nineteenth and early twentieth century preoccupation with communicable diseases was largely replaced by such preventative programs and specialty services. Tremendous advances, to be sure, had been made in the middle decades of the twentieth century against all forms of communicable disease and tuberculosis, but such advances stalled during the 1970s. One argument advanced for this lack of sustained improvement was the lack of power the Micmac, and Indian communities in general,

exercised over the health care delivery system. This thesis further argues that this lack of power exacerbates the feelings of poor health within Micmac communities, stemming largely from the different perceptions of what constitutes health.

Though the Micmac were alienated from the structures of power in the Indian health bureaucracy, this does not suggest that they were without power. Examples of this power have been cited throughout this thesis, but one important illustration is the aforementioned retention of indigenous perceptions of health and the continued use of the herbal pharmacopeia. Yet, recent decades have witnessed the increased participation of the Micmac community in the formal health care delivery system. The Community Health Representatives and Health Liaison Officers are significant manifestations of this participation. But does the entry of the Micmac community into the health care delivery system mark a reversal of the professionalization/bureaucratization process that will lead to a reduction of the power exercised by the medical profession? As has been demonstrated, the medical profession has historically proven to be rather adept at incorporating, subordinating or eliminating potential threats to the established order. The subordination of nursing has been previously mentioned. Other examples include the elimination of midwifery through patholigizing pregnancy and childbirth. Equally instructive is the absorption of a former competitor, homeopathy, as evidenced through Dr. H.H. Read, long a homeopathic practitioner in Halifax. In 1912, Read was paid by the Provincial Medical Board for examining a homeopathic candidate for licensure. Another, more contemporary example

may be found in the recent concern of the Ontario Naturopathic Association. Under recent proposed legislation in Ontario, non-prescription treatments such as chiropractic or osteopathy would be brought under the same legislative rubrics as doctors, nurses and dentists. This poses a serious threat to naturopathy, as the same legislation would forbid naturopaths to perform spinal manipulation or diagnosis, two of the central tenets of this alternative treatment. In this way, the regular medical profession would eliminate a potential competitor, naturopathy, while strengthening the 'alternatives' of chiropractic and osteopathic treatments which are, in fact, no real threat to medical orthodoxy. Similarly, Micmac endeavours into the health care delivery system are being incorporated into the existing structure, where they pose no real threat to the status quo, and this process may, in fact, even undermine traditional belief systems.

Finally, consideration must be given to the role of ideology in shaping the health care delivery system and this was most evident in the public health movement. The participation of philanthropic capitalism in the public health movement and the reform of medical education early in the twentieth century represents a convergence of the interests of capitalist and physician, rather than the former coopting the latter for his or her own interests. Scientific medicine deemphasized the class basis of disease, thereby reinforcing the prevailing social structure. Moreover, through elevating the prestige and income of physicians, the ruling class was bolstering its own membership. More striking, however, is how disease in Micmac communities was often attributed to the continued pursuit of game and the nomadic lifestyle. The reserve community, it was argued,

provided a more sanitary surrounding, thereby decreasing the likelihood of disease. Settlement on reserves would not only improve the health status of the Micmac, but also facilitate their participation in the industrial economy by undermining occupational pluralism that accompanied the pursuit of more traditional economic endeavours. The ideologies of sanitary reform and settlement on reserves became united in the Micmac reserve community which, in turn, served to legitimize both ideological concerns.

The history of health and the health care delivery system among the Micmac in Nova Scotia illuminates the interrelationships between the state, the medical profession and the Micmac community. Through an examination of the ideolgies and the relations of power, an understanding which sheds light on present structures within the Indian health bureaucracy. This thesis has situated this medical care firmly in the realm of the broader social history and, in doing so, has yielded evidence of how these changes had parallels with other concerns, as exemplified by the coalescing of interests of public health and Indian affairs in the early part of the century. Finally, this thesis has considered the role of the Micmac in shaping their own history, a role that was active and significant and ignored for too long.

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