

Delivery of Medicine to the Northwest Region of British Columbia,
1880-1960

by

Sheila Yeomans
B.A., Trent University, 1998

A Thesis Submitted in Partial Fulfillment of the
Requirements for the Degree of

MASTER OF ARTS

in the Department of History

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ABSTRACT

The Delivery of Medicine to the North West Region of British Columbia examines the relationship between medical culture and imperialism, religion and social progress from the arrival of the Hudson's Bay Company to the mid twentieth century. The evolutionary stages examined in this study move through imperialism to colonialism and the arrival of the medical missionaries, to the contract medicine of resourced based industries, to the ascendancy of nurses and the outpost hospitals and finally the emergence of modern state supported medicine. It contends that medicine should not be examined alone but within the context of its cultural and social influences.

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DEDICATION

For Stephen

In Appreciation

and

In Memory of

Bob Stewart

Archivist, United Church
Vancouver School of Theology
1939-2005

Chapter 1

Introduction

Delivering Healthcare On British Columbia's Northern Coast

This study examines the delivery of medicine to the northwestern region of British Columbia between the 1880s until the 1960s, a topic of medical history that hitherto has not been well investigated. The region is inherently difficult to service. It is sparsely populated and communities are often vast distances apart in rugged terrain, making the costs of delivering goods and services significantly higher than the southern areas of the province. Still, the area is rich in resources. Today, rural medicine is delivered through a centralized regional healthcare system, the Northern Health Authority. However, this was not always the case. In studying the delivery of medicine to the northwest, one becomes aware of the many overlapping medical systems which sustained local residents and First Nations communities, aided in the development of the region, and were vital for northwestern progress.

Until recently the history of healthcare in the northwest region of British Columbia seemed linear, as Euro-Canadian scientific medicine replaced First Nations healing arts. The progression went from Aboriginal to the frontier medicine of explorers, fur traders and the Hudson's Bay Company posts, onto an era of evangelical-scientific missionaries, to contracted medicine of the settlement period, the establishment of small hospitals and Red Cross outpost stations, and finally, to a centralized system of government run medicare. Today, contemporary historians, ethnobotanists and anthropologists have revisited the topic. They have found co-existence, cooperation and conflict, between indigenous and external systems of medicine at the regional level. In

fact, some of these “historical” different systems of medicine have continued to the present. Thus, northern healthcare should be viewed as a series of cultural layers.

Medicine is at once scientifically objective and culturally constructed. Thus, it does not stand alone but exists in forms which are socially created. Although the application of the scientific method to the investigation of disease is the hallmark of modern medicine, it has the effect of removing health and illness from the social context in which they are produced. Medicine is more than the study of pathogens and illness or a practice of technologies; disease also connects to the organization of society and its constructions. It lies in the manipulations of political power, in poverty and malnutrition, and, in the material circumstances of society.

Cultures as systems of representation can be analyzed as texts. Medicine as a reflection of culture is based on class, gender and ethnicity. As well, inherent in both medicine and western culture are the notions of progress, development, opportunism and power. Knowledge helps to shape power and the possessor of knowledge becomes important. Inspired by the writings of French philosopher and structuralist, Michel Foucault, revisionist colonial scholars have made medicine as a system of knowledge an important component of their studies because missionaries, as religious physicians, linked colonization and bodily transformations. The study of bio-power is concerned with the control of bodies. Early medical missionaries were agents of empire building because they reinforced Euro-Canadian notions of civilizing First Nations through hygienic and medical practices. Thus, medicine needs to be understood as an influential and authoritative vehicle. Lastly, the notion of the body as a subject of study closely follows the growth of imperialism. In colonial British Columbia, imperial medicine commenced

with exploration and was an integral component of the Hudson's Bay Company, a British fur trading organization.¹

The interweaving of medicine, exploration, and the colonial state is fundamental to our understanding of how western medicine became a tool of empire building. As part of the political and commercial expansion of British imperialism, there was collaboration between utilitarian science and government. Botany was a major commercial asset. Plant transfers were a means of strengthening the British mercantile position and destroying the monopoly of trade by other nations.² Eighteenth century explorers, Captains James Cook and George Vancouver, hired surgeon-naturalists to oversee the medical and dietary needs of their crews. In 1778, as part of their duties, William Anderson, surgeon-naturalist on the *Resolution*, and John Law, of the *Discovery* collected botanical specimens; Archibald Menzies (1791-95), Vancouver's surgeon and naturalist, catalogued the botanical assets of the northwest; took ethnographic notes on First

¹ Susan Neylan, *The Heavens Are Changing: Nineteenth-Century Protestant Missions and Tsimshian Christianity*, (Montreal & Kingston: McGill-Queen's University Press, 2003), 213-214. David Arnold, *Colonizing the Body: State Medicine and Epidemic Disease in Nineteenth Century India*, (Berkeley: University of California Press, 1993), 291. Michel Foucault, *Birth of a Clinic: An Archeology of Medical Perception*, Translated by A. M. Sheridan Smith, (New York: Pantheon Books, 1973) and Michel Foucault, *Discipline and Punish: The Birth of the Prison*, Translated by Alan Sheridan, (New York: Vintage Books, 1979). In *Birth of a Clinic* (1963), Foucault believes pure science owes its origins to eighteenth century social and cultural attitudes. It was during the enlightenment that medical ideas became transformed so that disease became a subject of new classification; the body could be mapped; and, doctors began to describe ailments. Not every-one agrees with Foucault's hypothesis. Dr. Alfred Lars Aronson maintains Foucault fails to recognize the influence which the other developing sciences had on medicine. The notions of causation, determinism, and scientific proof are vital to the study of medicine. Alfred Lars Aronson, "Medicine: History and Theory," book review of Michel Foucault, *The Birth of the Clinic: An Archaeology of Medical Perception*, (New York: Random House, 1973) in *The Yale Review*, Vol. 63, (1974), 475.

² "During the 1780s, Sir Joseph Banks, a veteran of Cook's first voyage and director of the Royal Botanical Gardens at Kew, had launched a global scheme for rebuilding the mercantile system with an "unabashedly economic" program of "plant transfer" to bring production of raw materials inside the British empire. Botany and great power rivalry became curiously intertwined, as nations endeavoured to guard their precious colonial treasures while seeking to filch those of their competitors." For instance, he organized the taking of spices to break the Dutch monopoly.—"As an example of the thoroughness of this (plant) traffic, the British had successfully imported over 200 species of plants to New South Wales by 1803." Wade Graham, "Traffick According To Their Own Caprice: trade and biological exchange in the making of the Pacific World, 1766-1825," *Seascapes, Littoral Cultures, and Trans-Oceanic Exchanges*, UCLA Conference, Dec. 15, 2003, <http://www.historycooperative.org/proceedings/seascapes/graham.html>.

Nations; and, produced a dissection of the sea otter (1795), from the Queen Charlotte Islands, for the Royal Society for Improving Natural Knowledge (RS).³ Years later, in 1824, the Horticultural Society of London sent him to Fort Vancouver and he returned to Britain with a record number of species for a single individual.⁴

In the contact era, when explorers and fur traders had limited encounters with northern First Nations peoples, Natives practiced healing techniques based on their view of the world in which the human and non-human realms overlapped. With the establishment of the Hudson's Bay Company (HBC) trading posts at Fort Simpson (1831) and Fort McLoughlin (1833), European medicine was permanently introduced in the northwest. The HBC, a British chartered company, since 1821, had the exclusive right to benefit from British North America's fur trade west of the Rocky Mountains. Their surgeons were sent to the posts to oversee the healthcare of company officials and their Aboriginal employees. This was a vital component of the fur trading enterprise because time lost for ill health affected company revenues.

Multiple roles typify colonial surgeons. Apart from their medical role of apothecary and physician, a HBC surgeon invariably acted as a company factor. As Chief Factors of the trading forts, surgeons were responsible for the everyday running and

³ Historical geographer, Daniel Clayton, argues the cartographic work done by Menzies and Vancouver on the Northwest Coast can be interpreted as a tool of imperialism and appropriation. Clayton, "Circumscribing Vancouver Island," *BC Studies*, 122, (Summer, 1999), 7-22. Robin Fisher and Hugh Johnston maintain mapping lead to control and economic exploitation and eventual cultural disruption and appropriation. Today, the impact of European explorers on the Pacific and its peoples is a matter of conflicting interpretations with the more negative views giving currency. R. Fisher and H. Johnston, eds., *From Maps to Metaphors: The Pacific World of George Vancouver*, (Vancouver: UBC Press, 1993), 6, 13. M.W. Thomas, MD., "Medical Pioneering in British Columbia," Part 1, British Columbia Medical Association (BCMA), Historical Articles Binder, 14d, 1931, 251. Menzies is responsible for identifying and naming the Pacific dogwood, maples, hemlock, red cedar and rhododendron. Douglas Cole, "Leisure, Taste and Tradition in British Columbia, Hugh Johnston, ed., *The Pacific Province: A History of British Columbia*, (Vancouver: Douglas & McIntyre, 1996), 345.

⁴ Johnston, *The Pacific Province*, 346. When Menzies returned in 1830, he collected from the Okanagan, the Fraser River and Stuart Lake. The entire collection was lost in an overturned canoe.

record keeping of the posts. Since business was the prime motivation of the company, surgeons were in the unique position of managing both the medical and economic aspects of the company's affairs.

The Royal Society (RS) collaborated with the Hudson's Bay Company. It was incorporated in 1662 by Charles II to "extend not only the boundaries of the Empire, but also the very arts and sciences."⁵ Because many of the founders were chartered members of both organizations, their mutual interests created a union of scientific and economic enterprises, in which HBC traders and surgeons collected flora, fauna, and minerals, thereby enabling the RS to gather considerable information about the colony. In addition, they recorded the language, government, religion, and the life of the Aboriginal peoples.⁶ Northwest HBC surgeons and fur traders, William Fraser Tolmie (1812-86) and Meredith Gairdner (1806-37) wrote botanical notes and collected numerous specimens, including some of birds and fish, which they catalogued, dissected or preserved. They sent the botanical samples to Kew Gardens, the centre of botanical science for Britain. Other scientific organizations also became sponsors. For instance, in 1826, the British Museum supported HBC ship surgeon-botanist, John Scouler with supplies for his visit to Fort Vancouver and Nootka Sound.⁷ The assistance of the HBC, along with the cooperation of company surgeons, enabled a closer integration of imperial possessions with the mother country. Historian W.B. Ewart remarks the association created an awareness that a

⁵ R.S. Stearns, "The Royal Society and the Company," *The Beaver*, (June 1945), 8.

⁶ For instance, in 1773, the Royal Society was interested in procuring "in any quantity" buffalo hides for book-binding and clothing, which the members felt "the importation may answer well to the Company." Swans were to be stuffed for display or their down used for powder puffs. Because their skins are "so valuable, an article of commerce at present," it was suggested to the HBC Governor and Committee to procure as many as possible. R.P. Stearns, "The Royal Society and the Company," 13.

⁷ Johnston, *The Pacific Province*, 346. John Scouler was ship surgeon on the HBC vessel *William and Anne*.

trading company “with an interest in research could improve commerce and enhance the power of the country and the Crown.”⁸

During the settlement period, the influence of the HBC declined, particularly in medical and scientific matters. Methodist and Anglican medical missionaries arrived on the northwest coast. Driven by ‘colonial-humanitarianism,’⁹ missionary physicians, unlike the HBC surgeons, used medicine as a tool for conversion. The ideas of power, medicine and ethnicity came together in the notion of ‘colonial humanitarianism’ or ‘imperialism in medicine’¹⁰ which was codified in terms of racial superiority, and in the notions of ‘difference’ and ‘stereotype.’ The missionaries believed the First Nations peoples needed to be medically ‘saved’ and ‘civilized.’ Thus, ‘benevolent assimilation,’¹¹ with its aim of the reformation of body and soul, came together with the arrival of medical missionaries. This understanding of race, of subjectivity and, of the ‘right to rule,’ allowed medicine to become a humanitarian (concern for the welfare of others) tool of empire. Early Anglican and Methodist missionary doctors combined a sense of obligation with the idea that cultural change was essential in order for Indigenous peoples to survive.¹²

As a consequence of their belief in the necessity of ‘saving’ through conversion, missionary doctors endured innumerable adversities, built hospitals and out-stations,

⁸ W.B. Ewart, “Thomas Hutchins and the HBC: A Surgeon on the Bay,” *The Beaver*, Vol. 75:4, August/September, (1995), 38. Ewart mentions the HBC added knowledge in areas of botany, zoology, meteorology, geography, astronomy, physics and chemistry.

⁹ Mary-Ellen Kelm, *Colonizing Bodies, Colonizing Bodies: Aboriginal Health and Healing in British Columbia, 1900-50*, (Vancouver: UBC Press, 1998), 100-103.

¹⁰ Roy McLeod, “Introduction,” Roy McLeod and Milton Lewis, eds. *Disease, Medicine, And Empire: Perspectives on Western Medicine and the Experience of European Expansion*, (London & New York: Routledge, 1988), 2.

¹¹ Warwick Anderson, “Postcolonial Histories of Medicine,” *Locating Medical History: The Stories and Their Meanings*, Frank Huisman and John Harley Warner, eds., (Baltimore and London: John Hopkins University Press, 296.

¹² Mary-Ellen Kelm, *Colonizing Bodies*, 100-101. Warwick Anderson, “Post Colonial Histories,” 295-299.

started nurses' training schools and provided public health clinics. As well, they enhanced provincial health services because they also oversaw the medical needs of settlers and contracted with resource-based industries. In the early twentieth century, the notion of social service and 'doing good works' superseded evangelical conversion. By then, the United Church Medical Services, a division of the union of Congregationalist, Methodist, and Presbyterian churches (1925), and the Anglican Columbia Coast Mission (1904), a medical and marine mission, established hospitals in several northwestern communities. Although the latter was vital to the delivery of medicine along the coast, it had overtones of paternalism and imperialism.

The arrival of medical missionaries reinforced the material and political objectives of colonialism because they mirrored their common interests of indoctrination, racial superiority and assimilation. Missionary physicians and colonial officials believed First Nations needed to adopt the Victorian cultural aims of progress and good management along with directions in cleanliness of body and home. As a consequence, missionary physicians acted as a powerful force in the ideological subordination of Canada's Aboriginal cultures. Mary-Ellen Kelm suggests missionary medicine sought to take from Aboriginals the sense that they had control over their bodies. By emphasizing non-Native healing as the only true 'medicine,' religious medical personnel cast the Natives as an afflicted people without the ability to heal themselves.¹³ In viewing Aboriginal customs and traditions as enemies of health and progress, religious doctors became low-cost representatives of the colonial state.

¹³ Mary-Ellen Kelm, *Colonizing Bodies*, 151. Myra Rutherford, "No Native Doctors': Medicine, Hygiene, Mission and the Re/formation of Aboriginal Bodies in Northern Canada, 1890-1940," Paper Presented to the 80th Annual Meeting of the CHA, Laval University, (May 2001). Although Rutherford's paper is concerned with the Inuit (Baffin Island) and Ojibways (Hudson's Bay), there are striking similarities in missionary writings.

This notion of difference: the 'otherness'¹⁴ of colonized peoples, as well as the combined effects of epidemics and continued infectious diseases on Native bodies lead to the perception they were disease carriers, and therefore needed to be segregated from the white population. At the same time, government and church officials attributed Aboriginal incidence of disease to their lack of adaptation to 'civilizing.' While the cultural construction of 'the other' shaped the European notion of white supremacy, it was never totally one-sided. First Nations did aid in shaping and defining their own experiences.¹⁵ Co-operation and hostility characterize the relationship. Many Natives chose Aboriginal medicine over western therapies; others partook of western medicine for diseases that they considered to be 'white' illnesses, and continued to use their own medicine men for their own diseases; while, some fully embraced European methods. At the same time, both cultures adopted remedies from the other culture. For instance, early settlers relied on Aboriginal midwives and used Native herbal medications; some Native healers encouraged a pluralistic employment of both systems. In the long run, missionary medicine did make substantial inroads into Native practices. Aboriginals gradually accepted elements of first aid, drug therapies, hospitalization and hygienic practices, but did not totally abandon their traditional practices.¹⁶

Although ideas of indoctrination, conversion and assimilation were fundamental to the medical missionary experience, missionary doctors interceded on Natives' behalf when government officials, the colonial power, to paraphrase Cole Harris, forcefully

¹⁴ David Arnold describes 'the other' as the physical and cultural stereotyping of non-white races: their weakness, lethargy, promiscuity, uncleanliness, and colour. David Arnold, "Medicine and Colonialism," *Companion Encyclopedia of the History of Medicine*, Volume 2, Ed. By W. F. Bynum and Roy Porter, (London & New York: Routledge, 1993), 1407.

¹⁵ Susan Neylan, *The Heavens Are Changing*, 5. Mary-Ellen Kelm, *Colonizing Bodies*, xvii.

¹⁶ Mary-Ellen Kelm, *Colonizing Bodies*, 153-172.

displaced people “from their land” and repossessed it for the culturally dominant colonial power.¹⁷ For instance, during the 1862 smallpox epidemic the Tsimshian peoples from Port Simpson asked “if the disease was sent to wipe them out to get their land.”¹⁸ In 1885, First Nations on the Skeena River, notified Anglican missionary physician, Robert Tomlinson, that land commissioner Peter O’Reilly had informed them their “rights beyond the designated reserves would not be respected.” Tomlinson, in correspondence with John A. Macdonald, Federal Superintendent General of Indian Affairs, maintained O’Reilly had “no right to allocate what was already owned” because land allocations had been wrongly drawn, allotted to the wrong Native groups, and cut off peoples from resources that they depended upon.¹⁹

By the end of the nineteenth century, British Columbia was rapidly industrializing. Although missionary physicians remained active in the field, now many isolated and sparsely populated areas received medical care from physicians under contract to various resource-based industries. Because work in the resource industries was unstable, the workers were often transient. Doctors often traveled with mining or logging firms to new sites. Because contract medicine, in which individuals often contributed to an organized fund, was an unpredictable source of income, such physicians often augmented their incomes by contracting with the Department of Indian Affairs

¹⁷ Cole Harris, *Making Native Space: Colonialism, Resistance, and Resources in British Columbia*, (Vancouver, UBC Press, 2002), xxiv.

¹⁸ Grant Keddie, *Songhees Pictorial: A History of the Songhees People as seen by Outsiders, 1790-1912*, (Victoria: Royal BC Museum, 2003), 77.

¹⁹ Cole Harris, *Making Native Space*, 185-6. Tomlinson’s correspondence to Macdonald stated the problem went beyond O’Reilly because of the division of power in the federal system. Once BC entered confederation in 1871, under the Terms of Union Native peoples became a federal responsibility and land, a provincial one. Tomlinson had resigned from the Anglican Church Missionary Society in 1883, and therefore, strictly speaking, was not an Anglican missionary in 1885. 368, n.50. In 1882, Methodist missionary, Thomas Crosby, wrote to Macdonald about the problems of Native rights along the Skeena and Nass rivers. O’Reilly’s decisions, along with the beginning of white settlement, and the arrival of the fishing industry drew “explosive” reactions from northwest Aboriginals. Harris, 184.

(DIA) to care for First Nations people, working as fur traders, miners or loggers, or by trying to start a private practice. If they could not earn a reliable living, doctors often moved on leaving some communities without resident medical care.

Contract medicine was an early form of health insurance because employers or employees financially contributed. As company debt and competition increased, the responsibility for medical care was passed onto their employees. In 1917, the provincial government established the Workmen's Compensation Board (WCB) which created a cost-sharing agreement between labour and capital for medical aid. Some resource-based industries provided private hospitals for their employees in which the WCB and employees also contributed to the operating costs. Following the passage of the Hospital Act of 1913, government provided some funds to all hospitals, provided they submitted monthly reports, had government representatives on the board, and gave free medical aid to local indigents. The British Columbia Medical Association, in 1936, tried unsuccessfully to investigate contract medicine because of numerous complaints about irregularities within the system. Until 1930, the typical rural physician had been a company doctor, at some time in his career.²⁰

The notion of power, gender and ethnic relations is associated with the nursing profession. Nursing has relied on an image of feminine respectability to legitimate its presence in the healthcare system. Kathryn McPherson suggests nurses' respectability and definition of gentility were European in origin and were constructed in a racial and national context.²¹ Class and gender played a defining role in their early elitist position.

²⁰ John Norris, "The Country Doctor In British Columbia: 1887-1975, An Historical Profile," *BC Studies*, No. 49, (Spring, 1981), 17.

²¹ Kathryn McPherson, *Bedside Matters: The Transformation of Canadian Nursing, 1900-1990*, (Toronto: University of Toronto Press, 2003), 17.

In the Canadian colonial structure, white women nurses were expected to be “role models for their social ‘inferiors,’ such as immigrants or non-Whites.”²² Emphasis on the racial superiority of nurses not only reinforced nurses’ real or perceived status as an elite among other occupational women, it also influenced their understanding of and relationship to First Nations. Early missionary nurses, while hard working and conscientious, were ‘missionaries of the state’²³ because they used western medical therapies in a variety of public health measures. Also, many nurses identified with the imperialistic notion of assimilation. As well, McPherson maintains some nurses who worked in isolated rural districts resolved their position as single working women by justifying their presence through aiding needy settlers or helping First Nations.²⁴

Feminist theorists have explored how nurses have often garnered significant community status, and invariably wielded considerable power.²⁵ This is especially significant in rural areas where a nurse was employed in a small hospital or had the sole responsibility of an outpost station. Nursing historians Kathryn McPherson and Meryn Stuart call for more research in this regard, particularly in understanding the nurse in a cross-cultural perspective. They suggest more analysis is required on how racial and ethnic values and beliefs shaped the dominant experience of Anglo-Canadian nurses. In northwest BC, the Canadian Red Cross Society (CRCS) in 1929 established an outpost

²² Kathryn McPherson, *Bedside Matters*, 17.

²³ Kathryn McPherson, “The Country is a Stern Nurse,” *Prairie Forum*, Vo. 20, No. 2, (Fall 1995), 195.

²⁴ *Ibid.*

²⁵ Nursing and feminist theorists have also repositioned doctors as long standing sources of subordination. Gender roles not only determine occupational membership-few men become nurses, but constitute a potential source of exploitation. Gender has been an ongoing influence not only on the structure of the healthcare system but also on educational opportunities, job choices and workplace experiences.

hospital programme to facilitate small towns to have access to healthcare. In many instances, the communities were racially mixed or Aboriginal.²⁶

Dedicated nursing personnel supported the medical requirements of northern populations. Independence typifies rural nursing either in small town and mission hospitals, or nurse-managed outposts, such as the Red Cross and Columbia Coast Mission stations, because they wielded more authority than their urban peers. For instance, when hospital nurses went with physicians to remote areas, they performed a variety of public health procedures. The remaining nursing staff managed the hospitals. Nurses came to rural areas for a variety of reasons: to satisfy a religious 'calling,' for an adventure, or to gain independence. Multitasking predominated rural caregiving. On any shift a nurse would be confronted with a variety of medical situations which, invariably, she would have to resolve on her own. The ideas of isolation and distance, whether socially, geographically, or professionally, play a major role in rural nursing and have always been problematic. While some women thrived on a sense of personal freedom and integration into the local community, others could not adjust to rural isolation.

The Canadian Red Cross Outpost Hospital managed programme was created to provide healthcare in isolated communities, until the area could financially take over the small establishment. One stipulation was that local citizens had to contribute financially and in volunteer hours before the outpost was established. The provincial government contributed special annual grants. Eighteen outposts were constructed between 1930 and 1965, mostly consisting of one to three beds. Nurses performed a variety of procedures: from public health duties to delivering babies, to teaching and school inspections. Traveling was commonplace and challenging as often distances were great and weather

²⁶ Kathryn McPherson and Meryn Stuart, "Writing Nursing History," 10-11.

conditions were poor. Doctors visited the outposts on a monthly basis but in between times nurses had full responsibility for making decisions.

The writing of medical history of the northwest region has many challenges, chiefly the dearth of source materials. Primary sources have often not been saved and secondary source material is mostly scattered throughout books whose main focus is another subject. Much of the available primary or secondary sources are celebratory in nature and therefore presents a one-sided viewpoint. This is especially true of the missionary physicians. The very limited material on missionary nurses is celebratory, as well.²⁷ Methodist missionary publications, such as *The Missionary Outlook* and *The Missionary Bulletin*, provide a great deal of information but must be read with a critical eye because they present a distorted view of the contact between Aboriginal peoples and the white man. Their primary purposes were to inform church society about missionary endeavors and to raise awareness for fund raising. They are located at the United Church Archives, School of Theology, in Vancouver and the United Church of Canada Archives, in Toronto. The voice of First Nations women is predominantly silent on their healthcare, either in the church-managed hospitals or CRCS outpost hospitals.

The CRCS individual outpost records have not survived—I suspect many records were left with their respective stations once a community decided to manage the facility itself. However, this does not explain the absence of records for closed outposts or for those that are still operating. My primary source materials are a variety of reports, from the home office in Ottawa or the Vancouver branch. The Columbia Coast Mission

²⁷ The exception is Mary-Ellen Kelm, *The Letters of Margaret Butcher: Missionary-Imperialism on the North Pacific Coast*, (Calgary: University of Calgary Press, 2006).

records, at the Anglican Archives, Vancouver School of Theology, are very sketchy and have many gaps. The main source is "*The Log*," published from 1906-1909 and then not again until 1930. Again, any mention of the various hospitals, which the Mission established on the coast, reflects the Mission's aim of having a magazine to reflect its social, moral and religious tenets. The notes of the mission's founder, Reverend John Antle's, contain short anecdotes on healthcare, as do a few other articles.

The Hudson's Bay Company's medical materials specific to British Columbia's northwest region are scattered throughout published primary texts. They are *The Journals of William Fraser Tolmie, Physician and Fur Trader*; Dr. John McLoughlin's *Fort Vancouver Letters*; Dr. John Sebastian Helmcken's *Reminiscences* and, Hartwell Bowsfield's *Fort Victoria Letters, 1846-1851*.²⁸ Elizabeth and Colin Briggs have written a useful text on HBC medicine, *Before Modern Medicine*, taken from documents from several archives.²⁹ The *Oregon Historical Quarterly* printed Dr. John McLoughlin's medical letters. Although the letters are few in number, they shed light on McLoughlin's early career.³⁰ Dr. McLoughlin's 'Inventory of Medicines, Fort William, October, 1816' is located at the Hudson's Bay Company Archives, Winnipeg and Dr. Helmcken's medical notebooks and list of equipment can be found in his medical supplies account at

²⁸ William Fraser Tolmie, *The Journals of William Fraser Tolmie, Physician and Fur Trader*, Howard T. Mitchell, Ed., (Vancouver: Mitchell Press, 1963); John McLoughlin, *Fort Vancouver Letters*, Vol. IV, (Toronto: Champlain Society, 1941); John Sebastian Helmcken, *Reminiscences of Doctor John Sebastian Helmcken*, Dorothy Blake Smith, Ed., (Vancouver: UBC Press, 1975) and Hartwell Bowsfield, Ed., *Fort Victoria Letters, 1846-1851*, Hudson's Bay Record Society, Volume XXXI, (Winnipeg: Saults & Philard, 1979).

²⁹ Elizabeth Briggs and Colin J. Briggs: *Before Modern Medicine: Diseases & Yesterday's Remedies: using Documents from the Hudson's Bay Company Archives, The Provincial Archives of Manitoba & The National Archives of Canada*, (Winnipeg: Westgarth, 1998).

³⁰ T.C. Elliott, Ed., "John McLoughlin, MD," *The Oregon Historical Quarterly*, Vol. xxxvi, Mar.1935-Dec.1935, (Salem: Statesman, 1935), 183-186; 325-33. Jane Lewis Chapin Ed., "Letters of Dr. John McLoughlin," *The Oregon Historical Quarterly*, Vol.xxxvii, Mar.1936-Dec. 1936, (Salem: Statesman, 1936), 293-300.

the BC Archives³¹ No HBC surgeons' journals from the northwest survive and, only a few post journals have survived.³² Lastly, the BC Medical Association (BCMA) has only two articles on contract medicine and, the result of a 1936 survey on contract medicine is incomplete.

Nevertheless, there is an observable historiography, which does progress through various stages. In early medical history on the north coast, hagiography was the norm: great names, great ideas and great practices. Underlying these accounts of people, institutions and professional organizations was the ongoing progress of scientific medical knowledge. As well, many earlier writings were by amateur physicians, who wrote biographies of their predecessors but ignored the social forces in society and medicinal knowledge.³³

An example of these earlier writings is *Drums and Scalpel: From Native Healers to Physicians on the North Pacific Coast* (1968), Dr. R. Geddes Large's history of the arrival of Methodist medical missionaries which glorifies "their timely arrival and efforts" and praises them for preventing the "complete annihilation of the Indian" on the coast. His mission-centered narrative approach, while useful from the standpoint of basic information on the establishment of medical facilities and the various Methodist doctors, takes on a paternalistic attitude when referring to First Nations. Large does connect

³¹ John McLoughlin, "Inventory of Medicines, Fort William, October, 1816," Hudson's Bay Company Archives: Archives of Manitoba, (Winnipeg), File SF. John Sebastian Helmcken, Helmcken Family Papers, MS-0505, British Columbia Archives (BCA). Helmcken House, in Victoria, features a display of the doctor's medical chest and equipment.

³² The HBC post journals on microfilm include one each from Fort McLoughlin (1833), Fort Rupert (1849-50) and three from Fort Simpson (1832-53, 1855-66, 1899). Hudson's Bay Company Archives.

³³ S. E. D. Shortt, "Antiquarians and Amateurs: Reflections on the Writing of Medical History in Canada," in *Medicine in Canadian Society: Historical Perspectives*, S. E. D. Shortt, Ed., (Montreal & Kingston: McGill-Queen's University Press, 1981), 2. Peter Wright and Andrew Treacher, "Introduction," in *Problem of Medical Knowledge: Examining the Social Construction of Medicine*, (Edinburgh: Edinburgh University Press, 1982), 2-4.

medicine to the development of the province, but in a very minor way. In the same light, Louise Johnson, in *Not Without Hope: The Story of Dr. H. A. McLean and the Esperanza Hospital* (1992), applauds the effort of the doctor 'to spread the gospel' and bring medicine to the isolated western coast of Vancouver Island. Her narrative approach is celebratory.

Hugh W. McKervill, a retired United Church minister in *Darby of the Bella-Bella* (1964) wrote about George E. Darby, a renowned Methodist missionary and physician who, for forty-five years ministered to Aboriginals and the white population on the coast. McKervill views Darby as a man "who had an uncommon balance of faith and works, profession and practice." Although he does mention Darby's "battle with witch doctors," he does little to analyse the roles of medicine and religion. Lastly, Reverend Bob Burrows, in 2004, wrote *Healing in the Wilderness: A History of the United Church Mission Hospitals*. As a former Chair of the United Church Committee responsible for mission hospitals across Canada, Burrows has written an engaging story about the men and women who brought medical services to Canada's remote areas. Although he places the Church in the context of the times, it is a narrative approach with little analysis. Burrows included biographies on Drs. Horace Wrinch and George Darby.³⁴

In 1972, T. F. Rose, in *From Shaman to Modern Medicine: A Century of the Healing Arts in British Columbia* and Robert E. McKechnie, in *Strong Medicine: A History of Healing on the Northwest Coast*, broke from the traditional approach and incorporated medicine into the province's social history. Both physicians suggest Native

³⁴ R. Geddes Large, *Drums and Scalpel: From Native Healers to Physicians on the North Pacific Coast*, (Vancouver: Mitchell Press, 1968), 134. Louise Johnson, *Not Without Hope: The Story of Dr. H.A. McLean and the Esperanza Hospital*, (Matsquie: Maple Lane, 1992). Hugh McKervill, *Darby of the Bella Bella*, (Toronto: Ryerson, 1964), 55. Bob Burrows, *Healing in the Wilderness: A History of the United Church Mission Hospitals*, (Madeira Park: Harbour, 2004).

healing arts were equal to early European medical practices. Rose has short chapters on a variety of subjects³⁵ while McKechnie includes sections on Native healing arts, nineteenth century illnesses and pharmacology.³⁶ E. Palmer Patterson included medicine in his regional-mission centered-ethnological approach. His *Mission on the Nass* (1982) deals with the Anglican Church Missionary Society's encounter with the Nishga. Although Palmer is primarily concerned with missionizing, he does show how a missionary physician, Robert Tomlinson, used medicine as a tool for conversion.³⁷

Two authors have written about the Anglican Columbia Coast Mission, a medical-marine organization. Michael L. Hadley, in *God's Little Ships: A History of the Columbia Coast Mission* (1995) and Doris Andersen, in *The Columbia Is Coming!* (1982). Hadley situates the mission in the context of the times and analyzes the influence of the social gospel and modernization on the medical mission. He points to the paternalism of the organization. Andersen's narrative approach emphasizes the social, medical and religious role of the mission to settlers and First Nations along BC's isolated coast.³⁸ Lastly, Eldon Lee, a physician, has written two 'sketch' books about medicine. In *Scalpels & Buggywhips: Medical Pioneers of Central BC* (1997) he sketches short biographies of various men and women who have contributed to healthcare. For this study I used his chapters on Horace and Alice Wrinch as well as construction camp

³⁵ Of interest for this study are his chapters on early doctors, surgery, nursing, the Columbia Coast Mission, Red Cross Outposts, and the Workman's Compensation Board. T.F. Rose, MD, *From Shaman To Modern Medicine: A Century of Healing Arts in British Columbia*, (Vancouver: Mitchell Press, 1972).

³⁶ Robert E. McKechnie, *Strong Medicine: History of Healing on the Northwest Coast*, (Vancouver: J.J. Douglas, 1972).

³⁷ E. Palmer Patterson II, *Mission on the Nass: The Evangelization of the Nishga (1860-1890)*, (Waterloo: Eulachon Press, 1982).

³⁸ Michael L. Hadley, *God's Little Ships: A History of the Columbia Coast Mission*, (Madeira Park: Harbour House, 1995). Doris Andersen, *The Columbia is Coming!*, (Sidney: Gray's, 1982). Oliver R. Howard, *Godships: Little Ships Carry the Gospel Up the BC Coast*, (Toronto: *The United Church Observer*, 1984). Howard's United Church mission-marine narrative has medicine scattered throughout the book but there is no attempt at analysis.

doctors. His autobiography, *A Western Doctor's Odyssey: From Cariboo to Kos* (1996) provides information on Native healing as well as describing his experience as a physician at Hazelton. In both books Lee incorporated social contents and made an attempt at analysis.³⁹

Academics have focused on First Nations as recipients of healthcare. Ethnohistorian Mary-Ellen Kelm, in *Colonizing Bodies: Aboriginal Health and Healing in British Columbia 1900-50* (1998), takes a province-wide approach in her extensive study. Her post-modern view situates how Native bodies have been constructed through colonial policies and practices. Like Palmer, she views early missionary physicians as colonial humanitarian agents of empire. However, she maintains Native peoples were more inclined to accept assistance from missionary physicians, rather than secular doctors, because of their shared view of the connectiveness of body and spirit. For the missionary, the purpose was evangelism. Kelm ends her study with "medical pluralism", the willingness of some Native communities to accept both western and First Nations medicine. While Native assertiveness is present, Kelm's overwhelming tone is one of condemnation for what was done to First Nations through colonization. Kelm uses medical history, archeology, and colonial sources as well as oral histories to substantiate her view.⁴⁰

Kelm's work is very informative and thought provoking, particularly her chapter on "Doctors, Hospitals, and Field Matrons." While her study deals with the impact of federal and provincial policies and how they were transcribed onto the Native body

³⁹ Eldon Lee, *Scalpels & Buggywhips: Medical Pioneers of Central BC*, (Surrey: heritage House, 1997). Eldon Lee, *A Western Doctor's Odyssey: From Cariboo To Kos*, (Surrey: Heritage House, 1996).

⁴⁰ Mary-Ellen Kelm, *Colonizing Bodies: Aboriginal Health and Healing in British Columbia 1900-50*, (Vancouver: UBC Press, 1998). The book won the 1999 Canadian Historical Association Sir John A. Macdonald prize and a Clio Award for British Columbia.

during the first half of the twentieth century, my focus is on how western medicine was established and interpreted on the northwestern coast of the province, commencing with the Hudson's Bay Company in 1821. From an institutional standpoint, her primary focus is on the Indian Health Services and its medical officers and matrons; mine is on the missionary physicians, nurses, the HBC, and resource-based industries. Kelm's study is an in-depth look at a major area of colonial concern; mine is an overview of the many facets of western medicine. However, we both are concerned with imperialism and colonialism, with First Nations and health.

In 1999, anthropologist Robert Boyd wrote *The Coming of the Spirit of Pestilence: Introduced Infectious Diseases and Population Decline among Northwest Coast Indians, 1774-1874*. In his ethnographical and historical approach, Boyd uses demographics, Hudson's Bay records, and oral histories to compute how epidemics and disease transfers aided in cultural change. Boyd writes not only about the decline in population, but about the decline of culture. Akin to Kelm, he writes on Aboriginal nutritional problems, and includes a section on the historical characteristics of epidemic diseases. As a source material, it is very useful in charting the types and time frames of various epidemics (e.g. smallpox, malaria, and measles) on the northwest coast. Michael E. Harkin, an anthropologist and ethnohistorian, studies the northcoast Bella Bella peoples. In *The Heiltsuks: Dialogues of Culture & History on the Northwest Coast* (2000), Harkin examines Methodist missionary encounters and cultural change. In order to understand how the Heiltsuks became the "paragons of the Victorian virtues of hard work, prosperity, and progress" while engaging in strategies of resistance, Harkin utilizes the dialogue process. This methodology focuses on communication and the task of

reconstructing the multiple discursive elements which can be located within source materials (e.g. Indian autobiographies, missionary correspondence). By trying to ascertain the underlying dialogue between the cultures, one can understand the various ways in which power and knowledge were transmitted.⁴¹ Although medical history is not his prime interest, he does mention missionary physician, Richard W. Large's authoritative manner. Lastly, Grant Keddie, in *Songhees Pictorial: A History of the Songhees People as seen by Outsiders, 1790-1912*, using archival images, illustrates the significant role contributed by the Songhees to the commercial growth of late nineteenth century Victoria, BC. His chapter on the 1862 smallpox epidemic is particularly useful for this study.⁴²

The history of nursing on the coast is explored. Although mission nursing is a component in Kathryn McPherson's *Bedside Matters: The Transformation of Canadian Nursing, 1900-1990* (2003), she acknowledges her research on ethnic and minority groups has just begun. McPherson explores how the position of nurses within the healthcare profession has been structured by class, gender, and ethnic relations over a ninety year span. She charts how nursing has gone from private duty in homes, to the exploitation of apprentice nurses in hospital settings, to unionization, and finally, the requirement of graduating with a university degree. She examines nursing-care hierarchies, past and present problems, and occupational boundaries. Her sources are oral

⁴¹ Susan Neylan, *The Heavens Are Changing*, 5.

⁴² Robert Boyd, *The Coming of the Spirit of Pestilence: Introduced Infectious Diseases and Population decline among Northwest Coast Indians, 1774-1874*, (Vancouver: UBC Press, 1999). Michael E. Harkin, *The Heiltsuks: Dialogues of Culture & History on the Northwest Coast*, (Lincoln and London: University of Nebraska, 2000). Grant Keddie, *Songhees Pictorial: A History of the Songhees People as seen by Outsiders, 1790-1912*, (Victoria: Royal BC Museum).

histories as well as archival material from hospitals and nurses' alumnae associations from Manitoba, Nova Scotia and British Columbia.⁴³

Mary-Ellen Kelm's, *Letters of Margaret Butcher: Missionary-Imperialism on the North Pacific Coast*, offers an insight into the experiences of a missionary nurse and teacher working at a residential school in Kitaamat between 1916 to 1919. While her major responsibility was as a teacher and instructor of sewing arts, Butcher assisted in school medical inspections and helped the village missionary nurse. Butcher was genuinely concerned about the appalling amount of sickness associated with the school, but her commitment lies in the imperialistic values of assimilation. Her 'English' superiority was very transparent. Butcher was part of a newer generation of middle-class single missionary women who found meaningful lives in community service with other women. As such, religion plays a secondary role to career incentives. Compensation for the isolation of mission life in a remote area lies in the camaraderie with fellow workers and settler society. The text sheds light on missionary work and attitudes in the early twentieth century and I found it valuable as a resource.⁴⁴

In *Totem Poles and Tea* (1996), Hughina Harold writes about her nursing experiences as the sole healthcare provider/teacher to the Aboriginals (Mamalilikulla) living on Village Island, an isolated area accessed by the Columbia Coast Mission. Her observations and perceptions of Native life and of settler existence are taken from letters she wrote home. Harold highlights the devastation of tuberculosis among First Nations; she is committed to instilling public health measures; and, she develops a rapport with

⁴³ Kathryn McPherson, *Beside Matters: The Transformation of Canadian Nursing, 1900-1990*, (Toronto: University of Toronto Press, 2003).

⁴⁴ Mary_Ellen Kelm, ed., *The letters of Margaret Butcher: Missionary Imperialism on the North Coast*, (Calgary: University of Calgary Press, 2006).

many of the Natives during her three years. Medical care provides the common ground for cultural exchange. Akin to Margaret Butcher, Harold finds companionship with settlers. Vi Keenleyside uses short biographies in *They Also Came* (1987), a review of the contributions of early Methodist-United Church missionary women and nurses on the coast. Her narratives are interesting and shed some light on the early experiences of women.⁴⁵

Lastly, although a tremendous amount has been written on the Hudson's Bay Company and its fur trading enterprise, there is little mention of the company's imperialistic and economic connections to the Royal Society or to medicine. Two articles, written by R. P. Stearns and R. J. Ruggles, link the economic aspirations of the Company to the Royal Society's goal of advancing British imperialism and scientific progress.⁴⁶

Other useful theoretical ideas include the notion of region as a valuable analytical tool in the writing of medical history. It can aid us in identifying the various factors in which medicine intertwined with the stages of colonial and provincial development.⁴⁷ The chapters which follow will show how medicine and culture were defined in northwestern British Columbia.

⁴⁵ Hughina Harold, *Totem Poles and Tea*, ((Surrey: Heritage House, 1996). Vi Keenleyside, *They Also Came*, (Duncan: Duncan United Church, 1987). The Ontario Red Cross Outpost Hospitals are mentioned by Jayne Elliott in "Blurring the Boundaries of Space: Shaping Nursing Lives at the Red Cross Outposts in Ottawa, 1922-45," *Canadian Bulletin of Medical History*, Vol. 21, Number 2, (2004), 303-325.

⁴⁶ Articles on medicine and the Hudson's Bay Company include: W. B. Ewart, "Thomas Hutchins and the HBC: A Surgeon on the Bay," *The Beaver*, August/September, (1995), 38-41; Cythia Toman, "George Spence: Surgeon and Servant of the Hudson's Bay Company, 1738-41," *Canadian Bulletin of Medical History*, Vol. 18, Number 1, (2001), 17-42; E.E. Rich, "The Fur Traders: Their Diet and Drugs," *The Beaver*, (Summer 1976), 43-53; Jody F. Decker, "The York Factory Medical Journals, 1846-52," *Canadian Bulletin of Medical History*, Vol.14, (1997), 107-131 and A. J. Ray, "William Todd: Doctor and Trader for the Hudson's Bay Company, 1816-41." *Prairie Forum*, Vol. 9, No.1. (1984), 13-26. R. P. Stearns, "The Royal Society and the Company," *The Beaver*, (June 1945), 8-13. R. I. Ruggles, "Governor Samuel Wigg, Intelligent Layman of the Royal Society, 1753-1802," *Notes and Records of the Royal Society of London*, Vol. 32, No. 2, (Mar., 1978), 181-199.

⁴⁷ Megan J. Davies, "Mapping "Region" in Canadian Medical History: The Case of British Columbia," *Canadian Bulletin of Medical History*, Vol. 17, Number 1-2, (2000), 73-92.

The first chapter introduces the various components of imperialism and medicine culture inherent in the colonial experience on the north coast. It also offers an overview of the overlapping themes of imperial exploration; the Hudson's Bay Company and early medical delivery; First Nations healing arts and epidemics; missionary physicians and colonial humanitarianism; contract medicine and the resource-based industries, the Columbia Coast Mission; and lastly, the role of nursing in northwestern British Columbia.

The introduction of medicine to the region by surgeons employed by the Hudson's Bay Company, their medical qualifications and the status of medicine in the early to mid-nineteenth century is the subject of the second chapter. Since profit was the company's prime issue, surgeons facilitated this by overseeing the business and health of company officials and a few First Nations employees. In their capacity as representatives of imperialism, surgeons collected and named plants, animals and minerals for delivery to Britain. This allowed the mother country to gain knowledge of its colonial possession. The chapter ends with an outline of First Nations healing arts and the devastating consequences of European introduced diseases and epidemics. Although the HBC was the first public health agency, it was the 1862 smallpox epidemic which propelled fur trade medicine to become an organized medical profession.

The Janus-faced side of colonial humanitarianism is the substance of the third chapter. The first part introduces the reader to the various early Anglican and Methodist missionary physicians and their role in supplying western medicine to First Nations and settler population on the north coast. While examining attitudes of racial superiority,

assimilation, and the 'right to rule,' inherent in the colonial experience, the chapter shows how medicine was used as a tool for conversion. Chapter Four examines the Anglican missionary physician system which delivered medicine and religion to settlers and First Nations along the coast of BC. The Columbia Coast Mission was vital to both the sustainability of development in the province as well as the medical and social well-being of coastal inhabitants.

In the settlement era, progress, opportunism and risk taking are interwoven with the involvement of medicine with resource-based industries. Like their HBC predecessors, settlement doctors were employed by a company and multitasked by either operating as workers within the industry setting or having several contracts. Due to variables, such as economics, competition and the formation of the Workmen's Compensation Board, the responsibility for healthcare was increasingly passed onto the worker. The source material for chapter five is spotty but I have illustrated the problems of contract medicine, in relationship to private and public hospitals, seasonal population and company finances, by drawing on the varied experiences of several hospitals.

Rural nursing is the subject of Chapter Six. Early missionary nurses assisted Methodist missionary physicians in laying the groundwork for missionary and medical work amongst First Nations and the settler community. Whereas these women were committed to the colonial notions of assimilation and racial superiority, later generations were more focused on career building. The Canadian Red Cross Society built nursing outpost stations in remote areas. Manned by independent and adventurous women, their contribution to medical delivery was vital for local inhabitants. Finally, the conclusion

offers a 'diagnosis' of the delivery of healthcare to the northwestern region of British Columbia.

Chapter 2

From Fur Trade Surgeons to Colonial Doctors

In recent decades disease and medicine have become a central theme in the history of European expansion. Scholars, initially viewed medicine as a humanitarian and progressive endeavor; however, revisionist scholars now view medicine as an instrument of empire and, link the practice of medicine with the material objectives and ideological imperatives of colonial rule. Thus, medicine becomes an imperializing cultural force. As part of the conscience of British colonialism and as community elites, many physicians made occasional forays into colonial politics. That intertwining of medicine and politics, of imperial goals and material gains is evident in the growth of British Columbia.¹

Rightly or wrongly, British Columbia has been described as “The Company Province.”² Certainly that idea can be applied not only to early medical practices of the Hudson’s Bay Company surgeons, but also to companies in the resource industries, or the medical missionaries who worked in close collaboration with logging and fishing companies. Thus, medicine, humanitarianism and opportunism coexisted during the primary years of provincial enterprises.

In the case of First Nations communities, scholars now recognize the introduction of western diseases as a major factor in their devastation and depopulation. Native peoples incorporated substantive healing practices into their belief system but could not cope with the onset and persistence of non-Native infectious diseases and epidemics.

¹ John L. Comaroff, “Images of Empire, Contests of Conscience: Models of Colonial Dominance in South Africa,” in *Tensions of Empire: Colonial Cultures in a Bourgeois World*, Frederick Cooper and Ann Laura Stoler eds., (Los Angeles: University of Berkeley Press, 1997), 166.

² Martin Robin, *The Rush For Spoils: The Company Province 1871-1933*, Vol. 1, (Toronto: McClelland and Stewart, 1972), 23.

Thus, it seemed that European medicine supplanted many Aboriginal healing practices but revisionist scholars now see that co-operation and hostility reflect the relationship between First Nations and European medical systems.³

Although early European explorers used western medical treatments, it was the Hudson's Bay Company (HBC) who introduced western therapeutics to what is now Canada. Established in 1670, the chartered company had a monopoly sanctioned by royal decree over the trading area within its jurisdiction. With the extension of its domain westward in 1821, the HBC (Figure 2.1) became the sole representative of British sovereignty and its mercantile interests in that part of British North America. In collaboration with the Royal Society (RS), the HBC was intent on extending the boundaries of British imperialism and so its surgeons, like those of other chartered companies, collected natural phenomena and made scientific observations. In this way the HBC contributed to the advancement of knowledge and reaped the profits in the form of new economic goods.

Medical plurality typifies frontier medicine. Regardless of whether the medical practitioners were licensed as either a surgeon or physician, their duties encompassed the combined role of surgeon, physician and apothecary. The multiple roles assumed by individual practitioners commenced with exploration. They used their training to oversee the health of the ships' crew, to gather botanical samples and to conduct surveys of new territories. During the HBC era surgeons operated as fur traders and as factors. They were responsible for distributing medical supplies to posts without a resident surgeon.

³ Mary-Ellen Kelm, *Colonizing Bodies: Aboriginal Health and Healing in British Columbia 1900-50*, (Vancouver: UBC Press, 1998), Introduction. Robert Boyd, *The Coming of the Spirit of Pestilence: Introduced infectious Diseases and Population Decline among Northwest Coast Indians, 1774-1874*, (Vancouver and Toronto: UBC Press, 1999), Introduction. Grant Keddie, *Songhees Pictorial: A History of the Songhees People as seen by Outsiders, 1790-1912*, (Victoria: Royal BC Museum, 2003), 77-82.

Several northwest surgeons assisted the HBC and the RS in collecting flora and fauna for their joint enterprises.

Medicine was an important component of the fur trading enterprise. The HBC valued surgeons for health, ethnic⁴ and business reasons and employed them on its ships and at trading posts because it was aware of the health hazards on board ship and at isolated posts.⁵ Company surgeons operated within an 'enclavist' framework: white doctors primarily tended to company officials or a few First Nations employees.⁶ The surgeon's primary mandate was to keep the posts self-reliant in matters of health care as days lost by ailing personnel meant fewer profits.⁷

The surgeons were responsible for ordering, storing, keeping track of inventory, and distributing medical supplies and instructions for their use to smaller posts where, because of the lack of a resident surgeon, the Chief Factor treated injuries and illnesses of the men under his command. Pacific coast surgeons William Tolmie (Figure 2.6) and Meredith Gairdner, for example, made up the packets of medicines at Fort Vancouver that

⁴ Although the HBC had been granted a charter and exclusive rights to a fur trade monopoly, over the years the company increasingly experienced competition from incursions of French traders and later, from British merchants who operated the Montreal based Northwest Fur Company. Therefore, they wanted to hire employees loyal to their London based operation. Cynthia Toman, "George Spence: Surgeon and Servant of the Hudson's Bay Company, 1738-41," *Canadian Bulletin of Medical History*, Vol. 18, Number 1, (2001), 21.

⁵ Today we refer to medical personnel as physician, surgeon or medical doctor. The HBC refers to all medical personnel as surgeons.

⁶ John S. Galbraith, *The Hudson's Bay Company as an Imperial Factor, 1821-1869*, (Toronto: University of Toronto Press, 1957), 1-4. In 1821 the British owned HBC amalgamated with the Montreal based Northwest Fur Company (NWC). Roy Porter, review of *Colonizing the Body: State Medicine and Epidemic Disease in Nineteenth Century India*, by David Arnold, in *Nature* (Vol.366, Nov. 1993), 119

⁷ W. B. Ewart, "Thomas Hutchins and the HBC: A Surgeon on the Bay," *The Beaver*, Vol. 75:4, August/September, 1995), 38. Toman, "George Spence-," 18. The first surgeon to be employed was Pierre Romieux who served on the HBC exploratory voyage to the Hudson's Bay (1668) on the *Nonsuch*. He remained as posts were established until 1674 when he was replaced by an English surgeon, Walter Farr. E. E. Rich, "The Fur Traders: Their Diet and Drugs," *The Beaver*, Vol. 56, (Summer 1976), 47.

were annually shipped to trading posts throughout the northwest.⁸ Supplies were ordered annually from England but often did not arrive for two or three years. The surgeon had to calculate the supplies needed, specify the quantity of each by mass (weight), capacity (gallon) or number (dozen, gross) and keep track of the medications used and those left over.⁹

Not all the surgeons' tasks were medical as they often had a dual role as either Factor or 'second-in-command' of the post. As E. E. Rich notes, "it was an advantage that so many of the English were one time surgeons turned traders" because business was the essential purpose.¹⁰ Not only could the surgeons fill two roles but they were noted for their literacy, their personal motivation and "their fidelity and diligence."¹¹ As factors, surgeons were expected to maintain accurate business records. In 1834, the HBC initiated the Deed Poll which required that annual inventories be taken at all posts on May 31st as the new trading year commenced on June 1st. Post journals (diaries) of daily activities were expected to be maintained. The diaries contain only sporadic entries pertaining to illness and injury.

Cynthia Toman suggests the way the Company used these journals constrained what was recorded. More senior officials closely scrutinized entries and used them as a basis for decisions of promotion, salary increases, company tenure and the recall of

⁸ John A. Hussey, *Fort Vancouver Historic Structures Report, Volume II*, Chapter II: "Indian Trade and Dispensary," Denver Services, US Department of the Interior, 1976. <http://www.nps.gov/fova/hsr/hsr2-2.htm> (Viewed 16 October 2005).

⁹ Toman, "George Spence," 22. Elizabeth Briggs and Colin J. Briggs, *Before Modern Medicine: Diseases & Yesterday's Remedies: Using Documents from the Hudson's Bay Company Archives, The Provincial Archives of Manitoba & The National Archives of Canada*, (Winnipeg: Westgarth, 1998), 133-34.

¹⁰ Toman, "George Spence," 18.

¹¹ Edith I. Burley, *Servants of the Honorable Company; Work, Discipline, and Conflict in the Hudson's Bay Company, 1770-1870*, (Toronto: Oxford University Press, 1997), 20. Toman, "George Spence," 18.

personnel. As a method of control, factors could influence company decisions because they could select the information that was forwarded.¹²

Employment in the HBC was hierarchical. Both factors and surgeons were considered as officers at the posts but the Company considered them to be “servants.” Surgeons were usually hired for one to three years; as clerk and surgeon, the contract was for four to five years. Like all other employees, surgeons were required to submit to the factor and to implement decisions of the London based committee. However, conflicts could arise between their medical commitment to patients and as subordinate members of the HBC or the NWC. For instance, not only did some surgeons believe they were inadequately compensated given their training,¹³ but conflict could affect their medical practice. In 1833, for example, William Tolmie was sent on a short overland excursion to Nisqually to gauge the feasibility of building a fort on the site. While there, an assistant, Pierre Charles, sustained a severe laceration to his ankle. Although Chief Factor McLoughlin (Figure 2.7) sent written orders telling Tolmie to return immediately to Fort Vancouver, the incoming Chief Trader C.F. Heron agreed with Tolmie who defied the orders and stayed at Nisqually for three months to oversee the medical care of his

¹² Toman, “George Spence,” 19-20. 39,ft.6. The HBC has a few post journals of the northwest on microfilm: one each from Fort McLoughlin (1833), Fort Rupert (1849-50) and three from Fort Simpson (1832-53, 1855-66, 1899). Ewart, “Thomas Hutchins-,” 38-41. Ewart described the career of surgeon Thomas Hutchins who was at York Factory from 1766-83 and mentions how difficult it is to try to reconstruct a practice using only post journals. Briggs, “*Before Modern Medicine*,-”133. Of the seven major categories in the post inventories, medicine is one.

¹³ When Doctor John McLoughlin Sr. was hired by the NWC to oversee the medical needs at Fort William in 1804, he expected his salary would reflect his medical apprenticeship and a reduced bounded time from seven to five years. When he did not receive the salary he expected, he seriously considered resigning. John McLoughlin, *Fort Vancouver Letters, First Series:1825-38*, (Toronto: Champlain Society, 1941),xxxii. McLoughlin replaced Dr. Henry Munro whose primary interest was as a trader. McLoughlin was not the only surgeon to feel he had not been properly compensated. William Todd, clerk and surgeon at Swan River District (1831-51), made a considerable mark as a doctor during the smallpox epidemic of 1837. He died a bitter man believing the HBC did not appreciate him and would not promote him to Chief Trader. Arthur J.Ray, “William Todd: Doctor and Trade, for the Hudson’s Bay Company, 1816-41,” *Prairie Forum*, Vol.9, No. 1, (1984), 13-24.

patient.¹⁴ Yet, when McLoughlin was surgeon at Fort William his notion of medical professionalism was paramount; in his position of Chief Factor, his concerns seem to favor business commitments over patient care.

John McLoughlin Sr. (1784-1857) who resided for twenty years at Fort Vancouver where his primary role was to build and oversee trading posts along the Pacific coast, was the only long term surgeon in the Northwest.¹⁵ Throughout most of his years at the post, McLoughlin usually had another surgeon working with him which was probably fortunate for his patients. During his years with the NWC at Fort William (1803-1824), his medical abilities were thought to be second rate.¹⁶ The fort was considered "one of the unhealthiest" because McLoughlin's "cures and mis-diagnoses were apparently worse than the presenting complaints."¹⁷ For instance, trader Daniel Harmon remarks, in 1808, "the Doctor (McLouglin) has not been able to learn –what my complaint is. He says it is more imaginary than any real Disease-but however that may be, the Medicins I have taken (on his own) in the course of last winter, have been of much service to me."¹⁸ This did not seem to impede McLoughlin's progress in the

¹⁴ Howard T. Mitchell, the editor of Tolmie's journal, states the surgeon's "description of his treatment of a servant of the company---stands as the first detailed report on a medical case written in the Pacific Northwest." *William Fraser Tolmie, The Journals of William Fraser Tolmie, Physician and Fur Trader*, (Vancouver: Mitchell Press, 1963), 398. In regards to labour relationships, Heron was disobeying McLoughlin's orders by wanting Tolmie to stay behind. Tolmie and McLoughlin had a mutual respect for each other. If there were consequences to Tolmie's actions he does not mention it.

¹⁵Henry H. Chown, "Medical Men and Medicine in Early Years in Western Canada," University of Manitoba, Faculty of Medicine Archives, Biographical Files 21.g, Folder #3. Paper read before the Winnipeg Medical Society, Sept. 17, 1915, 16. J. Gottfred, "Medicine in the Northwest" *Northwest Journal*, Vol.111, (2005) 15. <http://www.northwestjournal.ca/VII2.htm> (Viewed 16 October, 2005)

¹⁶ For instance, Dr Gairdner spent his six years working under Mcloughlin at Fort Vancouver. Fort William was the NWC's first post west of the Rocky Mountains. While at Fort Vancouver McLoughlin built sawmills and flourmills and established large farming and fishing businesses. Today he is remembered as the "Father of Oregon." Peter C. Newman, *Company of Adventurers*, (Markham: Viking Press, 1985), 285.

¹⁷ Decker, "The York Factory Medical Journals-," 108. Donald Sage, "Swirl of Nations,: The Hudson's Bay Company on the Pacific Coast to the mid-nineteenth century," *The Beaver*, Spring, 1963, 35.

¹⁸ Daniel Williams Harmon, W. Kaye Lamb, ed, *Sixteen Years In The Indian Country: The Journal of Daniel Williams Harmon, 1800-1816*, (Toronto: Macmillan Company, 1957), 109.

company as he was made a partner in 1814. His lack of skill may have been due to the seasonal lifestyle of traders; the NWC felt no need to keep a surgeon on duty after the traders had scattered to their posts for the winter. With few patients and prolonged time in between seasonal medical duties, McLoughlin probably became 'rusty' although on several occasions he did appeal for medical texts. McLoughlin's determination to stay in the fur trade was influenced by the need of his younger brother, David, for financial assistance to study medicine at Edinburgh University.¹⁹

Like McLoughlin, all of the HBC surgeons on the Pacific Coast were traders and had varied careers; unlike him, they frequently moved, on average every three years. Two of McLoughlin's contemporaries were John Frederick Kennedy (1805-1859) and William Fraser Tolmie (1812-1886). Kennedy was physician and surgeon, trader and accountant. Arriving at Fort Vancouver in 1831, Kennedy served briefly under McLoughlin before being posted to Fort Simpson (Figure 2.2) and Fort Rupert. During most of his time with the company, Kennedy was more involved in the fur trade than with medicine. After retiring in 1856, he was elected as representative from Nanaimo to the first House of Assembly for the Colony of Vancouver Island and contributed to the negotiation of First Nations treaties.²⁰

Tolmie joined the Company in 1832 as clerk and surgeon. During 1833-41 he served as Chief Trader and surgeon at Forts McLoughlin, Simpson and Nisqually after

¹⁹ McLoughlin, *Fort Vancouver Letters*, xxxii-xxxv.

²⁰ For instance, in 1851 Douglas sent Chief Trader Kennedy and his party of men to hunt for gold and to determine the advisability of forming an establishment on the Queen Charlotte Islands. Hartwell Bowsfield, ed., *Fort Victoria Letters, 1846-1851*, "Introduction" Margaret A. Ormsby, (Winnipeg: Hudson's Bay Record Society, Vol. XXXII, 1979), xci. Robert E. Mckechnie II, MD. *Strong Medicine: History of Healing on the Northwest Coast*, (Vancouver: J.J. Douglas Ltd., 1972), 95. Kennedy's interest in Native treaties might stem from the fact that he was a Metis, married to the daughter of Ligaic, a powerful Tsimshian chief. Through this alliance the Legaics controlled all trade with the HBC at Fort Simpson. Susan Neylan, *The Heavens Are Changing: Nineteenth-Century Protestant Missions and Tsimshian Christianity*, (Montreal & Kingston: McGill-Queen's University Press, 88).

which he does not appear to have practiced medicine on a regular basis²¹ Tolmie joined a fur trade expedition to the Stikine River and attempted an ascent of Mount Rainer in what is today Washington State. Mount Tolmie, near Victoria BC., is named in his honour. He was an avid botanist, an ethnologist and had an interest in phrenology. After moving to Victoria in 1859 Tolmie served on the HBC board of management until his retirement in 1870. He also had a political career. Encouraged by Dr. John S. Helmcken (Figure 2.4), Tolmie was elected to the House of Assembly in 1860 and served until 1866 when Vancouver Island merged with the mainland. After British Columbia entered Confederation in 1871, he was elected to the legislature in 1874 and in 1875, retiring after his defeat in 1878.²²

Accompanying Tolmie to Fort Vancouver on the HBC supply ship, *Ganymede* was Dr. Meredith Gairdner (1806-37). While on board they shared the responsibility for the medical needs of the passengers and crew. Gairdner's medical duties at the post included building a hospital to house the "2 to 300 cases" of malaria patients during an 1833 outbreak. Since the "marsh miasmata" were blamed for the fever, Gairdner's preventive measure included building pits around the hospital site so "smoke-producing fires" could "purify the contaminated air of the miasmata," a procedure that was used

²¹ After returning from a furlough in England and France, Tolmie managed the Puget Agricultural Company, a HBC subsidiary. He was responsible for starting the first HBC circulating library across the country. T.F. Rose, *From Shaman to Modern Medicine: A Century of Healing Arts in British Columbia*, (Vancouver: Mitchell Press, 1972), 5.

²² Johnston, *The Pacific Province: A History of British Columbia*, (Vancouver/Toronto: Douglas & McIntyre, 1995), 52. R. Geddes Large, *Drums and Scalpel: From Native Healers to Physicians on the North Pacific Coast*, (Vancouver: Mitchell Press, 1968), 3, 108. Toman, "George Spence," 17-18. T.F. Rose, *From Shaman to Modern Medicine*, 4-7. Daniel Francis, ed., *The Encyclopedia of British Columbia*, (Madeira Park, BC: Harbour Publishing, 2000), 707. In 1884 Tolmie collaborated with Dr. George Mercer Dawson of the Geographical Survey of Canada and published a collection of Indian vocabularies.

throughout the 1830's at the fort.²³ Like Tolmie, he was interested in botany, ethnology and phrenology and aided in classifying the Columbia coastal fish. A Washington state rainbow trout, *Salmo Gairdneri*, is named after him. His eyewitness report of the eruptions of Mount St. Helens in 1835 was published in the *Edinburgh New Philosophical Journal*. Gairdner died of tuberculosis in 1837.²⁴

In 1850 Doctor John Sebastian Helmcken arrived in Victoria where he remained in practice until ten years before his death in 1920. Helmcken was a Chief Trader (1863-1870) and, like Tolmie and Gairdner, supplied company posts with a variety of medications. He later served as coroner and as surgeon to the Victoria jail and was instrumental in establishing three hospitals in Victoria (the old and new Royal Jubilee, St. Joseph's, and the French Hospital). As founder of the British Columbia Medical Society (1885), Helmcken was instrumental in establishing the Medical Council of British Columbia (1886), the provincial licensing body.²⁵ As a son-in-law of Governor James Douglas, Helmcken played an active political role. In 1851, he officiated as justice to the peace as well as surgeon to the miners at Fort Rupert. Helmcken sat in the first assembly in 1856 and remained on the Executive Council of British Columbia and was one of the

²³ Robert Boyd, *The Coming of the Spirit*, 103. Miasmata was an environmental theory which stated that illnesses were caused by "foul exhalations from low and humid situations—prevailing the atmosphere." 93-94. Hussey remarks that two hospitals were built. "One was connected to the apothecary shop and reserved for the Company's "gentlemen"—the other, outside the stockade toward the river, was where the firm's "servants," their families, Indians and persons considered of low rank were treated." Hussey, "Fort Vancouver Historical Structures Report." Malaria was called "intermittent fever" by the British and "fever and ague" by the Americans. Boyd, 84.

²⁴ Anonymous, "Native Americans" American Voyageur Enterprises, <http://www.historytoursnw.com/nativeamericans.html> (Viewed 14 October 2005); Michael L. Charters, "Latin and Greek Meanings and Derivatives" page G -from Southern California Wildflowers and other Plants. (2003) <http://www.calflora.net/botanicalnames/pageG.html> (Viewed 13 October 2005).

²⁵ The Medical Council of BC was later renamed the College of Physicians and Surgeons of BC, which assumed responsibility for registering physicians, setting exams, and prosecuting offenses against the Medical Act.

British Columbia delegates who negotiated the terms of Union with Canada.²⁶ Helmcken was the first doctor on the coast to establish a private practice but it was not very remunerative mainly because of his reluctance to collect from the poor and the reluctance of better off patients to pay their bills.²⁷ His reputation drew patients from as far away as the Interior of the province and the United States. House calls could mean several days' journey by canoe or horseback.²⁸

These early surgeons arrived when the professionalization of medicine elsewhere was well underway. Kennedy, a Métis from what is now the province of Saskatchewan, graduated as a Licentiate from the Royal College of Surgeons in Edinburgh (1829), before joining the HBC; Tolmie attended the University of Glasgow (1829-31) before signing on with the Company as surgeon and trader. Gairdner a native of London, received his medical degree from the University of Edinburgh. Prior to leaving for Fort Vancouver he studied science in Germany. Helmcken apprenticed as a medical student

²⁶ John Sebastian Helmcken, *Reminiscences of Doctor John Sebastian Helmcken*, Dorothy Blakely Smith, Ed., (Vancouver: UBC Press, 1975), xiv-xvii. The Royal Jubilee was the first hospital on the coast.

²⁷ Helmcken, *Reminiscences*, xxix. The first clerk and surgeon to be appointed to Fort Victoria was Alfred R. Benson (1849). By 1860 there were 8 or 9 doctors in Victoria. Several became members of the Colonial and Provincial Legislatures. Dr. James Trimble (1818-1885) arrived in Victoria in 1858. Eight years later he was elected to the Colonial Legislature, was mayor of Victoria for two years and served as speaker of the first Provincial Legislature (1871-1878). Dr. John Ash (1821-1886), arriving in 1862 from England, combined a medical practice with being a member of the Colonial Legislature from 1865-66, and a member of the Provincial Legislature from 1872-1882. During this time he served as Provincial Secretary of Mines, 1872-1874. Dr. Israel Wood Powell (1837-1915), graduated from McGill in 1860 and arrived in Victoria 2 years later. From 1863 to 1866 he was a member of the Legislative Assembly of Vancouver Island, arguing strongly for a union between British Columbia and the Canadas, in a time when BC was tempted to join the United States. Powell supported the move towards Confederation and was vice-president of the Confederation League from 1867 until 1871. In 1872 he became Superintendent of Indian Affairs and for the next 17 years he fought to bring medicine and better education to First Nations people across the province. Following the passing of the BC Medical Act in 1886, Dr. Powell became the first president of the Medical Council. Powell River was named in his honor as well as many city streets. Lastly, Dr. G.L. Milne arrived in Victoria in 1880 and was instrumental in organizing the 1886 BC Medical Act. He was a member of the Medical Council, acting as its Secretary and Registrar from 1886 to 1896. M.W. Thomas, MD., "Medical Pioneering in British Columbia," Part 2, BCMA, Historical Articles Binder, 14d, 1931, 18-19. Dr. Israel Wood Powell, [Http://www.armourtech.com/museum/drpowell.htm](http://www.armourtech.com/museum/drpowell.htm) (Viewed September 7, 2006).

²⁸ His patients came from Yale, Port Madison, Nicola Valley and Salmon Arm. Honor M. Kidd, MD., "Pioneer Doctor John Sebastian Helmcken," Lecture given before the Osler Society, McGill University, October 17, 1946. British Columbia Archives (BCA) W H 36K, 53. Helmcken, *Reminiscences*-121.

for three years (1841-44) before entering medical school at Guy's Hospital in London. During his four years of study he won first prize in Chemistry and a second award for *Materia Medica*.²⁹ McLoughlin apprenticed for five years (1798-1803) with Dr. James Fisher of Quebec City, one of the most prominent physicians of his time who was regarded as the father of medical legislation in Lower Canada. While attending school in France, McLoughlin's son, John Jr., had an altercation with his uncle, Dr. David McLoughlin, who promptly sent John home to his father. John Jr. eventually was hired by the HBC as a surgeon even though he had not completed his medical education.³⁰

When Helmcken entered medical school in the 1840's, scientific perspectives had altered how medicine was taught. Prior to the mid-nineteenth century the style of intervention therapy was called drastic, or heroic. The use of drugs, many of which today we consider poisonous, combined with restrictive diets, vicious enemas, emetics and various means of bleeding, such as cupping, leeches and phlebotomy were given as a means to restore the body's balance. Heroic medicines (Figure 2.8), such as cupping and leeching are still in use today.³¹ By mid-century, the use of instruments for diagnostic

²⁹ McKechnie, *Strong Medicine*, 180. A surgical diploma from the Royal College in Edinburgh did not entitle the bearer to use the prefix "doctor." The person qualified as a licentiate. While a course in clinical surgery was compulsory, lectures in clinical medicine were "earnestly recommended." Charters, "Latin and Greek Meanings and Derivations." Opinions vary as to whether Tolmie graduated from the medical faculty in Glasgow. Rose suggests he graduated in 1832 while McKechnie maintains Tolmie had two years at the university and there is no record of him graduating or becoming a Licentiate of the Faculty of Physicians and Surgeons of Glasgow. Rose, *From Shaman to Modern Medicine*, 4. McKechnie, *Strong Medicine*, 97. In Tolmie's journals, his son, Dr. Simon F. Tolmie (Premier of BC 1928-33) states his father, in 1841, took a post graduate medical course in Paris. Tolmie, *The Journals of William Fraser Tolmie*, 390. "Although almost invariably referred to as Dr. Tolmie, he was not an MD: during these (1829-31) two years he worked toward a diploma as licentiate of the Faculty of Physicians and Surgeons of Glasgow, a body independent of the university." "His leave gave him finally the opportunity to spend some time in Paris, in May and June 1842. He studied and observed in hospitals and other institutions -" W. Kaye Lamb, *Dictionary of Canadian Biography, 1881 to 1890*, Vol.XI (Toronto: University of Toronto Press, 1982), 885-886. Helmcken, *Reminiscences*, xxxviii

³⁰ McLoughlin, *Fort Vancouver Letters*, xxx. McLoughlin Jr. was murdered at Fort Stikine in 1837.

³¹ Jacalyn Duffin, *History of Medicine: A Scandalously Short Introduction*, (Toronto: University of Toronto Press, 1999), 101. Today mercury in the form of calomel; antimony in the form of tartar emetic; jalap, a powerful cathartic; strychnine, opium and laudanum for pain and sleep; and, alcohol as a stimulant are

analysis and advancements in clinical observation techniques marked a break from the older method of treating symptoms. Helmcken was trained in the use of electro-therapy, in early anaesthetics, and herbal pharmacology. He left just before antiseptic technique was demonstrated and he was trained in vaccination for small-pox. His medical library consisted of over 100 volumes.³² The development of anaesthesia, antiseptics, germ theory and public health fundamentally altered conceptions in disease, in therapeutic modalities, and in the structure and function of the profession.³³

From Doctors McLoughlin, Tolmie and Helmcken we can gain an insight into the treatments and pharmacopoeia of the fur trade era. Their writings include the most common forms of medications, all of which were derived from plants (botany).³⁴ The most plentiful drugs were opium (for fevers, pain, sedation and diarrhea); calomel (an anti-venereal drug that contained mercury and could sometimes induce mercury poisoning); castor oil, rhubarb, jalap and sulphur (purgatives); camphor oil (to promote

classified as poisonous. Duffin remarks "the word 'heroic' which normally signifies admiration became a pejorative term in medicine. Originating from the vigorous last-ditch attempt to save lives, it now implies overdosing, overdosing, and overreacting." 101. Today cupping is "mainly recommended for the treatment of pain, gastro-intestinal disorders, lung diseases (chronic cough and asthma), and paralysis--." Subhuti Dharmananda, Director for Traditional Medicine, Portland, Oregon. "Cupping," <http://www.itmonline.org/arts/cupping.htm> (Viewed November 26, 2006) Leeches have made a comeback since the 1980s due to the advent of microsurgery such as plastic or reconstructive surgeries.

Aisha El-Awady, "Maggots and Leeches make a comeback," *Science in Africa: Africa's First On-Line Magazine*, <http://www.scienceinafrica.co.za/2003/july/leech.htm>. (Viewed November 26, 2006).

³² Electro-therapy has been used for the treatment of pain, gout and rheumatic disorders from ancient times to present day. A. Helmstadter, "The history of electrotherapy of pain—or what Voltaren has to do with voltage." <http://www.ncbi.nlm.nih.gov/entrez/query.fcgi?cmd=Retrieve&db=PubMed&list-uids=1>

(Viewed November 26, 2006) Antiseptic technique is the destruction of micro-organisms that produce sepsis or septic disease. The first technique, introduced in 1847 by Ignaz Semmelweis, was washing of hands and instruments in chlorine water to prevent childbirth fever. Joseph Lister followed, in 1865, using carbolic acid on open fractures. By stating wound infections were caused by bacteria, Lister confirmed the germ theory of Louis Pasteur. Jacalyn Duffin, *History of Medicine*, 229.

³³ Jacalyn Duffin, *Langstaff: A Nineteenth Century Medical Life*, (Toronto: University of Toronto Press, 1993) 3.

³⁴ The difference between medicinal and poisonous plants was classified. Nosology (the classification of disease) followed a classification schema (classes, genera, species) parallel to botany. This indexing lent scientific credibility to medical knowledge. John M. Naish, *The Interwoven Lives of George Vancouver, Archibald Menzies, Joseph Whidby and Peter Puget: Exploring the Pacific Northwest Coast*. Canadian Studies, Vol.17, (Lampton: Edwin Mellen Press, 1996) Douglas Deur, Reviewer. Toman, "George Spence," 24.

sweating and for inflammatory diseases); spruce-beer or spruce-juice (antiscorbutics for scurvy); dogwood root, quinine and chinchona bark (antimalaria); brazil root (emetic); olive oil, specuccianah powders and hartshorn (laxatives for constipation or to remove worms) and epsom salts (antiarthritic). Opium was also used for a variety of respiratory ailments such as pneumonia, pleurisy and tuberculosis. Alcohol (beer, brandy) was a “sovereign remedy.” When brewed with spruce, alcohol became a diuretic.

Ointments and plasters were in constant use as accidents and infections were plentiful. The ointments often referred to as basilicons, contained herbs (anise, basil, lavender, rosemary) and were mixed with a wax or glycerin base. Plasters, made with baking soda, resin (adhesive) and sulphur, were used to draw out infections. Elixirs, such as *Turlington's Balsam of Life*, were frequently recommended. They are clear sweetened alcoholic solutions. Herbs were added to elixirs to relieve gastro intestinal problems, such as griping or flatulence. Herbs were also used in tinctures or essences.³⁵ Lead was used as a sedative and as an astringent to treat cholera.³⁶

Their surgical instruments were varied. Each surgeon had amputating saws, cupping (bleeding), and eye equipment; syringes, probes and lancets; forceps (teeth extractions); catheters and catlins (surgical knives). The surgical kit (Figure 2.5) also included trephining equipment, which consisted of a device used to drill a hole into the

³⁵ Another common name for purgatives is cathartics. Decker, “The York Factory Medical Journals-,” 119. Gottfred, “Medicine in the Northwest”, 15-25,” Rich, “The Fur Traders:-” 48. Turlington's Balsam (1744) was a concoction of 27 ingredients. Thought of as the universal panacea, the elixir was supposed to cure a large number of diseases. When it was analyzed by the Philadelphia College of Pharmacy in 1822 it was found to contain tincture of benzoin, balsam of Peru, myrrh, angelica root and ammonia. Helmcken, *Reminiscences*, 121 McLoughlin introduced Tolmie to dogwood root as a substitute for quinine. Tolmie, *The Journals of William Fraser Tolmie*, 171. When alcoholic solutions contain volatile oils (peppermint, lemon) they are referred to as spirits or essences. When alcohol forms the dissolving solvent for drugs (myrrh) the solutions are known as tinctures. Today we classify the use of herbs as alternative medicine.

³⁶ Briggs, “Before Modern Medicine-”, 136. One wonders if some of their clients' gastro-intestinal problems may relate to lead poisoning from their various lead cooking utensils. Tolmie mentions drinking from a “foul tin teapot” which resulted in fever, flatus, soreness and loss of appetite. Tolmie, *The Journals of William Fraser Tolmie*, 241.

cranium to relieve the internal pressure after a concussion, and lithotomy instruments, used to remove stones from the bladder. Bougies were used as dilators, either for the bladder or to enlarge the esophagus. Tolmie had midwifery forceps and Helmcken, a vaginal speculum. McLoughlin listed a small electrifying machine; Helmcken, post mortem instruments and pulleys for dislocations. Day to day medical work consisted of healing broken arms and legs and gunshot wounds.³⁷

Tolmie's treatment for chronic hepatitis illustrates the heroic medicine that was still being practiced. He commenced treatment by bleeding, cupping and blistering.³⁸ A soothing lotion was applied to the inflamed arm and nonirritating plasters were administered. This was followed by sulphur and magnesium powders. The patient's diet was to be "sedulously watched" and foods eliminated if troublesome. A solution of "Corrosive Sublimate in Alcohol" was suggested. If the measures were not successful, a "blue pill" was to be taken every night until "slight Ptyalism" (excessive salivation) occurred. As a last resort, the patient was "reluctantly" advised to take an arsenic solution. It would appear the 'hero' was the patient!³⁹

Depression and mental illness were also treated. In 1850, Victoria had its first recorded case of insanity when a deranged Scottish immigrant allegedly assaulted Helmcken, the jail physician. The man was placed on a ship and returned to Scotland.

³⁷ McLoughlin, "Inventory of Medicines, Fort William, October, 1816," Hudson's Bay Company Archives: Archives of Manitoba, (Winnipeg), File: SF. Tolmie, *The Journals of William Fraser Tolmie*, 173. Doctor John Sebastian Helmcken, Medical notebooks and equipment found in his medical supplies account book, Helmcken Family Papers, MS-0505, Vol. 3, BCA.

³⁸ "From antiquity until the mid-twentieth century, bloodletting was standard treatment-." Duffin, *History of Medicine*-, 178. Blood-letting was considered a tried and true remedy for certain conditions such as fevers, inflammations, and a variety of diseases. It seemed a logical procedure when the foundation of all medical treatment was based on four humors: blood, phlegm, yellow bile, and black bile. Louise M Darling, Biomedical Library, UCLA, History and Special Collections, 2002.

<http://www.library.ucla.edu/libraries/biomed/his/blood/index.html>. (Viewed 16 October, 2005)

³⁹ Tolmie, *The Journals of William Fraser Tolmie*, 326-27.

Throughout the 1850s treatment consisted of confining patients into tiny, foul cubicles in the city's jail, or they were left to fend for themselves. Handcuffs, leather mitts, pinion straps and strait jackets were commonly used. In 1864 an infirmary for women was opened. Eight years later, in 1872, BC's first asylum for the insane was opened. Named the Royal Hospital, the complex had previously served as Victoria's quarantine hospital. A year later the Insane Asylum's Act was passed, which became BC's first legislation to address mental illness. Five years later the overcrowded Victoria asylum was closed and the newly-built Provincial Asylum for the insane was opened in New Westminster.⁴⁰

Although Helmcken had had a thorough medical grounding at Guy's Hospital, he did not entirely keep up or accept modern medical innovations. In the late 1860's when carbolic acid was introduced as an antiseptic measure, Helmcken "did not propose or oppose it—I knew too little about it to have an opinion." He considered the use of general anaesthetics for trivial operations as "an abuse, educating the people into greatly exaggerated conceptions of pain and so making them timid." Although he did use ether towards the latter days of his practice, he repeatedly failed to adhere to the anaesthetic's cautionary use. On one occasion he and his patient narrowly escaped facial injuries

⁴⁰ Rose, *From Shaman to Modern Medicine*, 143-144. "History: BC Mental Health Timetable," BC Mental Health and Addiction Services, <http://www.bemas.ca/AboutUs/History.htm>. (Viewed November 28, 2006). Historians debate the purpose of the asylum. Was the asylum designed to cure the insane, therefore a reforming impulse, or was it designed to provide custodial services as a form of social control? The former was based on moral treatment stating that insanity was curable and that the insane were human. Humane treatment was advocated. However, due to Michel Foucault's 1960s writings (e.g. *Madness and Civilization: A History of Insanity in the Age of Reason*), many historians agree with his premise that incarceration was due to capitalism and the rise of the middle-class who wanted control. Wendy Mitchinson, "Reasons for Committal to a Mid-Nineteenth Century Ontario Insane Asylum: The Case of Toronto," *Essays in the History of Canadian Medicine*, eds. Wendy Mitchinson and Janice Dickin McGinnis, (Toronto: McClelland and Stewart, 1988), 88. In 1865, Drs. J.S. Helmcken and John Ash, certified their political colleague, lawyer George H. Cary, as insane. They persuaded him to return to England "by contriving a telegram announcing that he was to be appointed chancellor--." He died the following year. His Victoria home, Castle Cary, was used as the official residence for the Queen's representative until it burnt down in 1899. George Hunter Cary, *Dictionary of Canadian Biography*, Online, <http://www.biographi.ca/EN/ShowBio.asp?Biold=38463&query=> (Viewed November 28, 2006).

because the ash from the cigar he was smoking ignited the patient's mask. A wet towel saved the patient's face but Helmcken lost his whiskers.⁴¹

While he may not have kept up with the standards of his times, he was greatly valued by his patients. Painter Emily Carr remarks that "you began to get better the moment you heard Dr. Helmcken coming up the stairs. If you wanted him in a hurry he got there in no time and did not wait for you to become sicker so that he could make a bigger cure." Dr. Honor M. Kidd states "if success be judged by the esteem, confidence, and love of his patients, then Helmcken was outstanding in his profession."⁴²

Helmcken, in his *Reminiscences*, does not mention childbirth, nor does Tolmie in his *Journals*. In 1863, Helmcken delivered the first child of Dr. John and Dorothy Ash.⁴³ One can only assume he delivered countless of children throughout his long career. Unfortunately accounts of childbirth and midwifery are scarce as the writers of the day were male and without the access to the private world of childbearing. Amelia Douglas, the wife of Governor James Douglas, was noted for her nursing and midwifery arts. In 1851, when she was seven months pregnant herself, Amelia acted as midwife to Mary Yates, the wife of James Yates, an independent trader and member of the first legislative

⁴¹ M.W.Thomas, MD., "Medical Pioneering in British Columbia," British Columbia Medical Association (BCMA) Archives, Historical Articles Binder 14d, September 1936, 285. Doctor Honor M Kidd remarks on Helmcken's "causal and therapy" which "both seem a bit fearsome to-day." She maintains that Helmcken had come "a long way from the painstaking and careful investigations of his patients that he carried out at Guy's Hospital in his student days." Kidd, "Pioneer Doctor-,"57. Emily Carr mentions Helmcken wiped his needle on his sleeve before putting it back in his case and used his fingers to take a broken needle out of her knee. Helmcken, *Reminiscences*-, xxix.

⁴² Helmcken, *Reminiscences*, xxix. Kidd, "Pioneer Doctor-," 64. Carr's remembrances should be read with caution as she was writing in 1942 about how she chose to remember events when she was age 6-12 (1877-1883). She describes Helmcken's office as "a tiny two-room cottage" in which "the outer room had a big table in the centre filled with bottles of all sizes and shapes. All were empty and all dusty. Round the walls of the room were shelves with more bottles, all full, and lots of musty books. The inner office had a stove and was very higgledy-piggledy. He allowed no one to go in and tidy it up." Emily Carr, *The Book of Small*, (Toronto: Oxford University Press, 1942), 200-201.

⁴³Dictionary of Canadian Biography, John Ash, Online:
<http://www.biographi.ca/EN/Show.Bio.asp?Biold=39469&query=> (Viewed November 30, 2006).

assembly on Vancouver Island. Amelia spent many hours with her during her labour and coached her to kneel by the bedside to ease the birth, a Cree practice she learnt from her mother.⁴⁴ Childbirth and the raising of a family were fraught with angst. Cecelia Helmcken died of pneumonia shortly after delivering her seventh child; Amelia Douglas bore thirteen children, but only six survived.

Another important activity in which many HBC surgeons participated was the scientific enterprise between the Hudson's Bay Company and the Royal Society for Improving Natural Knowledge. The members of the Royal Society were "experimental philosophers" who conducted informal scientific experiments and discourses with the objectives of advancing imperialism and science. To do so, they enlisted the support of medical and scientific men who would collect specimens of flora, fauna and minerals from exploratory and colonial lands.⁴⁵

The London Committee, which saw surgeons, as instruments of empire-building, requested that they "send home the roots of herbs, plants and shrubs, with seeds, berries and kernels, whilst the surgeons should identify them by their Indian names and list their qualities."⁴⁶ Sir William Hooker (1785-1865), Regius Professor of Botany at the University of Glasgow and future president (1841) of Kew Gardens had recommended

⁴⁴ Adams, *The Life of James and Amelia Douglas*, 69.

⁴⁵ R.P. Stearns, "The Royal Society and the Company", *The Beaver*, June (1945), 8-9. The Royal Society was granted a charter by Charles II in 1662, eight years before the HBC. Six of the founding RS members were either founding HBC members or were, in its early years, on its executive committee. Over the years twelve members were connected with both organizations. Although the HBC and RS collaborated on information, the collecting of artifacts, and aiding in scientific experiments, the company did not allow geographic data to be released until a change of policy occurred in 1775. Prior to this company policy considered geographical data crucial to its trading operations and thus, were commercial secrets. R. I. Ruggles, "Governor Samuel Wegg, Intelligent Layman of the Royal Society, 1753-1802," in *Notes and Records of the Royal Society of London*, Vol.32, No.2, (Mar. 1978), 182.

⁴⁶ Toman, "George Spence-," 24.

Tolmie to the HBC.⁴⁷ Tolmie corresponded with Hooker⁴⁸ and one of his reasons for climbing Mt Rainier was to gather herbs for medicinal solutions and to send samples back to England. While at Fort Vancouver he collected numerous plant specimens, some of which bear his name. At the post Tolmie was assisted by Gairdner. Plants were also named after them.

With their scientific background, the surgeons also acted as pioneer anthropologists. Imperialism, racial superiority and medicine were intertwined in the pseudoscientific study of phrenology.⁴⁹ In the early decades of the nineteenth century the strongest supporters of the subject came from the medical profession. Purporting it to be the “most intelligible and self-consistent system of mental philosophy that has ever been presented to inquisitive men,” phrenology became part of the medical educational curriculum. To many believers it was now possible to understand the mysteries of the mind and to perceive man’s moral and social conduct in a rational manner.⁵⁰ In Paris (1841), Tolmie attended classes on the topic and joined the Phrenological Society. He mused over the “striking differences in form between the English and the French National Head” concluding that the former had “greater inhabitiveness” and the latter, “greater ideality.” Contrary to what he had been lead to believe, Tolmie “did not observe any comparative deficiency” in the French: some even have “noble developments of the

⁴⁷ Tolmie, *The Journals of William Fraser Tolmie*, 3. Hooker considered Tolmie to be “one of my most zealous Botanical students.” Johnston, *The Pacific Province*, 346. Kew Gardens was the centre of botanical science for Great Britain and its empire.

⁴⁸ Tolmie, *The Journals of William Fraser Tolmie*, 64. “By 1841, Hooker’s Glasgow herbarium contained numerous plants sent by Scouler and Tolmie.” Johnston, *The Pacific Province*, 346. Onboard the *Ganymede*, he and Gairdner performed meteorological observations and collected plants from various islands.

⁴⁹ Phrenology is the study of external conformation of cranium as index to development of the various mental faculties. H.W. Fowler and F.G. Fowler, eds., *The Concise Oxford Dictionary*, (Oxford: Clarendon Press, 1964), 914.

⁵⁰ Roger Cooter, *The Cultural Meaning of Popular Science, Phrenology and the Organization of Consent in Nineteenth-Century Britain*, (Cambridge: Cambridge University Press, 1984), 28-35.

Intellectual and Moral Regions.” He maintained that there was a “close connection” between the advancement of the subject and the “progression of Humanity.”⁵¹

Not every-one viewed phrenology altruistically. While some people thought of it as a “radically imperfect science promoted by bigots,” adherents supported the study of racial anthropometry. Conceived as a system of measuring the human body and relating the findings to the study of evolution, anthropometry was a method of classifying races. The collecting of skulls became popular as a means to identify the criminal mind as well as raciology.⁵² Gairdner, fascinated by the Chinookan custom of head-flattening, exhumed the body of Indian Chief Comcomly and sent the severed head to the Royal Naval Museum (Haslar) at Portsmouth, England for study. He suggested that the phrenologists observe the “frontal development” because by using his “ability” and “cunning,” Comcomly was able to “raise himself & family to a power & influence which no Indian has since possessed.” The skull was not returned to the Chinooks until 1972.⁵³ Phrenology, as a study of character, intelligence and other human traits by reading the shape of the head, continued into the twentieth century.⁵⁴

It was during the fur trade era that European and traditional First Nations medicine intertwined. Their relationship can be categorized as one of cooperation and hostility. Aboriginal concepts of disease and illness revolved around notions of spirituality. Unlike the western concept of medicine in which there is a separation

⁵¹ Tolmie, *The Journals of William Fraser Tolmie*, 363.

⁵² Cooter, *The Cultural Meaning of Popular Science*, 259. Racial anthropometry led to the study of eugenics (study of human heredity aimed at ‘improving’ the genetic quality of human stock) and the notion of racial degeneration in the latter half of the nineteenth century.

⁵³ Nancy Lloyd, “Chief Concomoly Epitomized Brave Chinook Spirit,” (Viewed 26 November, 2005) http://www.lewisandclarkwa.com/pages/news_chobs_concomoly.html

⁵⁴ Phrenologists believed they could predict behavior, function, personality, and deviance with lesions in the brain or spinal cord, and with bumps on the head. Duffin, *History of Medicine*, 200.

between body and spirit, First Nations' understanding of bodily functions includes a dialoguing between the human and non-human. The real world was the world of the spirit. Although Shamans (medicine men) were consulted about many problems of tribal and personal significance, their influence was primarily concerned with the supernatural.⁵⁵

In order to restore the body's natural balance, shamans did diagnose and prescribe treatments. Northwest Native healing included making poultices for boils and drinking salt water as an emetic. Burns were covered with the raw liver of a skate, a fish. This technique foreshadowed our modern knowledge that cod liver oil can be useful for burns. Aboriginal children were encouraged to play in the nude throughout the summer. This facilitated the absorption of Vitamin D thereby preventing rickets. Salicylates, (the basic component of aspirin) were extracted from willow bark and used for fever and pain. An ointment made from pine relieved rheumatism. Spruce pitch or gum was mixed with lard and applied to sores. Steam or sweat houses addressed respiratory conditions. It is of interest to note that heroic medicine and shamanistic healing were concerned with restoring the body's rhythms. Shamans commonly prescribed herbal medications such as bark and pulp of black twinberry for toothache and ophthalmia (eyes) conditions. The chewing of yellow yarrow eased toothaches. When boiling water was poured over alder, the resulting tea was an effective treatment for eczema. Modern ethnobotanical studies have shown that the active ingredients in plant metabolisms function in medicine in a variety of ways, such as an astringent, antifungal, analgesic, diuretic or as an emetic.⁵⁶

⁵⁵ Kelm, *Colonizing Bodies*, 83-99.

⁵⁶ Eldon Lee, *A Western Doctor's Odyssey: From Cariboo to Kos*, (Surrey: Heritage House, 1996), 78-80. Nancy J. Turner, Marianne Boelscher Ignace, and Ronald Ignace, "Traditional Ecological Knowledge and Wisdom of Aboriginal Peoples in British Columbia," *Ecological Applications* (5), 2000, 1275-1287. Turner

Europeans were influenced by Native healing practices and readily adopted poultices, fomentations and the boiling of spruce needles to prevent scurvy. Because First Nations practiced bleeding, sometimes they were called in to administer to Europeans. Herbal remedies, drinking tea for its beneficial effects, and trephining were practiced by both cultures. Explorer Daniel Harmon remarked that Aboriginal “physicians frequently effect cures with their roots, herbs & in cases, which would baffle the skill and the drugs, of a scientifick physician.”⁵⁷

At the same time as Europeans adopted First Nations’ medical practices, they gradually started ministering to First Nations people. Skepticism and hostility were evident in contact relationships. Tolmie used his medical knowledge primarily for the benefit of company employees and only occasionally ministered to First Nations (gunshot wounds, laryngitis) because, if he failed, relatives would expect him to pay damages. He remarks that “it is a pity that the prejudices of the natives oblige one to withhold assistance, where it would probably be of service.”⁵⁸ Aboriginals believed that Europeans were possessed of a potent supernatural force and often saw epidemics as manifestations of the white man’s power. For some Natives, European immunity to disease became suspect. Remedies which involved strong and painful reactions were particularly suspect. In other situations, there was a good rapport between Aboriginals and physicians. For

states traditional ecological knowledge and wisdom (TEKW) ‘has received major recognition as being complementary to, equivalent with, and applicable to scientific knowledge.’ 1275.

⁵⁷ Eric Ross, *Beyond the River and the Bay: Some Observations on the State of the Canadian Northwest in 1811 with a view to providing the Intending Settler with an Intimate Knowledge of that Country* (Toronto: University of Toronto Press, 1970), 88. Rich, “The Fur Traders,” 50-52.

⁵⁸ Large, *Drums and Scalpel*, 3. Tolmie, *The Journals of William Fraser Tolmie*, 301, 308. Tolmie did not always hold back on assisting First Nations. Chief Factor Finlayson wrote from Fort Victoria to W. F. Tolmie at Fort Nisqually on January 13, 1845 about sending Tolmie a First Nations man who has severely injured himself in a fight. Finlayson wanted the Native to “have the benefit of your professional skill.” Tolmie replied “I shall do what I can for the poor Weenacumie, and after a fair trial send him back – whether cured or not.” HBC Archives, British Columbia Search File, B.226/b/1, fos 15d-15, R. Finlayson to W. F. Tolmie, Fort Victoria, January 13, 1845. HBC Archives, British Columbia Search File, B.226/b/1, fo. 16, Tolmie to Finlayson, Nisqually, January 23, 1845.

instance, Helmcken was influential in getting the Songhees Nation to accept smallpox vaccination in 1862, thereby avoiding the devastation which affected northern First Nations.⁵⁹

First Nations lacked natural immunity because they had not been previously exposed to the diseases and had few resources (medicine, public health) to deal with them. Northwest Natives suffered from a series of epidemics. There were outbursts of smallpox in the 1770's, in 1836 and in 1862. Mortality rates ranged from one-third to two thirds of their population, with the major losses being in 1862, when First Nations peoples who had been ousted from their encampment in Victoria because of small pox, carried this epidemic up the coast. The 1836 epidemic did not affect the entire coast because of previous immunity and the dissemination of vaccine to the posts from Fort Vancouver. Measles occurred in 1848 and in 1868 with lower death rates. The region was plagued with various localized epidemics of meningitis, venereal disease, mumps, dysentery, tuberculosis and influenza.⁶⁰

The notion of disease induced depopulation runs counter to the older idea that Europeans brought civilization, progress and salvation to First Nation peoples. Scholars still debate the relationship between disease and depopulation. Revisionist scholars look closely at the intertwining roles of disease, public health, colonialism and imperialism.⁶¹

⁵⁹ Rich, "The Fur Traders," 51.

⁶⁰ Boyd, *The coming of the Spirit*, 134, 198, 202-230. Smallpox raged at Port Simpson in 1836. Due to previous vaccination, it may have missed Fort McLoughlin. Grant Keddie, *Songhees Pictorial: A History of the Songhees People as seen by Outsiders, 1790-1912*, (Victoria: Royal BC Museum, 2003), 77-83.

⁶¹ Data includes Native oral myths and traditions, archeology, explorers, fur traders, early doctors, missionaries and Hudson's Bay Company notes, letters and journals. Boyd, "Commentary", 308. Opinions vary as to the arrival of certain epidemics. For instance, Robert Boyd disputes Cole Harris's conviction that smallpox originated on the Pacific Northwest with the Plains epidemic of 1780-81 Harris also maintains there is no evidence of a coastwide epidemic in 1775. Boyd believes that smallpox was introduced in 1775 by the Spanish expedition of Jean Francisco de la Bodega y Quadra. He acknowledges that a "strong case can be made for the Plains hypothesis" and he is "intrigued" by a Russian possibility. 307, 314.

In this revised view contact and settlement appear as destructive rather than creative. Some researchers view epidemic patterns as the major causative agent in a variety of socioeconomic, political and cultural responses and conditions. Other scholars place more emphasis on changing patterns and note how epidemics and depopulation coincided with changing technologies in transportation and communication which made isolated areas and their resources more accessible to world markets and infections. For instance, in 1848 Chief factor John Work, inadvertently spread measles up the northwest coast as he traveled on the HBC boat, the *Beaver*.⁶²

Contagious diseases resulted in changing medical practices. The HBC served as the first de facto public health agency in the country. Although inoculation (variolation) was performed in Europe since the late 1700's, the HBC preferred the well-established western public health practice of quarantine which was easy to invoke, if not always successful.⁶³ Over the years Europeans assumed they had existing immunity and were no threat to the Aboriginal population. Paul Hackett states this appears to be a valid assumption. He cites a smallpox epidemic of 1782 whereby, in spite of close contact of whites with Native victims of the disease at several posts, only one employee, a man of mixed Indian and European descent, is recorded as having contracted the disease.⁶⁴

⁶² Changes include population trends, band sizes and structures, tribal movements, balances of power, and native customs. Arthur J. Ray, "Diffusion of Diseases in the Western Interior of Canada, 1830-1850," *Geographical Review*, Vol.66, No.2 (Apr., 1976), 139. Cole Harris, "Voices of Disaster: Smallpox around the Strait of Georgia in 1782," *Ethnohistory*, Vol.41, No.4 (Autumn, 1994), 617-618. Immigration in the wake of the railway was a contributing factor in the growth of a White population.

⁶³ Inoculation (variolation) was the intentional infection of an individual with the variola (smallpox) virus in order to produce a mild form of the disease thereby inducing immunity.

Paul Hackett, "Averting Disaster: The Hudson's Bay Company and Smallpox in Western Canada during the Late Eighteenth and Early Nineteenth Centuries," *Bulletin of the History of Medicine*, 78.3, 2004, http://muse.jhu.edu.ezproxy.library.uvic.ca/journals/buletin_of_history_of_medicine/ .282. (Viewed 1 November 2005).

⁶⁴ Rich, *The History of the Hudson's Bay Company, 1670-1870*, Vol. 22, (London: The Hudson's Bay Record Society, 1972), 82. Rich states "with so much close contact the complete immunity of the English was astonishing--there is something very malignant that we are not sensible of, either in the Constitution of

Quarantine was the preferred method of control over inoculation because HBC surgeons, factors, and traders, who did not perform the technique adequately or failed to demonstrate a proper follow-up, resulted in spreading the disease. At that time society failed to recognize that inoculated individuals could spread the disease if they were carriers. Also Native people would likely blame the company for fatalities and threaten to retaliate against Europeans. The HBC practice of not inoculating the Indians “seems to be consistent with British policy in North America” This was the company’s standard practice until the introduction, in 1811, of vaccination (using cowpox serum).⁶⁵

There were problems associated with the use of quarantine. It required close supervision in order to ensure that the infected would not contact the susceptible.⁶⁶ This was evident in the 1862 smallpox epidemic in Victoria because, with no government authority (Governor James Douglas was away in New Westminster) and no public health policy to enforce quarantine, the police took matters in their own hands and expelled the northern Aboriginals from the town. As well, quarantine was not always successful because many posts lacked trained personnel to diagnose illnesses, and therefore misdiagnoses were not uncommon, which resulted in smallpox cases being unsupervised or undiagnosed. Compounding the problem were the similar symptoms of various diseases, such as smallpox and measles in their early stages. Some individuals produce

the Natives or in the Disorder, wrote [trader] Tomlinson.” Hackett, “Averting Disaster,” 586. He provides no further evidence for this remark.

⁶⁵ Briggs, *Before Modern Medicine*, 11. Hackett, “Averting Disaster-,” 582-584. Hackett remarks that in the late 1700’s “whatever confidence the British may have had in the safety and efficacy of smallpox inoculation for their own people, this conviction was not extended to the Aboriginal people of North America.” 584. Edward Jenner (1796) discovery of using cowpox (vaccinia) provided immunity to smallpox. Even if vaccination was not performed correctly, it did not result in a smallpox epidemic. By 1800 most of Europe had switched to vaccination. Hackett, “Averting Disaster,” 590-601.

⁶⁶ Hackett, “Averting Disaster-,” 592-607. Along with quarantine, smoking of clothes and sulphur was used. Once the smallpox vaccination program was accomplished, quarantine was still utilized as a method of control for measles, whooping cough and influenza. Ray, “Diffusion of Diseases-,” 142.

classic symptoms of an illness only once, thereby making subsequent attacks difficult to diagnose. Finally, in some areas different epidemics erupted at the same time, making proper cross-checking difficult. For instance, the northwest experienced epidemics of meningitis, smallpox, influenza, mumps and dysentery between 1835 and 1847.⁶⁷

It is not clear when the HBC started to ship vaccine on a regular basis to their posts.⁶⁸ The London office, writing to Governor Simpson in 1830, reminded him of the importance of vaccinating Natives for humanitarian and business reasons. Although the home office requested a proactive and prophylactic stance, company traders preferred a reactive approach. This meant Natives were not vaccinated until an impending epidemic. In many instances vaccine sat unused at the posts. It appears that surgeons and missionaries took a proactive approach. For instance, in 1824, John McLoughlin was one of the first to initiate a vaccination program.⁶⁹

When the HBC initially introduced vaccination, it did so only for Aboriginals who lived around the post.⁷⁰ This selective process resulted in differential treatment. For instance, Tolmie vaccinated Native populations living at Fort McLoughlin in 1833 and in 1837-38, and from Fort Vancouver he dispensed vaccine to other major company forts.

⁶⁷ Ray, "Diffusion of Diseases," 142. Boyd, *The Coming of the Spirit*, 116, 172. Keddie, *Songhees Pictorial*, 78.

⁶⁸ Most of the HBC personnel had experience in administering vaccine. This exposure went beyond the HBC. For instance, Reverend John Sheepshanks, in 1860, learnt the technique from Dr. Seddall, the physician associated with the Royal Engineers. Sheepshanks vaccinated the La Fontaine Aboriginals thereby averting disastrous results. Reverend John Sheepshanks, Rev. D. Wallace Duthie, ed, *Bishop In The Rough*, ((New York: E.P. Dutton, 1909), 67.

⁶⁹ Hackett, "Averting Disaster," 575. Some of the reluctance was on the part of First Nations as they were suspicious of having a foreign substance introduced into the skin.

⁷⁰ Robert Boyd suggests because only near-by fort Natives were vaccinated and not the entire population, the most acculturated segment of the population was given an edge on survival which was not shared by the unacculturated majority. *The Coming of the Spirit*, 135. Acculturation is the process by which continuous contact between two or more distinct societies causes cultural change. This can happen in two ways. The beliefs and customs of the groups may merge almost equally and result in a single culture. More often, one society completely absorbs the cultural patterns of another through the process of selection and modification. The change often occurs because of political or military domination. It may cause considerable psychological disturbances and social unrest.

As a result there were few cases. Helmcken, in 1862, vaccinated 500 Songhees around Fort Victoria (Figure 2.3) and sent vaccine to missionary William Duncan in Metlakatla, who successfully vaccinated most of his flock. However, because of the short supply, only those Natives who lived amidst white people in Victoria were vaccinated, while none of the coastal First Nations were afforded similar treatment.⁷¹

The effects of disease on First Nations brought everlasting change. Apart from a demographic decline there was the social and psychological impact. Village abandonment, tribal regrouping and the elevation of lower ranking individuals into positions of a higher social rank were common occurrences. Some Aboriginals responded with conversion to Christianity. The influx of miners and settlers signaled the end of the fur trade. Native people would have less autonomy and their wealth and power would diminish as the pace of cultural change accelerated.⁷²

The 1862 smallpox epidemic is pivotal in the development of medicine in British Columbia because it sheds light on public awareness being focused on the need for a public health care system, coordinated by medical personnel, and backed by government authority. This incident transformed fur trade medicine from colonial medicine into a colonial medical profession. It created the necessity of the medical profession to enlarge its perspective and care for more than just a one-on-one experience. If the Catholic and Anglican missionaries had not vaccinated First Nations in the interior and the lower Fraser River, and Anglican missionary Alexander Garrett, had not build a small Indian

⁷¹ Boyd, *The Coming of the Spirit*, 172. He suggests a "lack of government authority, fear, and a regrettable degree of bias" were the reasons for their expulsion.

⁷² Boyd, "Commentary on Early Contact-Era Smallpox in the Pacific Northwest," *Ethnohistory*, Vol. 43, No.2 (Spring, 1996), 17. Boyd, *The Coming of the Spirit*, 4. Cole Harris, *Making Native Spade: Colonialism, Resistance, and Reserves in British Columbia*, (Vancouver: UBC Press, 2002), 25.

Hospital in Victoria, the havoc would have been much worse. Helmcken considered his contribution to be a milestone in his public service.

In an effort to raise public awareness, the *Daily Colonist*, from June 13 to 24, 1862, ran four editorials pushing for “the incorporation of the city and the creation of an effective Indian Department and Board of Health, stressing what the absence of the latter had meant for the spread of the epidemic in the city.”⁷³ Seven years later, in 1869, the first Public Health Act was passed. The legislation created local Boards of Health; established health districts, and set proper means of enforcement. A health officer position was created to deal with extraordinary crises, such as epidemics. However, the bill was made meaningless by the provision that it should apply only “whenever there is good and sufficient reason.”⁷⁴ It remained on the books until 1893 when a smallpox outbreak precipitated the creation of a Provincial Board of Health and a revision of the act. This constitutes the basis of present day legislation.

The Hudson’s Bay Company’s contribution of introducing western medicine to British Columbia has been largely understated. Company policy was primarily concerned with material profit and imperial gains, and therefore medicine was important for these reasons. Exploration and Hudson’s Bay surgeons reported on scientific phenomena, conducted surveys and relayed vital information of the assets of a new country. They dispersed medical packets to the various HBC forts, acted in the capacity of apothecary or physician, and became company factors.

The HBC acted as the first public health agent, utilizing the techniques of quarantine and vaccination. Surgeons and traders made a concerted effort to block the

⁷³ Boyd, *The Spirit of Pestilence*, 182.

⁷⁴ Rose, *From Shaman To Modern Medicine*, 119.

1837 smallpox epidemic, but later traders took a reactive approach. As well, sometimes vaccine was in short supply. This neglect, coupled with Native suspicions surrounding vaccination added to their cultural destruction. The London office admonished Governor Simpson for this neglect stating that “the consequences may be calamitous.” The failure to carry out an all-inclusive proactive vaccination program was to limit the effectiveness of the HBC’s public health efforts over most of the nineteenth century.⁷⁵

The 1862 smallpox epidemic, which devastated northwestern Aboriginals, was instrumental in changing fur trade medicine into colonial medicine. It focused attention on the need for an integrated public health policy, the necessity for government involvement, and heightened awareness for responsible medical intervention on a large scale. The first step towards organizing the medical profession was taken in 1867, with the passage of the Medical Ordinance Act providing for the appointment of a registrar responsible of registering doctors. Dr. John S. Helmcken followed, in 1885, with the founding of the BC Medical Society, which drafted the essentials for the 1886 Medical Act. Another instrumental influence on the delivery of medicine to the northwest region of British Columbia was the arrival of medical missionaries.

⁷⁵ Hackett, “Averting Disaster,” 592.

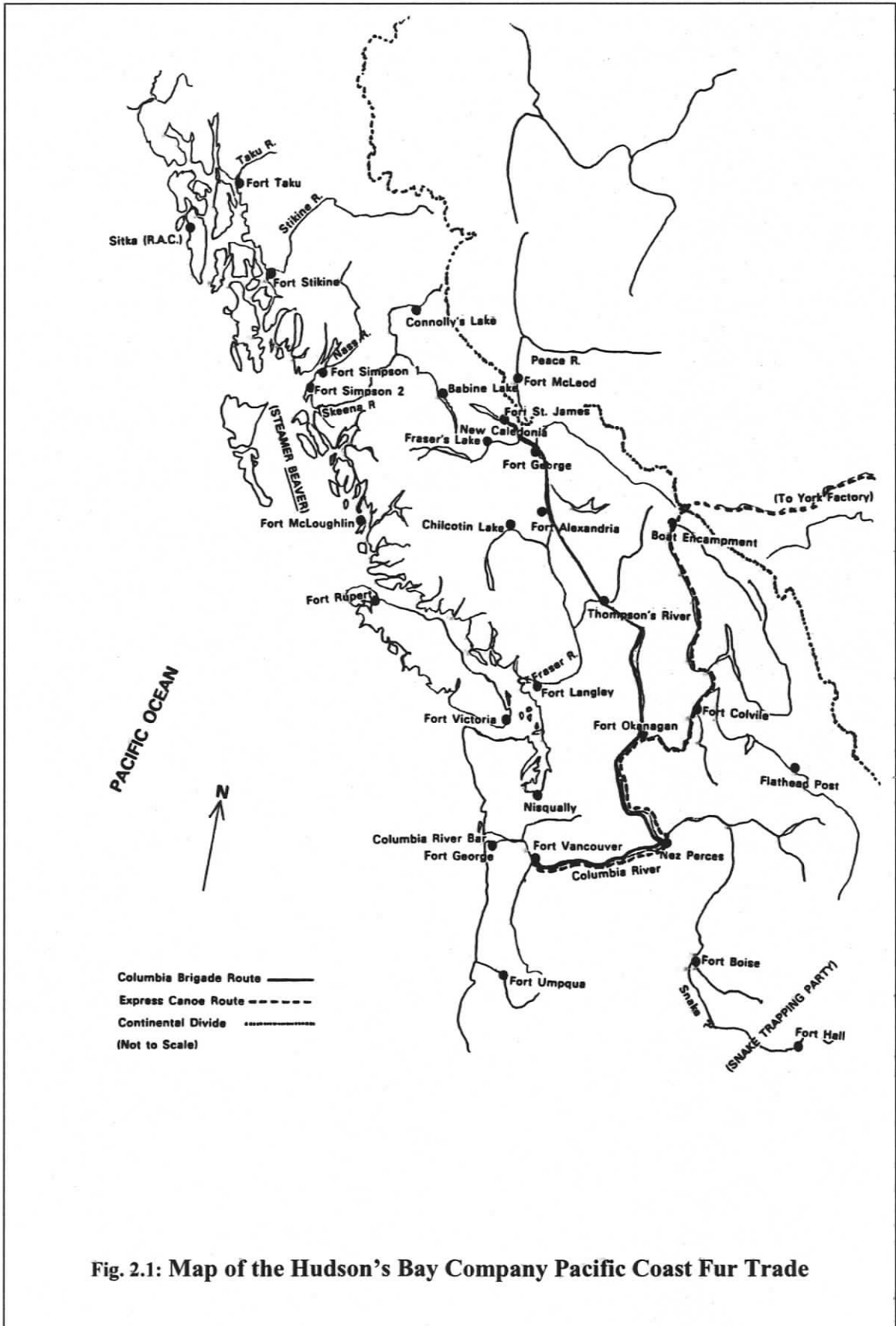


Fig. 2.1: Map of the Hudson's Bay Company Pacific Coast Fur Trade

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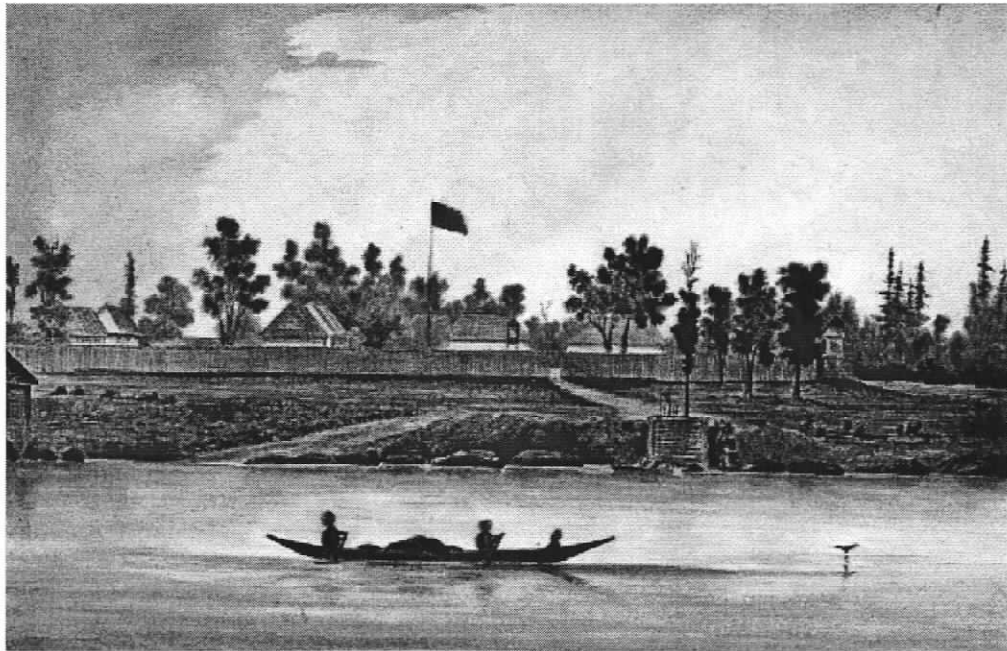


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Fig. 2.2: Fort Simpson, 1881.

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Fig. 2.3: Hudson's Bay Company's Fort at Victoria, Vancouver Island, n.d.

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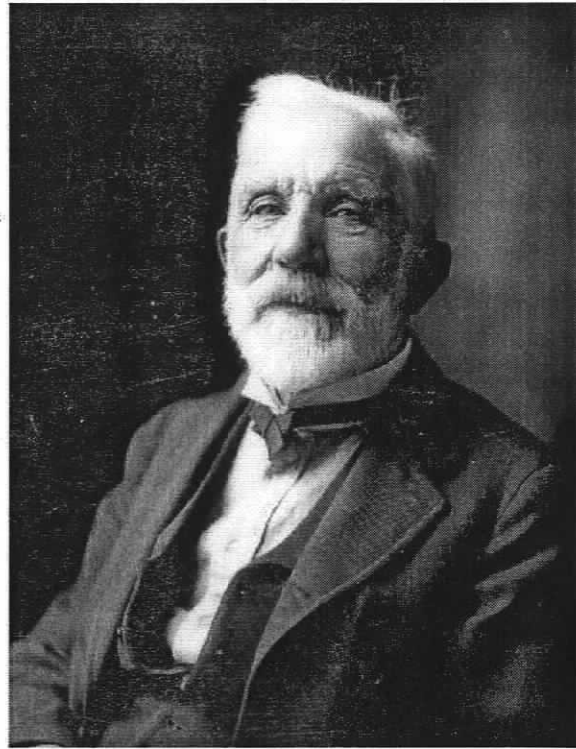


Fig. 2.4: Dr. John Sebastian Helmcken, 1824 – 1920.



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Fig. 2.5: Dr. John Sebastian Helmcken's Medical Chest.

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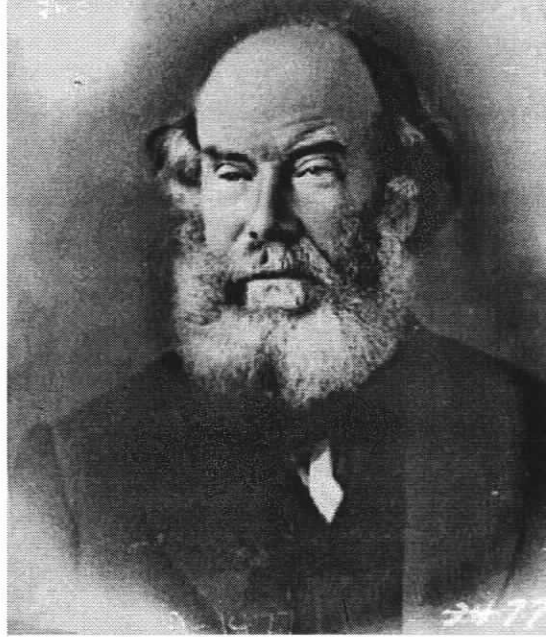


Fig. 2.6: Dr. William Fraser Tolmie, 1812-1886.

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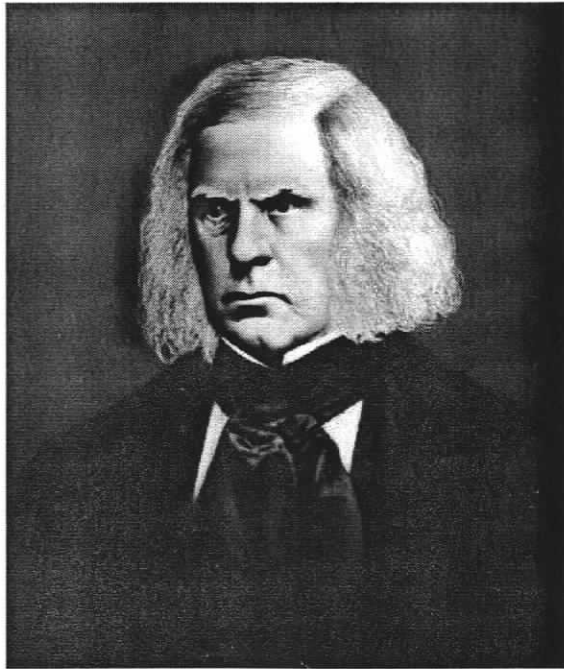


Fig. 2.7: Dr. John McLoughlin, 1784-1857.

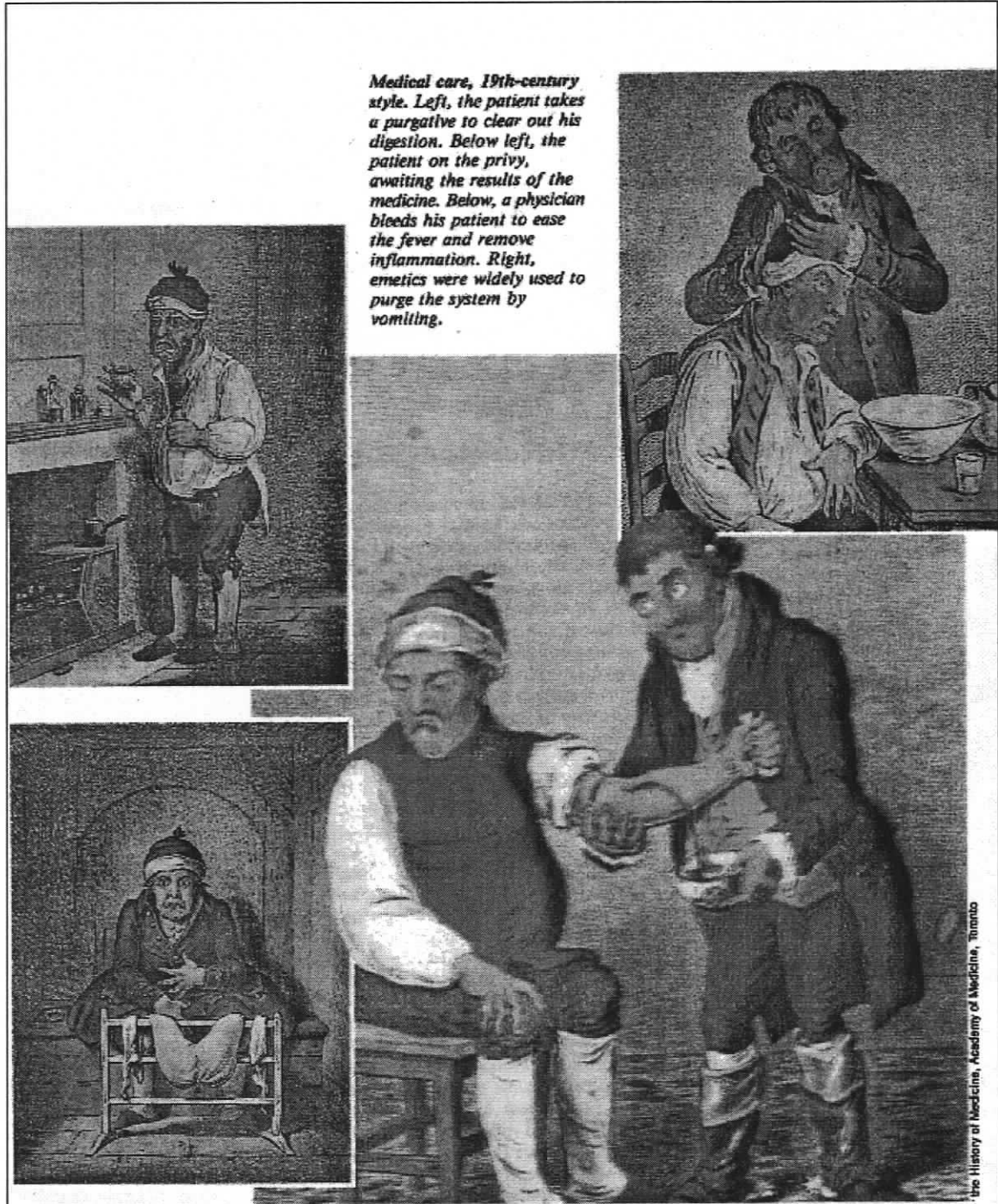


Fig. 2.8: 'Heroic' Medical Techniques
 Geoffrey Bilson, "Strong Medicine", *Horizon* Vol. 9, No.101, (1987), p. 2412.

Chapter 3

The Social Gospel of the Missionary Physician

A study of medical missions opens windows onto a fascinating range of substantive issues that govern relationships between First Nations and early settlers. The early medical missionaries were agents of Victorian imperialism. As practitioners of medicine, evangelism and education their influence was paramount in the formative years of the province. Missionary physicians supported the secular goals and achievements of empire: assimilation, materialism and global expansion. A study of missionary imperialism must include the medical and social consequences of encounters with Native peoples, where the relationship was based on humanitarianism, tainted with cultural superiority and the right to rule. This chapter will focus on these aspects of 'colonial humanitarianism': the first section focuses on the achievements of missionary physicians; the second part focuses on cultural conflicts.

Health services on British Columbia's north coast owe a substantial debt to the pioneering efforts of Christian medical missionaries. They were convenient and cheap sources for Department of Indian Affairs (DIA) contracts to provide medical care and public health services to First Nations people. Missionary doctors also served settler towns and resource-based industries. As members of the influential white society, they built hospitals, entered the arena of politics and contributed to the growing field of public health.¹

¹ Charles M. Good Jr., *The Steamer Parish; The Rise and Fall of Missionary Medicine on an African Frontier*, (Chicago: University of Chicago Press, 2004), Preface. Megan Vaughan, *Curing Their Ills: Colonial Power and African Illness*, (Stanford: Stanford University Press, 1991), Preface. Mary-Ellen Kelm, *Colonizing Bodies: Aboriginal Health and Healing in British Columbia 1900-50*, (Vancouver: UBC Press, 1998), 104-105.

In British Columbia, both the Methodist (Figure 3.1) and Anglican Churches sent evangelical medical missionaries to the northern coast. Early medical missionaries equating disease with sin and 'heathenism,' made the good work of providing medicine a persuasive tool in religious conversion. Mission societies "could not ignore the opportunities and social expectations inherent in the rapidly growing prestige and possibilities of scientific medicine."² The United Church Medical Services,³ which was established to oversee the missionary hospitals in 1925, and the Anglican Columbia Coast Mission, a marine and hospital medical service created in 1904, are modern concepts of the original medical missionary societies. Although the organizations are religion-based, their emphasis is on medical and humanitarian social services.⁴

Their origins lie in the Victorian missionary movement. Victorian era missionaries were regarded by the British government as "men of the world in the best sense of the term." The government believed "religion has done so much to promote justice, mercy, freedom, the arts of science and good government." Parliamentarians felt that "missionaries deserve a vote of thanks from the commercial world when one considers the value of their efforts in promoting the interests of commerce and civilization." In particular, the "benefits conferred –on the world in the realm of medical

² Charles M. Good Jr., *The Steamer Parish*-, 34-36.

³ In 1925 the United Church was formed from the union of the Methodist, Congregationalist and Presbyterian Churches.

⁴ Vaughan, *Curing Their Ills*, 72. The United Church Medical Services was a subsection of Home Missions. In 1988, when Dr. Peter Newbery replaced Dr. W. Don Watt as Superintendent of Hospitals and Medical Work for Canada, the name was changed to United Church Health Services. Newbery remained as Director of United Church Health Services until 2001. His present position is Director of Post-Graduate Family Practice at the University of British Columbia. In recognition of his outstanding service in improving the delivery of health care in rural Canada, Newbery was awarded the Order of Canada in 2003 and the Order of British Columbia in 2004.

science is immeasurable.”⁵ These accolades were directed towards the various missionary societies which, through religion and education, expanded the British Empire. The Church of England (Anglican) Church Missionary Society (CMS) and the Methodist Missionary Society (MMS) were part of this process in aiding the development of northern British Columbia.

The CMS, founded in 1799, was predominantly an Anglican evangelical lay and volunteer organization whereas the MMS, founded in 1841, was composed of paid Methodist ordained clergy. As each group sought to establish territorial supremacy with the different northern Native tribes, religious rivalry was common. Although both societies included medical missionaries, the MMS was largely responsible for establishing the first permanent hospitals on the northern coast of the province. The dictum of the missionary physicians was to win converts by using healing methods of Western medicine and surgery.

On the northern coast the first of these medical missionaries was Robert Tomlinson, a Church of England deacon, who ministered to the Tsimshian from 1867 to 1913. Although Tomlinson was called a physician, he was unlicensed. He had enrolled in medical training at Trinity College, Dublin but left before finishing his internship at Adelaide Hospital. According to Dr. R. G. Large, Tomlinson purposely refrained from writing his final exams so as to avoid the temptation to practice medicine full-time.⁶ In 1867 Tomlinson established a Native community at Kincolith from where he spiritually and medically administered to the surrounding villages on the Nass River for twelve years. The terms for living at the village were based on a strict adherence to the

⁵ *The Missionary Outlook*, May 1900, 113-114. Quoting Lord Macauley and Robert Moffat speaking in the House of Commons in 1843. United Church Archives, Vancouver School of Theology (UCA VST).

⁶ R.G. Large, *The Skeena, River of Destiny*, (Vancouver: Mitchell Press, 1957), 79.

missionary's view of Christianity. This self-selected group was admonished to relinquish paganism and potlatches, to become educated, and to extend mission work to other Indians. Cleanliness, orderliness and self-sufficiency were Tomlinson's goals. He built a sawmill, printed his hospital reports on his own printing press, and conversed with the Natives in their own language. He told Joseph W. Trutch, Chief Commissioner for Lands and Works for British Columbia, that his intention was "in every way the civilization and moral improvement of the natives."⁷

In 1871 Tomlinson, using Aboriginal labour, built the first hospital at Kincolith. It was widely used by First Nations as the nearest one was located at Nanaimo. It consisted of six rooms: a male and female ward, out-patient and storage rooms, an operating room and a pharmacy. Medications were given out gratuitously, irrespective of tribe or moral standing. All medical and surgical cases were treated as best as circumstances would allow. Tomlinson characterized the building of his hospital as experimental because he did not know whether the Indians would adjust to prolonged hospitalization.⁸

During the years of his medical ministry Tomlinson grew increasingly estranged from the CMS, the Anglican Church and its doctrines. This adversely effected medical delivery due to loss of funding and loss of support from colonial and British clergy. The crisis centered around Tomlinson's friend and fellow evangelist, William Duncan, Bishop George Hills and Dean Edward Cridge, the Hudson's Bay chaplain. Duncan had established, in 1862, a separate Anglican Christian mission at Metlakatla, populated by

⁷ The letter, written in June 1869, was to ask Trutch if the CMS could be granted Kincolith as a site for the mission buildings and a reserve. Trutch angered Tomlinson when he replied that the CMS could lease the property for ten dollars a year for seven years. Trutch was concerned about the presence of isolated mission stations where the missionary appeared to be more in charge of orchestrating conditions than was the government administration. Patterson, *Mission on the Nass*, 52-56.

⁸ Patterson, *Mission on the Nass*, 54-55. Tomlinson's policy of dispensing free drugs was unique. Other CMS missionaries (Doolan, Duncan) restricted their assistance, refusing aid to those who consulted the medicine man. *Ibid*, 23.

Tsimshians from Fort Simpson. Although the policy of the CMS was to have religion “grow from within a community, not imposed by some outsider,” Duncan had created his own fiefdom. As well, instead of training local Aboriginals to be ministers among their own people and to create a Native leadership, he insisted on absolute authority. Tomlinson’s Kincolith village had many similar features: a “creeping one-man imperialism.”⁹

The major dispute, in 1872, arose between Cridge and Hills over centralized episcopal and financial authority. Tomlinson and Duncan sided with Cridge.¹⁰ The rupture was deepened when Tomlinson and Duncan both refused ordination and refused to offer Holy Communion to First Nations because “it was foolhardy in communion to offer the body and blood of Christ to the spiritually “unpredictable” Indians.”¹¹ Duncan pointed out that “he had only recently succeeded in turning them from their earlier belief that eating the flesh of an animal was the way to gain that animal’s strengths”: Tomlinson

⁹ Joan Weir, *Catalysts and Watchdogs: BC’s Men of God, 1836-1871*, (Victoria: Sono Nis Press, 1995), 88. Patterson, *Mission on the Nass*, 24, 56. Patterson states Reverend Henry Venn’s, (visionary missionary head of the CMS), “idea of attempting to create Native Christian churches, sporadically and incompletely applied in the nineteenth century and the early twentieth century, has become the subject of interest in the late twentieth century as Christianity has begun to be indigenized in the world to which missions have been extended in the last two hundred years.” While both men ran authoritarian Christian missions, I have found no evidence of Tomlinson using the same physical intimidation as Duncan. Duncan formed a mission house for young Native women of which he was the only male allowed in. He scolded the women and resorted to beating the young Native boys and girls to make them ‘behave.’ Tomlinson was married. Church authorities “were especially troubled” by Duncan’s persistent refusal to regularize his religious practice. They were also troubled by his “unmarried status” because it “separated him from models of Protestant missionary masculinity that assumed men’s roles as husbands and fathers to be a critical part of their roles as exemplars of Christian manhood.” Adele Perry, “The Autocracy of Love and the Legitimacy of Empire: Intimacy, Power and Scandal in Nineteenth-Century Metlakahtlah,” *Gender & History*, Vol.16. No.2, August 2004, 266, 271, 274. Weir, 92.

¹⁰ Hills laid charges against Cridge because of the commotion Cridge caused in Church by denouncing the revival of ritualism as contrary to the law of scripture, to the law of the Church and, to the law of the land. When Cridge was found guilty, he was forced to tender his resignation. In protest he joined the American-based Reformed Episcopal Church. Tomlinson and Duncan sided with Cridge because they saw incoming liturgical reform as papistical and undesirable for Anglicans. Patterson, *Mission on the Nass*, 66-67. John Adams, *Old Square Toes and His Lady: The Life of James and Amelia Douglas*, (Victoria: Horsdal & Schubert, 2001), 198-199. “George Hills”, *Dictionary of Canadian Biography*, Jean Friesen, <http://www.biographi.ca/EN/ShowBioPrintable.asp?Bioid=40283>.

¹¹ “William Duncan”, *Dictionary of Canadian Biography*, Jean Friesen. <http://www.biographi.ca/EN/ShowBioPrintable.asp?Bioid=41470>.

“regarded ceremonialism as charlatanry and pagan survival.”¹² Over the next few years both men became increasingly estranged from the Anglican Church. Tomlinson’s license was temporarily revoked in 1877 and his attempt to sell the hospital further strained relations.¹³ A year later the CMS decided to send him to evangelize on the upper Skeena at Ankitlas, seven miles from the nearest small community of Kispiox.¹⁴

During his five years there, Tomlinson built a non-sectarian establishment akin to Kincolith. Conditions at Ankitlas were severe for the missionary and his family of six children. Much of their livestock had stampeded on the way up so food was scarce. They lived in a tent like structure placed on a log foundation. Medicine was dispensed to patients lodged in either their tent or in Native homes. Sometimes cots were placed in the salmon smokehouses. Home visits meant Tomlinson was away for one or two days at a time. His work was more surgical than medical because accident cases or gunshot wounds were common.

Tomlinson did not complete founding his hospital because Bishop Ridley ordered him to abandon Ankitlas and to re-establish his headquarters at Hazelton. By refusing to do so, Tomlinson completed his estrangement from the Church of England and the CMS. In 1883 he shut down his village and moved to Metlakatla to be near Duncan. Four years later he returned to the Skeena where he built another non-sectarian village at Minskinish. For twenty years the Tomlinsons spiritually and medically administered to their flock. When Tomlinson died in 1913, his son sold the property to the Methodist Church.¹⁵

¹² Weir, *Catalysts and Watchdogs*, 94. Patterson, *Mission on the Nass*, 61.

¹³ The Diocese of Columbia revoked Tomlinson’s license because he and Duncan attended Cridge’s installation as Bishop of the Reformed Episcopal Church. Patterson, *Mission on the Nass*, 64.

¹⁴ Eldon Lee, *Scalpels and Buggywhips: Medical Pioneers of Central BC*, (Surrey: Heritage House, 1997), 25.

¹⁵ Large, *The Skeena*, 79-84. Eldon Lee, *Scalpels and Buggywhips: Medical Pioneers of Central BC*, (Surrey: Heritage House, 1997), 23-28. Dr. Tomlinson has two areas named after him: Mount Tomlinson,

Tomlinson and Duncan's decision to go against the Anglican Church on transubstantiation¹⁶ was ill conceived. One could argue that their religious stand took precedent over imperialistic motivations because they broke with the Established British Church. However, their stance of taking an autonomous position in regards to Church doctrine worked against them. The government also questioned isolated settlements such as Metlatkatla and Kincolith. Land Commissioner Joseph Trutch believed "Missionary enterprise(s) should radiate gradually from the centre of civilization instead of isolating itself as once in points like Kincolith on the utmost verge of the Colony." He added that "so long as that Station is continued it must, most assuredly, be held under the protection of Government-." ¹⁷ From a medical point of view, the decision had negative results. The CMS stopped its essential funding of the hospital and trained Anglican medical missionaries were not sent to the region for five years. Lastly, as far as church rivalry was

a 8,050 foot peak in north-central BC and an area along the Kispiox River, entitled Tomlinson's Flats. He is also remembered as someone who manufactured bricks that, after 100 years, are still in good condition. Lee, 23.

¹⁶ Transubstantiation is "the conversion of whole substance of Eucharistic bread and wine into body and blood respectively of Christ" (Holy Communion). The Concise Oxford Dictionary, H.W. Fowler and F. G. Fowler, eds., (Oxford: Clarendon Press, 1961), 1380.

¹⁷ Patterson, *Mission on the Nass*, 57. Lynn A. Blake writes on the conflict between the Oblates of Mary Immaculate and the provincial government of BC. Using Michel Foucault's ideas on pastoral power and government Blake remarks, although the organizations had similar imperialistic notions on Native assimilation, responsibility, disciplinary power and knowledge, there was a marked difference. Whereas the Oblates wanted to fashion moral Catholic communities, using repressive measures such as surveillance and flogging, the government "envisioned an orderly subject population." Chief Justice, Matthew Begbie, stated "some 'enlightened' and able missionaries would make good 'mentors' to Natives (owing to their influence), therein lay the danger. - any able missionary could acquire a great deal of power amongst his neophytes and become far more than a mentor. Large portions of the reserve population would fall under the direct influence of missionaries, worse, that power might be seen as having been handed over by the government." Tomlinson's "creeping one-man imperialism" falls into the same category. Lynn A. Blake, "Pastoral power, governmentality and cultures of order in nineteenth-century British Columbia," *Transactions of the Institute of British Geographers*, New Series, Vol. 24, No. 1. (1999), 86. Patterson, *Mission on the Nass*, 56.

concerned, the absence of an active Anglican presence enhances the presence of the Methodist Church.¹⁸

Medicine remained a concern of the CMS. In the late 1880's, the organization sent Tomlinson's cousin, Dr. Bluett-Duncan, and Dr. Prager, to assist William Duncan at Metlakatla. In 1889, Dr. Vernon Ardagh, a graduate of Edinburgh University, was sent to replace them. Ardagh spent the winter of 1900-01 up the Skeena River at Kisgegas and in the spring of 1901 he returned to Metlakatla where he improvised a small hospital by using two empty Native houses. The hospital was staffed by a trained nurse from England and Dr. Webb, a CMS physician from Australia. After it was destroyed by fire a few months later, the hospital did not reopen. Ardagh returned to England where he set up a practice. In 1911 he came back to British Columbia and was ordained an Anglican priest, after which he was sent to take charge of the mission at Kitwanga. Upon retiring to Port Coquitlam, he spent the remaining years of his life engaged in translating the Gospels into the Gitksan dialect. For many years Tomlinson and Ardagh were the only physicians on the northern coast.¹⁹

The Methodist Church and the Methodist Missionary Society (MMS) was the second religious-healthcare system to be established on the northwest coast. The lack of a medical presence concerned Thomas Crosby, an itinerant Methodist preacher, who was deeply affected by the ravages of the 1862 smallpox epidemic on First Nations communities. As part of his ministry, Crosby made annual fund raising trips to Ontario

¹⁸At times the Anglican Church was able to secure doctors for other areas. For example, in 1909, Bishop du Vernet sent A. Ross Fraser, a medical missionary who had served in South Africa, to aid the Haidas and settlers on the Queen Charlotte Islands. Fraser and his wife, a trained nurse, and their five children lived in New Masset. His first hospital, a tent, was demolished by a storm. A log cabin replaced the tent and, in 1914, a joint community-government effort resulted in establishing a medical facility. He received a salary from the DIA. Kathleen E. Dalzell, *Queen Charlotte Islands: 1774-1966*, Volume 1, (Madeira Park: Harbour, 1968), 155-157.

¹⁹Large, *The Skeena*, 87.

where he frequently spoke about the need for missionary physicians to come to the coast to establish small outpost stations.²⁰

The first to respond to Crosby's appeal for Methodist missionary physicians was John Clark Spencer. Untrained in either the ministry or medicine, Spencer (1859-1928) took employment with the Canadian Pacific Railway. He arrived in British Columbia in 1888 and the MMC sent him to assist Crosby at Port Simpson. Following his ordination in 1893, Spencer ministered at Kispiox in the winter and traveled with the Natives to their fishing grounds on the Nass River during the summer months. Over the following years he took several leaves of absence to study for his medical degree at Stanford University in California. From 1899 until 1907 Spencer served as a missionary physician at Bella Coola (Figure 3.12). He was transferred to Skidegate on the Queen Charlotte Islands where he built the first hospital in 1908. Following a ten year posting to Port Simpson (1914-24) Spencer moved to Bella Bella where he remained until his death.²¹

Another Crosby recruit was Alfred Edward Bolton (1861-1913). After graduating in medicine (1888) from Queen's University, Bolton took post-graduate training in New York. Deeply interested in religious work, Bolton contacted the MMS to offer his services. The General Secretary of the Society refused his offer stating that the organization was short of funds and was reluctant to undertake medical work.

²⁰ Thomas Crosby, *Up and Down the North Pacific Coast by Canoe and Mission Boat*, (Toronto: The Missionary Society of the Methodist Church: The Young Peoples Forward Movement, 1914), 282-303. Susan Neylan, *The Heavens Are Changing: Nineteenth-Century Protestant Missions and Tsimshian Christianity*, (Montreal & Kingston: McGill-Queen's University Press, 2003), 57-58. Neylan states "is quite natural to Crosby that spreading religious values also meant disseminating commercial and technological ideas, and in his mind, Canada's 'social structure and cultural values, complete with Christian symbols, formed an integrated whole—and was presented to the Native people as such.'" She also mentions 'Crosby longed for the day when medical missionaries would come to British Columbia,' 216.

²¹ Large, *The Skeena*, 97-99. R. Geddes Large, *Drums and Scalpel: From Native Healers to Physicians on the North Pacific Coast*, (Vancouver: Mitchell Press, 1968), 88-89. Spencer financed his medical training out of his missionary salary.

Undeterred, Bolton, at his own expense, traveled to British Columbia where he commenced his ministry at Port Simpson in 1889.²² Bolton was responsible for building three hospitals: Port Simpson (1892) (Figure 3.4); and two summer outstations to serve First Nations and cannery workers: Port Essington (1895) (Figure 3.5) and Rivers Inlet (1897). In 1891 he gathered a group of six cannery operators and missionaries together to form a hospital management committee. The cannery operators donated \$100.00 each. They started a subscription list from their employees and immediately collected \$250.00. The men bought two lots for the Port Simpson Hospital from the Hudson's Bay Company for twenty-five dollars each.²³ Because Port Simpson was not registered as a town, it required a special act of the provincial legislature to incorporate the complex as a public hospital.²⁴

The facility housed eleven surgical and medical patients. At times, tents housed tuberculosis patients. Using chloroform, Dr. Bolton conducted many complex operations including the correction of hare-lip and hip displacements in children. Accident cases

²² Large, *The Skeena*, 100. Crosby, *Up and Down the Coast*, 295. The missionaries in the northern region pooled their financial resources and paid Bolton's salary for the first year.

²³ R.W. Large, MD. "The Young Peoples Forward Movement:" "The Methodist Hospital at Rivers Inlet, BC", *The Missionary Outlook*, February 1907. UCA VST.

²⁴ "Copies of Documents Respecting Hospital at Port Simpson, BC. sent for the Information of the District. February 5th, 1910," Prince Rupert Regional Archives (PRRA), Dr. R.G. Large Collection, L984-38 458-150. In 1900 the Methodist Board questioned the policies of the Port Simpson Hospital. In an interview with Bolton, the Board realized that Bolton and his friend, Mr. Clifford and not the Missionary Society owned the hospital. The physician owned his residence. The Port Simpson Hospital Board consisted of 12 white members, six of whom were church members, the remaining six were residents. (I don't know if the church members were residents or non-residents). The public perceived it as a public hospital, not a Methodist institution, because the hospital had received grants from the Dominion and provincial governments. The Methodist Board preferred to hold the property in trust with only a few public members on the hospital board since this made the property "an asset of the Church" and allowed "untrammelled religious work." The disadvantage of it being termed a Methodist Hospital was "public alienation" and lack of funding from governments. In the end, the Board decided to "adopt some form of the Public Hospital scheme, the Church's interests to be safe-guarded to its satisfaction."

Prior to Bolton building the Port Essington Hospital, the area was spiritually and medically overseen by Rev. A. W. Sheldon MD, an itinerant Anglican minister. Sheldon drowned in 1888 when his dugout canoe split apart while he was crossing the Skeena River. Oliver E. Howard, *Godships: Little Ships carry the gospel up the B.C. Coast*, (Toronto: United Church Observer, 1984), 175.

often required amputations. He also dealt with epidemics (la grippe, smallpox) and contagious diseases (measles, whooping cough), accidents and dental work. Cancer and other acute conditions were common.

The outstations were built at seasonal fishing areas on the Skeena and Nass Rivers where First Nations, Chinese and Japanese peoples worked in the canneries. Until the twenty-five bed hospital was built at Port Essington, Bolton practiced medicine and surgery in a small school room. The facility remained in operation for over forty years. The nine-bed hospital at Rivers Inlet burned down in 1904 and was replaced two years later by a larger complex that remained open until 1957.

Unlike William Duncan at Metlakatla, Bolton had good relations with the Department of Indian Affairs (DIA).²⁵ The DIA gave Bolton a contract which required him to journey up the Nass River ministering to the various Native reserves. Depending on the season, he traveled either by Union Steamships, the Methodist mission boat *Glad Tidings* or by snowshoes. Bolton took them back with him any Aboriginals requiring hospitalization. If there were outbreaks of smallpox, as in 1901, Bolton established quarantine. This necessitated returning to the region to check on his patients. Bolton was aided in this commitment when the MMS, in 1898, sent W.T. Rush to be resident minister-physician at the Native village of Lak Kalzap. Before poor health forced him to return to Toronto three years later, Rush built a small outpost station with a Native nurse in charge.²⁶

²⁵ Duncan and his Native adherents rejected the Indian Act (1876) as "inapplicable to their civilized community. They argued that the land belonged to the Metlakatlans and the CMS had no rights to the two acres of the village known as Mission Point, where the Church and other buildings lay." William Duncan, *Dictionary of Canadian Biography*, Jean Friesen, online.

²⁶ "The Indian Work," Methodist Missionary Society Annual Reports 1901-02, xlvii. United Church of Canada Archives (UCCA), Toronto, BV2550.2.

Some of the local inhabitants certainly appreciated Bolton's excursions. Charles Robinson, a Native leader who operated a store and a clam cannery on a nearby island, was gravely ill with a disease of the knee joints. In the *Na Na Kwa*, a small newspaper published by the Kitamaat Mission, Robinson described his medical care. In this rare writing by a First Nations' person, he wished "all poor sufferers it matters not what the trouble may be to go to Dr. Bolton's hospital and be cured. If it had not been for Dr. Bolton's care and the good attention of the kindest nurses, I would have been in my grave to-day. To them I owe a thousand thanks."²⁷ This must have pleased Bolton as missionaries believed if they could convince and convert leaders of First Nations tribes, it made it easier to gain an inroad with other members of the respective group.²⁸

Bolton stayed at Port Simpson until he was forced to resign for financial reasons in 1901, and went into private practice in Victoria. The Methodist Church had never recognized him as a missionary, or paid him as such, even though he was largely responsible for establishing a Methodist presence on the northern coast. Beginning in his second year, at Port Simpson, the Missionary Society did grant him \$600-\$800 annually but after a few years he voluntarily dropped the grant, retaining only one hundred dollars a year until 1901.²⁹

Missionary physician William T. Kergin, administered the hospital for the next nine years. He owned his own gas boat, *Sunbeam* (Figure 3.10), which he used to travel to isolated regions, when his services were needed. Kergin's peers considered him "of

²⁷ C.A. G. Robinson, "Port Simpson Hospital", *Na Na Kwa*, April 1900. PRRA L984-38 M5 #458-146. Campbell, *Prince Rupert Daily News*, Dec. 10, 1982. PRRA. M5

²⁸ Neylan, *The Heavens Are Changing*, 88. She mentions missionaries were frequently facilitated by "the essential support and initiative supplied by Native mission workers," such as Native catechists.

²⁹ Large, *Drums and Scalpel*, 101. Bolton referred to his grant as a bonus. He died in Vancouver at the early age of 52.

outstanding ability in his chosen field.”³⁰ For example, when he and his biological sister, a nurse, were operating on badly burnt bodies at Port Essington, Kergin peeled skin from his sister’s arms and then removed some skin from his own arm to provide a skin graft. As an active member of his community Kergin served one term (1907-09) as a Liberal member in the Provincial Legislature, but then moved to Prince Rupert to set up a private practice.³¹

At Port Simpson Kergin was succeeded by Richard W. Large (1873-1920), a missionary physician (Figure 3.3) who had already had a career at Bella Bella. He had replaced Rev. J. A. Jackson MD., who had arrived there on 4 July 1897 to begin spiritual and medical work among the Heiltsuks, but died of a heart attack a year later. During his twelve years at Bella Bella, Large, like Kergin, used his own small vessel to visit canneries in Rivers Inlet. In 1902, Large, with Aboriginal help, built a seven-bed hospital that became a public facility in 1903 and was enlarged in 1907. A tent cottage was erected on the beach for the treatment of tuberculosis patients and another cottage was built for isolation. Three years later, in 1910, Large moved to Port Simpson to replace Kergin. Large remained until his death in 1920 from a heart attack. His successor, Dr. William Sager (Figure 3.9), also owned his own boat, the 36 foot gasoline-powered vessel, *Leila*, which he used to make weekly clinic visitations at the eleven canneries operating on the Skeena River. Sager was the last missionary physician to come to Port Simpson. When he left in 1926 the position was granted to Dr. R. Geddes Large, a son of the former medical superintendent. Although he was deeply religious, Large Jr. was not a

³⁰ Large, *The Skeena*, 101.

³¹ Large, *The Skeena*, 102. Vi Keenleyside, *They Also Came*, (Duncan: Duncan United Church, 1987),67.

missionary physician.³² The Port Simpson Hospital became part of the United Church Health Services in 1931.³³

Until the early twentieth century, all MMS recruits, except Bolton, had graduated in both theology and medicine and were a strong presence in both the church and medical work. Health care in the northwestern portion of the province had been largely supplied by the mission hospitals. But, changes were in progress. The establishment of Prince Rupert in 1910 and the coming of the Grand Trunk Pacific Railway fostered the building of communities along its route. Coupled with the growth in the fishing, mining and forestry industries, other doctors and institutions entered the area.

Unlike Tomlinson, these early Methodist missionary physicians embraced the growing secular world. Despite DIA and provincial medical contracts, many left the mission hospitals to open private practices no doubt because of the need for a higher income to meet family educational and financial responsibilities. As mentioned earlier, Alfred Bolton and William Kergin set up private practices. Medical Superintendent Richard Large's appointment at Port Simpson Hospital was under the provincial and dominion governments. Each physician had children who needed a higher education.³⁴

³² Large Jr., while at Bella Bella assisting Dr. George Darby, was required to conduct a few church services. When one reads his reasoning for not becoming a missionary doctor, his racism is evident. "--the summer appointment at Bella Bella [should] entail [ed] duties other than medical. It seemed natural, therefore, to journey across the channel on Sunday morning and hold a church service for the Indian people at the cannery. After all, it was not very demanding! The people were simple folk and the Sunday School lesson sufficed for a sermon. Imagine my consternation then one Sunday morning, during the singing of the first hymn, to see Mrs. Dick Goose, the wife of the cannery operator enter the building with the whole white cannery crew in tow! ---Experiences such as this and a few attempts at preaching in the Bella Bella church convinced me that the practice of medicine presented sufficient challenge for any man, and the ministerial calling had better be left alone!" Large, *Drums and Scalpel*, 99-100.

³³ Bob Burrows, *Healing in the Wilderness: A History of the United Church Mission Hospitals*, (Madeira Park: Harbour, 2004), 34-35. The hospital doctors were under contract to oversee the canneries.

³⁴ Large, *Drums and Scalpel*, 97. Several early physicians died at an early age from heart attacks (Large, Jackson) and Bolton also passed away at an early age. It is quite possible that they were overworked.

Nevertheless, the Methodist Church continued to recruit physicians for its hospitals. Methodist minister and physician, George Elias Darby (1889-1962) arrived in Bella Bella, in 1914 and remained as the Medical Superintendent of the hospital for forty-five years (Figure 3.2).³⁵ Renowned up and down the coast, Darby earned the love and admiration of the Heiltuks as well as settlers, loggers and cannery operators. Darby was another of Crosby's recruits. Through conversations with Thomas Crosby, after Crosby retired to Vancouver, Darby became interested in missionary medicine. During the summer of his senior year as a medical student at the University of Toronto, Darby replaced Dr. A. Lepper at Rivers Inlet who died suddenly from a throat infection while assisting during a tonsillitis outbreak. Following his internship at Vancouver General Hospital Darby was sent by the Methodist Church to Bella Bella where he built the eighteen bed, R. W. Large Memorial Hospital.³⁶ Apart from his hospital work, like many of the other medical missionaries, Darby made regular or emergency trips to canneries, logging camps or to isolated lighthouses. Sometimes he traveled on the Union Steamships but more often it was on the hospital launch (Figure 3.11) or the mission boat. Late each summer, before his medical assistant left for the winter, he made a journey on the mission boat, *Thomas Crosby*, to estimate the amount of work required for the winter season.³⁷

Because funds were often scarce, Darby was obliged to treat epidemics and accidents with ingenuity. A few times he operated on a patient's kitchen table. If he was

³⁵ Large, *Drums and Scalpel*, 55 Dr. Large graduated from Trinity Medical College in Toronto and was ordained in the ministry while volunteering for mission work at Steveston, BC.

³⁶ Burrows, *Healing in the wilderness*, 146. Darby won the silver medal in medicine when he graduated in 1913. He was ordained in 1918.

³⁷ Boats were essential to the operation of the hospitals at Bella Bella and Rivers Inlet. Over his career Darby used four small boats. Only the last, the *William H. Pierce*, a 45 foot diesel-powered cabin cruiser was purchased by the United Church in 1947. Large, *Drums and Scalpel*, 120. Howard, *Godships*, 232-236.

not sure of a surgical procedure, he would read from his textbook while operating. Tuberculosis was prevalent and Darby set up various TB clinics. In the 1920's medical students assumed responsibility for the Bella Bella Hospital while Darby worked the summer months at Rivers Inlet. At times, he utilized the three summer months to take a furlough in order to further his medical studies. In 1932 a federal government grant made it possible to have another permanent physician on the mission boat. This saved Darby a lot of commuting but not until 1952 did he have a year round physician to assist him. When Darby retired in 1959 at age seventy he became a part-time coordinator for the United Church Health Services. He died of cancer three years later.³⁸

Darby represents a unique figure in the Methodist medical system because he bridged the change from the early doctors to contemporary physicians. Like the older missionary doctors his primary role was to oversee the medical needs of a First Nations community. As well, he cared for the expanding white communities, traveling on his motor boat visiting logging camps, light houses and canneries. Darby contracted with the DIA, was made a justice of the peace and, akin to Tomlinson, was an authority figure at Bella Bella. He was actively involved in the church, many times preaching the sermons. However, unlike the early physicians, Darby did not to leave the Methodist Church medical system. Instead, his wife and four children moved to Vancouver and for twenty five years (1923-48) he saw his family over the summer holidays when they would return to Bella Bella. He was a man who "never for a moment considered (ing) leaving his calling."³⁹ There is no mention of how his wife and family felt about his choice.

³⁸ Burrows, *Healing in the Wilderness*, 145-152. Hugh W. McKervill, *Darby of Bella Bella*, (Toronto: Ryerson Press, 1964).

³⁹ Burrows, *Healing in the Wilderness*, 149.

Darby had an expanding interest in the medical field. He took periodic furloughs to further his medical knowledge and had an ongoing interest in disease control and ethnology. He researched and wrote on blood studies and was a member of the Royal Anthropological Institute.⁴⁰ This is representative of contemporary medical thought in which physicians are expected to upgrade their knowledge on an ongoing basis. At times, Drs. R. G. Large and W.T. Kergin consulted with him on medical problems. Darby encouraged the integration of medical students into his practice during the summer. This not only lessened his medical responsibilities but afforded him time to teach younger physicians his skills. In summary, Darby was a dedicated physician whose primary concern was his 'calling.' He enjoyed the exaltation afforded him by the First Nations and surrounding communities. As a consequence, it was his family who played 'second-fiddle.'⁴¹

Horace Cooper Wrinch was one of Darby's long time associates. After graduating from the Faculty of Agriculture in 1894, Wrinch, like Darby, enrolled in medicine at the University of Toronto, graduating four years later. Recruited by Thomas Crosby, Wrinch (1864-1939) went to Kispiox. Medical work commenced in a log building which was office, dispensary and operating room. He relocated to Hazelton as it became the head of steamship navigation for the Skeena River and the supply centre for trappers and prospectors. The area was largely populated by the Native Gitksan people, and the head of steamship navigation on the Skeena River and the supply centre for trappers and

⁴⁰ McKervill, *Darby of Bella Bella*, 99.

⁴¹ In 1944, Darby was honored by Chief Moody Humchitt and the Heiltsuks when they decreed he would be known as Chief Wo-Ya-La, "the Highest." Burrows, *Healing in the Wilderness*, 151.

prospectors.⁴² His residence, completed in 1903, became the temporary infirmary. Wrinch performed operations on the kitchen table and housed patients in the sitting room until a twenty-bed hospital was completed a year later (Figure 3.7). The beginning of construction of the Grand Trunk Pacific Railway and an increase in the white and Native population a few years later necessitated additions to the hospital.⁴³ Wrinch (Figure 3.8) was contracted as the physician for the railway, looking after the construction workers' illnesses and accidents. He also had an office and a dispensary in the town. Wrinch traveled extensively, by horse, snowshoes or dog sled to attend to people in the outlying areas. In the summers he also journeyed by paddle wheeler or dugout canoe. In his travels during the influenza outbreak of 1918 Wrinch often slept on the side of the road in his cutter wrapped in fur robes.⁴⁴

Medical work did not occupy all of Wrinch's time. He was ordained in 1910 and in 1924 was elected to the BC Legislature where he served until his retirement in 1933. One of his accomplishments, in 1928, was to introduce a motion favouring health insurance.⁴⁵ Another was the 1931 World Hospital Convention in Toronto which named his hospital among the ten best in Canada (Figure 3.6). Wrinch, from 1922 to 1924

⁴² Crosby, *Up and Down*, 299. Wrinch collected medications from the Victoria office of the DIA. He won the Governor General's gold medal for excellence in agriculture. Jacqueline A. Burt, "Dr. Horace Cooper Wrinch: Pioneer British Columbia Physician" Unpublished Thesis. Medicine 4, February 20, 1966. Hazelton District Public Library, Hazelton, BC.

⁴³ By 1912 the hospital staff consisted of "a nursing superintendent and five nurses, a housekeeper, and several assistants in wards, kitchen, and garden, took care of patients. There was also a house surgeon always in attendance." Eva MacLean, *The Far Land*, ((Prince George: Caitlin Press, 1993), 110.

⁴⁴ Jessie Gould, "Wrinch Memorial Hospital," Hazelton Hospital, Vertical File, UCA VST. Probably his most arduous trip was from Hazelton to Victoria, in 1901, to write the compulsory provincial medical examination. He walked 120 miles on snowshoes, canoed 60 miles down the Nass River, caught a river boat to Kincolith and then a coastal steamer to Victoria. The total distance was 1000 miles each way. His nearest colleague was Dr. Large at Port Simpson, 200 miles away. Wrinch established a farm which supplied the hospital with sufficient vegetables and dairy products. L.S. McGill, "Hazelton Hospital Was Built In Seeming Wilderness," *The Province*, August 8, 1926. BC Hospitals, Vertical File, UCA VST

⁴⁵ The 1929 provincial Royal Commission appointed to report on health insurance nearly succeeded putting a medical plan in place in 1937 but because of opposition from physicians the government did not implement it. Daniel Francis ed., *Encyclopedia of British Columbia*, (Madeira Park: Harbour, 2000), 322.

served as second president of the BC Hospital Association. In 1939 he supervised the building of a new hospital. When he died later that year his son succeeded him as superintendent of the hospital. The facility was renamed the Wrinch Memorial Hospital.

Wrinch, like Darby bridged the changing medical scene. He was actively involved in his church, and like R.W. Large, Darby and Spencer, conducted church services. He also had a private practice. Akin to his fellow Methodist missionary physicians, he contacted with the DIA as well as the Grand Trunk Pacific Railway. Like Kergin, he had a political career and, like Darby, he had a breadth of medical interests, particularly the BC Hospital Association. Whereas the early missionary doctors left the Methodist medical system, both Darby and Wrinch adhered to the philosophy of serving both the 'body and soul' of mankind. Financially this was possible through their private medical fees and contracts as well as church stipends as ministers. Methodist Medical Services financed furloughs while Darby earned additional income from his writings and Wrinch from his stipend as a member of the legislature.

The outcome of the presence of the Methodists in the northwest differed from that of the Anglicans in that, while both were religion-based, the former established a vital hospital and medical care system to service First Nations and isolated white communities. The latter, due to the influence of Tomlinson, never became a major factor in the delivery of northwestern healthcare. The Methodist physicians became part of their respective communities, broadening their interests through politics and medical pursuits. Tomlinson stayed insular, preferring to withdraw from society rather than embrace it. Whereas the Methodists aided in sustaining northern development by their presence, the withdrawal of Tomlinson left the northern interior without any Anglican medical influence.

This generation of Methodist missionary physicians was personally responsible for each hospital and raised money to start construction. Large borrowed money from his mother: Wrinch collected donations from local residents. Labour and financial donations came from First Nations. The Young Peoples Forward Movement aided with furnishings and bedding. The Methodist publications: *The Missionary Outlook* and *The Missionary Bulletin* published annual appeals.

Different Methodist organizations supported the physicians in fund raising. For instance, the Epworth Leagues supported doctors through the Young People's Forward Movement for Missions.⁴⁶ The Epworth Leagues of the Toronto General District directly supported both Large and Wrinch.⁴⁷ In the formative years, the Woman's Missionary Society supported the nurses and provided linens. In 1925 the Board of Home Missions assumed responsibility for the five hospitals in the province. From then on, the Board and the WMS supplied personnel and funds for joint evangelistic, educational and medical work.⁴⁸

Other support came from the DIA which paid hospitals for each First Nations patient on a per diem basis. The provincial government provided annual grants and hospital boards could request special additional grants. Bolton and Wrinch earned some money from a private practice but invariably they returned the major portion back to the hospital. Settlers and cannery operators contributed (Port Essington, Hazelton, Port

⁴⁶ The Epworth Leagues were formed in 1889 to further "the spiritual and moral needs of children and young people." Neil Semple, *The Lord's Dominion: The History of Canadian Methodism*, (Montreal & Kingston: McGill-Queen's University Press, 1996), 385.

⁴⁷ Large, *Drums and Scalpel*, 13. Rev. R.W. Large, MD., "Bella Bella Indian Mission" *The Missionary Outlook*, January 1907. Rev. H.C. Wrinch, MD., DD. "A History of the Hazelton Hospital" June 1938. Hazelton File, UCA VST. *Missionary Outlook* (1881-1925) and *Missionary Bulletin* (1903-21) were critical in the institutional evolution of the church, as well as in defining its role during the late nineteenth and early twentieth centuries. Semple, *The Lord's Dominion*, 207.

⁴⁸ Semple, *The Lord's Dominion*-, 280, 290, 296.

Simpson). Large and Wrinch also started hospital tickets, an early form of hospital insurance.

Generally missionary physicians fared better financially than their DIA contracted medical counterparts. Over and above their DIA contracts, cannery and logging contracts, and private practices, missionary physicians received a stipend from the Church for their missionary services, whereas DIA physicians had to rely on private practice and other means to supplement their federal income. As well, medical missionaries came to the province with the full backing of the Church and built institutions and reputations based on their work with Aboriginal people. This enhanced their status as opposed to DIA physicians, who made their reputations by contributing to their new settler communities rather than devoting their energies to Aboriginal health care. Mary-Ellen Kelm suggests many lay physicians saw BC as a “professional backwater” and therefore Aboriginal health care was “simply a means to ensure financial survival.”⁴⁹ Contrary to departmental policy, missionary doctors were more apt to dispense drugs free of charge to their Native clientele. This implies a concern for their well-being. Lastly, their interest in First Nations included advocacy roles such as Native land rights and research (Darby).⁵⁰

Although northwestern communities benefited and relied upon the medical practices of missionary physicians, it was not one sided. These doctors became privileged elites, who used the combination of religion, medicine and community dependence to gain political office and garner esteemed careers. Although they were dedicated to improving the health of First Nations, they arrived at their respective areas with preconceived notions of racial superiority. Their imperialistic notions of assimilation,

⁴⁹ Kelm, *Colonizing Bodies*, 144.

⁵⁰ Kelm, *Colonizing Bodies*, 144-146.

paternalism and materialism created cultural conflicts. This becomes evident when one looks at how they used medicine as a tool for religious conversion.

In their capacity as messengers of God, missionary physicians were authority figures: teachers of a new religion. Also, the mix of spirituality and European medicine appealed to many First Nations because of their similarities to Native healing. First Nations accepted the notion of having a doctor (healer) pray with his “saving grace” while ministering to illness. Both shamans and western medical men removed foreign objects from the body as a “healing ritual,” an accepted Aboriginal cultural practice. The hypodermic needle effects a bodily penetration, denoting the introduction of a foreign substance. Michael Harkin suggests that this procedure could be seen as a counterirritant, a traditional medical practice involving the cutting and puncturing of the skin in order to allow the escape of the malignant substance.⁵¹

Early missionary physicians viewed sickness as both a need for medical intervention and a potential for conversion. Tomlinson built his hospital at Kincolith because he believed physical healing was the “prelude to spiritual health.” His medical work kindled a growing interest in Christianity. His first conversion came about as a result of treating a chief of the Gitlakdamiks at his hospital. The chief later asked Tomlinson to teach interested people at his village. Spencer remarked that “a deeper interest in medical work among them” led to a “greater attendance upon the church and Sabbath School services.” Dr. Rush believed that “under God’s blessing” he had “been able to bodily relieve many sick ones, and a good proportion of those who came for

⁵¹ Neylan, *The Heavens Are Changing*, 57, 214-217. Michael E. Harkin, *The Heiltsuks: Dialogues of Culture & History on the Northwest Coast*, (Lincoln and London: University of Nebraska Press, 2000), 88. An aspect of Methodism was religious revivalism. Some Native groups (Tsimshian) had a predisposition towards dramatic transformative experiences, so Methodists found a receptive audience for their enthusiastic ministrings.

physical healing claimed to have found health of soul as well, for which we are very thankful.”⁵²

Exploitation and opportunism were common aspects of medical healing and conversion. Bolton, referring to his “philanthropic effort as a chance to teach practical Christianity,” observed that “by the bedside of the sick or dying heathen—I find my best opportunity to teach, enforce and exemplify Christian character.” He explained:

Religious effort which always accompanies our bodily ministrations, meets also with varied success, but in both lines (Native inherited weaknesses and vitiated constitutions) we have less to do with the results than, with obedience to our orders, which are to preach the Gospel and heal the sick, and which we have tried conscientiously to do.⁵³

Large contended that his “hospital has been a great blessing in caring for the bodies of the people, and many, very many, have been healed of sickness, both of body and soul.”⁵⁴

Following epidemics, the number of converts typically increased as Native people sought protection from diseases over which their own shamans and healers had no power. Nurses provided patients with Bibles, discussed religious matters with them, and reported numerous sickbed conversations.⁵⁵

Not all First Nations were enamored with the medical missionaries’ taking advantage of health problems for religious purposes. Some Natives approached medicine and conversion with caution. Large remarks, “they seem just about as willing to use these privileges (hospital) as others are. They have listened quite readily at our religious services, but it is difficult to ascertain, until they get among their people, just how deep

⁵² Patterson, *Mission on the Nass*, 50, 60-61. “The Indian Work,” Methodist Missionary Society Annual Reports 1901-02, xxxv, 1899-1900, xlvii. UCCA. BV 2550.2.M5.

⁵³ “The Indian Work,” Methodist Missionary Society Annual Reports 1899-1900, 1. UCCA. BV 2550.2.M5
Dr. A. E. Bolton, “Along the Line: The Medical Mission at Port Simpson,” *The Missionary Outlook* August 15th, 1891, 174. UCA VST.

⁵⁴ “The Indian Work” Methodist Missionary Society Annual Reports 1898-99, xlv. UCCA BV 2550.2.M5.

⁵⁵ Neylan, *The Heavens Are Changing*, 211. Harkin, *The Heiltsuks*, 95.

an impression has been made upon them.” Wrinch mentioned, “two persons have made profession of Christianity while in the hospital. – We believe that many others have gone out with deeper conviction of righteousness.”⁵⁶ Spencer wrote, “some are doubtful and shy of white man’s methods, and in many cases prefer weeks and months of suffering to submitting to treatment. As in all things else there must be the educative period.”⁵⁷

Many First Nations people were unconvinced of Western medicine’s claim to universal efficacy and resented the notion of conversion. Their own indigenous healing was often more available, more effective and more relevant. They believed white medicine was needed for white diseases while their own healers could treat all other forms of illness.⁵⁸ Large found that many Natives “still prefer to remain in their own homes under many disadvantages rather than come to the “sick-house” for treatment.”⁵⁹ Bolton mentions that “the old people especially were prejudiced against my medicines, and sometimes when administering doses I heard—the white man’s medicine is not good for us.”⁶⁰

One might ask if there was any difference between the treatments afforded First Nations by missionaries, missionary physicians and lay doctors. Mary-Ellen Kelm mentions that missionary zeal seems to have prevented the kinds of abuses so prevalent among lay doctors from spreading to their clerical counterparts.⁶¹ The medical missionaries and missionaries had a goal of proselytizing but their treatment of using

⁵⁶ “The Indian Work,” Methodist Missionary Society Annual Reports 1903-04, xlvii. 1904-05, lii, UCCA BV 2550.2.M5.

⁵⁷ Rev. J.C. Spenser, MD. “Letter from Missionaries,” *The Missionary Outlook*, August 1900, 174. UCA VST.

⁵⁸ Kelm, *Colonizing Bodies*, 155.

⁵⁹ “The Indian Work,” Methodist Missionary Society Annual Reports 1903-04, lii, UCCA BV 2550.2.M5.

⁶⁰ Dr. A. E. Bolton, “Along the Line: The Medical Mission at Port Simpson” *The Missionary Outlook* August 15th, 1891, 174. UCA VST.

⁶¹ Kelm, *Colonizing Bodies*, 146.

medicine for that means varied. For instance, Dr. Tomlinson's village at Kincolith "almost always contained non-believers who had come to receive medical treatment." Most missionaries seem to have aided with vaccination, quarantine or medications. Missionary Thomas Crosby vaccinated 'hundreds' during the 1862 smallpox epidemic, traveling from the Lower Mainland of British Columbia up the Vancouver Island Coast from Victoria to Nanaimo.⁶² John Booth Good took "several courses in doctoring at St. Augustine's" and used his modest medical expertise on the Nlha7apmx peoples.⁶³ However, missionaries William Duncan and Robert Doolan sometimes withheld medications and, Henry Schutt constantly refused to treat First Nations with appropriate therapies.⁶⁴ At the Hazelton Hospital, fear of being accused of witchcraft or of being seen as ineffective caused Wrinch to refuse admittance to hopeless cases. He stated:

One of our most difficult questions arises in connection with cases hopeless from the first. To take them in seems dictate of humanity, to refuse them is sometimes that of mere policy. Perhaps you wonder how it can be policy to ever refuse these people admittance. The conditions are different to those among the intelligent whites. The heathen Indians (or women) are on the watch to discredit our work, and when a death occurs in the hospital no matter how hopeless the case may have been and no matter how thoroughly all the possibilities have been explained to their friends, there are always some of them ready to blame the hospital or the doctor and to assure the relatives that they would have cured the sick one all right. - - - There are too many going out who give unmistakable evidence of having benefited, for any one to be able to persuade the people that we are doing no good and in admitting patients we find that the dictates of humanity can generally be followed, regardless of what policy might commend.⁶⁵

⁶² Susan Neylan, *The Heavens Are Changing*, 88, 216.

⁶³ Brett Christophers, *Positioning the Missionary: John Booth Good and the Confluence of Cultures in Nineteenth-Century British Columbia*, (Vancouver, UBC Press, 1998), 94.

⁶⁴ Patterson, *Mission on the Nass*, 76.

⁶⁵ Jacqueline A. Burt, "Dr. Horace Cooper Wrinch: Pioneer British Columbia Physician", Unpublished Paper, Medicine 4, February 20, 1966, Hazelton District Public Library, 27. Rev. Arthur Barner, *Surgeon of the Skeena: A Brief Resume of the Life and Work of Rev. Horace C. Wrinch, MD DD.*, 1940, 11-12, 23. Kelm, *Colonizing Bodies*, 145.

Medical work was supposed to convince First Nations to surrender their spirituality and accept western style healing techniques and Christianity. As with Wrinch, when medical failure, such as 'hopeless cases,' would jeopardize the goal of conversion, medical treatment could be withheld.

The missionary physicians did not accept Native healers. They wanted to promote health changes in First Nations and targeted the medicine men as a negative power. They believed it was their duty to free First Nations from a state of ignorance and enlighten them to God's grace. Consequently they saw the medicine man as "the greatest source of opposition to both medical and evangelical work." Their conviction was that the Gospel according to the Methodist Church was the only antidote for Native heathenism. If medicine was a way to aid in illuminating mind-body healing, then any interference was deemed unacceptable.⁶⁶

The missionary doctors felt "the work of the medicine man [shaman] is more in the nature of a witch."⁶⁷ 'Superstition' played a significant role in the relationship between western doctors and First Nations people as the scientific medical people regarded the medicine men as relying on 'superstition.' They comment that many of the Aboriginals were afraid of relinquishing ties with shamans for fear of retribution. Large wrote about a chief's wife who was seriously ill. The chief suspected witchcraft caused his wife's internal pain because another Native had thrown a stone outside her window. Large tried to convince him that this was not the case but could see that the chief wished to call in the medicine man. By performing a small operation he was able to show the couple the real cause of her pain. The husband became one of the mission's most active

⁶⁶ *The Missionary Outlook*, August 1906. UCA VST.

⁶⁷ Rev. J.C. Spencer MD., "An Introduction to the Medical Work in British Columbia," *The Missionary Outlook*, September 1901, 202. UCA VST.

supporters.⁶⁸ Spencer wrote that once “an Indian gets as notion that a medicine man is working upon him he will cease to eat, and gives up on all hope of recovery.”⁶⁹ He found that the ‘superstitions’ made medical work more difficult as in the case of a little boy in the hospital suffering from a bowel hemorrhage. When the bleeding didn’t abate, the father blamed it on a dog that had been prowling round the complex. He feared the animal was the medicine man who had the power to cause the death of his son. Nothing the staff could say was effective in dispossessing the father of his conclusion.⁷⁰

Susan Neylan suggests that symbolic practices (e.g. superstitions, sicknesses) were the very sites of engagement in the colonial experience, in which the different parties brought their own understandings and priorities. Because both shamans and missionaries were seen as bearers of power, and because, in Native understanding medical and religious skills went hand in hand, it is not surprising that healings were major contested areas. Although missionaries received considerable attention and achieved success through their exercise in medical skills, particularly in reference to epidemics, Neylan states “missionaries were viewed as shamanic healers or as malevolent witches (depending on the context).”⁷¹

The missionary physicians varied in their handling of the medicine man and ‘superstition.’ At times they were heavy-handed. Large, in 1901, told the Heiltsuk medicine men “if they did not stop misleading the people we would report them to the Government. They (Dr. Sam and Dr. Charley) promised to stop their practices entirely,

⁶⁸ R.W. Large, MD., “Rivers Inlet Hospital” June 12, 1903. *Missionary Bulletin*. Volume #2, June 1903.

⁶⁹ Rev. J.C. Spencer, MD, “An Introduction to the Medical Work in British Columbia,” *The Missionary Outlook* September 1901, 202. UCA VST

⁷⁰ Rev. J.C. Spencer, MD., “British Columbia Conference” August 25, 1899. *The Missionary Outlook* October 1899, 212. UCA VST.

⁷¹ Neylan, *The Heavens Are Changing*, 215.

and so far as we have been able to learn have kept their promises.” Large later learned that Charley “had been secretly practicing at odd times, but it has been difficult for me to catch him, as his patients screen him, and he pays his visits at night, or after my usual time of making calls.” Large described his dilemma:

Trying to reach him with the law might create a large measure of sympathy for him, and would also be interpreted as a proof of our jealousy and unwillingness to leave the results of our work to fair comparisons. Were we to show special interest in him and provide for his needs, this might be taken to mean that we are afraid of his opposition, and so paid him to cease practice. Belief in his curative powers is very slight, and all serious cases come to me.⁷²

Other times, missionary physicians were conciliatory. Wrinch had a “sense of pride and accomplishment” with each new conversion especially that of the Gitksan medicine man at Kispiox.

The work of the medicine man was not the only “reprehensible custom” which Western missionaries confronted. They condemned the potlatch, a Native custom in which prestige was enhanced by the giving away of accumulated material wealth, for health, moral and economic reasons. In fact, there is an overlapping of these issues. Because Natives congregated for feasts and the redistribution of property, missionaries believed potlatches were breeding grounds for infections and communicable diseases. They censured the potlatch system because it led to the increased use of Native women as prostitutes as a source of funding for procuring material goods. Lastly, by far the most frequent arguments for banning the potlatch, was economic because the prolonged ceremonies reflected on Native incompatibility with the European notion of establishing settled habits of labour and industry. The loss of time from agriculture, ranching, and

⁷² Large, *Drums and Scalpel*, 21, 65-68. Indigenous doctors were often charged with fraud or witchcraft. Kelm, *Colonizing Bodies*, 158.

fishing, coupled with the potlatch's destructiveness of the accumulation of savings, were cited as paramount reasons for stopping the celebrations. The potlatch was banned in 1884 by the Dominion government, primarily at the urging of missionaries who believed it stood in the way of progress. The ban had little effect, particularly on coastal Natives who were acquiring greater wealth because of their growing dependence on Euro-Canadian material goods.⁷³

Living conditions, cleanliness and progress were targets of Victorian culture in which missionizing played a major role. Missionary physicians aided in this "moral improvement" by expounding on an ideology that showed an outer sign of a new internal state of grace. They advocated the adoption of European clothing and sanitation measures. Neat and tidy homes replaced communal houses. The physicians banned the use of alcohol as they considered drinking a form of moral backsliding and a cause of disease. To stem tuberculosis and other infectious diseases, Large imposed "public-health" ordinances against alcohol and against public spitting. The physicians gave daily advice either in Chinook (the common Native trading dialect) or the appropriate tribal language.⁷⁴

Conversion and colonial humanitarianism were at the heart of the missionaries' good intentions. Yet, they were blind to their own prejudices and manipulative powers to dominate because they drew support from a powerful sense of their own national character and imperial responsibility. All the missionary doctors held government positions as Justices of the Peace and, in this capacity could impose fines and reprimands.

⁷³ Johnston, *The Pacific Province*, 174. "What Is Killing The Indians?" *Na-Na-Kwa*, No. 18, Kitamaat, BC, April 1902, PRRA. Douglas Cole and Ira Chaikin, *An Iron Hand Upon The People: The Law Against the Potlatch on the Northwest Coast*, (Vancouver: Douglas & McIntyre, 1990), 5-20.

⁷⁴ Harkin, *The Heiltsuks*, 93-96.

A sense of duty and obligation is evident in their writings. Bolton stated “we as a people owe this dying, despised and wronged race”—“he is our neighbor scripturally and geographically, and as such we shall give him a few crumbs from our table.”⁷⁵

Racism is evident in early Methodist and Anglican missionary letters and in hospital policy. Words such as “heathenism, savages, and degraded souls, ignorant minds, physically degenerate and morally uninspiring” filter through. Bolton believed when the Aboriginals were ill, they were “suffering a just rebuke and punishment” which required “repentance” because they had “offended God.”⁷⁶ Tomlinson informed Trutch of his desire to “change the natives from ignorant, bloodthirsty, cruel savages into quiet useful subjects of our Gracious Queen.”⁷⁷ Hospitals had segregated wards for First Nations and white patients and employed few Native hospital staff. This policy was in place until the mid-1950’s when Dr. Ted Whiting, superintendent of the Hazelton Hospital, addressed the issues.⁷⁸ Darby was the exception as he does not seem to have held racist notions. Dr. Adam Waldie mentioned Darby was “an extremely versatile man with deep human understanding.” Rev. Grant Bracewell stated “Darby was non judgmental. If he had a failing it was that he saw himself as the patriarch of Bella Bella. By the 1950’s it was an anachronism to act as if you were a patriarch.”⁷⁹ Darby

⁷⁵ “Dr Bolton’s Medical Work”, January 21, 1893, *The Missionary Outlook*, 37. “The Port Simpson Hospital”, February 3, 1892, *The Missionary Outlook*, April 1892.50. UCA VST. Bolton’s comments were written as part of fund raising for the hospital and printed on the editorial page.

⁷⁶ Dr. A. E. Bolton, “Along the Line: The Medical Mission at Port Simpson, August 16, 1891. *The Missionary Outlook*, UCA VST.

⁷⁷ Patterson, *Mission on the Nass*, 53.

⁷⁸ Burrows, *Healing in the Wilderness*, 101. The federal government was slow in providing tuberculosis sanatoriums for First Nations people. The first of these was the 180- bed Coqualeetza Hospital at Sardis (1941); followed by the Miller Bay Hospital in Prince Rupert (1946); and, the 200-bed Nanaimo Hospital (1948). 100.

⁷⁹ Dr. Adam Waldie, “Pacific Coast Medical Missions of the United Church,” Dr. A. C. Waldie Fonds, Box No. 2, File 2-4., Research, Writing and Historical Topics, BCMA. Interview with Rev. Grant Bracewell, August 19, 2003. In 1949 Bracewell was the boat handyman for Darby at Rivers Inlet. From 1955-58 he was the United Church minister at Bella Coola.

represents the attitudinal change within the Church. By this time, physicians employed by the United Church Medical Services reflected the 'new' emphasis on medical and humanitarian social services.

These racial attitudes did not apply exclusively to First Nations but extended to other groups. Wrinch, in his capacity as MLA, in 1925, was instrumental in supporting a provincial inquiry to investigate mental retardation and "foreign misfits." During the late nineteenth century and the first few decades of the twentieth century the notion that society's ills were caused by hereditary problems replaced the environmental notions (poverty, unemployment) of illness. Medical degeneration theorists (eugenicists) perceived the 'retarded' person as a social threat for which medical intervention, namely an aggressive policy of sterilization, was essential to counter what some professionals' believed was the rising numbers of mentally deficient. In support, many women's groups (e.g. the National Council of Women) joined some members of the "helping professions" to press for restrictions on the entry of immigrants into Canada, many of whom were thought to be feeble-minded. Wrinch contended that although new policies were required, it would take years of education before the public would see the wisdom of sterilizing the feeble-minded and placing restrictions on marriage and immigration. Wrinch appears to be the only early missionary physician who professed this view.⁸⁰

⁸⁰ Angus McLaren, *Our Own Master Race, Eugenics in Canada, 1885-1945*, (Toronto: McLelland and Stewart, 1990), 91-94. The notion of rising retardation numbers was erroneous. The medicalization of the province's school system began in 1907 whereby children were subjected to a variety of intelligence tests, examinations and medical inspections. Those who met the new norms were declared "normal;" those who did not were labeled as inadequate. McLaren suggests the reason for the perceived rising numbers was "because the community's demands on children were increasing. Larger and larger numbers of children were labeled as incapable of being educated because they failed to respond adequately to a specific form of education they were compelled to experience." "The IQ tests to which students were subjected naturally relied on "cultural experiences and the verbal skills and practices" of the cultural elite. "As a social product of the middle class they (examiners) necessarily confused innate intelligence with an appreciation of bourgeois norms." 92, 95-96. In 1933 BC and Alberta passed sterilization laws.

By drawing on their sense of cultural superiority, the missionary physicians viewed Aboriginals as an inferior, dying and diseased race. To them, assimilation was the answer. Large remarks “our aim on this Coast should be to get the Indians ready for moving away from the reserves in the future, and mingling more with the whites.”⁸¹ It never occurred to them that whatever the benefits, the yoke of imperialism was burdensome and often humiliating. They misunderstood the consequences of trying to radically restructure a First Nations society in such a short time. Pursuing their sustained policy of change, missionaries demonstrated a morally intense commitment to rule in which missionary medicine offered unparalleled opportunities for proselytizing and discipleship.⁸²

Missionary physicians increasingly face resistance in non-Native communities. Proselytizing was not solely restricted to the Native population. Many members of the white community, seeking medical treatment only, resented religious interference. Some criticized Darby for praying over patients prior to surgery.⁸³ In 1912, Eva MacLean, the young wife of Hazelton’s veterinarian and Presbyterian minister, went to Wrinch’s hospital to await the birth of her first child. She remarks that:

the days passed more pleasantly for me, but the waiting period seemed long until my baby girl was born, three weeks overdue. It seemed to me that the doctor’s methods were outdated, and he was more missionary than medical. When my time came and the baby still refused to be born, in extreme agony I begged for an anesthetic, but he told me sternly, “You will just have to bear it Mrs. MacLean. We are all born in travail, and birth

⁸¹ Harkin, *The Heiltsuks*, 147. Aspects of Aboriginal culture were admired by Large. During his years at Bella Bella he amassed a large collection of Heiltsuk art and cultural artifacts which are now housed in the Royal Ontario Museum in Toronto. Francis, *Encyclopedia*, 405.

⁸² Good, *The Steamer Parish*, 15, 41. Darby refused to learn the Heiltsuk language believing that the Natives would adapt better if they learnt English. McKervill, *Darby of the Bella Bella*, 90.

⁸³ McKervill, *Darby of the Bella Bella*, 86. Darby was also criticized for his “classical Methodist observance of no work on the Sabbath so if the boat arrived with supplies he refused to have the freight for the hospital and village moved from the shed on the wharf until Monday.”

is woman's most wonderful experience." I had enough in the next ten hours to make him change his mind, and the last four hours I was on the operating table. Somehow I was unable to find birth a wonderful experience, thanks to him and his religious scruples about the purifying effect of pain. He really was a Torquemada!⁸⁴

In another instance, on June 24, 1936 the Board of Home Missions of the United Church presented an ultimatum to the Board of the Bella Coola Hospital (Figure 3.12) that if they did not fire Dr. Herman Alexander McLean as superintendent (1930-37), they would withdraw their support.⁸⁵ Residents of the community had complained to the central board about the doctor's conduct. They complained he was a "radical evangelical" who was always "going down on his knees before surgery in the operating room." Another resident reported that McLean "did a bible study once a week—so he sometimes would not be at the hospital when he was needed." The irony is that a religious organization was complaining about a staff member being too religious! After the Bella Coola Board accepted his resignation, McLean went to the Shantyman's Christian Mission and established the hospital at Esperanza (Figure 3.16) on the west coast of Vancouver Island.⁸⁶

⁸⁴ Eva MacLean, *The Far Land*, 114.

⁸⁵ Minute Book of the Bella Coola Hospital Board, 1908-1948. Box 1, BC Hospitals. UCA VST. The hospital had been under the auspices of the United Church since 1927.

⁸⁶ Interview with Dr. W. Don Watt, retired head of the United Church Health Services (1962-1987) January 28, 2005. Watt replaced Darby as medical head of the health services. While McLean was at Bella Coola he was responsible for organizing the medical clinic which went to Anaheim Lake. Because the area was remote, it took two weeks to complete the circuit. Harvey V. Thommasen, Peter Newbery, and W. D. Watt, "Medical History on the Central Coast of British Columbia" *BC Medical Journal* Vol 41, No. 9, 1999. 467 The Shantyman's Christian Mission was started in the 1903 by Percy Willis, an itinerant preacher. The mission never owned land or established churches. The goal was to preach the Gospel in remote communities where logging, fishing and mining camps were located. Willis hired McLean and they formed the Nootka Mission Association. Together they built the Esperanza Hospital in 1937. Prior to this the area had a clinic supplied by Canada Packers Company. McLean visited the logging camps at nearby Tahsis and Zeballos as well as the surrounding Aboriginal villages. The mission had three boats: *Messenger II*, *Bedouin* and *Elizabeth* which McLean used. Louise Johnson, *Not Without Hope: The Story of Dr. H. A. McLean and the Esperanza Hospital*, (Matsqui, BC, Maple Lane Publ., 1992).

Alder A. Bloom remarks: "While McLean was there (Zeballos) he did some exceptional things in emergencies but he always maintained that he would rather save souls than bodies, so most people were reluctant to visit him if they had an alternative." Referring to emergency surgery for a duodenal ulcer: "Dr.

With the amalgamation of the Methodist, Congregationalist and Presbyterian Churches into the United Church of Canada in 1925, a new era began. The United Church Medical Services (UCMS) mandate was to hire physicians and nurses to go to areas that were having difficulty providing for their own health-care needs. The health-care workers had to be willing to work to improve the spiritual and physical well-being of the rural communities in which they worked. But the emphasis was on health-care, rather than a mixture of religion and medicine. This system continues today as the United Church Health Services (UCHS). The UCHS is responsible for four hospitals in British Columbia: Bella Bella, Bella Coola, Hazelton and Queen Charlotte City.⁸⁷

Missionary physicians played an essential role in the development of northwestern BC. They aided in sustaining healthcare to the isolated region by building hospitals, contacting with various industries, and overseeing the medical needs of First Nations and the growing settler population. Many doctors settled permanently and established illustrious careers. The late nineteenth and twentieth-centuries, a time of momentous change in the history of western medicine on the lives of the Native inhabitants, was heightened with the arrival of missionary physicians. Early Anglican and Methodist missionary doctors used medicine as a tool for religious conversion and were often sympathetic to colonial imperialistic ideological expectations. Identifying disease and medicine as sites of contact, conflict and cooperation, illuminates the early

McLean operated that night under the most primitive of conditions, with people holding lamps and flashlights”—It saved his (Jack McKay) life. That was one of the fantastic things that McLean did, but he often messed up smaller things.” Alder A. Bloom, “Memories of Ceepeecee: Life at a West Coast Cannery” Howard White, Ed. *Raincoast Chronicles* No.19, (Madeira Park: Harbour., 2003), 19-20.

⁸⁷ Thommasen, “Medical History on the Central Coast of British Columbia,”466. Burrows, *Healing in the Wilderness*, 144, 159. A few years after the implementation of provincial hospital insurance, in 1948, and increased provincial funding to municipalities to renew or expand their health facilities and services, the UCMS underwent a second review to ascertain the necessity of continuing with mission hospitals. It decided to have the hospitals supervised by a joint committee of WMS and the Board of Home Missions. In 1988, the name was changed to the United Church Health services.

missionary physicians attitudes of racial superiority, inequality and paternalism. By the 1920s, medicine as a means of religious conversion was replaced by church medical services where humanitarian and medical social services were paramount.

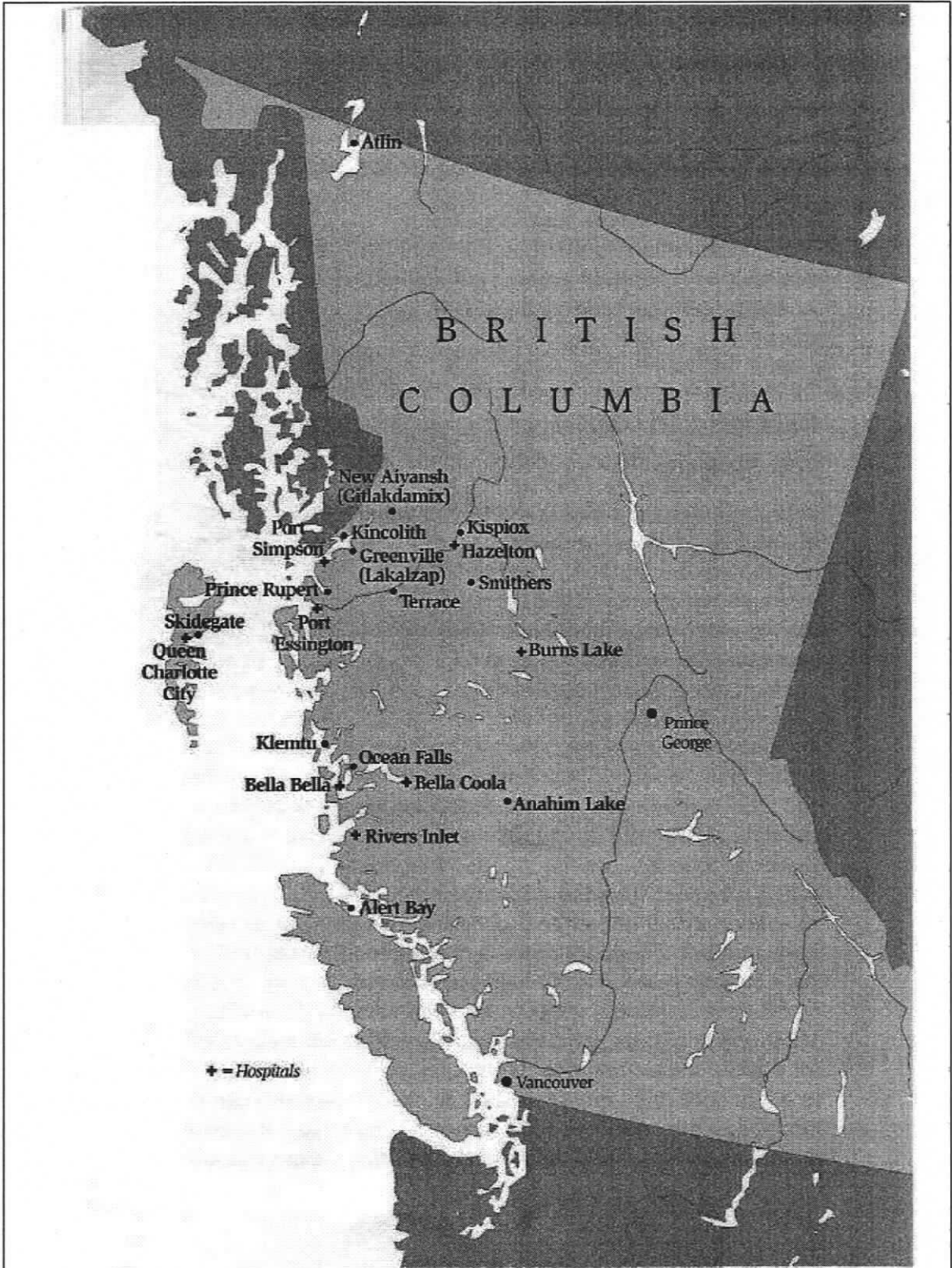


Fig. 3.1: Methodist Church Hospital Locations.

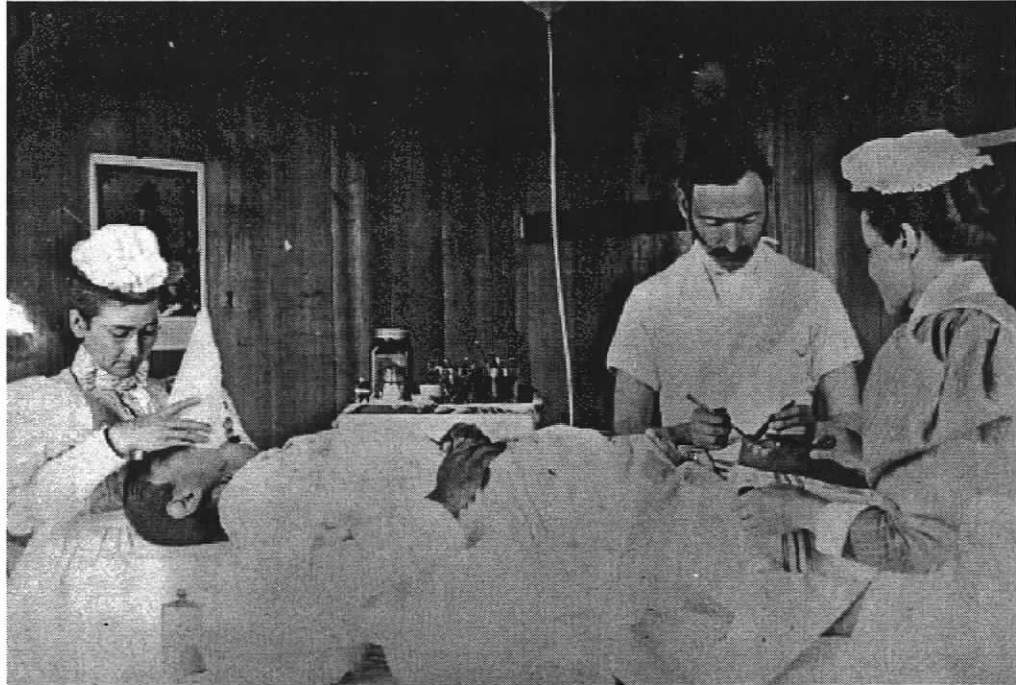
Courtesy of Bob Burrows



Fig. 3.2: United Church Hospital, Bella Bella, 1930.



Fig. 3.3: Dr. Richard Whitfield Large, n.d.
Courtesy of Bob Burrows



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Fig. 3.4: Dr. A.E. Bolton, Port Simpson Hospital, 1895.



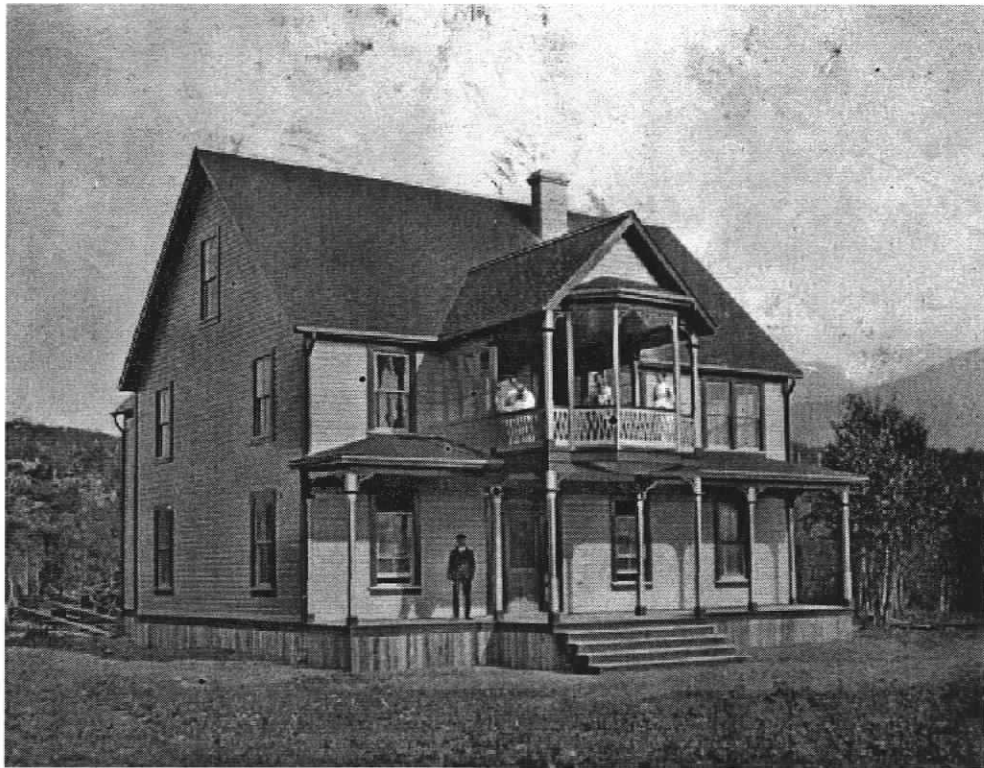
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Fig. 3.5: Port Essington, Methodist Church and Hospital, 1915.



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Fig. 3.6: Dr. H.C. Wrinch and staff, Hazelton Hospital, 1911.



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Fig. 3.7: The first Hazelton Hospital, 1905.

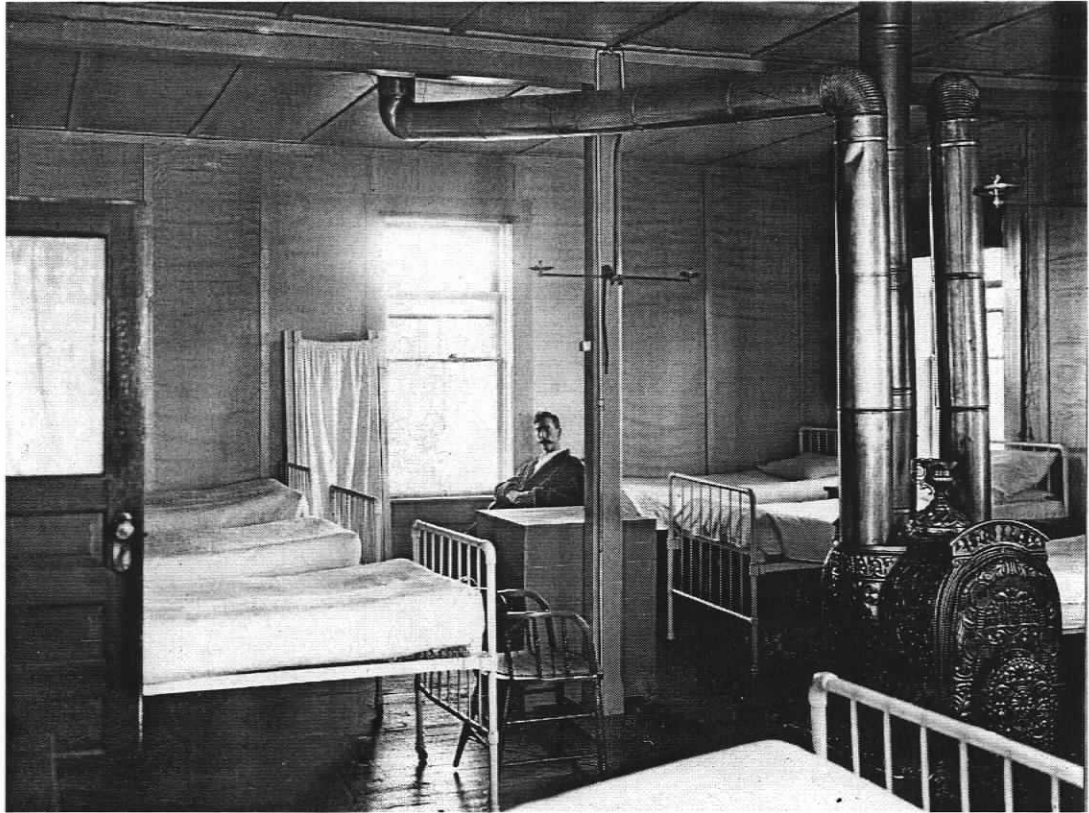


Fig. 3.8: Dr. H. C. Wrinch in the men's ward at the Hazelton Hospital, 1904.
Courtesy of Bob Burrows



Fig. 3.9: Dr. William Sager, Hazelton Hospital, 1915 to 1916.
Courtesy of Bob Burrows



Fig. 3.10: The Sunbeam III, purchased by Dr. R. Geddes Large in 1927 served the Port Simpson Hospital for many years.
Courtesy of Bob Burrows



Fig. 3.11: Dr. George E. Darby's hospital boat, the Wm. H. Pierce, 1947.
Courtesy of Bob Burrows



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Fig. 3.12: Staff outside the Bella Coola Hospital, [193-].

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Fig. 3.13: A Beaver aircraft crashed in poor weather near a logging camp on the west coast of the Queen Charlotte Islands. Two passengers were killed and three of the five survivors had broken backs. Dr. Don Watt and the RCMP constable were flown to an area near the crash scene, and hiked through the bush to carry out the injured.
 Courtesy of Bob Burrows. Photographer: Dr. Don Watt. n.d.

BC Archives Photo #1-82573. Supplied for Research Only.



Fig. 3.14: Dr. W. S. Kergin returning to the airplane after flying from Prince Rupert to the Queen Charlotte Islands to oversee the medical needs of local residents, 1940.

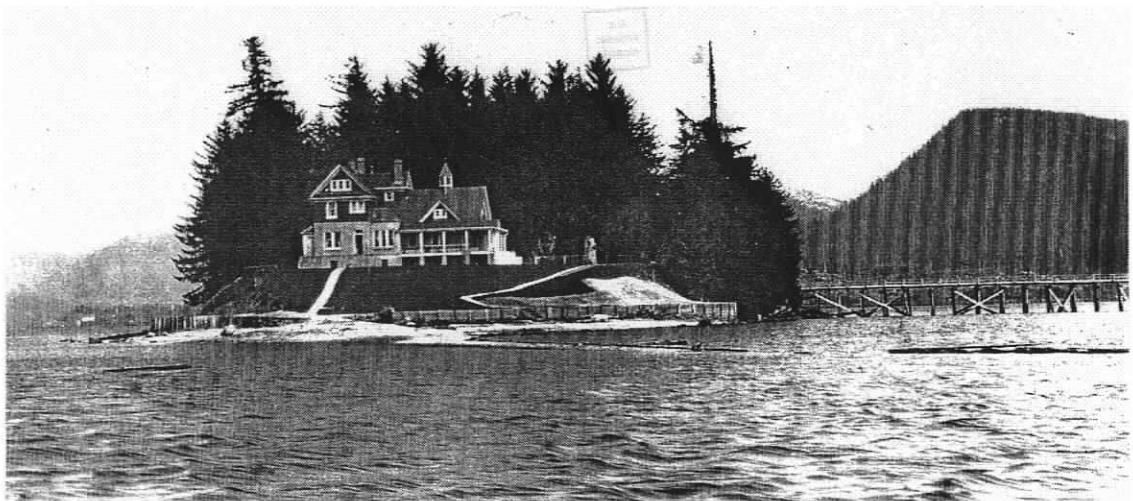


Fig. 3.15: Quarantine Hospital, Digby Island, Prince Rupert, 1916.
 Courtesy of Prince Rupert City & Regional Archives and Museum of Northern BC.
 WP1998-071-17564



Fig. 3.16: The Shantyman's Mission Hospital at Esperanza, 1939.
Courtesy of BC Archives HP 67239

Chapter 4

The Columbia Coast Mission: Delivery of Medicine by Sea

The third missionary system, the Columbia Coast Mission, was founded in 1904 by Reverend John Antle (1865-1949). The Mission supported healthcare services in logging and fishing camps and villages along the coast of BC. Originally from Newfoundland, Antle's unique marine mission delivered medical and missionary work to isolated peoples and lighthouses.¹ The Mission advertised itself as ministering to the body, soul and mind from its opening until its closure in 1969. The Mission established five outpost hospitals and created several medical clinics and covered twenty thousand square miles of land and sea and involved about fifty-six ports of call. Connecting the various hospitals and medical clinics were seven pastoral mission-ambulance boats, of which the hospital vessel, the *Columbia*, was the flagship. It served the CCM until 1958.²

In 1910, the *Columbia* (Figure 4.1) was fitted out as a marine hospital ship with two hospital beds, dispensary, an operating table, and an x-ray machine. A well stocked supply room consisted of surgical equipment, splints and dressings. A radio-telephone

¹ Antle was influenced by Sir Wilfred Grenfell (1865-1940) who created the Grenfell Mission. His marine mission serviced Labrador and Newfoundland by providing hospitals, nursing outstations and mission work to isolated fishermen on the coasts. C.F. Poole, "Do or Die" *Horizon Canada* Vol.3 No. 29, September 1985. Antle was ordained in 1892. He was not the first to establish a marine mission on the BC coast. The Roman Catholic Church had founded the Nootka Mission in 1874 on the west coast of Vancouver Island but it did not become a marine mission until 1950. For thirteen years the *Sea Queen* operated out of Friendly Cove. Its successor, *Star of the Sea*, served a three-hundred mile area covering Simoon Sound, Alert Bay as well as the Methodist territory of Bella Bella, Bella Coola, Namu and Klemtu. The Anglican steam vessel, *Evangeline*, covered the northern coast from 1880 until 1892 when it had to be sold due to rising operating costs. In 1912 when the Anglican Diocese of Caledonia (Rev. W. F. Rushbrook) launched the forty-five foot vessel, *Northern Cross*, from its land-based Prince Rupert Coast Mission. Three years later the *Western Hope* was launched. None of these were medical missions. Michael Hadley, *God's Little Ships: A History of the Columbia Coast Mission*, (Madeira Park: Harbour, 1995), xvii.-xviii. Walter Field Rushbrook, "The Prince Rupert Mission," *Mission World*, (Toronto: Missionary Society of the Church of England in Canada, 1962), 3-15.

² Hadley, *God's Little Ships*, xviii.-xix,174. The sixty foot *Columbia I* (1905) was followed in 1910 by the hundred foot *Columbia II*, the *Governor Musgrave* (1911), the *Makehewi* (1919), the *Rendezvous* (1924), the *John Antle* (1933) and the *John Antle II* (Figure 4.2) in 1936.

greatly facilitated serving emergencies. In addition, the boat had a library and supplied periodical literature to the camps and settlements. Emphasizing the link between medicine and mission, the main salon was used for chapel services, marriages, funerals and baptisms. The *Columbia* had a regular route forming a Figure "8," with Alert Bay as the center. About forty-five calls were made every two weeks.³

The hospitals were located at Rock Bay (Queen's Hospital-1905-1945); at Alert Bay (St. George's-1909-1947); at Vananda on Texada Island (Columbia Hospital-1907-1920); and Pender Island (St. Mary's-1930) (Figure 4.5). Queen's Hospital was destroyed by fire in 1911 but rebuilt as St. Michael's Hospital (Figure 4.3) the same year. Similarly, St. George's Hospital burned in 1923. It was replaced and reopened two years later. The John Antle Memorial Medical and Dental Clinic at Whaletown on Cortes Island was established in 1944. In the same year the Aged Folks' Guest Houses, adjacent to the hospital on Pender Harbour, opened as retirement homes. The operation of the Rock Bay and Texada Island hospitals was a joint effort between the Victoria Order of Nurses (VON) and the administrative services of the CCM.⁴

Coast logging camps frequently moved and the Anglican Church replaced the hospital on Texada Island with a two-building floating hospital (Figure 4.4) that could follow the floating camps of loggers from area to area. Renamed the Columbia Hospital, it serviced the northern section of the Mission area from Carriden Bay to the Queen Charlotte Strait. It operated intermittently for eight years within the fluctuating work

³ Hadley, *God's Little Ships*, 27. W.E. Playfair, "John Antle, the Dr. Wilfred Grenfell of the Pacific," *Boston Evening Transcript*, Nov. 19, 1930. BCA M AN9. There were four Columbia ships all told.

⁴ The medical and dental clinic which Reverend Rollo Boas established at Whaletown (1944) was held twice a month with doctors and dentists coming from Campbell River to Heriot Bay by water or land taxi and then being ferried from there to Whaletown in the CCM *Rendezvous*. Prior to the facility being completed, the clinic was first held in the vicarage, the dentist was in the children's bedroom and the doctor's office in the unfinished upstairs quarters. It was renamed after John Antle in 1951. Doris Andersen, *The Columbia Is Coming!*, (Sidney: Gray's, 1982), 128. Hadley, *God's Little Ships*, 26.

patterns and commercial fortunes of the logging industry. In 1929, en route to being towed to Pender Harbour, the hospital was struck by a gale and destroyed.⁵

Finances for the CCM and its hospitals came from a variety of sources. Antle's major funding came from two Church of England organizations, the London-based British Columbia and Yukon Church Aid Society (1910), and the evangelical Toronto-based Missionary Society of the Church of Canada (MSCC). He made annual trips to eastern Canada and to England to solicit funds. Smaller annual grants came from the Anglican Dioceses of New Westminster (Vancouver) and British Columbia (Victoria). Federal, provincial and private grants aided as did the Union Steamships who wrote off fifty percent of the associated freight costs.⁶

Cooperation between the logging companies and the CCM was also vital to its success. Not only did the industry aid in financing the hospitals, the companies (e.g. Hastings Mill Co.) collected a dollar a month as a form of health insurance. Mining (e.g. Tacoma Steel) and fishing (e.g. BC Packers) companies also contributed to the building of the hospitals. In the 1950's the hospital ship was operating with federal (DIA) and provincial government grants as well as an annual grant from the Community Chests of Greater Vancouver and Victoria.⁷

At times the relationship between the loggers and the CCM was tension filled. A few years after the opening of the Rock Bay Hospital Antle plunged into a crusade against coast saloons. Loggers, unable to cash their pay cheques in company stores, could

⁵ Hadley, *God's Little Ships*, 47. Honor M.Kidd, "John Antle," *The Canadian Medical Association Journal*, Vol.65, 1951, Anglican Church Archives, Vancouver School of Theology (ACA VST), PA 198-6 #81-22. 4.

⁶ Hadley, *God's Little Ships*, 21-49. The property for St. Mary's hospital at Pender Harbour was donated to the CCM by Mr. R. Brynildsen of Garden Bay.

⁷ Hadley, *God's Little Ships*, 26. Kidd, "John Antle," 4. Logging, finances and the CCM were intertwined. For instance, the winters of 1907 and 1908 were lean months for the logging industry, many of the camps were closed and the income of the CCM considerably reduced.

do so in local liquor stores, which encouraged them to drink up most of their wages. Antle, by appealing to Attorney-General W.J. Bowser, was able to prevent the renewal of many saloon licenses because they operated under hotel licensing. This angered loggers. Although the bitterness faded over time, Antle continued to discourage the opening of liquor stores that promoted alcoholism among the loggers. Also, the dispute paved the way for the arrival of the United Brotherhood of America (UBA) and its health insurance scheme.⁸

From the onset of the CCM, Antle had initiated a health insurance scheme whereby loggers could pay \$1.00 per month hospital fee for year-round service. Frequent collections proved difficult, and yearly tickets of \$10.00 were substituted. The insurance plan worked well at first, but ran into trouble when competition arose from the UBA.⁹ Vigorously opposing Antle and the CCM, the UBA offered a plan whereby loggers could receive treatment at any hospital for an initial payment of \$5.00 and a yearly fee of \$12.00. Although hundreds joined, little of the insurance money was paid to the mission hospitals which treated the men. After three years, the UBA manager disappeared leaving about \$3000.00 owing to doctors, hospitals, undertakers and grocers.¹⁰

Paternalism and authoritarianism was also evident in other ways under Antle's ministerings. Michael Hadley suggests Antle "was comfortable with making radical decisions entirely on his own" (e.g. he would make financial decisions without consulting

⁸ Andersen, *The Columbia Is Coming!*, 35.

⁹ UBA was established in 1881 as the United Brotherhood of Carpenters and Joiners of America. At the turn of the century British and US carpenters' unions engaged in bitter competition in BC. Although no information on his hospital ticket revenue is available, it is likely that competition would have reduced Antle's income.

¹⁰ Andersen, *The Columbia Is Coming!*, 35.

others). Antle, who probably was sexist, admired self-sacrifice and would “chide well-heeled church-women back in civilization” to be more like “Florence Nightingales.”¹¹

The Mission was similar to the Methodist and Anglican missionary organizations in that it reflected an attitude of paternalism and British imperialism towards First Nations. This disposition created “little inclination toward the concept of dialogue.” Hadley maintains “this attitude of cultural and religious superiority [resulted in] early Church of England missionaries [being] scarcely aware of their ingrained bias.” Akin to Mary-Ellen Kelm and Susan Neylan, Hadley views this as a reflection of both the British and Canadian governments’ ideas. Similarly, he refers to the Mission’s “abiding” concern for Native welfare.¹²

The philosophy behind the CCM was based the late nineteenth and early twentieth-century notion of the Social Gospel. Antle and his successor, Alan Greene (1889-1972), believed that a “church” should be a spiritual community for mutual nurturing and support. In their view, Christianity had to be more relevant to the social issues of the times. Isolated families, industrial camps and small communities needed the reinforcement of pastoral care and medical aid in order to invoke social change. There was to be no hint of proselytizing or preaching. The social gospel purported to provide a new rationale for Christianity and a new mission for the church as Christian preoccupation with man’s salvation was gradually replaced by a concern with social salvation.¹³

¹¹ Hadley *God’s Little Ships*, 79, 174.

¹² Hadley, *God’s Little Ships*, 173.

¹³ Hadley, *God’s Little Ships*, 27, 44-45. Ramsay Cook, *The Regenerators: Social Criticism In Late Victorian English Canada*, (Toronto: University of Toronto Press, 1985), 174-176. Antle retired in 1936. Cook suggests the social gospel was not merely a response to disparities between the wealthy and the poor and the harsh conditions of industrialization, but was a “reaction to a profound intellectual crisis, and as part of that a questioning of the role of the clergy and the Church in modern society.”⁴, 175.

Christian ministry and health care of First Nations were of concern to the CCM. Before its coming, there was no physician in Alert Bay. Antle reported the young Native boys at the industrial school were riddled with unattended ailments, including visible scrofula (glandular swellings which have a tendency to become consumption) sores. Antle made a "mental note" which served as a strong argument many years later when he undertook to prove to the Minister of the Interior in Ottawa the necessity for a doctor and hospital at Alert Bay.¹⁴ Native health problems in Alert Bay prompted the CCM to begin its work among other Indigenous peoples. Initially conceived as a medical venture, the first *Columbia* visited numerous Native settlements as part of her regular patrol.¹⁵ In 1919, Dr. Wilson reported that ninety percent of the Indians from Alert Bay and adjacent Islands were suffering from a variety of ailments, ranging from anaemia, scrofula, or rheumatism, to enlarged tonsils and adenoids, or deafness, blindness and venereal disease. Seventy percent were victims of tuberculosis.¹⁶ By the 1930s tuberculosis rivaled measles, influenza and venereal disease as the main health problem and leading cause of death among BC Natives. Prolonged stays in the hospital became a fact of life for many First Nations people.

The Mission's 1930 annual report stressed the work of the Alert Bay's hospital staff "had been of incalculable benefit to the Indians, who are depending more and more on the services of the Mission." The report cited the steady increase in Native maternity cases as an example.¹⁷ Consideration was given to the social aspects of Aboriginal culture

¹⁴ John Antle, "Memories of John Antle," 49. BCA HA AN8

¹⁵ Other settlements included the Kwagiulth village on Kingcombe Inlet; Village Island; Fort Rupert; Karlukees, and Nahwii. Hadley, *God's Little Ships*, 174.

¹⁶ Andersen, *The Columbia is Coming!*, 78.

¹⁷ Hadley, *God's Little Ships*, 53. Dara Culhane Speck, *An Error in Judgement: The Politics Of Medical Care In An Indian/White Community*, (Vancouver: Talonbooks, 1987), 85.

by allowing Native families to visit patients at all hours. The staff was respectful of patients' need to have family near-by during an illness. In this regard the *Columbia* would often bring in a boatload of relatives and their belongings to be with the patient. Informality was practiced. When the CCM relinquished administrative control of St. George's in 1947, its replacement, the St. George's Hospital Society and its white representatives, enforced a strict regime thereby causing the local Aboriginal population to miss the old informality.¹⁸

Unlike the Methodist missionary physicians (Bolton, Wrinch, Large) and his Anglican successor, Alan Greene, Antle was sympathetic to the potlatch. In the 1930s he asserted that a complete prohibition on the potlatch "led altogether to the detriment of the Indian and any work, medical, social, or religious, that his well-wishers may be trying to do for him." Antle believed there "is much in the potlatch that is worth preserving—Frankly, our sympathies will go with the Indian, and our hope is that the authorities will go carefully into the matter and devise some modification to the present condition [of sweeping prohibition]."¹⁹ In arguing against the ban, Antle states "the ruthless tragedy upon ancient customs comes not too well from a Christian nation."²⁰ After Antle retired,

¹⁸ Andersen, *The Columbia is Coming!*, 57. Speck, *An Error in Judgement*, 86.

¹⁹ Hadley, *God's Little Ships*, 178

²⁰ Judith Williams, *Two Wolves at the Dawn of Time: Kingcome Inlet Pictographs, 1893-1998*, (Vancouver: New Star Books, 2001) reviewed by Phyllis Reeve in *British Columbia Historical News: Journal of the British Columbia Historical Federation*, Volume 36, No.2, (Spring 2003), 35. Paul Tennant, in *Aboriginal Peoples and Politics: The Indian Land Question in British Columbia, 1849-1989*, (Vancouver: University of British Columbia Press, 1990), argues Protestantism on the northern coast allowed for the continuation of the potlatch, but in a disguised form. Marble tombstones substituted for totem poles, and the missionary and the church choir participated in the exchange of gifts along with clan chiefs. "The vitally important potlatch feasts in which clan leaders received their inherited names and positions were now conducted, often in church halls, with the blessings from the missionary and music from the church's brass band. The missionary himself would have been adopted into a house and clan, and a potlatch would have been held to sanctify his status." He mentions clan and tribal people came to regard these elements as "perfectly normal and correct." 78. However, in Antle's area, there was "a pronounced effort" by "white authorities" to suppress the potlatch. Antle's pro-potlatch stance might have come from personal convictions or through education by an angry First Nations community. "For a period following WWI, however, the government

his successor Alan Greene, condemned “this ancient practice” as he sought to convince the “‘Indians’ of the White man’s altruistic benevolence in all things.”²¹ Greene’s attitude towards First Nations is one of colonial humanitarianism: paternalism, racial superiority and cultural imperialism.²²

The mission boats brought medical, spiritual and social comfort to countless of isolated families. Knowledge that the mission boats would check on them periodically and answer any emergency call was reassuring to isolated settlers. One upcoast resident wrote “we have the comfortable feeling that if we had an emergency she (mission boat) would be here as soon as called to do all possible –we can’t thank them enough for all they have done for us.”²³ When there was an emergency beyond the settlers’ “pioneering powers they hang out a bed sheet with the left corner turned up--sometimes there is SOS in lipstick red scrawled across it—and wait for their particular mission boat to see it and come to the rescue.” In one instance, the *Columbia* towed a complete float house and family to the Carriden Bay Hospital because the sick mother had no one with whom to leave her four children. Another time a stretcher was improvised by removing a cabin

pursued the ban with special zeal, making several arrests. In Dec. 1921 a Kwakwaka’waka potlatch held by Dan Cranmer at Village Island (CCM territory) resulted in charges being laid against 49 people. In the end, 26 were jailed. –Traumatic as the suppression of 1921 was, it did not end the potlatch, which remained illegal until the ban was dropped from the revised Indian Act in 1951.” Francis, ed., *The Encyclopedia of British Columbia*, 570.

²¹ Hadley, *God’s Little Ships*, 195. Greene wrote this in 1944 when the Allies were at war in Europe and many Native people were also serving overseas. He disregarded this fact but concentrated on his viewpoint that if Germany won the war “the Indians would become dirt under their feet and ALL your liberties would be treated as nothing.” “The Church supports the State in this matter [of eradicating Native customs and the potlatch]. She never wishes to hurt you. She wants to lead you on step by step to the day when the Indians prove to the Government of Canada and its citizens that they are wise people, eager to learn from the wisdom of the White people-” Hadley, *God’s Little Ships*, 196-197. The CCM also differed on the approach to education. Whereas the Anglican Church supported the government in sending First Nations children to residential schools, the Mission preferred to have them attend village schools and remain amongst their own culture and with their parents.

²² Hadley, *God’s Little Ships*, 196.

²³ Andersen, *The Columbia is Coming!*, 55-56. Lukin Johnston, *Beyond the Rockies*, BCA, NW 471M J72, 63.

door from one of the mission boats and a logger's wife was rushed to the nearest mission hospital where she was operated on for acute appendicitis.²⁴

Not all settlers were able to cope. Some lived alone, leading a hermit's existence. Others suffered from mental disorders. Their living conditions were dreadful, often the bed was a pile of branches and food was reduced to berries or handouts from an occasional passer-by. Periodically Greene was forced to brave gunfire before he was allowed to come ashore and leave food and other necessities. Often the inhabitants could not be persuaded to return to civilization for hospital care.²⁵

By the 1940's secularization was replacing evangelical work on the north coast. At the same time the social and medical context of logging company operations changed. Larger companies began to take over smaller operations. These amalgamations produced larger communities which the companies supported family life by supplying attractive housing, recreational centers and playgrounds. Moreover, technology reduced isolation. Water taxis connected island communities and made clinic doctors accessible to many coastal residents. Radio telephones linked isolated individuals and families to the outside world.

Increasingly the logging companies relied on aircraft and not boats to evacuate medical emergencies. Rather than rely on medical mission boats, the companies chartered float planes to rush serious medical cases to Vancouver. Sometimes the companies flew in medical specialists from Vancouver to operate in the local hospitals. In the 1940's Jim Spilsbury, owner and operator of the Queen Charlotte Airline, performed an average of twenty mercy flights each month. Pilots, crew members and passengers

²⁴ Gilian Douglas, "Salt Chuck Salvation," 1950, ACA VST, PSA 203-3 81-22.

²⁵ Andersen, *The Columbia is Coming!*, 63.

came to expect delays in scheduled flights or sometimes had to sit beside corpses or badly injured accident victims.²⁶

In the early 1960s, the CCM and the United Church jointly used an aircraft. Rev. Peter Newbery MD, a pilot for the UCMS out of Alert Bay, joined forces with Rev. Ivan Futter of the CCM. The *Columbia* would transport aviation fuel to a rendezvous point where it would serve as operations base for Newbery's aircraft. Both chaplains rode the aircraft and both shared the hospitality of the *Columbia* as itinerant parish churches. On occasion the *Columbia* would answer an emergency call to pick up seriously ill people and bring them back to Alert Bay.²⁷ Dr. Jack Pickup (1919-1996) was hired by St. George's Hospital in 1947. Throughout his long medical career at Alert Bay he became known as the "flying doctor" because he used to pilot floatplanes into inaccessible areas in order to reach accident victims. He did so because there was then no other charter service and he was the only available physician. He gave up flying at the age of 67.²⁸

Air travel was not the only change. Medical services were rapidly overtaking the work of the CCM. Despite cooperation from the College of Physicians and Surgeons, securing permanent doctors for the hospitals and the *Columbia* became increasingly difficult. The Second World War reduced availability as able-bodied physicians joined the forces. Others preferred to work in urban surroundings. Community Chest grants and

²⁶Hadley, *God's Little Ships*, 13. During one unfortunate incident, while trying to locate an emergency call, the company plane crashed killing all seven occupants. From that time on Spilsbury decided not to perform mercy flights unless the weather conditions were conducive for air travel. Howard White and Jim Spilsbury, *The Accidental Airline: Spilsbury's QCA* (Madeira Park: Harbour, 1988), 78-88. The Union Steamships aided settlers and logging companies in the days before airplanes. Because of a increasing number of hospital cases, the Union's overnight passenger ships were fitted out with a special "hospital cabin." The day vessels also had an emergency bed. Gerald A. Rushton, *Whistle Up The Inlet: The Union Steamship Story*, (Vancouver: J.J. Douglas Ltd., 1974), 103.

²⁷Hadley, *God's Little Ships*, 265-266.

²⁸Jack Meadow, "Dr. Jack Pickup: British Columbia's "Flying Doctor," *Aeroplane Monthly*, March, 1977. <http://www.canadianflight.org/history/pickup01.htm>. (2 November 2004).

other donations either were reduced or not renewed. As a consequence, the CCM relinquished management of three hospitals and turned them over to local boards: the St. Michael's Hospital Society (1945), the St. George's Hospital Society (1947) and, the St. Mary's Hospital Society (1953).²⁹

Other changes occurred, initiated by the state. The provincial government employed public health nurses to undertake the medical inspection of school children as well as province-wide programmes for tuberculosis, venereal diseases, cancer and mental health. The BC Hospital Insurance Service was created in 1948. In the same year the National Department of Health and Welfare, in cooperation with its provincial counterpart, established a province-wide programme of dental examinations. As the state increasingly took over fiscal responsibility for healthcare, the Anglican mission replaced some ship's doctors with public health nurses. The Columbia Coast Mission, by integrating itself into the social processes of the secular world gradually signaled its own demise.

The Social Gospel, which had influenced the early direction of the CCM,³⁰ did bring about change. Of paramount influence was its medical service which has left its legacy to outside institutions. The Mission combined medical aid with personal contact and religion. Its unique usefulness is widely recognized as having met real needs throughout the coastal society. In many respects, the coastal communities of British Columbia were able to survive and develop into viable centres due to the dedication of missionary physicians associated with the CCM.

²⁹ Andersen, *The Columbia is Coming!*, 132, 140.

³⁰ Cook, *The Regenerators*, 232. By the 1920's, the late Victorian social gospel was steadily moving towards its demise.



Fig. 4.1: The second *Columbia*, launched on 8 July 1910, the one-hundred foot hospital ship, served the Columbia Coast Mission until 1958, c.1930's.
Courtesy of BC Royal Museum. PSA5-887.



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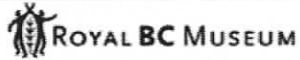
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Fig. 4.2: The Columbia Coast Mission Boat, *John Antle*, 1929.



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Fig. 4.3: St. Michael's Hospital, Rock Bay, [193-].



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Fig.4.4: Floating Hospital at O'Brien Bay, [192-].



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Fig. 4.5: St. Mary's Hospital, Pender Harbour, 1930.

Chapter 5

Marginal Medicine: Contract Doctors on the Resource Frontier

Contract medicine was a vital component in the development of northwestern British Columbia. After 1885, as the economy diversified, logging, fishing and mining firms on BC's north coast hired physicians to oversee the healthcare needs of their workers. The seasonal and cyclical nature of much of this work created an economic uncertainty for doctors and communities. Global economics and national depressions affected northern production levels, which were reflected in the community's ability to support healthcare. Funding to hospitals and to doctors from government sources in such ways as special grants, residency fees, and liquor profits were important for the operation of northern healthcare. The uncertainty of the sustainability of the delivery of medical services is as prevalent today as it was in its inception.

Until after the First World War, the typical doctor was the company physician on contract. Contract medicine was an early form of health insurance as employers and/or employees contributed financially. Since their remuneration depended on industrial circumstances in a "boom and bust" economy, doctors augmented and hedged their precarious incomes with multiple contracts or private practice. If the major industry in a small and isolated community shut down, physicians often left because of a lack of paying patients. That often left the remaining residents without medical care since the provincial government only provided funding on an ad hoc basis until the implementation of the Hospital Act in 1913.

Once they arrived, principally from Great Britain and Eastern Canada, conscientious physicians traveled great distances, often covering up to thirty miles a day

by horse, sleeping with their saddles as pillows. On average, they visited the mining, coal or lumber camps twice a month. Dr. William Percy Johns spent three years (1908-10) as a physician with the Grand Trunk Pacific Railway. From his small camp hospital at Baseman's Landing, near Terrace, BC, Johns treated railroad personnel, missionaries, settlers and First Nations. In winter, he traveled the Skeena River on snowshoes, accompanied by dogs who carried his medical bag; sometimes he slept with them for warmth during blizzards. In summer, Johns went by canoe, at times narrowly escaping drowning in swift rapids. He was also the local dentist, using a tree stump as his patients' chair. Johns learned to operate a telegraph key, the only means of communication between camps. On one occasion, he telegraphed birthing instructions to the husband of a pregnant Italian woman as he was unable to walk the distance in time for the delivery.¹

Not all the doctors were dutiful and intrepid. Some were alcoholics, who sorely neglected their patients. In the 1890's, Dr. Robert E. McKechnie, who was employed by the New Vancouver Coal Company in Nanaimo, had as his surgical assistants, two "local doctors, one addicted to morphia, the other morphia and whiskey. The latter was so dirty that I had to put him to holding the patient's wrist, for he was bound to help, his job being to watch the pulse."² Some "physicians" were not qualified and few construction camp doctors were registered with the College of Physicians and Surgeons of British Columbia.³ Delbert John Millar spent one year at Queen's University medical school (1909) before accepting a job as a doctor for crews building the Grand Trunk Pacific

¹ Mrs. Clarence Johns to Dr. R. G. Large, Sept. 30, 1972, informing him of the early activities of her father-in-law. Dr. R.G. Large Collection, Prince Rupert Regional Archives (PRRA), L 984-38 458-150.

² Robert Edward McKechnie, Osler Lecture, "Reminiscences of Forty Years' Practice," British Columbia Medical Archives (BCMA), Historical Articles Binder, 14b, 1931.

³ Eldon Lee, *Scalpels and Buggywhips: Medical Pioneers of Central BC*, (Surrey: Heritage House, 1997), 83.

Railway. Major tent and log construction camps were positioned every one hundred miles between Jasper to Prince Rupert. Each camp had a crude log hospital with one or two attending physicians and a reasonable stock of surgical instruments. Doctors performed appendectomies, sutured lacerations and set broken bones. Drugs and other pharmaceutical supplies were distributed from Prince George. Millar worked as a construction doctor for three years before obtaining his BC certificate. He received his medical degree from Queen's in 1919 and two years later became Chief Medical Officer for the B.C. Workmen's Compensation Board.⁴

Because these Grand Trunk Pacific doctors were forbidden to care for patients other than construction workers, and settlers were not officially allowed into company hospitals, tensions sometimes developed between the medical personnel and railway officials.⁵ To illustrate, since 1904, Dr. Wrinch, Hazelton Hospital director, was under contract to the railway. Dr. Henry Esson Young, the Provincial Secretary, after reading the Hazelton Hospital's 1911 Annual Report, which had mentioned remuneration for hospitalized employees, informed the Hospital Board that the government would not pay for patients from the camps who were already paying the \$1.00 per month to the companies for medical attendance. He advised the hospital to make arrangements with the doctors in charge or with the contractors and to not include these cases in its returns.⁶

⁴ Robert E. McKechnie II, *Strong Medicine: History of Healing on the Northwest Coast*, (Vancouver: J.J. Douglas Ltd., 1972), 145. Lee, *Scalpels and Buggywhips*, 82-83. Delbert John Millar, MB., MD., CM., "Biographical File," BCMA Archives.

⁵ Lee, *Scalpels and Buggywhips*, 83.

⁶ Chief Clerk to Secretary, Hazelton Hospital Board, 9 February 1912. On February 9th, 1912, British Columbia Archives (BCA), GR 1549, BC Provincial Secretary, Hospital Programs Administration, Hazelton Hospital, Box 1 File 14, 1911. Dr. Young studied medicine at Queen's and McGill Universities, in England and in the United States. He was elected to the BC legislature in 1903, becoming provincial secretary and minister of education in Premier Richard McBride's government in 1907. He was instrumental in establishing the University of British Columbia, a tuberculosis sanatorium at Tranquille, and a mental health facility called Essondale (Riverview). After retiring in 1916, Young served as

Medical plurality typifies the company doctor. Doctors augmented their income from company contracts by contracting with the Department of Indian Affairs (DIA) and the Workmen's Compensation Board (WCB). Dr. Donald John Macdonald (1874-1943) is a good example. After graduating from Queen's University in 1906, he practiced in the mining community of Stewart. In 1909 Macdonald moved to Kincolith on the Nass River where he supplemented his DIA contract with postmaster duties and as an independent fur trader.⁷ His contract practice included the nearby canneries to which he traveled to by canoe or gas boat. Macdonald did not have a proper hospital, but used three small rooms in a cottage, where his wife helped him with the nursing care. Serious cases were sent to the hospital at Port Simpson as soon as transportation became available. When he retired in 1939, his son, Dr. J.A. Macdonald succeeded him.⁸

In the early years the contracts were between a doctor and the management. Although the stipulations varied, generally the contract was for complete coverage for \$1.00 per month, with the exclusion of venereal disease and accidents suffered off the job. The deduction came off the monthly payroll because, according to an early medical historian, many men were destitute by the end of the month having spent their income on women and alcohol. For instance, Dr. L.G. C. d'Easum's 1936 contract with the "Doctor's Committee of the Community of Atlin" included \$1.50 a month for single or

provincial medical health officer and is sometimes called BC's 'father of public health.' Daniel Francis, ed. *Encyclopedia of British Columbia*, (Madeira Park: Harbour, 2000), 787.

⁷ Macdonald's DIA contract for 1909 and 1910 was \$720.00 per year. "Return of officers and Employees of the Department of Indian Affairs on April 1, 1909," *Sessional Papers No. 27, Dominion of Canada Annual Report of the Department of Indian Affairs, Year Ended 1909, 120, Year Ended 1910, 142*. Medical officers, in 1909, in the southern portion of the province: Vancouver \$1,200.00; Nanaimo \$500.00; Victoria \$500.00; in the northern portion: Port Essington \$600.00; Prince Rupert \$720.00; Hazelton \$660.00 (Dr. H. Wrinch); Bella Bella \$600.00 (Dr. R.W. Large); Port Simpson \$1,080.00 (Dr. W.T. Kergin). Except for Vancouver, it appears physicians in the north were paid more than their counterparts in the south. There is no record of Macdonald's income from his cannery, fur trade or postmaster duties.

⁸ R. Geddes Large, *Drums and Scalpel From Native Healers to Physicians on the North Pacific Coast*, (Vancouver: Mitchell Press, 1968), 115-116.

married men with no dependents or \$2.00 for single or married men with dependents. His exceptions were treatment or cure of VD; any illness resulting from the use of intoxicants or drugs or the treatment of any chronic ailment or condition.⁹

Not all employees liked private medical contracts. The history of Prince Rupert Hospital illustrates this. In 1906-07 medical services for the workers of the Grand Trunk Pacific Railway terminus at Prince Rupert were conducted from a couple of tarpaper shacks. Dr. J.E. Tremayne, the contract physician from the nearby Indian village of Metlakatla, commuted between his home base and Prince Rupert, often transporting accident cases in his launch to Port Simpson. Railway workers fared better than the doctor and his family.¹⁰

In 1907, Tremayne decided to move permanently to Prince Rupert and opened a private practice. A year later, the railway construction contracting firm of Foley, Welch and Stewart built the first company hospital and hired Dr. Ewing as the company physician. Workers did not care to go to him because of the way he “conducts his hospital.” Desiring a voice in the “business of a hospital association and to medical care and treatment,” they maintained, “the hospital service is part of that firm’s business system, and it is run to make money.”¹¹ In protest, the Prince Rupert citizens called a public meeting for the purpose of taking steps to build a public hospital. The railway

⁹ Rose, *From Shaman*, 13. John D. McDermott, MD., “Prepaid Plans in BC,” BCMA Archives, Box 1 #153, File 1-10. Dr. L.G.C.d’Easum, BCMA Archives, Committee of Medical Economics Fonds, Medical Contracts in BC 1936-1937, Series 8 File No. 2., 2-19.

¹⁰ Dr. Tremayne graduated in 1895 from the University of Toronto. While at Metlakatla (1895-1906), Dr. and Mrs Tremayne experienced lean years. J.W. Pillsbury, son of the first assistant harbour engineer at Prince Rupert, (1906) writes: “many years later Mrs. Tremayne told Mr.P. that that roast was the only one they had had in a month—all meat came casually from Port Essington, and while the engineers thought the doctor’s family well provided for, they actually sat upstairs night after night with mouths watering over the smell of good meat cooking in the engineer’s kitchen below—for naturally, the thirty men had to be well-fed as a matter of course!” J.W. Pillsbury, “Earliest Days In Prince Rupert,” BCA, G P43 P64, 7.

¹¹ *The Empire* February 20, 1909, PRRA, Hospital File, 6. J.W. Pillsbury, “Earliest Days In Prince Rupert,” 17.

workers preferred a public facility because laborers on the Crow's Nest Pass had received such poor medical treatment that the government had appointed a commission to investigate the health situation.¹² The Prince Rupert laborers did not want to confront a similar situation. Although Ewing was able to stop the movement for a year, the Prince Rupert General Hospital opened in 1911.¹³

Increasingly, while continuing to deduct monthly dues from employees' pay cheques, companies passed the responsibility for contract medicine onto their workers. This was the consequence of business competition, abortive attempts to initiate government sponsored health-care, and fear of being co-defendants in medical malpractice suits. Employment-based funds, where members hired the doctor, were not run for profit.¹⁴ As a consequence, employees contracted with doctors either through a work related group or through membership in a variety of lodges, such as the Oddfellows Fraternal Lodge in Prince Rupert.

Workers who could not participate in employment-based funds could also seek medical insurance through such fraternal lodges as the Elks, Moose, Foresters and Oddfellows. Participation in fraternal lodges was an extension of the British nineteenth-

¹² *Evening Empire*, Saturday, September 21, 1907. PRRA.

¹³ *The Empire*, July 20, 1907, PRRA, Hospital File. In anticipation of Prince Rupert becoming a major northern terminus, the federal government built a quarantine station on Digby Island (Figure 3.15) in 1911. It was connected by a bridge to Dodge Island (Hospital Island) where a three story hospital was constructed. It was equipped with an operating room, two wards and three private rooms. The quarantine station was only used once and the hospital on Dodge Island was never used. The quarantine station was relegated to the class of an unorganized maritime quarantine station and the inspector was transferred to Victoria. In 1922 the property was handed over to the Department of Public Works and the doctor's residence was placed at the disposal of the Department of Naval Service. The remains of both establishments are still there. "Quarantine Station-Dodge Island," contains abstracts from a letter to Alex Johnstone, Deputy Minister of Marine in Ottawa, from the Director-General of Health and a letter to Dr. H. Rundle Nelson, William Head, Victoria, BC, April 6, 1922. PRRA, Hospital File. Ken Campbell, "Northwest Memories: Disease Control in the Early Years," October 2, 1981. PRRA, Hospital File. Dr. Ewing left and opened a practice in Vancouver.

¹⁴ J. Ross Davidson, MD., "Problems of Contract Practice," *The Bulletin of the Vancouver Medical Association*, BCMA Archives, BC Historical Articles Binder 14e, December, 1938, 63.

century self-help movement. Although such organizations provided medical and funeral benefits, lodge members had the added components of ritual and sociability. However, by the 1920s the role of the friendly societies in providing medical care declined as members feared that the failure of lodges to raise their dues beyond approximately a dollar a month left them under-insured as medical costs rose. By attempting to increase their coverage by joining more than one society, workers lessened the effectiveness of individual lodges and increasingly relied on employment plans.¹⁵

The 1917 formation of the Workmen's Compensation Board (WCB) allowed companies to pass responsibility onto their workers.¹⁶ The WCB Act focused on making a cost sharing arrangement for medical aid between capital and labour, and meeting the concerns of hospital and medical personnel who were absorbing the expense of unpaid medical bills. Often hospitals received injured workers, only to later find that the employers' insurance company refused to reimburse for costs, ostensibly because the cause of the injury was not covered by the policy. In other instances, hospitals could not claim their fees because insurance companies had previously negotiated bedside settlements with the injured worker from whom the hospitals were unable to recover. In 1915, the provincial government established a Committee of Investigation of Compensation Laws which reviewed laws in Eastern Canada and some American States. One study revealed that "some BC employers, notably the railroad contractors, deducted

¹⁵ Lynne Bowen, "Friendly Societies in Nanaimo: The British Tradition of Self-Help in a Canadian Coal-Mining Community," *BC Studies*, No.118, (Summer, 1998), 70-80.

¹⁶ Under the first Employers Liability Act of 1897, the maximum amount of payment to injured workers or widows was \$2,000.00, which was reduced to \$1,500.00. Five years later, a form of a Workmen's Compensation Act was passed, but without a board of administration. Workmen's Compensation Board, *Fifty Years of Service, 1917-1967*, (Vancouver: Workmen's Compensation Board, 1967), 2. BCA, NW 368.41 B862. Ian Tom Coneybeer, "The Origins of Workmen's Compensation in British Columbia: State Theory and Law," M.A. Thesis, Simon Fraser University, 1986. WorkSafe BC (Workmen's Compensation Board) Library, Richmond, BC. 176.

as much as two dollars per month for “medical service” that included neither sick nor death benefits. The medical ruse was “so badly abused in BC” that it was “necessary to pass an act to regulate it.” The amendment to the *Master and Servant Act* that was introduced on February 15, 1915 required employees to maintain separate accounts for all medical deductions, the amount of expenditure, the eventual disposition, and the filing of a bi-annual statutory declaration. Workers were also empowered to appoint a committee from their ranks at any time to inspect and audit record books.¹⁷

The WCB Act addressed the question of physicians’ fee losses, which ranged between 50 and 90 %, when workers were unable to pay their bills. This meant doctors either lowered fees or risked receiving nothing at all. Workers had complained some physicians compromised their professional integrity by functioning solely to reduce compensation costs to employers and asked that only physicians whose reputations were high enough to satisfy the requirements of employers or insurance companies be hired¹⁸ In the end, provision for the direct payment of physicians’ fees was established; employers contributed under a collective liability principle; and, workers contributed a cent per day from their pay cheques for first aid. Every employer directly or indirectly operated any mine, camp or construction-work or industry employing more than thirty persons, and located more than six miles from the office of a medical practitioner, was required to maintain at least one person possessing a certificate of competency to render first aid to the injured. The Act was BC’s first major social legislation concerned solely with accidents and industrial diseases.¹⁹

¹⁷ Coneybeer, “The Origins of Workmen’s Compensation in British Columbia,” 176-177.

¹⁸ Coneybeer, “The Origins of Workmen’s Compensation in British Columbia,” 173-182.

¹⁹ Coneybeer, “The Origins of Workmen’s Compensation in British Columbia,” 173-182. Workmen’s Compensation Board, *50 Years of Service*. British Columbia Sessional Papers, 1918, K 13. For instance,

The most successful medical contracts were a joint participation between workers and the employer. The first experiment of this kind in Canada was at Nanaimo, when Dr. Robert E. McKechnie (1861-1944), the first fully qualified surgeon to reside in the province, was hired as company doctor by Samuel M. Robins, President of New Vancouver Coal Company.²⁰

Ocean Falls and Anyox are examples of two northwestern communities which had such arrangements. In 1909 Ocean Falls sawmills were producing lumber for the coast, including the newly created port of Prince Rupert. Dr. Ingolls erected a one-bed hospital and Dr. Jamieson took it over in 1910. Three years later, as part of the boom and bust cycle, Ocean Falls went into receivership.²¹ Without a company doctor, the town had to rely on Dr. George Darby, a missionary physician from Bella Bella, who either took accident victims back with him on the four-hour boat ride or operated in the tiny company hospital.²² In 1916 the revived Pacific Mills Pulp and Paper Company hired Dr. J. Christie, who built a twenty-five bed hospital (Figure 5.1). Staffed by two nurses, the hospital was administered by a joint hospital committee made up of company nominees and elected representatives. Pacific Mills contributed fifty percent of the necessary funding which entitled employees to medical treatment and all hospital facilities.

many people tried to claim for the Spanish Flu, 1918-19, which took more than 2000 lives in BC, and were refused by the WCB. Rates for medical aid visits to doctor's offices for dressing of minor wounds varied from \$1-\$2.00; hospital stay for patients charged to the WCB varied from \$1-\$1.50 per day. In 1946 workers' medical aid contributions were discontinued and employers paid the total cost of compensation and medical aid.

²⁰ Robert Edward McKechnie, "Biography file", BCMA Archives. McKechnie, in his Osler lecture, "Reminiscences of Forty Years' Practice," remarks that in the 1890's Nanaimo had a forty bed hospital with no trained nurses. In this, the "dirtiest" building in town, McKechnie provided and sterilized his own instruments. "About half of my operating was done in the miners' houses as it was just as easy to get ready there as at the hospital." McKechnie, BCMA Archives, Historical Articles Binder, 14b, 1931.

²¹ The province was in a recession from some time in 1912 until 1915. Major northern projects were affected: the Grand Trunk Pacific and the Canadian Northern railways went bankrupt. The former adversely affected the growth and potential of the city of Prince Rupert. Bruce Ramsey, *Rain People: The Story of Ocean Falls*, Second Edition, (Kamloops: Wells Grey Tours Ltd, 1997), 51.

²² Ramsey, *Rain People*, 57.

Although the hospital had a pharmacy, laboratory and x-ray equipment and was considered to be the finest private hospital in BC, until the 1920's some essential services were still somewhat primitive. The ambulance was a horse drawn express wagon and expectant mothers went to the hospital sitting on a bar room chair²³

Under a plan approved by the WCB, Ocean Falls employees paid \$1.75 per month which covered physician fees, accidents, sickness, hospitalization and medical treatment except for venereal disease and alcoholism. The fees did not cover the workers' families but they were charged less than the fees stipulated by the BC Medical Association (BCMA). Non-company workers were charged \$3.00 per month. The hospital board paid \$300.00 per month to the company as rent for the hospital and the upkeep of the building and its grounds. The men voluntarily contributed ten cents a month towards an emergency fund which was used to send indigent people back to their homes.²⁴

A similar situation evolved at Anyox, the site of the Granby Consolidated Mining and Smelting Company, a large copper mine on the far north coast, which opened in 1912. The first company doctor, Edward Hicks Tavener Hyde, practiced medicine there until his death in 1925.²⁵ His hospital consisted of four beds in the upstairs of a rooming house. In 1917 Dr. W. E. Dickson built an eighteen bed hospital (Figure 5.2) staffed by three physicians and several nurses. In total, thirteen physicians and their assistants worked at the hospital treating a decreasing population until it closed in 1935. For instance, from 1918 to 1923, Dr. Joseph Bancroft practiced medicine and was the assistant

²³ Hospital Inspector Frank Degray states that Ocean Falls "is the best company hospital in British Columbia." BCA, GR 2569, files with regard to Funding of Hospitals, Orphanages 1890-1947, Ocean Falls, Box 50, File 1, May 21, 1924 Ramsey, *Rain People*, 121. Workers in private hospitals were brought under the WCB Act in 1936. Workmen's Compensation Board, *Fifty Years of Service*, 11.

²⁴ C.L. Barker, Chairman of Ocean Falls Hospital Board to the BC Provincial Secretary, June 9, 1931. Barker was applying for funding to become a public hospital. BCA, GR 2569, Ocean Falls, Box 50 File 1.

²⁵ It is not known how Dr. Edward Hicks Tavener Hyde died.

manager of the mine. He left to go to McGill University where he completed a degree in geology.²⁶

As in Ocean Falls, the medicare system was a joint arrangement between WCB, Granby Mining Company and its workers. Employees contributed \$2.00 per family or \$1.00 per single person each month for medical and surgical care. A week's hospital confinement for a maternity case was \$35.00 and ward care was \$15.00. As part of the financing arrangement, the mining company covered the hospital's deficit which, on average, ranged between \$8,000.00 to \$10,000.00 per year.²⁷

The provincial government also contributed to the support of the hospitals in Ocean Falls and Anyox. From the time of Confederation in 1871 on, the provincial legislature voted sums towards erecting and maintaining hospitals without reference to any particular system. As demands became more numerous, the government implemented the Hospital Act of 1913. The Act, designed to standardize regulations, stipulated that institutional funding be based on the number of patients treated. Government financing included an annual residency fee for a physician in a remote area, providing the doctor was the only practitioner in the vicinity.²⁸ The government required that each public hospital board had to have one or two governmental representatives and indigents received free medical and surgical treatment.

Public funding was also based on a community's desire to contribute to the maintenance of a hospital. For instance, in 1927, when the citizens of Stewart raised

²⁶ Oswald Hutchings, "Anyox Remembrances," BCA, G AN 9 H97, 20.

²⁷ Large, *Drums and Scalpel*, 119. Peter Loudon, "Gone but Not Forgotten: Anyox, BC, Lives on in the Memories of its Former Residents," *Canadian Geographic*, Jan/Feb. 1992, 61-66. Anyox's ambulance was also horse drawn until the 1920's. Oswald Hutchings, "Anyox, Remembrances," 19-21, 136.

²⁸ For instance, resident physician fees in Atlin, 1907 and 1908, were \$300.00 and \$225.00 respectively. Resident physician fees in Stewart, in 1910, were \$300.00. *Journals of the Legislative Assembly of the Province of British Columbia*, Session 1907, 75; Session 1908, 77; Session 1910, 65.

\$500.00 towards hospital repairs, the government granted the board an additional \$200.00. The province supervised all hospitals, whether private or public, but gave financial aid only to public ones.²⁹ As hospitals increasingly relied on government per capita grants for funding, company hospitals, such as Ocean Falls (1932) and Anyox (1914), relinquished their private status and became general hospitals. The 1930s depression and the decline in markets for paper also precipitated Ocean Falls becoming a public hospital.³⁰

Many small isolated communities, without the backing of a successful company, had precarious medical experiences. The reasons were numerous. Population fluctuations and the low income levels of the citizenry contributed to the uneven medical care. In isolated industrial camps medical help was compromised. Small mining companies seldom financially supported the nearest hospital and the government was reluctant to provide expensive emergency medical care. The high cost of transportation increased the cost of goods and services. Lastly, even though wages in isolated hospitals were often higher than other hospitals, there was a lack of skilled labour.³¹

Even with government funding, hospital closures and re-openings were common. Queen Charlotte City and Stewart are typical. Lumber, mining and fishing are the main industries on the Queen Charlotte Islands. Logging accidents were numerous. Some camp owners failed to provide adequate first aid. At one camp, loggers had to fabricate a

²⁹ R.E. Gosnell, ed., *The Year Book of British Columbia 1911-1914*, (Victoria: The Government of BC, 1914), 333-334. Community support was in the form of bazaars, dances and raffles. BCA, GR 2569, Stewart Hospital, Box 10 File No. 5, 1923-1946.

³⁰ Ramsey, *Rain People*, 152. Granby Mining Co. wanted public funds to offset its financial responsibilities in Anyox.

³¹ BCA, GR 2569, Atlin Hospital, Box 1 File 35, 1927-1945. In December 1942, government agent, G. H. Hallett wrote unofficially to Deputy Provincial Secretary, P. Walker, explaining why the hospital in Atlin was costing \$21,000.00 per year. He stated the cost was due to high freight rates, higher prices, wages, and a lack of skilled labour. Hallett explained the 578 residents donated several thousand dollars from the sale of dance and sports tickets, as well as donations, towards the hospital's expenses.

stretcher out of axes and saws to carry an injured man away. In another incident a worker, who had seriously cut his leg, had to walk the half-mile to camp. When a search for antiseptic and bandages proved unsuccessful, a pillowcase was used. After a ten hour delay the employee was taken by boat to a cannery hospital. The need for an adequate medical facility was apparent.³²

In 1908, the citizens of Queen Charlotte City organized a hospital society and constructed a twelve bed facility as a community effort (Figure 5.3). The township donated the lot, the Moresby Island Lumber Company donated the building materials and a group of volunteers from the Haida village of Skidegate and loggers erected the complex. The provincial government provided \$2500.00 of which \$1000.00 was for equipment. The government residency fee was \$300.00. The hospital was a boon to the area as the nearest hospitals of Port Simpson and Bella Bella were only accessible by boat.³³ Dr. James W. Cross and two nurses arrived in 1909. Within a year Cross disappeared, leaving the hospital society with \$2,000.00 in debts. Over the years physicians came and went. Sometimes the physicians were elderly men who couldn't hold a practice anywhere else. Throughout World War I there was no doctor as many physicians enlisted in the armed services. At the time of the Spanish Flu of 1918, the Imperial Munitions Board, which was cutting airplane spruce on the islands, re-opened

³² Richard Rajala, *Up Coast: Forest People and Industry on British Columbia's North and Central Coast, 1870-2005*, (Victoria: Royal BC Museum/UBC Press, 2006), 100-102. Even after the Queen Charlotte City Hospital was built, a few small camps set up rudimentary hospitals to provide care for the men because of the distance to Queen Charlotte City Hospital and the possibility that no doctor would be there.

³³ Kathleen E. Dalzell, *The Queen Charlotte Islands, 1774-1996* Volume 1, Third Edition, (Madeira Park: Harbour, 1993), 260. R. W. Henderson, "These Hundred Years: The United Church of Canada in the Queen Charlotte Islands 1884-1984," (Queen Charlotte City: United Church of Canada, 1984), 21. United Church Archives, Vancouver School of Theology (UCA VST), Vertical File.

the hospital but the only health professional on the site was a local nurse, Mrs. Lottie Duval, who dealt both with such serious illnesses as smallpox and accident victims.³⁴

From 1922 until 1926 Dr. Guy Palmer tried to manage the facility. In seeking funding for major renovations, he explained to the provincial secretary that the hospital was, except for a small hospital at Massett, a 110 mile and fourteen hour boat trip away, the only one between Vancouver and Prince Rupert.³⁵ When logging accidents occurred men had to travel forty miles by gas boat from some of the isolated camps for treatment. Because the population was so small, Palmer complained that his private practice was negligible. He had difficulty surviving on his residency and DIA monies. A provincial grant of \$500 did not save the hospital and it closed in 1926. With the exception of a few months in 1928 the facility remained closed until 1931 when Dr. C. A. Charter took over. This, however, was not much help. Charter was incompetent. For example, he was unable to operate the hospital's x-ray machine. His wife, who acted as matron, was not qualified, and suffered a stroke during her first year there and had to go to Prince Rupert for medical care. The Victorian Order of Nurses did operate on the Island but they focused on house calls and would not undertake hospital work. Charters could not afford a nurse.³⁶

³⁴ Dalzell, *The Queen Charlotte Islands*, 261. Mining recorder John Barge, to Deputy Provincial Secretary P. Walker, April 23, 1921. BCA, GR 2569, Queen Charlotte Island, Box 9, File 3, 1921-1936. Information on Dr. Cross: BCA, BC Provincial Secretary, GR 1549, Queen Charlotte Islands, Box 1 File 27. In 1921 Dr Traynor received \$500.00 a month as resident physician and \$750.00 per month from the DIA.

³⁵ Although Dr. Palmer stated the hospital was the only one between Vancouver and Prince Rupert, in effect the hospital at Ocean Falls is half way.

³⁶ BCA, GR 2569, Queen Charlotte Islands, 1921-1936, Box 9, File 3. Palmer's letters are dated June 23, 1922; October 23, 1922; Feb. 1924 (exact date not legible). Palmer mentions the population of Queen Charlotte City as 74; Skidegate Indian Reserve 325; Skidegate 10; Wireless Station 10; 30 people (8 families) along the coast. Two hundred and men were employed at several logging camps and the area had four canneries and a whaling station. Prospectors and hand loggers also lived on the island. In 1935 Charters received the DIA grant, the provincial grant, and a small amount from private fees out of which he was responsible for paying any other personnel. His total income was \$284.00 with a deficit of \$3.77. The provincial government sent him an additional \$250.00 for operating expenses.

Community members complained of the "inadequate" and "unsanitary" condition of the facility, including an open cesspool under the hospital windows. The citizens wanted a health inspector to survey the situation and demanded competent medical care. The government complied in 1937 when Charters admitted responsibility for killing an eight year old Native child by administering an overdose of morphine during a tonsillectomy.³⁷

Because Charters was not qualified to perform surgery, the provincial Department of Welfare often had to fly patients to Prince Rupert. This was costly and, due to weather conditions, planes were not always available. Once, when a plane was unavailable, the police boat was used but the patient died of a ruptured appendix on the operating table. Patients who required minor surgery had to pay their own way to Prince Rupert. They had to charter a boat or wait a week for the Union Steamship.

The Second World War added to the hospital's staffing and financial problems. The hospital society closed the hospital for a time in 1942 while trying to get the government or the logging companies or some responsible authority to take over its operation and staffing. The chairman and some of the board members resigned. In November, George Affleck, the United Church minister, persuaded local inhabitants to take over some jobs such as cook, bookkeeper, housekeeper and maintenance. These employees brought not just their skills, but also an understanding of the local situation,

³⁷ BCA GR 2569, Queen Charlotte City Hospital, Box 9 File No. 3, 1921-1936. Dr. C. A. Charters to provincial secretary G. M. Weir, May 24, 1936. Norman A. Watt, Government Agent, to Superintendent of Welfare, June 15, 1936. Farmers' Institute to Premier Duff Pattullo, September 5, 1936. Pattullo was also the MLA for the region.

In the investigation into the death of a Native child, who was in the hospital for a tonsillectomy, Charters stated "The reason that I ordered ¼ gr. of morphia to be given instead of 1/8 gr. was because at a previous recent operation on an Indian girl 6 years of age I had ordered 1/6 gr. before the operation, and had to order a further 1/8gr. after the operation on account of the patient's pain and restlessness." Charters accepted responsibility for the death. March 28, 1937. BCA, GR 2569, Queen Charlotte City Hospital, Box 9 File No. 2, 1937-43.

thereby creating stability in the overall operation. Affleck became secretary-treasurer of the Society and, with the help of a new nursing superintendent, Miss Veronica Page, the hospital remained open.³⁸

In 1946 the community asked the United Church Medical Services to assume responsibility for administering the hospital, but the Church did not take over until 1955. In the meantime, the facility was declared inadequate in 1948 and in 1952 it was condemned as being unsafe. When the United Church took over, it constructed a twenty-one bed hospital. Funding for the quarter million dollar complex came from all island communities, logging and fishing companies and the government. The new Skidegate Inlet General Hospital at Queen Charlotte City was opened in November 1955. In summary, many small isolated communities could not sustain a dependable medical delivery system in spite of doctors having a variety of income sources.³⁹

The mining township of Stewart followed a similar pattern. When it was established in the early 1900's, Dr. W.T. Kergin attended to its medical needs by commuting to Stewart from Port Simpson on his own gasoline boat.⁴⁰ When the first hospital was built in 1909 (Figure 5.4), the hospital committee decided that the resident physician, Dr. Richards, should receive all the monies derived from contract patients, but

³⁸ Henderson, "These Hundred Years," 22. Veronica Page had been in charge of a similar small hospital in the Yukon and was considered "admirably suited to dealing with the problems in Queen Charlotte City." Dr. Size, the Islands' first resident dentist, arrived with his family in 1923 and practiced until his death in 1938. He and his nurse would cover the whole of the Islands periodically, carrying all their dental instruments, including a portable wheel, on their backs. He had homes in Masset as well as in Queen Charlotte City to recuperate after the journeys. Dalzell, *The Queen Charlotte Islands*, 264.

³⁹ Henderson, "These Hundred Years," 22.

⁴⁰ Sometimes Dr. W. T. Kergin would send his assistant, Dr. Richards, to Stewart to oversee the community's medical needs. Dr. Richards built Stewart's first hospital. In 1910, Drs. Kergin and Richards each had a claim given to them by Scott Delworth, chief prospector of Premier Mine, as payment for medical services when Delworth broke his leg. Ian McLeod, *Prospectors, Promoters and Hard Rock Miners: Tales of the Stewart, BC and Hyder, Alaska Camps*, (Kelowna: S.H. Co. Ltd., 2004), 35. Years later, Dr. W. S. Kergin, son of Dr. W.T. Kergin, went to Stewart as the resident physician for Premier Mine. Large, *Drums and Scalpel*, 111-112.

pay full rates to the hospital if his patients required hospital care.⁴¹ When the mine folded in 1911, the hospital was shut down. For the next six years, a visiting doctor from Premier and a resident nurse provided medical care. When the mine reopened so too did the hospital but it had trouble retaining a resident physician because the citizenry could not guarantee a regular salary (private practice contract) or an expense fund. Instead, the board wanted the physician to pay all the costs for running the hospital including nursing staff, fuel and supplies. When no physician was present, Dr. Chase, from nearby Hyder, Alaska, oversaw patients from Stewart.⁴²

Finances were always a problem. Although the hospital was of great benefit to the surrounding small mining companies, residents did not feel obliged to support it financially as community members discovered when they tried to get them to make annual subscriptions. The hospital board wanted to sponsor a sweepstake but the government frowned on the notion because "it might upset the virtuous."⁴³ Stewart had the added burden of an unusually large proportion of aged indigent men who had followed the prospecting and mining fields since the Yukon gold rush. The citizens raised money through tag days, hospital auxiliary teas, bake sales and dances. Additional funding came from Hyder, Alaska where a hospital association was formed to raise funds for Stewart Hospital. As well, Governor George Parks of Alaska reimbursed the hospital board for its care of American indigents.⁴⁴

⁴¹ Large, *Drums and Scalpel*, 111-112. BCA, GR 1549, Hospital Programs Administration Files, Stewart 1923-46, Box 2, File 34.

⁴² Dr. R.E. Page to the provincial secretary, September 6, 1919. He resigned two months later. BCA, GR 1549, Stewart 1923-46, Box 13, File 46. Dr. Chasse: Box 19 File 5, March, 1922.

⁴³ BCA, GR 1549, Stewart 1923-46, Box 10, File 5. November 5, 1931. Holding sweepstakes was illegal under the Canadian Criminal Code.

⁴⁴ BCA, GR 1549, Stewart 1923-46, Box 39, File 16, September 23, 1929. A representative from Hyder sat on the Stewart Hospital Board. Box 47, File 7, January 21, 1931.

Although the hospital was officially shut down in 1931, the doctor lived in some of its rooms and was allowed to use the equipment on an emergency basis. Two years later the hospital was finally closed, only to be reopened in 1934 on an emergency basis. The government assisted with this arrangement by issuing an annual grant of \$300.00 so that the hospital could be used as a first aid station. This lasted for ten years. When the last doctor left in 1942, the hospital closed and the 400 residents of Stewart had to rely for medical care on the physician from Premier Mine who came one afternoon each week and for emergencies. In 1953, under the influence of Dr. Bill Hick, a new complex was established. Until 1996 when an explosion made the facility unsafe, Stewart had a functioning hospital. A temporary hospital was established in a nearby building until a new complex was built a few years later. Therefore, until the 1950s, even with the support from Alaska, Stewart's doctors could not make the community's hospital economically viable.⁴⁵

A problematic source of hospital funding was the annual grants from provincial government liquor profits. When a liquor store was opened in an area, a certain amount of the profits accrued to the respective municipality which usually turned them over to the local hospital.⁴⁶ Unincorporated areas and private hospitals, however, did not qualify for these grants. Although most small hospitals counted on receiving these funds, some religiously-based hospital committees took an opposing view.⁴⁷ For instance, in 1924, Miss Isabella Pringle, assistant hospital secretary to the Women's Missionary Society in

⁴⁵ Ian McLeod, *Prospectors, Promoters, and Hard Rock Miners: Tales of the Stewart, BC and Hyder, Alaska Camps*, 163-164.

⁴⁶ Letter, May 21, 1924, explaining liquor profits, from the Deputy Secretary to the vice-president of Pacific Mills Company in Ocean Falls. That year the sum was 25 cents per day. BCA, GR 2569, Ocean Falls, Box 50 File 1.

⁴⁷ Liquor profits for 1923 in: Anyox \$404.00. Total from 1923-30 is \$9,190.75. Atlin: 1923 \$38.00. Total from 1924-30 is \$1,106.75. Queen Charlotte City 1922 is \$119.00 Total from 1923-30 is \$583.25. Stewart 1923 is \$77.50. Total 1924-30 is \$1,552.00. BCA, Liquor Profits, GR 2569. Box 25 File 3.

Toronto, asked Deputy Provincial Secretary, J. S. White not to send liquor money to the small hospital in Francois Lake. The chairman of the hospital board Mr. Snodgrass took an opposite view, stating that the money was needed to pay the doctor. In the interim, the WMS disassociated itself from staffing and funding the hospital. In the end the government agent was fired because he disagreed with the WMS and the hospital board went "dry."⁴⁸

The funding of hospitals and availability of health care in communities were not the only medical problems. Over the years, the BCMA and many doctors became increasingly dissatisfied with contract medicine. The BCMA disliked the unregulated and unchecked nature of contract practice and, for many years, refused to acknowledge it as a "vital part of their programme."⁴⁹ This meant that without a guide to making contracts, physicians were left to their own resources in framing the transactions. Many of them were exploited. For instance, in some situations, where a doctor was on salary and the work was seasonal, his case load could vary from 500 to 1,000 employees but his remuneration would not reflect the added patients. In other contracts, a physician received no added remuneration for work performed on WCB cases as the doctor was required to reimburse the company for these patients. Physicians lacked economic security because they were "subject to the whims of those peoples or societies that employ them, and are apt to find themselves relieved of their jobs with absolutely no

⁴⁸ BCA, Millicent Lindo Papers, BC Hospitals 1931-1967, MS 1037, Francois Lake 1917-35. Box 4 File 2, August 19, 1924. The hospital was moved to Burns Lake, largely due to this disagreement.

⁴⁹ Davidson, "Problems of Contract Medicine," 63.

private practice to depend upon.” This forced many doctors to use whatever savings they had to establish themselves elsewhere.⁵⁰

Contract medicine fostered strife among physicians. A major complaint was the discrepancy it caused because, while some physicians grew “inordinately wealthy” from contracts, it encouraged other physicians to do as little as possible.⁵¹ Since the “cardinal” issue of all contracts was “what constitutes adequate medical and surgical care,” many doctors were critical of their fellow practitioners who worked in isolated areas. City doctors perceived their rural counterparts as having only “adequate training” with no time off to improve their skills by taking post graduate or continuing studies. Many physicians viewed hiring a recent medical graduate or someone without post graduate experience as “neither protecting the public nor the medical profession.” Moreover, the rural doctors usually had no assistants or consultants. Since this could affect diagnoses and treatments, the patient community sometimes had a negative impression of the medical profession.⁵²

Complaints were numerous. Physicians who contracted to absorb the cost of hospitalization were often caught in a financial disaster and others faced disputes over who should pay for prescription medications. Some contracts called for free medications; some for medicines to a limited degree, while others required patients to pay some part of the cost. Many of the newer therapies were beyond the financial means of the local physician. In some instances, the doctor, society or company would not contract to pay

⁵⁰ Davidson, “Problems of Contract Medicine,” 67. At the BCMA Annual Meeting, June 23rd 1931, the Chairman of the Industrial Service Committee, Dr. J.A. Gillespie, reported “after many years of exploitation in a certain district a satisfactory solution has been found and all doctors in that district have signed an agreement which prohibits them from accepting this (lodge contracts) work except on a satisfactory basis, acceptable to our Association.” The district was not mentioned. Dr. J.A. Gillespie, BCMA Annual Meeting, June 23rd, 1931, Industrial Service Committee, BCMA Archives, Vertical File.

⁵¹ Coneybeer, “The Origins of Workmen’s Compensation in British Columbia,” 178-179, n.56.

⁵² Davidson, “Problems of Contract Medicine,” 63-64.

for specialists' services.⁵³ Because pre-existing conditions were often not covered under the contract, patients had to be carefully screened before becoming clients. Lastly, patients under the contract system often objected to not being free to choose their own physician.⁵⁴

In response to criticisms, in 1936, the BCMA sent a questionnaire to its 150 members who held contracts, but the results of the questionnaire have not survived.⁵⁵ Four years later, Chairman W. A. Clarke, MD., remarked that the survey on contract practice, lodge practice and the status of salaried medical officers was still underway but the Committee was experiencing "difficulty in getting accurate information." Ultimately the goal of having one standard contract was not achieved.⁵⁶ Despite many problems, over the years many physicians did establish private practices in rural areas and numerous medical men retained their status of company doctor until retirement. For instance, in Trail, from 1909 until 1923, two or more doctors were in partnership and together they had their own private practice, ran the hospital, provided contract medical

⁵³ Dr. Davidson remarks, in regards to the WCB: "the Board allows certain companies or societies that have their own hospitals and doctors to forego any payment for medical service to the Board and they in turn do not have to pay either the doctor's fees or hospitalization." "Problems in Contract Medicine," 66.

⁵⁴ Davidson, "Problems of Contract Medicine," 63-67. MacDermott, "Pre-paid Plans in BC," 153-154.

⁵⁵ Doctors were asked for the number of employees who contributed; whether they were single or married; the number of dependents; what benefits the physician contracted to supply (e.g. full medical care, surgery, major surgery, drugs, hospital care); what were the exceptions (e.g. venereal disease, mental illness, tuberculosis, maternity); if full or partial benefits were offered to dependents; the monies contributed by the employee, the employer or any other source; details of how the doctor was paid; and, the fee schedule. M.W. Thomas MD, Secretary, and Dr. S. C. MacEwan, Chairman of Committee on Economics, College of Physicians and Surgeons of British Columbia. 1936. BCMA Archives, Committee of Medical Economics Fonds, Medical Contracts in BC 1936-1937 Series 3 File No. 19.

⁵⁶ Dr. W.A. Clarke, Chairman, Committee on Economics, January, 24th, 1940. Clarke mentions successful medical services contracts with BC Telephone Company and the BC Electric Company Office Employees Association.

The only reference that Wendy Hunt, BCMA Archivist could find was "a report to the BCMA from the committee on Economics of January 1940 noting that the committee was still pursuing the matter. (Wendy Hunt, BCMA Archivist, e-mail to the author, December 1, 2005).

care for smelter workers, and took turns serving as city Medical health Officer.⁵⁷ Although contract medicine gave way to established private practice in the 1930's, company doctors continued to provide a significant proportion of rural practitioners until the Second World War.⁵⁸

Contract medicine was precarious for both physicians and communities on the northwest coast. While some communities, with larger industries and therefore a greater population, were able to support a prolonged medical delivery system, smaller industrial areas invariably went without a medical presence for fluctuating periods of time. The seasonal and cyclical nature was reflected in the sustainability of medical delivery. Public funding for medical services from government in the form of special hospital grants, DIA, resident physician fees and liquor profits were vital sources of income for both the physician and the community hospital.


Are these problems relevant today? Yes, they are. In our contemporary regionalized healthcare system, where specialized medical services are centralized, rural communities are concerned about the loss of specialty services and subsequent health professionals. Placing core services in specific areas has increased competition between areas, such as Smithers, Terrace and Prince Rupert. In the mid 1990s the provincial government threatened to close down twelve rural small hospitals. Dr. Peter Newbery, as head of the Family Practice Medical Rural Residency Program, stopped the process by pointing out to the authorities the hospitals were used as rural teaching institutions. It was

⁵⁷ Margaret Andrews, "One Scene, Two Views: A Cross-Border Comparison of Smelter-Town Health Care, 1898-1923," *Health and Canadian Society*, Vol.1, Issue 2, (1993), 263. Andrews mentions "health insurance contracts, which guaranteed contracting doctor's payment for medical attendance and hospital care, were important in keeping doctors and the hospital(s) functioning-."

⁵⁸ John Norris, "The Country Doctor in British Columbia: 1887-1975: An Historical Profile," *BC Studies*, No.49, (Spring 1981), 17-20.

the same situation in regards to the threat of relocating the rural internship program. Newbery halted the procedure by illustrating that rural communities provide a “superb example of what family medicine is all about.” He suggested rural family physicians “go above and beyond-they provide a whole range of services and (we) are not prepared to relocate.” It appears the northwest region of the province has a continual ongoing problem with delivering medical services.⁵⁹

⁵⁹ Interview with Dr. Peter Newbery, July 20, 2004. Newbery started the Family Practice Rural Program at UBC in 1995.

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Fig. 5.1: Ocean Falls Hospital, 1916.

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Fig. 5.2: Anyox: Granby Hospital, 1926.

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Fig. 5.3: Queen Charlotte City Hospital, 1947.

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Fig. 5.4: Stewart General Hospital, 1930.

Chapter 6

Rural Nursing along Coastal BC

Health services in the northern region of British Columbia could not have been established without the sustained efforts of dedicated nurses. Attracted by the challenge of nursing in remote isolated areas, nurses worked in a variety of settings. Some women preferred to work in missionary outpost hospitals and nursing stations, others liked the small-town atmosphere of rural hospitals. When public health was their option, nurses could be employed by the Canadian Red Cross Society (CRCS) Outpost Division or as federally funded nurses, hired by Department of Indian Affairs, and later by First Nations bands.¹

Nursing became a part of the organized health care system in the province in 1912 with the formation of the Graduate Nurses Association of BC, the forerunner of the Registered Nurses Association of BC.² At that time nursing training consisted of a three year apprenticeship programme in approximately twenty hospitals scattered throughout the province. In 1919 the University of British Columbia initiated a four year baccalaureate degree programme. A year later, a fifth year was added. Students could specialize in pedagogy or public health nursing. At the end of their fourth year, they

¹ Mary-Ellen Kelm, *Colonizing Bodies: Aboriginal Health and Healing in British Columbia, 1900-50*, (Vancouver: UBC Press,) 1998, 147. Field matrons, appointed by the DIA or Christian Churches, often took the place of DIA contracted doctors. Many did not have nurses training and were paid monthly stipends, considerably less than the physicians. For instance, in 1934, an untrained field matron received \$120: if she had a family to support, the pay was \$360 per year. Trained nurses, who became field matrons, received a yearly salary of \$540. Field matrons came from a variety of sources: some were wives of missionaries or school teachers, others were local settler women who had some nurses training, and still others were white women who had married into a reserve community. Some women, who stayed for longer periods of time, became almost legendary.

² The RNABC was changed to College of Registered Nurses in British Columbia (CRNBC) in 2005.

wrote their RN exams and could then either continue for their final year or work in the field before completing their degree programme.

Public health training in British Columbia was initiated by the Canadian Red Cross Society which sought to promote health and the prevention of illness, particularly in the rural areas. To achieve this goal the CRCS, in conjunction with Dr. Henry Esson Young, Secretary of the BC Provincial Board of Health, in 1919 established a three month diploma course in Public Health Nursing at the University of British Columbia. The Red Cross Chair of Public Health was maintained for three years, enabling many nurses to be trained in the public health field.³

The broad base aspects of their training prepared women (few men became registered nurses) to provide health care in sparsely populated areas and gave them the knowledge necessary to develop an understanding and concern for the community's total health. The isolated locale of their practice promoted integration with the community that exists in few other professionals. Thus, the nurse could work at strengthening and maximizing the community's assets and potential while, at the same time, minimizing its weaknesses and threats. Nurses met the community's health needs in various ways

³ The BC government enlisted the cooperation of voluntary organizations (Women's Institutes, Red Cross, Imperial Order of the Daughters of the Empire (I.O.D.E.) to aid in establishing its 1919 public health program throughout the province. L.G. Hiltz, "History of Outpost Hospitals and Nursing Services in British Columbia 1919-1967," Canadian Red Cross Society British Columbia-Yukon Division, March 1967, 6, CRCS-Ottawa. "Nursing Services," A Rep., 1932, 42, CRCS-Ottawa. Jayne Elliott, "Blurring the Boundaries of Space: Shaping Nursing Lives at the Red Cross Outposts in Ontario, 1922-1945," *Canadian Bulletin of Medical History*, Vol. 21 Number 2, 2004, 306. As mentioned in Chapter Five, Dr. Young came to the province in 1901 under contract with a mining company at Atlin. Two years later, when his contract finished, he entered politics, representing Atlin and serving as minister of education in the McBride administration. He later became a provincial civil servant.

including visiting the elderly at home, farmers in their fields and forestry workers at their camps as well as serving those who came to their clinics or hospitals.⁴

The training programme for nurses included more than medicine. The uniforms, the training school rules and disciplinary measures, and the celebration of 'character' helped nursing administrators mould apprentices into a skilled, inexpensive, respectable, and subordinate labour force. In the hospital hierarchy, nurses were subordinate to the male-dominated medical staff. From this vantage point one can say that gender played a pivotal role in shaping medical relationships. Kathryn McPherson suggests women's virtual monopoly over nursing work was justified in terms of 'natural' female nurturing, and the presence of the trained nurses' at the bedside legitimized by their adherence to Victorian codes of femininity.⁵ Class was also a force. Although nursing draws from across the spectrum of class structure, nursing rules and regulations were designed to inculcate trainees in the values and behaviors of middle-class society. Therefore, subordination, femininity, gentility and educational requirements helped shape nurses' position.⁶

This chapter will build on the ways in which women who chose to nurse in rural areas often wielded administrative and medical authority that surpassed that of their peers who worked in an urban hospital setting. Rural nurses, whether in male-dominated hospitals or in public health milieus, such as nurse-managed outpost hospitals or nursing stations, had more independence of thought. Role diffusion characterizes rural caregivers. On any hospital shift or nurse-managed station a nurse was expected to be able to

⁴ Barbara Bavinton, "Nurse-Managed Health Centres in Rural British Columbia," Department of Nursing, Gonzaga University, January 20, 1994, Canadian Red Cross Society-BC Division (CRCS-BCDiv.), 3-4.

⁵ Kathryn McPherson, *Bedside Matters: The Transformation of Canadian Nursing, 1900-1990*, (Toronto: University of Toronto Press, 1996), 39.

⁶ McPherson, *Bedside Matters*, 26-40.

perform a variety of diverse tasks. An emergency could overlap with the birthing of a baby, the care of a dying patient or a pediatric trauma. Dietary and pharmacology decisions were commonplace.

Rural nursing attracted women interested in adventure, in gaining independence, or in pursuing a religious 'calling.' In regards to the latter, this chapter will focus on the gender, class and racial components of early missionary nurses. Although sources are limited, there is evidence that religiously inclined nurses espoused the views of colonial humanitarianism. From a gender point of view, missionary nursing appealed to women who liked an independent lifestyle in a community of other women. While many women left to marry or found the northern existence too isolated, the work too hard, or became ill, there was camaraderie amongst the women because of the isolation.⁷

Isolation and distance: geographically, socially, and professionally, continue to be important factors in rural nursing despite modern transportation and communications technology. Social and professional isolation has always been problematic. While some women have thrived on running outpost stations, others left their respective hospital or outpost stations because of the lack of social and professional contact. For instance, in the 1956 Red Cross "Report of Provincial Outpost Hospital Committee," Chairman F.C. Bell observed:

it is not surprising that there are few nurses who will be attracted by such conditions (social and professional isolation) and responsibilities and will

⁷ Mary Jane McCallum in "This last Frontier: Isolation and Aboriginal Health," *Canadian Bulletin of Medical History*, Volume 21:1, (2005) suggests "isolation was a metonym for cultural difference, and overcoming the difficulties of transportation and communication was ultimately tied to a broader project of assimilation. The location of Aboriginal health on the outer reaches of the nation ultimately served the broader project of colonization--."104.

accept such duty when positions less exacting are available on every hand in the more settled and better organized parts of our Province.⁸

A distinguishing characteristic of rural nursing is the opportunity to incorporate public health procedures into generalized nursing. Regardless of whether a nurse has had additional public health training (as most Red Cross nurses do), rural nurses engage in a variety of community programmes and procedures educating their clientele in cleanliness, nutrition, preventative and curative measures, that is, in ways to keep healthy. Because these nurses often went into homes, they were able to focus on the particular needs of an individual patient or family. For instance, Marjorie McDowell, who nursed at Bella Bella, recalled that her “unorganized public health clinics” had a “great deal more scope –because she was able to “see patients in a home setting.” She also met patients at the monthly pre and post natal clinic in the hospital’s outpatient department. Though McDowell found her hospital experiences were “very frustrating” she regarded them as “rewarding” because they allowed her to have “a broad nursing experience”: case room, operating room, pediatrics, public health and general duty.⁹

One of the drawbacks of rural nursing was a lack of anonymity. In small communities a nurse might be a wife, a mother, or a member of the local church. However, her role as a nurse gave her a note of distinction among her fellow citizens. As she might be the only care giver in the community, invariably she was asked questions while out socially or be called upon while off duty. Public health nurses connected to the Red Cross outpost hospitals and the solitary nurse at the small Columbia Coast Mission

⁸ Helen J. Lee, RN, PhD, Ed., *Conceptual Basis for Rural Nursing*, (New York: Springer, 1998). F.C. Bell, Chairman, British Columbia Red Cross, “Report of Provincial Outpost Hospital Committee”, 1956, CRCS-Ottawa, 48.

⁹ Burrows, *Healing in the Wilderness: A History of the United Church Mission Hospitals*, (Madeira Park: Harbour House, 2004) 106. Oral History Project: Marjorie McDowell Thompson, interview, Call Number OH#101, 1976, CRNBC.

Native outpost station on Village Island typify this aspect of rural nursing. For instance, Sheila Chambers, the Red Cross nurse at Bamfield, often served as the local vet, the pharmacist, or social worker.¹⁰

Missionary nurses also experienced the communities' dependence. Many of the young women who worked in missionary hospitals came through the patronage of a women's missionary society. Invariably missionary nurses stayed in remote areas either because they had a sense of 'calling,' or were married to physicians, missionaries or local residents. This provided continuity to hospital life. Apart from their medical duties, missionary nurses taught Sunday school, became deaconesses or held church services on the wards. In northwestern British Columbia the Presbyterian and Methodist Women's Missionary Societies, based in Toronto, recruited and paid the salaries of nurses who wanted to combine nursing with evangelism.¹¹

The Atlin Nursing Committee, the forerunner of the Women's Presbyterian Missionary Society (1903), was formed in 1898 by the women of St. Andrew's Church in Toronto, in answer to a plea from itinerant Presbyterian minister, John Pringle and his concern for the lack of health care workers in the Klondike region. The Committee recruited Helen Bone and Elizabeth Mitchell (Figure 6.2) who for five years attended to the medical and spiritual needs of approximately 1,200 prospectors in Atlin (Figure 6.1).

¹⁰ Bonnie Kreps, "Bamfield: A pristine coastal village gets jittery over tourism," *Western Living*, September, 1981, 121.

¹¹ For instance, Miss Spence, the first nurse hired as a matron by the Methodist Women's Society in 1892, remained at Port Simpson Hospital for thirteen years. At the R.W. Large Hospital in Bella Bella, Flora Moffat stayed for fourteen years (1944-58); Marjorie McDowell was matron for seventeen years (1941-58). In all writings Miss Spence was never referred to by her Christian name.

The Nursing Committee paid them \$25 per month, plus food and accommodation, and sent them supplies (Figure 6.3).¹²

The Women's Missionary Society of the Methodist Church (WMS) began recruiting nurses once the northern Methodist church hospitals were established. Over the years nurses provided a vital source of skilled medical attendance for poorly serviced rural districts. Missionary work provided a singular opportunity for ambitious unmarried women who preferred, either permanently or temporarily, a professional career. Eight percent of the women the WMS employed were nurses; twenty percent were teachers, and the rest were laborers. The vast majority did not stay longer than one to three years. This seems typical of the Methodist Church nurses as often they worked short handed. Rosemary Gagan mentions illness, isolation, and hard work were the three most prevalent reasons for women leaving. Missionary writings confirm her observations. For instance, Lucy Pringle, nursing-superintendent of the hospital at Burns Lake (Figure 6.4), stayed for one year (1926-1927) before resigning because of "great difficulties and handicaps," which resulted in "the work [being] too taxing." Her replacement, Miss Haines, remained for four years, citing ill health as her reason for leaving. Elizabeth Mitchell left Atlin because she was "worn out."¹³

¹² Bob Burrows, *Healing in the Wilderness*, 32-34. "The Nurses at Atlin," *Presbyterian Witness*, United Church of Canada Women's Missionary Society, Home Missions Medical Work, Atlin BC-St. Andrew's Hospital, Box 126-1, Series 17, Acc. #83.058c, January 10, 1903, UCCA. The women's missionary societies remained separate until church union in 1925. Whereas in BC, the Methodist Church had a stronger medical presence, nationally the Presbyterian Women's Society financially supported nineteen facilities. They paid for doctors and nurses and covered the annual deficit of most of their small rural hospitals. Their nurses had a sabbatical every seven years and generally higher salaries than Methodist nurses. The goal for the Society was to turn the respective hospital over to the community once it was able to be financially self-sufficient. Conversation with Bob Burrows, May 17, 2006.

The Women's Missionary Society of the United Church of Canada ended in 1962.

¹³ Rosemary Gagan, *A Sensitive Independence: Canadian Methodist Women Missionaries in Canada and the Orient* (Montreal & Kingston: McGill-Queen's University Press, 1992), 164, 190. United Church Women's Missionary Society Home Missions Medical Work, *History of the W.M.S. Medical Missions*, 1949, 36, 6, United Church of Canada Archives, Toronto, Box 115, Asc. 83.058C.

Missionary nurses were between 22-30 years of age, and generally had had some previous nursing experience before being called to do evangelical work. Gagan suggests nursing was a responsible career for a Victorian middle-class single woman whose parents could not support her indefinitely. A missionary nursing career offered a “marginal improvement” in their financial status over nurses in urban areas. The WMS offered better salaries than most Canadian churches. For instance, urban salaries in the early 1900s were \$2.00 per day: Miss Spence and her assistant at Port Simpson Hospital had combined salaries of \$840.00 per year.¹⁴ Margaret Butcher, a teacher-nurse at Kitaamat (1916-1919), remarks that part of her consideration for entering missionary work with the WMS was financial--- because it “assures my maintenance if I continue for a few years, a small sum, relative in value to the number of years service [will be paid] per annum.”¹⁵

The community of women was an important aspect of missionary nursing. In an era of maternal feminism, women’s missionary and nursing work, with its concern for the less fortunate, “was grounded in a nurturing or social form of feminism.”¹⁶ For instance, nurse Flora Moffatt (Figure 6.10) wrote about friendships among the female staff at R.W. Large Hospital in Bella Bella. Margaret Butcher mentions the congeniality among members of the residential school.¹⁷ However, in reality, conflicting motives and

¹⁴ Gagan, *A Sensitive Independence*, 57. The Port Simpson Hospital Financial Statement, *Na-Na-Kwa*, January 1899, Prince Rupert Regional Archives (PRRA), Vertical File.

¹⁵ Mary-Ellen Kelm, ed., *The Letters of Margaret Butcher: Missionary-Imperialism on the North Pacific Coast*, (Calgary: University of Calgary Press, 2006), 6.

¹⁶ Gagan, *A Sensitive Independence*, 13.

¹⁷ Flora Moffatt, “One Foggy Morning,” Dr. A.C. Waldie Fonds, Research and Writing-Biography File, Dr. George Darby, Box No. 3, File 3-1, British Columbia Medical Association Archives (BCMA). Moffatt also mentions her sociability with First Nations. “This occasion (Chief Moody Humchett’s bestowing the name of Wo-Ya-La (the highest) on Dr. George Darby) was the first of many functions I was to enjoy socially among Indian people, and I am indebted to them for much kindness both in their homes, and on many sight seeing trips around the coast in their fishing boats.” 1.

ambiguous perceptions of their work and surroundings were prevalent. Butcher took delight when Mrs. Moore, a settler's wife, ostracized Miss Alton, the village WMS field nurse. Alton had employed Mr. Moore to build her home, which occupied a great deal of his time. When it came time for her confinement, Moore opted to ask for Butcher.¹⁸

This illustrates Kathryn McPherson's suggestion that single nurses in a rural society were often marginalized. While rural nursing allowed a significant number of women to support themselves as single women (Alton had a 30 year nursing career with the WMS), McPherson maintains rural gendered ideological structures constricted many women. In an urban setting, independent working women were more socially acceptable. In rural areas, where farmers' or miners' wives worked without pay, nurses were often viewed as "spinsters seeking husbands." She argues that nurses in isolated rural districts resolved the contradictions inherent in their position as single working women by justifying their presence through helping the needy settlers and First Nations peoples. By doing so, nurses "stood socially superior" and were viewed as "missionaries of the Canadian state."¹⁹

As missionaries of the Canadian state, missionary nurses espoused the view of colonial humanitarianism. They worked to excoriate Native culture and believed Aboriginal religion was 'paganistic.' Butcher thought First Nations were "very slow in speech and action" (she omits the point that English was not their first language), had been "so recently brought from savagery" and, although they suffered immensely from various illnesses, "they lived longer for being civilized." She maintained the death of older Aboriginals "is good for the Christianizing of the people because with them die

¹⁸ Kelm, *The Letters of Margaret Butcher*, 112. Mrs. Moore resented being left alone.

¹⁹ Kathryn McPherson, "The Country is a Stern Nurse," *Prairie Forum*, Vol.20, No.2, (Fall, 1995), 195.

many of the old heathen customs.”²⁰ Mr. and Mrs. Ernest Christmas, a pastoral and nurse team who worked among the First Nations at Kingcome, “deplored the Natives’ “open reversion” to their old ways.”²¹

Gendered reforms were important aspects of missionary nursing. In their view, disease and suffering were part of an Aboriginal racial inheritance and therefore First Nations women needed to be taught the basic rudiments of hygiene, westernized cooking and child rearing. As well, because Butcher and others viewed Native women as downtrodden, they believed “Aboriginal people required intervention in their domestic affairs precisely because they were inappropriately gendered.”²² Butcher “repeatedly depicted village women as slovenly, exposing their children to disease through unhygienic homes.”²³ Throughout her years at Hazelton, Alice Jane Wrinch acted as an unofficial public health nurse, teaching First Nations women how to care for their children and sewing clothing for them. Although Wrinch was teaching what she believed to be the proper method of child care, inherent in this endeavor is the scientific western belief of cultural superiority.²⁴

Alice Wrinch (1869-1923) graduated with a silver medal in nursing from Grace Hospital in Toronto. She married Horace Wrinch, a missionary physician, and together they engaged in medical and missionary work. During her early years at Kispiox and Hazelton she assisted Horace Wrinch in surgical procedures, administering anaesthetics

²⁰ Kelm, *The Letters of Margaret Butcher*, 85, 118. Gagan, *A Sensitive Independence*, 190.

²¹ Michael L. Hadley, *God's Little Ships: A History of the Columbia Coast Mission*, (Madeira Park: Harbour, 1995), 198.

²² Kelm, *The Letters of Margaret Butcher*, 220-221.

²³ Kelm, *The Letters of Margaret Butcher*, 225.

²⁴ Burrows, *Healing in the Wilderness*, 51. Eldon Lee, *Scalpels & Buggywhips: Medical Pioneers of Central BC*, (Surrey: Heritage House, 1997), 46-48. *Missionary Outlook*, July 1900 Vol. XIX # 37, UCA VST. Four years after Alice Wrinch's death in 1923 Horace Wrinch remarried. His new wife, May Hogan, had been a nurse and matron at the hospital for twelve years.

and working on the wards until her growing family necessitated her retirement from daily nursing. She continued to accompany her husband on many of his house calls and was president of the women's auxiliary at Hazelton Hospital.

A married couple, acting as a missionary physician and nurse was not uncommon. Reverend Fred Inglis MD and his wife/nurse, Alice, arrived in Telegraph Creek in 1905 to begin a Presbyterian medical mission. The community consisted of miners, merchants and a few Tahltan First Nations people. Five years later, with the aid of the Presbyterian Women's Missionary Society (WMS) and the provincial and Dominion governments, they built a ten bed hospital. The WMS appointed two nurses. When Inglis left in 1914, after the gold rush petered out, the WMS tried in vain to have another medical missionary replace him. The closing of the facility meant patients had to be taken by dog-team the 225-300 miles to the hospital in Atlin.²⁵

Nurses often stayed in the field because they married local residents. In 1905 Ella Kergin followed her brother, missionary physician William T. Kergin, to the hospital at Port Simpson where she assisted him on house calls at the summer hospital at Port Essington in addition to her general duties. At Port Essington she met and married Francis Hardy, a fellow missionary. They moved to Skidegate on the Queen Charlotte Islands to evangelize and, until the arrival of missionary physician John Spencer in 1907, Ella was the field matron responsible for the medical care of the Native community.²⁶

Not all missionary nurses married fellow missionaries. In 1927 Vera Mitchell, a Methodist nurse from Brandon, accepted a position at the Skidegate Mission Hospital. While there she met and married a local boat builder, Ernie Gladstone and raised a family

²⁵ Burrows, *Healing in the Wilderness*, 34-35. "The Women's Missionary Society in British Columbia, Diamond Jubilee 1887-1947", UCA VST, 16-19.

²⁶ Vi Keenleyside, *They Also Came*, (Duncan: Vibook Committee, Duncan United Church, 1987), 67-70.

of four children. During her forty years on the Islands Gladstone acted as nurse and postmistress. She was permanently on call in the village and looked after injuries and illnesses, epidemics, births and terminal care. When she married, the Church discontinued her monthly salary of \$90.00. As a field matron, the federal government agreed to pay \$30.00 per month but neglected to pay Gladstone anything for a year-and-a-half. Her salary remained the same for the majority of her nursing years because the DIA argued that since she was married to a band member and had the support of the community and her family, her expenses would not be very high. She retired in 1967.²⁷

Not all nurses were associated with the missionary movement or agencies such as the Red Cross. Some care givers wanted the adventure and challenge of living and nursing in a rural area. Mr. and Mrs. George Pitts-Turner tried to make a living on the Queen Charlotte Islands. Arriving in 1912, Mrs. Pitts-Turner was immediately hired by Dr. Spencer to assist him at the Skidegate Mission Hospital. She remarks that “the first night I was there I was needed to deliver a baby—after that she lost count of how many she brought into the world--.” “Sometimes I would get a dozen eggs to deliver a baby—but it didn’t really matter, we went whenever we were needed.”²⁸

The challenge of nursing in a newly established rural hospital appealed to two nurses from Seattle. In 1908 when Dr. J.W. Cross took charge of Queen Charlotte City Hospital, he hired Superintendent Miss Carey, and her assistant, Miss Rogers. They

²⁷ R.W. Henderson, “These Hundred Years: The United Church of Canada in the Queen Charlotte Islands, 1884-1984”, (Queen Charlotte City: Board of the Queen Charlotte United Church, 1984), UCC VST, 21. In 1914, when missionary physician J.C. Spencer was reassigned to Bella Bella, his position was taken over by a series of church-sponsored nurses. Miss Mitchell was recommended for the position by her uncle, Rev. Thompson Ferrier, Superintendent of Indian Hospitals for the Methodist Church in Canada. In 1970, Diane Brown took charge of community health in the village. She worked with trained staff from a well equipped Health Centre, built in the village by the federal government in 1975. Henderson, “These Hundred Years,” 21. Kelm, *Colonizing Bodies*, 148.

²⁸ Kathleen E. Dalzell, *The Queen Charlotte Islands: 1774-1966*, Volume 1, (Madeira Park: Harbour, 1968), 273.

remained on staff for quite a few years. In 1909, Cross hired nurse Lottie (Duval), from Winnipeg. Although she resigned the next year to marry Archie Duval, the local blacksmith and logger, she was always called upon whenever there was a serious illness or accident and is remembered for her long nursing service to the community. "As we often had no doctor, or sometimes elderly men who couldn't hold a practice anywhere else, Lottie Duval had to do many things in emergencies that were considered far beyond a nurse's duty—and many were the lives she saved in the forty years she unstintingly gave her service to this community."²⁹ Kathleen Dalzell suggests nurses like Lottie Duval, Vera Gladstone and Mrs. George Pitts-Turner were "exceptional women" who "truly were the Florence Nightingales of the Islands."³⁰

While many women stayed for long periods of time, staffing was always a consideration. The Methodist Hospitals sought to solve their staffing problems by copying a common practice of hospitals elsewhere, namely offering a three year training programme. This gave young women in the various communities an opportunity to get a nursing education close to their homes and at a minimum of cost.³¹ Dr. Alfred Bolton established a hospital training school at Port Simpson (1893); Richard Large at Bella Bella (1902) and Horace Wrinch at Hazelton (1904). Wrinch's first trainee started before the school was officially opened. The wife of the local Indian agent required surgery. Because no staff member was available to assist Wrinch, the woman's teenage daughter,

²⁹ Dalzell, *Queen Charlotte Islands*, 261.

³⁰ Burrows, *Healing in the Wilderness*, 137. Keenleyside, *They Also Came*, 63. Dalzell, *Queen Charlotte Islands*, 273. Vera Gladstone "attributed her constant state of overwork to the fact that more and more [Native] women were having difficult labours, and she was the only non-Native medical practitioner who would help them. In 1942, she observed that four of the first ten maternity cases she had at Skidegate were 'bad instrument cases [difficult deliveries assisted by invasive medical procedures].'" Kelm, *Colonizing Bodies*, 170.

³¹ Jacqueline A. Burt, "Dr. Horace Cooper Wrinch: Pioneer British Columbia Physician," Unpublished Thesis. Medicine 4, February 20, 1966, Hazelton District Public Library, Hazelton, BC, 13.

Constance Hankin, helped out. Wrinch continued to teach her and she was his only assistant for quite some time. After the school started Hankin became one of Wrinch's first graduates.³²

In order to attract women to nursing Wrinch advertised under the slogan "every young lady a nurse." However his definition of "young lady" was limited to a small portion of the local populace, that is women who had "some education, were white, and, from a good family."³³ Prior to establishing his nursing school Large, using hospital funds, employed young First Nations women as assistants. Their duties included kitchen work and he gave them "instruction in simple nursing." Once the training school opened, the hospital stopped employing Aboriginal women because, in part, of what Large suggested was his "disappointment in our Indian assistants" who left once the fishing season started.³⁴ This was not the only reason. Nurse Sarah Alton believed "the Indian girls, who were "not as intelligent as the men," were incapable of formal training."³⁵

Not all nurses were as racist. From 1908 to 1915, Ida Mae Burkholder was in charge of St. Andrew's Hospital in Atlin. Thora McIlroy Mills remarks Burkholder "was herself remarkable in that she insisted on allowing an Indian girl of the area to be a nurse-in-training—a successful experiment for the girl and for the hospital, and a breakdown of racial prejudice. She proved to be an excellent practical nurse. Her smile each morning started the day right for everybody."³⁶

³² Burrows, *Healing in the Wilderness*, 28.

³³ Eldon Lee, *A Western Doctor's Odyssey: From Cariboo To Kos*, (Surrey: Heritage House Publ., Co., 1996), 75.

³⁴ *The Missionary Outlook*, September 1903, 202. UCA VST. *Missionary Bulletin* "Letter from Richard W. Large, MD.," November 1904, Vol.xxiii, # 11, 196, UCA VST.

³⁵ Gagan, *A Sensitive Independence*, 197.

³⁶ Thora McIlroy Mills, *The Church and the Klondike Gold Rush: The Contribution of the Presbyterian Church to the Yukon During the Gold Rush, 1897-1910*, (Toronto: Committee on Archives of the United Church of Canada, 1978).98, #112.

The majority of the women who trained at the hospitals left afterwards to nurse elsewhere or to marry. Some women withdrew from training "on account of ill health" or a change of heart. This proved to be "rather embarrassing at times."³⁷ Not every applicant was a local girl. Ella Kergin (Hardy) enrolled at the hospital and completed one year before leaving to marry. Ethel Pierce (Freeman) came from Ontario to train at Port Simpson. After graduating, Pierce became assistant matron and night supervisor at the R.W. Large Hospital for four years. In 1926 she returned to Port Simpson and was the hospital matron for four years. Sarah Alton was the matron at Coquileetza Residential School before training at Port Simpson Hospital.³⁸

In time, the Registered Nurses Association, which was concerned about a need for uniformity and standardization of training, opposed the smaller hospitals conducting training schools. Consequently, in the 1910s, new regulations required trainees to complete their last year at Vancouver General Hospital. Because Hazelton was a larger hospital, its training school survived until 1930 when provision was made for students to complete their programme at the Royal Columbian Hospital in New Westminster. With the onset of the depression in the early 1930s and the subsequent decrease in hospital revenues, attracting students became difficult. In 1932 all of the small schools closed down.³⁹

One challenge of living and nursing in a rural setting was accommodation. While the Methodist Hospitals provided separate nurses' residences, other nurses were not always so fortunate. The first trained nurse in Atlin was a Miss Elliott, an employee of

³⁷ *The Missionary Outlook*, "Work among the Indians," September, 1904, xviii. UCA VST.

³⁸ Oral History Project: Ethel Freeman interview, Call Number OH #20, 1987, CRNBC.

³⁹ Jacqueline A. Burt, "Dr. Horace Cooper Wrinch," 13-14. For instance, Ethel Freeman (Pierce) completed her third year at Vancouver General Hospital in 1922. Oral History Project: Ethel Freeman interview.

the BC Government in 1898. Her "hospital," built by the provincial government, consisted of a log cabin with almost no facilities. It had a mud floor and four cots made of poles and canvas. Elliott withdrew as soon as Presbyterian missionary nurses Misses Bone and Mitchell arrived in 1899.⁴⁰ For months Bone and Mitchell attempted to care for miners in undesirable circumstances. The nurses erected a tent to house typhoid patients. At times they housed patients in their own lean-to accommodation. Weather conditions ranged from 30 to 40 below zero and heat was limited to a small stove. They worked every day, rotating in 12 hour shifts, with the off-duty nurse cooking the meals and doing the chores.⁴¹

The following year Reverend Mr. Pringle persuaded the local citizenry to construct a nine bed ward facility. This was enlarged two years later to house a six bed maternity ward. Named St. Andrew's Hospital, it became the first Presbyterian frontier hospital in Canada and was solely run by women. Until 1929 the superintendent and nurse arrangement continued, at which time St. Andrew's Hospital was turned over to the local populace. The hospital continued to operate until 1943 when it became a first aid station. The Red Cross assumed responsibility in 1954.⁴²

⁴⁰ Thora MacIlroy Mills, *The Contribution of the Presbyterian Church to the Yukon During the Gold Rush, 1897-1910*, (Toronto: Committee of Archives of the United Church of Canada in collaboration with Victoria University, 1978),90.

⁴¹ "The Nurses In Atlin," *Presbyterian Witness*. The nurses had to contend with miners who were ill with scurvy, nervous disorders, alcoholism and venereal diseases.

⁴² Burrows, *Healing in the Wilderness*, 32-34. Mills, *The Contribution of the Presbyterian Church to the Yukon During the Gold Rush, 1897-1910*, 52-55. The nurses' salaries went up to \$50 per month in 1904. In the same year they instigated the selling of hospital tickets. Like early medical insurance, the prospectors paid the nurses a dollar a month. This entitled the men to get free board and nursing.

In the second decade of the 20th century Placer Mines established a presence in Atlin. The company managers made it a point to collect from each employee every month. The first permanent doctor arrived in 1917. Presbyterian Church of Canada, Women's Foreign Missionary Society, Annual Reports 1914-15, 78-82, Box No. 5, UCA VST. Pat Kermeen, Red Cross Outpost Hospital Manager, "Atlin Community Assessment," June 2002, 1, CRCS-BC Division.

From 1920-33 Dr. H.F.Kergin (brother of Methodist physician William T. Kergin) represented Atlin as an MLA. On September 25, 1927 he requested the provincial government to pay 50 % of the cost to buy a new

Accommodation and medical aid for nurses and patients in the remote areas of Burns and Francois Lakes concerned Reverend George Wilson, superintendent of the Presbyterian Church. In 1919, the WMS sent out Mary Kennedy and a Miss Wales, who opened a small hospital in a log farmhouse near Francois Lake. The Society managed to hire doctors but none remained more than a year or two because of the difficult winter travel.⁴³ As a consequence, in 1924 the hospital was transferred to Burns Lake on the railway line, where it was easier to keep nurses and doctors. For four years health care at Burns Lake was provided in a log cabin until a nineteen bed facility was built in 1929. That year Dr. T.C. Holmes began a private practice and brought medical stability to the community until his retirement in 1955.⁴⁴

Another aspect of living and nursing in remote areas is isolation. Flora Moffat spent fourteen years at Bella Bella. The installation of a radio telephone in 1947 greatly eased the sense of loneliness for the staff and made medical work easier as Dr. Darby and staff could be in touch with ill or injured people on route to the hospital. Moffat cites the

x-ray machine for St. Andrew's. The government refused as its policy stipulated that money was provided for buildings, not furnishings. BC Provincial Secretary, GR 2569, Atlin Hospital, Box No. 1, File #5, 1928-46, BCA.

⁴³ They cared for 49 people in 1920. The WMS also provided a housekeeper. Because the hospital was not incorporated and therefore government funding was not available, the WMS supplemented fees of \$600.00. This placed a heavy burden on the WMS and supplied a small revenue to the doctor. "The Women's Missionary Society in British Columbia: Diamond Jubilee 1887-1947," (Vancouver: Clarke & Stuart Co. Ltd., 1947), 19. Millicent Lindo Papers, BC Hospitals 1931-1967, MS 1037, Francois Lake 1917-35, Box 4, File 2, BCA.

⁴⁴ Burrows, *Healing in the Wilderness*, 85-86. Because the WMS contributed \$4000 towards construction of the hospital as well as providing \$1500 for furnishings the WMS insisted on owning title to the hospital. The provincial government refused to agree as it ran contrary to the Hospital Act. A compromise was suggested whereby the hospital would buy the property and then convey the land to the WMS. In the end, the government donated the land. BC Provincial Secretary, GR 2569, Burns Lake, Box 1 File 8, 1928-46, BCA. As mentioned in Chapter Five, the hospital was also moved to Burns Lake because of the controversy between the WMS and the Francois Lake Hospital Board over liquor profits.

A thirty-six bed hospital replaced the older one in 1960. Funds came from the provincial government, the WMS and the local population. It housed both white and First Nations people. "Burns Lake & District Hospital," Burns Lake Vertical File, UCA VST. "The Women's Missionary Society in British Columbia: Diamond Jubilee 1887-1947," (Vancouver: Clarke & Stuart Co. Ltd., 1947), 19, UCA VST. "History of the W.M.S. Medical Missions," United Church of Canada Women's Missionary Society, Home Missions Medical Work, Box 115 Acc. #83.058c, UCCA.

case of a husband who was transporting his wife in his fish boat from Kitamaat, a distance of one hundred and fifty miles. The wife had given birth to twins at home and suffered a severe hemorrhage. Because of the phone, the hospital had blood transfusions ready when she arrived and she survived.⁴⁵ Technological change, namely the introduction of air travel, also allowed for the evacuation to Vancouver of critically ill patients such as burn victims who after being given first aid, stabilized, could be flown to Vancouver for specialized care rather than staying in the local hospital for months.⁴⁶

Many nurses liked the authority and independence of rural nursing. When doctors Wrinch, Bolton, and Darby made periodic visits to various First Nations villages to oversee Native medical needs, they always took one or two nurses to assist in various procedures. While they were away the hospital administrative and medical duties became the responsibility of the nurses. For instance, Miss Spence traveled with Dr. Bolton on his yearly excursions to the Skeena. This provided her with the opportunity to engage in public health procedures at the Native villages. During their absence Ethel Pierce (Freeman) managed the Port Simpson Hospital. She comments "we had to act in the doctor's absence, delivering babies or handling emergencies. There were no undertakers, so we had to prepare and dress the deceased, ready for burial."⁴⁷

Similarly, when Dr. Herman McLean (Figures 6.5-6.9) and two nurses made yearly excursions on horseback from Bella Coola to visit the isolated Native communities at Anaheim Lake, Nurses Ivy Whitmore and Mary Munn dealt with a variety of public

⁴⁵Flora Moffat, "One Foggy Morning," Reminiscences, Christmas 1976, Dr. A.C. Waldie Fonds, Research and Writing-Biographical, Box No. 3, File 3-1, BCMA, 2.

⁴⁶ Moffat, "One Foggy Morning," 2. One of her more challenging cases was when a man arrived at the hospital at 6 am walking with only a blanket for protection. His boat had caught fire and sunk. He had second and third degree burns over most of his body. She managed to give him first aid treatment, and after he recovered from the initial shock, he was flown to Vancouver where he remained for many months. Oral History Project: Florence Moffat, interview, Call Number OH #100, 1976, CRNBC.

⁴⁷ Keenleyside, *They Also Came*, 60-62. Spence's salary was \$400.00 per year.

health necessities. They administered whooping cough serum, checked for signs of tuberculosis and respiratory ailments, and aided in physical examinations.⁴⁸ When Dr. Darby and a nurse went to the summer hospital at Rivers Inlet, nursing duties included administering anaesthetics and developing x-rays. During one summer there, Flora Moffat aided in delivering six babies in five days. Every afternoon Darby, Moffat and a medical student held clinics at the various fishing camps. Immunization was a yearly procedure. At other times Moffat accompanied the Indian Agent to Klemtu and Kitammat. They would be away for nine days ministering to First Nations.

Frequently, nurses are the sole healthcare providers for people living in a rural setting. Public health nurses connected to the Canadian Red Cross Society (CRCS) and the solitary nurse at the small Columbia Coast Mission Native outpost station on Village Island are typical rural care givers. These health care providers were career-minded women who liked the notion of being able to organize their professional day as they see fit (except for emergencies). Being adventuresome and able to adapt their urban-based public health training to a rural experience were attributes necessary to cope with a challenging career.⁴⁹

⁴⁸ Burrows, *Healing in the Wilderness*, 91. In 1955 a road to Williams Lake and Bella Coola was officially opened. That eliminated the annual two week trek to serve the health needs of the Carrier people at Anaheim and Ulkatcho as now it could be done by having a monthly clinic. 113.

⁴⁹ Kingcome Inlet was visited by the Columbia Coast Mission boat every two weeks. From 1930 until the 1960's nurses oversaw the health needs of the small Native community. Writing about Kingcome Inlet, Rev. Allen Greene states "The former [nurses] make a daily round of the village, administering medicines and giving advice and direction on matters of health. This is a very isolated place, but we have had some splendid nurses in there, whose salaries have been paid by the Old and "New England" Company [British Indian Missionary Society which funded Indian work in Canada.] " Allen Greene, Superintendent, CCM, to Miss Mabel F. Gray, Department of Nursing and Health, UBC, February 19, 1940. Contributions to Medical Work-Nursing, PA 198-8, 8-22, ACA VST.

The Red Cross Outpost Hospitals and Nursing Stations programme for BC began in 1929.⁵⁰ In order to obtain the provincial government's per diem rates, the Red Cross designated all of its facilities as outpost hospitals (Figures 6.12-6.14). The intent was to provide competent medical service in isolated communities that could not afford to pay for the service. Once a community could take over the financial responsibility of maintaining the hospital, the Society withdrew its support. Municipal Councils, Women's Institutes, Rate Payers Associations and concerned Citizens Committees were among the groups who requested such a hospital. The CRCS classified a nursing station as a facility staffed by a registered nurse and usually a housekeeper. Bed capacity ranged from one to three beds, frequently with a bassinette. Outpost hospitals were larger complexes staffed by several nurses, a housekeeper, and had a physician in close proximity.⁵¹

Between 1930 and 1965 the Red Cross and local citizenry jointly raised funds for the hospitals. The latter was responsible for securing the land and financing the building and equipment. The CRCS agreed to manage each establishment on a one year contract that could be renewed by mutual agreement. The Red Cross appointed, supervised and paid all nursing and housekeeping staff and provided fuel, drugs, food and general supplies.⁵²

The provincial government gave special annual grants to the Society to pay for a third of the capital expenditure on land and buildings. The government evolved a policy

⁵⁰ Outposts had been established on the Prairies in 1920 and in Ontario in 1922. Prior to commencing the BC outpost hospital programme in 1920, the Society sent nurses to visit all the lighthouses annually. This lasted for several years. At the same time eight nurses were placed in isolated districts in the province to do Public Health Nursing (Vancouver Island (4); East Kootenay (1); Shuswap Lake (2); Arrow Lake (1); and Creston (1). Due to lack of funds this service was discontinued in 1923. Hiltz, "History of Outpost Hospitals," 6-7.

⁵¹ Mike Powley, "History of Outpost Hospitals BC Division Minutes, 1922-1962" Canadian Red Cross Society British Columbia-Yukon, 1962, 13, CRCS-Ottawa:BC Division.

⁵² Powley, "History of Outpost Hospitals BC Division," 3-7.

whereby larger hospitals of ten beds (Terrace, McBride) were paid on a per diem basis while the smaller ones of three to nine beds (Kyuquot, Bamfield, Cecil Lake) received a lump sum grant. Support also came from the BC Hospital Insurance (1949), the Public Health Department and the Federal Government.⁵³ Between 1930 and 1965 the Red Cross built eighteen outpost hospitals.⁵⁴ They were housed in a variety of structures: converted old homes (McBride, Stuart Island), a log cabin with coal-oil lamps (Cecil Lake), a new building (Kyuquot, Blue River), or old hotels (Greenwood, Edgewood). In order to maintain the power of professional control, while giving as much financial responsibility as possible to the local community, the BC Red Cross, in 1946, grouped the hospitals in three categories. Group A were small outposts which were not self-sufficient (Bamfield, Cecil Lake); Group B consisted of hospitals where the community was required to make definite financial contributions towards the operation (McBride);

⁵³ Powley, "History of Outpost Hospitals BC Division," 8. For instance, the lump sum grant in 1948 was \$1,800.00. There is an ongoing cooperation between the Provincial Department of Health and the Red Cross. For instance, in 1940 the Provincial Board of Health contributed \$105.00 towards public health nursing carried out by four Red Cross outposts. Bamfield received \$15.00; Kyuquot-\$25.00; Cecil Lake-\$50.00; and Pemberton Meadows-\$15.00. Millicent Lindo Papers, BC Hospitals 1931-1967, Feb.22, 1940, MS 1037, BCA. Grants to Cecil Lake have been paid since 1930: before 1939 it was \$25.00. Grants to Pemberton Meadows paid since 1937; to Kyuquot since 1938; Bamfield since 1939. Pemberton Meadows was an emergency station (1937-45) run by Mrs. Ada C. Taylor. The Red Cross supplied her with "dressings and other aids for emergency cases. About fifty people received the benefit of this service in 1939." Report of the Standing Committee on Outpost Hospitals and Nursing Service for 1939,"3, CRCS-Ottawa:BC Division. These yearly grants were small, but during World War II funds were limited.

⁵⁴ The outpost hospitals are Pouce Coupe (1930—established in 1921 by the Alberta Division, taken over by the BC Division); Cecil Lake (1935); McBride, Kyuquot (1937); Zeballos, Bamfield (1939); Greenwood (1946); Stuart Island, Edgewood (1947); Terrace, Lillooet, Blue River, Lone Bute (1948); Hudson Hope, Alexis Creek (1949); Atlin (1954); Masset (1955), and Wadhams (1965). Hiltz, 2. Six were later turned over to their respective communities: Pouce Coupe (1938), McBride (1954), Zeballos (1942), Greenwood (1950), Terrace (1951) and Lillooet (1945). Five outposts have closed: Cecil Lake (1953), Stuart Island (1951), Hudson Hope (1966), Lone Bute (1960) and Wadham's (1967). The remaining six (Blue River, Edgewood, Kyuquot, Alexis Creek, Atlin, Bamfield) became part of the BC Regional Health Authority in 2005. Powley, "History of Outpost Hospitals BC Division," 2. Masset was closed in 1973. It had been a joint effort by the Minister of Health and Welfare and the Red Cross to oversee "approximately one thousand with approximately 60% living in the Native village." Hiltz, "History of Outpost Hospitals,"18. During the war years (1939-45) the CRCS Outpost Hospital Programme came to a standstill and many hospitals were closed in order to devote funds to the war effort and because of a shortage nurses and doctors. In BC only Bamfield, Cecil Lake and McBride remained open. Hiltz, "History of Outpost Hospitals," 12. "Annual Report of Outpost Hospital and Nursing Service for 1940,"1928-39, 1, CRCS-Ottawa:BC Division.

and, Group C were larger facilities in which the community (Terrace) had requested the Red Cross to take over and operate the outpost.⁵⁵

The nursing programmes were as varied as the type of communities served: First Nations, farmers, lumbermen, fishermen, miners and their families. The services consisted of primary and preventative care, emergency, surgery, public health, and some home care. This included collecting blood samples, changing dressings, dental extractions, workshops on communicable diseases and school education. Because medical decisions were made in the community and not at a distant clinic or hospital, Red Cross health care can be characterized as an integrated system in which the patient was treated as a whole person.⁵⁶

Maternal and child welfare programmes and clinics were of paramount importance to the Red Cross. During the interwar years Canadians were concerned about an alarming number of maternal deaths and infant mortality. However, until World War II, maternal deaths were consistently lower among rural mothers who were attended at home by husbands, friends, midwives, nurses or physicians, than among urban mothers who had hospital care. Jo Oppenheimer suggests many women preferred home deliveries because of the risk of infection associated with hospital births and their association of hospitals with charity. Hospital births became more acceptable when lying-in hospitals and homes for unwed mothers were established and when non-medical midwifery was

⁵⁵ Powley, "History of Outpost Hospitals BC Division,-"13-15.

⁵⁶ "Closer to Home since 1929," Red Cross Outpost Hospital Program, 1994, 3-4, CRCS-Ottawa: BC Division.

made illegal. Lastly, the public became more aware of healthful living and demanded that maternal and infant deaths rates be lowered.⁵⁷

A major component of public health nursing was pre-natal care which the medical profession viewed as the way to overcome complications such as miscarriages, eclampsia, stillbirths, malformations and congenital weakness, even though studies showed that maternal mortality was largely due to puerperal infection and non-medical factors, such as poor nutrition, poverty and overwork.⁵⁸ Emphasizing medical complications and the need for medical advice and care placed control of pregnancy more in the hands of physicians' rather than in those of the pregnant woman. Prenatal care emphasized the abnormality of the pregnant state. Wendy Mitchinson suggests that because "medicine could do only so much" and "could not ensure that all women had enough to eat, worked or lived in safe environments," doctors believed that women needed their "ideal care."⁵⁹

The Red Cross outstation nurses encouraged expectant mothers to visit monthly clinics where maternal and childcare care was emphasized. The Society's nurses reflected the growing contemporary thought that the hospital was the accepted place for women to have their babies. As a consequence, rural nurses delivered hundreds of babies, either on

⁵⁷ Jo Oppenheimer states maternal mortality increased in hospital deliveries due to sepsis and abortion. This was not curbed until the introduction of sulpha and antibiotic drugs in the 1940s. Jo Oppenheimer, "Childbirth in Ontario: The Transition From Home to Hospital in the Early Twentieth Century," Katherine Arnup, Andree Levesque and Ruth Roach, *Delivering Motherhood: Maternal Ideologies and Practices in the 19th and 20th Centuries*, (London & New York: Routledge, 1990), 66-67.

⁵⁸ Wendy Mitchinson, *Giving Birth in Canada, 1900-1950*, (Toronto: University of Toronto Press, 2003), 120.

⁵⁹ Mitchinson, 156. She remarks fear of death was increased during the interwar years because of the effects of World War I and the 1918 influenza epidemic.

their own or assisting a visiting physician. Because the nurses were also women, patients were also likely to perceive them as midwives.⁶⁰

While the majority of births were without complications, problems did arise. Sometimes a premature delivery would necessitate the nurse aiding in a home delivery before being able to transfer the patient to the outpost. When premature twins were born at Bamfield the nurse had to improvise incubators. She wrapped the babies in warm towels and placed them in a drawer surrounded by hot water bottles. Occasionally a child was born at an outpost, such as Kyuquot, while the mother waited for a plane to take her to her own doctor. Stillbirths were either a rarity or not reported.⁶¹

Hughina Harold, the outpost nurse (1935-37) at Village Island, recorded her dealings with the midwife, Sarah. On one occasion she was called to the home of a woman who had recently delivered a baby. She discovered that Sarah had improperly tied off the cord and the baby was haemorrhaging. Another time Harold sustained a woman through a difficult delivery of a stillborn baby. Harold's attentiveness was greatly appreciated by the Aboriginal women who invariably gave her presents.⁶² First Nations women also assisted in difficult childbirths. For instance, Butcher was asked by nurse Alton to assist her with a delivery. When the labour did not progress and they assessed

⁶⁰ Elliott, "Blurring the Boundaries-,"310-11 Elliott mentions that most nurses "planned a public health program that centred on maternal and child welfare." She states "health professionals increasingly insisted that pregnancy and childbirth should be medically supervised." "Obstetrical care was a significant feature of Red Cross nursing work. —often attending women for their confinements on their (Red Cross) own stretched the boundaries of accepted nursing practice, but hospital space allowed nurses the opportunity to uphold contemporary standards for obstetrical nursing care." In the early decades of the twentieth century there was a high rate of maternal morbidity from post-puerperal septicemia, which good prenatal care could not prevent. Vi Woodward, the outpost nurse at Cecil Lake (1930-46) mentions she delivered fifty babies. She does not mention if the population was mixed or Aboriginal. Oral History Project: Vi Woodward interview, Call Number OH #35, 1987,CRNBC.

⁶¹ W.S. Barclay, MD., "Report of the Outpost Hospital Committee January 1,1966-December 31,1966," 27, CRCS-Ottawa-BC Division. In a random selection of statistics I found one stillbirth in 1939. "Report of the Standing Committee on Outpost hospitals and Nursing Service for 1939,"1928-39, 3.

⁶² Hughina Harold, *Totem Poles and Tea*, (Surrey: Heritage House, 1996), 74, 112.

the infant was dead, both women withdrew because, according to BC law, they were not allowed to intervene using instruments. Although this caused Butcher distress, she did not return to visit the patient. The next day she found out the Haisla women had done exactly what she had wanted to do. If the First Nations women had not intervened both mother and child would have died.⁶³

Native women were taught from an early age not to fear childbirth and to rely on their own abilities and those of midwives when in labour.⁶⁴ Mary-Jane McCallum mentions that some physicians viewed midwives as “self-appointed and untrained” and criticized traditional Indian methods of child-bearing. These physicians assumed that “maternal and infant ill health was directly related to lack of contact with outside agencies, which left no room for the possibility that an alternative culture of childbirth might have existed and been viable.”⁶⁵ Doctors believed Aboriginal health needed to be monitored because of the high rates of infant mortality. Although doctors advocated supervised childbirth, Native women were reluctant to come. For instance, in Atlin, in 1929, the hospital report stipulated that “Indian mothers do not come into the hospital to have their babies but they come willingly at any other time.”⁶⁶

However, after 1947, First Nations women increasingly accepted an outpost as a place to deliver their babies.⁶⁷ The reasons for this increase are uncertain but Mary-Ellen Kelm suggests that it related to the prevalence of measles which has a detrimental affect on the health of mothers and fetuses. Tuberculosis and venereal disease which

⁶³ Kelm, *The Letters of Margaret Butcher*, 229.

⁶⁴ Kelm, *Colonizing Bodies*, 167.

⁶⁵ Mary-Jane McCallum, “This Last Frontier: Isolation and Aboriginal Health,” 111-112.

⁶⁶ United Church Missionary Society-Home Missions, Medical Work, *History of the W.M.S. Medical Missions*, United Church of Canada Archives, Toronto, Box 115, Acc.83.058C, 34.

⁶⁷ Helen G. McArthur, National Director, Nursing Services, “In the Far North,” *Red Cross World*, Vol.xxxvii No.1, January-March 1957, 34.

contributed to difficult deliveries may also have been factors. Experience may have also encouraged First Nations women to seek professional help.⁶⁸

Other major public health programmes were school medical inspections, immunizations and home visits. In the interwar years, the Red Cross, as well as other social welfare organizations, believed trained nurses were “ideal recruits for marching the message of good health into the homes and schools of the nation.”⁶⁹ In BC, because most outposts were small nursing stations with little accommodation for in-patient care, they sent patients requiring long term care to the nearest hospital (e.g. Kyuquot patients were sent to Port Alberni). This probably gave the nurses more uninterrupted time to do public health work. Rebecca Bancroft, a nurse at the Kyuquot outpost dispensed polio vaccine on a yearly basis to school children. This required her to travel by boat to Tahsis. Before the arrival of Dr. H. McLean at the Esperanza Hospital, Bancroft made monthly boat trips along the coast to various logging camps to visit each family and check on their health needs.⁷⁰ Likewise, as district nurse, Vi Woodward, the outpost nurse at Cecil Lake, regularly visited three schools, performing medical check-ups and inoculations. She also tried to assess each student for potential nutritional problems. In addition, she visited homes to counsel mothers, many of whom were new to life in an isolated community, on nutrition and to deliver layettes for new babies. Home visits to every family were done on a monthly basis unless situations warranted attention. She considered home visits a “great

⁶⁸ McArthur, “In the Far North,” 34. Kelm, *Colonizing Bodies*, 170. In 1956 the Red Cross managed nine hospitals. There were a total of eleven outpost deliveries and three home deliveries. “Report of Provincial Outpost Committee-1956,” CRCS-Ottawa: BC Division, 47.

⁶⁹ Elliott, “Blurring the Boundaries,” 315. She observed that Red Cross public health programmes in Ontario outposts were invariably interrupted because nurses were preoccupied with in-patients.

⁷⁰ Oral History Project: Rebecca Bancroft, interview, OH #76, 1987, CRNBC. Bancroft remarks that Dr. McLean used to send for her to assist him in surgical work, usually administering anaesthetics. On one occasion a teacher’s wife died from a mishandled caesarian section. Polio vaccine became available in Canada in 1955.

advantage both to the families and to the nurses as it enabled them to know each family and their particular circumstances and needs.”⁷¹

While most nurses visited schools, Hughina Harold was a teacher who also served as a village nurse. She became a familiar figure trotting along the pathways, black bag in hand. By visiting each family every day she was gradually able to gain the confidence of the small Mamalilikulla Native community. When the inhabitants came to see her, the kitchen became Harold’s “nursing station and dispensary.” Aspirins, mild laxatives, red mercurochrome and cough mixtures were popular remedies. Although most of Harold’s nursing was for lesser complaints such as colds, cuts and splinters, she oversaw tuberculosis patients who were housed in separate quarters. In 1936 nearly everyone in the village was ill with a virulent flu. Since it was before the days of antibiotics, treating flu involved labour and ingenuity. Tepid sponge baths, alcohol rubs, mustard plasters and dripping warm oil into aching ears were the accepted remedies.⁷²

Rural nursing has its challenges. Nurses travel many miles, often on dirt roads, through snow or mud to care for their clientele. Hours are spent escorting patients to the nearest medical centre and waiting for return transportation. It takes ten hours to transport patients from Cecil Lake to Fort St. John or two hours from Atlin to Whitehorse, Yukon.⁷³ Nightly on-calls are frequent. Often this entails traveling on a boat (Kyuquot),

⁷¹ Oral Project, Vi Woodward, interview. Vi did not complete high school in Estevan, Saskatchewan but in 1927, the Vancouver General Hospital accepted her grade eleven certificate thereby allowing her to enter nursing training. Pat Kermeen, Red Cross Outpost Hospital Manger, “Atlin Community Assessment,” June 2002, 18. CRCS-BC Division.

⁷² Harold, *Totem Poles and Tea*, 52-53, 161.

⁷³ The ambulance in Atlin was installed in 1977. An agreement between the Yukon and BC governments guarantees an exchange of government services between Atlin and Yukon. Administrative difficulties arose in 2001 when the Yukon government required people to be resident in the territory before even being allowed to put their names on the one to three year waiting list for “access to health care facilities such as McAulay Lodge (Level 1 and 11 senior citizens’ residence) and McKenzie Centre (Level 111 and 1V) in the Yukon.” British Columbia was no kinder to Atlin residents. Its officials told residents “not to bother

a horse or open cutter (Cecil Lake), or walking along trails where wild animals lurked. Their responsibility for overseeing health care services at Pachena Lighthouse meant that Bamfield nurses often had to travel in hazardous weather conditions. Hughina Harold frequently was asked to accompany First Nations in their boats to tend an ill person. In many cases she did not know where she was going. On one occasion she was taken to a nearly deserted Native village where she found a young child suffering from pneumonia. She arranged to have the youngster taken to the hospital at Alert Bay (Figure 6.11). Another time, she was taken to a small encampment where she found an unconscious man. Harold marshaled some villagers to flag down a passing tugboat in order that an S.O.S. could be sent to the *Columbia*.⁷⁴

Emergency ambulance plane service was used for serious accidents or illnesses. A nurse's judgment had to be "very keen as calls for air transport are expensive and hazardous."⁷⁵ A fisherman who had had a heart attack at Bamfield in 1961, was airlifted to St. Joseph's Hospital in Victoria.⁷⁶ Accidents at the tiny nursing station in Wadham's (Rivers Inlet) meant seriously ill cases went by plane to Bella Bella, the less serious by boat; patients requiring 24-48 hour nursing care were admitted.⁷⁷ Ambulances had to cover long distances. A very ill man drove forty-eight km. to the Alexis Creek outpost.

putting their names on long-term facilities in Prince George and other BC Northern cities where the waiting lists are equally long." In addition, when BC Pharmacare required prescriptions to go through their computer based system, Whitehorse pharmacies did not buy the necessary but expensive software and refused to fill Atlin prescriptions unless the patient paid up front. Atlin residents requiring long term medication had to deal with distant pharmacies in Dawson Creek, Prince George or Terrace. As well, residents requiring ambulance service had to pay \$100 and if they were referred to Whitehorse or Vancouver for outpatient treatment or diagnosis, they have to pay for their own accommodation. Kermeen, "Atlin Community Assessment," 19-20.

⁷⁴ Harold, *Totem Poles and Tea*, 132-136, 160-164.

⁷⁵ McArthur, "In the Far North," 32.

⁷⁶ "Director's Report, May 1961," 11. CRCS- Ottawa: BC Division.

⁷⁷ W.S. Barclay, MD, "Report of the Outpost Hospital Committee, January 1, 1966-December 31, 1966," 27. T. F. Rose MD, *From Shaman to Modern Medicine: A Century of the Healing Arts in British Columbia*, (Vancouver: Mitchell Press, 1972), 116.

He was a diabetic but had been drinking for several days and now was vomiting and very dehydrated. After an intravenous was started, he was quickly taken by ambulance to the hospital at Williams Lake, a distance of 112 km.⁷⁸

The outposts had physicians who visited on a monthly basis. They held clinics and left standing orders for the nurse who then accepted full responsibility for the patients. If a doctor was located in a nearby area, a nurse contacted him to come in on an on-call basis. Some outposts were fortunate to have another nurse who was a resident of the community and who would do relief work. Mollie Fullerton, the first nurse in Bamfield in 1939, was a long term community resident. After her retirement she became the outpost relief nurse. In Atlin, Jessie James (1961-80) was a relief nurse for several years before assuming full responsibility.⁷⁹

Outposts relied heavily on volunteer help. Local Women's Auxiliaries (Figure 6.13) assisted nurses in raising money for purchases of special items not included in the budget. Sometimes they painted and redecorated the facility, arranged for other community members to build a garage or formed a local crisis team. By the 1960s, in First Nations areas, one member of the community served as the Community Health Representative. The outpost nurse relies on this member to aid her in conducting various community health responsibilities.⁸⁰

Working in missionary outpost hospitals, the Columbia Coast Mission or the Canadian Red Cross Society outpost hospitals, nurses have contributed greatly to the

⁷⁸ "Closer to Home since 1929," 2.

⁷⁹ "Director's Report, May, 1961," 2, 11. In the past couple of decades other health-oriented services commenced. Suicide prevention workers, mental health counselors, social service, home support and infant and child development workers made visits. Beverly Robson, "Kyuquot Community Health Study," June 2005, CRCS-BC Division, 2:13.

⁸⁰ Robson, "Kyuquot Community," 2:33.

medical well-being of British Columbia's rural inhabitants. Rural nursing is a special variety of nursing in which a nurse must have a wide range of knowledge, skill and ability. Nursing in remote areas requires multiple tasking and the ability to adapt to a variety of circumstances. These attributes are essential qualifications in remote healthcare because nurses have to have more independence of thought in the decision making process.

Northwest missionary nurses, supported by the Methodist and Presbyterian Missionary Societies, supported the race, class and gender views of colonial humanitarianism. While a few single women made life-time careers of missionary nursing, more often women left because of hard work, illness and isolation. Because of the isolation, living in a community with other women and forming close bonds, was an important aspect of missionary nursing, but it could cause friction.

Whether a healthcare giver is in a small hospital setting, a mission hospital, or in Red Cross outpost stations, the field of public health and its related programmes are essential for the health of the region. The integration of a nurse into the community is a unique feature of rural nursing. This allows her to assess the community so that she can be better prepared. By so doing, nurses are singularly challenged as they are stripped of their own anonymity. However, this is offset by their gain in autonomy. Isolation and distance are major factors to which nurses must adjust. Nursing in remote areas requires a generalist approach in which a nurse can be described as needing to be 'all things to all people.'

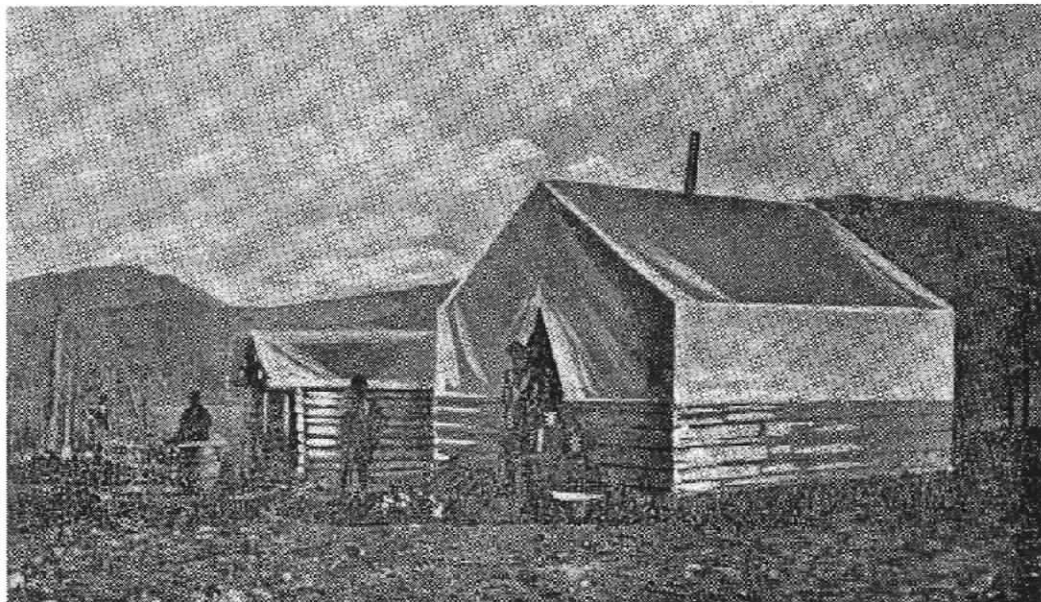


Fig. 6.1: Presbyterian Women's Missionary Society Hospital in Atlin, 1899.

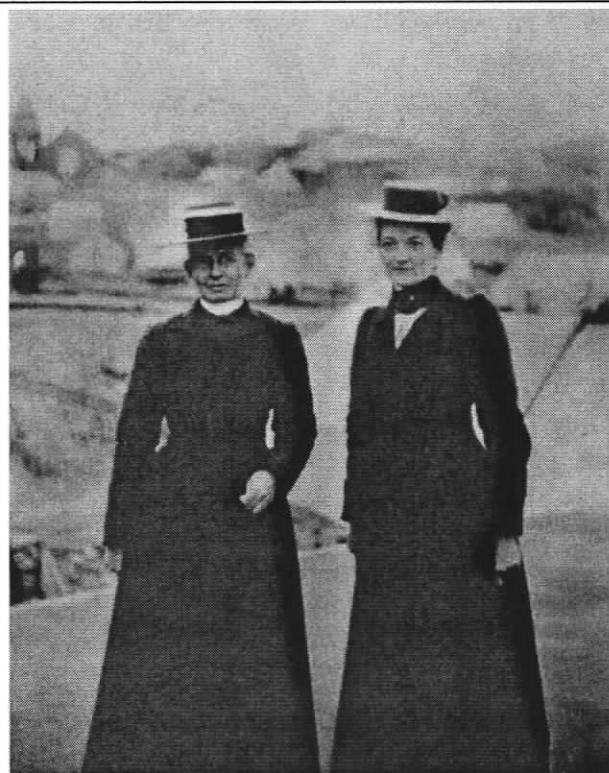


Fig. 6.2: Nurses Elizabeth Mitchell and Helen Bone in Atlin, 1899.

Courtesy of Bob Burrows

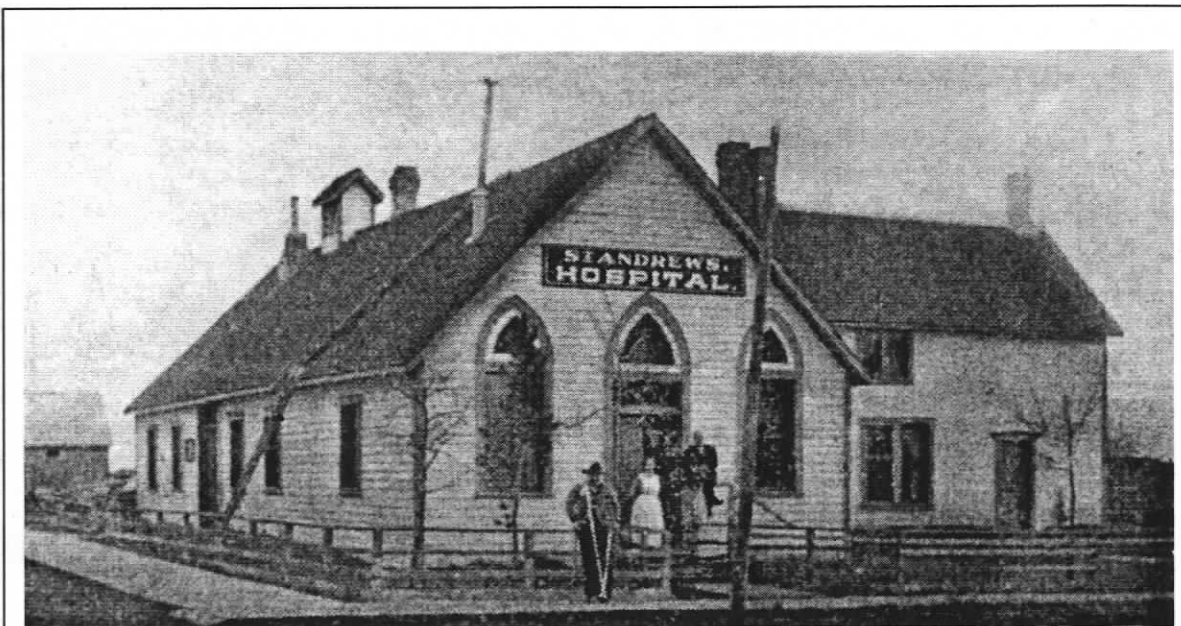


Fig. 6.3: St. Andrews Hospital in Atlin, 1900.
Courtesy of Bob Burrows



Courtesy of BC Archives collections - Call Number: B-00957

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Fig. 6.4: Burns Lake Hospital, n.d.



Fig. 6.5: Dr. Herman McLean and Nurse Ivy Whitmore on their annual Pack-Horse Trip to the Anaheim and Ulkatcho Reserves, 1934.
Courtesy of Bob Burrows. Photographer: C. Kopas.



Fig. 6.6 Dr. H. McLean and Nurse I. Whitmore with 'old Cahoose,' 1934.
Courtesy Bob Burrows. Photographer: C. Kopas.



Fig. 6.7 Dr. H. McLean and Nurse I. Whitmore dispensing whooping cough serum to child, 1934.

Courtesy of Bob Burrows. Photographer: C. Kopas.



Fig. 6.8 Nurse I. Whitmore assisting Dr. H. McLean shaving, 1934.

Courtesy of Bob Burrows. Photographer: C. Kopas.



Fig. 6.9: Old Cahoose, on the Anaheim Reserve, survived for three years in this isolation tent, separated from his family because of his advanced pulmonary tuberculosis, 1939.
Courtesy of Bob Burrows. Photographer C. Kopas.

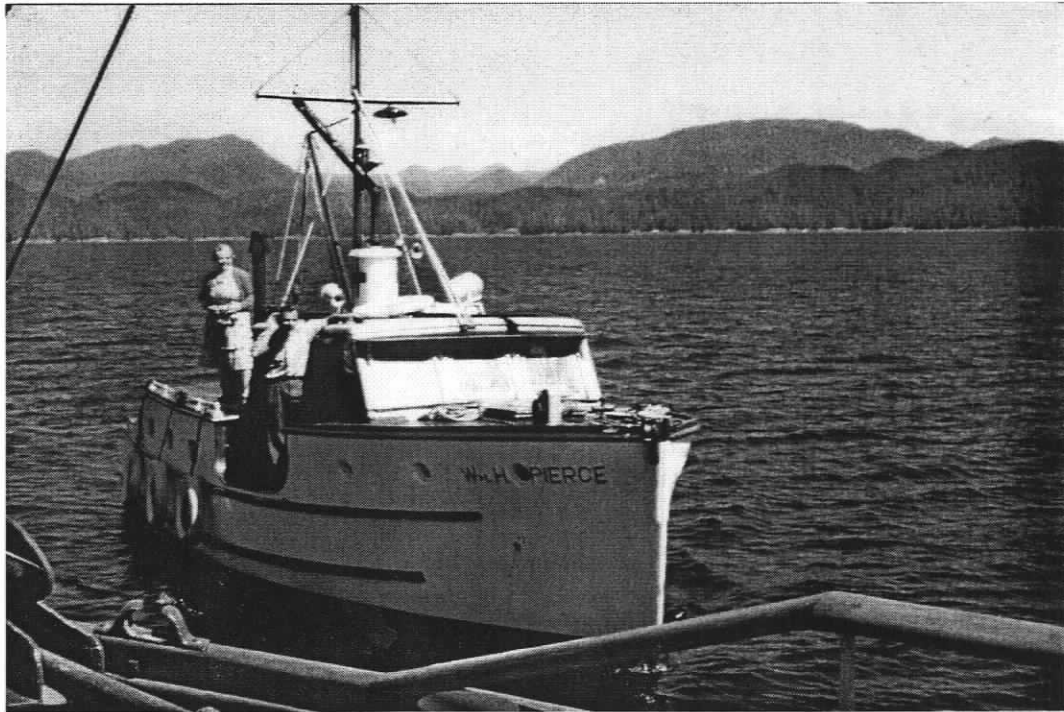


Fig. 6.10: Dr. David Preston and Nurse Flora Moffat on board the *Wm. H. Pierce*, 1961.

Courtesy of Bob Burrows. Photographer: Frank Fidler.

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Fig. 6.11: Nurses and patients at St. George's Hospital, Alert Bay, 1953.
 Courtesy of BC Archives, E-04620



Fig. 6.12: Red Cross Outpost Hospital, Greenwood, 1946.
 Courtesy of BC Archives, C-07996



Fig. 6.13: Red Cross Outpost Hospital, McBride, 1955.
Hospital Auxiliary President H. Lonsdale and Treasurer K. Godfrey presenting fracture bed to Matron D. Popaw
Courtesy of BC Archives, HP54911

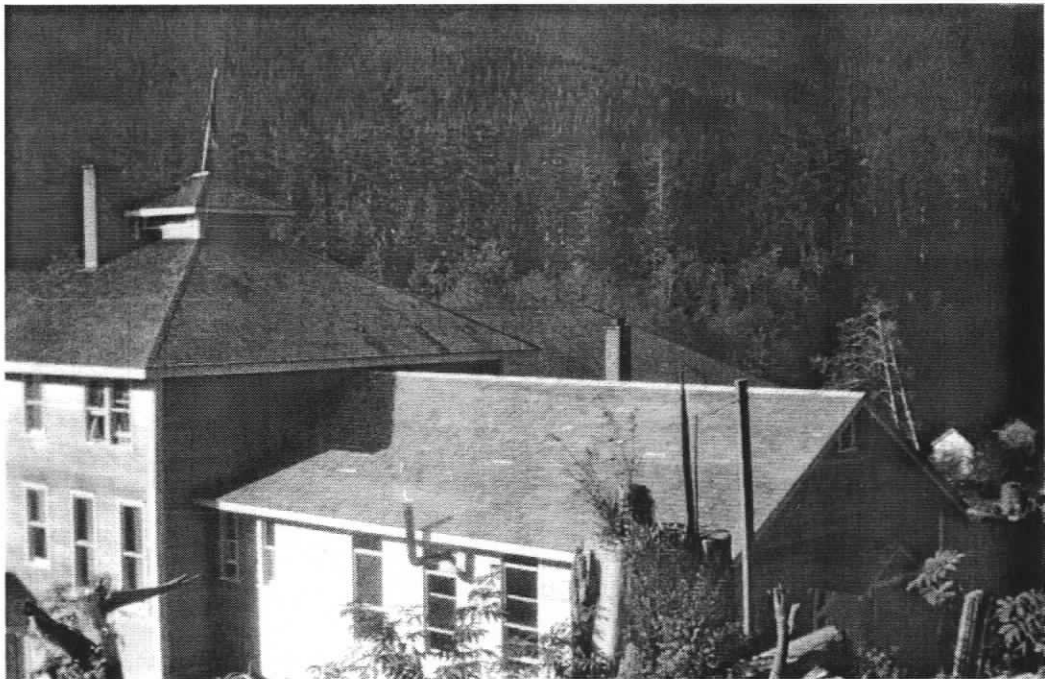


Fig. 6.14: Red Cross Outpost Hospital, Zeballos, 1947
Courtesy of BC Archives, HP58621

Chapter 7

Conclusion: 'Diagnosis' of Northern Healthcare.

The historical study of medical practice cannot be divorced from the specific circumstances of time and place in which it occurred. On the northwest coast, it began with the Hudson's Bay Company's policy of hiring surgeons to oversee the healthcare needs of their employees and the need to protect communities from epidemics. The arrival of missionary physicians began a process to indoctrinate First Nations as Christian citizens of the Empire. Matters of hygiene, dress, public health and assimilation became goals and missionary physicians acted as agents of the state. The Columbia Coast Mission, an Anglican missionary and medical organization, was vital to the development of the region because its medical vessels and land hospitals aided in providing healthcare to local inhabitants and industries. Medicine as progress is evidenced in the opportunism of contract medicine dependent on provincial economic development. Lastly, the advancement of western medicine could not have been sustained except for the concerted efforts of the nursing profession. As teachers of public health measures, nurses became representatives of western medicine in the family home, school and isolated clinic.

Medicine was an integral part of imperialism in the era of exploration. In the eighteenth century the study of botany was the hallmark of early scientific endeavors. Surgeon-naturalists, such as Archibald Menzies, on Captain George Vancouver's voyage, was asked to investigate the natural history of coastal British Columbia to ascertain how it would be suitable for settlers from England. Menzies was specifically requested by

Lord Grenville to itemize animals, birds and fish 'likely to prove useful either for food or in commerce' and to list the "customs, language and religion of natives."¹

The Hudson's Bay Company brought in surgeons to supervise the medical needs of employees since employee sick time meant a loss of company revenue. Company policy was, at first, an 'enclavist' framework: the healthcare needs were almost exclusively aimed towards the white inhabitants, but soon expanded to protect the trading Indian population from epidemics. Surgeons had numerous tasks as apothecaries, physicians and as medical suppliers of medications to forts. which were predominantly imported botanicals to other posts. Although surgeons were considered officers, they were also company employees and, at times experienced a conflict between their company and medical duties. As influential members of the newly emerging colonial elite, many engaged in politics, either in the colonial or provincial legislatures. Others embraced the social milieu and intermarried into First Nations communities.

HBC surgeons and physicians were largely responsible for introducing European prophylactic health procedures to First Nations peoples. As part of the HBC public health policy, First Nations were quarantined or vaccinated. Along with economic and political considerations, today we know that imported pathogens underlay the success of European imperialism. Although the intent was not deliberately genocidal, Native populations suffered massive depopulation. Therefore, medicine and disease control justified the control of Aboriginal people and their confinement to reserves. But, the 1862 smallpox epidemic and the subsequent public health crisis transformed early doctors into

¹ Archibald Menzies, *Menzies' Journal of Vancouver's Voyage: April to October, 1792*, C.F. Newcombe Ed., (Victoria: Archives of British Columbia, 1923), ix-x. Menzies was also asked to itemize the Native names of flora and fauna used by First Nations. Sir Joseph Banks organized Kew Gardens for King George 111 (1773) and Lord Grenville was a member of the British parliament.

colonial physicians. The roots of the contemporary Provincial Board of Health and the Public Health Act can be traced to this episode.

Racist tendencies were incorporated into medical science as part of colonial development. Through missionary doctors' encounters with First Nations we glimpse the sometimes precarious nature of unequal relationships. Paternalism and colonial humanitarianism personify the relationship. Early missionary physicians were dedicated to the empirical notion of assimilation and to the paramount religious idea of saving souls through conversion. To this end, medicine was used as a tool, as "physic and faith criss-cross and overlap at many points."² In the northwest, two missionary medical systems, sponsored by the Methodist and Anglican Churches, embraced the dual role of eradicating sickness and the medicine-man by campaigning against Native beliefs and practices. Missionary physicians saw themselves as paternalistic saviors of Aboriginal peoples. But, medical missionaries faced a dilemma. While they protested against the colonial policy of dispossessing Natives of land, by their very presence they were agents of empire, thereby making it possible for the success of Euro-Canadian expansion and indoctrination.

Other tensions developed between religion and Empire. A theological schism between competing elements within the early Anglican Church also led to land dispossession. Preferring 'saving Native souls' to the Established Church belief in transubstantiation, missionary physician Robert Tomlinson, left the Church Missionary Society, the Anglican Church, his hospital, and Christian village. Why he and his fellow evangelist, William Duncan, would doubt the abilities of the Tsimshian peoples to

² Roy Porter, "Religion and Medicine," W. F. Bynum and Roy Porter, Eds., *Companion of the History of Medicine*, Volume 2, (London & New York: Routledge, 1993), 1449.

understand the Christian ritual when they “already had an elaborate and integrated ceremonial life”³ remains questionable and Tomlinson’s decision adversely affected the delivery of medicine to the isolated area.

As agents of empire, Methodist missionary physicians built hospitals, established nursing schools, and traveled extraordinary distances to oversee the healthcare needs of their patients. Under contract with the Department of Indian Affairs, missionary doctors laboured tirelessly to indoctrinate First Nations in aspects of health and hygiene. Enforcing a sanitary order was part of the political order they helped to maintain. Yet, Natives had mixed responses to western medicine and missionary physicians’ intrusions into their beliefs and practices. While some Aboriginals integrated European therapies into Indigenous healing arts and cultural values, other First Nations either rejected or partially accepted westernized medicine and values. Although western medicine eventually took precedence over Native practices, today incorporation of Indigenous herbal remedies can be found in alternative medicine. Unlike the Anglican missionary physician system, the Methodist missionary physicians built permanent hospitals, embraced secular interests in politics and established private practices. Therefore, the imperialistic notion of progress was both an impulse and an attitude.

.The creation of private medical practice was also a component of contracted medicine. As part of provincial industrial development, physicians contracted to resource-based companies. Many doctors who stayed on, established careers and supplemented their income with contracts from the Department of Indian Affairs and the Workmen’s Compensation Board. Contract medicine was an early form of health insurance with employees contributing through company funding or through membership

³ Patterson, *Mission on the Nass*, 65.

in fraternal lodges. For instance, in 1911, as an incentive for the new Prince Rupert Hospital, members of the Oddfellows, Knights of Pythias and Masons wanted to enhance their membership support by offering to furnish hospital wards. By doing so, the membership hoped to benefit by reduced rates but the hospital ultimately decided not to have benevolent society wards.⁴

Building and maintaining small company hospitals depended on seasonal variations and the ups and downs in the international economy which affected northern development. This resulted in fluctuating population and income levels, which affected the ability of a community to sustain medical service. Over the years, company hospitals increasingly relied on provincial funding, thereby relinquishing their private status to become public facilities. As well, larger northern public hospitals, such as the Prince Rupert General Hospital, are still subject to varying northwestern economies. Seasonal occupations, city finances, and the lack of industry have constrained medical services. For instance, the hospital, in 1914, decided to offer prepaid medical care, consisting of hospital tickets at \$10.00 per year for medical care and a hospital bed. A resident physician was hired, to treat patients except those suffering from venereal disease or alcoholism. He only lasted a year because local doctors objected to their reduced patient load and subsequent income reduction. In the end, the hospital proposed a free choice of physician for ticket holders, with the ticket monies being split, sixty percent being retained by the facility. Money making schemes, such as socials, concerts and raffles were annual events. When the hospital and city went into receivership in 1933, the hospital issued endowment bonds, which are still in use. From its inception, the Board

⁴ Dr. R. G. Large, *History of the Prince Rupert General Hospital*, (Vancouver: Mitchell Press, 1972), R.G. Large, Dr., Collection, Prince Rupert Regional Archives (PRRA), L984-38 458-150, 3.

appealed annually for city grants and to the Provincial Government for special grants. Yet, in spite of its ongoing financial difficulties, the hospital has survived and today provides a vital service to a major northern community.⁵

Industrial companies also contributed to the building of several Anglican Columbia Coast Mission hospitals and aided by collecting monthly insurance fees from their employees. Public health was a major focus of this third mission-centered marine medical delivery system to the north coast. The organization built hospitals and clinics to service isolated logging camps, Native populations and settler communities. Based on the notion of practical Christianity, whereby health was an integral part of social service, the medical marine mission was an essential component of coastal living. For more than sixty years hospital and ambulance ships patrolled the coast, rescuing and delivering inhabitants to the various mission hospitals. In the 1960's, when modern technology and communication superseded ship-borne medical services, and local community boards operated the mission hospitals, the mission was closed. Although the new era meant emergency rescue by plane or the Coast Guard, the value of a medical mission service to the growth of the province is incalculable.

Similar to the earlier Anglican and Methodist missionary physician systems, the Columbia Coast organization was steeped in colonial imperialistic attitudes including the gender bias of its founder Reverend John Antle. Although Antle favored First Nations continuing their tradition of potlatching, his successor, Alan Greene, vigorously opposed it. Both men, in their respective ways, exhibited qualities of superiority. This attitude, at times, must have strained relationships with women and with First Nations.

⁵ Large, *The History of Prince Rupert Hospital*.

Religious ideals and notions of racial superiority were incorporated into missionary nursing. The notion of service to others and the belief that cleanliness was next to Godliness were tenets of their Christian belief. As part of their calling, missionary nurses aided physicians in conversion, taught Sunday school and distributed Bibles on the wards. Sponsored by Methodist and Presbyterian Women's Missionary Societies, missionary nurses' encounters with First Nations were also gender specific because they perceived Native women as needing their intervention in household and child-rearing activities. Their self-appointed role as arbiters of European gentility and femininity mirrored colonial notions of class.

Whether women were attracted to rural nursing because of a religious need, adventure, or a desire to gain independence, they wielded more authority than their urban peers. Leadership and courage personify rural nurses as frequently they were put in decision making positions. In the absence of doctors, nurses became hospital administrators, delivered babies and coped with emergencies. Public health procedures were commonplace, with teaching an important secondary element. From this vantage point, nurses could be called 'missionaries for health.'⁶

The on-the-job autonomy of public health nursing appealed to Red Cross Outpost Hospital nurses. Commencing in 1929, Red Cross nurses managed eighteen small hospitals, initiated a variety of health clinics, home care, and school inspections. Committed to "prevention, education and reform,"⁷ public health nurses became an integral part of a community. Because the northwest region is vast, traveling significant

⁶ Kathryn McPherson and Meryn Stuart, "Writing Nursing History in Canada: Issues and Approaches," *Canadian Bulletin of Medical History*, Volume 11, (1994), 13.

⁷ Kathryn McPherson, *Bedside Matters: The Transformation of Canadian Nursing, 1900-1990*, (Toronto: University of Toronto Press, 2003), 61.

distances to nurse patients was challenging. Unlike an urban hospital setting, where doctors were at hand, outpost nurses decided when a physician needed to be consulted. Although many caregivers preferred rural experiences, isolation and distance remained problematic for rural nurses. Because of this, female relationships played a significant role in the nursing community of women.

In this inquiry, I have been interested in viewing medicine as a social construct. Although medicine is grounded in scientific principles and the specifics of disease and health, it spreads from the body, its political and professional site, into such varied areas as religion, economics, entrepreneurialism, public health, education and diet. Rather than a study excluding social forces, modern history has examined the nuanced relationship between medicine and those social forces that shape its practices and institutions. As Ludmilla Jordanova suggests, uncovering the fully social and cultural nature of medicine in all its facets requires an historical approach that takes ideas about health and healing and conceptualizes them in a social context.⁸

⁸ Ludmilla Jordanova, "The Social Construction of Medical Knowledge," *Locating Medical History: The Stories and Their Meaning*, Frank Huisman and John Harley Warner Eds., (Baltimore and London: John Hopkins University Press, 2004), 357.

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College of Registered Nurses Association of British Columbia *Oral History Project*

Primary interviews:

Rebecca Bancroft	1987
Ethel Freeman (Pierce)	1987
Flora Moffat	1976
Marjorie McDowell (Thompson)	1976
Vi Woodward	1987

Interviews by author:

Rev. Robert Bracewell	Sept. 9, 2003
Dr. Douglas Galbraith	Dec. 8, 2003.
Dr. Mitchell Greene	June 25, 2003
Pat Kermeen (CRCS)	Feb. 7, 2006
Dr. Peter Newbery	July 20, 2004
Dr. W. Don Watt	June 28, 2005