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Circular Progress: Health and Healthcare within Albertan Indian Residential Schools, 1920 - 1950

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UNIVERSITY OF CALGARY

Circular Progress:

Health and Healthcare within Albertan Indian Residential Schools, 1920 - 1950

by

Paula Larsson

A THESIS

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Abstract:

This study provides a systematic analysis of the physical, mental, emotional, and spiritual health of the pupils in Indian Residential Schools from 1920 – 1950. It focusses on a single province – Alberta – and utilizes an inter-disciplinary approach to understand how the interaction between the biological and the psychosocial conditions of the schools contributed to both immediate and chronic health problems for Aboriginal students. Through an examination of nutrition, sanitation, disease, healthcare interventions, and mental health in the schools, it is seen that any “progress” the Department made in regards to the health of students was circular. Department officials used the inherent flaws in the system of school governance – which gave a few men ultimate power over the living conditions of thousands of children – to circumvent the responsibility they held towards the health of students. The ultimate result was a malnourished and vulnerable student population suffering from endemic disease and psychological trauma.

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The path to completion of this thesis has been diverse and challenging. Each step of its creation served as a thorough education in the many factors that comprise the conclusion of a historical research project. At the beginning of the journey, I strode confidently into the crossroads, holding tight to a vision of the direction my path would take and the brilliant destination that was surely just around the corner. Yet as I travelled further down the road of research it slowly became clear that I had strode into a deep and laborious cavern and that shining destination was simply a mirage on the horizon, meant to tempt ambitious – or foolish – researchers like myself into the precarious world of academic study. It wasn't long before I came upon the first foes which sought to disrupt my quest – time management and organization. These proved to be the greatest obstacles to overcome while I struggled through the researching, analyzing, writing, editing, re-writing, and re-editing of my thesis. If not for the help and support of others who kept me advancing down my path – sometimes with a gentle push forward and sometimes with a forcible pull back from the abyss of distraction – I would never have arrived at the destination. I would therefore like to acknowledge the following individuals, who served as a light when I was lost in the dark.

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Introduction:

“Someone once said that the hardest wounds to recognize and identify are those that go back to the distant past of our childhoods. We sometimes no longer remember the wounds, or who or what caused them. All that remains are the rigid behaviours and defensive reactions stirred up by the slightest offence. We continue to feel these childhood misfortunes at an unconscious level throughout our lives.”¹

- Theodore Fontaine, 2010

The western province of Alberta is well known to Canadians as a wealthy prairie province, boasting a rapidly increasing population and a growing prominence in national politics. Statistics Canada recorded the population of Alberta at a record four million in 2014 and further increases are projected.² The province has a reputation for vast natural wealth in the form of crude oil and abundant oil sands. Yet Alberta’s landscape was rich with a different kind of wealth before its colonization by Europeans. The seas of golden prairie grass were covered with roaming herds of buffalo and populated by nomadic tribes of First Nations people. The modern borders of the province were a distant spectre and the landscape was divided only by the seasonal migration routes of Native animals and the Native peoples who hunted them.

The plains peoples – the Blackfoot, Cree, Ojibwa, Assiniboine, Nakota and Dakota – populated much of the prairie regions of Canada.³ These cultures stretched from the woodlands of southeastern Manitoba to the edge of the Rocky Mountains in what is now Alberta. There are many

¹ Theodore Fontaine, *Broken Circle: The Dark Legacy of Indian Residential Schools, A Memoir* (Vancouver: Heritage House Publishing Company Ltd., 2010), p. 188.

² Statistics Canada, “Population and Dwelling Counts, for Canada, Provinces and Territories, 2011 and 2006 Censuses,” Accessed December 10, 2014, <http://www12.statcan.gc.ca/census-recensement/2011/dp-pd/hltfst/pd-pl/Table-Tableau.cfm?LANG=Eng&T=101&S=50&O=A>.

³ This study has utilized the categories laid out by *Historica Canada* to maintain consistency with the general Canadian understanding. *Historica Canada*, “Aboriginal People: Plains,” accessed March 15, 2015, <http://www.thecanadianencyclopedia.ca/en/article/Aboriginal-people-plains/>.

creation stories which explain how each nation came to reside on this land.⁴ The Cree creation story talks of the trickster Wesakechak who was punished by the Creator for his neglect of the animals and humans of the earth. The Creator flooded the world, leaving only one otter, one beaver and one muskrat alive. Wesakechak cried at this loss and the three remaining animals worked to help him form a new island, created from a piece of earth that the muskrat fetched from the depths of the ocean. The new island – North America – was populated with a second generation of animals and humans by the Creator.⁵ This creation story is unique to the Cree peoples and when told properly in its original language, is narrated with a characteristic life and humour.⁶ The Blackfoot creation story features a similar trickster character – Na’pi, or “Old Man.” According to the Blackfoot stories, Na’pi travelled to the north from the south and he created the landscape and animals as he went. Na’pi is an important character in many Blackfoot legends, playing tricks on the animals and people of the land, though usually with good intentions.⁷ These differing creation stories are the history and heritage of the plains peoples and they embody the cultural knowledge passed down through generations by oral traditions.

Although Europeans had been settled in Eastern Canada since the early 1600s, contact with the Aboriginal peoples on the western plains did not occur for over 100 years.⁸ First contact occurred with the French fur traders who established trading posts at Lake on the Woods (in modern day Manitoba) to access the Winnipeg River. Trade relations were initiated with the Cree, Assiniboine, and Monsoni Anishinabe peoples of the north-eastern prairies. The French traded

⁴ Alberta Government, *Aboriginal Peoples of Alberta: Yesterday, Today, and Tomorrow* (Edmonton: Alberta Aboriginal Relations, 2013), pp. 1 – 2.

⁵ *Ibid.*, pp. 4–6.

⁶ *Ibid.*, 6.

⁷ *Ibid.*

⁸ James Daschuk, *Clearing the Plains: Disease, Politics of Starvation and the Loss of Aboriginal Life* (Regina: University of Regina Press, 2013), p. 18.

firearms and other goods to the different tribes in exchange for furs. This gave the eastern tribes a significant advantage over their enemies, as feuding had always been present between the Assiniboine and the more western Sioux peoples. Increased warfare contributed in part to the coming population decline in future decades.⁹

More deadly was the spread of disease which accompanied the trade. The populations which inhabited prairie soil were transformed as Smallpox and other epidemic diseases drove many tribes out of their traditional lands. In the 1730s and 1780s waves of Smallpox spread across the Assiniboine and Monsoni Anshinabe peoples, nearly destroying the Monsoni as a people.¹⁰ The Assiniboine and Cree were pushed further westward after 1700, where they came into conflict with the Blackfoot people.¹¹ Increased conflict enabled disease transmission to new populations which had never before encountered such infectious diseases.¹² Historian Paul Hackett recounts one such event in the summer of 1781, when a group of Cree, Assiniboine, Peigan, Sarcee, Blood, and Atsina warriors encountered a Shoshone enemy camp on the Red Deer River, in modern-day southern Alberta. The Shoshone camp was heavily infected with Smallpox and the advancing warriors were confronted with the sickening sight of the “mass corruption” of the dead and dying.¹³ Although the attackers withdrew from the terrible scene, Smallpox was carried with them

⁹ Ibid.

¹⁰ Maureen Lux, *Medicine that Walks: Disease, Medicine and Canadian Plains Native People, 1880–1940* (Toronto: University of Toronto Press, 2001), pp. 20-21.

¹¹ Ibid., pp. 14 – 22.

¹² For a discussion on the impact of epidemic diseases on North American Indigenous populations, see: Alfred Crosby, *Ecological Imperialism: The Biological Expansion of Europe, 900–1900*, New Edition (Cambridge, UK: Cambridge University Press 2004).

¹³ Paul Hackett, *A Very Remarkable Sickness: Epidemics in the Petit Nord, 1670 to 1846*, (Winnipeg, University of Manitoba Press: 2002), p. 99.

northward and diffused among their tribes upon return.¹⁴ Disease, coupled with inter-tribal conflict, served to erode the strength of the First Nations people on the plains.

Population losses were compounded in the 1870s by the growing disappearance of the buffalo. Before the buffalo disappeared, the plains peoples were healthy and robust, enjoying an active hunting lifestyle and a regular subsistence on a large variety of local berries and root vegetables.¹⁵ Yet the pressures from increased westward migration and the appearance of white buffalo hunters on the plains began to depress herd sizes. Records from the Hudson's Bay Company note game scarcity on the plains as early as the 1760s.¹⁶ This process was accelerated after 1860 when buffalo leather became a valued commodity in industrial production. By the 1870s a lucrative trade had begun in bison hide, leading to the indiscriminate slaughter of millions of bison on the plains. Historian Maureen Lux has found that one American firm contributed to the slaughter of “more than *two-and-a-half million animals annually* from 1870 to 1875” (emphasis in original).¹⁷ The loss of the buffalo left a gaping hole in the economic and spiritual systems of the plains peoples and left them facing imminent starvation.

At the same time the dominion government was developing larger policies which governed the status of Aboriginal peoples within Canada. In 1857 the *Gradual Civilization Act* was passed to “encourage the gradual Civilization of the Indian Tribes” in the province of Canada.¹⁸ Confederation in 1867 led the new federal government to take further steps towards regulating the Aboriginal population and achieving their eventual absorption into the Canadian populace. The

¹⁴ Ibid.

¹⁵ Royal Commission on Aboriginal Peoples, Report of the Royal Commission on Aboriginal Peoples, *Volume 1: Looking Forward, Looking Back* (Ottawa: Canada Communication Group, 1996), p. 66. https://qspace.library.queensu.ca/bitstream/1974/6874/5/RRCAP1_combined.pdf.

¹⁶ James Daschuk, *Clearing the Plains*, p. 11. This will be further discussed in Chapter 1.

¹⁷ Maureen Lux, *Medicine that Walks*, p. 22.

¹⁸ *Gradual Civilization Act*, Statutes of the Province of Canada 1857, <http://caid.ca/GraCivAct1857.pdf>.

Gradual Enfranchisement Act was passed in 1869 and eventually the *Indian Act* was passed in 1876. The *Indian Act* incorporated and expanded on the policies of the two preceding Acts and gave legal grounding to the idea that the assimilation the ‘Indian’ into the dominant society would be the best way to “improve and elevate his character and condition.”¹⁹ The *Indian Act* outlined what it meant to be an ‘Indian’, the rights given to bands and individuals, and the ways in which those rights could be taken away. Ultimate power over First Nations people was given to the Superintendent of Indian Affairs in the Department of the Interior, which later became its own government Department in 1880 – titled the Department of Indian Affairs (hereafter referred to as the Department).²⁰ The Department of Indian affairs would later be incorporated into the Department of Mines and Resources in 1936 and again reorganized into the Department of Citizenship and Immigration in 1950.²¹ Officials of the Department had the power to withdraw the rights of any First Nations person at will should they deem the individual to be dishonest, intemperate, immoral, or incompetent.²² The *Indian Act* created a parental relationship between the Canadian Government – in the form of the Department of Indian Affairs – and the First Nations people. The First Nations were seen as incapable and child-like, in need of regulation, control, and moral guidance.²³ The legal implications of the *Indian Act* also formed the basis for a legacy of gender inequity, as women were prevented from exercising any political power in bands and the

¹⁹ LAC, RG10, Volume 2952, File 202, 239. Quote from the Ryerson Report on Indian Education, 1947.

²⁰ The Department of Indian Affairs would undergo a later consolidation with the Department of Mines and Resources in 1936 and would become a branch in this Department until 1950, when it became a branch in the Department of Citizenship and Immigration.

²¹ Library and Archives Canada, “Indian Affairs Annual Reports, 1864 – 1990,” accessed April 20, 2015, <http://www.bac-lac.gc.ca/eng/discover/Aboriginal-heritage/first-nations/indian-affairs-annual-reports/Pages/introduction.aspx>.

²² *Indian Act*, Statutes of Canada 1876, https://www.aadnc-aandc.gc.ca/DAM/DAM-INTER-HQ/STAGING/texte-text/1876c18_1100100010253_eng.pdf.

²³ Royal Commission on Aboriginal Peoples, *Volume 1*, p. 254.

legal term 'Indian' could only be applied to a woman who was the offspring of or "was lawfully married" to a man defined as such.²⁴

The *Indian Act* legislation went hand in hand with the signing of Treaties between the Canadian Government and the First Nations people across the prairies. When the Canadian Government purchased Rupert's Land from the Hudson's Bay Company in 1869, it used the promise of a trans-continental railway to entice British Columbia into confederation.²⁵ This promise necessitated quick settlements to be made of the newly acquired area and large land grants to be given to the Canadian Pacific Railway for construction. Yet the presence of the First Nations people interfered with these goals, as the local populations made it clear that settlement of their lands would only be possible if their rights were first protected.²⁶ The Canadian Government, for its part, was legally bound by the Royal Proclamation of 1763 to acknowledge the rights of the Aboriginal people to their lands. Thus the government initiated a process of Treaty-making with the First Nations people across western Canada.

Eleven numbered Treaties, encompassing most of western Canada, were signed between 1871 and 1921. In present day Alberta, Treaty 6 was signed first, covering the area in central Alberta and Saskatchewan where the Cree, Assiniboine, and other tribes resided.²⁷ These populations were hit the hardest by the disappearance of the buffalo and were suffering near starvation when they agreed to sign the Treaty. Treaty 7 soon followed, signed by the Siksika (Blackfoot) nation, the Stoney, Kainai (Blood), Piikani (Peigan), Tsuu T'ina (Sarcee), and others.²⁸ The First Nations viewed the Treaties as vital documents, which protected the futures of the nations

²⁴ Ibid.

²⁵ Paul Hackett, *A Very Remarkable Sickness*, p. 99.

²⁶ Ibid.

²⁷ Royal Commission on Aboriginal Peoples, *Volume 1*, pp. 155-157.

²⁸ Ibid.

and would guarantee their survival. A Treaty "was an exchange of promises in perpetuity – as long as the sun shines, the rivers flow, and the grass grows."²⁹ This viewpoint was not shared by most Indian Agents or the government, as Treaties were believed to be the best way of controlling the Aboriginal populations. Indeed, the Commissioner for Indian Affairs, Edgar Dewdney (1835 – 1916), soon used the distribution of rations to the starving bands as a coercion tactic to induce dissenting Chiefs and their followers into the Treaties.³⁰

Each Treaty entailed a large surrender of lands to the government in exchange for annuity payments and other resources for the First Nations who signed. The true spirit of the Treaties – which in the First Nations understanding were not an agreement to surrender their land, but instead an agreement to share it – has been the focus of many political and social histories in Canada.³¹ In addition to annuity payments, the Treaties held promises for the provision of agricultural equipment, tools, and farming implements, in order to facilitate the transition from traditional lifeways to subsistence agriculture on reserve lands. Without the buffalo such changes were necessary to avoid starvation. Native concerns over hunting rights during the treaty negotiations were a clear indication of the subsistence problems they were facing. During Treaty 6 negotiations, the Cree leaders were very insistent that the government limit the buffalo hunt to First Nations hunters only, as white and Métis hunting was severely limiting the already dwindling herds.³² The First Nations leaders therefore recognized the need to try other forms of subsistence and they

²⁹ Chief John Snow, *These Mountains are our Sacred Places: The Story of the Stoney People* (Calgary: Fifth House Publishing, 2005), p. vii.

³⁰ John Tobias, "Canada's Subjugation of the Plains Cree," p. 527.

³¹ See Richard Price, *The Spirit of the Alberta Indian Treaties*, (Edmonton: University of Alberta Press, 1999), Treaty 7 Elders and Tribal Council et al., *The True Spirit and Original Intent of Treaty 7* (Montreal: McGill-Queen's University Press, 1995), and James R. Miller, *Compact, Contract, Covenant: Aboriginal Treaty-Making in Canada* (Toronto: University of Toronto Press, 2009).

³² John Tobias, "Canada's Subjugation of the Plains Cree, 1879–1885," *Canadian Historical Review* 64, no. 4 (1983): 519 – 548, esp. 523.

insisted on the provision of farming equipment, livestock and instruction in the basics of agriculture in Treaty negotiations.

Treaty 6 additionally promised assistance for the First Nations people during times of famine or disease. It was agreed that during the experience of “any pestilence, or general famine” the government would be responsible for providing rations and “assistance” to the First Nations groups on the prairies in order to relieve their suffering.³³ The government likewise agreed to provide healthcare in the form of a “medicine chest” that would be “kept at the house of each Indian Agent for the use and benefit of the Indians.”³⁴ These two clauses led to the establishment of the ration system on reserves and federal assumption of the legal responsibility for the healthcare of First Nations people.

Another key component of the treaties was the guarantee of education for Aboriginal children. Faced with starvation and sickness, the First Nations’ sought to survive through the transition to an agricultural way of life. However, as farming was a foreign concept to the traditionally nomadic tribes, vocational training was necessary for successful adaptation to a new form of subsistence. Historian John Tobias has demonstrated that the First Nations Chiefs in the west were avidly aware of this need during negotiations and made pointed demands for the provision of “mills, blacksmith and carpentry shops and tools, and instructors in farming and the trades” before they entered into Treaty negotiations with the Government.³⁵ These instructors would be key to the success of agricultural practices for the First Nations communities.

³³ Aboriginal Affairs and Northern Development, “Treaty Texts – Treaty No. 6,” accessed Sept 11, 2015, <https://www.aadnc-aandc.gc.ca/eng/1100100028710/1100100028783>.

³⁴ Ibid.

³⁵ Ibid., p. 524.

In the First Nations understanding, education would be gained through the creation of a “great teaching wigwam” to give their children the advantage of European schooling. This education would allow them to adjust to the dramatic changes of the future and would provide future generations with footing equal to their European neighbours.³⁶ A legacy of educating children through mission schools was already present in the west and thus further education was easily agreed to by the Government of Canada. Indeed, the government had already planned for such a program, having commissioned a report on Native Education from Egerton Ryerson (1803 – 1882) as early as 1847.³⁷ The *Ryerson Report* recommended the establishment of Industrial schools “to give a plain English education adapted to the working farmer and mechanic.”³⁸ Ryerson was also one of the first to assert that Native children would need to be removed from their parents care and instead given instruction in “orthodox Christianity” in order to “make the Indian a sober and industrious man.”³⁹ The agreement to open schools was a small one in the Treaties, consisting of one short line: “and further, Her Majesty agrees to maintain schools for instruction in such reserves hereby made as to Her Government of the Dominion of Canada may seem advisable, whenever the Indians of the reserve shall desire it.”⁴⁰ The result was the establishment of the Indian Residential School System across Canada.

The Indian Residential School System can be seen as a product of the societal processes which characterized Canadian society in the later nineteenth century. Firstly, it was an outcome of colonial ideologies and policies which sought to displace – both physically and ideologically –

³⁶ James Miller, “Troubled Legacy: A History of Native Residential Schools,” *Saskatchewan Law Review* 66, no. 7 (2003): pp. 357 – 382, esp. 360 – 361.

³⁷ LAC, RG10, Volume 2952, File 202, 239. Quote from the Ryerson Report on Indian Education, 1947.

³⁸ *Ibid.*

³⁹ *Ibid.*

⁴⁰ Aboriginal Affairs and Northern Development, “Treaty Texts – Treaty No. 6,” accessed August 1, 2015, <https://www.aadnc-aandc.gc.ca/eng/1100100028710/1100100028783>.

Indigenous peoples and their cultures from their historical place in Canada. Aboriginal values and beliefs were dismissed as ‘primitive’ and ‘savage’ and western colonizers believed it a moral duty to force Indigenous people to abandon their ideologies in favor of western values.⁴¹ This duty was carried out in what has been termed a “forced assimilation plan” through the residential schools, which taught Aboriginal children that their heritage was inferior and that success in life could only be achieved through the adoption of white, Anglo-Canadian morals.⁴²

Secondly, these principles can be closely tied to the ideologies of Social Darwinism which infiltrated the intellectual culture of Canada at this time. As the idea of natural selection became more and more accepted in scientific communities, associated notions about the ‘survival of the fittest’ were extended to social policy within the country. The Canadian state was highly influenced by new revisionist thinkers, who sought scientific solutions to the problems inherent in urbanization, disease, poverty, and the perceived moral degeneration of society.⁴³ The later nineteenth century saw the beginnings of increased state control over populations thought to be the cause of these problems. A process of institutionalization began and the isolation of individuals labelled as vagrants, deviants, and insane became possible through the opening of government controlled prisons and asylums across Canada.⁴⁴ These marginalized populations were segregated

⁴¹ Royal Commission on Aboriginal Peoples, *Volume 1*, p. 132.

⁴² Marie Battiste, *Decolonizing Education: Nourishing the Learning Spirit* (Saskatoon: Purich Publishing, 2013), p. 23.

⁴³ Erica Dyck, *Facing Eugenics: Reproduction, Sterilization, and the Politics of Choice* (Toronto: University of Toronto Press, 2013), p. 5.

⁴⁴ Andre Cellard and Marie-Claude Thifault, “The Uses of Asylums: Resistance, Asylum Propaganda, and Institutionalization Strategies in Turn-of-the-century Quebec,” in *Mental Health and Canadian Society: Historical Perspectives*, ed. James E. Moran and David Wright (Montreal: McGill-Queen’s University Press, 2006), p. 97.

from the populace as part of a larger project of maintaining social order and control within the new Canadian state.⁴⁵

State control was similarly established over Aboriginal populations after the passing of the *Indian Act*. The First Nations people were viewed at this time as a “dying race” that was experiencing first-hand the processes of natural selection at work within society. Policy makers and intellectuals alike believed the Aboriginal population was undergoing a natural decline, as they succumbed to high mortality rates and assimilative policies.⁴⁶ In the minds of many Canadians, the struggle between “primitivism and modernity” was being waged on the reserves through the policies which encouraged the civilization and enculturation of First Nations people.⁴⁷

Central to these policies was the education of Aboriginal children. The industrial schools – and later the residential schools – were another type of state-controlled institution which sought to eradicate unwanted behaviours among marginalized groups. Children were taken from the influence of their families and placed in an institute for the majority of the year, where they were taught to abandon their traditional culture and instead adhere to western values – including discipline, Christian morals, and adhesion to the Canadian state. The early policing of parental rights and capability among the Aboriginal population hints at the later influence which eugenic policies would gain in Canada, especially in the case of Alberta.⁴⁸

⁴⁵ For more information on this, see: James Moran, *Committed to the State Asylum: Insanity and Society in Nineteenth-Century Quebec and Ontario* (Montreal & Kingston: McGill-Queen’s University Press, 2000).

⁴⁶ Erica Dyck, *Facing Eugenics*, p. 56.

⁴⁷ Mary Ellen Kelm, “Diagnosing the Discursive Indian: Medicine, Gender, and the “Dying Race,”” *Ethnohistory* 52, no. 2 (2005): pp. 371 – 406, esp. 372.

⁴⁸ For more on the process of Eugenics in Canada, see, Angus McLaren, *Our Own Master Race: Eugenics in Canada, 1885 – 1945* (Oxford: Oxford University Press, 1990) and Erica Dyck, *Facing Eugenics: Reproduction, Sterilization, and the Politics of Choice* (Toronto: University of Toronto Press, 2013).

The government based their education program on the original efforts of priests who had long since established missions in Rupert's Land to bring Christianity to the Natives. Reverend John West (1807 – 1845) had established a school for Native children in the Red River settlement as early as 1820.⁴⁹ In emulation of this early arrangement, the school system was founded as a joint endeavour between the Christian churches and the Canadian government. Initially, the system included three types of schools – day schools, industrial schools, and boarding schools.⁵⁰ Day schools provided a western education to students for part of the day, after which children would return home to their families. Boarding schools and industrial schools, on the other hand, involved the isolation of the students from their families through permanent residence within the institution. Industrial schools were the larger of the two and training focused on providing Aboriginal children with experience in agriculture, trades, and domestic skills, in addition to an education in English and Christianity. Boarding schools had less specialized training, focussing solely on farming and the socialization of the child in western morals.⁵¹

However, by the 1910s it became clear to federal officials that the so-called ‘dying race’ was far more resilient than previously thought. As one senior official in Indian Affairs wrote:

The Census shows that Indians are not decreasing in numbers. They are here to stay and the question naturally arises, -what are we to do with them ? (sic) and what obligations devolve upon the Government in regard to providing means for their advancement and civilization ? (sic) Are they always to remain a charge on the country, or shall we, by educating the rising generation, endeavor to make them self supporting and fitted for the duties and privileges of civilized life?⁵²

⁴⁹ John Milloy, *A National Crime: The Canadian Government and the Residential School System, 1879 to 1986* (Winnipeg: University of Manitoba Press, 1999), p. xi.

⁵⁰ Jennifer Pettit, "To ‘Christianize and Civilize’: Native Industrial Schools in Canada" (Ph.D. Dissertation, University of Calgary, 1997), p. 2.

⁵¹ *Ibid.*

⁵² LAC RG 10, Volume 6039, File 160-1, Part 1. Memorandum, Department of Indian Affairs, July 15, 1897.

The Aboriginal people not only began to recover their population numbers, but were showing a marked stubbornness in abandoning traditional spiritual practices. Despite an amendment to the *Indian Act* in 1895 which placed harsh restrictions on traditional practices like the Sun and Thirst dances, many of these ceremonies were still held annually.⁵³ The Department therefore began a revitalization process of the school system in the 1920s. The old (and usually much debilitated) industrial and boarding schools were gradually shut down or consolidated. In their place the Department built new residential schools.⁵⁴ These schools had an education system similar to that of industrial schools, but with less attention to trade skills and instead a focus on farming and agriculture. The revitalization process reveals a new policy in Aboriginal education, which recognized the failure of previous assimilation policies and instead refocused itself on preparing students for a life on the reserves, segregated from the Canadian populace.⁵⁵

The organization of the residential school system required a partnership between the two powers involved in administration – the Department of Indian Affairs and the Christian churches. Initially, the government only supplied funding to construct a few select schools – including four industrial schools and a few of the early residential schools in Ontario, such as the Mohawk Institute and Mount Elgin.⁵⁶ The construction of the majority of the early boarding and day schools were the result of church missionary efforts into the northwest. In many cases Church officials would initially found and build a school in a new location. The church would then lobby the Department to have the school classified as an official boarding school. Official classification

⁵³ Maureen Lux, *Medicine that Walks*, pp. 88 – 89.

⁵⁴ Jennifer Pettit, *To 'Christianize and Civilize'*, p. 2.

⁵⁵ Scott Trevithick, "Native Residential Schooling in Canada: A Review of Literature," *Journal of Native Studies* 18, no. 1 (1998): pp. 49 – 86, esp. 50.

⁵⁶ LAC RG 10, Volume 6039, File 160-1, Part 1. Memorandum, Department of Indian Affairs, July 15, 1897.

would require the Department to provide for the maintenance of the school and would enable it to receive a support grant from the government for the cost of feeding and keeping Aboriginal children.⁵⁷ In 1892 a standardized financial system was implemented with an annual per-capita grant provided to each school as a subsidy for each child in attendance. Although the amount of the per capita grant varied over the next half a century, ranging from \$72-\$150, the per capita system of funding stayed in place until the 1950s.⁵⁸ In exchange for the per-capita grant, schools were to “conform to the Regulations of the Department as to the course of study, dietary, clothing, admissions and discharges, and [were] subject to inspection by authorized officers of the Department.”⁵⁹

The government therefore took on a regulatory role in the administration of the schools. It provided the funding for maintaining schools and established the standards by which school administrators were to abide. Children were to be supplied by the churches with “suitable and sufficient clothing, subsistence, lodging and accommodations, and all other articles necessary to their personal comfort and safety.”⁶⁰ Such standards were to be maintained through the inspection of Indian Agents, and later school inspectors, who would report on the conditions and cleanliness of the schools during annual or semi-annual visits. Additional inspections could, however, be made by Indian Agents, travelling nurses, construction officials, and sometimes the Commissioner for the Prairie Provinces (appendix 2). While the upkeep of the children was to be funded through the per capita grants, the Department also agreed to pay for other necessary school expenses including,

⁵⁷ Ibid.

⁵⁸ Ibid. Statement of Industrial Schools, Showing the Number of Pupils Provided for, the Accommodation and the Attendance at Each School, February 18, 1901.

⁵⁹ LAC RG 10, Volume 6039, File 160-1, Part 1. Memorandum, Department of Indian Affairs, July 15, 1897.

⁶⁰ LAC, Volume 6039, File 160-1, Part 1. Agreement between Church and Department, 1910.

“medicines, school-books, stationery and school appliances.”⁶¹ The regulations of the Department furthermore provided a means for coercing parents to send their children to school. While the regulations outlined many ways in which children could be exempt from school attendance – including living distance, being needed at home, or for the “reason of sickness or other unavoidable cause” – attendance at school was nonetheless deemed mandatory by Department officials. As early as 1897 the Department authorized the appointment of “truant officers” on reserves to ensure the attendance of children who officials considered should be in school. These officers would “be vested with police powers” for their duties and could take legal action against parents or guardians who failed to comply.⁶² In 1920 an amendment was made to the *Indian Act* in 1920 which made absence from school illegal for all First Nations children between the ages of seven and fifteen.⁶³ The Department therefore took on the role of direction, regulation, and supervision of the residential school system. It was the senior partner in the education effort and had the ultimate legal responsibility for the welfare of the children within the schools.

The Department also maintained control of the schools through the regulation of expenses. Whenever a school was in need of maintenance or repair, the principal of the school was obliged to have the total expense of the work or supplies first quoted and then sent to the Department for approval.⁶⁴ This included any maintenance or repair work required for the school to maintain its mandate of providing a safe and sanitary environment for students, as well as the provision of medications. The purchasing of equipment for farming or school appliances was similarly controlled by Department approval and these items were often denied by the Department when it

⁶¹ Ibid.

⁶² LAC RG 10, Volume 6039, File 160-1, Part 1. Memorandum, Department of Indian Affairs, July 15, 1897.

⁶³ John Milloy, *A National Crime*, pp. 70–71.

⁶⁴ LAC, Volume 6039, File 160-1, Part 1. Agreement between Church and Department, 1910.

was felt they were too costly or not worth the expenditure. This system gave the government a primary of control over the state of school buildings and school grounds. It likewise discouraged school administrators from making expenses which were not deemed to be “absolutely necessary” for the running of the school.⁶⁵ Such a stipulation often discouraged schools from undertaking necessary maintenance which could improve student health and it also failed to provide for any emergency repair work which schools may need. This arrangement of Departmental oversight was in place until the 1950s, after which the government assumed even greater control of the system, introducing integration and closing down some of the more isolated schools.⁶⁶

The churches handled the specifics of school administration, personal education, and the primary care of the children. This meant that the church officials who served as school officials – i.e. principals, teachers, and staff – would be the individuals who saw the children on an everyday basis and were in charge of their daily welfare. School staff were obligated to ensure that children were adequately clothed and fed, and that their health was looked after. This included ensuring that they were “clean and free from vermin both in their clothes and persons” as well as providing a sanitary living environment.⁶⁷ The school officials were similarly in charge of the regular education of students within the schools. Although schools were obliged to follow a specific curriculum mandated by the Department, how the curriculum was taught was largely determined by the churches’ ideological standpoint on the condition of the ‘Indian’. When the school system was first developed, each church outlined a philosophy of education “as will effect the complete civilization and enlightenment of the Indians not simply ultimately but within the briefest period

⁶⁵ LAC, RG 10, Volume 6016, File 1–1–13. R.T. Ferrier, Memorandum, March 23, 1927.

⁶⁶ James Miller, “Troubled Legacy,” p. 380.

⁶⁷ LAC, Volume 6039, File 160-1, Part 1. Agreement between Church and Department, 1910.

possible.”⁶⁸ The philosophies laid out by the churches correlated the education of students with the idea of the assimilation of “the heathen”.⁶⁹ In the eyes of the churches, this assimilative philosophy was best achieved through direct control of the children. Thus the staff of the schools became the primary caregivers of the children, as they could provide proper “religious instruction” to pupils, as opposed to a “secular education.”⁷⁰ The attitudes of principals in this regard were often strongly expressed in correspondence. Control of the Aboriginal child was a jealously guarded right by school administrators, who tended to care less about the physical welfare of the child and more about the condition of their soul.⁷¹ Principals of different denominations would frequently argue over which school a student should attend based on the religious differences between parents. Principals were similarly argumentative over whether students should be allowed to stay home from school – and therefore under the influence of their family – in cases of sickness or other pressing conditions. These arguments often overlooked the fact that schools were already overcrowded and had little space or money to care for another child.⁷² Contact with a child’s traditional culture was seen as inherently dangerous and the churches consistently petitioned the

⁶⁸ LAC, RG 10, Volume 6039, File 160–1, Part 1. Memorial, Privy Council of Canada, June 6, 1892.

⁶⁹ *Ibid.*, Memorial of the Members of the Baptist Ministerial Association of the City of Toronto.

⁷⁰ *Ibid.*, Resolutions Passed by a Conference of the Representatives of the English, Methodist and Presbyterian Churches held in Manitoba College, Winnipeg, Dec. 1st, 27th and 28th, 1906.

⁷¹ The need to control the students is a regular theme in the records of the schools and in the more recent accounts of the students who attended them. One residential school survivor, Carole D., remembered a similar attitude in the principal of St. Michael’s Residential School in Southern B.C. Carole was fifteen when she ran away from the school. The RCMP officer who captured her that night sexually assaulted her before bringing her back to the principal of the school. She remembers that the principal was furious at the incident, but the anger did not come from concern for her welfare – but the belief that “the students in the school were more his little possessions.” Indeed, the fact that the incident was never reported by the principal indicates that he did not feel it warranted legal intervention, so long as she was back under his control. Where are the Children, “Stories,” Carole D. – St. Michael’s Indian Residential School. Oral Interview, accessed July 24, 2015, <http://wherearethechildren.ca/en/stories/#>.

⁷² See pages 42, 116, and 172.

government for greater restrictions on cultural activities seen as a threat to students. In a joint letter addressed to the Department in 1906, the Protestant churches wrote:

We would ask that the clauses of the Indian Act of the Indian Treaties or of regulations of the Indian Department forbidding dances of the Indians known as the War-dance, the Sun-dance the Ghost dance and other similar ceremonies having reference to the old and evil tribal customs, should be as far as possible strictly enforced on the Reserves as being detrimental to morals and progress.⁷³

In light of such 'moral' concerns, the teachers and staff of the schools were often reverends, priests, or nuns appointed by the churches to the different schools, who were to help improve student morals through a thoroughly Christian education.⁷⁴

I.I – Historiography:

The historiography on the Indian Residential school system has demonstrated a trend towards consistently negative interpretations of these schools over time. Early studies in the 1970s and 1980s recognized the problems with school regulation, but tended to present government policy in the light of 'good intentions'. In the 1990s, this idea underwent serious revision as scholars began to recognize the self-serving nature of the school policy – which was intended to maintain western power over Aboriginal communities.⁷⁵ More recent scholarship has taken an even harsher stance on government policy, as scholars have emphasised how the lasting impacts of the residential school system still inhibit racial equality today. They have argued that the Canadian government consciously undertook a program of cultural genocide against Aboriginal populations and that this program has left a legacy of inequality, disparity, and pain among First Nations, Metis, and Inuit people. The recent report of the Truth and Reconciliation Commission of Canada (TRC)

⁷³ Ibid.

⁷⁴ John Milloy, *A National Crime*, pp. 26 – 30.

⁷⁵ Scott Trevithick, *Native Residential Schooling in Canada*, p. 49.

has brought particular credence to this view, as the testimony of survivors has empathized how Indian residential schools sought “the destruction of those structures and practices which allow the group to continue as a group.”⁷⁶

In his article titled *Native Residential Schooling in Canada: A Review of Literature*, Scott Trevithick has outlined two interpretations present in the scholarship on residential schools. The "traditional" interpretation sees the flaws of the schooling system as stemming from poor regulation but good intentions.⁷⁷ It holds that assimilation and integration policies were the underlying goals of the implementation of the residential school system. The second interpretation, which Trevithick has deemed the "revisionist" school of thought, rejects the benevolent intentions of government policy and instead posits that the Department was actually carrying out a program of control and regulation of Native peoples. This position argues that, while the government may have stated the best of intentions in regards to assimilation, the actions of the Department of Indian Affairs and the chronic neglect and underfunding of the schools reveal that the true intentions behind the Indian Residential School System were to eradicate the “Indian problem” by destroying Aboriginal culture.⁷⁸

One of the earliest reports written about the Indian Residential School System was published in 1922 by Dr. Peter Bryce, former Medical Inspector for the Department of Indian Affairs. Bryce’s work – titled *The Story of A National Crime* – was highly critical of the schools and the healthcare system on reserves in general, claiming that due to the nature of the system, “it

⁷⁶ The Truth and Reconciliation Commission of Canada, *Honouring the Truth, Reconciling for the Future: Summary of the Final Report of the Truth and Reconciliation Commission of Canada* (Truth and Reconciliation Commission of Canada, 2015), p. 1.

⁷⁷ *Ibid.*, 50–52.

⁷⁸ *Ibid.*

was hopeless to expect any improvement.”⁷⁹ Bryce laid the blame for the high mortality and disease rates among reserve populations at the feet of the officials in charge of the Department. Some of these officials he accused of utilizing bureaucratic structures to avoid doing even “the simplest effective efforts to deal with the health problem.”⁸⁰ Others he took an even harsher stance with. Bryce was particularly condemning of the actions of Duncan Campbell Scott (1862 – 1947), a Department official who served in leadership positions within the Department for over two decades. In one quoted letter to the Superintendent of Indian Affairs discussing Scott, Bryce wrote:

Am I wrong in assuming that the vanity of Mr. D.C. Scott, growing out of his success at manipulating the mental activities of Mr. Pedley, has led him to the fatal deception of supposing that his cleverness will be equal to that of Prospero in calming any storm that may blow up from a Tuberculosis Association or any where else, since he knows that should he fail he has through memoranda on file placed the responsibility on Mr. Pedley and yourself.⁸¹

Bryce claimed that the Department administration was so inadequate at dealing with diseases like tuberculosis, it was tantamount to a “criminal disregard” of the Department’s Aboriginal wards. He hoped his pamphlet would be an “appeal for the Indians of Canada before the King’s representative and the Parliament of Canada, feeling sure that justice will be done both to them and myself.”⁸² While Bryce’s words were highly critical of the schools and healthcare on reserves, Bryce himself still believed that assimilative policies were key to helping the Native populations. This can be seen in *The Story of A National Crime* when Bryce offers a defence of the File Hills farming colony in Manitoba, which was one of the more successful enculturation programs.⁸³

⁷⁹ Peter Bryce, *The Story of a National Crime: Being an Appeal for Justice to the Indians of Canada, the Wards of the Nation, Our Allies in the Revolutionary War, Our Brothers-in-arms in the Great War* (Ottawa: James Hope & Sons Ltd, 1922), p. 12.

⁸⁰ *Ibid.*, p. 13.

⁸¹ *Ibid.*, p. 6.

⁸² *Ibid.*, p. 18.

⁸³ *Ibid.*, pp. 9 – 10.

Aside from Bryce's work, the majority of early writings about the residential schools tended to highlight the altruistic intentions of Aboriginal policy makers. Many of these writings were created by individuals with firsthand knowledge or experience of residential schools and they generally portrayed the schools in a positive light. One such account was by Rev. Edward Ahenakew (1886 – 1961), a Cree priest and was published in 1965. His work described the reopening of the Little Pine Indian day school, Saskatchewan. The work has a distinctly positive tone, emphasizing the guidance given to students while in the school. Most significant is his comment, "the Department of Indian Affairs showed that there is nothing reasonable it will not do to help such a school."⁸⁴ This statement praises the Department of Indian Affairs as a benevolent caretaker, intent on helping its charges in any way it could. While Ahenakew saw the school through the eyes of a Christianized educator, other students of residential schools look back on their years in a less positive light.

Basil Johnston's *Indian School Days* demonstrates the mixture of emotions former students often have when recalling their memories of residential school life. This is an autobiographical book, filled with an interesting combination of sad memories and dry humour. Johnston attended a school in Northern Ontario, called Spanish Indian Residential School. He noted the constant hunger "both physical and emotional" of his experience at the school and his work reflects an underlying anger at the conditions of school life.⁸⁵ He also recounts the fear and confusion associated with the harsh introduction to school life and his first experience arriving at the school:

With fear and misgiving I followed the priest to the third floor, where he ordered me to shed my clothing. He handed me a bar of carbolic soap and shoved me in the shower. "Scrub. Scrub hard." The shower hissed and then stopped. The curtain opened. Father Book (it was really Father Buck, but because of his German accent I first heard it as

⁸⁴ Rev. Edward Ahenakew, "Little Pine: An Indian Day School," *Saskatchewan History* 18, no. 2 (1965), pp. 55 – 62, esp. 62.

⁸⁵ Basil Johnston, *Indian School Days* (Toronto: Key Porter Books, 1988), p. 137.

“Book”) poured some vile-smelling substance on my head that smelled like turpentine and gasoline and coal oil combined. “Wash! Wash good!” The shower resumed. I washed good!⁸⁶

Yet Johnston’s account is likewise filled with stories of boyish pranks, games, and other memories of being a child within residential school. This provides a darkly humorous picture of the Spanish Residential School, where children colluded to thwart and upset their overseers while finding different ways of coping with the condescending attitudes teachers, who viewed Aboriginal beliefs as “old pagan primitive beliefs” that were dismissed with “a wave of [the] hand.”⁸⁷

In the field of history, residential schools did not become a major topic of study until the 1970s and 1980s. One early study was undertaken by Jacqueline Kennedy in 1970.⁸⁸ Kennedy looked at daily life inside the Qu'Appelle Industrial School, Manitoba and argued that officials in charge of the school saw the passage through religious rites as initiation rites into Canadian society. She bluntly argues, “the prevalent view of the government and missionary administrators was that selected Indians – preferably youths – should be guided from a state of impurity, incompetence and ignorance, to a state in which they would function as adults acceptable to the white society.”⁸⁹ She therefore outlines the assimilative policies and heightened concern which these officials felt towards the successful civilization of students. While Kennedy condemns the government and the churches for poor health and administration of the school, her criticisms fall mainly on the government, which she chastises for neglect and mismanagement. This is an early precursor to the criticism which would come later in the historical scholarship. Yet Kennedy’s work still falls into Trevithick’s traditional view of scholarship, as she has yet to step out of the paradigm which

⁸⁶ Ibid., p. 22.

⁸⁷ Ibid., p. 129.

⁸⁸ Jacqueline Kennedy, “Qu’Appelle Industrial School: White ‘Rites’ for the Indians of Old North-West,” (Master’s Thesis, Carleton University, 1970).

⁸⁹ Ibid., p. 5.

viewed ‘civilization’ as a benevolent goal. This is seen in her discussion of the File Hills farming colony, which housed students after graduation, in hopes that they would be prevented from returning to their Native ways. Kennedy writes, “Interested and capable agents and an adequate supply of concerned parish workers could have extended the success of the colony experiment, in helping ex-pupils put moral and technical training to use, and in raising the economic and social quality of their lives.”⁹⁰ Thus Kennedy demonstrates that she accepts to some degree the idea of benevolent civilization.

Another early study on residential school policy was undertaken 1976 by Sylvia Dayton. In her MA thesis in Anthropology, she outlines the underlying premises of “Indian Policy pertaining to education.”⁹¹ This policy, she argues is based on a “group ideology” of white superiority which still regulated First Nations education in the 1970s.⁹² Through an anthropologic analysis of the implementation of school policy, Dayton demonstrates how this ideology was intricately tied to euro-centric conceptions of civilization and western superiority. She concludes that these beliefs, coupled with a sense of Christian duty, led the government to carry out a program of assimilation, or “pacification” of the Native peoples.⁹³ This interpretation of the system holds with the traditional view through its acknowledgement of the goal of assimilation. However, Dayton is nonetheless skeptical of any benevolent intentions on the part of the officials in charge of the system, instead pointing to the governmental concern with “basic economic forces” and a desire to save money.⁹⁴

⁹⁰ Ibid., p. 251.

⁹¹ Sylvia Dayton, “Ideology of Native Education Policy,” (Master's Thesis, University of Alberta, 1976), V.

⁹² Ibid., p. 53.

⁹³ Ibid.

⁹⁴ Ibid.

The writings of James R. Miller represent some of earlier historical research into the subject of Indian Residential Schools and Aboriginal education policies. Miller is highly critical of government handling of residential schools and he denies that assimilative policies had any benevolent intentions. This is seen in his work *Shingwauk's Vision*, when Miller states "clearly, Canada chose to eliminate Indians by assimilating them."⁹⁵ Miller is also one of the first researchers to recognize the legacy of emotional suffering which radiated from the history of residential schools and of the abuse which many students suffered. Indeed Miller is quite critical of the situation produced by poor government oversight, which he says was "liable to create conditions in which abusers can thrive... and are certain to be hellholes of exploitation if no authoritative agency exercises an effective oversight."⁹⁶ His criticisms even foreshadow the conclusions made by the TRC in their final report, as he labels residential school policy as one of "cultural genocide."⁹⁷

The writings of historian John Milloy expand on the conclusions of Miller to present a larger picture of the particulars of the residential school experience.⁹⁸ In his foundational work, *A National Crime*, Milloy provides the first comprehensive analysis of the Indian Residential School System as a whole across Canada. His analysis advances chronically through the initial foundational ideas of the system, to its implementation and actual reality. He outlines the rhetoric of assimilation and the belief that a civilization policy was a "sacred trust" in the mind of the government.⁹⁹ Yet he takes this analysis farther than other scholars by concluding "By every

⁹⁵ James Miller, *Shingwauk's Vision: A History of Native Residential Schools* (Toronto: University of Toronto Press, 1996), p. 184.

⁹⁶ *Ibid.*, p. 433.

⁹⁷ *Ibid.*, p. 9.

⁹⁸ See, John Milloy, *A National Crime*.

⁹⁹ *Ibid.*, p. 6.

indicator – health, employment, income, education, housing – Aboriginal people, far from being assimilated, were still separate and second-class citizens.”¹⁰⁰ Milloy argues that the government was informed many times about issues of sanitation and nutrition but chose to do nothing about them despite many opportunities for the implementation of policies which would have prevented further problems. Milloy’s work also advances the criticisms of Miller by undertaking a deeper analysis of the experience of psychological, physical, and sexual abuse by former students of the schools. This work therefore offers a middle ground to the traditional school of thought and the revisionist position. Milloy was one of the more outspoken critics of Residential school policy in the 1990s, and he recognizes the outcomes of dominance and control. Nonetheless he still refers to the "sincere Christian certainty" and the "national duty" which the government felt when creating the schools.¹⁰¹

Early literature on residential schools viewed the flaws of the Indian Residential School System as a symptom of misguided and poorly implemented good intentions. These studies posit that the Aboriginal education program was created to raise the First Nations from their perceived inferior lifestyles and bestow upon them the many advantages of western civilization. This required a process of “enlightenment” and assimilation, which was believed to be easier to implement among children rather than adults.¹⁰² Although early critics of the system, such as Peter Bryce, did exist, much of the early writings took government rhetoric at face value. Government policy was therefore framed as a humanitarian one for, despite its flaws, it was created with a base intention of helping the First Nations people. This viewpoint forms the basis of the writings which belong to what Trevithick has termed the ‘traditional’ interpretation.

¹⁰⁰ Ibid., p. 9.

¹⁰¹ Ibid., p. 6.

¹⁰² LAC, RG 10, Volume 6039, File 160–1, Part 1. Memorial, Privy Council of Canada, June 6, 1892.

However scholarship in the 1990s became increasingly jaded towards government intentions as the idea of residential school came to be synonymous with the notion of child abuse and a legacy of pain. The rhetoric of benevolence was condemned as a mask of the true intentions behind government policy. Scholars began to argue that in reality, while residential schools were proclaimed as a fix to the problems associated with the transition to reserves, they were underfunded, unregulated, and neglected by the Department.¹⁰³ Therefore later research on the schools emphasized the many times government officials ignored reports on poor conditions in the schools, or misrepresented school conditions to the public.¹⁰⁴ It became obvious to many scholars that the residential schools were in practice a means of controlling the Native population and teaching them obedience to white authority, while attempting to provide as little as possible to fulfill the obligations stipulated within the Treaties.

Historian Agnes Grant's *No End of Grief* is demonstrative of the critical turn in the literary dialogue on residential schools. When Grant considers the reasons behind the establishment of the residential school system, she argues that both the government and the churches "felt that the Indian race and culture were inferior."¹⁰⁵ The advancement of such an inferior race to 'civilization' would come in the form of an abandonment of the 'savage' ways of First Nations and their eventual integration into the dominant Canadian society.¹⁰⁶ Grant's argument therefore seems in keeping with the traditional school of thought, which recognizes the higher sense of 'duty' felt by school and government officials. Yet her work also acknowledges the self-serving nature of governmental policy. Grant later states that "the goals of Aboriginal education were structured to meet the needs

¹⁰³ James Miller, "Troubled Legacy," 375 – 382.

¹⁰⁴ See John Milloy, *A National Crime*, pp. 129 – 156.

¹⁰⁵ Agnes Grant, *No End of Grief: Indian Residential Schools in Canada* (Winnipeg: Pemmican Publications, 1996), p. 61.

¹⁰⁶ *Ibid.*

of the colonizers."¹⁰⁷ The sooner Aboriginal people could adopt the norms of western society, the sooner the Government would be able to sever its financial obligations to them. Grant also highlighted the curriculum of residential schools, which she argues taught students “that they were inferior but that “might makes right.” They had to accept without question, that those in authority knew what was best for them.”¹⁰⁸ Grant’s work therefore reveals a changing trend in the historiography. Government policy became reframed as a conscious choice by the government to maintain white power through the control of the Aboriginal peoples.

Elizabeth Furniss's book *Victims of Benevolence* provides a far darker picture of government policy.¹⁰⁹ Furniss undertakes a new approach to residential school studies in this work by stepping away from the traditional focus on government intent and policy and instead discusses the experience of children within the residential schools. As her title suggests, she recognizes the 'benevolent' justification for the residential school system. Yet she looks at the school through the eyes of two victims who died while attending residential school. This bottom-up analysis was an innovative approach for historians in the field, who up until this point had looked primarily at administration and policy – from the top down. In *Victims of Benevolence*, Furniss provides a micro-historical account of the death of two boys at the Williams Lake Residential School in British Columbia. She demonstrates how these boys lived a cruel existence at school between 1902 and 1920, suffering excessive physical abuse and emotional trauma. One boy died while fleeing the school, while the other committed suicide.¹¹⁰ Furniss's work characterizes a new insight into

¹⁰⁷ Ibid., p. 89.

¹⁰⁸ Ibid., p. 106.

¹⁰⁹ Elizabeth Furniss, *Victims of Benevolence: The Dark Legacy of the Williams Lake Residential School* (Vancouver: Arsenal Pulp Press, 1995).

¹¹⁰ Ibid., p. 14

the actual consequences of abuse and suffering which occur when a few individuals are given unregulated authority over disadvantaged and vulnerable populations.

The bottom-up approach was also effectively utilized by Celia Haig-Brown in her analysis of the student experience at Kamloops Residential School.¹¹¹ She has relied on oral history from former pupils to analyze the emotional scarring which characterized the experience of residential school life. Haig-Brown conducted interviews with thirteen individuals who attended the Kamloops school in southern British Columbia. Her research captured the emotion associated with transition from Native life to school life. The first couple of days were especially challenging for new students who had experienced the sudden shock of having their appearances changed and being denied the ability to speak their language. One readily apparent fact was that transition from family life to the strict regimentation of the schools was sudden and difficult for all students.¹¹² Additionally, Haig-Brown's study raised awareness of secondary forms of abuse within the school, such as isolation, identity crisis, and the loss of traditional beliefs and customs. This loss was the result of total control over students while attending school, as children were taught that their language, beliefs and cultures were inferior and evil.¹¹³

The emphasis on control was again put forth by Jennifer Pettit in both an MA thesis and a PhD Dissertation in History. Pettit argued that the education of Aboriginal children was based upon a goal of frightening Aboriginal children into obedience to governmental authority.¹¹⁴ She says that the physical and psychological abuses in residential school are evidence that the professed

¹¹¹ Celia Haig-Brown, *Resistance and Renewal: Surviving the Indian Residential School* (Vancouver: Arsenal Pulp Press, 1998).

¹¹² *Ibid.*, pp. 47 – 49.

¹¹³ *Ibid.*, pp. 126 – 130.

¹¹⁴ See Jennifer Pettit, "To 'Christianize and Civilize': Native Industrial Schools in Canada" (Ph.D. Dissertation, University of Calgary, 1997) and Jennifer Pettit, "From Longhouse to Schoolhouse: The Mohawk Institute 1834–1970" (Master's Thesis. University of Western Ontario, 1993).

goal of assimilation greatly differed from the actual goal of social control, which she argues “all church and government officials” agreed on.¹¹⁵ Because of their function as Industrial institutions which taught students to become "managed and subservient members of society," the schools served as state mechanisms of social control. Pettit argues that the Government never truly wanted education for its Aboriginal wards, but instead sought to simply ensure that they were 'manageable'.¹¹⁶

The more recent scholarship has taken a different approach to the Indian Residential School System by focussing on its long term legacy in Canadian Society. As public awareness around the extent of suffering experienced within the schools has increased, scholars have begun to argue that residential schools are a fundamental reason behind current racial inequalities within Canadian society. Some scholars have even posited that these inequalities were not only purposefully produced, but that they were subsequently maintained by the government to preserve power over First Nations groups. In 2009 Brian Titley published a study which analyzed the actions of the various Indian Commissioners from the Department of Indian Affairs and discussed their individual relation to the development and implementation of the Indian Residential School System.¹¹⁷ He uses the prosopographic approach to trace the lives of six different commissioners and the ways in which their personal ideologies influenced the administration of schools. This approach gives a face to the men who implemented government policy and regulated the school system. Titley's analysis demonstrates how policy was bent and reworked by each man based upon their individual goals. This, he states, led to “a flawed organization implementing a flawed policy

¹¹⁵ Jennifer Pettit, "To 'Christianize and Civilize'," p. 43.

¹¹⁶ Ibid., p. 44.

¹¹⁷ Brian Titley, *The Indian Commissioners: Agents of the State and Indian Policy in Canada's Prairie West, 1873–1932* (Edmonton: University of Alberta Press, 2009).

[which] could not have expected success."¹¹⁸ As such, he finds that the only possible expected outcome of residential school policy was the realization of a larger project of British dominance and colonization of Aboriginal people.¹¹⁹ His perspective brings new meaning to residential schools by placing it in light of the broader colonial goals of the government and outlining how policy was the work of individuals who had their own “intolerant mindset” that worked to shape the lives of Aboriginal peoples for over a century.¹²⁰

Former Aboriginal claims worker and current organizer of the Truth and Reconciliation Commission Canada, Paulette Regan, has also published a highly influential work on the lasting legacy of the Indian Residential School System in Canadian society.¹²¹ Her work provides new insight into the process of historical healing within a modern context. In her study Regan argues that residential schools have left a legacy of trauma and inequality in modern Canada. Trauma originating from the psychological suffering of students in residential schools has impacted the healthy adjustment to family life after the schools.¹²² Aboriginals of today have inherited generations of abuse and pain through 100 years of attendance in the schools and the result is a lasting inequality between Aboriginals and non-Aboriginals in Canada today.¹²³ She argues that it is the duty of modern non-Natives to recognize and take responsibility for this legacy. The establishment of the Indian Residential Schools Truth and Reconciliation Commission in 2008 was the first step in this direction. Regan states that one of the most important steps to healing is “learning to bear deep witness to survivor’s testimonial stories, paying careful attention to our

¹¹⁸ Ibid., p. 211.

¹¹⁹ Ibid.

¹²⁰ Ibid., p. xi.

¹²¹ Paulette Regan, *Unsettling the Settler Within: Indian Residential Schools, Truth Telling and Reconciliation in Canada* (Vancouver: University of British Columbia Press, 2010),

¹²² Ibid., p. 1.

¹²³ Ibid., p. 123.

responses as indicators of our empathy for, or resistance to, the hard historical truths we are hearing.”¹²⁴ Her study calls for an active recognition of existing problems associated with the schools and action to create accountability for the legacy of government policy. Regans work is thus an activist history of the schools, which urges further action from Canadians today.

Perhaps the most famous study of government abuse of residential school students was recently put forth by Ian Mosby. Mosby is a historian of food, health, and nutrition and his work outlines government sanctioned nutritional experiments which were undertaken on students at residential schools. These experiments involved students from six schools across Canada and included 1,300 First Nations children.¹²⁵ They spanned a ten year period at the end of the Second World War, from 1942 – 1952. This was a time when government officials and nutritional scientists were first beginning to study the effects of nutrition on population health. Mosby found that the students were deemed ideal for such experiments because malnutrition was the inherent condition of the children while attending the schools. Researchers controlled the vitamin intake of students, purposefully denying proper nutrition to some groups who acted as controls.¹²⁶ These nutritional trials are most shocking when considering that they took place right after the Nuremburg Trials, which horrified the globe with descriptions of the human experimentation undertaken by the Nazi regime.¹²⁷ Mosby's study places the Canadian government in a whole new light, as his work makes it clear that the government not only knew of the deficiencies of the residential school systems but exploited their powerful position over Native peoples.

¹²⁴ Ibid., p. 32.

¹²⁵ Ian Mosby, "Administering Colonial Science: Nutrition Research and Human Biomedical Experimentation in Aboriginal Communities and Residential Schools, 1942–1952," *Histoire sociale/Social history* 46, no. 91 (May 2013): 145 – 172, esp. 146.

¹²⁶ Ibid., pp. 158 – 164.

¹²⁷ Ibid., p. 166.

These studies, coupled with a media focus on the physical and sexual abuse of students in the schools have painted a demonized picture of the schools in the public consciousness.¹²⁸ Yet the residential school experience was not exclusively negative to all students and the intentions of those who taught at the schools were often well-meaning. As such, some scholars have tried to provide an alternative perspective on the schools, highlighting the good intentions of teachers and staff who cared for the children out of a sense of Christian charity. The most notable work from this perspective is *Indian Residential Schools: Another Picture*, by Eric Bays. Bays' short work outlines what he terms the "other side" of the Residential School story, aiming to "identify some of the aspects of the schools that were beneficial to the students who attended them."¹²⁹ While recognizing the many flaws inherent within the system, he seeks to provide a counter-balance to the pessimistic narratives of Indian Residential Schools and demonstrate that not every teacher or principal who taught at residential school was abusive.

Bays' work relies heavily on an earlier account of the residential schools, self-published by Bernice Logan in the early 1990s, titled *The Teaching Wigwams*.¹³⁰ Logan's massive 700 page, multi-volume work contains stories, letters, and photographs from former students at residential schools in Atlantic Canada. Logan undertook her work to respond to the public targeting and demonizing of the staff who worked in the schools. Her book outlines how teachers in the schools did their best to care for the students and had the best of intentions while working in difficult circumstances. She also highlights the many positive skills and experiences that students of the

¹²⁸ See, Pieta Woolley, "For Residential School Kids, a Legacy of Sex Abuse," *The Pyee* (September 16, 2013); Mark Kennedy, "At Least 4,000 Aboriginal Children Died in Residential Schools, Commission Finds," *The National Post Canada* (January 3, 2014); Cynthia Wesley-Esquimaux, "Residential School Survivors and their Descendants Share their Stories," *The Globe and Mail* (May 31, 2015).

¹²⁹ Eric Bays, *Indian Residential Schools: Another Picture* (Ottawa: Baico Publishing Inc., 2009), p. iii.

¹³⁰ Bernice Logan, *The Teaching Wigwams* (Tangier, NS: R.B. Logan, 1993–1995).

schools gained from their residential school education. She says that this is the "true story" of the residential schools."¹³¹

Both of these works were produced by individuals with clear prerogatives and both lack the academic rigor of true historical studies, as they focus solely on the task of rescuing the name of the schools and lack any scholarly review. Additionally, many of the justifications made for the actions of church and school officials are explained in terms of Christian duty and religious doctrine. Yet despite the many flaws inherent in these works, they serve as a caution to blatant generalizations when discussing the Indian Residential School System. While stories about the severe physical and sexual abuse of children in the schools have become sensationalized in media coverage – and abuse has become intimately associated with school attendance – there are still many survivors who have yet to tell their stories and therefore more time is needed to reveal the experiences of all former students. In Alberta many school survivors from the Stony Nakota Nations boycotted the Truth and Reconciliation events, which were held “in large urban centres, where Residential School survivors are expected to speak to a room full of strangers in front of cameras and lights. What is certain however, is that the emotional shock of the transition to school life, the continual feelings of loss and loneliness associated with the process of assimilation, and poor health due to disease and malnutrition, were present in residential schools across the country. Even when school staff strived to do their best to care for their charges, the system itself was a form of structural violence against First Nations children, identity, and culture.”¹³²

¹³¹ Bernice Logan, "Residential Schools Not a Scandalous System," *Pincher Creek Echo*, June 12, 2008.

¹³² The idea of structural violence is the idea that a social institution can have violent effects on a group of people within a society by preventing their access to fundamental human needs. This term is based on the definition put forth originally by Johan Galtung. Mark Vorobej, "Structural Violence," *Peace Research* 40, no. 2 (2008): pp. 84 – 98, esp. 84.

I.II – Methodology:

This study investigates how the Indian Residential School System impacted the health of First Nations communities in Alberta. It focusses on the student experience of health while residing within the residential school. As the primary focus is on the experience of the children within the schools, this study has taken a culturally relative understanding of health. The model of the medicine wheel is utilized to gain insight into the spiritual, emotional, mental, and physical impacts of the residential school on the health and wellbeing of students. Yet this is also a medical history, as it places health – and the subsequent healthcare interventions initiated by the Department of Indian Affairs – within the context of the public health and medical innovations of the early twentieth century. This study therefore forms a bridge between the different perspectives. It analyzes Department policy, the reality of its implementation to school life, and the effects that both of these had on the overall health of students.

It is recognized that Alberta’s First Nations population is highly heterogeneous, being comprised of 45 distinct nations.¹³³ Each nation has its own cultural knowledge, power, and identity. When cultural knowledge is discussed, this study ensures the recognition of unique cultures by specifying which nation is associated with the cultural belief that is elucidated. When the term “plains peoples” is used, it refers to all the nations that fall under this category in Canada – the Blackfoot, Cree, Ojibwa, Assiniboine, Nakota and Dakota.¹³⁴ When this study refers to “Alberta First Nations” or “Alberta Aboriginal people,” it refers only to the 45 Nations of Alberta,

¹³³ Health Canada, “Health Determinants for First Nations in Alberta,” accessed July 5, 2014, <http://report.hcom.ca/people>.

¹³⁴ This study has utilized the categories laid out by *Historica Canada* to maintain consistency with the general Canadian understanding. *Historica Canada*, “Aboriginal People: Plains,” accessed March 15, 2015, <http://www.thecanadianencyclopedia.ca/en/article/Aboriginal-people-plains/>.

which are geographically associated with the 140 designated reserves within the province.¹³⁵ The term “Aboriginal” is used only as an adjective and is applied interchangeably with the terms “Indigenous” and “Native” throughout this paper. In some cases the term “Indian” appears when discussing or utilizing historically relevant descriptions or quotations.

Aboriginal communities today suffer from many health issues, ranging from infectious diseases such as tuberculosis and HIV, to chronic conditions like diabetes, hypertension, and heart disease.¹³⁶ These health problems have caused an increased interest in utilizing culturally appropriate healthcare practices among these communities. Federal, provincial, and territorial governments have begun to develop strategies of healing and wellness for Aboriginal communities which incorporate traditional understandings of wellness and traditional healing practices. In Alberta, Alberta Health Services implemented the Aboriginal Health Program in 2013 across the province.¹³⁷ This program has three essential elements which allow for culturally relevant care of patients, including:

Holistic Approach – Aboriginal people often have a holistic view of health that includes: physical, mental, emotional, and spiritual well-being.

Culturally Congruent/Safe – Providing care that is both culturally safe and competent will facilitate access and improve outcomes.

¹³⁵ For a full breakdown of the different First Nation Communities in Alberta and the locations of the reserves, see: Aboriginal Affairs and Northern Development Canada, “First Nations in Alberta,” accessed March 15, 2015, <http://www.aadnc-aandc.gc.ca/eng/1100100020670/1100100020675>.

¹³⁶ Health Canada, *First Nations Health Status Report, Alberta Region 2011-12* (Minister for Health, 2013), http://publications.gc.ca/collections/collection_2013/sc-hc/H26-4-2012-eng.pdf.

¹³⁷ Other provinces have similar programs, including the Aboriginal Health Directorate in British Columbia, and the Aboriginal Health and Wellness Strategy in Ontario. For more information on the Aboriginal Health Program, see Alberta Health Services, “What is the Aboriginal Health Program?” accessed January 15, 2015, <http://www.albertahealthservices.ca/7629.asp>.

Working in Partnership – Health programs and services developed and implemented in partnership with Aboriginal communities ensure appropriateness, effectiveness, and sustainability.¹³⁸

Through the Aboriginal Health Program and partnership with the Wisdom Council, Alberta Health Services is taking steps to incorporate an Aboriginal understanding of health with healthcare practice.

Indigenous health programs in Alberta often utilize the framework of the Medicine Wheel when working with First Nations communities.¹³⁹ This is an excellent tool for ensuring that healthcare remains culturally relative to Aboriginal patients. The medicine wheel model is based on elder teachings and is generally utilized among First Nations groups across Canada. The medicine wheel represents the interconnectedness of all life, with a circular understanding of the life journey and its connections to wellbeing and nature. The wheel encompasses the four directions, each associated with an aspect of health (image 2). Each step of the wheel symbolizes a stage of the life journey and wellness is associated with a balance between all four aspects of health – physical, mental, spiritual, and emotional. Imbalance, neglect, or disregard for any one of these areas results in a lack of wholeness – and therefore a lack of health.¹⁴⁰ This study believes that culturally relative understandings should also be utilized in historical research. The practice of history is necessarily a conversation between the events of the past and the interests of the present and therefore historians must make similar efforts to incorporate relevant understandings into their research.

¹³⁸ Ibid.

¹³⁹ See, Vasiliki Douglas, *Introduction to Aboriginal Health and Health Care in Canada: Bridging Health and Healing* (New York: Springer US, 2013)

¹⁴⁰ Ann Dapice, “The Medicine Wheel,” *Journal of Transcultural Nursing* 17, no.3 (July 2006): 251–260.

In order for history to be meaningful, it must engage with the issues and concerns of the present day.¹⁴¹ The increased literature about Indian Residential Schools – a movement which this study belongs too – exemplifies how the subjects of historical research are highly influenced by contemporary concerns. Since the Indian Residential School System was brought to the scrutiny of the public eye – starting in 1996 with the Royal Commission Report on Aboriginal Peoples and cumulating in the national journey of the Truth and Reconciliation Commission – the historical literature on the subject has expanded significantly.¹⁴² This study seeks to provide a culturally engaged analysis of the history of the Indian Residential School System in Alberta. It is based on the assumption that a history of Aboriginal health in the province can only be adequately understood when Indigenous beliefs surrounding health are considered in conjunction with western notions.

Although the Indian Residential School System was federally operated, this study chose to focus on only one province for its analysis. This choice was made for two reasons. The first is that many of the health statistics collected for First Nations communities today are collected within geographic regions in Canada, usually by province or Nation. As such, this study binds itself geographically to one province, to maintain relevance with modern populations. The time period covered by this paper (1920 – 1950) falls after the signing of the treaties, when the Aboriginal populations in Canada also became geographically bounded by their relocation to reserves. The

¹⁴¹ Allan Brandt, “Emerging Themes in the History of Medicine,” *The Milbank Quarterly* 69, no. 2 (1991): pp. 119 – 214, esp. 201.

¹⁴² An extensive literature list on Indian Residential Schools has been compiled by the Legacy of Hope Foundation and by Library and Archives Canada. See, Legacy of Hope Foundation, “Recommended Resources,” accessed April 23, 2015, <http://www.legacyofhope.ca/about-residential-schools/recommended-resources> and Library and Archives Canada, “The Legacy of the Residential School System in Canada: A Selective Bibliography (August 2009),” accessed April 23, 2015, <http://www.bac-lac.gc.ca/eng/discover/Aboriginal-heritage/Pages/residential-schools-bibliography-2009.aspx>.

second reason for the geographical limitation was the desire to illuminate Aboriginal history within the province of Alberta, especially the experience of Treaty 7 Nations. The experience of the Aboriginal population in Alberta has been largely avoided in historical studies. While scholars such as Maureen Lux and James Daschuk have explored the historical decline in physical health of First Nations on the prairies, these are broad studies which discuss the prairie experience as a whole and only touch on the health of children within the residential schools.¹⁴³ Similarly the historiography has tended to focus on schools in Ontario or British Columbia, or described the system as a whole. This study seeks to fill the gap in the historical literature by illuminating the experience of students on the prairies.

Schools from all three Treaty areas within Alberta were examined in this study. The breakdown of schools examined is shown below in Chart 1. For a map of the location of Indian Residential Schools in Alberta, see Appendix 3.

Chart 1: Schools Included in Study

School Name	Location	Denomination
Blue Quills Residential School	Lac la Biche; Sacred Heart Reserve	Roman Catholic
Crowfoot Residential School	Blackfoot Reserve	Roman Catholic
Edmonton Residential School/Edmonton Institute	7 miles North of Edmonton	United Church
Ermineskin Residential School	Hobbema Reserve	Roman Catholic
Lesser Slave Lake/ St. Peter's Mission School	Lesser Slave Lake	Anglican
Morley Residential School	Stoney Reserve	United Church
Old Sun's Residential School	Gleichen, AB	Anglican
Red Deer Industrial School	Red Deer, AB	United Church

¹⁴³ See Maureen Lux, *Medicine That Walks* and James Daschuk, *Clearing the Plains*.

St. Cyprian Residential School	Brocket, AB/Peigan Reserve	Anglican
St. Bruno's/Grouard Residential School	Grouard, AB	Roman Catholic
St. Bernard/Joussard Residential School	Joussard, AB	Roman Catholic
St. Joseph's Industrial School	Dunbow, AB	Roman Catholic
St. Paul's Residential School	Blood Reserve	Anglican
St. Mary's Residential School /Blood Roman Catholic School	Blood Reserve	Roman Catholic
Sacred Heart Residential School	Brocket, AB/Peigan Reserve	Roman Catholic
Whitefish Lake Residential School	Whitefish Lake, AB	Anglican

These schools were chosen due to the amount of documents preserved from their administration and the types of information held within the historical record. For instance, Blue Quills Residential School was one of the few schools in Alberta to have preserved its orders of medical supplies. These requisition lists were invaluable to understanding the types of illness present within the school and Departmental policy on providing medicines and medical care. Similarly, St. Peter's Mission School was included in this study due to the preservation of a large number of photographs from the school. These visual records provide a deeper insight into life at the school than could be obtained through purely textual records.¹⁴⁴ Although the primary focus of this study is on Alberta, some examples have been drawn upon from Saskatchewan and British

¹⁴⁴ See, Carol Payne and Andrea Kunard (eds.), *The Cultural Work of Photography in Canada* (Montreal: McGill-Queen's University Press, 2011) and Susan Close, *Framing Identity: Social Practices of Photography in Canada, 1880-1920* (Winnipeg: Arbeiter Ring Publishing, 2007).

Columbia schools, when comparable evidence was found necessary to help provide context for differentiation between provinces.

The temporal focus of this study is on the period from 1920 to 1950. This date range was chosen for a number of reasons. Firstly, the Indian Residential School System went through major changes within the 1920s, when industrial schools were discarded in favour of residential schools across Canada. The last industrial school closed in 1923 and many of the residential schools included in this study were rebuilt between 1920 and 1925.¹⁴⁵ After the revitalization of the system, school curriculum was altered to focus on providing simple agricultural and domestic skills for children, as well as eradicating behaviours that hindered the process of ‘civilizing’ them.¹⁴⁶ In addition, this time period saw an amendment to the Indian Act in 1920, which made school attendance mandatory for all First Nations children between the ages of seven and fifteen.¹⁴⁷ Thus, this time period is one where colonial control of First Nations children increased dramatically.

Furthermore, significant advancements in Canadian public health occurred during this time, as numerous associations concerned with implementing public health measures first started.¹⁴⁸ It will be seen that as Canada’s public health system developed, the healthcare provided to Aboriginal children was far from adequate.¹⁴⁹ Despite Department rhetoric claiming that the protection of Aboriginal health was “prime importance,” Department officials continuously used the inherent flaws in the system of school administration to circumvent their responsibility towards the health of students.¹⁵⁰ This meant that as the Canadian populace was benefiting from

¹⁴⁵ Jennifer Pettit, “To ‘Christianize and Civilize’,” p. 3.

¹⁴⁶ *Ibid.*, p. 217.

¹⁴⁷ John Milloy, *A National Crime*, pp. 70–71.

¹⁴⁸ See, Robert Lampard, *Alberta’s Medical History: “Young Lusty and Full of Life”* (Canada: Library and Archives Canada Cataloguing in Publication, 2008).

¹⁴⁹ For a more specific discussion of this, see Chapter 4.

¹⁵⁰ LAC, RG 10, Volume 6016, File 1–1–13. Canada, News Bulletin, March 4, 1932.

development of new vaccines, new medical interventions and the creation of more clinics, hospitals, and sanatoria, Aboriginal children suffered under a wholly inadequate healthcare system which failed to care for many sick children out of a concern for expenditure.

This study ends in 1950, as another transition within the Indian Residential School System began. After the Second World War, the Department began to transfer the control of school administration from the churches to the federal government.¹⁵¹ The goal was to eventually open schools up to integration. This time period has already been discussed thoroughly by John Milloy in *A National Crime*.¹⁵² Similarly, much of our knowledge of the residential school experience comes from the period after 1950, which is the focus of the TRC hearings. The student experience after 1950 has been amply expressed through the many survivor stories collected by the TRC.¹⁵³ Therefore this study does not venture into the era of living memory and instead focusses on a time in which our knowledge of the residential school system is comparatively limited.

The discussion of student health is divided into five chapters. Chapter one focusses on the nutrition of pupils while attending the schools. It begins with a discussion of the spiritual significance surrounding Aboriginal subsistence patterns and demonstrates how children were left physically and spiritually malnourished by the diet of the schools. Although the 1920s saw the rebuilding of many schools across the province and an expansion of agricultural practices to supplement student diets, chronic underfunding for repairs and farming equipment prevented most schools from effectively utilizing their increased farmland and stock. Even as the Department attempted to implement new measures to ensure children received proper nutrition, the inadequate system of per capita funding - coupled with church insistence on taking in more children than it

¹⁵¹ Elizabeth Furniss, *Victims of Benevolence*, p. 30.

¹⁵² John Milloy, *A National Crime*, pp. 189 – 293.

¹⁵³ Truth and Reconciliation Commission, *The Survivors Speak: A Report of the Truth and Reconciliation Commission of Canada* (Ottawa: Library and Archives Canada, 2015).

had both capacity and funding for – did not provide enough for the upkeep of children. This system failed to prevent schools from economic crisis during times of low crop production or to provide for emergency expenses. As schools struggled through the drought and inflated prices of the Great Depression, closely followed by a wartime economy, students within the schools experienced a declining level of nutritional health over time. The result was chronic malnourishment and the associated psychological and emotional suffering of the student population.

The second chapter discusses the situation of sanitation and hygiene within the schools. Sanitation in the schools experienced a similar decline between 1920 and 1950. Generally conditions were at their best right after the institutes were rebuilt. The new buildings, though cheaply made, were built with a focus on accommodating larger populations. Yet over the course of the 1930s and 1940s standards declined significantly, as the Department continuously refused to invest in necessary repairs for buildings which had begun to break down quickly. The initial promise of improved sanitation within the new buildings grew stagnant with time – much like the water systems employed by the schools themselves. Hygiene conditions similarly degenerated as more students were added to already overcrowded institutions. The result was increased incidents of preventable diseases of the skin, eye and ear. In this case the Department once again chose the cheaper solution – by increasing the orders of medical supplies to treat these diseases, instead of the more expensive provision of providing new mattresses, sheets, clothing or repairing the buildings.

Chapter three focusses on the resulting experience of illness among children who resided within the degenerating institutions. The children attending residential school had little choice in the matter and faced a variety of illnesses as a result of attendance. This chapter explores the relationship between the poor sanitary and nutritional conditions of the schools and the

development of disease. Diseases were the physical expression of school conditions upon the bodies of the students. Child suffering and the death of students represented the failure of Department officials to protect the health of the students within their care. The Indian Residential School System gave ultimate power over thousands of First Nations children to a few men who were far removed from the living conditions of the schools. Officials who were ignorant to the daily physical, mental, emotional, and spiritual suffering of Aboriginal children easily overlooked the need to improve conditions within the institute. Throughout this period, the Department failed to see the irony of removing Aboriginal children from their families to ‘protect’ them, only to expose those children to a number of debilitating illnesses within the schools.

How the Department chose to deal with those illnesses is the focus of chapter five. The healthcare system implemented within the schools was promoted by the Department as “key” to solving the problems of infectious disease on reserves.¹⁵⁴ Yet the reality was far different from the rhetoric. The healthcare system implemented within the schools – which was intended to provide students with proper medical attention from admission to graduation – fell short at every turn. Medical examinations, nurse and physician attendance, the provision of medications, and institutional care were limited and inadequate.

The final chapter of this thesis examines the mental health of students within the residential schools. While attending residential school, students experienced a mixture of grief, anger, shame, and guilt caused by the circumstances of school life. Grief and shame were encouraged by the isolation of students from their families, languages, and cultures. Neglect of physical health and the use of excessive punishment, contributed to declining mental health and feelings of guilt or

¹⁵⁴ LAC, Indian Affairs Annual Reports, 1864 – 1990, *Annual Report of the Department of Indian Affairs for the Year Ended March 31, 1933*.

anger. Students grew up isolated from the emotional supports of a caregiver and this bred a legacy of intergenerational trauma.¹⁵⁵ The associated emotional suffering of students was expressed through attempts to escape the schools or by acting out, sometimes harming those around them. An analysis of student agency within this chapter provides insight into the minds of students and the effects that isolation, neglect, and abuse had upon their mental and emotional health.

Like any historical work, this project has its limitations. Despite a thorough scouring of the Provincial and Federal archives, there are still many documents which were inaccessible to this study. The process of releasing documents from the residential schools has been a long one and many thousands of documents are still unreleased by the government for research. There are also restrictions on access to many documents held by Oblates of Mary Immaculate, the Roman Catholic association which administered many schools within Alberta. This study bases its conclusions on the information contained within the documents that were available and acknowledges the possibility of source bias in its conclusions.

The perspective of the author should also be acknowledged here. This paper was written by a non-Aboriginal who has lived on the other side of the schools, within the society that created them. Although great care has been taken to utilize a mixed perspective – incorporating cultural understandings from the different First Nations communities in the study, as well as historically contingent western beliefs – it would be unrealistic to believe that a truly balanced perspective was achieved. Instead it can only be stated that this approach is an attempt at balance, an attempt at weaving the various perspectives into a holistic understanding. This weave was created with tools obtained through training as a historian and an anthropologist, within a western university. The

¹⁵⁵ Intergenerational Trauma is the idea that psychological trauma and abuse results in a “cycle” of similar suffering as traumatized children subsequently become dysfunctional parents. Peter Menzies, “Developing an Aboriginal Healing Model for Intergenerational Trauma,” *International Journal of Health Promotion and Education* 46, no. 2 (2008): pp. 41 – 48, esp. 41.

web of meaning is therefore necessarily stronger in western understanding than it is in Indigenous knowledge.

This study nonetheless attempts to present the Aboriginal perspective through the day-to-day experiences of pupils within the schools. The Aboriginal voice has been teased out from the actions and words of Department and school officials who oversaw the pupils and who created the documentation that discussed the conditions of their daily lives. The students who attended these schools cannot be asked what they thought or how they felt about their experiences, but a narrative can be constructed of their reality based on the historical record. These documents form only one small part of the story of the Indian Residential School System in Canada and must be considered in conjunction with the many stories – past and present – which are told about the schools. The voices of students, parents, teachers, and officials must all be considered for true introspection and reconciliation. These voices reveal where we are as a society and how we can justly deal with overcoming the legacy of colonization which infiltrates Aboriginal and non-Aboriginal relations today.

Chapter 1: Nutrition:

*“The new diet made the people weaker. It was too much change, too quickly.”*¹

- Kaye Thompson, Assiniboine Elder, 1998

As the Second World War came to an end and the Canadian Government began to once again focus on matters at home, the Department of Indian Affairs turned its attention to the many problems which had plagued the Indian Residential School System during its long administration. One issue that stood out was the problem of malnourishment among the thousands of students who resided in the schools. Department Officials therefore decided to undertake a nation-wide nutritional study on the amount and variety of food which residential school pupils received on a daily basis. The Department contracted the services of a dietician, Miss A.M. MacGready, to conduct a survey study of “feeding problems” in the schools, with an eventual plan to develop a “continuous dietary service for [the] Residential Schools.”²

Miss MacGready visited six schools in Alberta and forwarded her findings onto the Department in 1947. What she found was distressing at best. In her reports MacGready reported that “at no school does the variety of the diet meet the requirements in respect to Vitamin content, and that no school principal has sufficient revenue to enable him to provide a wholly satisfactory diet.”³ At the Ermineskin School, she noted that the boys’ dining rooms were “dark, dingy, damp and unhealthy,” and were located in the basement of the institute.⁴ At the Edmonton school she

¹ Quoted in Maureen Lux, *Medicine That Walks*, p. 3.

² LAC, RG 10, Volume 6033, File 150-44, Part 2. B. Neary to F. Matters, December 28, 1946.

³ Ibid., E.L. Stone to the Director of the Department of National Health & Welfare, March 3, 1947.

⁴ Ibid., Report on Inspection of Food Service Ermineskin Indian Residential School, Hobbemma, Alberta, February 19 – 22, 1947.

found that food “servings fall short in respect to Citrus fruit or Tomatoes, Other fruit, Vegetables, the use of whole wheat or Canada Approved Vitamin B bread, Butter, Eggs, Cheese and the use of Iodized salt.”⁵ Yet the real problem MacGready noted with every single institute was the “inadequate facilities” for the buildings, which were “old, antiquated and over-crowded.”⁶

Yet what wasn’t mentioned in MacGready’s reports, or in any of the correspondence surrounding the issue of malnutrition within Indian residential schools, was the culpability of the Government officials whose obligation it was to provide adequate facilities for the thousands of children legally required to attend residential school. Schools under the control of the Department had continuously degraded for the last thirty years, despite their revitalization in the early 1920s. Throughout this period, the men in charge of the system consistently denied necessary improvements to buildings, kitchens, and agricultural equipment.

This chapter focusses on the nutritional health of students while attending Indian Residential Schools in Alberta during the period of 1920 to 1950. An analysis of nutrition within the Albertan residential schools demonstrates that nutritional health was at its best among students after the institutions re-built in the 1920s. These new institutions were constructed to accommodate larger agricultural undertakings – including increased crop cultivation and livestock rearing. Although the schools were still funded by the per capita grant system, plentiful harvests and the sale of livestock allowed schools to supplement their income. This in turn enabled the purchase of necessary fruits, meat or vegetables to feed the children in the institution. Some schools were entirely self-sufficient during the 1920s, raising enough food to provide for the meals without having to purchase any for the year.

⁵ Ibid., Report on Inspection of Food Service Edmonton Indian Residential School, Edmonton, Alberta, January 27 0 31, 1947.

⁶ Ibid., Report on Inspection of Food Service Ermineskin Indian Residential School, Hobbemma, Alberta, February 19 – 22, 1947.

The nutritional health of children took a drastic downturn during the 1930s with the Great Depression. Crop failures forced the school to buy more food than usual at inflated prices. The per capita grant was still the only funding provided for the purchase of food and the small grant not enough to provide adequate nutrition with the institutions. These schools were left stagnant throughout the 1930s and 1940s and by the 1940s, students were demonstrating higher incidence of vitamin deficiency. Therefore, the project of rebuilding the schools and expanded farm operations in order to create self-sufficient schools was ultimately negated by the compounded issues of drought and Department neglect. The Department's attempts to improve nutritional health of children through agricultural expansion were put on hold for over twenty years and were not revisited until the nutritional investigations of the late 1940s and subsequent nutritional experiments.

The Indian Residential School System also removed Aboriginal spirituality from Aboriginal subsistence patterns, directly eliminating the psychosocial aspects of traditional diet patterns. Medical investigations into chronic disease have identified that chronic disease development can be linked to “the biological, behavioural and psychosocial pathways that operate across an individual's life course, as well as across generations.”⁷ These pathways – which refer to the links between circumstance and health – affect the mental and physical well-being of individuals in ways that can adversely affect their wellbeing.⁸ In Canada, medical researchers have found that adverse social circumstances - unemployment, disrupted family life, or substance abuse – are high risk factors in the development of diabetes. This demonstrates a direct connection

⁷ Yoav Ben-Shlomo and Diana Kuh, “A Life Course Approach to Chronic Disease Epidemiology: Conceptual Models, Empirical Challenges and Interdisciplinary Perspectives,” *International Journal of Epidemiology* 31, no. 2 (2002): 285 – 293, esp. 285.

⁸ Pekka Martikainen and Tapani Valkonen, “Excess Mortality of Unemployed Men and Women During a Period of Rapidly Increasing Unemployment,” *The Lancet* 348, no. 9032 (1996): 909 – 912.

between mortality and psychosocial pathways. Researchers on the prairies have determined that the links between biology, behaviour and psychosocial pathways are strong enough to list Aboriginal ethnicity as an independent risk factor for the development of Gestational Diabetes (GDM) during pregnancy.⁹

The psychosocial connections between nutrition and health are key to understanding the nutritional health of students from a combined First Nations and western perspective. We must consider the physical and spiritual health that stems from a traditional diet and uncover how these psychosocial connections were disrupted and altered through the standardized diet within residential schools in Alberta. Uncovering these changes will provide a more meaningful understanding of how the Indian Residential School System disrupted Indigenous health in the province.

1.1 – Subsistence and Spirituality:

Nutritional health before the Indian Residential School System is best understood through a discussion of the spiritual and nutritional importance of traditional foods to Alberta's Plains peoples. The buffalo dominated the diet before the signing of the treaties. The meat of a buffalo was harvested and prepared in various ways – usually dried or cooked – to be made into jerky, soups or pemmican. Pemmican, a mix of shredded dried meat, berries and fat, was a particularly important source of nutrition for First Nations on the plains, as it provided a high source of protein and fat that could be stored for long periods of time.¹⁰ The process of hunting, gathering,

⁹ See, Roland Dyck et al., “A Comparison of Rates, Risk Factors, and Outcomes of Gestational Diabetes between Aboriginal and Non-Aboriginal Women in the Saskatoon Health District,” *Diabetes Care* 25, no. 3 (2002): 487–493, and Shaila Rodrigues et al., “Interaction of Body Weight and Ethnicity on Risk of Gestational Diabetes Mellitus,” *Journal of Clinical Nutrition* 70, no. 6 (1999): 1083–1089.

¹⁰ “Pemmican,” *Nutrition Reviews* 19, no. 3 (1861): pp. 73 – 75, esp. 73.

harvesting, and processing buffalo meat included many physical, spiritual, and emotional benefits to First Nations health.

Anthropological studies on pre-contact nutrition on the among plains peoples have found that these groups were exceptionally well-nourished. Through research into measured skeletal heights, Richard Steckel has shown that height among North American Native populations was much higher than other, non-Indigenous North American populations before the introduction of the reservations.¹¹ Height has long been understood as a key method to determine the health of individuals, as average height among a population is sensitive to nutritional consumption throughout development.¹² Steckel found that equestrian nomads on the prairies born between 1830 and 1872 “were taller than any national population living in the mid-nineteenth century.”¹³ These populations exceeded the next tallest groups – European descendants in America and Australia – by about a centimeter. This indicates that before the move to the reservation system, plains peoples maintained sufficient diets for adequate nutrition.

The majority of nutrients consumed were derived from the buffalo. As the largest terrestrial mammals in the New World, buffalo have dominated the North American landscape since the Pleistocene extinctions of 10,000 years ago.¹⁴ In Canada, wild buffalo herds were present across the west, roaming from the lands of the now-Northern Territories and through the four western

¹¹ See, Joseph Prince and Richard Steckel, “Nutritional Success on the Great Plains: Nineteenth-century Equestrian Nomads,” *Journal of Interdisciplinary History* 33, no.3 (2003): 353 – 384.

¹² For a greater discussion of how height and standard of living are correlated, see Richard Steckel, “Stature and Standard of Living,” *Journal of Economic Literature* 33, no. 4 (1995): 1903 – 1940, Harold Alderman, John Hoddinott, and Bill Kinsey, “Long Term Consequences of Early Childhood Malnutrition,” *Oxford Economic Papers* 58, no. 3 (2006): 450–474, and Galit Alter, “Height, Frailty, and the Standard of Living: Modelling the Effects of Diet and Disease on Declining Mortality and Increasing Height,” *Population Studies* 58, no. 3 (2004): 265 – 279.

¹³ Richard Steckel, “Inequality Amidst Nutritional Abundance: Native Americans on the Great Plains,” *The Journal of Economic History* 70, no.2 (2010): 265 – 286, esp. 266.

¹⁴ Scott Taylor, “Buffalo Hunt: International Trade and the Virtual Extinction of the North American Bison,” *The American Economic Review* 101, no. 7 (2011): 3162 – 3195, esp. 3166.

provinces during their migrations southward. These herds were hunted by many different First Nations groups, who, unhindered by modern borders and boundaries, would follow the migration patterns of the buffalo, hunting in methods dictated by season and location. The buffalo provided the plains peoples with clothing, shelter, tools and other implements, while serving as the main source of sustenance in the traditional diet.¹⁵

A stable diet of buffalo offered a stable source of protein. Buffalo provided a leaner source of meat than beef and was high in iron and vitamin B. The high amino acid intake would have enabled these populations to build strong, lean muscles and would have been a contributor to the higher height measurements outlined in Steckel's study.¹⁶ The reliance on a mobile food source would have also contributed to the physical fitness of Indigenous hunters. Buffalo hunting required a high amount of energy expenditure, which was adequately supplied through subsistence on a high-fat, high-protein diet.

The disappearance of the buffalo is a much debated topic in the historical literature. The striking reduction in herds occurred over a short amount of time, with half of the pre-contact buffalo population being eliminated within ten years after 1870.¹⁷ Scholars have titled this sudden decrease a "slaughter" due to the systematic and purposeful way the herds were eliminated by white buffalo hunters across the Great Plains.¹⁸ The slaughter of the buffalo herds is attributed to the growth of the world hide market in the late 1800s, which increased the demand for hides at a time when incentives for conservation or regulation of the trade were minimal to non-Aboriginal

¹⁵ Maureen Lux, *Medicine What Walks*, pp. 10 – 12.

¹⁶ Richard Steckel, "Inequality Amidst Nutritional Abundance," p. 266.

¹⁷ Scott Taylor, "Buffalo Hunt," p. 3165.

¹⁸ See, John Hanner "Government Response to the Buffalo Hide Trade, 1871 – 1883," *Journal of Law and Economics* 24, no. 2 (1981): 239 – 271 and Scott Taylor, *Buffalo Hunt: International Trade and the Virtual Extinction of the North American Bison* (Cambridge, MA: National Bureau of Economic Research, 2007).

policy makers.¹⁹ The increased land left vacant by the buffalo herds opened up space for settlement and agriculture. The hides of the buffalo were ideal sources of leather after 1870, when European tanners developed a method for converting the buffalo hides into a sturdy, cheap leather – used mainly in industrial machinery belts.²⁰ Very quickly buffalo meat became a secondary concern to non-Aboriginal hunters, who instead slaughtered herds and skinned the animals for their hides while leaving the meat to rot. One account from the diary of American buffalo hunter George Brown (1839 – 1916) illustrates this practice vividly. In May of 1871, Brown wrote:

We told them the weather was getting so warm it was almost impossible to get the meat to market before it spoiled. They said to me, ‘Why don’t you skin them and just take the hides, and let the meat lay?’ I says, ‘What the devil would I do with the hides?’ One man said, ‘Ship them to Leavenworth to W.C. Lobenstine. He’ll buy your hides and send a check.’ So Burdett and I on our next trip went to skinning.²¹

This hide hunting practice succeeded in eliminating the wild buffalo herds from the Canadian Plains by 1879.²²

The buffalo was of central focus in plains Aboriginal spirituality. The stories recorded from George First Rider illuminate the importance of the buffalo in Blood ceremonialism. George First Rider was interviewed in the late 1960s and early 1970s as part of a project of heritage conservation. These interviews are stored in the Provincial Museum and Archives of Alberta in both audio and transcription format. In one interview, titled “Significance of the Buffalo in Blood Indian Ceremonialism,” First Rider describes how the buffalo sacrifices itself to the sacred ceremonies, giving its hide, tail, horns, hooves and fetlocks. The buffalo also donated facial paintings and songs to the different ceremonies. In this way First Rider describes how the buffalo

¹⁹ Scott Taylor, “Buffalo Hunt,” p. 3165.

²⁰ *Ibid.*, pp. 3168–3169.

²¹ *Ibid.*, p. 3169.

²² *Ibid.*

is present in all the sacred bundles and ceremonies. The centrality of the buffalo is expressed through First Riders words: “The children of the past play buffaloes. Now us humans, we make our robes out of buffalo hides and we make our moccasins out of buffalo hides and we eat the buffalo. All our regalias are from the buffalo.”²³ Thus the buffalo was far more than just a means of subsistence, it was the heartbeat of Aboriginal spirituality and the pulse of ceremonial practice.

While meat was a central part of the traditional diet on the Western plains, the Plains peoples utilized a variety of natural fruits and vegetables from the landscape as well. Maureen Lux has highlighted the many plants utilized by Plains cultures in her study, *Medicine that Walks*. A brief discussion of these plants will highlight the diverse and insightful ways these populations gathered nutrients from their local environments. Some of the most common vegetables harvested by plains peoples were root plants, which were dug up and eaten either raw, boiled or roasted. These included: Onion bulbs, (*allium cernuum*; *A. stellatum*), Cow Parsnip – or “Indian Celery” (*Heracleum ignatum*), and Prairie Turnip – or “Indian Breadroot” (*Psorlea esculenta*).²⁴ These vegetables served as a high source of vitamins, especially vitamins A, B6 and C, and they provided complex carbohydrates and starches for energy. The prairie turnip was so important to Blackfoot culture that locations where it was found were named for the plant.²⁵ It was often called the “holy turnip” and used to treat pain or brewed as a tea to stop haemorrhage.²⁶ George First Rider emphasized its importance to an interviewer in 1969, stating “a person will have a broken leg or a broken arm, the turnip will be chewed and will be applied on the broken portion and the person will be relieved.”

²³ Provincial Museum and Archives of Alberta, George First Rider, “Significance of the Buffalo in Blood Indian Ceremonialism,” *Indian Heritage Project*, Disc 56 (May 8, 1969), IH – AA.087.

²⁴ Maureen Lux, *Medicine That Walks*, p. 11.

²⁵ Provincial Museum and Archives of Alberta, George First Rider, “Ethnic Botanical Discussion,” *Indian Heritage Project*, Disc 47 (April 10, 1969), IH–AA.021.

²⁶ *Ibid.*

Wild fruits and were also present in the traditional diets found across the plains. The most important berry was the Saskatoon berry, which was used in the pemmican that fueled the western fur trade. The Blackfoot also used the wild berries of the prairies – especially Saskatoon berries – in ceremonial blood soups, which were a nutritionally and spiritually significant meal.²⁷ The cooking and preparation methods of the time demonstrate how well-adapted the Plains peoples were to their nutritional ecology. Long sugar chains were present in many of these plants, which required proper processing to enable digestion. The pit roasting method was developed to handle this task and allowing the digestion of the various carbohydrates harvested on the prairie landscape.²⁸ Another typical preparation method – sun-drying – held spiritual significance, as it imbued the food with the spiritual energy of the sun, while allowing for food preservation and easy transportation.²⁹

The significance of the traditional diet is in the value – physically, mentally, emotionally and spiritually – that this diet had on population health. Medical professionals have taken a keen interest in dietary trends among Canadian Indigenous populations in the last decade.³⁰ Population research has investigated the various micronutrients populations receive (or failed to receive) from modern and traditional diets. Traditional Indigenous diets had higher protein intake and were typically richer in micronutrients such as iron, zinc, copper, magnesium and phosphorus, due to a

²⁷ Maureen Lux, *Medicine That Walks*, p. 11.

²⁸ *Ibid.*, p. 12

²⁹ *Ibid.*

³⁰ For a few of these studies, see: Harriet Kuhnlein and Olivier Receveur, “Dietary Change and Traditional Food Systems of Indigenous Peoples,” *Annual Review of Nutrition* 16, no. 1 (1996): 417 – 442; Eleanor Recey, Jean Sabry, and Frederick Evers, “Food Consumption Patterns and Use of Country Foods by Native Canadians near Wood Buffalo National Park,” *Canadian Arctic* 44, no. 3 (1991): 196 – 205; Olivier Receveur et al. “Decreasing Traditional Food Use affects Diet Quality for Adult Dene/Metis in 16 Communities of the Canadian Northwest Territories,” *Journal of Nutrition* 127, no. 8 (1997): 2179 – 2186; Veronique Gaudin et al., “A Mixed Methods Inquiry into the Determinants of Traditional Food Consumption Among Three Cree Communities of Eeyou Istchee from an Ecological Perspective,” *International Journal of Circumpolar Health* 73, no. 10 (2014): 1 – 13.

high meat consumption – though they were lower in both Vitamin A and calcium.³¹ The western diet is higher in carbohydrates and total fat count, especially saturated fats and sodium.³² Higher intake of these nutrients through the increased reliance on processed foods is associated with many health issues today – including high cholesterol, heart disease and diabetes mellitus.

1.2 – The Residential School Diet, pre-1920:

The transition to a western diet was heavily facilitated by life in the Indian Residential School. These schools typically followed a regimented menu, with little access to meat or other protein sources. The menu was followed by students, but staff had the option of outside items, like fresh fruit, chocolate and canned salmon.³³ The Department of Indian Affairs initially attempted to regulate the menus of all schools, to ensure standardization across the system.³⁴ This, however, was a difficult undertaking, as growing conditions and crop selections varied significantly in different parts of Canada. The schools – especially the industrial schools – were expected to be fairly self-sufficient - either producing the food that would be needed to feed their own students, or using their per capita grant to purchase any additional foods required.³⁵ Therefore nutrition of students was highly contingent on the conditions of the school – where it was located in relation to the reserve and to local markets, the conditions of the land it was cultivating, and the financial support it was able to procure from either the Department or its religious administrators.

³¹ Susan Whiting and Michelle Mackenzie, “Assessing the Changing Diet of Indigenous Peoples,” *Nutrition Reviews* 56, no. 8 (August 1998): 248 – 250, esp. 249.

³² *Ibid.*

³³ John Milloy, *A National Crime*, p. 117.

³⁴ *Ibid.*, pp. 117 – 121.

³⁵ *Ibid.*, p. 120.

Nutritional statistics are difficult to find in the Indian Residential School files, as most accounts of meals were written by inspectors or administrators, the latter of which were often treated to a display of proper meals and the former whom had a vested interest in keeping the true nature of food deficiency hidden from officials and the public in general. To gain some sense of the expected caloric intake of children, we must look to other sources for information, namely official reports from the period which investigated the question of food and nutrition. Historian John Milloy has discussed the early problems with nutrition in his analysis of such a report undertaken at the Regina School by three officials in the 1890s: J. McKenna, the Assistant Commissioner to the Department of Indian Affairs, J. Menzies, an accountant from a firm that representing the Presbyterian Church, and R. MacKay, another Presbyterian official. This report compared the dietary allowances which had been set out in 1894 with the *actual* consumption of food by students and staff at the Regina School. The report found a significant gap between the expected nutritional intake and the actual consumption of different foods by the students. The findings of the study are shown in Chart 2 below.

Chart 2: Results of Nutritional Report Undertaken by the Presbyterian Church, 1900³⁶

Foodstuff	Amount per child per annum (lbs)	Allowance in 1900 for Regina School (lbs)	Actual Consumption in 1900 for Regina School (lbs)	Quantity of Allowance Received (%)
Beef	182	21,580	13,866	64.26%
Cheese	51	515	73	14.17%
Currants	21	206	456	221.35%
Beans	12	1,236	700	56.63%
Rice	12	1,236	730	59.06%
Raisins	11	102	200	196.08%

³⁶ This information was taken from John Milloy, *A National Crime*, p. 117.

The results of the study demonstrate that students in the Regina School were deficient in all areas except in the case of fruits.

Unfortunately nutritional studies such as this were rarely done within the schools, leaving us with little information on variation in nutrition over time and between provinces. We must therefore look to the more qualitative evaluations of the residential school diet, which were voiced by former students, parents, doctors, and concerned citizens. As the writings of Peter Bryce in the 1920s demonstrate, there were numerous cases where inspectors and doctors protested the poor diet of students within the schools.³⁷ Milloy has found similar incidences in his research, especially in schools in British Columbia, where doctors warned the Department that pupils “were in every case undernourished owing to inadequate supplies of meat, fish and vegetables.”³⁸ Milloy’s discussion highlights the nutritional deficiency which stemmed from a transition away from the traditional diet provided by families and communities who were “still living on the land,” to the poor diet found in the schools.³⁹

After struggling to keep the diet within the schools standardized for many years, the Department of Indian Affairs handed the control of dietary concerns over to the churches in 1922. The Department still maintained some nutritional regulation, by requiring the schools to list their own expected food allowances, and to submit their expected menus to the Department for review. Although these menus were to be submitted to the Department of Health for nutritional verification, Milloy found little evidence of this action ever occurring when investigating the dietary conditions within the schools.⁴⁰

³⁷ Peter Bryce, *The Story of a National Crime*.

³⁸ John Milloy, *A National Crime*, pp. 120 – 121.

³⁹ *Ibid.*, p. 121.

⁴⁰ *Ibid.*, p. 118.

The diet within the schools in Alberta nonetheless kept to a fairly standardized menu based upon the types of foods available on the prairies. Because the residential schools in this study usually had a pupilage of more than 100 students, large scale meals had to be cooked three times a day, with as much efficiency in resources as possible. This resulted in mostly liquid meals, which could be easily prepared in large vats by the cooks. The usual diet for students looked like this:

- Breakfast: Porridge, with milk. Some starch, either bread or potato.
- Lunch: Soup or stew with meat and other garden vegetables, stewed fruit.
- Dinner: Meat or cottage pie with potato, bread and butter, tea with milk, stewed fruit.⁴¹

Fruit was dependant on season and the amount of vegetables, meat, or gravy varied depending on the economic situation of the school.

Information on the diet and nutrition within the different schools can be found in various locations throughout the school documents. Building maintenance records are a particularly rich resource, as the principals of the different schools often corresponded with different Department officials, attempting to justify various equipment and building costs needed for farming the land. The per capita grants received from the Department were often used by paying salaries and maintenance expenses, so purchasing food for the students was an unlikely undertaking. Instead the schools grew most of their wheat and vegetables themselves, saving money for the purchasing of important foods like meat.⁴² Some schools were even lucky enough to have plentiful pig and cattle herds, which allowed them to slaughter their own meat and save money.⁴³ A good crop

⁴¹ LAC, RG 10, Volume 6340, File 751-13, Part 1. Report of Travelling Nurse, Blue Quills Indian Residential School, Feb. 19-20, 1923.

⁴² Department Annual Reports often show schools taking an advance on their annual grants to pay for beef. LAC, Indian Affairs Annual Reports, 1864 – 1990. Annual Report of the Department of Indian Affairs for the Year Ended March 31, 1921.

⁴³ The Edmonton Institute is a good example of this, see page 65.

meant that excess crops could be sold and earn the school extra money for purchasing better food items. A bad harvest would limit the food students received, while also depressing the yearly income of the school and preventing the school from purchasing more food variety for the students.

1.3 – Farming and Stock:

The quality and abundance of food that a school had access to was directly dependant on its cultivating power. This fact led the schools to expand their farming operations at every opportunity. Many of the residential schools in Alberta expanded farming operations during the early 1900s, as more students were brought into the schools and the economic pressure to obtain more food increased. For instance, the Crowfoot Indian Residential School built a new cattle shed in 1924, to hold their expanded herd, which had started at 10 cows in 1912 and had grown to about 30 cows by 1924.⁴⁴ The expanded farming operations seemed an important achievement to the principal of Crowfoot school, as more farming was ideal for the school lessons and focus. However, this enthusiasm was not shared by the Indian Commissioner W.H. Graham (1867 – 1939) in Regina. After visiting the Crowfoot school in 1924, he wrote a memo to the Superintendent of Indian Affairs at the time, D.C. Scott, stating that the school had been given a quarter of land recently, “on which I am told they are going to carry on farming in a small way. I hope it will be in a small way.”⁴⁵

The expanded farming and ranching operations at Crowfoot were eventually approved by the Department, which approved a new cattle shed to be built in September of 1924.⁴⁶ The school

⁴⁴ LAC, RG 10, Volume 6349, File 752–5, Part 1. Extract from Gooderham letter, September 29, 1924.

⁴⁵ Ibid., W.M. Graham to D.C. Scott, April 3, 1924.

⁴⁶ Ibid., A.F. Mackenzie to J.H. Gooderham, September 15, 1924.

curriculum focussed on “mixed farming and care of stock”, teaching these techniques to the children, while supplementing their food stores.⁴⁷ Yet Crowfoot school only carried out minimal farming, certainly not enough to need a silo on the grounds for silage storage.⁴⁸

Other schools in Alberta were far more equipped for the task of farming and stock raising. The Edmonton Residential School was one of the better equipped schools. The school was located seven miles north of Edmonton and officially opened as a new school in 1924. As a newer school, its land was chosen with an eye for farming, to enable the school to be as self-sufficient as possible. The school farmed 500 acres, growing wheat, oats and barley – producing a yield of 300 bushels of wheat, 5500 bushels of oats, and 1500 bushels of barley in the 1929 harvest.⁴⁹ The low wheat yield was due to damaged crops from frost, which the school experienced a few times in the 1920s and 1930s. In the past the school had sold up to “ten thousand dollars worth of grain.”⁵⁰ The school also grew a large garden of potatoes, which yielded the school 2,000 bushels in the same year. Needless to say, this rather large farming enterprise would have allowed for greater access to grains and vegetables in the diet of students. This state of affairs was reflected in the inspection report of 1929, which stated that students “presented a clean, well dressed, healthy and happy appearance.”⁵¹

The Edmonton Residential School was also fortunate to have a large supply of livestock, which provided labour, milk, and meat to the school. The inspector noted the total number of animals held at the school in 1929, placing their livestock totals at: 14 work horses, 35 cattle – 12 of which were milk cows – and 60 hogs. The hogs were being raised to sell at the Edmonton market

⁴⁷ Ibid., Extract from Godderham letter, September 29, 1924.

⁴⁸ Ibid.

⁴⁹ LAC, RG 10, Volume 6364, File 760–2, Part 1. W. Murison to W.M. Graham, April 2, 1929.

⁵⁰ Ibid., W.M. Graham to Scott, September 17, 1926.

⁵¹ Ibid., W. Murison to W.M. Graham, April 2, 1929.

and were apparently in very fine condition, having been graded as “Select and No.1.”⁵² The raising of hogs was a central form of income for the school and they continued to expand their stock, with a reported 125 hogs raised the next year.⁵³ Sales of cattle also helped supplement the income of the school and in 1929 the school sold 7 steers and 2 cows for a profit of \$937.00.⁵⁴ The school did have a notable lack of poultry however, having no henhouse at the time. This was supplied by the Department that next year, allowing the institution to secure “a sufficiently large flock of hens to supply eggs for the institution.”⁵⁵

The Edmonton Residential School was therefore well supplied in the production of dairy, eggs, vegetables, and meat. Inspection reports consistently noted the students had a healthy appearance. The true nutritional health of these students is difficult to ascertain, without sources that discuss student nutrition. However, it is reasonable to assume that this school – which was well located in relation to the market in Edmonton and had one of the most extensive farming operations of all the schools in Alberta – likely had correspondingly better nutritional intake.

Yet nutrient intake is only half the equation when determining nutritional health of an individual. Physical activity and its corresponding increase in metabolic processes are also necessary to consider when determining net nutritional health. The Edmonton Institute had large farming operations, which provided the school with greater food yields, but also necessitated a large amount of student labour. Much physical energy was put into farming, gardening, and caring for the livestock at the school. The children, often under instruction from the principal or a farming instructor, ran dairy operations and farming operations, and produced milk, cream, butter, eggs and other farming products. Whether these products were made available to the students once

⁵² Ibid.

⁵³ Ibid., W. Murison to W.M. Graham. October 05, 1929.

⁵⁴ Ibid. This is approximately \$16,000.00 now in Canadian currency. (August 08, 2015.)

⁵⁵ Ibid., W. Murison to W.M. Graham, April 2, 1929.

produced was entirely dependent on the school. Milloy has found that it was common practice in British Columbia for these products to be sold off for school, while the students subsisted on skim milk and were “very badly fed.”⁵⁶ At Edmonton, which had such a large revenue from its crop sales, it seems likely that the sale of milk, eggs and vegetables was less important and the students would have had access to at least a large portion of these products.

The energy spent on the various farming industries was high at the Edmonton school. Students attended school for the first half of the day and spent the afternoons working.⁵⁷ With 500 acres of cultivation, student labour would have been essential to the success of the farm (image 4 and 5). The male students formed the core of this labour, chopping wood, caring for the livestock, cleaning and maintaining farm equipment and milking the dairy cows on a daily basis. Boys who were too young to work with livestock or farming equipment were involved in the planting and harvesting of the vegetable gardens, although images from different schools in Alberta indicate seed planting was done by both boys and girls during “gardening class.”⁵⁸ Girls spent their work time on indoor labour, cleaning the floors and walls, cooking meals in the kitchen, and sewing clothes and other items used by students (image 8).

Students would also expend energy through helping with the many building alterations and repairs done at the institute. In order to economize on maintenance expenses, the principal was often compelled to use student labour as the main source of work when additions or maintenance were required on the schools grounds. This happened quite frequently at the Edmonton Residential School. In October of 1926, the older boys at the school were put to work on repairing and upgrading the stairs. The Department had only agreed to pay for this upgrade, if “no unnecessary

⁵⁶ Milloy, *A National Crime*, p. 120.

⁵⁷ *Ibid.*

⁵⁸ See Image 6, from the Red Deer School and Image 7 from St. Peter’s Mission School.

expense should be incurred and as much of the labour as possible should be performed by the school management.”⁵⁹ The next year student labour was used to build a new residence for an incoming farm labourer. Although the Department had originally pledged \$5,000.00 to the erection of this building, they eventually limited the allowed amount to \$3,500.00. The new building took about a month to complete and the school provided “the greater part of the labour.”⁶⁰ A new tool shed was built by students in February 1929.⁶¹ In the spring the students were once again put to work, this time to add an additional upstairs floor to the main building.⁶² The Residential school at Brandon was closing in 1929 and 83 students were expected to be transferred to Edmonton from Manitoba. This necessitated an extensive upgrade to the Edmonton institute, which took a few months to complete. The construction of the upstairs finished in July 1929 and the whole building was repainted as well. The principal, J. Woodsworth, was very specific to state that “the school supplied all the labor” in his report to the Department, for fear of accusations that the expense was too high.⁶³ Renovations and upgrades seem to occur at this school at least once a year and the guarantee of student labour was the only way that most projects were approved by the Department. These projects, coupled with the continued work demands the school required, would have placed abnormal demands on the metabolic systems of the students and would have had an adverse impact on their net nutrition.

The high farming yields and growing stock herds seen in the 1920s at the Edmonton Institute were not the norm for other schools in Alberta. The differing experience of the two residential schools located on the Blood reserve demonstrate the many health advantages of newly

⁵⁹ LAC, RG 10, Volume 6350, File 753-5, Part 2. J.D. McLean to W. M. Graham, October 05, 1926.

⁶⁰ Ibid., J. Woodsworth to Secretary, May 26, 1927.

⁶¹ Ibid., J. Woodsworth to J.D. McLean, Feb 12, 1929.

⁶² Ibid., J. Woodsworth to J.D. McLean, July 10, 1929.

⁶³ Ibid.

built schools like the one at Edmonton, which opened in 1925.⁶⁴ The Blood reserve was home to both a Roman Catholic Indian Residential School – St. Mary’s – and an Anglican Residential School – St. Paul’s. Farming was notably difficult on this reserve, due to an abundance of calcareous soil and high soil erosion.⁶⁵ The St. Mary’s school was very old and run down in the early 1920s and even the superintendent general of Indian Affairs believed it to be “almost beyond all usefulness for the purpose of a boarding school.”⁶⁶ Farming was nearly non-existent at this time, as the school had no equipment to carry out such an enterprise and the Department did not feel it advisable “to spend very much on the old school building, either by way of repairs or equipment.”⁶⁷ The justification for this was that the Department had plans to build a new school in place of the old one in 1922. Unfortunately for the students, no such new school was constructed until late in 1925, meaning that the students suffered under the old building for more than five years before anything was done.

At this time, the Indian Commissioner William Graham still claimed that “the children are well fed.”⁶⁸ The accuracy of these words is unlikely, as the school was struggling to get by on the per capita grants and unlike at Edmonton, the Roman Catholic school had no farming yields to supplement the school income.⁶⁹ The state of nutritional health is made especially clear by remarks made by the school inspector who evaluated the health of students after the new school was built.

⁶⁴ Ibid., Ibid., J. Woodsworth to J.D. McLean, January 30, 1925.

⁶⁵ This has been a significant hindrance to agricultural practices for much of the twentieth century. Alberta Agriculture and Forestry, “Soil Map: Lethbridge area 82H NW (1980) and “Soil Map: Lethbridge Area 82H NE,” accessed May 20, 2015, [http://www1.agric.gov.ab.ca/\\$Department/deptdocs.nsf/All/sag15320](http://www1.agric.gov.ab.ca/$Department/deptdocs.nsf/All/sag15320).

⁶⁶ LAC, RG 10, Volume 6343, File 750-5, Part 2. J.D. McLean, Memorandum to Hon. Sir James Lougheed, July, 19 1921.

⁶⁷ Ibid.

⁶⁸ Ibid., W.M. Graham to D. C. Scott, April 3, 1924.

⁶⁹ The St. Mary’s School would not begin large-scale farming until after the school was rebuilt in 1925.

In these reports, the inspector consistently emphasized how the health of students had improved significantly with the new building. In one report the inspector wrote:

I must say that there has been a great improvement in the appearance of the children during the last few years. I remember Doctor Stone visiting this school with me two or three years ago and at that time he remarked that he was not satisfied with the appearance of the children.⁷⁰

In another report he stated “as far as the health of the children is concerned, they look 100% better than they did two years ago.”⁷¹ Clearly Graham’s assessment was based more on his own desire to assure the Department of the merits of the schools, than on the reality of nutritional health.

The new school building was placed on land with ample room for farming and the Department provided the necessary equipment for cultivation and storage. By 1929 the school was cultivating wheat, oats, barley, potatoes and “a lot of other vegetables.”⁷² The harvest in 1929 was greater than that of Edmonton, with a successful yield of 3,000 bushels of wheat, 2,300 bushels of oats, 860 bushels of barley, and 600 bushels of potatoes. The school had also successfully expanded its livestock quantities, with horses, cattle, pigs, and chickens that provided meat, dairy and eggs for the school. The inspection report of 1929 noted that between 16 and 20 cows were being milked during the year “and the children are receiving all the milk they require. Eleven hundred pounds of butter were packed during the summer for the use of the children this winter.”⁷³ This is a significant finding, as it shows that the students had ample access to fat sources during this time. The pupils of the Roman Catholic school were also surprisingly well supplied in protein sources, as the cattle and pig livestock was large enough to keep the school menu well supplied.

⁷⁰ LAC, RG 10, Volume 6343, File 750-5, Part 3. Inspection Report, M. Christianson to H. McGill, December 2, 1932.

⁷¹ Ibid., Inspection Report, M. Christianson to W.M. Graham, December 6, 1929.

⁷² Ibid.,

⁷³ Ibid.

In 1932 the school owned 205 head of cattle, 400 chickens and between 70 – 100 pigs.⁷⁴ The nutrition of pupils at this school had clearly taken an upturn between 1926 and 1933, as reports noted:

All the hams and bacons required for the school are cured on the premises. No cream, butter or eggs are sold, but are used at the school, and all the beef required is slaughtered at the school. 30 head of cattle were put through the slaughter house last year. The children are obviously very well fed, and with the splendid garden, they receive a great variety of food as well.⁷⁵

Unfortunately for the students, the years of abundance were short. St. Mary's encountered the same struggles that the rest of Alberta did in the 1930s with the onset of the Great Depression.⁷⁶ Crops began to fail and schools had to purchase their own feed, grain, and meat.⁷⁷ At the time the Department of Indian Affairs encouraged a type of farming that was common to Canadians at the time. This method believed that the standardized "'scientific' dry farming methods" would be ideal for prairie farming techniques.⁷⁸ The practice of summerfallowing was especially prominent in this type of farming, although agriculturists have since determined that summerfallowing was very damaging to the soil.⁷⁹ In 1932 the school was noted as "summerfallowing about 120 acres" of land.⁸⁰ The next year, crops began to fail and the extra income produced through harvest sales disappeared. Instead the school had to find money to purchase flour and vegetables elsewhere at

⁷⁴ Ibid.

⁷⁵ Ibid.

⁷⁶ For a discussion of how the economic circumstances of the 1930s impacted prairie farming, see Curtis McManus, *Happyland: a History of the "Dirty Thirties" in Saskatchewan, 1914–1937* (Calgary: University of Calgary Press, 2011) and David Jones, *Empire of Dust: Settling and Abandoning the Prairie Dry Belt* (Calgary: University of Calgary Press, 2002).

⁷⁷ LAC, RG 10, Volume 6016, File 1-1-13, Part 1. R.A. Hoey to W.H.B. Sharpe, February 4, 1938.

⁷⁸ Valerie Jobson, "The Blackfoot Framing Experiment, 1880–1945" (Master of Arts Thesis, University of Calgary, 1990), p. 3.

⁷⁹ Ibid, 4.

⁸⁰ LAC, RG 10, Volume 6343, File 750-5, Part 3. Inspection Report, M. Christianson to H. McGill, December 2, 1932.

inflated prices. In 1934, Inspector Christenson reported "their farming operations were a failure last year on account of the drought."⁸¹ The dismal circumstances did not improve over the next few years, and the Indian Agent was forced to write the Department seeking aid in 1936, stating that "crops at both schools [were] very poor, averaging about 4 bushels to the acre. The potatoe(sic) crops were also useless and they will be faced with purchases in both flour and potatoes."⁸²

The nutritional health of students at this school did not improve for a long time after the Great Depression. Indeed, the nutrition of students at St. Mary's Residential School had taken such a drastic downturn in the 1930s and 1940s, that the school was deemed to be a perfect fit for the now-famous nutritional experiments which were undertaken by nutrition researchers in the late 1940s.⁸³ Students in the Roman Catholic School were found to have a "high incidence of riboflavin deficiency" and the possibility of a thiamine deficiency.⁸⁴ Having control of a population suffering from endemic malnourishment posed a perfect scientific laboratory for nutritional researchers in Canada. Thus certain schools with known nutritional issues were selected for the nutritional experiments. St. Mary's was used to test the efficiency of nutritional supplementation to the diet. The students of the school were left with a nutritionally deficient diet for two years – to provide a "baseline" for the experiment – and then introduced to a diet which contained "Newfoundland Flour Mix," a flour product with added thiamine, riboflavin, niacin, and bonemeal.⁸⁵ The students at St. Mary's were kept on the diet for five years, while the medical researchers conducted their study.

⁸¹ Ibid., Inspection Report, M. Christianson to H. McGill, April 30, 1934.

⁸² LAC, RG 10, Volume 6343, File 750-5, Part 3. Report of Indian Agent, J.E. Pugh. August 31, 1936.

⁸³ For a full discussion of these experiments see: Ian Mosby, "Administering Colonial Science: Nutrition Research and Human Biomedical Experimentation in Aboriginal Communities and Residential Schools, 1942–1952," *Histoire sociale/Social history* 46, no. 91 (May 2013): 145–172.

⁸⁴ Ibid, p. 162.

⁸⁵ Ibid.

The result of this unethical nutritional experiment was an increased incidence of anemia among the students. The blood haemoglobin levels declined significantly in the students during the study, although whether this could be attributed to the Newfoundland Flour Mix, or simply continuous poor nutrition, is uncertain.⁸⁶ For the lead researcher in this case, Doctor Lionel B. Pett, this result was highly disappointing and only highlighted the need for further research.⁸⁷ For the unfortunate First Nations students who were subjected to the experiments, it meant several years of subsisting on a diet which was known to be nutritionally inadequate and a callous disregard for their rights to health and bodily integrity.

The nutritional situation at St. Paul's Indian Residential School showed a similar pattern to that of St. Mary's. This Anglican school was also located on the Blood reserve. It, too, received a new school building in 1923⁸⁸, with three new barns and farming equipment for cultivation provided in 1924.⁸⁹ In the case of St. Paul's school, we are lucky to have a first-hand account of the student diet from Pauline Dempsey, a former student of the school. Dempsey attended St. Paul's for eight years, between 1934 and 1942.⁹⁰ In her account, she vividly recalls the stark contrast between food eaten at home during the summer and food eaten at school. Dempsey talks fondly of her mother's large garden and how her family would go out berry picking – “for saskatoons, chokecherries, bull berries, and strawberries.”⁹¹ At home traditional foods such as pemmican and berry suet were commonly eaten and meat was plentiful because her “dad killed

⁸⁶ Ibid, p. 164.

⁸⁷ Ibid, pp. 164 – 165.

⁸⁸ LAC, RG 10, Volume 6371, File 764-5, Part 1. Scott to W.M. Graham, May 12, 1924.

⁸⁹ Ibid., W.M. Graham to Stewart, April 17, 1924.

⁹⁰ Pauline Dempsey, “My Life in an Indian Residential School,” *Alberta History* 59, no. 2 (2011): 22 – 27, esp. 22.

⁹¹ Ibid.

and butchered his own meat... we had bacon and ham.”⁹² The practice of milking cows provided Dempsey’s family with whole milk, butter and “thick cream for our porridge.”⁹³ These luxurious meals were a special treat for Dempsey and her sister, as “mother probably knew that our meals at the boarding were terrible for the most part and that’s why she made it especially nice for us during the two months we were home.”⁹⁴

When the girls returned to St. Paul’s in the fall, the transition back to the institutional diet was very difficult. There were about 200 students in the institution so the cooks prepared meals in large vats. Liquid food was the most convenient type of meal and Dempsey remembers that they primarily ate “porridge, soup and stew – always we had stew.”⁹⁵ The stew was usually thin and lacking in meat or gravy, so much so that the discovery of a piece of fat in the bowl was a novelty to the students. Dempsey recalled:

Any fat which was in the stew we fished out and used for butter for our bread. Whoever found a piece of fat would pass it onto the next girl who then used it and passed it onto the next until it was used all up. Sometimes it became so dirty it did not resemble fat any more but looked more like a piece of eraser!⁹⁶

There was some respite from the meagre diet however, for every Sunday the parents were allowed to visit and they would bring with them home cooking to help the students through to the next week. This amount of food was not enough to counteract the poor nutrition experienced on the other six days of the week; for the St. Paul’s school was also selected as a suitably deficient school for the nutritional experiments of the late 1940s.⁹⁷ The students were found to have similar

⁹² Ibid, pp. 22–23.

⁹³ Ibid, p. 23.

⁹⁴ Ibid.

⁹⁵ Ibid.

⁹⁶ Ibid.

⁹⁷ Ian Mosby, “Administering Colonial Science,” p. 162.

thiamine deficiencies as the students in the nearby St. Mary's School, but St. Paul's was selected as the "control" school for the experiment. This meant that,

No changes were made to its menus during the course of the study, despite the fact that the initial investigation had found that students were being fed poor quality, unappetizing food that provided inadequate intakes of vitamins A, B, and C as well as iron and iodine.⁹⁸

The students at St. Paul's did not experience the same increase in anemia as the pupils at St. Mary's had, but they were placed into the nutritional experiment with no choice as to participation and they were consciously kept on a nutritionally deficient diet by the authorities that were entrusted with their care.⁹⁹

1.4 - Dietary Supplementation:

Nutritional health of students attending Indian Residential School in Alberta can also be assessed through an examination of the documents produced by the Blue Quills Indian Residential School, located in St. Paul, Alberta. Travelling nurses and inspectors at this school often reported that the school was providing an "abundant" amount of food to the children.¹⁰⁰ One nurse, H.E. Gerry, visited the school semi-annually in 1923 and 1924 and reported on the menu. Both years the school conformed to the standard porridge and soup diet, with milk to drink for younger children and tea for older.¹⁰¹ The nurse was also impressed by the fruit and bread selection, which included fresh biscuits and baked apple pudding. In her 1923 report she commented that the

⁹⁸ Ibid.

⁹⁹ For more information on human experimentation in North America during this time, see Susan Lederer, *Subjected to Science: Human Experimentation in America before the Second World War* (Baltimore: Johns Hopkins University Press, 1995)

¹⁰⁰ LAC, RG 10, Volume 6340, File 751-13, Part 1. Report of Travelling Nurse, Blue Quills Indian Residential School, February 19–20, 1923.

¹⁰¹ Ibid. and Ibid., Report of Travelling Nurse, Blue Quills Indian Residential School, June 23/24, 1924.

“children appear happy, are well nourished and well kept.”¹⁰² One can imagine that the children were likely quite happy to have a few days with excellent meals and apple pudding while the nurse visited. It is hard to believe that this was the normal menu year-round though when one considers the many reports of inadequate food from parents, children, and outside observers.¹⁰³

Given these two contradictory accounts, we require another form of evidence to confirm – or disprove – the truth behind the nurse’s assessment. One such resource are the annual lists of medical supply requisitions. Blue Quills was the only school in this study, or in Alberta, where the medical documents associated with the school were saved. These documents were available at Library and Archives Canada (LAC) for research and include requisitions for specific medications which were used to treat “weak or undernourished persons.”¹⁰⁴ Such medications include cod liver oil, cod liver oil with emulsion of hypophosphates, iron tonic and Blaud laxative. These items were requisitioned by the school through an annual order put through to local druggists and the Department.¹⁰⁵

Cod liver oil was a staple nutrient booster in Canada during the first half of the twentieth Century. Nursing manuals from 1916 outlined the benefits of cod liver oil as it “is more truly a food than a medicine” which “supplies the need of the tissues for fat.”¹⁰⁶ Matrons in the Residential schools were encouraged to give visibly malnourished children two teaspoons of cod liver oil a day, “three times a day after meals.”¹⁰⁷ The administration of

¹⁰² Ibid., Report of Travelling Nurse, Blue Quills Indian Residential School, February 19–20, 1923.

¹⁰³ John Milloy, *A National Crime*, pp. 122 – 127.

¹⁰⁴ LAC, RG 10, Volume 6016, File 1–1–13, Part 1. Department of Indian Affairs, January 14, 1928: To Principals of Residential Schools.

¹⁰⁵ LAC, RG 10, Volume 6340, File 751-13, Part 1. Medical Matters, 1923 – 1937.

¹⁰⁶ Lavina Dock, *Materia Medica for Nurses*, 6th ed. (New York and London: G.P. Putnam’s Sons, 1916), p. 264.

¹⁰⁷ LAC, RG 10, Volume 6016, File 1–1–13, Part 1. Department of Indian Affairs, January 14, 1928: To Principals of Residential Schools.

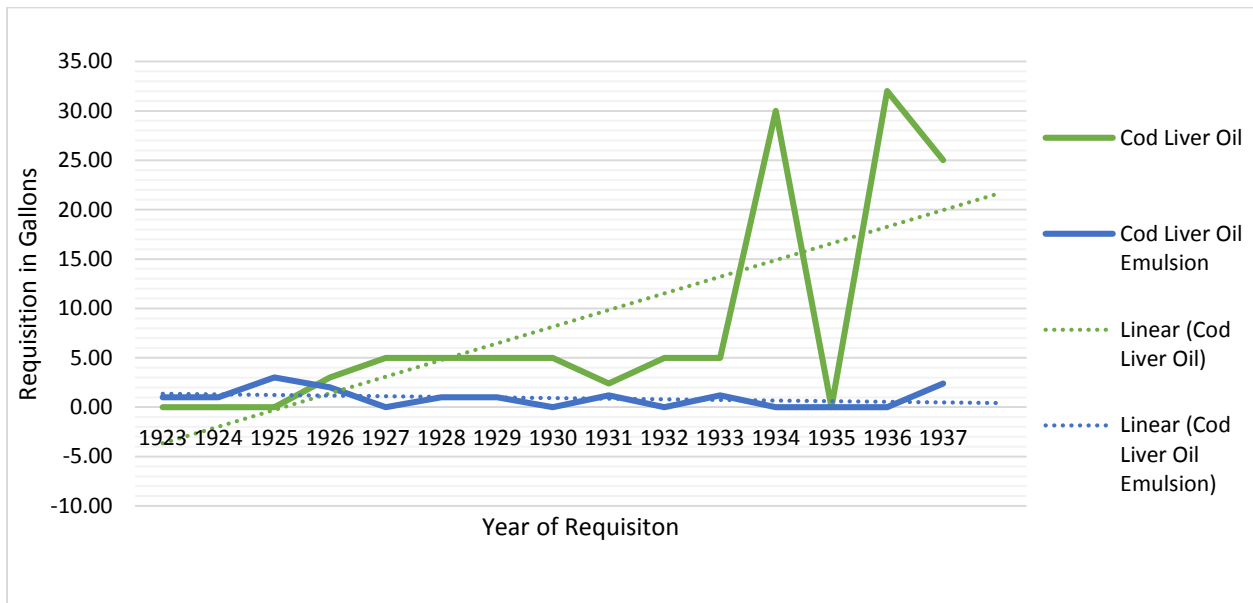
cod liver oil could be unpleasant as “the smell of cod-liver oil is unpleasant and sometimes causes nausea.”¹⁰⁸ In case a student refused to take the oil, the school often had on hand a variant: cod liver oil with an emulsion of hypophosphites, which contained a sweet malt that made it more pleasant to the taste buds. This oil was usually given to the smaller children “who refused the plain oil” and contained about half the concentration of regular oil.¹⁰⁹ In consequence, the dose for this oil was twice that of the plain oil, also given three times a day.

The amount of cod liver oil or cod liver oil with malt that was requisitioned each year is a good indication of the nutritional health of the students within the Blue Quills School. Chart 3 below illustrates the amount in gallons ordered by the school for each year between 1923 and 1937. The medical files unfortunately contained no supply requisitions beyond 1937. It should be noted that the student population at the school doubled in size between 1932 and 1934.

¹⁰⁸ Lavina Dock, *Materia Medica for Nurses*, pp. 264 – 265.

¹⁰⁹ LAC, RG 10, Volume 6016, File 1–1–13, Part 1. Department of Indian Affairs, January 14, 1928: To Principals of Residential Schools.

Chart 3: Blue Quills School – Requisitions for Cod Liver Oil, 1923-1937



The findings of Chart 3 seem to confirm Nurse Gerry’s statements. Indeed the supply requisitions for cod liver oil in 1923 and 1924 were some of the lowest in the period. The higher amounts ordered in 1925 indicate that the 1924 year was perhaps worse for nutrition, causing the requisition for malted oil to jump to three gallons, which is triple the amount ordered in 1924. As time went on the school came to favor the pure oil over the malted oil, likely due to it being more cost effective. Both oils cost roughly the same amount per gallon throughout this period, while the malted version was only half as nutritionally beneficial as the pure oil.

The data from Chart 3 also highlights the increasing need for cod liver oil to supplement nutrition as time went on. The student population at Blue Quills stayed consistent at sixty-five pupils throughout the 1920s, yet this period saw a drastic increase in the amount of oil ordered, especially between 1927 and 1930. During these three years the school placed subsequent requisitions for five gallons of pure oil - which is five times the amount requested in 1923 and 1924. Clearly, the need for this nutritional supplement had significantly increased by the late

1920s. It is also likely that the nutrition of students underwent a corresponding decrease during the same period.

The requisitions for cod liver oil spiked drastically in the next decade. The doubling of the number of students at the school during 1931 would account for a corresponding doubling of the order, yet in 1933 the school ordered six times the amount of pure oil than it had previously requisitioned. This far exceeds any expected increase. Yet the school again increased their order amount in 1936, putting through an order for thirty-two gallons of oil, followed by twenty-four gallons in 1937. The increasing need for cod liver oil as time went on implies that students at Blue Quills likewise experienced a growing need for dietary supplementation.

Based on the evidence from Chart 3, we can see that the nutritional health at the Blue Quills School was continuously suffering between 1923 and 1937, declining slowly through the 1920s and then dropping drastically in the 1930s. These conclusions are not too surprising, considering the conditions of drought at the time. The continued increase in requisitions was a likely remedy to the impoverished farming conditions of the time, which would have impacted the Blue Quills School much like the rest of Alberta. It seems, therefore, that Nurse Gerry's assessment of the student's nutritional health in 1923 and 1924 was fairly accurate, for those years were the two healthiest – at least nutritionally – between 1923 and 1937.

While cod liver oil was the most common way to treat malnutrition, the Department of Indian Affairs also recommended providing iron tonic to weak individuals. The recommended dose of iron tonic was similar to that of cod liver oil – “One or two teaspoonfuls three times a day before eating.”¹¹⁰ Iron tonic was a mixture of 32 grains of Iron Nucleinate (per ounce), with small

¹¹⁰ LAC, RG 10, Volume 6016, File 1-1-13, Part 1. Department of Indian Affairs, January 14, 1928: To Principals of Residential Schools.

amounts of quinine, strychnine and cascara.¹¹¹ Malt extract was added to the tonic to sweeten it slightly, as it was known to be very bitter. The added components of iron tonic are something of a concern, as quinine and strychnine are both toxic substances with highly dangerous effects on the digestive tract and nervous system in larger doses.¹¹² However, strychnine was commonly thought to be a stimulant for neural and motor action in weak individuals, due to its effect on the nervous system. This explains its inclusion in the tonic. Quinine was used for similar purposes and in iron tonic was considered by medical practitioners of the time to be “the most important of the mineral tonics” due to its ability to give one “the feeling of tone and energy, both bodily and mental, which belongs to perfect health.”¹¹³ The requisitions for iron tonic put through by Blue Quills School are shown on Chart 4 below.

The ordering of Iron tonic did not begin until 1928, when the Department standardized its medical supply distributor (see Appendix 6). Before 1928, schools would place an order for supplies with the Department, who would then send a request for a quotation to two or three druggists in the area. Once a quote was made by each druggist, the Department would accept the cheapest quote and request that the supplies be forwarded onto the school that placed the requisition. In 1928, the Department instituted new regulations which limited the types of medicines allowed to be ordered by schools, although the Department regulations assured school officials that “care has been taken to include remedies sufficient for the treatment of all conditions commonly met with.”¹¹⁴ The list of allowed medications available for order included the Iron tonic, which became the standard iron supplement ordered by Blue Quills after 1928. Before the change

¹¹¹ Ibid.

¹¹² For further information on these substances, see Appendix 4 and 5.

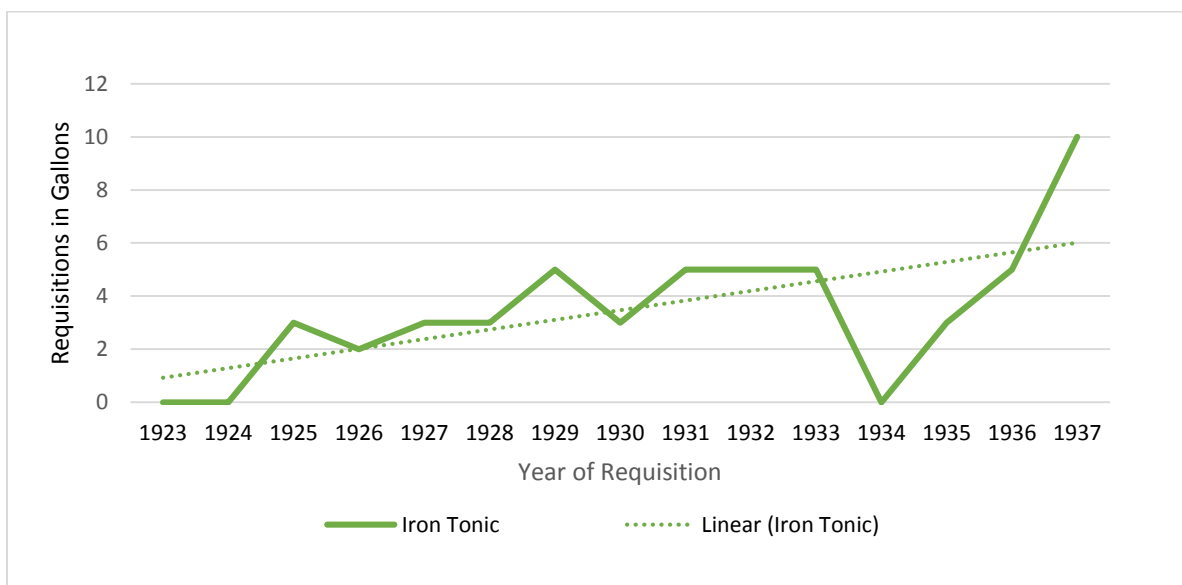
¹¹³ Lavenia Dock, *Materia Medica for Nurses*, p. 73.

¹¹⁴ LAC, RG 10, Volume 6016, File 1-1-13, Part 1. Department of Indian Affairs, To Principals of Residential Schools, January 14, 1928.

in regulations, the school ordered a liquid iron supplement known as Ferrogen, as well as a general tonic described as “tonic for anemic cases,” which was likely an iron supplement of some type.¹¹⁵

The information contained on Chart 4 only includes the order amount for iron tonic, as these medications were not directly translational and the tonic for anemia has an unknown composition.

Chart 4: Blue Quills School – Requisitions for Iron tonic, 1923-1937



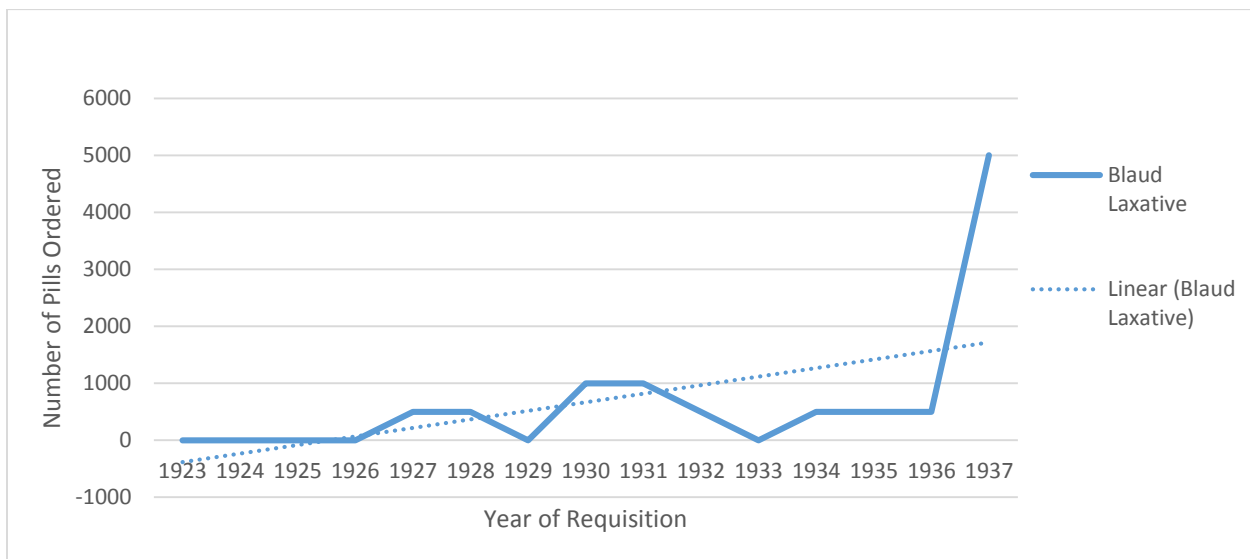
The results of Chart 4 show that requisitions for iron tonics followed a similar pattern as requisitions for cod liver oil. In 1923 and 1924, the school had little need for the iron supplement, which means that this is likely when nutritional health was at its best among students. By 1929, iron tonic was being ordered in 5 gallon requisitions and in 1937, a requisition for 10 gallons was put into the Department. Although the school requested 10 gallons of the tonic, when the order was received, the Department reduced the order to 3 gallons, as they considered the requisition to

¹¹⁵ LAC, RG 10, Volume 6016, Part. 1. Revillon Wholesale Limited, August 19, 1927.

be far too high.¹¹⁶ Although the Great Depression had taken a severe toll on the health of students, the Department continued to economize where it saw fit, including in the case of nutritional supplements.

Another iron supplement which provides insight into the nutritional health of students at Blue Quills was known as Blaud Laxative. The Department recommended giving this as “a general tonic, especially for pale, weak persons, or young women whose monthly sickness is irregular.”¹¹⁷ Blaud Laxative was administered in a pill and given three times a day after meals. Chart 5 shows the trend in requisitions for Blaud pills between 1923 and 1937.

Chart 5: Blue Quills School – Requisitions for Blaud Laxative, 1923-1937



Above we see the now familiar upwards trend in requisitions - beginning with no requisitions for pills until 1927, then requisitions for 500 or 1,000 pills between 1927 and 1936 and a dramatic requisition in 1937 of 5,000 pills. To save money, the Department similarly reduced the order of

¹¹⁶ LAC, RG 10, Volume 6016, Part. 1. Department of Indian Affairs, Requisition for Drugs. June 24, 1937.

¹¹⁷ LAC, RG 10, Volume 6016, File 1-1-13, Part 1. Department of Indian Affairs, To Principals of Residential Schools, January 14, 1928.

Blaud pills upon receipt of the requisition in 1937, reducing the amount to 3,000 pills rather than 5,000.

The medical supply orders put through by the Blue Quills School therefore provide important insight into the increasing malnourishment of students during the 1920s and 1930s. Unlike students at the Blood reserve, the students of Blue Quills experienced their most stable nutritional health in the early 1920s. As time went on, the school began to require more and more nutritional supplementation, especially in the form of cod liver oil. The need for nutritional supplementation reached its peak in the late-1930s. This indicates an increase in nutritional strain, similar to the experience of the other Albertan schools. This implies that the circumstances of the Great Depression – crop loss and lack of food – universally impacted child nourishment within the Indian Residential Schools in the 1930s.

1.5 – Traditional Subsistence to Western Diet:

The shift from a traditional diet to the residential school diet caused fractures along the cultural and spiritual health of First Nations students. The first division from traditional subsistence patterns occurred between the student and the traditional practices of hunting and trapping food. Students within residential schools did not have much opportunity for hunting, especially in the southern schools.¹¹⁸ While some students within the schools attended to the farm and livestock, these are western practices which require western understanding. Farming and raising livestock in the western paradigm requires a conception of human dominance and control of the land. This understanding is against traditional First Nations teachings, which emphasize unity and respect for

¹¹⁸ This is not the case in all schools however, as pictures from the St. Peter's Mission school illustrate rabbit snaring in winter time. See image 9.

nature. Children who would have spent much of their life learning about the power and significance of the buffalo and other subsistence animals were isolated from this cultural knowledge for extended periods. The loss of traditional hunting practices also resulted from the shift to agriculture, resulting in less time spent outdoors and a decrease in protein intake. Instead only older boys were responsible for farm cultivation, while girls and younger boys spent much of their time indoors – cleaning, prepping food, and sewing.

The residential school system also taught western style cooking – with its staple use of starches and breads, and a deficiency in protein sources.¹¹⁹ The art of harvesting meat and preparing traditional foods through drying and pounding – both of which are outside activities – was instead replaced with domestic training in western cooking methods. This was undertaken by the girls in the school, limiting their time spent outdoors and isolating them from the spiritual significance of food preparation. The extended periods of time which were traditionally associated with hunting, harvesting, and preparing food was removed from the daily lives of First Nations students within the schools, resulting in a decrease in nutritional health, and in cultural and spiritual wellness.

Conclusion:

In 1933 the Department of Indian Affairs compiled its annual report on health among the Aboriginal populations on reserves and submitted it to Parliament. The previous year saw many epidemics of infectious diseases, including Measles, trachoma, and whooping cough. One thing notably absent from First Nations communities, however, was an abundance of chronic diseases. The Superintendent of Indian Affairs wrote in his report:

¹¹⁹ See image 8 and Ian Mosby, “Administering Colonial Science,” p. 140.

Organic heart disease, diabetes, chronic kidney disease and cancer are not major causes of death among Indians, as they are among white people. They appear among those Indian communities who have acquired a fair amount of white blood. It would be very interesting to study this problem from a scientific standpoint. If, for example, it could be discovered why Indians, relatively speaking, do not have cancer, it might be possible to find why white people have it in apparently increasing numbers.¹²⁰

The irony of this statement is only notable in hindsight, with our current understanding of chronic disease.

Today, chronic health conditions such as heart disease, hypertension, diabetes, rheumatism, and kidney disease disproportionately affect First Nations communities across Canada.¹²¹ For example, medical studies have demonstrated that type II diabetes (insulin resistant diabetes) occur in Canada's Aboriginal population at rate 2-5 times higher than in the general population.¹²² The First Nations Regional Longitudinal Health Survey (RHS) has undertaken many health studies in Alberta on the prevalence of chronic disease in First Nations communities (image 3).¹²³ These rates were age-adjusted and compared to the chronic disease rates of Non-Aboriginal Canadians. The results were troubling, showing a high prevalence in all chronic conditions among on-Reserve populations, including arthritis/rheumatism, asthma, cancer, diabetes, heart disease and high blood pressure.¹²⁴ The significant variation in rates of diabetes, heart disease and high blood pressure between Aboriginal populations and non-Aboriginal

¹²⁰ LAC, Indian Affairs Annual Reports, 1864 – 1990. *Annual Report of the Department of Indian Affairs for the Year Ended March 31, 1933*, p. 12.

¹²¹ Health Canada, *First Nations Health Status Report, Alberta Region 2011-12*, p. 24. See Image 3.

¹²² Richard Oster et al., "Recent Epidemiologic Trends of Diabetes Mellitus Among Status Aboriginal Adults," *Canadian Medical Association Journal* 183, no. 12 (2011): 803 – 808, esp. 803.

¹²³ See for example the region specific reports for RHS. First Nations Regional Longitudinal Health Survey "RHS Phase 1," accessed August 4, 2015, <http://fnigc.ca/our-work/regional-health-survey/rhs-phase-1.html>.

¹²⁴ Health Canada, *Health Determinants for First Nations in Alberta*, p. 24.

populations in Alberta can be linked to the prevalence of certain risk factors, including smoking, low levels of physical activity, unhealthy eating habits and being overweight or obese.¹²⁵

The presence of these heightened risk factors for disease among on-Reserve populations is intimately tied to the transition from a traditional lifestyle, to life on reserves under colonial influence.¹²⁶ Medical professionals, most notably Burkitt and Trowell, have studied the distinct pattern of disease which develops as Indigenous populations worldwide begin to adopt westernized diets and lifestyles.¹²⁷ Obesity and type II diabetes rates have been the first to surge, soon followed by increased rates in hypertension, cerebrovascular disease, and stroke. Angina and myocardial infarction rates also begin to increase drastically, though these diseases are often non-existent before the westernization of diet occurs.¹²⁸ Alberta's First Nations populations are currently experiencing a similar trend in chronic disease which can be linked to the transition in diet which occurred after settlement on reserves. After the disappearance of the buffalo, First Nations communities underwent a sudden shift in diet and lifestyle, which focussed on the adoption of western foods – initially through the ration system, and then through the adoption of western agricultural methods.¹²⁹

The irony of the 1933 Departmental report becomes clear when the residential schools are seen as a facilitator to this transition. Students who attended residential schools had no choice but to subsist on an inadequate diet high in starches and low in proteins. Schools taught agricultural practices to children who were served a standardized menu of western-approved foods.

¹²⁵ Ibid.

¹²⁶ See, Hugh Trowell and Denis Parsons Burkitt, *Western Diseases: Their Emergence and Prevention* (Cambridge, MA: Harvard University Press, 1981)

¹²⁷ Ibid.

¹²⁸ Michael Milburn, "Indigenous Nutrition: Using Traditional Food Knowledge to Solve Contemporary Health Problems," *American Indian Quarterly* 28, no. 3/4, Special Issue: The Recovery of Indigenous Knowledge (2004): 411 – 434, esp. 413.

¹²⁹ Maureen Lux, *Medicine That Walks*, p. 37.

Carbohydrates formed the core of the residential school diet, with a minimal supplementation of meat and fruit. Nutrition of students was affected by numerous factors, including the location of the school, its farming capabilities, and the success of crops, which varied from year to year. Because of these factors, the diet of students was often unvaried and lacking in proper nutrients. Although the revitalization of the system in the 1920s provided a temporary boost to the diet of students the effects of the Great Depression and subsequent funding cuts to the schools prevented any lasting improvement in student health. This was clear in the late 1940s when the two schools on the Blood Reserve were selected for inclusion in the nutritional experiments of 1947.

Thus poor nutrition had both immediate and lasting effects on the lives of children in these institutes. While attending residential school students had to deal with the constant experience of hunger and deprivation of food. These experiences could translate into long term suffering – from both the spiritual and emotional anguish caused by the disconnection with traditional foods and the physical manifestation of their schooling experience through an increased susceptibility to disease.

Chapter 2: Sanitation and Hygiene:

“It is well for every one who is interested in the welfare of his country to remember that the health of the school children is of paramount importance, for they are the men and women of the next generation, and a race of strong men and women, vigorous and capable to endure a life of work, cannot come from a race of puny, sickly, and badly nourished children.”¹

- Harvey Bashore, 1906

Good health is intimately tied to the existence of adequate sanitation, safe drinking water, and decent hygiene.² Population health and quality of life are improved significantly when these three factors are present.³ Indeed, sanitary improvements have been a leading cause in the minimization of many diseases within modern western societies.⁴ Numerous infectious diseases – such as typhoid, cholera, and polio – are transmitted via the faecal-oral route, therefore the introduction of safe sewage disposal, along with personal and domestic hygiene are the most important steps to disrupting the transmission of these diseases. Today, improved sanitation is a primary goal of the World Health Organization (WHO) in developing countries.⁵

This chapter investigates the presence of sanitation and hygiene within the Indian Residential Schools in Alberta. For the purposes of this study, sanitation refers to the safe disposal of human waste. This includes both the physical disposal of human excreta and the presence of a safe and sanitary location for excrement. This definition of sanitation is based on the classification

¹ Harvey Bashore, *Outlines of Practical Sanitation: For Students, Physicians and Sanitarians* (New York: J. Wiley & Sons, 1906), p. 95.

² Mara, Duncan et al., “Sanitation and Health”, *Journal of Public Medicine* 7, no. 11 (November 2010): pp. 1 – 7, esp. 1.

³ *Ibid.*, 1.

⁴ Stella Lowry, “Sanitation,” *British Medical Journal* 300, no. 6718 (January 20, 1990): pp. 177 – 179, esp. 177.

⁵ World Health Organization, “Water Sanitation and Health (WASH),” accessed January 7, 2015, http://www.who.int/water_sanitation_health/en/.

of sanitation utilized by modern health professionals in investigations regarding sanitation and health worldwide.⁶ The presence of sanitation is intimately tied to the presence of safe drinking water, as all the schools in this study drew their water from localized ground water sources – which could easily be contaminated by improper sewage containment and treatment. Nevertheless, water contamination can also occur through exposure to microbiological hazards from the ground or air, causing illness. Ingestion of contaminants through contaminated water or food sources can adversely affect health and will therefore be examined in this chapter as well. Finally, the level of personal and domestic hygiene will be discussed with a focus on the impact of these factors on the health of students.

The students attending residential schools in Alberta were exposed to situations of exceedingly poor sanitation, poor water quality, high food contamination, and low domestic and personal hygiene. These factors were beyond the control of the students, who had no choice but to live, work, and play under these depressed circumstances. The level of sanitation and hygiene varied between schools and over time, with the worst sanitation found before the introduction of new institutions during the 1920s. Nonetheless, the new institutions were still unsanitary in many ways and this had a negative impact on student health. The result was the persistent presence of preventable diseases among the student populations and a depressing quality of life for the pupils of these schools.

⁶ This definition of sanitation is utilized in Mara, Duncan et al., “Sanitation and Health,” p. 1.

2.1 – The Early Years, 1890 – 1920:

Sanitation and hygiene within the schools were at their worst in the earliest years of school administration. The research of John Milloy has demonstrated that many criticisms of sanitation were put forth by outside observers during this period.⁷ In 1897, Martin Bensen – the Department accountant – undertook a general review of the school system. In his review he found sanitation within the schools to be deplorable, citing serious drainage problems at many schools across the country, including Regina, Brandon, Elkhorn and St. Paul’s.⁸ Benson criticized the site choices for many of the early Industrial schools, writing, “drainage [was] well nigh impossible and without any consideration being had for ordinary sanitary laws, and in the most exposed situations.” Albertan schools suffered from these same sanitary issues. In 1903, the new principal of the Red Deer Industrial School, Dr. J.P. Price, arrived from Toronto to find the state of his pupils quite shocking. He wrote “the sight of the ragged ill-kempt and sickly looking children was sufficient to make me sick at heart.... Sanitary conditions of the buildings are exceedingly bad.”⁹

The impoverished conditions of students in this early period began with the poor quality of the buildings which were built by the Department. The original buildings had been constructed “without due consideration for the purpose for which they would be required, hurriedly constructed of poor materials, badly laid without due provision for lighting, heating or ventilating.”¹⁰ In order to economize the undertaking, the Department had insisted that the new schools be made of the “simplest and cheapest construction.”¹¹ This was especially true in the unsettled west, where

⁷ John Milloy, *A National Crime*, pp. 94 – 102.

⁸ *Ibid.*, p. 81.

⁹ *Ibid.*, p. 78.

¹⁰ *Ibid.*

¹¹ *Ibid.*

building materials and supplies had to be shipped for construction. The Department built the cheapest buildings possible with the idea that they could be upgraded later, when the trains arrived and supplies were easier to come by out west.¹²

Unfortunately for the students, the schools were not upgraded at all during the next thirty years and the result was a continued disintegration of the sanitation and hygienic facilities within the schools. The Calgary Industrial School serves as a quintessential example of this process. The institute was opened in 1896 with twenty students in attendance. According to Benson, a disastrous location had been chosen for their site. In his review, he stated: “the site of the present school is unsuitable, there being no drainage and constant danger from floods and it would be extremely risky to spend more money in enlarging it.”¹³ In 1904, his concerns were echoed by the Medical inspector for the Department, Dr. P.H. Bryce. Bryce reported that “the site of the school and the buildings is on the river bank and well chosen except that at high water in the Bow the water forces itself up the house sewer preventing the use of closets and sinks, while ground water rises in the lowest basement some two feet.” By 1906, the inspector J. Markle was recommending closure due to the sanitation difficulties of the institute. The school was closed later that year.¹⁴

In 1907 and 1908, two reports were issued on the conditions of the schools, largely in response to the increased criticisms from doctors, concerned citizens, and the churches. These reports, referred to as the *Bryce Report* and the *Paget Report* respectively, outlined the continued difficulties the schools had with maintaining adequate sanitation and hygiene. In his report of 1907, Bryce outlined the problems he found across the country with ventilation, adequate lighting, and over-crowding.¹⁵ The *Paget Report* is even more revealing on the conditions of schools on the

¹² Ibid., p. 79.

¹³ Ibid., p. 81.

¹⁴ Ibid.

¹⁵ Ibid., p. 77

prairie. F.H. Paget, a Department accountant, based his report on fifteen boarding schools and six Industrial schools in Saskatchewan and Alberta. Paget found that the Red Deer institute had some of the lowest levels of sanitation among the six Industrial schools.¹⁶ He found St. Paul's School on the Blood reserve, Alberta, to be in a similarly deplorable state, describing it as "an old log building of two stories with low ceilings, unplastered and quite unfit for the purpose it is being used for."¹⁷ According to Paget, it was "without exception the worst building I was in on my travels and no time should be lost in replacing it with a modern structure."¹⁸ Paget's remarks on the other Alberta schools he visited were not much better. He reported that "Crowfoot was too small and badly ventilated" and that "Sarcee could not be heated, was unfit to be used as a school and could not be modernized."¹⁹ Additionally, "Old Sun's was unsanitary and unsuitable, and Blue Quills had to be modernized."²⁰

By the 1910s many schools were beyond help. The Department therefore initiated a plan to rebuild many of the schools and thereby fix the terrible conditions which received such harsh criticism. In 1911, the Department made a new contract with the churches, which focussed on better sanitation and stricter health regulations for accepting students into the schools.²¹ Schools were classified as Class, A, B or C, and funding levels varied based upon whether the school maintained "the best sanitary arrangements."²² The increased incentive for sanitation and hygiene was beneficial for a few years, but the beginning of the First World War in 1914 led to a decrease in funding for the Department – and a corresponding decrease in the ability to fund improvements

¹⁶ Ibid., p. 83.

¹⁷ Ibid.

¹⁸ Ibid.

¹⁹ Ibid.

²⁰ Ibid.

²¹ Ibid., p. 94.

²² For more information on the school classifications, see Milloy, *A National Crime*, p. 94.

to the schools. Duncan Campbell Scott, Deputy Superintendent General for the Department of Indian Affairs, remarked on this in 1919 after receiving many reports about the urgent need to upgrade both the Roman Catholic and Anglican Schools on the Blood Reserve. Scott justified the neglect of these schools in a letter to the Secretary of the Missionary Society of the Church of England, stating:

It is the policy of the Department to rebuild our schools when necessary on more improved plans. Previous to 1914 we had an extensive plan outlined looking forward several years under which we were to replace in order of necessity, as far as possible, buildings considered no longer fit for the purpose which they were serving... the war however, intervened and we were obliged from economical reasons to curtail very largely our building schemes.²³

Therefore the implementation of better sanitation and hygiene did not begin until the 1920s, which became the revitalization of the school system. Though it wished to improve the situation of students, it could not – and would not – risk investing in a school that would eventually be torn down. Therefore the state of sanitation sat stagnant until the 1920s, when the Department finally brought its attention back to the thousands of students who were awaiting an improvement in their daily existence within the schools.

2.2 – Sanitation, post – 1920:

After leaving many schools to suffer through poor conditions for several years, the Department finally returned to the plan of rebuilding in the 1920s. During this decade many of the old Industrial and boarding schools were closed down, including: the two schools on the Peigan reserve (Anglican and Roman Catholic), the two schools on the Blood reserve (also Anglican and

²³ LAC, RG 10, Volume 6343, File 750–5, Part 2. D.C. Scott to Rev. Canon Gould, August 19, 1919.

Roman Catholic), the original McDougall Orphanage at Morley, the Blue Quills Residential School, and the Old Sun's Industrial School. New institutes were built in their place. The four schools on the Peigan and Blood reserves were instead combined into two new schools – St. Paul's Anglican and St. Mary's Roman Catholic – and built at a better location on the Blood reserve. The McDougall Orphanage was upgraded to the most advanced building on the Morley reserve in 1926.²⁴ The Old Sun's School on the Blackfoot Reserve was destroyed by fire in 1928 and rebuilt in 1930/1931 – this building still stands today and is now the Old Sun Community College. The Blue Quills Residential School was moved to a new location and rebuilt in 1918 on the Saddle Lake Reserve. A brand new institute was also opened seven miles north of Edmonton in 1924, which became the Edmonton Indian Residential School.²⁵ The new institutes were a much needed upgrade to the debilitated schools, which had been continuously deteriorating throughout the past two decades.

The conditions of the schools were therefore at their worst in the early 1920s, before revitalization. The example St. Mary's Roman Catholic on the Blood Reserve serves well to demonstrate this point. The school building had actually been condemned in 1908 due to its poorly chosen location by the river, which consistently overflowed and flooded the school.²⁶ Yet it remained open for 16 more years, despite numerous reports about it being “beyond all usefulness for the purpose of a boarding school.”²⁷ from the local Agent, Inspectors, and even the Indian Commissioner, W.M. Graham. Moreover, during this time period, the Department refused to

²⁴ James Tandy, “*Curriculum in the Morley School, 1923 – 1958*” (Master of Arts Thesis, University of Calgary, 1980), p. 21.

²⁵ Paula Larsson, “Edmonton Industrial School,” *Eugenics archives*, accessed February 4, 2015, <http://eugenicsarchive.ca/database/documents/526b7f48dc1dc8b865000009>.

²⁶ LAC, RG 10, Volume 6343, File 750–5, Part 2. E. Ruax to D.C. Scott, September 5, 1924.

²⁷ *Ibid.*, J.D. McLean to Hon. James Lougheed, July 19, 1921.

invest any money in repairing or maintaining the building, as it was "not considered advisable to spend much on the old school building, either by way of repairs or equipment."²⁸ The result was a state of deplorable sanitation, from which the students had no means of avoidance. One doctor, Dr. Alan Kennedy, visited the reserve in 1921 and was shocked at the state of affairs he found at St. Mary's. After seeing the state of the school, he sent an angry letter to the Department stating "I was absolutely amazed to find them as they were... something will have to be done about this at once, or the Indian Department will be very negligent in its duties."²⁹ His letter to the Department provides a graphic description of the sewage disposal from the school, which was drained to a location around a hillside behind the school:

Here this dirty water lies, a small lake of it in fact, which is the most beautiful location for the breeding of all kinds of germs, practically outside the kitchen doors, where flies abound, and these flies which are the proven carriers of Typhoid germs alternate between the stinking pool of dirty water and the refuse, and the food that is being prepared for the Indian children... It is really one of the most glaring pieces of unsanitation that I have come across, and is a disgrace not only to the school, but to the Indian Department as well.³⁰

Despite the complaints, the condition of the sewage disposal remained unchanged for the next three years. The issues with sanitation were so bad that the local Indian Agent even offered to give the school the tub from his own house, "in which case the cost of a new tub would be saved & I can get along better without a hot plunge than the Indian children can with typhoid."³¹

Yet the Department continued with its refusals to invest in maintenance for the old school. Department funds were limited and officials had to decide which schools they could afford to invest in – and which schools were simply not worth the expenditure. The St. Mary's School fell

²⁸ Ibid.

²⁹ Ibid., Dr. A. Kennedy to J.T. Faunt, November 19, 1921.

³⁰ Ibid.

³¹ Ibid., J.T. Faunt to J.D. McLean, November 21, 1921.

into the latter category. This is made clear in a 1922 memorandum from Russel T. Ferrier, the Superintendent of Indian Education.³² When deliberating between investing in the schools on the Peigan and Blood reserves, and investing in brick veneering on the outside of the Crowfoot Indian Residential School, on the Blackfoot Reserve, the more modern school (Crowfoot) was deemed to be the best investment option. This was partially due to a concern that the Oblates of Mary Immaculate – who ran the two Roman Catholic schools – were unsure of their ability to keep up missions in Southern Alberta. Yet more importantly, the Superintendent was of the opinion that investing in the Crowfoot school was the better option, “because of the large capital and interest moneys of the Blackfoot band.”³³ The Blackfoot people had over \$800,000 in their tribal accounts at this time, in contrast to their Peigan neighbours who only controlled about \$80,000.³⁴ The Department therefore considered the Blackfoot band more important to please than their impoverished Blood and Peigan neighbours, though the students on these reserves were in a far more desperate situation.

The circumstances were left unchanged for three years before new institutions were finally erected on the Blood reserve. The replacement St. Paul’s Anglican school came first in 1924 and was closely followed by the new St. Mary’s Roman Catholic institution in 1925. These new buildings were built for a much larger student population, with a capacity of 160 students.³⁵ The St. Paul’s and St. Mary’s schools were soon the two most modern buildings on the reserve, with an electric lighting system, newly upgraded flush toilets, many wash basins and tubs, a pharmacy,

³² *Ibid.*, Superintendent of Indian Education, Memorandum to D.C Scott, May 27, 1922.

³³ *Ibid.*

³⁴ LAC, Indian Affairs Annual Reports, 1864 – 1990, Annual Report of the Department of Indian Affairs for the Year Ended March 31, 1922, p. 188.

³⁵ *Ibid.*, J.T. Faunt to J.D. McLean, December 6, 1924.

and the only telephones on reserve.³⁶ As can be expected from an upgraded building, the sanitation situation was far better at these two new schools than it had been at the previous schools on the Blood reserve. The sewage disposal system was modernized to safely dispose of waste away from the water supply of the school.³⁷ The flush toilets enabled for a far better sanitary condition at the school as well.

Nonetheless, even in the new institution there were problems with sanitation. One particular lavatory proved to be a continuing source of trouble for the institution. In 1929 the Medical officer which visited noted that “the boys’ lavatory is not in a very sanitary condition. The floors are wet with seeping down from some of the closets and there is a foul odour in the adjacent playroom.”³⁸ The Indian Agent noted that this same lavatory was still unfixed the next year during one of his inspections, stating that “the wooden seats and covers have been broken so badly that they were removed, and that they should be replaced, and the flush tank valve replacing.”³⁹ The Agent estimated the expense for repairs at \$60.00, but the Department denied the school this funding, stating they had “no funds at the present time to pay for the cost of having the repairs and renewals carried out.”⁴⁰ When the Department decided that the expenditure was not worth the benefit of repair, this general response was used. Consequently the boys’ lavatory was still a health concern in 1934, when the Indian Agent again noted it was “in such a condition below the basins that the plaster was all rotted.”⁴¹

³⁶ Ibid., A. Naessen, to Mr. Orr. February 7, 1925; Ibid., J.D. McLean to W.M. Graham, September 29, 1925; Ibid., Telegram J.D. McLean to W.M. Graham, October 1, 1925.

³⁷ Ibid., W.M. Graham to J.D. McLean, October 2, 1925.

³⁸ LAC, RG 10, Volume 6343, file 750–5, Part 3. J.D. McLean to Rev. E. Ruaux, November 8, 1929.

³⁹ Ibid., J.E. Pugh to J.D. McLean, January 10, 1930.

⁴⁰ Ibid., A.F. MacKenzie to J.E. Pugh, January 25, 1930.

⁴¹ Ibid., J.E. Pugh to J.D. McLean, July 9, 1934.

Similar sanitary situations occurred in other schools in Alberta. At the Edmonton Residential school the lavatories had to be replaced within five years of the opening of the school, as they had “got into such bad condition that further repair was impossible, so [they] had to get some new tanks and one new bowl. They were all out of commission and nothing else was possible.”⁴² At the Morley school the septic tank was listed as one of the many things needing to be fixed at the school in 1939. The inspector wrote the Department stating that the tank at the school was “too small, unsatisfactory and unsanitary.”⁴³

2.3 – Drinking Water:

The quality and quantity of drinking water was also an important factor which influenced student health. Water supply was a consistent issue in the majority of Indian Residential Schools. Every school examined in this study exhibited problems with water supply at one point during the time period examined (1920-1950). These problems were largely due to the inherent difficulties associated with dug wells, but were exacerbated in all cases by the unwillingness of the Department to follow the frequent recommendations for improved water systems made by principals, Agents, and inspectors. When the deficiencies present in the systems were pointed out to the Department, officials consistently ignored the recommendations made by people on-site and instead went with the most inexpensive – and consequently inadequate – option available.⁴⁴

The experience of the Edmonton Indian Residential School is an illustrative example of this process. The Edmonton school was a brand new institution opened in 1924. The constructed

⁴² LAC, RG 10, Volume 6364, File 760–2, Part 1. J. Woodsworth to Secretary, November 16, 1929.

⁴³ James Tandy, *Curriculum in the Morley School, 1923 – 1958*, pp. 49.

⁴⁴ See for example page 76.

water system at the school included a compressed air system with two large water tanks, supplied by a well dug 175 ft. deep.⁴⁵ This well supplied the institution with ground water for all its domestic and sanitary needs.⁴⁶ However, the design for the system was based upon “specifications received from Ottawa,” rather than the expertise of someone on-site.⁴⁷ Upon opening, the water system was a complete failure. The engineer in charge of the system wrote the Department immediately, stating,

As engineer in charge of this plant I find it my duty to and without apology to condemn the water system absolutely, as inadequate to do the work required of it... The pressure tanks are a hoax in so far as service is concerned, they simply cannot furnish the plant with the necessary water supply. In case of fire no protection whatever would be available.⁴⁸

The engineer’s criticisms were backed up by the principal of the school, who also penned a letter to the Department in anger at the problems with the water system. He wrote “the water system installed in this school has entirely failed to meet the requirements of the institution” and that the “toilets stopped working altogether, as the pressure couldn’t be kept up. They finally were used only with pails.”⁴⁹ This would have been quite an issue at the time, as about 150 people were present at the opening of the institution.⁵⁰

The Department seemed poised to respond to the water issues at the school, as they recommended that they should get “a full report by a competent outside man in order that we might be assured that the right action would be taken to remedy the difficulty.”⁵¹ However, in the

⁴⁵ LAC, RG 10, Volume 6364, File 760–2, Part 1. J.W. Mould to W.M. Graham, March 25, 1924.

⁴⁶ Ibid., W.M. Graham to Hon. Charles Stewart, March 25, 1924.

⁴⁷ Ibid.

⁴⁸ Ibid., S.A. Coppen, to W.M. Graham, March 26, 1924.

⁴⁹ Ibid., J. Woodsworth to W.M. Graham, March 26, 1924.

⁵⁰ Ibid.

⁵¹ Ibid., Hon. C. Stewart to W.M. Graham, April 9, 1924.

meantime the plumber had recommended reconnecting the system to “provide drainage” at an expense of \$500. This, the Department decided not to do, instead opting for building outside closets, as they were “cutting [their] expenditure to the bone and every hundred dollars counts.”⁵²

An inspection from the Department architect, Gurney Orr, occurred the next month. The architect recommended that a water tower be constructed at the Edmonton School to remedy the issues with “water supply and fire protection.”⁵³ The cost of a water tower would be about \$12,000, but would ensure an adequate and safe water supply to the school for the foreseeable future. A water tower had also been the recommendation of the plumber who initially reported on the condition of the school during the previous month.⁵⁴ Unfortunately the cost of building the institution had taken a lot out of the Department funds for the fiscal year. Such expensive upgrades were simply not possible. The superintendent of Indian Affairs (D.C. Scott) responded to the architect by stating that “no funds have been provided by Parliament for this purpose.”⁵⁵ For his part, Graham was not satisfied with the recommendations made by the two experts who had examined the system. He instead went in search of a third professional to examine the system, and sent a short note two weeks later to Stewart stating:

I would advise not acting on any report re water supply Edmonton involving an expenditure of much money. The man I propose sending thinks the system can be made to work. I am opposed to outside tank system as Monro suggests too expensive. I would advise sending my man.”⁵⁶

Graham’s man inspected the system and recommended changing the lavatories to low-down tank systems rather than the newer pressurized system, to compensate for the low water pressure. He

⁵² Ibid.

⁵³ Ibid., Architect to Scott, Memorandum, April 10, 1924.

⁵⁴ Ibid., D.C. Scott to W.M. Graham, April 9, 1924.

⁵⁵ Ibid., D.C. Scott to J.W. Mould, April 16, 1924.

⁵⁶ Ibid., W.M. Graham to Hon. C. Stewart, April 21, 1924.

also installed a “booster air pump” to help increase water pressure and pump water more effectively.⁵⁷ With these alterations, Graham declared the system in “first-class working shape.”⁵⁸ The system was finally ready by the beginning of June, although the concerns about enough water storage in case of a pump malfunction or fire were left unaddressed.

The ‘quick-fix’ option at the school did not last long. In 1929 the pump rods at the well gave out, due to the constant pumping they had endured for five years. The school was left without water for three days. In light of such drastic circumstances, the inspector recommended that a second well be dug, to be utilized in cases of emergency such as this. The principal agreed and wrote the Department exclaiming, “We have absolutely no reserve supply for either a breakdown, such as we had, or for fire. I would strongly recommend another well.”⁵⁹ A second well would be a cheaper option than a water tower and would allow for a higher water output at the school. However, Graham once again opposed the plan based upon a concern about cost. He wrote Scott while they were deliberating over a new well, stating, “In my opinion, there is no necessity for digging another well, which might entail an expenditure of five or six thousand dollars.”⁶⁰

While the Department deliberated over the cost of a new well, the students at Edmonton experienced another water shortage. The well broke down once again within three months, but this time the institution was left without water for 10 whole days. This left the principal with no choice but to “take every boy out of school and carry water from the sloughs and ditches by the road side.”⁶¹ This was obviously not a very clean source of water, but with 150 individuals residing in the institution and in need of water – as well as an abundance of stock – it was the only option

⁵⁷ Ibid., W.M. Graham to Hon. C. Stewart, May 9, 1924.

⁵⁸ Ibid., W.M. Graham to Hon. C. Stewart, May 16, 1924.

⁵⁹ Ibid., J. Woodsworth to J.D. McLean, Jan 17, 1929.

⁶⁰ Ibid., W.M. Graham to D.C. Scott, April 14, 1929.

⁶¹ Ibid., J. Woodsworth to J.D. McLean, April 18, 1929.

possible at the time. The principal again wrote the Department about the issues with the well, stating, “We are liable without warning to be left without water for days or longer that is the serious fact, and this is a community of some 150 people to say nothing of stock or sanitary conditions, and also possible fire.”⁶²

The need for a better water system was evident. The school required either a second well to accommodate higher output needs or a water tower to store more water for an institution of Edmonton’s size. This need was even more pressing in 1929, as the Edmonton school was preparing to receive a transfer of 83 students from the closing Brandon School in Manitoba within the year. Although the need for a new system was evident, the Department wasn’t ready to commit the funds to the school just yet, and so arranged for an inspection of the water system to be undertaken by the Commissioner of Irrigation at Calgary.⁶³ The report came in the next month and not surprisingly, it included a scathing condemnation of the current water system. The Irrigation Inspector wrote: “The water supply condition at present is unsatisfactory and unreliable.... The existing pumping plant at the well is in such a condition that it is urgent that steps be taken immediately to provide a supplementary supply.”⁶⁴ According to the inspector, a second well would best suit this purpose.

The now familiar response came from the secretary of the Department in a few weeks: “I regret to inform you that there is no appropriation for this improvement and the matter will have to stand until next year.”⁶⁵ The size of the Department budget once again prevented the students from access to an adequate water supply. The eventual fix that the Department decided on was to

⁶² Ibid. It is likely that this water would have been boiled before use, but it did hinder the availability of washing and other hygienic activities.

⁶³ Ibid., J.T. Johnston to J.D. McLean, April 23, 1929.

⁶⁴ Ibid., J.T. Johnston to J.D. McLean, May 20, 1929.

⁶⁵ Ibid., J.D. McLean to J.T. Johnston, May 31, 1929

simply replace the pump that was already present in the first well. This was the least expensive option available and would provide at least a temporary solution to the issue. A new pump was installed in the new school year and Graham himself visited the institution to check on its effectiveness. Not surprisingly, he found it to be a perfect solution to the water supply problem and in his report back to headquarters he wrote:

They have a splendid well at the Edmonton School. A new pump has been installed that is giving perfect satisfaction, so that as far as the water supply is concerned it is ample. If anything should go wrong with the pump an expert could be obtained from Edmonton in a very short time to put it right, and I am not looking for anything to go wrong.⁶⁶

Once again health and safety concerns were secondary to financial concerns in the eyes of the Department. Convenient distance from the schools made it easy for officials to deny necessary interventions required to give an appropriate supply of water to their institutions. Unfortunately it was the children who suffered most from this negligence, as they were left without a supply of clean water for extended periods.

The experience at Edmonton School was repeated in the other residential schools as well. The two schools on the Blood reserve were consistently pumping muddy water from their wells during the 1920s and 1930s.⁶⁷ Break downs were common at both schools due to rod wear on the pumps and corrosion of the piping. The drought that characterized the experience of the Great Depression on the prairies in the 1930s was also an issue, causing the wells at these schools to dry up in 1933 and again in 1940, leaving the schools without water for weeks at a time.⁶⁸ In 1941 the St. Mary's school was left without a working water system for over 3 weeks, necessitating the

⁶⁶ Ibid., W.M. Graham to J.D. McLean, November 15, 1929.

⁶⁷ LAC, RG10, Volume 6343, File 750-5, Part 5. C.P. Schmidt to R.A. Hoey, January 9, 1941.

⁶⁸ LAC, RG 10, Volume 6343, File 750-5, Part 3. J.E. Pugh to A.F. MacKenzie, September 18, 1933; LAC, RG10, Volume 6343, File 750-5. A. McMillan to Secretary, Telegram, December 30, 1940.

release of students from the school.⁶⁹ The records of the Blue Quills School also demonstrate water supply issues, which often forced the school administrators to rely on meltwater for washing and domestic purposes.⁷⁰ Adequate water supply was therefore a consistent problem within the schools. This affected students' access to clean water for drinking, washing, and waste removal purposes.

2.4 – Food Safety:

Ingestion of safe food is another important factor in the maintenance of good health. Food borne illness can be caused by the consumption of contaminated food or water which contain harmful bacteria, viruses, parasites, or toxins.⁷¹ Common food-borne pathogens include *Salmonella*, *Listeria*, *Shigella*, *Trichinella spiralis*, and *Yersinia*.⁷² Contamination of food can occur in many places during the journey from food production to food consumption. An animal suffering from illness can inadvertently pass those pathogens onto humans through either direct contact or consumption of animal products. Tuberculosis or Brucellosis in a cow can be transmitted to humans through consumption of infected milk or meat.⁷³ Similarly, *Yersinia* or *Salmonella* bacteria often live in the intestinal tracts of animals such as pigs and chickens and contaminate the meat of the animals during slaughter.⁷⁴ Inadequate refrigeration of meat allows for these organisms

⁶⁹ Ibid., Francis P. Carroll to Hon. T.A. Crerar, January 22, 1941.

⁷⁰ LAC, RG 10, Volume 6340, File 751–13, Part 1. Report on Pupils of Blue Quill Boarding School, Travelling Nurse, H. E. Gerry, December 15/18, 1924.

⁷¹ Andrea Linscott, “Food–Borne Illnesses,” *Clinical Microbiology Newsletter* 33, no. 6 (March 15, 2011): pp. 41 – 45, esp. 41.

⁷² See Appendix 7.

⁷³ Heather Green et al., “Bacterial Foodborne Disease,” in *Bacterial Infections of Humans: Epidemiology and Control*, 4th edition, eds. Alfred S. Evans and Philip S. Brachman, 121 – 158 (New York: Springer US, 2009): p. 121.

⁷⁴ Ibid.

to multiply to dangerous levels. Contamination of food is also possible during storage and preparation if adequate surface and hand washing is not completed before food is prepared.

In the case of plant-based diseases, unclean water is a common contaminate of crops and gardens – especially if the soil or water contain remnants of infected human or animal faeces.⁷⁵ In these cases, contamination of water from sewage leakage, or run-off from water used to clean barns or stables can easily be absorbed by near-by crops.⁷⁶ Another common plant contaminant is ergot. Rye and other cereal grains are particularly susceptible to the growth of the fungi ergot in years of cold winters or high rainfall. In 1953, an investigation was undertaken into the rates of ergot contamination in wheat, rye, and barley crops across Alberta. It was found that about 13% of wheat and barley fields in Alberta and about 53% of rye fields were infected with ergot.⁷⁷ Ergot poisoning can cause convulsions, gangrene or gastrointestinal complications when ingested by humans and is particularly dangerous to young children.⁷⁸

Food borne illness was largely overlooked within the schools, as the symptoms of these illnesses were usually intestinal and would have been fought off by the immune system of an infected individual. Treatment would have instead been directed at the symptoms of the illness, especially stomach ache or diarrhea. Nonetheless, an analysis of the sanitary conditions surrounding the production and consumption of food within the schools can provide some insight into the likelihood of food borne illness among students.

⁷⁵ Alfred S. Evans, “Epidemiological Concepts,” in *Bacterial Infections of Humans: Epidemiology and Control*, 4th edition, eds. Alfred S. Evans and Philip S. Brachman, 1 – 50 (New York: Springer US, 2009): p. 19.

⁷⁶ *Ibid.*, pp. 19 – 20.

⁷⁷ Ibra Conners, “Ergot in Cereals in Western Canada in 1953,” *Canadian Plant Distribution Survey* 33, no. 1 (1954): pp. 23 – 28, esp. 26.

⁷⁸ Sarah Belser-Ehrlich et al., “Human and Cattle Ergotism since 1900: Symptoms, Outbreaks and Regulations,” *Toxicology & Industrial Health* 29, no. 4 (May 2013): pp. 307 – 316, esp. 307–308.

One of the most common food safety concerns found was the absence of refrigeration facilities for meat products within the residential schools. Although ice boxes of various sorts were widely available at the time, the residential schools were built without these conveniences in mind.⁷⁹ The lack of refrigeration facilities was noted at Morley, Edmonton and St. Mary's schools. The inspector at the Morley school noted in a report of 1929 that "one thing that is badly needed at this school is a Frigidaire as they really have no place where they can keep anything in the way of perishable food supplies."⁸⁰ Graham forwarded the requests made for other renovations at the school in the same year – including a wider stable and a fresh paint job – but he curiously refused to request funds for the refrigerator, stating in his letter to Scott "I am not asking anything for the supplying of Frigidaire."⁸¹ The principal bought a refrigerator in the 1930s for \$300, presumably with money from church support, rather than Department funding.⁸² Yet this means that the school had existed without cold storage facilities for nearly ten years, since it re-opened in the newly constructed building in 1923.

The St. Mary's school faced a similar situation, yet it was lucky enough to eventually receive Department funding for the erection of an Ice House at the school in 1928. This Ice House cost \$1200.00 – indicating that the storage facilities at St. Mary's were likely far superior to the facilities at Morley.⁸³ This difference was likely because the principal at Morley was forced to

⁷⁹ Susanne Friedberg, *Fresh: A Perishable History* (Cambridge, MA: Harvard University Press, 2002), p. 22. For further information on the use refrigerators, see: Jonathan Rees, *Refrigeration Nation: A History of Ice, Appliances, and Enterprise in America* (Baltimore: Johns Hopkins University Press, 2013) and Shelley Nickles, "Preserving Women," Refrigerator Design as Social Process in the 1930s," *Technology and Culture* 43, no. 4 (2002): pp. 693 – 727.

⁸⁰ LAC, RG-10, Volume 6356, File 757-5, Part 2. M. Christianson to W.M. Graham, Report on the Indian Residential School, July 5, 1929.

⁸¹ *Ibid.*, W.M Graham to D.C. Scott, July 10, 1929.

⁸² James Tandy, *Curriculum in the Morley School, 1923 – 1958*, p. 41.

⁸³ LAC, RG 10, Volume 6343, File 750-5, Part 3. T.R.L. MacInnes to W.M. Graham, May 31, 1928.

economize on the purchase of a refrigerator, while St. Mary's received Department support for their cold facilities.

The Edmonton Residential School was also lucky enough to receive Department support for the installation of an ice box. In 1929 the travelling Nurse visiting the Edmonton School remarked on the lack of cold storage facilities. She noted that while the school had a good stock of animals for meat, there was “no real sanitary way of keeping said meat.”⁸⁴ The school inspector confirmed her statements in his inspection later that year. In his inspection report to the Department, he wrote, “there are no facilities for keeping fresh meat or other supplies at this institution and they are very necessary.”⁸⁵ Although two reports had already come in about the need for refrigeration facilities, Graham still decided to investigate the matter himself. He arrived at the school in November of 1929 to determine the true needs of the school for himself. Upon examination, even Graham agreed that the expenditure was necessary and he decided that “one of the modern plants should be installed” at the Edmonton School.⁸⁶ This installation thankfully occurred in 1930 – a year after the large influx of students from the Brandon institute. There was nonetheless a six year period without appropriate cold storage for meat or other perishable products at the school, which would have heightened the chance of food borne illnesses among students at the school.

The proper storage and handling of alternative food products is also a factor to consider in the question of food borne illness. Fruit, root vegetables, and canned goods were often kept in the cellars of the institutions, as the cooler location encouraged preservation. Unfortunately cellars were not always the most sanitary of locations, as any draining issues the school had would result

⁸⁴ LAC. RG 10, Volume 6364, File 760–2, Part 1. Extract from Report of Miss Annie Ledrew, Travelling Nurse, May 8, 1929.

⁸⁵ *Ibid.*, W. Murison to W.M. Graham, Inspection of Expenditures Report, October 05, 1929.

⁸⁶ *Ibid.*, W.M. Graham to J.D. McLean, November 15, 1929.

in their flooding with sewage. This was a consistent problem at the St. Mary's institute for many years. It was first reported by the Inspector in 1929, whose report read that water was continually draining into the "sub-basement" of the institute (the cellar), because it was "below the basement proper."⁸⁷ Inspector Christianson wrote that the depth of the cellar meant that the waste water could not "be drained into the sewer" and had to instead be continuously pumped out.⁸⁸ Christianson noted, "the existing condition is not very good as there is a smell from the stagnant water. The basement is continually being pumped out, but it is always damp."⁸⁹ This was a huge sanitation problem for the school, for the cellar was still used "as a storehouse for fruit, canned goods, etc." despite its flooding issues.⁹⁰

The poor state of sanitation was left unfixed for over four years.⁹¹ This occurred despite it being reported to the Department multiple times and repeated requisitions for supplies to refinish the room. The Department finally allowed the principal to replace the cement floor in 1932, though the issues with flooding and dampness were left unaddressed.⁹² One can easily imagine the contamination problems which occurred with the storage of food in such a room for long periods of time. The conditions of the room had failed to improve by 1939, when the Indian Agent remarked on the storage of the bread racks in the cellar, which was still a "damp location."⁹³

The condition of the animals is another consideration for food safety. Stock animals need to be kept clean to avoid contamination of the food during milking or slaughter.⁹⁴ The most

⁸⁷ LAC, RG 10, Volume 6343, File 750-5, Part 3. M. Christianson, Report on Schools in Blood Agency, December 6, 1929.

⁸⁸ *Ibid.*

⁸⁹ *Ibid.*

⁹⁰ *Ibid.*

⁹¹ *Ibid.*, M. Christianson to A.S. Williams, Inspection Report, June 29, 1932.

⁹² *Ibid.*, M. Christianson to Secretary, July 11, 1932.

⁹³ *Ibid.*, J.E. Pugh to R.A. Hoey, October 16, 1939.

⁹⁴ Alexander Johnston, "Animal Health and Food Safety," *British Medical Bulletin* 56, no. 1 (2000): pp. 51 – 61, esp. 52.

important influence on animal cleanliness was the conditions of the barns and pens. Unfortunately the state of the barns and other outbuildings was usually perceived as secondary issues by Department officials. While officials encouraged the schools to be as self-sufficient as possible, they were often reluctant to spend money on things they deemed as non-essential to the general running of the institution. The experience of the Edmonton School is illustrative of this fact. When the school opened it had new barns in excellent condition and had room for 24 heads of cattle.⁹⁵ Yet within five years the herd had grown, reaching 45 heads in 1929. By this time the barn was overcrowded and the inspector was recommending an extension to ensure that the animals could be kept in a more hygienic condition.

Much like humans, cattle kept in poor conditions are more likely to develop diseases. As one common disease which can be transferred from an infected cow to humans is bovine tuberculosis, schools were especially susceptible to the contraction of tuberculosis from their cattle. In her nutritional survey of the Wabasca School, Miss MacGready noted that “the cows have never been tested for T.B.”⁹⁶ Her recommendations similarly emphasized the need to pasteurize milk at all six of the schools she surveyed. This practice had been considered by the Department since 1939, in response to three epidemics of undulant fever which broke out at different schools across the country.⁹⁷ Yet it had failed to be implemented in the majority of schools over a decade later.

⁹⁵ LAC, RG 10, Volume 6364, File 760-2. W.M. Graham to J.D. McLean, July 13, 1927.

⁹⁶ LAC, RG 10, Volume 6033, File 150-44, Part 2. Report on Inspection of Food Service, St. John's Indian residential School, Wabasca, Alberta, February 11 – 14, 1947.

⁹⁷ LAC, RG-10, Volume 6016, File 1-1-13. E.L. Stone to R.A. Hoey, January 20, 1939.

A similar situation occurred with the hog pen at the school. An inspection of the hogs in April of 1929 demonstrated that they were all graded “Select and No.1” at the Edmonton market.⁹⁸ The school had about 60 hogs at this time, but they quickly acquired more, reaching 150 pigs by October. The reasoning behind such growth was that “the raising of hogs forms a valuable source of income for the school.”⁹⁹ Yet this sudden stock expansion meant that the school needed to upgrade its hog pen to accommodate the increased numbers. The pen was in bad shape at the time, being in “a damp condition owing to the ice forming on the roof of the building.”¹⁰⁰ It was noted by the inspector that in these conditions, several hogs had been “crippled with rheumatism” and he recommended that a new ceiling be put in.¹⁰¹

These outbuilding improvements were denied by Graham, who went to the school to make a “special report” on the improvements needed.¹⁰² At the time Graham was seething over the previous report from the inspector, which had been requested by the principal of the Edmonton School without first being authorized by the Department. Graham had sent a very angry letter to Scott the day he received the inspection report, complaining about the neglect of his position as Commissioner to the Prairie Provinces. It seems he carried this grudge with him during his own inspection, as he adamantly denied the need for both facilities. In the case of the cattle barn, he believed that a “cheap shelter for young stock would be better,” as an addition to the barn “would be a useless expenditure of money.” In the case of the hog pen, he similarly dismissed the previous recommendations, stating “we have a wonderful hog pen at this school... which will hold all the

⁹⁸ LAC, RG 10, Volume 6364, File 760–2. W. Murison to W. M. Graham, Inspection Report on Schools in Edmonton Agency, April 2, 1929.

⁹⁹ LAC. RG 10, Volume 6364, File 760–2, Part 1. W. Murison to W. M. Graham, Inspection of Expenditures Report, October 05, 1929.

¹⁰⁰ Ibid.

¹⁰¹ Ibid.

¹⁰² Ibid., J.D. McLean to W.M. Graham, October 12, 1929.

pigs that should ever be kept at an Indian school. These schools are not meant to be money-making institutions.”¹⁰³ The conditions of the barn and pen were therefore left unchanged, which would have adversely affected the health of the animals over time. This would have increased the chances of pathogens and harmful diseases among the animals and the humans who cared for – and eventually consumed – them.

2.5 – Evidence of Food Borne Illness:

One of the most common symptoms of illness contracted from contaminated water or food is diarrhea.¹⁰⁴ We can therefore gain some idea through the commonality of disease of poor sanitation by looking to how often diarrhea or other intestinal issues were treated at the schools. In this case, the medical supply requisitions made by the Blue Quills School is very useful. Matrons had a variety of medications which they could request to treat diarrhea or gastro-intestinal issues. Most common were simple Diarrhea mixtures, which came in different doses for adults, children or infants.¹⁰⁵ Somewhat alarmingly, the “adult” diarrhea mixture was a pill consisting of lead and opium.¹⁰⁶ Throughout the 1920s, the Blue Quills School requisitioned 2 lbs of diarrhea mixture for children every year, while the adult mixture was only ordered in 1927.¹⁰⁷ In 1929, the school switched to the use of tablets to treat diarrhea and they requisitioned 300 child tablets and 200 infant tablets during the first year.¹⁰⁸ This increased the following year, with 1000 tablets ordered

¹⁰³ Ibid., W.M. Graham to J.D. McLean, November 15, 1929.

¹⁰⁴ Elaine Scallan et al., “Foodborne Illness Acquired in the United States—Unspecified Agents,” *Emerging Infectious Diseases* 17, no. 1 (2011): pp. 16 – 22.

¹⁰⁵ LAC, RG 10, Volume 6016, File 1–1–13, Part 1. Department of Indian Affairs, January 14, 1928: To Principals of Residential Schools.

¹⁰⁶ Ibid.

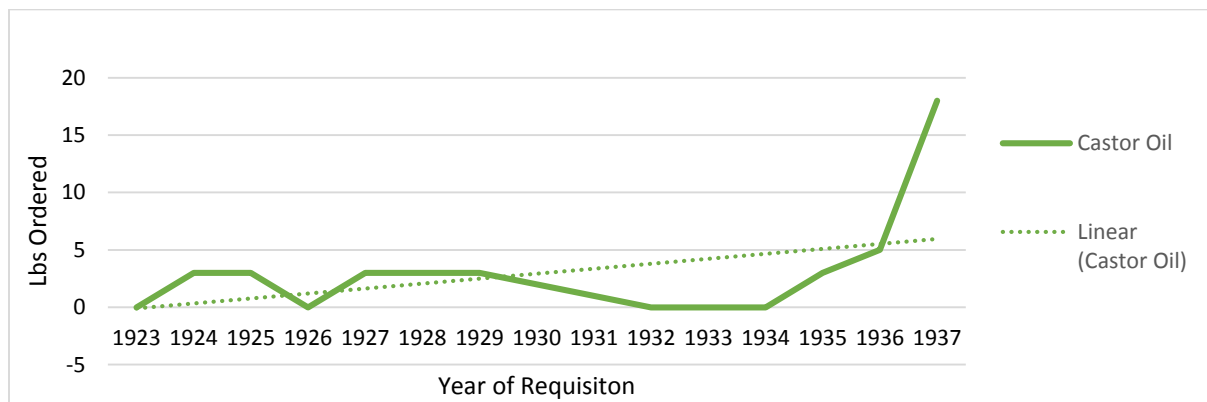
¹⁰⁷ LAC, RG 10, Volume 6340, File 751–13, Part 1. Blue Quills School – Medical Matters, 1923 – 1937.

¹⁰⁸ Ibid., Requisition for Drugs, Blue Quills School, July 3, 1928.

in 1930.¹⁰⁹ Castor Oil was to be given with the child and adult compounds, as an aid to digestion.¹¹⁰

The requisitions for Castor Oil are shown in Chart 6 below. Similar to the diarrhea mixture requisitions, castor oil requisitions stayed fairly consistent throughout the 1920s. The requisitions dropped for most of the 1930s, with a sudden large order of the oil put through in 1937.

Chart 6: Blue Quills School – Requisitions for Castor Oil, 1923-1937



Other tablets used for digestion problems or intestinal issues included a Bismuth compound, Gastric Alkaline Tablets, Calomel Tablets, Cathartic Vegetable pills, and A.B.S. & C. pills. These medications contained a mixture of bismuth, sodium bicarbonate, opium, capsicum, camphor, and chloroform.¹¹¹ The requisitions for these medications are shown below on Chart 7.

¹⁰⁹ Ibid., Requisition for Drugs, Blue Quills School, July 10, 1930.

¹¹⁰ Ibid., Department of Indian Affairs, January 14, 1928: To Principals of Residential Schools.

¹¹¹ Ibid.

Chart 7: Blue Quills School – Requisitions for Gastro-Intestinal Medications, 1923-1937

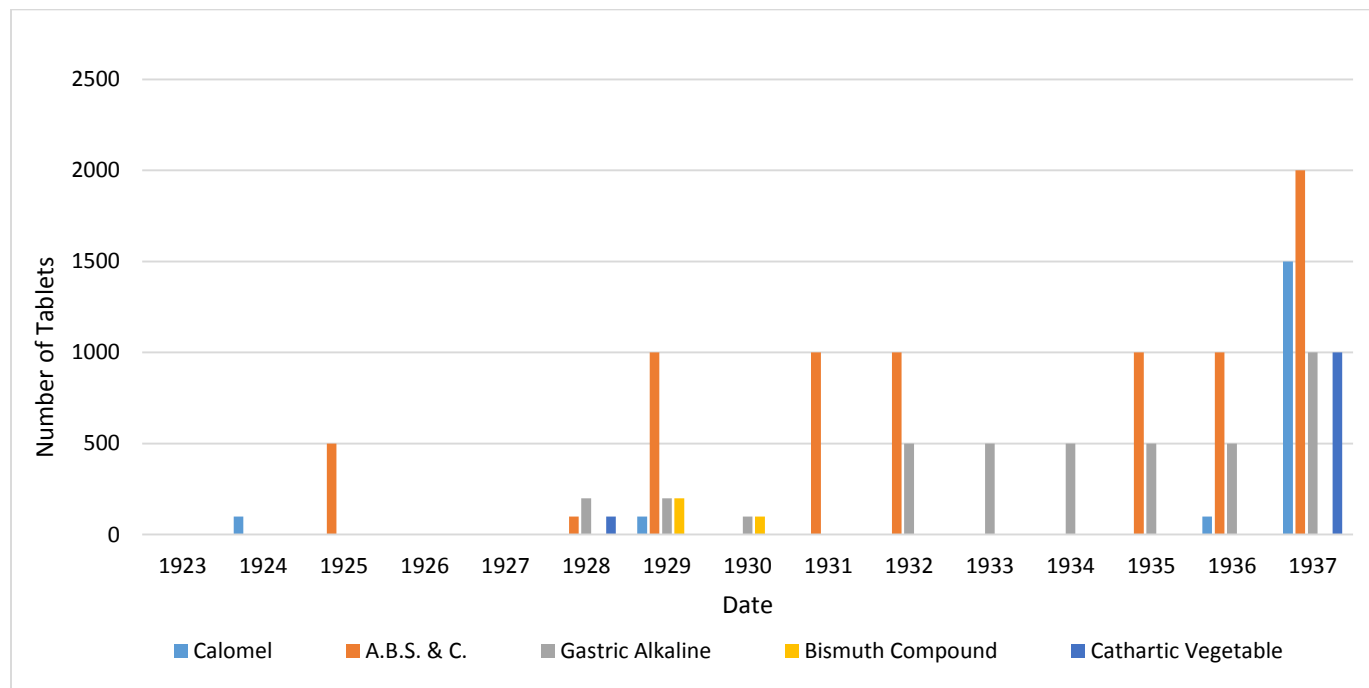


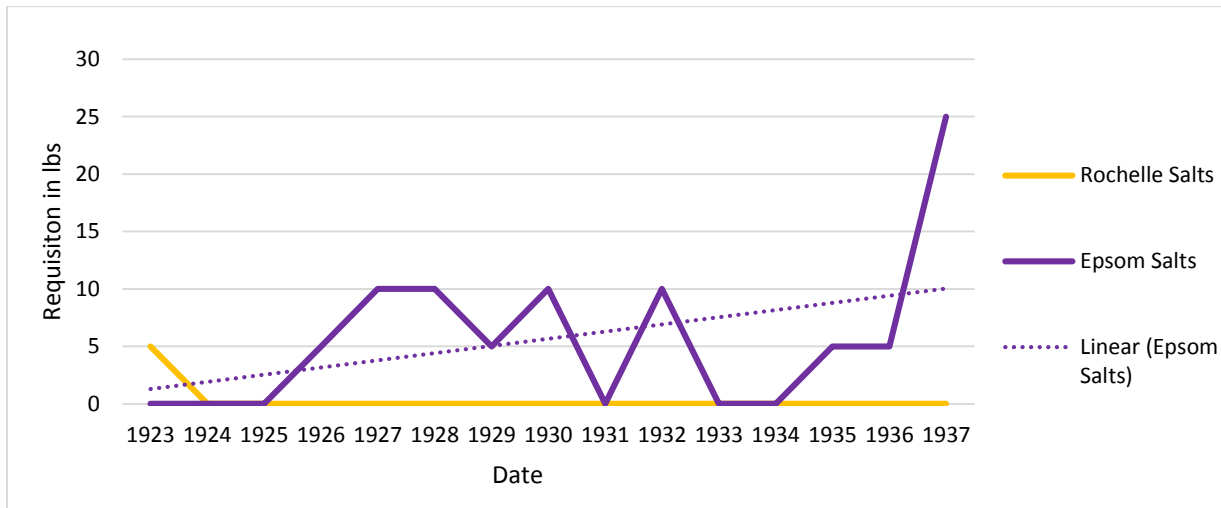
Chart 7 demonstrates that the school relied largely on A.B.S. & C and Gastric Alkaline tablets to treat indigestion during the 1930s. It seems that the diarrhea mixture ordered in the 1920s was replaced with alternative medications in the 1930s to treat gastro-intestinal illness. The orders for these medications stayed fairly consistent in this decade as well, until the late 1930s when we see a large requisition for four of the medications. This was likely due to the compounded need for medication over time, with the impact of the Great Depression on the health of students. Nonetheless, these orders were curtailed by the Department upon receipt in 1936 and 1937. The order for castor oil was reduced by 3 gallons and the requisition for A.B.S. & C. Tablets was cut half in 1937.¹¹²

The last medications to be discussed in connection with gastro-intestinal illness are Epsom Salts (Magnesium Sulphate) and Rochelle Salts. These medications were used as sudden laxatives

¹¹² Ibid., Requisition for Drugs, Blue Quills School, June 24, 1937.

to cure stomach pain or digestion problems.¹¹³ The Blue Quills School relied mainly on Epsom salts for this purpose, only ordering Rochelle salts in 1923. The requisitions for these salts are plotted on Chart 8 below.

Chart 8: Blue Quills School – Requisitions for Salts, 1923-1937



The school commonly requisitioned between 5 or 10 lbs of salts during this period, with a dip in the early 1930s and a spike in the late 1930s. When these results are coupled with the information from Chart 6 and 7, it can be seen that there was a consistent need to treat gastrointestinal issues at the Blue Quills School throughout the period of 1923 – 1937. Although the treatment for these illnesses varied over time, the consistent need for these medications point to a similarly steady presence of illnesses which cause diarrhea, stomach pain, or gastro-intestinal problems. It is logical to assume that with the sanitary and hygienic conditions present at most of the schools, these illnesses can be tied to contaminated water and food supplies.

¹¹³ Lavinia Dock, *Materia Medica for Nurses*, pp. 50, pp. 60.

2.6 – Personal Hygiene:

Good personal hygiene is one of the most effective preventions of illness.¹¹⁴ Proper hygiene necessitates the frequent washing of hands, face, and body, in clean water, with a disinfecting Agent such as soap. The importance of personal hygiene was established long before the period analyzed in this study – with medical publications on the subject made available in Canada throughout the early 1900s.¹¹⁵ By 1910 hygiene measures had been introduced into Ontario public school curriculum and practice.¹¹⁶ Yet hygiene was often a neglected area of health in the case of residential schools.¹¹⁷ The lack of washing facilities was central to this issue. It has already been seen that the St. Mary’s school on the Blood reserve completely lacked bathing facilities before it was rebuilt.¹¹⁸ Bathing facilities were in fact denied to the school in 1921 due to the fact it was “not considered advisable to spend much on the old school building.”¹¹⁹ Bathtubs were eventually installed later in 1922, in response to the scathing report sent in from the visiting doctor Alan Kennedy in November of 1921.¹²⁰

Washing facilities were nonetheless still a problem in the newer buildings. Wash basins were expensive commodities and therefore building plans for the new school only included a

¹¹⁴ Health Canada, “The Benefits of Hand Washing,” (Public Health Agency of Canada, 2009): p. 1. For more information on how hygiene prevents illness, see: Centers for Disease Control and Prevention, “Water, Sanitation & Environmentally-related Hygiene,” accessed May 16, 2015, <http://www.cdc.gov/healthywater/hygiene/dental/index.html>; World Health Organization, “Hygiene,” accessed May 16, 2015, <http://www.who.int/topics/hygiene/en/>.

¹¹⁵ For example, see: William Sedgwick, *Principles of Sanitary Science and the Public Health* (New York: The Macmillan Company, 1902) and Walter Pyle, *Personal Hygiene, Proper Living on a Physiological Basis* (W.B. Saunders Company, Philadelphia and London, 1908).

¹¹⁶ Archibald Knight, *The Ontario Public School Hygiene* (Toronto: Copp. Clark Company Ltd, 1910), p. 1.

¹¹⁷ John Milloy, *A National Crime*, pp. 98 – 99.

¹¹⁸ See page 90.

¹¹⁹ LAC, RG 10, Volume 6343, File 750–5, Part 2. J.D. McLean to Hon. J. Lougheed, July 19, 1921.

¹²⁰ *Ibid.*, Dr. A. Kennedy to J.T. Faunt, November 19, 1921.

minimal number to economize.¹²¹ The pupils of the Edmonton school felt the burden of this economizing as well. In 1929 there were only about 24 basins available for over 200 children in the dormitories at the school.¹²² Four new basins were put in when the school expanded to accommodate the 83 Brandon children.¹²³ Even so, crowding would have been a notable issue that hindered proper washing, as all of the children shared the facilities during the mornings and evenings.

Another important influence on hygiene was the conditions of the mattresses upon which the children slept. During the 1910s and 1920s, the Department supplied schools with straw mattresses, which quickly deteriorated and were an easy place for mite or parasite infestation.¹²⁴ In 1924, the travelling nurse who visited Blue Quills School remarked that “The boys are having new mattresses (made of wool) as the old straw ones are not fit for use.” Wool mattresses were the choice replacement for the mattresses at the Edmonton Institute as well. These mattresses were noted to be in a “very poor condition” by the Inspector during his visit in 1929.¹²⁵ He went on to emphasize that the mattresses were so filthy “even ticks filled with fresh straw would be much better than those in use.”¹²⁶ In his correspondence on the issue, Graham recommended that the mattresses be replaced, but not out of a concern for health or hygiene. Instead he wrote: “Good mattresses should be supplied in an institution of this kind that is so much before the eyes of the public. It gives a very bad impression to people passing through these dormitories to see such poor

¹²¹ *Ibid.*, G. Smith to G. Orr, July 8, 1925.

¹²² W. Murison to W. M. Graham, Inspection of Expenditures Report, October 05, 1929.

¹²³ *Ibid.*

¹²⁴ LAC, RG 10, Volume 6340, File 751–13, Part 1. Report of Travelling Nurse, Blue Quills Indian Residential School, June 23/24, 1924.

¹²⁵ LAC, RG 10, Volume 6364, File 760–2, Part 1. W. Murison to W. M. Graham, Inspection Report on Schools in Edmonton Agency, April 2, 1929.

¹²⁶ *Ibid.*

beds.” As usual with Graham, the health of the children attending the school was a secondary concern.

2.7 – Lice, Scabies, Impetigo, and Eczema:

Poor sanitation and hygiene can result in increased infections on the body – including infections of the skin, eyes and ears. Improper washing allows organisms to settle on or beneath the dermal layer, causing itching, rash, or scabbing. One common result of poor hygiene, especially in children, is a lice infestation (also known as louse). The problem of lice infestations is one that medical researchers investigated heavily in the 1920s and 1930s.¹²⁷ As one medical man wrote, “Apparently the louse has been the inseparable companion of man since the earliest times,” but with the development of “a new order of cleanliness” humans have made great stretches towards its eradication.¹²⁸

Lice are tiny parasites which live off the blood of humans and infestations can be found on the body, most commonly in areas of concentrated hair. Lice lay their eggs in the hair shaft or in the clothing worn by an individual, including hats, mitts, shirts, scarves, or even pillow cases.¹²⁹ The presence of lice results in a skin inflammation known as pediculosis.¹³⁰ Pediculosis results as the parasites crawl around and bite the skin, causing itching and inflammation. Itching usually worsens the condition, as scratching creates lesions on the skin which allow for more “food material” for the lice, who then breed faster.¹³¹ Transmission of lice is common – through shared

¹²⁷ “Lice and History,” *Journal of the American Medical Association* 104, no. 2 (1935): pp. 123, esp. 123.

¹²⁸ *Ibid.*

¹²⁹ Sharon Peter, “Head Lice,” *CPJ: Canadian Pharmaceutical Journal* 135, no.2 (2002), pp. 11–12, esp. 11

¹³⁰ *Ibid.*

¹³¹ Jamieson Hurry, *Vicious Circles in Disease* (Toronto: The MacMillan Company of Canada, 1913), p. 194.

hairbrushes, hats, clothes, bed sheets, or skin to skin contact. The recommended treatment for lice in the 1920s was to poison the lice with a tincture of larkspur, Kerosene and sweet oil. Vinegar and potassium carbonate were also used.¹³²

The issue of head and body lice was a problem in many residential schools across the country.¹³³ To their credit, the Department attempted to stay up to date with the current medical research and trends on this issue. Journal articles and paper clippings on the prevention and treatment of lice were collected by the Superintendent of Medicine in the 1920s.¹³⁴ It would therefore seem that the Department was poised to effectively combat this problem by keeping up-to-date on the medical literature surrounding it. In reality however, the Department would have had to first educate the school officials on the importance of hygienic practices in combatting lice. They would also have needed to provide the recommended treatments to the school, along with effective washing facilities.

In 1930 the Department was sent a booklet titled “Practical Lessons on Hair Hygiene- Especially Designed for use in Schools” from the Cereal Soap Company. This booklet contained information on “the latest, scientific methods of looking after the hair.”¹³⁵ It recommended frequent washing and brushing, and it warned against the sharing of hairbrushes. The booklet stated “it is just as important to wash the hair once a week as to take a daily bath.”¹³⁶ Yet despite clear awareness of these procedures, there was no attempt to rectify the sanitary practices of the

¹³² Josephine Baker, *Healthy Children: A Volume Devoted to the Health of the Growing Child* (The Musson Book Company Limited: Toronto, 1920), pp. 193–194.

¹³³ John Milloy, *A National Crime*, p. 99.

¹³⁴ LAC, RG 10, Volume 6016, File 1–1–13, Part 1. G.A. Auden, M.A. Cantab, F.R.C.P. Lond, D.P.H. Camb, “The Problem of the Head Louse,” *The Medical Officer* (June 21, 1911).

¹³⁵ *Ibid.*, Cereal Soaps Company, *Practical Lessons on Hair Hygiene – Especially Designed for use in Schools* (New York, 1928), p. 2

¹³⁶ *Ibid.*, p.6.

schools. Hairbrushes were scarce at the schools – at Blue Quills orders for Camel hairbrushes were put through only twice – once in 1928 and again in 1937.¹³⁷ Both times the order was only for a dozen brushes. Daily baths were another unheard of experience. Children bathed once a week at the schools, often in shared water.¹³⁸

With these poor hygienic practices within the schools, coupled with close contact to agricultural animals which often carry mites or parasites, the continuous presence of lice was a clear issue within the schools.¹³⁹ When the travelling nurse visited the Blue Quills School in 1924 she found several cases of “itch” among the students. She recommended treatment with “a wash of Blue-stone (Copper Sulphate) and then an ointment, using special attention to the children’s underware(sic).”¹⁴⁰ She also wrote that the children’s heads were “only fair as to cleanliness,” as there were “several cases of nits found.”¹⁴¹

The most recommended treatment for head lice, one that is still utilized in treatments today,¹⁴² was Derbac Shampoo (Melathion).¹⁴³ American Indian Boarding schools had already adopted this treatment for the control of lice, after “exhaustive experiments” to control the problem.¹⁴⁴ Yet the Department did not utilize this treatment for their lice problems. Instead they relied on topical ointments to cure the problem. School matrons were provided with an Ammoniated Mercury Ointment (5%) to “rub daily” on children who demonstrated “chronic skin

¹³⁷ LAC, RG 10, Volume 6340, File 751–13, Part 1. Medical Matters, 1923 – 1937.

¹³⁸ LAC, RG 10, Volume 6343, File 750–5, Part 2. E. Ruaux, to J.T. Faunt, May 4, 1922.

¹³⁹ Paul Chapman and Wayne Dinsmore, *Livestock Farming* (Atlanta: Turner E. Smith & Company, 1953), pp. 337–338, p. 455.

¹⁴⁰ LAC, RG 10, Volume 6340, File 751–13, Part 1. Report of Travelling Nurse, Blue Quills Indian Residential School, June 23/24, 1924.

¹⁴¹ *Ibid.*

¹⁴² Christine Ko and Dirk Elston, “Pediculosis,” *Journal of American Dermatology* 50, no. 1 (2004): pp. 1 – 12, esp. 8.

¹⁴³ LAC, RG 10, Volume 6016, File 1–1–13, Part 1. G.A. Auden, M.A. Cantab, F.R.C.P. Lond, D.P.H. Camb, “The Problem of the Head Louse,” *The Medical Officer* (June 21, 1911).

¹⁴⁴ *Ibid.*, H.A. Fortington to Minister, January 31, 1930.

diseases, Impetigo, Sores, Ringworm or Crab lice.”¹⁴⁵ It is unclear as to why the Department felt that a highly irritable and potentially poisonous ointment was a superior treatment than the proven-effective Derbac shampoo.¹⁴⁶ The potential danger of mercury poisoning was known to the Department, as the medical instructions Matrons received warned that this ointment “must not be used for small children who may be poisoned by getting it on the fingers and so into the mouth.”¹⁴⁷ The Blue Quills School nonetheless ordered 33lbs of this ointment between 1928 and 1937 to combat dermal infestations.¹⁴⁸

Lice was not the only skin disease that improper hygiene led to within the Albertan schools. Scabies, Eczema, and Impetigo were all present among pupils of the schools. Scabies is a skin disease caused by the burrowing of the mite *Sarcoptes scabiei* into the skin.¹⁴⁹ Symptoms include rash or small papules from the burrowed mites, which usually start between the fingers and toes, and on flexor surfaces such as wrists, elbows, armpits, and genitalia.¹⁵⁰ Transmission occurs through skin to skin contact or through shared clothing, towels, handkerchiefs, sheets, etc.¹⁵¹ This condition was considered a ‘vicious cycle’ of disease as the itching caused by the mite leads to further irritation of the condition and the transmission of the *scabiei* parasite from the skin to the fingernails – which can cause the spread of the disease across the body.¹⁵² Treatment for scabies

¹⁴⁵ LAC, RG 10, Volume 6016, File 1-1-13, Part 1. Department of Indian Affairs, January 14, 1928: To Principals of Residential Schools.

¹⁴⁶ Werner Aberer, George Gerstner, and Hubert Pehamberger, “Ammoniated Mercury Ointment: Outdated But Still In Use,” *Contact Dermatitis* 23, no. 3 (1990): pp. 168 – 171, esp. 168.

¹⁴⁷ LAC, RG 10, Volume 6016, File 1-1-13, Part 1. Department of Indian Affairs, January 14, 1928: To Principals of Residential Schools.

¹⁴⁸ LAC, RG 10, Volume 6340, File 751-13, Part 1. Medical Matters, 1923 – 1937.

¹⁴⁹ Olivier Chosidow, “Scabies,” *The New England Journal of Medicine* 354, no. 16 (2006): pp. 1718 – 1727, esp. 1718.

¹⁵⁰ *Ibid.*, pp. 1718 – 1719.

¹⁵¹ Josephine Baker, *Healthy Children*, p. 188.

¹⁵² Jamieson Hurry, *Vicious Circles in Disease*, p. 193.

between 1920 and 1950 was to scrub the skin lesion, wash them down and then to apply a sulphur ointment in the affected areas.¹⁵³

Impetigo and Eczema were also present in children within the schools. These cases are not surprising – as lice, scabies, eczema, and impetigo are all commonly contracted when working closely with livestock and poultry raising.¹⁵⁴ Hogs especially have their own forms of lice and scabies infection.¹⁵⁵ Mite infestations and the subsequent skin conditions were likely first contracted by the boys in the schools, as they “did the work in the barns, cleaning them, taking care of the cattle, milking and separating the milk from the cream, gathering wood for the furnace, and bringing coal from the nearest railway siding to heat the school.”¹⁵⁶ The skin conditions would then spread to the girls in the schools through fomites (inanimate objects that harbor the disease organism) such as clothing – as the care of clothes was primarily the work of the girls in the institution.¹⁵⁷ Transmission would also have likely occurred due to overcrowding in the schools, which often took in more students than could be properly accommodated in the sleeping quarters provided.¹⁵⁸ At the Morley school, consistent overcrowding led to the sharing of desks and beds among students, which would have heightened disease transmission among students.¹⁵⁹

¹⁵³ Josephine Baker, *Healthy Children*, p. 183.

¹⁵⁴ United States Department of Agriculture, “Lice, Mites and cleanliness: Boys and Girls Poultry Club Work,” *Department Circular* 16 (1919): pp. 1 – 8, esp. 2.

¹⁵⁵ James Sequeira, *Diseases of the Skin* (The MacMillan Company of Canada: Toronto, 1911), 81.

¹⁵⁶ Pauline Dempsey, “My Life in an Indian Residential School,” p. 24.

¹⁵⁷ LAC, RG 10, Volume 6343, File 750–5, Part 3. M. Christianson to H. McGill, Inspection Report. December 2, 1932.

¹⁵⁸ John Milloy, *A National Crime*, pp. 86–88.

¹⁵⁹ James Tandy, *Curriculum at the Morley Indian Residential School*, pp. 43 – 45.

The treatments recommended by the Department for “scabies or itch” and “skin irritation” were ointments of Sulphur with Potassium Carbonate, and of Zinc Oxide, respectively.¹⁶⁰ In the case of scabies, the ointment was:

To be rubbed thoroughly all over the body at night, following a hot bath with soap and water and a brush. Treatment to be given nightly for three nights, then all clothing changed and heated in an oven. Heat clothing hot but do not scorch. Boil washable clothing. Pay particular attention to mitts and gloves.¹⁶¹

The Zinc Oxide ointment for skin irritation was a milder ointment, mostly used on young children with sensitive skin.¹⁶² At times requisitions were also made for more generic ointments, including: Eczema Ointment, Impetigo Ointment, Mecca (also known as Mica) Ointment, Blue Ointment¹⁶³ Ozonal Ointment, Sabadilla, Boracic Acid Powder, Ointment for Scabies and Itch, and Boric Ointment. A generic ‘vermin powder’ was also ordered, presumably for the treatment of mites or parasites on the body. The requisitions made by the Blue Quills School for all of these medications (except sabadilla) have been plotted on Chart 9. The requisitions for Sabadilla have been left out of the information on Chart 9, as this ointment was supplied in tubes and ordered by the dozen, while the others were all supplied in pounds (lbs) – and are therefore comparable on the same graph.

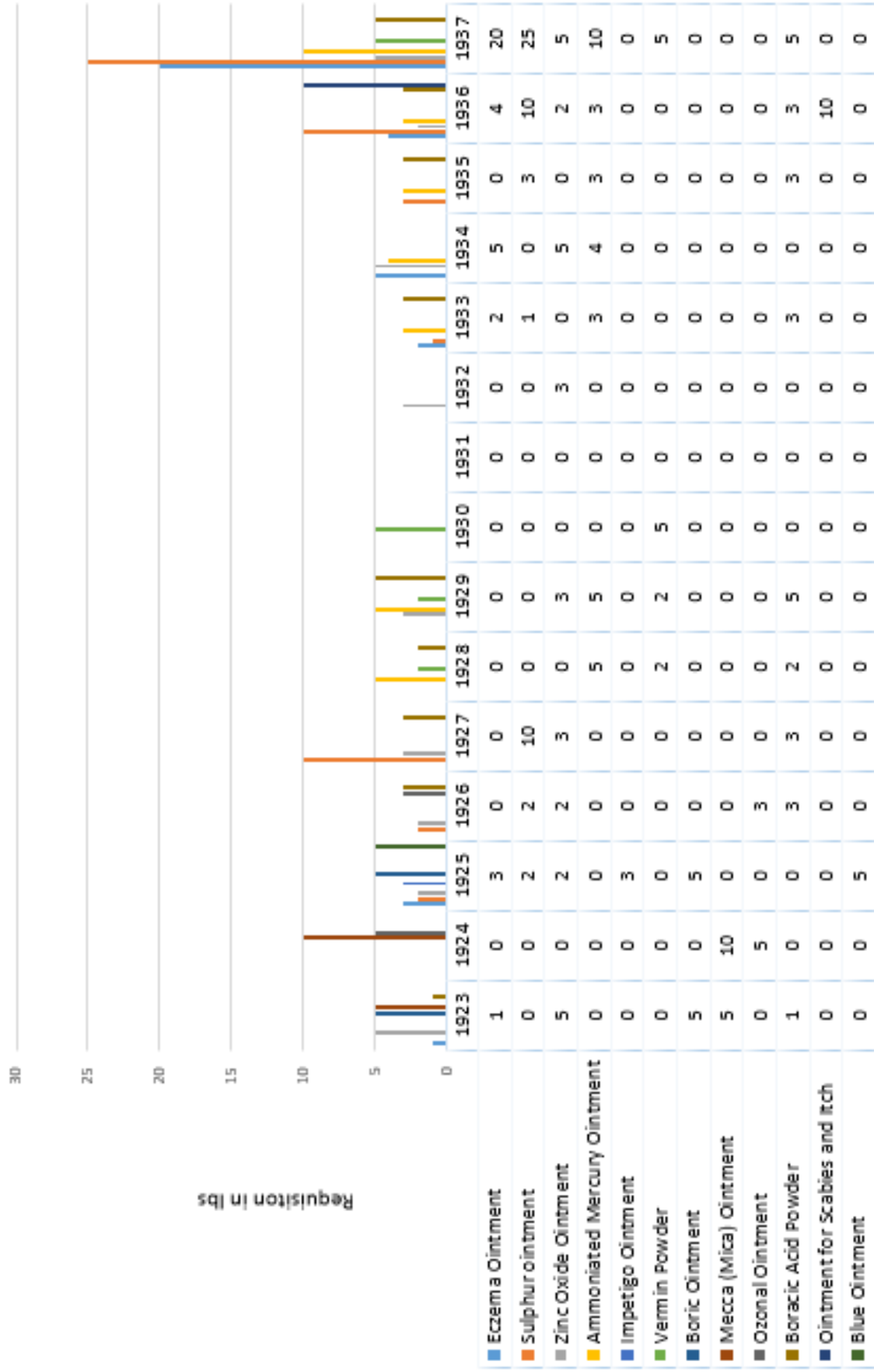
¹⁶⁰ LAC, RG 10, Volume 6016, File 1–1–13, Part 1. Department of Indian Affairs, January 14, 1928: To Principals of Residential Schools.

¹⁶¹ Ibid.

¹⁶² Ibid.

¹⁶³ Was used in conjunction with kerosene to kill bed–bugs. “Bed–Bug Exterminator,” *The Annals of Hygiene* 4, no. 11 (1889): pp. 565.

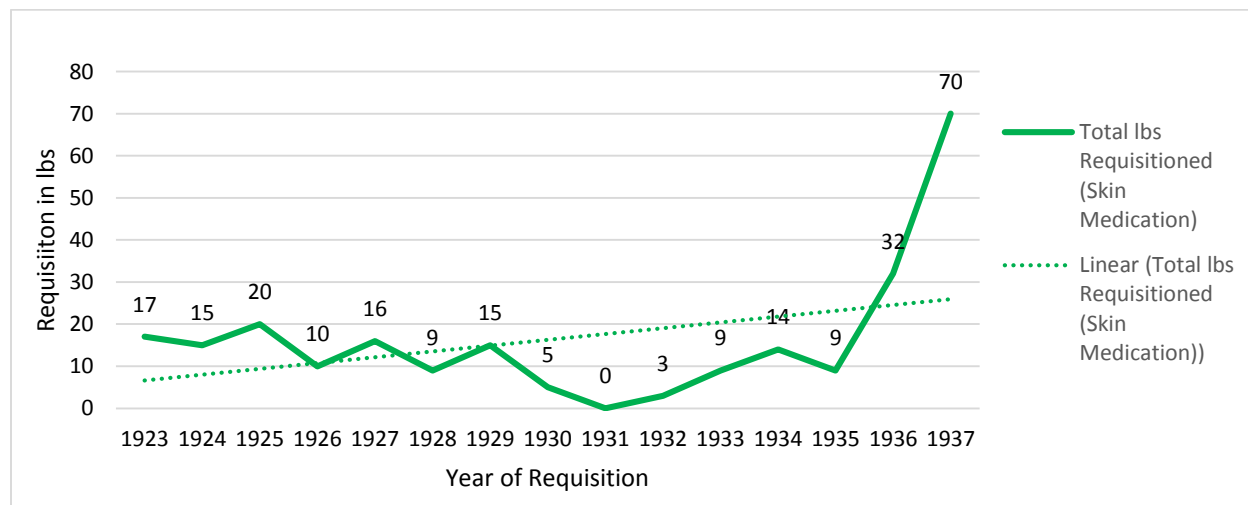
Chart 9: Blue Quills School – Requisitions for Skin Disease Medications, 1923-1937



Year of Requisition

Chart 9 demonstrates that the Blue Quills School frequently alternated between the types of medications it ordered to treat skin diseases. It nonetheless required skin medications of some sort almost every year to treat Lice, Scabies, Impetigo, or Eczema. The total combined amount ordered each year for these medications is plotted on Chart 10 below.

Chart 10: Blue Quills School – Total lbs of Skin Medication Requisitioned, 1923-1937



The school consistently ordered around fifteen pounds of skin medications throughout the 1920s. The need for these creams drastically increased in the later 1930s. Nonetheless, the order in 1937 was reduced by the Department upon receipt. The eczema ointment order of twenty pounds was reduced to five lbs, the Sulphur Ointment for Scabies was reduced from twenty-five lbs to ten lbs, and the requisition for vermin powder was crossed off all together.¹⁶⁴

2.8 – Eye and Ear Infections:

The hygienic conditions of the schools also meant that students were prone to infections of the eyes and ears. Common eye conditions which result from unsanitary conditions include

¹⁶⁴ LAC, RG 10, Volume 6016, Part. 1. Department of Indian Affairs, Requisition for Drugs. June 24, 1937.

conjunctivitis (pink eye) and trachoma.¹⁶⁵ Conjunctivitis can be caused by bacterial or viral infections, chemical exposure, trauma to the conjunctiva, or an allergic reaction.¹⁶⁶ The presence of lice can also lead to eye inflammation and discharge, as the mites can travel to the eyelashes and lay their eggs.¹⁶⁷ The symptoms include inflammation of the conjunctiva around the eye and associated redness, pain, itchiness, or discharge.¹⁶⁸ Trachoma of the eye displays similar symptoms and is caused by the bacterium *Chlamydia trachomatis*.¹⁶⁹ Trachoma infection can also result in granular scarring on the inside of the eyelids, which can cause the eyelashes to scratch the cornea and result in blindness.¹⁷⁰ One poor child at the Blue Quills School suffered from severe trachoma for over a year before medical attention was received. Napoleon B. was first reported to have “bad eyes” in September of 1923.¹⁷¹ By June of 1924 the travelling nurse was advising hospital treatment.¹⁷² By December of 1924 nothing had yet been done and he was presenting “granular lids.”¹⁷³ The nurse found his condition to be highly “distressing” and once again insisted that he receive attention from the doctor. No account of hospital expenses were found in the documents

¹⁶⁵ Tabbara, Khalid, “Infectious Conjunctivitis,” *Ocular Infections: Essentials in Ophthalmology*, eds. Khalid Tabbara, Ahmed Abu El-Asrar, Moncef Khairallah, 63 - 72 (New York: Springer US, 2014), pp. 63.

¹⁶⁶ Sherman Alter et al., “Common Childhood Bacterial Infections,” *Current Problems in Pediatric Adolescent Health Care* 41, no. 10 (2011): pp. 256 – 283, esp. 265.

¹⁶⁷ John Yuen and George Jaresko, “Pharmacotherapeutics of Ocular Infections,” *Journal of Pharmacy Practice* 4, no. 4 (1991): pp. 247 – 268, esp. 262.

¹⁶⁸ Harvard Children’s Health, “Conjunctivitis (Pink Eye),” accessed July 17, 2015.

<http://go.galegroup.com/ps/i.do?id=GALE%7CA169434534&v=2.1&u=ucalgary&it=r&p=AONE&sw=w&asid=f42176927867aadf6fd0f535c77fdb4>.

¹⁶⁹ Centers for Disease Control and Prevention, “Water, Sanitation & Environmentally-related Hygiene,” accessed July 17, 2015, <http://www.cdc.gov/healthywater/hygiene/disease/trachoma.html>.

¹⁷⁰ Ibid.

¹⁷¹ LAC, RG 10, Volume 6340, File 751–13, Part 1. Report on Pupils of Blue Quills Boarding School, September 28, 1923.

¹⁷² Ibid., Report of Travelling Nurse, Blue Quills Indian Residential School, June 23/24, 1924.

¹⁷³ Ibid., Report of Travelling Nurse, Blue Quills Indian Residential School, December 15/18, 1924.

to demonstrate Napoleon B. ever received the necessary treatment. It is likely that his eyesight was permanently damaged from such a prolonged infection.¹⁷⁴

Eye infections were definitely a concern in the two years that the travelling nurse visited the Blue Quills School. In her examinations she noted that nine children had either a “shadow,” “film,” or “spot” on one or both eyes.¹⁷⁵ The Department recommended medical treatments for these eye infections which were in keeping with the conventional medical wisdom of the time. Trachoma was to be treated with a Yellow Oxide of Mercury Ointment, twice daily after “cleansing the lids.”¹⁷⁶ Matrons were instructed to “squeeze a little ointment on the lid, and inside it; smear along lid with absorbent cotton.”¹⁷⁷ In retrospect, application of a mercury based ointment directly to the eye was likely extremely harmful. Nonetheless, it was a medically accepted treatment at the time and the Blue Quills School requisitioned nearly 200 tubes of the ointment between 1928 and 1937.¹⁷⁸

Eye Water Drops and Eye Water Tablets were the primary cleansing agents for eye infections and contained primarily Boracic Acid, with a bit of Zinc Sulphocarbolate.¹⁷⁹ Although we now know that excessive use of Boracic Acid in eye washes can be toxic, at the time it was commonly used as a disinfectant in many eye, ear, and skin conditions.¹⁸⁰ Luckily, highly diluted

¹⁷⁴ Trachoma is the leading cause of preventable blindness worldwide today and most commonly affects the most marginalized communities in the world. Centers for Disease Control and Prevention, “Water, Sanitation & Environmentally-related Hygiene.”

¹⁷⁵ LAC, RG 10, Volume 6340, File 751–13, Part 1. Report on Pupils of Blue Quills Boarding School, September 28, 1923; Ibid., Report on Pupils of Blue Quills Boarding School, June 23/24, 1923; Ibid., Report on Pupils of Blue Quills Boarding School, December 15/18, 1924.

¹⁷⁶ LAC, RG 10, Volume 6016, File 1–1–13, Part 1. Department of Indian Affairs, January 14, 1928: To Principals of Residential Schools.

¹⁷⁷ Ibid.

¹⁷⁸ LAC, RG 10, Volume 6340, File 751–13, Part 1. Medical Matters, 1923 – 1937.

¹⁷⁹ Ibid.

¹⁸⁰ William Whitla, *A Dictionary of Treatment, Including Medical and Surgical Therapeutics* (Toronto: J.F. Hartz, 1920), pp. 172–173.

solutions can be used without adverse side effects,¹⁸¹ so while the experience would not have been pleasant, Boracic Acid poisoning was likely uncommon. For eye infections with acute inflammation and a discharge of pus, the Department recommended the use of Argyrol (silvol) tablets, which were to be dissolved in water and applied to the eye as a wash.¹⁸² Eye Water Drops, Eye Water Tablets, Argyrol Drops and Silvol Dissolvable Tablets were ordered consistently between 1923 and 1927, indicating that eye infections continuously plagued the students within the Blue Quills School.¹⁸³

Ear infections are a common childhood issue¹⁸⁴ and children within the residential schools were also exposed to these types of infections. In the travelling nurse reports of 1923 and 1924 at Blue Quills, it was noted that 4 students had “sores” in their ears, implying some form of bacterial or viral infection.¹⁸⁵ One student, Veronique M., was found to have “suppurating ears” which the nurse drained and “irrigated,” and the matron was instructed to continue this procedure until the problem was gone.¹⁸⁶ A general cleanser – Chlorazene (Abbot) – would have been used for this practice.¹⁸⁷ Generic “earache drops” were also frequently ordered as a treatment for ear infections throughout the 1920s at Blue Quills.¹⁸⁸

¹⁸¹ John Yuen and George Jaresko, “Pharmacotherapeutics of Ocular Infections,” 261.

¹⁸² LAC, RG 10, Volume 6016, File 1–1–13, Part 1. Department of Indian Affairs, January 14, 1928: To Principals of Residential Schools.

¹⁸³ For a full breakdown of the amounts of these medications ordered, see Table 8.1, Appendix 8.

¹⁸⁴ Richard Sagall, “Ear Infections,” *Early Childhood Education Journal* 7, no. 3 (1990): pp. 47.

¹⁸⁵ LAC, RG 10, Volume 6340, File 751–13, Part 1. Report on Pupils of Blue Quills Boarding School, September 28, 1923; *Ibid.*, Report on Pupils of Blue Quills Boarding School, June 23/24, 1923; *Ibid.*, Report on Pupils of Blue Quills Boarding School, December 15/18, 1924.

¹⁸⁶ *Ibid.*, Report of Travelling Nurse, Blue Quills Indian Residential School, December 15/18, 1924.

¹⁸⁷ LAC, RG 10, Volume 6016, File 1–1–13, Part 1. Department of Indian Affairs, January 14, 1928: To Principals of Residential Schools.

¹⁸⁸ See Table 8.2, Appendix 8.

2.9 – Dental Hygiene:

The last aspect of hygiene to consider in this discussion is dental hygiene. Dental hygiene refers to the proper care and cleansing of the mouth, gums, and teeth through the effective removal of debris and plaque.¹⁸⁹ When dental hygiene is neglected, it can lead to diseases of the gums and teeth, including gingivitis (inflammation of the gums), plaque buildup, dental caries (cavities) and tooth decay.¹⁹⁰ It was already recognized at this time that dental caries was a common issue among children and young adults.¹⁹¹ During the time period of this study (1920-1950), dental professionals recommended brushing the teeth after every meal to prevent tooth decay.¹⁹²

The care of teeth was difficult within the residential schools, as access to toothbrushes was limited. The Department wavered between providing toothbrushes to the schools and requiring the school authorities to purchase their own toothbrushes. From 1925 to 1930, the Department issued toothbrushes to many schools across Canada.¹⁹³ However, schools were prioritized based on size and location, so the only schools in Alberta to receive toothbrush allotments during this period were the Peigan Roman Catholic school (96 Brushes in 1925 and 150 brushes 1926)¹⁹⁴ and the Edmonton School (144 brushes in 1928).¹⁹⁵ The others were left to either purchase their own with school funds or to go without. In fact the Edmonton school was denied a further request for toothbrush allotments in 1930, when they requisitioned 200 toothbrushes so that they would have

¹⁸⁹ Lindsay Dingwall, *Personal Hygiene Care* (Dundee, UK: Wiley–Blackwell, 2010), p. 39.

¹⁹⁰ *Ibid.*, pp. 40–42.

¹⁹¹ Charles Johnson, “Dental Hygiene for the Child,” *American Journal of Public Health* 15, no. 2 (1925): 107.

¹⁹² Josephine Baker, *Healthy Children*, p. 66.

¹⁹³ RG10, Volume 6016, File 1–1–13, part 1. List Showing Distribution of Tooth Brushes to Indian Schools (1925–1929).

¹⁹⁴ *Ibid.*, List Showing Distribution of Tooth Brushes to Indian Schools (1925–1927).

¹⁹⁵ *Ibid.*

enough for the new school year. The Department responded to the request stating, “the stock of these brushes which the Department had on hand has been entirely distributed... In future, when tooth brushes are required at residential schools, they will have to be purchased by the school authorities from their per capita grant or other receipts.”¹⁹⁶ This statement is in direct contradiction with the actions of the Department however, as they continued to supply other schools across the country with toothbrushes for the rest of the year and throughout the next.¹⁹⁷ No other Alberta schools were supplied with toothbrushes after 1929.

Such minimal supplies of toothbrushes meant that students had to either use the same toothbrush for many years, share toothbrushes among themselves while at school, or simply not brush their teeth at all. As many were young, tooth loss would have been normal as the baby teeth were shed and the permanent teeth came up. When a tooth decayed enough to be of a concern, it was likely to be noted by the nurse and extracted by the local dentist.¹⁹⁸ Otherwise, children with toothaches were treated with “toothache drops.”¹⁹⁹ It is unclear what these drops consisted of, but they likely contained either benzyl alcohol, chloroform or opium, which were common toothache treatments in the 1920s and 1930s.²⁰⁰ Tooth ache was clearly common, as Chart 11 demonstrates below.

¹⁹⁶ LAC, RG 10, Volume 6364, File 760–2. J.D. McLean to J. Woodsworth, September 4, 1929.

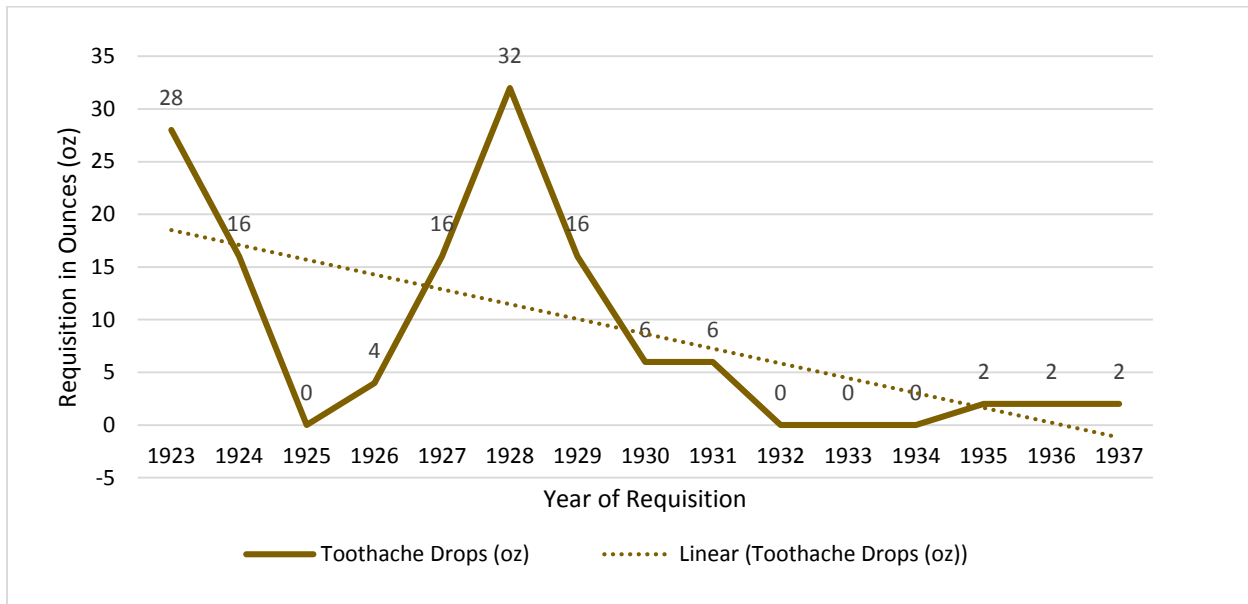
¹⁹⁷ LAC, RG 10, Volume 6016, File 1–1–13, Part 1. List Showing Distribution of Tooth Brushes to Indian Schools (1930–1931).

¹⁹⁸ LAC, RG 10, Volume 6340, File 751–13, Part 1. Report on Pupils of Blue Quills Boarding School, September 28, 1923.

¹⁹⁹ LAC, RG 10, Volume 6016, File 1–1–13, Part 1. Department of Indian Affairs, January 14, 1928: To Principals of Residential Schools.

²⁰⁰ Arthur Thomas Pitts, “Modern Technique in Treatment: The Palliative Treatment of Toothache,” *The Lancet* 203, no. 5236 (1924): pp. 41 – 42; David Macht, “Benzyl Alcohol for Toothache,” *Journal of the American Medical Association* 75, no. 18 (1920): pp. 1205; “On Toothache,” *Canadian Pharmaceutical Journal* 4, no.12 (1876): pp. 433 – 436, esp. 435.

Chart 11: Blue Quills School – Requisitions for Toothache Drops, 1923-1937



It seems from the data that dental health actual increased over time, as the requisitions for toothache drops dropped as time went on. Another possibility for this decrease was that school matrons stopped treating toothaches as the Depression years hit.

Yet poor dental health could have serious repercussions for children in the schools. The death of Caroline M. demonstrates that infections caused by inadequate dental care could be deadly if left alone. Caroline was a student at the Blue Quills institute who was found to be suffering from a mediastinal abscess in her mouth, which ultimately led to an infection of the bone. On November 2, 1944 she took ill and was confined to bed by the matron.²⁰¹ Her parents happened to visit the school two days later and at their insistence the school called the doctor about her condition. She was suffering from a severely high fever and the doctor who answered the called ordered that she

²⁰¹ LAC, RG 10, Volume 6348, File 751-23, Part 1. Memorandum of Inquiry in to the Death of Caroline M., November 17, 1928.

be immediately brought into the hospital. Caroline stayed in the hospital for ten days before she passed away from a pulmonary embolism as a result of the infection.²⁰²

Conclusion:

An analysis of sanitation and hygiene within the residential schools in Alberta is highly indicative of the circular nature of health interventions within the schools. The appalling conditions of the old school buildings in the early 1920s demonstrated some of the worst sanitation and hygiene during the period of 1920-1950. Yet when the Department rebuilt many of the schools, they still continuously ran into the issues of deficient sanitation and hygiene due to the lack of funds available to invest in these areas of health. Instead, the Department often relied on cheaper fixes to issues with water and food sanitation, which increased the chances of contamination of student food and water sources.

A similar situation occurred in the case of personal and domestic hygiene. Although the Department stayed up to date on medical treatments for infections of the skin and body, the lack of hygiene and education of cleanliness prevented effective hygienic interventions from reaching the schools. Instead students were left with a variety of preventable diseases which would have been eradicated if adequate sanitation and hygiene had been present.

The division of the students from a clean and sanitary environment would have had serious spiritual and emotional ramifications for their holistic well-being. First Nations spirituality emphasizes the importance of cleansing for a balanced healthy body.²⁰³ Medicine bundles, some

²⁰² Ibid.

²⁰³ Provincial Museum and Archives of Alberta, George First Rider, "Medicine Pipe Sweat Lodge," Indian Heritage Project, Disc 53 (December 2, 1968), IA-AA.063.

of the most important artifacts of First Nations spirituality, go through cleansing ceremonies within the sweat lodges before being put away.²⁰⁴ Cleansing ceremonies were vital to the healing of the body from injury or sickness.²⁰⁵ The inability to be clean would have had a deeper significance to the First Nations students within the schools. It meant illness, infection, infestation, and a deep fissure in their spiritual and emotional health. Former survivors of the schools often remark that they were made to feel “dirty” for not being born white.²⁰⁶ This analysis illuminates just how accurate that feeling was. First Nations students attending the schools in Alberta lived with a constant reality of ‘dirtiness’ – unclean water, unclean food, unclean clothes and mattresses, unclean bodies. This created a deep crevice in their health – physically, mentally, emotionally, and spiritually.

²⁰⁴ Provincial Museum and Archives of Alberta, George First Rider, “Steam Baths,” Indian Heritage Project, Disc 58 (September 11, 1969), IA-AA.106.

²⁰⁵ Ibid.

²⁰⁶ See Legacy of Hope Foundation, “Where are the Children,” Lorna Rope, St. Paul’s in Lebret, SK and David Striped Wolf, St. Mary’s Indian Residential School, accessed August 1, 2015. <http://wherearethechildren.ca/en/stories>.

Chapter 3: Illness and Disease:

“I quite often hear from the Indians, that they do not want to send their children to school as it is a place where they are sent to die.”¹

- William M. Graham, 1925

Disease has been a constant companion to humans throughout our existence. Different modes of ecological interaction enables the transmission of microorganisms between humans, animals, insects and the environment. Infections can occur through exposure to harmful microorganisms – such as bacteria, viruses and fungi – which adversely affect the regular cellular processes of the human body. This leads to the development of symptoms – some visible, others difficult to notice or observe. An individual’s health is intimately impacted by the presence – or absence – of physical illness within their life. Some illnesses are sudden and acute, affecting individuals for only a short time before recovery. Acute illnesses have little impact on the long-term health of the affected individual, unless the disease is severe enough to result in mortality or deformity. However, some acute diseases contracted in childhood are correlated with the development of chronic illness later in life.²

Chronic diseases have a more lasting impact on overall health. The continued influence of a chronic illness such as cancer, diabetes, or asthma will impact the everyday life of the afflicted individual for extended periods of time. The presence of physical disease has been found to be

¹ LAC, RG 10, Volume 6016, File 1–1–13, Part 1. W.M. Graham to D.C. Scott, February 10, 1925.

² Rheumatic fever is an example of this, as childhood instances of rheumatic fever causes rheumatic heart disease in adults. Ramarathnam Kumar and Rajendra Tandon, “Rheumatic Fever & Rheumatic Heart Disease: The Last 50 Years,” *Indian Journal of Medical Research* 137, no. 4 (2013): pp. 643.

intimately connected with happiness, quality of life, and mental health.³ Chronic disease affliction during childhood can be even more traumatic than contraction during maturity, as it can influence the overall development of the body as the individual grows.⁴

Historically, diseases like Smallpox, Measles, influenza, and whooping cough were common in western society among children.⁵ This was especially the case with the development of public school systems in Canada. The gathering of children within schools and the subsequent sharing of germs which occurred lead to the active spread of many diseases.⁶ Wide-spread vaccination practices keep the majority of childhood diseases under control and help to prevent epidemic outbreaks among our children today.⁷ If not for these vaccination programs, epidemics of disease would pose a great threat to Canada's childhood population as they did before the creation of many vaccinations and the discovery of antibiotics.⁸

Such childhood epidemics were unknown to First Nations communities before contact. Epidemics of infectious diseases such as Measles, influenza, and pertussis are characterised by

³ See Scott Patten, "Long-Term Medical Conditions and Major Depression in the Canadian Population," *Canadian Journal of Psychiatry* 44, no. 2 (1999): 151–157 and Michel Bédard, Carrie Gibbons and Sasha Dubois, "The Needs of Rural and Urban Young, Middle-Aged, and Older Adults with a Serious Mental Illness," *Canadian Journal of Rural Medicine* 12, no. 3 (2007): pp. 167–175.

⁴ See, Kevin C. Oeffinger et al., "Chronic Health Conditions in Adult Survivors of Childhood Cancer" *New England Journal of Medicine* 355 (2006): pp. 1572–1582, H. Hesham A-Kader and Fayez K. Ghishan, "Chronic Hepatitis in Childhood," in *Textbook of Clinical Pediatrics*, eds. Abdelaziz Y. Elzouki et al., 2075 – 2093 (Springer-Verlag: Berlin, Heidelberg, 2012), and Ursula Kyle, Lara Shekerdemian, and Jorge Cross-bu, "Growth Failure and Nutrition Considerations in Chronic Childhood Wasting Diseases," *Nutrition in Clinical Practice* 30, no. 2 (2015): pp. 227–238.

⁵ See John Duffy, *The Sanitarians: A History of Public Health* (Urbana, Illinois: University of Illinois Press, 1990).

⁶ James Goodhart, *The Diseases of Children* (Toronto: Macmillan, 1910), p. 224.

⁷ Public Health Agency of Canada, "Chapter 3 – The Health of Canadian Children," accessed July 04, 2015, <http://www.phac-aspc.gc.ca/cphorsphc-respcacsp/2009/fr-rc/cphorsphc-respcacsp06-eng.php>.

⁸ For example Alberta experienced polio epidemics in 1927/8, 1937 and 1941. Robert Lampard, *Alberta's Medical History*, p. 11.

rapid onset and a short duration of infection.⁹ Plains peoples lived a nomadic lifestyle which limited contact of children and prevented epidemics from occurring within the larger population. The nomadic tribes of western North America covered a large territory and only came together for communal hunts or large religious celebrations, such as the Sun Dance.¹⁰ This largely prevented the epidemiological spreading of such crowd diseases among the First Nations communities of the prairies.¹¹

Some infectious diseases were nonetheless endemic in the New World, including tuberculosis, hepatitis, and polio.¹² Pre-contact populations were also subject to environmental diseases, including parasites like roundworm, pinworm and tapeworms,¹³ and nutritionally-deficient conditions.¹⁴ As hunting and gathering was the main form of subsistence there, was also limited contact with animals – which are known vectors of many diseases.

The arrival of Europeans and the subsequent destruction of Aboriginal health through exposure to new diseases is something which has been well-documented by historians, anthropologists and medical professionals.¹⁵ This chapter will analyze the types of diseases which First Nations students faced while attending the Indian Residential Schools in Alberta in the first

⁹ Ann Ramenofsky, Alicia Wilbur, and Anne Stone, “Native American Disease History: Past, Present and Future Directions,” *World Archaeology* 35, no. 2 (2003): 243.

¹⁰ James Daschuk, *Clearing the Plains*, p. 16.

¹¹ Ann Ramenofsky, et al. “Native American Disease History,” p. 243.

¹² James Daschuk, *Clearing the Plains*, p. 2.

¹³ Karl J. Reinhard, “Archaeoparasitology in North America,” *American Journal of Physical Anthropology* 82, no. 2 (1990): pp. 145–163.

¹⁴ See, Richard Steckel, “Inequality Amidst Nutritional Abundance: Native Americans on the Great Plains,” *The Journal of Economic History* 70, no. 2 (2010): pp. 265 – 286.

¹⁵ See, Alfred Crosby, *Ecological Imperialism: The Biological Expansion of Europe, 900–1900*, (New Edition. Cambridge: Cambridge University Press, 2004), Ann F. Ramenofsky, et al., “Native American Disease History: Past, Present and Future Directions,” *World Archaeology* 35, no. 2 (2003): pp. 241 – 257, Henry Dobyns, *Their Number Became Thinned*, (Knoxville: University of Tennessee Press, 1983) and Paul Hackett, *A Very Remarkable Sickness: Epidemics in the Petit Nord, 1670 to 1846*, (Winnipeg, University of Manitoba Press: 2002).

half of the twentieth century. The epidemiological causes, transmissions, and impact of illness with be examined to provide insight into the experience of the children within these schools. Analysis of disease within the schools demonstrates that disease was a consistent companion to the pupils of these schools and the prevalence of disease was reliant on the conditions of the schools and the medical treatment which students received.

3.1 – Disease in Residential Schools, pre-1920:

The rates of disease within the Indian Residential School system were at their worst before the period covered in this study. Research conducted by scholars such as John Milloy and Maureen Lux has illuminated the depressed conditions of the schools during the early period.¹⁶ The high rates of disease resulted from high rates of disease in general among individuals living on reserves. The First Nations communities of Alberta underwent a significant population loss due to the impact of Smallpox in the previous century.¹⁷ The disappearance of the buffalo and the subsequent starvation on the ration system left the First Nations physically weak and unresistant to the diseases which threatened the communities through increased contact with the white population. Especially destructive was tuberculosis, which thrived in the conditions of over-crowding, poor sanitation and weakened immune systems, all of which were present on the reserves.

The admission of children to the Indian Residential Schools from the impoverished conditions on reserve had a detrimental effect on student health as well. Although reserves were notorious for their high infection rates, many Aboriginal families had still been able to avoid the

¹⁶ See John Milloy, *A National Crime*, Maureen Lux, *Medicine That Walks*, and James Daschuk, *Clearing the Plains*.

¹⁷ Maureen Lux, *Medicine That Walks*, p. 16.

diseases through their isolated outdoor lifestyle. While children were able to avoid infection and disease while living with their family, were unable to avoid it within the Residential Schools'.¹⁸ The practice of the yearly per-capita grants, coupled with the religious jealousies on reserves, led principals to bring in as many children from the reserves as they could – regardless of the state of their health.

The two schools on the Blood reserve are a good example of this practice. The Anglican Church and the Roman Catholic Church both controlled a school on this reserve and jealously fought for control over the souls of the Blood children. The two principals “were coaming the missionaries”¹⁹ to find children and often took in children from a very young age – prompting a scolding from the Department stating the schools “should not be considered as nurseries.”²⁰ The Blue Quills reserve had similar rivalries and the principal of the Roman Catholic school was known to take in children who were sick or dying. The fear of “poor little children” being forced to “change their faith” due to lack of room within the school often served as his justification for the over-crowding and insanitation in the school.²¹

The shocking rates of illness within the schools came to the public eye in 1907 when an examination of student health in the prairie schools was released by Dr. Peter Bryce. The *Bryce Report* covered thirty-five schools in the Prairies and illuminated the severe health problems of tuberculosis, insanitation, and poor nutrition. He wrote:

General ill health from the continued inspiration of an air of increasing foulness is inevitable; but when sometimes consumptive pupils and, very frequently, others with discharging scrofulous

¹⁸ Ibid., p. 107.

¹⁹ LAC, RG 10, Volume 6342, File 750–1, Part 1. J. Vern to Secretary, February 23, 1901.

²⁰ Ibid., Indian Commissioner to Secretary, September 19, 1899.

²¹ LAC, RG 10, Volume 6345, Part 1. H. Grandin to Hayter Reed, August 5, 1891.

glands, are present to add an infective quality to the atmosphere we have created a situation... dangerous to health.²²

The *Bryce Report* found that thirty-five percent of all children who attended the schools he examined were either sick or dead. At the File Hills school in Saskatchewan Bryce found that 65 percent of all ex-pupils of the institute were dead.²³ He pointed to the practice of admitting sick children to the school as the cause for such high morbidity rates, especially when coupled with the deplorable conditions of sanitation, hygiene, and nutrition. A subsequent investigation by Dr. Lafferty of five Alberta schools in 1908 found even worse rates of infection – with 34 of 35 students at the Old Sun’s School infected with pulmonary tuberculosis, and 22 of 39 infected at the Catholic Crowfoot School.²⁴

Although medical certificates had technically been required for the admission of children to schools since 1894, the Department had little control over admissions – and irregular inspections prevented any real oversight of the student health.²⁵ After the reports from Bryce and Lafferty came out, the Department sent out a standardized health form and stated that the submission of the form was mandatory for each student before admittance to the school.²⁶ Yet the conditions of the schools continued to degrade until the 1920s, posing prime environments for disease. Smallpox, tuberculosis, Measles, whooping cough, typhoid, and influenza continuously posed a threat to the lives of pupils.²⁷

²² Maureen Lux, *Medicine that Walks*, pp. 122 – 123.

²³ *Ibid.*, pp. 123.

²⁴ *Ibid.*, pp. 128.

²⁵ John Milloy, *A National Crime*, p. 89.

²⁶ *Ibid.*

²⁷ LAC, Indian Affairs Annual Reports, 1864 – 1990. *Annual Report of the Department of Indian Affairs for the Year Ended March 31, 1914*, pp. 27 – ii – 6.

The influenza pandemic in 1918 hit the Aboriginal population especially hard.²⁸ The students – already in poor conditions of health – were unable to escape its terrible impact. The crowding within schools ensured that students were vulnerable to the disease when it struck the reserves. At the Red Deer Industrial Institute, five children died from influenza within two days, causing the principal of the school to write the Department about the “criminal” conditions they lived in.²⁹

The rates of disease among pupils of the Indian Residential Schools were extremely high during the early 1900s. Initial medical examinations of students were limited and many times sick children were admitted to the schools, allowing for the spread of more illness among students. The practice of admitting sick children was encouraged by the per-capita funding system, as an increased number of children within an institute would allow the principal to apply for increased funding. Principals were often more concerned with obtaining a funding increase or maintaining a stronger spiritual foothold on the reserves than with regulating the rates of disease. The Department did little to combat these issues before the 1920s, as the enforcement of medical examinations was lax and the improvement of the run-down buildings was deemed unworthy of the expenditure.³⁰

The building of new institutions in the 1920s helped combat the worst of these conditions, but it did not eliminate disease from the schools altogether. The following sections discuss the types of disease experienced by students while attending residential schools in Alberta between

²⁸ See: D. Ann Herring, “There were Young People and Old People and Babies Dying Every Week”: The 1918–1919 Influenza Pandemic at Norway House,” *Ethnohistory* 41, no. 1 (1993): pp. 73–105, Mary–Ellen Kelm, *Colonizing Bodies: Aboriginal Health and Healing in British Columbia, 1900–50*, (Vancouver: UBC Press, 1999) and Mark Osborne Humphries, *The Last Plague: Spanish Influenza and the Politics of Public Health in Canada*, (Toronto: University of Toronto Press, 2013).

²⁹ Maureen Lux, *Medicine That Walks*, p. 186.

³⁰ Both schools on the Blood reserve were condemned before 1910 due to their poor conditions. LAC, RG 10, Volume 6343, file 750–5, Part 2. E. Ruaux to D.C. Scott, September 5, 1924; LAC, RG 10, Volume 6371, file 764–1, part 1. O. I. Grain, Report on Blood Reserve, January 18, 1914.

1920 and 1950. Students suffered from both communicable (infectious) diseases and non-communicable diseases or conditions. Although each illness is discussed separately here, it is important to note that these conditions should not be seen in isolation from one another. Many children experienced multiple infections while at school and these often occurred in conjunction with other illnesses – often aggravating conditions and increasing suffering.³¹

Infectious diseases thrive in populations with over-crowding, low sanitation, and poor nutrition.³² The presence of all three factors within the residential schools – even after their revitalization – meant that these diseases frequently presented themselves among the students. Infectious disease outbreaks were intimately tied to the school conditions and diseases peaked during the times of poorest conditions and ebbed when buildings were renovated, updated, or replaced. Some diseases disappear from the historical record all together, indicating that the conditions of disease transmission – at least in some cases – were eradicated from the schools.

The diseases discussed in this chapter were all found to be present within the historical record in the Alberta schools. Department officials, Indian Agents, principals, doctors, nurses, and matrons were all involved in the production of these records and had the sole authority over diagnosis and care of ill students. The limitations in diagnosis is a hindrance to the accuracy of the historical record, as the first line of defence against illness was the school matron – who generally lacked any official training in medicine. The sources are therefore highly biased towards the understandings and intentions of the white officials who created the documents. The suffering felt by the students was interpreted and labelled by those in control, who chose how and why a disease should be recorded. This has an important influence on the types of documents which were

³¹ The experience of appendicitis is a good example of this, see page 165.

³² Ann Ramenofsky et al., “Native American Disease History,” p. 247.

preserved which discussed diseases in the schools. Epidemics within schools were often left out of the official reports of Indian Affairs and were only mentioned if they affected the overall expenditures of the Department.³³ Similarly, epidemics within the schools were generally only mentioned in the correspondence with the Department if they affected the school funding in some way. This included worries over school closures and subsequent reductions in the per-capita grant for the time without students. It also included required expenditures on medication, hospital treatments, or other medical expenses, which often needed authorization if the Department was to cover the cost. Localized sicknesses which were dealt with in the school would not have to be mentioned to the Department and are therefore absent from the records. Thus while this chapter discusses a number of cases of disease, many more outbreaks would have gone unrecorded. Death records of students were similarly incomplete until official regulations were implemented in 1935 which mandated the reporting of student deaths within the schools.³⁴ These limitations in the sources mean that the true rates of illnesses among the students are difficult to ascertain. The following will nonetheless attempt to illuminate the variety of illness encountered by students within the schools and give some insight into their frequency.

³³ For example the typhoid epidemic at Blue Quills in 1919 required the establishment of a temporary hospital and other healthcare interventions which cost the Department money. These items were included in the expense lists of the Annual Report, yet the description of health within the province for that year read “Tuberculosis, pneumonia, and scrofula are the diseases most prevalent among the Indians of this province, and in some bands they are responsible for a heavy mortality,” but neglected to mention the typhoid crisis. LAC, Indian Affairs Annual Reports, 1864 – 1990. *Annual Report of the Department of Indian Affairs for the Year Ended March 31, 1920*, p. 27.

³⁴ LAC, RG 10, Volume 6016, File 1–1–23, part 1. Headquarters – re deaths of pupils at Residential Schools, 1935–1938.

3.2 – Typhoid Fever:

Typhoid fever is an acute disease caused by a generalized intestinal infection from ingestion of the *S. Typhi* (*Salmonella enterica serovar Typhi*) bacteria.³⁵ Epidemiological transmission of typhoid fever involves the faecal oral route, often facilitated by the presence of contaminated water ingested by humans. Typhoid is a disease often associated with impoverished conditions and is most commonly seen today in developing countries.³⁶ Nonetheless, it is a disease which has afflicted humans in the Western world for many centuries and, once contracted, was largely untreatable before the arrival of antibiotics. Early vaccines were developed in the late 1800s and by the start of the First World War, typhoid vaccination had become the standard practice of the British Army.³⁷

Typhoid has already been mentioned in connection with health in the Indian Residential Schools during the discussion of sanitation in chapter two.³⁸ The harsh criticisms of Dr. Alan Kennedy illuminate that typhoid was a serious concern to health professionals who visited the schools. Kennedy's condemnation of the water supply also illuminates the fact that many school officials simply lacked an understanding of proper care for sanitation and the potential disease risks involved with the improper removal of human waste. It is nonetheless important to mention that the historical record demonstrated a limited presence of typhoid fever within the Alberta schools.

Only one outbreak was found in the historical record. In 1919, a serious epidemic of typhoid fever broke out on the Sacred Heart reserve and it wasn't long before the Blue Quills

³⁵ Myron Levine, "Typhoid Fever," in *Bacterial Infections of Humans*, eds. A.S. Evans, P.S. Brachman pp. 913 – 938 (New York: Springer Science + Business Media, 2009), p. 913.

³⁶ *Ibid.*

³⁷ *Ibid.*, 914.

³⁸ See pages 90.

School was afflicted. Five children died during the epidemic. Two nuns also died from the fever and a third was seriously sick at the time church officials reported the epidemic to the Department. Medical studies of typhoid epidemiology have shown that the death-rate from this disease ranges from 10-20 percent.³⁹ Forty-five students were in attendance at the school and therefore the death rate was consistent with typical outbreaks of this disease, assuming that every student at the school was afflicted. This is a safe assumption, as the epidemic occurred in December, so the students and staff would have all been drinking from the same water source for about three months.

The epidemic was only mentioned to the Department because the school authorities requested allowance to close for a month in order to “disinfect the school thoroughly.”⁴⁰ This raised the fear that the per-capita grant would be reduced due to the reduced student attendance for the year. The church was anxious to stop this and so the local bishop penned a letter to the Department to ensure that the full grant would still be received, as “the sisters could not well stand the expenses incurred during the epidemy(sic)” without it.⁴¹ The need for student attendance – to the point of endangering health – is a common theme in correspondence surrounding disease within the schools. It is unclear whether the nuns would have admitted the students into the school sooner, had the grant been reduced based on attendance. There was nonetheless a clear pressure felt by school officials to maintain attendance and this pressure spurred the bishop to write the Department about the matter personally. The bishop’s letter was effective in this case and the Department allowed the school a month long reprieve to sanitize, white-wash, and repaint the school. The interventions seem to have been successful, as no further mention of typhoid fever is made at this school.

³⁹ Myron M. Levine, “Typhoid Fever,” 913.

⁴⁰ LAC, RG 10, Volume 6345, File 751–1, Part 1. Rev. H. Grandin to D.C. Scott, December 18, 1919.

⁴¹ Ibid.

Typhoid fever was not mentioned again in the records for the period studied. It seems that this disease was eradicated within the Alberta schools once the newer buildings were constructed. However, water purity and sanitation were still consistent issues throughout the next thirty years, so there is a possibility that further typhoid epidemics occurred during this time. Indeed, typhoid fever was still a consistent problem on reserves across the country for many years, with large epidemics recorded in 1934, 1938, 1940, 1941, 1944, 1945, and 1946.⁴² Nonetheless, it seems that the Alberta schools saw the last of typhoid fever as early as 1919.

3.3 – Smallpox:

The First Nations communities of Alberta – like the other indigenous groups of North America – have a tragic history with Smallpox. The earliest well-documented epidemic on the prairies was seen in upper Missouri in 1781-2.⁴³ From there it spread to the Cree and Assiniboine people and the resulting mortality permanently altered the political and ethnic distinctions of these tribes.⁴⁴ A far deadlier epidemic hit the Blackfoot, Blood, Sioux, and others in 1837-8, drastically reducing their numbers. Yet the population recovered within a few years and the Blackfoot were able to resume warfare activities with the Cree by 1839.⁴⁵ Another epidemic hit the Blackfoot and associated tribes in 1870, when the tribes were already suffering from the disappearance of the buffalo. The mortality rates were estimated at twelve to sixteen percent during this epidemic.⁴⁶ Inoculation was introduced to the far western plains in the 1800s, first by Hudson's Bay doctors

⁴² LAC, Indian Affairs Annual Reports, 1864 – 1990.

⁴³ Maureen Lux, *Medicine That Walks*, p. 14.

⁴⁴ James Daschuk, *Clearing the Plains*, p. 41.

⁴⁵ Maureen Lux, *Medicine That Walks*, p. 16.

⁴⁶ *Ibid.*, p. 17.

and then physicians of the Royal Canadian Mounted Police.⁴⁷ These early vaccination programs began the process of Smallpox eradication in Canada and the disease officially disappeared from the country in 1962.⁴⁸

The residential schools were key to this process. Beginning in the late 1920s, Department regulations required that all new students be vaccinated for Smallpox upon entrance to the school.⁴⁹ This regulation was introduced after the Quebec Provincial Hygiene Service announced a new law requiring that no students within the province were to be admitted to a school without both “a medical examination and proof of small pox vaccination.”⁵⁰ If a student was admitted without these items, the Provincial Hygiene Service would fine the principal of that school for “twenty (\$20.00) dollars and an additional fine not exceeding (\$1.00) per day for each day, in addition of two, during which the infraction is continued.”⁵¹ The cost of this would have been expensive indeed had the provincial board been able to impose its fine on the residential school within its provincial borders. However the Department argued that this legislation could not “be enforced on Indian reserves,” as the *Indian Act* superseded the authority of the Provincial Government.⁵² Nonetheless this initial legislation spurred the Department to come out with its own regulations regarding the vaccination of students soon after in 1929, the same year a severe outbreak of Smallpox occurred on the reserves in Quebec.⁵³

⁴⁷ Ibid. It should be noted that Dr. William Todd of the Hudson’s Bay Company was inoculating Aboriginal people on the plains as early as 1836. Arthur Ray, “Todd, William (d. 1851),” *Dictionary of Canadian Biography* 8 (University of Toronto/Université Laval, 2003), accessed September 1, 2015, http://www.biographi.ca/en/bio/todd_william_1851_8E.html.

⁴⁸ John McIntyre and Stuart Houston, “Smallpox and its Control in Canada,” *Canadian Medical Association Journal* 151, no. 12 (1999): pp. 1543 – 1547, esp. 1546.

⁴⁹ LAC, RG 10, Volume 6340, File 751–13, Part 1. A.F. MacKenzie to W.E. Gullion, July 13, 1933.

⁵⁰ LAC, RG 10, Volume 6016, File 1–1–13, part 1. Elzear Pelletier to School Boards, August 13, 1926.

⁵¹ Ibid.

⁵² Ibid., A.S. Williams, Memorandum to Schools Branch, April 17, 1926.

⁵³ LAC, Indian Affairs Annual Reports, 1864 – 1990. *Annual Report of the Department of Indian Affairs for the Year Ended March 31, 1920*, pp. 12.

Assumedly, Smallpox vaccination was a yearly occurrence within the Alberta schools beginning in 1929. Unfortunately the only vaccination records preserved come from the Blue Quills Residential School, which was the only school to have kept a separate file for ‘Medical Matters.’ The absence of vaccination records from the other schools does not necessarily mean that vaccinations against Smallpox were neglected. The eventual eradication of the disease, coupled with the absence of any major Smallpox outbreaks in Alberta, suggests that students were protected against this disease. The only reference found to a Smallpox epidemic within the Alberta schools occurred in 1918 at the Red Deer School, when expense reports list expenditures for “nursing small-pox patients” for 58 days at the school.⁵⁴ Nonetheless, immediate adherence to these regulations would have been an unlikely occurrence. Even the Blue Quills School did not begin their vaccination programs until 1933, “several years” after the Department instructions had been issued.⁵⁵ In the first year 45 children were vaccinated successfully at the school.⁵⁶ These vaccinations reoccurred on an annual basis after 1933, so it is likely that similar programs were successfully implemented at the other schools in Alberta at the same time.

3.4 – Black Measles:

Black Measles – also known as Rocky Mountain Fever – obtains its name from the characteristic presentation of a dark rash on the afflicted individual.⁵⁷ This disease is a bacterial infection caused by the *Rickettsia rickettsii* bacterium. Upon contraction of the bacteria a rash

⁵⁴ Ibid., *Annual Report of the Department of Indian Affairs for the Year Ended March 31, 1919*.

⁵⁵ LAC, RG 10, Volume 6340, File 751–13, Part 1, A.F. Mackenzie to W.E. Gullion, July 13, 1933.

⁵⁶ Ibid.

⁵⁷ Aaron Milstone and J. Stephen Dumler, “Rocky Mountain Spotted Fever,” in *Bacterial Infections of Humans*, eds. A.S. Evans, P.S. Brachman, 661 – 676 (New York: Springer Science + Business Media, 2009), p. 661.

appears on the extremities of the body, especially around ankles and other joints, before spreading to the trunk of the body. In severe cases this sickness can affect the Central Nervous System – causing delirium, the onset of a coma, and even renal failure.⁵⁸ Black Measles is spread between individuals through the bite of infected ticks and person to person transmission does not occur.⁵⁹

The Morley Residential School was struck with a Black Measles epidemic in 1937. During the summer the epidemic spread through the local population on the reserve. The sickness was so bad that the school had to serve as a supplementary hospital during September to accommodate the many afflicted.⁶⁰ On the recommendations of the Medical Health Office the school stay closed until October 01, as the sickness had been “very rampant among the children”.⁶¹ There aren’t any official reports which record the numbers infected with the fever during this epidemic, but at least one associated death occurred among the students later in the year. Black Measles doesn’t often result in fatality among children, unless a secondary infection occurs.⁶²

In February of 1938 a young female student at the Morley School named Annie H. died from complications of tuberculosis and Black Measles.⁶³ The enquiry into her death reveals the painful suffering which can occur when an infectious disease is combined with an underlying condition such as tuberculosis. Like many of her classmates, Annie had suffered from Black Measles during the summer of 1937. Unfortunately the epidemic had compromised her immune system, leaving her open to a secondary infection from tuberculosis. She suffered from active

⁵⁸ Ibid.

⁵⁹ Ibid., p. 666.

⁶⁰ James Tandy, “Curriculum in the Morley School,” p. 39.

⁶¹ LAC, RG 10, Volume 6355, File 757–1, Part 2. E.J. Stanley to Secretary, September 18, 1937.

⁶² Aaron Milstone and J. Stephen Dumler, “Rocky Mountain Spotted Fever,” p. 662.

⁶³ LAC, RG 10, Volume 6358, File 757–23, Part 1. Memorandum of Inquiry into the Death of Annie H., February 13, 1938.

pulmonary tuberculosis for a month and a half at the Morley School before the doctor was called and she was taken to the hospital for treatment of her “very obvious T.B. condition resulting from Measles.”⁶⁴ Her condition showed no improvement by January, so her parents took her home in hopes that traditional “Indian Medicine” would help her suffering.⁶⁵ The doctor who was in charge of her at the hospital advised against taking her home and declared that, “her condition was hopeless when she left the hospital.”⁶⁶ Annie spent her last few weeks with her family before she died on February 13, 1938.⁶⁷

3.5 – Measles and German Measles.

The incidence of both Measles and German Measles within Albertan Indian Residential Schools will be discussed together in this section. Although these two diseases are caused by two differing viral infections, their presentation and transmission are nonetheless similar.⁶⁸ Additionally, references to incidence of Measles within the historical record seldom differentiate between the two kinds of Measles and they must therefore be considered together when discussing their impact on students.

Measles – caused by the virus rubeola – is one of the most contagious diseases which can infect humans. The most common symptoms that develop upon infection with the Measles virus are rash, fever, cough, and coryza (running nose). Symptoms usually develop fourteen days after

⁶⁴ Ibid.

⁶⁵ Ibid.

⁶⁶ Ibid.

⁶⁷ Ibid.

⁶⁸ Samuel Katz, “John F. Enders and Measles Virus Vaccine – a Reminiscence,” In *Measles: History and Basic Biology*, ed. by Diane Griffin et al. (Heidelberg: Springer, 2009), p. 5.

contraction and can last for several days once presented. A Measles infection lasts longer than a German Measles infection (caused by the rubella virus) and has more complications associated with it – including encephalitis and other neuro-degenerative disorders.⁶⁹ When Measles infection occurs in undernourished individuals experiencing a deficiency of Vitamin A, blindness is often a secondary complication that can arise.⁷⁰

In contrast the Black Measles, German Measles is caused by the rubella virus and its symptoms present for a shorter period of time. There are far less complications associated with rubella infection, except in the case of infection during pregnancy.⁷¹ Both viruses are transmitted through airborne transmission via moisture particles expelled from infected victims during coughing. Today vaccination for both viruses is given in the form of the Measles–Mumps–Rubella (MMR) vaccine, usually given to infants. Yet the first vaccine for Measles was not developed until the 1960s.⁷² Before inoculation was a possibility, treatment was limited to quarantine measures and medications aimed at treating the symptoms of the diseases.⁷³ Similar to many viral infections, contraction of either form provides immunity for the individual after recovery.

There were a few cases in the records when German Measles was specifically mentioned in relation to an outbreak. The records of the Morley Residential School revealed that the students faced an outbreak of German Measles in 1936.⁷⁴ Another outbreak of German Measles was recorded at the St. Mary's Residential school in 1935. Although the outbreak was recorded to be

⁶⁹ *Ibid.*, pp. 5–6.

⁷⁰ William Moss and Diane Griffin, “Measles,” *The Lancet* 379, no. 9811 (2010): pp. 153 – 164, esp. 158.

⁷¹ Nathaniel Lambert, et al., “Rubella,” *The Lancet* 385, no. 9984 (June 2015): pp. 2297 – 2307, esp. 2298.

⁷² Barbara Gastel, “Measles: A Potentially Finite History,” *Journal of the History of Medicine* 27, no. 1 (1973): pp. 41–43.

⁷³ James Frederic Goodhart, *The Diseases of Children*, pp. 225–226.

⁷⁴ James Tandy, “Curriculum in the Morley School,” p. 40.

of German Measles and believed to be “very mild” at the time, the epidemic nonetheless saw three serious cases and one child die.⁷⁵ Donald S. died from “complications” associated with the illness – namely the development of a high fever, followed by appendicitis and bronchial pneumonia.⁷⁶ The case of Donald S. demonstrates the ways in which student illness was effected by the attitudes and conceptions of the teachers at the school. Although Donald had complained of feeling unwell to the teacher in charge, it was still decided by staff that he was “fit to attend classroom” before he was finally overcome with fever.⁷⁷ Although German Measles was specified in the report by the Indian Agent in this death, the number of secondary infections that Donald suffered implies that this infection was more likely one of Measles. Other children also experienced complications during this epidemic, further supporting the likelihood of Measles over German Measles. It was noted in the report of the Indian Agent that Donald’s brother Allen was also sick with a “complication” and was “very ill at the present time.”⁷⁸

Another Measles epidemic occurred in October of 1941 at the Sturgeon Lake Residential School at Calais, Alberta (see Appendix 1). This outbreak was again associated with numerous secondary infections. The doctor attending to the students wrote that “there were a number of other pupils ill with bronchial pneumonia which they developed following Measles.”⁷⁹ One death was reported following this outbreak. Residential student Mabel K. came down with Measles on October 20, 1941. She was quarantined and treated with “cough syrup three times daily, aspirin every four hours when temperature was high” and “eye-bathing” for her secondary infection of

⁷⁵ LAC, RG 10, Volume 6344, File 750–23, Part 1. J.K. Mulloy to J.E. Pugh, May 23, 1935.

⁷⁶ *Ibid.*, Memorandum of Inquiry into the Death of Donald S., May 20, 1935.

⁷⁷ *Ibid.*

⁷⁸ *Ibid.*, J.E. Pugh to Secretary, May 25, 1935.

⁷⁹ LAC, RG 10, Volume 6376, File 765–23, Part 1. Memorandum of Inquiry into the Death of Mabel K., December 8, 1941.

conjunctivitis.⁸⁰ Another notable treatment given to Mabel was the inclusion of vitamin-rich foods in her diet, such as “eggs and milk.”⁸¹ The fact that these foods were specifically given to Mabel when she became sick seems to indicate that they were notably absent from her daily diet at the Sturgeon Lake School before the Measles struck. Unfortunately for Mabel, her weakened immune system – due to a prolonged battle with Measles infection and also a high likelihood of malnutrition – left her vulnerable to secondary infections and she died from pneumonia in December of 1941.⁸²

3.6 – Pneumonia:

The complications notably associated with Measles infections raises questions about the prevalence of pneumonia within the schools. Pneumonia is a disease of the lungs characterized by coughing, fever, chills, and a shortness of breath. It can be caused by various bacterial infections, but infection from *Streptococcus pneumoniae* is the most common cause of pneumonia.⁸³ However the bacterium *Haemophilus influenzae* can also cause pneumonia and is especially prevalent in individuals with underlying chest diseases, such as dormant tuberculosis. Thus it is quite likely that pneumonial cases among the pupils in the Residential Schools were often caused by *H. influenzae*. The presence of high rates of pneumonia is particularly concerning from a population health perspective, as contraction of pneumonia during childhood development has been found to

⁸⁰ Ibid.

⁸¹ Ibid.

⁸² Ibid.

⁸³ Deborah Talkington and Ken Waites, “Mycoplasma Pneumoniae,” in *Bacterial Infections of Humans: Epidemiology and Control*, 4th edition, eds. Alfred S. Evans and Philip S. Brachman, 519 – 542 (New York: Springer Science + Business Media, 2009), pp. 519 – 520.

have long term effects on lung development and can create pulmonary complications during adulthood.⁸⁴

Furthermore, pneumonia is often an opportunistic disease, striking individuals with already compromised immune systems – whether due to malnutrition or the presence of another infection. Such was the case in the death of both Mabel and Donald (as described above). Both of these students had already contracted Measles before they contracted a secondary infection of pneumonia. The death of another student named Louis B., follows a similar pattern. Louis was a student at St. Cyprian’s School who died on May 15, 1937 from pneumonia.⁸⁵ On his death report the doctor wrote that Louis had suffered from a “weak heart,” which was listed as a contributing factor towards his death. During his illness, Louis was treated for his symptoms, rather than their cause. He was given cough mixture mixed with mustard plaster to control the coughing, a thermofuge (heating cream) application to the chest, and brandy. These treatments failed to affect the underlying bacterium and were outdated for pneumonial treatment at this time. Serotherapy was more commonly utilized during this time to treat pneumonia cases (closely followed by sulfapyridine in 1939), but as serotherapy was a long and expensive procedure, such an intervention had not been applied in the case of Louis.⁸⁶ Cyanosis set in soon after he arrived at the hospital and Louis died four days later.

⁸⁴ Ian Johnston, David Strachan, and H. Ross Anderson, “Effect of Pneumonia and Whooping cough in Childhood on Adult Lung Function,” *The Journal of New England Medicine* 338, (February 1998): pp. 581–587.

⁸⁵ LAC, RG 10, Volume 6370, File 763–23, Part 1. Memorandum of Inquiry into the Death of Louis B., May 15, 1937.

⁸⁶ *Ibid.* For more information on the treatment of pneumonia during this time, see: Arnold Branch, “Serotherapy and Chemotherapy in Pneumococcus Pneumonia,” *Canadian Medical Association* 42, no. 4 (1940): pp. 379–380, Scott Podolsky, “The Changing Fate of Pneumonia as a Public Health Concern in 20th-Century America and Beyond,” *American Journal of Public Health* 95, no. 12 (2005): pp. 2144–2154, Scott Podolsky, *Pneumonia Before Antibiotics: Therapeutic Evolution and Evaluation in Twentieth-Century America* (Baltimore, MD: Johns Hopkins University Press, 2006).

Another case of pneumonia resulting in death was that of Marie L., a student at the Ermineskin School who died on April 28, 1938. It was written at the inquiry that Marie had suffered from a “severe chill while at home”⁸⁷ when the children had been allowed to leave the school for one day during the payment of interest money.⁸⁸ In his report, the principal was careful to emphasize that Marie had contracted the illness while she was under the care of her parents. Shifting the blame for the death of a pupil away from school authorities was a common theme among the written death reports of students. When children took ill, principals often made sure to point out that the illness had begun while the child was on holiday or while in the care of their parents. This placed the blame for the child’s death on the family and by doing so justified the removal of children from home and their placement in the schools. Yet in reality the children were left in the care of the school administrators for over ten months of each year and Marie’s condition was far more likely caused by the poor conditions at the Ermineskin School – rather than a single night in the care of her parents. A contractor had examined the building only a week before Marie developed pneumonia and he stated that parts of the building were so rotted that “you could pull them to pieces with your bare fingers.”⁸⁹

Pneumonia also broke out at the Edmonton School in 1936, resulting in the death of at least one student. Charles F. developed bronchial pneumonia on October 26, 1936. The principal noted that “the boy was apparently suffering no pain and apart from the slightly swollen face and limbs on first noted ... he gave no indication of anything wrong.”⁹⁰ When the doctor later made a visit

⁸⁷ LAC, RG 10, Volume 6354, File 754–23, Part 1. Memorandum of Inquiry in to the Death of Marie L., April 28, 1938.

⁸⁸ *Ibid.*

⁸⁹ LAC, RG 10, Volume 6353, File 7454–5, Part 3. A. Lewis to Secretary, April 16, 1938.

⁹⁰ LAC, RG 10, Volume 6352, File 753–23, Part 1. Memorandum of Inquiry into the Death of Charles F., October 28, 1936.

to the school to check up on the students, Charles reported feeling an intense pain in his side. It was soon discovered that he was suffering from acute nephritis and he was taken to the hospital almost immediately, where he died four days later.⁹¹ Although Charles spent four days in the hospital before he died, the principal of the Edmonton school neglected to inform his father he was there until just before he passed away. One could easily imagine the anger felt by Charles' father at not being notified of his child's condition sooner. Indeed, the Department made a point of instructing the principal of the Edmonton institute to "inform the parents as soon as any child is sent to the hospital from the school" in the future, to ensure that a similar situation did not arise.⁹² This case illustrates how school authorities were prone to assume that parents of children were far less important in the guardianship of their children than school authorities. The principal did not believe that the presence of Charles' father was very important while the boy was in the hospital. This was likely due to a fear his father would insist the boy should go home after discharge to be cared for by his family instead, thereby removing Charles from the principal's guardianship (and taking away a per-capita grant earner in the process). Yet because of this decision, Charles was left without the emotional comfort of a parent during his last days alive and alone in a hospital room.

3.7 – Tuberculosis:

Although Measles and pneumonia outbreaks occurred periodically within the schools, the most frequent illness that pupils faced was tuberculosis. Tuberculosis had been a health concern for First Nations populations since they were first regulated to reserves in the middle of the 19th

⁹¹ Ibid.

⁹² Ibid.

century. In 1903, Manitoba inspector J.A. Macrae compared the death rates from tuberculosis between the white and Aboriginal populations in the province and found that Aboriginal death rates from tuberculosis were nearly twice those of the white population.⁹³ The mortality rates in Alberta were similar to the rest of the prairies. On the Blood and Peigan Reserves, for instance, the Indian Agent recorded the deaths of nine children from tuberculosis within a two month span in 1901.⁹⁴

Tuberculosis could be contracted by students in many ways during their time in the Residential Schools. Historian John Milloy has found in his study that tuberculosis was contracted through the consumption of infected milk.⁹⁵ This kind of Tuberculosis – called bovine tuberculosis – infects the bones, joints, and glands of an individual, but cannot be transmitted between humans.⁹⁶ In 1922 one school in BC was told to tear down its infection-ridden barn, “because it was a log structure and could not be disinfected.”⁹⁷ The school had lost 18 cattle in the last three years due to the disease.⁹⁸ Although no mention of bovine tuberculosis was made in the Alberta school records, the barns nonetheless shared similar conditions to those in British Columbia. As seen in the previous chapter, poor sanitary conditions within the overcrowded barns ensured a high chance of infectious disease among the cattle and cattle were seldom tested for such infections. Additionally, the practice of pasteurizing milk was not even considered by the Department until

⁹³ Maureen Lux, *Medicine That Walks*, p. 156.

⁹⁴ *Ibid.*, p. 159.

⁹⁵ John Milloy, *A National Crime*, p. 84.

⁹⁶ Stefan Berg and Noal Smith, “Why Doesn’t Bovine Tuberculosis Transmit Between Humans?” *Trends in Microbiology* 22, no. 10 (2014): pp. 552 – 553, esp. 552.

⁹⁷ John Milloy, *A National Crime*, pp. 84.

⁹⁸ *Ibid.*

1939,⁹⁹ after continuous outbreaks of undulant fever and typhoid fever were connected to the drinking of infected milk.¹⁰⁰ Yet in her survey of six Alberta schools in 1947, Nutritionist A.M. MacGready noted that the practice of pasteurization of milk was absent from all six schools she visited.

Tuberculosis could also be contracted through person to person transmission of the bacterium via air. This type of tuberculosis is pulmonary in nature and is caused by *Mycobacterium tuberculosis*.¹⁰¹ The amassing of children together within the schools created an ideal environment for transmission of tuberculosis between children. Although medical exams were still required for all children admitted to the schools, many children were still admitted even while they presented obvious health issues. To give an idea of how common this was even after the 1920s, we need not look farther than the admission records of the St. Paul's School on the Blood Reserve. Between 1934 and 1940, eighteen children were admitted to the school with some form of noticeable health issues.¹⁰² Their medical exams noted conditions which ranged from infected tonsils, to fevers, to swollen glands on their neck.

In 1932 the Saskatchewan Anti-Tuberculosis League undertook a study of rates of tuberculosis on the children within 10 residential schools in Saskatchewan. The next year it was revealed that of the 1,091 pupils examined for their study, 107 were suffering from tuberculosis.¹⁰³

⁹⁹ To provide some perspective on this, the city of Toronto passed legislation requiring pasteurization of all milk sold in the city as early as 1915. George Brink, "How Pasteurization of Milk Came to Ontario," *Canadian Medical Association* 91, no. 18 (1964): pp. 972 – 973, esp. 972.

¹⁰⁰ LAC, RG 10, Volume 6016, File 1-1-13, Part 1. E.L. Stone, Memorandum to Dr. Hoey, January 30, 1939.

¹⁰¹ Public Health Agency of Canada, "Tuberculosis Prevention and Control in Canada," accessed July 10, 2015, <http://www.phac-aspc.gc.ca/tbpc-latb/pubs/tpc-pct/index-eng.php>.

¹⁰² LAC, RG 10, Volume 6374, File 764-10, Part 1. St. Paul's Residential School, Admissions & Discharges, 1934 – 1940.

¹⁰³ LAC, RG 10, Volume 6016, File 1-1-13, part 1. Memorandum to Dr. McGill, November 27, 1933.

Twenty-two of these had active Tuberculosis and it was believed that twelve of these required admission to sanatoria. The rest were deemed chronic cases, and twenty-one were believed to be “potential spreaders” of the disease to other children.¹⁰⁴ The League recommended that two “special” schools be set up for tuberculosis children to keep the most serious cases separate from the rest of the students.¹⁰⁵

Unfortunately these recommendations were not followed. The Director of Medical Services for the prairies, Dr. E.L. Stone, noted in his report on the findings that the “Department is under continued pressure to bring its tuberculosis program into line with that of the Provinces.”¹⁰⁶ Yet the efforts to fight tuberculosis among Aboriginal populations in the 1930s had come to what he termed a complete “standstill,” due to the lack of funds.¹⁰⁷ He therefore urged the Department to follow through with the recommendations, especially those for separate schools. Although the twelve recommended cases were eventually sent to sanatoria by the Department, no steps were made to set up special schools to isolate potentially infectious cases from the main population of students. The Department once again stated that it simply did not have the funds to undertake such a suggestion.¹⁰⁸

Tuberculosis was a consistent problem in the schools between the 1920s and the 1950s. When a travelling nurse, H.E. Gerry, visited the Blue Quills School in 1924, she found nine cases of swollen neck glands, many with sores. This indicates a high presence of scrofula – a tubercular infection of the lymph nodes on the neck, which presents as open, seeping sores around the glands.

¹⁰⁴ Ibid.

¹⁰⁵ Ibid.

¹⁰⁶ Ibid.

¹⁰⁷ Ibid.

¹⁰⁸ Ibid., H. McGill to W. Murison, February 7, 1934.

The treatment of this condition at the time was to paint the glands with iodine to reduce swelling. Between 1923 and 1930 the school requisitioned 38 lbs of iodine for this purpose.¹⁰⁹

Tuberculosis remained a problem among students at Blue Quills until the 1940s. One student named Victoria L., died from tuberculosis-born meningitis in 1942. Victoria had been in bed suffering from the disease for two weeks when the doctor made his rounds to the school. Upon seeing Victoria, he ordered immediate hospital treatment. The matron in charge of Victoria at the school had not called the doctor in this case as she stated that “the case did not appear alarming.”¹¹⁰ After a week in the hospital Victoria’s father took her home, where she passed away in the care of her family three days later. Another student at Blue Quills died from a similar infection a year later. After spending almost a year in the hospital with chronic tuberculosis, John A. was sent back to school in the very last month to finish his school year. He returned home for the summer holidays. Throughout the summer he was bed-ridden, continuously battling the tuberculosis infection while in the care of his mother. By September John was still “not well enough to walk” and so his mother refused to bring him into the school.¹¹¹ Despite his condition, the principal drove out to her home and personally retrieved the sick boy so that he could attend school. He died within 24 hours of arriving at the school.¹¹²

The Edmonton Residential School had its share of tuberculosis deaths as well. In 1935, residential student Olive W. succumbed to myocarditis and tubercular pneumonia, with complications from erysipelas.¹¹³ Olive was a known tuberculosis case at the school. In June of

¹⁰⁹ LAC, RG 10, Volume 6340, File 751–13, Part 1. Medical Matters, 1923 – 1937.

¹¹⁰ LAC, RG 10, Volume 6348, File 751–23, Part 1. Memorandum of Inquiry in to the Death of Victoria L., November 17, 1942.

¹¹¹ Ibid., W.P.B. Pugh to Indian Affairs Branch, Department of Mines and Resources, October 9, 1943.

¹¹² Ibid.

¹¹³ LAC, RG 10, Volume 6352, File 753–23, Part 1. J. Williamson to Department, November 14, 1935.

1935 she was examined by the doctor and found to have “enlarged glands on both sides of her neck which had not broken down.” Her symptoms worsened over the summer, which she spent in residence at the school. By September the doctor found that her “heart revealed some leakage in valves.”¹¹⁴ She was soon rushed to the hospital for care and she remained there until her death in November. The doctor noted that her case had been “practically hopeless from the beginning of her illness in September.”¹¹⁵

Another case of tuberculosis resulted in death at the Edmonton Institute in 1937. Residential student Isaac B. had just entered student to the school and was admitted to the Edmonton Institute on September 1, 1937. His medical examination form, dated to September 6, indicated that he had no health issues when admitted. Yet Isaac suddenly died from tuberculosis in November of the same year. This means that Isaac either contracted the disease upon reaching the school, or that he was already suffering from tuberculosis before admission and the doctor’s examination was poorly done. Indeed, the practice of tuberculosis testing had been almost entirely absent from schools before the 1940s, despite the fact that tuberculosis tests had been widely available since the 1910s.¹¹⁶ Instead doctors relied on a basic examination of the physical signs of a student health – temperature, heart rate, and any visible signs of illness.

Wherever the initial infection occurred, Isaac’s health took a sudden downturn when he arrived at the Edmonton School. It was noted in the report of the Indian Agent that the doctor had examined Isaac two weeks before his death about a “T. B. gland on the right side level of collar

¹¹⁴ Ibid.

¹¹⁵ Ibid.

¹¹⁶ Alexander MacKay, “The Method of Dealing with Tuberculosis in the Public Schools of Toronto,” *The Canada Lancet* 49, no. 1 (1915): pp. 13 – 22, esp. 17.

bone.”¹¹⁷ Isaac began suffering from “stomach disturbances” before he suddenly suffered a series of seizures in the early morning of November 14, 1927.¹¹⁸ He was taken to the hospital where he died later that day.

As was seen in the case of Isaac, tuberculosis often went unreported and undiagnosed among students within the residential school system. It is therefore especially difficult to give an objective representation of the extent of tuberculosis among pupils. One case of tuberculosis was only discovered by accident at the St. Mary’s Roman Catholic School on the Blood Reserve. The child, Peter G., injured his foot when a bench dropped on it.¹¹⁹ The foot swelled significantly despite the application of compresses, so he was taken to the hospital the next day for care. Upon examination of Peter, the doctor found that not only had he been suffering from a “diffuse” tuberculosis of the lungs, he was also found to have diabetes mellitus. Both conditions had been neglected and Peter stayed in the hospital for a month before he passed away from tuberculosis.¹²⁰

The high rates of tuberculosis within the schools during the 1920s and 1930s did eventually convince the Department of Indian Affairs to take more serious action to fight the disease. More facilities for the care of tuberculosis cases were opened in the 1940s and students in the schools were more frequently discharged to hospitals or home if tuberculosis was found.¹²¹ In 1940 the Department report on tuberculosis highlighted the “progress” it had made in the fight against the disease, stating “a survey of 12 Indian Residential Schools [in Alberta] made in 1938 disclosed 30

¹¹⁷ LAC, RG 10, Volume 6352, File 753–23, Part 1. G.C. Laight to T.R.L. MacInnes, November 16, 1937.

¹¹⁸ Ibid., Memorandum of Inquiry in to the Death of Isaac B., November 14, 1927.

¹¹⁹ LAC, RG 10, Volume 6344, File 750–23, Part 1. Memorandum of Inquiry in to the Death of Peter G., January 10, 1936.

¹²⁰ Ibid.

¹²¹ LAC, Indian Affairs Annual Reports, 1864 – 1990, *Canada Department Of Mines And Resources Report Of Indian Affairs Branch For The Fiscal Year Ended March 31, 1940*, p. 185.

active cases, whereas a re-survey the following year showed only 11 active cases.”¹²² A Tuberculin test implemented at the Morley school in 1942 found similar numbers of Tuberculosis among students. Of the 98 children tested, only 6 had a positive reaction to the test.¹²³

Yet there were still cases of children within the schools developing tuberculosis in the 1940s. In 1943, for example, eight school children from the Morley school were found to be residing at the Morley Indian Hospital and one of these died from the illness.¹²⁴ At the Old Sun’s Indian Residential school another of tuberculosis case led to the death of a child in 1946. Rose M. was a student at the Old Sun’s School who “had been an observation case” before she became ill.¹²⁵ Although X-rays of her chest were taken, the doctor noted that the findings “never indicated disease.”¹²⁶ She was confined to bed with a sore stomach and fever on January 6, 1946 and taken to the hospital on January 14th. She succumbed to the tuberculosis on January 29th.¹²⁷

The increased incidence of tuberculin testing and x-ray screening for tuberculosis indicates that Department had finally begun to take an initiative in the fight against tuberculosis among school children. Hospital treatment and discharge of students, when tuberculosis cases were found to be present, was becoming more common. Additionally, the Department finally responded to the calls for a special isolation school for students suffering from tuberculosis on the prairies. In 1948 a Preventorium was set up at the Crowfoot Indian Residential School for the treatment of latent

¹²² Ibid., p. 186.

¹²³ John Tandy, “Curriculum at the Morley School,” p. 51.

¹²⁴ Ibid.

¹²⁵ LAC, RG 10, Volume 6361, file 758–23, Part 1. G.H. Gooderham to Indian Affairs, February 28, 1946.

¹²⁶ Ibid.

¹²⁷ Ibid., Memorandum of Inquiry into the Death of Rose M. January 29, 1946.

cases.¹²⁸ This facility took in about ten students a month for proper monitoring and care. The cost of housing the students in this facility was 50 cents a day, making it a cheaper alternative to hospital care for the Department.¹²⁹ These interventions were nonetheless a delayed response to a disease which had plagued First Nations populations since the previous century. Methods of testing for tuberculosis and for providing caring for those who suffered – within sanatoria – were present in Western Canada long before appropriate measures were implemented by the Department. In the thirty years covered by this study, the Department consistently balked at appropriate interventions among the children due to the cost of such programs.

3.8 – Cough, Cold and Flu:

Respiratory illnesses among pupils were not limited to tuberculosis. Children in the schools experienced periodic outbreaks of cough, colds, and influenza throughout their time enrolled. Since these diseases are seasonal, it is not surprising that outbreaks occurred during the school year, rather than in the summertime. The gathering of students with compromised immune systems in crowded conditions ensured that influenza and colds were endemic within the schools throughout the thirty years covered in this study.

The frequency of both influenza and colds are discussed together here due to the nature of diagnosis and treatment at the time. Children who suffered from both illnesses were kept in bed and given cough medicine until they recovered.¹³⁰ Treatment was carried out by the school matron

¹²⁸ LAC, RG 10, Volume, 6349, File 752–25, Part 1. Crowfoot – Indian Residential School – Preventorium, 1948 – 1949.

¹²⁹ For context, hospital care for a First Nations person in Calgary in 1955 was \$12.75/day. Maureen Lux, “Care for the ‘Racially Careless’: Indian Hospitals in the Canadian West, 1920s – 1950s,” *The Canadian Historical Review* 91, no. 3 (2010): pp. 407 – 434, esp. 418.

¹³⁰ LAC, RG 10, Volume 6358, File 757–23, Part 1. Memorandum of Inquiry in to the Death of Susan T., June 7, 1935.

and pursued in the school setting itself – so records of these two illnesses are almost entirely absent from the documents produced by the schools. Nonetheless, when influenza is mentioned in the records, it is usually in reference to a large outbreak. This section bases its conclusions on both the recorded evidence of influenza or colds within the schools, as well as the requisitions for medical supplies made by the Blue Quills School during the 1920s and 1930s.

One thing is certain – many children in the residential schools and on reserves were hit with the devastating influenza epidemic of 1918. This pandemic affected people across Canada, but the debilitated conditions on reserves ensured that it hit the Aboriginal population much harder than the white one. Historian Maureen Lux estimates that the mortality of Canadian Native people was roughly 4,000 deaths, at a rate of 37.7 deaths per thousand.¹³¹ This is far better than the death rate for non-Natives, which was about 6.5 per thousand in the province of Saskatchewan.¹³² At the Red Deer Institute children were buried two to a grave after many perished from the devastating sickness.¹³³ The influenza epidemic struck so badly at the school – which laboured through the epidemic without any medical attention – that the principal pleaded with the Department for aid, writing that “the dead, the dying, the sick and convalescent, were all together” in the school and help was desperately needed.¹³⁴

A resurgence of influenza also went through the schools during the second wave of the disease in 1919. At the St. Paul’s School even the matrons were hit with the disease, which saw “several patients” requiring medical attention. A nearby nurse was called to the school to care for the sick and she stayed on site for two weeks during the epidemic.¹³⁵ This outbreak was

¹³¹ Maureen Lux, *Medicine That Walks*, p. 185.

¹³² *Ibid.*

¹³³ John Milloy, *A National Crime*, p. 97.

¹³⁴ *Ibid.*

¹³⁵ LAC, RG 10, Volume 6371, File 764–1, Part 1. S. Middleton to Secretary, January 15, 1919.

nonetheless mild compared to the previous one and it passed through the school without any causalities.

In 1928 an influenza epidemic broke out at the Morley Residential School. This epidemic was quite serious, infecting many children and resulting in the death of one boy at the school.¹³⁶ During the epidemic the principal denied access to parents and this caused many tensions between the school and the local First Nations community.¹³⁷ The parents blamed the staff for the illness, while in return the principal blamed the parents for the outbreak of flu, citing the fact that the children had attended a celebration on reserve over the winter holidays. The principal was of the opinion that attending a large gathering in cold weather was to blame for the epidemic and that this had caused the illness to spread through the school.¹³⁸

The inspector believed that the presence of a cold concrete floor at the school should be acknowledged as a contributing factor to this outbreak as it was a very cold location for the children to play on and had no matting to cover it.¹³⁹ However when the suggested purchase of a mat for the floor was put before Commissioner W.M. Graham, it was indigently denied, as he “could not believe that the floor was dangerous to the health of the students.”¹⁴⁰

The Morley school saw another epidemic of influenza in 1935. This epidemic affected 70 pupils at the school.¹⁴¹ No deaths were recorded during the epidemic, however one child – Susan T. – developed active tuberculosis after she contracted influenza. Susan was released home to her

¹³⁶ James Tandy, “Curriculum at the Morley School,” p. 39.

¹³⁷ LAC, RG 10, Volume 6355, File 757–1, Part 2: M. Christianson to W.M. Graham, February 10, 1928.

¹³⁸ Ibid.

¹³⁹ Ibid.

¹⁴⁰ James Tandy, “Curriculum at the Morley School,” p. 40.

¹⁴¹ LAC, RG 10, Volume 6358, File 757–23, Part 1. Memorandum into the Death of Susan T., June 7, 1935.

family after treatment at the school and hospital failed to improve her condition. She died at home four months later.¹⁴²

Sometimes epidemics would break out in rapid succession while children were at school. This occurrence is highly indicative of poor living conditions among the students. The experience of pupils at the St. Mary's School on the Blood Reserve in 1941 is a quintessential example of successive epidemics. The children in the school first experienced a Measles outbreak in the spring. This outbreak was quickly followed by a bout of influenza and a subsequent epidemic of pneumonia.¹⁴³ George G. was a pupil at the school during this year and he caught both Measles and influenza before he came down with lobar pneumonia in both lungs. He was eventually taken to the hospital for treatment, where he remained for two weeks before his parents insisted on bringing him home. He was taken back into the hospital on May 18th, where he died from the multiple infections.¹⁴⁴

Upon George's death, the doctor, the Indian Agent, and the principal of the school stated that the best way to prevent such deaths in the future would be to prevent students from returning home after they were discharged from the hospital.¹⁴⁵ All three believed that George's death resulted from his brief four days at home in the care of his parents – rather than the 7 months he had spent in the care of the school, where he contracted three consecutive diseases. The attending Doctor wrote there was “no fault whatever on part of school or hospital” in his death.¹⁴⁶ One can imagine the frustration and distrust which his parents felt at this statement. This is especially likely

¹⁴² Ibid.

¹⁴³ LAC, RG 10, Volume 6344, File 750–23, Part 1. Memorandum of Inquiry into the Death of George G., May 18, 1941.

¹⁴⁴ Ibid.

¹⁴⁵ Ibid.

¹⁴⁶ Ibid.

when considering that George was the second child they had lost in the St. Mary's School. George's brother Peter had died six years earlier.¹⁴⁷

Coughs and colds would likely have been as common in the residential schools as they are in public schools today. As these illnesses seldom require hospital treatment, records of colds among pupils in the Residential Schools are only present when the cold resulted in severe complications. This was the case in the death of Pearl B. on November 28, 1942. Pearl was suffering from tubercular meningitis before she contracted a cold while attending the St. Paul's School. She was treated for her cold symptoms and sent to the hospital for the tuberculosis. The doctor who oversaw her treatment considered her death "an eventuality that was inevitable."¹⁴⁸ Nonetheless her tubercular condition was aggravated by the contraction of the secondary cold infection.

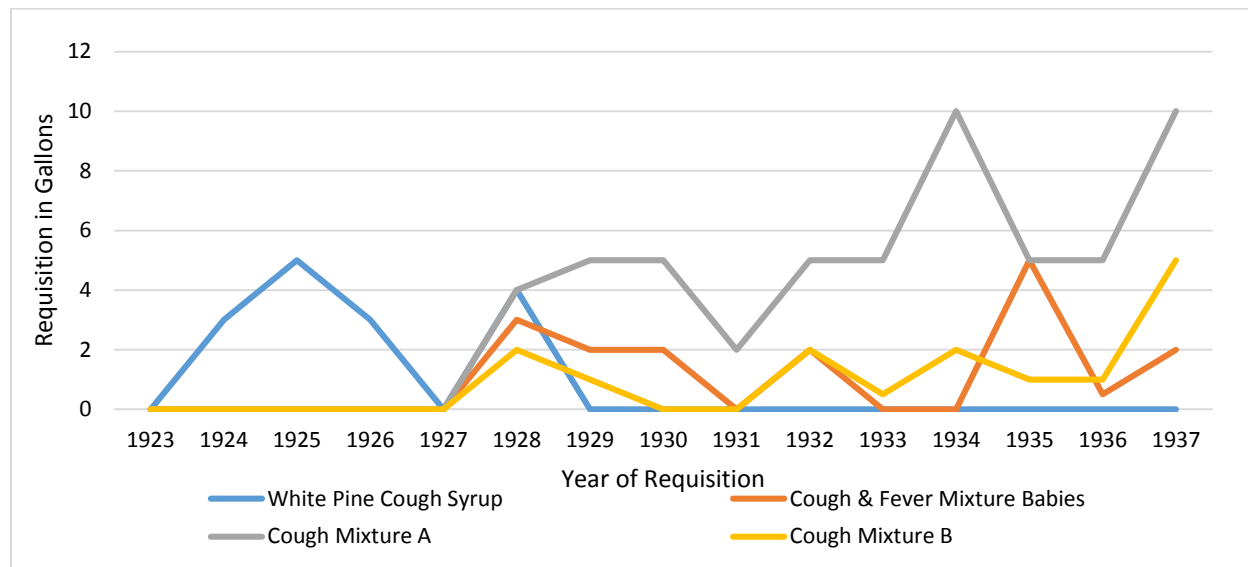
Another method of gaining insight into the frequency of cough, cold, and influenza is through an analysis of the medical requisitions put through by the Blue Quills School. When the pupils experienced the above-described infections they were often treated with cough syrup for their respiratory symptoms and aspirin for a fever. Before the Department standardized the medical orders which could be put through by the schools (which occurred in 1928), the Blue Quills School utilized "White Pine Cough Syrup" to treat cough and cold in students. The school ordered between three and five gallons of this syrup annually before 1928. After 1928 cough and cold was treated with three different types of cough syrup, depending on the age of the patient and the severity of the cough. "Cough Mixture A" and "Cough Mixture B" were both used for adults, while "Cough

¹⁴⁷ See page 146.

¹⁴⁸ LAC, RG 10, Volume 6344, File 750-23, Part 1. Memorandum of Inquiry in to the Death of Pearl B., November 28, 1940.

and Fever Mixture – Babies” was used for younger children. The number of gallons requisitioned for each of these syrups has been plotted on Table 10 below.

Chart 12: Blue Quills School – Requisitions for Cough Syrup, 1923-1937



As can be gleaned from Chart 12, 1923 and 1927 were the only years when no cough syrup was ordered by the school. On the contrary, the Blue Quills School went through gallons of cough syrup every years between 1923 and 1937. As Cough Mixture A was utilized “for ordinary coughs and colds” it is no surprise that this syrup was used more frequently than the other types.¹⁴⁹ Yet this syrup also contained a chloroform base, making its frequent ingestion very harmful if continued over an extended period of time. The Cough Mixture B was used “for troublesome night cough” and was not to be given to children under the age of ten. This syrup was codeine-based and its administration to children therefore ran the risk of respiratory depression and toxic conversion to morphine.¹⁵⁰ For younger children, the school used Cough and Fever Mixture for Babies, which

¹⁴⁹ LAC, RG 10, Volume 6016, File 1-1-13, Part 1. To Principals of Residential Schools, Department of Indian Affairs, January 14, 1928.

¹⁵⁰ Lisa Watt and Paul Arnstein, “Codeine for Children: Weighing the Risks,” *Nursing* 43, no. 11 (2013): pp. 62 – 63, esp. 62, Catherine Ciszkowski et al. “Codeine, “Ultrarapid–metabolism Genotype, and Postoperative Death,” *New England Journal of Medicine* 361, no. 8 (2009): pp. 827–828.

contained a base of ipecac wine for emetic purposes (Appendix 9).¹⁵¹ The consistent requisition of all three of these cough medicines throughout the 1930s provides evidence that cough and colds were a common experience among children at the school.

3.9 – Whooping cough:

Whooping cough, also known as Pertussis, broke out periodically among children on reserves and in the schools. Whooping cough commonly results from infection of an individual with the *Bordetella pertussis* bacteria, and its symptoms include whooping and post-tussive vomiting.¹⁵² This disease has a high mortality rate and is still a common issue for unimmunized children in developing countries today.¹⁵³ In 1915 the disease was thought to have killed about 10,000 children per year in the United States.¹⁵⁴

A Whooping cough outbreak hit the Saddle Lake Reserve in the north of Alberta in 1936. This outbreak infected many children from both the Edmonton School and the Blue Quills School. The doctor on the reserve recommended that the students should stay home from school for three weeks to prevent the further spread of the disease.¹⁵⁵ However, the principals of both schools found this absence undesirable, as it interfered with the per-capita grant amounts they would receive from the Department of Indian Affairs. Reverend Angin, the Principal of the Blue Quills School, was particularly upset about the closing of the school. He protested the children's absence, claiming

¹⁵¹ LAC, RG 10, Volume 6016, File 1-1-13, Part 1. To Principals of Residential Schools, Department of Indian Affairs, January 14, 1928.

¹⁵² James Cherry, "Historical Review of Pertussis and the Classical Vaccine," *The Journal of Infectious Diseases* 174, no. 3 (1996): pp. S259 – S263, esp. S259.

¹⁵³ *Ibid.*

¹⁵⁴ "Whooping cough a Serious Disease," *The Canada Lancet* 49, no. 4 (1915): pp. 192.

¹⁵⁵ LAC, RG 10, Volume 6340, File 751-13, Part 1. Rev. Jos. Angin to H. MacGill, August 24, 1936.

that “only 6 or 7 pupils” were sick with the disease and the rest should be sent in. Nonetheless, the Indian Agent refused to allow any of the children to return until the epidemic had passed, citing the recommendations of the doctor in defence of his ruling.¹⁵⁶ When Angin wrote the Department of Indian Affairs in protest, the Department chastened the Agent – asking for proof of the doctor’s report because the Department “could not understand why [the Agent] kept all the children home” when it seemed only a few cases were present.¹⁵⁷ However it seems that the Agent’s instruction to keep all the children home was the correct decision, as the whooping cough outbreak had spread far beyond just a few children on the reserve. The doctor wrote to the Agent that he had “found so many cases since that I am convinced the above action was amply justified.”¹⁵⁸

This case demonstrates that preventative measures employed to ensure the health of children were highly dependent on the person supervising the children at the time of the outbreak. In this case, the Indian Agent and Doctor had authority over the children’s return to school because the children were already on summer holidays when the epidemic broke out. The danger of spreading the disease did not however stop principal Angin from repeated attempts to coerce the parents of pupils to return their children to the school regardless of official orders.¹⁵⁹ Angin managed to secure the return of twenty-three children in this way and acted “in direct contravention of the health regulations issued by the Department.”¹⁶⁰ Had the students all been in the institution, the outbreak would likely have been far worse and spread to many more of the children at the Blue Quills School. Indeed, an outbreak of lobar pneumonia (which is a danger to the functioning

¹⁵⁶ Ibid., W.E. Gullion to Secretary, August 21, 1936.

¹⁵⁷ Ibid., A.F. MacKenzie to W.E. Gullion, September 1, 1936.

¹⁵⁸ Ibid., J.P. Decosse to W.E. Gullion, August 20, 1936.

¹⁵⁹ Ibid., W.E. Gullion to Secretary, September 18, 1936.

¹⁶⁰ Ibid,

of whole areas in a child's lungs) occurred at the Blue Quills School within a month.¹⁶¹ Ten cases of pneumonia immediately had to be taken to the hospital between September 15 and October 14, 1936 and of these, four cases were suffering from "double pneumonia"- infection on both sides of the lungs.¹⁶² Had the additional burden of whooping cough been introduced to the children, the results would likely have been devastating.

The 1936 whooping cough outbreak was not the only one of its kind. In Canada, whooping cough occurred periodically on reserves for much of the early 20th century. Department records mention Aboriginal deaths from whooping cough epidemics as early as 1890.¹⁶³ In Alberta, outbreaks of whooping cough were noted on reserves almost every year from 1903 to 1910.¹⁶⁴ Although the reported incidence of this disease decreased as time went on – with only a few mentions of whooping cough occurring in the 1920s and 1930s – in 1933 whooping cough was still a problem for children on reserves. The 1933 Annual report of the Department of Indian Affairs noted:

Measles and whooping cough ... have been very prevalent, and have caused a good many deaths among young children. The death rate from these diseases, and their complications, in any section of the population, is higher than is usually realized. It is very difficult to prevent their spread, there is, no acknowledged specific remedy, and recovery depends largely on the ability of the mother to give adequate nursing care.¹⁶⁵

¹⁶¹ Ibid., J.P. Decosse to Director of Medical Services, November 4, 1936.

¹⁶² Ibid., W.E. Gullion to Secretary, November 7, 1936.

¹⁶³ LAC, Indian Affairs Annual Reports, 1864 – 1990, *Annual Report Of The Department Of Indian Affairs For The Year Ended 31st December, 1890*, p. 21.

¹⁶⁴ Ibid. See Annual Reports from 1903 to 1910.

¹⁶⁵ Ibid., *Annual Report Of The Department Of Indian Affairs For The Year Ended March 31, 1933*, pp. 11.

The Department's comment about treatment of whooping cough is false. Vaccines for whooping cough were available at the time, though their use was limited.¹⁶⁶ Complications associated with their administration had been noted since they were first widely used in 1915. Therefore use of vaccination for the prevention of Pertussis had been a controversial topic in the medical community until the 1930s.¹⁶⁷ Yet in 1936 a new whole-cell vaccine was developed.¹⁶⁸ This vaccine was made available for distribution across Canada from many provincial Departments of health, including Alberta.¹⁶⁹ Yet the first efforts made by the Department to initiate vaccination programs for whooping cough were not undertaken until 1943.¹⁷⁰ When vaccination for residential school children was eventually introduced, it was only utilized as a reactive measure, rather than a preventative one. During 1943 and 1944, the Department only instituted vaccination in schools after an outbreak of whooping cough had already begun among the population. This system improved over time, as the value of inoculation became more and more accepted by the Department of Indian Affairs. By 1945 the Annual Report claimed it had become common practice "to immunize Natives against Smallpox, diphtheria, whooping cough, and typhoid wherever possible."¹⁷¹

¹⁶⁶ Anonymous, "Pertussis Vaccine," *Journal of the American Medical Association* 76, no.7 (1921): 466 – 468.

¹⁶⁷ Thomas Bumbalo, "Treatment of Pertussis with the New York State Pertussis Vaccine," *American Journal of Diseases of Children* 52, no. 6 (1936): pp. 1390 – 1396, esp. 1390.

¹⁶⁸ Daniel LaPointe, "Immunization Against Whooping cough: A Clinical Study," *The Journal of Pediatrics* 29, no. 3 (1946): pp. 363–366.

¹⁶⁹ Christopher J. Ruddy, "The Challenge of Whooping cough: Canada and the History of Pertussis Vaccines," Health Heritage Research, accessed July 20, 2015, <http://www.healthheritageresearch.com/Pertussis/Pertussis-history.html>.

¹⁷⁰ LAC, Indian Affairs Annual Reports, 1864 – 1990. *Canada Department Of Mines and Resources Report Of Indian Affairs Branch For The Fiscal Year Ended March 31, 1943*, p. 153

¹⁷¹ *Ibid.*, *Canada Department Of Mines and Resources Report Of Indian Affairs Branch For The Fiscal Year Ended March 31, 1945*, p. 167.

3.10 – Venereal Diseases:

Although not as common as other infectious diseases students contended with while attending the Residential Schools, venereal disease was present in the residential student populations of Alberta as well. There was evidence of children within the schools suffering from topical venereal infection of parasites – such as crabs and scabies – as well as syphilis, gonorrhoea, and chlamydia. As the prevalence of lice, crabs, and scabies has already been discussed in chapter two, these infectious diseases will not be analyzed here.¹⁷² It should however be noted that it is unclear from the evidence whether the high incidence of mite diseases were the result of sexual abuse or sexual activity within the schools or were solely the result of poor hygienic conditions. The nature of such abuse and the absence of the children’s voices in these documents would have prevented evidence of sexual abuse from being recorded in the historical record.

The presence of gonorrhoea among students at the Blue Quills Schools is suggested by the medical supply requisitions of the school. Potassium Permanganate tablets were used for the treatment of gonorrhoea at the school. Tablets were to be “dissolved in a cupful of warm water” and used as an antiseptic wash or for injection.¹⁷³ The school made a requisition for 100 of these tablets in 1929. In 1933 they increased their order to 500 tablets, indicating that either the number of infected individuals at the school had increased, or treatment for gonorrhoea was becoming more regular in those infected.¹⁷⁴ Whether treatment was given to staff or students is not recorded. Urotropin was also used as a treatment for gonorrhoea at this time. Urotropin is formed through

¹⁷² See pages 112 – 115.

¹⁷³ LAC, RG 10, Volume 6016, File 1–1–13, Part 1. To Principals of Residential Schools, Department of Indian Affairs, January 14, 1928.

¹⁷⁴ LAC, RG 10, Volume 6340, File 751–13, Part 1. Medical Matters, 1923 – 1937.

the action of formaldehyde and ammonia and was ingested as a tablet to “sterilize the urine.”¹⁷⁵ The Blue Quills School put through an order for 100 Urotropin tablets in 1923 and 300 in 1927, again indicating an increased incidence of the condition.¹⁷⁶ It therefore seems likely that these infections were spreading within the school, though at a slower rate than the other infections previously discussed. Both of these treatments would have done little for curing the bacterial infection, but would have helped to relieve some of its symptoms. A Potassium Permanganate wash was the standard treatment for cleansing and irrigating at the time and it would have helped to cleanse pus or sores.¹⁷⁷ Unfortunately most local cleanses – potassium permanganate included – had little therapeutic effect of these conditions and could even have adverse effects on sensitive genitalia. Local treatment of the infection was therefore abandoned by the 1940s, in favour of sulfonamides and antibiotic remedies.¹⁷⁸ Urotropin – now known as methenamine – is still used to relieve urinary tract irritation, though it is not commonly prescribed. It nonetheless would have helped relieve the symptoms of chronic gonorrhoea.

The presence of syphilis among students within the schools was noted through both medical requisitions and through the deaths of two students during this period. Due to the very low frequency of syphilis and its chronic nature, the contraction of this disease likely occurred in the children at the time of their birth, rather than later in life. Syphilis is known to be contracted by infants on their passage through the birth canal of an infected mother.¹⁷⁹ Syphilis was treated in the schools only by the prescription of a medical doctor before 1928. This prescription was ordered

¹⁷⁵ Lavina Dock, *Materia Medica for Nurses*, p. 311.

¹⁷⁶ LAC, RG 10, Volume 6340, File 751–13, Part 1. Medical Matters, 1923 – 1937.

¹⁷⁷ Abraham Wolburst, *Gonococcal Infection in the Male* (St. Louis: The C.V. Mosby Company, 1927), pp. 73–75.

¹⁷⁸ Evangeline Morris, *Public Health Nursing in Syphilis and Gonorrhoea* (Philadelphia & London: W. B. Saunders Co., 1946): pp. 120 – 121.

¹⁷⁹ David Seal and Uwe Pleyer, *Ocular Infection*, 2nd ed. (New York: Informa Healthcare, 2007), p. 150.

only once at the Blue Quills school, in 1926. This child was suffering from secondary syphilis – meaning that the disease had advanced significantly enough to leave the child with sores on genitalia, mouth, and other areas.¹⁸⁰ The standardization of the medical supply forms in 1928 allowed for more generic treatment of the condition, as a matron could then simply order medication without first obtaining a prescription from the physician in charge. The medication used was one Potassium Iodide tablet, to be given after each meal.¹⁸¹ The matron at Blue Quills ordered 300 tablets in 1928, 200 tablets in 1929, but only 100 tablets in 1930.¹⁸² No more requisitions were made after 1930 for potassium iodide, indicating that syphilis was no longer a concern at the school after 1930.

This was indeed the case, as the student suffering from syphilis had died in 1930. Henry N. was a young residential student at the Blue Quills School who was taken to the Saint Theresa Hospital for treatment in 1930. His hospital form labelled him as a “luetetic & cephalitis case.”¹⁸³ These symptoms are characteristic of chronic Syphilis. It is unclear whether the prescribed medicine for secondary syphilis which was ordered by the Blue Quills School in 1926 was for Henry, but his advanced stage of the disease seems to suggest so. X-rays were taken of his spine upon arrival at the hospital and he was given “medicine and treatment” for his condition. Unfortunately there was not much to do for syphilis at the time (penicillin would not be invented

¹⁸⁰ LAC, RG 10, Volume 6340, File 751–13, Part 1. Wholesale Druggists, Quotation on Drug Supplies for Blue Quills Residential School, Saddle Lake Agency, August 19, 1926.

¹⁸¹ LAC, RG 10, Volume 6016, File 1–1–13, Part 1. To Principals of Residential Schools, Department of Indian Affairs, January 14, 1928.

¹⁸² LAC, RG 10, Volume 6340, File 751–13, Part 1. Medical Matters, 1923 – 1937.

¹⁸³ LAC, RG 10, Volume 6340, File 751–13, Part 1. Hospital Account Form, March, 1930.

for more than a decade) so Henry could only be made comfortable before he passed away.¹⁸⁴ He died after spending eleven days in the hospital.¹⁸⁵

The second recorded case of syphilis was found at St. Bruno's School in Grouard, Alberta. On the morning of September 16, 1936, one of the teachers went to wake up the boys in their dormitory, only to find that one had died during the night.¹⁸⁶ This boy was named George B. and his death had come as a major shock to all the pupils and staff at the school. The Royal Canadian Mounted Police (RCMP) was called to investigate the death and interviewed all members of staff. The answers given by the other children and by staff denied that George had complained of any pain or sickness while he was at school. His brother did however mention that he had been sick over the summertime.¹⁸⁷ When the doctor examined the body he found that George had died of heart failure from "influenza of both respiratory and gastric intestinal type," which was aggravated by congenital syphilis.¹⁸⁸ Yet the doctor also found that George "had a well marked scabies condition" before he died, indicating that poor hygiene – both in and outside of the school – was probably a contributing factor to his health.¹⁸⁹ The presence of scabies – an easily treatable and controllable disease at the time – illuminates that health and hygiene were clearly not a priority among children at this school. George was ten years old when he died.

¹⁸⁴ See, Lorenzo Zaffiri, Jared Gardner, and Luis Toledo-Pereyra, "History of Antibiotics, From Salvarsan to Cephalosporins," *Journal of Investigative Surgery* 25, no. 2 (2012): pp. 67 – 77.

¹⁸⁵ Ibid.

¹⁸⁶ LAC, RG 10, Volume 6366, File 761–23, Part 1. Royal Canadian Mounted Police File no. 36K 1190/5–88.

¹⁸⁷ Ibid.

¹⁸⁸ Ibid.

¹⁸⁹ Ibid.

3.11 – Trachoma:

Venereal disease is also intimately correlated with the incidence of trachoma among students at the school. Trachoma is an infection of the eye that is initially associated with the bacterial infection of Chlamydia in an individual.¹⁹⁰ This bacterium, *Chlamydia trachomatis*, can similarly be transferred to an infant born through an infected birth canal, though once contracted it is highly contagious through personal contact. The result was symptoms of “sore eyes” and a gradual scarring of the cornea over time, eventually leading to deteriorating sight and blindness.¹⁹¹ Although trachoma has already been discussed in chapter two, it will be discussed in relation to its epidemiology again in this section.¹⁹²

While the condition itself is associated with the presence of venereal disease, it is a highly infectious disease which can – and did – pass easily from person to person in unhygienic conditions. Hygienic practices such as shared towels, or simply rubbing the eyes and transferring the bacteria to other surfaces can spread the disease to other children. The sharing of towels was likely a common practice in the larger schools such as Edmonton – which could not afford to supply individual towels for each child. The novelty of individual towels was expressed in one inspection report at the Whitefish Lake School, which stated satisfactorily that the fourteen enrolled each had “his own individual towel, as well as a tooth brush.”¹⁹³ Chances of a similar state of affairs in schools of over 100 children was unlikely.

¹⁹⁰ Jim Higgins, “B. Franklin Royer: A Half Century in Public Health,” *Pennsylvania History: A Journal of Mid-Atlantic Studies* 81, no. 2 (2014): 196.

¹⁹¹ *Ibid.*, 197.

¹⁹² See pages 120 – 121.

¹⁹³ LAC, RG 10, Volume 6355, File 756–5, Part 1. St. Peter’s Indian Residential School, March 4, 1931.

Cases of trachoma are most noticeable in the record of the Blue Quills School. This school often admitted children who had already contracted the disease, increasing the likelihood of its spread.¹⁹⁴ One outbreak was noted to have occurred at the school during 1932. When the doctor visited the school in February he “found several cases of trachoma,” which the sisters were still treating in April.¹⁹⁵ The application of Copper Citrate Ointment to the inside of the eye was used to treat this infection.¹⁹⁶ Other “prevention” measures were also put in place to control the spread of this disease though exactly what measures taken were not specified. It seems likely that the practice of towel and pillow sharing between infected and non-infected individuals would have been prevented. Nonetheless the order of 1,000 wooden applicators and 36 tubes of Copper Citrate Ointment that April suggests that the infection was shockingly widespread among the population of sixty-nine pupils.

This was not the first time pupils within the Blue Quills School had experienced an outbreak of trachoma. In February of 1929, four students were taken to visit an eye specialist for the disease. By February of 1930, two of the four required hospital attention.¹⁹⁷ One more student was sent into the hospital for treatment of her eyes in April of 1930.¹⁹⁸ Another case of eye disease occurred in 1924. A boy by the name of Johnson L. was sent to the Edmonton Hospital for treatment of “cornea of the eye.”¹⁹⁹ Although the infection which led to Johnson’s cornea trouble is unspecified, this was likely caused by either trachoma or a staphylococcal infection leading to

¹⁹⁴ LAC, RG 10, Volume 6347, File 751–10, Part 1. Application for Admission John N., August 16, 1934; and *ibid.*, Application for Admission Laura M., August 6, 1934.

¹⁹⁵ LAC, RG 10, Volume 6340, File 751–13, Part 1. W.E. Gullion to Secretary, April 23, 1932.

¹⁹⁶ *Ibid.*, W.E. Gullion to Secretary, April 23, 1932.

¹⁹⁷ *Ibid.*, Voucher No. 3025, November 25, 1929 and Doctor’s Monthly Account Form, February 10, 1930.

¹⁹⁸ *Ibid.*, Voucher No. 3103, April 12, 1930.

¹⁹⁹ *Ibid.*, J. Pugh to Secretary, April 7, 1924.

blepharitis. He was treated for almost two weeks at the hospital for his condition.²⁰⁰ It is unclear if other cases were present in the early 1920s, but a high number of children were suffering from “defective vision” in the nurse reports at the Blue Quills School in 1923 and 1924.²⁰¹ As most of these cases also had the development of a “film” over the eyes, infection is likely.²⁰²

These cases, coupled with the later outbreak, demonstrate that trachoma was clearly a continuous issue for students within the Blue Quills School. Although school officials tried to control the infections through the use of the recommended ointments, and hospital care when necessary, the eradication of the disease simply was not possible with the crowding and unhygienic conditions of the schools, which facilitated its contagious spread among the students. These conditions, coupled with the continued practice of admitting trachoma cases, ensured that trachoma was a consistent problem for the students at the school throughout the period of this study.

The Blue Quills School was not the only facility that had issues with trachoma. The Morley school also experienced an outbreak in 1931.²⁰³ The problem of trachoma was so widespread in fact – both in the schools and on the reserves – that the Department employed “an eye specialist who has intensive training in the diagnosis of Trachoma” to study its prevalence in the Aboriginal populations.²⁰⁴ The specialist found it to be “very prevalent among the Indians living in the settled district of the prairie provinces” as well as across the province of British Columbia.²⁰⁵ The annual

²⁰⁰ Ibid.

²⁰¹ Ibid., Report of Travelling Nurse, Blue Quills Indian Residential School, June 23/24, 1924.

²⁰² Ibid., Report of Travelling Nurse, Blue Quills Indian Residential School, February 19–20, 1923.

²⁰³ James Tandy, “Curriculum in the Morley School,” p. 40.

²⁰⁴ LAC, Indian Affairs Annual Reports, 1864 – 1990. *Annual Report of the Department of Indian Affairs for the Year Ended March 31, 1932*, pp. 9.

²⁰⁵ Ibid.

report of the Department stated, however, that “a substantial beginning” had been made by 1932 through treatment of students in the residential schools.²⁰⁶ It went on to describe how children in the schools were receiving treatment, despite the conditions which were favourable to transmission of the disease:

They are, however, under control and supervision which would be lacking at home, and the opportunity for treatment is vastly better at the school. A simple plan of preventive treatment, designed to protect the unaffected, is in use, and is considered to be effective. The affected pupils are under treatment, carried out by the nurse or other person in immediate charge, under the direction of the local doctor, and supervised by the Departmental specialist at his periodical visits. The school is utilized as a centre for examination of the surrounding Indian population, and encouraging reports have been received of the interest of the Indians at home having been awakened by letters from their children at school.²⁰⁷

The school was therefore seen as the primary site for intervention and treatment of trachoma on reserves. Yet it is interesting to note an absence of discussion surrounding the prevention and treatment of venereal disease among Aboriginal populations, though this was known to be a common cause of eye infection and subsequent blindness in children.²⁰⁸

3.12 – Appendicitis:

One interesting epidemic of appendicitis was found to have occurred at the Sacred Heart Residential School in 1948. Four children took ill with the condition during 1948 and one child died from it.²⁰⁹ Appendicitis occurs when the appendix becomes inflamed and blocked due to some

²⁰⁶ Ibid.

²⁰⁷ Ibid.

²⁰⁸ John H. Stokes, *To-Day's World Problem in Disease Prevention: A Non-Technical Discussion of Syphilis and Gonorrhoea* (Ottawa: Department of Health, 1919), p. 38.

²⁰⁹ LAC, RG 10, Volume 6363, File 759-23, Part 1. Memorandum of Inquiry into the Death of Aloysuis McDougal, October 28, 1948.

form of infection.²¹⁰ As appendicitis is not an infectious condition, its occurrence in multiple children at the school indicates that some environmental factor was causing the infection to occur in the children. Whether this was due to sanitation or food quality is unknown, but the Chief of Education for the Department seemed to think the condition was due to “overeating.”²¹¹ The Indian Agent, on the other hand, believed the illness to be due to an overindulgence on “sweet stuffs” by the children.²¹²

More recent medical studies have demonstrated that a diet reliant on starchy potatoes but lacks the presence of other green vegetables is directly correlated with the development of appendicitis.²¹³ The formerly held belief that a diet containing high meat and sugar intake causes appendicitis has also since been disproven through medical studies.²¹⁴ While the irony of the speculations made by the doctor and the Indian Agent is easy to see in hindsight, it is important to note that the cause of appendicitis was largely unknown at the time. It is therefore not surprising that both the doctor and the Agent associated the disease with common vices and the perceived lax moral behaviour of the students, rather than the poor diet of the school.²¹⁵

3.13 – Tonsillitis:

Probably the most common condition found among students within the Alberta schools was tonsillitis. Tonsillitis is the inflammation and infection of the tonsils at the back of the throat

²¹⁰ Edward Livingston, “Appendicitis,” *Journal of the American Medical Association* 313, no. 23 (2015): pp. 2394.

²¹¹ LAC, RG 10, Volume 6363, File 759–23, Part 1. Philip Phelan to A. McMillan, January 4, 1949.

²¹² *Ibid.*, Memorandum of Inquiry into the Death of Aloysuis McDougal, October 28, 1948.

²¹³ David Barker, Julie Morris, and Mark Nelson, “Vegetable Consumption and Acute Appendicitis in 59 Areas in England and Wales.” *British Medical Journal* 292, no. 6525 (1986): pp. 927–930.

²¹⁴ *Ibid.*, 928.

²¹⁵ *Ibid.*

and can be caused by numerous bacterial and viral infections.²¹⁶ It should be acknowledged that tonsillitis is not itself a disease, but rather the symptom of alternative infections within the body. The tonsils are the first defence against infection, and thus become inflamed periodically when diseases gain access to the body through the nose and throat. Tonsillitis is particularly common in children and can be a sign of many other diseases, including influenza, cold, and measles. It has been considered separately here because it is unclear what the true cause of tonsillitis was among the children in this study. When the travelling nurse made her examination of the students at the Blue Quills School in 1924, she found that 29 of the 56 students had tonsillitis, with severities ranging from a “fair” tonsillitis condition, to poor enough that removal was recommended.²¹⁷ These numbers mean that nearly sixty percent of students at this school were suffering from inflammation of their tonsils and throat.

Many children were also admitted into the schools with tonsillitis. On the admission forms for students of the Blue Quills School, eleven were found to have infected tonsils in 1935 alone. Fewer cases were found on the Blood Reserve, as only six pupils presented tonsillitis on admission between 1946 and 1949. Many students were, however, admitted to this school with blank or missing medical examination forms, so other cases may have been present. At the Edmonton School seven cases of tonsillitis were found in children entering the school between 1936 and 1939. The presence of this condition demonstrate that many children were often fighting off some form of infection even before admittance to the schools – where they would likely spread that disease further among the student population.

²¹⁶ Christos Georgalas, Neil Tolley, and Antony Narula, “Tonsillitis,” *Clinical Evidence* 10, no. 503 (2009): pp. 1 – 12, esp. 1.

²¹⁷ LAC, RG 10, Volume 6340, File 751–13, Part 1. Report of Travelling Nurse, Blue Quills Indian Residential School, June 23/24, 1924.

Once admitted to the school, students presenting tonsillitis would be treated by gargling with an antiseptic solution.²¹⁸ The school requisitions reveal that Alkaline Antiseptic Tablets – also called Seiler’s tablets – were used for this purpose. Tablets would be dissolved in warm water and used for cleansing the throat and nose.²¹⁹ The Blue Quills School consistently requisitioned 1,000 antiseptic tablets between 1928 and 1937 for the treatment of tonsillitis at the school.

In cases where the tonsils were deemed exceptionally bad, nurses and doctors recommended a tonsillectomy. The removal of tonsils was a common practice in medicine at the time. Tonsillectomy was standard treatment for enflamed tonsils across North America beginning in the 1910s, as tonsils were believed to be the portals through which infection travelled to the rest of the body.²²⁰ Thus, the Department began to employ doctors to carry out the procedure in 1924. As was usual in the case of the Department, this treatment was only to be given in the worse cases, when “Large infiltrated tonsils with crypts of pussy or other material” were found.²²¹ In other cases, the “conservative” route was deemed best, as it was less costly.²²² As it was, the doctors were usually only brought in to perform surgery when many cases were present. At the Blue Quills School, the doctor determined that twelve cases were bad enough for surgical removal in 1927.²²³ Yet the Department eventually only agreed to pay for the operation of three students, as the cost of all twelve would have been “\$300.00 or more.”²²⁴

²¹⁸ LAC, RG 10, Volume 6016, File 1-1-13, Part 1. To Principals of Residential Schools, Department of Indian Affairs, January 14, 1928.

²¹⁹ Ibid.

²²⁰ Gerald Grob, “The Rise and Decline of Tonsillectomy in Twentieth-Century America,” *Journal of the History of Medicine and the Allied Sciences* 62, no. 4 (2007): pp. 383 – 421, esp. 389.

²²¹ LAC, RG10, Volume 6016, File 1-1-13, part 1. Extract from letter of Dr. D. A. Clark, Asst. Deputy Minister of Health, November 15, 1924.

²²² Ibid.

²²³ LAC, RG 10, Volume 6340, File 751-13, Part 1. W.E. Gullion to W.M. Graham, September 16, 1927.

²²⁴ Ibid., W.M. Graham to Secretary, September 22, 1927.

The high frequency of tonsillitis provides insight into the student experience within the residential schools. Firstly, it tells us that although we aren't always sure exactly what diseases the students were facing within the schools, we can be sure that the majority were fighting off some sort of infection while in attendance. If 60% of students at the Blue Quills Schools demonstrated enlarged tonsils, than this also indicates that the everyday experience of life in the school was consistently overshadowed by the presence of a sore throat for many children. When one imagines suffering from a chronic sore throat, it reveals a lot about the condition of life within the school, even for those who were fortunate enough to escape the other skin, eye, and lung diseases present within the schools.

3.14 – Trauma:

The presence of heavy machinery, work animals, and large Industrial kitchens means that there was an increased risk of trauma for students within the schools. Trauma could include broken bones, burns, or wounds. It is unclear how frequently the children experienced problems like broken bones, but when they did occur the children were attended to with standard medical aid. Wounds were cleansed, burns were wrapped, and broken limbs were set and casted until healed. One image from the St. Peter's Mission School depicts a smiling boy standing for his school picture with his leg in a cast.²²⁵

The frequency of burns among students is unclear from the historical records, but given the quality of kitchen appliances it is likely that they happened at least occasionally at the schools. Even the brand new schools utilized second-hand appliances to save money and these easily wore down with the excessive usage. Many simply could not meet the high output needs of the schools.

²²⁵ See Image 10.

The St. Mary's School is a good example of this. According to one report in 1920, the bake oven had to be running from "four o'clock in the morning until nine o'clock in the evening" in order to meet the output needs for the students.²²⁶ In 1932 the inspector reported that the cook stove at the school was "getting badly burnt out" as it was over fourteen years old.²²⁷ Two years later the inspector reported the bake oven was also "burnt out" and was too small for the school anyway, so would also need to be replaced.²²⁸ The presence of faulty and worn-out appliances would have contributed to a higher frequency of burns among students – especially girls, who were the main kitchen workers – at the schools.

Aside from reports on the conditions of the kitchen appliances, the only means of analysis we have for the frequency of burns are the medical supply orders. Schools requisitioned a specialized "Burn Dressing" produced by Mowatt & Moore pharmaceuticals to treat topical burns.²²⁹ The dressing was placed on the afflicted area with a wet gauze and treated by the matron twice a day until healed.²³⁰ The matron at the Blue Quills School put through an order for three pounds of burn dressing each year between 1929 and 1933.²³¹ The lack of requisitions after 1933 seems to indicate that whatever problem had caused the burns to students and staff had been fixed by 1934.

At least two children died within the Alberta schools due to other physical trauma-related incidents. Both deaths occurred while the children were out playing on school grounds. In 1937,

²²⁶ LAC, RG 10, Volume 6343, File 750–5, Part 2. Principal to J.E. Ostrander, March 1, 1920.

²²⁷ Ibid., Christianson to Secretary, December 2, 1932.

²²⁸ Ibid., Christianson to McGill, Inspection Report, April 30, 1934.

²²⁹ LAC, RG 10, Volume 6016, File 1–1–13, Part 1. To Principals of Residential Schools, Department of Indian Affairs, January 14, 1928.

²³⁰ Ibid.

²³¹ LAC, RG 10, Volume 6340, File 751–13, Part 1. Medical Matters, 1923 – 1937.

Josephine L. died after being pinned to the Ice box wall from a “wheeled trailer”²³² She had been playing with the trailer on a nearby hill with some other girls when the children lost control of the vehicle. It rolled backward down the hill with Josephine trapped behind it, crushing her against the wall. The doctor was called immediately but Josephine died from her internal injuries within “a few minutes” of the incident.²³³

The second case of mortal trauma occurred at the Edmonton Institute in 1942.²³⁴ In this case, a young boy by the name of Joe S. was hit by a passing car while tobogganing down a hill. The hill was unfortunately located near the road and tobogganing down it placed Joe – and his play companions – directly into the path of any oncoming traffic. Joe unfortunately slid onto the icy road just as a neighbour was driving past and was caught between the wheels of the car. He suffered from severe head injuries and died upon reaching the hospital.²³⁵

In cases where a child’s death occurred through abnormal circumstances – such as physical trauma or sudden death – a legal inquest was held into the circumstances of their death. The RCMP would be called to collect statements from the school officials in charge and any students who were associated with the event. In the two cases of mortal trauma all parties involved were exonerated after the inquest was made. In the case of Josephine L., the sisters and staff of the school were judged to be innocent by proclamation of a jury.²³⁶ In the case of Joe S., the highway

²³² LAC, RG 10, Volume 6363, File 759–23, part 1, Memorandum of Inquiry into the Death of Josephine L., September 12, 1937.

²³³ Ibid.

²³⁴ LAC, RG 10, Volume 6352, File 753–23, part 1. Memorandum of Inquiry into the Death of Joe S., January 24, 1942.

²³⁵ Ibid.

²³⁶ LAC, RG 10, Volume 6363, File 759–23, Part 1, Royal Canadian Mounted Police, 37K 636/15–134, September 14, 1937. It should be noted that the jury was made up of six local white men from nearby Pincher Creek and Brockett.

constable judged the incident to be “purely accidental” after closely examining the scene of the accident and the car involved.

Nonetheless the Department showed great concern over the death of Joe. This concern was derived from the fact that Joe’s sister had also died at the school two years previously, making Joe the second child of that family to have died while attending school.²³⁷ The loss of another child left Joe’s father irate and he blamed the school for the death of his 16-year-old son.²³⁸ It seems from the record that the Department recognized its own culpability in this case. The Principal – J. Woodsworth – had been charged with the care of the children at the school, yet he had allowed the boys to use the hill for tobogganing despite the danger it posed. Woodsworth wrote at the inquiry that the boys had in fact used the hill “as a slide” for 15 years.²³⁹ Throughout the inquiry Woodsworth continuously stated that he had told the boys not to use the hill (in both English and Cree) and that he had even “had enough cinders put on the hill to make sleighing impossible.”²⁴⁰ Yet the boys were still left unattended – despite the knowledge that they would still likely utilize the hill for their games. The guilt of the Department in this matter even led the Indian Agent to authorize an expensive funeral for the boy, back on reserve, despite this not being “in accordance with the Department’s instructions.”²⁴¹ An expensive funeral was hardly retribution for the loss of a child due to the negligence of the school authorities.

²³⁷ LAC, RG 10, Volume 6352, File 753–23, Part 1. W.P.B. Pugh to Secretary, February 6, 1942.

²³⁸ Ibid., Memorandum of Inquiry into the Death of Joe S., January 24, 1942.

²³⁹ Ibid.

²⁴⁰ Ibid., J. Woodsworth to Secretary, February 8, 1942.

²⁴¹ Ibid., J. Pugh to Secretary, February 6, 1942.

3.15 – Other Conditions:

Although this chapter has attempted to cover the majority of health issues students faced within the schools, other conditions did occur but were difficult to quantify in a section of their own. The problem of hemorrhoids is one such health issue which was present among students, but lacked evidence in the Alberta Schools. Hemorrhoids are caused by a poor diet leading to irregular excretion due to constipation in an individual. A treatment for hemorrhoids was present during this period and it was included in the list of medical supplies which schools could order from after 1928. The condition was to be treated with an ointment of gall and opium, applied to the bowel opening after cleansing with hot water daily.²⁴² This condition was, however, largely absent at the Blue Quills School. Requisitions for this ointment only occurred twice – once in 1923 and once in 1932 – and both times the required amount was only 1 pound.

There were also a few cases of illness which could not be directly linked to a specific disease. One such illness was “brain fever”, the name used to describe acute encephalitis.²⁴³ Encephalitis is a very serious condition and the only case of it found in the Alberta schools resulted in the child’s death. This case occurred at the Morley school in a young girl named Annie H.²⁴⁴ Annie experienced acute brain swelling on May 24, 1941.²⁴⁵ She was put to bed and watched over by a “special nurse” during her sickness.²⁴⁶ She received Aspirin to reduce her swelling and fever but no improvement was seen in her condition for over a month. After consulting with the doctor

²⁴² LAC, RG 10, Volume 6016, File 1–1–13, Part 1. To Principals of Residential Schools, Department of Indian Affairs, January 14, 1928.

²⁴³ LAC, RG 10, Volume 6358, File 757–23, Part 1. Memorandum of Inquiry into the Death of Annie H., June 16, 1941.

²⁴⁴ This is a different Annie H. than the one previously discussed on p. 143, who died from an infection of Black Measles.

²⁴⁵ Ibid.

²⁴⁶ Ibid.

on June 9th it was decided that “there was no hope of recovery” so Annie was sent home to her parents. She remained with them until her passing on June 16th.²⁴⁷

Conclusion:

Illness was a constant companion to the students who attended the Indian Residential Schools in Alberta. Disease came in many forms, affecting children’s eyes, ears, skin, glands, lungs, and brain. Infection occurred both in and out of the schools, but contagion thrived most when the population of pupils were brought together during the school year. While both the staff and the students of the school suffered during epidemics, the students were the true victims. They were required by law to attend the schools and any attempts to keep them home – no matter their condition – were met with pressure from the school authorities and the Department.

This chapter has focussed heavily on the deaths of children which occurred inside the Alberta schools. It is therefore important to note that the schools were at fault in these deaths primarily because of the environmental impact they had on the health of students. Poor sanitation created an environment for diseases like scabies and trachoma to thrive. The overcrowding of children, especially in the dormitories, allowed for increased transmission of illness between the pupils. Poor nutrition weakened their immune systems, increasing their susceptibility to the diseases they encountered. Thus, while matrons, nurses, and doctors usually acted as quickly as possible when a disease presented itself, the intervention was focussed on the body of the sick child – rather than the environment which caused the infection to take root in the body. The

²⁴⁷ Ibid.

combined presence of overcrowding, poor sanitation and malnutrition, the schools formed a perfect trifecta of conditions for diseases to take hold and flourish.

A consistent theme in the reports of deaths within the schools is the shifting of responsibility away from those in charge of the children – teachers, principals, doctors and nurses – to either the parents of the students, or the diseases which they suffered from. Statements during inquiries frequently noted the ‘hopelessness’ of the child’s condition – implying that no matter what kind of treatment they received, the disease was already too far gone to be cured by any medical intervention. This, of course, raises the question of where the illness arose originally. Officials in these cases consistently pointed to time spent at home as the cause. The conditions of the home and the care of Aboriginal parents was believed to be the true origin of these diseases. The fact that children were in the care of school officials for the majority of each year was never mentioned. Even when signs of illness were clearly present – such as infected tonsils or enlarged neck glands – doctors and school authorities often simply let the condition run its course. Children received hospital treatment when the disease worsened and were finally sent home to their family only once their recovery was deemed ‘hopeless’.

Chapter 4: Healthcare:

“The Department considers that Indian patients in many places are admitted to hospital for less serious complaints, and kept in hospital longer than would be the case if they were paying their own accounts or were indigent members of a white society.”¹

- Department of Indian Affairs, 1932.

Many layers of treatment were woven together into what can be considered the healthcare system within Indian Residential Schools. Each layer utilized different aspects of the Canadian and provincial health systems – doctors, nurses, hospitals, medical supplies – yet the final product was a flawed tapestry, constructed of the cheapest materials and filled with gaping holes. The primary layer of care was laid when children were first admitted to the schools. Initial assessments of health were undertaken by a local, Department approved, physician before admittance was accepted by the Department. The focus of the system was care given within the school at the hands of school matrons. The majority of students who passed through the system saw no more healthcare interventions than this.² Occasional visits from travelling nurses and doctors occurred in some schools and these became more frequent over time. If the condition of an illness was concerning enough, local hospitals were utilized for both short and long term care. Some students were taken to dentists for tooth fillings and extractions, though this was an infrequent occurrence. Severe eye troubles were referred to a local eye specialist.³ When these treatments are seen as a whole it seems that the healthcare system was quite thorough, attending to all the healthcare needs of the students

¹ RG 10, volume 6016, file 1–1–13, part 1. Department Circular Letter 9–1E, March 1, 1932.

² John Milloy, *A National Crime*, pp. 51 – 52.

³ LAC, RG 10, Volume 6340, File 751-13, Part 1. Medical Matters, 1923 – 1937.

within the Residential Schools. This was certainly the picture which the Department painted of the healthcare system, who claimed that the provided care was more than “sufficient to provide for actual necessities.”⁴

Yet a closer scrutiny reveals the many cracks in the façade the Department painted of the healthcare system. Initial medical examinations of the incoming students were often delayed and sometimes completely neglected. When they did occur, visible signs of illness went unacknowledged or understated. Medical care received in the schools was constrained by the knowledge – or lack thereof – of the school Matrons, who were largely untrained. Medicine was supplied to schools with consideration of need and of cost, with cost consistently dominating as the most vital factor. Regular visits from nurses and doctors were only possible at schools near larger population centers and were neglected at the remote schools. Hospital treatment was provided at the most reduced rate possible and care was consistently cut short when the benefits of treatment were deemed less valuable than the expense.

When coupled with a staunch opposition to traditional healing practices – and indeed the absence of any Aboriginal spiritual beliefs or medical care – the healthcare system provided to students was incredibly meagre. It consistently neglected the health needs of the students from their admission to discharge. Treatment within the schools was consistently reactive, not proactive. It ignored the conditions which created disease and was provided when symptoms of illness worsened, not as they began. It was limited by a concern for cost, not treatment. Throughout the first half of the century, medical professionals, school authorities, and Department officials, were all ignorant to the irony of a system which removed children from the care of their parents due to

⁴ Ibid.

an assumption of neglect and inadequate care, only to keep them in schools which bred disease, deny them adequate treatment, and to return them when care was deemed too costly a burden.⁵

4.1 – Health and Medicine from a First Nations Perspective:

The First Nations conception of health is one of holism, obtained through an awareness and understanding of the connections between the body, the mind, the heart and the spirit.⁶ Holistic health recognizes that wellness is only reached when care is given to all four of these aspects. Healthcare within an Aboriginal focus has therefore focussed mainly on maintaining that balance. Alberta's current healthcare system is focussed on culturally appropriate care for First Nations across the province in the form of the Aboriginal Health Program.⁷ This is a relatively new initiative in the province, introduced with consultation from the wisdom council in 2012/2013.⁸ Previous health care programs in Alberta have focussed heavily on preserving non-Aboriginal health through the intervention of modernized western healthcare practices. The treatment of Aboriginal healthcare was kept separate from the system which treated non-Aboriginals, in order to protect national health.⁹

Yet the first type of health care ever practiced on the Prairie's came from First Nations communities. Medicine holds a special significance within Plains Aboriginal spirituality. The concept of medicine went beyond just treatment to encompass healing of the body, mind and spirit.

⁵ John Milloy, *A National Crime*, pp. 212–214.

⁶ Chansonneuve, Deborah. *Reclaiming Connections: Understanding Residential School Trauma Among Aboriginal People. A Resource Manual*. (Ottawa: The Aboriginal Healing Foundation 2005), p. 23.

⁷ Alberta Health Services, "What is the Aboriginal Health Program?," accessed July 08, 2015, <http://www.albertahealthservices.ca/7629.asp>.

⁸ Alberta Health Services, *Annual Report 2012–2013*, p. 148.

<http://www.albertahealthservices.ca/Publications/ahs-pub-2012-2013-annual-report.pdf>

⁹ Maureen Lux, "Care for the 'Racially Careless'," p. 410.

Traditional medicine on the Plains came in many varieties. First Nations healers utilized the abundant plant and herb resources of the prairies to deal with the different illnesses they encountered. The majority of traditional medicines were considered to be “discoveries” – referring to the use of medicinal plants and herbs which were commonly known to help with various illnesses.¹⁰ One such plant was “Fragrant Smell” – colloquially known as Sweet Grass – which was used frequently in various Blackfoot remedies. The smoke of Fragrant Smell would be used to revive a person who had stopped breathing suddenly.¹¹ As the incense of Fragrant Smell held the power of revival, it was also used in many ceremonial practices for its healing and cleansing power. The dried stems would be braided into thick strands and small pieces would be broken off to burn on the coals for incense. The grass could also be brewed to help “a person that has hemorrhage.”¹² Hemorrhage referred to a person with any condition which caused coughing or spitting up blood. The sweetness of Fragrant Smell was believed to bring healing power to the inside of the body, while bitter tasting food and drink were to be avoided.¹³ Among the Peigan “it [is] believed that a person [will] not lie if he [uses] the incense.”¹⁴ Other medicines which were “discoveries” of the Aboriginals include Pine Stem, (yarrow), Double Turnip (yampa) and Rattle Weed (locoweed).¹⁵

While discovery medicines were widely understood by the Plains peoples, traditional healers were the holders of the “revealed” medicines. These were decoctions revealed to a healer

¹⁰ Provincial Museum and Archives of Alberta, George First Rider, “Ethnic Botanical Discussion,” *Indian Heritage Project*, Disc 47 (April 10, 1969), IH-AA.021.

¹¹ *Ibid.*

¹² *Ibid.*

¹³ *Ibid.*

¹⁴ Michael Ross, *Weasel Tail: Stories told by Joe Crowshoe Sr. (Áápohsoy'yiis), A Peigan–Blackfoot Elder* (Edmonton: NeWest Press, 2008), p. 95

¹⁵ Provincial Museum and Archives of Alberta, George First Rider, “Ethnic Botanical Discussion,” *Indian Heritage Project*, Disc 47 (April 10, 1969), IH-AA.021.

through dreams and visions and held a special power to heal which was only available when created by the healer themselves.¹⁶ These healers were shamans and they could specialize in a variety of types of healing, including hot coals, steam, decoctions from animal pelts or birds, and even specialized songs for healing. The power of a healer was exclusive to the holder and a potent form of physical and spiritual healing.¹⁷

It is important to acknowledge the potent presence of First Nations medicine on the prairies before the introduction of Europeans. Medical understanding among First Nations cultures includes more than just the administration of herbs, pharmaceuticals or medical care to affected individuals. It also encompasses actions and virtues which heal the spirit and bring one closer to a cultural, emotional, and spiritual “wholeness.” Medicine was a core aspect of First Nations lifeways before contact and was the foundation of well-being for an individual, their family, and their tribe. Before the arrival of western medicine, traditional medicine was the dominant healthcare available in the land that would become Alberta. The herbs and plants utilized by the First Nations were quickly adopted for use by homesteaders and others. Maureen Lux has described how local prairie families utilized Yarrow tea to help in cleansing the body of illness and “discovered” senega root to be used as a painkiller.¹⁸ Homesteaders who harvested the root could make up to ten dollars a day in the 1880s by selling it to the patent medicine industry.¹⁹

¹⁶ Ibid.

¹⁷ Ibid.

¹⁸ Maureen Lux, *Medicine That Walks*, pp. 98–99.

¹⁹ Ibid.

4.2 – Healthcare within the Schools, pre-1920:

The concept of preventative public health was a clear concern for Albertans in the early 1900s.²⁰ Hygiene and preventative disease measures were promoted. Physicians, nurses and hospitals became well established in the province and Alberta's healthcare system soon fell in line with the standards across Canada. Clinics, hospitals, asylums, and sanatoria were opened and the availability of nurses and doctors grew exponentially.²¹ Yet these progressive steps only extended to the non-Aboriginal population. Healthcare on reserves and schools was limited by Department concerns for the cost of healthcare – and the dangers of providing too much healthcare to First Nations people. When Bishop Grandin (1829 – 1902) wrote the Department pleading for annual doctor visits to schools in the Saddle Lake area, he was pointedly turned down. The response of the Department characterized its belief about providing healthcare to First Nations people for much of the early period. Hayter Reed, the Deputy Superintendent General responded to the Bishop's request by writing:

The Indians have not been willfully neglected but treated on a well defined policy which is to leave hunting Indians in outlying districts to their own resources, until the failure of the hunt may convince them of the necessity for settling down and learning to farm... It has not been considered inconsistent with the policy defined to send the Indians some relief when emergency has arisen, and such has been done; but to give such assistance as now asked for would only retard the eventual settlement of the Indians, and do more harm than good.²²

Civilization was the only path to health in the eyes of the Department and healthcare would in fact work against their well-being if provided.

²⁰ Daniel G. Revell, "The Conservation of Alberta's Greatest Natural Resource," *The Saskatchewan Medical Journal* 2, no.9 (September 1910): pp. 257 – 271, esp. 258.

²¹ Robert Lampard, *Alberta's Medical History*, pp. 1–13.

²² LAC, RG 10, Volume 6345, File 751–1, Part 1. H. Reed to Bishop Grandin, August 26, 1898.

After years of inadequate healthcare in the schools and the subsequent disease problems which resulted in the high mortality rates among children, the churches held a conference in Winnipeg to discuss the renegotiation of the contracts with the Government.²³ They put forth a number of resolutions in 1907 outlining demands for upgrading schools, increasing the per-capita grants, and the provision of adequate medical services for “tubercular and other contagious disease.”²⁴ The result was a renegotiated contract between the churches and the Department. The new contract outlined the responsibility of the schools to only admit children after a qualified medical examination was undertaken by a physician, to keep buildings sanitary and children “clean and free from vermin both in their clothes and person.”²⁵ The Department was required to assume a greater portion of the administrative and maintenance costs of the schools and to provide a larger grant based on the quality of the schools.²⁶ The cost of medical supplies, school books, stationary, and other goods were also assumed by the Department in hopes that these things would be a “benefit to the physical condition and the intellectual advancement of the Indian children.”²⁷

4.3 – The Changing System, Post–1920:

The influx of war casualties and disabled soldiers back into the province after the First World War, coupled with the severe Spanish Flu epidemic in 1918, did much for the public health care system in Alberta.²⁸ There was a marked increase in clinics, hospitals, physicians, and nurses in the province over the next decade. This allowed for increased medical care of Aboriginal

²³ John Milloy, *A National Crime*, p. 72.

²⁴ *Ibid.*, p. 73.

²⁵ *Ibid.*, p. 74.

²⁶ *Ibid.*

²⁷ *Ibid.*

²⁸ Robert Lampard, *Alberta's Medical History*, p. 9.

patients, if simply because doctors were more available in the province. After more than thirty years of ill health the Department began to understand that the Aboriginal population was not simply going to die out but, despite the odds, had survived with increasing populations. Thus, better healthcare was necessary, if only to protect surrounding white communities from the dangers of Aboriginal disease.²⁹

The 1920s saw the beginning of many official healthcare initiatives within the residential schools. After the renegotiation of the school contracts between the churches and the Department in 1911, there was an increased incentive for better medical facilities in the schools.³⁰ A new system of grading schools – as Class A, B, or C – came into play. Class A schools were provided with larger grants if they followed improved health regulations. An adherence to maximum student attendance based upon the regulations on “air space and ventilating systems,” and also possessed a separate infirmary for medical care were given a higher per capita grant – \$125 versus \$100.³¹ This encouraged renovations and care of buildings by the schools. As an example, the Blue Quills School worked hard to improve its standing in regards to the new regulations. New “steam heating and electric lighting systems” were added and improvements were made at the school in 1918 to ensure “sanitary plumbing and drainage.”³² The laundry was refitted to act as an “Isolation Hospital” on site, with separate accommodation for boys and girls.³³ The school officially made it to a Class A school in 1919.³⁴

²⁹ Maureen Lux, “Care for the ‘Racially Careless’,” p. 414.

³⁰ John Milloy, *A National Crime*, p. 94.

³¹ *Ibid.*

³² LAC, RG 10, Volume 6345, File 751, Part 1. Architect to D.C. Scott, Memorandum, September 4, 1918.

³³ *Ibid.*, J.D. McLean to Rev. H. Grandin, January 2, 1919.

³⁴ *Ibid.*

The upgrades to the schools meant that on reserves without hospitals or resident medical officers, schools served as the main distributor of medical supplies. This is clear from the 1928 circulation with updated medical instructions for matrons and medicine dispensers at the schools. The Department issued clear instructions for the dispensing of medications to “outside Indians.”³⁵ The circular recommended care and conservative practices when issuing school medications to outsiders, warning that “only such quantities as are required are to be issued, and medicines are only to be given out to such persons as are likely to use them as directed.”³⁶ Thus the school became a focal point for healthcare of both students and residents in the isolated areas of the country.

4.4 – Initial Medical Examinations:

Theoretically, the first contact that children would have with school medical care was through the doctor’s exam received on entrance to the schools. This consisted of a physical examination of the overall health of the child. Records of the height, weight, age, temperature, pulse, vision, and hearing were made. An examination of their skin and glands were made and any noticeable issues were recorded, such as sores or enlargement. The condition of the throat and teeth was recorded, along with the any signs of “mental deficiency”.³⁷ The physical examination form also required doctor evaluation of the presence of trachoma, tuberculosis, or syphilis in students. Any other irregularities or notes on the health of students could be remarked on in a section for general “defects” noticed which the “principal of the school should have warning.”³⁸

³⁵ LAC, RG 10, Volume 6016, File 1–1–13, Part 1. Department of Indian Affairs, January 14, 1928: To Principals of Residential Schools.

³⁶ Ibid.

³⁷ RG 10, Volume 6374, File 764–10, Part 1. Physical Examination Form, Chris S., January 1, 1940.

³⁸ Ibid.

The physical exam would thus appear to have been quite a thorough evaluation of health. Yet a number of factors combined to limit the usefulness of the initial physical exam for preserving health in students. The first factor was a habit of simply ignoring any problems pointed out by the doctor on the medical examinations. Many issues like high temperature, abnormal pulse rates or infected tonsils were noted by doctors, but ignored as a sign of illness. The high prevalence of fevers among children admitted to the schools is a notable example of this. At the St. Paul's School, seven children were admitted with fevers between 1934 and 1940. Despite recording high temperatures of over 100, under the sections regarding fevers, the Doctor would often write "nil" or "no fever" on the physical examination forms.³⁹ Abnormal pulse rates were also consistently recorded on physical examination forms. Recorded rates of students ranged from the absurd low of twenty-nine beats per minute to the excessive high of one hundred beats per minute.⁴⁰

The second factor which affected the effectiveness of the medical examinations was the lack of reliability in the diagnoses of doctors. The previously discussed case of Isaac B. who died from tuberculosis within two months of being admitted to the Edmonton Institute is a prime example of this. Isaac's medical examination noted that he was in perfect health, yet the doctor was noted to have examined a tubercular gland on his neck within three weeks of admittance.⁴¹ In the case of the presence of syphilis, one doctor who routinely examined the students at the Edmonton Institute consistently wrote "probably not" on the medical form.⁴² Other forms were simply left completely blank by the doctor, but still signed.⁴³

³⁹ *Ibid.*, Physical Examination Form, William Rabbit, April 1, 1937.

⁴⁰ *Ibid.*, Physical Examination Form, John Henry Creighton, August 15, 1935; *Ibid.*, Physical Examination Form, Vernon M., March 19, 1940.

⁴¹ LAC, RG 10, Volume 6352, File 753-23, Part 1. G.C. Laight to T.R.L. MacInnes, November 16, 1937.

⁴² LAC, RG 10, Volume 6352, File 753-10, Part 1. Physical Examination Form, Elsie L., June 22, 1936.

⁴³ RG 10, Volume 6374, File 764-10, Part 1. Physical Examination Form, Elizabeth M., January 29, 1940.

These were only problems if the child was actually examined. Students were often simply admitted without any physical examination taking place. The Indian Commissioner for the Prairie Provinces wrote an enraged letter to the Department about this practice in 1925. In the letter he urged the Department to “do something to stop this indiscriminate admission of children without first passing medical examination.”⁴⁴ Graham recommended that principals be once again reminded that a medical exam needed to be passed before admission of children was allowed.

Scott responded to these concerns with a circular sent out to all Agents and inspectors for schools. He acknowledged that “it is our own officers, who pick up orphans, delinquents and others, that are causing the difficulty, as occasionally no application forms are forwarded.”⁴⁵ Scott also assured Graham that “a more careful checking of the medical officers’ remarks” would occur in the case of applicants to the schools.⁴⁶

Yet not a month later, the Department received a letter from the Indian Agent at Grouard, Alberta, protesting the requirement due to the difficulties with securing a doctor for the examination of students in the Northern reserves.⁴⁷ The Agent declared that it was “manifestly impossible” to follow such a demand at the outlying missions in the agency, which contained six residential schools.⁴⁸ Instead he placed his confidence in the school officials, who he believed were “capable of judging whether children seeking admission to Residential Schools are in ordinary good health and that they would refuse to admit such as might endanger the well-being of those in the schools.”⁴⁹ The Department agreed with the Agent and declared in response “it will be

⁴⁴ LAC, RG 10, Volume 6016, File 1–1–13. W.M. Graham to D.C. Scott, February 10, 1925.

⁴⁵ *Ibid.*, D.C. Scott to W.M. Graham, February 16, 1925.

⁴⁶ *Ibid.*

⁴⁷ *Ibid.*, H. Laird to R. T. Ferrier, March 9, 1925.

⁴⁸ *Ibid.*

⁴⁹ *Ibid.*

satisfactory to the Department if the procedure in the past is followed.”⁵⁰ A similar allowance was made at the Sturgeon Lake School in 1926. The Department assured the school that admittance of students was fine so long as students were “examined on entrance by the Reverend Sister who looks after the nursing duties” at the school.⁵¹

4.5 – Healthcare within the Schools:

Once children were admitted to the schools, primary healthcare was in the hands of the school matron. The school matron was usually a female teacher who was assigned to the overall care of the health of students. The matron was usually untrained and had to rely on instructions provided by nurses, doctors or the Department for the care of illnesses. In the 1928 circular letter, the Department revealed exactly how untrained it expected most matrons to be within the schools, but providing detailed instructions on the administration and dispensing of each medication.⁵² The Department made the circular sufficiently detailed so that it could be used by “any intelligent person” for the care of students within schools.⁵³ Matrons were usually evaluated by the inspectors who visited the schools, though they were equally untrained in medicine and could offer little insight into the effectiveness of treatment. At the Edmonton Institute the inspector reported that the matron, Miss MacDonald, was “very devoted to her duties and her time appeared to be occupied very fully from 6 o’clock in the morning until the children retired to bed.”⁵⁴ This

⁵⁰ Ibid., R.T. Ferrier to H. Laird, March 16, 1925.

⁵¹ Ibid., R.T. Ferrier to H. Laird, November 29, 1926.

⁵² LAC, RG 10, Volume 6016, File 1–1–13, Part 1. Department of Indian Affairs, January 14, 1928: To Principals of Residential Schools.

⁵³ Ibid.

⁵⁴ LAC, Volume 6351, File 753–5. Inspection Report on Schools in Edmonton Agency. W. Murison To Graham, April 2, 1929.

evaluation is more a commentary on the need for care, than how well the matron carried out her duties.

In the schools which did not have a separate infirmary, children were kept in bed when sick. Isolation was therefore difficult to carry out, as the student would sleep in confined quarters with the rest of the children when sick. This was common practice at the Old Sun's School, Morley, and at the northern schools in the Saddle Lake area.⁵⁵ Quarantine procedures were therefore effectively eliminated from the medical treatment of students, resulting in the many large outbreaks of infectious diseases like Measles, influenza, or pneumonia.⁵⁶

Medicines were supplied to the schools as early as 1910 in Alberta.⁵⁷ However this supply was highly inconsistent and varied between schools. At the Blue Quills School and the Edmonton School, medical supply orders were put through annually each year between 1920 and 1937.⁵⁸ Yet both the Morley School and the Roman Catholic School on the Blood Reserve were only provided with medical supplies in 1928 and 1929.⁵⁹ The Old Sun School received no medical supplies at all during this time, while St. Bruno's in the North put through only one order for supplies in 1927.⁶⁰ Supplies were also reduced if the Department believed that proper economy had not been exercised by the Matron who put through the order. The 1937 medical supply requisition for the Blue Quills School was drastically reduced by the Department upon receipt. Orders for cough syrup, cod liver

⁵⁵ LAC, RG 10, Volume 6348, File 751-23, Part 1. Memorandum of Inquiry in to the Death of Victoria Large, November 17, 1942; LAC, RG 10, Volume 6358, File 757-23, Part 1. Memorandum of Inquiry into the Death of Annie Hunter, June 16, 1941; LAC, RG 10, Volume 6366, File 761-23, Part 1. Royal Canadian Mounted Police File no. 36K 1190/5-88.

⁵⁶ See Chapter 3, pages 121 – 140.

⁵⁷ LAC, RG 10, Volume 6345, File 751-1, Part 1. Requisition for Drugs Required for Use of the Children of Blue Quill Boarding school, May 17, 1910.

⁵⁸ LAC, Indian Affairs Annual Reports, 1920 – 1940.

⁵⁹ *Ibid.*

⁶⁰ *Ibid.*

oil, iron tonic, and others were all reduced, usually by more than half of the requested amount. One order for five gallons of petroleum was reduced to only one gallon.⁶¹

4.6 – Travelling Nurses and Doctor Visits:

While the fulltime care of students was entrusted to the matrons, the Alberta schools were also visited irregularly by travelling nurses and doctors. The Department employed two travelling nurses for this purpose in the Prairie Provinces.⁶² Field nurses were employed by the Department in both Saskatchewan and Manitoba as well, Alberta was not assigned such a post.⁶³ Travelling nurses would periodically visit the schools and complete a full checkup of the health of students. They would record temperature, pulse and respiration rates. An examination of student's eyes, ears, nose and throat, neck, skin, head, and teeth would also be undertaken.⁶⁴ Any remarks the nurse had about the health of the child would be recorded in a report which was submitted to the Indian Agent and then forwarded onto the Department. A more general report would also be written by the nurse about the general condition of the students and the types of food she believed they were served. These visits would enable the Department to keep track of any sanitation and hygiene issues which arose in the schools and generally ensured that student health was reported on.

Yet the reporting on student health did not directly translate to the improvement of student health. This was seen at the Blue Quills School, which the travelling nurse visited in both 1923

⁶¹ LAC, RG 10, Volume 6340, File 751-13, Part 1. Department of Indian Affairs, Requisition for Drugs. June 24, 1937.

⁶² LAC, RG 10, Volume 6016, File 1-1-13. Canada, News Bulletin, March 4, 1932.

⁶³ Ibid.,

⁶⁴ LAC, RG 10, Volume 6340, File 751-13, Part 1. Report of Travelling Nurse, Blue Quills Indian Residential School, June 23/24, 1924.

and 1924. In her 1923 report, Nurse Gerry noticed many children were suffering from tonsillitis and advised that they gargle frequently until the condition had subsided. Yet the same students were still noted to have enlarged tonsils over a year later when she revisited the school in 1924.⁶⁵ The ability to track illness was therefore present, but not utilized by the Department, who had access to successive reports on student conditions provided by the nurses.

The visits of nurses were highly infrequent in the Alberta schools. In the documents from Alberta, only two nurse reports surfaced – both from the Blue Quills School. The Annual Reports of the Department are similarly sparse in records of nurse visits to the schools. The financial records of the Department only record nurse visits at three schools during the 1920s – St. Paul's in 1925, Morley in 1928, and Edmonton in 1929. It is likely that more nursing visits did occur during this time, but they were obviously not a frequent occurrence in the Alberta schools in general.

Visits from physicians were highly dependent on the location of the school. Access to physician care was far more likely if a full-time doctor was employed by the Department on the reserve. Doctors were employed full time at the Blackfoot reserve, the Sarcee Reserve and the Chipewyan area in Alberta for much of the 1920s and 30s.⁶⁶ These doctors could be called by the school if a child's health reached a concerning level. Yet calling the doctor was often a last resort, as the matron would attempt to treat the illness first – sometimes waiting months before calling the doctor.⁶⁷ The Department actively discouraged the calling of doctors for what it believed were often “trivial ailments” and therefore the schools attempted to avoid physician care if at all

⁶⁵ Ibid., Report of Travelling Nurse, Blue Quills Indian Residential School, February 19/20, 1923; Ibid., Report of Travelling Nurse, Blue Quills Indian Residential School, June 23/24, 1924.

⁶⁶ LAC, RG 10, Volume 6016, File 1–1–13. Canada, News Bulletin, March 4, 1932.

⁶⁷ LAC, RG 10, Volume 6358, File 757–23, Part 1. Memorandum of Inquiry into the Death of Annie H., February 13, 1938.

possible.⁶⁸ There was, however, at least the possibility of physician care for students in the southern schools. The more northern schools at Saddle Lake had far less access to physician care during this period. There were no regular physicians employed by the Department at the reserves and the nearest hospitals which could be utilized by Aboriginal patients were the Edmonton General or the small hospital at Vegreville.⁶⁹ These schools were left to their own devices for healthcare.

A doctor's visit could also be in regards to the removal of infected tonsils or adenoids from children. In 1924 D.C. Scott wrote the Minister of Health, Dr. D.A. Clark, to clarify the status of medical opinion on surgical removals of tonsils and adenoids. Although this practice had been occurring for years in the schools, Scott seemed concerned about the "difference of opinion" held by medical men at the time regarding these surgeries.⁷⁰ His enquiries confirmed the need for surgical removal in all cases of adenoids – as they had a tendency to inhibit breathing – and removal in most cases of tonsils, as they were believed to be "very vicious foci of infection" by Clark.⁷¹ In the same year the Department came out with an official policy in regards to the practice of tonsillectomy on students. They would perform the surgical procedures only when absolutely needed and the procedure would be done at a rate of \$10.00 per case for the doctor, if five or more operations were needed, and \$2.50 per case for the anaesthetist.⁷² This amount was almost half the amount of "regulation" fees provided to doctors, as the Director of Medical Services pointed out in an angry letter to the Department in 1925.⁷³ Yet the Department maintained its fee and even

⁶⁸ LAC, RG 10, Volume 6016, file 1-1-13, Part 1. Department Circular Letter 9-1E, March 1, 1932.

⁶⁹ LAC, Indian Affairs Annual Reports, 1864 – 1990. Annual Report of the Department of Indian Affairs for the Year Ended March 31, 1922.

⁷⁰ *Ibid.*, Extract from Letter of Dr. D.A. Clark, Asst. Deputy Minister of Health, November 15, 1924.

⁷¹ *Ibid.*

⁷² *Ibid.*, Assistant Deputy Minister, Department of Health, to D.C. Scott, November 29, 1924.

⁷³ *Ibid.*, W.C. Arnold, to D. C. Scott., April 17, 1925.

reduced it further when possible. In 1927 the operating doctor at Blue Quills was only paid \$7.00 per case for his services in three tonsillectomies.⁷⁴

In 1922 the Department employed the services of Dr. A.H. Kennedy to undertake mass surgery on about 60 pupils in Southern Alberta.⁷⁵ Children were placed under general anaesthesia and had tonsils, adenoids and decayed teeth removed, in what historian John Milloy has termed an “assembly-line” of surgery.⁷⁶ Such a dramatic surgical undertaking was noted by Graham as “unusual to say the least,” yet it was believed to have saved the Department thousands by having the operation done at the schools, rather than at the hospitals. Once again the cost of treatment was principal to the discussions surrounding the employment of physicians to attend to students within the schools.

The infrequent visits by doctors were even noted as inferior by officials within the Department. In 1926, one school inspector in British Columbia wrote the Department to suggest that doctors visit the schools annually to check up on the children. He expressed concern over the inability to track the health of students after enrolment within the schools. In his letter to Scott, he wrote:

In connection with the physical welfare of the children, I might say that this is of as much importance to the Agents as is the question of education. We are constantly being accused of under-feeding and overworking the children, and although we know that this is not so, we have nothing but the doctor's original inspection reports at the enrolment of the child to go on.⁷⁷

⁷⁴ LAC, RG 10, Volume 6340, File 751–13, part 1. Department of Indian Affairs, Voucher No. 2638, St. Theresa Hospital, November 15, 1927.

⁷⁵ John Milloy, *A National Crime*, p. 100.

⁷⁶ *Ibid.*

⁷⁷ LAC, RG 10, Volume 6016, File 1–1–13. 1926 Extract from Letter From Inspector Col. G.S. Pragnell. December 7, 1926.

The Agent argued that annual physician visits would eradicate the health issues and help the Department to fend off charges of mistreatment or neglect. Scott's response to the message was a polite thank you for his "helpful letter" and a vague assurance that the suggestion was receiving consideration.⁷⁸ As no such regulation was implemented, the suggestion was clearly rejected by the Department.

4.7 – Hospital and Institutional Care:

Hospital care was provided for students if their condition deteriorated enough to warrant the cost. Yet in this case as well, the location of schools was a contributing factor to the frequency with which hospitals were utilized. For example, financial records reveal that hospital attendance was paid for on an almost annual basis at the Edmonton Institute.⁷⁹ As this school was located in close proximity to the City of Edmonton, it had far greater access to hospital facilities than most of the other Residential schools in the province. If hospital care was warranted, students from the Edmonton Institute would be taken into the city to be treated at the Edmonton General Hospital.⁸⁰ Schools located at greater distances from the main hospitals – including Crowfoot, Old Sun's, and St. Cyprian's – had no records of hospital services in the annual reports or the school files between 1920 and 1938.⁸¹ It seems that the administrative officials at these schools turned to hospital care on an infrequent basis, likely due to the greater distances which students would have to travel while sick or injured.

⁷⁸ Ibid., D.C. Scott to Col. G.S. Pragnell, November 17, 1926.

⁷⁹ LAC, Indian Affairs Annual Reports, 1864 – 1990.

⁸⁰ Ibid., *Annual Report of the Department of Indian Affairs for the Year Ended March 31, 1921*.

⁸¹ LAC, Indian Affairs Annual Reports, 1864 – 1990.

Treatments received at hospitals were regulated by the amount the Department was willing to pay for medical procedures. In 1932 the Department issued a list of “allowed procedures” to all physicians, nurses, and hospitals.⁸² This list provided a comprehensive outline of the types of procedures covered by the Department and how much would be paid for each procedure. The listed fees were “intended to include routine after care in uncomplicated cases” for individuals in the hospitals.⁸³ Yet despite the assertion that the Department covered the costs of healthcare for First Nations communities, many times the funds were taken from band and tribal accounts – meaning that the First Nations actually paid for up to half of their own care.⁸⁴

Another medical institution which pupils could be sent to for care included Sanatoria. The high instances of tuberculosis on reserves and in the schools made many in the student population prime candidates for Sanatorium care. Although Aboriginal patients were generally kept out of sanatoriums in the west,⁸⁵ there were a few recorded instances of students being discharged for care in the province of Saskatchewan.⁸⁶ These cases were only admitted to the Sanatorium from school because of the recommendation of the Anti-Tuberculosis League.⁸⁷ Students in Alberta were far less likely to receive care in a provincial sanatorium. When cases of tuberculosis were present, students remained at school even after the sickness required confinement to bed.⁸⁸ In rare

⁸² LAC, RG 10, Volume 6016, File 1–1–13, part 1. Schedule of Fees for Medical and Surgical Treatment of Indians.

⁸³ *Ibid.*

⁸⁴ Maureen Lux, “Care for the ‘Racially Careless’,” pp. 416 – 417.

⁸⁵ *Ibid.*, p. 419.

⁸⁶ LAC, RG 10, Volume 6016, File 1–1–13, part 1. Memorandum to Dr. McGill, November 27, 1933.

⁸⁷ *Ibid.*

⁸⁸ See for example the case of Annie H. at the Morley school. LAC, RG 10, Volume 6358, File 757–23, Part 1. Memorandum of Inquiry into the Death of Annie H., February 13, 1938.

cases, the sick students would be taken to a local hospital for prolonged care of the illness.⁸⁹ When a case was deemed “hopeless” the student was sent home to die in the care of their family.⁹⁰

Advances in institutional care for tuberculosis cases did not take place until 1949 in Alberta. Despite recommendations by the churches for Department sanatoria as early as 1910, no significant advances occurred in the School Healthcare System for nearly forty years.⁹¹ The Department eventually set up its own Preventorium at the Crowfoot Indian Residential School in Southern Alberta, once new antimicrobial drugs were made available for the treatment of the disease.⁹² The Preventorium was open for half a year, from December of 1948 to April of 1949.⁹³ It provided specialized tuberculosis treatment to 10 children a month. Patients were kept on a steady diet to help them gain weight and the newly developed chemotherapy was provided for treatment of their tubercular symptoms. Maintenance at this Preventorium was much cheaper than at a sanatoria. Children stayed at the hospital for the rate of 50 cents a day.⁹⁴ The care they received at Crowfoot seemed to have a good benefit on their health as they were often discharged with notes like ‘general improvement’, ‘doing well’ or ‘gaining weight’.⁹⁵ Nonetheless, this intervention came exceedingly late. Recommendations for similar programs had been made consistently by doctors, church authorities, and health organizations throughout the early 1900s. The Ontario

⁸⁹ In the case of Joe A. at the Blue Quills School, Joe spent almost a year in the hospital before he was discharged. *Ibid.*, W. P.B. Pugh to Indian Affairs Branch, Department of Mines and Resources October 9, 1943. See page 144 – 145.

⁹⁰ LAC, RG 10, Volume 6358, File 757–23, Part 1. Memorandum of Inquiry into the Death of Annie H., February 13, 1938; LAC, RG 10, Volume 6358, File 757–23, Part 1. Memorandum of Inquiry into the Death of Annie H., June 16, 1941;

⁹¹ John Milloy, *A National Crime*, p. 72.

⁹² LAC, RG 10, Volume 6349, File 752–25, Part 1. Crowfoot – Indian Residential School – Preventorium. 1948 – 1949.

⁹³ *Ibid.*

⁹⁴ Maureen Lux has found that hospital care for non–Native hospitals in the 1930s was not less than \$4 a day per patient. Maureen Lux, *Medicine That Walks*, p. 195.

⁹⁵ *Ibid.*, Monthly Report for the Crowfoot Industrial Residential School Preventorium, January 1949.

Women's Christian Temperance Union had written the Department to propose a similar institution as early as 1926.⁹⁶ Comparable recommendations were also made by the Saskatchewan Anti-Tuberculosis League in 1933. After their investigation into the presence of T.B. in the Saskatchewan Residential Schools, the League endorsed the establishment of a separate "special" school for children who were carriers.⁹⁷ Yet economy restricted the actions of the Department in all aspects of the healthcare system and the result was a forty-year delay on institutional intervention for students suffering from Tuberculosis.

4.8 – Dental Care:

The healthcare system within the schools provided students with some access to immediate medical intervention – in the form of matron care, physician consultation, and hospital accommodation. However conservational care – such as dental or ophthalmic care – was far less likely to be provided to students. Official dental care was almost entirely absent from the Alberta schools, as the work had to be undertaken by the contract of a local dentist. The Department had a habit of employing one dentist to undertake all necessary teeth removals within a short period of time.⁹⁸ The employed dentist would be paid by the month to travel to a number of schools and complete all necessary dental work required at each school.⁹⁹ The dentist would take about two weeks at each school to undertake his work, before he moved onto the next one.¹⁰⁰ This occurred at five of the larger schools in Saskatchewan during 1923¹⁰¹ and at six schools in southern British

⁹⁶ LAC, RG 10, Volume 6016, File 1-1-13. B.C. Ashcroft to D.C. Scott, October 20, 1926.

⁹⁷ See Page 143.

⁹⁸ LAC, RG 10, Volume 6016, File 1-1-13, J.D. McLean to Mr. Foran, August 23, 1923.

⁹⁹ Ibid.

¹⁰⁰ Ibid., Department of Indian Affairs, Voucher no. 1992, August 12 – September 30, 1923.

¹⁰¹ Ibid.

Columbia in 1925.¹⁰² Dental work was undertaken on a recurring basis in the Southern B.C. schools throughout the 1920s, with over twelve schools receiving a visit from a dentist in 1927.¹⁰³

In Manitoba, the Canadian Red Cross Society organized dental care to schools on their own initiative after 1924.¹⁰⁴ The Society established their own dental clinics throughout the rural areas of the province for much of the 1920s, employing a local dentist, Dr. Murdoch, to travel between rural areas to offer his services to the local population. The dentist offered services to rural communities at a special “red cross rate” of .25 cents for tooth extractions or \$1.00 for fillings.¹⁰⁵ This was also the standard rate for dental work allowed by the Department to approved dentists employed in Saskatchewan and British Columbia.¹⁰⁶ The Red Cross offered Dr. Murdoch’s services to the Department of Indian Affairs in 1925 and he began to hold clinics at residential schools in the area of Lake Winnipeg within the year.¹⁰⁷

Yet, despite the practice of dental visits in other provinces, official dental care was almost entirely absent in the Alberta residential schools. This absence wasn’t due to a lack of dentists willing to visit schools to perform the required work. In 1927, Graham located a young dentist who was willing to visit all the schools in the Prairie Provinces that year to perform necessary dental work, at a flat rate of \$300 per month.¹⁰⁸ As dental care had been spotty at best in the majority of Albertan schools, this would have helped to fill the hole in dental care provided to students on the prairies.¹⁰⁹ However after deliberation on the issue, the Department decided that

¹⁰² Ibid., R.T. Ferrier, Memorandum, May 11, 1925.

¹⁰³ Ibid., Memorandum, Re Dental Services Residential Schools British Columbia, March 17, 1927.

¹⁰⁴ Ibid., Report of R.H. Murdoch (Dentist) to the Junior Red Cross Advisory Committee, 1925.

¹⁰⁵ Ibid.

¹⁰⁶ Ibid., R.T. Ferrier, Memorandum, March 23, 1927.

¹⁰⁷ Ibid., D.C. Scott to Mrs. Speechly, January 26, 1925.

¹⁰⁸ Ibid., W.M. Graham to Secretary, May 23, 1927.

¹⁰⁹ Financial reports on the school expenses reveal that dental work was only carried out four times at Alberta schools in the 1920s. The Roman Catholic school on the Blood reserve reported dental expenses

“such an appointment cannot be made at this time.”¹¹⁰ Dental work in the Alberta schools was to be limited to “urgently required” work only, which could be attended to by local dentists.¹¹¹ As extraction of a decayed tooth was the most common procedure needed by children, the Department was of the opinion that this should be carried out by “the medical officer or the school nurse,” rather than an actual dentist.¹¹²

Finally in 1929 the Department authorized a local professional in Cardston, Alberta to undertake the dental procedures required at the two blood schools (St. Paul’s and the Blood Roman Catholic School).¹¹³ Students were taken together in groups to the dental office and work was done at the same reduced rate paid to the dentists who visited schools in British Columbia and Manitoba.¹¹⁴ The Department believed this arrangement to be “in the main quite satisfactory” for the care of student teeth in Alberta and it remained the norm throughout the next decade.¹¹⁵

Even when dental work was approved and carried out within the schools, dentists were limited to providing only the bare minimum of dental treatment.¹¹⁶ They were to pay all their own expenses for travelling and living while they visited the schools. No official fee was paid to the dentist for the inspection of teeth itself.¹¹⁷ The work was to be limited to only extractions and fillings of permanent teeth. No cleaning was permitted of the students’ teeth, despite the fact that this would have been exceptionally beneficial to the provision of dental health and finally, the

in 1926, the Edmonton Institute and St. Paul’s school showed dental expenses in 1927, and Morley had expenses for dental care in 1928. LAC, Indian Affairs Annual Reports, 1864 – 1990.

¹¹⁰ LAC, RG 10, Volume 6016, File 1–1–13, A.F. MacKenzie to W.M. Graham, May 30, 1927.

¹¹¹ Ibid.

¹¹² Ibid., A.F. MacKenzie to F. Edwards, March 21, 1928.

¹¹³ Ibid., A.F. MacKenzie to J.M. Pugh, April 23, 1929.

¹¹⁴ Ibid.

¹¹⁵ Ibid.

¹¹⁶ Ibid., G.D. McLean to W.M. Graham, April 4, 1927.

¹¹⁷ Ibid.

Department made sure to, once again, clearly point out that dental intervention was also only allowed in the cases of “absolutely necessary work”.¹¹⁸

4.9 – Parental Consent:

The last thing which needs to be discussed as part of the healthcare system is the general disregard for parental consent in any medical procedures. As First Nations children were removed from their parents care and designated as wards of the state, the control of their health was completely transferred to the Department of Indian Affairs. Children were compelled to attend the schools by law, with the purpose removing them from what government and church officials considered to be “evil surroundings.”¹¹⁹ By doing this, it was believed that the children would be introduced to western ideals and brought into the “circle of civilization.”¹²⁰

Part of this circle was the provision of western healthcare, regardless of how parents felt about the care of their child.¹²¹ The Department assumed full control over all medical decisions made regarding a child’s health while attending a Residential School. This was made clear in the response of the Department to a letter from, J.F. Woodsworth, principal of the Edmonton Institute. Woodsworth wrote the Department in 1924 inquiring about if he should attempt to secure parental consent for operations on children. He was told by the Department that such consent was needless, so long as the medical officer had deemed the operation necessary for the health of the pupil and the expenditure had been approved by the Department.¹²² While parental consent was considered

¹¹⁸ Ibid., R.T. Ferrier, Memorandum, March 23, 1927.

¹¹⁹ John Milloy, *A National Crime*, p. 33.

¹²⁰ Ibid.

¹²¹ This was seen in the case of Annie H. from Morley, who was only released home after the parents insisted multiple times that she be released from the hospital. LAC, RG 10, Volume 6358, File 757–23, Part 1. Memorandum of Inquiry into the Death of Annie H., February 13, 1938.

¹²² LAC, RG 10, Volume 6016, File 1–1–13. J. D. McLean to J.F. Woodsworth, November 24, 1924.

irrelevant, the Department made sure to emphasize that its own consent was absolutely necessary for any medical procedures. The response penned to Woodsworth by the Department impressed upon the principal the absolute necessity of first securing Department authority “for incurring the expenditure” of an operation before it could be carried out.¹²³ This reinforced the idea that the Department held the final authority over whether or not healthcare was provided to students.

This authority extended to both the decision to provide care, and the decision *not* to provide care in any given situation. This was especially seen in the case of tonsil removals at the Blue Quills School. Although the visiting physician recommended twelve cases be operated on at this school in 1927, the Department only allowed for operations on three children by the doctor, in order to save on expenses.¹²⁴ Similarly, the Department rejected the opportunity to employ a travelling dentist in Alberta when Graham proposed the idea.¹²⁵ This rejection occurred despite the employment of similar travelling dentist in other provinces in Canada.

The extent to which guardianship allowed for the withholding of healthcare was a contentious one even within the Department. When Graham authorized the visiting doctor at the Elkhorn institute in Manitoba to undertake any operations deemed necessary, Scott was incised at the resulting high number of operations.¹²⁶ The disagreement between the two was based around whether or not the opinion of the trained medical officer should take precedence over the Department’s fear of needless expenditures. Scott was of the opinion that giving a physician full

¹²³ Ibid.

¹²⁴ See pages 167 – 169. LAC, RG 10, Volume 6340, File 751–13, Part 1. W.M. Graham to Secretary, September 22, 1927.

¹²⁵ See page 197.

¹²⁶ The exact number of operations is not mentioned in the records, but it was sufficiently high to cause Scott to reprimand Graham for not exercising more caution. Ibid., Extract from Deputy Supt. General’s Letter to Commissioner Graham, March 17, 1925.

rights to decide which students needed operation was fiscally irresponsible.¹²⁷ Graham believed that the expertise of a trained medical professional should be trusted when operations were recommended, arguing that “it is not for me or the principal to say whether this should be done or not.”¹²⁸

Nonetheless disagreements over who maintained the final authority over healthcare interventions never considered that the parents should be involved in the final decision. Parental care was consistently seen as the fountain from which ill health sprung among students.¹²⁹ Healthcare began first and foremost through the separation of the child from the influence of their home and family.

Conclusion:

The *façade* of a healthcare system provided to the First Nations people during this period is neatly summed up by one event that occurred in 1932. On March 4 of that year, the Superintendent of Indian Affairs drafted and issued a Canada News Bulletin, titled “Canada Guards Indians’ Health.”¹³⁰ This bulletin promoted the system of healthcare provided by the Department, describing how the Department considered the protection of Aboriginal health to be of “prime importance.”¹³¹ It went on state that this concern was addressed through a health system “whereby not only bodily ills are attended to but the Indians are trained in personal hygiene and otherwise grounded in the fundamentals of preventative medicine.”¹³² The bulletin listed the

¹²⁷ Ibid.

¹²⁸ Ibid., W.M. Graham to D.C. Scott, April 17, 1925.

¹²⁹ See the discussion around blaming parents for disease in Chapter 3, conclusion.

¹³⁰ LAC, RG 10, Volume 6016, File 1–1–13. Canada, News Bulletin, March 4, 1932.

¹³¹ Ibid.

¹³² Ibid.

number of hospitals maintained by the Department, and the numerous physicians, field nurses and travelling nurses under Department employment. The average reader who read the bulletin would walk away with a sense that the healthcare system was exceptionally implemented and maintained, and certainly more than adequate to provide for the First Nations communities in the country.

Yet only three days before, the Department had distributed a Circular Letter to all doctors, nurses, matrons, dispensers and hospitals, outlining the important need to “curtail expenditure for medical and hospital attendance.”¹³³ Officials were warned to exercise the utmost caution in allowing hospital admittance or treatments which were not “absolutely necessary.”¹³⁴ This duality – a belief in the excellence of the system, while simultaneously restricting expenditures in any way possible – was characteristic of the system as a whole.

Children who were admitted to the Indian Residential Schools faced many adversaries to good health. Confronted with unclean living spaces, poor washing facilities, unsanitary plumbing, crowding, and poor nutrition, illness and disease were a common result. Sickness was met by the Department of Indian Affairs with a minimalist healthcare system which cared primarily about expense over health. On the surface, this system seemed thorough and complete, as it engaged physicians, matrons, nurses, hospitals, and dentists to care for the health of children throughout their tenure at school. Yet a closer look reveals the many weaknesses of the system, which served more to sway criticisms of the Department than to actually care for the continual health of students.

The Residential Schools also served to divide the children from traditional beliefs and medical practices. “Indian medicine” was taken out of the realm of possible treatment for sick children, unless western physicians had determined that the case was “hopeless.”¹³⁵ Medicine was

¹³³ Ibid., Department of Indian Affairs, Circular Letter 9–1E, March 1, 1932.

¹³⁴ Ibid.

¹³⁵ LAC, RG 10, Volume 6358, File 757–23, Part 1. Memorandum of Inquiry into the Death of Annie H., February 13, 1938.

redefined as an exclusively Western dominance, and medical intervention was divided from the land and the spirit. It was controlled and administered by white authority, which determined who received care and who did not. Despite many calls for improved school conditions and healthcare for students, the Department saw parental care and traditional beliefs to be the true dangers to the bodies of First Nations children and used this rhetoric to justify their separation from family and culture. Traditional medicine was deemed trivial at best, and called “criminal neglect” at worst.¹³⁶ Student health was redefined through assimilation to western beliefs and the Department seemed completely naïve (or willfully ignorant) to the irony of a system which justified the removal of children from their families for the purposes of health, while denying proper care to children once guardianship was assumed.

¹³⁶ LAC, RG 10, Volume 6016, File 1-1-13. J.K. Mullan to J. Pugh, May 4, 1935.

Chapter 5: Mental Health:

“They were very nice when our parents were there. I always remember that. As soon as they walked away they slapped me on the head. “You stop crying or I’ll give you something to cry about.”¹

- David Striped Wolf, 2001

The mental health of residential students is difficult to qualify through a retrospective historical study. The lack of an Aboriginal voice in the documents and the systemic oversight of student opinions pose serious challenges to a thorough analysis of student mental health. Yet the student perspective can be found through an indirect approach – by analyzing the circumstances of their existence within the school and the ways in which they responded to them. The actions that students took to express their feelings about the schools speaks volumes about the thoughts and opinions they had about their situation. Students frequently acted out when the opportunity arose. They expressed their opinion of the school by running away, or even attempting to burn it down. Others still found ways to form bonds and lasting relationships while in school, creating support systems amidst the poor conditions and ill health they encountered. Sometimes these systems of support resulted in a collective action from students, usually in attempts to escape their situation – one way or another. The suicide of one boy and the attempted suicide of eight others at the Williams Lake School in British Columbia is a good example.² Students in the Alberta schools would often run away together, likewise making a combined protest against their situation.³

¹ Legacy of Hope Foundation, “Where are the Children Exhibition,” David Striped Wolf: St. Mary’s Indian Residential School, accessed August 01, 2015, http://wherearethechildren.ca/en/stories/#story_40

² John Milloy, *A National Crime*, p. 148.

³ This occurred at both the Edmonton and the St. Paul’s school on numerous occasions.

The need to escape the schools stemmed from more than just the physical suffering students encountered. While in attendance, pupils were subjected to isolation, neglect, and abuse.⁴ This chapter analyzes the mental health of students through a discussion of circumstances of residential schooling. Children were separated from their parents and families for almost ten months each year. They were isolated from their language, beliefs, and culture – and constrained under the bounds of western values promoted by the churches and the Department of Indian Affairs – such as “the practice of cleanliness, obedience, respect, order, and neatness.”⁵ These ideologies were intimately linked to notions of racial dominance and eugenics understanding.⁶ Through regulation of the morals of students, the colonial forces of the government and the churches hoped to bring Aboriginal people into the folds of the dominant culture.⁷ Students experienced a systemic neglect of their bodily health and safety, resulting from the consistent problem of funding and maintaining the schools. For all the rhetoric put forth by officials about the “progress” obtained through schooling, the teachers in the schools were unqualified and underpaid, resulting in a sub-par education system for students.⁸ Through it all was a sub-culture of physical, sexual, and psychological abuse which left children with traumatic memories of their time in the schools. These factors combined to create emotional and mental suffering of students and resulted in a

⁴ Many survivors report on the pain of separation from their families and culture and the systemic neglect and abuse they faced while attending residential schools. For further information on this, see, Legacy of Hope Foundation, *Where are the Children*, <http://wherearethechildren.ca/en/stories/> and Truth and Reconciliation Commission, *The Survivors Speak*.

⁵ John Milloy, *A National Crime*, p. 35.

⁶ For more information on racism and eugenics see, Erica Dyck, *Facing Eugenics: Reproduction, Sterilization, and the Politics of Choice* (Toronto: Toronto University Press, 2013) and Paula Larsson, “Racial Segregation,” *Eugenics Archives*, accessed August 10, 2015, <http://eugenicsarchive.ca/discover/connections/535fe7db7095aa00000000403>.

⁷ Truth and Reconciliation Commission, *Honouring the Truth, Reconciling for the Future: Summary of the Final Report of the Truth and Reconciliation Commission of Canada* (Ottawa: Library and Archives Canada, 2015), 1.

⁸ LAC, RG 10, Volume 6371, File 764–1, Part 1. *St. Paul’s Indian Residential School Year Book*, 1926, p. 3.

legacy of grief, guilt, shame, and anger among graduates.⁹ These experiences were shared with the students who attended residential school between 1920 and 1950.

5.1 – Isolation:

The Residential School System was a tool of assimilation, designed to “kill the Indian in the child” and replace it with notions of western civilization and culture.¹⁰ This involved the adoption of western lifeways, language, and appearance. As one Albertan principal put it,

Under the service of this educational system the Indian is casting away the things which typify his old barbarous life. He has gone from the moccasin to the shoe, from the blanket to the coat, from feathers to the hat. He has exchanged the bow for the plough, and turned from the buffalo to the white man’s herd and flock.¹¹

The first step in this process was the separation of children from the main influence of that ‘barbarous life’ – their parents. Recruitment was nonetheless a difficult task, as parents were often reluctant to send their child off great distances for schooling. The words of one parent petitioning for a day school in Saskatchewan characterized the concern parents felt over sustained isolation from their children. Joseph S. wrote the Department stating,

We think we are capable of taking care of our children when not at school. The whiteman loves his children and likes to have them round in the evenings and on the days in which school is not open. We also love our children with just as warm an affection as the whiteman and we want to keep them round us.¹²

⁹ Dee Dionne and Gary Nixon, “Moving Beyond Residential School Trauma Abuse: A Phenomenological Hermeneutic Analysis,” *International Journal Mental Health Addiction* 12, no. 3 (2014): pp. 335 – 350, esp. 336.

¹⁰ Truth and Reconciliation Commission, “About the Commission,” accessed June 06, 2015. <http://www.trc.ca/websites/trcinstitution/index.php?p=39>.

¹¹ LAC, RG 10, Volume 6371, File 764–1, Part 1. *St. Paul’s Indian Residential School Year Book*, 1926, p. 5.

¹² John Milloy, *A National Crime*, p. 67.

Yet the School and Department officials worked hard to encourage, persuade, and coerce parents into enrolling their children into the schools. One Agent recorded the finding that principals had begun to “literally buy children into school” by paying parents when students were recruited.¹³ Officials believed that Aboriginal people were under the conception that placing their children in the schools was “doing the Government and Principal a favor,” and parents needed to “be made to realize that no one is in the receipt of a favor except the ... Indians.”¹⁴

Agents took it upon themselves to “bring pressure to bear” on parents who refused to admit their children in schools.¹⁵ In 1914 the Indian Agent on the Blood Reserve sent out a bulletin to all parents on the reserve, stating that “it has been decided that children of school age that are not attending school without a reasonable excuse shall receive no free ration at the ration house. The Government of Canada will feed the children in the school.”¹⁶ Parents were left with the option of sending away their children or risking starvation. This left them little choice and it is not surprising that the Agent reported “no difficulty in getting recruits for the schools” that year.¹⁷ The same Agent went out to solve the “truancy” problem in the schools by sending one parent to jail for ten days after he had “deliberately took his child from school without leave.”¹⁸

The ultimate solution to ensuring parents surrendered guardianship to the schools came in the implementation of mandatory school attendance for children. In 1920 the *Indian Act* was amended to make it compulsory for every Aboriginal child between the ages of seven and fifteen

¹³ LAC, RG 10, Volume 6371, File 764–1, Part 1. W.J. Dilworth to Assistant Deputy and Secretary, August 8/10, 1914.

¹⁴ *Ibid.*, To the Principals of the Dunbow Industrial School, Indian Agent, August 8, 1914.

¹⁵ *Ibid.*

¹⁶ *Ibid.*, To the Blood Indians, W.J. Dilworth, undated.

¹⁷ *Ibid.*, W.J. Dilworth to the Assistant Deputy and Secretary, August 8/10, 1914.

¹⁸ *Ibid.*

to attend school.¹⁹ Once school officials had the weight of the law behind them, recruiting of students was far more effective. Parents no longer had the power to keep their children home, no matter the reason. When a child was kept from school after the holidays, the school authorities could easily contact the police, who would provide all the “assistance in [their] power” to ensure parents released their children back into the custody of the schools.²⁰ The use of force and coercion to ensure that Aboriginal parents obeyed the Department demonstrates the mechanisms of state control in action.²¹

Any attempts made by parents to keep their children were viewed with suspicion and vehemently opposed by school principals. When parents on the Blood Reserve petitioned the Department to keep some of the older boys’ home to help with farming, the principals of the schools expressed the opinion “that this is used by the boys with their fathers to circumvent the holiday rule and get out of school for a time.”²² At the Edmonton School children were often outright denied holidays due to both the expense associated with sending children home and the “risk of not getting them back.”²³ Some children had “not been home for three or four years” after they first arrived at the school.²⁴

Sustained separation from family was nonetheless dependant on the school and the officials in charge. Former student Pauline Dempsey remembers how her “parents visited on Sundays” at the St. Paul’s school on the Blood reserve in the 1930s.²⁵ These visits were always the highlight

¹⁹ John Milloy, *A National Crime*, p. 70.

²⁰ LAC, RG 10, Volume 6371, File 764–1, Part 1. M. Christianson to W.M. Graham, October 28, 1927.

²¹ See, Michel Foucault, *Discipline and Punish: The Birth of the Prison* (New York: Vintage Books, 1979).

²² LAC, RG 10, Volume 6344, File 750–5, Part 5. Pugh, Extract Report on Blood Agency for Month of March 1939.

²³ LAC, RG 10, Volume 6352, File 753–10, Part 1. J. Woodsworth to Secretary, June 14, 1937.

²⁴ *Ibid.*

²⁵ Pauline Dempsey, “My Life in an Indian Residential School,” p. 23

of her week and she recalled how her mom would bring home cooked food for her and her sister to eat as well.²⁶ Parents were able to visit the St. Paul's school because of its close proximity to many homes on the Blood reserve and this raised the question of whether parents who lived nearby could take their children home on weekends. In 1939 a few families petitioned the Department in this regard, requesting "the privilege of having their children now at this school, spend part of the weekends at home."²⁷ As no schooling would be interrupted, this seemed an ideal arrangement to parents. However both the Principal and the Superintendent were of the opinion that such an arrangement "would work to the detriment of the general administration of our residential schools."²⁸ The request was denied on these grounds. In light of such denials, it does not come as much of a surprise that 115 pupils failed to return to the school by the first day of school in the fall term.²⁹ While students trickled in steadily over the next few weeks, many parents at this school kept their children out until the Indian Agent took legal action.³⁰

Yet occasional visits from family members did not eradicate the feelings of isolation and loneliness that many students experienced upon arrival to the school. One news article published in the 1920s tells "The story of the life of an Indian girl, at St. Peter's Indian Boarding School."³¹ This article was meant to promote the great benefits which came to children from the education they received at the school. It outlined how one girl, Annie, had learned to cook, clean, and care for the younger children while at school, effectively assuming the ideal role of a western women. Yet Annie admits that "I did not like my new home at first and often cried to be taken home."³²

²⁶ Ibid.

²⁷ LAC, RG 10, Volume 6374, File 764-10, Part 1. Rev. J.B. Westgate to R.A. Hoey, April 11, 1939.

²⁸ Ibid., R.A. Hoey to Rev. T.B. Westgate, May 11, 1939.

²⁹ Ibid., J.E. Pugh to P. Phelan, September 9, 1939.

³⁰ Ibid., Agent's Report on Blood Agency for Month of October, October 31, 1939.

³¹ Glenbow Archives, *William James Kent Fonds*, St. Peter's Mission Indian Residential School Photograph Album, p. 55.

³² Ibid.

However this changed as she came to accept her role as a homemaker and caretaker within the school. She describes her life in the school as:

Now I am fifteen years old and the oldest pupil in the school, I find myself looking after the little ones, keeping them tidy, and trying to help generally and many of our people, who send their children here, like me to care for them specially. Every other month during school term I am staff girl and work in the kitchen, making bread and doing every kind of housework. In our school work half an hour every morning is devoted to Bible teaching and reading, and also our Catechism.³³

At the end of the article Annie states, “you ask if I am happy. I cannot help being so when trying to remember and carry out the many helpful lessons we receive day by day.”³⁴ This statement was clearly meant to address any criticisms placed on the school about the misery of students.

Separation from the influence of parents was the first step towards indoctrinating children into the dominant culture. Once school authorities had full control over the education and activities of the children, the next step was to instill in them Anglo-Christian values. Males and females were separated, which effectively cut off any interaction between siblings of the opposite sex.³⁵ This further isolated children from their families and social connections. Long hair was cut, heads were sterilized, and children were given standardized uniforms in exchange for the clothes they wore from home.³⁶ One survivor of a school described this process of eradication, stating “We all had the same little bundle of clothing, pinafores, black clothes, socks. You couldn’t tell one kid from the other; they transformed individuals into a group.”³⁷

³³ Ibid.

³⁴ Ibid.

³⁵ James Miller, “Troubled Legacy,” p. 376.

³⁶ The many images from residential schools demonstrate how standard this practice was in schools across the country. See Image 13.

³⁷ Agnes Snow, “Residential school trauma: A dynamic study of issues, their effects, and resolution,” in *Journey towards Wellness: From Trauma and Loss to Cultural Healing and Restoration*, 58–63 (Chilliwack, BC: Native Mental Health Association of Canada, 1999): p. 58.

Children were taught to communicate primarily in English, discarding their Native tongue and adopting the language of the colonial power. This was seen as a vital part of the civilizing program, for “so long as [the child] keeps his Native tongue, so long will he remain a community apart.”³⁸ The admission records of many students illuminate how significant a change this would have been to incoming students. At the Edmonton School only twenty-two of the sixty-seven children admitted to the school between 1935 and 1940 spoke English and of this number, five were listed as knowing only a little.³⁹ Students were even worse off at the Blue Quills School, where not a single one of the fifteen admitted during 1933 and 1934 spoke English.⁴⁰ The emphasis on the essentiality of adopting the English language is derived from the common conflation of language with mental capability during this time period.⁴¹

Many residential school survivors remember being punished for speaking their own language while at school.⁴² Dempsey’s article on her experience at the St. Paul’s school reveals that this was the norm on the Blood reserve. She recalls how speaking the Blackfoot language would earn a “licking” from the matron in charge.⁴³ There were, however, some exceptions to this rule. In contrast to the norm, students at the Lesser Slave Lake school learned in both Cree and English. Although English was still the dominant language, the national anthem was sung in Cree and the school even had a school cheer which was said in both English and Cree.⁴⁴ There is also

³⁸ John Milloy, *A National Crime*, p. 38.

³⁹ LAC, RG 10, Volume 6352, File 753–10, Part 1. Admissions & Discharges, 1935–1940.

⁴⁰ LAC, RG 10, Volume 6347, File 751–10, Part 1. Admissions & Discharges, 1933–1934.

⁴¹ See, John Richardson, *Howard Andrew Knox: Pioneer of Intelligence Testing at Ellis Island* (New York: Columbia University Press, 2011).

⁴² Rhonda Claes, Deborah Clifton, “Needs and Expectations for Redress of Victims of Abuse at Residential Schools,” *Final Report Submitted to the Law Commission of Canada* (October 23, 1998).

⁴³ Pauline Dempsey, *My Life in an Indian Residential School*, p. 24.

⁴⁴ Glenbow Archives, *William James Kent Fonds*, St. Peter's Mission Indian Residential School Photograph Album, p. 9.

evidence that children at the Edmonton Institute had some access to their Native language, as during the inquiry into the death of Joe S. the principal emphasized how he had told the boys not to toboggan down the hill in both English and in Cree.⁴⁵

Nonetheless, Native languages in schools were always regulated to a secondary status as children were taught all school courses in English and provided with English books while at school.⁴⁶ This caused many problems for students who did not know English, as they were effectively silenced until they learned it. Children were unable to express themselves through words, and would have spent months in frustration trying to learn the language, not understanding what was said to them by teachers and staff at the schools. Being punished for speaking their language would have likewise impacted their ability to form bonds with other students until they had learned enough English to talk with their peers.⁴⁷

The negative reinforcement surrounding Native language served as a reminder to children that their traditional culture and lifeways were inferior to western ones. This reinforcement was just one aspect of the systemic indoctrination into western colonial ideals of citizenship and race.⁴⁸ Children in the Alberta schools joined Anglo-Canadian organizations like Girl Guides, Boy Scouts, and Cadets.⁴⁹ Through these activities pupils were shown the importance of nationalism, order, and obedience. When the students at the Morley school organized their own ‘militia’, the

⁴⁵ LAC, RG 10, Volume 6352, File 753–23, Part 1. Memorandum of Inquiry into the Death of Joe S., January 24, 1942.

⁴⁶ LAC, RG 10, Volume 6367, File 762–5, Part 1. Extract From Report of Inspector L.B. Yule, November 26, 1923.

⁴⁷ Rhonda Claes, Deborah Clifton, *Needs and Expectations for Redress of Victims of Abuse at Residential Schools*, p. 24.

⁴⁸ Mary–Ellen Kelm, *Colonizing Bodies*, p. 80.

⁴⁹ The children at the St. Paul’s School were organized into a Cadet corps as early as 1926. LAC, RG 10, Volume 6371, File 764–1, Part 1. Children at Morley joined both Girl Guides and Boy Scouts in 1941. LAC, RG10, Volume 6355, File 757–1, Part. 1. R.A. Hoey to Rev. E.J. Staley, April 7, 1941.

Superintendent of Welfare and Training, R.A. Hoey, was very pleased, stating that these activities were great training exercises in “initiative and general deportment and, what is perhaps still more important, the development early in life of a sense of responsibility.”⁵⁰ The theme of nationalism and the power of the state was similarly promoted to students through the regular singing of the national anthem and the prominent presence of the Ensign flag and the Union Jack within the schools (images 11 and 12).⁵¹ Children were constantly reminded of their place in the Dominion as the “primitive race,” whose only hope of redemption was through faith and education.⁵² These two factors would rise them from the state of savagery, “towards the goal of complete citizenship.”⁵³

The devaluation of Aboriginal culture, practices, and heritage made many to essentially feel ashamed of their ancestry.⁵⁴ Children were taught that they stood at the bottom of the racial hierarchy, under the “superior race” of white Canadians.⁵⁵ Through they were indoctrinated into the norms of the dominant culture, First Nations’ students could never truly achieve an equal place in society because of their Aboriginal heritage. This disconnection from their cultural heritage and devaluation based on race left many students to struggle with their self-identity well after they left school.⁵⁶ More recent survivors of the schools have reported years of self-hate and cycles of

⁵⁰ LAC, RG10, Volume 6355, File 757–1, Part. 1. R.A. Hoey to Rev. E.J. Staley, April 7, 1941.

⁵¹ Glenbow Archives, *William James Kent Fonds*, St. Peter's Mission Indian Residential School Photograph Album, pp.13–14.

⁵² LAC, RG 10, Volume 6371, File 764–1, Part 1. *St. Paul's Indian Residential School Year Book*, 1926, p. 5.

⁵³ LAC, Indian Affairs Annual Reports, 1864 – 1990. *Annual Report Of The Department Of Indian Affairs For The Year Ended 31st December, 1920*.

⁵⁴ Madeleine Dion Stout and Gregory Kipling, *Aboriginal People, Resilience and the Residential School Legacy*, (Ottawa: Aboriginal Healing Foundation, 2003), p. 31

⁵⁵ LAC, Indian Affairs Annual Reports, 1864 – 1990. *Annual Report Of The Department Of Indian Affairs For The Year Ended 31st December, 1920*.

⁵⁶ Madeleine Dion Stout and Gregory Kipling, *Aboriginal People, Resilience and the Residential School Legacy*, p. 52

substance abuse associated with their feelings of inferiority and cultural loss while attending school.⁵⁷

5.2 – Neglect:

Neglect presented itself in many forms within the schools. The neglect of physical health has been the subject of discussion in the last four chapters and will therefore only be summarized here. Students lived much of their lives in unhygienic buildings of poor repair. One inspection of the Sarcee School in 1921 found the building to have dirty floors and windows, with bed sheets that were “stained with blood and puss (sic) marks old and recent.”⁵⁸ Children drank water from unhealthy sources and sewage contamination was noted more than once. St. Bruno’s School was reported to be using water from a nearby lake, which was subject to “pollution and contamination” from seepage of nearby barns, fields, and hay meadows.⁵⁹ The nutritional intake of children was often inadequate, resulting in systemic malnourishment.⁶⁰ This neglect presented itself on the bodies of children through endemic disease and illness, and continued in the form of an inadequate healthcare system which worried more about cost than health.

The concern about expenditure was a major driving factor in the conditions of neglect that characterized the schools. The Department of Indian Affairs simply did not have the money to effectively run and administrate a system of this size.⁶¹ The lack of funds available for repairs and

⁵⁷ Truth and Reconciliation Commission, *The Survivors Speak: A Report of the Truth and Reconciliation Commission of Canada*, pp. 124 – 125.

⁵⁸ Maureen Lux, “Care for the ‘Racially Careless’,” p. 412.

⁵⁹ LAC, RG 10, Volume 6366, File 761–5, Part 3. C.K. LeCapelain, Memorandum to C.M. Walker, January 31, 1939.

⁶⁰ Ian Mosby, “Administering Colonial Science,” p. 161.

⁶¹ John Milloy, *A National Crime*, pp. 269–271.

supplies was constantly used as justification for denying requests made to the Department for school improvements. This translated into a stagnant system which could do little to change the day to day conditions of student life. The physical surroundings were simply left to degrade until the Department or Church authorities found the funds to make improvements.⁶² Until then, it was the children who breathed, slept, ate, played, and survived in schools that promoted infection, disease, and poor hygiene.

The physical neglect of students likewise translated into a neglect for their overall safety. This disregard was especially potent in the area of fire safety in the schools. Fire escapes were installed at many of the schools in the late 1910s.⁶³ As the schools were revitalized in the 1920s, fire escapes were installed at all of the new institutions. However the effectiveness of escapes varied between institutes. Escapes were usually placed down the hallways on the second floors, outside the students dorms. This usually caused problems with accessibility as there were many doors between the students and the escapes. In both schools on the Peigan Reserve it was noted by Commissioner Graham that “all doors leading to the fire escapes open in” (emphasis in original).⁶⁴ At the Edmonton Institute, the doors to the fire escapes were located through the staff rooms, which would have posed a severe problem anytime the staff locked their rooms.⁶⁵ Graham consistently wrote Deputy Superintendent Scott about these issues, suggesting improvements to fire escapes, including double doors – which opened outwards – and escapes within the dormitories so children could have immediate access. Graham emphatically stated that the fire escapes at many institutions inadequate, emphasizing how “the opening inwards of exits to fire escapes is considered bad

⁶² See Chapter 3.

⁶³ RG 10, Volume 6343, file 750–5, part 2. Receipt, December 7, 1917.

⁶⁴ LAC. RG 10, Volume 6364, File 760–2. W. Graham to D.C. Scott, October 03, 1927.

⁶⁵ *Ibid.*, W. Murison to W.M. Graham, Set. 26, 1927.

practice in this western country,” and that placing exits in private rooms risked that “access to them might be rendered extremely difficult by the carelessness, fright or timidity of the occupant.”⁶⁶ Yet the cost of installing new fire escapes at larger institutions was usually enough to delay approval for the construction for a few years, leaving student safety at risk for extended periods of time.

Fire safety was similarly compromised by the staff at the schools, who often neglected to hold fire drills with students. This was noted in both inspector and nursing reports of Alberta schools. The travelling nurse made note of this issue in her 1923 visit to the Blue Quills School.⁶⁷ The absence of fire drills reported to the Department in the early 1920s led them to issue a circular letter which was meant to “impress” upon principals the importance of fire drills and fire safety.⁶⁸ Yet staff and principals of schools still found reasons to neglect the safety of students. At the Morley school it was reported that the principal made a point of keeping the fire doors locked, in order to “safeguard the morals of the children.”⁶⁹ Despite numerous reprimands by the Agent and the Department, the principal insisted that locking the doors was “purely a matter of morals” and said he would only leave them unlocked if an alarm was installed.⁷⁰

5.3 – Abuse:

The presence of abuse within the Indian Residential Schools is a topic which has received significant attention in the public focus in recent years. Since Phil Fontaine – who was the Grand

⁶⁶ Ibid.

⁶⁷ LAC, RG 10, Volume 6340, File 751–13, Part 1. Report of Travelling Nurse, Blue Quills Indian Residential School, February 19–20, 1923.

⁶⁸ LAC, RG 10, Volume 6364, File 760–2. W. Graham to D.C. Scott, Letter November 1, 1927

⁶⁹ James Tandy, “Curriculum at the Morley School,” p. 52.

⁷⁰ Ibid.

Chief of the Assembly of Manitoba Chiefs in 1990 – first came forward publicly with his experiences of physical and sexual abuse in school, abuse has been the focal point of criticism for the Residential School System as a whole.⁷¹ Many former pupils of the schools have come forward with personal stories of abuse suffered at the hands of staff, officials, or other students, while attending the schools.⁷² The Department of Indian Affairs was well aware of many of these abuses as they were occurring, yet consistently ignored the problems and silenced any individuals who objected to the situation.⁷³ In one case of reported abuse from parents at the Blue Quills School, it took the Department over fourteen months to investigate the charges laid against staff.⁷⁴

The extent of abuse present within the schools during the time period covered (1920 to 1950) is a difficult thing to determine from the sources available. These documents were created by a population of officials and staff who were in control of the system who had a vested interest in painting the administration of the schools in the best light possible. Yet there are a few cases in the files where outside officials or observers complained about conditions in the schools and these cases will be discussed here. For the purposes of this study, the term ‘abuse’ refers to the physical, sexual or psychological mistreatment of children, resulting in harm or emotional suffering.⁷⁵ By this definition, children in the schools were subject to forms of physical abuse, sexual abuse, and psychological abuse while they attended the schools.

⁷¹ Wayne K. Spear, “I Had Been Sexually Abused at Residential School,” *The Huffington Post Canada*, November 01, 2012.

⁷² Truth and Reconciliation Commission, *The Survivors Speak: A Report of the Truth and Reconciliation Commission of Canada*, pp. 153 – 164.

⁷³ See, John Milloy, *A National Crime*, pp. 129 – 156.

⁷⁴ LAC, RG 10, Volume 6345, File 751–1, Part 1. J.A. Markle to Secretary, March 25, 1914.

⁷⁵ This definition is in keeping with the definition utilized by other studies of abuse in the residential schools and with the broader legal concept of child abuse as defined by the *Alberta Child, Youth and Family Enhancement Act*. See, Rhonda Claes, Deborah Clifton, *Needs and Expectations for Redress of Victims of Abuse at Residential Schools*, p. 3 and Province of Alberta, “Child, Youth and Family Enhancement Act,” *Revised Statutes of Alberta*, Chapter C–12 (2000). Accessed August 06, 2015. <http://www.qp.alberta.ca/documents/Acts/c12.pdf>.

Dempsey's article about life at the St. Paul's school on the Blood reserve does much to illustrate the frequent nature of abuse at the schools. She remembers how the entire girl's side of the school would be punished whenever one girl misbehaved.⁷⁶ This type of group discipline ensured that misbehaviour carried with it more than just individual punishment – it also brought a sense of guilt and alienation for causing the suffering of peers. When she and two others ran away from the school, as punishment “we were whipped to the point of injury” with a “three-inch slab of tractor belting.”⁷⁷ The punishment was so harsh she remembers how “the matron was sweating from the exertion.”⁷⁸ Yet the punishment received at St. Paul's was still not as bad as those at the Roman Catholic school nearby. According to Dempsey, “they were beaten more, sometimes with whips. They were humiliated in front of other students and called names like savages and dirty Indians. Whenever they did anything wrong, they were told they would go to the everlasting fires of Hell.”⁷⁹

Similar punishments were seen at other schools in the province. One case in particular stands out at the Old Sun's School. In 1919 a new principal was appointed to the school, named – perhaps ironically – P.H. Gentleman. Gentleman had just been removed from his place on the staff at the John Smiths School, at what he considered was the “unjust desire” of the Department, which had deemed his work “unsatisfactory.”⁸⁰ Yet despite the reasons for Gentleman's removal from the John Smiths School, the Anglican Church simply re-appointed him – this time as Principal of the Old Sun's School. Three months later a report was forwarded from the Hobbema agency about Gentleman's previous actions while teaching. After three boys had used the horse and rig to escape

⁷⁶ Pauline Dempsey, *My Life in an Indian Residential School*, 24.

⁷⁷ *Ibid.*

⁷⁸ *Ibid.*

⁷⁹ *Ibid.*, pp. 24–25.

⁸⁰ LAC, RG 10, Volume 6358, File 758–1, Part 1. P.H. Gentleman to Secretary, November 8, 1919.

the school, one of the boys was “most brutally and unmercifully beaten with a horse quirt until his back was bleeding and bruised.”⁸¹ This boy, George, also typed up his own letter to send to Graham about the incident. He wrote,

He whipp me and hit my head all over, also my hand is awful sore. I was starting to go back to School. I did not mean to do it. I was sorry afterward. You can see all the mark on my back. The blood just running where he hit me with the whip.⁸²

In a statement taken by the constable who heard George’s complaints about the incident it was also revealed that he had first been “shackled” to the bed and had had his hands tied before the beating took place.⁸³ The next morning he received “another whipping.”⁸⁴

After the report came out, Graham wrote Scott stating that it appeared that the Department had “made a serious mistake in having anything to do with this man Gentleman” and that in his opinion, Gentleman “should be relieved of his duties at once.” Scott, however, handed the matter off to the church authorities, who justified Gentleman’s actions by saying that in the case of corporal punishment, “permitted or not, it is applied, more or less, in every boarding school in the country” and that “the circumstances reported in connection with this case would seem to indicate that reasonable corporal punishment was fully deserved.”⁸⁵ In his own defence, Gentleman wrote that “the whip and shackle was the same as Mr. Giggle had left at the school and was I am told, often using, for far less serious offences than this.”⁸⁶ Such comments indicate that corporal punishment was a widespread feature of residential school experience.

⁸¹ Ibid., T. Graham to W.M. Graham, December 1919.

⁸² Ibid., George B. to W.M. Graham, undated.

⁸³ Ibid., Statement taken by Const. Wright, November 27, 1919.

⁸⁴ Ibid.

⁸⁵ Ibid., Canon Gould to D.C. Scott

⁸⁶ Ibid., P.H. Gentleman to Canon Gould, January 12, 1920.

The chaining of students did indeed seem to be a common occurrence around this time. In 1921 the Department responded to a report from the nurse who visited the Crowfoot school in November. After paying a sudden visit to the school based on reports of “trouble there,” the Indian Agent found that “three boys were chained to the benches in the dining room.”⁸⁷ Complaints had also been made to the Agent that one girl had been “severely marked from the result of a thrashing.”⁸⁸ Despite finding marks on the girl, the nurse had failed to report her condition to the Agent when she last visited. However, she did later submit a report to the Department stating she felt “it is decidedly wrong to chain Indian boys and girls to benches as they are doing there” and promising to check up on the school to ensure the practice was discontinued.⁸⁹

Yet the problems of abuse did not disappear from the schools as time progressed. One girl at the Morley School – named May – reported an incident to her parents in 1945, where a teacher of the school, Mr. Leppard, “hit her, bruised her, [she] says he hit her over the face, knocked her down and she fell down the steps and bruised her hip.”⁹⁰ Apparently the abuse was brought on by Mr. Leppard’s conviction that May had taken his lost pocket knife. Yet May did not report the incident to the matron at the school, or to her parents, for over a year. When asked why she had waited for so long, May said, “I was afraid Mr. Leppard might hit me again if I reported it.”⁹¹ Leppard completely denied the incident when he was questioned about it, stating,

I have no recollection of having done what she claims to have suffered at my hands. I believe the story to be just another lie coming from the same pack of liars, who, for reasons best known to themselves, have sought to embarrass and discredit all the work of the school during the past year or two.⁹²

⁸⁷ LAC, RG 10, Volume 6348, File 752–1, Part 1.

⁸⁸ *Ibid.*

⁸⁹ *Ibid.*, Nurse Ramage’s Report for November, December 3, 1921.

⁹⁰ LAC, RG 10, Volume 6355, File 757–1, Part 2. Statement from Tom S., September 26, 1945.

⁹¹ *Ibid.*

⁹² *Ibid.*, C.E. Leppard to Mr. Iredale, October 16, 1945.

Leppard's account of the incident was believed over May's and the matter was dropped by the Department.

Unfortunately this allowed for further abuses to occur at the school. In January of 1947, a young girl named Rosa braved the frigid weather to escape the Morley school and find her way home. She was brought back in by her father, as keeping her at home was against the law. He did however question the principal – Rev. Inglis – about the incident, asking if he knew why Rosa had felt the need to run away in the first place. He told Inglis that Rosa said she “had been whipped by the matron on several occasions six times a week” and had even “been whipped twice by Mr. Inglis.”⁹³ After signing the necessary paperwork and asking her father to leave, the principal called all of the girls at the school into his office, presumably to make a public display of Rosa's punishment for having run away. Rosa's reaction was predictably fearful and she “grabbed her father by the arm as she did not want to go to the office.”⁹⁴ The principal did not appreciate any disagreement to his rule and when Rosa's father objected to her coming chastisement, Inglis forcibly ejected both Rosa and her father “through the front door of the building.”⁹⁵

The Department looked into the many complaints they received against the principal and matron at Morley and came out with a list of regulations for punishing the students, which they sent out to the United Church for reference in such cases. The regulations stated that “corporal punishment will be used only where all other methods of disciplining a pupil have failed,” and that strapping would be “administered only on the hands with a proper school strap (regulation 15” rubber).”⁹⁶ In addition the Department said a “maximum number of strokes on each hand is [in]

⁹³ Ibid., Re. Complaint of Moses W., January 22, 1947.

⁹⁴ Ibid.

⁹⁵ Ibid.

⁹⁶ Ibid., B. Neary to Dr. Dorey, February 6, 1947.

no instance to exceed four in number” and should be administered in the presence of the principal to ensure that no abuses were taking place.⁹⁷

Far more difficult to determine from the historical record was the extent to which sexual abuse was a problem in the Alberta schools. No reports were found regarding incidents of sexual abuse from staff at the schools during the period studied, unlike in other provinces.⁹⁸ Dempsey’s discussion of the St. Paul’s school likewise notes an absence of such abuse among the girls at the school. She does however recall that the younger boys had to sleep in the girl’s dorm to keep them “away from the senior boys” at night.⁹⁹ This indicates that student victimization was present, and clearly recognized by the staff, if such measures were taken to prevent abuse.

Although student experiences within the schools before 1950 are difficult to access, the many reports from pupils who attended these schools in the 1960s and 1970s highlight a legacy of sexual and psychological abuse. Survivors who attended the Blue Quills School have told stories of humiliation and sexual abuse at the hands of staff in this school, sometimes of children as young as five years old.¹⁰⁰ Survivor stories recall the pain and humiliation associated with bed-wetting after being sexually assaulted by staff.¹⁰¹ Children who wet their bed were lined up in the morning and “made to be laughed at” by the other students.¹⁰² Other survivors tell of teachers offering money to buy candy to those children they abused.¹⁰³ These experiences reveal how easy it was to take advantage of the vulnerability inherent in a controlled student population. The systemic

⁹⁷ Ibid.

⁹⁸ See, John Milloy, *A National Crime*, pp.129 – 156.

⁹⁹ Pauline Dempsey, *My Life in an Indian Residential School*, p. 25.

¹⁰⁰ Truth and Reconciliation Commission, *The Survivors Speak*, pp. 59 – 60.

¹⁰¹ Ibid. p. 59.

¹⁰² Ibid., p. 60.

¹⁰³ Ibid.

neglect of the system created many chances for potential abusers to exploit their positions of power over First Nations children.

One significant indicator of abuse was the so-called “runaway student.” Students fled the schools when punishment became too much for them to bear, often braving cold winter conditions with little to no outdoor clothing for protection. As the words of one local Agent exemplify, “there is certainly something wrong as children are running away most of the time.”¹⁰⁴ The frequency of breakouts therefore speaks volumes about the feelings of students at each school. When students ran away from the schools they expressed their unhappiness through each step they took away from the institute that had confined them.

The rates of escape varied between schools. The two schools on the Blood reserve both saw higher rates of truancy and breakouts. This is probably partially due to the closeness of the schools to the reserves, but the consistent incidence of runaways points to abuse as a contributing factor in student flight. During the late 1920s the Roman Catholic school noted as having a particular problem with “desertion.”¹⁰⁵ The inspector noted how some of the boys at the school seemed to be continually getting away.”¹⁰⁶ Although these pupils were usually promptly returned by either their parents or the police, they nonetheless escaped again “the same evening.”¹⁰⁷ The students would usually escape in groups of three or four, indicating that the escapes were planned by the students before they were carried out. Yet the inspector at the school never thought to question the students about the reasons behind their breakouts. Instead he blamed it on the

¹⁰⁴ John Milloy, *A National Crime*, p. 142.

¹⁰⁵ LAC, RG 10, Volume 6371, File 764-1, Part 1. M. Christianson to W.M. Graham, October 28, 1927.

¹⁰⁶ Ibid.

¹⁰⁷ Ibid.

inattention of the staff in charge, who he said “is lazy and would rather read a book than be around where the boys are playing.”¹⁰⁸

The St. Paul’s school experienced its worst bouts of runaways in the late 1930s. In one report from an Indian Agent, he described the consistent escapes as an “epidemic of truancy.”¹⁰⁹ In one month during 1938 six boys repeatedly ran away from the St. Paul’s school. When they were brought back they escaped again the next night, much to the frustration of the school authorities and Indian Agent. The very next month eight girls ran away from the school. It was reported that they “were all found about three hours after leaving, and though very cold were not in anyway suffering from their escape.”¹¹⁰ Whatever problem had caused the truancy persisted and after the summer holidays fifteen pupils did not return and had to be tracked down by the police and the Agent before they were brought back in.¹¹¹ The problem only persisted and by the next year a shocking one hundred and fifteen pupils remained truant from the school after the holidays.¹¹²

In contrast to the Blood schools, the Edmonton School only experienced a few instances of student runaways between 1920 and 1950. This seems to point to less of a reliance on corporal punishment at this school, in comparison with the other schools in the province. When faced with one particularly rebellious girl, the principal seemed unsure with how to handle her behaviour, as he did not want to “raise unlooked for criticism” through the “severe corporal punishment” of a young woman.¹¹³ Additionally, the only case found of a student running away from the institute

¹⁰⁸ Ibid.

¹⁰⁹ LAC, RG 10, Volume 6374, File 764–10, Part 1. J.E. Pugh, Report for Month of January, January 31, 1938.

¹¹⁰ Ibid., J.E. Pugh, Report for Month of February, February 28, 1938.

¹¹¹ Ibid., J.E. Pugh, Report for Month of August, 1938.

¹¹² Ibid. Telegram, J.E. Pugh to Secretary, September 7, 1939.

¹¹³ LAC, RG 10, Volume 6352, File 753–10, Part 1. J. Woodsworth to Secretary, April 5, 1938.

was that of a teenage boy who had left the school in order to return to his elderly father.¹¹⁴ His father was noted to have been recently incapacitated “due to a severe hernia” and needed assistance in tending to the house and land.¹¹⁵

Aside from running away, students could express how they felt about their situation in other ways. Acting out and misbehaviour were common outlets for students and enabled them to enact some agency over their situation. Acting out could even provide a more permanent escape from the schools if it resulted in a students’ expulsion. Misbehaviour could manifest in both a direct retaliation against staff, and the incitement of others to act up or run away. In 1933 one boy – Joe G. – was expelled from the Blue Quills School for planning a joint escape with three other students.¹¹⁶ Joe was described on his discharge form as “leader of the runaways” and the Principal declared that his actions were the reasons behind the group escape from the school.¹¹⁷ On other girl who was part of the group achieved expulsion as well, being similarly noted as a “bad girl” on her discharge form.¹¹⁸

At St. Paul’s School, the absence of the Principal was used as an opportunity by some of the older boys to act violently toward the matron in charge. The staff had to call the Indian Agent to the school to retake control. When the Agent arrived, he found that one boy of about fifteen “had struck Miss Neville, the boys’ matron, in the face” at the encouragement of another.¹¹⁹ After checking out the situation at the school, the Inspector advised the Department that “Miss McGarry, the matron, is certainly capable, but where there are a lot of big boys, from 16 to 18 years of age,

¹¹⁴ Ibid., A.D. Moore to Secretary, March 25, 1936.

¹¹⁵ Ibid.

¹¹⁶ Ibid., Rev. J. Angin to J.D. Sutherland, December 27, 1933.

¹¹⁷ Ibid.

¹¹⁸ LAC, RG 10, Volume 6347, File 751–10, Part 1. Rev. J. Angin to J.D. Sutherland, December 11, 1933.

¹¹⁹ LAC, RG 10, Volume 6371, File 764–1, Part 1. M. Christianson to W.M. Graham, October 28, 1927.

it takes a man to supervise them properly.”¹²⁰ The perceived need for greater strength and discipline when dealing with the First Nations children highlights how the schools fostered a cycle of violence. A similar situation occurred at the Red Deer School in 1902. The students rebelled against the staff at the school one day by seizing knives and threatening the teachers. A telegram was sent to the Department stating that staff “badly fear hourly” the actions of the students.¹²¹

Violence against staff was only the first step in rebellious behaviour for students. Some students sought a more permanent solution by attempting to burn down the schools themselves. In 1929 three young boys at the Blue Quills Institute set a fire under the stairway of the boys’ dormitory.¹²² Their original plan to set the flame in the basement of the school, was foiled by staff members who noticed their “peculiar behaviour” in the afternoon and locked the basement door. The flame was therefore promptly extinguished by the sisters in charge and the attempt failed. When the question arose of what to do about the incident, the principal requested that the boys be transferred to another school in order to provide them with “another sphere of influence.”¹²³ However Assistant Deputy and Secretary of the Department, J.D. McLean, was of the opinion that such action was not necessary for boys “of these tender years” and that the request to transfer them indicated that “the school principal is not a very strong disciplinarian.”¹²⁴ It was decided that the boys would remain at the school, provided that the school management ensured they were “properly looked after.”¹²⁵

¹²⁰ Ibid.

¹²¹ John Milloy, *A National Crime*, p. 134.

¹²² LAC, RG 10, Volume 6345, File 751–1, Part 1. W.M. Graham to Secretary, September 27, 1929.

¹²³ Ibid., W.M. Graham to Secretary, October 19, 1920.

¹²⁴ Ibid., J.D. McLean to W.M. Graham, October 14, 1929.

¹²⁵ Ibid., J.D. McLean to W.M. Graham, October 24, 1929.

The Blue Quills case was not the first time students in Alberta attempted arson at a Residential school. Another case occurred much earlier at the St. Paul's Mission school in 1904.¹²⁶ In this case, three girls deliberately set fire to the girl's dorm, in retaliation to "certain changes" in discipline which had been introduced to the school, which were meant to "place the general tone of the school on a sounder footing."¹²⁷ If a "sounder footing" had been the intention, the result was a well-planned arson attempt which almost resulted in the complete destruction of the school. The harsh disciplining of students was therefore closely tied to the increased delinquency of pupils within the Residential Schools.

When students rebelled, it served as a means to control the situations they found themselves in. Sometimes it was used as a means to achieve a permanent escape from the schools. One case in particular stands out as an example. Emily L. of the Edmonton school was expelled in 1938 for her delinquent behaviour. Emily was seventeen years of age when she was discharged and would have graduated "honorably" from the institute within the year if not for her misbehaviour.¹²⁸ Before 1938, she had been a normal student, and acted in compliance with the school rules and the modes of acceptable behaviour. Yet something caused her to lose patience with the system that year and, upon her return from holidays, she began to give "indications of insubordination."¹²⁹ As the year went on Emily continued to act out, and her "number of violations of discipline" increased, even resulting in "violence" during her "outbreaks."¹³⁰ The principal was quite indignant at her behaviour, writing the Department about how she had not only defied the staff, but "even the

¹²⁶ LAC, RG 10, Volume 6371, File 764-1, Part 1. Report on Attempted Burning of Girls' Home, December 8, 1904.

¹²⁷ Ibid.

¹²⁸ LAC, RG 10, Volume 6352, File 753-10, Part 1. J. Woodsworth to Secretary, April 5, 1938.

¹²⁹ Ibid.

¹³⁰ Ibid.

matron and myself.”¹³¹ According to the principal, Emily next began to incite rebellious behaviour in the other pupils and “seriously threatened the whole discipline of the school.”¹³² At last he decided to expel Emily from school and she was sent home. Once she was expelled, Emily admitted that “she had been working to this end” and had used misbehaviour as a means of escape from the institute.¹³³

The actions of students enrolled in the schools provide insight into their perception of their treatment while attending the institutes. Students experienced harsh discipline at the hands of staff, while others were subject to the abuse of other students. Former students often remark on the culture of fear these experiences produced.¹³⁴ Many children took action against their circumstances in the only ways they could – by running away or by fighting back. The former usually provided only temporary escape from the reality of the schools, while the latter worked to create a cycle of violence which translated into long term mental and emotional suffering for pupils.¹³⁵

Conclusion:

¹³¹ Ibid.

¹³² Ibid.

¹³³ Ibid.

¹³⁴ Truth and Reconciliation Commission, *The Survivors Speak*, pp. 109 – 115.

¹³⁵ For more information on the long-term impacts of Residential Schools on mental health, see Raymond Corrado and Irwin Cohen, *Mental Health Profiles for a Sample of British Columbia's Aboriginal Survivors of the Canadian Residential School System* (Ottawa: Aboriginal Healing Foundation, 2003); Rhonda Claes and Deborah Clifton, *Needs and Expectations for Redress of Victims of Abuse at Residential Schools: Final Report Submitted to the Law Commission of Canada* (October 23, 1998); Dawn Smith, Colleen Varcoe, and Nancy Edwards, “Turning Around the Intergenerational Impact of Residential Schools on Aboriginal People: Implications for Health Policy and Practice,” *Canadian Journal of Nursing Research* 31, no. 4 (2005): 38 – 60; and Madeleine Dion Stout and Gregory Kipling, *Aboriginal People, Resilience and the Residential School Legacy*, (Ottawa: Aboriginal Healing Foundation, 2003).

The physical, mental, emotional, and spiritual suffering of First Nations' while in residential school is the basis for many forms of trauma today. Medical practitioners, psychologists, anthropologists, sociologists, historians, and others have defined the legacy of the schools through the lens of intergenerational trauma, race-based trauma, and historical trauma.¹³⁶ The separation of children from their families created a deep wound in the family structures of First Nations communities. Children experienced fear and insecurity while parents were denied their right to make decisions about the health and happiness of their children. The negligence and mistreatment suffered in the schools have been implicated in the creation of a lasting cycle of abuse and neglect that still persist in Aboriginal communities today.¹³⁷

While mental health is a difficult thing to analyse through the preserved documents of the residential schools, certain factors enable some conclusions to be drawn. The school survivors point to certain factors in their residential school experience which caused them to suffer feelings of grief, shame, guilt, and anger. While the memories of earlier pupils went largely unpreserved, there is ample evidence of a continuity in the oppressive factors which traumatized later students. Separation from family, language and culture was a feature of School life since the inception of the system. This isolation would have created a sense of loneliness in students and caused many to feel ashamed of their identity and cultural heritage. Neglect was built into the Residential Schools at a systemic level, perpetuated by chronic underfunding and lax regulation on the part of the Department of Indian Affairs. This neglect presented itself on the bodies of students, who suffered a variety of endemic diseases and who lived in environments of insanitation and poor hygiene. Lastly, incidents of physical, sexual, and psychological abuse kept children under the

¹³⁶ Elizabeth Fast and Delphine Collin-Vezina, "Historical Trauma, Race-based Trauma and Resilience of Indigenous Peoples: A Literature Review," *First Peoples Child and Family Review* 5, no. 1 (2010): pp. 126 - 136, esp. 126.

¹³⁷ *Ibid.*, 129.

constant mental and emotional strain of fear and anger. The result was an environment where students felt that they had to run away or act out to exert some control over their situation. The result was a reinforcing system of abuse and a long term legacy of mental trauma.

Discussion:

Confidently it may be said that the Indian has justified the trust that the early missionaries placed in him, his mentality and temperament and constitution fitted him for progress, and he has valiantly borne the ordeal of contact with our boasted civilization.¹

- Annual Report of the Department Of Indian Affairs, 1920.

In 1930, Canon S.H. Middleton stepped up to the podium of the Paget Hall in Calgary, Alberta. His audience was the assembled Women's Auxiliary board members of the Anglican Church, who had gathered together at the hall for a general meeting. In his speech, Middleton outlined the history of Aboriginal and non-Aboriginal relations in the province, which had led to the reduction of the Aboriginal population and their fall to the "lowest level" of development.² Yet his message was a hopeful one. It described how the church "pioneered the movement to help the Indians" in their transition from a "purely Indian" life to the one brought by "the white man."³ Because of this, Middleton declared himself to be in the "age of progress" for the Aboriginal population.⁴ Progress would be realized by the mission to bring "education and cultural advantages" to the Indians, who were "quick to recognize" that these advances were for their own good.⁵

¹ LAC, Indian Affairs Annual Reports, 1864 – 1990. *Annual Report Of The Department Of Indian Affairs For The Year Ended 31st December, 1920.*

² LAC, RG 10, Volume 6371, File 764-1, Part 1. "Indians of Blood Reserve Benefit by Civilization: Cannon Middleton Claims They are the Finest in the Dominion; Eagerly Seek Education," September 16, 1930.

³ Ibid.

⁴ Ibid.

⁵ Ibid.

Middleton's progressivist attitude characterizes the standard western conceptualization of the Indian Residential School System between 1920 and 1950.⁶ The schools were the means to "solve the Indian problem" of a "half clothed, half starved, half sick" population that was "growing up ignorant."⁷ Officials feared that, without schooling, Aboriginal children would "all their lives be dead weight on the government."⁸ The only means of saving these people was a policy of progress, which included education, healthcare, and an adoption of the values of "the superior race."⁹

Yet the implementation of 'progress' within residential schools was a self-defeating process. Each time the Department of Indian Affairs attempted to bring about lasting change in student health, they were thwarted by their own inadequate system. Lax regulations and chronic underfunding prevented the Department from maintaining the early strides it made in improving sanitation and nutrition within the schools in the 1920s. These issues were compounded by the occurrence of the Great Depression and the Second World War, which further restricted Departmental funding.

Financial concerns were not the only reason behind the failures of healthcare within the residential school system. Contributing to the reality of poor health was the decided reluctance on the part of both the Department of Indian Affairs and the school officials to take responsibility for the health of students. The responsibility for the poor health of the children was consistently placed either on the students themselves or at the feet of their parents. In the Annual Report of 1914 one

⁶ One official wrote in 1909 "if we are to keep the race alive it must be through the schools." LAC, RG 10, Volume 6032, File 150-40A, Part 1. W.E.S. James to F. Oliver, February 22, 1909.

⁷ Ibid.

⁸ Ibid.

⁹ LAC, Indian Affairs Annual Reports, 1864 – 1990. *Annual Report Of The Department Of Indian Affairs For The Year Ended 31st December, 1920.*

official reported that the “heavy mortality among infants and young children due to bronchial and intestinal troubles,” was the fault of Aboriginal eating habits which included the “sole use as a food diet, of beef and bannock” – not the impoverished, tuberculosis-ridden conditions on the reserve.¹⁰ The report went on to state that illness would persist “until these Indians realize that domesticated beef is not so healthy for them as the buffalo meat was in the old days, and change their diet to one mixed with vegetables.”¹¹ The report said nothing however about the similar situation seen in the residential schools, despite the almost non-existent access to meat in the children’s diet.¹²

The perception that Aboriginal people were to blame for their own nutritional deficiencies did not disappear as time went on. In the 1940s the Department of Indian Affairs was still laying the responsibility for nutritional problems of Aboriginal children on the diet they received while at home. While the nutritional deficiencies of students in the schools were brought to light by nutritionists who went in to study the state of nutrition among pupils of the schools, the Department launched a campaign “to improve the food habits of the Indians by health education, stressing the use of dairy products, gardening, and the proper cooking of vegetables.”¹³ The nutritional investigations in the schools however, resulted in the use of the malnourished students for nutritional experiments and the denial of any other forms of healthcare while the experiments were on-going.¹⁴

¹⁰ LAC, Indian Affairs Annual Reports, 1864 – 1990. *Annual Report of the Department of Indian Affairs for the Year Ended March 31, 1914*, p. 27

¹¹ *Ibid.*

¹² Pauline Dempsey, “My Life in an Indian Residential School,” p. 22

¹³ *Ibid.*, Canada Department Of Mines And Resources Report Of Indian Affairs Branch For The Fiscal Year Ended March 31, 1943, p. 148.

¹⁴ Ian Mosby, “Administering Colonial Science,” pp. 161.

When discussing the incidence of poor hygiene among children on reserves, in its annual report in 1926, the Department claimed that it was making “every effort” to “instil in the minds of the children at least a rudimentary knowledge of hygiene” through the residential schools.¹⁵ When a child succumbed to an illness and died within the school, official reports always highlighted how parental contact had led to the contraction of an illness. This effectively absolved both parties from the moral and legal responsibilities of student death and allowed the Department to continue ignoring the poor sanitation and hygiene which defined student existence within the schools.

The healthcare system itself faced similar issues. Despite rhetoric outlining the many levels of healthcare provided to the students, the regulation of student health was disrupted at many points along the way. Measures implemented to protect the students – enrollment limits, physician examinations before entrance to the schools, the provision of medical supplies to matrons – consistently fell short of their intended aims. The nature of the funding for the schools encouraged principals to admit children above and beyond their funding cap, resulting in overcrowding and a further strain on the resources of the schools. New diseases were easily introduced to the confined population of students, as incoming students usually resided in the schools long before they were first examined by a doctor and visible signs of illness were neglected when they were examined.

Even when small items for improving the overall health of students were suggested to the Department, there was a sustained scepticism about the need for intervention. When the Edmonton Institute attempted to expand its agricultural production to supplement its meagre income, the Department pointedly halted these plans, stating that, “schools are not meant to be money-making institutions.”¹⁶ A similar conservatism led the Department to deny purchasing toothbrushes for the

¹⁵ LAC, Indian Affairs Annual Reports, 1864 – 1990. Annual Report of the Department of Indian Affairs for the Year Ended March 31, 1926, p. 8.

¹⁶ LAC. RG 10, Volume 6364, File 760–2, Part 1. W.M. Graham to J.D. McLean, November 15, 1929.

same school in 1930.¹⁷ These examples, plus the many others throughout this study, show that cost was always placed first and foremost in the consideration of the health of students.

The potent neglect of physical health was coupled with the separation of Aboriginal students from their traditional languages, beliefs and cultures. The spiritual significance of subsistence, purification, and traditional medicine were lost to the students while in the schools. The legacy of First Nations spirituality was disconnected from students, as they were taught to accept the inferiority of Aboriginal culture and actively discouraged to engaged in traditional ceremonies and spiritual practice. This opposition could even bleed out into life outside of the schools. Such was the case in 1942 when John House – the principal of the Anglican school on the Blackfoot Reserve – actively participated in a campaign to depose two Blackfoot chiefs, largely due to their support for the traditional dance ceremonies.¹⁸ One former pupil on the Peigan reserve even recalls being warned not to attend the Sun Dance one summer by their principal, who threatened to strap any student who did when they returned the next fall.¹⁹ This type of violent coercion would have been particularly traumatizing to students, who had to make a conscious choice between their physical safety or their emotional and spiritual wellness.

Mental health was intimately affected by the experience of emotional and psychological trauma within the schools. The loss of culture and emotional turmoil caused by neglect and abuse would have adversely affected the mental wellness of residential school children. The actions they took to regain control over their lives speaks to their psychological distress. Some students responded to the conditions of the schools by running away. Sometimes this occurred during the school year and in these instances students usually acted together, undertaking a collective protest

¹⁷ LAC. RG 10, Volume 6364, File 760–2. J.D. McLean to J. Woodsworth, September 4, 1929.

¹⁸ Truth and Reconciliation Commission, *Honouring the Truth, Reconciling for the Future*, 7.

¹⁹ Truth and Reconciliation Commission, *The Survivors Speak*, p. 56.

of their treatment in the schools. By breaking out of the schools, students demonstrated that they would rather brave the winter conditions and the long journey home than stay another day within the institution that confined them. Other students used the advantage of their summer holidays to delay their return to the schools, sometimes in shocking numbers.²⁰

A number of children responded to the culture of fear and violence within the schools by retaliating in kind. Many survivors recall a time when they fought back against an abusive teacher or student.²¹ In the historical record of Albertan schools, there were a number of incidents of violent or delinquent behaviour by students in the schools. More than once pupils hatched a plan to burn down the institutions where they resided.²² Such acts of rebellion were part of a cycle of violence perpetuated by the atmosphere of isolation, neglect, and abuse within Indian Residential Schools. This cycle of violence has been tied to issues of substance abuse, domestic violence, and increased suicide rates among survivors and their descendants.²³

The repercussions of the Indian Residential School System are still felt today. School survivors have gathered at national, provincial, civil, and local reconciliation events across the country during the last six years. These events were part of a national journey of understanding and healing led by the Truth and Reconciliation Commission of Canada. The Commission just finished its final year and has recently published a report on its findings. First and foremost, the schools are labelled as a system of “cultural genocide” which sought the systematic destruction of the Aboriginal cultural structures, political institutions, and religious practices.²⁴ In the 1920

²⁰ For instance when one hundred and fifteen students were truant from the St. Paul’s school in 1938. See page 224.

²¹ See, Truth and Reconciliation Commission, *The Survivors Speak*.

²² See pages 226 – 227.

²³ James Miller, “Troubled Legacy,” p. 376;

²⁴ Truth and Reconciliation Commission, *Honouring the Truth, Reconciling for the Future*, p. 1.

words of Deputy Minister of Indian Affairs, Duncan Campbell Scott, “our object is to continue until there is not a single Indian in Canada that has not been absorbed into the body politic.”

For the Aboriginal people who were the subjects of this assimilative policy, the residential schools have left them with a historic trauma which is slowly being overcome through the rebirth of Aboriginal traditions and the public awareness of the legacy of suffering many individuals are still dealing with today. However, the words of former Grand Chief of the Assembly of Manitoba Chiefs, Phil Fontaine, demonstrate that in addition to a legacy of trauma, there is also a legacy of resilience. In the early 1990s Fontaine said,

Some people say that residential school was the best thing they could have had because it taught them to work, it taught them discipline, and it helped them establish friendships. For those people, I think residential school represented an important part of their lives and one shouldn't take that away from them. They deserve to remember residential school for the good things that it may have brought to their lives. But for the many other that remember residential schools for the hell-holes they were, they should be given an opportunity to re-examine those negative experiences so they can put them to rest. When you put something to rest, it doesn't mean you forget about it. You remember it in different ways, in ways that that give you strength.²⁵

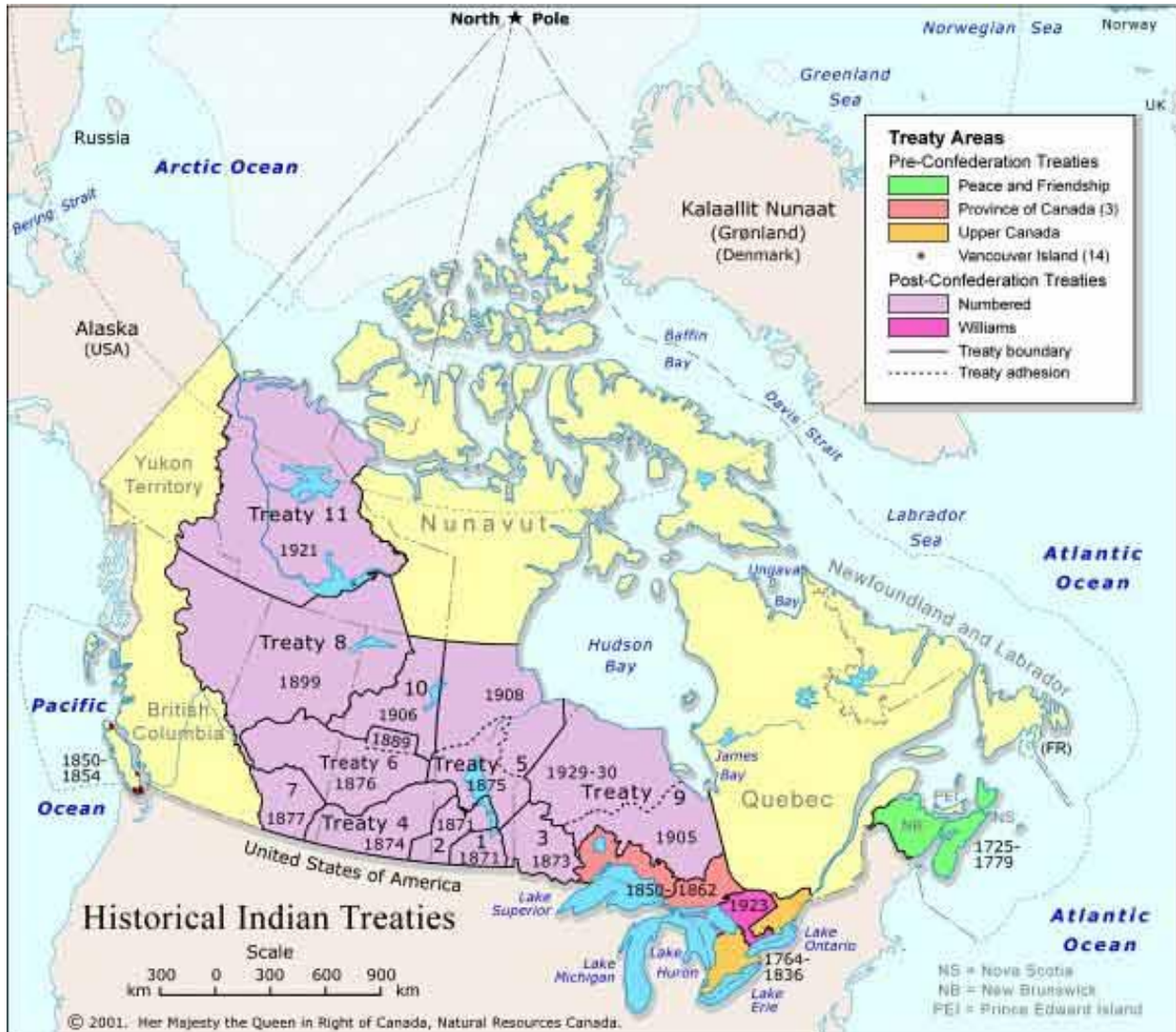
This strength was seen among the many survivors and witnesses who told their stories at the Truth and Reconciliation meetings.

This study has sought to illuminate the experience of residential school for the many children who resided in them across Alberta between 1920 and 1950. It has focussed on the manifestation of health in students to better understand how the system affected the mental, physical, emotional, and spiritual wellness of students. It is hoped that this culturally relative approach to the study of a system which did its best to eliminate the culture of students will work towards the greater project of reconciliation.

²⁵ Phil Fontaine, quoted in Linda Jaine, *Residential Schools: The Stolen Years* (Saskatoon: Extension Division Press, University of Saskatchewan, 2003), pp. 62– 63.

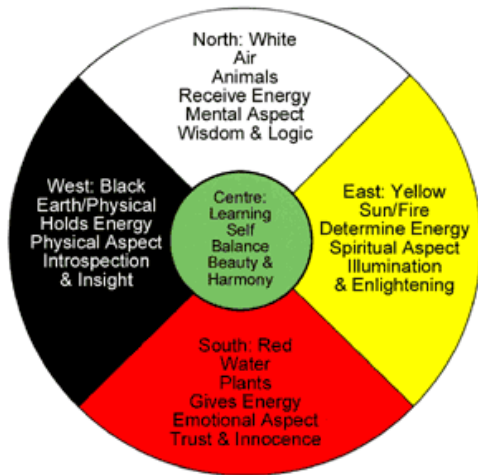
Images

Image 1: The Numbered Treaties



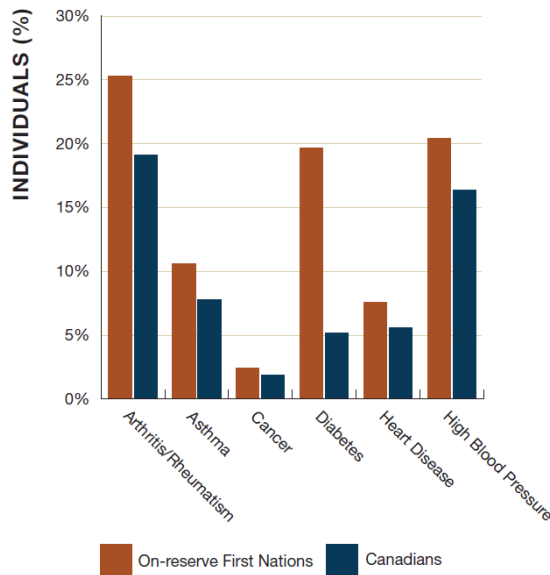
Source: Canada's First Peoples, "Confederation and Treaty-Making in the West," *Treaties & Change* (2007) Accessed September 05, 2015, http://firstpeoplesofcanada.com/fp_treaties/fp_treaties_confedandtreatieswest.html.

Image 2: The Medicine Wheel



Source: University of Ottawa, “Aboriginal Medicine and Healing Practices,” *Society, the Individual, and Medicine*, (July 2009) Accessed November 06, 2014, http://www.med.uottawa.ca/sim/data/Aboriginal_Medicine_e.htm.

Image 3: Rates of Chronic Disease in On-Reserve First Nations Communities



Source: *The First Nations Regional Longitudinal Health Survey (RHS)*, presentation Assembly of First Nations, 2006

Source: Lachance, N; Hossack, N; Wijayasinghe, C; Yacoub, W; Toope, T. *Health Determinants for First Nations in Alberta*, (Health Canada, 2009), p. 24.

Image 4: Student Ploughing Field, Edmonton Institute, 1930.



Source: UCCA, 93.049P/868N, <http://thechildrenremembered.ca/school-locations/edmonton/>.

Image 5: Boy with Horses, Edmonton Institute, 1930



Source: UCCA, 93.049P/869N,
[http://thechildrenremembered.ca/photos/?id=1109&school=edmonton.](http://thechildrenremembered.ca/photos/?id=1109&school=edmonton)

Image 6: Students Planting Seeds for Gardening Class, 1910



Source: UCCA, 93.049P/851N,
<http://thechildrenremembered.ca/photos/?id=1089&school=Red%20Deer>.

Image 7: “A Good Harvest”, St. Peter’s Mission School, 1926



Source: Glenbow Archives, *William James Kent Fonds*, St. Peter's Mission Indian Residential School Photograph Album, p. 71.

Image 8: Cooking Class, Edmonton Indian Residential School, 1930



Source: UCCA, 93.049P/885N,
<http://thechildrenremembered.ca/photos/?id=1126&school=edmonton>.

Image 9: Boys Trapping Hares, St. Peter's Mission School, 1924.



Source: Glenbow Archives, *William James Kent Fonds*, St. Peter's Mission Indian Residential School Photograph Album, p. 29.

Image 10: Confirmation Photograph with Boy in Cast, St. Peter's Mission School, 1924

The boy on the far right in this photograph is leaning on a crutch, with a cast on his left leg.



Source: Glenbow Archives, *William James Kent Fonds*, St. Peter's Mission Indian Residential School Photograph Album, p. 15.

Image 11: Ensign Flag in Interior of Church, St. Peter's Mission School, 1924

The superior placement of the Ensign flags gives them a presence of importance in the interior of the church.



Source: Glenbow Archives, *William James Kent Fonds*, St. Peter's Mission Indian Residential School Photograph Album, p.13.

Image 12: The Arrival of Santa Claus, St. Peter's Mission School, Lesser Slave Lake, 1924

Santa arrives carrying the Union Jack.



Source: Glenbow Archives, William James Kent Fonds, St. Peter's Mission Indian Residential School Photograph Album, p.3.

Image 13: 'Before and After' at the St. Peter's Mission School, 1923-1924



Source: Glenbow Archives, *William James Kent Fonds*, St. Peter's Mission Indian Residential School Photograph Album, p. 20.

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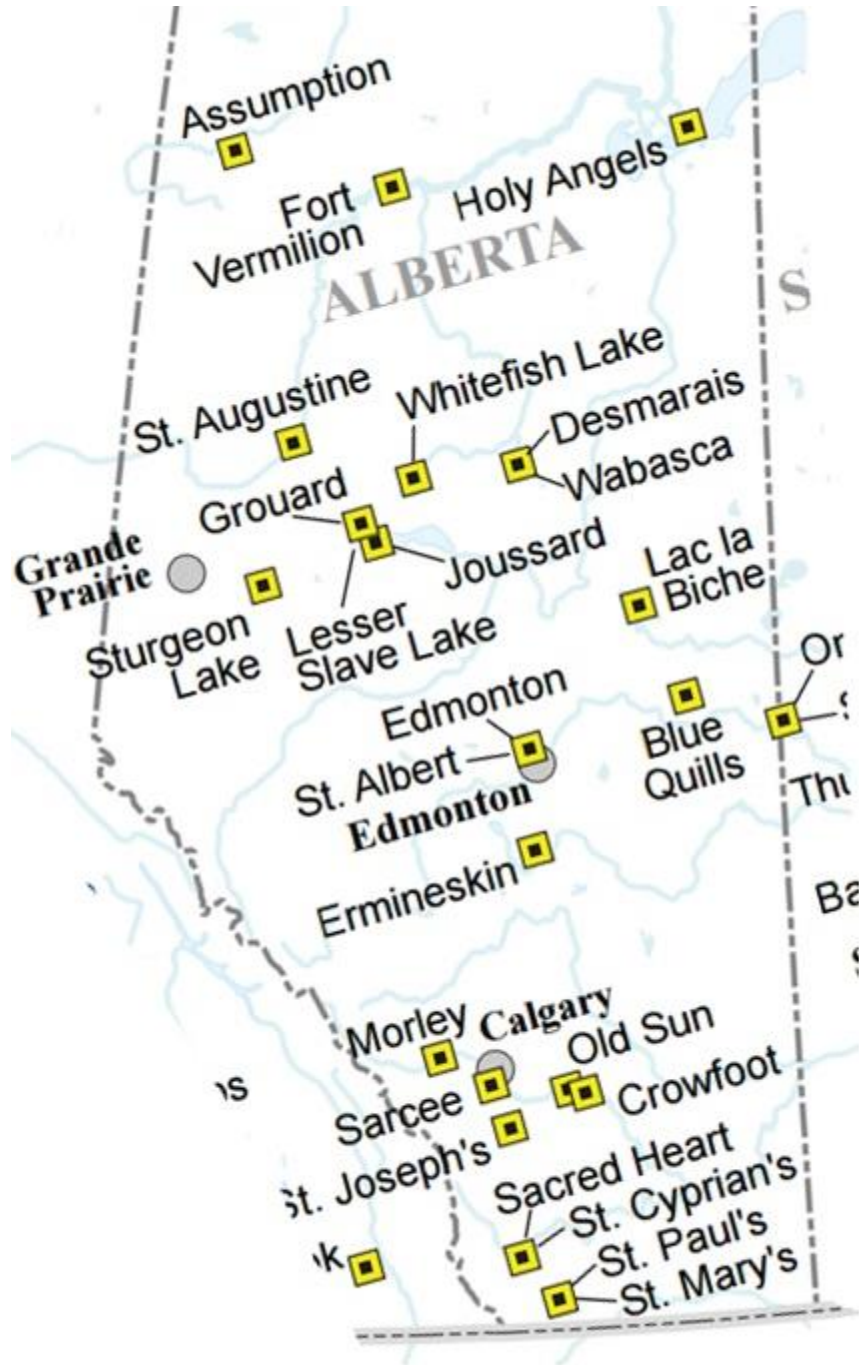
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Appendix

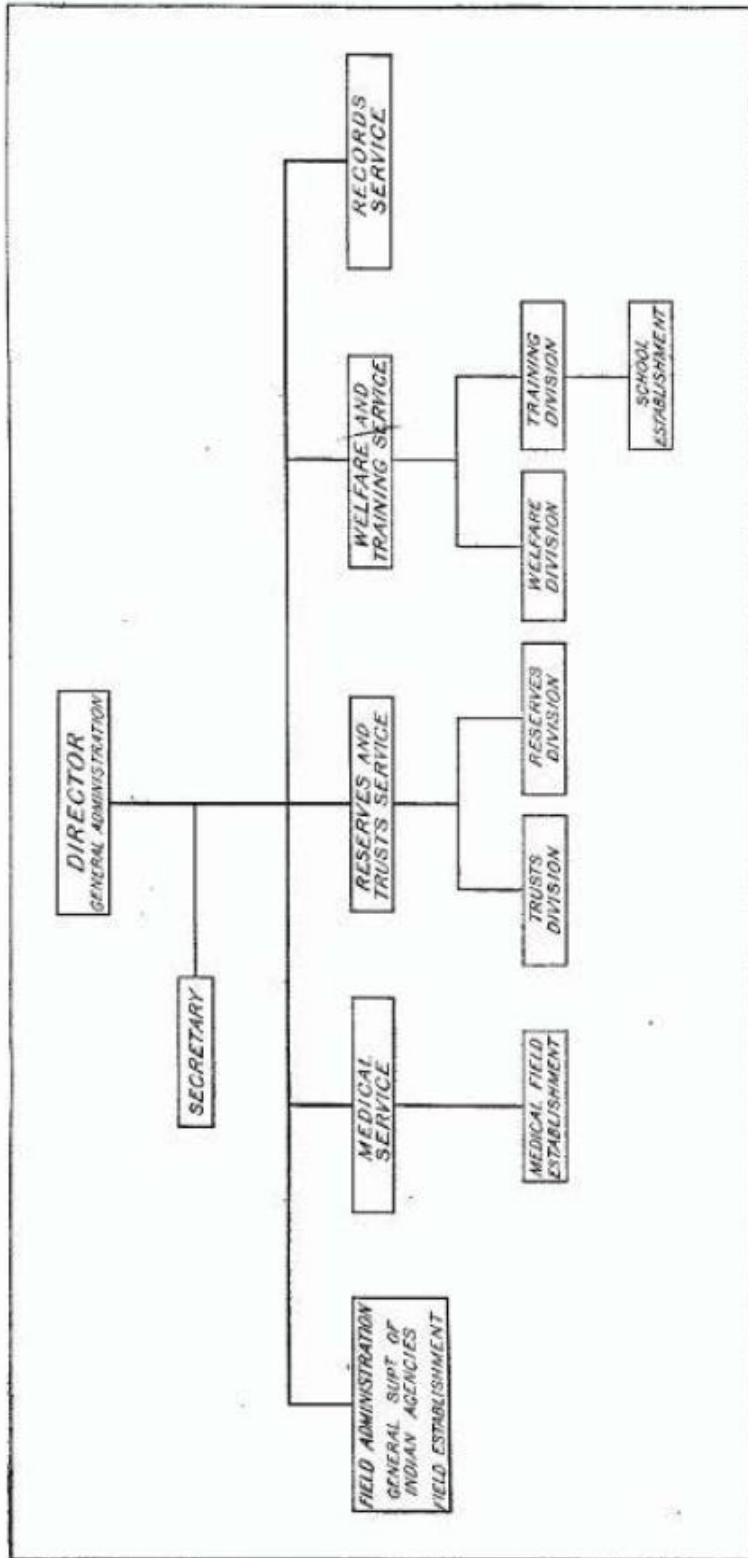
APPENDIX 1: Map of Residential Schools In Alberta

<http://projectofheart.ca/maps-visual-aids/> accessed, July 08, 2015.



APPENDIX 2: Organization of the Indian Affairs Branch, Department of Mines and Resources

LAC, Indian Affairs Annual Reports, 1864 – 1990. *Canada Department Of Mines And Resources Report Of Indian Affairs Branch For The Fiscal Year Ended March 31, 1940*, p. 180.



Organization Chart, Indian Affairs Branch.

APPENDIX 3: List of Names Mentioned:

DEPARTMENT OF INDIAN AFFAIRS (1880 – 1936), DEPARTMENT OF MINES AND RESOURCES (1936 – 1950)

<u>NAME</u>	<u>Position</u>	<u>Dates</u> <u>Referenced</u>	<u>Education</u>
ARNOLD, W.C.	Director of Medical Services	1925	-
BAILEY, W.M.	Departmental Purchasing Agent	1939	-
BENNETT, R.B.	Acting Superintendent General	1927	-
BENSEN, M.	Department accountant	1897 – 1904	-
BRYCE, P.H.	Medical Inspector	1904 – 1923	-
CALDWELL, J.C.	Private Secretary to Superintendent General of Indian Affairs	1921	-
CHRISTIANSON, M.	Inspector of Indian Agencies at Calgary, General Superintendent of Indian Agencies	1929 – 1942	-
CLARK, D. A. DR.	Assistant Deputy Minister of Health	1924	M.D.
CRERAR, T.A. HON.	Minister	1935 – 1937	-
DOUCET, A.J.	Training Division	1942	-
FERRIER, R. T.	Superintendent of Indian Education	1920 – 1932	-
GOODERHAM, G.H.	Indian Agent, Blackfoot Agency	1922	-
GRAHAM, W.M.	Indian Commissioner for Prairie Provinces	1922	-
HOEY, R.A.	Superintendent of Welfare & Training	1938 – 1942	-
JOHNSTON, J.T.	Director	1929	-
LECHAPELAIN, C.K.	Assistant Engineer	1939	-
LEHEINI, J.	Departmental Engineer	1925	-
LOUGHEED, J.A. SIR	Superintendent of Indian Affairs	1920 – 1921	-
A.M. MACGREADY	Dietician/Nutritionist	1946 – 1948	Clinical Training
MACINNES, T.R.L.	Acting Secretary (DIA)	1928 – 1934, 1942	-
MACKENZIE, A.F.	Acting Assistant Deputy and Secretary	1926- 1934	-
MARKLE, J.	School Inspector	1906 – 1920	-
MCGECKIN, T.	Acting Secretary (DIA)	1934- 1938	-
MCGILL, H. DR.	Deputy Superintendent General	1937 -	-
MCLEAN, J.D.	Assistant Deputy and Secretary, DIA	1920 – 1927	-
MEIGHEN, A.	Superintendent General	1917 – 1920	-
MURISON, W.	Inspector of Indian Agencies	1929	-
MURPHY, T.	Superintendent of Indian Affairs	1930 – 1934	-
NEARY, B.F. COL.	Superintendent of Welfare and Training	1947	-
ORR, G.	Architect, DIA	1924	-

PAGET, F.H.	Accountant & Purchasing Agent	1908	-
PHELAN, P.	Chief of Training Division	1938 – 1941	-
PRAGNELL, G.S.	Inspector of Indian Agencies	1926	-
ROCHE, W.J.	Superintendent General	1912 – 1917	M.D.
ROSS, J.T.	Deputy Minister of Education	1920	BA, Doctor of Laws
SCHMIDT, C.P.	Inspector of Indian Agencies, Alberta Inspectorate	1939	-
SCOTT, D.C.	Deputy Superintendent General	1913 – 1932	-
SMITH, G.	Inspector of Construction	1925	-
STEVENS, H.H.	Acting Superintendent General	1926	-
STEWART, C. HON.	Superintendent of Indian Affairs	1921-1929	-
STONE, E.L.	Director of Medical Services	1933	M.B.
SUTHERLAND, J.D.	Superintendent of Indian Education	1933	-
TURPEL, W.M.	Medical Superintendent	1930	M.D.
YULE, L.B.	Inspector of Indian Agencies	1923	-
WILLIAMS, A.S.	Departmental Solicitor; Acting Deputy Superintendent General	1926; 1932	-

INDIAN AGENTS

<u>NAME</u>	<u>Reserve</u>	<u>Position</u>	<u>Dates Referenced</u>
EDWARDS, F.	Kenora, Ont	Indian Agent	1928
DILWORTH, W.J.	Blood	Indian Agent	1914
FAUNT, J.T.	Blood	Indian Agent	1921-1926
GOODERHAM, J.H.	Blackfoot	Indian Agent	1913 - 1920
GOODERHAM, G.H.	Blackfoot	Indian Agent	1921 - 1936
GRAHAM, T.	Hobbema	Indian Agent	1919
LAIRD, H.	Grouard	Indian Agent	1925
L'HEUREUX, N.P.	Joussard	Indian Agent	1931
MCMILLAN, A.	Blood	Clerk-In-charge, Indian Agent in 1942.	1940
MOORE, A.D.	Muncey	Indian Agent	1936
OSTRANDER, J.E.	Blood	Indian Agent	1921
PUGH, J.E.	Blood	Indian Agent	1926 – 1938

CHURCH OFFICIALS

<u>NAME</u>	<u>Position</u>	<u>Institution</u>	<u>Dates</u>	<u>Places</u>	<u>Church</u>	<u>Education</u>
ANGIN, J. REV.	Principal	Blue Quills	1933	Onion Lake, SK	Roman Catholic	-
CARROLL, F.P.	Bishop	-	1941	Calgary, AB	Roman Catholic	-

CHARRON, P.A.	Principal	Blood Roman Catholic/ St. Mary's	1937	Blood Reserve, AB	Roman Catholic	-
DOREY, G. REV. DR.	Acting Secretary	Board of Home Missions	1947	Toronto, ON	United Church	D.D.
FALHER, C. REV.	Principal	St. Bruno's	1931	Joussard, AB	Roman Catholic	-
GIROUX, J.B.H. REV.	Principal	St. Bruno's	1920 – 1930	Joussard, AB	Roman Catholic	-
GUY, J.	Bishop	-	1931	Grouard, AB	Roman Catholic	-
GENTLEMAN, P.H.	Principal	John Smiths School, Old Sun's School	1919	Blackfoot Reserve, AB	Anglican	-
LANGLOIS, U.	Provincial	-	1930	Edmonton, AB	Roman Catholic	-
LEBRIS, J.	Parish Priest	-	1925	Lethbridge, AB	Roman Catholic	-
MCVITTY, S.R. REV.	Principal	Mt. Elgin Institute	1926	Muncey, ON	Anglican	-
NAESSAN, A.	Procurator for the Oblate Fathers	-	1925	Blood Reserve, AB	Roman Catholic	-
PRICE, J.P. DR.	Principal	Red Deer Industrial Institute	1903	Red Deer, AB	Anglican	M.D.
ROUTHIER, H.	Provincial	-	1941	Edmonton, AB	Roman Catholic	-
RUAUX, E.	Principal,	Blood Roman Catholic/ St. Mary's	1916 – 1937	Blood Reserve, AB	Roman Catholic	-
WOODSWORTH, J. REV.	Principal	Edmonton Institute	1924 – 1934	Edmonton, AB	Anglican	-

MEDICAL PROFESSIONALS

<u>NAME</u>	<u>Position</u>	<u>Affiliation</u>	<u>Dates</u>	<u>Schools Worked on</u>	<u>Province</u>	<u>Education</u>
LEDREW, A.	Travelling Nurse	Department of Indian Affairs	1929	Edmonton Institute	Prairie Provinces	Nurse

GERRY, H.E.	Travelling Nurse	Department of Indian Affairs	1923 – 1924	Blue Quills	Prairie Provinces	Nurse
JOHNSTON, E.P.	Travelling Nurse	Department of Indian Affairs	1921	Blue Quills	Prairie Provinces	Nurse
MACDONALD, C.	Nurse	Department of Indian Affairs	1931	Inspectorate	-	Nurse
MAXNER, J.W.	Nurse	Department of Indian Affairs	1931	Inspectorate	-	Nurse
SPEECHLEY, H.M	Superintendent	Junior Red Cross	1922 – 1923	Manitoba schools	Manitoba	-
MURDOCH, R.H. DR.	Dentist	Junior Red Cross	1922 – 1928	Manitoba schools	Manitoba	Dentist

OTHER OFFICIALS

<u>NAME</u>	<u>Position</u>	<u>Affiliation</u>	<u>Dates</u>	<u>Location</u>	<u>Education</u>
COPPEN, S.A.	Engineer	Alberta Water Inspection	1924	Edmonton, AB	-
PELLETIER, E.	Secretary	Quebec Provincial Hygiene Service	1926	Quebec	-
WALKER, C.M.	Unknown	Unknown	1939	Banff, AB	-
WESTGATE, T.B. REV.	Secretary	Indian and Eskimo Residential School Commission	1939	Winnipeg, MB	D.D.

APPENDIX 4: 'Quinina, Quinine':

Extract from: Lavinia Dock, *Materia Medica for Nurses*. 6th Edition, pp. 207 – 210.

THE VEGETABLE KINGDOM.

207

The yellow bark contains most quinine, the pale bark most cinchonine, and the red bark about equal quantities of each. Besides these important alkaloids and a number of unimportant ones, cinchona bark contains tannic and other acids, a resinous substance, coloring matter, etc.

Physiological Actions.

The preparations of cinchona bark as a whole are used as bitter **stomachics** and **tonics**.

They are too bulky to be used as antipyretics or antiperiodics if quinine can be obtained. They have some **astringent** action, due to the tannin they contain. They should be given half an hour before meals.

Preparations.

Tinctura Cinchonæ.

Tincture of Cinchona.

Strength, 20%. Average dose, 3 i.-4 mils.

Tinctura Cinchonæ Composita.

Compound Tincture of Cinchona.

Contains cinchona, glycerin, bitter orange-peel, serpentaria, and alcohol. Average dose, 3 i.-4 mils.

Fluidextractum Cinchonæ.

Fluidextract of Cinchona.

Average dose, ℥ xv.-i mil.

The sulphates of cinchonine and cinchonidine are also official. Average dose, gr. iiss.-0.15 Gm.

Quinina, Quinine.

Quinine is prepared from the powdered cinchona bark by various chemical processes, in the course of which an alkali and sulphuric acid are both used.

Alkalies, and their carbonates, and tannic acid are

phylactic must belong either to the class of restoratives, supplying a deficiency of some natural and essential condition of the body, or to the class of germicides, preventing disease by destroying the injurious agent.)

Quinine has some power as an **oxytocic**, contracting the uterus. In times past it was taught that it was capable of producing abortion, but the weight of evidence is believed by most authorities to be against this theory.

Incidental Effects.

Eruptions of the skin are sometimes observed after the use of quinine, even in small doses. A rash resembling that of scarlet-fever may appear, followed by severe itching and smarting, and desquamating finally.

More rarely the eruption resembles urticaria, popularly known as "hives" or "nettle-rash." Occasionally irritation of the urinary organs is caused, with pain, congestion of the kidneys, or even hemorrhage. This is more liable to occur with old people. Idiosyncrasy exists in a marked degree with some persons in regard to quinine, forbidding the use of even the smallest doses.

If much prostration follows the administration of quinine, strong black coffee with brandy is the best antidote. In giving quinine, ringing in the ears and deafness are the first symptoms to be looked for.

There are now eight official preparations of quinine—Quinine Bisulphate, Dihydrochloride, Hydrobromide, Hydrochloride, Salicylate, Sulphate, and Tannate, all of which except the last have an average dose of gr. $\text{r}\frac{1}{2}$ –0.1 Gm. as tonics, and gr. xv.–1 Gm. daily as anti-malarial remedies. The dose of the tannate is gr. iii.–0.2 Gm.

Last is a preparation for hypodermic use, Quinine and Urea Hydrochloride. Average daily dose, gr. xv.–1 Gm.

Quinine is usually given in pills or capsules on account of the bitter taste. Sometimes, when rapid action is desired, it is given in solution. The taste is

very persistent and is better removed by a piece of dry bread, or an olive, than anything else. The powdered sulphate may be given in sherry wine.

Quinine pills should not be more than ten days old, as then they become so dry and hard as to be useless, passing through the alimentary canal without dissolving. Quinine should be given on an empty stomach, or after the process of digestion is partly over. If a patient is on milk diet quinine should not be given in solution near the milk, as it is very liable to cause vomiting. Otherwise there is no incompatibility between quinine and milk.

Warburg's Tincture. Not official.

A preparation with an exceedingly long formula, containing over a dozen drugs of vegetable origin, with a certain proportion of quinine, the most active ingredient (between 9 and 10 grains to the ounce). It is used as a diaphoretic, and is best given at night.

Dose, $\frac{5}{3}$ ss.-15 mils.

Ipecacuanha, Ipecac.

The dried root of *Cephaelis Ipecacuanha*, of Brazil. Ipecac contains from $\frac{1}{4}$ to 1% of the active principle, emetine, and also a glucoside, starch, gum, etc.

Physiological Actions.

Externally, powdered ipecac irritates the skin, causing a pustular eruption. Mucous membranes are similarly irritated, and an increased bronchial and nasal secretion, sneezing, etc., follows its local application. Taken internally, it tends to soften and liquefy hard and tenacious mucous secretions.

In the stomach ipecac in very small doses (gr. $\frac{1}{4}$) is a **gastric stimulant**, increasing local circulation and secretion. In these minute doses it checks vomiting.

In large doses it is a familiar **emetic**, safe and prompt, and non-depressing. Its action is partly direct and partly indirect, the act of vomiting being promoted both by local action on the stomach walls,

APPENDIX 5: Strychnine – ‘Nux Vomica’:

Extract from: Lavinia Dock, *Materia Medica for Nurses*. 6th Edition, pp. 220 – 222.

220 *MATERIA MEDICA FOR NURSES.*

Death, when it occurs, may do so in a few hours, and has been known to result from taking one sixth of a grain.

Treatment of Poisoning.

Poisonous symptoms are treated by emetics, alcoholic stimulants, external heat, electricity, and artificial respiration, if necessary.

Preparations.

Fluidextractum Gelsemii.

Fluidextract of Gelsemium.

Average dose, ℥ ½–0.03 mil.

Tinctura Gelsemii.

Tincture of Gelsemium.

Strength 10%. Average dose, ℥ iv.–0.25 mil.

Nux Vomica.

The seeds of *Strychnos nux-vomica*, an East Indian tree. The active principle is the alkaloid, strychnine, an important poison. Two other important principles are brucine and igasuric acid. Brucine is of half the strength of strychnine.

Physiological Actions.

Nux vomica in medicinal doses is **tonic**, with the qualities of **bitter stomachics**; it increases appetite, aids digestion, and promotes peristalsis. It also stimulates respiration, the heart, and vaso-motor centres. These actions are largely due to the presence and influence of strychnine. Strychnine enters the system rapidly, especially the nervous tissues, on which its pre-eminent action, that of a **motor excitant**, is shown. It is excreted very slowly, not disappearing from the tissues for several days, and therefore accumulates in the system when given in continuous doses, even small ones.

The power of strychnine in regard to the nervous

system is exerted on the motor centres of the spinal cord and all the important nerve centres in the medulla.

The first constitutional symptoms are a feeling of restlessness, with slight trembling of the extremities.

After a full dose (gr. $\frac{1}{10}$), there are noticeable muscular twitching and jerking of the limbs, slight stiffness of the jaw, a tense feeling about the head, stricture of the throat and chest, shuddering, and a feeling of anxiety.

Symptoms of Poisoning.

After poisonous doses (gr. $\frac{1}{4}$ for an adult), violent symptoms come on very suddenly, probably within fifteen minutes, with tonic convulsions resembling the spasm of tetanus. The legs are rigid, extended, and the feet averted, or the body may be bent backward until the head and heels meet (opisthotonos). The arms are bent, and hands clinched; the eyes open and staring. The corners of the mouth are drawn up by the muscles in a mechanical grin, the "risus sardonicus," which gives a ghastly unmeaning expression, and the face—at first pale—presently becomes livid from asphyxia.

Between the paroxysms there is a period of relaxation and quiet, but the slightest sound, or touch, or breath of air brings on the spasms again instantly by reflex action, owing to the condition of intense irritability.

In cases which terminate fatally, the spasms succeed each other quickly, and death takes place in two or three hours from paralysis of the respiratory muscles. The mind usually remains clear up to the last. Sometimes asphyxia produces insensibility just before death.

Strychnine convulsions resemble tetanic and hysterical convulsions in some particulars. The special points of difference are as follows:

Strychnine.

The convulsions begin with a restless, excited state; the special senses are sharpened. Muscular symptoms

come on very rapidly, either beginning in the extremities or appearing simultaneously over the body. The jaw is the last part affected and the first relaxed. The eyes are open, and the muscles are relaxed between the convulsions.

Tetanus.

The symptoms come on gradually, with pain and stiffness of the back of the neck and occasional slight muscular twitchings. The jaw is the first part affected, and is rigid (trismus, or lock-jaw). There is a permanent state of general muscular rigidity.

Hysteria.

Begins with weakness and blindness. The muscular symptoms begin with stiffness of the neck. The extremities are affected last. The jaw is set before a convulsion and remains fixed between them. The eyes are closed.

Treatment of Poisoning.

In treating strychnine poisoning, tannic acid or a soluble iodine salt is given as an antidote, followed quickly by emetics, as the compounds thus formed are not permanent. The bladder must be emptied to prevent re-absorption; then absolute quiet is of the greatest importance. Inhalations of chloroform are used, with full doses of chloral and bromide of potassium given internally.

Precautions.

In giving strychnine, the possibility of its cumulative action must always be kept in mind as a grave feature. It is more likely to develop if the medicine is in pill form than if in solution. With the liquid preparation of iron, strychnine, and quinine, the danger exists also as the strychnine is apt to precipitate. It must always therefore be well shaken. Strychnine is more effective with old people.

APPENDIX 6: Iron tonic – ‘Ferrum’ (Iron):

Extract from: Lavinia Dock, *Materia Medica for Nurses*. 6th Edition, pp. 73 – 77.

THE METALS.

73

Alumen Exsiccatum. **Exsiccated Alum.**

Alum which has been deprived of its water by heat, and powdered. Combined with alcohol (in which it is insoluble), in the proportion of ʒ i.-iv. to alcohol ʒ v.-vi., it is used to harden the skin, as a preventive of bed-sores.

Ferrum (Iron).

All the salts and preparations of iron are made directly or indirectly from the metal.

Physiological Actions.

Iron is the most important of the mineral **tonics**, and may be more properly described as a food rather than as a medicine, being one of the most essential constituents of the red blood corpuscles. It exists normally in the blood in the proportion of 1 part iron to 230 parts red corpuscles, and in a state of health enough iron is taken with various kinds of food, to supply the demand. Beef especially, as an article of diet, provides iron, as it contains 1 part iron to 194 parts red corpuscles.

Iron has been called the great respiratory food. In the lungs it takes up oxygen from the inspired air, and carries it to all the tissues. No function of the body can be carried on without oxygen; the muscular system especially is dependent for its perfect activity on the presence of oxygen, and muscular power is in direct proportion to the efficiency of the respirations.

The feeling of tone and energy, both bodily and mental, which belongs to perfect health, comes from an ample supply of oxygen, and it is in this primary way that iron acts as a **tonic**; **stimulates** and **strengthens** the **heart, nerves, and muscles**; **raises** the **temperature** of the body and **increases** the **appetite**.

It is not absorbed by the unbroken skin, but on

exposed tissue and mucous surfaces its action is **astrin-
gent**, coagulating the albumin of tissue and plasma,
diminishing the circulation by compression of the ves-
sels, and arresting hemorrhage. Iron is thus classed
as a **styptic or hæmostatic**.

Taken internally there is an astringent taste, and the
tongue and teeth are darkened by a sulphide which is
deposited as a result of decomposition. If given in
excess or on an empty stomach it decomposes the
digestive fluid, and acts as an irritant and astringent
upon the mucous membrane.

The digestion or absorption of iron takes place partly
in the stomach and partly in the intestines, and depends
upon the presence, in normal quantities, of the gastric
and intestinal juices.

Organic and inorganic compounds of iron are be-
lieved to be absorbed with equal readiness in the
alimentary canal, principally in the duodenum, whence
they pass to the spleen, where they are stored
up, being given off to the blood later, and carried to
the liver, where they assist in forming hæmoglobin.
Some part of the iron is afterwards taken into the
blood, and is excreted by the cæcum and large intestine.
This is the prevalent view regarding the absorption of
iron and its distribution throughout the system. Some
claim that the inorganic iron combines with the sulphur
in the intestines, forming the sulphide of iron which is
excreted in the fæces, thus leaving all the food iron to
be absorbed. Part of the food iron would be taken into
combination, otherwise, by the sulphur, preventing
absorption.

Iron has sometimes an **irritant** action on the bladder;
its astringency in the alimentary canal causes constipa-
tion; and it is said that it decreases the secretion of
milk in nursing women. An excess of iron is elimi-
nated from the system in almost every possible way,
but principally by the fæces, which it colors black by
forming a sulphide.

The local irritant action of iron explains why it is
always given well diluted and after meals.

Incidental Effects.

In administering a course of iron, two things must be provided for:

1. The bowels must be loose.
2. The digestion must be good ; and in the course of administration any one or more of the following symptoms may be noticed, indicating an excess in the system: frontal headache, slight disturbances of the digestion, irritation of the stomach or of the bladder, a feeling of weight at the epigastrium, constipation, a feverish condition. An acne of the face and chest is sometimes produced by iron, and the reduced iron causes eructations of gas.

It is very important to remember that all preparations of iron stain clothing, carpets,—in fact everything touched, and that the stains are with difficulty removed. Silver spoons should never be used for iron, but if they have been used, the stain will come off if rubbed with ammonia water undiluted. Oxalic acid will take the stains out of muslin or linen.

Preparations of Iron.

The five preparations of iron which are especially prescribed because of their effectiveness and because they are the least irritating of the iron compounds are:

- Tincture of the chloride.
- Syrup of the iodide.
- Solution of the acetate of iron and ammonia ("Basham's Mixture").
- Pills of the carbonate ("Blaud's Pills").
- Iron and potassium tartrate.

*(Saline Combinations.)***Tinctura Ferri Chloridi.****Tincture of Ferric Chloride.**

Sometimes called the muriated tincture.

It is reddish-yellow in color, and has peculiar properties. It is the most frequently used of all the

preparations of iron. It is **astrigent, irritating,** and somewhat **corrosive.** It has **diuretic** and **anti-spasmodic** qualities, owing probably to the ether, and is **antiseptic** by virtue of the chlorine and iron; **tonic,** as are all iron preparations. It contains about 4% of metallic iron.

Tr. of iron should never be given at the same time with tea, or with other medicines containing tannin, as an ink-like combination results. It should not be added to whiskey, but may be well given in milk, being dropped in at the moment when it is to be taken. It may be given with glycerin, 3 parts to iron 1 part, the glycerin to prevent constipation, or it may be dropped into egg albumen to prevent its action on the teeth. It is a very incompatible drug, and should not be given at the same time that another drug is administered. Iron attacks the teeth, unless properly diluted, and should always be given through a glass tube. When the throat is gargled with iron, the teeth should be brushed after each application, or washed off with salt water.

Average dose, ℥ viii.—0.5 mil, half an hour after meals, in a tumblerful of water.

Liquor Ferri et Ammonii Acetatis.

Solution of Iron and Ammonium Acetate.

Basham's Mixture.

Composed of tr. of ferric chloride, diluted acetic acid, solution of ammonium acetate, elixir of orange, glycerin, and water. It should be freshly made.

Average dose, ʒ iv.—15 mils, well diluted.

Syrupus Ferri Iodidi.

Syrup of Ferrous Iodide.

Iodide of iron affects the teeth seriously. It has iodine, iron, and syrup, and exerts a special action on nutrition by means of the iodine.

Average dose, ℥ xv.—1 mil, largely diluted.

Mistura Ferri Composita.
Compound Iron Mixture.
(Griffith's Mixture.)

Contains ferrous sulphate, potassium carbonate, and myrrh.

Dose, $\frac{z}{3}$ ss.—15 mils.

Liquor Ferri Subsulphatis.
Solution of Ferric Subsulphate.
Monsel's Solution.

Contains about 13 % of metallic iron.

Ferrous sulphate, sulphuric and nitric acids are constituents of Monsel's solution. It has a deep red color and the consistency of syrup. It is an active **styptic**, but it is rather uncertain in its action, sometimes causing severe sloughing, and is not much used.

Liquor Ferri Tersulphatis.
Solution of Ferric Sulphate.

Contains about 10 % metallic iron. The chief employment of it is in making other ferruginous preparations. It should always be kept on hand for the quick preparation of the antidote to arsenic.

Pilulæ Ferri Carbonatis.
Pills of Ferrous Carbonate.
Blaud's Pills.

Contains sulphate of iron and carbonate of potassium, althæa, tragacanth, and glycerin. Dose, pil. i.

Ferrum Reductum.
Reduced Iron.
Quevenne's Iron.

A light gray powder, quite tasteless, and of all the preparations of iron the most free from astringency. Dose, gr. i.—0.06 Gm., taken after meals in pill form. It may be given to children in candy or lozenges.

APPENDIX 7: Food Borne Illness:

Table 1. Common causative agents of food-borne illnesses

Organism	Incubation period	Signs and symptoms	Epidemiology	Laboratory diagnosis
<i>Bacillus cereus</i> – preformed enterotoxin, emetic type	1 to 6 h	Sudden onset of nausea and vomiting, with or without diarrhea	Cooked foods, like meat or fried rice, that have not been properly refrigerated	Usually not performed; stool and food sources may be needed for public health investigation.
<i>Bacillus cereus</i> – diarrheal type	8 to 16 h	Abdominal pain with diarrhea	Variety of foods from meat, vegetables, pasta, deserts, cakes, sauces, milk	Usually not performed; stool and food sources may be needed for public health investigation.
<i>Brucella</i> sp.	7 to 21 days	Fever, night sweats, backache, muscle aches, diarrhea	Raw milk or other unpasteurized dairy products, meat	Positive serology and/or blood culture(s)
<i>Campylobacter jejuni</i>	2 to 5 days	Fever, abdominal cramping, diarrhea with or without blood; Guillan-Barre syndrome can be seen in some individuals.	Raw and undercooked poultry, unpasteurized milk, contaminated water	Stool culture with specific medium, temperature, and atmospheric conditions; rapid immuno-chromogenic tests or molecular assays
<i>Clostridium botulinum</i> – preformed toxin	12 to 72 h	Abdominal cramping, nausea, vomiting, diarrhea, double vision; death or long term nerve damage may be seen.	Improperly canned foods, herb-infused oils, baked potatoes in aluminum foil	Toxin testing of serum, stool, and/or food performed at some state health department laboratories or CDC
<i>Clostridium botulinum</i> – infant	3 to 30 days	Floppy baby syndrome – lethargy, weakness, poor head control; constipation, poor feeding and sucking reflexes	Honey, home-canned vegetables and fruits, corn syrup	Toxin testing of serum, stool, and/or food performed at some state health department laboratories or CDC
<i>Clostridium perfringens</i> – toxin	8 to 16 h	Diarrhea, abdominal cramping, and nausea	Meat, poultry, gravy, inadequately reheated food	Test stool for enterotoxin; not routinely performed in most clinical laboratories
<i>Cryptosporidium</i> sp.	2 to 10 days	Watery diarrhea, abdominal cramps; severity depends on host immune status.	Undercooked food or food contaminated by ill food handler, contaminated drinking water	Detection of oocysts in stool using modified acid-fast stain, direct fluorescent antibodies, or with immunoassays
<i>Cyclospora cayetanensis</i>	1 to 14 days	Watery diarrhea, abdominal pain, nausea, loss of appetite, and weight loss	Fresh fruits and vegetables	Detection of oocysts in stool using modified acid-fast stain
Enterohemorrhagic <i>E. coli</i> – O157:H7 and other Shiga toxins	1 to 8 days	Bloody diarrhea, abdominal pain and vomiting; fever may be absent; hemolytic uremic syndrome.	Undercooked beef, unpasteurized milk and fruit juices, raw fruits, and vegetables	Isolation of the organism from stool culture using Sorbitol MacConkey or CHROMagar media; confirmation using antisera or latex agglutination; detection of the shiga toxins by immunoassay testing

*Linscott, Andrea. “Food-Borne Illnesses.” *Clinical Microbiology Newsletter* 33, no. 6 (March 15, 2011): 42.

APPENDIX 8: Requisitions for Medical Supplies to Treat Eye and Ear Infections

Table 8.1: Requisitions for Medication to Treat Eye Infections

Year of Requisition	Eye Water Drops (lbs)	Eye Water Dissolvable tablets	Yellow Oxide of Mercury Ointment (tubes)	Argyrol or Silvol Drops (oz)	Silvol Dissolvable Tablets
1923	1	-	-	2	-
1924	-	-	-	-	-
1925	5	-	-	2	-
1926	-	-	-	2	-
1927	-	-	-	2	-
1928	-	100	100	-	-
1929	-	100	-	-	-
1930	-	500	-	-	100
1931	-	500	24	-	100
1932	-	500	-	-	100
1933	-	-	-	-	-
1934	-	-	24	-	-
1935	-	-	24	-	50
1936	-	-	24	-	50
1937	-	-	-	-	100

Table 8.2: Requisitions for Medication to Treat Ear Infections

Year of Requisition	Earache Drops (oz)	Chlorozyne Tablets
1923	8	-
1924	-	-
1925	-	-
1926	16	-
1927	-	-
1928	-	200
1929	32	100
1930	-	100
1931	-	-
1932	-	-
1933	-	-
1934	-	-
1935	-	-
1936	16	-
1937	-	1000

*Information compiled based upon information contained in LAC, RG 10, Volume 6340, File 751-13, Part 1. Medical Matters, 1923 – 1937.

APPENDIX 9: 'Ipecacuanha, Ipecac':

Extract from: Lavinia Dock, *Materia Medica for Nurses*. 6th Edition, pp. 210 – 211.

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MATERIA MEDICA FOR NURSES.

very persistent and is better removed by a piece of dry bread, or an olive, than anything else. The powdered sulphate may be given in sherry wine.

Quinine pills should not be more than ten days old, as then they become so dry and hard as to be useless, passing through the alimentary canal without dissolving. Quinine should be given on an empty stomach, or after the process of digestion is partly over. If a patient is on milk diet quinine should not be given in solution near the milk, as it is very liable to cause vomiting. Otherwise there is no incompatibility between quinine and milk.

Warburg's Tincture. Not official.

A preparation with an exceedingly long formula, containing over a dozen drugs of vegetable origin, with a certain proportion of quinine, the most active ingredient (between 9 and 10 grains to the ounce). It is used as a diaphoretic, and is best given at night.

Dose, $\frac{z}{3}$ ss.—15 mils.

Ipecacuanha, Ipecac.

The dried root of *Cephaelis Ipecacuanha*, of Brazil. Ipecac contains from $\frac{1}{4}$ to 1 % of the active principle, emetine, and also a glucoside, starch, gum, etc.

Physiological Actions.

Externally, powdered ipecac irritates the skin, causing a pustular eruption. Mucous membranes are similarly irritated, and an increased bronchial and nasal secretion, sneezing, etc., follows its local application. Taken internally, it tends to soften and liquefy hard and tenacious mucous secretions.

In the stomach ipecac in very small doses (gr. $\frac{1}{4}$) is a **gastric stimulant**, increasing local circulation and secretion. In these minute doses it checks vomiting.

In large doses it is a familiar **emetic**, safe and prompt, and non-depressing. Its action is partly direct and partly indirect, the act of vomiting being promoted both by local action on the stomach walls,

and by stimulation through the influence of emetine of the vomiting centre in the medulla.

The emesis caused by ipecac takes place in from twenty to thirty minutes after administration, and occurs usually only once. There is but very little nausea before or with the act of vomiting, nor is it followed by exhaustion. It is accompanied by a decided increase in the secretions of the gastric and bronchial mucous membranes, and, the sputum thus being made more fluid, with the expulsive act there is a general clearing out of the bronchial tubes, the trachea, and the nasal cavities.

Ipecac, as an emetic, is between sulphate of zinc and tartar emetic, not being as prompt as the first, nor as nauseating as the second. It is not powerful enough to give alone in cases of poisoning, but is then used as an aid to other emetics. It is very suitable for children, and they bear it in relatively large doses.

Ipecac is a **sedative expectorant**, a direct **cholagogue**, increasing the flow of bile, and a **diaphoretic**.

Preparations.

Pulvis Ipecacuanhæ et Opii.

Powder of Ipecac and Opium. See Opium.

Average dose, gr. xv.—1 Gm.

Syrupus Ipecacuanhæ.

Syrup of Ipecac.

Strength, 7 parts fluid ext. to 100. Dose, expectorant, ℥ xv.—1 mil; emetic, ʒ iv.—15 mils.

Vinum Ipecacuanhæ. Not official.

Wine of Ipecac.

Strength, 1 part fluid ext. to 8 white wine. Dose, ℥ x.—xx. (0.65—1.3 mil.)

Fluidextractum Ipecacuanhæ.

Fluidextract of Ipecac.

Average expectorant dose, ℥ i.—0.05 mil.

Emetic dose for adult, ℥ xv.—1 mil.