PUVALUQATATILUTA, WHEN WE HAD TUBERCULOSIS

PUVALUQATATILUTA, WHEN WE HAD TUBERCULOSIS: ST. LUKE'S MISSION HOSPITAL AND THE INUIT OF THE CUMBERLAND SOUND REGION, 1930–1972

By

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ABSTRACT

This thesis explores the history of Church- and State-mediated tuberculosis treatment for Inuit of the Cumberland Sound region from 1930 to 1972. Pangnirtung's St. Luke's Mission Hospital sits at the centre of this discussion and at the nexus of archival evidence and regional Inuit knowledge about tuberculosis. Triangulating information gained from fieldwork, archives, and a community-based photograph naming project, this study brings together the perspectives of Inuit hospital workers, nurses, doctors, and patients, as well as of Government and Anglican-Church officials, during the tuberculosis era in the Cumberland Sound.

The study arose from conversations with Inuit in Pangnirtung, who wondered why they were sent to southern sanatoria in the 1950s for tuberculosis treatment, when the local hospital had been providing treatment for decades. Canadian Government policy changes, beginning in the 1940s, changed the way healthcare was delivered in the region. The Pangnirtung Photograph Naming Project linked photos of Inuit patients sent to the Hamilton Mountain Sanatorium to day-book records of St. Luke's, and culminated in an emotional ceremony in 2009, during which copies of the photographs were returned to survivors or relatives.

Information in hospital day books was used to map the yearly distribution of tubercular Inuit in traditional camps, which were progressively abandoned as Inuit in-migrated to Pangnirtung, in response to increased Government incursions and concerns about Arctic sovereignty. Contrary to the pattern for Canadian Arctic Inuit, more tubercular Inuit were treated locally at St. Luke's than were sent away for treatment to southern hospitals on board the Government-commissioned medical-patrol ship, *CGS CD Howe*.

This thesis underlines the importance of linking archival sources to local Inuit knowledge, in a collaborative, community-based research environment. It also speaks to current concerns about the re-emergence of tuberculosis and the importance of developing culturally-appropriate community initiatives to manage infectious diseases in Nunavut.

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Piusiq, ipigiqatautiniq umatitiningatuq tavani unikasaqijasimlarituqmi amisuit akilitaugatik kaujimajaminik, ipigijaminik amma titinaqtuni, tunisilaliqut, tunisijauluti ajinguani puvaluqatatuminini attitugilu, Hamiltonmi puvalutunu najutaulautumi. Taana ajilrini amalu iqaumajamini uqausiqatuti amisuni piujuni saqilaupu, tukisiqatautiluti inutianimi, amma aanianimi tamaani inuit nunangani 1930mi 1972mu tikitugu. Takua utitatilunga uqausirijangi atuutiqalaupu attusimajamini ammalu puvalunimi, tukisititikanituti kangitualumi (panituup kangitualua). Kuujalivunga nunaliit ikajuruumaningini, piqajaujumaninginilu tungananinilu taikunanga oovani ikajulautuni.(translation by Nancy Anilniliak and Noah Maniapik)

The tradition of caring for each other is at the heart of this story. Many volunteers contributed their time, knowledge, enthusiasm, and humour. In exchange, the members of the community received a photographic collection naming many tuberculosis patients sent the Hamilton Mountain Sanatorium. Yet, the community photograph naming project and sharing of memories enriched this dissertation in surprising ways by linking many sources of information together toward an understanding of the impact of health and illness throughout the region from 1930–1972. Because of the individuals who never tired of my return visits to talk about what I had discovered, their consultation brought the voice of experience on matters of their own history and enriched the larger purpose in telling the story of tuberculosis in the Cumberland Sound region. I am thankful for this generous outpouring of community participation and the kindness from those who have helped me.

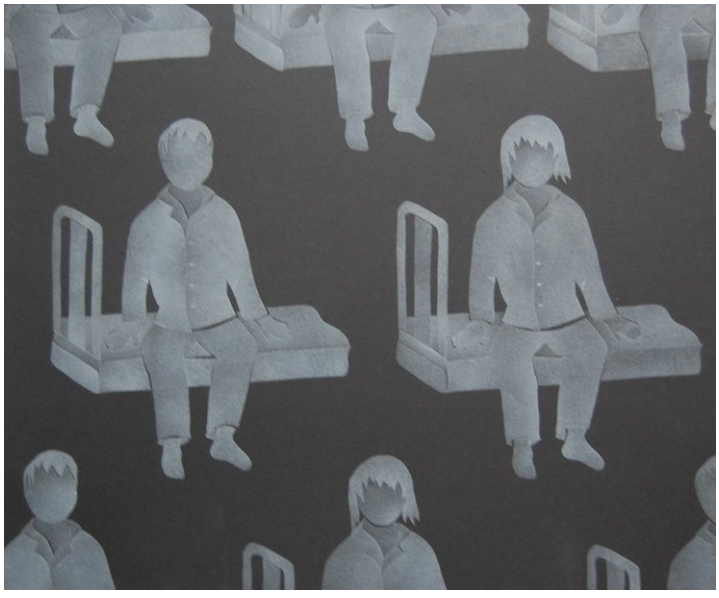
The project committee and researchers include: Nancy Anilniliak, Billy Etooangat, Mary Kilabuk, Rosie Veevee, May Akulukjuk Lonsdale, Pudloo Adam Kilabuk, Elijah Nowldlak, and Arna Akulukjuk. I would like to acknowledge all individuals who assisted the committee and research partners in the naming of photographs during committee meetings and the advisory contribution of Noah Maniapik and Monty Yank, as well as David Kilabuk for his photographs of the community celebration.

Many agencies and funders provided project support over the years, the Indigenous Health Research Development Program Research Grant and Graduate Scholarship (IHRDP), the Northern Scientific Training Program (NSTP) Research Grant, and McMaster University Graduate Scholarship and Field Study funding. Qikqitani Inuit Association provided airfare for a consultation meeting. Parks Canada Agency Nunavut Field Unit provided the generous and ongoing donation of accommodations and meeting rooms, office support services, and the public audiovisual theatre. Finally, the Hamlet of Pangnirtung donated the community town hall meeting space.

My thesis supervisor, D. Ann Herring, and committee members, Trudy Nicks and T. Kue Young provided me with collegial support, encouragement, and guidance. Professor Emeritus Pauline Mazumdar advised me about the medical-history aspects of my research. I am fortunate to have benefited from the sharing of skills and academic mentorship from these scholars as part of my foundational training.

The Head Archivist, Nancy Hurn, and Assistant Archivist, Laurel Parsons, of the Anglican Church of Canada General Synod Archive in Toronto, believed in the importance of this project and provided unwavering support by opening the archive to an agreement that assisted in the development of this one-of-a-kind analysis of St. Luke's Mission Hospital.

The individuals behind the scenes who are the core of my personal life deserve this expression of appreciation for all things given in support, endured, and sacrificed to help me accomplish the community photograph naming project and thesis.



***Puvaluqatatiluta*. Artist: Emily Cowall. Printmaker: Noah Maniapik. ©2011.**

What we have done for ourselves alone dies with us;
what we have done for others and the world remains and is immortal.

– Albert Pike

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Chapter One
Introduction

This thesis investigates the ethnohistory of medical services for tuberculosis among the Inuit of the Cumberland Sound region of Baffin Island in the Eastern Canadian Arctic from 1930 to 1972. I argue that tuberculosis is the agent of change that brought these Inuit into the Canadian system of federal healthcare. The site of this research is St. Luke's Mission Hospital, the Anglican hospital in Pangnirtung, Nunavut. St. Luke's Mission Hospital was a contested site where the Church and the State battled to control the health care of the Inuit.

Pangnirtung is a hamlet community located on a fjord that connects to the Cumberland Sound of Baffin Island (Figure 1.1). The Inuit of this region have a long history of participating in academic research, including studies by anthropologist Franz Boas in 1901 (Barr et al. 1998), who, in 1883–4, spent time in the region during the whaling era, often considered the origin of contact-period tuberculosis (Stevenson 1997: 123–25). In recent times, Pangnirtung Elders have provided information on a variety of subjects, including the whaling industry (Stevenson 1997), and traditional knowledge and modernisation among Eastern Arctic peoples (Damas 2002; Laugrand et al. 2003). This study builds on this tradition of northern research.

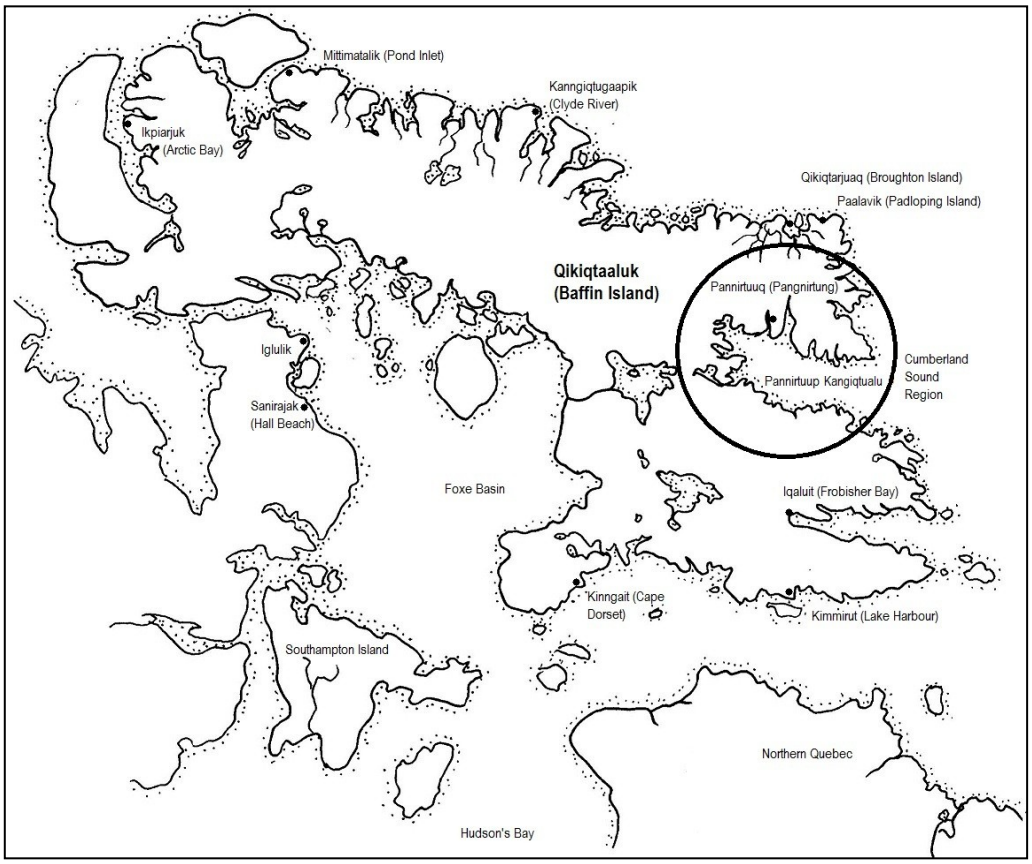

Figure 1.1: Map of Qikiqtaaluk (Baffin Island) indicating the Pannirtuup Kaniqtualu (Cumberland Sound) region, as well as the communities serviced by St. Luke's Mission Hospital. ©Emily Cowall 2011.[1]

I trace the history of the medical missionaries stationed at Pangnirtung and of the Government's involvement in medical policy and patient funding. I pay particularly close attention to the local effects of Government health programs, especially on the extraction of tubercular Inuit patients to the Mountain Sanatorium in Hamilton, ON, during the 1950s. The Hamilton Mountain Sanatorium had the largest population of Inuit outside of

[1] Map artwork by Emily Cowall redrawn from Stevenson (1997:34). Used with permission of Oxford University Press Canada (January 27, 2011). Scale 3cm=250km. The place names do not show all Baffin communities, but instead are the locations of patients who were admitted to St. Luke's Mission Hospital, especially in the period 1960–1972.

the Arctic at that time. Between 1958 and 1962, the Government southern hospitalisation program for patients in the Eastern Arctic facilitated the transfer of 1272 Inuit from the western and eastern Arctic to Hamilton (Williamson 2006:181). The research presented here thus connects the local experience of tuberculosis at St. Luke's to the larger external forces that affected Inuit communities, and linked them in turn to medical care in the south.

Objectives and Purpose of the Research

This ethnohistory evolved out of fieldwork conducted in Pangnirtung from 2007 to 2009, the analysis of archival documents, and a community-based participatory research project aimed at repatriating a collection of historic photographs of Inuit tubercular patients who had been relocated and treated at the Mountain Sanatorium between 1954 and 1961. When this ethnohistory project was first envisaged, it was my intention to use the photograph collection to evoke memories and oral histories of tubercular patients from Pangnirtung, to better understand their experience of the disease and treatment for it. During the course of the research, project participants decided against the use of oral history as a research method. Nonetheless, we continued the work necessary to identify in the photos as many individuals as possible from Pangnirtung and surrounding region, which made it possible to create a subcollection of named photographs. Without this project, the analysis of the archival materials would not have reached the depth presented in this thesis.

In addition, working with former tubercular patients proved to be an intensely focused introduction to the kinship relationships, traditional camp structures, and personal stories shared publicly during photograph-identification sessions. These experiences expanded my ability to read the historic records. From this direct experience, I was better able to interpret the written documents because I had become familiar with the link between those named in the Hamilton Sanatorium Patient Photograph Collection, and their name recorded as admitted or transferred in the St. Luke's Hospital day books. Although I am unable to bring oral history as a direct voice into this thesis, the experience of the community-based participatory research project enriched my ability to interpret the archival narrative and make connections between disparate documents.

My goal for this dissertation is to understand the complexity of the relationship between Church- and State-mediated medical treatment and care programs for Inuit in the Cumberland Sound region from 1930–1972. To do so, I draw on archival evidence from the 1920s through the 1970s (letters, diaries, hospital and physician day books, patient photographs, health surveys, as well as personal conversations with Pangnirtung Elders, co-research partners, and community participants). This fusion of archival materials represents the voices of Church officials and nurse missionaries, Government officials and medical doctors, and includes reflection from Inuit of the Cumberland Sound region commenting on this past tuberculosis era in the eastern Arctic. The story of tuberculosis is also the story of the Canadian government's concern with Arctic sovereignty, as it strove to bring its most remote region and peoples under federal control and governance. The

policy of transferring tubercular Inuit to southern sanitaria, moreover, became the precedent and model for the centralised hospital care in use today.

This thesis is not about Christianity and disease nor the specifics of Christian conversion of Inuit in the Arctic and the Cumberland Sound (Rutherdale 2002); neither does it investigate links to Inuit Shamanic practices (Laugrand, Oosten 2009) nor explore Inuit perceptions of health and healing (Fletcher & Kirmayer 1997).

I probe the history of health care provision for Inuit of the Cumberland Sound to chronicle the role played by tuberculosis care in leading to the end of Anglican mission medical care at St. Luke's Hospital in 1972. This is a local history, situated within the literature describing the overarching experience of tuberculosis among the Inuit (Grygier 1994; Grzybowski 1972; Olofsson 2008; Vanast 1991).

Pangnirtung is the place where people from divergent background and intention cross the borderlands and unite. As the ensuing chapters show, the local story of St. Luke's Anglican Mission hospital in Pangnirtung reveals how tuberculosis changed regional Inuit culture in the Cumberland Sound and reveals the variety of factors that influenced the decline of endemic tuberculosis in the region.

Structure of the Dissertation

This study contributes a regional analysis of tuberculosis in the Eastern Arctic to the literature on tuberculosis among the Canadian Inuit, including Arctic-wide perspectives on this era (Grygier 1994), the provision of health services as part of the sovereignty agenda and modernisation of the North (Damas 2002; Duffy 1988; Jenness

1972), the relationship between contact and infectious disease (Fortuine 1981, 2005; McGhee 1994; Stevenson 1997; Waldram et al. 2006; Young 1988; Young & Bjerregaard 2008), the history of Anglican missions in the Arctic (Laugrand et al. 2003; Lister 2004; Rutherdale 2002; Tester 2006; Trott 2004), and the history of health care in the Canadian North (Bonesteel & Anderson 2008; Brett 1969; Graham-Cumming 1969; Schaefer 1993).

Chapter Two describes the complexity of acquiring permission for the access to sensitive and confidential archival collections that include patient records, the development of an appropriate community collaborative research project, the subsequent management of the outcomes to benefit the participants, and the dissertation data-analysis process.

Chapter Three chronicles the historic events leading to the introduction of missionary medical care in the Cumberland Sound Region and the interconnected tensions between Church and Government at St. Luke's Hospital. This history begins in 1894, in which tuberculosis is endemic to the region and a major focus of medical care, and where incidences of influenza, *ship colds*[2] and daily general care, surgeries, and childbirth are also part of the services provided. This chapter follows the voices of Church and Government officials, doctors, nurses, and the Inuit throughout the timeline to show the mounting impact of the changes in government patient funding policies for tuberculosis care, which started to occur in the mid-1940s, and became fully implemented

[2] The term used to describe the annual colds that happened because of contact with the incoming ships.

in the 1950s. During this period, relationships were formed and the hospital as a healthcare industry centralised the development of the community hamlet and its expanding infrastructure.

Chapter Four details the conflict between the Anglican Church and Government departments regarding expansion, patient grants, nursing and medical staff, and healthcare dollars. The policy shift reducing patient funding grants imposed the implementation of the centralised system of healthcare, which involved transferring a number of tubercular Inuit patients to sanatoria in southern Canada.

Chapter Five details a decade of patient care using data derived from St. Luke's Mission Hospital's day books. Information on traditional camps of tubercular Inuit is mapped to show the distribution of tuberculosis during this ten-year period. The flow of tubercular patients admitted to St. Luke's and their transfer to other specialised centers paints a picture of tuberculosis in the Cumberland Sound region and shows that fewer patients were sent away than were treated locally.

Chapter Six reflects on the local care of tubercular patients at St. Luke's Hospital and its evolution from a general hospital to a long-term care facility. Transfers to southern sanatoria slowed, and patients from various locations through Baffin Island were sent to Pangnirtung for long-term care and tubercular drug programs. This chapter concludes with an overview of the events from the 1960s onward that lead to the closure of St. Luke's Mission Hospital in August 1972.

Chapter Seven summarises the 42-year history of St. Luke's as a place in which Church and State wrestled over the control of Inuit healthcare. I argue that the State gained control over Inuit healthcare, but St. Luke's won their hearts.

Chapter Two
From the Archive to the Lived Experience: Research Materials, Methods, and Process

Three archives contributed materials used in this dissertation: the Anglican Church of Canada General Synod Archives (ACC/GSA, Toronto, ON), the Royal Ontario Museum Bildfell Collection (Toronto), and the Hamilton Health Sciences (HHS) Archive at the History of Medicine Unit of the McMaster University Health Sciences Library (Hamilton, ON). The majority of documents studied here were drawn from the Anglican Church of Canada General Synod Archives. The records specific to St. Luke's Mission Hospital in Pangnirtung are remarkably comprehensive.

I have been studying these records since 2001, through a progression of community research projects and my 2006 M.Sc. thesis, "*Take Your Medicine: The Knowledge of Resourcefulness. Inuit, Nurse Missionaries, Medical Doctors and Sanitary Science"* in the Department of Anthropology at the University of Edinburgh, and have come to appreciate the complexity of the chronicle of the history of the Anglican medical mission in the Eastern Arctic. With this previous work accomplished, I was better able to cross-reference the files and develop a chronology of medical events at St. Luke's to investigate the involvement of the Anglican Church in tuberculosis care. At the center of this investigation are the files containing the St. Luke's Mission Hospital day books. I first give a brief overview of the materials and process leading to the Pangnirtung community project, and conclude with the outcomes of this fieldwork.

Hospital Day Books

The St. Luke's Mission Hospital day books (Physician's Day Book 1931–1954, 1955–1966, 1967–1972) proved to be the richest document from the General Synod holdings that I have permission to use in this analysis. The St. Luke's physician's day books (hospital day books) start in 1931 and end in 1972, anchoring the letters, reports, and other qualitative sources consulted for this study. The hospital day books are hardcover bound ledgers and contain the supervising nurses' handwritten records of each patient. This series of books is a complete record of the entire admittance and discharge history of the medical services provided to all of the Inuit and non-Inuit patients cared for at St. Luke's Mission Hospital in Pangnirtung, and stands alone as the only record of its kind.[3] To the best of my knowledge, this is the first time that the hospital day books for St. Luke's have been studied and analysed.

The patient information content of the 1930–1972 hospital day books is confidential material monitored by the Anglican General Synod Archives. Permission to access this information resulted from a mutually negotiated set of guidelines.[4] To meet this commitment, names and Eskimo Numbers (E#) were excluded to protect the individuals' right to confidentiality concerning the specifics of their case. The materials

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[3] Although the Anglican Church of Canada operated several medical care facilities throughout the Arctic, the St. Luke's Mission Hospital day-book archive is the only surviving complete record of patient care.

[4] Prior to entering into graduate studies, I was a health professional regulated in the Province of Ontario. My 25-year professional career in the health-care sector prepared me for the restrictions faced when working with historic records containing confidential information. Further, I was involved in round-table consultations concerning patient-confidentiality legislation and profession-specific ethical guidelines. My regulatory experience and skills aided me in creating the memoranda of understanding used in this study, to be able access a wide variety of primary archive resources identified as patient-confidential materials protected by privacy legislation.

relating to the hospital day books were returned to the Anglican General Synod Archive in Toronto at the completion of my research. This study has not suffered because of the restrictions in place to protect patient confidentially. The hospital day books were used in this study for the calculation of monthly and annual totals of patients and conditions requiring care at St. Luke's Hospital, the Government payment of health care provided to the Inuit, and the verification of significant events mentioned in correspondence and reports during the study period.

The hospital day books also present a counterpoint to letters and reports about disease and patient numbers written by Anglican nurse missionaries and Government medical doctors. In some instances, statements in letters or reports do not correspond with the patient numbers recorded in the ledgers. To some extent, this difference is the result of conversational writing, and estimation versus accurate records. The three hospital day book ledgers contain an accurate verification of the patient in-hospital records, tracking each individual from admittance to discharge. Further, the hospital day books are useful for verifying facts, such as government accounts for payment of patient treatment grants. I consulted a range of correspondence between the Bishop and other church officials with the Pangnirtung nursing staff, as well as letters with various government departments and officials that are located in numerous separate files within the Arctic Diocese Collection of the Anglican Church of Canada General Synod Archives. These documents provide statistical information concerning patients, types of infectious disease in this region, the prevalence of hospital-treated tuberculosis, and the accounts that formed the basis for the payment of patient care grants from the Government to the Church.

St. Luke's Hospital provided treatment for two classifications of patients: general medical patients who were visitors to the outpatient clinic or admitted into hospital for care from regions within reach of the hospital, and patients brought by ship or dog team patrol from various locations throughout Baffin Island. These transient patients were termed "destitute" or "indigent" patients because they remained in the hospital facility, in the upstairs dormitory, after discharge. These patients were Inuit waiting to return by ship to their original point of departure (Department of Mines and Resources 1941).The Industrial Homes were first established in 1938 at the Chesterfield Inlet Roman Catholic hospital, and two years later at St. Luke's in Pangnirtung (Jenness 1964:69).

Jon A. Bildfell Collection

The Department of World Cultures at the Royal Ontario Museum (Toronto, ON) provided access to the Dr. Jon A. and Muriel Bildfell. This collection contains files in the form of reports and journals of three medical officers—Drs. J. A. Bildfell, A. G. McKinnon, and T. Orford—who served the Eastern Arctic Medical Patrol at Pangnirtung from 1922 to 1942. Together, these documents represent the experiences of men serving as doctors and officers, who came to the Arctic to bring medical care to the Inuit.[5] They offer insight into how the medical programs at St. Luke's were administered, and provide a record of the decisions that controlled tuberculosis care.

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[5] I attempted to locate the entire list of medical doctors serving the Eastern Arctic Patrol throughout its history. Unfortunately, this record is neither compiled nor available. Although this analysis is limited to the reports of three doctors, the information provided is specific to St. Luke's and the Cumberland Sound region and injects a narrative that supports the day-book accounting.

The Mountain Sanatorium Inuit Patient Photograph Collection

A collection of 2,014 black-and-white photograph negatives of unidentified Inuit patients sent to the Hamilton Mountain Sanatorium proved to be central to this study (Hamilton Mountain Sanatorium N.d.). The collection is held in the Hamilton Health Sciences Fonds at the History of Medicine Unit of the McMaster University Health Sciences Library, also in Hamilton, Ontario. The photographs in this collection appear to be an annual visual inventory of patients' portraits, taken by volunteer amateur photographers from 1955 until 1969. The photographers posed the patients mostly at their bedside or in bed, in small groupings, or individually. Interspersed throughout the collection are images showing scenes of gatherings such as parties, children in school, patients constructing sewn goods, or making soapstone carvings.

Recognising the significance of the collection, I arranged to bring this collection into my doctoral thesis as a community-based research project (for other community-based research projects that use photographs as part of their methodology, see Banks 2001; Becker 1998; Bouquet 2000; Chalfen 1995; Collier 1986; De Cuyper 1998; Peterson 2005; Scherer 1995; Vastokas 1996; Wang 1997). The community partners wanted to identify unnamed persons in the photographs and obtain copies of them for their family albums. I wanted to explore how photographs of tubercular patients might provide important visual evidence of personal history (Edwards & Morton 2009; Pink 2001, 2004), provoke memories of the collective history (Brown & Peers 2006; Kuhn 2006) for the Inuit of the Cumberland Sound, and guide the project toward oral history (Olofsson 2008). However, as the project continued, the participants decided against

sharing personal histories because they considered them to be private and not appropriate for a dissertation. They simply wanted to name their family members and receive copies of the photographs. Respecting their wishes, we continued the project, named individuals in the photographs, and celebrated the return of copies of photographs to the individual or their relative. I made the commitment to protect their privacy and respect the confidential information I heard and witnessed.

During the 2008 fieldwork visit in Pangnirtung, the photographs did provide insight into their intended purpose. Several members of the Elder Advisory Committee confirmed that it was their understanding that the photographs represent patients who remained in the sanatorium. Their photographs, taken at the time when other patients were being discharged, were then sent to their families to show that their loved ones were well and cared for. It was evident that Inuit patients realised that having their photograph taken meant that they would remain in hospital, rather than return home. Two members of the community brought me their original photographic prints kept in their personal photo albums, verifying their understanding of the purpose of the tubercular-patient photographs. The Hamilton Health Sciences Archive does not have any record of the purpose of the photographs.

After the community project ended, the data identifying many of the Pangnirtung patients sent to the Hamilton Sanatorium made it possible to interpret and glean more information contained in the hospital day books and cross-reference it to other archival documents.

Situating the Research in Pangnirtung: Relationships Formed in the Past

In addition to studying and cross-referencing the documents described above, I conducted fieldwork in Pangnirtung, on and off, from 2007 to 2009 totalling seven separate visits for consultations, project work, community celebration, and follow-up meetings to share results of the data analysis. These were not my first sojourns there. I lived in Pangnirtung from 1985 to 1986, and formed lasting friendships within the community. I have returned to Pangnirtung on annual visits since 1992, and through these relationships, have participated in several community-based studies of the mission hospital (Cowall 2004, 2005).

When I started my doctoral program in 2006, my long-standing friend, Nancy Anilniliak, asked me to investigate the topic of tuberculosis. Nancy told me her childhood story in which she remembered being taken from Pangnirtung on a ship and sailing to a hospital in the south. She did not know how old she was, where she had gone to, or why. Nancy's request impelled me to undertake this dissertation project. During research at McMaster's Health Sciences Library, I located the collection of black-and-white photograph negatives that depict unidentified Inuit patients treated at the Mountain Sanatorium in Hamilton from the 1950s to 1960s. As I viewed the contact sheets, I recognised faces of Inuit from Pangnirtung. I consulted Nancy concerning her availability to review my findings and to comment on the appropriateness of proposing a community project.

Nancy Anilniliak visited Hamilton in the summer of 2007. Together, we reviewed the photographs in the collection, and she confirmed my original observation that there

were many portraits of Inuit from Pangnirtung. During this review, we also found a photograph of her in her bed. The archivist at McMaster's History of Health and Medicine Library located the original copy of Nancy's sanatorium discharge card, completing the search for the record of her experience.

I arranged a tour of the buildings at the former site of the Mountain Sanatorium, and it was there, in the former children's ward at the Holbrook Pavilion (Figure 2.1), that Nancy recalled details of her experience 48 years previous when she lived at the sanatorium. I was with Nancy when she lingered in one room as we toured, remembering the position of her bed by aligning this memory to the view through the windows.

(a)

(b)

(c)

Figure 2.1: Nancy Anilniliak (a) at the Holbrook Pavilion, (b) the door to her room, and (c) in her childhood room. Photographs: ©Emily Cowall 2007.

Figure 2.2: Photograph of Nancy Saimajuk Anilniliak (Hamilton Mountain Sanatorium, N.d.), used with consent.

This visit to the former Hamilton Mountain Sanatorium helped Nancy locate her personal hospitalisation history, which resolved her many unanswered questions about her illness experience. This discovery of the potential to bring the photographic collection into the methodology of a community-based collaborative research project had its beginnings in this successful outcome for Nancy Anilniliak.

Pangnirtung Research Partnerships

The Nunavut Research Institute (NRI) is mandated to ensure the methodological process aimed at the protection of Inuit intellectual and cultural property and provides ethical and collaborative project model guidelines, which are distributed electronically to researchers via the NRI website (Nunavut Research Institute 2006). Non-Inuit researchers working in Nunavut must build respectful relationships with Inuit experts. Partnerships use consensus models, and negotiated community-based research projects provide local Inuit with the opportunity to engage as co-researchers and build knowledge transfer

capacity (Bennett & Rowley 2004; Laugrand et al. 2003; Ootoova et al. 2001). In my case, having a long-standing relationship with the community of Pangnirtung has not made my work as a researcher easier or privileged. I still had to be mindful of conflicts between my personal interest and the role of a researcher, causing me to be exceptionally aware of my conduct. This responsibility caused me to engage Inuit partnerships under the NRI guidelines and ethical expectations at the community level to aid in navigating the complexities of my position throughout this field research.

Nancy Anilniliak has supported my education in appropriate research practices when she introduced me to the co-management of projects with the cultural specialists and research partners, during our first collaborative study in 2003. With each successive project, I have sought guidance and clarity, which has expanded my own capacity in community collaborations. Together, we discussed the details of the project and shared opinions and suggestions for project modifications or improvements, in order to reach a consensus and collaborative approach to our work. This vital partnership ensured that I did not disadvantage or place my participants in compromising situations brought on by miscommunication, or by a bias that may have been inherent because of my long-standing relationships within the community. I also relied upon my Inuit co-partners to engage in pre-meeting discussions before working with the community or meeting officials, talk over my presentation plan, and provide advice on protocol. The cultural specialists, Elder advisors, and research partners guided every aspect of the project. They became the primary investigators and I supported their work. This methodology provides the opportunity to build community research capacity (Crisp et al. 2000), yet is also formed

and guided by the specific self-identified needs of the community itself. Collaboration with the Inuit of Pangnirtung has provided me with an opportunity to engage in the expected research methodologies and has allowed me to learn through both observation and participation (Cowall 2004). The cultural specialists, research partners, and Elder advisors enriched this study with personal knowledge of events, or specific clarifications required to detail maps or to help answer questions arising from my research. They provided consent to include their opinions, knowledge, and contributions. Some requested to remain anonymous and this wish was respected.

Inuktitut is important for the process of building community partnerships and respecting the needs of participants working on project details. I requested that project-working sessions be conducted in Inuktitut, without simultaneous translation and relied on my partners to translate important details, or when they observed that I might not have understood the conversations. I have acquired a basic understanding of Inuktitut, sufficient to follow word phrasing and patterns and have a general grasp of conversations. I first studied Inuktitut when I lived in the community in 1985, and I have since taken formal introductory Inuktitut language courses. My friends patiently spoke Inuktitut to engage me in dialogue, and, although I did not have a masterful command of the language or fluency in it, my basic language skills have provided me with the ability to be an active listener, responsive and engaged in conversations.

The Pangnirtung Photograph Naming Project

The Photograph Naming Project became an important part of the research process for this dissertation. I developed it as a community-based participatory research project aimed at identifying, naming, and repatriating print copies of the personally identified black-and-white photographs of the Pangnirtung Inuit tuberculosis patients cared for at the Mountain Sanatorium. Our criterion for inclusion was based on the E6 series numbers assigned to Cumberland Sound regional Inuit (see Alia 1994:38). In this project, the term "repatriation" refers to the returning of printed copies of the identified photographs either to the individual (surviving) or to a family member (deceased). The original negatives used in this study remain in the Hamilton Health Sciences Archives at McMaster University (Accession #1993.60).

In preparation for the project, I relied on the archival materials at the Anglican Church of Canada General Synod Archives in Toronto (hereafter, Anglican archives) and Hamilton Health Sciences Archives, History of Medicine Unit of the McMaster University Health Sciences Library, Hamilton (hereafter, McMaster archive). At the two archives, I was required to submit a copy of my research proposal and letters of request to access the collections. Both archivists were obliged to discuss the importance of privacy legislation, and the sensitive nature of files containing information about medical treatment. The purpose of my research at the Anglican archives was to link Inuit tubercular patients transferred from St. Luke's Mission Hospital in Pangnirtung to the Hamilton Mountain Sanatorium.

At the Anglican archives, I studied the St. Luke's Hospital Day Books, and used the 1957–1959 sections of the ledgers that contained notes indicating the transfer of the tuberculosis patient to the Sanatorium in Hamilton. From this section of the ledgers, I identified 37 patient transfers. I submitted the list of 37 patients to the archivist at McMaster and requested a search of the Central Patient Discharge Cards (Hamilton Mountain Sanatorium N.d.). The purpose of this search was to verify the transfer between St. Luke's and the Sanatorium. The archivist was able to verify the records of 24 Inuit patients out of the original list of 37 that I had submitted. Moreover, the McMaster archive verified that 22 surviving discharged Inuit patients returned home after an average stay length of one year. In addition, the bodies of two deceased Inuit were returned to the Arctic for burial. The effort involved in comparing and cross-referencing two separate archival collections confirmed identifiable information on specific individuals and served to anchor the project to a documented starting point and list of tubercular patients.

With the verification of patients accomplished, I counted the images in the McMaster Archives collection, revealing 2,014 individual black-and-white photographs of Inuit tubercular patients. The archivist arranged to print the collection's 35-mm photographic negative strips onto 117 contact sheets labeled by year or, in some instances, with a note that stated the location in the Sanatorium complex. I negotiated the use of the photographic archive and converted the slide negatives into digital files.

Once the digital files were prepared, the next phase of the project involved taking them for viewing at Pangnirtung. The first community consultation meeting took place on February 23, 2007, during which I introduced the research material to the Hamlet Council

and community to provide them with the opportunity to consider volunteering to participate in the project. Community endorsement, research participants, an Elder advisory committee, and support from various sources brought us together in our two-year pursuit of viewing photographs and identifying the sub-collection of Inuit from the Cumberland Sound region. The project proceeded to obtain research a license from the Nunavut Research Institute, as well as the McMaster Research Ethics certificate.

Many agencies and funders provided financial support over the years, including the Indigenous Health Research Development (IHRDP) Program Research Grant and Graduate Scholarship, the Northern Scientific Training Program, and McMaster University Graduate Field Study funding. Qikqitani Inuit Association provided airfare for a consultation meeting. Parks Canada Agency Nunavut Field Unit supplied meeting rooms and accommodations, office support services, and the public audiovisual theatre. Finally, the Hamlet of Pangnirtung provided the community town hall for meetings.

Billy Etooangat was the principal research partner who assisted me throughout the entire project and was instrumental in conducting all meetings in which the groups examined the photographs to name those they could identify. Nancy Anilniliak was the driving force behind all negotiations in Nunavut, especially in accessing various levels of government. The Elder advisory committee, as well as all of the elders and community members who attended the hours of photograph viewing, did so with patience, humour, and dedication. Anilniliak and Etooangat co-hosted the proceedings of the Photograph Project Celebration "Bringing the Pictures Home"—held at the Pangnirtung Community Centre on March 22, 2009—and handed out the copies of the identified photographs.

(a)

(b)

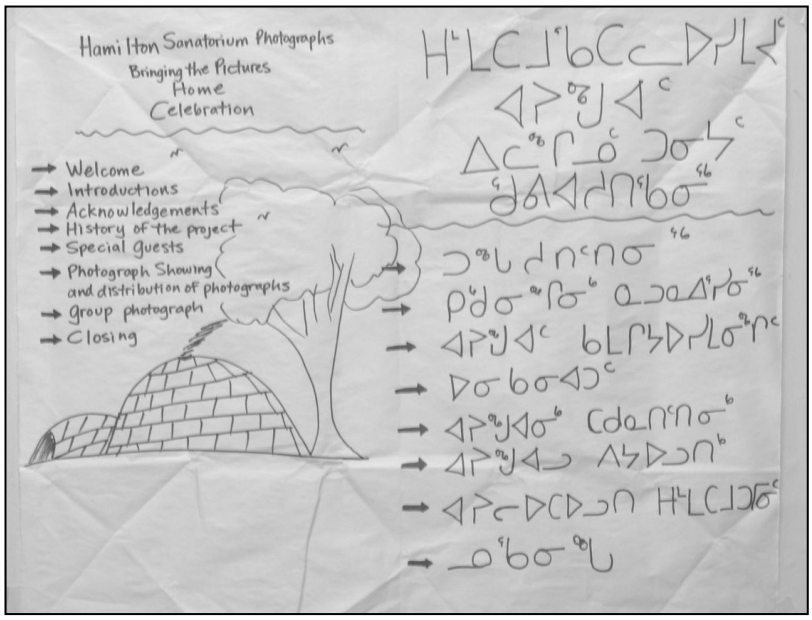

Figure 2.3: (a) Nancy Anilniliak with the welcome sign, on March 22, 2009. (b) Closeup of sign detail. Photographs: ©Emily Cowall 2009.[6]

[6] Nancy and I co-created the agenda for the celebration and the welcome sign. Nancy wanted to bring the elements of trees with the *iglu* to represent the coming together of the two places that these patients had experienced. I provided the drawing of the tree and English poster, Nancy provided the drawing of the *iglu* and Inuktitut translation.

Figure 2.4: Nancy Anilniliak handing Billy Etooangat his Hamilton-Sanatorium photograph. Photograph: ©David Kilabuk 2009, used with permission.

This event provided the opportunity for surviving tuberculosis patients to share memories of their time away at the Hamilton Sanatorium, medical treatment, and return home. They, together with family members of deceased former patients, received a copy of their photograph, completing this phase of the research. A local photographer, David Kilabuk, recorded the event, providing a visual record of this moving occasion.

Figure 2.5: Community celebration on March 22, 2009. Photograph: ©David Kilabuk 2009, used with permission.

Community members reflected on their personal resolution and sense of coming to terms with the past as a result of receiving their photograph. The Mayor of Pangnirtung, Mosesee Qaapik, congratulated the committee, researchers, and volunteers for their diligence and expressed his belief that this project benefited the ongoing work of community-wide reconciliation and healing.

Figure 2.6: Former Mountain-Sanatorium TB patients who attended the community celebration: *Back row, from left to right:* Sinea Kakee, Lucy Nuvaqiq, Norman Akpalialuk, Jeannie Alivaktuk, Adam Pudloo Kilabuk, Billy Etooangat, Leopa Akpalialuk, and Nancy Anilniliak. *Front row, from left to right:* Emily Cowall, Leah (Kudloo) Evic, Rosie Veevee, Elijah Nowdlak, and May Akalujuk Londsdale. Photograph: ©David Kilabuk 2009, used with permission.

The project provided the participants with three years to reflect on tuberculosis, its treatment either near or far from home, and share in remembrance through the naming of patient photographs. During the community celebration, the Mayor of Pangnirtung expressed his opinion that the project contributed to the healing process for those affected

by this experience directly, and that the results were also important to the families of the former patients and would serve to inform future generations of this important history. The former patients reassured me that they viewed the sanatorium as a place where they were cured of their tuberculosis. Witnessing this resolution through the expression of stories of hardships during travel to the sanatorium, their lives while away, and the difficult return and reintegration to ultimately express their gratitude, was an important contributor to my understanding of this process.

My participation in the three-year Pangnirtung photograph-naming project shifted the focus of this dissertation and provided me with insights that fostered my ability to view archival sources with a new and intimate perspective. When I returned to reading the St. Luke's Hospital day books to confirm the numbers of transferred patients and to verify statistics, it was apparent that my experience with the community illuminated the information. I understood the significance of the records left from the hospital in Pangnirtung in a new way. I recognised the patterns of disease distribution, as well as those who had shared their stories as I reviewed the monthly numbers of patients. This provided a unique perspective for analysis and interpretation and, ultimately, assisted in identifying gaps in the St. Luke's Hospital day books.

Chapter Three
Church and Government Health Services for Northerners, 1894–1950

Using a chronological progression of events from the late nineteenth to the mid-twentieth century, I discuss in this chapter the history of contact between Panniqtuumiut[7] and foreigners, the establishment of interpersonal relationships, and the development of the hospital in Pangnirtung and its ensuing community-wide acceptance. I document significant acute epidemics and their impact on the population, and the path that lead to tubercular-patient care of in Pangnirtung and, eventually, in distant hospitals to the south.

This was a period during which public health strategies such as hygiene and sanitation became integrated into Inuit culture through encounters between doctors, nurses, and Panniqtuumiut at the hospital and in the wider community. For example, these new strategies were implemented by designating specific places for sewage and garbage disposal, introducing oil stoves to melt ice for hot water, as well as scrub boards and washing machines. At the same time, the Inuit exposed the doctors and nurses to traditional knowledge and skills about travel and survival on the land during medical patrols. The deeply cherished cultural values of community and family were translated into respectful relationships with doctors, nurses, and Church officials (Cowall 2004; Hankins 2000; Trott 2004; Pangnirtung Hospital St. Luke's General File 1938–1983).

I draw on a variety of documents that reflect multiple perspectives and include the mission-hospital reports, as well as correspondence between Anglican nurse missionaries

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[7] The transliterated Inuktitut spelling of Pangnirtung is *Panniqtuuq*, and the Inuit of this place are referred to as *Panniqtuumiut*.

and Church and Government officials (Anglican Church of Canada General Synod Archives), correspondence authored by Eastern-Arctic medical-patrol doctors (Royal Ontario Museum), and Inuit hospital workers' oral-history accounts (Cowall 2004).

Before the Hospital: The Cumberland Sound Region 1880–1913

The arrival of the Churchman's Missionary Society of England (the precursor to the Anglican Church of Canada) coincided with the employment of Inuit in the European bowhead whaling industry in the Cumberland Sound region of Baffin Island, from the mid-1800s to 1913 (Stevenson 1997:88-90). In 1894, Reverend Edmund J. Peck built a mission station at Umanaqjuaq (Blacklead Island)[8] alongside a whaling station, and there engaged the Inuit in conversion to Christianity (Oosten et al. 2006:452–454; Figure 3.1).

Figure 3.1: Rev. Peck and Inuit, in Blacklead Island (Uumanarjuaq), on September 5, 1903.
Photograph: National Archives of Canada (PA53574).

[8] Stevenson (1997) refers to Blacklead Island by using *Umanaqjuaq* as the spelling. Oosten et al. (2006) refer to Blacklead Island using *Uumanarjuaq* as the spelling. Both researchers used spellings advised by Inuit participants, and both spellings are present in this thesis, depending on the citation.

Peck and his two assistant clergymen, Reverends Julian Bilby and Edgar Greenshield, assisted in the introduction of a written form of the Inuktitut language using an adapted system of Cree syllabics (Laugrand et al. 2003:32). They trained Inuit catechists to aid in Christian conversion at the traditional Inuit camps located away from the central mission (Laugrand et al. 2003:36). Many missionaries who served the Missionary Churchman's Society undertook general medical training prior to their tours of duty, and Bilby and Greenshield were no exception. Bilby and Greenshield built a medical shack used to administer basic medical respite (Arctic File N.d.). They tended to the needs of the ill and injured at Uumanarjuaq (Blacklead Island), yet their medical work was not without its problems. A traditional *angakok*, or Inuit shaman, administered to the needs of the camp, and their authority predated the arrival of the missionaries. This was extensively studied by Boas from 1882 to 1884 (Oosten et al. 2006:450–452) and Bilby later published observations of events such as the Sedna ceremony and shamans (*angakkuit*[9]) administering to illness (Bilby 1923:224). Nonetheless, the foreign medical care provided by these missionaries in their small shack coexisted beside traditional healing methods and eventually found acceptance (Arctic File N.d.). As whaling ended at the Cumberland Sound stations, the mission station at Uumanarjuaq closed in 1913.

[9] Oosten et al. (2006) use the spelling *angakok*, while Bilby (1923) uses the spelling *angakkuit.*

Figure 3.2: Construction of the hospital "shack". *Uumanarjuaq* (Blacklead Island), 1894. To the left is Edgar Greenshield, to the right is Julian Bilby. Photograph: ACC/GSA (P7502-35).

Boas' census of the Cumberland Sound in December 1883 counted eight settlements, each with ten to twenty persons, and one large whaling station of eighty-two, for an average of 18.8 persons per camp (Damas 2002:9,20). Later, Stevenson mapped a total of forty-eight sites of historic and archeological significance throughout the Cumberland Sound (Stevenson 1997:51). He suggests that Boas' census represents approximately 1500 Inuit in contact with the whalers and traders in the 1850s (Stevenson 1997:58), although it is unclear which camps he included in this estimate. However, he adjusted this by overlaying Boas' account on the structure of Cumberland Sound camps as described by Eeoolooapik's 1939 map (Stevenson 1997:62), to arrive at a contact population of 1,165 Inuit.

The Medical Mission in Context

The establishment of the Uumanarjuaq (Blacklead Island) mission station medical shack represents an example of what Rosemary Fitzgerald (1997) refers to as "Clinical Christianity", in which missionary medical work during the colonial era became an emerging tool for Christian conversion. The Christian concept of service to others as a work of mercy is a perspective that recognises the link between Christian medical work and a system of belief in which care of the sick is integral to saving the soul of the faithful and the potential convert (Goldin:1994).

The extent of global Christian medical care predates the nineteenth century colonial missionary era and the important role of Christian women in caring for the sick throughout history has received considerable attention by historians of medicine and nursing (Burrows 2004; Choa 1990; Fields 1982; Glittenberg 1974; Hodge 1971; Rutherdale 2006; Van Zandt 1999). Anthropologists have studied colonial missionary stations, schools, and hospitals throughout the world (Arnold 1993; Biswamoy 2001; Cohen 1990; Dunch 2002; Fitzgerald 2001; Hawkins 1997; Kelm 1998; Kwong 1997; Lalu 1998; Landau 1996; Miller 1970; Pollock 1996; Thomas 1994; vander Geest 1992; Worboys 2000), viewing missionaries as an extension of colonial empires and criticising them for their role in the cultural assimilation of Indigenous peoples. On the other hand, Christian scholars reflecting on their own experiences (in medical missionary endeavours) reveal a consciousness and sensitivity toward cultures and culture change, evidenced in their journals, autobiographies, and ethnographic notes (Laugrand 2003; Marsh 1987; Sperry 2001).

In this case, missionaries converted the Cumberland Sound Inuit to Christianity with syllabic Inuktitut (Rasmussen 2006). This introduction of a written system of language may have been rooted in the Churchman's Missionary Society's goal to convert them by introducing translated bibles or prayer and hymnbooks, but the introduction of written language had far-reaching secular impacts. The Inuit language shifted from being an exclusively oral traditional, and entered into a new form of exchange through the activity of writing of letters and reading correspondence, bibles, and publications (Laugrand et al. 2003:6–14). Through this initiative, spanning 1894 to 1913, the Cumberland Sound Inuit were enmeshed in the global process of Indigenous people's entry into colonisation and modernity.

Structure of the Government Administration

Much of the discussion throughout this dissertation refers to the 'Government' as a term applied across the timeline to describe the Canadian Federal Government Administration, and 'Territorial Government' refers to the Northwest Territories Government Administration. In some instances, I am able to provide the details of specific Departments, and the names and official titles of administrators, from documents contained in my archival evidence. However, this is not intended to represent a comprehensive list of Government officials in their capacity; rather, it focuses on the conversations closest to events linked to St. Luke's Mission Hospital and the Anglican Church House in Toronto.

Government Administration in the north is complex, and the history of program and policy underwent many changes during the 1930–1972 timeline of this study. Following the 1890–1913 whaling era in the Cumberland Sound, the Hudson's Bay Company (HBC), the Northwest Mounted Police (NWMP), and missionaries became established in Pangnirtung between 1913 and 1929. Important events in these organisations coincided during the developing relationship between Canada and the Inuit.

According to Sarah Bonesteel and Erik Anderson (2008), the term "Eskimo"[10] required a definition under legislation, and an amendment to the 1876 Indian Act occurred in 1924, whereby Inuit were recognised as Canadian citizens, instead of Wards of the State. Responsibility for the Inuit was assigned to the Department of Indian Affairs and the Minister of the Interior until 1928, when an order in council transferred authority to the Northwest Territories (NWT), operating within the Department of the Interior. During 1930–1932, the Department of the Interior required the Province of Quebec to refund money to the Canadian Government for the Inuit programs because of their northern Inuit population. This brought about the refusal to pay for these programs on the part of Quebec, and the seeking out of judgment to shift responsibility for the Inuit back to the Federal Government. This resulted in the 5 April, 1939 Supreme Court of Canada decision, *Re Eskimos* classifying the Inuit constitutionally as Indians under Section 91(24) of the *Constitution Act*, 1867, and returning responsibility for the Inuit back to the Canadian Government. This decision then underwent appeal for reversal at the Privy

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[10] This term predates the use of *Inuit*.

Council in England, was dropped during the Second World War, and in the absence of comprehensive policy governing the Inuit, two departments responsible for northern affairs (Department of the Interior and Department of Mines and Resources) managed Inuit affairs (Bonesteel & Anderson 2008:6–7).

From 1939–45, the Second World War was the foremost priority for the Government, which held sway over Inuit welfare. Although appeals to amend the decision of the Supreme Court were unresolved, leaving the Inuit without legislation or policy, the *Re Eskimos* decision entitled Inuit to specific and relevant programming, including a provision for health care (Bonesteel & Anderson 2008:7).

1945 was a pivotal point at which the establishment of the Department of National Health and Welfare was formed, bringing the Inuit into a variety of social welfare programs, such as family allowances and healthcare (Jenness 1972:77). Bonesteel and Anderson (2008:7) suggest this marks the beginning of comprehensive programs, such as healthcare, under Government control and decline of funding to religious charities.

Attempts to assert sovereignty over the Arctic Archipelago brought about the 1953–1955 relocation of Inuit to the high Arctic (Damas 2004:52–57; Jenness 1972:58; Tester & Kulchyski 1994), while the Cold War era brought with it the building of the Distant Early Warning Line commencing in 1954 (Lackenbauer et al. 2005:3). In 1962, Indian Health and Northern Health Services merged with other independent federal field services and created the Medical Services Branch (Health Canada 2007). This overview of Government administrative structure frames the relationships between Church and State in the administration of health care from 1930–1972.

Table 3.1: Government administration governing Inuit relevant to the 1930–1972 period (after Bonesteel & Anderson 2008; Jenness 1972; Nixon 1989; Waldram et al. 2006).

Date	Government bureaucracy and milestones governing Inuit	Source
1880	Order in council Governing the Arctic Archipelago	Jenness 1972
1905	North West Territories Act	Jenness 1972
1920–1921	O.S. Finnie, Director of the Northwest Territories Branch	Jenness 1972
1921	North West Territories (NWT) and Yukon Branch, operating within the Department of the Interior	Waldram et al. 2006 Jenness 1972
1924	Department of Indian Affairs took responsibility for Inuit	Bonesteel & Anderson 2008
1930–1932	Department of the Interior	Bonesteel & Anderson 2008
1931–1940	Bureaucracy: Deputy Minister of the Department of the Interior replaced Finnie; Northwest Territories Council comprised of Deputy Minister of Mines, the commissioner of the Royal Canadian Mounted Police, the Superintendent-General of Indian Affairs, Deputy Commissioner of the Northwest Territories and Department of the Interior Secretary.	Jenness 1972
1932	Indian Act amended to delete the Inuit provision	Waldram et al. 2006 Jenness 1972
1935	Department of Mines and Resources	Waldram et al. 2006
1936	Department of Mines and Resources	Bonesteel & Anderson 2008 Jenness 1972
1945	Department of National Health and Welfare	Bonesteel & Anderson 2008 Jenness 1972
1946	Dr. Percy Elmer Moore Appointed as the Director of Indian and Northern Health Services in 1946, he served in this capacity until 1956	Nixon 1989
1947	Department of National Health and Welfare, Campaign against tuberculosis in the Arctic launched	Jenness 1972
1950	Department of Mines and Resources reorganises and department responsible for Inuit is merged and named Resources and Development	Jenness 1972
1950	Department of National Health and Welfare Eskimo health program founded	Jenness 1972
1953	Reactivation of the Advisory Committee on Northern Development	Jenness 1972
1955	North West Territories placed under the Northern Health Service Department of National Health and Welfare	Waldram et al. 2006
1962	Indian Health and Northern Health Services with other independent federal field services created the Medical Services Branch	Bonesteel & Anderson 2008
1966	Department of Indian Affairs and Northern Development	Bonesteel & Anderson 2008

Church Medical Services in the Arctic

The majority of hospitals and nursing stations established from 1867 until the 1920s were operated throughout the Arctic by missionaries and, in particular, by the Roman Catholic and Anglican Churches. In 1922, the Northwest Territories and Yukon Branch of the Department of the Interior implemented the Eastern Arctic Medical Patrol (Brett 1969: 523–524; Graham-Cumming 1969:527; Waldram et al. 2006:199). Dr. Leslie David Livingstone traveled throughout the Arctic Archipelago on the government patrol ship, the RMS *Arctic* (Graham-Cumming 1969:527). In 1925, the Anglican Church established All Saints Mission Hospital in the Western Arctic settlement of Aklavik. The Roman Catholic Church built their own hospital in 1926, and Livingstone cared for patients in both hospitals during his posting there. He opposed the duplication of medical services in a single location and disapproved of religious rivalry and the atmosphere of competition between missionaries. Privately, he opposed the continued development of mission health services that did not have trained physicians on staff (Graham-Cumming 1969:527).

In 1927, Livingstone stationed himself in the newly formed post at Pangnirtung, and accepted the appointment of senior officer for the Federal Government Arctic Medical Patrol in 1928 (Finnie 1928). Livingstone was the principal physician in the north at this time, and would eventually oversee a team of medical doctors that served the Western and Eastern Arctic Medical Patrols. The Federal Government planned to station their medical officers at medical headquarters strategically positioned across the Arctic. From there, doctors traveled to settlements or traditional camps with local guides to offer

care to the regional population. During this period, there were approximately 16 camps in the Cumberland Sound Region (Stevenson 1997:146).

Livingstone preferred land-based services that traveled using a traditional sledge-and-dog team guided by Inuit helpers, and these patrols followed the movement of people in their traditional camps. Livingstone believed that Inuit should remain in traditional camps, consuming a traditional diet, and that any use of the hospital for inpatient care should be as short-term as medically appropriate (Brett 1969:524).

During this period, Pangnirtung was developing into the largest Eastern Arctic post and, at the same time, the Anglican Archdeacon Fleming (soon to become Bishop of the Arctic) was in England raising funds for the hospital (Copland 1967:60). The push was on to build an Anglican mission hospital in Pangnirtung.

St. Luke's Mission Hospital 1930–1931

The 1925 construction of a mission hospital in Aklavik prompted Reverend Archibald Lang Fleming (1883–1953), Bishop of the Arctic Diocese of the Anglican Church of Canada, to lobby for the construction of a second mission hospital in the Baffin region. The memoir of Mrs. Elizabeth Lukens Fleming (1899–1990), written in 1942, offers a detailed account of her observations and reflections on her husband's work. She notes that the Federal Government was lethargic and indifferent to matters of health care for the Eskimos, asserting that the pioneering efforts of the Arctic diocese provided every form of medical service when the Government would not (Arctic File N.d.). Elizabeth Fleming's opinions are not simply those of a wife biased by the work of her husband;

scholars have also characterised the approach of the Federal government to the health care of the Eskimos as distanced indifference (Duffy 1988:3–18; Grygier 1994:181–182).

The Church reached the goal of establishing a mission hospital in Pangnirtung through a multifaceted process that involved liaising with the Canadian Government and extensive congregation fundraising. Traveling to England in 1929, Fleming successfully raised half of the funds required to build and equip St. Luke's Mission Hospital in Pangnirtung; a Montreal benefactor contributed a legacy fund and a Churchill, MB benefactor made a personal donation in support of the hospital. Donations from the Anglican congregation in Canada and England brought the hospital building project within the financial reach of the Church. The Anglican Church built the hospital at a reported cost of $10,000; the Federal Government provided no funds to aid in the construction of this facility (Arctic File N.d.).

Returning to Toronto, Fleming received the news informing the Church to proceed with their plans to build. Although the Church funded the building of the hospital, the Government arranged for the free transportation of the hospital food and medical supplies on the annual government ship, paid the Church per capita patient grants, and provided some medical equipment. The X-ray machine arrived on the ship in 1932, but was useless until 1935, when a gasoline-fuelled generator arrived to provide enough electrical current to achieve substantial images. Even then, the X-ray machine did not fulfill its diagnostic potential. Hospital staff had to send the films for interpretation on the annual ship to Ottawa, and the results and reports returned long after the diagnostic information was required. However, in the meantime, the hospital also had a fluoroscope,

which provided immediate diagnostic information. The iron lung, sent in 1936, was another example of misplaced technology because there was no polio in Pangnirtung.

Other forms of beneficent activity supported the operations of the hospital. The Endowment of Hospital Beds donations were either held in trust to the Diocese of the Arctic (Figure 3.3), or were supported through memorial donations, monies generated by Women's Auxiliary (W.A.) fundraising, and Sunday-school projects (Endowments of Hospital Cots File 1930–1939). Other Church member donations, especially memorial funds, supplied furnishings to provide comfortable living and work environments. The Dominion Board of the W.A. provided for St. Luke's bathroom, and the Toronto Diocesan W.A. donated $1,000 in supplies, such as flannel sheets, pneumonia jackets, aprons, and rugs (Arctic File N.d.).

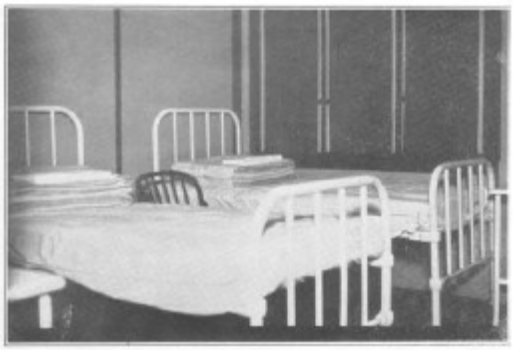

Figure 3.3: Hospital beds (The Living Message File 1931).

The financial and material support for St. Luke's Hospital continued to flow from the Anglican Church and private benefactors. R. Evan Perry, Architects, Toronto (the architect for the Department of Health), supplied the blueprints for a proposed hospital in 1930 and the hospital powerhouse in 1932. John Witchall, a contractor supplier, donated

his time to organise the acquisition of supplies for the building. George Nicholson, a trained missionary and carpenter-builder, donated his time to supervise the project. Price Brothers of Quebec donated half the shipment of "Donnacona"[11] insulating fiberboard needed to line the structure (The Living Message File 1931).

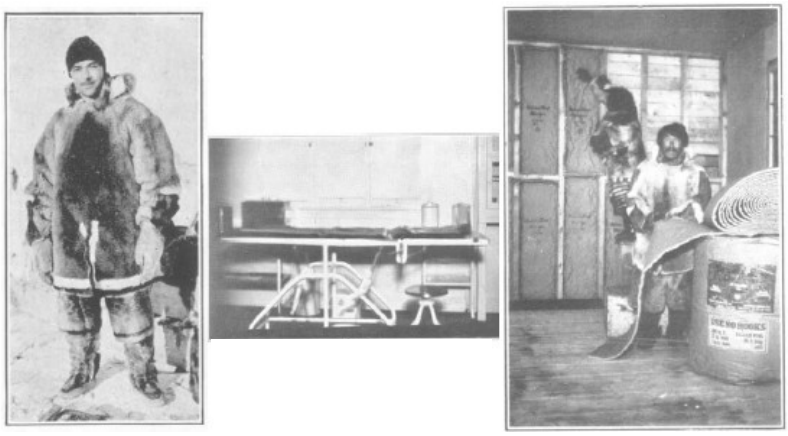

Figure 3.4: The builder (Mr. Nicholson), the operating room, and Inuit helpers (The Living Message 1931).

The construction of St. Luke's Hospital started in 1930, and on October 6, 1931, its doors opened for hospital care (Physician's Day Book 1931–1954). A plaque mounted in prominent view inside the doors of the hospital in Pangnirtung explained to all that St. Luke's Hospital was supported by "contributions received from patients able to pay … per capita grants from the Dominion Government and free will offerings from friends in the North and South". During a personal conversation in 2003, former Inuit hospital

[11] Donnacona is a brand-name fiberboard, known for its insulating properties and manufactured in Donnacona, QC (Dominion Tar and Chemical Company, c. 1959).

workers told me that patients did not have to convert to Christianity before receiving medical care (Cowall 2003).

Figure 3.5: Ground plan of St. Luke's Hospital, 1931 (The Living Message File 1931).

St. Luke's Hospital housed living quarters for the nurses, a solarium and nursery, separate wards for men and women, an operating room, a kitchen and, according to the endowment of beds funds, two beds for TB patients when the doors opened in 1931. Over time, as the hospital expanded, the bed allocation for TB patients expanded as well. The hospital provided treatment for all health conditions, including influenza, typhoid, 'ship time' disease, surgeries, and any other medical emergencies. The doctors performed minor surgeries and dentistry and traveled by land throughout the region on traditional camp patrol (Hockin 1930–1936).

The mission hospital provided general medical and surgical care with an adjunct facility for tubercular patients, while the Government doctors conducted surveys of the population and patrols to examine Inuit in remote locations. The doctors were

Government employees first recruited in 1921 by the Northwest Territories Branch of the Department of the Interior and, after 1935, by the Department of Mines and Natural Resources (Waldram et al. 2006:199). The port of Pangnirtung provided a location for medical patrol ships and later for the air transport of patients. Stevenson has charted the populations of the region and settlements from 1923–1936, with over 25 different place names, Pangnirtung included. The population for the region in 1923 was 325 Inuit, with 39 located in Pangnirtung. In 1927, there were 323 Inuit in the region and 66 in Pangnirtung. In 1930, the population in Pangnirtung was unknown, yet regionally there were 269 Inuit. In 1933 and 1936, there were 54 Inuit in Pangnirtung, and throughout the region, the population ranged from 340–391(Stevenson 1997:99).

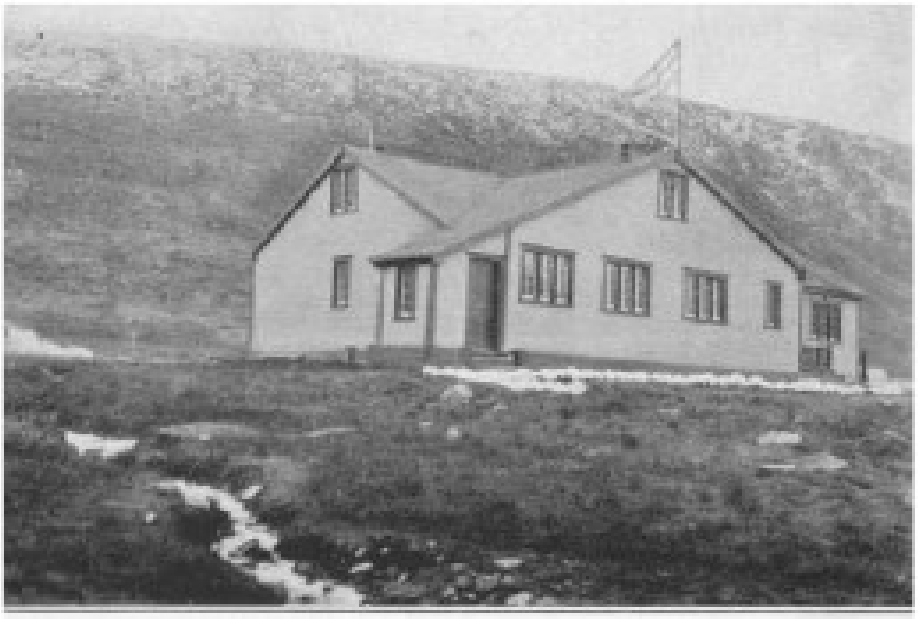

Figure 3.6: St. Luke's Hospital, 1931 (The Living Message File 1931).

Nurses for the Hospital, 1930

The economic crash in 1929 through 1933 increased the number of both married and single women seeking work outside of the traditional role of homemaker. Women were paid less than men were, and employers took advantage of that. The Depression saw an increase in single woman professionals, such as teachers and nurses who appreciated the financial security of working, which helped support their families (Mills N.d.). Nursing was a popular profession for women, and service in Church-operated hospitals offered nurse missionaries the possibility to travel to regions and places that presented them with the prospect of adventure and unconventional independence (Rutherdale 2002).

To recruit women for service as nurse missionaries, a process managed by the Missionary Society of the Church and the Woman's Auxiliary, applicants had to complete a form, titled *Candidates' Committee Personal Questions to be answered by Women* (St. Luke's Hospital Personnel File 1965–1972). In addition to answering a variety of questions about her education, professional training, and missionary or church involvement, prospective applicants could indicate their desired role, such as nursing or teaching, as well as preferred location for service. The Diocese of the Arctic sent reports on the candidates to the Bishop and selection committee, and then arranged personal interviews. This process was similar to nurse applications for Government or private hospital work; however, the Church expected nurse missionaries to place missionary service in the forefront of their nursing tour of duty (Hockin 1930–1936).

Once selected, the Church submitted a request to the Federal Government for the appointment of the nurse as a public servant receiving a Government salary. In 1930, the

monthly salary grant received from the Government was $90 and the Church deducted a monthly board of $25 (Hockin 1930–1936). Anglican women missionaries were obliged to provide spiritual conversion as part of their duties. The term of service was five years. For some, the demand of nurse and missionary would prove to be an opportunity for success and unexpected individual growth. Edith Prudence Hockin, the first head nurse at Pangnirtung in 1931, exemplifies this. She went on to serve Inuit and other northerners for more than thirty years. Hockin received the honor of Companion of the Order of Canada in 1980 for her exceptional service. The Order of Canada website states that Hockin was known as the "great queen lady". During a personal discussion in 2003 with three Elder women in Pangnirtung who were former hospital workers (Rosie Veevee, Evie Anilniliak, and Siloah Metq), they told me that they called Hockin, *anaana*, which is 'mother' in Inuktitut. However, nursing tours of duty were not always so successful; some women were not suited to the isolation of life in the north, and some suffered ill health or experienced tragic circumstances and had to leave Pangnirtung (Diocesan File 1938-1983).

Figure 3.7: Edith Prudence Hockin, circa 1930. Photograph: ACC/GSA (P9314-47).

The nurses, like the doctors, were not immune to the excitement of the life of adventure provided in this remote tour of duty, and they wrote insightful journals and letters from a woman's perspective. Their influence as nurses and missionaries was critical in developing the modern role of women in the community (Rutherdale 2002) and they provided guidance to many of the young women hired as nurses' aides (personal conversation with Evie Anilniliak, Pangnirtung, 2004). The nurse diaries and journals, such as the ones written by Florence Hirst, and letters to Church House or family and friends, reflect a poetic sensibility. The women write about relationships and community experiences, which adds a dimension to the history of St. Luke's (Hirst 1928–38).

From time to time, in letters to the Bishop, the nurses drop their guarded opinions and remark on frustrations with the Government policies affecting their work at the hospital. Edith Prudence Hockin's letters, written during her tours of duty as head nurse, narrate the experience and perspective of the nurses. Her letters and her reports to the Bishop underline the developments in daily operations of the hospital; over time, they reveal her opinions on matters of Government impact on the hospital's mission.

In a letter dated October 6, 1943, she expresses frustration to the Bishop in her remarks about patient transfers from other parts of Baffin Island,

> The *Nascopie* arrived on the 4th in the midst of a snow storm … We were a little disappointed not to get any patients this year as we had heard there were several. The people from Resolution were left at Lake Harbour by the *McLean* and are <u>still</u> there. There were also patients at Wolstenholm, Lake Harbour and Pond. No very good reason seems to be forthcoming for not bringing any. Looks like a straight case of "saving on the Hospital bills" to me. Dr. Collins from the Dept. is on the Nascopie and of the Resolution people he said it would be a pity to clutter this place up with them, they are all sick (Hockin 1943).

The mission hospital was a place of contrast between the philosophy of Christian medical charity and the policy of Government funding. The Government medical doctors were the authorities who controlled and monitored incoming patients and ensured that the patient numbers stayed in line with the Government-sanctioned bed space and budget. The Nurse missionaries were hired to fulfill their duty to the Church and provide medical care (Hockin 1930–1936). The nurses had mixed feelings during the years of "the economical doctors" who held back on admitting patients. Equally, they faced challenges in the years when no doctor was stationed in Pangnirtung (for example, in 1944), when they were required to consult a local council of men composed of the manager of the Hudson's Bay Company and RCMP officers. The authority of men dominated over the judgment of these trained women (Foster 1944).

The Eastern Arctic Medical Patrol and Officers Reports 1922–1940

Medical patrols in the Cumberland Sound were the prime concern of the doctors stationed at Pangnirtung (Table 3.2). The members of the patrol included a doctor and Inuit helpers who were to act as guides and assist in the rigorous travel over sea and land.[12] However, the medical patrols were usually conducted on a local scale and involved touring the regions of the Cumberland Sound adjacent to the Pangnirtung Fjord. A news article describes Etuangut and Otto Schaefer who traveled to "the 14 camps in the area twice a year by dog team journeys of up to 2,000 km" (Hankins 2000:79–82).

[12] Two patrol maps are found at the Anglican Archives showing the details of this journey (Pond Inlet NWT File 1929–1953).

The medical reports are also personal narratives, part adventure story and part self-reflection, that highlight each doctor's individual experience. The medical officers describe and comment on annual infectious disease patterns, endemic tuberculosis, the cultural environment, trade and economic conditions, nutrition, health care services, and public health strategies; in short, they provide commentary on conditions affecting health and illness.

Table 3.2: Eastern Arctic Medical Patrol officers dates of service and materials.

Eastern Arctic Medical Patrol Dates of Service	Name of Doctor	Materials
1927–1933	Leslie Livingstone	published findings
1933–1934; 1941–1942; 1953–1954; 1959	Jon Bildfell	reports 1933–1934; 1941–1942
1934–1936	AG MacKinnon	reports 1934–1936
1938–1939	Thomas J Orford	reports 1938–1939
1944	Dr. Gaulton	no reports
1955–1957	Otto Schaefer	published findings
1958–1959	Dr. Sabien	no reports

Table 3.2 refers to the doctors based in Pangnirtung who were involved in the focus of this analysis. Other doctors served the patrol, and provided medical service at St. Luke's during 1960–1972. Their records and reports are not included in this analysis.

All of the doctors traveled with Etuangat Aksayuk (1901–1996) and, under his guidance, experienced firsthand the demands and enjoyments of living and traveling on the land. Etuangat received the Order of Canada in 1995, as the last whaler of the Cumberland Sound (Hankins 2000:208–211). The doctors lived with their Inuit traveling companions, wore traditional skin garments, traveled by dog team, and hunted animals for their food.

The doctors reflect on this rugged adventure in their journals. Bildfell, MacKinnon, and Orford wrote extensively on Inuit culture and took exception to interference from outsiders that affected the traditional way of life, including the actions of the Hudson's Bay Company. In his 1934 discussion on Native Welfare, Bildfell (1934:1) commented on the inequity of the relationship,

> Few natives here at Pangnirtung secure less than four foxes a year on the average of the four years in the fox cycle. If he does not he is a pretty poor specimen. But the great difficulty here is to expect a Commercial Company, and one operating a monopoly, to incorporate commercial philanthropy, and this holds for the North. Perhaps if the H.B.C. enjoys the protection which it appears to enjoy they will only be too glad to infuse a bit more benevolence toward the Native.

On the other hand, the reports can be found perpetuating the stereotype of the childlike nature of the Inuit people, as in McKinnon's 1935 observation, "In the evening, the whole camp turned out to play ball. It was a game of their own. The men seemed to versus the women. In their carefree laughter, they sounded like so many happy children" (McKinnon 1935b).

The View from the Medical Patrols

The Medical Patrol Reports, however, were intended to focus on the health of the people. Prepared by Government doctors, they provide important information about tuberculosis and other diseases from 1922 to 1942. Not all of the reports from the entire list of doctors serving the Eastern Arctic Patrol are accessible or available as preserved archives. Livingstone, Bildfell, MacKinnon, and Orford identified endemic tuberculosis, and ship time colds and flu as persistent concerns with a lasting presence among the Inuit,

which compromised their general health. None of the medical officers reported new cases of tubercular infections from an outside source, yet many other epidemics arrived from elsewhere on the annual ships that moored at Pangnirtung during the summer months. This group of medical officers remark on other infectious respiratory diseases, which include influenza, colds, pleurisy, and bronchial pneumonia, and comment on the effects of environmental, cultural, and natural stresses on the emergence of new cases of primary tuberculosis. Their reports agree that chronic and acute diseases caused problems for the Inuit living with latent tuberculosis, leaving them particularly vulnerable to ill health.

From 1922 to 1933, for example, Dr. Livingstone noted increasing rates of tubercular infection (Graham-Cumming 1969:528). After Livingstone transferred to the Western Arctic, Jon Bildfell (1933–1934, 1941–1942), A.G. MacKinnon (1934–1936) and Thomas J. Orford (1936–1938) conducted tours of duty as the medical officers of health stationed at Pangnirtung until the late 1940s. They made similar comments to those of Livingstone. Yet, it is difficult to know how the observations and opinions concerning tuberculosis infection were determined in the early years of the medical patrol. For example, Bildfell's (1933–1934:8) 1933 report claimed that tuberculosis in the Cumberland Sound was endemic with recurring acute outbreaks,

> Tuberculosis is so general among Pangnirtung Natives, that to speculate on any particular percentage is impossible. If the maxim, that every case of Tuberculosis begets three, holds good in the North, then it is safe to say that every person in the district and every infant to be born is infected or will become infected. As far as Pangnirtung is concerned, it so eclipses every other diseased condition, that it might be said that there prevails but one disease among them.

He also comments on how well adapted the Inuit appear to be to tuberculosis, "The way they tolerate the disease, once an infection has set in is remarkable, until such complications as dyspnoea, extreme weakness, deformity, etc. set in" (Bildfell 1933–34:8). On the other hand, he laments their vulnerability to tuberculosis, "Among these people everything appears to be in favour of the germ, and nothing to the advantage of the native in combating the disease … his mentality, the climate, the diminished efficiency of the sun, their living conditions, everything" (Bildfell 1934:8).

Disease, Nutrition, and Trade

The Medical Patrol Reports comment on the annual arrival of ships, crews, and infections at the Pangnirtung port between July and September. The first ships to arrive were usually the whaling ships, followed by the HBC cargo ships. The requirements for guiding, whaling, and off-loading cargo ships created jobs for Inuit workers. Women worked alongside men at the blubber station, and all community members directly or indirectly made contact with the ship's passengers or crew during these periods of activity. Given the extent of this close contact, it is reasonable to infer that infected Inuit workers carried various communicable diseases into the encampments and transmitted infections to the outlying areas.

The role of ship time in disease transmission is illustrated by Dr. A.J. Mackinnon's account for 1934. That year, he arrived in Pangnirtung on *MV The Nascopie,* noting that an outbreak of colds and influenza started aboard the ship in July,

and re-infection happened at the port of Churchill. All of the Whites and Inuit traveling on this voyage contracted both respiratory infections.

In the following year, his September 1935 report states that an influenza outbreak, and a fatal case of pneumonia, occurred after *The Nascopie* sailed. Drawing attention to the interaction between acute infections and tuberculosis, MacKinnon remarks, "There were no after affect unless it were that some of the deaths from tuberculosis were hastened [from the effect of the influenza epidemic]".

Recognising the annual threats posed by the ships, MacKinnon recommended vaccination for smallpox, diphtheria, and whooping cough for all Inuit. He also requested a supply of diphtheria anti-toxin and that all crewmembers be vaccinated or demonstrate satisfactory proof of previous vaccination. Failing that, he advocated on-board quarantine of all ill crew and passengers during the call at port to minimise contact (MacKinnon 1934–1936:6, 27, 35). From 1933 to 1942, the annual cycle of introduced respiratory infections, mostly influenza, pneumonia, and the common cold, continued to recur during ship time at Pangnirtung.

The doctors also reported on outbreaks of typhoid and paratyphoid fever, chicken pox, and sore throats. The reports and correspondence of Bildfell, Mackinnon, and Orford all agreed that the ship-time diseases synergise with latent tuberculosis that is present in the Inuit population, often stimulating the disease to erupt into an active state. They also agree that the ship-time diseases were involved in the secondary complications of tuberculosis seen as meningitis, asthma, and the like (Orford 1938; MacKinnon 1934–1936).

In addition to offering an opportunity for the introduction of infectious disease, trading also appears to have created pressure on resources, and the doctors' reports mention increased population density due to Inuit migrating to the vicinity of Pangnirtung at the annual ship time. Slowly, this growing influx of Inuit placed a premium on successful trapping for furs, gathering of seasonal land foods, and purchasing of trade goods, and it appears that from 1933 to 1942, more Inuit were living in the Pangnirtung encampment. The fur and whaling trade started to decline in the 1940s and finally collapsed in the 1950–60s (Damas 2002:48; Stevenson 1997:93–100).

In the Native Welfare section of his annual report for 1933, Bildfell (1933–1934) states that fox pelts are the chief source of revenue [and perhaps other furs], which were traded for a monetary credit of fifty cents per pelt with the Hudson's Bay Company (HBC). Later in his report, he states that a fox pelt was worth $10 native dollars (Bildfell 1933–1934:2). Each Inuit hunter had an account with the Company for a twelve-month period commencing and ending in May of each year. Supplies of company-store goods constituted a debt against the balance, with this credit cleared before the end of the year or all remaining credit balance would be lost.

Hunters relied on guns and ammunition to obtain their own food, as well as trade animals. Two fox pelts could purchase a rifle, and two additional fox pelts could be traded for ammunition. Not all Inuit were fortunate enough to make this quota system to acquire hunting essentials, and Bildfell recommended, "Ammunition and rifle supply should be protected by Government assistance only if the hunter cannot hunt fox quota to purchase his supplies" (Bildfell 1933–1934:1).

Trade goods that arrived on the annual HBC cargo ships did not last long on the shelves. During the July annual whale hunt, Inuit families who arrived in Pangnirtung and were employed as hunters or at the blubber station obtained their monetary credit and purchased goods before leaving for their traditional camps (Bildfell 1933–1934:1). Useful commodities, such as ammunition, rifles, duffle [thick wool cloth], flour, biscuits, and tobacco were out of stock by December.

Tobacco as a 'useful commodity' presents an interesting conundrum. Tobacco has no cultural significance or ceremonial meaning for Inuit, unlike First Nations; it is not regarded as a sacred plant among the Inuit. Rather, it is a trade commodity since tobacco smoking and chewing arrived in the Cumberland Sound region during the pre-Confederation contact with whalers and traders. Bildfell expressed his concern over the Hudson's Bay Company trading practices, referring to it as a monopoly of fluctuating prices and trade values, caustically commenting "… it is difficult to expect a monopoly to be benevolent and considerate in measures which do not benefit them materially" (Bildfell 1933–1934:3). He adds, "but the Native is ignorant ... he is happy in his ignorance. Let the Government and the Company exchange their favours … The Native understands little about the Companies [sic] exploitation, and less about the Government's half-hearted policy on Native Welfare (Bildfell 1934:3).

All of the doctors at Pangnirtung in these early years questioned the nutritional value of traded foods. In 1933, Jon Bildfell complained that reliance on flour, tea, and biscuits did not ward off starvation and that Inuit consumed excessive amounts of carbohydrates instead of meat. He considered seal to be "the one outstanding requirement

of the native" (Bildfell 1934:1) and that "The harm done by allowing tea, flour and biscuits, to largely replace seal has been noticed" (Bildfell 1934:2).

MacKinnon (1934–1936) took up this topic during his two-year tour of duty. He focused his monthly accounts on the details of traditional hunting seasons and worked out a seasonal food cycle (Figure 3.8). From March to July, all forms of hunting commenced in the regions. Seals, baby seals, and fish were harvested in April; fish, eggs, whales, and walrus, in July and August. This period marked the beginning of the caribou hunt. From September to November, seals were hunted. December to March was a period of shortage and of little successful hunting. In addition, MacKinnon observed limited hunting for arctic hare and ptarmigan, blackberry and blueberry gathering in spring, and sorrel and seaweed collection in summer. Seal harvesting decreased in the summer months because of difficulties in retrieving the body from the open water (MacKinnon 1934–1936:5).

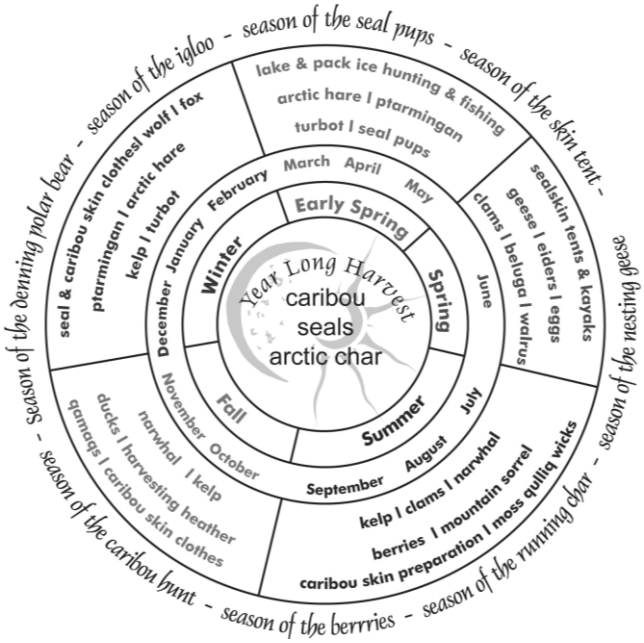

Figure 3.8: The Inuit cycle of seasons. Image: Parks Canada Agency (version 2.3_SMFL), used with permission.

MacKinnon's interpretation of patterns of disease among the Inuit focused on the role of nutrition, and he identified other challenges that had an effect on health and basic survival, such as blizzards, winds, ice conditions, and impassable snow, along with a lack of ammunition, nets, or hunting equipment. In 1934, MacKinnon expressed his concerns about the relationship between nutrition and the economy in this way,

> In regards to the white man's foods … biscuits, flour, tea and molasses. In the first place, they are stale and added to this they do not have vitality to them. White people living in this exacting country would not be very healthy on such a diet. The HBC, I understand, carries at least a large proportion of the flour and biscuits in stock over a year so that before it is consumed some of it is over two years old. These are lacking in fat or protein and the fat is very essential as a fuel producer. But there are times when they [white foods] are a very useful and practical addition to their diet. (McKinnon 1936a)

He also paid attention to Inuit employment and economic trade relationship with the HBC, providing details on the annual whale hunt. During his tour of duty in 1935, the hunts commenced on July 16, employing men and women in the hunt and preparation of whale blubber for export. The traditional harvesting of whale meat by Inuit supplemented their diets, but MacKinnon suggests that this provided only a limited additional food source. He reports that the HBC whale hunts of the 1935 season harvested 300 whales, which became the property of the HBC, and that the Inuit employees did not receive any of the meat or blubber. MacKinnon observed, "The rations the natives get while working are a help but have not the food value [found in seal] for working men and women". At the time, Inuit whalers usually earned $30 plus rations, and the wages were paid out in August at the end of the hunt (McKinnon 1935d).

During October and November that year, ship colds generally affected all of the population at Pangnirtung. MacKinnon commented on the exigencies of life in the north,

"Given ordinary care it was not severe. But to the native whose life demands that he get out in the cold, raw weather for hours at a time—it was different" (McKinnon 1935e). Although the ship cold in 1935 was not as severe as the previous year's outbreak, when he examined Inuit with colds, influenza, and pneumonia, MacKinnon (1935g) noted that their breath sounds were less clear than the white population, and that it took the native weeks to throw off colds,

> Whether these findings are due to which of the following: pulmonary tuberculosis, hours of exposure to damp cold weather or breathing the air of their small dwellings in which, in the long winter at least, there are the kudlus [lamps] using up the oxygen as well as giving off some smoke, I am trying to ascertain.

The impact of poor weather conditions on survival resonated in March 1936, when Inuit informants made MacKinnon aware of starvation among the Inuit at the Padley camp. This camp did not have any reserve caches of seal or other game animals. Bad weather and impassable conditions resulted in unsuccessful hunting expeditions, and the Inuit at this camp slaughtered and ate most of their dogs in order to survive. This sacrifice then created an additional burden. The depletion of a dog team population reduced or eliminated the ability for the Inuit to travel, relocate, or continue to hunt. MacKinnon added that one of the men living at this camp had eaten most of his skin tent in an attempt to stave off starvation (McKinnon 1936e).

Dr. Thomas J. Orford (1938) reflected on the problem of a growing reliance on HBC supplies when, in 1938, Inuit informants reported death by starvation in one unnamed camp that had lost eight children and four adults. Orford (1938:6) noted the connection between living conditions and disease, "Health problems are more or less

allied to their economic situation". Concerned by the pattern of Inuit purchases from the HBC, which were all carbohydrate foods, especially flour, he noted that these new foods were preferred over indigenous foods. Orford observed that over a period of years, this was producing both good and bad results, and he noticed that the Inuit consumed more of the southern food supplies when hunting and access to fresh meat was at a low ebb or absent in the harvesting year. Orford (1938:6) also observed that during this time, the Inuit suffered infections and eye conditions, and suspected that these types of illness were the result of nutritional deficiencies.

Orford found similar respiratory conditions in Pangnirtung when, in 1938, he performed autopsies on three Inuit adults, who "showed lungs blackened more than many city dwellers in civilisation. The cause must be the inhalation of carbon from the burning seal oil in their tents. Certainly the tents receive a generous coating of black" (Orford 1938:7). There is no further information about these autopsies or indication if he performed them in the surgery room of St. Luke's, neither is there any Inuit opinion concerning the performance of an autopsy.

Orford echoed Bildfell and MacKinnon's opinion that exposure to dampness and cold appeared to influence and/or lower the resistance to respiratory conditions. Some of the earliest observers of life in arctic regions commented on the effects of dry air on the lungs of the Inuit. Evidence of this dates back to early encounters with Europeans; for example, in observations made by Captain Edward Parry during his 1821 expedition, where he writes of a "serious outbreak of respiratory disease … with violent colds and coughs … catarrhal disease and pleurisy" caused by exposure to wet thawing conditions

in winter. This opinion may have been a reflection of the humoral system of medicine that prevailed at the time (Fortuine 1981:28–29). Otto Schaefer also reported that Chronic Obstructive Pulmonary Disease (COPD) was a common ailment among male hunters due to decades of exposure to and inhalation of extremely cold, dry air (Hildes 1993:36). Robert Fortuine's study of disease in Alaska notes that chronic lung conditions, especially anthracosis, were the most common ailments found in mummified human remains, a condition he linked directly to the inhalation of smoke (Fortuine 2005:85). Other findings in mummified remains include "pathogenic changes to lungs and pleurae, moderate emphysema, bronciectasis, fibrosis, pneumonia and possible histoplasmosis, a chronic fungal infection of the lung" (Fortuine 2005:85). Life in the traditional camp setting exposed Inuit at Pangnirtung to extreme cold, dry air in winter, and respiratory irritation caused by inhaling smoke from the seal oil used in the stone lamps that provided heat and light in traditional dwellings throughout the year. Perhaps, in this instance, the humoral "wetness" has given place to "smoke inhalation" as a modern explanation.

Those mostly affected by the smoke from lamps were women, as it was their role to tend to the maintenance of the flame. From the Pauktuutit – Inuit Women of Canada (2006) association document, *Keepers of the Light, Inuit Women's Action Plan 2006*,

> The qulliq is a traditional crescent shaped Inuit stone lamp. It was used to light and heat the igloo, melt ice for water, dry clothes, and cook food. A wick made of moss or Arctic cotton was used to draw seal, caribou, or beluga oil to the flame. In the winter, it was the only source of light. It was the woman's responsibility to make sure that the qulliq was always lit. Without it, Inuit would not have survived Canada's Arctic conditions. The qulliq symbolises survival and Inuit physical and emotional well-being.

Bildfell suggested that women in particular appeared more greatly affected by smoke inhalation, and stated,

> This I attribute to the fact that women are practically all day sitting behind their koodlee [oil lamp], and seldom go into the open air. The tupik [tent] is without question a regular hive for the bacteria, admitting little fresh air, and no sunlight. Perhaps men tolerate the disease better than the female, and are less complaining, but the fact that they are usually out in the open appears to be a more logical explanation (Bildfell 1933–1934:8).

But, it would appear that everyone was exposed to these conditions. Orford added an interesting observation on Inuit resistance and susceptibility to tuberculosis and respiratory disease in general,

> In spite of the apparently comparative resistance to tuberculosis they are extremely susceptible to upper respiratory infection when brought in contact with people from civilization. This is not strange however when we take into account that the white population is every bit as much affected some of us more severely than the Natives. The condition seems to die out almost completely until further contact (Orford 1938:7).

Public Health and the Anti-Tuberculosis Campaign

The medical patrol reports submitted by Drs. Livingstone and Bildfell in the early 1930s indicate that they considered tuberculosis infection among the Inuit of Pangnirtung to be endemic. When Dr. A.G. MacKinnon started his medical service at St. Luke's in 1934, there were already tubercular patients, either in treatment or in advanced stages of the disease. In his September 1934 monthly report, MacKinnon (1935a) notes,

> … two young native women died during the year [of tuberculosis] and one oldish woman whose cause of death was pulmonary tuberculoses and these deaths may have been hastened by the influenza infection.

In addition, two tubercular patients—both young females approximately 20 years old—were transported into hospital care to isolate and prevent them from spreading infection. Both were terminal cases, and MacKinnon decided that hospital care provided the greatest comfort and nutritional support. The first young woman died in October 1934, and the second in February of the next year (McKinnon 1935a).

In 1935, MacKinnon deviated from earlier approaches, such as Livingstone's view that tubercular Inuit received the best care in the familiar surroundings of their camps, by bringing tubercular patients to the hospital, which acted as both sanatorium and isolation facility. The nursing staff provided patients with a traditional Inuit diet, especially seal meat, in addition to the fortified tubercular diet that included eggs, milk, vegetables, fruit, Cream of Wheat, oatmeal, and teas. MacKinnon advocated this form of treatment because of the synergy between malnutrition and infection, "Shortage of food and latent tuberculosis do not go well together" (McKinnon 1936c). While on patrol, he consistently observed Inuit living day-to-day amidst changing environmental factors that made it difficult to create caches, such that Inuit living in camps generally had no food reserves to rely upon. He observed first-hand that food insecurity was a major cause of ill health; simply, "poor nutrition makes an impact on disease" (McKinnon 1936c).

MacKinnon (1936b) considered there to be a relationship between tuberculosis and childbearing, noting that Inuit girls married early and that childbearing lowered their resistance to disease,

> A woman was in hospital with a tubercular spine when I arrived in 1934. She was being treated to affect a cure. I thought that she could continue her treatment at home. Unfortunately, she became pregnant shortly after she went home and the combination of the two conditions caused her death shortly after the birth of the babe.

MacKinnon suggested Inuit most susceptible to infections, especially tuberculosis, were generally between the ages of 15 and 25. In addition, he asserted that the family environment in which Inuit usually lived together in one room shared by all members of the family was a contributing factor in the spread of disease, "They share dishes, and do not have the ability to boil water to use for cleaning utensils, or themselves" (McKinnon 1936a). MacKinnon (1936c) added, "To them, soap is a luxury and it is surprising that they are as clean as they are". Ultimately, MacKinnon (1936c) focused his recommendations on a familiar public health solution,

> As tuberculosis needs to be treated, not only as an individual disease, but also as a disease of the community, I feel more can be done [through] education of the native. Education would be along the lines of trying to get them to understand the infectiousness, and how to protect themselves against infection.

In 1938, Orford reported that pulmonary tuberculosis was a greater problem than the previous year, "at least 34 cases, of which most are arrested, or in quiescent [inactive] stage; 7 are active, of whom one died", in addition to one case of active bone tuberculosis (Orford 1938:6). Orford's opinion was that Inuit with active cases were able to carry on without difficulty for years, only occasionally experiencing flare-ups from which they could recover at their camps. Many cases were quiescent for years, and a "great majority" reached the arrested stage and lived on to old age,

> Few die as a direct result of the infection [tuberculosis] and as a rule a fatal case comes to a rapid termination. Very fortunately, they seem to have a marked resistance to what might be expected, whether their active life and the food is the answer to this is uncertain. Probably both play a part in conjunction with some inherent trait … (Orford 1938:8).

Orford suggested that life in camp and the Inuit diet had a potentially positive influence on the course of the disease; yet, that the isolation of the infected was virtually impossible in a camp situation. Orford's (1938:9) closing recommendations in 1938, (similar to ones made by Bildfell in 1933 and MacKinnon between 1934 and 1936), were concerned with the practicality and success of public health campaigns,

> A great number of the infections could be eliminated by more cleanliness but this [*sic*] a difficult innovation to enforce owing to the natural living conditions. The Native could do a great deal more in this matter than they do but constant talking will not seem to bring much in the way of results with the majority of them. A few are very clean and take pride in keeping themselves in that condition but these few are superior in every way to the rest and their example does not appear to bear any fruit as yet.

Throughout the 1930 and 1940s, Bildfell, MacKinnon, and Orford advocated personal hygiene and sanitary living. They recommended vaccination programs and patient isolation to contain disease transmission. This approach is similar to the efforts that were already in place throughout Canada to address tuberculosis transmission and provide medical care for tubercular individuals. Canada's Digital Collections produced an excellent historical timeline of events (Brancker et al. 1992), and George Jasper Wherrett's 1977 *The Miracle of the Empty Beds* provides a description of the Canadian anti-tuberculosis movement and the program as it applied to the Inuit.

To effectively introduce public health strategies, the missionary nurses implemented a community-wide cleanup and maintenance program of the outside areas surrounding the buildings. Further, the local chapter of the Women's Auxiliary and the Inuit women workers at the hospital learned techniques and procedures of hygiene and sanitation, which these women shared with others, and eventually took these skills from

the workplace into their living spaces in Pangnirtung or in the camps. The film *Atanarjuat, the Fast Runner* depicts Inuit at camp, airing out dwellings, and leaving skin garments in the sun to dry and air clean them. Inuit traditional knowledge informs us about a sense of personal and domestic hygiene (Bennett & Rowley 2004). Inuit tools, such as bird-feather brooms swept living spaces clean of debris, and clothing was continuously replaced when the skins were beyond all possible reconditioning.

The small stone lamp, the *qulliq*, was present in all dwellings and required seal oil to burn for heat and cooking. The seal oil fuel was a conserved resource, because it was important for producing light and heat in the dwelling. Although the *qulliq* could boil water for tea or some cooking, excessive amounts of seal oil would be required to produce large amounts of boiling water. However, an important aspect of improvements in personal hygiene and sanitation (especially within camp life) depends on access to ample supplies of hot water and soap. Large cook stoves that burned fuel oil with water hoppers installed in the hospital melted large quantities of snow and ice for hot water. This allowed Inuit patients admitted for care, as well as nurses' aides living and working at St. Luke's, to enjoy and maintain a higher level of personal hygiene through access to bathing in ample supplies of water (Cowall 2004).

The Hospital in Action: The View from the Day Books

The hospital day books provide a detailed accounting of patients' days and the grants for transient patients that supported the operation of the hospital. These ledgers are especially valuable because they document the growth of acceptance of St. Luke's in

Pangnirtung and offer quantitative evidence that supports, refutes, or expands on comments made by the doctors and nurses in reports, diaries, and correspondence. They also constitute the documents through which the hand of the Government becomes visible in the daily operation of St. Luke's. The system of reporting includes various sets of information that account for patient day totals and payment of grants, in addition to the reporting of statistics concerning the population. Two different sets of documents on file at the Anglican General Synod Archive demonstrate the system of accounting and the payment of grants for the Arctic hospitals (Department of the Interior N.d.).

As Table 3.3 shows, St. Luke's admitted few patients (13) when it first opened in 1931, despite the observations regarding the disease load among Inuit made by medical officers. Nurse Hockin (1936) wrote to Archbishop Fleming, explaining that the small number of patients was due to low bed capacity, resistance to hospital admission on the part of the Inuit, and some reluctance on the part of the doctors to admit patients in favour of caring for them in their camps.

Table 3.3: Cumulative monthly patient admissions to St. Luke's hospital 1931–1939 (Physician's Day Book 1931–1954).

Month	1931	1932	1933	1934	1935	1936	1937	1938	1939
Jan	0	2	3	5	7	10	4	8	6
Feb	0	2	4	7	7	8	4	7	8
Mar	0	0	5	7	2	11	5	6	4
Apr	0	2	4	4	5	10	5	6	0
May	0	4	0	5	4	13	4	5	23
Jun	0	3	0	6	7	7	2	4	14
Jul	0	1	2	7	10	10	3	7	12
Aug	0	3	2	7	7	7	3	4	20
Sept	0	2	3	5	11	7	11	5	17
Oct	5	0	2	9	11	5	9	4	13
Nov	4	0	2	4	6	6	6	5	12
Dec	4	4	2	7	7	7	6	6	15
Totals	**13**	**23**	**29**	**73**	**84**	**101**	**62**	**67**	**144**

Ultimately, the nurses were responsible for the acceptance of hospitalisation through their consistent presence in the lives of Inuit in the community. The medical officers were away from the facility for prolonged periods of time due to the distances between camps. In 1936, for example, the medical patrol travelled all around Baffin Island and this journey lasted for the better part of an entire snow travel season, September to May (Pond Inlet NWT File 1929–1953). While the medical patrol was away, the nurse missionaries remained on the front line and were central to establishing health care for the community as a whole.

In a letter to the Bishop, Hockin (1936) described the first days at St. Luke's in 1931, reflecting on the Inuit resistance to the hospital. She suggests that the Inuit found the nurses to be strange; however, an Inuit woman worker clarified that their previous experience had involved working for white men; they had never worked for women before. Hockin notes that the first patients were mostly children or gravely ill adults. The Inuit took the position that because death was imminent, the hospital could do no harm. At first, many would only take the medication portion of treatment offered to the sick, because the grandmothers would not give permission for the family member to stay in hospital. Further, she discusses the first operation, performed in 1931 to remove a broken needle from a boy's heel, after which the child's mother taught him to associate the painful aspect of the procedure with the hospital.

This phase did not last long and Hockin reports in the same letter that by 1935 relations and acceptance of the hospital had improved. This is confirmed by the hospital day book, in which recorded patient day numbers increased from 13 in 1931 to 84 in

1935, then to 144 in 1939. Hockin speculates that this acceptance developed through the good will arising from the outpatient department. In the first year of operation in 1931, the hospital cared for an average of just over one patient per day, and 200 outpatient cases. By the fifth year of operation, the average had risen to five patients per day with 1200 in the outpatient department. By 1936, Hockin would write that, "This shows that the Eskimo now understand what the hospital is for and that they are appreciative". Hockin concludes this letter by stating that approximately 500 Inuit benefited directly from the hospital. She adds that others out of reach of this facility had no medications or training to care for their sick (Hockin 1936). In a second letter, dated September 2, 1936, directed as a report on the hospital's progress to the secretary of the Diocese of the Arctic, Hockin (1936) requests that the Church consider sending a third nurse to aid in the increasing nursing demands.

It is apparent that Government grants for patient care and the cooperation of the medical doctors participating in the admittance of patients consistently affected the hospital's viability. Government grants for patient days in hospital affected the numbers admitted by the doctors and, at times, doctors held back on bringing Inuit into care. The reason for holding back on admissions is twofold.

First, in the early years of the hospital, Government grants were uncertain or undergoing re-structuring and some doctors limited admissions in an attempt to control spending. The doctors' apparent unwillingness to hospitalise patients sparked tension among the nursing staff. In a letter to the Bishop on 30 September 1936, Hockin (1936)

laments the departure of Dr. McKinnon, a doctor decidedly willing to hospitalise patients, and worries about the new Dr. Orford, whose treatment philosophy was unknown,

> I expect the guaranteed Gov. grant [annual set amount for patient days] will keep the medical work going, it has certainly made a difference to our admissions this year. In our first four years, we had 100 admissions [since the announcement] and this last year we had 57 admissions. That little assurance that the Gov. was willing [the approval for patient days funding] was all Dr. MacKinnon needed to send the medical work right along.

From the nurse's perspective, each incoming doctor disrupted the function of the hospital.

Second, some doctors believed that the Inuit were better off in home camps rather than in hospital. For example, Orford's (1938:6) observation of health conditions stated the following on tuberculosis,

> Of the Pulmonary cases the greater number appear to be arrested or in a quiescent stage … The treatment of this condition along generally accepted lines is rather difficult with these people. The active cases can carry on their usual hunting life for years without any apparent difficulty aside from an occasional flare up from which they recover in their own camps. The great majority appear to reach an arrested stage and proceed on to old age. Many more become quiescent for years. Only a few of them die as a direct result of the infection and as a rule a fatal case comes to a rapid termination. The life they lead in the camps and their natural diet all appears to be conducive to fair results.

Orford (1938:6) added the proviso that the hardship of removing tubercular camp leaders and hunters for prolonged hospitalisation compromised the well-being of their families and outweighed the risk of transmission by keeping them in camp. Further, he suggested that the combination of diet and active life possibly enhanced some form of inherent ability to overcome the disease,

> If they did not have a disease similar to tuberculosis amongst themselves before the white man came in contact then it is by no means certain that they did not pick it up generations ago during the time of the early explorations and have developed a certain immunity.

The first decades of the operation of St. Luke's Hospital established the relationships between doctors, nurses, and Inuit. In this remote location, the hospital and its employment opportunities for the Inuit as helpers, together with its supplying of foods and other goods, created a local medical trade industry. Medical systems had been put in place and the community accepted the care provided there, so much so that the growing use of St. Luke's Hospital required an increase in supplies and furnishings.

Letters to Hockin from Church House dated 10 April, 1940 discuss supply requisitions that had been filled to meet the increased demand on the hospital's services (Church House 1940). The letter states that, in 1937, Church House sent six beds, mattresses, springs, bedding, bedside tables, washbasins, and serving trays for St. Luke's TB Ward. Scheduled deliveries through the Hudson's Bay Company in the summer of 1940 included an expanded food supply to accommodate the indigent home and general supplies for the hospital.

Sequential Epidemics in 1941

The arrival in 1937 of new furnishings for the hospital was timely, because in 1941, three acute infectious epidemics emerged with dramatic and devastating results. The combined voices of the nurses, clergy, doctors, and Inuit hospital workers, supplemented by information contained in the day book record (Table 3.4), confirmed the extent of the epidemics, which exceeded any other disease episodes in the history of the hospital, including tuberculosis.

Table 3.4: Cumulative monthly patient admissions into St. Luke's hospital 1940-1949 (Physicians Day Book 1931–1958). Numbers in bold (1941) indicate the patients in hospital during the epidemics.

Month	1940	1941	1942	1943	1944	1945	1946	1947	1948	1949
Jan	14	10	19	12	5	11	13	3	4	11
Feb	22	12	19	11	7	11	13	7	7	10
Mar	16	12	18	10	8	8	13	5	15	14
Apr	18	12	11	8	8	11	17	10	15	19
May	16	13	6	9	6	13	12	10	8	19
Jun	9	10	7	8	4	10	5	8	7	10
Jul	16	11	8	10	7	9	8	12	6	17
Aug	10	**24**	7	10	11	10	4	9	7	12
Sept	11	**28**	4	4	10	11	2	7	13	16
Oct	15	**78**	13	7	21	9	4	7	5	14
Nov	7	**39**	11	4	10	6	1	7	11	14
Dec	8	**39**	9	9	7	13	2	7	11	13
Totals	**162**	**288**	**132**	**102**	**104**	**132**	**94**	**92**	**109**	**169**

Dr. Jon Bildfell returned for his second medical tour in Pangnirtung on the incoming Government ship in the fall of 1941. His report for 1941–1942 describes three separate, virulent epidemics of paratyphoid, influenza, and chickenpox that affected 556 Inuit. The first report outlines a paratyphoid epidemic, most likely caused by food or water contaminated by *Salmonella paratyphi* that affected 100 Inuit, which Bildfell (1941–1942) estimated to be approximately 20 per cent of the population. Of these, 52 were treated in hospital, where seven died from the disease (Bildfell 1941–1942:1) and twelve died in outlying camps.[13] All of the camps in the district seem to have been affected, but the number of cases is difficult to estimate because the subsequent influenza ("ship flu") epidemic—the second to strike the region in short order—interacted and synergised with the paratyphoid epidemic. Bildfell (1941–1942) writes,

[13] These totals may not only represent hospitalised patients; there may have been some patients cared for at the outpatient clinic that was included in his tally. When compared to the hospital day books of admissions, there are differences in reporting.

> It is extremely difficult to estimate the number of cases in the fall group which was due to the paratyphoid organism alone, because of the concurrent infection of influenza which broke out following the departure of the supply ship. This was epidemic in nature and generally more severe than the former. In the Fall group, the earliest cases were of the flu type with bronco-pneumonia complications and a marked degree of physical prostration. Among those cases were uncomplicated diarrheas but the greatest number of cases complaining of this condition in the fall, came in the wake of the Ships Flu. It was not uncommon for patients to recover from the Influenza and to be taken down in a day or two with diarrhea, cramps, blood and mucus. The possibility of these cases being a manifestation of gastro intestinal flu was not lost sight of but as the epidemics progressed the division of the two into separate groups became obvious. We were not without either diarrhea or pneumonia in the district during the whole winter.

Bildfell (1941–1942) described the ship-flu epidemic (July–November 1941) as highly infectious and widespread, an outbreak that infected almost the entire population. The mortality rate was high and accounted for 50% of the total deaths in the region for the year, with 65 deaths in hospital and another 67 deaths in the outlying camps. It was a mixed type of influenza epidemic—carrying with it pneumococci that increased its overall virulence—and the Inuit suffered marked physical prostration, pains, weakness, and secondary complications, such as pneumonia, otitis media, and also paratyphoid. St. Luke's was equipped with basic laboratory supplies and a microscope for the doctors to make simple diagnostic observations. Bildfell (1941–1942:8) reported that a gastrointestinal syndrome also accompanied this epidemic, and that two confirmed cases of typhoid and paratyphoid were identified.

Prudence Hockin's (1941) perspective on the 1941 influenza epidemics emerged in a letter to Mr. Foster at Church House, Toronto, later published as a special article for the Anglican readership. The Anglican Church of Canada publication "*The Living Message*" featured a section about the activities of the northern missionaries, and printed

letters as feature articles. On the original document, the following can be read in handwriting, "An unexpected letter dated 25th October 1941, has been received from Miss Prudence Hockin, nurse in charge of St. Luke's hospital, Pangnirtung. We share it with our readers:". Hockin writes, "We are having the worst epidemic of flu and pneumonia that has ever been here as far as anyone knows" and she details the patient numbers and challenges faced in dealing with the onslaught of incoming patients. Like Bildfell, Hockin links the onset of the epidemic to the onset of "ships cold", and discusses how some Inuit stayed in Pangnirtung, while others left for winter camp. Seven severe cases at camp, which were not reached in time, died, while others suffered the full course of their illness at camp without medical aid. Hockin states that the maximum number of patients the hospital can take is 41.

This outbreak pushed the hospital's capacity beyond its limits (see Table 3.4) and every available space, including the hallways, solarium, and operating room, was occupied by the sick. The iron lung, an unused piece of Government equipment, became a cot for a child. Mattresses loaned from every location in the community accommodated the patients, placed on the floor or elevated on boxes; sealskins were used as sleeping mats, and three children occupied a larger three-quarter size bed. The epidemic affected the trade and wage economy of the hospital, placed a strain on the annual supply allocation, and depleted the stores of medications. Hockin (1941) reported that the supply

of the drug "Dagenan"[14] was insufficient and that the necessity of rationing doses compromised patient recovery.

The Anglican minister at St. Luke's mission in Pangnirtung, Reverend Arthur Turner, was involved in the care of ill patients during the 1941 epidemic. He reports in his journal,

> The annual whale drive was held in August this year but several families arrived at Pang in July, expecting to make this drive in July as usual. They stayed on here waiting. July 26th have a visit by two American Army schooners. (Morrissey) (Capt. Bob Bartlett) paid us a visit. The *Nascopie* arrived Sept 25th. About ten days later severe colds attacked the natives turning to pneumonia in many cases. Some had already left for their camps and others were taken ill as they prepared to leave. Two boatloads of sick people arrived out of them that had left earlier for their camps and motorboats were sent out to visit other camps and bring in ill in various degrees. Later trips were made to those camps, some more sick ones brought in and reports of other deaths. Diarrhea attacked the children during the summer and several were in hospital at ship time running high temperatures. After ship time more children and some adults were also affected, so far the adults have responded well to leadiprim treatment but not all of the children have recovered as yet (Oct 24th). The supply of dageran for pneumonia now exhausted and three very sick people wait at Lasalusi to be brought in. A boat left today but had to come back on account of rough seas (Turner 1941).[15]

The doctor, minister, and nurses cared for the people afflicted by the epidemic. The Inuit men and women hospital workers continued to provide nursing assistance, housekeeping, cooking, and building maintenance. During my 2004 field-study interviews with the former Inuit workers of St. Luke's hospital in Pangnirtung, participants recalled eyewitness accounts of the epidemic events of 1941.

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[14] Dagenan is a sulfonamide antibiotic. The sulfonamides are synthetic bacteriostatic antibiotics with a wide spectrum against most gram-positive and many gram-negative organisms. During 1941, St. Luke's was supplied with Dagenan, as it was indicated for use elsewhere in Canada (Graham et al. 1939).

[15] The purposes of the drugs *leadprim* and *dageran* are unidentified. Turner may have phonetically spelled these drug names. *Lasalusi* is the place name of a traditional camp in the Cumberland Sound.

Evie Anilniliak, one of the former nurse aides, discussed the epidemic and her experience of working inside the hospital during that time,

> It was over crowded, even the minister's house was full of sick children and upstairs was used for sick patients and (the downstairs nurses) living room (was also used) for sick patients. Even the people coming in from the camps brought dead people who died on route. In the hospital it was full, crowded, the nurses hired extra people to help. Even the previous male worker Veevee, [retired], who was sick (himself) but the doctor brought him as a guide [to the camps] during that time. All the patients who were still living in the hospital in the epidemic year were (placed on the floor); fed, bathed and medicated by all the ladies who were working that year. The nurses were always welcoming and kind. The Anglican minister's house was a church and a bedroom; the children were taken there for their medical care while the adults stayed in the hospital during the epidemic; everybody was having earache, lung infection. The dead were taken out by the male workers and placed into the shed. The dead bodies were piling up in the shed just outside of the hospital; canvas covering the pile of bodies. Those bodies were buried at one time [in the graveyard is evidence of the mass burial].[16]

Qanaq Qupee, one of the maintenance men working at the hospital, agreed with Anilniliak's report that bodies were stacking up because he could not keep up with the demand to build coffins, as he did not have enough lumber in supply,

> When someone died it was my job to [build, and] put the body in the coffin, put the coffin in the church and then buried it the same day, and some had to be buried the next day if it could not be done that day. In wintertime when someone died, we buried the body, but we had to leave the body on the tundra and then in spring we had to dig out [the ground] and put the body in the ground. Coffins were carried by stretchers to the graveyard or by komatik (sled). It was fall and it was cold and it had snowed so that made it easy for the komatiks (to move the bodies).[17]

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[16] Evie Anilniliak spoke in Inuktitut and her conversation was translated by Meeka Alivaktuk, co-researcher for the Hospital Workers field study conducted in 2004 in Pangnirtung, NU. The interviews took place in the former hospital building.

[17] Translation by Meeka Alivaktuk, Pangnirtung, NU.

Many of the Inuit hospital workers became ill and had to be hospitalised. Inuit women from the community at large assisted in duties such as laundry, cooking, and cleaning. The people from the Industrial Home helped with dish cleaning, running messages and encouraging hydration by assisting children with their water cups. The former hospital workers spoke sadly of these events as they remembered them. They lamented that there were more patients than beds, and that sick people were lying on the floor in every room. In addition, alternative places throughout the community allowed the nurses, the minister and his wife, doctors, Inuit hospital workers, and community members to care for those afflicted who did not have beds in hospital (Cowall, field notes, 2003). The minister's wife helped with patient intake and delegated nursing tasks to Inuit women helping in the convalescent area set up in the church.

A third wave of infection followed, and Bildfell described a chicken pox epidemic that occurred in March 1942 at St. Luke's hospital. The epidemic affected fourteen children ranging in age from one to sixteen years, and Bildfell suspected that chickenpox caused an infected umbilicus three days postnatal in one of the newborns. Outpatients suffering from other diseases—tuberculosis and paratyphoid— appear to have had a heavier reaction to the chicken pox than those free from other infections.

The chickenpox epidemic had no relationship to ship time infection, and no one in Pangnirtung carried the disease. After extensive investigation, Bildfell identified two possible routes of transmission into the hospital. The first was a letter sent to one of the nurses from a friend in Southern Canada who had a child with active chickenpox at the time she wrote her letter. The second potential source of infection was an air pilot, who

occasionally came in and out of the community and stayed in the hospital residence. Contact with an infected pilot would seem the more likely way to introduce chickenpox to Pangnirtung.

The hospital day books show how devastating the epidemics of 1941 were in the region (Table 3.3). The patient days for August through December show how stretched the hospital's resources were compared to other years, with anywhere from two to five times the normal number of patients treated during those months. October was an especially awful month, recording 78 patient days compared to the more usual four to fifteen patients in the rest of the decade.

Tuberculosis

St. Luke's doctors kept a careful eye on the prevalence of tuberculosis in the Cumberland Sound region. Doctors Jon Bildfell (1933–1934), MacKinnon (1934–1936), and Orford (1936–1938) commented on the presence of an endemic tubercular infection that exhibits periods of latency and resurgence, and their reports delved into specific stressors during periods of resurgence to explain the rates of infection. In their opinion, the vicissitudes in tuberculosis infection rates did not stem from reintroductions of *Mycobacterium*; rather, all acute tubercular infections were traceable to specific exacerbating factors.

During 1941 and 1942, Bildfell conducted systematic testing for tuberculosis, and his findings are among the only detailed records of this kind. He read and interpreted the results of tuberculin testing with Koch's OT (Old Tuberculin)[18] among 300 Inuit of the Cumberland Sound region. He then related his observations to corresponding X-ray data (Bildfell 1941–1942:15–17).

Of the 280 Inuit tested with Koch's OT and X-rays, Bildfell stated that 72 per cent tested sensitive to tuberculin protein. Based on these results, he drew the conclusion that few individuals in the district would have escaped at least a primary infection. He reported that children aged from zero to ten years had the highest number of negative responses and, when tubercular sensitivity was noted, Bildfell suggested this group had the highest rate of fully healed primary infection, or had never had the disease. Bildfell identified the "danger age" as the young adult grouping, aged 20–30 years, which had the greatest number of positives and highest-level susceptibility. He found that 16 per cent of the 40-year old age group tested negative, and interpreted this as evidence of complete healing of each re-infection. In the 40–50-year-old age group, he noted that 48 per cent showed three plus reactions to Koch's OT. In the final age group, the 50–year-olds and over, only 24 per cent presented with three plus reactions to Koch's OT. Bildfell speculated that these individuals were "choice physical specimens", were highly resistant or had less stress in their lives.

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[18] Koch's OT [Old Tuberculin] was first developed in 1890 as a treatment for TB, but only later was it adapted as a skin test for tuberculosis (Ritchey 2008).

Bildfell's reading of the X-ray films was highly detailed; however, he noted obvious findings that would be consistent with tubercular infection, such as calcified structures in a variety of lobes. Bildfell's solution to what he believed was a widespread tuberculosis problem was to decrease the stressors that undermined Inuit health: starvation, childbirth [he recognised this as unavoidable], prolonged nursing of infants, cycles of epidemics such as ship colds, typhoid, influenza, and the white man's food and clothing. He also developed a list of recommendations, starting with the hospitalisation of children during the active phase of the disease (with an average length of stay in hospital of 2 months) and the isolation in hospital of adults in the active disease phase, followed by discharge to supervised camps (Bildfell 1941–42:11,17). He also recommended early surgical intervention in the case of tubercular bone foci, and the provision of an adequate traditional diet for all tubercular patients in hospital or for those living with active disease in camps. These recommendations are particularly significant in light of the contradictory policy decisions made later that led to the transfer of tubercular patients from St. Luke's Hospital to southern sanatoria in the 1950s.

Bildfell (1941–1942) concluded that tuberculosis appeared to be more actively obvious and serious than it had been in 1931–1933 and added, "What will be the situation ten years from today?". Yet, it is difficult to know with certainty if his observations and opinions were fully accurate. The 1941 test results are one-of-a-kind documents in the archive, and no previous test results to which to compare the data are available. The accuracy of the X-ray film images is also questionable, as is evidenced in correspondence from Hockin (1941:2) to Church House, in which she communicates her concerns,

> Regarding x-ray supplies, this year we have endeavoured to take a chest plate of every Native tributary to Pang and have taken nearly 400 plates to date. This of course has used up all our old plates and the newer ones too and is the reason why I had asked for more in the winter. The doctors differ so widely in their use of the machine that it is very difficult to estimate in advance. I also think it would be advisable to get DuPont plates in preference to Eastman, DuPont plates that were two years older than the Eastman plates took very good pictures while the Eastman plates that were out of date were very poor. Had they been left a little longer, they would have been useless.

Bildfell's 1941 report contains information that may have made an impact on the future treatment of tuberculosis in the Arctic. It is worth recalling that the Medical Officer reports not only commented on the overall health status of the population, but also presented recommendations for Government policy and administrative decisions around healthcare in the north. Bildfell's 1941–1942 study presented his statement on the state of tuberculosis among the Inuit. It foreshadowed policy decisions made by the Government in 1947, which would bring the delivery of health care at St. Luke's Mission Hospital closer into line with the emerging national health program.

The Views of the Inuit of the Cumberland Sound

The Inuit were equal contributors to the functioning of the hospital as a health-care industry. St. Luke's Mission Hospital was the largest employer of the region and hired both women and men of the Inuit community to assist in the function of the hospital. It also functioned as a central gathering place that acted as a trading center for supplementary food for patients from 1930 to 1972 (Cowall 2004). These working relationships established through hospital care and employment bonded Inuit, nurses, and doctors in subtle and profound ways.

Former Inuit workers who participated in an oral-history project I conducted in 2004 reflected on their direct knowledge of the hospital and nurses (Cowall 2004).[19] I was mindful that the Elders were looking back on their own experience, and that they held fond memories of the facility. Evie Anilniliak and Siloah Metuq, who were both young girls when taken into the hospital as resident nurse aides, remarked,

> There were always people from outpost camps, not employees of the hospital and not living in Panniqtuuq. They would trade, for instance bring berries to trade for something else. No one was turned away, country foods, skins, full seal, handicrafts etc. Sometimes they would get clothing or food, baby clothing. The country food that was traded for was for the patients, and workers in the hospital [also] depended on this form of food supplement (Cowall 2004:11).

Qanaq Qupee, a male worker stated, "every one respected the hospital; patients were very well behaved even if they stayed a long time".

Figure 3.9: Rosie Veevee, Siloah Metuq, Neevee Nowdlak, Qanaq Qupee, and Evie Anilniliak. Photograph: ©Emily Cowall 2004.

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[19] Meeka Alivaktuk conducted the 2004 study in Inuktitut and facilitated the interpretation of the content of the conversation recorded during the focus group. Evie Anilniliak, Neevie Nowdlak, Qanaq Qupee, Rosie Veevee, and Siloah Metuq are the former workers of St. Luke's who participated in the focus group. This study informed my understanding of the centralising influence of this healthcare industry in the history of Pangnirtung.

Throughout the Pangnirtung Photograph-Naming project, from 2007 to 2010, I observed the continued respect for St. Luke's Hospital and heard stories about the hospital's importance in the lives of the community. While the photographs provided community members with an opportunity to see visual evidence of themselves or their loved ones at the Mountain Sanatorium, these images also provoked memories of the lived experience of their disease, as well as aspects of their previous care under local treatment in Pangnirtung.

Chapter Four
The Transition to Government Control: Tuberculosis as an Agent of Change

My discussion in this chapter focuses on the interconnectedness of St. Luke's Mission Hospital and Government administration of health care to illustrate the way policy affected the tubercular Inuit of the Cumberland Sound region. Events occurring at a great distance, both geographical and political, filtered into the lives of doctors, nurses, and Inuit in Pangnirtung. Letters exchanged between Church officials and both Federal and Territorial Government officials testify to the conflicts and tensions that underlay the rapid movement toward the modernisation of medical services in the north.

The "Economical" Doctor and Organisational Change

Government grants for patient care affected the operation and economy of St. Luke's Hospital. E. Prudence Hockin (1943:1), the Head Nurse of St. Luke's Hospital, wrote to Bishop Fleming on September 11, 1943 to discuss hospital personnel in which she expressed a recurring worry: hospital admissions depended upon the doctors,

> I fear we have an Economical Doctor this time. There has not been very much sickness though. The Home continues to have 7 or 8 in it so that if one Department is down the other keeps up fairly well.

There is no clear indication of who the "Economical Doctor" in Hockin's letter was; however, the letter also discusses Dr. Collins, one of the medical officers conducting the Eastern Arctic Medical Patrol, and his reluctance to send ill patients to the hospital. Her report demonstrates concern for the economic challenges to the operation of the

hospital. Without a sufficient number of admissions, the consequent reduction in Government grants threatened St. Luke's operational viability.

Another source of anxiety centered on the pressures associated with World War II, which affected the funding of patient care in the north. While Hockin was concerned about the financial impact of diminished admissions to the hospital in 1943, at the same time, the Second World War drained support and grants from the Federal Government coffers for patient care and medications, and reduced the availability of doctors. At the same time, the Canadian Government was concerned with issues of Arctic sovereignty and protecting the Archipelago.

C. L. Foster, the Honorary Secretary of the Diocese of the Arctic in Toronto, sent a letter to Nurse Hockin on June 5, 1944. Foster (1944:1) advised that the Government had not recruited a replacement doctor and that St. Luke's patient day funding had been reduced to a minimum guaranteed grant that would cover payment for four patients and eight Elders. This constituted a considerable reduction compared to the funding for 1943, when the guaranteed grant paid for an average of seven patients and seven Elders (Hockin 1944b:2). Foster (1944:1) also noted that it was likely that there would be delays in the appointment of a doctor, and included a direct quote from the Government communiqué,

> The administration feels that natives should only be hospitalized where necessary care cannot be extended otherwise. The reports of experienced officers seem to indicate that in certain types of cases, which permit home treatment the natives are happier if they are cared for under conditions to which they are accustomed, and that there is ground for believing that their welfare in such cases can be safeguarded on this basis. This is not to be taken as any indication that the benefits of hospital treatment in necessitous cases are not appreciated or that hospitalization is to be refused where it is warranted, but it does seem that when there is no doctor at the hospital it would probably be well to adopt, as a temporary expedient for control of admissions …

Foster (1944:1) reassured Hockin that the Church trusted her judgment, and closed his letter with his personal reflection on the funding cutbacks to St. Luke's, "This of course is just one more bill for Hitler to pay and we will hope that better days are not too far off ".

The Government directed the hospital nursing staff to exercise judgment in the type and number of admissions (Hockin 1943:1). The crux of the problem at St. Luke's was that, while the nurses wished to admit patients into the hospital, they had no authority to make those admissions. Government policy dictated that the head nurse was required to consult a committee of community advisors that included the Anglican minister, a Royal Canadian Mounted Police officer, and Hudson's Bay Company store manager, although there is no archival record of this committee convening for this purpose in Pangnirtung (Hockin 1943:1). This arrangement was cumbersome, and Hockin (1944a) wrote a letter to Mr. Foster on September 1, 1944 concerning her anticipation of a doctor to relieve the nursing staff from this unwieldy policy,

> In reply to yours of June 5 re. Doctor, I am more than thankful that we will have a new Dr. as those arrangements were rather complicated. However, I know that Mr. Turner would have agreed to all admissions and with a little tact. I suppose the others concerned might also have agreed but it is anything but an ideal arrangement. I rather fancy the admitting might have been done first and the conference held after. Having tried the "home treatment" idea, I don't think much of it here.

Hockin's statement suggests that Mr. Turner, the parish minister, and the HBC and RCMP members of this advisory committee would take her recommendations and agree on the admission of patients. She also stated that the admission process might involve admitting the patients to the hospital first and then convening this committee. In this example, it appears that Government policy required a different application in

practice. The work at the hospital and the medical outpatient clinic carried on regardless of reductions in funding, limited supplies, and reduced patient admissions, because the nurses were intent on caring for patients and community health.

In a letter to Bishop Marsh dated September 4, 1944, Nurse Hockin discussed maintenance work to improve the buildings, the status of patients, the activities of the Women's Auxiliary meetings and changes in staff. In this letter, Hockin expresses her view, "Our medical work has been a little disappointing, but with a new Doctor we hope to do a little more. There is more that could be done. We hear that the Can. Gov. is going to use the air bases for scientific and medical centres. You probably know there is a good hospital at each base" (Hockin 1944b:2). Here, Hockin conveyed her awareness of the establishment of Government-administered nursing stations near the Distant Early Warning Line (DEW-Line) military installations across the Canadian Arctic Archipelago.

The transitional years of increased Government involvement in health matters created a flurry of outside experts analysing the situation and making recommendations (Duffy 1988:52). Duffy (1988) suggests that the establishment of increased numbers of Government Nursing Stations occurred because the Canadian Government was under the scrutiny of the allied forces, especially the United States Military and Air Force, and health care was factored into the Arctic-sovereignty agenda. Duffy (1988) cited in a 1943 report on the inadequacies of hospital and medical operations in the Eastern Arctic, authored by J.L. Robinson, the Government's geographer, in his "Preliminary Report and Recommendations for the Administration of Canada's Eastern Arctic, 26 October 1943". In this report, Robinson recommends co-locating the Government hospitals and military

airbases (a prime example of which is the Frobisher Bay airbase developed by the U.S. Military). He also recommended aircraft as the means to transport doctors to outposts and small hamlets or to evacuate patients back to Government medical centres. Robinson also suggested that these centres could serve as prime locations for medical research on Arctic diseases and care. The hatching of such plans would depend upon developing the air transportation infrastructure (Duffy 1988:54). In 1946, the Government hoped for air services to transport patients from remote centres to centres of care in southern Canada, and remained committed to sending doctors to the north, yet at the same time, it was becoming increasingly difficult to recruit doctors (Duffy 1988:51–5).

Maj. D. L. McKeand, the bureau chief of the Lands, Northwest Territories and Yukon Branch of the Department of the Interior, was also aware that servicing the north using aircraft was easier said than done, because building remote airstrips required engineering expertise to deal with the rocky and uneven terrain of Baffin Island (Duffy 1988:54). In my own experience living in Pangnirtung in 1985–6, and during visits in subsequent years, I recall many occasions when the medical-evacuation twin-otter aircraft could not land in Pangnirtung due to the cross-turbulence or headwinds created by the shape and length of the mountains lining the fjord. In 1986, for example, a young man suffered a severe concussion and ensuing coma caused by a hockey head injury, and it took three days before the plane could land safely and evacuate him to the hospital in Iqaluit (the former Frobisher Bay). Another challenge for medical air evacuation are blizzards, either in Iqaluit, Pangnirtung, or elsewhere, during which planes cannot fly. Aircraft delays due to weather and wind conditions or mechanical breakdown is the

realistic and known challenge that remains part of air service to northern settlements, regardless of how developed the infrastructure has become. The early years of arctic aviation would have faced many similar challenges.

During the 1940s, Government services developed over the course of a progressive series of events. Providing supplies and building infrastructures in northern locations presented high budgetary costs, combined with complex logistical obstacles to bringing supplies and a skilled construction workforce. During the war years, the budgetary needs of northern sovereignty issues collided with the pressure coming from the external scrutiny of living conditions among the Inuit, causing the Canadian Government to focus on the welfare of all northerners (Duffy 1988:53–54). During all these changes, St. Luke's Hospital remained at the heart of the local level of care, and continued to serve the medical needs of the Cumberland Sound region and other settlements throughout the Eastern Arctic.

The Church and State behind the Scenes: Conflicting Agendas in 1946

In 1945, the responsibility of healthcare for the Inuit (and Indians) was transferred to the Department of National Health and Welfare (Waldram et al. 2006:200). Diminished support of Church-owned medical facilities resulted from watershed policies put in place under the direction of Dr. Percy Elmer Moore. Appointed as the Director of Indian and Northern Health Services in 1946, he served in this capacity until 1956 (Nixon 1989:166–167). P.E. Moore was determined to implement and deliver modern health services in response to documented poor health conditions among Aboriginal people, such as

endemic tuberculosis and high mortality rates (Nixon 1989:167). He also opposed privately funded medical services in the north, such as the Anglican medical missions, and this underlay the mounting resistance and tension that developed between him and Bishop Marsh (Nixon 1989:167). The Anglican Bishop Donald Marsh stood firm on the history of the work of the Anglican Church in the north and its proven record of providing medical care to Inuit prior to Moore's administration. The Anglican Church regarded the excellence of the missionary nursing staff, integration of local workers into the operation and maintenance of St. Luke's Hospital, and the results obtained from integrating the Inuit diet, Inuktitut language support, and close family contact, as having had a direct and positive influence on health outcomes. Yet, the conflicting relations between March and Moore arose from the same concerns: both Church and State were aware of the diminished health status of the Inuit and saw the need to provide high quality medical services. Both stakeholders, however, believed their expertise and quality of care was superior to the other's (Fitzgerald 2001:124; Nixon 1989:167).

Changes to Federal Government Financial Support

During the administrative changes in the 1940s, the Government continued to provide patient funding to Anglican Church missionary hospitals in the Arctic (St. Luke's in Pangnirtung and All Saints' in Aklavik), although patient funding, which supported the operating budget of the hospital, had gradually diminished. Although financial accounts of Government grants from 1930–1946 were not readily available during my archival research, a memo sent to Nurse Hockin by H.L. Alcorn (1947), the Honorable Secretary

Registrar, Diocese of the Arctic at Church House Toronto, dated 28 March 1947, outlined the Government's position regarding funding to St. Luke's Hospital in Pangnirtung.[20]

The memo contains accounting data that demonstrated the costs to the Anglican Church to operate the hospital, and the response from the Government concerning the grant that was forthcoming. The Anglican Church's 1946 financial report stated that there was an annual loss of $1,441.00, for the year 1945 and added that the average loss over five years amounted to $3,800.00 (Alcorn 1947:1). The memo states that the Government would meet the full cost of operation for the arctic hospital facilities and food requisitions, and compensate the Church for operational losses for the period of April 1, 1946 to March 31, 1947. The memo indicates that the Government was not interested in providing a subsidy; rather, an increase in patient funding was chosen as the method to compensate the losses. This payment scheme was provided under the Territorial Hospital Insurance Services Board (THISB)[21] and subject to review in October 1948 to assess its effectiveness. The memo states that the 1947 THISB patient-care funding awarded to St. Luke's Hospital was set at $7.00 per day for patients admitted to hospital, and $400 per year for the aged indigents in the Industrial home (Alcorn 1947:2).

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[20] This report also includes financial information for the Anglican Church All Saints' Hospital in Aklavik.

[21] North West Territories, government funded.

Church and State Interest in Health Care for the Inuit

Tuberculosis and medical treatment decisions lay at the center of the conflict between Bishop Marsh and P. E. Moore. A series of three letters from February to March 1951 demonstrates the mounting tension between them over issues of building additional hospitals in the north and the program of sending Inuit to southern hospitals for care (Department of Resources and Development 1950–1952:1). The letters are a series of responses between the two men, with the occasional letter from other officials on behalf of Moore. The Bishop consistently opposed the removal of Inuit to southern hospitals. He advocated for local hospital treatment and proposed the building of a hospital in Frobisher Bay, especially for the treatment of tubercular Inuit. In the years to follow, this request from Marsh was similar to recommendations under consideration by the Government, which ultimately built a hospital in Frobisher Bay.

P. E. Moore responded to a proposal from Bishop Marsh concerning a suggestion for a hospital in Frobisher Bay by way of a letter, dated 26 February, 1951, to G. E. B. Sinclair, Director of the Department and Resources and Development (Department of Resources and Development 1950–1952:1). In this letter, Moore "concedes the desirability of providing hospital facilities as close to the homes of the Eskimos of Baffin Island as possible, [even though] the practical difficulties seem very great" (Moore 1951:1). He goes on to say that, as the population of the region from Cape Dorset to Frobisher accounted for approximately 1,000 persons, the provision of a modern hospital would be financially inefficient, in light of the costs to renovate existing buildings or replace them with a new structure for the care of tuberculosis. Moore further suggests that

even if there were a tuberculosis hospital, it would be difficult to locate and secure specialised medical officers and staff to work there. In his opinion, a new facility would amount to a shelter for accumulated cases of tuberculosis, when they would be better off remaining among family in their homes. Moore suggests more hospital beds in the north and a small nursing station in Frobisher Bay would be more valuable for minor cases of TB. The crux of his letter is his preference for centralised care,

> As unsatisfactory as it is from a social aspect, we believe that the only way to make definite advances in the treatment of tuberculosis is to have the patients at an institution where they can receive advanced medical and surgical care. In our present thinking it impossible to provide this type of care except at a large centre such as Halifax, Quebec or Montreal. (Moore 1951:1)

Bishop Marsh persisted in his position, which advocated for keeping Inuit in the Arctic for specialised tuberculosis care, instead of Moore's suggestion to transfer Inuit patients to sanatoria in the south. In his letter of response, Marsh (1951:1) disagrees with Moore's assessment that building a hospital at Frobisher Bay was difficult. Marsh again expresses his concern for the challenges encountered by Inuit that resulted from their removal to southern hospitals and their return home. Marsh (1951:1) advocated again his opinion that building a Frobisher Bay facility was a means "to save us from the horrible mess into which we are being precipitated by the present system of Health and Welfare with regard to the Northwest Territory". Marsh contended that Inuit returned in an unsettled state from their hospitalisation in the south, and that the abrupt change to a

southern diet for three or four years hindered their transition back to indigenous food.[22] Marsh (1951:1) is also critical of the nutritional value of foods provided in the sanatoria, where a diet of flour "in turn weakens resistance to Tuberculosis". This criticism of southern sanatoria care and nutritional programs is a reflection of the long-standing program of providing indigenous foods, especially seal meat and fish, in the diet for tubercular patients at the Pangnirtung and Aklavik hospitals.

Marsh further opines that tuberculosis was on the increase, and suggests that Inuit transferred to hospitals in the south are ill prepared to deal with a second exposure to the disease on their return. Based on the Anglican Church's experience with mission hospitals in the Arctic, Bishop Marsh proposes that the only solution is to establish hospitals in the north that would incorporate indigenous diets and keep families together. Marsh (1951:1) also criticises the Government's bottom-line approach to Inuit health,

> The situation to me seems very absurd and is merely passing the buck of the whole vital question of what is needed for the sake of the people and not from a point of view of what is easily administered by a Government Department.

Relentlessly, Marsh (1951:2) leaves his continued lobbying with Sinclair in the "hope that the Northwest Territories will consider this matter from the point of view of the native rather than from an executive and financial standpoint".

The decision to send tubercular Inuit patients to southern hospitals was already in motion. The 1950 commission of the newly built icebreaker *The CD Howe*, for use during

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[22] A small numbers of patient transfers were already in progress at the time of the commission of the *CD Howe* in 1950, and earlier transfers occurred on board *The Nascopie* in the mid-1940s to Parc Savard in Quebec City (Grygier 1994: III).

the Eastern Arctic Medical Patrol, focused on general health and dental care, X-ray screening to identify cases of active TB, and the removal of tuberculosis patients to southern sanatoria. Further, Moore's administration established the use of available military hospitals only for the purposes of intermediate, rehabilitative care and as staging facilities for tubercular patients waiting to transfer south (Nixon 1989:167).

Bishop Marsh did not cease his efforts to promote arctic-based tubercular care options, which kept the Inuit in their communities, over sending them south to the sanatoria. He believed that the Anglican Church had a proven record of tuberculosis care that was effective precisely because the Inuit remained in the Arctic.

Letters to the Prime Minister and Minister of Health

In two separate letters to Ottawa, Marsh wrote to the Prime Minister in 1954 and to the Minister of Health and Welfare in 1955, advocating on behalf of the Inuit and asserting his position on the concerns arising from the removal of Inuit to southern hospitals. The following discussion presents the essential content of these letters.

Bishop Marsh's (1954:3) letter-writing campaign resumed with a letter to the Honorable Louis St. Laurent, Prime Minister of Canada, dated November 10, 1954. In this letter, Marsh established himself as a missionary of 28 years, with a spiritual responsibility for 82% of the arctic population. He expressed his deep commitment and love for the Inuit, which compelled him to continue to press authorities to establish hospitals in the arctic regions. He reminded Prime Minister St. Laurent of the historic relationship in which the Government and Church had come to an agreement to permit

the building of St. Luke's, and that the Church had funding earmarked for expanded hospital establishment,

> My predecessor, The Right Reverend Archibald Lang Fleming, pressed the Department of Mines and Resources for many years to allow him to build hospitals in the Arctic (for which there were and are funds available), pointing out the need for such services particularly in Hudson Strait. I still have on file in my office the blueprints which he had drawn for these projected hospitals. The only hospital which the Bishop Fleming was able to persuade the government to allow him to build was the one at Pangnirtung which the Department of Mines and Resources insisted should be built at that place rather than at Lake Harbour (Marsh 1954:3).

Marsh criticised the Government for its inhumane policy decisions and its disregard for the fair treatment of the Inuit. He drew the Prime Minister's attention to the growing fear and resistance of Inuit toward their mandatory removal to hospitals in the south,

> I have just returned from my sixth trip this year in the arctic and at every outpost I heard that the Inuit fled inland before the ship with the medical officers on board, for fear that they would be wrestled from their homes and shipped outside never to return, as has happened to so many of their friends and relatives. It is indeed hard to believe that this is the only way that a great nation like Canada can care for a small minority in her midst and who are, after all, our oldest Canadians (Marsh 1954:2).

Marsh (1954:2) ends his appeal with a comment that building hospitals, "and the return of the poor Eskimo to their own country would make an excellent proof for the belief that Canada really believes in the future of her own Northland and that she cares for her own people-the Eskimos".

In 1955, the Northern Health Service was established by the Federal Government and the medical services of the Northwest Territories were placed under the administration of the Department of National Health and Welfare (Waldram et al. 2006:200). The year after he wrote to the Prime Minister, Bishop Marsh sent a letter to the Honourable Paul Martin, Minister of National Health and Welfare, dated June 22,

1955. Marsh commented on a variety of concerns about decisions to hospitalise Inuit at southern sanatoria. While he did not deny the quality of care provided to patients, he stressed the enormous cost involved in sending and returning people to their homes, the inadequate diet devoid of indigenous foods that patients received at the sanatoria, and the importance of psychological wellbeing in the treatment of tuberculosis. He underlined the devastating effects of being away from family, especially for those who were seriously ill and would die while away (Marsh 1955a:3).

Marsh (1955a:3) also challenged the Government to be accountable for its actions, which he asserted contradicted promises and past relationships,

> Repeatedly the question of hospitalization of Eskimos in the North has been brought up both to yourself and to Dr. Moore, your representative at that Committee [1954 Advisory Committee on Eskimo Affairs]. Emphatically and categorically, he has told the members that the Department of National Health and Welfare do not intend to build any hospitals in the Arctic … I am glad to hear of the plans to remove every native with an infectious disease from contact with his family. This has been the avowed policy of the Department for a long time and one with which I think everybody is in complete agreement. It is for this reason that the Church, long years before the Government became interested, built hospitals in the North and desired, and still desires, to extend this service to the people of the Arctic. Your Nursing Stations have instructions that they are not to hospitalize patients with tuberculosis nor long-term patients. Thus, they are of little value in the picture, and a doctor with a plane to fly around the North would do far better work for much less money.

The letters from Marsh to Moore, St. Laurent, and Martin resonate with similar themes, and clearly express the Bishop's exasperation. Marsh's claim that Inuit left for traditional camps during ship time to avoid the possibility of transfer to southern hospitals was confirmed by Inuit in Pangnirtung during the Photograph Naming Project.

On July 19, 1955, Paul Martin acknowledged receipt of the Bishop's letter, and confirmed the plans for a Government hospital in the Western Arctic at Aklavik. This

decision responded to Bishop Marsh's concerns, and resulted from economic and political decisions made at the level of the Eskimo Advisory Committee, in conjunction with Federal and Health and Welfare policy. Martin (1955:3) also responded to Marsh's concern over removing Inuit to the sanatoria,

> Each year the number of cases of tuberculosis found on our annual X-ray surveys seems to be decreasing and it is hoped that before too long this dread disease will be brought under control among our Eskimo population. I wish to thank you for the information contained in your letter and to assure you that whenever possible or practical, full consideration will be given to your representations.

Despite this partial victory for Marsh, the hospital at Pangnirtung was in the crosshairs of other outsiders. The RCMP Inspector, H.A. Larson, supported the building a Government hospital at the site of the former U.S. Air Force base in Frobisher Bay. Duffy (1988:57) cites Larson's disparaging view of the care provided by the mission hospitals, saying, "Such [Government] hospitals should be much better than the present native hospitals existing at Pangnirtung and Chesterfield Inlet, which in the opinion of many persons are just disease traps and unfit for human habitation". In the struggle between Church and State, Director P.E. Moore's administration maintained its position that medical officers—the Government doctors—were the best people qualified to act as administrators of the hospitals in the north. As such, missionary hospitals were required to have resident Government doctors on the premises; non-compliance would result in the withdrawal of funding. In a letter to Bishop Marsh in 1955, P. E. Moore (1955:3) clearly articulated, "It is our intention to do all we can to discourage hospitals where there is no doctor in attendance on patients under care". This position harkens back to earlier times when the Government could not recruit a new doctor for St. Luke's and the Head Nurse

was obliged to bring patients in need of admission to a committee for approval (Hockin 1944b:2). Medical officers who served in the north did not always share the view of Ottawa that missionaries were incapable of caring for the wellbeing of the Inuit. Dr. Otto Schaefer, medical officer at Pangnirtung from 1955 to 1957, defended the missionaries and their work in a response to a negative article published in an unidentified magazine,

> … [missionaries] did much to protect Eskimos against some of the worst abuses and exploitation by whalers, trappers and traders; filled a real void when the old animistic ghost world collapsed; and prepared Eskimos as best they could for onslaught of military (DEW line), government, and industrial development which, wanted or not, came their way (Hankins 2000:111).

In Chapter Five, I discuss in detail the capability of St. Luke's to manage concurrent multiple epidemics and strategise care for tubercular patients in the years before and during the 1950 changes in Government policy that would result in the centralisation of tubercular patient care.

Chapter Five
On the Record, 1950–1959

In this chapter, I discuss the flow of tubercular Inuit patients admitted into St. Luke's Hospital and their transfer to other specialised centers, as recorded in St. Luke's Mission Hospital Day Books (Physicians Day Book, 1955–1966). Information on traditional camps in the day books made it possible to map the distribution of tuberculosis in the Cumberland Sound during this ten-year period. The information, therefore, situates the ongoing work at the local hospital within the context of regional life in the Cumberland Sound and Government healthcare reforms that called for Inuit patients to be transferred to centralised care establishments in southern Canada.

It is important to bear in mind that the hospital day books only capture part of the picture of tuberculosis in the region. St. Luke's also provided general medical care and health status assessments through its outpatient department. Baby-wellness checkups, treatment for minor injuries, and tuberculosis screening were just some of the services provided to people who did not require hospitalisation. There are no records of the work done in the outpatient department, thus my discussion of tubercular individuals is based on Inuit who were hospitalised. I have relied on the experience of former hospital workers to fill in gaps in the available documentation and to bring Inuit perspectives into my discussion of the records.

Hospital Admissions at St. Luke's

St. Luke's Hospital continued to be a hub for patient care in the Cumberland Sound during the 1950s. The hospital day books for 1950–59 indicate that some 152 to 277 patients received care at St. Luke's annually, with an average of 212 patients in hospital per year, and a monthly average of 17.6 (Table 5.1a).

Table 5.1a: 1950–1959 Monthly and annual patient admissions, St. Luke's Mission Hospital (Physicians Day Book 1955–1966).

Year	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Total
1950	12	17	25	15	20	10	12	11	13	17	13	14	**179**
1951	15	11	17	14	14	12	10	11	13	12	10	13	**152**
1952	13	12	20	15	14	13	15	12	13	18	8	10	**163**
1953	11	17	24	19	24	44	37	27	16	18	20	20	**277**
1954	25	21	19	23	24	22	20	28	18	26	20	20	**266**
1955	21	22	25	31	23	15	16	22	27	21	19	17	**259**
1956	17	18	19	19	19	14	20	21	18	14	13	13	**205**
1957	20	16	21	23	31	19	12	16	21	18	17	23	**237**
1958	28	10	12	10	21	17	12	13	16	19	14	17	**189**
1959	18	15	21	16	19	13	12	14	18	17	12	20	**195**

Table 5.1b: 1950–1959 Annual totals of male and female patients in St. Luke's Mission Hospital (Physicians Day Book 1955–1966).

Year	Female	Male
1950	105	74
1951	69	83
1952	75	88
1953	181	97
1954	179	87
1955	139	120
1956	95	110
1957	120	117
1958	81	108
1959	77	119
Average	**112.1**	**100.3**

Females were more likely than males to be hospitalised; however; this is likely a reflection of women who came to the hospital to give birth (Table 5.1b). The breakdown by gender also includes newborns. On average, there were 112 females and 100 males in the hospital each year during this decade (Physicians Day Book 1955–1966).

During the 1950s, the hospital day books show an important shift in the recording of patient information. From January 1, 1950 to September 20, 1953, the day books provide no information on patient diagnoses, a continuation of the practice since 1931. However, on September 20, 1953 and throughout the remaining years of the hospital day book records (which end in July 1972), a column was added to record the patient's diagnosis (medical condition) and another column for additional comments (Physicians Day Book 1955–1966:92). Four conditions were identified: pyelo-nephritis, extraction (of tooth), obstetrical, and newborn (Physicians Day Book 1955–1966:92). The first record of pulmonary tuberculosis is listed in December that year, along with one case of Pott's paraplegia (deceased). The case of pulmonary tuberculosis was first admitted on November 20, 1953 and there was no note of the diagnosis at that time; however, at the time of discharge on December 3, 1953, a note was entered into the day book that the patient had pulmonary tuberculosis (Physicians Day Book 1955–1966:93–94). The practice, therefore, was to record the diagnosis for each patient at the time of either discharge from the hospital, transfer to another location, or death. These details are present in the remainder of the day book entries.

The addition of diagnostic information into the St. Luke's day book also coincides with the identification of tuberculosis patients and the Government designation of the

Mountain Sanatorium in Hamilton as the location to receive tubercular Inuit from the Eastern Arctic. However, there are no direct notes in the 1950–1957 hospital day books that identify transfers to the Hamilton Sanatorium. From 1957 onward, however, transfers to Hamilton are noted.

The hospital day books also include a record of patient E# (Eskimo Disc Number)[23], which proved useful for sorting the hospital admissions by individual. Some people were in the hospital on a variety of occasions over a single year, or over the decade (for example, a female patient in the hospital for childbirth who returned for another admission, for pneumonia, later that year). The E# also made it possible to identify individuals who were in hospital for long-term care. At times, the same individual was in hospital for many months and therefore was counted more than once in the annual total.

From Camp to Hospital

The appearance of diagnostic information in September 1953 made it possible to explore from which camps in the Cumberland Sound tubercular Inuit were admitted to St. Luke's Hospital. It is common knowledge among the Inuit of Pangnirtung that the guide, Etuangut Aksayuk, worked with the doctors and brought tuberculosis patients from

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[23] The transcription of materials in a database was by permission of the Anglican Church of Canada General Synod Archive's research agreement describing the protection of the confidential patient information. The database generated by my analysis and all day-book materials are the property of the archive and were used for the sole purpose of data analysis. This Excel database version of the materials generated during my analysis has been gifted to the Archive to remain in their holdings.

traditional camps to the hospital.[24] A biographic account of Otto Schaefer's work in Pangnirtung during1956–58 describes his travel to the outlying camps with Etuangut and the doctors' reliance upon his skills and knowledge of the region to reach the camps (Hankins 2000:82). Stevenson's map of winter hunting routes (Stevenson 1997:239) and an illustration of the progressive formation of winter ice in the Cumberland Sound (Stevenson 1997:38) show the seasonal knowledge required by the medical patrol to navigate the routes between traditional camps. Stevenson also mapped the summer and winter hunting regions and the types of animals pursued (Stevenson 1997:111), such that his study establishes the strategic importance of the locations of traditional camps and how people moved between camp groups over the cycle of the Inuit year.

Less well known, however, is the role played by a wider network of local people—outside of and separate from the medical patrol—in transporting the sick to the hospital for treatment. Noah Maniapik (personal conversation, March 16, 2011, Iqaluit, NU), for instance, recalled his late father, Joanasie, and some of his uncles bringing sick people from traditional camps to the hospital.[25] During my final report to the Pangnirtung Hamlet Council in March 2011, the Mayor, Sakiasie Sowdlooapik (personal conversation, March 29, 2011, Pangnirtung, NU), shared his own story of acute illness with tuberculosis, and his recollection of his father bringing him from their camp to St. Luke's

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[24] Research partner, Billy Etooangat, shared many remembrances of his grandfather Etuangut with me during our three years working together on the community project. I have my own memories of knowing Etuangut. He was very important in the community and to those who contributed to this study.

[25] Noah Maniapik (personal communication, March 16, 2011, Iqaluit, NU) reviewed my maps for the accuracy of place names and location of traditional camps. During this consultation, we had some discussion about the movement of patients to the hospital.

Hospital. He expressed the view that his father's quick action in transporting him to St. Luke's saved his life. These and other accounts make it clear that it was common practice to bring sick persons to hospital, rather than leaving them behind in the camps and wait for the medical patrol. They also reinforce the local opinion that the hospital was an accepted place for medical care, actively sought out, rather than a place to be avoided at all costs.

Monitoring Tuberculosis

St. Luke's was the only hospital in the Eastern Arctic and the headquarters for the Medical Officer of the Eastern Arctic, who was in charge of decisions concerning which cases of TB would be admitted to hospital. The resident doctor also made decisions about which patients would be transferred to centres of specialised care. St. Luke's was equipped with both an X-ray machine and a fluoroscope for tuberculosis screening; consequently, the hospital staff did not rely on the annual Eastern Arctic patrol ship to provide X-ray screening of tuberculosis patients. Instead, when tuberculosis patients from the Cumberland Sound arrived at the mission hospital, they were immediately assessed and then either admitted or transferred to other facilities, regardless of the time of year. I spoke with several of the Elders who were former hospital workers to ask about the process of assessment, admitting, or transferring patients. Evie Anilniliak and Rosie Veevee (personal conversation, translated by Ooleepeeka Arnaqaq, March 23–30, 2011, Pangnirtung, NU) confirmed that the hospital outpatient department conducted ongoing monitoring of tuberculosis throughout the Cumberland Sound region. This monitoring

function is unique in the Eastern Arctic, and was made possible by the hospital's capacity and operational mandate. Further, the outpatient department conducted a daily clinic that assessed individuals and provided immediate treatment for all conditions not requiring hospitalisation. No records of the number of cases seen in this outpatient clinic survived. This vital aspect of the hospital's two-pronged approach to health care provision, medical clinic and front-line tubercular screening, is not part of the retrievable archival record.

As discussed in Chapter Four, the Government administration of patient care funding at mission-owned facilities changed during the tenure of P.E. Moore as Director of the Indian Health Department from 1946 to 1956 (Nixon 1989:167). These directions affected Territorial Health Insurance payments for tubercular patients at St. Luke's Hospital. It also appears that the Government permitted only the uncomplicated cases of tuberculosis to remain in care at St. Luke's, yet the practicalities of following Government policy at the local level remain unclear. I brought this point up to the former hospital workers for their interpretation of how the policy was enacted at St. Luke's. Evie Anilniliak said she understood that the criterion for admission was active tuberculosis, and that patients stayed in hospital until they were cured. In the early years, they remained in hospital until they were past the acute phase (interpreted as the cure after being very sick). During the years when tuberculosis drugs were made available to the admitted patients, Anilniliak (personal conversation, translated by Ooleepeeka Arnaqaq, March 30, 2011, Pangnirtung, NU) stated the patients would remain in hospital until their medicine was finished and they were cured.

The CD Howe and the Eastern Arctic Medical Patrol

The health care role played by the ship *CGS CD Howe* during its commission from 1951–1969 for the annual Eastern Arctic Medical Patrol included shipboard medical or dental treatment, TB screening, and the transfer of Inuit patients south (Duffy 1988:57). The role of the *CD Howe* in medical care for Inuit in the Cumberland Sound supplemented the ongoing work accomplished at St. Luke's.

Medical doctors on the *CD Howe* were empowered to extract tubercular Inuit patients along the patrol route of the annual voyage and to remove these patients to medical centers in Quebec and Ontario. In most cases, the medical patrol stopped in locations that lacked a hospital or a nursing station. Inuit were brought from shore to the ship and screened for TB (Figure 5.1). If they tested positive, they were kept on board for transport south (Grygier 1994:95).[26] The ship could accommodate a maximum of eighty-eight passengers and a crew of fifty-eight. Among the passenger complement, there were two doctors, two nurses, two dentists, X-ray technicians, social workers, and various officials or additional support persons (Maginley 2001:145). The *CD Howe* stayed in port for twenty-four hours, and up to forty-eight hours in major centres (Grygier 1994:90).

[26] The 2008 film *Necessities of Life* (French: *Ce qu'il faut pour vivre*; Inuktitut: *Inuujjutiksaq*) portrays the process of collecting Inuit at the shores, and the onboard screening for TB. This film depicts the main character, Tiivii (played by Inuit actor Natar Ungalaaq, known for his leading role in *Atanarjuat: the Fast Runner*), and his journey from Baffin Island in July 1952 to a Quebec City sanatorium, his treatment, struggles with separation and personal anguish, and return to his family after his cure.

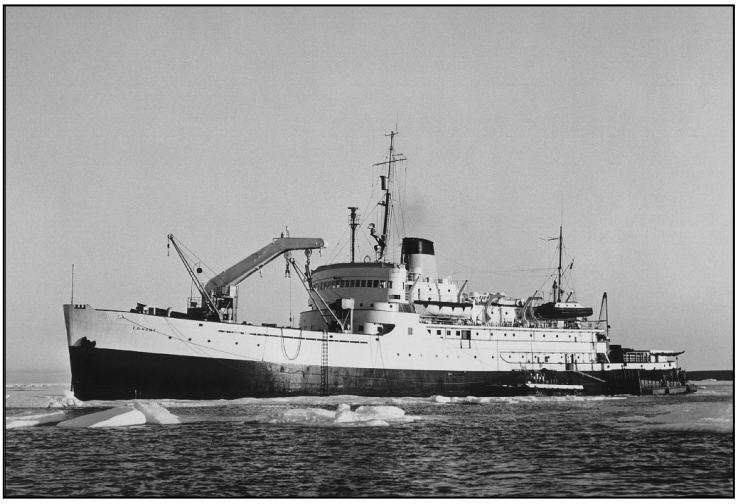

Figure 5.1: The *CGS CD Howe*. Photograph courtesy S. Peck, Canadian Coast Guard, used with permission.

The ship's itinerary included a round trip route of 14 ports of call, over a span of 43 days. It travelled outbound through the St. Lawrence Seaway, rounded Newfoundland and Labrador toward the top of Quebec to visit Chimo, Sugluk, and Ivugivik, and then crossed Hudson's Bay toward Churchill. From there, it navigated toward Baffin Island, along the southern coast toward Frobisher Bay, onward to Pangnirtung, then along the northern shoreline of the island toward the Clyde River, before turning back to Pangnirtung to begin the return voyage to Montreal (Department of Transport 1953:5).

Thirty-six bunk beds were available onboard for Inuit patients, but the ship is known to have transported many more than this. Grygier notes, for instance, that eighty-three patients were transported in 1958. They were accommodated by placing mattresses on the floor in the segregated patient area, and by doubling up the children in bunks (Grygier 1994:97). The ship also carried returning patients. When the ship was in the Baffin region, it also took on passengers moving from one port to another. Grygier reports

that eighteen tubercular Inuit patients were on board during the return voyage to the south in 1950; in 1951, eleven were returning home. In 1953, 16 Inuit returned home and up to 68 were in transit, while in 1957, 88 were on board and 50 were in transit. These figures, however, do not distinguish the Inuit who used the *CD Howe* for transport from one location to another from the tubercular Inuit patients (Grygier 1994:90).

The hardships endured by the Inuit on board the *CD Howe,* their life in sanatoria filled with dramatic cultural adjustments, and the isolating distance experienced when returning home have been discussed extensively in the literature (Bonesteel & Anderson 2008; Damas 2002; Duffy 1988; Grygier 1994; Wherrett 1977). During the Pangnirtung Photograph naming project, participants who had been transferred to Hamilton on the *CD Howe* spoke of cramped quarters, rough seas, loud noises from the anchor chain and engines, and fearful uncertainty. The trip was fraught with dread and suffering. They also recalled how they adapted to life in the Mountain Sanatorium, the friendships formed there, the activity of visiting each other, and the kindness and care provided to them by the nursing and medical staff. In the 1950s the return journey home to Panniqtuuq for Inuit from the Cumberland Sound region was accomplished for the most part by air transport. Billy Etooangat recalled the years prior to the establishment of the Pangnirtung airstrip, stating that the airplanes landed on the frozen fjord. This accounts for the transfers recorded for the months of January or February, when the ice was established and capable of supporting aircraft. During the community celebration in Pangnirtung, on March 22, 2009, many of the former tubercular Inuit who left for southern sanatoria remembered a sense of strangeness, or of being outside of their family network, upon

their return. Mostly, they recalled that this period of isolation and awkwardness passed as they reintegrated their lives into the overall community. Their response was clearly one of resilience. Although the transfer from Pangnirtung on the *CD Howe* was inordinately difficult, and undisputedly the worst part of the journey, many participants expressed gratitude for the treatment they received, and the sense of obtaining a cure for their tuberculosis that allowed them to live full, productive lives.

For the Inuit of the Cumberland Sound region, the *CD Howe* does not represent the center of their memories of tuberculosis, as their collective experience also included local treatment at St. Luke's hospital and transfers by aircraft. Elsewhere on Baffin Island, where there was no local hospital, the annual voyage of the *CD Howe* played a larger role. In Pangnirtung, St. Luke's Mission Hospital was the place of contact where culture, disease, and health initiatives merged.

From the Cumberland Sound to the Mountain Sanatorium in Hamilton

From the economic standpoint of the Government's restrictions on medical financing and St. Luke's patient grants, Inuit bodies were circulated as medical capital. In 1954, the Government designated the Mountain Sanatorium in Hamilton, Ontario as the principal Eskimo hospital in Eastern Canada (Williamson 2006:173),[27]

[27] The Charles Camsell Hospital served the Eskimo of Western Canada.

> With the discovery of effective drug therapy in 1943, the need for years of bed rest came to an end. Now the beds, for which there used to be a long waiting list, were sitting empty. It was clear to the Board of Directors that the Mountain Sanatorium would have to change its mandate or close which was the fate of many sanatoriums. They managed to give themselves more time to plan by accepting Inuit patients who were suffering from tuberculosis. There weren't enough hospitals in the north to treat the Inuit so the Federal government asked several sanatoriums in the south for help. Between 1958 and 1962, 1,272 Inuit were treated at the Mountain Sanatorium for tuberculosis (McMaster University 2011).

In keeping with the Government's use of the Mountain Sanatorium, a record of patients diagnosed with tuberculosis appears in St. Luke's day books (as of September 1953) and was maintained until the hospital closed in 1972. Unfortunately, the day books do not reveal the reason why some were selected to stay in St. Luke's and why others were sent to sanatoria. Some insight into this process is contained in a letter from St. Luke's Head Nurse, Prudence Hockin, to Bishop Marsh on September 17, 1959. Hockin reports that the *CD Howe* arrived on 10 September, 1959 and departed for Hamilton two days later. She names six additional Inuit who were taken south, including a sixty-six-year-old male, a fifteen-year-old male, a six-year-old female from Pangnirtung (for the investigation of a kidney lesion), a twelve-year-old female from Pangnirtung (with an old injury of her knee), and a thirty-six-year-old male (for a hernia operation). Hockin (1959) adds, "They have evacuated the cases they found [of tuberculosis] but left the 5 we have here". I investigated Hockin's account with one of the individuals named in this letter, and she confirmed that she was not admitted to the hospital; instead, she recalls being taken to the ship and not being allowed to leave after her assessment.

Although the St. Luke's day books provide a detailed account of the tubercular Inuit treated locally and transferred elsewhere, they do not provide information on any

Inuit removed directly from the shore and assessed on board the *CD Howe.* Elder participants in the Photographic Naming Project discussed going to the ship for medical and dental checkups, but also recalled that the onboard medical staff came ashore to the hospital for surgeries and screening. During the years in which acute cases assessed in St. Luke's outpatient clinic could not be accommodated at the hospital, it is possible that these identified cases would have been the candidates eligible for transfer on the *CD Howe*. Because there are no records for Inuit screened on board the *CD Howe* when it was in port at Pangnirtung, it is impossible to determine how many additional Inuit may have been transferred to sanatoria using this method.

Mapping Tuberculosis in the Cumberland Sound

The quality of information contained in the St. Luke's hospital day books stands in marked contrast to the records for Inuit transported on the *CD Howe* (either overall, or regionally), which are incomplete. Steven Peck (personal conversation, November 2009), the Canadian Coast Guard Historian, explained that passenger manifest records were not routinely retained on file, and he was unable to provide any copies of the return-voyage passenger manifests of the *CD Howe* from 1950 to 1969 (Grygier 1994:86). St. Luke's Hospital day books, however, record the camp locations of Inuit admitted to the hospital, and the locations of the specialised medical facilities to which they were sent. Figure 1.1 showed the communities serviced by St. Luke's Mission Hospital in Qikiqtaaluk (Baffin Island), including the Pannirtuup Kaniqtualu (Cumberland Sound) region, and Figure 5.2 shows in detail the camps in the Cumberland Sound.

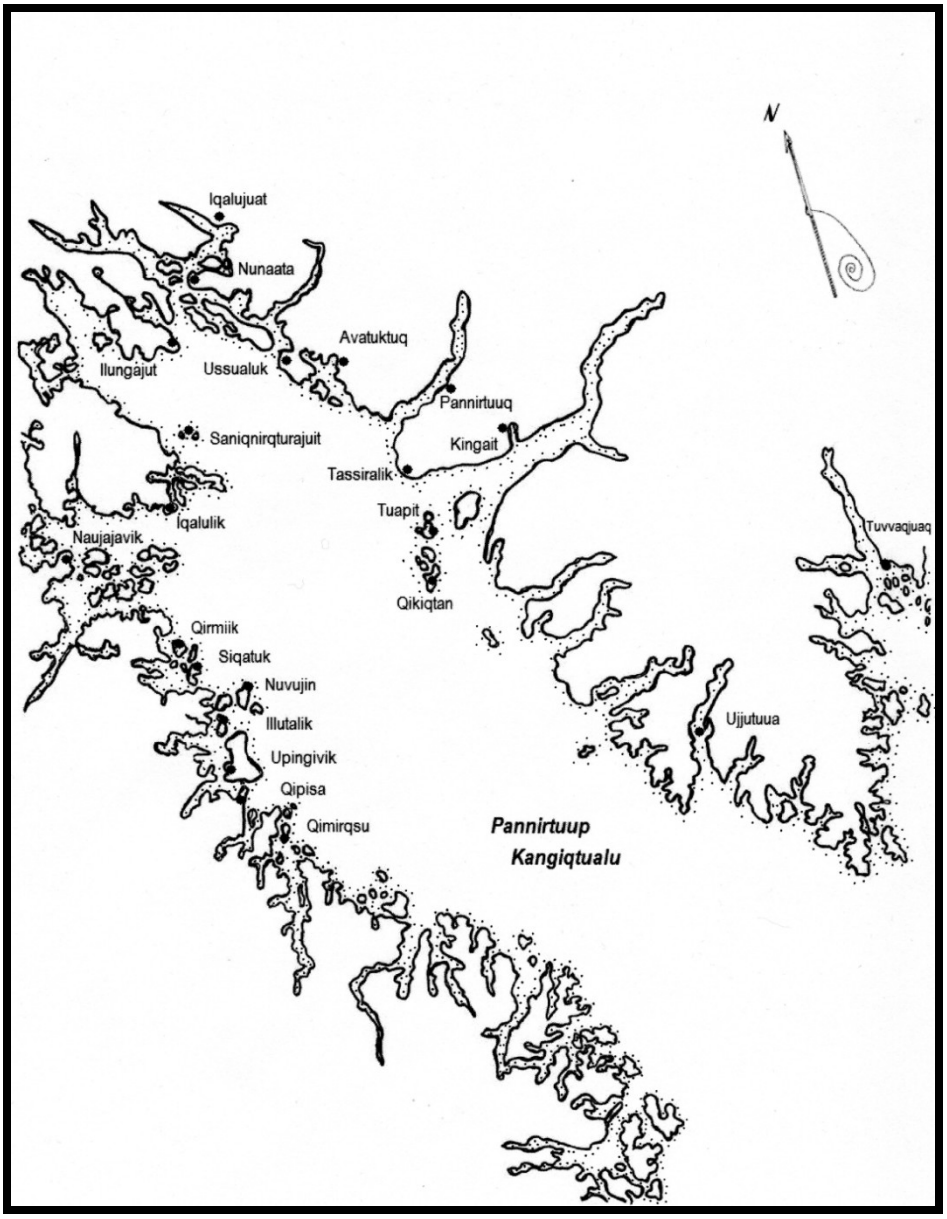

Figure 5.2: Map of Pannirtuup Kangiqtualu (Cumberland Sound) showing the traditional camps serviced by St. Luke's Mission Hospital 1931–1972. ©Emily Cowall 2011.[28]

[28] Map artwork by Emily Cowall redrawn from Stevenson (1997:146). Used with permission of Oxford University Press Canada (January 27, 2011). Scale 4cm=50km. Place naming was performed in consultation with Nancy Anilniliak (February 6, 2011), Billy Etooangat (April 1, 2011), Noah Maniapik (March 15, 2011), and Monty Yank (March 30, 2011).

Traditional Camps in the Cumberland Sound

The hospital day book records bring an important understanding of the extent of the impact of St. Luke's Hospital when viewed from the perspective of traditional camps in the Cumberland Sound. Marc Stevenson's (1997) study of the organisational structure of the Inuit in the Cumberland Sound provided the foundation for the maps that I have redrawn to show the locations where Inuit were living during the 1950s. The population census in 1951 was 461 Inuit living in 16 camps around the Sound region, with 75 Inuit residing in Pangnirtung. The RCMP did not permit "loitering" in Pangnirtung and Inuit were encouraged to return to their camps if the hospital, Hudson's Bay Company, or Government agents did not employ them (Damas 2002:61). Stevenson's (1997:146) research also identified 16 camps. However, there are several camp locations listed for tubercular patients in the hospital day books that are not included in either Damas's or Stevenson's accounts.

To develop a map of the camps, I consulted with the community research partners on the spelling of traditional camp names written by the nurses in the hospital day books. The day book entries were spelled phonetically and, as it turned out, contained many errors. These discrepancies were reviewed and corrected by Nancy Anilniliak, Billy Etooangat, Noah Maniapik, and Monty Yank. Table 5.2 shows the outcome of this consultation and lists the traditional camps recorded by the nurses in the hospital day books in the first column, with the corrected spelling in the second. Note that although St. Luke's Mission Hospital was located in Pangnirtung, an encampment of Inuit also lived there.

Table 5.2: Cumberland Sound traditional camp names (Anilniliak, Etooangat, Maniapik, and Yank, personal conversation, March 30, 2011) **and their equivalents in the St. Luke's Hospital day books** (Physicians Day Book 1931–1954, 1955–1966, 1967–1972).

Traditional camp name	Camp name as recorded in the day books
Avatuktuq	Avatuktoo
Illutalik	Ilootalik
Ilungajut	Bon Accord
Iqalujuat	Ilkalooakjuak
Iqalulik	Ilkaloolik and Iglootalik
Kingait	Kingnait
Nunaata	Noonata
Paalavik	Padloping
Panniqtuuq or Pannirtuuq	Pangnirtung
Qikiqtan	Kekerton
Qikiqtarjuaq	Broughton Island
Qimirqsu	Kimiksoon
Qipisa	Keepeeshaw
Saniqnirqturajuit	Imegan
Tassiralik	Tesserali
Tuapait	Tuwapiat
Tuvvaqjuaq	Papatsie's camp
Upingivik	Opinivik

To map the distribution of tuberculosis by traditional camps in the Cumberland Sound region in the 1950s, I first compiled the patient data for tubercular Inuit by camp from 1952 to 1959 (Table 5.3). This information is charted by year. I then transferred the information to the base maps of the Cumberland Sound (Pannirtuup Kangiqtualu) and Baffin (Qikiqtaaluk) regions (Figure 5.3).

Table 5.3: Distribution of tubercular patients by traditional camp 1952–1959 (Physicians Day Book 1931–1954, 1955–1966).

Camp	1952	1953	1954	1955	1956	1957	1958	1959	Total
Avatuktuq	0	1	0	2	3	4	2	2	**14**
Illutalik	0	0	0	0	3	0	0	0	**3**
Ilungajut	0	0	2	3	1	2	7	1	**16**
Iqalujuat	0	0	0	0	1	1	0	0	**2**
Iqalulik	0	0	0	3	4	0	0	0	**7**
Kingait	0	0	1	1	1	0	0	0	**3**
Nunaata	0	0	0	3	1	3	1	0	**8**
Paalavik	0	0	3	3	1	1	0	0	**8**
Pannirtuuq	0	2	2	3	6	11	10	5	**39**
Qikiqtan	0	0	0	1	1	0	0	0	**2**
Qikiqtarjuaq	0	0	0	0	1	0	0	0	**1**
Qimirqsu	0	0	0	0	0	4	1	1	**6**
Qipisa	1	2	0	0	0	0	0	0	**3**
Saniqnirqturajuit	0	0	0	1	3	1	1	6	**12**
Tassiralik	0	0	1	3	3	3	2	1	**13**
Tuapait	0	0	0	2	4	4	0	3	**13**
Tuvvaqjuaq	0	0	0	1	1	1	5	2	**10**
Upingivik	0	0	0	0	1	0	2	2	**5**
Total	**1**	**5**	**9**	**26**	**35**	**35**	**31**	**23**	**165**

This chart suggests that camps within easy reach of St. Luke's Mission Hospital had more cases; however, consulting with the projects research partners, these camps experienced increased population density in all likelihood because of migrating groups during seasonal hunting cycles and during the consolidation of camp populations from one location into another (N. Maniapik, personal conversation, March 16, 2011).

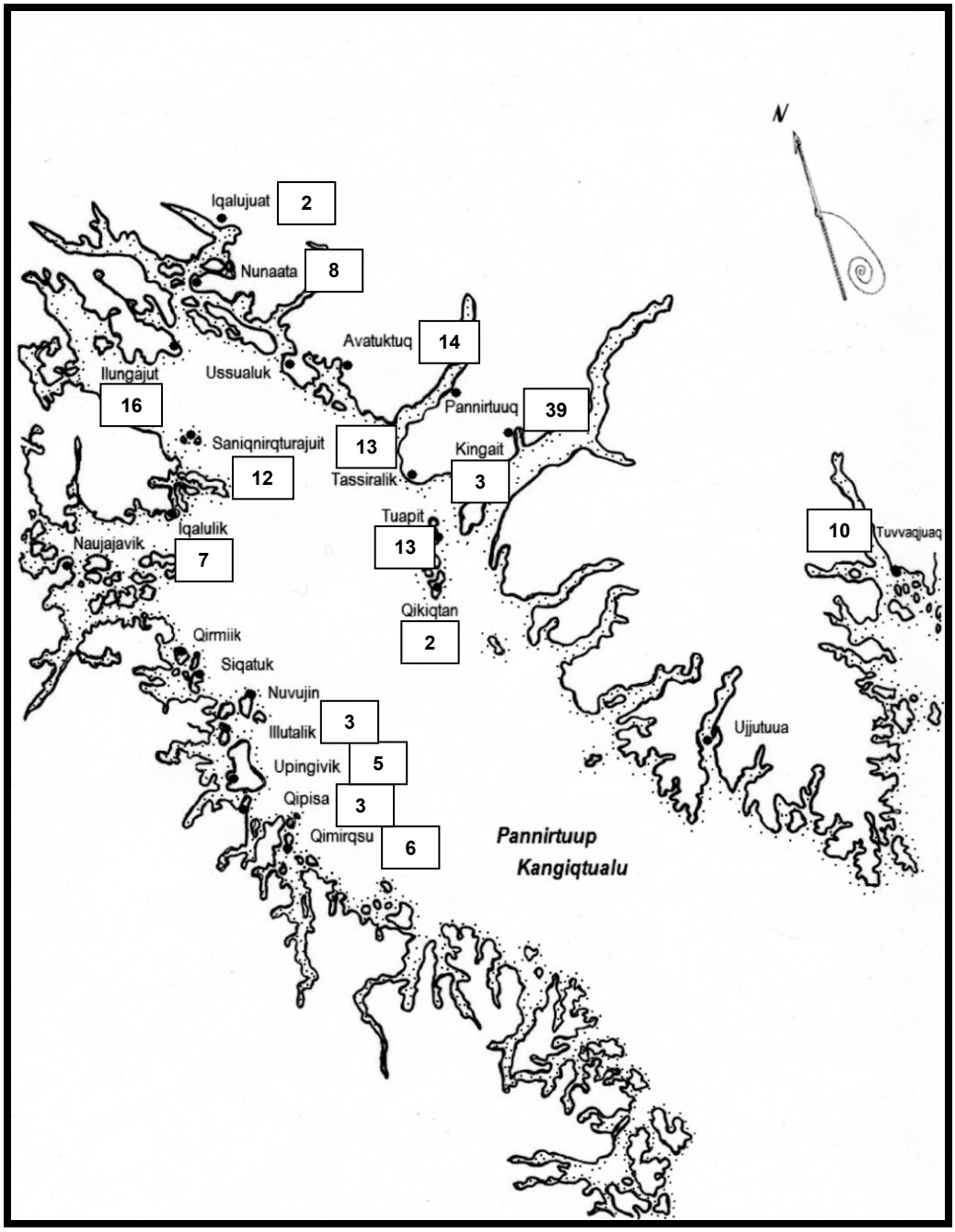

Figure 5.3: Distribution of tubercular patients, by traditional camp and region, from 1952 to 1959 (cross-reference Table 5.3). (Physicians Day Book 1931–1954, 1955–1966).

Photographs and Day Books: The Hamilton Connection

Despite the push in the 1950s to send Inuit patients to southern sanatoria, in the case of St. Luke's, the majority of Inuit were treated locally. According to the day books, 165 tubercular Inuit were admitted to St. Luke's Hospital for medical care from 1952–1959 (Table 5.3) and 45 patients were transferred to the Mountain Sanatorium in Hamilton. There are no verifiable photographs from the Pangnirtung Community Photograph naming project or hospital day book records for 1950 (Physicians Day Book, 1955–1966).

Linking Photographs to Hospital Records

I was able to verify St. Luke's records of patients admitted and transferred to the Hamilton Mountain Sanatorium by comparing them to the individuals named in the Pangnirtung Photographic Naming Project. This process of verifying transferred patients using the hospital day book records was accomplished through two steps. In the first step, I reviewed the identified photographs with Nancy Anilniliak. She was able to designate the traditional camp or place location for each of the 135 named persons in the photograph collection. From these, 68 Inuit were identified as coming from locations outside of the Cumberland Sound region, mostly from Qikiqtarjuaq and Paalivik (Broughton Island and Padloping Island). The patients from Qikiqtarjuaq and Paalivik were transferred to the Hamilton Sanatorium through the screening done by the Eastern Arctic medical patrols on the annual voyage of the *CD Howe*, not through St. Luke's Hospital (see inset map Figure 5.3). After setting aside the photographs of patients from

outside the Cumberland Sound, I checked the hospital day books to find records for the 67 remaining tubercular Inuit in the photographs (135 in the collection minus the 68 from outside the region).

First, I cross-referenced photographs with the list of named tubercular patients transferred to the Hamilton Sanatorium recorded in the 1957–1959 St. Luke's Hospital day books (Table 5.4). I then cross-referenced the names of the patients and their traditional camp information against the hospital day book entries for 1950–1957. This made it possible to link 19 more TB cases to entries in St. Luke's day books. At the end of this process, 25 photographs remained unlinked to the hospital day books for 1950–1959. The 25 remaining Inuit patients may have been sent to Hamilton through St. Luke's outpatient department without ever having been admitted to hospital; presumably, some were treated through the outpatient department. The former hospital workers were also clear about the coming and going of tubercular patients and, in most instances, recalled that acute cases or individuals in need of advanced care were among those chosen for transfer. The record-linkage process revealed that at least 45 Cumberland Sound Inuit were transferred from St. Luke's to the Hamilton Mountain Sanatorium between 1954 and 1959 (Table 5.4).

The time of year when patient transfers occurred sheds light on the relatively small role played by the *CD Howe* in servicing the Cumberland Sound region and the hospital at Pangnirtung. The list of 45 tubercular patients transferred from St. Luke's to the Hamilton Mountain Sanatorium from 1954 to 1959 (Table 5.4) shows the various month and dates across the years in which the transfers occurred. Only transfers occurring

during August and September align with the annual visits of the *CD Howe* serving as the medical patrol ship. All other transfers during the months of January, March, and June indicate that those patients were transferred by airplane, not by ship. Evidently, more than sixty percent of the Inuit patients sent to Hamilton from St. Luke's Hospital travelled by air, not via the *CD Howe.* The continuous presence of tuberculosis screening and designated TB beds at St. Luke's Hospital changed the way in which the annual medical patrol operated in this particular region, and this is supported by the transfer dates. St. Luke's Hospital did not rely on the annual Eastern Arctic Medical Patrol or on the facilities onboard the ship to screen for tuberculosis infection.

Table 5.4: Transfers by traditional camp from St. Luke's Mission Hospital to Hamilton Sanatorium 1954–1959 (Physicians Day Book 1931–1954, 1955–1966) informed by the names of the identified photographs in the Pangnirtung Photograph Naming Project.

Year	Camp	TB	Month+date	Age	Gender
1954	Illungajut	pulmonary TB	Aug-02	23	F
1955	Tassiralik	pulmonary TB	Mar-03	18	M
1955	Nunaata	TB renal	Sep-01	20	F
1956	Tuvvaqjuak	KUB	Jan-17	20	F
1956	Illutalik	pulmonary TB	Aug-18	23	F
1956	Nunnata	pulmonary TB	Aug-18	6	M
1957	Tuapait	miliary	Jan-05	7	F
1957	Panniqtuuq	meningitis	Jan-05	4	F
1957	Tuapait	pulmonary	Jun-04	5	M
1957	Nunatta	pulmonary	Jun-04	8	M
1957	Avatuktuq	Primary	Jun-04	3	M
1957	Tuapait	Primary	Sep-08	4	M
1957	Tuvaqjuaq	Primary	Sep-08	5	F
1957	Panniqtuuq	Primary	Sep-08	11	F
1957	Avatuktuq	pulmonary	Sep-08	30	F
1957	Qimirqsu	pulmonary	Sep-08	34	M
1957	Qimirqsu	Primary	Sep-08	3	M
1957	Qimirqsu	pulmonary	Sep-08	3	M
1957	Qimirqsu	Primary	Sep-08	6	M
1958	Illungajut	pulmonary	Jan-20	65	F
1958	Tassiralik	pulmonary	Jan-27	8	M
1958	Nunatta	pulmonary	Jan-27	10	M
1958	Nunatta	pulmonary	Jan-27	5	F
1958	Panniqtuuq	pulmonary	Jan-27	16	M
1958	Saniqnirqturajuit	pulmonary	Jan-20	69	F
1958	Illungajut	pulmonary	Jan-20	73	F
1958	Panniqtuuq	pulmonary	Jan-27	7	F
1958	Panniqtuuq	Primary	Jan-27	22 months	M
1958	Panniqtuuq	Primary	Jan-27	22 months	M
1958	Illungajut	pulmonary	Jan-27	25	M
1958	Panniqtuuq	far advanced	Jan-27	56	M
1958	Panniqtuuq	pulmonary	Jan-27	78	M
1958	Illungajut	pulmonary	Jan-27	4 months	M
1958	Illungajut	Primary	Jan-27	7 months	M
1958	Panniqtuuq	Frozen feet+ TB	Jan-27	58	F
1958	Tuvakjuaq	renal TB	Jan-27	29	F
1959	Tuvakjuaq	pulmonary	Jan-09	17	M
1959	Avataktuq	pulmonary	Jan-09	36	M
1959	Panniqtuuq	pulmonary	Jan-09	32	M
1959	Upingivik	pulmonary	Jan-09	61	M
1959	Upingivik	pulmonary	Jan-09	21	F
1959	Tassiralik	pulmonary	Jan-09	31	F
1959	Tuvaqjuaq	pulmonary	Mar-30	26	M
1959	Tuapait	pulmonary	Mar-30	30	M
1959	Panniqtuuq	pulmonary	Mar-30	19	F

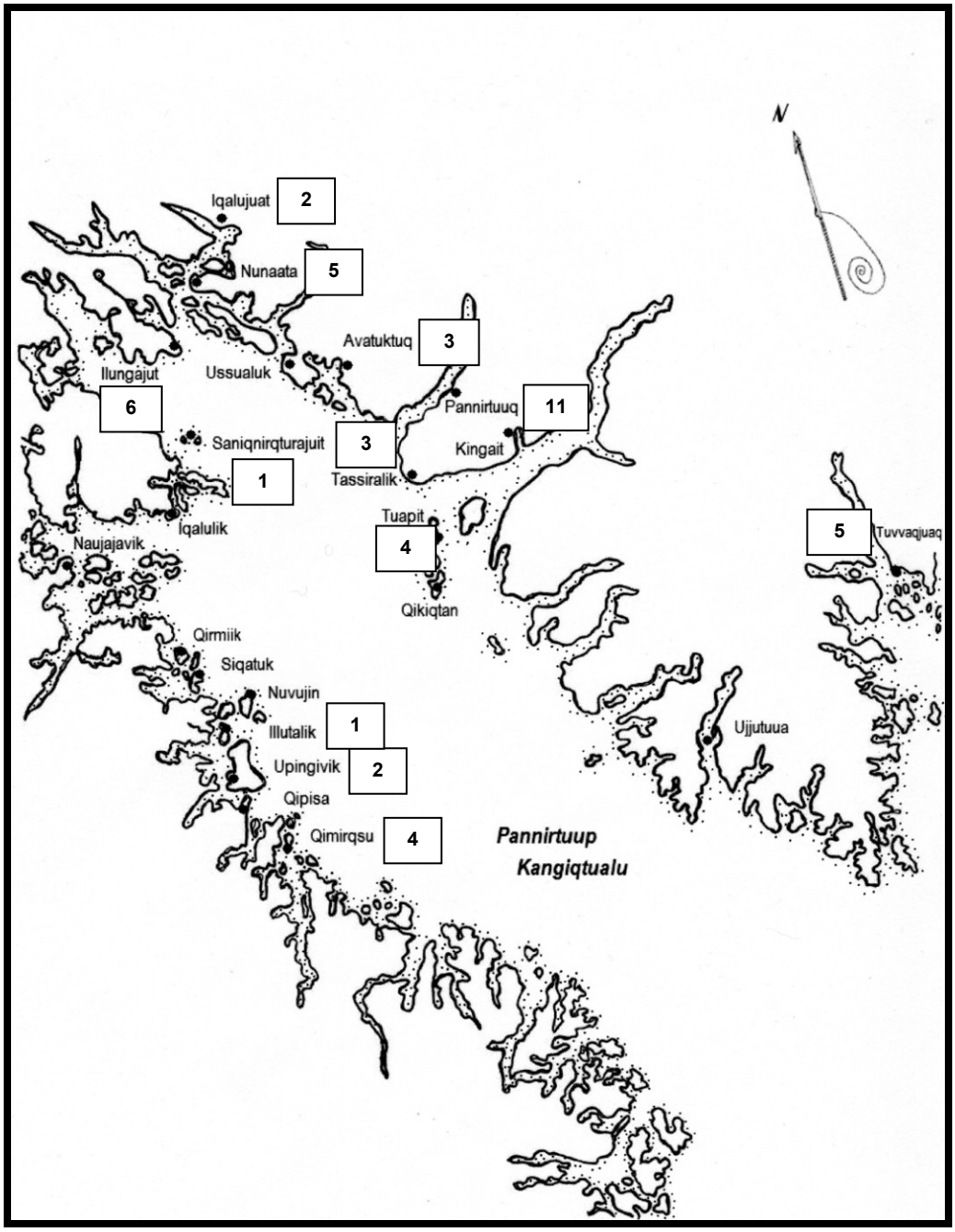

Figure 5.4: Transfers of tubercular patients from St. Luke's Mission Hospital to the Hamilton Mountain Sanatorium, by traditional camp, from 1954 to 1959. (Physicians Day Book 1931–1954, 1955–1966) informed by the names of the identified photographs in the Pangnirtung Photograph Naming Project.

During the 1950s, the experience of disease in the Cumberland Sound was undergoing an interesting intergenerational shift. According to Otto Schaefer, introduced infectious diseases had previously had a major effect on mortality rates, such as the typhoid fever epidemic in 1941, which killed 12% of the regional population (Schaefer 1993:27, also see Chapter Four). Schaefer asserts that exposure to infection over time diminished the impact of new outbreaks. The Inuit population had access to medical care and, by the 1950s, antibiotics were available to treat secondary bacterial infections. Yet, newly introduced diseases, such as rubella in 1956, had a significant impact on people who had tuberculosis. Schaefer (1993:29) remarks, "In general viral epidemics were less feared by that time for their direct mortality than for their role in lowering resistance to tuberculosis resulting in the flaring-up of old and quiescent infections". Schaefer (1993:29) suggests, however, that by the 1950s, medical surveys, hospitalisation, and treatment had effectively contained the tuberculosis problem,

> Mortality from tuberculosis remained very high for the Indian and Inuit population of the Northwest Territories into the late 1940's, when more than one percent died from the disease annually. Following systematic medical and radiological surveys; hospitalization and the advent of efficient chemotherapy that rate declined rapidly during the 1950's and fell to near zero.

The 1959 hospital day books show a decline in the transfer of patients to the Mountain Sanatorium. In the 1960s through to 1972, the hospital's focus shifted toward long-term care and medications monitoring. Tubercular patients were transferred to a variety of facilities, and St. Luke's admitted incoming patients from communities around Baffin Island. Chapter Six examines the patient data and circumstances that took the hospital through to its closure in 1972.

Chapter Six
1960–1972

This chapter presents the final twelve-year history of patient care at St. Luke's Mission Hospital from 1960 to 1972. I examine the distribution of tuberculosis patients in the Cumberland Sound and Baffin Island receiving drug treatment there during this period, the decline in the number of tubercular patients transferred to southern hospitals, and the circumstances that lead to the closure of the hospital in 1972. Three major influences appear to have affected tuberculosis treatment at St. Luke's during this period: the establishment of Frobisher Bay Hospital in 1961, the closure of the Hamilton Mountain Sanatorium in 1962, and Government hospital regulations and policy changes that affected patient funding.

The Transition from Church to Government

The 1950s were a time of dramatic change in the approach to the care of tuberculosis in the Eastern Arctic, shifting the focus away from treatment at the local mission hospital to a larger network of public facilities in other parts of Canada. The Diocese of the Arctic kept close watch on the Inuit patients transferred from western and eastern parishes to hospitals and sanatoria. Patients from the Eastern Arctic were sent to Ontario and Quebec. Two reports sent to Bishop Marsh, the Anglican Bishop of the Arctic, provide accounts for the number of Inuit sent to various southern hospitals for treatment (Cantley 1955:1–2). According to the 1955 report, 367 Inuit from the Eastern

Arctic were hospitalised in Ontario and 43 in Quebec. As of 31 October that year, 280 Inuit patients were at the Mountain Sanatorium (Table 6.1).

Table 6.1: Ontario and Quebec Tuberculosis Placements for Eastern Arctic Inuit, 1955 (Cantley 1955:1–2)

Ontario	**Location**	**Total**
Moose Factory Indian Hospital	Moose Factory	75
Mountain Sanatorium	Hamilton	280
Muskoka Lake Sanatorium	Gravenhurst	10
Sick Children's Hospital	Toronto	2
Quebec	**Location**	**Total**
Alexandria Hospital	Montreal	3
Children's Memorial	Montreal	2
Verdun Protestant (Mental)	Verdun	1
Kateri Memorial Hospital	Caughnawaga (Kahnawake)	7
Parc Savard Immigration Hospital	Quebec	30

In 1960, Bishop Marsh received another report of the "Eskimos in Residence at the Mountain Sanatorium, 1955–1964", which describes the place and gender of these patients (Hamilton Sanatorium File 1955–1964). The details are shown in Table 6.2. I have highlighted Broughton Island (Qikiqtarjuaq), Kivitoo (Qimirqsu), Padloping (Paalavik) and Pangnirtung (Pannirtuuq), as they represent Inuit patients from the Cumberland Sound region. Qikiqtarjuaq and Paalavik are geographically close to each other, and Inuit from Qikiqtarjuaq have kin relations in the Cumberland Sound.

Table 6.2: "Eskimos in Residence-Mountain Sanatorium" (Hamilton Sanatorium File 1955–1964).

Camp/Location	Male	Female	Total
Arctic Bay	3	6	9
Aggu Bay	1	0	1
Belcher Islands	0	1	1
Broughton Island	0	2	2
Cape Dorset	2	10	12
Cape Dyer	0	2	2
Cape Hooper	0	1	1
Chimo	1	0	1
Coppermine	1	0	0
Clyde River	3	7	10
Fox Main	0	3	3
Frobisher Bay	28	25	53
George River	1	0	1
Great Whale	1	0	1
Igloolik	8	11	19
Kivitoo	2	0	2
Koartak	0	2	2
Lake Harbour(Sugluk)	5	0	5
Pangnirtung (camp)	0	3	3
Padloping	1	0	1
Pond Inlet	8	9	17
Port Harrison	1	0	1
Sam Ford Fjord	1	0	1
Totals	**67**	**82**	**149**

Comparing the patient totals for Tables 6.1 and 6.2 shows the decline in sanatorium transfers. Table 6.2 indicates 53 transfers from Frobisher Bay, and only 3 from Pangnirtung. During consultation in the community, a former tubercular patient recalled how their transfer to Frobisher Bay was the first stop over and, if selected for further transfer to Hamilton, patients were sent on from there. Perhaps this contributes to the high numbers from Frobisher Bay. In 1955, there were 280 Inuit at the Mountain Sanatorium, but by 1960, there were only 149, a reduction of almost one half. This decline at the Mountain Sanatorium resulted from the phasing out of tubercular care there and the beginning of a new phase of its history when, in 1961, the Mountain Sanatorium

was closed to new incoming tubercular patients, and the site was renamed the Chedoke General and Children's Hospital (Williamson 2006:180).

The commission of the *CD Howe* did not end until 1969, but tuberculosis patients stopped being sent from Pangnirtung. In a letter to Miss Johnson, on September 14, 1964, Jean Turner (1964) writes,

> The C.D. Howe arrived here on the 6th Sept. and stayed two days. Quite a lot of natives were in from their camps this year so there was plenty of work for the Dr.s [sic] and Dentists. No T.B. patients went out from here this year on the Howe. Isn't that good news?

Scrutiny of the hospital day book records confirms Turner's statement that no tuberculosis patients were transferred during the 1964 medical patrol visit (Physicians Day Book 1955–1966:72).

However, patient transfers to a variety of specialised tubercular care centers continued after the Mountain Sanatorium closed. The hospital day book records for 1960–72 indicate that 32 patients were transferred to Toronto Western Hospital, Montreal Royal Edward Chest Hospital, and to the Government-operated hospital in Frobisher Bay (Table 6.3). Patients were occasionally sent to Frobisher Bay General Hospital for reassessment and then transferred elsewhere. One former patient shared his story of being sent to Frobisher Bay Hospital at the age of five, and from there to the Hospital for Sick Children in Toronto for tubercular care.

Table 6.3: St. Luke's Mission Hospital tubercular patients transferred to Hamilton Mountain Sanatorium, Frobisher Bay General, Montreal Royal Edward Chest Hospital, and Toronto Weston Sanatorium 1960-1972 (Physician Day Book 1955–1966, 1967–1972).

Year	Hamilton	Frobisher	Montreal	Toronto	Total
1960		1	1		2
1961	1	2			3
1962		3			3
1963		6			6
1964					0
1965				5	5
1966		3			3
1967		3			3
1968		1			1
1969					0
1970			2		2
1971			3		3
1972		1			1
Total	1	20	6	5	32

St. Luke's had been the only hospital in the Baffin Region for general medicine and tubercular care until the 35-bed Frobisher Bay Hospital was established by the Government in 1961 and then served as the regional link between Pangnirtung and the Government's nursing station network that was rapidly expanding throughout the Eastern Arctic (Damas 2002:118; Duffy 1988:62-3). However, the 1960–1972 day book record indicates that tubercular patients from other communities were in care as medical boarders at St. Luke's. This role ended in 1972 when the mission hospital closed.

The 1960 Hospital Inspection: Aligning with Healthcare Reform

Continuing policy change, funding reductions and limitations on the criteria for patient admittance instituted by the Territorial Health Insurance Services Board and the Indian Health Services Department set into motion changes that contributed to the

inevitable decline of St. Luke's Hospital. One such event was a mandated hospital inspection in 1960, in which Northern Health Services conducted a system-wide audit of medical facilities and assessed the operational details of the capacity of each location to respond to various medical-care demands. Accordingly, on October 17, 1960, National Health and Welfare requested that St. Luke's comply with a hospital inspection (Wiebe 1960).

The cover letter from J. H. Wiebe (regional superintendent, Eastern Region, Indian and Northern Health Service) to Bishop Marsh, which precedes the copy of the completed hospital survey (Wiebe 1960:1), explains that the purpose of the survey is to "pin-point strengths and weaknesses that exist". Yet, Wiebe explains that the results were considered against the overall context of the facility, such as its background, when standards differed from the current expectations. In addition, Wiebe indicates that the hospital survey was used by the Territorial Hospital Insurance Service Commission to assess "the relationship that should exist between it and the hospital" (Wiebe 1960:2).

St. Luke's survey was conducted by Dr. J. J. Murie, the executive officer of the 1960 Eastern Arctic patrol. Prudence Hockin, the head nurse, assisted during the inspection. The survey is a standardised form issued by the Department of National Health and Welfare, Northern Health Service (1960), and is 40 (S1-1-40) pages in length, with 30 categories and 147 questions. The 30 categories examined in the survey are shown in Table 6.4.

Table 6.4: Hospital-survey categories (Northern Health Service 1960).

Access (Seasonal)
Admissions Procedure
Autopsy
Bed Capacity
Blood Bank
Central Supply Service
Dental Department
Dental Staff
Discharge Procedure
Hospital Services Committee
Housekeeping
Isolation Facilities
Laboratory
Laundry
Library
Medical Records
Medical Staff
Nursing Personnel
Nursery
Office Misc Services
Operating Room
Outpatient Department
Personnel Management
Pharmacy
Physio and Occupational Therapy
Public Health
Social Worker Facilities
Storage, General
Wards
X-Ray Department

St. Luke's lacked various items listed for inspection, such as a Hospital Service Committee (Northern Health Service 1960:S1-3), sinks with running water at each patient bed (S1-6), a separate nursery ward with equipment (S1-23), a blood bank (S1-27), a physio- and occupational-therapy department (S1-30), and a fully equipped dental department (S1-36). The hospital nevertheless passed with an adequate rating. In some cases when the requirements were deemed either minimal or not appropriate to the location, the item received a passing grade, with a short explanation noted in the category.

For example, Item 57(f) asks, "Is there an in-service education program for personnel and what classifications of employees may benefit?" Here, Wiebe notes, "Because of the size of the hospital it is not felt practical to maintain an in-service education program" (S1-14). The survey described areas of the hospital that served multiple purposes and noted that the surgical services were for emergency cases only, with a minimally equipped operating room (S1-21). As there was no separate autopsy room, post-mortem examinations were conducted in the operating room (S1-30).

This survey also provides an overview of how St. Luke's had developed its resources and equipment to care for admitted patients, regardless of discrepancies in its operating standards. In 1960, St. Luke's Hospital was servicing a population of 700 people in the Cumberland Sound region (Northern Health Service 1960:S1-2). During the summer, air and ship service provided access to incoming personnel, mail and freight, but during freeze up and in winter, access to the hospital was only available by air and dog team (S1-3).

The hospital was built in 1930–31, with an addition constructed in 1940. A second addition in 1955 established the capacity totals surveyed in 1960 (Northern Health Service 1960:S1-4). The wards, which were separate rooms in the hospital, were divided into 1 surgical ward, 1 pediatrics ward, 2 medical wards, 4 tuberculosis wards, 1 custodial ward, and 1 isolation ward (S1-15). The patient bed capacity (Table 6.5) shows that, in 1960, there were 18 adult beds available for tuberculosis patients.

Table 6.5: St. Luke's patient bed capacity, 1960 (Northern Health Service 1960:S1-4).

Bed capacity	**Adult**	**Cribs**
General Medical	4	
General Surgical	1	
General Obstetrical	2	
Newborns		4
General Pediatric	5	
General Isolation	2	
Tuberculosis	**18**	
Custodial, Convalescent or Boarder	2	
Total	**34**	**4**

Diagnostic Capacity

St. Luke's laboratory and X-ray equipment was essential to the diagnosis of both outpatient and hospitalised patients. The laboratory routinely screened samples for haemoglobin, sedimentation rate, and urinalysis. Additional diagnostic procedures included W.B.C. (White Blood Count), R.B.C (Red Blood Count), blood typing, spinal fluid examinations, and stained sputum examination. Wiebe notes, "Item 104: Haemoglobin, sedimentation rate and routine urinalysis are performed by the Director of Nursing. All other laboratory tests are performed by the local physician" (Northern Health Service 1960:S1-27).

The X-ray department was equipped with one machine, described as a single-phase type 3 A model S.F.R.A 3- made by the United Electric Company. Its capacity was 30 mA, 90 kVp, and was supplied by an 18-hp generator. The walls were lead-lined. In addition, the hospital was equipped with a fluoroscope. The hospital did not hire an X-ray technician, rather the Matron or Registered Nurse operated the machinery and the local physician interpreted the results (Northern Health Service 1960:S1-28).

At the time of the 1960 hospital survey inspection, St. Luke's had functioned for thirty years as the central health service facility for the region. With a 34 bed capacity, this hospital had a comparable bed capacity to that of the 1961 Frobisher Bay Hospital, which opened with 35 beds (Damas 2002:118; Duffy 1988:62-3). The deficiencies highlighted in St. Luke's inspection were in line with the remoteness of the Pangnirtung location, which did not provide for sophisticated amenities, such as extensive running-water supply or flush toilets. The electrical equipment required oil and gasoline generators and imported fuel to sustain it. Here, the nurse missionary staff, matrons, local parish, and Inuit workers were able to maintain the hospital's functionality simply and efficiently with local resources.

Patient Hospital Admissions, 1960–1972

The hospital day books for 1960–1972 (Physicians Day Book 1955–1966, 1967–1972) indicate that St. Luke's served from 140 to 288 patients annually (Table 6.6). The average number of patients in hospital was 209 per year. In comparison to 1950–1959, when 159 to 277 patients were admitted annually and the yearly average was 212, the hospital appears to have maintained consistent patient numbers.

Table 6.6: 1960–1972 General patient hospital admissions in St. Luke's Mission Hospital (Physicians Day Book 1955–1966, 1967–1972).

Year	Males	Females	Total
1960	108	66	174
1961	135	109	244
1962	132	156	288
1963	86	133	219
1964	91	101	192
1965	137	174	311
1966	108	162	270
1967	82	151	233
1968	49	91	140
1969	80	106	186
1970	72	88	160
1971	80	94	174
1972	47	79	126

There is a marked change in the type of patients admitted to St. Luke's from 1960 to 1972 and a wider varieties of conditions were present, such as bronchitis, pneumonia, and general medical cases (Physicians Day Book 1955–1966, 1967–1972).

Modernisation also brought new technologies, and housing and public-health measures influenced living conditions (Damas 2002:116), which may have had a positive impact on the decrease in prevalence of tuberculosis. Years of removing tubercular Inuit out of the region may also have dispersed clusters of contact within families and therefore reduced the potential for the spread of infection.

Table 6.7: Tubercular patients admitted to St. Luke's Mission Hospital by traditional camp distribution, 1960–1972 (Physicians Day Book 1955–1966, 1967–1972).

Camp	Patients
Avatuktuq	11
Illutalik	11
Ilungajut	1
Iqalujuat	1
Iqalulik	6
Kingait	0
Naujajavik	2
Nunaata	1
Paalavik	0
Pannirtuuq	24
Qikiqtan	0
Qikiqtarjuaq	0
Qimirqsu	6
Qipisa	3
Saniqnirqturajuit	11
Tassiralik	0
Tuapait	2
Tuvvaqjuaq	0
Ujjutuua	6
Upingivik	0
Total	**85**

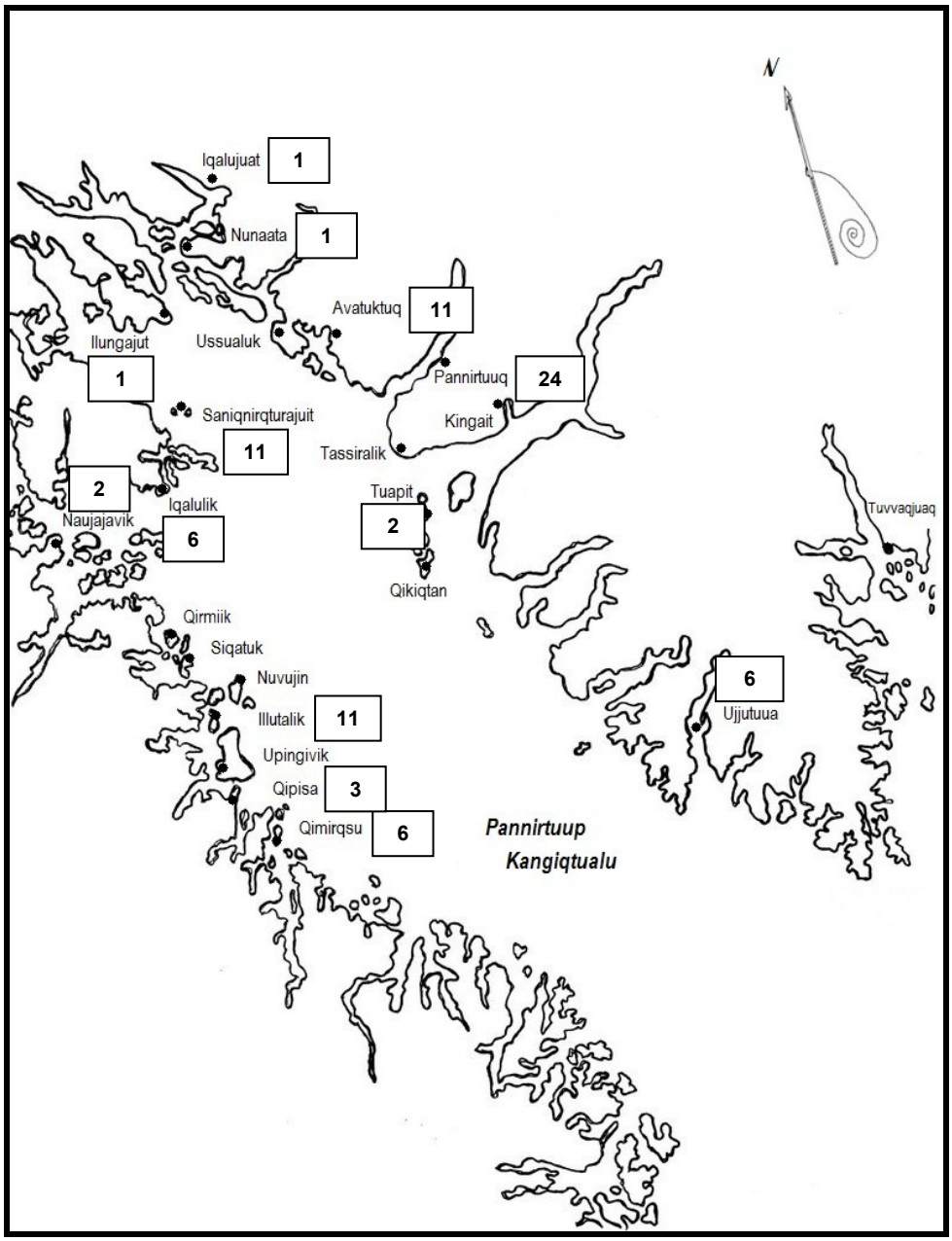

Figure 6.1: Tubercular patients admitted to St. Luke's Mission Hospital, by traditional camp, from 1960 to 1972 (Physicians Day Book 1955–1966, 1967–1972).

Table 6.8: Comparison of total tubercular patients in the Cumberland Sound traditional camps, 1950–1959 and 1960–1972 (Physicians Day Book 1931–1954, 1955–1966, 1967–1972).

Camp	1950–1959	1960–1972
Avatuktuq	14	11
Illutalik	3	11
Ilungajut	2	1
Iqalujuat	16	1
Iqalulik	7	6
Kingait	3	0
Naujajavik	0	2
Nunaata	8	1
Paalavik	8	0
Pannirtuuq	39	24
Qikiqtan	2	0
Qikiqtarjuaq	1	0
Qimirqsu	6	6
Qipisa	3	3
Saniqnirqturajuit	12	11
Tassiralik	13	0
Tuapait	13	2
Tuvvaqjuaq	10	0
Ujjutuua	0	6
Upingivik	5	0
Total	**165**	**85**

In some cases, the decline or absence of tubercular Inuit from a particular location reflects the abandonment of traditional camps (Table 6.8). For example, during the 1950s, 10 tubercular patients came from Tuvvaqjuaq, whereas no tubercular patients were recorded during 1960–72 for this camp due to camp relocations toward Ujjutuua (N. Maniapik, personal communication, May 24, 2011). Interestingly, the hospital day book record shows no patients from Ujjutuua during the 1950s, yet this camp shows 6 tubercular patients after the abandonment of Tuvvaqjuaq. Maniapik further noted that other camps with a previous history of tuberculosis patients in the 1950s (Ilungajut, Kingait, Qikiqtan, Tassiralik, Tuvvaqjuaq, Upingivik), but which lacked patients in the

1960s, were among those abandoned during relocations into Pangnirtung. Although the numbers of tuberculosis cases were on the decline at the traditional camps of the Cumberland Sound because of the consolidation of camps, Pangnirtung came to have the largest concentrated population of tubercular patients, now as a result of the in-gathering of the population from camps into the settlement.

The population of Cumberland Sound Inuit remained dispersed throughout the traditional camps at the beginning of the 1960s, and this was due in part to the RCMP policy of preventing loitering in Pangnirtung. In addition, most Inuit preferred life on the land. However, in 1962, an outbreak of canine disease triggered Government intervention in the Cumberland Sound, which resulted in a systematic culling of dog teams by RCMP officers, accelerating the centralisation of the population into Pangnirtung from regional camps (Damas 2002:145). The Government and RCMP commissioned an inquiry into the issue of the dogs being culled unnecessarily, finding no incidences of wrongdoing regarding the dog cull or centralisation of the population (Royal Canadian Mounted Police 2006).

The Qikiqtani Truth Commission (N.d.) released a statement that presented the diverging Government and Inuit perspectives on this issue. According to this Commission, a large number of dogs were killed in the Cumberland Sound region without following the procedures required by the NWT Ordinance Respecting Dogs. For the Inuit of the Cumberland Sound and elsewhere in the Arctic, this multi-year reduction in the dog population resulted in changes to hunting practices, permanent movement into

settlements, snowmobiles replacing dog teams, and the need for wage-based employment (Damas 2002:144).

From the local perspective, the loss of dogs and movement into the settlement of Pangnirtung had profound effects. Not all Inuit were in favour of centralisation shaping their lives, and hunters in particular were directly affected by the loss of their customary ways of hunting and their roles in the traditional camp structure. Another consideration rarely brought forward is the effect these changes had on alcohol consumption and the general state of depression experienced by the Inuit because of these events. Eventually, Pangnirtung became a "dry settlement" where alcohol prohibition came into force in 1988 (George 2009a).

Movement of Tubercular Patients across Baffin Island

During 1960–1972, more tubercular patients from various settlements throughout the Baffin region came to St. Luke's for tuberculosis pharmacological treatment (Table 6.9a,b,c). Just as the traditional camps of the Cumberland sound region were consolidating or moving into Pangnirtung, the eventual in-gathering of traditional camps into settlements was occurring throughout the Baffin region (Damas 2002).Tuberculosis patients from locations such as Cape Dorset or Broughton Island were also experiencing population shifts. Previously, the tubercular patients from these places were part of the Eastern Arctic medical patrol work carried out annually by the *CD Howe*. Thus, the increased number of tubercular patients coming to St. Luke's from these settlements (13 and 8, respectively) and the wider catchment area from which they were drawn, is

explained by the de-commissioning of the *CD Howe* (Figure 6.2). I was unable to find any letters or other documentation that supported a decision to send tubercular patients to Pangnirtung instead of southern facilities. However, air transport between these settlements and Pangnirtung was possible during 1960–1972 and the bed capacity for tubercular boarders available at St. Luke's likely made it more efficient to treat them locally than send them elsewhere.

Table 6.9a: Tubercular patients from Baffin-Island locations admitted to St. Luke's Hospital, 1960–1966 (Physicians Day Book 1955–1966).

Baffin Location	1960	1961	1962	1963	1964	1965	1966
Arctic Bay (Ikpiarjuk)					2	2	
Broughton Is. (Qikiqtarjuaq)			1	1	1	1	
Cape Dorset (Kinngait)							
Clyde River (Kanngiqtugaapik)						1	
Frobisher Bay (Iqaluit)							
Hall Beach (Sanirakjak)							
Igloolik (Iglulik)		1					
Lake Harbour (Kimmirut)							
Pond Inlet (Mittimatalik)							

Table 6.9b: Tubercular Patients from Baffin Island Locations Admitted to St. Luke's Hospital, 1967–1972 (Physicians Day Book 1967–1972).

Baffin Location	1967	1968	1969	1970	1971	1972
Arctic Bay (Ikpiarjuk)						1
Broughton Is. (Qikiqtarjuaq)		1	1	1	1	
Cape Dorset (Kinngait)			1	5	5	2
Clyde River (Kanngiqtugaapik)		2	2	2		
Frobisher Bay (Iqaluit)				2	1	2
Hall Beach (Sanirakjak)				1		
Igloolik (Iglulik)			3	3		
Lake Harbour (Kimmirut)						1
Pond Inlet (Mittimatalik)						1

Table 6.9c: Tubercular Patients from Baffin Island locations Admitted to St. Luke's Hospital, 1960–1972 (Physicians Day Book 1955–1966, 1967–1972).

Baffin Location	Patients (1960–1972)
Arctic Bay (Ikpiarjuk)	5
Broughton Is. (Qikiqtarjuaq)	8
Cape Dorset (Kinngait)	13
Clyde River (Kanngiqtugaapik)	7
Frobisher Bay (Iqaluit)	5
Hall Beach (Sanirakjak)	1
Igloolik (Iglulik)	7
Lake Harbour (Kimmirut)	1
Pond Inlet (Mittimatalik)	1
Total	**48**

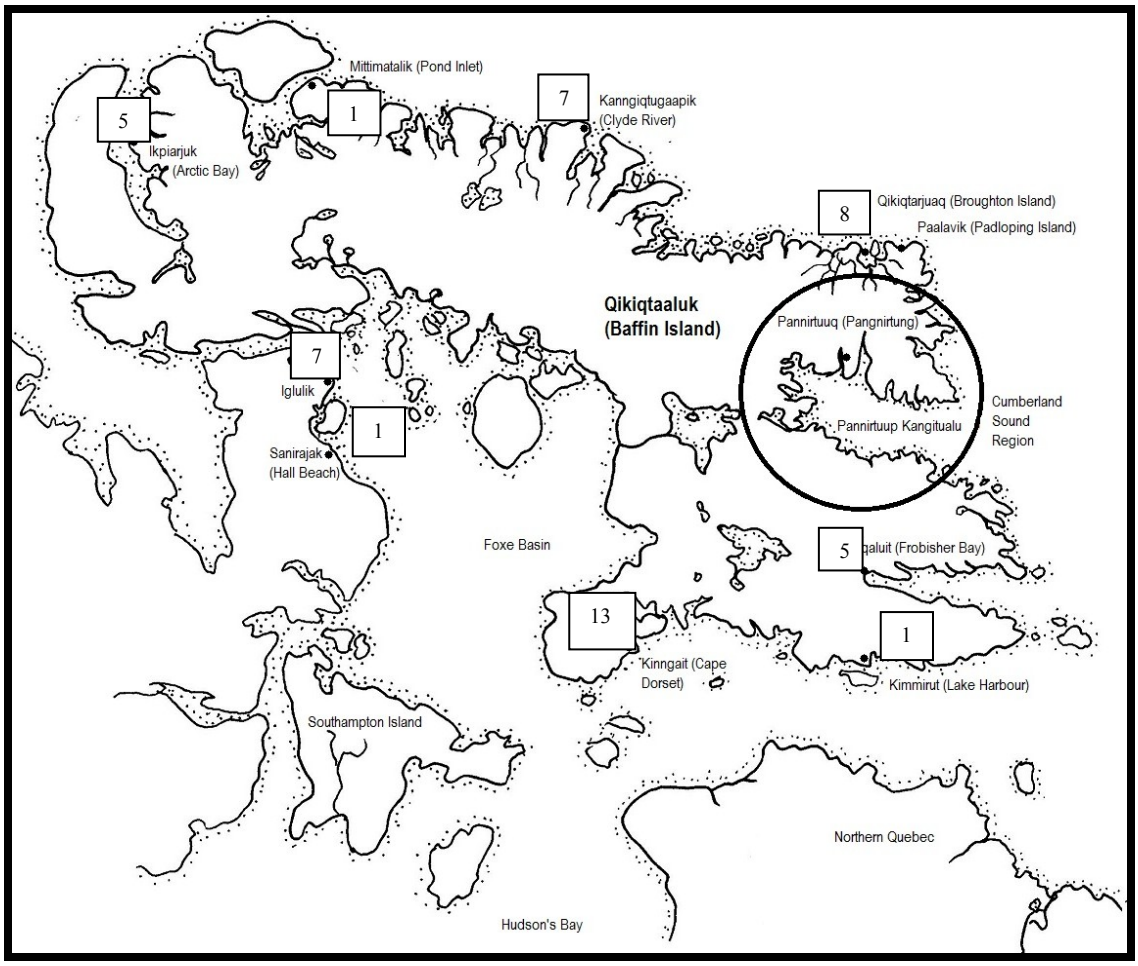

Figure 6.2: Tubercular patients admitted to St. Luke's Mission Hospital by Baffin region, from 1960 to 1972 (Physicians Day Book 1955–1966, 1967–1972).

Closure of St. Luke's Mission Hospital

Dr. J. A. Collins, the chief officer of the 1945 Eastern Arctic Patrol, considered the increasing cases of tuberculosis as the impending "scourge of the Arctic" (Duffy 1988:67). St. Luke's, however, had been caring for tubercular Inuit since the 1930s and other missionary facilities had been in place even longer (Table 6.10), so that 1945 is perhaps best viewed as the period in which the Government began to take an active interest in the problem. Tuberculosis in the north was considered a disease of poverty, overcrowding, diminished nutrition, and underdeveloped infrastructure. Budget allocations for social welfare, housing, and education became the focal point for Northern Health tuberculosis programs and health services restructuring (Duffy 1988:68–74).

Grygier considers that the actions of Health and Welfare Canada and the reforms and programs to northern health policies disregarded the Inuit experience and the cultural norms of northerners (Grygier 1994:76). As discussed previously, Bishop Marsh was vocal in his opposition to the decision to remove Inuit from home locations and send them for tubercular care in southern institutions. Marsh believed that the existing systems of care required bolstering, and that Inuit would be better serviced by building facilities in the north, not by transferring patients away. Mission and Church medical facilities had dominated Northern Health service from 1867 until 1939. As Table 6.10 shows, the Government Nursing Station Network expanded throughout the Arctic from 1945 to 1967 (Brett 1969:523–524). Much of the expansion of new health centres followed the distribution of Distant Early Warning (D.E.W.) Line sites, and medical care was serviced by Government nursing stations (Duffy 1988:59–61).

Table 6.10: Church and Government Health Facilities, NWT, 1867–1967. (Brett 1969:523–524).

Date	Anglican (A), Roman Catholic (RC), and Other (O) Churches	Government
1867	Nursing Station (RC) Fort Providence	
1895	Blacklead Island (A) Cumberland Sound	
1903	Nursing Station (RC) Fort Resolution	
1914	Mission Hospital (RC) Fort Smith	
1916	Mission Hospital (RC) Fort Simpson	
1925	Mission Hospital (RC) Aklavik	
1926	All Saint's Hospital (A) Aklavik	
1930	St. Luke's Hospital (A) Pangnirtung	
1931	Fort Simpson Hospital (RC)	
1939	Mission Hospital (RC) Fort Resolution	
1939	Bishop Bompas Hospital (A) Fort Norman	Fort Norman Nursing Station
1940	Faraud Hospital (RC) Fort Rae	
1945		Fort McPherson Nursing Station
1947		Coppermine Nursing Station
1950	Hay River Nursing Station (A)	Clinic and doctors residence Fort Rae
1952		Lake Harbour Nursing Station
1953	Pentecostal Mission Hospital (O) Hay River	
1954		Fort Simpson Medical Clinic
1955		Frobisher Bay Nursing Station
1957		Baker Lake Nursing Station
1957		Hall Beach Nursing Station
1958		Cambridge Bay Nursing Station
1958		Fort Smith Nursing Station
1960		Fort Laird Nursing Station
1960		Yellowknife Health Center
1961		Aklavik Nursing Station
1961		Inuvik Hospital
1962		Eskimo Point Nursing Station
1962		Coral Harbour Nursing Station
1962		Spence Bay Nursing Station
1963		Hay River Health Center
1964		Frobisher Bay Hospital
1965		Fort Franklin Nursing Station
1965		Rankin Inlet Nursing Station
1966		Pond Inlet Nursing Station
1966		Igloolik Nursing Station
1967		Fort Resolution Nursing Station

In the case of Pangnirtung, St. Luke's Mission Hospital maintained operations until 1972 and closed as a result of a constellation of factors. The 1960 Hospital Survey clearly demonstrated that the building was already outdated, in terms of its construction

materials, the age of the buildings and lack of amenities deemed essential, such as running water (Northern Health Service 1960). However, the hospital passed the inspection in 1960, despite the discrepancies. St. Luke's Hospital continued with twelve more years of admitting patients into care, receiving patient funding through Indian Health Services (IHS) and from the Territorial Hospital Insurance Fund (THIF).[29] However, St. Luke's admission declined under the influence of Health and Welfare policy changes and, after 1961, the nursing staff and doctors conformed to the policy of transferring complicated cases to the General Hospital in Frobisher Bay (Iqaluit).

From 1967 onward, Nursing Stations serviced most communities and Government funding was efficiently providing a level of standardised care throughout the Arctic (Arctic Hospitals File 1971–1972). St. Luke's was coming into line with the case loads in these other locations, especially since the routine transfer of patients to Frobisher Bay General Hospital lowered the numbers remaining in long-term care (Physicians Day Book 1967–1972).

In 1971, the Church faced an inspection conducted by the Territorial Fire Marshall's department. Numerous items outlined in the code failed to meet the required standards. Compliance with the necessary renovations and improvements to bring the hospital up-to-code standards was the financial responsibility of the Anglican Church. This represented insurmountable costs to the Anglican Church, and reluctantly, the final decision was made to close the hospital. An agreement was negotiated that permitted the

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[29] Throughout the 1960–1972 day books, the nurses placed notes concerning patients' payment by IHS or THIF.

phasing out of the hospital's operations, with the Government providing hospital insurance payment for patients until August 31, 1972 (Arctic Hospitals File 1971–1972). The following year, a Government nursing station was built to service the community and region.

The closure of St. Luke's Hospital was emotional, especially for the Inuit of Pangnirtung and the Cumberland Sound region who had participated in the function of the facility as workers, and used its services as patients (Cowall 2004). The mission hospital proved to be a substantial facility, with a demonstrated capacity for managing a large sustainable health industry, and serving a widespread regional population for 42 years. The improvements required in 1971 to bring the building and operations into compliance with fire code standards proved that the mission hospital could no longer compete within the new vision of the Northern Health Services scheme. Ultimately, St. Luke's Mission Hospital was a centralising force affecting the health and wellness of the Inuit of the Cumberland Sound Region, and provided a legacy of important insights concerning infectious disease in northern communities, including the potential of local solutions to problems of health and disease.

Chapter Seven
Conclusions and Contributions

This ethnohistory set out to explore the question of Church- and State-mediated tuberculosis treatment for the Inuit of the Cumberland Sound region by placing the history of St. Luke's Mission Hospital, Pangnirtung at the nexus of archival evidence and Inuit knowledge. My focus on tuberculosis arose from conversations with former tubercular patients in Pangnirtung who wanted to know why they had been sent away to sanatoria in the south, such as Hamilton Mountain Sanatorium, while other patients were able to stay in the community and be treated at St. Luke's. This seemingly simple question had no simple answer, but it led me to explore the history of St. Luke's Hospital through documents held by the Archives of the Anglican Church of Canada, Hamilton Health Sciences Archive at McMaster University, and the Royal Ontario Museum. I also consulted with former tubercular patients during fieldtrips conducted in Pangnirtung and Iqaluit from 2006 to 2011. By triangulating the information from these sources, it was possible to gain multiple perspectives on the changes to life and medical care that took place from the time of the hospital's founding in 1931 to its closure in 1972.

Thus, the history of the hospital from 1931 until the beginnings of the transfer of tubercular patients to southern sanatoria in the 1950s can be seen as the history of a relatively circumscribed network of nurses, doctors and Inuit engaged in social relations and exchanges created by the hospital. The Inuit shared traditional knowledge, provisioned and provided labour for the hospital, and taught the doctors and nurses the skills necessary to survive in the arctic environment; the doctors and nurses introduced

western medical ideas of sanitary science and technology, and cared for the sick and injured. At the same time, St. Luke's Hospital was also the place where Church and State struggled for the control of health care for the Inuit, especially during the last two decades of the hospital's operation, when Bishop Marsh fought with P.E. Moore over the transfer of tubercular patients to southern sanatoria. At the beginning of this project, I had hoped that Panniqtuumiut would share their perceptions of tuberculosis and reflect on their medical treatment for it. Stimulated by a series of unidentified black-and-white photographs taken of Inuit patients treated at the Hamilton Mountain Sanatorium (held at the Hamilton Health Sciences Archive at McMaster University), I developed a community-based research partnership, the Pangnirtung Photograph Naming Project, aimed at identifying the former patients, repatriating their photographs, and investigating their experiences in Hamilton. Although project participants were pleased to obtain copies of their photographs, and celebrated the valuable opportunity for reconciliation and healing experienced through their participation in the consultative process and sharing of their reflections with their peers, they declined to share their experiences for use in this dissertation.

The Pangnirtung Photographic Naming Project nevertheless proved to be invaluable for this thesis. It yielded a visual archive of confirmed patients sent to the Hamilton Mountain Sanatorium and a database of named individuals who could then be cross-referenced to information contained in other documents, notably the day books for St. Luke's Hospital. The hospital day books contained details for each verified person, including their camp, which made it possible to map the locations from which tubercular

patients in the Cumberland Sound came to St. Luke's from the 1950s onward. Although it is common practice to include Inuit participants in research projects[30], the Pangnirtung Photograph-Naming Project also made it possible to identify patients in the hospital day books who had *not* been transferred to the sanatorium. One important result of this analysis is the finding that more tubercular Inuit from the Cumberland Sound were treated at St. Luke's Mission Hospital than were sent away to southern medical facilities. This differs from the more general situation described for Inuit as a whole during this period (Grygier 1994; Olofsson 2008).

1930–1950

By the 1930s, when St. Luke's Mission Hospital opened, Christianisation in the Cumberland Sound region in the previous century had already influenced considerable aspects of culture change. The hospital, however, brought new ideas and medical technology, and connected the Cumberland Sound Inuit to a global process through which Indigenous people received health care because of the presence of Christian hospitals. Although slow to get started—because of low bed capacity, resistance to hospital admission on the part of the Inuit, and reluctance on the part of the doctors to admit patients—within a decade the mission hospital had become the central industry employing and engaging local Inuit workers. St. Luke's served an important economic

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[30] Inuit community participation and advisory inclusion is a prerequisite component of all applications to obtain a Nunavut Research License (Nunavut Research Institute 2006). For example, Pat Sandiford Grygier (1994) included consultation with tubercular Inuit in her analysis.

and social function in the region, over and above the provision of medical service, and a medical work force emerged in Pangnirtung (Cowall 2004). From the outset, the Federal Government provided technology, transportation, per capita patient grants, and wages for the medical staff, all of which tied St. Luke's to policies and practices developed in Ottawa.

The hospital became a magnet for non-Inuit men and women seeking careers and experiences in the Canadian north. For women, nursing in remote, wilderness settings was an acceptable and attractive career, and the role constituted a working ideal for feminine pioneers (Rutherdale 2002:22). As the front line workers in St. Luke's, the nurse missionaries had a lasting influence on the community and were largely responsible for establishing health care for the community as a whole. For medical doctors—all of whom were male—St. Luke's Hospital offered an adventurous tour of duty that involved being away from the hospital for prolonged periods of time and the rigors of travelling from camp to camp in the Cumberland Sound. Nurses and doctors often clashed in their philosophies toward patient admission, with doctors frequently reluctant to admit patients (because of restrictions on Government funding per patient day or because they felt patients fared better in their camps) and nurses viewing the work of the hospital as vital to Inuit health and wellbeing.

The dedication and kindness of the missionary nurses at St. Luke's was a topic discussed by participants in my study as they reflected on the hospital days. The hospital itself is fondly remembered by those who accessed it during its operation, many of whom long for qualities of care thought absent in the present day health care system (Cowall

2004). The basic nursing practice described by Inuit hospital workers resonates with Florence Nightingale's method of nursing outlined in her 1859 *Notes on Nursing*. This method may have influenced the nurse missionaries at St. Luke's.[31] They trained Inuit women workers to act as aides, and the aides observed the nurses focusing attention on providing adequate ventilation and creating a warm environment; taking patients outside in their beds to observe celebration days or to get fresh air; ensuring there were clean beds and bedding for the patients, as well as exposure to light filled rooms; maintaining hygienic cleanliness of rooms and of each person's body and clothing; and observing the patient and their progress (personal conversation with former Inuit hospital workers, 2004, Pangnirtung, NU). The nursing method taught in the hospital, in turn, was transferred into the homes of the Inuit, where women brought sanitary science and the hospital-based skills of cleaning and cooking into day-to-day life. Inuit women were modifying their home building skills, and this was the direct result of their experience as hospital workers.

Missionary nurses were also in direct contact with the Inuit, caring for the sick who sought medical care and treatment. Their Women's Auxiliary activities became the connection to faith building. The fundamentals of Christianity were inseparable from the Church's care of the Inuit at St. Luke's Mission Hospital. Transformation was not about metaphorically cleaning the heathen or savage soul; the application of western medical concepts of personal hygiene was a method to control infectious disease. Simple things

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[31] The Anglican Church of Canada's Book of Alternative Services includes the Canadian Calendar of Holy Persons, which commemorates Florence Nightingale each May 12 (Anglican Church of Canada 1985).

were revolutionary, such as the fuel oil stoves providing ample hot water, a new technology-and the cleaning up of people and the community that resulted from the presence of the hospital as health care industry and employer, where increased public health aided in the containment of disease.

The nurses also played a vital role in other aspects of community organisation. Prudence Hockin, for example, regarded food management, especially the system of incorporating traditional foods into the hospital diet, as an essential element of patient care at St. Luke's (Rutherdale 2002). She engaged the community in an exchange system in which food was traded for supplies. Although women participated in the food exchange network, this was the main avenue for hunters to interact with the nurses and the hospital by providing animal protein. Inuit men also formed relationships with the doctors and acted as guides for the medical patrol visiting traditional camps throughout the Cumberland Sound region. Outside of the medical patrol times, Inuit men also brought sick people directly from camps to the hospital. This shows how the hospital had become integrated into community life, and an accepted choice for medical treatment. The doctors were influential in terms of their discussions with and reports to the Federal Government concerning the incidence of diseases, medical surveys, and general assessments of conditions in the Cumberland Sound. Their correspondence linked the region, the Inuit and St. Luke's Mission Hospital directly to the Ministry of Health and Northern Affairs. As medical authorities, the doctors consistently stressed the severity of the tuberculosis problem in the Eastern Arctic.

There are limited studies that specifically examine the work of the doctors stationed at St. Luke's Hospital. Lister (2004), for example, discusses Dr. Jon Bildfell as a collector of artefacts and McNichol & Tester (2006) focus on Bildfell's frustration that Inuit did not accept medical technologies. Hankins' (2000) study of Dr. Otto Schaefer stands out as the single, detailed study of the hospital-doctor relationship. This is certainly an area of inquiry that offers rich research possibilities for future research.

Responding to criticism and scrutiny from international Governments interested in gaining control of the Arctic Archipelago, the Canadian Federal Government directed efforts toward deploying the Inuit body as an object of the sovereignty agenda, by relocating Inuit to high arctic locations 1953–55 (Dussault & Erasmus 1994). Inuit were used to stake a claim to territory, and yet, as Duffy (1988) emphasises, the Government was reluctant to take on their medical care. Instead, it was useful to the State to continue to co-opt missionary and Church interests and allow on-going medical practice in this area. The arrangement between State and Church, therefore, was a mutually collaborative and financially advantageous pursuit, and this collaboration remained in place until World War II brought a military presence, both within the Dominion and the international arena, to the Canadian North.

Canada's participation as an allied force in the Second World War affected national spending budgets. The effects of the war trickled into the small hamlet of Pangnirtung by limiting medical and other supplies that could be shipped north, placing local Inuit culture change, heritage, and disease within the context of world history (McGhee 1994:578). The heightened international visibility of the social conditions in

which Inuit lived placed the Canadian Government's policies under question and scrutiny. The Arctic Archipelago became an integral strategic zone for expressing Canadian sovereignty, and efforts to assert control over it ensured a new focus by the Canadian Government on all aspect of northern affairs.

On the other hand, the State's role in decommissioning Church medical care facilities, such as St. Luke's, was not solely based on concerns about sovereignty. The Canadian wide system of managing TB infection and providing medical care for tuberculosis relied on hospitalisation, rehabilitation, medication and public health (McCuaig 1999). The sanatorium system was considered at the time to be a proven and successful method of tuberculosis treatment and control: patients were isolated from the general population (limiting the spread of infection), provided with nursing care, fresh air, sunlight, nutrition and rest. Notwithstanding, the idea that sanatoria were successful has been challenged (see, for example, Dubos & Dubos 1952). Long-term isolation treatment declined when streptomycin combined with TB medications ended the need for long-term internment, allowing patients to receive drug therapy while living at home. The turning point came as the sanatoria emptied of long-term care patients (Wherrett 1977:46). This study of St. Luke's Hospital is situated in the shadow of these changes. Tubercular Inuit patients from the Cumberland Sound region (and elsewhere) were being sent to specialised medical care at a time when effective chemoprophylaxis for TB was becoming available. In the context of the Inuit, the decision to send patients away is *siniqvi inatilugi*, which translates as "filling the empty beds", the theme of Wherret's (1977) study, The Miracle of the Empty Beds.

The intense scrutiny under which the facilities and treatment at St. Luke's was put during the 1948–1958 Moore administration exemplifies the battle between secular and missionary medicine (Nixon 1989). However, thorough tuberculosis-care practices were in place, practices that were consistent with sanatorium treatment throughout Canada. It is difficult to determine to what extent removal of tubercular Inuit to the south and drug treatment cut the chain of infection among Cumberland Sound families and camps and, in turn, explains the reduction in TB from the 1950s to the 1960s. Certainly the distribution of tuberculosis changed as camps were abandoned and Inuit moved in increasing numbers into the settlement of Pangnirtung. Although St. Luke's hospital facility was rustic, it was capable of providing local, effective care that was rooted in hygiene and sanitation practices. More significantly, this care was imbedded within local life in this newly formed community, permitting space for interaction within the local norms of day-to-day life, such as hospital visitors, and participation in outside festivities.

The Canadian Government's decision in 1948 to realign health care dollars through policy changes resulted in the State gaining control of the mission hospital in terms of patient funding, which in turn affected the core of its operations. The new restrictions on how patient care dollars were spent, coupled with increased accountability, allowed the Government to direct operations at St. Luke's, and shore up the rationale to switch over to Government established medical facilities. This policy change marked the beginning of the end for St. Luke's Hospital, not only as a medical facility and local sanatorium, but as a regional center and significant driver of the local economy in the Cumberland Sound.

Tuberculosis, Church, and State: 1950–1960

The decade between 1950 and 1960 became the turning point, and tuberculosis the disease, over which Church and State struggled to control Inuit healthcare. The struggle is illustrated by the hospital day book data for St. Luke's during this time. At their most basic, the day books present the number of patients in hospital so that the Church could receive per capita funding from the State to maintain local operations. The hospital day book records for this period begin to provide patient diagnoses in 1953 and thus are transformed into accounts of specific conditions treated at the hospital, including tuberculosis, to meet the strict requirements for Government patient grant payments. Church officials requested increased Government support for tubercular care at St. Luke's and hoped for more northern hospitals to be built to replace the southern hospitalisation program (Grygier 1994:76).

Medical officer reports for previous decades had fuelled concern about the growing incidence of tuberculosis among the Inuit. Opinions on the state of tuberculosis in the Cumberland Sound varied. In 1934, Dr. J. Bildfell declared it impossible to determine the percentage of infection throughout the population; in 1937, Dr. A.G. McKinnon considered TB to be the most important medical problem (Grygier 1994:59). In 1939, Dr. T. J. Orford envisioned way to keep the Inuit in a three-stage program that included screening and care at St. Luke's hospital, a halfway stage, with camps set up for the discharged patients to live, before final reintegration back to home camps. Tuberculosis nonetheless became a priority medical issue, with extensive infection reported throughout both the Western and Eastern Arctic. P. E. Moore did not respond to

the requests of Marsh, the Bishop of the Arctic, to build more hospitals in the north. Moore's solution was centralisation—to group Inuit into four designated sanatoria in southern Canada (Grygier 1994:80).

The decision to send Inuit south served several purposes. It was, in part, a response to criticism of the Canadian Government's treatment of Inuit and the desire to be seen to be offering health care on a par with other citizens. At the same time, the sanatorium system was reaching the end of its usefulness because of the adoption of effective multi-drug treatment that did not require hospitalisation. The Inuit extraction policy also bolstered the Government's decision to transition from Church-State medical care to a Canada-wide system of secular, Government-funded health services.

Part of the extraction strategy involved transport on the Government commissioned ship, the *CD Howe,* which was also used in the sovereignty agenda to relocate Inuit from northern Quebec to Resolute Bay on Cornwallis Island and Grise Fjord on Ellesmere Island. Both sets of relocations—to the high arctic and to sanatoria in the south—brought extreme hardship to affected families and communities. The *CD Howe* has become a potent symbol of Government disregard for the Inuit, not only because of the overcrowded living conditions aboard ship, but also because of the lack communication between the Eastern Arctic Patrol and affected families, and the Patrol's use of power to control the Inuit with little regard for their rights. The extraction enterprise has the image of a snatch-and-grab operation, with reports of Inuit fleeing to camps to avoid the arrival of the ship (Grygier 1997).

Some of the oral history accounts shared at the Pangnirtung Community Photograph project celebration echo that image and the considerable difficulties experienced aboard the *CD Howe*. On the other hand, the hospital day books revealed that more Inuit were transferred to Hamilton Mountain Sanatorium by airplane than on the annual voyage of the *CD Howe* (Table 5.4). The peak years of transfer from St. Luke's hospital to Hamilton occurred from 1957 to 1959, during which 39 Inuit were sent away for treatment while 50 were treated at St. Luke's (Tables 5.3 and 5.4). As a regional center, Pangnirtung had year-round air service and the presence of a local hospital ensured that tubercular Inuit from the Cumberland Sound region were continuously assessed, monitored, and treated for TB. In the other settlements and ports in the Baffin region in which year-round medical care was absent, the *CD Howe* assumed greater importance in terms of the annual screening, intervention, and extraction of tubercular Inuit. Thus, the way in which tubercular Inuit were treated in the Cumberland Sound deviated from what is considered to have been the norm for Inuit as a whole. This study has opened the possibilities for studying local hospitals, such as Frobisher Bay General, to examine the contrasts or similarities in tuberculosis screening and treatment.

Despite the very moving recollections of the gruelling experiences aboard the *CD Howe,* former patients also spoke at the photograph repatriation celebration about the quality of care they received for tuberculosis, especially those who went to Mountain Sanatorium in Hamilton. Mountain Sanatorium accommodated 1,272 Inuit tubercular patients, which created the largest community outside of the Arctic (McMaster University 2011). They were provided with radio broadcasts in Inuktitut, and translators. Anglican

Church officials, such as the Bishop of the North, and representatives from the adjacent diocese and churches, focused their attention on the Inuit, their progress and their connections with home (Grygier 1994:113). This supportive infrastructure appears to have created a unique social environment for tubercular Inuit at the Hamilton Sanatorium. In contrast, those hospitalised with only a few other Inuit in a sanatorium or hospital in English-speaking Canada, or in facilities in Quebec, in all likelihood had a different experience of being hospitalised than those sent to the Inuit-focused environment of the Mountain Sanatorium. During the Pangnirtung Photograph Naming Project celebration (March 22, 2009), the presenters discussed different experiences, not only of being at Mountain Sanatorium, but also being in other hospitals, such as the Hospital for Sick Children in Toronto. Some shared their experiences, suggesting that it may be possible to study the sanatorium experiences of Eastern Arctic Inuit after the Mountain Sanatorium closed in 1962.

From General Hospital to Long-Term Care: 1960–1972

The 1960s brought significant changes to the hospitalisation strategy for tubercular Inuit, prompted by a constellation of events and policy changes. St. Luke's Daybooks show that from 1960 to 1972, fewer active tuberculosis cases were admitted for care and fewer patients were transferred to sanatoria, compared to the peak years of transfers to Hamilton (1957–1959). By 1962, Hamilton Mountain Sanatorium had phased out its operations and was no longer receiving new patients (Williamson 2006:180) and the Government reduced the volume of Inuit patients being extracted from the North.

Improved and effective tuberculosis drug protocols had eliminated the need for long-term sanatorium care, and patients were now undergoing treatment as outpatients. Only those with complicated or active TB remained hospitalised. The network of hospitals also changed in the 1960s, with the Government sending Cumberland Sound Inuit to other facilities, such as those in Toronto and Montreal.

It was in this context that St. Luke's evolved from a general hospital into a long-term care center for the Baffin region. Reforms to the funding schemes for tubercular patients at St. Luke's meant that tubercular Inuit were admitted for several months, during which time they were on drug therapy, and then discharged home. Although it is not possible from the data at hand to determine why some Inuit were still sent for treatment elsewhere, it is likely that their cases were more complicated or too difficult to be handled locally.

The day book accounts not only shed light on the numbers of tuberculosis cases, and St. Luke's transition to convalescent care, but they also document significant changes to life in the Cumberland Sound during this tumultuous period. Maps made from information on tubercular Inuit admitted to St. Luke's show how the structure and distribution of traditional camps in the Cumberland Sound were undergoing transformation. Maps for the 1960s to 1970s appear to show that tuberculosis was found in a smaller number of locations, compared to the more widely dispersed network from which tubercular Inuit came in the 1950s. This shift could be misinterpreted as a change in the behaviour of the disease when in fact it reflects the abandonment of many traditional camps in the Cumberland Sound. This reduction in camps resulted directly

from the controversial sled dog slaughter that began in 1963 and the Government-driven relocation of growing numbers of Inuit to the settlement of Pangnirtung (Damas 2002:142–145). This process of centralised settlement was Arctic-wide, but its local effects in Pangnirtung are made visible through the day book records.

In its long-term care function during the sixties and seventies, St. Luke's operated at a similar bed capacity to the newly established Frobisher Bay General Hospital. There are no studies of the Frobisher Bay hospital, but such research would be invaluable for fleshing out a more detailed history of disease, medical care, and social change among eastern Arctic Inuit. It appears that for the period between 1962 and 1972, the two hospitals operated in the Eastern Arctic, with Frobisher Bay taking on emergency and acute care roles and St. Luke's retaining its convalescent-care function. This short-lived expanded care capacity ended with the 1970s and the establishment of the new, Government-funded nursing station structure of medical care. St. Luke's hospital closed in 1972, and with it, the era of mission health care in the Eastern Arctic ended.

The closure of St. Luke's hospital was a shock to the community. After 42 years as a center of community life, it was gone. The loss of its medical capacity, along with the employment and trading opportunities it created, added to the atmosphere of severe loss that pervaded Pangnirtung. The sled-dog culling, the imposed movement from camps into the settlement, and now the loss of the largest industry was a crushing blow. I would argue that this turning-point marks the beginnings of social problems that would mount in the following years. The reluctance on the part of the Government to work collaboratively with the Anglican Church to renovate St. Luke's and bring it up to fire code was a missed

opportunity. In the short-sighted decision to condemn the buildings as unfit, a functioning long-term care hospital with a locally-trained work force disappeared, taking with it the social and economic benefits that came from its presence. The economic impact affected the hospital workers directly, and the loss of trading for indigenous foods to provide to patients affected a larger group of workers. Not only had the cull of dogs and the movement from the traditional camps affected hunters working to feed their families, this also affected the economy that existed to provide food for the hospital.

Many of the Inuit who participated in my study expressed dissatisfaction with the health care provided at the new nursing station, as well as a desire to return to the style of health care that preceded it. They long for the quality of caring care provided by the people familiar to them in their established relationships formed in the early days of the hospital. Further, they recognised the value of local treatment where family and kin are nearby and the patient has the ability to remain integrated within community activities. That said, many participants also recognised the value of their TB treatment received in the south and the benefits of integration into a new language (English). Yet, the consensus remains in favour of local treatment and a future with services available at home.

Future Research

This dissertation project underlines the importance of linking archival sources—based on the records for named individuals—to local Inuit knowledge in a collaborative, community-based research environment. Although the thrust of this project is historical, it speaks to present day concerns over management of the re-emerging incidences of

tubercular infection (McCluskey 2011). During my final consultation in Nunavut, CBC Radio North interviewed me for a series of broadcasts during the 24 March 2011 World TB day activities. I reported on the history of TB in the Cumberland Sound, and emphasised the participation of the local hunters and gatherers to provide the mission hospital with Indigenous foods to supplement the diet of TB patients in hospital. In addition, I talked about how hunters able to transport ill people from the camps into the hospital for testing and treatment did so because the local Inuit were confident about the level of care provided at the hospital. Although there is a long-standing history of Christianisation for this region, it is common knowledge that no one was expected to convert to Christianity to receive medical care.[32] In addition, many local Inuit were hospital workers not only caring for the building and its maintenance but also serving in the role of nursing aides. By providing the history in which Inuit participated in the care and nutritional needs of other Inuit with tuberculosis, current advocates for TB testing and treatment (Taima TB initiative) are turning to this successful past to empower the present day focus on culturally appropriate community initiatives. The broadcast was applauded by Taima TB workers for adding value to their campaign, by reinforcing the need to participate in TB testing, the importance of drug treatment permitting individuals to remain at home and not be hospitalised, and the emphasis on improved nutrition, especially Indigenous foods, as integral to building wellness (Natasha Steven, personal communication, March 24, 2011, Iqaluit, NU).

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[32] During my consultations, participants and friends unanimously agreed that no one had to convert in order to receive medical care, nor did they feel any guilt, pressure, or obligation to do so after receiving said care.

Equally important, the hospital day books also recorded a variety of other diagnoses, in particular, pneumonia, bronchitis, and bronchopneumonia which represent the cluster of infectious respiratory disease influencing the incidences of tuberculosis. Although outside of the scope of this study, the disease clusters and trends in hospitalisation for illness and starvation, and their relationship to social conditions, lends itself to an investigation of the question as to what extent syndemic conditions contributed to the tuberculosis era in the Cumberland Sound region (Singer and Clair 2003; Herring and Sattenspiel 2007).

Although this dissertation focuses on tuberculosis, it also contributes to studies of cultural heritage in the Eastern Arctic. The success of the Pangnirtung Photograph-naming Project and the analytic approach used in this study initiated communications between the Nunavut Government archivist, the National Archives of Canada Project Naming, and the Hamilton Health Sciences Archive at McMaster University (Hamilton Mountain Sanatorium N.d.), with the aim to foster future collaborations. In other words, the photograph-naming project laid out the necessary steps to bring the services of territorial and Government archives together with the holdings of the McMaster University to share resources in meaningful ways and, more importantly, to return copies of cultural materials to the Inuit people. The experience of community collaboration and connection to the photographs of self or kin at the Hamilton Sanatorium also engaged the former patients with valuable reconciliation and healing, and provided a legacy for generations to explore.

The future intention is to develop a program of collaboration where the archivists continue the work of providing access to photographs to engage Inuit in the process of naming the remaining unidentified patients in the Mountain Sanatorium Inuit Patient Photograph collection. Further, the Nunavut Territorial Archivist expressed interest in the dissertation as a foundational document that provides new data and an in-depth analysis of an important piece of Nunavut medical history. Recognising the limited pool of literature on this topic, the archivist looks on this work as a valuable regional contribution (Edward Atkinson, personal communication, March 29, 2011, Pangnirtung, NU).

This study provides a foundation for future inquiry to expand the understanding of tuberculosis (and other diseases) and health services in the Eastern Arctic. In particular, investigations of the hospitals, facilities and doctors linked together in this northern network are needed to provide more detailed, local histories of tuberculosis among the Inuit. Such research will also help unravel the complex story of how the switch over to secular Government hospitalisation played out in different parts of the eastern Arctic.

This project was enhanced enormously because of the ability to link records kept in two hospital settings (day books from St. Luke's and photographs from the Hamilton Mountain Sanatorium), and then illuminate their meaning through conversations with Inuit, and triangulation with other archival sources. Can similar studies by undertaken for the Frobisher Bay Hospital and its southern network of hospital facilities to which Inuit were sent? Projects of this nature would provide a broader basis for understanding the decline of tuberculosis in the eastern Arctic and the role played by direct patient care. Mountain Sanatorium in Hamilton attempted to provide Inuit patients with a supportive,

culturally-sensitive infrastructure. Detailed analyses of the environments in which treatment for tuberculosis was offered in other southern facilities, such as Montréal Royal Edward Chest Hospital or Toronto Weston Sanatorium, will place the experience of the Cumberland Sound Inuit sent to Hamilton in comparative perspective.

The ability to link St. Luke's to other locations through records, correspondence, and oral accounts, which together reveal the perspectives of Inuit patients, physicians, nurses, Government and Church officials, also suggests that it may be useful to approach the history of the hospital from other medical anthropological perspectives. Future analysis of St. Luke's as a case study of a "contact zone" (Pratt 1991) or within a framework that focuses on the colonisation of the Inuit body (Arnold 1993; see also Kelm 1999) may be fruitful.

The battle between the Church and State for control of health care for the Inuit resolves itself in interesting ways and returns this study to the question of "why were we sent away" that was repeatedly asked of me during the years of community visits and consultations. The State won control through the administration of southern hospitalisation programs. The Inuit at the Pangnirtung Photograph Naming Project community celebration appreciated the quality of care provided to them while away at Hamilton and were grateful for their cure. Tubercular Inuit were sent away from local care, in part due to the severity of their acute infection, and because of the shift toward northern inclusion in the Canada-wide administration of healthcare programs. For a short time, the Inuit of the Cumberland Sound participated in the southern hospitalisation

program, and in part they were *siniqvi inatilugi*, "filling the empty beds", but this is not where their collective memory resides.

For those Inuit of the Cumberland Sound influenced by St. Luke's Mission Hospital, this study represents their story of *puvaluqatatiluta*, "when we had tuberculosis". The Government decision to close the hospital in 1972 was a missed opportunity to utilise the experience and capacity that developed in Pangnirtung because of the presence of St. Luke's. When they had tuberculosis, the Inuit of the Cumberland Sound region were partners for over forty years in effecting local health care strategies. This is the enduring memory of this time, and the quality of care many long for.

Figure 7.1: St. Luke's Mission Hospital, Pangnirtung, in 2010. ©Emily Cowall 2010.

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