INUIT MEDICAL EVACUEES AND TUBERCULOSIS IN HAMILTON: THE MAKINGS OF A PROBLEM

INUIT MEDICAL EVACUEES AND TUBERCULOSIS IN HAMILTON: THE MAKINGS OF A PROBLEM

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ABSRACT: In early twentieth century Canada, the tuberculosis (TB) epidemic struck far and wide (Herring, 2007) and its effect was greater on indigenous populations, particularly the Inuit (Public Health Agency of Canada, 2013). In 1906, the Mountain Sanatorium was founded by the Hamilton Health Association (HHA) in an effort to curb the disease (Wilson, 2006) and was designated as a treatment centre for Inuit from the Eastern Arctic. Controlling TB became a movement extensively documented by The Hamilton Spectator – a prime news provider. This research concerns the way in which social problems emerge and the responses they generate. Drawing on the literature on social problems, this thesis examines the HHA's claims-making activities regarding tuberculosis in 1953-1963 along with The Spectator's role in helping to define TB as a problem. It examines 1) how the HHA constructed TB as a problem 2) how the HHA understood the problems and solutions of tuberculosis; 3) it ascertains whether the HHA and The Spectator drew from a biomedical model or considered social determinants of health (SDOH) in their control and reportage of the disease; 4) the portrayal and treatment of Inuit patients; 5) the role of legitimacy; and 6) the importance of Pfeffer and Salancik's resource dependency theory in the Sanatorium's efforts to survive as an institution. This was executed through a content analysis of the HHA's annual reports and newspaper articles by The Spectator. The examination of this case through the theory of social problems and resource dependency provides a lens to understand how TB became a problem and why hospitals are more than treatment facilities.

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INTRODUCTION

Over the course of Canadian history, there have been numerous epidemics. Smallpox, typhus, cholera and tuberculosis are well known examples. For the purpose and scope of this research, attention was directed on TB among the Inuit. TB is a highly infectious disease caused by bacteria known as mycobacterium tuberculosis (Herring, 2007; WHO, 2016). Mycobacterium "enters the body through inhalation or ingestion (Enarson, Chiang and Murray 2004: 16; Ryan 1992: 19)" and results in pulmonary tuberculosis, the most common form of the disease (Herring, p.6, 2007). When a person becomes infected they are "never cured and either is prone to developing clinical symptoms later in life or relapsing" (Ryan 1992:19-20)" (Herring, p.7, 2007). Symptoms consist of "persistent cough, bloody sputum, exhaustion, fever, loss of appetite and breathlessness (Cox and McLeod 1912:32; Ryan 1992:22)" (Ibid.). TB is a chronic disease that may emerge in an active form within the individual and as an epidemic in the community when the social conditions under which people live deteriorate, and privation and stress become the reality of daily life (Daschuk, Hackett & MacNeil, 2006; Ryan, 1992).

The widespread occurrence of deadly disease may bring to light, the social, political and economic arrangements of a given society. When disease strikes all regardless of class, it may fuel the cooperation of the elite class, who were previously unconcerned by its effects on the lower strata. Many infectious diseases, including TB, disproportionately affect the poor (Health Poverty Action, 2015; National Institute of Allergy and Infectious Diseases, 2012; WHO, 2016). The tuberculosis epidemic brought

to light colonial and imperial components of the Canadian state, particularly its race-relations, its push towards economic advancement, and its poor knowledge of disease. Disease-oriented campaigns and the emergence of medical facilities would later materialize with the widespread outbreak of life-threatening diseases including tuberculosis. Present within these campaigns and the principles or values guiding them, were particular articulations of their problems and potential solutions. The TB epidemic garnered responses from lay people, medical and media professionals, and political agents. Their combined responses left a significant impact on Indigenous Peoples, particularly the Inuit.

In the 1940s, the Canadian government executed a large scale medical survey of Indigenous People residing in the Arctic and those suspected of TB were evacuated to sanatoria in the south (Olofsson, Holton & Partridge, 2008). Among those evacuated were the Inuit. In the mid 1950s, when evacuation was at its peak, it is estimated that about "7 to 10% of the Inuit population of Canada was hospitalized with tuberculosis (Duffy 1988; 71; Grygier 1994: 71; Jenness 1972: 143, 146)" (Olofsson, Holton & Partridge, p.128, 2008). Another estimate suggests that about 15 percent of the Inuit by 1956 were in a southern sanatorium and in the 1950s, at least 33 percent of the Inuit population were infected with tuberculosis (Grygier, 1994). Among Indigenous Peoples, "the highest TB rate was found among Inuit at 177.6 per 100,000 population" (Public Health Agency of Canada, 2013).

Lay people, medical and media professionals, and political agents had their own understanding and responses. Key responses came from the media and medical

professionals who contributed to the establishment of sanatoria, with the Mountain Sanatorium in Hamilton regarded as among the best in North America (Wilson, 2006). The central question that guides this research is: how did the medical personnel at the Sanatorium and reporters at The Spectator understand the problems and solutions to the tuberculosis epidemic?

At the heart of this research, lies tuberculosis treatment among the Inuit between the 1950s and 1960s. The construction of TB as a problem in Canada at that particular time, the motivations behind it and the consequences of such articulations were examined. A series of questions that follow the central research question include: was TB articulated as a biomedical and/or social issue, and to what extent? What evidence was provided to support claims of a biomedical and/or social model? Were there any solutions provided and to what extent were they biomedical and/or social remedies? In exploring these questions, annual reports and newspaper articles published in 1953-1963 were utilized.

The theoretical approach used to examine the research questions include: the sociology of social problems and organizational legitimacy theory (Suchman, 1995). Social problems are the "definitional activities of people around conditions and conduct they find troublesome, including others' definitional activities" (Schneider, p. 209, 1985). Spector and Kitsuse (2001) posit that social problems are a claims-making activity whereby individuals or collectives (whether they represent organizations or not) define certain objective conditions as problems. Loseke and Best (2003) define claims as "any verbal, visual, or behavioural statement that tries to persuade audience members to take a condition seriously and respond to it as a social problem" (p.9). Loseke asserts that claims

makers construct a set of claims concerning the presence of a particular social problem and potential solutions (2003). These set of claims constitute diagnostic, motivational, and prognostic framing (Mahood & Satzewich, 2009). The usage of "facts" (usually statistics) which contextualizes the social problem and enables one to measure its extent is fundamental in diagnostic framing (Mahood & Satzewich, 2009). Constructing social problems entails the use of motivational frames which provide potential allies reasons to be concerned about the facts (Mahood & Satzewich, 2009). In framing certain conditions as a violation of deeply held values, ideologies, or beliefs regarding how the world ought to be, claims-makers appeal to their audience (Mahood & Satzewich, 2009). Lastly, prognostic frames offer potential solutions (Mahood & Satzewich, 2009). Using the social problems tradition, I attempt to unpack the ways in which what constitutes TB becomes defined as a problem of which a solution is necessitated. In particular, I examine the diagnostic, motivational, and prognostic frames promoted by the HHA and The Spectator.

Using organizational legitimacy theory, this thesis focuses on what Suchman (1995: 579) calls moral legitimacy. Suchman suggests that some organizations claim moral legitimacy to advance their claims that their approach to an issue is the 'right thing to do'. This type of legitimacy involves a positive normative assessment of an institution and its activities (Suchman, 1995). Gaining, maintaining, and repairing legitimacy are general challenges Suchman examines. In *The External Control of Organizations*, Pfeffer and Salancik (1978) argue that organizations are unavoidably entangled in the state of affairs of their environment. They argue that organizations' capacity to survive can be measured by its degree of effectiveness which is contingent on how it manages demands,

particularly those of interest groups that it relies on for resources and support (1978). Organizations face the issue of acquiring and maintaining resources because they rarely exercise full control over all the essential workings of their operation (Pfeffer & Salancik, 1978). This results in interdependence as organizations have to exchange with other components of the environment to acquire vital resources (Pfeffer & Salancik, 1978). Organizations are generally influenced by entities in control of the resources they depend on. Successful influence is dependent on a multitude of conditions (Pfeffer & Salancik, 1978). Factors that are critical in determining the dependence of one organization on another include: the importance of the resource; the extent to which the interest group has discretion over resource allocation and use; and the extent to which there are few alternatives (Pfeffer & Salancik, 1978).

The significance of this research is that it demystifies the assumed expertise of medical professionals and the media's impartiality. It raises important questions, such as, who is funding biomedical research on TB and what do they have to gain? It also asks who benefits from making tuberculosis strictly a biomedical matter? It thereby helps to shed light on how the Sanatorium as an institution possibly benefited from the emergence of the TB epidemic and other "medical concerns" that have manifested thereafter and in turn the role that the general public assumed. It also sheds light on how broader colonial ideologies and practices shaped understandings of the health and well-being of Indigenous People in Canada.

The increasing recognition that a strictly biomedical model is inadequate in serving the needs of medical-care recipients, affirms the importance of this research.

Research on the social determinants of health has revealed that various types of disease, such as TB, are the result of factors which cannot be strictly attributed to biology or personal behaviour. In fact, TB today is widely regarded by various health care organizations as a disease of poverty (Health Poverty Action, 2015; National Institute of Allergy and Infectious Diseases, 2012; WHO, 2016). In *The Miracle of Empty Beds*, Wherrett (1977) asserts that the "Indian's" vulnerability to a hit was a result of factors in their daily life. These factors have been argued to consist of: living in crowded housing; a precarious method of obtaining food (hunting); the migration and disappearance of buffalo; inadequate food rations; poor sanitation; the inaccessibility of medical services; and the encroachment of White settlement forcing an undesired lifestyle (Wherrett, 1977). The full degree to which Inuit people felt distressed is unknown (Selway, 2016). Though the accounts are few, Inuit TB patients, social workers, interpreters, and nurses have spoken on their experiences of TB evacuation and treatment. There are few Inuit patient narratives of the sanatorium experience and they take on a captivity narrative (Selway, 2016). "The fullest personal account of the experience of an Inuk at Mountain Sanatorium is a scant six or seven pages. It is that of Minnie Aodla Freeman and appears in her memoir of growing up motherless in the James Bay region in the mid-twentieth century" (Selway, p.173, 2016). Born in 1937 and raised by her grandparents, Aodla Freeman went to an Anglican and Catholic school and was later encouraged to become a nurse (Ibid.). In 1952, she was hospitalized for a spot on one lung and kept herself active by translating for the medical staff for Inuit and Cree patients (Ibid.). After she got better,

she struggled with the choice to remain but stayed in southern Canada out of compassion until 1954 (Ibid).

Although TB rates have significantly declined in comparison to the early 19th century, recently there have been growing outbreaks (Ho, 2004; WHO, 2016). Knowledge of how TB and other "medical" matters are articulated is important given that the conditions in which people become more susceptible to tuberculosis such as crowded housing, poor sanitation and lack of ventilation and access to basic needs (National Institute of Allergy and Infectious Diseases, 2012) continue unabated. Incorporating the social determinants of health approach has been argued by scholars and medical professionals as a means to combat the tendency to focus strictly on biomedical models, and more importantly, reach equitable and sustainable measures. Doing so necessitates delving into the process by which TB is constructed and articulated. Some may question the relevance of examining the 1950s and 1960s when one can explore how it is currently articulated. Using a historical approach has its benefits, as the present articulation of TB and other infectious diseases have their roots in earlier articulations. It is important to understand the way in which certain social, political and economic phenomenon has shaped the definitional shifts of an illness such as tuberculosis.

I hypothesized that claims-makers relied heavily on a biomedical model to combat the TB epidemic. I also hypothesized that directors at the Sanatorium were strategic in their actions such that social and/or cultural initiatives were only discussed when they appeared to benefit medical and/or institutional agendas. For instance, when securing the funding of prestigious families and organizations, on which the Sanatorium depended.

It may be fair to argue that most of what is known about TB has been oriented around a biomedical model at the expense of fully acknowledging the role of social determinants of health. The role of these SDOH is seen in the process by which TB emerged as an issue of public health. This study contributes a new understanding of TB and health-oriented movements. In unmasking the activities of claims-makers, one can begin to understand TB as matter that generated recognition as a legitimate problem because of the work of various actors. Chapter one covers a brief history of the evolution of public health as it concerns the Inuit and discusses the placement of Inuit populations within provincial and federal health jurisdictions as it relates to TB. A major debate that spoke to the significance of placement is the question of whether the Inuit are "Eskimos" or "Indians", which had noteworthy implications for the Inuit and healthcare providers. Two sets of literature – Canada's colonial and medical history – are amalgamated to give context for understanding of the dynamics that led to the emergence of the TB epidemic and the Sanatorium. Identifying where Inuit people fit into this history is critical in understanding their treatment and portrayal during the epidemic. Chapter two, maps out the theoretical framework as it synthesizes the sociological literature, particularly the SDOH scholarship. Chapter three outlines the methodology and lays out the context, of which The HHA's administration of the Sanatorium is discussed. Chapter four is an analysis of the HHA's annual reports while chapter five is an analysis of The Spectator's articles. Both chapters discuss claims-making activities, legitimacy, and resource dependency theory as it concerns TB conceptions, problems and solutions from 1953-1963. The research comes to an end with a discussion and conclusion in chapter six.

CHAPTER 1: THE INUIT, TB AND THE EMERGENCE OF HEALTH CARE IN CANADA

This chapter begins with a description of the Inuit and their complex relationships with successive waves of European settlers, traders and political authorities. It then focuses on the changing roles of the provincial and federal governments in assuming administrative and financial responsibility for Inuit, and their health and well being. Drawing from Backhouse (1999), it shows that between Confederation and 1939, the Inuit were defined as provincial government responsibilities as it concerned the provision of health and social services. In 1939, following a Supreme Court decision, the Inuit became defined as 'Indians,' making the federal government formally responsible for their provision of health and social services. Finally, Canadian medical history is briefly outlined as it pertains to the Inuit and TB treatment. This account draws mainly from settler-Canadian sources. It is thus written from a non-indigenous perspective.

The Inuit

It is commonly thought that over four thousand years ago, the Inuit passed through the Bering Strait and established themselves in what would later become northern Canada and Alaska while subgroups migrated elsewhere (Thibeault, 2002). Whether Inuit people believe this themselves may be up for debate. The Inuit are a large population with subgroups scattered across Canada, Alaska, Greenland, Siberia and Russia (Thibeault, 2002). They share a common language known as Inuktitut with dialects dependent on region (Backhouse, 1999; McGhee, 1996), a common spiritual culture identified as shamanism and a close-knit family arrangement known as Ilagiit (McGhee, 1996). They

are a semi-nomadic people, whose routine travels, with arrivals to the same encampment sites are dictated by the season (Grygier, 1994; Mitchell, 1996). The life of the Inuit was not only significantly influenced by the seasons as it determined the shelter they sought but it also involved living in smalls groups of approximately five families, settling only for a few months until it was time to embark on a trail and hunt to ensure their survival (Grygier, 1994). Due to the low temperatures, the waters near the coast are accessible only in the summer for two to three months (Grygier, 1994). In fact "some typical average Celsius temperatures for January are as follows: Cambridge Bay, high -30, low -37; Pond Inlet, high -26, low -35; Iqaluit, high -22, low -30" (Grygier, p.17-18, 1994).

Their survival required that they travel as their reality was immensely risky and precarious (Grygier, 1994). Fishing and hunting excursions could be deferred if there was not enough ice when it was needed, but such deferrals could also result in starvation (Grygier, 1994). The Inuit also needed to be at the right place and time to find and trap the animals on which their survival depended (Grygier, 1994). The Inuit way of life within the Arctic, was oriented around the collection of a rich bounty consisting of caribou, seal, birds, fish and berries (Backhouse 1999; Richmond, 2009). They relied on these country foods in the face of harsh climate (Backhouse, 1999). Sea animals provided fat which could be eaten, utilized for boats, and even clothing. Success could only be assured by the precise timing of the animal's migration patterns and disaster for the group may result if patterns are disturbed whether through excavation, military action, or natural causes (Grygier, 1994).

The Inuit are such a diverse group that within Canada alone, the way in which they refer to themselves, is dependent on which region they reside in within the Arctic. Some Inuit groups referred to themselves by the use of place names bearing the suffix miut (Mitchell, 1996). Only in recent times, did the Inuit identify themselves as a community with a common history and interest, despite their continual homogenization (Mitchell, 1996). The Inuit have historically been known as "Eskimos," a term that has been imposed upon them. Its origins are often attributed to an Algonquian term which translates to "eater of raw meat" while others argue that it derived from another term and means "those who speak a strange language" (Backhouse, p.27, 1999). Inuit is however the term those labeled as "Eskimos" refer to themselves and it translates as "the people" (Backhouse, p.27, 1999).

The Northwest Passage

The hunt for the Northwest Passage led to the earliest large-scale contact with Europeans in Canada (Thibeault, 2002). By the time European explorers documented initial contact, the Inuit had already populated Northern Canada for centuries (Backhouse, 1999). Initial contact between Europeans and Inuit transpired when the Norse (known as the Scandinavian people or Vikings) came into conflict with people who they thought were strange and referred to as Skraelings, as they traveled along the shores of Labrador in A.D. 1000 (Backhouse, 1999). It is said that the Vikings, either vanished or withdrew and European fishing boats would return five centuries later (Backhouse, 1999). Initial documentation of European and Inuit encounters are from the early eighteenth century

when seal and cod fisheries in Labrador were developed by the French (Mitchell, 1996). Trading with the local Inuit took place despite fragile and unfriendly relations (Mitchell, 1996).

A small number of French fur trappers set out into Inuit territory prior to Frobisher and Franklin's expeditions (Thibeault, 2002). Frobisher, an English explorer, was an exception given that he put together the earliest noteworthy accounts of the Inuit (Mitchell, 1996). Encounters between explorers and Inuit gradually increased and became personal as explorers strengthened their efforts to gain entry to Asia's riches via the Northern Sea (Thibeault, 2002). A consequence of this expedition was the major death toll among the Inuit caused by disease foreign to the New World (Thibeault, 2002). Mitchell (1996) makes reference to D'Anglure, (1984) who argued that encounters with explorers differed across the Arctic with the Inuit in Northern Quebec running into British, Danish and French vessels in search of the Northwest Passage in the late sixteenth century. D'Anglure identifies these explorers as Frobisher, Davis, Weymouth, and Hudson among others (Mitchell, 1996).

Early Explorers and Traders

The first encounter with European explorers in the northern region of the Hudson Bay occurred within early to mid-nineteenth century (Mitchell, 1996). As noted earlier, contact with explorers varied across the Arctic. In some areas such as the northern coast of the Hudson Strait, there were temporary trading opportunities as vessels arrived during the summer while in other areas such as the Southampton Island, the influence of

explorers was almost nonexistent prior to the arrival of whalers (Ross 1975; Mitchell, 1996). Explorers sought out Indigenous Peoples for aid and trade as they began to acknowledge their resourcefulness (Mitchell, 1996).

Much like the early explorers, the early traders in the Arctic, left an insignificant impact on the Inuit. It is fair to presume that indigenous social and economic arrangements were left for the most part intact for the reason that, contact between explorers and early traders was irregular and temporary (Mitchell, 1996). Despite a minor impact on their socioeconomic arrangements, they left a significant impact on the means of production leading to changes in the techniques employed in production (Mitchell, 1996). Within this age of contact, Fitzhugh asserts that instead of substituting supplies used within indigenous arrangements of exchange, the raw materials and man-made items obtained from European people added to them (Mitchell, 1996). In fact, these new commodities improved an individual's status within the community and enabled hunting and domestic duties to be carried out more efficiently (Mitchell, 1996). Those among the first to come in contact with the Inuit, pressured them to hunt and produce more than necessary for their immediate needs for trading purposes, which required that they remained on the land (Mitchell, 1996). Indigenous practices were destabilized with this increasing exploitation of raw materials to support trade (Mitchell, 1996). Though initial relations of trade helped with the establishment of structural shifts, explorers and early traders did not bring about a transformation (Mitchell, 1996). Mitchell (1996) makes reference to Francis (1984) who asserts that whalers were a different case as they brought new means of living, legislation, commodities, and unforeseen prosperity and mortality.

Whalers: Subsistence to Market Economy

Whalers make up the second wave of contact and unlike explorers and early traders, they sustained relationships with Indigenous communities (Mitchell, 1996). A long time prior to venturing into other regions of the Arctic, Hudson Bay, Baffin Island and Herschel Island, whalers were operating in Labrador (Mitchell, 1996). A key whaling territory, located on the west shores of Baffin Island was Cumberland Sound for the reason that it was packed with whales and populated by a large Inuit community whose labour was available for the whalers (Mitchell, 1996). Social interaction between whalers and the Inuit were intensified as the whalers settled in the Sound over the winter months and established long-term whaling posts (Backhouse, 1999; Mitchell, 1996). Inuit within the area were easily drawn into close economic and social relationships with the crews (Mitchell, 1996). This relationship is exemplified in the fact that, among other responsibilities, the Inuit operated boats, hunted whales and caribou, skinned animals, transported blubber, served as guides and produced and repaired clothing made of skin (Mitchell, 1996). Mitchell (1996) makes reference to Usher (1970), who asserts that Herschel Island was the most important centre of whaling activity in the western Arctic. In fact, the whalers had a much greater impact, albeit negative, at Herschel Island than in the Eastern Arctic (Mitchell, 1996). Mitchell (1996) also makes reference to Frances (1984), who asserted that the Inuit at Mackenzie located in the western Canadian Arctic, numbered approximately 2, 500 prior to the arrival of whalers but were decimated to 250 while whaling declined as a consequence of epidemic disease introduced by the whalers.

The brunt of whaling led to more than an initiation of disease since the Inuit provided labour and the whalers engaged in trade (Mitchell, 1996).

Inuit traditional way of life was affected as whalers settled and established themselves in secluded areas (Thibeault, 2002). Thibeault (2002) makes reference to Freeman (1990) and Woodman (1995) who contend that without any doubt, the leading key impact for the Inuit was letting go of their nomadic status. Participation in their traditional duties and responsibilities, more importantly, dropped as the market economy became an increasingly prominent aspect within the Arctic (Richmond, 2009). Not surprisingly, notable consequences concerning their social, cultural, economic, and physical wellbeing ensued with the transfer from a traditional economy based on subsistence to a market economy tied to surplus (Richmond, 2009).

According to Thibeault (2002), Eber (1989) argues that in regards to occupation, Inuit hunters began to trade goods with whalers and The Hudson's Bay Company and unlike never before, they began harvesting beyond their immediate needs. Whalers oddly positioned caribou hunters by the sea while fishing communities were relocated inland – both in unfamiliar circumstances without survival supplies (Thibeault, 2002). Unsurprisingly they frequently faced near starvation and this was authorized by the state (Thibeault, 2002). The Inuit endured a multitude of health problems as they endured dramatic changes concerning their traditional diet and nutrition (Thibeault, 2002). To make things worse, a new diet largely consisting of foods high in sugar and oil was coupled with a shift away from nomadic life, negatively affected Inuit health status

(Bobet, 1997; Thibeault, 2002; Wentworth, 2001). Fur traders took over after 1910, when the whaling industry declined as a consequence of the baleen market caving in and overfishing (Backhouse, 1999). In the following decade, European traders established additional stations to enlarge a growing industry as the demand for fox fur strengthened (Backhouse, 1999).

Guns and whaleboats were the latest means of production introduced by whalers which in turn secured Inuit labour and created an incentive for people to hunt in order to exchange material (Mitchell, 1996). Given that hunters were now expected to provide beyond their families, the firearm became very useful to the Inuit as it allowed them to hunt more game (Mitchell, 1996). The Inuit laboured to produce a surplus in addition to providing the whalers with food and clothing from the animals and were given firearms and ammunition in exchange (Mitchell, 1996). With the aid of new goods such as firearms, clothing, boats, and new foods (i.e. flour, sugar, tea, canned fruit, butter and jelly), the Inuit found it increasingly challenging to revisit their traditional lifestyle (Backhouse, 1999). A move to a sedentary life, led to permanent settlements inhabited by both the Europeans and the Inuit (Backhouse, 1999). Wildlife began to decline due to increasing pressure caused by changes in the patterns of migration and climate change (Grygier, 1994). Disease introduced by Europeans – such as Influenza, syphilis, measles, alcoholism and tuberculosis – dramatically decimated the Inuit, often wiping out a third of their population (Backhouse, 1999). The Inuit society then started to experience increasing differentiation in responsibilities, wealth, and social standing unlike their traditionally egalitarian arrangements (Backhouse, 1999).

Different relations of production became possible as whalers made contact with the Inuit who unlike before officially became members of the workforce (Mitchell, 1996). Settlements in close proximity with the whalers became significantly more attractive because of the employment opportunities being provided and suffering ensued as a consequence of this shift away from a nomadic lifestyle and subsistence hunting (Mitchell, 1996). Employment was paired with benefits consisting of regular meals, medical services including dental care as well as producing and mending tools and machinery (Mitchell, 1996). Though informal, whalers provided the Inuit with welfare and Ross (1975) notes that "the provision of these services, and the responsibility whalers took for Eskimo welfare, made employment" a matter more complicated than an abuse of labour (Mitchell, p.75, 1996). The relationship between the Inuit and the whalers cannot be summarized as simply a traditional employer and employee relationship despite being employed by the whalers for the first time (Ibid.). According to Mitchell (1996), writers have noted a mutual dependency between the Inuit and whalers which they argued is oriented around food as a necessity, where whalers rely on food hunted by the Inuit while the Inuit rely on processed foods provided by the whalers when game is inaccessible (Ross 1975, 63; Coates 1985, 138-9). Mitchell (1996) makes reference to Ross (1975, 80) who maintains that this mutual dependency was reinforced and grew over time with the "Eskimos becoming more organized in their hunting for the ships and the whalemen assuming additional responsibility for Eskimo welfare." Mitchell again makes reference to Ross (1975, 80) who asserts "gradually, certain Eskimos began to assume the role of liaison between captains and the rank and file of native labour, and to function as labour

bosses or, as the whalemen termed them, 'head natives' "(p.75, 1996). Coates (1985, 139) notes that while the whaling industry integrated cooperation, it was exceptionally abusive for the reason that "area after area was abandoned after the whaling resources were depleted; the whalers simply moved on to a new, hopefully profitable field. This recurring cycle of resource discovery, intensive harvesting and abandonment brought temporary prosperity to regional groups, but just as systematically induced resource depletion and economic dislocation" (Mitchell, p.85, 1996). Indigenous peoples experience significantly higher mortality and morbidity rates when compared to the setter-Canadian population (Adelson, 2005; Gabel, 2012; Codon, 2005; Frohlich, Ross & Richmond, 2006; MacMillan, MacMillan, Offord & Dingle, 1996). This inequality is rooted in "a legacy of colonial relations, dispossession from traditional lands and territories, rapid cultural change and dependency (Bartlett, 2003; Gracey & King, 2009; Waldram, Herring, & Young, 2006)" (Kulmann and Richmond, p.1, 2011). The identities of Indigenous peoples and how they understand their place and role in the universe is intimately woven into their relations to the land thus the seizure of Indigenous land is an attack on their existence (Gabel, 2012).

Colonial Administration and Arctic Sovereignty

Under Canadian law, Canada's Indigenous Peoples including the Inuit are under the authority of a branch within the federal government which is akin to colonial management (Mitchell, 1996). Only towards the end of the nineteenth century, as explorers and whalers fueled a ruckus, did Canada embark on establishing its presence in

the Arctic (Mitchell, 1996). As a means to make it very clear to the Inuit that the territory they inhabited belonged to Canada, representatives of the state, namely the police were sent up north. To Canada, the Inuit were not a top priority but instead seen as squatters to aid in Canada's declaration to Arctic sovereignty (Mitchell, 1996). Mitchell (1996) makes reference to Francis (1984, 105, 106) who asserts that the Arctic was now the territory of the European as it housed a range of traders, trappers, police officers, missionaries, scientists, and explorers particularly prospectors who ensured that isolation for the Inuit was no longer a reality.

Traders, Police, and Missionaries

The arrival of traders, missionaries and the police marks the third wave of contact in the Arctic which took place at the turn of the twentieth century (Mitchell, 1996). Traders, missionaries, and police took control of the Arctic for about 40 years beginning from about 1920 and who for their own benefit, left a significant impact on indigenous traditions (Mitchell, 1996). Forcing their way through, fur trading corporations found the Arctic conducive to their work given that whalers who previously dominated the area, laid the foundation as they not only drew Inuit to stations that could be reached by ships but also produced necessities between them (Mitchell, 1996). Mitchell (1996) makes reference to Bromley (1986, 7) and Usher (1970, 1: 16) who contend that "the establishment of permanent posts in the Eastern Arctic and elsewhere was hampered by Inuit hostility, competition from whalers, and environmental conditions, but once begun, expansion of the fur trade throughout the territory took only fifteen years." In order to

foster a competitive advantage with traders, The Hudson's Bay Company employed distinguished Inuit in exchange for goods and in some cases housing (Mitchell, 1996). During the Great Depression, nearly all adult Inuit could recall experiences of starvation and death as well as individual traders who came to their aid. Though traders provided refuge, it was not necessarily for altruist purposes given that the HBC gained a monopoly of trade on the condition that they would provide aid in the event that Indigenous communities were starving (Mitchell, 1996). The HBC managers were in charge of handing out family-allowance and welfare cheques until the police took over these services (Mitchell, 1996).

Within the Canadian Arctic, except for Labrador where the Moravians succeeded, Catholic and Anglicans were in competition over converts (Mitchell, 1996). In the 1950s, as Canada took charge of health and education, competition involving the two denominations over finances to manage schools and hospitals came to an end (Mitchell, 1996). In their pursuit for Inuit souls, the Inuit holy man known as the angakoq became a common enemy for Catholics and Anglicans (Mitchell, 1996). The missionary's power over education helped in facilitating their intentional efforts to destabilize Inuit heritage and traditions (Mitchell, 1996). According to Oswalt (1979, 286), missionaries had a pattern of becoming knowledgeable in the Inuit language, translating sacred materials followed by operating schools (Mitchell, 1996). Missionaries were doctors, dentists, welfare agents, healers, and spiritual counsellors in addition to teachers (Valle 1967a, 154). Though to a smaller degree, the state of affairs in the Arctic, was similar to that of Quebec given that the church controlled schooling, health and social services until the

1950s (Mitchell, 1996). Federal polices systematically strengthened the assimilation project. Thibeault (2002) makes reference to Ipellie (1992) who contends that the end of Inuit nomadic way of life and the restoration of residential schools took root in the middle of the twentieth century. Inuit children found themselves isolated from their kinship groups, their homes and engrossed in a language foreign to their own in religious training establishments (Thibeault, 2002).

Entire groups were wiped out by disease for which Indigenous communities had no immunity in addition to recurring starvation for which the federal government intervened partly because of appeals from missionaries (Mitchell, 1996). This time like before, the state did not intercede for altruistic reasons. Rather than being concerned with the wellbeing of those inhabiting the Arctic, Canada was interested in extracting resources and its claims to sovereignty (Mitchell, 1996). Claims to sovereignty were implemented by sending policemen up north. Although the ideal role of the police was to implement and reinforce legislation, in the Arctic the RCMP much like the missionaries had many functions. According to Valle (1967a, 100), they served as "administrators, registrars, census takers, ambulance operators, allocators of relief, mailmen, and rescuers" (Mitchell, p.109, 1996).

Canada and Racelessness

The issue of race permeates through Canada's colonial and medical history. It is evident in the invasion of the early explorers and traders, particularly their claims to sovereignty and colonial policy towards Indigenous peoples. Although the meaning of

race has changed over time, its significance has permeated throughout the centuries. Initially the letters w, r, b and y were used to designate race (by the Canadian government in its 1901 consensus) with reference to white, red, black and yellow (Backhouse, 1999). The intent behind this method of categorization was an effort to differentiate "groups in the population having similar cultural characteristics, based on a common heritage" (Backhouse, p.5, 1999). Decades later, race and color, were more carefully inscribed as reference to the colors noted above withered away. Census workers were now instructed to probe for origin and respondents later made reference to biology, geography and culture (Backhouse, 1999). During the late 1930s and early 1940s, people began to realize the frightening implications of racial discrimination having witnessed Hitler's Nazism. Throughout the late 1940s, a host of policies proclaiming their aim to abolish racial discrimination were adopted by western political leaders under the authority of the newly established United Nations (Backhouse, 1999). It was no longer socially acceptable to be considered racist. Backhouse sheds light on Canada's unyielding efforts to appear as a raceless nation. Backhouse asserts 'race' does not appear as a recognizable legal category of classification between 1900 and 1950. Legal cases were not indexed by reference to race. Statues drawing in all manner of racial distinctions were frequently 'raceless' in title. Legal commentary in treaties and periodicals rarely adverted to race" (p.13, 1999). The series of events that transpired with the invasion of communities of interest over the centuries can be better explained by Canada's relationship with race and the way in which it manifested in the provincial and federal scramble over jurisdiction and responsibilities concerning the health of Indigenous People.

Welfare

Britain transferred indigenous land supposedly under the control of The Hudson's Bay Company to the province of Canada which became the Northwest Territories in 1870 (Backhouse, 1999). "In 1898, the Canadian Parliament unilaterally transferred to Quebec jurisdiction over the lands west of the coast of Labrador, north to Churchhill River, over the divide to James Bay, and north to the Eastmain River, in an effort to ensure political equity between Quebec and Ontario. In 1912, Robert Borden's Conservative government conveyed the Ungava district to Quebec, along with an area from the Eastmain north to Hudson Straits, a transaction measuring approximately half a million square miles of land" (Backhouse, p.32, 1999). In its yearly police and health inspections, the federal government in the 1920s included the Ungava Inuit in its patrol of the Eastern Arctic (Backhouse, 1999). While the federal government was eager to deny legal responsibility for the Inuit, arguing that they were actually citizens of Quebec, policemen on these patrols were sanctioned to hand out food, clothing, and medication to Inuit in harsh conditions who they deemed needy (Backhouse, 1999). Backhouse states that "in early 1929, the two governments struck a deal that authorized the federal government to provide minimal subsistence to the Inuit in Quebec, with the province agreeing to reimburse for expenses incurred between 1929 and 1932, Quebec forwarded a total of $54, 660.16" (p.34, 1999). The shortage of money did not make an impression on Quebec's politicians. In an attempt to reinforce how frugal they could be, Quebec's government in 1932 stated that this sum would mark an end to their transfer of funds (Backhouse, 1999). Quebec insisted that under the British North America Act (BNA) of

1867, legal responsibility for the Inuit belonged to the federal government (Backhouse, 1999). Authority over "Indian" people and land set aside for them, was assigned to the federal government, specifically under section 91 (24) of the BNA Act (Backhouse, 1999). The Quebec government stood its ground in arguing that the Inuit were 'Indians" and in doing so made known its plans to sever itself from any responsibility (Backhouse, 1999). To straighten out this dispute with the provincial government, the federal government called on Canada's Supreme Court for their legal position (Backhouse, 1999).

The federal government was given official authority to forward questions to the Supreme Court of Canada in hopes of coming to an agreement or solution since 1875 when it was first conceived. Backhouse asserts that "the 'reference' power, as it became known, permitted the government to obtain advisory rulings on important matters of law or fact pre-emptively, before a concrete lawsuit had arisen. Consequently the federal government put the question squarely to the Court: 'Does the term "Indians"...include "Eskimos"? (p.34-35, 1999). Though the matter greatly concerned Indigenous Peoples, predictably, only the federal and provincial government were represented at the legal proceedings (Backhouse, 1999). This was predictable given Canada's colonial legacy as a settler state. "Prior to 1960, Aboriginal peoples were invisible to Canadian politicians and the concept of Aboriginal self-government was non-existent" (Gabel, p.33, 2012). "Policies of direct extermination, displacement, or assimilation" form the basis and preservation of settler states which make way for settlers to effortlessly takeover as Indigenous People and presence is erased (Lawrence & Dua, p.123, 2005).

The case began in 1937 and culminated in 1938 although the oral component lasted for less than a week (Backhouse, 1999). Lawyers representing the federal government asserted that 'Eskimos' were by no means misunderstood under the term 'Indians,' when James Stewart conceded that Christopher Columbus was incorrect in categorizing Indigenous Peoples in North America as 'Indians' (Backhouse, 1999). Backhouse asserts "tracing back to the Royal Proclamation of 1763, which referred to 'Indians' as 'the several nations or tribes of Indians with whom we are connected and who live under our protection,' Stewart argued that the 'Eskimo' were never 'organized or commonly spoken of as "nations or tribes." Nor had they ever been entered into any treaties with them, nor had it designated any 'reserves' in their name" (p.39, 1999). In the absence of reference to 'Eskimo,' a comprehensive scheme concerning the administration of Indian Affairs was distributed in 1775 to Governor Carleton of which enclosed was a list of 'Indian tribes' residing in North America (Backhouse, 1999). In arguing that Inuit are not Indians, Stewart noted the Encyclopedia Britannica published in 1842, "describing it as a 'standard reference work' available to legislators in 1867, when the Constitution was enacted. The entry on' Esquimaux' defined the Inuit as 'a people of North America, inhabiting the vast tract of land known by the name of Labrador" (Backhouse, 1999). In asserting that all well-informed sources differentiated between 'Indian' and 'Eskimo' as these terms gave rise to clearly diverse descriptions, Stewart extensively cited memoirs, diaries, and journals composed between 1733 and 1861 by explorers, traders, and missionaries (Backhouse, 1999). Historic events in which the terms Indians and savages were used in reference to Inuit people were noted by August Desilets (Backhouse, 1999)

the attorney general of Quebec. In fact, Backhouse asserts that "Desilets was able to point to numerous occasions when the federal government's own census publications, annual reports of the Department of Indian Affairs and atlases issued by the Department of Interior included 'Eskimos' in tables and population graphs regarding Indians (p. 40, 1999). He was ready to argue that compared to other Indigenous Peoples, the Inuit differed in how they dressed, what they ate, hunting activities, the fuel they used and where they resided during the winter months (Backhouse, 1999). Desilets however agreed that it was obvious that the Inuit and Indians were alike when it comes to key features of their existence (Backhouse, 1999).

The Supreme Court's Conclusions

In coming to a decision, the Supreme Court did not cite any of the anthropological sources presented. Instead, the judges drew from sources prior to Confederation with the idea that they should base their decision on the thoughts and opinions of those who partook in drafting the works which led to the BNA Act (Backhouse, 1999). The judges concluded that "these two Fathers of Confederation always understood that the English word 'Indians' was to be constructed and translated as 'sauvages' which admittedly did include all the aborigines living within the territories in North America under British authority, whether Imperial, Colonial, or subject to the administrative powers of the Hudson Bay Company" (Backhouse, p.53, 1999). The judges all in all avoided being trapped in having to deal with an array of variables utilized in the past in efforts to legally classify race (Backhouse, 1999). This is affirmed as Backhouse asserts "perhaps wisely,

the Supreme Court made no attempt to sort through this profuse and rambling list of variables, or to offer guidance on matters of racial designation for the future. It simply declared that, as a matter of Canadian constitutional law, the Inuit were 'Indians' because the framers of the British North American Act had regarded them as such" (p.53, 1999).

Administration: the Department of Northern Affairs and National Resources

Government intervention in the Arctic was fixed on national resources and neglected the Inuit whose status within Canada was uncertain. The Inuit were being administered under the 1924 Indian Act despite not signing any treaties with Canada (Mitchell, 1996). As discussed above, in 1939, the Supreme Court of Canada ruled that the Inuit were Indians following an extensive dispute concerning their status to determine if they were under the Indian Act (Mitchell, 1996). Mitchell (1996) makes reference to Morrison (254, 1986) who contends that given that yearly and semi-annual police patrols were the only means of contact between the Inuit and the government made the matter controversial. The Department of Northern Affairs and National Resources extended social services to the Arctic while resource development remained their central focus (Mitchell, 1996). Canada's interest in the North also included changes in health care as medical professionals tested for TB which led to the mass evacuation of Inuit people to Hospitals in the south (Grygier, 1994; Mitchell, 1996; Selway, 2016). This measure took place without their consent (Grygier, 1994; Selway, 2016). The Cold War until the mid-1960s served as a reason for evacuating Inuit people in efforts to enforce sovereignty over the Arctic (Tester & Kulchyski, 1994). They were forcefully evacuated to sanatoriums

without proper documentation of their name, kinship groups or community and this not only alienated families but made it sometimes impossible to reconnect (Tester & Kulchyski, 1994).

The traditional subsistence economy had been replaced by the late 1950s and the Inuit and their day to day activities became concentrated near trading posts and operations (Mitchell, 1996). The means of production changed considerably as the work carried out by the Inuit consisted of trapping to sell animal skin, supplemented with subsistence hunting with increasing dependence on industrialized tools and seasonal wage labour (Mitchell, 1996). For the Inuit, power over the economy was nonexistent and they could no longer meet their needs with their own resources (Mitchell, 1996). Capitalism took over as practices informed by the dominant ideas among the Inuit moved into hiding (Mitchell, 1996). On the political front, a new tribal identity took shape as Inuit and their extended family members were merged into synthetic communities (Mitchell, 1996). New relations seeped into indigenous means of production and the stability of practices preceding contact and those taken on with the introduction of Western capitalism, were transformed significantly that they could no longer be revisited (Mitchell, 1996).

Canadian Medical History

On the health front, in the early 1800s little attention was given to what we now call public health. Healthcare at that time in Canada consisted of self-treatment or occasional visits from a doctor. In the late 1800s, epidemics were spoken of as "visitations of providence and punishment for sin" (Wherrett, p.3, 1977). In fact little

thought was given to disease prevention. Until the 1860s, Canada was an extensive reserve of natural resources with primary industries such as fishing, lumbering and wheat-growing (Wherret, 1977). In efforts to protect itself from the U.S as well as measure up to it, Canada undertook an expansion project and ensured that immigration became a significantly easier process (Wherret, 1977). But Canada soon found itself with a slum problem as knowledge of disease was poor, growth in urban centers was rapid and there weren't enough jobs to sustain its growing population (Wherrett, 1977). There was great confusion as to how to approach health matters. A little over a decade later in 1873, the Public Health Act of Ontario was passed. Echoing the confusion and poor knowledge of disease, Sir Oliver Mowat in response to the act, stated "we have passed the legislation, but have little knowledge of just what there is to do" (Wherrett, p.5, 1977).

As industrialism increased, the linkage between filth and disease became clear. Canada's medical tradition at the time continued to rely on practitioners who dealt with individual cases. With the influence of the United States and Britain, physicians later made a shift from cure to prevention. Hospitals emerged as doctors attended to a higher number of patients. In 1877, the Canadian Medical Association announced that both provincial and local boards ought to be formed (Wherrett, 1977). As a means to set in motion health research on the causes of death, doctors sought out statistics. In 1879, registrars encountered resistance from the public as disclosing one's illness caused social stigma given the conceptions of illness at the time as it was associated with punishment resulting from sin (Wherrett, 1977). Following the announcement of provincial and local boards, it was not surprising then that the 1880s and 1890s became a time for the passing

of public health acts, the establishment of boards across the country and health education campaigns (Wherrett, 1977). Simultaneously, provincial and federal governments were scrambling over jurisdiction and responsibilities concerning health care.

The rate of TB among Indigenous Peoples, served as an additional stimulus to the crusade. The linkages between the inequalities stemming from colonialism and the illness, violence and high mortality rates of Indigenous People in Canada, has been noted in historical research (Kulmann & Richmond, 2011; Moller, 2010; NCCAH, 2009). In this highly racialized time there was immense fear that Indigenous Peoples could infect white settlements. In fact, the provision of health care for Aboriginal People later became a reality in the federal government's effort to control the spread of disease to settler-Canadians (Jacklin & Warry, 2004). Even though hard statistics were nonexistent at the time (there were no federal or provincial departments of health or statistics), there was a general understanding in Canada, that tuberculosis was the top killer. Although smallpox, measles, typhus and cholera did present problems in Canada, they were relatively less problematic at the time. As a result, it became the centre of many conversations and stirred "campaigns against bad living and working conditions" (Wherrett, p.10, 1977). Dr. Peter Bryce, known as a key player in the public health movement, was well aware of the extent of TB among Indigenous peoples of Ontario, even pointing to the significant role residential schools played in nurturing TB (Wherret, 1997). He endeavoured to improve sanitary conditions on reserves as well as compiled statistics and annual reports. This marked a change in approach to "Indian" medical services. Although the BNA Act relegated health as a provincial responsibility, the health of Indigenous Peoples was and

has remained a federal matter. The provision of health services was however never fully recognized by the government as its responsibility. Rather, the government assumed that Indigenous Peoples would and could eventually provide their own medical services (Wherret, 1997). In the 19th century, European explorers exposed the Inuit to TB but the Canadian government responded several decades later after thousands of Inuit had died and numerous reports had been filed (Grygier, 1994; Tester & Kulchyski, 1994, Moller, 2010). The perception that Inuit people would and could fend for themselves, continued until medical services were paid for by the provinces, and the emergence of hospitals and medical programs. It then became an issue of integrating provincial services with services for the Inuit and determining the means to finance them (Wherrett, 1977).

A complete lack of appreciation for the medical needs of Indigenous Peoples was apparent in the newly established Department of Mines and Resources in 1936. Those able to observe the period in which "Indian" medical services were being developed, felt that the grave deficiency was recognized and concrete efforts were made to correct the changes only after they became a division of the Department of National Health and Welfare in 1945 despite changes in the policy (Wherrett, 1977). Up until this point, disease prevention was taken very lightly as a government policy for those legally defined as Indians. In comparison to the time when Indian Affairs was a free standing federal government department, there appeared to be less interest under this new organization (Wherrett, 1977).

During Confederation in 1867, recurring epidemics of which tuberculosis was the top killer were key problems of public health. For the purposes of dealing with these matters, health boards at the provincial and local level were established (Wherrett, 1977). In 1896 the start of coordinated efforts to address tuberculosis took place in Ontario with the founding of the National Sanatorium Association (Wilson, 2006). It was founded by Sir William Gage with the intention of building sanatoria for the treatment of tuberculosis (Wilson, 2006). The Muskoka Cottage Hospital was its earliest sanatorium and symbol of progress given that prior to its establishment, TB patients had to seek treatment outside of Canada (Wilson, 2006). In the following years, came the establishment of two organizations - the Toronto Association for the Prevention of Consumption and Other Forms of Tuberculosis in 1898, and the Ontario Association for the Prevention of Consumption and Other forms of Tuberculosis in 1900 (Wherrett, 1977). It soon became evident that the fight against TB would require movements at a national level.

Conclusion

The lack of appreciation for Indigenous health concerns and the federal and provincial scramble over healthcare jurisdiction and responsibilities is a matter that cannot be disconnected from conceptions of race and Canada's claims to sovereignty. The Inuit are among those severely hit by TB for reasons of which include the interference of communities of interest, namely; the early traders and explorers, whalers, fur traders such as The Hudson's Bay Company, and later the RCMP, missionaries, doctors, and scientists. Certain factors in the Inuit community (i.e. increasing trade, the relocation of

certain Indigenous tribes, and the ambiguous stance the federal government had towards these communities) demonstrate exactly why the reduction of explaining the TB epidemic in light of pure biomedical causes, misses the mark on the social and living conditions that produced various health problems. All of these crossroads are forgotten and medical problems are often understood in a way that is divorced from the social and living conditions that have produced it. The emergence of the SDOH research has contributed to a broader understanding of health and more equitable measures.

CHAPTER 2: SOCIAL DETERMINANTS OF HEALTH: A LITERATURE REVIEW

The sociology of medicine investigates social factors as determinants of health and wellbeing (Frankel, Speechley & Wade, 1996). Popular discussion within the sociology of medicine concerns the social determinants of health approach (SDOH). According to Raphael (2006), "the concept of the social determinants of health has become the current shorthand for describing health approaches that move beyond biomedical and behavioral risk factor approaches to health promotion" (p.662-663). He argues that the notion that significant linkages can be drawn between social factors and health is not original and cites Rudolf Virchow and Friedrich Engels. Virchow and Engels noted social, economic, and political elements that not only served as threats to health and wellbeing but contributors to disease and untimely death (Raphael, 2006). Raphael asserts that there have been extensive efforts by sociologists and social epidemiologists within the historical materialist tradition to shed light on the ways in which different modes of production, more than ever in capitalist societies, persuade the allocation of political, economic, and social resources and in turn impact health outcomes (2006). In spite of the fact that the historical materialist tradition prevails, "these analyses concerning the structural determinants of health – and their most recent expressions – remain outside the mainstream of current discourse on determinants of health among policymakers and health researchers in North America and in other nations" (Raphael, p. 652, 2006).

The SDOH approach to public health, research, and the development of public policy in North America continues to be secondary to long-established paradigms

oriented in biomedical and behavioral components of health (Raphael, 2006; WHO, 2008). Historically, matters regarding health and disease were strictly relegated to the health sector as the sole responsibility of medical professionals (Illich, 1977; WHO, 2008). More recently, people are noting the importance of acknowledging that health concerns and how they are treated should entail responsibility beyond the health sector. In the previous twenty years, efforts have been reinvested in looking beyond medical and behavioral contributors to health and disease at the international level (Braveman, Egerter & Williams, 2011; Raphael, 2006). Social determinants of health as a term emerged with the pursuit to identify the particular means by which different levels of health and sickness are endured by people of noticeably different socioeconomic status (Raphael, 2006). The acknowledgement of differences in population health nationally, served as another incentive to explore SDOH (Raphael, 2006).

The Commission on Social Determinants of Health was tasked with collecting health data concerning the implications of the SDOH and health equity on which to take action (WHO, 2008). The World Health Organization (2008) maintains that there is nothing inherent in the asymmetrical allocation of health-threatening experiences as they are an outcome of weak policies and social programmes, paired with an unjustly structured economy and poor governance. Interest in the structure and allocation of social and economic resources are a common thread across the scope of approaches to SDOH (Raphael, 2006). According to Evans, Barer and Marmor (1994), The Canadian Institute of Advanced Research identified a range of health determinants including “income and social status, social support networks, education, employment and working conditions,

physical and social environments, biology and genetic endowment, personal health practices and coping skills, healthy child development, and health services" (Raphael, p.653, 2006). In addition, the efforts of The Canadian Institute of Advanced Research, a working group in Britain and the U.S Centers for Disease Control culminated in their identification of several SDOH, namely "Aboriginal status, early life, education, employment and working conditions, food security, health care services, housing, income and its distribution, social safety net, social exclusion, and unemployment and employment security" (Raphael, p.653, 2006). These SDOH have also been identified by various institutions including the Commission on Social Determinants of Health through the World Health Organization.

Evidence on the Social Determinants of Health

The weight and significance of several social determinants of health, is supported by sizeable data. Overall progress in the health of people in developed countries in the past century, variations in health among groups within nations, and health variations of populations across developed countries, are explained by these determinants (Raphael, 2006). A significant body of evidence also ties every SDOH to particular changes in health status, with some examples being arthritis, the likelihood of heart disease, diabetes and psychological illness (Raphael, 2006).

Health Disparities and Primary Determinants

Pronounced health disparities between residents of developed countries persist although there have been remarkable advancements in health overall. Differences in

health are accounted for by the relationship between social determinants of health and residing in places relatively diverse in quality (Raphael, 2006). A very significant determinant is socioeconomic status given that it is an indicator of encounters with multiple SDOH (Raphael, 2006; WHO, 2008). Four decades of medical sociology has uncovered numerous examples of the social patterns of disease with the most obvious being the strong association between health and socioeconomic status (Link & Phelan, 1995). Health and disease fall along a social hierarchy with lower socioeconomic status resulting in relatively poorer health (WHO, 2008). In fact, the quality of early life, food security, education, income, wage-labour and its conditions are determined by socioeconomic status (Raphael, 2006). Also shaped by socioeconomic status are one's housing conditions, joblessness and precarious work, whether one requires a social safety net, and whether one has endured social exclusion across their lifespan (Raphael, 2006). As a demonstration of the significance of socioeconomic status, "Statistics Canada examined the predictors of life expectancy, disability-free life expectancy, and the presence of fair or poor health among residents of 136 regions across Canada. The health predictors included sociodemographic factors (percentage Aboriginal population, percentage visible minority population, unemployment rate, population size, percentage of population aged 65 or over, average income, and average number of years of schooling)" (Raphael, p.655-656, 2006). How often one smokes and engages in physical activity, obesity, heavy alcohol consumption, high levels of stress and depression were among other predictors (Raphael, 2006). Sociodemographic elements were effective in

estimating health status (Raphael, 2006). These findings challenge the preoccupation with biomedical and behavioural risk factors inherent in traditional approaches to medicine.

Themes in Social Determinants of Health Research

Themes that have emerged in the work on social determinants of health "concern explanatory frameworks, life-course perspectives, the role of public policy, and barriers to implementation of health determinants-related public policy" (Raphael, p.656, 2006). The materialist, neomaterialist and psychosocial approaches are explanatory frameworks that have become central (Raphael, 2006). These approaches are applicable in explaining the role of income disparity and the significance of other SDOH (Raphael, 2006). How the HHA and The Spectator understood the problems and solutions to TB is divorced from these explanatory frameworks and life-course perspectives. Their failure to draw from Indigenous conceptions of health also speak to a continuous failure to generate and implement Inuit and patient-centered health policies.

The materialist approach concerns the role that material wealth may play in health. It is specifically concerned with living conditions as health determinants. Over the course of their lives, people are exposed to a range of harmful as well as favourable circumstances that mount up and engender adult health outcomes (Raphael, 2006). From this perspective, the deplorable living conditions Indigenous People endure, account for their disportionately higher rates of illness (TRC, 2015). Socioeconomic status is dominant in forecasting health status within nations given that it is an indicator of material gain and hardship over one's lifetime (Raphael, 2006). Raphael makes reference

to Keating and Hertzman (1999) in asserting "material conditions predict likelihood of physical (infections, malnutrition, chronic disease and injuries), developmental (delayed or impaired cognitive, personality, and social development), educational (learning disabilities, poor learning, early school leaving), and social (socialization, preparation for work and family life) problems" (p.657, 2006). The Commission on Social Determinants of Health make reference to Kivimaki et al., (2003) who assert that evidence demonstrates that mortality is considerably higher for those with precarious employment when compared to employees who have secured permanent work. After accommodating for different variables, many researchers have seen the effects that income or wealth has on health (Braveman, Egerter & Williams, 2011; Daly et al., 2002; Kawachi, Adler & Dow, 2010; Larson & Halfon, 2009). Material conditions are linked to behaviours that impact health given that people experiencing material scarcity and stress tend to resort to risky and health-threatening behaviours (Braveman, Egerter & Williams, 2011; King, Smith & Gracey, 2009; Raphael, 2006). King, Smith and Gracey (2009) discuss addictive behaviour as a way to self-medicate often in response to a multitude of stressors. They assert that "for many Indigenous people, there are many layers of stressors – racism, poverty, poor education, unemployment, family instability, and residential instability" (King, Smith & Gracey, p.79, 2009). Braveman, Egerter and Williams, go more in-depth in discussing racism as a social determinant of health through chronic stress tied to experiences of racial discrimination (2011). Race is a significant factor given its ties to socioeconomic status as racialized minorities tend to have a lower socioeconomic status than white Canadians, with some exceptions.

The neomaterialist approach is concerned with living conditions and social infrastructure as health determinants. The allocation of resources within the general public plays a role in the health discrepancies between cities, regions and countries (Raphael, 2006). The neomaterialist perspective is mainly concerned with communal forces that establish the nature of different SDOH and the health consequences of the circumstances in which people live (Raphael, 2006). The way in which societies allocate their resources plays a considerable role in the nature of different SDOH (Raphael, 2006). The Commission on Social Determinants of Health discuss urban planning and environmental effects on health. They maintain that "communities and neighbourhoods that ensure access to basic goods, that are socially cohesive, that are designed to promote good physical and psychological well-being and that are protective of the natural environment are essential for health equity" (WHO, p.4, 2008). They argue that health equity between rural and urban areas can be nurtured through persistent investments in rural development, challenging discriminatory policies and actions that result in rural poverty, displacement and landlessness (WHO, 2008).

Social stratification and social distance are seen as health determinants in the psychological comparison approach. The way in which individuals interpret their social standing within the hierarchy is argued to significantly sway their health disparities (Braveman, Egerter & Williams, 2011; Raphael, 2006). This is argued to take place at the individual and community level. At the personal level, anxiety and ill health result from the view and experience of one's standing in communities ravaged by inequality (Raphael, 2006). Social cohesion deteriorates at the societal level as social stratification is

extended and reinforced (Raphael, 2006). The endorsement of community-oriented establishments such as social services and public health and education is undermined when people grow sceptical and lose trust in each other (Raphael, 2006). Scholars have noted the significance of social relationships and social support, even identifying it as a health determinant (Braveman, Egerter & Williams, 2011; Richmond, 2009; WHO, 2008). The linkages between mutual trust among residents and lower murder rates have been discussed (Braveman, Egerter & Williams, 2011; Morenoff, Sampson & Raudenbush, 2001; Sampson, Raudenbush & Earls, 1997). Richmond (2009) discusses friendships, intimacy, and supportive social networks as strong predictors of health. She argues that "while many authors have described the significance and importance of social networks (6, 27), social support (26), kinship (28) and family/community social structures in the daily lives of Inuit people (29-31), few authors have framed social support as a determinant of Inuit health (32, 33)" (Richmond, p.475, 2009). The numbers within this quote refer to references within Richmond's original text. A variable that further reinforces the significance of supportive social networks in health is inclusion. The Commission on Social Determinants of Health contends that "the material, psychosocial, and political empowerment that underpins social wellbeing and equitable health" necessitates that people feel included in society (WHO, p.18, 2008). The psychosocial consequences of public policies which undermine SDOH are the focus of the psychological comparison approach (Raphael, 2006). The work in social determinants of health lacks conversation on the role of class and its significance in capitalist societies (Raphael, 2006). The SDOH literature identifies the most important determinants as

social status, income, and socioeconomic ranking and this depoliticizes a great deal of conversations regarding social hierarchy (Raphael, 2006). This is relevant given that the HHA and The Spectator's understanding and presentation of TB as it concerns Inuit People depoliticized it by divorcing it from Canada's colonial legacy.

The Life-Course Approach

Overcoming biomedical measures of risk and behaviours that threaten health has been highlighted by traditional approaches to health and illness (Raphael, 2006). Unlike traditional strategies, the life-course perspective is concerned with the accumulation of experiences during one's lifetime and the effect it has on health (Raphael, 2006). "Latent effects, pathway effects and cumulative effects" are health effects applicable to the life-course perspective that has been outlined by Hertzman (Raphael, 2006). The relevance of these effects is that they account for the various settler-colonial activities that Indigenous People have endured over the course of Canadian history and continue to endure which have engendered their alarming rates of T.B. Latent effects consist of biological and developmental components given that experiences in the early stages of life work to sway health status later on (Raphael, 2006; WHO, 2008). Pathway effects however are "experiences that set individuals onto trajectories that influence health, wellbeing, and competence over the life course. As one example, children who enter school with delayed vocabulary are set upon a path that leads to lower educational expectations, poor employment prospects, and greater likelihood of illness and disease across the life span" (Raphael, p.659, 2006). Braveman, Egerter and Williams also assert "among the strongest

bodies of SDOH evidence is work considering adverse health effects of early childhood experiences associated with family social disadvantage" (p.388, 2011). Researchers have found that children's cognitive, physical, and behavioural development is affected by experiences early in life that can be used to foresee health status later in life (Bradley & Corwyn, 2002; Cohen, Janicki-Deverts, Chen & Matthews, 2010; Hertzman, 1999; Phillips & Shonkoff, 2000). Differences in the quality of children's home environments, which are tied to socioeconomic status, help to account for developmental variations (Bradley & Corwyn, 2002; Evans, 2004; Guo & Harris, 2000; Votruba-Drzal, 2003; WHO, 2008). The buildup of favourable and unfavourable experiences in life that in a span of time is revealed in ill health is representative of cumulative effects (Braveman, Egerter & Williams, 2011; Raphael, 2006; WHO, 2008). The life-course perspective focuses on the ways in which SDOH operate at all stages, from early childhood to adulthood, to shape health and create a foundation for health or disease later in life (Raphael, 2006). Evidence supporting the impact of cumulative effects on health later in life is indisputable (Raphael, 2006).

Knowledge Gaps and Action

The biomedical model as an approach entails the separation, examination, and treatment of disease as single components existing in isolation from other forms of disease (La Valle, 2014) and splits individuals from their community and social ties (Shah, 2003). Link & Phelan (1995) assert that our propensity to concentrate on the linkage of "social conditions to single disease via single mechanisms at single points"

over time forsakes the intricacy and fluidity of the course of action by which social variables may shape health and this in turn may lead to an incomprehensive understanding and assessment of the role social variables play in health (p.81). Risk factors that are relatively proximate causes of disease such as diet, cholesterol level, exercise and the like has been the focus of this research (Link & Phelan, 1995). Link and Phelan make reference to Becker (1993) who maintains "this focus on proximate risk factors, potentially controllable at the individual level, resonates with the value and belief systems of western culture that emphasize both the ability of the individual to control his or her personal fate and the importance of doing so" (p.80, 1995). Focusing on proximate risk factors thus dismisses the relationship between health and political, economic, and social structures.

In North America, the central public health strategies employ an individualistic outlook rooted in long-established biomedical and epidemiological practices which clash with the understanding of health and health determinants through a structural approach that looks at its relationship to larger systems and structures (Raphael, 2006). This explains why policymaking and the discussion of public health efforts lack concepts of SDOH (Raphael, 2006). Individualist outlooks go hand in hand with approaches to neoliberalism in Canada, the United States, and other developed countries. In these nations, "the emphasis on the market as the arbiter of societal functioning conflicts with a social determinants of health approach that requires commitment to equitable income distribution, support of public social infrastructure that provides adequate housing, food

security, and strong public health and social services" (Raphael, p.660, 2006). David Coburn (2004) makes a similar argument in *Beyond the Income Inequality Hypothesis*.

Contrary to western conceptions of health, Indigenous Peoples see health as a communal matter encompassing the health of the entire community and the natural environment they inhabit (Gabel, 2012; Stephens et al., 2005). For Indigenous Peoples, wellbeing transcends physical health or the absence of disease as their definition is relatively broad (King, Smith & Gracey, 2009; Lavoie et al. 2008). Good health from an indigenous standpoint occurs when the body, mind, spirit, and emotions are in equilibrium and harmony (Gabel, 2012). It comes as no surprise then that their pluralistic, holistic and communal view is translated in their approaches to health and disease as they make use of both traditional and allopathic medicine (Stephens et al., 2005). With good health there is a recognition that every individual is connected to, contributes to, and is dependent on the family, community and the land (Lavoie et al. 2008). While the medicine wheel is not an Inuit symbol, Inuit and other Indigenous communities have embraced it. All life forces are represented in the medicine wheel as the physical, mental, emotional and spiritual which work to sustain health (King, Smith & Gracey, 2009). Among Indigenous Peoples, there are variations in terms of how they understand health and their usage of symbols. The medicine wheel captures the essence of health as a phenomenon transcending the biomedical. For Indigenous Peoples balance transcends the individual for the reason that being at peace with those around you, your community as well as the spirit world is essential to health and healing (King, Smith & Gracey, 2009). It is thus not a revelation that healthcare institutions fail to provide services that embrace

Indigenous perspectives on health and that are appropriate for their needs (Gabel, 2012; Stephens et al., 2005).

Conclusions and Concerns

Epidemiological Perspectives

"Cholesterol and glucose levels, weight, tobacco and alcohol use, diet, and sedentary behaviour" are examples of "individual biomedical and behavioural risk factors" affiliated with illness that have been the focal point of long-established approaches (Raphael, p.661, 2006). In extending their work to incorporate the physical environment, social conditions, and the political climate that conditions are produced and maintained, social epidemiologists have assisted remarkably in understanding the function of SDOH (Raphael, 2006). How societal arrangements regulate SDOH and its connection with health status is the concern of structural approaches which include horizontal and vertical structures (Raphael, 2006). Horizontal structures are the more pressing factors by which health and wellbeing are created and they include "the quality of childhood and family environments, the nature of work and workplace conditions, the quality and availability of housing, and the availability of resources for food, recreation, and education" (Raphael, p.661, 2006). Horizontal structures have been the focal point of work in SDOH (Raphael, 2006). Vertical structures however are the macrolevel concerns in which health and wellbeing are created and they incorporate social, economic, and political forces that to a large degree establish the nature of horizontal structures

(Raphael, 2006). Scholars (Braveman, Egerter and Williams, 2011; Stephens et al., 2005) have discussed these structures using the terms upstream and downstream determinants.

Sociological Perspectives

Stress and its health outcomes have been the focal point of many medical sociologists, particularly in the United States rather than structural matters linked to resource allocation (Raphael, 2006). Other medical sociologists have responded delicately to matters of knowledge construction and the research questions identified and explored (Raphael, 2006). Within sociological perspectives, great emphasis is placed on understanding and appreciating how health and health determinants are devised and the reactions they generate as well as acknowledging that reality even as it concerns health is socially constructed (Frankel, Speechley & Wade, 1996; Raphael, 2006). Acknowledging social construction and its role enables one to ask "why is it that the social determinants of health are not the primary understandings held by the public, health workers, and government policymakers? It has been pointed out that the "holy trinity of risk" of tobacco, diet, and physical activity receives the predominant share of attention by public health workers and government policymakers, though the evidence concerning the importance of these factors is contested (Nettleton, 1997)" (Raphael, p.663, 2006). The conversation on health determinants rooted in the society becomes challenging for health professionals and researchers, policymakers, and the general population that have to comprehend its ideas when the political economy in which one resides, gives special importance to individualism and individualizes health threats (Raphael, 2006). Raphael

maintains that it is important to ask who gains an advantage when professionals and the general public subscribe to particular conceptions of health determinants in societies where the powerful and affluent have a strong say in public policy issues (2006). The provision of equitable income, family-oriented labour and employment policies, social welfare and how healthcare and social programs among other resources are allocated within populations, is significantly influenced by public policy (Raphael, 2006). Despite this reality, many researchers concerned with population health have abandoned the function of public policy in establishing the nature of different SDOH (Raphael, 2006).

Limitations and Suggestions for Future Research

Raphael (2006) maintains that failing to bear in mind *"a master conceptual scheme"* that highlights the social, economic, and political mechanisms that construct the quality of SDOH is a limitation of SDOH research. Some of the work in this area thereby lacks a critical lens. In referring to North America, Raphael (2006) contends "most public health jurisdictions remains limited to health education approaches to behaviour change, with a grudging recognition based on work in functional sociology and community psychology – that risk behaviours are themselves socially determined" (p.654).

The evidence base on health inequity, the SDOH, and what works to improve them needs further strengthening. Unfortunately, most health research funding remains overwhelmingly biomedically focused (Braveman, Egerter & Williams, 2011; Raphael, 2006; WHO, 2008). Another obstacle is the tendency to support research centered on single diseases which is highlighted in Braveman, Egerter and William's assertion "most

U.S. research funding supports studies of single diseases rather than causal or contributory factors with effects that manifest across multiple diseases, putting SDOH research at a disadvantage" (p.390, 2011). There is also a consistent need for health research on the life-course "including longitudinal studies to build public-use databases with comprehensive information on both social factors and health" gathered in a period of time where generations can be included so as to enable researchers to identify the health outcomes of early childhood experiences (Braveman, Egerter & Williams, p.390, 2010). Braveman, Egerter and Williams maintain that although there are considerable exceptions, little is known about how to successfully tackle social factors in order to improve health and lessen health inequalities, particularly "when, where and how" intervention should take place (p.389, 2011). Inquiry is needed on the pathway from SDOH to recovery from disease (Raphael, 2006). Research that directs translation of the current data on SDOH into policies that can be effectively implemented is vital (Braveman, Egerter & Williams, 2011). In addition to evidence, political will and capacity building is also fundamental as it is often the barrier to facilitating policy decisions and implementation (Braveman, Egerter & Williams, 2011; WHO, 2008). Implementation of recommendations sprouting from the SDOH research necessitates facilitating competence among practitioners which encompasses integrating training of the social determinants of health within the curricula of health and health practitioners (WHO, p.20, 2008). The bigger question is whether this is a matter of competence or political will and resistance.

CHAPTER 3: METHODOLOGY

This research was conducted using archival data from the Health Science Library at McMaster University. The archives consist of annual reports compiled by the Hamilton Health Association (HHA) from 1953-1963. An annual report is a comprehensive account of an institution's affairs throughout the previous year. They are written to provide stakeholders, media, the general public and other interested parties information concerning an institution's activities and more importantly their performance. The HHA's annual reports provide accounts of its activities and performance to interested parties.

Also contained within the archives are newspaper articles of various activities relating to TB treatment and the Sanatorium. These articles were collected by the HHA. Newspaper articles serve a slightly different objective than annual reports. Unlike annual reports compiled by various staff members of an institution, newspaper articles are written by journalists adhering to strict guidelines and usually for a relatively larger readership. They are also written to inform, explain, engage and entertain. Generally, they feature stories that represent the perspective of its management and its editors.

Identifying Themes

The initial step consisted of simply reading through the annual reports and newspaper articles. Secondly, it consisted of re-reading and underlining key phrases, slogans, descriptions, characterizations, unusual and common terminology, and emphasis of certain responses, terms and ideas relevant or potentially relevant to the overarching research question. That is, how did personnel at the HHA, and The Spectator understand

the problems and solutions to the tuberculosis epidemic? Attention was also directed to any discussions relevant to the biomedical model and SDOH. Careful attention was paid to discussions concerning the nature of TB, its problems and potential solutions, new developments in TB-related research, and characterizations of and responses to people with tuberculosis, particularly the Inuit.

In identifying themes latent coding was utilized. The presence and strength of a theme was determined by how often it occurred throughout the archives. Repetitions were sought among other theme indicators. The question of how many repetitions constitute an important theme was determined by whether the theme was evident throughout single or multiple archives. Various themes in the documents were identified by taking note of expressions in the data. Attention was directed at how often themes appeared and how widespread it was across different cultural ideas and practices.

In identifying themes, linguistic connectors were sought with careful attention to terms and phrases indicating causation, conditional relations and time-based relationships. Features, operational definitions, comparisons, functions, exemplifications, contingencies, circularity, typologies, and origins were also sought. Another technique employed included noting any similarities and differences between statements. Expressions from the same and different informants were examined to see how one expression was different from or similar to others. When particular themes were present in the expressions, any differences in degree or kind in which the theme was articulated were examined. Strong themes led to investigating whether subthemes could also be identified.

Themes were identified by looking to see what was missing. A lot can be drawn from data by looking for what is not mentioned and directing one's attention to concerns that have been avoided, whether deliberately or not. For instance the newspaper articles and annual reports generally lacked reference to or discussion of the SDOH.

Themes were also identified by looking for the use of case studies or personal profiles to tell stories and the use of active voices such as that of service users, staff members, investors, sponsors and volunteers. The Inuit did not have an active voice throughout the archives. While themes were identified in both data sets, not all techniques were used to the same degree for both archives given their objectives and functions.

Annual Reports

The annual reports were organized in a manner that reflected the set up and mission of the HHA. They discussed their programs and accomplishments in terms of their service to TB patients. The annual reports promote the work of the HHA – highlighting its achievements, and providing financial and additional data. It is in consulting annual reports that one becomes acquainted with an institution's objectives, priorities, and challenges or at least how they intend to be received by stakeholders and other members of their intended audience. The reports consisted of between 15 to 28 pages and became increasingly longer as they included financial statements, photographs, and reports concerning their new additions – the Brow Infirmary, Chedoke and Children's Hospital, and the Hamilton District School of Nursing. The annual report for 1953 contained 16 pages while that of 1963 contained 28.

The HHA's annual reports served as a marketing tool. Use of explicit themes, such as combating TB as a historical milestone, was evident throughout the reports. The reports also placed a spotlight on the HHA's role in improving lives through advancements in research and the spirit of charity and volunteerism. In fact, the HHA and the Sanatorium functioned much like a charity insofar as they operated and attracted funds in the same way that charities do. Like charities, the Sanatorium relied on volunteerism, held gala events, sold products, held events and artistic performances and attracted publicity**.** Positive stories such as the gradual decline in bed occupancy and length of stay in the Sanatorium and key events in the HHA's history (i.e. new additions to buildings or drugs-resistance) were included. In fact they are interspersed throughout the report which helped to increase its readership and draw new investors and interested parties. As a marketing tool, attention to the layout and design of the reports was taken into consideration. Interestingly, all the reports concluded with a persuasive advertisement and call to active membership. In detail, these advertisements describe the types of memberships available, the corresponding privileges, and include a membership application. There were three types of membership: associate, active and sustaining. Membership fees were $5.00, $10.00 and $50.00 respectively. All members were given access to all reports and admission to general meetings. Active membership unlike associate membership included voting privileges and was presented as an opportunity to "take an active and helpful part in the campaign against tuberculosis." Sustaining membership also included voting privileges and was presented as "an opportunity to help the San in a substantial way." The HHA was in fact actively selling membership as they

designated a significant number of pages to acknowledge members and included instructions on how and where to forward membership fees. A considerable number of pages in each report were allocated to membership and the acknowledgement of organizations working with the Sanatorium. These marketing efforts among others were examined in developing themes.

The annual reports highlighted the HHA's achievements. In addition, it outlined its mission and history. While financial accomplishments were included, other accomplishments are also noted, such as new developments in the prevention and treatment of TB, honors awarded to departments within the HHA, and funds accumulated from the Christmas Seal Campaign. Discussions of developments also contained data regarding the completion of new buildings and the introduction of new services and technologies to increase efficiency. The principal objective of sharing their achievements, one would deduce, was to convince shareholders and stakeholders that they made worthwhile investments and more importantly to secure their ongoing support.

Although not all the annual reports included a financial report, they generally discussed finances. They provided a breakdown of finances on the HHA's fiscal year. This breakdown consisted of a balance sheet that included: an income statement; a summation of finances; a statement of cash flows; and a financial note. Within the financial notes, accounting techniques used to record the HHA's transactions were explained. The HHA's balance sheet disclosed its allocation of funds to various operations and its assets and liabilities. The balance sheet could have been instrumental in

convincing contributors that they have made great investments as it disclosed how the HHA spent their money. This transparency could have also helped them in earning the trust of their partners and the general public.

The annual reports also introduced the HHA's board of directors and key personnel to the general public and in some reports, their photographs were included. These images served to reinforce the credibility of the organization and its stewardship. The annual reports began with an address from the HHA's president followed by its medical superintendent. The president and medical superintendent's address discussed campaigns, developments in TB research, and information concerning the HHA's challenges and plans for the future. These are among the HHA's highest members tasked with administration of the institution and their letters set the tone for the reports. In fact significant themes have been identified within their letters as it concerns their perceived challenges and potential solutions to the TB epidemic.

In observing evidence of promotional messages, including highlighting of achievements and discussion of finances and additional information, I first began with scanning through the table of contents as the items listed speak to the priorities of the HHA. The number of pages allocated to given topics and concerns were noted. For instance, much attention was given to administration and logistical matters, biomedically-oriented concerns (e.g. chest clinics and patient statistics), funding and membership while discussion or reference to SDOH was almost absent. This absence is customary as it speaks to contradictions concerning the use and recognition of SDOH. While the

Sanatorium recognized SDOH with regards to their occupational therapy program, they disregarded it in their response to drug-resistance and other developments in TB prevention.

Structure of Document

The table of contents is generally comprised of: a list of officers and directors; birth and progress; address by the president; report of the medical superintendent; annual report of the Mountain Sanatorium; patient statistics; chest clinics; growth of the Christmas Seal Fund; special donations; organizations and individuals which carry on special work at the Mountain Sanatorium; organizations which provide entertainment for the patients; honorary life members; sustaining members; active members; and associate members. Depending on the year, some annual reports included additional content.

In analyzing officers and directors, I took note of the various levels of administration, types of professionals, and the number of professionals in each given specialty within the HHA. Their area of focus was also examined as this may help reveal the areas of service the HHA found important to include in their work. Given that the focus of this research is on the work conducted at the Sanatorium, more attention was directed on discussions pertaining to the Sanatorium and TB developments. Attention was directed on honorary consultants, senior staff, medical staff, surgical staff, anaesthetics and the director of diagnostic clinics. For the honorary consultants, I looked for the different areas of medicine in which doctors were allocated. There were doctors of medicine, surgery, radiology, dermatology, anaesthetics, dentistry, gynaecology and

otolaryngology. The senior staffs were comprised of: head of medicine; head of surgery; admissions and discharges; otolaryngology; director of laboratory; and a dentist. When one looks at the focus of biomedical models, one can see that focusing on these particular areas of medicine to the exclusion of others speaks not only to the authority of biomedical models but also to the HHA's reliance on them.

In reading the president's address, I looked for discussions of priorities, developments in TB research and responses, references to SDOH and biomedical approaches, and perceptions of Inuit people. Biomedical or social definitions, descriptions or explanations of tuberculosis were also examined. In scanning the annual report of the Mountain Sanatorium – a component within the annual reports of the HHA– I looked for how TB was characterized, understood, and approached and whether any problems and/or solutions were identified. Use of the term "problem," "solution" and terms that imply or connote a problem or solution were noted. Careful attention was also paid to the context in which such terminology was used.

Statistics were presented with regards to the number of patients admitted for each given year, the condition of patients, age groups, patients discharged, conditions of patients during their discharge, TB mortality rates, and chest clinics as it concerned the number of examinations, new active cases, x-ray films taken and tuberculin tests conducted. The statistics were divided along gender and age. The Sanatorium took note of different types of TB and their stages, births in the Sanatorium, suspected cases of TB, cases with no evidence of TB and those transferred for treatment.

Contributions to the Christmas Seal Fund were also examined to see if there was anything unique in the types of establishments that contributed. For instance, since law enforcement agencies were heavily involved in the x-ray screening campaigns and the evacuation of Indigenous People to sanatoria in southern Canada (Grygier, 1994), this helped to account for the annual membership contributions of the Hamilton Police Association.

With regards to the section on organizations and individuals carrying on special work at the Sanatorium and organizations which provide entertainment for patients, organizations listed, particularly communities of interest who played a significant role in the large-scale surveys conducted in the Arctic were noted. They include the church, law enforcement agencies (e.g. the RCMP) and medical personnel. Christian establishments, medical facilities, media institutions, and legal and governmental agencies carrying on work at the Sanatorium were also noted. Not only were these institutions fundamental in supporting and affirming the anti-TB campaign, they also played a significant role in legitimizing the existence of the HHA and the Sanatorium. Media outlets and Christian institutions among others provided entertainment, exposure and promotion.

Newspaper Articles

Structure of Documents

Newspaper articles are generally structured with the following components: headline, byline, lead paragraph, and supporting paragraphs. One of the ways that the newspaper articles discussed matters relating to TB and the Sanatorium was through the

use of storytelling. Themes were identified by looking at which stories were told, how they were told, and their frequency. Themes were identified by looking for who or what was made the focal point in the stories. The stories often included the voices of service users, volunteers, staff members, investors and partners among others. Their stories were presented in ways that demonstrated the impact of the HHA and the Sanatorium, particularly the positive difference they were making in people's lives. These were often accompanied by quotes and images. In the period between 1953 and 1963, there were 38 newspaper articles excluding advertisements and photographs. Newspaper articles were only available for 1955-56, 1958-60 and 1963 with the majority published in 1958 to 1960. On average four to ten paragraphs were devoted to coverage of the Sanatorium and Inuit patients. Articles that covered clinical research developments were front page stories and often consisted of several paragraphs covering two to three pages. Some articles discussing the return of Inuit patients to the Arctic also made front page stories with the remaining articles in other sections.

Annual Reports and Newspaper Articles

It is interesting how themes were presented within the annual reports and the newspaper articles. In some cases it was subtle and in others it is conspicuous. In the subtle cases, one had to read between the lines and around the sentences to extract the theme. As with the conspicuous cases, themes were expressed throughout and directly. Themes were expressed through the use of one, a few or multiple techniques. In addition to character profiles, the annual reports and newspaper articles made use of imagery that

projected the HHA as respectable. Members of the board of directors are shown to be personable and approachable and one could argue that this presentation was an attempt to appeal to investors and the public. In some cases personal profiles were also used to illustrate the impact of the Sanatorium on people's lives. In the annual reports and newspaper articles, communities, organizations and collectives exemplifying what the HHA and their anti-TB campaign stood for were identified and celebrated.

In the annual reports and the newspaper articles, the HHA got their message across by making use of media, marketing, storytelling and by making their message appealing, clear and convincing. Their message was appealing because it concerned a matter countless people were anxious about. The HHA also made TB a public matter and their message was clear as they focused on one major task - the eradication of TB They were direct and they did so by making use of memorable slogans and symbols that people understood. TB struck people of all walks of life and its fight was supported far and wide giving it credibility.

Inuit patients were portrayed differently from other patients. They were described with reference to life in the Arctic and the administrations responsible for their health i.e. Indian and Northern Health Services. "Indians" and "Eskimos" were grouped under "native population." and were described as patients from the far North and indigenous to the area. Inuit patients were described as people on the receiving end of what the Sanatorium felt was their obligation to share their methods of disease control and their mode of life. They were portrayed as good and adaptable patients who were yet to take

their place on equal footing with the people of southern Canada and as people whose living conditions in the Arctic created problems which largely centered on Inuit rehabilitation. "Indian and Eskimo patients" were discussed mainly in reference to the number of patients in residence, particularly whether they increased or declined. Throughout the annual reports there was a differentiation – between Indian, Eskimo, and southern Canadian patients– with regards to patient population and changes in resource allocation such as an increase in teachers and occupational therapists to accommodate an increase in Inuit patients. With regards to the Indigenous patient population, "Indian and Eskimo" patients were consistently grouped together. For example the Annual Report of 1959 stated "Indian and Eskimo patients have continued to be admitted although the number in residence has declined from 181 to 163" (p.5).

Conclusion

Several steps were taken in identifying themes. These steps included: reading through the archives and underlining key phrases, characterizations, terminology, and emphasis of certain responses and ideas relevant to the research question. That is, how did personnel at the HHA, and The Spectator understand the problems and solutions to the tuberculosis epidemic? Attention was also directed to any discussions relevant to the biomedical model and SDOH. Careful attention was paid to discussions concerning the nature of TB, its problems and potential solutions, new developments in TB-related research, and characterizations of and responses to people with TB, particularly the Inuit. The annual reports promoted the work of the HHA – highlighting its achievements, and

providing financial and additional data. The HHA's annual reports served as a marketing tool which was examined in developing themes. One of the ways that the newspaper articles discussed matters relating to TB and the Sanatorium was through the use of storytelling. Themes were identified by looking at which stories were told, how they were told and their frequency. Finally, themes were identified by looking for who or what was made the focal point in the stories.

CHAPTER 4: AN ANALYSIS OF THE HAMILTON HEALTH ASSOCIATION ANNUAL REPORTS

The Hamilton Health Association was a body responsible for the administration of the Mountain Sanatorium. The Sanatorium resulted from Canada's crusade against tuberculosis at the beginning of the twentieth century (Wilson, 2006). The HHA's annual reports contained data acquired by staff and organizations working at the Sanatorium. They were composed with the objective of sharing its activities with the general public and securing their support. This chapter presents an analysis of annual reports from 1953-1963 and uncovers how medical professionals conceptualized TB and its problems and solutions alongside efforts to maintain legitimacy and secure their continued existence as an institution. The HHA's claims-making activities, namely its use of diagnostic, motivational, and prognostic frames are examined. Diagnostic frames make use of numbers and statistics to establish a problems' context and scale (Mahood & Satzewich, 2009). Motivational frames are efforts to convince people why they should be concerned about a problem and it often entails framing the actions of claims-makers as 'doing the right thing' (Mahood & Satzewich, 2009). Lastly, prognostic frames are the solutions put forth by claims-makers to address problems they have identified. These claims-making activities as one will see, aided in the HHA's legitimacy and access to important resources.

When the Canadian government accepted responsibility of Inuit health including the incidence of TB, "it remained to be seen who exactly would be selected to discharge that responsibility. As it happened, a group of mostly medical people, eventually

operating within the Department of Health and Welfare, got the job" (Selway, p.36, 2016). Reverend Donald Marsh, Anglican Bishop of the Arctic appointed himself as an advocate for patients and their families (Selway, 2016). Bishop Marsh advocated for the construction of a TB facility in Iqaluit to service the Eastern Arctic. The Department of National Health and Welfare rejected Bishop Marsh's proposal to build more hospitals in the North on the grounds of efficiency (Grygier, 1994; Selway, 2016).

According to P.G. Nixon in *Early Administrative Developments in Fighting Tuberculosis among Canadian Inuit*, doctors in charge also rejected proposals for northern treatment including rehabilitation centres in the Arctic (Selway, 2016). Based on Grygier's (1994) findings in the archives, arguments put forth against northern TB treatment included: the difficulty of attracting specialists to the Arctic; an expected decline in active TB cases in the near future thus resulting in an excess in beds; and the prime objective of northern hospitalization being the removal of infection from the community. The cost of hospitalization which was "almost double per capita what they were in southern Canada" (Selway. p.19, 2016) trumped all arguments. Streptomycin enabled Inuit people with TB and those in critical medical condition to be evacuated while those with serious cases but locally hospitalized could be discharged to die at home (Selway, 2016). In Hamilton, streptomycin came into use in 1947 and in 1948, the government of Ontario approved its usage for TB cases. The following year streptomycin was paired with PAS and in 1952 INH was introduced (Selway, 2016). Physicians later decided on a combination of streptomycin, para-aminosalicylic (PAS) and Isonicotinic acid Hydrazide (INH) after several trials (Selway, 2016).

The evacuation of Inuit people from the Arctic was made possible with the use of the C.D. Howe, a ship operated by the Department of Transport (Selway, 2016). Its primary mission was resupply and it operated its Eastern Arctic Patrol (EAP) every summer from 1950-1969 (Selway, 2016). Authority figures on the ship included "the captain, the chief medical officer and the officer in charge of the Eastern Arctic Patrol overall – the government's representative, the man in charge of administration concerns" (Selway, p.76, 2016). This individual was responsible for relaying any reliable data they observed and reported to public planners (Selway, 2016). The captain kept a daily record of the ship's arrivals and departures, distance traveled, and other factors concerning its operations. The medical and administrative officers filed reports. These reports consisted of daily "accounts of difficulties met and tasks accomplished, apparently worked up from journals, and contain many interesting details about conditions in the communities visited and often expressions of strong personal opinion on what should be done about what was seen" (Selway, p.76, 2016). Inuit people were evacuated to sanatoria in southern Canada without consent and some ran away to avoid evacuation (Selway, 2016). The medical team conducting the EAP went through great lengths to get Inuit people on the ship. Individuals who they saw as "doomed" were left to fight the disease in the Arctic while the treatable were brought to southern sanatoria (Selway, p.19, 2016).

In 1955, major changes in the x-ray procedure conducted during the EAP were orchestrated by John Willis, the Indian Health Services Regional Superintendent (Selway, 2016). Year after year, as arranged by Willis, those awaiting examination were gathered on the ship. One after the other, families were admitted to the "hospital unit passage"

where they were met by an interpreter who noted their "name, disc number, year of birth, infancy history and diseases history, usually from the mother" on a Family Record form (Selway, p.96, 2016). The disc functioned like a social insurance number. According to Willis, "as each name and disc number is recorded, the interpreter places opposite them, on the Family Record form, a serial number. At the same time this serial number is written with a blue ball-point pen in the back of the left hand of the Eskimo concerned. This number serves to identify him quickly throughout the medical examination" (Selway, p.97, 2016). The process of managing records from the examination process was obscure as complaints were filed about Inuit who became lost in the system meaning that while they were in southern Sanatoria, their families were not informed about their whereabouts and health conditions (Selway, 2016). The next step involved taking x-ray photographs. This was followed by each family assembling "in serial order to the Operating Room, where they undress and are examined stripped following the routine: Mouth, Eyes, Vision, Ears, Hearing, Skin, Nutrition, Chest, Heart, Abdomen, Neurological, Limbs, Genitals. An assessment of emotional stability has been attempted where information was available, and cleanliness of person and co-operation were recorded" (Selway, p.98, 2016). In 1956, Willis organized "a special Craig Harbour study, which involved members of the medical patrol preparing a detailed report on each family with regard to their "social habits, standards of hygiene, diet and contacts." Also housing, clothing and "degree of adoption of the white man's habits" (Selway, p.103, 2016). This report likely reached officials in Ottawa and influenced a policy concerning

how medical facilities (receiving Inuit from the communities in which this study was conducted) should respond to Inuit and conduct their treatment.

The total population of Canada for 1951 was 14, 009, 429 while the Inuit population was 9, 493 (Grygier, 1994). On the whole, five thousand people in Ontario were receiving TB treatment in hospital (Selway, 2016). During the advent of INH administration in the early 1950s, Cree and Inuit patients began to come in from James Bay. The Inuit patient population grew from nothing to three hundred with the start of INH trials in 1952 to 1955 (Selway, 2016). Out of a total of 1,578 Inuit hospitalized for TB treatment at all locations, the number of Inuit patients in residence at the Sanatorium grew to three hundred thirty-two in 1956 (Grygier, xxi) (Selway, 2016). Though officials rejected Marsh`s push for northern hospitalization, Dr. Moore compromised by agreeing to keep Inuit TB evacuees together in groups of fifty or more in sanatoria and to place a considerable number of Inuit as hospital staff (Grygier, 1994). Deliberations concerning the plight of Inuit patients aided in creating and embedding a better standard of care in sanatoria (Grygier, 1994). Patients at the Sanatorium were segregated according to their age, gender and the stage of their active disease (Selway, 2016). Their ages ranged from under 5 years old to over 60 years old. The largest number of patients at the Sanatorium consisted of adult males, then children followed by newborns. Generally there were 6-15 newborns, 47-185 children and 402-722 adults admitted annually to the Sanatorium.

From 1953-1960, the number of Inuit hospitalized grew from 376 to 448 while the total number of Inuit under care grew from 686 to 793 (Grygier, 1994). There were large

groups of Cree and Inuit evacuees, particularly up to three hundred at the same time (Selway, p.19, 2016). The percentage of Inuit patients for each year from 1953-1963 was not disclosed in the annual reports. Cree patients were referred to as Cree in the literature and referred to as Indian in the HHA Annual Reports while Inuit patients were referred to as Eskimos in both the literature and annual reports. The sum of "Eskimo and Indian" patients in residence was provided for 1955-1959. From 1955-1959, there were 42%, 51%, 46%, 50% and 56% Indigenous patients respectively. Other patients and their ethnic backgrounds were not disclosed. The number of Inuit or Cree patients as separate groups and the number of Indigenous newborns, children, and adults were not disclosed.

In Selway's discussion of the factors that determined the length of stay for pulmonary TB, he presents an excerpt from the *Indian and Northern Health Services Directorate Report of 1959* (p.57-58, 2016). According to the report, the duration of treatment for pulmonary disease is at least a year and determined by:

a) Type of disease – Primary of re-infections, new or reactivation.
b) Response to drugs – sensitivity of organisms.
c) Complications – such as heart disease, emphysema, endocrine disorder, geriatric problems.
d) Surgery – good or a poor risk.
e) Co-operation – good or recalcitrant, personality disorders.
f) In addition, poor environment conditions and the knowledge that out patients would not continue with the drugs at home influenced us to keep longer to complete the standard regimen.

There were generally 90 staff members working at the HHA and the Sanatorium combined. Officers and directors fell under various categories: board of directors (i.e., president, vice-president, secretary-treasurer); women's committee; The Mountain

Sanatorium; Chaplains; honorary consultants (medicine, surgery, radiology, dermatology, anesthetics, dentistry, otolaryngology); senior staff; medical staff; surgical staff, anaesthetists; and director of diagnostic clinics. The HHA's officers and directors remained the same over the years with a few exceptions in their senior appointments. Officers and directors at the Sanatorium consisted of: a medical superintendent; business manager; superintendent of nurses; chief dietitian; pharmacist; medical records librarian; housekeeper; and a farm manager. Those in charge of welfare included: a director in education, occupational therapy, rehabilitation, music, and radio. The director of radio and the director of music as titles were swapped considerably throughout the years. It is unclear whether the swap meant any significant changes in their roles and responsibilities. Perhaps the Sanatorium felt a need to shift or broaden the responsibilities of this director. It is possible that the responsibilities of the former director of music or radio were no longer a priority or that they were later assumed by the director of rehabilitation which remained until 1963. Until 1955, a director of education and that of occupational therapy took charge of welfare. Interestingly, in 1956 the former director of education became the director of rehabilitation and the director of occupational therapy was removed. Perhaps the responsibilities of the director of education and that of occupational therapy were assumed by the director of rehabilitation given general overlaps between education, occupational therapy and rehabilitation.

In 1959, unlike previous years, a social service director was introduced. Perhaps this director was in charge of the Sanatorium's plans for "a wider need of medical social service programs" (p.7, 1958 Annual Report). The HHA's senior appointments for 1962

did not however include a social service director. While this was consistent with their assertion that the function of a hospital does not include social and economic problems (Annual Report, 1959), it was inconsistent with their inclusion of this director later on. This brings into question whether this meant that the HHA later appreciated social and economic problems as health determinants. Secondly, if so, why was this director later removed? And lastly, if they felt that social and economic problems were not the function of a hospital, what was the role of the social service director? One would assume that the nature of their position concerned social and economic factors, at least as they concerned TB. The removal and inclusion of this director was not accounted for in the annual reports.

Characterization of Tuberculosis

Problems are generally understood as unwanted, detrimental or abnormal circumstances that call for resolutions. They can also be understood as a discrepancy between reality and a desired outcome. There are a multitude of ways to define problems and these definitions are contingent on context. Tuberculosis for the HHA presented a problem and was understood as multifaceted. Conceptions of TB have changed significantly, from the advent of the Sanatorium in 1906 to the present day. In fact, "the tuberculosis bacteria we know today, the general perception of the disease, and the terms used to refer to it have changed since the early 1900s and even as recently as the 1950s (Ott 1996:9)" (Herring, p.9, 2007).

<u>A Social Disease</u>

The HHA did not present an official definition of TB but discussed it in what could be understood as their conceptions of the disease. In their 1953 annual report, TB was presented as a social disease. In his address, the president of the HHA stated "TB is a social disease and presents problems beyond the conventional medical approach. The impact of social and economic factors must be considered as much as the mechanism by which tubercle bacilli causes damage to the human body" (p.4, 1953 Annual Report). What is remarkable about this statement is that the president borrowed it verbatim from Rene Dubos, an influential microbiologist. Here, along with Dubos, the HHA acknowledged the role of social and economic factors as equally significant as tubercle bacilli, a bacterium recognized as the cause of tuberculosis. Unlike the popular germ theory of disease, this was a broader understanding of TB (Ali, 2014). The germ theory of disease dictates that most infectious diseases are caused by microorganisms (Herring, 2007). At the turn of the twentieth century, the etiology of TB was well known to doctors (Herring, 2007). Here, they do not discredit tubercle bacilli to be detrimental to the human body as both biomedical and social conceptions are regarded as important. They supported the idea that TB was not only implicated by social and economic factors but produced challenges that necessitated alternatives to conventional approaches in medicine. There was recognition that TB produced problems that could not be adequately addressed with these approaches. There was also recognition that conventional approaches alone were not suitable for controlling the socially-constituted problem of TB. It is fair to assume that the president was referring to the biomedical model given its extensive use and that he was also asserting that social and economic factors were just as

important as the physical means "by which tubercle bacilli causes damage to the human body." Though the HHA characterized TB as a social disease, this was not consistent with their attempts to control the disease as a majority of their efforts, fell under the biomedical model. In addition to TB as a social disease, it was understood as a disease with social consequences. These consequences included personal discontent, lengthy hospitalization, and an inability to engage in public affairs resulting in the disruption of homes and everyday life.

In the 1953 annual report, the high incidence of TB was attributed to a changing population and economy. While the superintendent did not state that TB was caused by changes in population and economy, its incidence was associated with these factors. Interestingly, there was a lack of discussion concerning SDOH throughout this annual report. Overall, TB was understood as a disease that robed patients of their capacity to participate as members of society. A relationship was drawn between good citizenship and health status as patients free from infection were regarded as good citizens: "our goal is the eradication of tuberculosis, but in the process of carrying out this eradication we must remember that it is necessary to get our present patients back into society so that they will become again good citizens; that is, privately happy and publicly useful" (p.7, 1953 Annual Report). Patients however, could redeem themselves if they managed to fight the disease. Once discharged, they became good citizens again as they could reengage in public life. Here, active engagement in society and personal content was characteristic of a healthy and useful citizen.

Fear-mongering

The HHA strongly felt that people needed to be reminded of the dangers of tuberculosis and identified complacency as a threat to its eradication. TB was characterized as a danger that needed to be addressed at all costs. They did so by presenting fear-provoking statistics: "tuberculosis, in spite of the progress made, still kills more Canadians than all other infectious diseases combined. People forget that in Ontario some 5000 patients are hospitalized for this disease" (p.6, 1955 Annual Report). In stating the large number of people hospitalized for TB, the HHA instilled fear with credibility. This strategy is an example of how "claims-makers try to attach numbers to the problem and the larger the number of people seen to be affected by it the more convincing their claim becomes" (Mahood & Satzewich, p.61, 2009). Fear-mongering was evident in their consistent efforts to present TB as an impending danger. In addition to alerting the public of the number of people hospitalized, they mentioned social implications, particularly the disruption of homes and lives. TB was understood as a disease that would remain if the HHA did not engage in extensive screening. For the HHA, lowering morbidity rates meant that they needed to cure chronic cases and resort to isolation. Thus they engaged in searching out new cases in efforts to identify those infected, isolate, and treat them as they posed a danger to the uninfected population. The HHA strongly supported the removal of "all tuberculosis people from the community" (p.6, 1958 Annual Report). This was the standard approach to the control and treatment of TB across sanatoria. This removal was in fact a policy of the Department of Health and Welfare (Grygier, 1994; Selway, 2016). Only patients able to return were deemed safe: "modern methods of

treatment, resulting in the discharge of many long term patients who have been able safely to return to the community and an overall reduction of length of stay in the sanatorium" (p.6, 1958 Annual Report). The use of fear legitimized the HHA and its cause as it compelled people to seek their institutionalized health services.

A Bodily Experience

The HHA also understood tuberculosis as a bodily experience. TB was understood as an infection in the body that when dealt with appropriately, resulted in an improvement in one's physical condition: "the outlook of all patients has changed, and while the infection is still lurking in their bodies, nevertheless, we are finding that our patients are much better physically as a result of these new methods of treatment" (p.6, 1953 Annual Report). The method treatment was triple chemotherapy: a combination of streptomycin, PAS, and INH. The Sanatorium was up-to-date with regards to new developments as they made use of new methods of treatment. New drugs and procedures proved successful and superior to previous methods. Despite acknowledging that "a great deal has been accomplished in controlling tuberculosis" (p.3, 1959 Annual Report) the HHA felt that people needed to be reminded of what they understood as the nature of TB. They stated "there are probably more than one million persons in Ontario with living tuberculosis germs in their lungs" (Ibid.). TB was thus perceived as a physical danger, one that if ignored or taken lightly, would resurface in the body unwaveringly.

Adaptation

TB to the HHA was understood as an adaptable disease in which the types of hosts it affected changed. Decades ago tuberculosis was "basically a disease of young people, particularly females, whereas it is tending to become a disease of man in older age group" (p.6, 1954 Annual Report). This characterization of TB as once affecting mainly young females and later older men, suggests changes in the nature of the disease or changes in what doctors and scientists had discovered at the time. TB was understood as an unrelenting and tricky disease. According to the HHA, this was evident in its drug-resistance following weeks of treatment (1962 Annual Report). Drug-resistance led to further screening activities in which the HHA was convinced they would uncover unknown cases: "we will uncover a number of new cases many of whom will have no idea they are infected" (p.3, 1963 Annual Report). Cases in which people were unaware of their infection served to prove TB as a tricky disease that could live in one's body undetected. This understanding of TB, helped legitimize large-scale screening programs.

Funding Campaigns

Organizations present themselves in ways that strengthen their legitimacy (with selected audiences) and thereby secure the continued flow of (external) resources (Pfeffer & Salancik, 1978). The HHA depended on various sources of income and employed self-presentation tactics in its annual reports to secure funding. This was before the era of publicly funded health care at a federal level, so the HHA had to acquire income from other sources, including: notices of bequests, payments received from estates on account of bequests, donations, Christmas Seal Fund, and membership. These financial

contributions were made by a diverse group of individuals and organizations. The HHA depended largely on voluntary subscriptions and government aid.

Notices of bequests and payments received from estates on account of bequests were made annually to the HHA. It did not disclose the social status of its donors, the amounts they donated, or their ties to tuberculosis. It is fair to assume that, among them were well-to-do Canadians who knew someone with TB given that the disease struck far and wide (Herring, 2007). On average there were 8 bequests annually and in 1954, donations and bequests amounted to $169, 396 and $121, 473 in 1955. Donations were made by individuals and various corporations, agencies, associations, and humanitarian and legal institutions. They were also made to the Christmas Seal Fund, an annual fundraising campaign supported by several charities.

The HHA inconsistently included a financial statement in their annual reports. Financial statements were provided for 1955, 1961 and 1962. Their balance sheet consisted of a breakdown of assets and liabilities, the auditors' report and the HHA's statement of operations and equity. As of 31st December 1955, accounts receivable were broken down into governmental agencies ($125, 916), patients ($2, 913), sundry ($5, 183) and provision for doubtful accounts ($1,000). The HHA had $1, 491, 444 in investments and the sum of all assets was $3, 983, 940. Current liabilities amounted to $118, 563 while the HHA's equity including donations was $3, 865, 377. Revenue from all sources amounted to $1, 841, 286 in 1954 and $1, 859, 438 in 1955.

Unlike the annual report for 1955, those published in 1961 and 1962 only included a statement of operations and equity. The HHA's operating revenue from all sources amounted to $2, 690, 422 in 1961 and $3, 150, 470 for 1962. Their equity for 1961 was $7, 415, 173 and $7, 833, 314 in 1962. The balance sheet for 1955 proves that a significant percentage of their funds came from governmental agencies, inventory, investments, buildings and general equipment, and donations and bequests. The HHA's present capital investments grew from $3, 450, 000 in 1953 to $7, 500, 000 in 1961. The significant increase from $4, 660, 000 in 1958 to $7, 000, 000 in 1959 was accounted for by the HHA's new additions – the Brow Infirmary and Chedoke General and Children's Hospital. This increase in capital investments was likely the result of successful impression management. Investors and other interested parties provide resources to institutions that present themselves as desirable, appropriate or right (Pfeffer & Salancik, 1978). An increasing need for funding prompted the HHA to disclose its financial position. Perhaps such transparency enabled the investors, members, and other organizations on which the HHA depended to view the institution as reliable and worthy of their funding.

Strategies

The HHA directed its efforts towards securing the financial support of the community regardless of its financial position. They did so by assuring members and the public that they did not accumulate funds simply to accumulate but that with the ever changing times and the demands of TB treatment, it was in their best interest to ensure

that reserves are set aside. In 1954, the medical superintendent stated "one must always be quick to remind the supporters of the Mountain Sanatorium that this institution does not function for the purpose of accumulating large reserves, but that in this day of increased costs it is very necessary to have some substantial sums laid aside to make additions and alterations which are necessary for the future efficient operation of the institution" (pg.6). Such statements pressured members and investors to continue making contributions. While it may have been true that the HHA met increased costs during the course of its operation, emphasizing the importance of laying aside substantial sums, served to justify the institution's efforts to accumulate funds irrespective of their financial status.

While the HHA continued to push for the generous support of its members and the public, it made sure to reassure them that funds were being used effectively. In recognizing the huge sums of money they received annually, the HHA felt pressured to justify its push for funds. They worked to ensure that people saw their efforts and donations as contributions to improving the health of Canadians. They placed emphasis on the community's support as a vital component in meeting health and welfare needs and even framed their work as ensuring the protection of Canadians. According to the HHA, it operates to "actively use the funds given to it for the betterment of the health of the people of Canada and this community in particular. However, association can proceed with them. This thought is ever before your management and you can be assured that all expenditures of funds are made only after very careful consideration" (p.7, 1955 Annual Report). At a time when many had TB and/or were affected by it, this strategy was

effective given how vulnerable people were. Legitimacy is a perception that an entity conducts itself in a manner that is desirable, appropriate, or right with regards to a socially constructed set of "norms, values, beliefs, and definitions" (Suchman, p.574, 1995). The provision of services that promote health and wellbeing is generally understood as valuable and morally sound. In getting people to view their support as a contribution to public health, the HHA drew from deeply held beliefs and norms about the basic needs of human life. In framing their cause as a contribution to public health, the HHA was helping to present its work as the 'right thing to do' and thus morally legitimate.

Annual reports present an opportunity for institutions to paint themselves in a positive light. The HHA was no exception. It presented itself as uniquely Hamiltonian and a top institution supported by health departments at all levels of government. In their 1954 report, the president stated "there has always been noticed by visiting professional men the spirit of pride in its record and loyalty to each other, eagerness to maintain its high standing on the part of all attached to it" (p.4). The president reinforced the high regard with which the Sanatorium was attributed and justified it through the acknowledgment of professional men. Moral legitimacy involves an evaluation of leaders and representatives and rests in part on the "charisma of individual organizational leaders" (Suchman, p.581, 1995). The HHA's board of directors or "men of importance" as they are known, embodied personal legitimacy which extended to the Sanatorium. The 1954 annual report included photographs of the HHA's board of directors, all at the top of their specialized fields. The photographs are portraits characteristic of passport photos as

they captured their professional demeanor, suits, ties and well-groomed hair. These photographs introduced the directors to the public and more importantly legitimized the work of the Sanatorium through its affiliation with dignitaries.

The HHA depicted its work as one that would strengthen the nation. In 1954, it stated "Canada is a country of many races and we at the Mountain Sanatorium are attempting to do our share in developing a strong Canada – by learning what we can from cultures foreign to our shores and offering to those from other lands the benefits attainable here" (p.7). Canada's identity as a multicultural nation is evoked in this statement. They identify an obligation to take part in "developing a strong Canada" which they understood as requiring knowledge of foreign cultures. They also associated racial diversity with religious charity and other identity markers. In expressing gratitude for their volunteers, the president stated "irrespective of race, creed or color and of all ages, they, standing on the common ground of Christian charity "(p.5, 1953 Annual Report). In this statement, the president characterized organizations and individuals working at the Sanatorium as diverse and charitable people contributing to the common good. In doing so, he attributed a sense of moral superiority or at least moral worthiness to these volunteers. Here, contribution was framed as a moral duty, which distinguished some individuals from others. In casting itself as strengthening the nation and working with charitable people, the HHA further legitimized its cause.

Policy Considerations

The Hamilton Health Association was governed by a significant number of medical professionals. While the HHA was relatively autonomous, they sought and sometimes required the approval of provincial and federal health departments. Their activities were to some degree determined by the policies of these institutions. For example, the HHA's treatment of Inuit people was determined by the Department of National Health and Welfare (1954 & 1955 Annual Report). They also sought approval from the federal government before implementing changes to their TB-screening activities. In recognizing that TB could affect anyone, the Sanatorium cooperated with the Department of National Health and Welfare to take Indigenous Peoples under their care for TB treatment. The Department of Health and Welfare took the lead in allocating the Inuit to Ontario for TB treatment. In fact the department designated the Sanatorium as the facility for treating Inuit from the Eastern Arctic. Southern sanatoria needed patients to fill up their empty beds (Selway, 2016). In 1955, "between 250 and 300 Indian and Eskimo patients" (p.6) were at the Sanatorium out of a total of 700 patients. The Sanatorium's capacity to accommodate them was discussed in reference to the vacancy of beds which was determined by the Department of Health and Welfare's policy (1955 Annual Report).

In 1956, the HHA completed a mass x-ray survey for the Hamilton district and it was not as successful as they had hoped "as people of the community" were not "particularly interested in this aspect of case-finding" (p.6, 1956 Annual Report). Perhaps the means by which the HHA surveyed people was too invasive and discrediting as the response prompted authorities to review their case-finding activities. The Sanatorium felt

compelled to intensify these activities and this encompassed widening their reach. They did so by surveying people from all walks of life. For instance, they surveyed all welfare recipients and "an x-ray unit" was "installed in the local jail" (Ibid.). These were new measures instituted by the Department of Health for the Hamilton area. At the time, the HHA had plans to x-ray all applicants for employment in Hamilton and this was a plan they confidently proposed to federal authorities.

The Sanatorium also cooperated with the Federal Department of Indian and Northern Health Services, and the Federal Departments of Northern Affairs as it concerned Inuit patients (1960 Annual Report). Projects undertaken by the HHA were supported by grants from the Department of National Health and Welfare (1960 Annual Report). In 1961, the Sanatorium was left with 80 patients in residence, some of whom were Inuit soon returning to the Arctic. The Department of National Health and Welfare advised the HHA of their future plans to have Inuit patients treated in their own medical facilities (1961 Annual Report). By 1961 "as the Inuit population continued to rise and community development at DEW Line sites and elsewhere increased, existing medical personnel were unable to cope with heavy patient loads. Northern Health Services issued funding for the construction of nursing stations and hospitals across the Arctic and in northern Quebec" (Bonesteel & Anderson, p.73, 2008). This was known as the policy of resettlement and it involved a shift from sanatoria to outpatient or domiciliary care (Selway, 2016). The HHA saw the trend of declining bed occupancy as an opportunity to make way for treating other medical conditions. The Sanatorium underwent changes in the composition of their patients as a majority of "Indian and Eskimo" patients were

transferred to hospitals governed directly by Indian and Northern Health Services (1961 Annual Report). The number of Inuit patients continued to decline as the Department of National Health and Welfare informed the Sanatorium that these patients would soon be cared for in their own hospitals (1962 Annual Report). With the cooperation of the Indian and Northern Health Services together with the Department of Northern Affairs, in the course of several years, treating the Inuit entailed admitting them to other places. In discussing their experience with the Inuit since 1949, the Assistant Medical Superintendent stated "in having these Northern Canadians in our midst leads us to pay a most impressive tribute to the Ottawa authorities in their worthy efforts toward these citizens" (p.11, 1963 Annual Report). By 1963, the Sanatorium discharged its last Inuit patients which left "considerable mixed emotion" (Ibid.). The HHA was also directed by policies beyond the treatment of Indigenous Peoples. For instance, the Government and the Ontario Hospital Services Commission selected the HHA to put in place a District School of Nursing (1963 Annual Report).

Problems

The Hamilton Health Association made use of the term "problems" in discussing the activities of the Sanatorium and its fight against TB. In fact, the Sanatorium saw the disease as a problem they would continue to face for many years (1961 Annual Report). The problems they identified include: complacency, drug-resistance, other uses for the Sanatorium, and logistics.

<u>Complacency</u>

There was a consistent pattern of presenting the fight against TB as improving yet presenting numerous challenges. This can be identified as the theme of progress versus insecurity and it is apparent in how charities also present themselves. Akin to charities, the HHA was presented as an institution that was changing lives and accomplishing great things with the help of donors while facing an endless need for resources and incomplete work. Pfeffer and Salancik (1978) assert that insecurity and uncertainty as it concerns an institution's key resources threaten its survival because it leaves its partners in doubt. The HHA faced this problem when the number of patients in residence continuously declined and pressured them to consider other medical concerns to attend to. This decline presented a threat to their existence as an institution and they responded by deliberating on their future plans and even went as far as publishing this debate in The Spectator. Interestingly, the decline in mortality and morbidity rates served as both an advantage and disadvantage for the institution's survival. While the decline helped to assure patients, investors, and the general public that the Sanatorium was effective in TB treatment, it also dropped low enough to threaten its work because hospitals need patients to remain open. This presentation of progress in the midst of insecurity likely aided in keeping donors hopeful yet continuously supportive. Throughout the annual reports, progress and insecurity were discussed simultaneously. There was a consistent pattern of opening with a statistic such as death or morbidity rates, bed occupancy or developments in treatment followed by a warning against complacency. Discussions that spoke directly to this pattern included:

> "While the death rate has declined very rapidly we should not be unaware of the fact that the incidence of tuberculosis is still high"..."Undoubtedly, we are making progress in the reduction of the incidence of the disease but again let me stress that our progress cannot be gauged by the remarkable decline in the death rate" (p.7, 1953 Annual Report).
>
> "...for the first time in the history of the struggle against tuberculosis we have found ourselves with a small excess of sanatorium beds. While this is encouraging, we should not be lulled into a feeling of false serenity" (p.5, 1954 Annual Report).
>
> "People are too apt to become complacent and forget that tuberculosis, in spite of the progress made, still kills more Canadians than all other infectious diseases combined" (p.6, 1955 Annual Report).
>
> "While tuberculosis has not been eradicated and we are combating a wave of complacency concerning tuberculosis, we have made definite strides" (p.6, 1956 Annual Report).
>
> "There is always the fear of complacency in our outlook on tuberculosis and this is an attitude that every member of our community should fight" (p.5, 1959 Annual Report).
>
> "While the number of patients in the sanatorium may decrease, we should not be lulled into a false sense of security" (p.5, 1961 Annual Report).

As shown above, progress and insecurity was discussed repeatedly. The HHA felt the need to stress that work in fighting TB remained despite progress. In 1953, greater weight was placed on the incidence of the disease more than mortality rates and progress was measured by an excess of beds. This sign of progress, however did not warrant serenity. In the 1955 report, progress was attributed to a steady decline in death and morbidity rates. In fact, the fifty years in which the institution had been operating was described as years of progress. This is interesting given the tendency to remind investors, members, and the public of the dangers of complacency. The Sanatorium relied heavily on drug therapy as a method of treatment and it resulted in a decline in death rates.

Despite this decline, progress was described as "extremely slow" (p.6, 1955 Annual Report) with regards to eradicating TB. There was a reluctancy to embrace progress completely and its absence. The theme of progress and insecurity, demonstrated that TB research and treatment would continue to progress but there could never be enough progress to warrant complacency. There was always a lot that had been done and that needed to be done.

Drug-resistance

One of the biggest problems the HHA faced in their fight against TB was drug-resistance. In 1960, an increasing number of patients had become resistant to drugs used in treating the disease. That year, the medical superintendent stated "we are making very definite progress in searching out new cases and in treating them adequately but we are also faced with an increasing number of patients who are becoming resistant to the drugs and these leave a very definite pool of infection from which new cases may be drawn" (p.5, 1960 Annual Report). They found the management of drug-resistant patients as a definite problem and had their staff on the watch for new chemotherapeutic agents (1960 Annual Report). In attempts to control TB, the HHA introduced antituberculosis drugs which were initially effective in fighting the germs understood to cause the disease. Later in 1962, they discovered that these drugs had a tendency to become inactive later during the course of treatment. They attributed this inactivity to natural selection and the tubercle bacilli becoming resistant after remaining in the body following weeks of therapy. There was a pool of infected cases resulting from resistant bacilli which led to other infected

cases. Those infected as a result were not afforded the advantages of treatment from the antituberculosis drugs. The HHA found this as potentially posing a serious threat to their efforts to control the disease and became interested in investigating the magnitude of this circumstance and its rate of progression (1962 Annual Report). Despite progress in the search for new cases and treatment, this threat warranted greater efforts to control the disease. In fact the HHA, in searching out new cases, found enough to justify another mass x-ray survey in 1962.

Expansion

The HHA felt that it was facing a very complex problem. They had grown accustomed to treating one disease but that would change approximately fifty years later as "new and more successful methods of treatment" (p.7, 1961 Annual Report) were discovered. This led to major shifts in their focus as an institution. They had a "willingness to meet the changing times" (Ibid.) as the HHA felt an increasing need to consider future plans for the Sanatorium. The medical superintendent stated "the problem of other uses for our sanatorium beds has been considered on many occasions" (p.7, 1955 Annual Report). As treatment improved resulting in shorter stays in sanatoria and fewer patients, the HHA felt threatened as this posed questions concerning the use of empty beds and the future of the Sanatorium. Though it was not an immediate concern in 1955, they felt compelled to look further into this matter. They saw it wise to expand their health and welfare concerns but did not disclose the details of their future plans. The HHA felt strongly about ensuring their existence as an institution well into the future. As

an organization its primary goal was to eradicate TB and survive. In fact, it strongly believed that hospitals must not remain idle or closed. These goals are affirmed by their survival strategies and its evolution since 1906, from TB treatment in tents to a children's hospital.

Social Patterns

The medical superintendent was convinced that a lot had been accomplished for people with TB. The HHA felt that it was their responsibility to socialize discharged patients into following through with the routines and procedures they had become accustomed to while admitted: "...it behooves us to attempt more and more to fit the discharged patient into our social pattern" (p.6, 1953 Annual Report). This speaks to a sense of greater expertise on TB control. In stating "our social pattern," the superintendent implied that patients were admitted with a social pattern of their own and leave into a social pattern different from the one instilled at the Sanatorium. It also implied a belief in a superior social pattern hence they believed that it was incumbent on them to do more to socialize discharged patients into their way of life.

What is striking yet consistent with a focus on the biomedical model is the statement: "the policy adopted at the time of opening this new hospital was to screen carefully all patients being admitted. A hospital is not a centre to care for those people who have economic or social problems. It is a centre only for those who truly require hospitalization and need continued medical and skilled nursing care. Many people have felt that we should admit those people who require custodial care only, but this is not the

function of a hospital" (p.6, 1959 Annual Report). As documented by Denis (2006) in *Survival Strategies*, the Wellesley Hospital in Toronto took a different approach in response to threats to its existence. Its 1991 Strategic Plan amalgamated holistic health, the responsibility of hospitals to attend to psycho-social health determinants, and the advantages of working with local communities and including them in decision making (p.85, 2006). The Strategic Plan engendered an important shift in the functions hospitals should take in their communities (Ibid.). But despite its apparently successful turnaround, the hospital was forcibly shut just five years later by a provincially appointed commission in an era of funding cutbacks and health care retrenchment. Perhaps the Wellesley was punished for going beyond its mandate. It is not clear what the HHA and its facilities understood as economic and social problems. But it is clear that these problems were not to be dealt with in a hospital. This does not necessarily mean that the HHA and its facilities did not recognize the linkages between economic or social problems and health. It does however help to account for their reliance on drug therapy. It reveals that they saw economic and social problems as incompatible with or as separate from medical care. Interestingly, there was a recognition that problems aside from medical ones existed and needed to be dealt with. Examples included welfare and business problems for which a board member was assigned the task of addressing (1954 Annual Report). The Sanatorium had a business manager who was responsible for overseeing its activities and employee needs to ensure efficiency. The HHA used the term "problems" repeatedly throughout their annual reports and was tasked with problems which they understood as

complicated and that presented great implications for the future development of the Sanatorium (1955 Annual Report).

Logistics

Active infection and the need for continued treatment in sanatoria, presented logistical challenges, such as the need for more facilities (1953 Annual Report). In 1954, the medical superintendent asserted:

> "Many have questioned the advisability of bringing patients from the far North to the southern part of Ontario for treatment. Personally, I think that the decision to do so is a very sound one. As a nation we are moving into the north country in increasing numbers, a trend which will continue whether we like it or not. We are, therefore, virtually obligated to do what we can to give those who are indigenous to the area a greater knowledge of our mode of life and, at the same time, give them all the advantage of our methods of treating and controlling disease. It is more practicable at the moment to bring patients here from the North Country than to establish treatment centres there. We find that the Eskimo is an excellent patient and that he adapts himself well. We feel further, that in a few generations, he will probably be able to take his place on an equal basis with the people of Southern Canada. At the moment, however, certain problems are created which largely centre on Eskimo rehabilitation. Since the Eskimos have not had the physical advantages that we have had, we are attempting to help them acquire these advantages as quickly as possible" (p.6-7, 1954 Annual Report).

Questioning "the advisability of bringing patients from the far North" for treatment speaks to the attitudes of the wider public. There was perhaps a fear of contamination (Grygier, 1997) and an uncertainty in how to accommodate the Inuit given a lack of contact. Perhaps directors and staff at the Sanatorium anticipated language and cultural barriers resulting from geographical barriers and concerns such as transportation. In

stating his personal support for the decision to treat the Inuit in Ontario, the superintendent suggested that not all board members and staff supported this decision. The Sanatorium's arrangements concerning treatment were influenced to a considerable degree by larger political and economic structures. Their decisions were not simply determined by local affairs. In fact the HHA was influenced by national agendas and the relationships it built with TB establishments.

The Sanatorium felt obligated to treat Indigenous People given what they felt was an inevitable and increasing trend of Canadians moving up north. One cannot easily determine whether this obligation to intervene and treat Inuit people was driven by any genuine concern for their welfare and/or motivated by fear and greed for Inuit land and resources. There was an assumption that the HHA and even southern Canadians had a greater understanding of life. This was a way of stating that the Inuit had an inferior mode of life hence the need to impart a "greater knowledge of our modes of life." The Sanatorium understood itself as an institution which not only had advantageous "methods of treating and controlling disease" but also one that was obligated to introduce Indigenous Peoples to these methods. There is a perception that the mode of life in southern Canada was different from that among Indigenous People up north. It was also strongly implied that the latter was inferior. The HHA found it more practical to bring people from the Arctic to the Sanatorium for treatment than to develop facilities up North.

"An excellent patient" likely referred to one that was compliant, took orders from authority or one who placed their faith in medical personnel. The themes of othering and

ethnocentricism is apparent in the statement "we feel further that in a few generations, he will probably be able to take his place on an equal basis with the people of southern Canada." Though what is meant by the Inuit's place is vague, there is an understanding that a place for the Inuit existed but had not been fulfilled. Doing so was understood to be something that would take place in the far future. There is also an understanding of the Inuit's current place as not equal (perhaps even inferior) to those of southern Canadians. The HHA may have been referring to the transition into life in southern Canada in comparison to the Arctic. But even so, it is clear that life in the Arctic was characterized as inferior and impractical. This is demonstrative of Herbert Blumer's (1958) Group Position Theory. Blumer asserts that race prejudice in the dominant group always constitutes four types of feelings. They include: feeling innately superior (expressed through use of derogatory language); feeling that subordinate groups are intrinsically different; claims to privilege which are demonstrated in their exclusion and social control; and the feeling of fear and distrust (Blumer, p.4, 1958). At the heart of race prejudice lays a feeling of threat to one's sense of group position. When the subordinate group, engage in acts which the dominant group perceives as an intrusion into their "group exclusiveness," they are seen as failing to take their place (Blumer, 1958). The annual reports presented Inuit people as culturally subordinate and intrinsically different, and their claims to privilege were evident in their assumed authority over Inuit TB treatment.

"He will probably be able to take his place on an equal basis with the people of Southern Canada. At the moment, however, certain problems are created which largely centre on Eskimo rehabilitation" also speaks to the rhetoric around residential schools,

particularly Canada's policy of assimilation. The notion that Indigenous Peoples need to be separated and civilized in order to assimilate and that they will eventually be able to take their place in Canada alongside settlers is evident. Not only are claims to assimilation being made here, it is seen as their noblesse oblige to ensure that it happens. This obligation is affirmed by the curriculum and extracurricular activities patients participated in while at the Sanatorium.

In 1953 and 1954, the Sanatorium identified rehabilitation as a problem and directed considerable resources towards it. In the 1956 annual report, they identified two problems – one concerned treatment and the second concerned screening activities. Morbidity rates were declining rapidly in the Arctic while facilities were quickly improving. In providing treatment to Inuit patients, the HHA felt that it was assisting the federal government in addressing what they thought was a "difficult problem" and a "trying task in the North" (1962 Annual Report).

Solutions

While the HHA did not explicitly make use of the term *solution*, the measures they took in fighting TB could be argued as constituting them. These measures included: clinical research and drug therapy; rehabilitation; screening activities; scientific conventions, education campaigns and collaborating with TB institutions.

<u>Clinical Research & Drug Therapy</u>

The Sanatorium was presented as a high-functioning and up-to-date institution with regards to developments in TB research on prevention and cure. They discuss their use of pharmaceuticals, particularly streptomycin. Streptomycin was regarded as "the first and still the best of the so called miracle drugs" (p.4, 1953 Annual Report) used in treating the disease. Their emphasis on the benefits of drug therapy spoke to the use of the biomedical model. Use of new drugs and procedures resulting in significant benefits were mentioned throughout the annual reports. Before the advent of antibiotics, "treatment was less successful" and the Sanatorium found that patients were "much better physically as a result of these new methods of treatment" (p.6, 1953 Annual Report). They noted that these "new drugs and procedures" were an improvement compared to previous treatment (p.6, 1953 Annual Report) which consisted of combinations of streptomycin and PAS along with bed rest (in the late 1940s) in which streptomycin resulted in drug-resistance after a month of treatment (Selway, 2016). According to the Sanatorium, their use of drugs to treat TB was beneficial given that its complete use resulted in a decline in the number of patients returning with TB re-activation (1954 Annual Report). The HHA relied on a biomedical approach given their investment in clinical research and their extensive use of drug therapy, namely screening and antibiotics.

As a result of the effectiveness of new drugs, the HHA found itself treating fewer and fewer patients each year which was a trend they expected would continue (1956 Annual Report). Although equal attention was not given to both the biomedical model and SDOH, their reliance on drug therapy proved effective with fewer patients in sanatoria. This begs the question of whether the effectiveness of biomedical models can

be reduced to the use of drug therapy leading to fewer patients in hospitals. Methods of treatment employed by the Sanatorium had been effective given that by 1957, bed occupancy declined and patients could expect shorter stays. They did not attribute this to a rapid decline in morbidity rates but to significant improvements in treatment (1957 Annual Report). Reduction in the length of stay was once again attributed to what was understood as the "increasing efficiency of the drugs used in treatment" (p.5, 1960 Annual Report).

The HHA directed a lot of its resources towards clinical research projects. They saw these projects as efforts to strengthen their "knowledge of health problems" and as "delving into the secrets of medicine" (p.6, 1959 Annual Report). There was convincing evidence that the Sanatorium saw clinical activity as tremendously important and a solution to reducing the incidence of tuberculosis. This is supported by their increased clinical activities in Hamilton and surrounding regions, from Dundas and Stoney Creek to Halton County (1959 Annual Report).

The Sanatorium made use of anti-tuberculous chemotherapy and saw it as imperative in treatment: "the role of anti-tuberculous chemotherapy continued to be an essential factor in treatment, and varied regimes were used in one or more combinations, especially the inclusion of Isonicotinic Hydrazide (INH or Ison)" (p.11, 1960 Annual Report). Anti-tuberculous chemotherapy produced favourable results as it made it feasible for patients to be discharged relatively early. Unlike previous years, longer periods of

post-sanatorium anti-tuberculous chemotherapy were recommended for a larger number of patients as a response to drug-resistance.

The primary research conducted in the HHA's laboratories concerned isoniazid, a drug recognized as most effective in TB treatment. Dr. Armstrong, the Director of Laboratories at the Sanatorium, asserted that isoniazid's value could be enhanced had it not been the fact that "it is rapidly converted to inactive compounds in the tissues of many individuals" (p.16, 1960 Annual Report). These individuals were referred to as "rapid inactivators" and the Sanatorium asserted that about "44% of the white population were said" to fit under this category (Ibid.). "Pure blooded Eskimos" are rapid inactivators according to the results of research conducted at the Sanatorium. Drawing from this research, it not only "takes place more rapidly" among these Inuit but "the degree of inactivation which occurs is much greater in extent than with whites" (Ibid.). These results raised questions such as "whether or not the tuberculosis Eskimo population treated at the sanatorium has actively been receiving amounts of drug adequate best to cope with the disease" (Ibid.). An examination of those treated revealed that all patients including the Inuit responded favourably to standard therapy. The HHA had been exploring these facets of isoniazid. They found that "drug concentrations attainable and maintainable in the tissues of rapid inactive Eskimos are, indeed, sufficient to bring about cessation of growth of tubercle bacilli in vivo. On the other hand, it was observed that much higher isoniazid levels and longer exposures are required to bring about actual death of the organisms" (Ibid.). The Sanatorium was discussing these observations and taking potential clinical implications into consideration. Two projects were underway at

the time and they were "designed to assess proposed new diagnostic procedures" (p.17, 1960 Annual Report). In *A clinical study of isoniazid inactivation* Jessamine, Hamilton and Eidus (1963) refer to Dr. Armstrong's research and assert that genetic and racial factors may account for inactivation rates. Gangadharam et al. (1961) confirmed that "the rate of inactivation of isoniazid has been shown to be determined genetically, slow inactivation being a simple Mendelian recessive trait (Knight, Selin & Harris, 1959; Price Evans, 1959) which occurs with different frequencies in different racial groups (Harris, Knight & Selin, 1958; Armstrong & Peart, 1959)" (p.775). High rates of INH inactivation are probably not a consequence of failures in therapy therefore "the factor of INH inactivated by the patient must be taken into consideration in designing the best regimen of drug therapy" (Jessamine, Hamilton & Eidus, p.1215, 1963). The significance this racial comparison among rapid inactivators is that the Sanatorium needed to consider the effects of standardizing INH dosages. While they noted that some ethnicities have a higher % of rapid inactivators (Armstrong, 1960 Annual Report), inactivation varies from one individual to another (Huges, Schmidt & Biehl, 1955; Middlebrook & Dressler, 1956). Meaning that inactivation even among "full blooded Eskimos" must be determined on a case by case basis. Thus grouping all "full blooded Eskimos" as rapid inactivators might have had serious consequences such as drug-resistance influencing health deterioration.

In 1960, the Department of Laboratories published a detailed report concerning their study of "isoniazid time-concentration relationships in vitro" (p.16). Later their 1961 report disclosed that they further determined the boundaries of these relationships and the

findings helped to account for "certain discrepancies observed between theoretical and actual outcomes of isoniazid treatment of patients" (p.15). The HHA felt encouraged as the literature on T.B. research made reference to their published preliminary report. Anti-tuberculous medication was used extensively in sanatorium and post-sanatorium treatment. In fact, "extensive use of anti-tuberculous medication, not only in sanatorium but in the post-sanatorium phase of treatment, was extremely important, as in recent years" (p.10, 1961 Annual Report).

In 1961, clinical pathology which was a division of the HHA's laboratory was relocated. It was this reorganization that the HHA found to be their most essential task. This division of clinical pathology constituted "certain parts of hospital laboratory practice which are very closely concerned with patient care, viz: bacteriology, biochemistry, haematology and some parts of surgical pathology" (p.14, 1961 Annual Report). The HHA organized an educational exhibit known as *The Clinical Pathology of Tuberculosis* for a gathering of the International Union against Tuberculosis. The HHA's staff played an active role and was supported by the cooperation of departments in other hospitals. The exhibit comprised of photographs depicting all essential laboratory facets of TB. (1961 Annual Report).

The Director of Laboratories asserted "research will undoubtedly develop into vital importance, involving matters pertaining to a more effective tuberculosis vaccination; search for new bactericidal medication and further investigation into sensitivity to available chemotherapeutic agents" (p.12, 1962 Annual Report). In treating

TB, the Sanatorium relied on anti-tuberculous chemotherapeutic drugs along with "a continued period of treatment in the post-sanatorium period" (Ibid.). It assessed different facets of TB aside "modern efficient treatment measures." These included their search for "new bactericidal medication" and delving further into sensitivity to chemotherapeutic agents. A significant contribution in treating TB was the emergence of anti-tuberculosis drugs introduced in 1947 (1963 Annual Report) but resistance to these drugs later raised concerns. Isoxyl which is a medicinal agent became available during 1963 but its value could only be ascertained with further usage.

Rehabilitation

Rehabilitation concerns the return to one's former health and privileges and with therapy following illness, addiction or detention. Demands changed as a result of newer methods of treatment necessitating greater efforts in rehabilitation. The construction of new buildings was associated with these demands. Not only were there changes in treatment and efforts directed at rehabilitation but these changes were accompanied by changes in the physical development of the Sanatorium (1953 Annual Report). Efforts toward rehabilitation may speak to what the Sanatorium understood as a solution. The addition of "Indian and Eskimo" patients necessitated an increase in the number of teaching staff and occupational therapists (1954 Annual Report). The Sanatorium continued to direct its efforts towards rehabilitation which became challenging as patients increasingly had shorter stays, making it difficult to carry out new studies (1959 Annual Report).

Screening Campaigns

One of the means by which the HHA attempted to fight TB was to execute surveys. They attributed control of the disease to the removal of those infected. Mass x-rays surveys were used throughout the crusade from the advent of the institution, irrespective of the treatment and methods employed. The Sanatorium felt obligated to intensify its case-finding activities by expanding its reach to include all members of society. For instance, they surveyed welfare recipients and those in jail (1956 Annual Report). Increased case-finding activities resulted in what the Sanatorium saw as "favourable trends" (1957 Annual Report) that is, a decline in the number of patients in residence. The number of Indigenous and southern Canadian patients declined from the beginning to the end of 1957. As years passed, the Sanatorium's treatment methods improved and proved favourable as they later anticipated a steady decline in the incidence of TB. Their efforts to search for new cases increasingly intensified over the years.

The removal of people with TB from the community was understood as a requirement in decreasing morbidity rates (1958 Annual Report). The Sanatorium was so determined to search out all cases that it screened people who were incarcerated, on public welfare, unemployed, or admitted to hospitals and this resulted in a steady flow of new cases. This program was not only relatively new but also pushed for greater efforts in educating the public on health measures that they could take advantage of in controlling TB (1958 Annual Report). The push for health education was backed by local and provincial authorities and voluntary groups. The HHA saw extensive surveys, the

removal of TB patients from the community, drug therapy and educating the public on health measures as solutions to controlling the disease. This conception reflects the use of a biomedical model, the policies put in place by officials responsible for Inuit health and it helps to account for the dismissal of Inuit approaches to TB and other health issues.

Although the number of patients in residence continued to decline, the HHA actively continued their search for cases in southern Canada and the North. It developed and set in motion a mass x-ray survey (1959 Annual Report). The Canadian Tuberculosis Association and the Thoracic Society reached out to the HHA and requested that they conduct a survey of primary drug-resistance across Canada. The HHA met the request with a survey underway and it was their attempt to uncover its magnitude and rate of progression. The cooperation of TB establishments was sought in all provinces. Facilitates from which authorities had contributed to knowledge pertaining to these matters were identified. They were located in the United States, Britain, France and Denmark and were seen as centres which the chief investigator needed to consult in the early phase of the investigation. The HHA's Director of Laboratories later consulted these facilities and was given insight on concurrent perspectives concerning how to effectively carry out the investigation (1962 Annual Report).

The HHA continued to search out new cases of TB and they were convinced that there were "special high risk groups in the community" (p.12, 1962 Annual Report) of which their increased searches needed to target. They identified important groups to screen which included: seniors; public welfare recipients; inmates; diagnosed cases; and

those with years of inactive TB (1962 Annual Report). This measure was taken to ensure that all sources of infection were screened and removed. Shorter stays at the Sanatorium were attributed to advancements in medicine paired with identification of TB in its early stages. A mass survey was underway in the city at the time and the HHA was convinced that they would find new cases, including many who would be unaware of their infection (1963 Annual Report).

The HHA's laboratory attracted visitors, one of which included a dinner with Toronto scientists who had offered their valuable support and advice over the years. The clinical pathology division increased its work load as the project of scanning to determine the incidence of drug-resistant tubercle bacilli across Canada consumed the HHA's time. In fact, it became their major activity. TB facilities and laboratories across Canada cooperated in this project and the results showed that primary drug-resistance in the country were not yet a serious problem. Like previous years, the HHA's staff took part in conferences, panel discussions, scientific publications and professional programs they found relevant eradicating TB. In 1963, their Director of Laboratories presented a paper on bactericidal facets of the nation-wise survey of primary drug resistance to the Ontario Association of Pathologists and another on the findings of the investigation to the Ontario Tuberculosis Association. The HHA made plans to continue the survey of drug-resistance and resume research concerning time concentration relationships of antituberculosis drugs in 1964 (1963 Annual Report).

Conventions and Collaboration

The Sanatorium took it upon itself to have their members engage in what they felt were important conventions and become members of professional groups. They saw it as an opportunity to exchange, whereby selected members of the Sanatorium could impart their experience while becoming informed about the latest developments in TB treatment (1954 Annual Report). Conventions and professional groups presented opportunities for them to actively engage in claims-making activities by disseminating their mission, conceptions of TB and treatment. Their program in treating tuberculosis attracted the attention of visitors across the commonwealth. Their visits provided opportunities to exchange knowledge and discuss what they understood as common problems and solutions. The Sanatorium felt fortunate in the quality of facilities available in Canada and compelled to share what they had learned (1957 Annual Report). Their staff attended meetings, presented scientific papers, and engaged in panel discussions (1958 Annual Report). This was their means of keeping updated on new developments in the treatment and control of TB and imparting their approaches.

Conclusion

Once the Canadian government accepted responsibility for Inuit health, it also decided to evacuate Inuit people to southern sanatoria. The Mountain Sanatorium was among them and was designated for the treatment of Inuit from the Eastern Arctic. The annual reports provide a window into the activities of the HHA. It revealed its conceptualization of TB as a social, biological, adaptable and unyielding disease. Strategies employed in efforts to secure funding and policy concerns exemplified the

challenges of the institution beyond treatment concerns. The HHA like many organizations needed to maintain moral legitimacy and develop strategies (i.e. diagnostic, motivational, and prognostic frames) to manage external forces in order to continuously acquire resources necessarily for its operation. The annual reports also revealed the HHA's understanding of the problems and solutions of TB which was evident in their clinical research investigations, mass x-ray programs, and medical conventions.

CHAPTER 5: AN ANALYSIS OF TUBERCULOSIS AND THE HAMILTON SPECTATOR

The tuberculosis epidemic in Canada has been well documented by the media. TB coverage spoke to the significance of the disease as newspapers exposed the attitudes and fears of Hamiltonians (Herring, 2007). The HHA and its administration of the Sanatorium were supported by media institutions. Among them were: The Hamilton Spectator; Hamilton Review; Hamilton News; and Reid Press. The Canadian Broadcasting Corporation and radio stations CKOC, CHML, CJSH, and CFRB provided assistance to the Sanatorium through their services, membership and donations. Newspaper clippings retrieved from the Health Science Library Archives at McMaster University were mainly from The Spectator. It was a sustaining member and donor, and it provided extensive coverage of the HHA and its crusade against TB. This chapter presents an analysis of The Spectator's articulation of the disease with regards to its problems and solutions.

The Hamilton Spectator is a daily newspaper founded by Robert Smiley in 1846 and is debatably the longest running in English Canada (Wells, 2016). On publishing days, it was delivered to hundreds of thousands (Wells, 2016). The Spectator interests itself in "searching for truth, exploring the human condition, and striving, at least, to relay it to Hamiltonians accurately, fairly, and with flair" (Wells, 2016). Its founder and editor was known as a visionary man and a political conservative who immigrated to Canada from Ireland as a young boy (Wells, 2016). In his teenage years, he was apprenticed to a printer in Kingston and employed in Montreal as a printing foreman (Wells, 2016). In 1846, at the age of 29, Smiley was sought by the Conservative Party to start a newspaper

in Hamilton (Wells, 2016). Newspapers were partisan at the time and the party longed for a publication that would back the conservatism of John A. Macdonald, then a talented lawyer (wells, 2016). In 1855, Smiley died of TB at the age of 38 in Hamilton (Wells, 2016).

The Spectator was the main source of news in the 1950s and 1960s (Wells, 2016). Between 1953 and 1963, 38 articles have been preserved in the archives in addition to photographs and advertisements. These articles generally provided coverage on: developments in TB prevention and cure; the experience of Inuit patients particularly their transition, education, and return to the Arctic; Inuit soap sculptures; the conversion of the HHA's buildings for other uses; and social events hosted or attended by the HHA. Patterns in the reportage of TB were drawn, some of which reinforced those identified within the HHA's annual reports. The articles have been clustered according to their overall themes. Themes included: legitimization; medical expertise and mobilization; education as therapy; and othering, ethnocentricism and representation. The articles were examined to uncover conceptions of TB, problems identified, and measures implemented.

Legitimacy

The Spectator`s coverage of the HHA disclosed its challenges and accomplishments in fighting tuberculosis. The Spectator played an important role in supporting and promoting the HHA's claims by relaying its mission, activities, and concerns to the public. It did so in its reportage by providing profiles of the HHA's board of directors; spotlighting its key events; and headlining the spirit of volunteerism that

made the institution what it was. TB presented a social problem for the HHA. Spector and Kitsuse (2001) define the construction of social problems as consisting of: a condition, specifying why it is objectionable or unethical, identifying its causes, describing necessary measures and the process of its materialization. Defining social problems involves claims-making which "consist of demanding services, filling out forms, lodging complaints, filing lawsuits, calling press conferences, writing letters of protest, passing resolutions, publishing exposes, placing ads in newspapers" (Spectator & Kitsuse, p.79, 2001). Those involved in these activities participate in the process of defining social problems. In reporting on its administrators and activities, The Spectator took part in defining TB as a problem and legitimized the HHA.

Persona, Competency and Respectability

The Spectator engaged in claims-making in its projection of the HHA and the Sanatorium as an institution operated by personable, competent and respectable individuals. In 1956, The Spectator published *Elect H.F. Lazier Head of Health Association,* an article on H.F. Lazier, a native of Hamilton who had just been elected as the president of the HHA. It briefly mentioned the service of Lazier's father and grandfather who had been directors of the HHA. In making mention of their contributions, The Spectator set the case for H.F. Lazier as competent and deserving of presidency. Competency was then assured in a discussion of Lazier's education at the University of Toronto and at Osgoode Hall, and his role as a commanding officer and major during the Second World War. In 1957, The Spectator also published *Revered*

Physician, San Pioneer, Dies, an article that discussed the life of Dr. J. Howard Holbrook and his honourable service with the Sanatorium. Dr. Holbrook was celebrated as the man who "cut the tuberculosis death rate among Hamilton children almost to the vanishing point, and who built the Mountain Sanatorium from a tiny, one room institution into the largest tuberculosis hospital in the British Commonwealth." The 37 years he spent as a medical superintendent, his education at the University of Toronto and employment experience including his position as a surgeon at the Hamilton General Hospital, was discussed. Dr. Holbrook was spoken of as a man regarded highly by the Hamilton community for being a pioneer "in the field of tuberculosis prevention and treatment" and credited for "checking the once-dreaded great white plague." In discussing the life and contributions of the Lazier family and Dr. Holbrook, The Spectator presented the HHA as an honourable and legitimate institution. It made use of their credentials – education and public service – to legitimize the HHA given that these credentials are associated with good citizenship and authority.

The Spectator helped to legitimize the HHA by putting a face to its directors, staff, and volunteers. They did so by documenting the conventions it attended and events hosted by organizations working at the Sanatorium. The HHA was legitimized through its affiliation with dignitaries which was highlighted in The Spectator's coverage. In 1955, The Spectator presented photographs of the British Medical Association Convention in Toronto and a luncheon held at the Sanatorium for attendees. Attendees were pictured comfortably sitting outside, eating, and conversing. This imagery was instrumental in painting a picture of the HHA as an institution run by personable individuals who

laboured towards fighting T.B. yet found the time to enjoy the company of fellow community members. *25 Organizations Give Annual Reports on San* discussed an annual meeting held by the HHA in which 25 organizations presented reports concerning work conducted at the Sanatorium. Similarly, the 1957 article *Reports Heard from 50 Organizations Assisting*, discussed the HHA's annual meeting where organizations working at the Sanatorium again presented summaries of their volunteer efforts. These organizations assisted the HHA in meeting patients' needs that went beyond their capacity. Their efforts consisted of "friendly visits, small gifts and comforts, to educational and religious projects, and the presentation of expensive equipment and hospital supplies." These articles promoted and thus legitimized the HHA by shinning the spotlight on its work through the numerous organizations lending their support.

1956 marked the fiftieth birthday of the Sanatorium. For this reason, it was expected that The Spectator would report on its festivities. The Spectator presented pictures of staff and friends of the HHA, of which hundreds attended. In 1958, the Spectator published *San Stages Birthday Party to Say 'Thank You' to 700* which discussed voluntary contributions enabling the Sanatorium to become among the largest TB institutions in the British Commonwealth. At this party, "representatives of service, clubs, church and civic groups enjoyed tea and cookies, chatted and admired exhibits made by some of the 600 patients."According to the reporter, these exhibits included handiwork with proceeds given to the craftsmen. In fact "a large number of the patients at the Sanatorium are Eskimos, and their soapstone carvings – featuring walruses, canoes and similar objects – attracted many buyers." The article also noted school work

completed by children at the Sanatorium that had been displayed. Dr. Ewart, the president of the HHA remarked "once people came here with no hope: Today, there is every hope." That year, The Spectator also provided coverage of the HHA's annual dinner along with a photograph of guests. Reportage of the festivities served to represent the HHA as an institution revered by many. In discussing those who worked with and supported the HHA and those who attended its events and the programs held at the Sanatorium, The Spectator engaged in claims-making as these affairs constituted a contribution to the fight against TB. The theme of legitimacy is present given that it portrayed the HHA as a necessary establishment supporting and supported by the Hamilton community. The evaluation of leaders and representatives is an important component of moral legitimacy and rests in part on the "charisma of individual organizational leaders" (Suchman, p.581, 1995). Volunteers and organizations working at the Sanatorium who attended its festivities embodied legitimacy which extended to the Sanatorium. Communal support of the HHA reflects Suchman's reference to Jepperson (1991) who maintains "part of the cultural congruence captured by the term legitimacy involves the existence of a credible collective account or rationale explaining what the organization is doing and why" (p.575). The HHA's volunteers and partners helped to boost the association's collective account.

Volunteerism

The Spectator captured the spirit of volunteerism in its coverage of events and services run by organizations and individuals at the Sanatorium. The article *Patients at*

the Hamilton Mountain Sanatorium welcome a busy, cheerful visitor who is the... Godmother of the San greatly captured the spirit of volunteerism. The Godmother is Mrs. Torrance, who "has been visiting the San several days a week, carrying in her commodious shopping bag items requested by patients, special bargains put aside by Hamilton stores, and candles and beads destined to bring a smile of delight to the faces of Eskimo children at the San" (Mason, 1958). According to the article, it began when she visited a friend with TB and offered to purchase items for her. When she realized that other patients also needed someone to shop for them, she offered these services. It was her service to patients at the Sanatorium that explained why Mrs. Torrance "was made a life member of the Health Association" (Mason, 1958). In dedicating an entire article to Mrs. Torrance's volunteer service, The Spectator engaged in claims-making by supporting the HHA in its push for membership and volunteerism. In 1959, the Automobile Club hosted a party at the Sanatorium of which The Spectator documented. Their article *Automobile Club Host at Sanatorium Party*, detailed the experience of Inuit children unable to attend the festivities due to chicken pox. They were later entertained by a clown through a window as The Spectator snapped a photograph. This article, much like others published by The Spectator, placed volunteers and Inuit patients as the focal point in their discussion of the HHA's affairs. In doing so, it presented an image of the Sanatorium as a facility treating mainly Inuit patients and greatly supported by volunteers. This served to establish the Sanatorium as an altruistic institution sustained by model citizens rescuing "helpless" Inuit TB evacuees. Lastly, in another article, nine people from the Kiwanis Club of Hamilton were photographed during their weekly quiz

show at the Sanatorium in 1960. The caption read: "PROGRAM PANEL – The Kiwanis Club of Hamilton has started its weekly quiz program at the Hamilton Sanatorium, over closed circuit radio. Prizes are given to winners each week by the Club." Mrs. Torrance, the Automobile Club and the Kiwanis Club of Hamilton were among the volunteers documented by The Spectator which affirmed the HHA`s purpose as a worthy cause. It casts volunteers as morally upstanding citizens doing 'the right' thing and part of this meant white people helping poor Indigenous People which captures the white-saviour complex and a narrative of the deserving victim. The use of victims to define social problems is an important component in convincing people why they should be concerned (Mahood & Satzewich, 2009). By spotlighting the contributions of volunteers, The Spectator promoted volunteerism and the institution. Volunteerism was cast by the HHA and The Spectator as a necessary measure in the success of the HHA and its anti-TB movement.

Expansion and Existence

Claims-making is present in institutions' efforts to expand their scope and ensure their existence. An article that also spoke to the theme of legitimacy was *Hamilton Doctor's debate Children's Hospital* which reported on a debate between doctors concerning whether and where to build a children's hospital. One of the points noted was that empty beds at the Sanatorium necessitated expansion into other medical concerns. The medical superintendent asserted "we then did, and have since, made that fact public many times emphasizing that we could have to take on another activity before long. Two

years ago, we discussed tuberculosis with this Academy of medicine and we said then that we had many empty beds and would have to find a use for them." His statement affirms Spector and Kitsuse's assertion that social problems are the result of individuals and groups who take the initiative to identify certain conditions as problems (2001). Claims-making was evident given that although an increase in empty beds marked progress in the fight against TB, it also posed a threat to the existence of the Sanatorium as it needed to be oriented around a given health concern. Concerns create jobs and a clientele because people with grievances make demands which offer problem-solvers with a purpose and thus legitimacy. During the debate, a doctor remarked "faced with the problem of 500 empty beds, the HHA started surveying the various problems of health in the community several years ago." Another doctor asserted "everybody is interested in children but how many people are interested in alcoholics." These remarks speak to the role of constructing certain conditions as problems in what becomes perceived as a public interest or concern. In responding to whether the Sanatorium planned to remain open, Dr. Ewart remarked "there is no intention of making this a closed hospital. It is the responsibility of the board of directors to run a hospital" which illustrates the importance of expansion into other medical concerns as it would ensure their existence as an institution. The HHA wanted to justify its existence beyond the TB epidemic. It also presented a financial concern given that the institution relied heavily on volunteers to meet various needs and the construction of a hospital would cost tax-payers. Ultimately, the tension was between the interests of medical professionals and the public. They emphasized a need to balance the availability of resources such as empty beds and

resources needed, particularly whether to invest in children or alcoholics. This exemplifies how problems are generated given that a choice was being made on whether to treat children or alcoholics rather than it occurring as a given condition.

Lastly, Harold Lazier (president of the Hamilton Health Association) wrote an article *(San Story: From tents to $10, 000, 000 Layout)* which shed light on efforts toward ensuring the HHA's existence through membership, charity and expansion into other medical fields. The HHA explained the increase in empty beds as the success "of an all-Hamilton and district project" and that "membership in the Hamilton Health Association is open to anyone. Through their voting power, the members control the operations of the Association" (Lazier, 1960). Despite the support of the government, "there are still many things for which the Association must look to the generosity of the people of Hamilton and district" (Lazier, 1960). This helped to account for extensive advertisements persuasively calling people to donate to the Christmas Seal Fund. In fact, helping was framed as a responsibility towards the anti-TB campaign. Funding needs increased as the HHA included new divisions. The Sanatorium had to outgrow the problem of TB and become a general hospital in order to remain open.

Medical Expertise and Mobilization

Drugs, Clinical Investigation and Screening

At the heart of claims-making activities was the HHA's push for drug therapy, clinical research, and screening. These measures were promoted by The Spectator as stories concerning them made front page headlines and consumed significant sections

within the newspaper. Coverage of these measures also delved into the specific steps people could take in fighting tuberculosis and new developments in the prevention and cure of the disease. Jane Baker's (1956) article *Lab Workers Plan Tactics in War on 'White Plague'* centered on the work of the Director of Laboratories and 21 doctors and technicians in helping lower mortality and morbidity rates through clinical investigation and training. These medical professionals were cast as the "white army" equipped with the expertise to fight TB in the laboratory which was central to the Sanatorium. A key theme running through this article was that of medical expertise and mobilisation. It is evident in the article's use of medical jargon; its focus on TB as a biomedical matter necessitating an army of doctors; and use of doctors and technicians photographed in laboratories utilizing sophisticated medical devices.

The Captain of the Men of Death still Dwells with Us is an article written by Dr. Wherrett – the executive secretary of the Canadian Tuberculosis Association – who reinforced the legitimacy of medical staff at the Sanatorium. Dr. Wherrett described the staff as competent and trustworthy people dedicating their lives to conquering TB which he described as the "captain of the men of death," and a stubborn disease (1959). He wrote "all it needs to keep going is neglect down the line…It will yield only to continued pressure on all fronts" (Wherrett, 1959). It strongly implied that people who had not consulted medical professionals posed a threat and thus reinforced medical professionals as experts in charge of T.B. control. Health was defined as a matter of safety, in stating "the one to fear is the one with a persistent cough who hasn't had a tuberculin test or a chest x-ray" (Wherrett, 1959). In fact, those who were discharged were deemed safe

working companions and good employees. Dr.Wherrett then went on to present ten facts surrounding the nature of TB and the role people could play. This included making sure that loved ones got regular check-ups and adhered to doctor's orders. This article was persuasive in laying out the medical background and placing the onus on people to come forward for x-rays yet it placed power on medical professionals to fight the disease directly. It highlighted contributions of "earlier diagnosis plus new drugs and new strategy to augment traditional treatment" (Wherrett, 1959). It placed emphasis on aggressive and ongoing case-finding activities and on doctor's expertise and the notion that only patients who followed doctor's orders were safe and could be trusted. In doing so, it exemplified the theme of medical expertise and mobilization as the purview of medical professionals thus reinforcing the biomedical model. This theme was also exemplified in the presentation of facts on the nature of TB and the role people needed to take in helping to fight the epidemic.

Dr. Hugo Ewart, the medical superintendent, the director of nursing, and a physiotherapist are photographed in The Spectator in 1959 inspecting physiotherapy equipment at the new hospital for convalescent and chronically ill patients. This photo captured the HHA's reliance on technology which is characteristic of the biomedical model. Written on the front page of the Spectator is *Hamilton Lab Leads Defence as...The TB bacillus fights back!* The 1963 article discussed the findings of a nation-wide Hamilton-based survey on drug-resistance. According to the survey, drug-resistant germs produced "three to five percent of new tuberculosis cases reported in Canada." The study was "directed by Dr. A. R. Armstrong, director of laboratories for the Hamilton Health

Association. It accompanies mounting concern that tuberculosis may be adapting to drugs which have slashed its rate sharply during the past 15 years." According to this article, there was mounting fear that rates could climb to the levels of 1948 when the drugs were first used and most TB centres took part in the survey along with all the provinces. This is consistent with statements made in the 1962 and 1963 annual reports of the HHA concerning their screening activities and reports by their director of laboratories. According to The Spectator, "a spokesman for the HHA explained that three drugs have been found most effective against TB – Streptomycin, para-amino-salicylic acid and Isoniazid." Uncovering the extent of drug-resistance to the new form of the disease was the basis for the survey. This was seen as helpful in determining treatment for new patients. According to The Spectator, "when a participating centre receives a new TB patient, it sends to Hamilton cultures of the germs from that patient together with information about him. AT THE HHA laboratories, the germs are placed in bottles containing varying strengths of each of the three drugs. The action is checked against that of the drugs on non-resistant forms of TB germ." The article included photographs of laboratory staff dressed in laboratory gear while using equipment to examine incoming cultures. This imagery along with the findings of the survey spoke to a reliance on drug therapy and medical apparatus characteristic of the biomedical approach.

Health Education

The Hamilton Health Association's efforts at health education are discussed in the article *So Who's Ben Casey?* According to The Spectator, "Hamilton has joined the

movie medic trend but the scene being filmed here is aimed at educating, not entertaining. The Chedoke General and Children's Hospital has been chosen as the setting in which a 30-minute movie on the "community hospital" is being made." An important point to note was that this article was centered on the role of the doctor as an authority figure and the patient as a passive individual at the mercy of illness. It thus exemplified the HHA's efforts to mobilize the public through health education campaigns and reinforced medical expertise as exclusive to medical professionals.

Education as Therapy

Schooling

A considerable number of articles written by The Spectator were concerned with formal education at the Sanatorium, particularly that of Inuit patients. Articles written on the topic included: *San Pupils Will Study All Summer* in 1957; *San for Some is Door to World of Learning* in 1959; and *Long Weeks in Bed No Bar to School* in 1963. *San Pupils Will Study All Summer* included a picture of four young girls (three of whom were Inuit) at the Sanatorium dressed formally and smiling as they held dolls won for completed school work. The implication was that patients would need to build skills to prepare them for life after sanatoria. Summer classes at the Holbrook School were presented as an opportunity children looked forward to as it relieved "the monotony of weeks of tuberculosis treatment" (Kidd, 1957). *San for Some is Door to World of Learning* discussed the challenges and advantages of attending school while at the Sanatorium. Schooling was understood as a necessary component in helping patients accept and cope

with tuberculosis. In fact "lessons have played a big part in the recovery of many TB patients. They have kept the patient's mind and time fully occupied and maintained some thread in a suddenly shattered life." Patients were accommodated when possible, for instance when drugs caused drowsiness or students became bed-ridden. The article discussed the range of courses available (e.g. metal and coal mining theory, air navigation) and commercial subjects including "123 correspondence courses." The students were of all ages including "a 42-year-old Chinese who wanted to, and did, learn bookkeeping." The Sanatorium also made educational broadcasts through its closed-circuit radio-station. Lastly, *Long Weeks in Bed No Bar to School* discussed features unique to the Sanatorium school. These included the Sanatorium's radio station, bedside instruction, and its curriculum which encompassed "painting and commercial art, business courses, drafting and blueprint reading, English for New Canadians, watchmaking, home economics, practical electricity, radio servicing and broadcasting" (Calkin, 1963). Two photos were included in this article, each of which included a teacher providing a student bedside instruction. Education as an aid in TB treatment was evident in all the articles that discussed schooling. Within these articles, The Spectator presented schooling as one of the great accomplishments of the Sanatorium. In doing so, The Spectator helped to affirm the HHA's claim as a necessary institution helping Canadians cope with tuberculosis.

Counselling

While the church has played a significant role in the crusade against tuberculosis by setting up hospitals and schools in the Canadian Arctic, The Spectator's article *Man's Deepest Needs Sometimes Calls for Soul Surgery* written in 1963, sheds light into the key role they have played at the Sanatorium. Representatives of the church took up clinical pastoral work determined to help patients face crisis. According to The Spectator, "they include priests and ministers of the Anglican and various Protestant churches, theological students, and two young women religious leaders. Basically they are taking the clinical pastoral training course for ministers which is conducted each summer by McMaster University Extension Department, with the Rev. A. J. MacLachlan in charge" (Wilkinson, 1963). Their services involved attending to patients enduring physical and mental illnesses. Completing this work successfully "as representatives of the Christian Church, they are learning, involves gaining understanding of some of the deepest needs of man's soul – needs which often are not so much in evidence outside the confines of the hospital walls" (Wilkinson, 1963). The article depicted these counsellors as servants who acknowledged the troubles and anxieties patients faced regarding their previous demands and responsibilities such as mortgage payments, in addition to TB. These anxieties, which were seen as the result of having ample time to think while bedridden, were among "the problems facing those in whom the Church seeks to join its ministry with that of the doctors and nurses" (Wilkinson, 1963). Trainees were "taught something of the problems of general and psychiatric nursing. They are learning something about allergies, nerves, lung surgery, cancer, maternity, mental illness, heart trouble, alcoholism" (Wilkinson, 1963) What is interesting about this clinical pastoral work is the recognition (by the

pastors) that the needs of patients required both social and spiritual approaches. The inclusion of counselling may speak to the Sanatorium's recognition of the value of alternative responses although to a lesser degree than the biomedical approach. The article included photographs: one is of Rev. A.J. MacLachlan; trainees role-playing the patient and counsellor; and four ordained students discussing the problems of hospital counselling. This article depicted the HHA as an institution that considered alternatives to the biomedical model with regards to the emotional and mental wellbeing of their patients. Counselling was depicted as a necessary measure in coping with TB.

Othering, Ethnocentricism, and Representation

The theme of othering, ethnocentricism and representation was evident throughout many of the newspaper articles. This theme was present in discussions that concerned: educating Inuit patients; accomplishments in lowering TB rates; use of art as therapy; efforts in assimilating Inuit patients; and their return to the Arctic. Claims-making efforts were also evident within these discussions.

Education

Kingsley Brown's *New Eskimo Primer* discussed the challenges teachers encountered in teaching the "Eskimo language to Eskimo children." He noted that the primer was in line with "the federal government policy of fostering Eskimo language and culture" (Brown, 1956). Being a resource for language acquisition, it attracted the attention of the Department of Northern Affairs in Ottawa. Teaching Inuit patients English was stated as its main goal and teaching them their language was explained as

ensuring a means of communication with their families. There was the assumption that Inuit patients would not be able to relate to cultures they had not been exposed to, noting that they did not celebrate occasions such as birthdays, and thus promoting the primer. One responsible for teaching the children remarked "not long ago we put on an essay contest for them on the subject of the Eskimo's future in the Canadian community" and later stated "we took a group of our children for a visit in various Hamilton plants to give them an idea of what our civilization was like" (Brown, 1956). Referring to Mr. Gagne, the author of the primer, Kingsley Brown stated "Mr. Gagne said that the Danish gov't has taken a keen interest in Greenland Eskimos for 20 years, and as a result the Eskimo language and culture in that part of the Arctic is of a high order. They have their own literature and poetry, and have even produced an Eskimo philosopher" (Brown, 1956). Brown also made reference to Mr. Gagne and Miss Morgan who were in the midst of revising the primer and asserted "we are going to have a narrative on a fictitious Tommy Taylor of Hamilton as a means of acquainting the children with our own way of life" (1956). A process of othering was evident as this article suggested that "Eskimo" children would not be able to relate to cultures they had not been exposed to. The essay contest and narrative writing was perhaps a window into assimilation tactics as it could be seen as an attempt to mould them and define their identity and role within Canadian society. Thus it may be fair to argue that the Sanatorium was carrying out the same sort of work as residential schools at a time when the IRS system was beginning to be phased out. The article made reference to an author and authorities who spoke of the Inuit as though foreign to Canada, incapable of relating to southern Canadians and as having a primitive

culture in stating that only through the external assistance of the Danish government, were they able to develop a sophisticated language, literature, poetry and philosophy. This ethnocentricism was also present in the use of narratives within the primer and educational activities to impart the notion that our culture (that of settler-Canadians) is superior and that the children needed to be acquainted with "our own way of life."

An article by the title *Spectator Entertains Group: Falls Impress Visiting Eskimos* graced the front page. It detailed the experience of nineteen Inuit who were given an opportunity to visit their family and friends at the Sanatorium. Hearing of their visit to the Sanatorium, The Spectator offered them a trip to the Niagara Falls. They came from "the Royal Canadian Electrical and Mechanical Engineering school at Kingston where they were being taught how to handle jobs in the Arctic" Bullock reported. In photographs, they were captured dressed in oilskins, thrilled at the sight of the falls, and smiling as they reunited with family and friends. The visitors were accompanied by an interpreter with the Department of Northern Affairs. In seeing that the Inuit patients were shy and reserved as their visitors walked into their room, a man from the Department of Northern Affairs remarked "they're not very demonstrative," but "they are really very affectionate. They just don't show it" (Bullock, 1960). Administrators of the Department of Northern Affairs accompanied the visitors and provided insight on the Inuit such as where they resided and their progress at the Royal Canadian Electrical and Mechanical Engineering school where "most have been rated excellent and the remainder very good. The army authorities have been most impressed with the aptitude of the Eskimos in understanding the engines" (Bullock, 1960). There was a fascination and admiration of their

accomplishments. While appearing well-intended, this fascination and admiration wasn`t necessarily innocent. It was as though their accomplishment in adapting to life in Ontario was completely unexpected because of assumptions concerning their capacity and adaptability. According to the media coverage of the Inuit at the Sanatorium, the staff and wider community harboured perceptions of the Inuit people and culture as unsophisticated.

T.B. Rates

Douglas Blanchard's article *10 P.C. Incidence Rate Drops to Nearly 3 P.C.* discussed TB rates among the Inuit and the process by which it significantly dropped. It specifically discussed treatment, mentioning the role of drugs, good nutrition, and rest in curing patients. In mentioning the activities the Inuit engaged in while in the Arctic, colonial fantasies were invoked as the Inuit was spoken of as though doomed. Reinforcing the notion of primitivism, Blanchard writes "no longer are they confined to hunting seals or foxes and building igloos. They drive bulldozers. They operate machinery…they know how to make and spend money" (Blanchard, 1959). This notion, along with the theme of ethnocentrism though it appeared as unconscious in Blanchard's mind, was evident in his statement "they are remarkably quick to adapting themselves to our way of life. Backward? Primitive? Nonsense. Poppy-cock" and yet he later asserted "many have gone home cured and educated in the ways of the modern world" (Blanchard, 1959) as though Inuit cultures were fixed in time. The theme of othering is exemplified in their differentiation between Inuit and non-Inuit people including the mention of

difference in physical appearance, stating "they're just about the same as any patient…aside from the fact that most of them look oriental" (Blanchard, 1959). The use of narratives to mark a difference in culture and the notion of the civilized and uncivilized runs throughout the article. Civilization was cast as synonymous with modernization and there was an underlying assumption of the Inuit as primitive upon admission to the Sanatorium.

Art

Jon Vorres' article *Eskimo Carvers' Art 'Discovered' – Again*, discussed the process in which "Canada has come to accept Eskimo art as part of its artistic tradition" (1959). It discussed "Eskimo art" as a growing market starting with talented sculptors carving soapstones provided by the occupational therapy department of the Sanatorium. Art sponsors, price ranges and films inspired by and showcasing the art were mentioned. It noted that there were 60 Inuit sculptors at peak times and a large percentage sold to Hamiltonians, as well as the role of the art market in privileging quantity and speed over quality and leisure. Of importance to note was the assertion that "in the hard and desperate facts of their existence, Eskimos found the inspiration to produce a unique and highly expressive art. In the scarcity of material available to them they sought and moulded, with simplicity and sincerity, a novel aspect of beauty. And what is most important, their achievement asserts once more the fact that great art is not special domain of those who stubbornly claim to be civilized" (Vorres, 1959). The theme of othering is present in that the works of art created by Inuit patients were distinguished as

Eskimo art and referred to in discussing Inuit culture, language, appearance, food and economy as intrinsically different. This is not necessarily negative as some may consider it as recognition. However as Charles Taylor (1994) notes in his *Politics of Recognition*, "our identity is partly shaped by recognition or its absence, often by the misrecognition of others, and so a person or group of people can suffer real damage, real distortion, if the people or society around them mirror back to them a confining or demeaning or contemptible picture of themselves" (p.25). Inuit patients at the Sanatorium were being recognized within a colonial framework thus misrecognized. The use of essay contests, field trips, Christmas parties, nativity plays and promoting Inuit art contributed to Canada's settler-colonial project because through their participation, Inuit patients were misrecognized and being assimilated into Euro-Canadian culture and society.

Events

The Spectator published articles detailing annual events held at the HHA such as their anniversary, Christmas program, and commencement exercises. What is interesting about these articles is that they placed the focus on Inuit patients. Coverage of these events evoked the theme of representation as Inuit patients were put on display. They were displayed as though the HHA intended to make of them symbols of culture and assimilation resulting from socialization by the Sanatorium. *Delightful San Party this Year Marks Unique Fiftieth Anniversary* is an article in which othering and ethnocentrism was apparent. It covered highlights of the San party organized to celebrate the Sanatorium's fiftieth anniversary. 500 guests including members of the staff and

voluntary establishments were welcomed by Dr. H.T. Ewart, the medical superintendent, and nurses. According to The Spectator, the "highlight of the afternoon was a display of soap stone carvings by the Eskimos and of sewing, craftwork, leatherwork, fine instrument work, and even a hi-fi set and amplifier, all done by the patients as part of their occupational treatment. Also on sale were toys and stuffed animals made by the children." In discussing the guests in attendance, naming and including a picture of key figures of the Sanatorium and its activities, this article helped present the institution as one run by hospitable and respectable people supported by organizations on a voluntary basis. The theme of othering and ethnocentrism were visible through the use of art as an opportunity to put Inuit patients on display. Othering and ethnocentricism did not necessarily undermine the institution's positive image or its claims to legitimacy enough to present a problem. It was overshadowed by the HHA's activities and declining mortality and morbidity rates which appeared to be a bigger concern for the general public and/or maybe because othering and ethnocentricism were par for the course in 1950s Canada. The theme of ethnocentricism and othering was mainly present in The Spectator whose articles were an interpretation of the HHA's affairs.

In 1959, The Spectator published a photograph of Inuit children sitting in rows of chairs, dressed formally with a British flag and a "Merry Christmas" banner in the background. The caption read: "friday afternoon was a big day at the Holbrook Infirmary School of the Hamilton Health Association when Eskimo children, under the direction of Mrs. E. G. Manzer, primary teacher, assisted by Miss Sylvia James, Kindergarten teacher, put on their annual Christmas program. This year they did a dramatization of Mother

Goose rhymes." This article demonstrated how events such as the Christmas program, became an opportunity to represent the HHA and its efforts with Inuit patients, particularly what they've learned and their ability to assimilate. Similarly in *'...Canadian' Tots Have Big Day at San* which was written in 1959, three children are photographed at the Sanatorium taking part in its annual commencement exercises. The writer asserts "myriad children emotions were reflected in the faces of young patients finding a health cure thousands of miles south of the tundra and ice flows of their homeland." In front of visitors the children "sang songs, recited nursery rhymes, clanged and rattled percussion instruments, presented a puppet show, and received prizes and presents." Events were also an opportunity to express an identity and allegiance. The chorus in one of the songs sung was "we're Canadian children all...we love our country." While discussions of the patients distinguished between the Inuit and non-Inuit, Canadian identity as an umbrella term was affirmed. The use of "Canadian" to distinguish between Indigenous Peoples and settlers in some instances (othering) while using it for the erasure of Indigenous histories and cultures (i.e., assimilation rather than integration) in other instances contributed to a settler-colonial project. Lastly, in the article *Eskimo Children Top Bill*, Inuit children "literally stole the show yesterday afternoon at the Mountain Sanatorium Children's Christmas party. They put on a nativity play which left the audience spell-bound." Guests were welcomed by Dr. H.T. Ewart, the medical superintendent, and a director of the HHA who praised the work at the Sanatorium school. Annual events, as shown in this article, allowed the HHA to engage patients in patriotism and present itself in a positive light.

There was a consistent pattern of focusing mainly on the Inuit or differentiating between Inuit and non-Inuit people in coverage of the Sanatorium. The latter was also a pattern in the HHA's annual reports. This pattern was present in an article published in 1960 in which three Inuit women are photographed while entertained at the annual children's party hosted by the Hamilton Automobile Club. The caption read "ESKIMOS MEET A CLOWN – Eskimo patients at the Mountain Sanatorium had fun yesterday when they joined in the annual children's party given by the Hamilton Automobile Club." Similarly, in a photo below, an Inuk woman and two Inuuk children adorned with party hats posed for a picture. The caption read: "FROM DIFFERENT GENERATIONS – Kayava-suka, 64, one of the oldest Eskimo patients at the San, helps Phillipe Uvillik, seven, centre, and Rhodie Ulitie, five, right, to cut the party cake." While media coverage placed the Inuit at the centre of stories, their thoughts and concerns on TB treatment were sidelined. In fact, there was no coverage on the Inuit patient's thoughts and concern throughout the articles.

The Return

The late 1950s and early 1960s marked a time in which a considerable number of Inuit patients were returning to the Arctic. This was either a result of having overcome TB or the Department of National Health and Welfare's policy that stipulated that the Inuit continue treatment in the Arctic. Their return was well documented by The Spectator. *This is the Way We Go* was an article about three Inuit girls "who will leave tomorrow morning for Montreal, where they will board the C.D. Howe for the long

voyage home." They are pictured studying "a map of their route home to Baffin Island." In another article *Pipe for the Road*, an elderly Inuk woman is photographed holding a pipe of tobacco. Readers are informed that her name is Mrs. Kanekoochook, "*a 75-year-old Eskimo woman"* savouring some tobacco "before leaving the Mountain Sanatorium today for her home on Arctic Bay. She was one of a group of 27 Eskimoes who left the San for various points in the bleak northland." Lastly, Algar, an Inuk mother and her baby were photographed in winter coats outside the Holbrook Pavilion at the Sanatorium in1960. An article discussed the challenges that remained in the process of returning as not all patients left with friends and family. This was the case for Algar Tatoosie, whose baby was "born at the San" and who has gone back "home in the Arctic although the baby's father is still a patient at the sanatorium." In 1963, The Spectator published more articles detailing the return of Inuit patients to the Arctic. What is interesting about 1963 is that it was the year that the last group of Inuit patients left the Sanatorium. In *San Staff Bids Misty-eyed Farewell to 10 Arctic-bound Eskimo Patients*, readers are informed of the steps taken at the Sanatorium in preparation for their return home: "the Holbrook Pavilion at the Sanatorium, where the Eskimos have been convalescing, has been a beehive of activity for the past week as the staff worked extra hours to outfit the children in new dresses and clothes." A young Inuk girl, Martha, is captured holding a doll. She was "one of the five children among 10 Eskimos who left the Mountain Sanatorium today." Readers were also informed that it would be "one of the last groups of Eskimos to leave." Reflecting on their time with the Inuit, a staff member at the Sanatorium remarked "they are so quiet and patient. They adjust so easily to strange surroundings and never

complain." In *Only Five Eskimos Left at San: 3 Leave Sun for Cold Arctic*, The Spectator informed readers of their travel plans including their means of transportation and the assistance of the HHA and the Department of Northern Affairs. Children were accompanied to Montreal by "Miss H. McGhee, director of volunteer services for the Hamilton Health Association" at which the Department of Northern Affairs would assume responsibility and "deliver the three to their destination by plane." The response of staff and friends of the HHA to the return of Inuit patients as documented by The Spectator was consistent with statements made in the HHA's 1963 annual report. Although there was an obsession with Inuit people, which could be argued strengthened as the last groups left the Sanatorium, there was a glaring silence on how they felt about having been evacuated thousands of miles away from family and friends to battle the dreaded disease. This silence parallels the lack of Indigenous approaches to the control and treatment of communicable diseases in health care facilities that actively target SDOH. When the Inuit are referred to within the articles, it was often in relation to their ability to create art pieces, adapt to language and what was cast as the culture of southern Canadians. The conditions they have been accustomed to prior to their arrival at the Sanatorium were spoken of as primitive, harsh, and pre-modern. This thus serves to mark the Inuit as other, foreign, intrinsically different, and even culturally inferior.

Conclusion

Having examined the newspaper articles, it is evident that claims-making activities were prevalent in the construction of problems and solutions as they concerned

the TB epidemic. Themes evident in The Spectator's reportage of TB and the HHA's activities included: legitimacy; medical expertise and mobilization; education as therapy; and othering, ethnocentricism, and representation. Through the themes identified, the newspaper clippings revealed characterizations of TB and a reliance on the biomedical model though some workers at the Sanatorium acknowledged the importance of social and spiritual remedies. In discussing the HHA's directors and volunteers, expansion, and clinical investigations, The Spectator helped define TB as a problem and also grasped the HHA's dependence on external resources including legitimacy.

CONCLUSION

The central question that guided this research was: how did professionals at the Sanatorium and The Spectator, understand the problems and solutions to the tuberculosis epidemic? TB treatment among the Inuit between the 1950s and 1960s was at the heart of this research. Attention was directed on how the disease was constructed as a problem in Canada at the time, the motivations behind it and the consequences of such articulations. In exploring these questions, archival data, specifically annual reports and newspaper articles published between 1953 and 1963 was utilized.

The theoretical approach used included the sociology of social problems and resource dependency theory. Using the social problems tradition, I unpacked the ways in which what constitutes TB became defined as a problem requiring mainly biomedical solutions. Pfeffer and Salancik's Resource dependency theory (1978) was used to examine the measures the HHA took to acquire legitimacy and survive as an institution. The objective of this research was to unpack the ways in which the Sanatorium and The Spectator defined TB as a problem and to illustrate the consequences that ensued for those directly and indirectly involved.

Main Findings

The Hamilton Health Association Annual Reports

The HHA and the Sanatorium had a complex conception of tuberculosis and understanding of its problems and solutions. Medical professionals understood TB as a biomedical matter though they defined it as a social disease in one of their annual reports. In that report, TB was defined as both a social and biomedical disease in which both

social and biological factors were deemed equally important. While the HHA understood it as a disease with social consequences, as it robbed people of their capacity to participate as members of society, the remaining reports defined TB as a biomedical phenomenon. The HHA also understood it as a bodily experience. TB was understood as an infection in the body that when dealt with appropriately, resulted in an improvement in one's physical condition. Cases in which people were unaware of their infection served to exemplify TB as a tricky disease that could live in one's body undetected. It was also characterized as a danger that needed to be addressed at all costs. They thus engaged in extensive screening to identify and treat those infected. To the HHA, it was also an unrelenting and adaptable disease as it resisted drugs that were previously effective. Medical professionals identified complacency as a threat to the eradication of TB but one of the biggest "problems" the HHA identified was drug-resistance. They grew accustomed to treating one disease but that changed as more successful methods of treatment were discovered.

While the HHA did not explicitly make use of the term *solution*, the measures they took in fighting TB could be argued as constituting them. Use of new drugs and procedures resulting in significant benefits were mentioned throughout the annual reports. According to the Sanatorium, their use of drugs was beneficial given that its complete use resulted in a decline in the number of patients returning with a re-activation of TB. Although equal attention was not given to the biomedical model and SDOH, their reliance on drug therapy proved effective. The HHA directed its resources towards clinical research projects and saw this activity as extremely important in reducing morbidity rates.

The Sanatorium made use of anti-tuberculous chemotherapy which they saw as vital in treatment. Anti-tuberculous chemotherapy produced favourable results as it made it feasible for patients to be discharged relatively early. As a response to drug-resistance, longer periods of post-sanatorium anti-tuberculous chemotherapy were recommended. Mass surveys were used as the removal of people with TB from the community was understood as necessary to decrease morbidity. They also pushed for greater efforts in educating the public on health measures. The HHA saw drug therapy, extensive surveys and the removal of TB patients from the community, rehabilitation and health education as solutions to control the disease.

Tuberculosis was articulated as mainly a biomedical problem but one that had social consequences along with responsibilities. Evidence provided to support this claim included the implementation of heavy drug therapy, clinical investigations, and extensive screenings. Social measures implemented but not to the same degree as the biomedical approach, consisted of formal education and craftwork. The solutions proposed were mainly biomedical and they were directed at controlling the disease in the body while social measures mainly concerned the efficient operation of the Sanatorium so that it could better direct its resources to the cause.

The Hamilton Spectator Newspaper Articles

In the newspaper clippings, tuberculosis was characterized as a disease that necessitated clinical investigations conducted by an army of doctors. The use of imagery depicting doctors and technicians utilizing laboratory equipment and medical jargon

affirmed the conception of TB as a biomedical matter. TB was described by Dr. Wherrett, an executive secretary of the Canadian Tuberculosis Association as the "captain of the men of death" and was characterized as a dreaded disease also known as the "great white plague." It was understood as a stubborn disease that when neglected ceased to succumb. TB was also seen as adaptable given that it became resistant to drugs previously effective in significantly lowering death and morbidity rates.

Much like the annual reports of the HHA, TB was defined as a danger of which people needed to take personal responsibility. It was seen as a disease in which those who had persistent coughs and had not been screened were deemed irresponsible and posed a danger. This perception of TB can be understood as stigmatization. Goffman (1963) defines stigma as an undesirable attribute that results in exclusion from characteristics accorded to one based on the group they are ascribed within society. The stigmatized attribute (TB) is not only defined as undesirable but because of it people are isolated and denied opportunities and dignity. It serves the function of clarifying boundaries between the 'normal' and 'abnormal' (Goffman, 1963). In this case people with TB are differentiated from the non-infected population as contaminating.

Danger was also posed by those who had not been safely discharged from the hospital. TB was understood as a disease that required individuals to take personal responsibility which included ensuring that individuals and their loved ones went for regular check-ups and adhered to doctor's orders. While the onus was placed on individuals to take these actions, TB treatment was reserved for medical experts.

Drug-resistance was presented as a problem. Like the HHA's annual reports, The Spectator defined drug-resistance as a serious problem in its reportage of new TB cases and the Sanatorium's plans to conduct a survey along with other TB centres to investigate its degree. The Spectator also spoke on the logistical problems facing the HHA as it relied on the support of various organizations to meet the needs of patients beyond their capacity. Another logistical matter concerned the need to expand by attending to other health and welfare needs given that bed occupancy had declined. Building the case for a need to build a children's hospital is an example of what Spector and Kitsuse (2001) identified as the process of individuals and groups generating social problems.

Actions implemented in attempts to control TB included the use of drug therapy and clinical research. Reliance on drugs was evident in the promotion of streptomycin, para-amino-salicylic acid and isoniazid which were identified as the most effective against TB. Doctors and laboratory technicians were seen as the solution to fighting the tubercle bacilli especially with the new threat of drug-resistance. The use of a biomedical approach was evident in the statement "the one to fear is the one with a persistent cough who hasn't had a tuberculin test or a chest x-ray." This conception of T.B. captures what it means to be a "responsible citizen" according to medical personnel and administrators. Emphasis was placed on the use of TB screening activities. An example discussed in The Spectator, is the nation-wide Hamilton-based survey on drug-resistance in 1963. While a majority of the articles that concerned developments in TB prevention and cure promoted the use of drugs, TB screening and clinical research, an article highlighting the significance of a spiritual approach was also presented.

The Spectator documented conferences the HHA took part in and provided coverage of the HHA's efforts at health education through their participation in a movie on the Chedoke General and Children's Hospital. Formal education was also an important aspect. It was seen as a means for disrupting the monotony of life at the Sanatorium. It enabled patients to take their mind off the stresses of treatment and direct it towards something they had better control over. Schooling at the Sanatorium was depicted as a necessary component in equipping patients for the outside world upon their discharge and more importantly accepting and recovering from TB.

A large number of Inuit patients at the Sanatorium made soapstone carvings. Like schooling, this form of art was seen as a means to productively cope with the demands of TB. In Eskimo Carvers' Art 'Discovered' – Again, Vorres asserted "in the hard and desperate facts of their existence, Eskimos found the inspiration to produce a unique and highly expressive art." Soapstone carving was discussed as an activity supported by the Sanatorium's occupational therapy department. In fact craftwork and other forms of art created by patients were "part of their occupational treatment."

The Spectator echoed many of the HHA's conceptions of tuberculosis and its understanding of its problems and solutions. The Spectator however directed more attention on formal education and art as it concerned Inuit patients at the Sanatorium, while equally reporting on clinical activity.

Significance

The increasing recognition that a strictly biomedical model is inadequate in serving the needs of medical-care recipients affirms the importance of this research. Research on the SDOH has revealed that various types of disease including TB are the result of factors which cannot be strictly attributed to biology (Gracey & King, 2009; Kulmann & Richmond, 2011; Raphael, 2006; Richmond, 2009). In fact, TB today is widely regarded by various health care organizations as a disease of poverty (Health Poverty Action, 2015; National Institute of Allergy and Infectious Diseases, 2012; WHO, 2016). However, the HHA and The Spectator did not frame TB in this way. The policy implications of the recognition of TB as a disease of poverty, is that in order to prevent the disease, policy makers must implement policies which directly target poverty and poverty-related issues. Doing so means creating and implementing policy for and by Indigenous Peoples. The Inuit community which continues to endure alarmingly higher rates of TB **(**Public Health Agency of Canada, 2013**)** have created the Inuit-specific TB Strategy "to increase awareness of the need for more effective approaches to TB prevention, control, and care for Inuit, and to present a path forward for reducing the incidence of TB disease" (Inuit Tapiriit Kanatami, p.2, 2013). The challenge to creating and implementing policy for and by Indigenous Peoples as Gabel (2012) notes is that government funding agencies expect Indigenous People to create and implement programs that operate within their limited parameters. The problems is that their "working definitions of holistic and culturally sensitive health services often do not coincide with First Nations' visions for the delivery of health care in their communities" (Gabel, p.105, 2012). Though TB rates declined significantly compared to the early

19th century, more recently there have been growing outbreaks (Ho, 2004; WHO, 2016). It is for this reason that TB and its study remains a relevant and crucial endeavor. Understanding how TB and other health matters are articulated is important given that the conditions in which people become more susceptible to TB such as crowded housing, poor sanitation, lack of ventilation (i.e., the conditions of residential schools) and access to basic needs such as clean water (National Institute of Allergy and Infectious Diseases, 2012) continue unabated though they affect some populations more than others. Using archives, this research combined content analysis with social problems and resource dependency theory. It contributes a political, social, and economic perspective on how an infectious disease came to be medicalized, problematized and a catalyst for a movement. It enables one to see how the underlying social, economic, and political climate determines health outcomes more than genetics and personal behaviour. It demonstrates the overwhelming need for political will. It contributes to an understanding of TB as a socially constituted disease that continues to be addressed mainly through a biomedical and Euro-Canadian model. This way of understanding TB helps eliminate the problem and improve peoples' quality of life by affirming the recognition that the failure to adequately address TB is in large part the result of a lack of political will. Health-oriented movements are advanced by claims-makers who must negotiate and manage environmental contingencies. Efforts to eradicate disease are as much a matter of its control and treatment as it is about the need for organizations to acquire legitimacy and survive. This study thus confirms and advances the significance and role of legitimacy, social problems as claims-making activities and resource dependency.

Limitations

A limitation of this study is that it made use of annual reports and newspaper clippings which presented a front stage perspective that may not reflect the back stage reality of the HHA. While the documents used are authentic, there is no guarantee that their content was consistent with the backstage perspective although that is unlikely. The content in the annual reports and newspaper clippings, are public statements and claims. It is possible that some doctors, administrators, and reporters felt differently. Another limitation was inaccessibility and incompleteness of the archival records as some components of the documents had not been preserved. For instance dates, authors, and the beginning and conclusion were missing or illegible in some of the newspaper articles. Thus other sources needed to be consulted to contextualize the archives and paint a clearer picture of TB in Canada in the mid-twentieth century.

Directions for Future Research

The atrocious residential school experience, which many Indigenous People were forced to endure, has been cited as a contributing factor in TB development and transmission among Indigenous People (Inuit Tapiriit Kanatami, 2013; Selway, 2016; TRC, 2015). Residential schools which were funded by the Canadian government's Department of Indian Affairs, separated Indigenous children from their families by keeping them in school throughout the year (Inuit Tapiriit Kanatami, 2013; TRC, 2015). Their objective was to instill Euro-Canadian perspectives and values and the erasure of their indigeneity and traditional cultures (TRC, 2015). Dr. Peter Bryce, the chief medical

officer to the Department of Indian Affairs conducted a survey of thirty-five residential schools in 1907 and found that a quarter of the students who had attended the school in the previous fifteen years succumbed to TB (Milloy, 1999). Neil Walker, a superintendent in Indian Affairs campaigned in favour of day schools in 1948 (Milloy, 1999). Walker, Bryce, and others were convinced that residential schools were ideal for TB transmission and thought that it should come to an end (Milloy, 1999). Sanatoria, like residential schools gained "entire possession" of the tuberculous Inuit (Selway, 2016). Residential schools were part of Canada's policy of assimilation. The policy of assimilation in Canada stipulates that Indigenous Peoples in Canada can only acquire rights by forfeiting their indigeneity and assimilating into Canadian culture (Herbert, 2009). The Sanatorium engaged in the assimilation of Indigenous patients through patient participation in essay contests, Christmas nativity plays and parties, singing Euro-Canadian patriotic songs, field trips and other extracurricular activities. Like residential schools, sanatoria were supported and operated by churches. The TRC concluded that it may be impossible to acertain the number of deaths or missing children, partly because of the practice of burying students in unmarked graves (2015). Inuit patients who died at the Sanatorium were also buried in unmarked graves (Selway, 2016). Survivors of residential schools and their families suffered from historic trauma (Reimer & Bombay, 2010; Robertson, 2006; Wesley-Esquimaux & Smolewski, 2004) much like Indigenous medical evacuees. Research that investigates the parallels between residential schools and sanatoria as it concerns the colonial-settler project from the perspective of Inuit people is crucial. "Community-based Participatory Research, or CBPR, is one approach that is increasingly

recognized as an important approach to conducting research *with* rather than *on* communities" (Gabel, p.9, 2012). In the course of research, it identifies the community involved as a partner, includes them equitably, and acknowledges their unique contributions (Jackson, 2003).

Future research can also delve into the first-hand experience of Inuit patients at the Sanatorium, as their perspective and thoughts on the matter were overlooked. This project would certainly draw in very few participants given that most of the members and patients have died. However, some patients were discharged as young children and can help paint a more accurate picture of Inuit sanatorium experiences. This research could entail interviews on their relationships with sanatorium staff, administrators of the Department of Indian and Northern Affairs (currently known as Aboriginal Affairs and Northern Development) and their return home.

While drug therapy proved to be effective, more research is needed on the effectiveness of occupational therapy. Research that looks more into the role of formal education, arts and clinical pastoral work in patient's ability to fight TB is needed. This could be enhanced by including the perspectives of former teachers, directors of rehabilitation and occupational therapy, chaplains and former students. A qualitative research project in which members of the HHA and reporters at The Spectator are interviewed on their experience of TB in Hamilton is essential. Lastly, a comparative study of past and current TB responses and treatment in Indigenous communities is vital given that modern global processes encourage further TB outbreaks in a manner that is

reminiscent of it historically. This research must be policy oriented in order to better respond to the emerging cases of TB among Indigenous communities. Ultimately research must contribute to the betterment of the community it concerns. That means that it must produce tangible policies controlled by the communities concerned. These policies "hold great promise for improving Aboriginal public health as they allow for practical responses as a way of gaining ground with some of the jurisdictional hurdles which are so often compromised as obstacles to success" (Gabel, p.158-159, 2012). Much like tuberculosis, when pressing matters are not dealt with directly, they re-emerge with more resistance and intensity. Tuberculosis has become a metaphor for how broader issues have been dealt with by Canadian authorities given the tendency to treat its symptoms rather than its causes. The research on TB has been extensive and has proven that alternative approaches to the biomedical model are vital. It has also shown that Indigenous peoples have their own set of social determinants of health. The question is not whether the research or resources are available. The question is whether we as non-Indigenous Canadians have the political will to work with Indigenous communities (on their terms) to implement what the research shows and what Indigenous communities have known all along.

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