PROVIDING CARE IN DIVIDED SPACE: NURSING IN NORTHERN SASKATCHEWAN 1944-1957 AND BEYOND

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By

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ABSTRACT

In 1944, the Government of Saskatchewan created the Northern Administrative District (NAD), which established Northern Saskatchewan as a spatial entity within the provincial milieu. Attention was focused on modernizing the region, and public health nursing became one of the first state-sponsored institutions to be introduced by the provincial government. By examining the day-to-day activities of nurses who worked at remote nursing outposts in Northern Saskatchewan between 1944 and 1957 and beyond, this research examines the complex internal factors involved in region-making.

Nurses lived and worked amongst their patients in small remote communities, thus making them effective vehicles for promoting modernization principles through preventative and educations programs. Despite the government's intention to modernize Northern Saskatchewan, a colonial relationship emerged between the region and the rest of the province. This situation left nurses in a confusing and often difficult position, because the institution behind initiatives to modernize the region was also their employer to whom they had certain obligations. Furthermore, the colonial attitude towards the region also extended to the nursing stations and the nurses, which often frustrated their attempts to provide medical care. As such, the small cadre of nurses played an ambiguous role, both as agents of modernization, but also opponents of its egregious effects.

The research examines the role of nursing in region-making through two types of geography: A geography of region-making where the literature focuses on the formal process of institutionalization, and a geography of social life, where the emerging literature on the geography of nursing provides an entry point. This two-part approach

provides an opportunity to use different lenses to view the processes involved in shaping Northern Saskatchewan as it emerged as a distinct northern place within Canada.

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A very special thanks to my husband Malcolm for his steadfast conviction that I would stay-the-course and complete the dissertation. He was an attentive sounding board, buoyed me up when spirits lagged, and was the best in-house "I.T." person I could have hoped for. Words cannot capture my gratitude to family, friends, fellow students, and colleagues for their invaluable support. While I am pleased to have completed my thesis and gained my PhD, without so many generous people offering their encouragement and gently nudging me along, it would have been an empty and perhaps unattainable goal.

Special recognition goes to the nurses, both past and present, whose experiences are the foundation of this research. In particular, a warm “thank you” to Jean Graham, whose accounts about nursing in Northern Saskatchewan piqued my curiosity long before I visited the area, and to Muriel Innes for graciously sharing her stories of nursing in the region.

DEDICATION

This thesis is dedicated to the memory of our son, Stuart Andrew McBain.

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LIST OF ABBREVIATIONS

CIHR	Canadian Institute of Health Research
DIAND	Department of Indian and Northern Development
FNIHB	First Nations and Inuit Health Branch
INHS	Indian and Northern Health Services
MNS	Métis Nation of Saskatchewan
MSB	Medical Services Branch (Health and Welfare Canada)
NAC	National Archives of Canada
NAD	Northern Administrative District
NET	New Emerging Team
NITHA	Northern Intertribal Health Authority
RN	Registered Nurse
SAB	Saskatchewan Archives Board
SRNA	Saskatchewan Registered Nurses' Association
VON	Victoria Order of Nurses

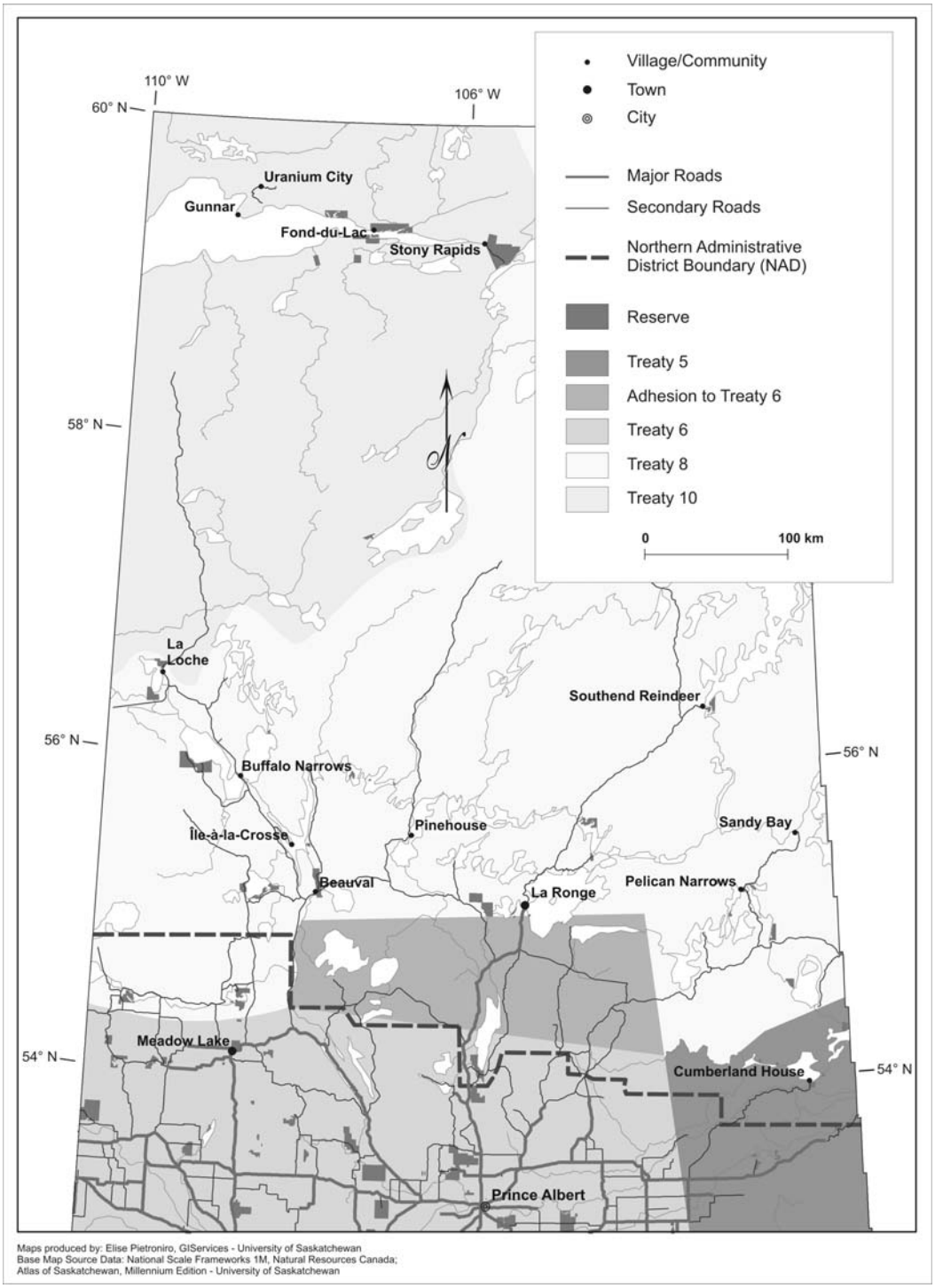
Introduction

This research looks at the role of nursing in shaping Northern Saskatchewan between 1944 and 1957. Finnish geographer Anssi Paasi (1986, 1991) developed a theoretical model outlining the social processes involved in the emergence of regions. One phase – the emergence of state-supported institutions – is particularly relevant to the northern Canadian situation because of the strong role that government played in providing a wide range of social services to the primarily Aboriginal population who lived in the region. Boundaries were drawn and programs were implemented to modernize and develop the north, with nurses serving as one of the conduits to bring about change. But inappropriate programs, a lack of local control and support, and inadequate resources, resulted in the north's colonization by the south. These deficiencies affected both the resident population and those responsible (i.e. the nurses) for modernizing the region (Morantz 2002; Quiring 2004). These are processes internal to Northern Saskatchewan. Paasi's model does not consider endogenous factors which contribute to social and regional change (Reynolds 2004). Therefore this research will address that gap.

The dissertation follows a manuscript format, consisting of four distinct papers. In this section, I discuss the rationale and theoretical approach for the study, data sources, and methodology. I also include a discussion of how I came to this research to show how my experiences as a nursing student, an instructor teaching Native Studies, and an employee working in Northern Saskatchewan influence this work.

FIGURE 1

NORTHERN SASKATCHEWAN



Research Questions

Two primary research questions shape this thesis: How did nurses respond to being both part of, but also the recipients of, strategies of colonization processes? What roles did nurses and the nursing profession play in shaping Northern Saskatchewan as it emerged as a distinct region? These questions are addressed in four discrete papers.

In the first paper "Jurisdiction and Nursing: the Challenges of Providing Care in Divided Space" the question is: How did the jurisdictional divisions emerge and affect health care delivery in the region? Furthermore, how did the nurses react to the challenges brought on by the boundaries? The second paper "Pulling up their Sleeves and Getting on with it: Providing Health Care in a Northern Remote Region" asks why nurses at the outposts had to contend with difficult conditions in the first place? Moreover, how did the challenges affect the nurses' ability to provide healthcare? The third paper, "Caring, Curing, and Socialization: Ambiguities of Nursing in Northern Saskatchewan 1944-1957" focuses on the role of nurses in the socialization process. What was the nurses' role and how did it contribute to shaping the region? Did socialization activities reinforce the colonial-like relation that had emerged? Lastly, the fourth paper "Telehealth: Can Technology Overcome the Challenges to Nursing Proximities" asks, can new communication technologies such as telehealth overcome historical frictions of jurisdiction and distances in health care delivery in Northern Saskatchewan?

Rationale and Theoretical Approach for the Study

Staples theory has been a powerful explanation of regional development in northern Canada (Innis 1930; Watkins 1993). The model situates development within the

context of resource extraction and goes a considerable way to explaining the relationship between natural resources and economic and political development in Canada, and to elucidating how the shifting nature of resource extraction affects regional fortunes. But it pays little attention to the part of social institutions in regional formation.

Consideration of social change in the north has been limited to the social impacts of economic development on Aboriginal peoples, within the context of resource extraction (e.g. Berger, 1977; Bone 1992; Notzke, 1994; Usher, 1999; Waldram, 1989). Many of the studies such as Anderson's (1999) work on the Meadow Lake Tribal Council's economic development initiatives, identified ways to maintain cultural practices while integrating Aboriginal people into the workforce. Others have looked at issues related to Aboriginal title and rights and the impact of contemporary development practices (Anderson, 1999; Elias, 1991; Elias, 1995). Significant research has also taken place on social institutions such as education and the impacts of residential schools on Aboriginal populations (Miller, 1995), while Lux (2001) and Kelm (1998) examined the impact of colonization on the health of Aboriginal people living on the Plains and in British Columbia. To date, however, there is a lack of research that examines the broader role of healthcare as a region-shaping process. By examining the interactions of top-down and bottom-up processes as represented by the nurses' experiences, this dissertation contributes to a clearer understanding of how external *and* internal processes shape a region such as Northern Saskatchewan.

Little attention has been given as to how professionals such as nurses interact at the institutional, community and individual levels, although there is growing awareness of the significant contribution that health care providers make to community development

and sustainability (Farmer 2003). In the north, nurses are considered the backbone of health care services and provide an impressive range of health care services to residents of the region (O'Neil 1979; Andrews 2003). By examining the introduction of the nursing stations into Northern Saskatchewan this dissertation seeks to address the omission and contribute to a better understanding of the role that the nursing profession played in region building in Northern Saskatchewan.

A geography of northern nursing is developed with two types of geography: a geography of region-making where the literature focuses on the formal processes of development and institutionalization; and a geography of social life, where the emerging literature on the geography of nursing provides an entry point. I merge theoretical perspectives to illustrate the contradictions between nursing and the goals of the state.[1] This two-part approach provides an opportunity to use different lenses to view the bottom up (informal) and top-down (formal) processes involved in region-making.

Another compelling reason for this research is to address the lack of women's perspective in the historical record, particularly with respect to their *work* in northern, remote regions of Canada. Women's travel accounts are at long last receiving due consideration; attention is also starting to focus on women who were paid to *work* in the north. Therefore, one objective of this research is to fill the void with respect to nursing in Northern Saskatchewan, and to explore the role of the nursing profession in region formation.

[1] In this research, "the state" refers to the *apparatus* or "set of institutions and organizations through which state power is exercised (Johnston et al 2000: 790). The state apparatus consists of a range of sub-apparatus, including governments, administration, and services such as health, education, and welfare that provide for the population's well-being.

Theoretically, the first paper, "Jurisdiction and Nursing: The Challenges of Providing Care in Divided Space" draws from Paasi's (1986, 1991) model of regional institutionalization. The second paper, "Pulling Up Their Sleeves And Getting On With It: Providing Health Care in a Northern Remote Region" employs Quiring's (2004) model of internal colonialism, Morantz's (2002) framework of bureaucratic colonialism, and Malone's (2003) theory of distal nursing. The third paper, "Caring and Curing in Northern Saskatchewan: The Nursing Experience 1944-1957" also utilizes Quiring's (2004) and Morantz's (2002) theories of internal and bureaucratic colonialism. The fourth paper, "From Wrangling to Collaboration? Telehealth Technology and Jurisdictional Challenges in Rural and Remote Spaces" returns to Paasi's (1986, 1991) model of regional institutionalization and Malone's (2003) theory of distal nursing.

On the surface these theories may seem unrelated, but the nature of my research which questions the role of nurses and nursing practices in region formation involves different levels of inquiry – from one-on-one nurse-patient relationships to state policies that affected those interactions. By using components of each model to varying degrees, depending on the relationship being examined, I am able to show how efforts to modernize Northern Saskatchewan through institutions such as public health nursing, were confounded by administrative inadequacies and a lack of awareness about the region's history, culture, and circumstances. The timeframe for the first three papers covers the period when the outposts were first established - approximately 1944 to1957. The fourth paper considers the present-day situation and, drawing from issues raised in the first three papers, considers how previous conditions related to northern nursing and region formation affect contemporary circumstances.

Methodology

How affairs actually played out in the north have been produced by explorers, factors, and police; mostly male account. Therefore examining the accounts of nurses who worked in the region provides perspectives not previously considered and expands our understanding of places where people live (Morris and Fondahl 2002). However, with much of the archival record written and preserved by men, dealing with the silences or hidden spaces in the archival record is complicated (Domosh and Morin 2003; Duncan 1999). Domosh and Morin (2003: 262) contend that "writing women's lives, voices, stories, and experiences remains a pressing issue and…to do the task, scholars must search out non-traditional sources to recover women's historical biographies". However, in the course of this research I found that while women's voices may be muted in the historical record, they *do* exist - in a variety of forms. The challenge, however, is to unearth women's versions of events while keeping their stories intact (Fraser 2003).

> Each jotted note, each new file adds to the sum of reality. One idea opens magically to ten or twelve others, and she knows by now that this is going to be a problem, that there's altogether too much twirl and spread to her inquiry and not enough in the way of tight, helpful boundaries (Shields 1992: 33).

Carol Shield's description of a folklorist's work bears a striking resemblance to the situation encountered while examining the data in this research. I had no idea that the materials would reveal such ambiguity, and like the folklorist, at times the twirl challenged the boundaries of research methodologies. In retrospect, as a researcher using qualitative methodology, I should not have been surprised because the purpose of such methods is to "understand lived experiences, reflect on, and interpret the understanding and shared meaning of people's everyday social world and realities" (Limb and Dwyer 2001:7) - undoubtedly a very complex process.

Data Sources

The research for the first three papers in this dissertation is based mainly on two archival collections that document the experiences of nurses working in Northern Saskatchewan. The first collection consists of letters written between nurses working in outpost hospitals in Northern Saskatchewan and their supervisors in Regina from 1944 to the mid-late 1950s. These documents are housed in the Saskatchewan Provincial Archives at the University of Saskatchewan in Saskatoon. The records show that twenty public health nurses worked at the nursing posts between 1944 and 1957, with only eight in the north at any one given time.

The second source of information consists of thirty-four taped interviews conducted by Joy Duncan in the mid 1970s. Ms. Duncan secured a Canada Council Grant, traveled across the country and recorded the experiences of nurses who worked in the outpost hospital system. The collection, known as the "Joy Duncan Frontier Nursing Project", also contains diaries, pictures, newspaper clipping and other memorabilia donated by the nurses. Ms. Duncan donated all of the materials to the Glenbow Museum in Calgary where it remains. However, permission was obtained from Ms. Duncan to use the collection in this dissertation.

The two discrete collections were collected in different places and at different times – the letters contained in the Saskatchewan Archives were written as events occurred, while the Joy Duncan interviews were conducted many years after the nurses' experiences. The materials also served different purposes. The correspondence in the public health collection conveys the "official" stance of the nurses and their supervisors on activities related to running the nursing stations. Although more formal, in most cases

the exchanges are personal and affable, and reflect the nurses' perspectives while living in the small remote communities. The interviews in the Joy Duncan Collection were conducted between peers, often after the nurses had retired and were no longer living in the north. The majority of the interviews were conducted with nurses who did not nurse in Northern Saskatchewan but at other nursing posts operated by the federal government across northern Canada. In four instances, however, both the written correspondence and taped interviews carried out twenty-five years later were available for the same nurse, which provided a rare opportunity to examine nurses' perceptions as events occurred as well as retrospectively, thereby adding a unique dimension to the dissertation.

Other relevant materials were obtained from the National Archives of Canada in Ottawa. The RG10 (Department of Indian Affairs and Northern Development files (DIAND) and RG15 files (Métis) were examined but little health related information was found in the files. As Indian and Northern Health Services (INHS) is part of Medical Services Branch (MSB) of Health and Welfare Canada, the RG29 records were examined and found to contain significant sources of health-related information with respect to Indian people. Similar records were not available for Métis people because they were considered part of the general Canadian population. In many instances, however, access to files (designated as code 32) in the Indian Health records was denied because of the confidential nature of the information. Nevertheless, the RG29 files provided documents such as: correspondence (i.e. between bureaucrats, politicians, Indian leaders, physicians); interdepartmental memos; regional annual reports; conference proceedings; policy addresses, and newspaper articles, on a range of matters relating to the provision of healthcare to Indians in Canada. Resources were also obtained from the First Nations

Treaty Centre in Hull, Québec. Materials included journal articles, newspaper clippings, and some materials previously found in the RG 29 files.

The Annual Reports of the Department of Public Health, Division of Public Health Nursing, for the province of Saskatchewan provided valuable statistical information related to the nursing posts, such as the number of home and office visits. The reports included births, deaths, the incidence of disease and illnesses, the number of nurses who were employed at the outpost hospital, and descriptions of the various programs being implemented in the communities. The reports also included data about the nurses themselves including the number employed in individual health districts, professional qualifications, new hires, resignations, and those on educational leave. There was some discussion about the difficulties in recruiting and retaining nurses in light of on-going nursing shortages. Lastly, Environmental Impact Assessments such as the Churchill River Board of Inquiry (1978) and the Bayda (Cluff Lake) Inquiry (1978) provided comprehensive scans of Northern Saskatchewan and the services that were introduced to residents starting in the mid 1940s.

In addition to the materials used in the first three papers in this dissertation, findings in the fourth paper are based on my participation in a Canadian Institute of Health Research (CIHR) New Emerging Team (NET) research projects. Since 2003, this team has been examining the use of telehealth in assessment, diagnosis, and management of individuals with dementia in rural and remote regions of Saskatchewan. During travels to telehealth sites in Northern Saskatchewan during 2003 and 2004, the team learned that the same problems identified by nurses more than fifty years earlier, and

discussed in the first three papers of this thesis, continue to pose problems for nurses and patients alike.

Interpreting the Data

Using archival data is demanding because records are often incomplete, fragmented and it is impossible to observe the phenomena first hand (Wishart 1997). In addition, interpreting the thoughts and experiences of others is both sensitive and difficult. Representation or "who can speak for whom", particularly when interpreting the historical record, presents considerable challenges (Harris 1997). This is particularly significant given the interval between writing this dissertation and the nurses' accounts, and it is not realistic to believe that an individual of today can think the thoughts of a person more than half a century ago.

However, while there is no disputing that interpreting the experiences of others requires considerable sensitivity and expertise (Harris 1997), there are advantages to utilizing archival materials because they "neither accuse nor excuse…and sometimes the silences in records speak as loudly as the privileged voices" (Cook 1996). There may also be a higher degree of separation when using archival materials because the researcher is not as personally involved (Baker 1997). However, I took the advice of Martin (2001: 198) who suggested against translating "anecdote single case studies and partial stories into policy debates."

I am also mindful that the letters in the Saskatchewan Archives were not written for researchers to analyze more than fifty years later. I organized them according to individual nurses, to reveal more complete stories that go beyond the anecdotal and helped me discover much about the policies that were guiding development in the region.

When the letters are viewed in conjunction with other modernization processes taking place, it is clear that the introduction of health care services in Northern Saskatchewan was part of much broader plans for the region, which did not necessarily coincide with the goals of the nurses, or the people living in the area.

The written correspondence between the nurses and their supervisors in Regina consisted of several hundred letters. Initially, notes were taken from the nurses' correspondence, but due to the volume of data and a concern that the context of the information would become diluted, 600 letters with the most information were photocopied. The letters were grouped according to geographic location, and reorganized according to individual nurses, and then annotated according to themes. The themes that emerged are the topic of the four discrete papers in this dissertation (i.e. jurisdiction, socialization, caring). Individual passages were not separated from the correspondence because it was important preserve the context of the writings. While this strategy was cumbersome at times because of the large amount of data, it was necessary in order to maintain the flow of the accounts. Data in the National Archives of Canada and the Saskatchewan Archives Public Health Division are considered public domain; therefore names were not changed.

Copies of the Joy Duncan interviews were requested from the Glenbow Museum in Calgary, and once obtained, (a process which took almost a year), the tapes were transcribed. The quality of the recordings was extremely poor at times, which slowed the process. Once transcribed, as with the written correspondence, the interviews were annotated and themes noted. Although the circumstances in which the oral interviews were conducted differed significantly from that of the letters, remarkably similar themes

emerged. For example, the challenges presented by jurisdiction, the processes of socializing and caring for patients, and the allure of the northern landscape were also evident in the interviews.

Working with recorded interviews conducted almost thirty years ago by someone else has certain drawbacks. For example, non-verbal behaviour is not recorded (Jackson 2001). The original interviewers may have had other intentions and therefore may have asked different questions than those a contemporary researcher might pose. Furthermore, an ethics board did not approve the questions asked during the interviews, and participants were not required to sign consent forms. However, Ms. Duncan verbally guaranteed confidentiality to the nurses she interviewed, and she asked that this research uphold that promise. Thus pseudonyms are used in place of the nurses' names to protect their privacy.

Positioning Myself

Several personal experiences inform this research. First, I was once a nursing student, a circumstance that cannot help but influence my interest in the nurses' stories and shape my interpretation of their experiences. Second, ten years of teaching Native Studies provided me with the opportunity to learn how relationships between Aboriginal people and the Canadian government emerged, evolved, and continue to play an important role in shaping interactions in a variety of areas, particularly health care. Third, working for a First Nation health organization (Northern Intertribal Health Authority (NITHA)) and participating on a Canadian Institutes of Health Research (CIHR) research project allowed me to see firsthand the central role that nurses continue to play in providing healthcare in remote communities. But most notably, I saw how the

barriers that nurses encountered in the past continue to persist and challenge the provision of health care. Lastly, I have traveled extensively throughout Northern Saskatchewan and can appreciate the challenges that confronted the nurses who lived and worked in the region.

Many of the experiences I had in nursing school were similar, if not the same, as those discussed by McPherson (1996) related to the transformation of nursing in Canada between 1900 and 1990. For example, the long hours, the hospital hierarchy, and numerous divisions amongst students, nurses, and physicians resonated with my own experience. The difference was that the working conditions I encountered in England in the 1970s applied to the second generation of nurses in Canada who trained between 1900 and 1920! However, nursing school also illustrated the importance of hospitals and medical staff to local communities. The hospital where I trained served the surrounding, less than affluent, area, but regardless of their hardships local residents supported the hospital, staff and students however they could. The perception was that St. Olave's was "their" hospital and we were "their" nurses. Yet, although we felt welcome in the community, we remained separated by our privileged position and the need to maintain professional distance. Therefore, when the data revealed similar situations in Northern Saskatchewan I was able to readily identify with the sometimes-confusing relationship.

Another experience that influences this research is teaching in the Department of Native Studies at the University of Saskatchewan and working for several Aboriginal organizations, such as the Métis Nation of Saskatchewan (MNS) and NITHA. In these positions I not only learned about how relations developed between Aboriginal people and the state in Canada, but also different interpretations of how events unfolded. The

relationships that have emerged as a result of the interactions between Aboriginal and non-Aboriginal people are complex, and are further compounded by Constitutional divisions within the Aboriginal population. Being aware of the legal diversity of the Aboriginal population has helped me to interpret the empirical materials used in this research. Furthermore, working with Aboriginal people and communities, has reinforced that the Aboriginal population, like all populations, are not homogenous in their points of view, actions, and reactions to events, which serves as a constant reminder as I sort through the contradictions and paradoxes encountered in this research.

Finally, my position with a First Nation health organization (NITHA) and participating in the NET research project reinforced the critical role of nursing in providing healthcare to remote communities. Listening to nurses discuss their current experiences in northern Saskatchewan was as interesting and revealing as reading the letters and listening to the tapes of their predecessors working in the same places many years ago. What was surprising, however, was that many of the obstacles (i.e. distance, isolation, and jurisdiction) that posed problems to the nurses over fifty years ago continue to frustrate them today.

The experiences described above strongly influenced what I expected to find in this research, and complicated the seemingly straight-forward task of determining how regions such as Northern Saskatchewan emerge and the role of nurses in the process. Based on my brief experience as a student nurse, I expected to find the nurses in my research to be heavy-handed and authoritarian in their approach to a compliant Aboriginal population that lacked any "say" about their care. But that is not the picture that emerged. The nurses were professional, and caring, and went to great lengths to

provide care to the northern population. New notions of healthcare and ways of living were introduced to Aboriginal societies in the region, but individuals played an active role in and accepting, rejecting, or integrating practices promoted by the nurses. In return, nurses also revealed a willingness to adapt some elements of care to the local situation (e.g. finding ways to improve rather than replace traditional diets). Although these findings were unexpected, they were only a hint of the many contradictions that constantly emerged during the research.

As the contradictory nature of the nurses' position in Northern Saskatchewan became more evident, the research became increasingly "messy" and ambiguous. There was always a "yes, but…" or a "no, but…" dilemma to address. I struggled with these tensions in an effort to reach clear conclusions about the role of nursing in region building processes, which in hindsight, probably only added to my frustrations. Eventually it became clear that to find the answers to my research questions, I would have to delve into the very fuzziness that had caused me so much angst. Therefore, rather than trying to downplay the ambiguous nature of the findings in this research, I proceed into it with what Bondi (2004:5) refers to as a "politics of ambivalence…a politics not about 'sitting on the fence', but about creating spaces in which tensions, contradictions and paradoxes can be negotiated fruitfully and dynamically." Presenting my research in this manner might be compared to opening Pandora's box, but I believe the risk is worth taking in order to reach a better understanding of the regions where we live and the processes and players involved in their creation.

Setting the Stage: The North

Northern Saskatchewan encompasses 252,430 square kilometers or about half the province of Saskatchewan's total land mass. Northern Saskatchewan is part of the provincial norths, a vast sub-Arctic belt, running from the coast of British Columbia through the Canadian Shield and on to Labrador; a region which has long been ignored, considered politically weak, economically unstable, and home to substantial Aboriginal populations (Coates and Morrison 1992). The region is bordered by the Northwest Territories to the north, Manitoba to the east, and Alberta to the west. The southern boundary consists of an irregular east-west line bisecting the province just north of Prince Albert (Figure 1).

Early resource development had little impact on Native people in Northern Saskatchewan and their patterns of life continued to evolve much as they had since the fur trade (Rea 1976, Seaborne 1973). Incursions into the area brought about few changes as the new activities associated with the fur trade were integrated into existing ways of life. However, the fur trade influenced where and how people lived and included economic domination by the Hudson Bay Company (HBC) and psychological domination by the churches. By the early 1900s interest and government involvement in the region consisted of yearly visits to northern communities by a single RCMP officer and an Indian agent. Even the period between the two World Wars saw only a handful of provincial and federal civil employees become permanent residents in the region (Dobbin 1981). After World War II, the region's relative isolation changed dramatically because of growing energy demands, the "roads to resources" program, and government economic and social programs were introduced to northern residents. The proliferation

and scale of the post-War institutions and the nature of programs were vastly different from those that had taken place previously and they affected every aspect of life for residents in the region (Weick 1992).

In 1944, the Saskatchewan provincial government created the Northern Administrative District (NAD) to "provide sound administration…and to plan for the future" (Smith, 1992). The region, however, was not simply a blank space upon which to inscribe new boundaries. Generations of Cree, Dene, and Métis people had previously shaped the region, establishing boundaries associated with their occupancy and their traditional ways of life. Policies of the British and Canadian governments towards Aboriginal people and their lands had also changed the political and social landscape of the region. For example, the treaty-making process between the federal government and Indian people in Canada created boundaries that delineated reserve (federal jurisdiction) from non-reserve (provincial jurisdiction) spaces.[2] And when the Canadian government assumed responsibility for Canadian Indians in the nineteenth-century, a classification system in the form of the *Indian Act* was established to differentiate Status Indians from the general population (Brizinski 1993).

When the NAD as a spatial entity became entrenched in provincial legislation in 1944, the stage was set for extraction of the area's natural resources. This action effectively established the region as a resource-rich colony of the southern portion of the province (Barron 1997, Quiring 2002). At the same time, however, the government was compelled to address the dreadful living conditions experienced by the Indian and Métis

[2] The term "Indian" rather than "First Nation" is used in this work to reflect the language of the time. "Indian" remains widely used in Saskatchewan. For example the provincial organization representing Status or Treaty Indians in the province is identified as the "Federation of Saskatchewan Indian Nations".

populations who lived "virtually as indentured labour to the [Hudson Bay Company] HBC and other private entrepreneurs…lacking education, medical facilities, decent housing, communications, and social services" (Dobbin 1981: 166). Consequently, attention was focused on modernizing the north, and public health nursing became one of the first state-sponsored institutions to be established in the region by the provincial government. However, the nursing stations where the nurses lived and worked were chronically under resourced. Furthermore, the number of nurses was inadequate to operate the outpost hospitals and to provide care to the northern population. Thus, although the provincial government made a commitment to improve conditions in the north, the lack of resources made it a very difficult mandate to fulfill, particularly for those such as nurses who worked in the field. Ultimately the barriers and challenges to providing care affected development in Northern Saskatchewan and contributed to shaping the region.

In Canada, the state has taken an active role in defining the "north" and "northerners". The resulting assortment of definitions was prompted for a variety of reasons including issues related to Canadian sovereignty and the economic potential of the north (Dickason 2002; Dosman 1975; Zaslow 1988). Central to this research is that the north is not limited to the area north of 60 degrees latitude, but also includes the provincial norths which Coates and Morrison (1992) refers to as the "forgotten norths". The idea of the Canadian north is reflected in Canadian literature, art, music, drama, history, politics, geography, and popular culture. Furthermore, the notion of Canadians as "northern" is used to exploit a distinct national identity, and according to Grace

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However, the phrase "First Nation" is gradually replacing the use of "Indian". For example, the Saskatchewan Indian Federation College recently changed its name to First Nation University of Canada.

(2001), reinforces the region as a colony of the south. But the boundaries that delineate northern spaces are unclear and vary depending on perspective and criteria used to define the area. Over time, there have been attempts to define northern boundaries in Canada by geographers such as Hamelin (1979) who created an Index of Nordicity based on community polar rankings. The concept became more relevant for social scientists with the application of Census Divisions from Census Canada (Ironside 2000). Regardless of how the north is defined, the region is imagined as vast, isolated and resource- rich. Geographic distance is frequently equated with cultural distance. But for those who live in the region, the north is not isolated; it is a homeland rather than a resource-rich place to be exploited by the south (Berger 1977; Bone 1992; White 1979).

Women's Northern Experience

Women's northern experiences have been documented primarily through travel accounts, but have received little recognition of their contribution to our understanding of the region and its people. However, armed with a critical approach and an appreciation for the times and literary genre in which their stories were recorded, new interpretations show that women's writings provide rich descriptions of the northern landscape and the people who lived there (e.g. Hessing et al. 2005).

The works by Rutherdale (2002), Ross (1997), and Kelcey (2001) have also made significant contributions with respect to women's experiences and their perceptions of the north. First, Rutherdale (2002) examines the perceptions and experiences of Anglican missionary women who were part of the mission frontier between 1860 and 1940. In an attempt to understand why some women were attracted to mission work, Rutherdale's research shows how preconceived notions about "empire, colonialism, race and culture,

travel, gender and religion" often contradicted women's actual experiences. Second, Ross (1997) presents Margaret Penny's accounts of life on a whaling ship as she accompanied her husband on voyages to the Arctic. Wives rarely joined their husbands on expeditions, and by doing so Penny became the first European woman to winter at Baffin Island. Margaret Penny visited and commented on "snowhouses, rode in a dogsled, walked on landfast ice, watched hunters stalking seals, shared their maktak, entertained Inuit women on board ship every evening and celebrated festive occasions with enthusiasm" (Ross 1997: 128). Through Penny's journals, Ross captures a women's impression of the Arctic landscape and indigenous people who lived in the region in the mid nineteenth-century. Lastly, Kelcey (2001) employs a variety of sources to describe the experiences of European women (including some nurses) who traveled in the Northwest Territories prior to 1940.

While women's accounts of their northern experience are finally being recognized, the material available on women who *worked* in the north remains limited. O'Neil (1979: 125) described the working and living conditions of nurses at Gjoa Haven, Northwest Territories and argued that the success or failure of the nursing station rested "squarely on the nurses' shoulders." Hodgson (1980, 1982) conducted an anthropological study of outpost nursing in northern Manitoba and the Northwest Territories, while Canitz (1989, 1990) examined the work of nurses in the Canadian Arctic. These works all identified stress, power and control, isolation, gender, and cross-cultural identification as key challenges facing northern nurses. More recently, Scott and Kieser's (2002) collection of northern nurses' reminiscences presents rich stories of northern nursing that reviewer Marian Botsford Fraser suggests academics "could and

should have a field day with…as the material is charged with heroics, subversive activism and resourcefulness" (Fraser 2004: D3). Finally, Bates et al. (2005) completed a comprehensive history spanning four hundred years of nursing in Canada that has helped to alleviate the paucity of material available on the experiences of northern nurses.

However, because so few nurses (fewer than eight at one time) worked at nursing outposts in Northern Saskatchewan between 1944 and 1957, their voices have not been heard. By adding the nurses' experiences to the growing collection, this research contributes another piece to the story of northern nursing and how nurses shaped the places where they worked, regardless of their numbers. .

Introducing the Nurses and Nursing Posts in Northern Saskatchewan

The first accounts of nursing in Saskatchewan began in 1860 when the Sisters of Charity Grey Nuns founded the mission at Ile a la Crosse in Northern Saskatchewan. The objectives of the Grey Nuns (founded 1738) were to "care for the sick, the forgotten and aged, and the orphaned" (Robinson 1967: 7). The journey from Montréal to Ile a la Crosse took sixty-seven days during which the nuns experienced a succession of accidents, difficulties and crossings of all kinds. The three Sisters who traveled to the region were not formally trained nurses, as prior to 1860 there were no nursing schools. However, they were certainly experienced in the nursing techniques and practices of the time, as well as dedicated.[3]

The presence of the Grey Nuns at Ile a la Crosse in 1860 is significant because it is from that community that "word" of nurses and their practices diffused across the north. As a result people living in Northern Saskatchewan were well aware of different

ideas about health care long before the establishment of the first nursing post in 1929. The long-time presence of the nursing sisters also helps to explain the large number of visits made by Aboriginal people *to* the outposts almost as soon as their doors opened.

As settlement expanded across Canada, the need for medical assistance and facilities increased. The Cottage Hospital system was established through loans from the Victorian Order of Nurses (VON) to help people in sparsely settled areas in remote areas. The Victorian Order of Nurses (VON), the Women's Institute, and the Red Cross Society all played a major role in establishing public health nursing services and outpost hospitals on the prairies (Duncan 1999, Robinson 1967). Between 1920 and 1946, when the Saskatchewan Hospital Services Plan came into effect, twenty-two Red Cross outpost hospitals were established in Saskatchewan, where nurses provided "sympathetic professional care in the midst of hardship and discomfort" (Robinson 1967: 103-104). None of the facilities, however, was situated in Northern Saskatchewan.[4]

Public health nursing began in Saskatchewan with the birth of province in 1905. The main emphasis was on the prevention of communicable diseases such as smallpox, typhoid, and tuberculosis. Nurses were considered important players in the nation-building process. In her work on the National Council of Women and nursing, Boutilier (1994) describes how the Council looked to nursing as a way to empower prairie women in their role as nation-builders. The Council felt it was important to attend to the medical needs of women and children on the Canadian prairies who faced an array of diseases

[3] For a discussion of the religious sisters' contribution to healthcare in Saskatchewan see: Kambeitz, Sister Teresita 2005 "Shaping a gentle province: Catholic sisters in Saskatchewan" *Prairie Messenger* Vol. 83 (11) September 14, 12-15

[4] Although no facilities were established in Northern Saskatchewan, the outpost nursing stations at Buffalo Narrows and Stony Rapids, were originally operated by the Red Cross before being transferred to provincial jurisdiction.

such as typhoid, as well as an alarmingly high maternal mortality rates (Boutilier 1994). School districts and women's organizations such as the National Council of Women, the Women's Institute, and the United Farm Women petitioned the government of Canada to do something about the lack of medical personnel in the west (Stewart 1979). Their efforts appear to have fallen on deaf ears, however, and the Council ended up passing a resolution requiring the National Council itself to "act in concert with local councils to devise and implement…a practical solution to a problem that imperiled not just lives, but the very health of the nation itself" (Boutilier 1994:33). Consequently, the Home Helper scheme (precursor of the Victoria Order of Nurses) was established with the objective of providing trained, skilled nurses to all "classes of population" (Boutilier: 1994: 38). While much of the attention was focused on the plight of the urban poor, the Canadian Red Cross Society introduced outpost hospitals in remote areas of Saskatchewan.

Public health nursing eventually expanded across the country and, combined with a better understanding of the etiology of diseases, the profession made a significant contribution to improving health conditions for Canadians. Germ theory confirmed the "ancient idea that cleanliness was important to health", and through vaccination, chlorination of water, and sewage treatment – preventative rather than curative medicine – between 1850 and 1950, the longevity of people in developed countries such as Canada increased by more than thirty years (Meade 2000: 5, 317).

However, as Meade (2000) contends, germs are not the only factors to consider when looking at disease. The causes of diseases are complex and are based as much in culture as on biology. For example, the presence of the tuberculosis bacillus (TB) is necessary to cause TB but the disease depends on nutrition, genetics, treatment, and the

presence of disease conditions including crowding and ventilation (Meade 2000: 5). Dyck (1992: 245-247) also maintains that the practice of medicine is just one aspect of health and that work, social networks, and government institutions and practices either contribute to or can be detrimental to people's health.

The prevention of disease, therefore, requires an approach that includes knowledge not only of medical science but also of the complex relationship between the determinants, and nurses were trained in holistic-based health practices (Duncan 1999). In Northern Saskatchewan, the majority of nurses who worked at the nursing stations had post Registered Nursing (RN) training in Public Health and therefore not only provided bedside care, but also played a crucial role in *preventing* diseases and illnesses.

Nursing's Structural Position

Nursing is steeped in traditions of self-sacrifice, devotion to duty and dedication to patient welfare (Slater-Smith 1987). Nurses were proud of their profession for a number of reasons. They were recognized as educated women before education for women was common; they were admired and respected for their work; and their profession eventually gained status from the government. However, this pride also created barriers to economic progress as requests for improved wages and working conditions were seen as selfish, impertinent, and demeaning (Slater-Smith 1987). Nurses felt that the Saskatchewan Registered Nurses' Association (SRNA) represented them professionally and would lobby on their behalf. However, the SRNA was adamantly opposed to collective bargaining since bargaining was associated with the activities of unions, not professionals. When a new *Trade Union Act* was introduced by the provincial government in 1944, the SRNA immediately petitioned to have nurses

excluded from the *Act* on the grounds that they were professionals. Association representatives believed that society recognized nurses as professionals and as such would pay what they were worth (Slater-Smith 1987). But this did not happen, and nurses did not receive adequate compensation for their education and responsibilities. Eventually, in 1964, the SRNA finally acknowledged that the ongoing exploitation of nurses was no longer acceptable and approved a collective bargaining process (Slater-Smith 1987).

However, during the time of this research (1944-1957), nurses' wages were controlled with no extra pay for being on duty twenty-four hours a day, seven days a week, and performing a list of domestic chores that went beyond the scope of their professional responsibilities. That is not to say the nurses working in Northern Saskatchewan did not ask for additional pay, because a few of them did. But unfortunately their requests did not result in improved wages and there was little the SRNA could do.

Nursing stations were established throughout Northern Saskatchewan at a time when there was a general shift (in Canada) to providing medical care in hospital settings (Kerr, 1988; McArthur et al 1996; Richardson 2002; Smith and Nickel 1999). Because Northern Saskatchewan was so sparsely settled, governments considered it impossible to provide complete medical services to people in the area. The government believed that little more could be done than to provide the minimum of medical care to the population through medical outposts from which patients could be evacuated to larger centres by air. Consequently, a network of nursing stations, operated usually by a lone nurse and

perhaps a caretaker, and an air ambulance system were established in the region (Sigerist Report 1944; Robinson 1967).

There are claims that western-based medical knowledge challenged traditional healing systems (Scheper-Hughes 1992). But without knowing more about what the nurses actually *did*, assuming that western style medicine was oppressive and detrimental to people's welfare is superficial (Jones 2002). The evidence provided in this dissertation shows that the act of providing health care services was far more complex and contradictory. For example, although the nurses' actions may have indirectly contributed to the state's objectives of changing the way northern people lived, it would be arrogant to assume that recipients of the different health care systems were incapable of discriminating between those services and ideas which were useful and those that were not (Jones 2002). Furthermore, although nurses were employed by the government, they were not simply tools of the state, and had to contend with their own social and professional boundaries in addition to the institutional boundaries established prior to their arrival.

To illustrate the amount of work that nurses did, Tables 1 and 2 gleaned from the Annual Reports of the Department of Public Health, Public Health Nursing Division 1944-1957 provide an overview of the number of patients who visited each nursing station and the number of home visits made by the nurses. The information is included to underscore the *volume* of patients seen by the small number of nurses - never more than eight - working at the few nursing stations scattered throughout a region that encompassed almost half the province.[5] The reports also contain additional information

[5] The nurses referred to here are those employed by the Provincial government and do not include the nursing Sisters at Ile a la Crosse. No nurses were employed by the Federal government in the region during

about the nurses such as their professional credentials, continuing education programs, the number of nurses on leave for education purposes, where they went for further studies/training, and reasons why nurses resigned from the Public Health Department, recruitment programs.

TABLE 1
Number of Home Visits and Number of Nurses 1947-1953

	1947	**1948**	**1949**	**1950**	**1951**	**1952**	**1953**
Buffalo Narrows		136/1	309/1	134/1	324/1	122/1	223/1
Cumberland House	833/1	682/1	635/1	403/1	384/1	201/1	277/1
Goldfields					278/1	*	
Lac La Ronge					210/1 pt ***	345/1 pt	1033/1
Sandy Bay				567/1	382/1	365/1	473/1
Snake Lake (Pinehouse)		28/1 pt	101/1 pt	56/1 pt	252/1 pt	386/1 pt	**
Stony Rapids		169/1	208/1	74/1	80/1	94/1	332/1
Uranium City						346/1 pt	426/1
TOTAL	833/1	1015/3 + 1 pt	1253/3 + 1 pt	1234/4 +1 pt	1910/5 +2 pt	18594 +3 pt	2764/6

Source: Government of Saskatchewan, Department of Public Health, Public Health Nursing, Annual Reports 1947-1953
* Nursing Station moved from Goldfields to Uranium City
** pt = part time
***Services provided for Snake Lake (Pinehouse) are included in Lac La Ronge total

TABLE 2
Number of Office Visits and Number of Nurses 1947-1953

	1947	**1948**	**1949**	**1950**	**1951**	**1952**	**1953**
Buffalo Narrows		766/1	1429/1	1695/1	1381/1	1635/1	2097/1
Cumberland House	1653/1	1357/1	1538/1	1795/1	1435/1	1214/1	1457/1
Goldfields					233/1	*	
Lac La Ronge					28/1 pt**	20/1 pt	333/1

this timeframe, until a nurse was hired to work at La Ronge in 1950/1951 and subsequently another at Pelican Narrows in 1955.

	1947	**1948**	**1949**	**1950**	**1951**	**1952**	**1953**
Sandy Bay				578/1	802/1	1290/1	1405/1
Snake Lake (Pinehouse)		4/1 pt	196/1 pt	249/1 pt	316/1 pt	266/1 pt	***
Stony Rapids		1	1455/1	1595/1	1314/1	1075/1	966/1
Uranium City						441/1 pt	804/1
TOTAL	1653/1	2127/3 + 1 pt	4618/3 + 1 pt	5912/4 + 1 pt	5509/5 + 2 pt	5941/4 + 3 pt	7062/6

Source: Government of Saskatchewan, Department of Public Health, Public Health Nursing, Annual Reports 1947-1953

* Nursing Station moved from Goldfields to Uranium City

** pt = part-time

***Services provided for Snake Lake (Pinehouse) are included in Lac La Ronge total

The preceding overview provides details of the number of nursing stations and nurses who worked at each site between 1947 and 1957. Although it provides information on the number of patients seen by those few nurses, it does not illustrate the range of responsibilities the nurses held, their successes or their frustrations. Nor does it tell how nurses worked as mediators between southern administrators and northern residents. This more complex story is told in the chapters that follow.

McPherson (1996:77) maintains that while "historians of nursing have looked at nurses' structural position within the Canadian health care system, less analysis has been devoted to understanding what they did with that structural position." With that in mind, the following papers examine what nurses "did" as they worked within the structures (i.e. Public Health Department) that provided health care to people in Northern Saskatchewan.

Dissertation Organization

The dissertation follows a manuscript format consisting of four distinct papers. The first paper "Jurisdiction and Nursing: The Challenges of Providing Care in Divided Space" examines how internal factors such as top-down boundary-making processes

divided the northern population and their lands into federal and provincial realms. Using evidence from the nurses' accounts, I show how the internal divisions affected patients' access to care, how it frustrated the nurses' efforts to provide medical assistance, and how the nurses responded to jurisdictional barriers. This paper draws from Paasi's (1986, 1991) model of regional institutionalization but expands the theory by demonstrating how internal factors (i.e. modernization and colonization) influenced the process in Northern Saskatchewan.

The second paper, "Pulling Up Their Sleeves And Getting On With It", illustrates the complexities of providing nursing care in Northern Saskatchewan. I begin with a discussion of the conditions that precipitated creation of the nursing stations and the steps taken by governments to deal with what I refer to as a "landscape of hardship". The theoretical frameworks employed in this paper include internal/bureaucratic colonization (Quiring 2004; Morantz 2002) and theory of distal nursing (Malone 2003). The distal nursing model (Malone 2003) introduces the spatial aspects of nursing which establishes a link between geography and nursing. How the outposts functioned, the often overwhelming workload of the nurses, and how bureaucracy both at the federal and provincial levels interfered with the nurses' ability to do their jobs are also examined in this paper.

Employing dimensions of internal colonialism (Quiring 2004; Morantz 2002), the third paper, "Caring and Curing in Northern Saskatchewan: The Nursing Experience 1944-1957" explores the socialization process that was an integral part of northern nursing. Nurses' understanding about prevention and treatment of diseases and illnesses were closely linked to notions of cleanliness, nutrition, and housekeeping standards.

Conforming to the medical model and standards of the day required a fundamental shift in how the majority of northerners lived their lives. On the other hand, nursing care had been available to northerners through the Catholic Hospital established at Ile a la Crosse in 1860. Although it was only one hospital in such a vast region, information about the facility had diffused throughout the north and people were aware of its presence. Nevertheless, interactions between nurses and their supervisors, and nurses and their patients were infused with power on a number of levels (i.e. gender, cultural, professional). These social relationships are explored within the context of a rapidly changing northern (social and economic) landscape that both nurses and patients had to accommodate.

The fourth paper "From Wrangling to Collaboration? Telehealth Technology and Jurisdictional Challenges in Rural and Remote Spaces", looks at the intersection of telehealth technologies and the long-standing (internal) jurisdictional challenges confronting remote communities in Northern Saskatchewan. The central purpose of this paper is to look at how, despite the ability of improved technology to overcome barriers related to physical distance in the north, nurses continue to face challenges hauntingly similar to those reported by their colleagues sixty years ago. The theoretical foundation for this paper is found in Paasi's (1986, 1991) model of regional institutionalization and Malone's (2003) theory of distal nursing. Empirical materials for this paper consist of the nurses' historical accounts in conjunction with findings based on my participation in a Canadian Institutes on Health Research (CIHR) Newly Emerging Team (NET) research project.

The last section, contained in Chapter 6, provides a summary of findings and conclusion of the dissertation. I loop back to the beginning, restate the basic premise and research questions. I summarize my argument and the theoretical positions my study advances. The limitations of the study are also discussed, as is the contribution that the work makes to northern region building processes and the geographies of health care. The dissertation concludes with a section on implications and extensions of the research. These include how historical practices set the scene for contemporary issues (jurisdiction, access etc.), on-going neglect of northern/remote areas, and the need for increased cooperation among various levels of government and Aboriginal involvement. The issues need to be addressed if new initiatives, such as telehealth are to be successful in bridging the gap in health care provision caused by distance and isolation.

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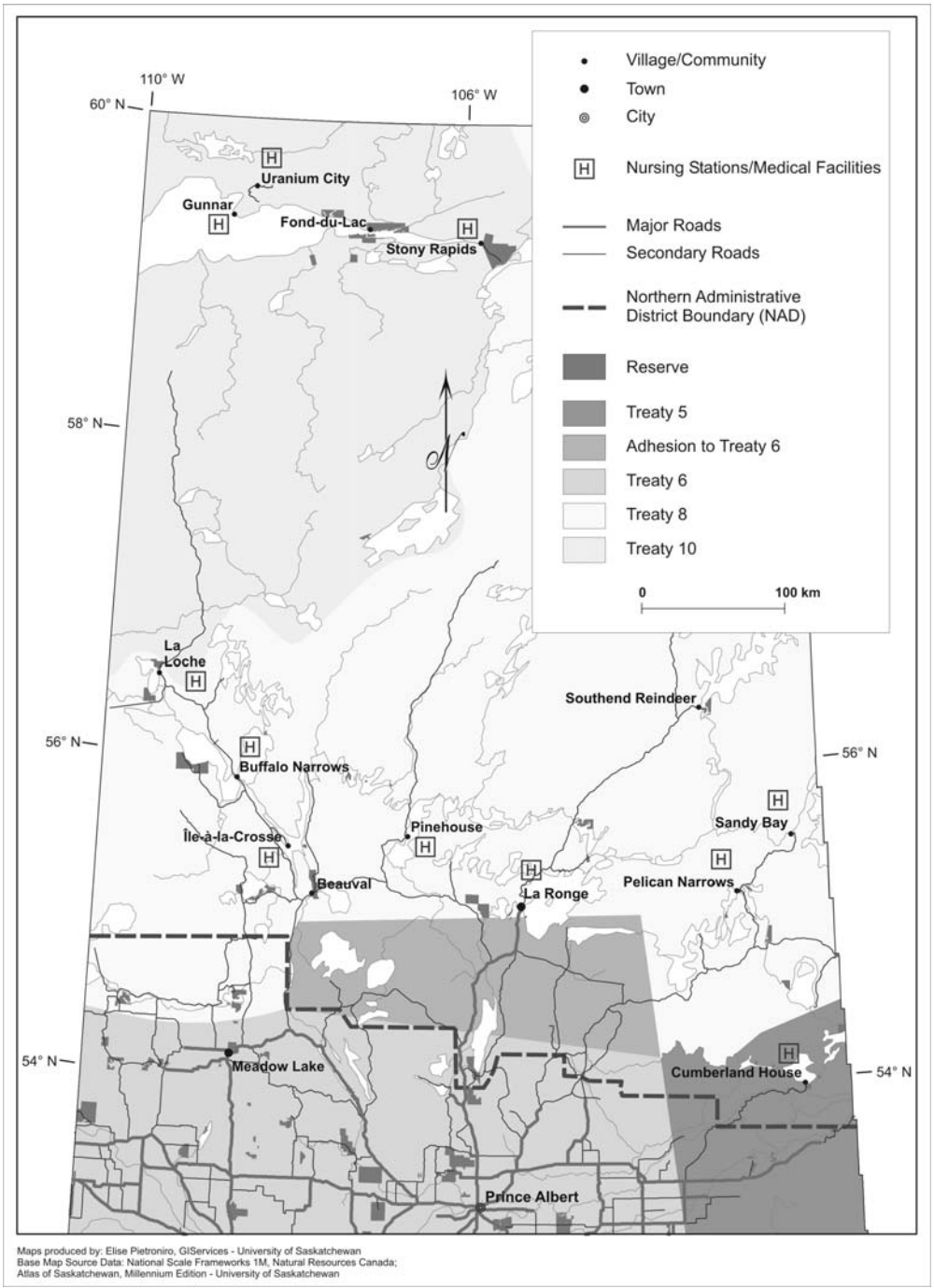
JURISDICTION AND NURSING: THE CHALLENGES OF PROVIDING CARE IN DIVIDE SPACE

FIGURE 1

NORTHERN SASKATCHEWAN

NURSING STATIONS



Jurisdiction and Nursing: The Challenges of Providing Care In Divided Space

Introduction

Professional nursing services were introduced into Northern Saskatchewan following World War II, with the goal of providing health care to the previously neglected residents of the region. Nursing outposts were established at points throughout the region where qualified nurses were employed by the provincial Division of Public Health and the federal Division of Indian Health Services (a division of the Department of National Health and Welfare). The basis for these two distinct jurisdictional realms was rooted in the historical relationships that had evolved between the state and Aboriginal people in Canada. The provincial nurses were responsible for the non-status Indian, Métis and non-Aboriginal population, while the federal Indian Health Services nurses attended to the status Indian population. Although these boundaries established distinct spheres of responsibility, a tug of war emerged between the federal and provincial governments as each sought to minimize their health and welfare obligations in the region. Ultimately the jurisdictional wrangling interfered with the way nurses carried out their duties and put both patient health and professional nursing standards at risk.

It is important to understand the connection between jurisdiction and the provision of health care because the tension between the two continues to influence contemporary efforts to address the gap in health care provision caused by distance and isolation. A chronological understanding of how the jurisdictional issues evolved reveals that there are dimensions and scales involved in region formation that have not been previously considered, and incorporating them into an analysis broadens our

understanding of the complex process. Therefore, the purpose of this paper is to show how the jurisdictional divisions emerged and affected health care delivery in Northern Saskatchewan between 1944 and 1957, and how nurses responded to these challenges.

The plan of this paper is: first, I describe the setting, and situate the paper within the theoretical frameworks that act as a foundation for this research; second, I examine the evolution and impact of jurisdictional realms that are key to this study; third, I present the empirical evidence to show how differences between the federal and provincial governments affected the day-to-day activities of nurses and how they responded to the challenges. I conclude with a discussion of how, by dealing with the jurisdictional struggles between the two levels of governments, nursing as an institution contributed to the emergence of Northern Saskatchewan as a distinct place.

The Setting

Northern Saskatchewan encompasses 252,430 square kilometers or about half the province of Saskatchewan's total land mass. Northern Saskatchewan is part of the provincial norths, a vast sub-Arctic belt, running from the coast of British Columbia through the Canadian Shield and on to Labrador; a region which has long been ignored, considered politically weak, economically unstable, and home to substantial Aboriginal populations (Coates and Morrison 1992). The region is bordered by the Northwest Territories to the north, Manitoba to the east, and Alberta to the west. The southern boundary consists of an irregular east-west line bisecting the province just north of Prince Albert (Figure 1).

Although Northern Saskatchewan is part of one of the three Canadian prairie provinces (Manitoba and Alberta being the other two), it can be described as "as

Saskatchewan that does not exist in the popular imagination but rather is a treed Saskatchewan, clothed in boreal forest, rock, water, and muskeg… and is firmly ensconced in the geography and ethos of the north" (Cariou 2003: 16).

For the most part, until the end of World War II, the provincial government ignored the region due to the fact that the federal government retained control of both natural resources[1] and responsibility for the Indians living in the region. There was no need to assimilate northern Natives as the region held little potential for agriculture and its small, dispersed, population did not threaten western settlement. Exploitation of the region's natural resources, particularly forestry and rich uranium deposits, did not begin until after World War II. At that time, a marked change in the role of the state occurred and the traditional laissez-faire policy towards the region's economy was replaced with a level of involvement that, within little more than a decade, made the government the most important industry and major employer in the north (Rae 1976).

When Northern Saskatchewan became formalized as a region in 1944, living conditions for people, who were primarily of Aboriginal descent, were appalling. Education and medical facilities were lacking. There was little decent housing, communication and transportation systems were inadequate, and there was an almost complete absence of government-run social services. Indeed for northern residents, this was a landscape of hardship. It is into this landscape of hardship that small outpost nursing stations, operated by a lone public health nurse, were introduced. But the nurses quickly encountered historical obstacles that, at times, impeded their efforts to provide much needed health care services.

[1] The federal government retained control of natural resources in Saskatchewan until the Nature Resources Transfer Agreement (NRTA) of 1930 which transferred responsibility to the province of Saskatchewan.

Data Sources

This paper is based mainly on two archival collections that document the experiences of nurses working in Northern Saskatchewan. The first collection consists of letters written between nurses working in outpost hospitals in Northern Saskatchewan and their supervisors in Regina from 1944 to the mid 1950s. These documents are housed in the Saskatchewan Provincial Archives at the University of Saskatchewan in Saskatoon. The records show that 20 public health nurses worked at the nursing posts between 1944 and 1957, with only 8 in the north at any one given time.

The second source of information consists of 34 taped interviews conducted by Joy Duncan in the mid 1970s. Ms. Duncan secured a Canada Council Grant, traveled across the country and recorded the experiences of nurses who worked in the outpost hospital system. The collection, known as the "Joy Duncan Frontier Nursing Project", also contains diaries, pictures, newspaper clipping and other memorabilia donated by the nurses. Ms. Duncan donated all of the materials to the Glenbow Museum in Calgary where it remains. However, permission was obtained from Ms. Duncan to use the collection in this paper

The two discrete collections were collected in different places and at different times – the letters contained in the Saskatchewan Archives were written as events occurred, while the Joy Duncan interviews were conducted many years after the nurses' experiences. The materials also served different purposes. The correspondence in the public health collection conveys the "official" stance of the nurses and their supervisors on activities related to running the nursing stations. Although more formal, in most cases the exchanges are personal and affable, and reflect the nurses' perspectives while living

in the small remote communities. The interviews in the Joy Duncan Collection were conducted between peers, often after the nurses had retired and were no longer living in the north. The majority of the interviews were conducted with nurses who did not nurse in Northern Saskatchewan but at other nursing posts operated by the federal government across northern Canada. However, both the written correspondence and taped interviews carried out twenty-five years later are available for four nurses, which provided the opportunity to examine nurses' perceptions as events occurred as well as retrospectively, thereby adding a unique dimension to the dissertation.

Other relevant materials were obtained from the National Archives of Canada in Ottawa. The RG10 (Department of Indian Affairs and Northern Development files (DIAND) and RG15 files (Métis) were examined but little health related information was found in the files. As Indian and Northern Health Services (INHS) is part of Medical Services Branch (MSB) of Health and Welfare Canada, the RG29 records were examined and found to contain significant sources of health-related information with respect to Indian people. Similar records were not available for Métis people because they were considered part of the general Canadian population. In many instances, however, access to files (designated as code 32) in the Indian Health records was denied because of the confidential nature of the information. Nevertheless, the RG29 files provided documents such as: correspondence (i.e. between bureaucrats, politicians, Indian leaders, physicians); interdepartmental memos; regional annual reports; conference proceedings; policy addresses, and newspaper articles, on a range of matters relating to the provision of healthcare to Indians in Canada. Resources were also obtained from the First Nations

Treaty Centre in Hull, Québec. Materials included journal articles, newspaper clippings, and some previous materials found in the RG 29 files.

The Annual Reports of the Department of Public Health, Division of Public Health Nursing, for the province of Saskatchewan provided valuable statistical information related to the nursing posts, such as the number of home and office visits. The reports included births, deaths, the incidence of disease and illnesses, the number of nurses who were employed at the outpost hospital, and descriptions of the various programs being implemented in the communities. The reports also included data about the nurses themselves including the number employed in individual health districts, professional qualifications, new hires, resignations, and those on educational leave. There was some discussion about the difficulties in recruiting and retaining nurses in light of on-going nursing shortages. Lastly, Environmental Impact Assessments such as the Churchill River Board of Inquiry (1978) and the Bayda (Cluff Lake) Inquiry (1978) provided comprehensive scans of Northern Saskatchewan and the services that were introduced to residents starting in the mid 1940s.

Interpreting the Data

Using archival data is demanding because records are often incomplete, fragmented and it is impossible to observe the phenomena first hand (Wishart 1997). In addition, interpreting the thoughts and experiences of others is both sensitive and difficult. Representation or "who can speak for whom", particularly when interpreting the historical record, presents considerable challenges (Harris 1997). This is particularly significant given the interval between writing this paper and the nurses' accounts, and it

is not realistic to believe that an individual of today can think the thoughts of a person more than half a century ago.

However, while there is no disputing that interpreting the experiences of others requires considerable sensitivity and expertise (Harris 1997), there are advantages to utilizing archival materials because they "neither accuse nor excuse…and sometimes the silences in records speak as loudly as the privileged voices" (Cook 1996). There may also be a higher degree of separation and objectivity when using archival materials because the researcher is not as personally involved (Baker 1997). However, I took the advice of Martin (2001: 198) who recommended against translating "anecdote single case studies and partial stories into policy debates."

I am also mindful that the letters in the Saskatchewan Archives were not written for researchers to analyze more than fifty years later. I organized them according to individual nurses, to reveal more complete stories that go beyond the anecdotal and helped me discover much about the policies that were guiding development in the region. When the letters are viewed in conjunction with other modernization processes taking place, it is clear that the introduction of health care services in Northern Saskatchewan was part of much broader plans for the region, which did not necessarily coincide with the goals of the nurses, or the people living in the area.

The written correspondence between the nurses and their supervisors in Regina, consisted of several hundred letters. Initially, notes were taken from the nurses' correspondence, but due to the volume of data and a concern that the context of the information would become diluted, 600 of the most significant letters were photocopied. The letters were grouped according to geographic location, reorganized according to

individual nurses, and then annotated according to themes (e.g. jurisdiction, socializing, caring, fascination with the northern landscape). Individual passages were not separated from the correspondence because it was important preserve the context of the writings. While this strategy may have been cumbersome at times given the large amount of data, it was necessary in order to maintain the flow of the accounts. Copies of the Joy Duncan interviews were requested from the Glenbow Museum in Calgary, and once transcribed, the interviews were annotated and themes noted. Although the circumstances in which the oral interviews were conducted differed significantly from that of the letters, remarkably similar themes emerged particularly with respect to jurisdiction.

Theoretical Framework

The theoretical framework that guides this inquiry is based on Anssi Paasi's (1986, 1991) theory of how regions become institutionalized. Institutions are defined as the "sets of rules, decisions making procedures and programs that define social practices, assign roles to the participants in those practices, and guide interactions among the occupants of individual roles" (Young 2002: 5). Motivated by dissatisfaction with methods used to analyze the emergence of regions, Paasi called for the inclusion of social and historical approaches to regional studies, arguing that social institutions such as economic, political, legal, education, and cultural systems produced regions. The institutionalization model underscores the fact that a region (such as Northern Saskatchewan) does not just appear out of mid air but is a "complex synthesis or manifestation of objects, patterns, processes, and social practices derived from simultaneous interactions of social processes" (Paasi 1991: 242). As social constructs, therefore, regions should be understood as historically continuous processes, expressed

from the bottom-up or local scale. Four steps are involved in the institutionalization of a region (Paasi 1986, 1991):

1. Development of territorial shape which is determined by social practices and the reach of a region's power;
2. Formation of "symbolic shape" where symbols, particularly names, are attached to regions;
3. The emergence of institutions. The state is the central apparatus involved in this stage. The state legitimizes the process through systems of socialization such as education and public health care systems. The state also endows others with the power to institutionalize people into social or geographic communities; and
4. Maintenance of continued reproduction of the region as a social entity through policy and program deployment.

MacLeod and Jones (2001) point out that the steps in the institutionalization process are theoretical, and all regions do not necessarily go through the same stages in linear sequence. However, the formation of Saskatchewan as a province in 1905, forty years prior to the formal institutionalization of Northern Saskatchewan as a specific region, provides a fitting example to illustrate the steps and players involved in the institutionalization process.

The province of Saskatchewan is a relatively new entity, having been formed in 1905 when the province was carved from the Northwest Territories. Unlike Newfoundland or Québec, there was no historic or linguistic basis upon which to nurture a sense of provincial consciousness (Smith 1992). Therefore, it was up to the provincial politicians of the day to create a sense of "province-hood" among their constituents. According to Smith (1992: 35) this sensibility was accomplished fairly quickly:

> The establishment of the province of Saskatchewan rests with the actions of government as much as any legal definition or jurisdiction. The deliberate use of public power to weld together dispersed settlements in what initially were pioneer conditions took definite form in Saskatchewan, either as direct government involvement or as indirect encouragement of cooperative activity by others. The speed with which a separate provincial imprint became visible within the imaginary

boundary line Parliament drew across the prairies revealed the potency of the provincial form created in 1905.

Having delineated the region's shape and established institutions necessary for socializing a diverse population with a sense of provincial awareness, settlers flooded into the southern part of the province, leaving the north neglected and beyond integration into provincial life for the next four decades (Smith 1992). After World War II, efforts were made by the provincial government to formally institutionalize Northern Saskatchewan and integrate it into the provincial milieu. This time, however, the purpose was not to "promote unity out of scattered farms and isolated settlements" (Smith 1992: 16) as in the case of Southern Saskatchewan forty years earlier, but rather, to set the stage for exploitation of the north's natural resources, particularly uranium.

The institutions (i.e. social welfare, education, health) that were introduced into Northern Saskatchewan by the provincial government were administered from Regina, the provincial capital, located in the southern part of the province. Programs were administered in the traditional bureaucratic fashion with little, if any, attempt to foster institutions and processes appropriate to the North. As a result, the new arrangements changed people's "structures of expectations" which are "the ways in which people organize their knowledge of the world and use it in the interpretation of new information, events and experiences" (Paasi 1991: 249).

While the stages and structures described in Paasi's (1986, 1991) model resulted in consolidation in southern Saskatchewan, the situation in the north was very different. In particular, no consideration was given to processes that had altered the northern landscape prior to the implementation of plans to modernize the region, and to the fact that the resident population already had its own institutions in place. The region's

population and history differed from that of the south and with the imposition of southern-based institutions superimposed on that diversity, the end result was simply not as coherent. Consequently, although Northern Saskatchewan experienced some of the stages outlined in Paasi's (1986, 1991) framework, the region did not emerge as a coherent unit, as this lack of coherence prevented its full institutionalization.

Northern Saskatchewan went through the first two stages of the model with delineation of the area's territorial shape and allocation of a distinct name. But it is the third step – the emergence of institutions and the role of the state[2] – where the process faltered and provides a point of entry for examining northern nursing and its role in shaping the region. In this case, the federal and provincial governments, and nurses, who were government employees, represented the state. However, although the state gave nurses the power to advance a particular agenda (e.g. modernization) that control was undermined by ongoing jurisdictional strife between the two levels of government. This relative disorganization had significant ramifications for the establishment and implementation of programs, for the people who lived in the north, and for the nurses who were responsible for providing healthcare.

Paasi's framework on region formation is considered one of the major advances in geographical thought. However, a limitation of his work is that the model provides "no endogenous means of accounting for social and regional change" (Reynolds 1994: 236). Paasi's (2003) contemporary work begins to address this omission, by illustrating how First Nation (Indigenous) people around the world are challenging internal boundaries by

[2] In this research, "the state" refers to the *apparatus* or "set of institutions and organizations through which state power is exercised" (Johnston et al 2000: 790). The state apparatus consists of a range of sub-apparatus, including governments, administration, and services such as health, education, and welfare that provide for the population's well-being.

trying to influence legislation and territorial governance established by dominant national groups. I maintain that the jurisdictional struggles between the federal and provincial governments ran counter-productive to the nurses' efforts to provide healthcare services; therefore, they serve as examples of *internal* factors that strongly influenced the institutionalization process. By examining the internal issues that played a role in shaping Northern Saskatchewan, the goal of this research is to contribute to Paasi's exploration of these new facets of region formation. But before discussing the impact of jurisdictional conflicts on nursing activities, it is necessary to examine how the various boundaries emerged in Northern Saskatchewan.

Spatial and Non-Spatial Jurisdictional Boundaries in Northern Saskatchewan

The treaty-making process between the federal government and Indian people in Canada had resulted in the creation of boundaries that delineated reserve (federal jurisdiction) from non-reserve (provincial jurisdiction) spaces. In the nineteenth-century the Canadian government also assumed responsibility for Indians, and a classification system in the form of the *Indian Act* was established to differentiate Status Indians from the general population (Brizinski 1993). While the value of the treaties negotiated between Indian people and the federal government is significant to all Canadians, this research shows that interpretation of the treaties, combined with the terms of the *Indian Act* formed the basis of the jurisdictional problems that caused no end of grief for the nurses in their day-to-day activities. The following provides a glimpse into the complex historical processes that established boundaries prior to the establishment of Northern Saskatchewan as a specific region.

Treaty Boundaries

Under the terms of the Royal Proclamation of 1763, land was only available for settlement after negotiations had taken place with Indian people for its surrender. This marked the beginning of the treaty-making process in Canada. With Confederation in 1867, the Canadian government assumed responsibility for the process from the British Crown. The Canadian government's position was that the treaties extinguished title to Indian land in exchange for certain rights and services, while Indian people viewed the treaties as formal agreements whereby they agreed to share their land in exchange for certain inalienable rights (Barry 1999, Brizinski 1993, Laliberte at al 2000). Furthermore, from the Indian perspective, the treaties were the means by which they would integrate their traditions with the contemporary world and participate in the emerging Canadian society (Dickason 2002). Northern Saskatchewan falls within Treaties 6 (1876), 8 (1899) and 10 (1906) (Figure 1).

Treaty 6 covered the area most likely to be used for settlement in Saskatchewan as well as the route for the anticipated railroad. The treaty was unique because it contained three clauses not included in other treaties. For example, the terms relating to agricultural assistance was more generous in Treaty 6, and the government was also required to assist Indian people in times of famine or pestilence (Barry 1999). But the most significant clause was the medicine chest clause that stated "a medicine chest shall be kept at the house of each Indian Agent for the use and benefit of the Indians at the direction of such agent" (Treaty 6, 1876). It is this clause that provided the foundation for the Indian conviction that health care was a treaty right. Indian health care was transferred from the Department of Indian Affairs to the division of Indian Health Services under the newly

created Department of National Health and Welfare in 1945. This marked a time when interpretation of the treaties and in particular the medicine chest clause became increasingly contentious as opinions between the federal government and Indian political organizations began to differ. Presently, in Canada, responsibility for health care is designated primarily to the provinces, and the federal government maintains that any medical services it provides to Indians are a matter of policy rather than legal obligation (Waldram et al 1995).

Reserve Boundaries

In Canada, reserves are defined as lands set aside for the Indians' continued use upon surrender of most of their territory (Dickason 2002). As noted above, reserve boundaries demarcate Indian (federal jurisdiction) from non-Indian (provincial jurisdiction) land, each with their own set of rules and regulations.[3] Reserves were originally established under the guise of protecting Indians from the negative influence of settler society and to "prepare them for assimilation through agriculture and religious instruction", although the policy had the effect of creating Indian people as "others" rather than as participating members of Canadian society (Peters 1997). The federal government needed a way to designate and classify Indians. Thus, through the 1876 *Indian Act*, legislation that consolidated all earlier laws pertaining to Indian people, was enacted.

Social Boundaries created by the *Indian Act*

A Status Indian is a Native person who is registered under the *Indian Act* as an Indian and therefore falls within federal jurisdiction. The Indian Act does not apply to

[3] Over time the position of the federal government has shifted from one of assimilation to negotiating self-government agreements.

non-Status Indian, Métis, or Inuit people who, with the rest of the general population, are considered a provincial responsibility.[4] Major revisions were made to the *Indian Act* in 1951 and again in 1985 (Bill C-31) but the *Act* that prevailed during the timeframe of this research was basically the same as the initial 1876 *Act*. For example, Indian people could not vote (until 1960) unless they gave up their Indian status (enfranchised). Furthermore, women were considered Status Indians only if their fathers or husbands were Indians. If Indian women married non-Status men, they lost their Indian Status as defined by the *Indian Act*, including their right to live on reserves, inherit property from reserve relatives, or even to be buried on reserve (Brizinski 1993). On the other hand, if non-Indian or non-Status women married Status Indian men, they gained status and therefore the rights and restrictions of the Indian Act. These complex spatial and social boundaries became significant for both nurses and nursing care in Northern Saskatchewan.

Consequences of the Jurisdictional Divisions

> The last day or so another problem has come in connection with the Treaty Indians. A non-treaty Métis came into Stony Rapids from the far north this week with a message that his wife is very ill following childbirth…His wife was a Treaty Indian before her marriage and I understand still receives her treaty money. However the Constable tells me that the province is responsible for her as far as sickness, that she has no right to medical care from the Indian Department. Therefore he says it is up to me to decide if she should be sent out or not. Mr. Tilden seems to be of the opinion that if an Indian woman receives treaty money even if she is married to a non-treaty man that she should receive medical care under the provisions of Treaty Indians. This problem has never come to my attention before and I would appreciate a letter from you with definite instructions as to this matter. There is also a Treaty Indian sick in the same *northern place* and a plane coming in to-day may go up for them. I expect if they go for them it will be up to me to decide if either or both should be taken out. The problem of paying will have to be decided later. It took this man two days to come down from the north and he has been here two days so I expect the woman will be better, worse or dead by now (Saskatchewan Archives Board (SAB) Pierce to Totten April 17, 1948).

[4] In 1939 the Supreme Court of Canada decided that the federal government should assume responsibility for the Inuit. However, the *Indian Act* does not apply to the Inuit.

The above quote contained in a letter from an outpost nurse at Stony Rapids to the Medical Officer in Regina, illustrates quite clearly, the confusion that the jurisdictional divisions caused for the nurses working in northern communities. Although the decision to fly patients out was up to the nurse, it was costly and if deemed unnecessary, nurses were often reprimanded for their decisions. In their defense, nursing education did not include diagnosis, which caused considerable consternation for the nurses who understandably would err on the side of caution. Nevertheless, the jurisdictional divisions created logistical problems not only for the nurses but for patients as well. It is difficult to imagine the situation outlined in the above quote, where after traveling for two days to reach medical assistance, jurisdiction determined whether or not a person was entitled to treatment. In this case, while the nurse was looking for "official" direction, it appeared she would do whatever was necessary regardless of issues surrounding jurisdiction and payment.[5]

In another example of jurisdictional squabbling, the superintendent of Indian Agencies (federal) received a call from the Provincial Department of Public Health saying that the nurse at Cumberland House had taken in an Indian woman for confinement and two more Indian patients were waiting. The superintendent told the provincial supervisor:

> I instructed them to advise their nurse there not to take in any more Indian cases unless it was a real emergency. The above mentioned Health Unit, at Cumberland House, was opened recently with a nurse in charge, and there are only four beds,

[5] The quote is from Myrtle Pierce, who spent 35 years with the provincial Department of Public Health. Ms. Pierce spent 18 years as a public health midwife in Northern Saskatchewan, the last 8 as nursing supervisor. In recognition of her services Pierce Bay at Fir Island, Black Lake was named in her honour (Robinson, Marguerite E. 1967 *The First Fifty Years* (Regina: Saskatchewan Registered Nurses' Association))

> which are for the benefit of the few white people and half-breeds in that area (National Archives of Canada (NAC) M. Christianson to "Sir" April 17, 1941).

The superintendent went on to say that the Indians living in the area came under jurisdiction of The Pas Indian Agency, but:

> On account of the distance I do not suppose they receive very much medical attention. As the Indians on Cumberland Lake evidently trade at Cumberland House, which is an old Hudson's Bay Post, the nurse stationed there would no doubt be called upon by the Indians to attend to their needs. Therefore I would ask you instruct me as to what steps you want taken so that I can discuss them with the Deputy Minister of Public Health for the Province. In the meantime I have instructed that no expense be incurred unless it is a real emergency (NAC Christianson to "Sir" April 17, 1941).

The situation caused considerable concern for the nurse at Cumberland House who had a long history in the community and continued to live there long after her retirement. Denying care to anyone seeking attention would have been both unprofessional and unpopular for both the nurse and residents, so it is unimaginable that the nurse would have turned people away regardless of instructions. Indeed, in his discussion of the Uranium City Hospital, McIntyre (1993) documents examples of nurses caring for patients in their own home:

> During the winter of 1953-1954 the old hospital at Goldfields Box Mine was obtained from Consolidated Box Mines and moved over the ice to Uranium City…The old frame hospital with its eight beds and accommodations for staff was to serve the community for only three months. In the early morning hours of May 6th, 1955, the tinder-dry frame structure went up in flames…No one was injured in the blaze, but all hospital equipment was lost…With the hospital destroyed, the immediate problem was, what to do with the dislocated patients? Once again it was the hardworking Public Health Nurse who was called upon to supply the solution, who took the patients into her own house (McIntyre 1993: 125-126).

The preceding illustrates that although the provincial government attempted to humanize living conditions in Northern Saskatchewan after the Second World War, jurisdictional differences *within* the Aboriginal population living in the region, hindered

the process. The terms of the *Canadian Constitution* which designated Treaty Indians as a federal responsibility and the rest of the population a provincial responsibility meant that "periodic attempts to improve services were not well synchronized, either in terms of timing or quality" (McArthur 1978: 8). As such, efforts to improve services followed a stop and go pattern, where initial development such as establishing the nursing stations, was followed by periods of neglect (McArthur 1978). These patterns intensified as jurisdictional divisions became more entrenched, which presented considerable challenges for those trying to provide healthcare in the region.

Dealing With All Those Boundaries!

It is clear that the spatial and non-spatial jurisdictional boundaries of Northern Saskatchewan were founded prior to legislation that established the region. But as social institutions such as health care were introduced, the boundaries became more divisive, confusing, and entrenched, resulting in considerable jurisdictional wrangling between the two levels of government. Nurses were often caught in the middle of these debates. Ideally cost-sharing arrangements could have been negotiated, and indeed recommendations were made to adopt this approach by some bureaucrats. In a 1959 Report on Development in Northern Saskatchewan it was argued that although considerable time and effort were required to plan joint services, coordination was believed to be the only way to eliminate the problems caused by existing division of responsibilities (NAC Report on Saskatchewan Development 1959). Regardless of the recommendations, the jurisdictional differences were entrenched. The provincial government made it clear that it was responsible only for White and Métis population but not for Indian people as they were considered a federal responsibility (Smith 1992). The

federal government considered health care to be “primarily a provincial matter” that was based on policy rather than treaty rights (Government of Canada, Department of National Health and Welfare 1966: 3).

The Department of Indian Health existed because of what the federal government saw as “a considerable and rather unique body of Canadian citizens long indigenous to the country…with peculiar need and helplessness to whom provincial resources were rarely if ever available” (Government of Canada, Department of National Health and Welfare 1961: 1). The role of Indian health was to ensure that essential medical care was available to Indian and Inuit people in Canada in a systematic and coordinated manner. Rather optimistic reports stated that arrangements with the provincial health departments and local provincial health units resulted in the workload being shared equally by federal and provincial staff, and as a result of such cooperation, the Native population was said to have enjoyed the same healthcare services that were available to the general population (Government of Canada, Department of National Health and Welfare 1966: 3). There was a qualifier however. It was pointed out that such conditions did not apply in areas where the federal government felt it was responsible for providing all services or supplementing what was locally available. These comments reflected growing concern over the cost of providing health care in remote regions such as Northern Saskatchewan, and alluded to the role of the provincial governments in delivering services.

The medical facilities that were established to serve the population of Northern Saskatchewan are listed in Table 1. The provincial government provided care through a system of outpost nursing stations together with the first air ambulance system in North America created specifically to provide back up services for the nursing stations. For the

most part, provincial facilities were established relatively quickly following World War II. The federal government placed a nurse at La Ronge in the late 1940s, but did not establish a physical presence until 1950 in a shared facility with the province.[6] In remote northern areas where the federal government felt it was not economical to station staff based on "only a handful" of people, it was customary to enlist the help of "some intelligent local person, a teacher or missionary, the wife of a trader of police officer as a lay dispenser on a small stipend. The people chosen to fulfill this role also acted as first aid personnel and reported outbreaks of diseases (Government of Canada, Department of National Health and Welfare 1961: 8). Doctors employed by the federal government also accompanied the treaty parties during annual visits to communities to pay treaty annuities, but due to the brief stay little could be done for people beyond screening for tuberculosis and recommending treatment for the acutely ill.

TABLE 1
Medical Facilities in Northern Saskatchewan (1957)

Community	Established	Jurisdiction
Ile a La Crosse	1927 (although the Sisters of Charity Grey Nun began caring for people at the mission in 1860)	Erected by Provincial and Federal Governments; administered by Oblates; operated by Grey Nuns of Roman Catholic church
Cumberland House	1941 (1929)	Provincial
Gunnar	1944	Gunnar Mines
Buffalo Narrows	1947	Provincial
Sandy Bay	1948	Provincial
Snake Lake (Pinehouse)	1948	Provincial
Stony Rapids	1948	Provincial
La Loche	1951	Church (Roman Catholic)
Lac La Ronge	1951	Provincial/Federal (shared)

[6] This is not to say that the federal government was not operating facilities elsewhere in Saskatchewan. As of 1958, Indian and Northern Health Services, Department of National Health and Welfare reports the following facilities: 2 hospitals (Fort Qu'Appelle and North Battleford); 3 clinics (Fort Qu'Appelle, North Battleford, Prince Albert); 4 nursing stations (Fort a la Corne, Lac La Ronge, Onion Lake, Pelican Narrows) and 8 health centres (Broadview, Kamsack, Meadow Lake, Punnichy, Rose Valley, Shellbrook, Uranium City, White Bear Lake)

Community	Established	Jurisdiction
Uranium City	1952 (relocated from Goldfields)	Community
Pelican Narrows	1955	Federal

Source: Government of Saskatchewan, Department of Public Health Nursing Annual Report 1957

Negotiating a Joint Facility

One of the most contentious issues that arose with regard to providing health care facilities, and which served to highlight the conflict between the federal and provincial governments, was construction of the hospital at Lac La Ronge. In 1946, the province began plans for establishing its system of nursing stations and wanted to know what facilities Indian and Northern Health Services were going to establish in Northern Saskatchewan. Indian Health reported that they had no plans to construct a nursing post at Lac La Ronge, but went on to say if the province felt it was necessary to build a nursing post to fulfill their responsibilities then they should do so; once the facility was constructed, Indian Health would establish a nurse at the hospital and pay for services extended to Status Indians (NAC Moore to Roth August 10, 1956).

In the mid 1950s, the provincial government began pressing the federal government to commit to sharing the cost of building a small hospital at Lac La Ronge. The population in Lac La Ronge at the time was reported to be 3000 people with two-thirds having Indian status (NAC Moore to Deputy Minister August 15, 1957). Indian Health Services continued to operate a small facility run by one nurse to serve the Indian population of the region. The nursing station consisted of a converted missionary residence that was considered dilapidated, inefficient and inadequate. While acknowledging that the nurses were housed in poor facilities, the Director of Indian and Northern Health Services seemed more concerned that a great deal of the nurses' time

was taken up by half-breeds, Whites and tourists in the summer (NAC Moore to Deputy Minister March 29, 1957). No mention was made of the fact that two-thirds of the people in the area were Status Indians. However, Moore did acknowledge that the Indians and Métis in the area had been neglected, and recommended that the federal department should share the cost of a proposed hospital with the province.

A cost-sharing agreement was eventually reached and a hospital was built in La Ronge in 1951 that housed a nurse employed by the provincial government and part-time nurse employed by the federal governments. Working with other nurses should have provided professional support and companionship for nurses, yet work-related tensions between the nurses emerged in the shared space. However, the provincially-employed public health nurse was encouraged to work out any problems with the nurse at the Indian hospital because as the supervisor stated, "there was no reason why you should not be able to work together quite effectively and happily" (SAB Director of Nursing Services to A. Hanson May 1, 1951).

Nurse Hanson took the advice of the Director of Nursing Services and within a few months reported that during an outbreak of whooping cough, she and nurse Talmay worked closely together (SAB Hanson to Smith, September 18, 1951). But cooperation between the nurses was perceived in a different light and the supervisor wrote:

> I am sorry that you have had worry and confusion regarding immunization. I think, with you, that Miss Talmay should leave that phase of the work to you. However, remember that she is a representative of the Department of Indian Affairs and if she cares to immunize Indian children, I would not worry too much about it…Being a government employee, I think that you should definitely follow departmental policy, unless you are given specific instructions to do otherwise (SAB E. Smith to A Hanson Regina October 5, 1951).

Despite instructions to maintain the province's authority, the nurses continued to consult with one another which did not appear to please the Director of Nursing, who wrote:

> It has been noticed that when emergency flights are made from La Ronge in order to take patients in for hospitalization or medical treatment, that Miss Talmay has been consulted. It is felt that as you are the representative of the department of public health at Lac La Ronge that you are the person who should make the decision regarding the necessity for these emergency flights (SAB Smith to Hanson October 29, 1952).

Thus, while the nurses may have shared the physical space of the new facility, the government bureaucracy that guided their activities differed. Furthermore, providing health care services to a jurisdictionally divided population also reinforced the legal boundaries between people, which each respective government was intent on sustaining. Nevertheless, nurses working at the outpost hospitals operated by the provincial government provided their nursing expertise to all people regardless of their jurisdiction. But the nurses found that the jurisdictional issues often frustrated their efforts to provide medical care and treatment, not to mention the affect on patients, particularly given that the presence of the federal government was minimal. As nurse Lewis reported:

> I saw Mr. Stewart (and) he tells me that the Medical Superintendent is coming along the lake next months, because he at last does realize that they, the Indian Health Service will have to do more regarding these people. From Edmonton, he is unable to get a true picture of the isolated places that some of their people live. The Nurse who was sent in to help during the measles epidemic went back with a story that has since proved to be wrong. It is hoped that the Indians from here will be able to go to Prince Albert for treatment but that will have to be approved from Ottawa…I hope that this clarifying of the situation will make the work of caring for the people in here easier…" (SAB Lewis to Smith August 4, 1953).

The paucity of federally-funded services and staff in Northern Saskatchewan contributed little to improving the health of northern residents, which is not difficult to understand in light of the limited facilities. The situation did not go unnoticed, however,

including comments by some responsible for making decisions. For example, in 1954, the local Member of Parliament (MP) for Meadow Lake expressed concern that Indian constituents in his riding were not receiving adequate care.[7] The MP pleaded with the federal Minister of Health to construct a nursing station at Dillon to deal with the destitute and unhealthy conditions in that community. He wrote: "In addressing this to you, I know that I am talking to someone who feels as strongly as I do about the welfare of his fellow man…honour me with your company and I will drive you from Ottawa there [Dillon] and return" (NAC Harrison to Martin November 3, 1954). It was difficult to understand the lack of a nursing station especially as the community had a portable sawing machine to provide wood to build the nursing station and local people were willing to provide the labour. Only a few years later at a conference on development in Northern Saskatchewan, a statement was made that the excellent quality of medical care and treatment provided to the Indians of Saskatchewan was actually a barrier because it prevented people from moving away from reserves (NAC Report on Saskatchewan Development 1959). It is difficult to understand this statement based on earlier comments about the lack of services in the north, but it forces one to recognize that there were competing views and perceptions about conditions in the north.

Comments such as the above reinforce the belief that reserves originally served as places where Indian people were to be isolated, educated, and assimilated into Canadian ways before being integrated into mainstream society. The expectation was that Indian people would eventually leave their reserves, and having served their purpose, the system would be dismantled. But the strategy did not go as planned, and because of their

[7] The concern expressed in this example is particularly interesting in light of the fact that Indian people could not vote in federal elections in Canada until 1960 – unless they surrendered their Indian Status (Dickason, Olive P. 2002)

isolation, reserves actually served, to some degree, to preserve and protect language, spiritual, and cultural practices. While the initial intent of reserve policy failed, Indian people clung to the last of their unsurrendered territory, making it their new homelands. Given the evidence presented in this paper, attributing the reluctance of people to move away from reserves to the excellent quality of medical care is simply untrue. Such comments fail to recognize the lack of facilities, people's attachment to their communities, as well as the structural barriers that made it difficult for Indian people to move off reserve, even if they chose to do so.

Reports from Indian Health indicated that the lack of resource and staff posed problems for regions within the division overall.[8] For example, in 1958, the federal Division reported that staff and funds of Indian and Northern Health Services were barely able to keep pace with the increase in the Indian population, and they were "running as hard as they could in order to stand still" (Government of Canada, Department of National Health and Welfare 1958: 16). Frustration was also evident in the 1960 Directorate Report where it stated: "all of us dealing with Indians repeat over and over and over again that babies die who should survive under normal conditions…This tragic loss could be largely prevented. Poverty, ignorance, bad housing and generally substandard environment appear to be the major factors at fault" (Government of Canada, Department of National Health and Welfare 1960: 21). Another frustrated bureaucrat stated that his only personal (and therefore purely unofficial) criticism (of Indian Health Services) was that not enough emphasis had been placed on securing a sufficient number of well-trained personnel to implement health programs more rapidly. He felt that the

[8] The timeframe for this study is 1944-1957. However, the following comments made between 1958-1962 are included here as they reflect the lack of involvement by the federal government in Northern Saskatchewan, and some of the consequences of that inaction during the period of this study,

only way to remedy the situation was to allocate more finances to Indian Health (NAC Roth to Cameron March 13, 1962). With only two facilities operating in Northern Saskatchewan at the time (Lac La Ronge and Pelican Narrows), it is hardly surprising that the region was considered under serviced. The brunt of providing day-to-day health care services to the northern population then fell to the nurses employed by the Nursing Services Division of the province of Saskatchewan Department of Public Health.

Jurisdictional divisions were at the root of many of the challenges faced by the nurses working at northern remote nursing stations in Saskatchewan. While the specific jurisdictional realm of patients needed to be clarified for billing purposes, this often led to more confusion than clarification. The province of Saskatchewan had established publicly funded hospital insurance in 1944 fifteen years prior to the introduction of Medicare in 1962 (Ostrey 1995), but northerners were initially excluded from the plan because the north had no public medical facilities. The situation changed when the outpost hospital system was implemented (Barron 1997). In the meantime, someone had to pay for services rendered and because the province provided most of the day-to-day care for everyone, the need for reimbursement was not unreasonable.

On the other hand, nurses pointed out that medicines designated for treaty Indians were distributed to non treaty patients…

> Do I understand correctly from your letter that you do not wish the treaty medicines to be transferred to the hospital?…At (another non-treaty community) we used all supplies for anyone and the Métis really profited because they were in the majority and the Indian Department were generous in their supply given to us. Also there was no charge made to anyone for medicines given out. My supply here is very limited but so far I have not made a charge as most of these people have very little money (SAB Pierce to Totten, February 17, 1948).

Treaty doctors and nurses assisted with immunization programs and follow-ups, although the spirit of cooperation varied between individuals. Nurses reported that treaty doctors understood the difficulties that they faced and offered their assistance in determining which patients were to be flown out (SAB Pierce to Smith August 14, 1948; Lewis to Smith January 13, 1953).

Transportation costs associated with flying patients out to larger centres for care was a significant issue for both the federal and provincial governments. The provincial government had implemented an air ambulance system in conjunction with establishing the outpost hospital system, but the criteria for determining when patients should be flown out seemed to vary between jurisdictions. Nurse Lewis wrote that:

> The Doctor from the Department of Indian Affairs was here, he is very good with the people and very understanding of my problems. We talked the charter plane situation over and it amounts to the same as before. If there is a patient so ill that it is necessary that they get to hospital, I have been told that I can send them without consulting Larry if need be, and any help or guidance that I may need he will be only too pleased to give, so there we are (SAB Lewis to Smith January 13, 1953).

Although construction of the joint facility at Lac La Ronge provided a well-needed facility to serve the growing population, it also intensified the jurisdictional arguing between the two levels of government. However, jurisdictional conflicts were not limited to any one particular facility, and in one instance intensified to the point where the Premier of Saskatchewan's involvement was required. While it is unclear just what the jurisdictional issue was, Dr. Hames the Deputy Minister for the Province of Saskatchewan wrote to Nurse Lyons at Buffalo Narrows:

> I have discussed with the Premier and Minister of Public Health the problems which you presented to me some weeks ago when you were in my office. Mr. Douglas (the Premier) requested me to advise you that you are in complete charge of the hospital at Buffalo Narrows. No other department has jurisdiction over the

> hospital. If you continue to have interference of the type you mentioned to me, would you kindly inform those who are carrying out the interference to leave the hospital and would you kindly report the circumstances to me (SAB Hames to Lyons August 23, 1948).

The federal government billed the province for care provided to non-Indian patients, to which the province took great exception, stating that the services they provided to Indians in other communities were equal to any services provide at Lac La Ronge. Federal bureaucrats disagreed and argued that the costs they encountered at Lac La Ronge were greater (NAC Harvey to Indian Health Services July 22, 1953). And on and on it went. The jurisdictional wrangling intensified when universal medicare was introduced in Saskatchewan in 1962, requiring arduous and complex negotiations to resolve.

Taking Matters into Their Own Hands: Jurisdiction and Proximities of Care

> There was immunization to be done and theoretically, the provincial public health representative was to immunize the White people along the way and I was to immunize the Indians, but that wasn't the way we managed it (Wilson 1965).

The jurisdictional divisions disrupted the relationship between nurses and their patients and hindered the nurses' efforts to provide health care to residents of Northern Saskatchewan. But as illustrated in the above quote, the distance that caused them problems also enabled them to carry out certain practices the way they saw fit. This is in keeping with Mitchell's (1989) argument that it can be difficult to keep track of how policies are implemented in the field particularly when staff are scattered throughout a large area.

The reality of providing health care in the remote region presented challenges unique to the north, which was difficult for those outside to comprehend. Visits, particularly by federal authorities, were infrequent, making it even more difficult for

those in charge of decision making to appreciate the situation facing nurses and northern residents. The nurses welcomed visits from the medical superintendent believing that the federal government had to do more for Indian people. They also believed it was impossible to get a true picture of the isolated places where some people lived sitting in an office in Edmonton (SAB Lewis to Smith August 4, 1953).

As mentioned previously, there were no instances of care being denied for any reason, not just because of jurisdictional differences. As professionals, nurses challenged the status quo and raised questions when jurisdictional divisions affected their practices and their patients' health. For example, the nurse asked why some communities were screened for tuberculosis (T.B.) while others were left off the list. "Was it not possible for the TB van to visit all communities? Could blood clinics not be held for everyone especially as "people mixed so much"? (SAB Hanson to Smith July 15, 1952). Schedules were arranged according to Treaty party visits, which meant access to services varied; a practice that the nurses considered unfair. After all, disease and illness does not recognize social divisions and nurses felt that in order to fulfill the purpose of having nurses and nursing stations, all points should be visited (SAB Broome to Smith July 4, 1952). There were so many chronically ill people in the north that sorting them out in one visit was an impossible task (SAB Lewis to Smith August 4, 1953). Visits by the doctors, however, were often unpredictable leaving nurses with insufficient time to round up everyone needing medical attention. Calls were made for a mass survey of the population, similar to the TB screening system, but it was doubtful whether the idea would have found favour with the Indian Affairs Department due to their constant concern about expenditures (SAB Janzen to Edwards February 3, 1954).

It is safe to say that nurses did not hesitate to offer their nursing expertise, regardless of jurisdictional divisions, and dealt with the consequences after. In one example, a nurse made a 100 kilometre canoe trip to see a number of ill children and along the way visited families, the majority of whom were treaty Indians. Upon returning, she asked what should be done about expenses. She did not raise the issue of, nor was she reprimanded, for visiting both treaty and non-treaty people (SAB Broome to Smith September 12, 1951). Her supervisor replied that she was not sure what to do about expenses for the trip but asked for more details regarding the visit, what she did, and to "please be more definite about the numbers of treaty and others seen" (SAB Smith to Broome September 20, 1951).

The nurses in the field were not complacent about the extent to which jurisdictional issues interfered with their nursing practices, and conveyed their concerns to those in charge. For example, Nurse Pierce made her position about dealing with the jurisdictional divisions very clear. In a letter to the Chief Medical Officer for the province she wrote:

> At last I have obtained the population of (3 primarily treaty communities). This may not be the picture you expected. As far as my work has been here, home visits and office calls have been almost all treaty. I give them a note to Mr. S. at the Hudson's Bay store for medicine required…I certainly do not intend to make any arrangements with the treaty doctor when he comes in. It is my opinion that all arrangements should be made between the Department of Public Health in Regina and the Indian Department. I do not think I should have anything to do with finances. Also I do not think that we can give a service in here and not include the treaty Indians. While I am not doing public health among them I make sick calls and take office calls whenever they ask me (SAB Pierce to Totten February 17, 1948).

The above quote supports the assertion that nurses found the jurisdictional divisions problematic because it interfered with their professionally responsibility -

providing health care. At the same time, it also speaks to the fact that when it came to providing health care, the nurses did not necessarily follow jurisdictional protocols. They made their own decisions on certain matters which were simply not open to negotiation.

The provision of supplies by the federal and provincial department also caused confusion and concern, particularly when stocks ran low. At times, shipments were delayed or missed altogether which left the nurses in a difficult predicament. For example, when Indian Affairs failed to renew its supplies, the situation caused the nurse at the outpost considerable anxiety because there were no medicines. She was at a loss as to what to do, and sought advice from her supervisor (SAB Lewis to Edwards July 30, 1954).

But it was screening for diseases, such as tuberculosis, where jurisdictional divisions presented one of the most significant obstacles to the nurses' efforts in identifying and treating patients: As the nurse working at Uranium City reported:

> The Treaty party has come and gone. The results were disappointing from my point of view. The Treaty Indians turned out for xray to a man, ninety-one in all. So also did large number of métis and white, all of whom were turned away. This was extremely disconcerting, since I had been telling them for weeks to be sure to report for xray when the party came round….When I asked the reason for this attitude since, as I pointed out, they had always been willing on previous years to take all comers, I was told that the province had never paid for work done by Indian Health Services, therefore, they had precise instructions to do only the Treaty Indians…it would seem that until the various departments come to an agreement, there is little encouragement for field personnel to put forth the efforts they have done in the past. The Treaty party did not go to Camsell Portage at all, which makes the third year that they have missed (SAB Shannon to Edwards June 26, 1954).

Two months later, Nurse Shannon reported that an alarming number of T.B. cases had been identified in the T.B. survey (mentioned above) amongst Treaty Indians, and she was "very much afraid there would be similar results among the Métis and sincerely

hoped some action would be carried out by the Anti T.B. League" (SAB Shannon to Edwards August 6, 1954). It is unclear what steps were taken to screen the Métis people because just a few weeks later, Nurse Shannon submitted her resignation, citing her reasons as "it being impossible to carry on home duties with any degree of satisfaction while attending to an occupation which demands twenty-four hour attention" (SAB Shannon to Edwards August 24, 1954).

Conclusion

Paasi (1986) maintains that the history of a region is important if we are to have a more complete understanding of the socio-spatial processes involved in its emergence. As the evidence presented in this paper indicates, the jurisdictional challenges facing Northern Saskatchewan are based on events that occurred prior to the creation of the region as a formal entity, but they made a significant contribution to shaping the region and its people during the timeframe of this research. The treaty-making process, reserve making policy, and the *Indian Act* divided both the population and their lands into federal and provincial jurisdictions and set the stage for disagreements between the two levels of government.

Combining historical events of boundary-making with the on-the-ground accounts of the nurses extends Paasi's (1986, 1991) model of regional institutionalization by revealing the role that *internal* social factors play a significant role in the process. For example, although the first two stages of Paasi's (1986, 1991) model – identifying the region's shape and name – left their impression on Northern Saskatchewan, the third phase – the emergence of institutions – faltered. As discussed earlier, the population already had its own institutions in place and new ways of organizing their activities may

have been inappropriate for their lifestyles. Where institutions such as health care could benefit people, internal factors, particularly the jurisdictional differences between the provincial and federal governments, prevented the development of appropriate, well-supported institutions to enhance the quality of life for northern residents. A lack of knowledge about the region, its history and people, by government agencies, only served to compound the jurisdictional problems further.

The objective of nurses in Northern Saskatchewan was to provide professional care to northern residents. In the course of carrying out their daily activities, nurses faced a myriad of problems, but jurisdictional wrangling between the federal and provincial governments proved to be the most frustrating, not to mention hazardous to people's well being. Although nurses confronted, objected to, and sometimes resisted the internal boundaries, the jurisdictional divisions continued to hinder institutions as they tried to establish a foothold in the region. Nursing and jurisdictional divisions represented the state, but they were in sharp contrast with one another – nursing was inclusive, jurisdiction was divisive. Nevertheless they both played a significant role in shaping Northern Saskatchewan as it emerged as a distinct – if ambiguous - region within the provincial and federal milieu.

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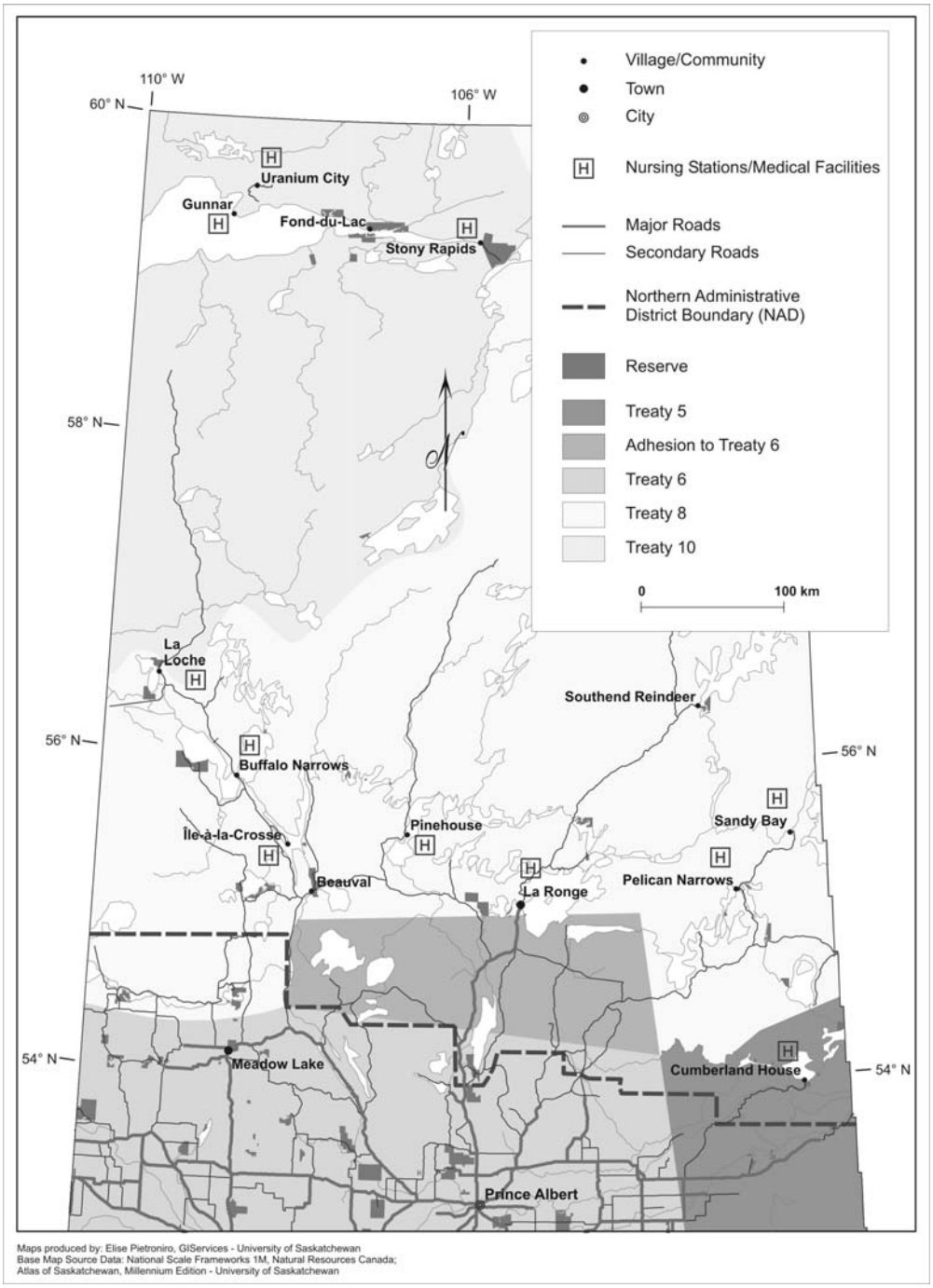
PULLING UP THEIR SLEEVES AND GETTING ON WITH IT: PROVIDING HEALTH CARE IN A NORTHERN REMOTE REGION

FIGURE 1

NORTHERN SASKATCHEWAN

NURSING STATIONS



Pulling Up Their Sleeves And Getting On With It: Providing Health Care In A Northern Remote Region

> She was stormbound for three days on her way to Stony Rapids and had forgotten her sleeping bag. Conditions were pretty primitive when she first arrived at the new hospital. There was a furnace but no pipes, a bathtub but no water, and lamps but no coal oil…Conditions may have been primitive but she [the nurse] pulled up her sleeves and not being a woman given to neurotic tears or the "oh, pity poor me" class of hysterics, she got on with it. Today the hospital is bright and clean as a newly minted coin, is modern right down to a built in bathtub and dressed up with the comfortable sort of accessories that make a home and not an institution (Tyre 1949).

Introduction

At the end of World War II, the Saskatchewan provincial government began providing healthcare to residents living in northern remote communities as part of the overall plan to "modernize" the region, and set the stage for increased resource extraction. Starting in the mid 1940s, several small outpost hospitals, operated by a single nurse, were established in communities in Northern Saskatchewan (Figure 1). Despite the impressive range of health care services that they provided to residents, the nurses' activities and the role they played in shaping the region have received little attention. Yet, as the above quote indicates, nurses assigned to outpost hospitals in Northern Saskatchewan often confronted less than ideal conditions.

The opening statement above, taken from the *Saskatoon Star Phoenix*, described the experience of an outpost nurse sent to open and operate the nursing station at Stony Rapids in 1949. The author of the quote suggests that the professional tenets and personal tenacity of the nurse prevailed in overcoming the adversity that she encountered and resulted in a comfortable home-like establishment. Having been given the responsibility of opening and operating the nursing station, however, the nurse simply

had no choice but to get on with the job in spite of the "primitive" conditions that she encountered. While not to detract from the efforts put forth by the nurse to transform her surroundings into a place where she could live as well as provide medical care, the sanguine description of her circumstances downplays what must have been a difficult situation. And by remarking on the fact that the nurse was a woman with no propensity for tears diminishes the personal fortitude that must have been required in order to persevere in such conditions. The question is why, as professional nurses assigned with the responsibility of providing healthcare to northern people, were such difficulties encountered in the first place, and how did the challenges affect the nurses' ability to provide healthcare and thereby contribute to shaping the region?

Through an examination of nurses' accounts, this paper illustrates that although nursing stations were established to provide care for the northern, primarily Aboriginal population, they were under-resourced to the point of often testing the nurses' resolve. I contend that the nurses were not quite as stoical about the lack of support as the above quote would have us think, because it jeopardized relationships between themselves and their patients. Furthermore, without glorifying the nurses and their profession, this paper will acknowledge that nurses often went to extraordinary lengths to provide care despite the obstacles that they encountered in northern remote settings.

The plan of this paper is as follows. First, I situate the paper within the theoretical frameworks that guide this paper, with an emphasis on how the structural apparatus of modernization disrupted nurses' proximities to their patients. Second, I describe Northern Saskatchewan and its circumstances in the 1940s when nursing stations were introduced into the region. Third, I introduce the empirical evidence consisting of the

day-to-day activities of the nurses to illustrate how they provided care in northern isolated communities in spite of the often-harsh conditions and lack of institutional support. I conclude the paper with a discussion of how examining nursing activities through a combination of processes contributes to a clearer understanding of how both 'outside' and 'inside' networks interact and shape, in this case, a northern remote region.

Establishing Links Between Geography and Nursing

> All human relationships have spatial aspects. This is true not only because we are material beings with bodies that move and have volume, but because our proximity to or distance from others and from places have meaning for us…Nursing as a human practice also has spatial aspects. Since the relationship with the patient is considered central to nursing practice, nursing depends at least in part upon sustaining some meaningful proximity to patients (Malone 2003: 2318).

There have been calls for greater connections between geography and nursing, based on the theory that research in both disciplines would benefit from a greater degree of interaction (Andrews 2003). But to date geographers have not fully examined the numerous material and symbolic dimensions of giving and receiving care (Parr 2003). With respect to nursing, there is also a lack of understanding of how nurses interact at the institutional, community and individual levels (Andrews 2003). At the same time, the role of health professionals in shaping remote communities has received little attention although the contribution they make to community development and sustainability is significant (Farmer et al 2003). In northern Canada, the role is even more significant because the institution of nursing has constituted the backbone of healthcare provision in the vast region for decades (Waldram et al 1995; Canitz 1990; O'Neil 1979). Consequently, to strengthen the relationship between geography and nursing, it is necessary to examine how the two disciplines are linked.

One way to gain a clearer understanding of the relationship between nursing and place is by examining the personal accounts of nurses who worked at the nursing stations in Northern Saskatchewan. The nurses' narratives provide insight into how affairs played out on the ground, which have not been part of the conventional record produced by explorers, Hudson Bay Company (HBC) factors, and police, mostly male accounts. The nurses were in a middle position, situated between the government(s) that employed them and the patients to whom they had professional obligations. Consequently, in the course of carrying out their responsibilities, the nurses encountered a number of contradictions that challenged them both professionally and personally. But, regardless of the ambiguous nature of their position, it is important to examine the experiences of middle actors such as the nurses so that the places people live can be better understood (Morris and Fondahl 2002). This course of inquiry will also contribute to a better understanding of the role that nursing plays in region formation.

Northern nursing can be developed through several types of geography. For example, there are top-down (formal) processes, where a geography of region-making focuses on processes of institutionalization (Paasi 1986, 1991, 2003). With respect to the Canadian context, the formal processes that are most applicable are those related to modernization and internal colonization theories (Morantz 2002; Quiring 2004). Another way to approach northern nursing is through a geography of social life, where the emerging literature on the geography of nursing presents an entry point. This two-pronged approach provides an opportunity to use different lenses to view the simultaneous interactions between the informal and formal processes involved in region-making. This paper draws on theoretical approaches to modernization and internal

colonization with theory associated with the proximities of nursing care (Malone 2003) to demonstrate how these processes simultaneously contributed to the institutionalization of Northern Saskatchewan.

Data Sources

Domosh and Morin (2003: 262) contend that "writing women's lives, voice, stories, and experiences remains a pressing issue and…to do the task, scholars must search out non traditional sources to recover women's historical geographies". As such, the research in this paper is based mainly on two archival collections that document the experiences of nurses working in Northern Saskatchewan. The first collection consists of letters written between nurses working in outpost hospitals in Northern Saskatchewan and their supervisors in Regina from 1944 to the mid 1950s. These documents are housed in the Saskatchewan Provincial Archives at the University of Saskatchewan in Saskatoon. The records show that 20 public health nurses worked at the nursing posts between 1944 and 1957, but only 8 were in the north at any given time.

The second source of information consists of 34 taped interviews conducted by Joy Duncan in the mid 1970s. Ms. Duncan secured a Canada Council Grant, traveled across the country and recorded the experiences of nurses who worked in the outpost hospital system. The collection, known as the "Joy Duncan Frontier Nursing Project", also contains diaries, pictures, newspaper clipping and other memorabilia donated by the nurses. Ms. Duncan donated all of the materials to the Glenbow Museum in Calgary where it remains. However, permission was obtained from Ms. Duncan to use the collection in this dissertation.

The two discrete collections were collected in different places and at different times – the letters contained in the Saskatchewan Archives were written as events occurred, while the Joy Duncan interviews were conducted many years after the nurses' experiences. The materials also served different purposes. The correspondence in the public health collection conveys the "official" stance of the nurses and their supervisors on activities related to running the nursing stations. Although more formal, in most cases the exchanges are personal and affable, and reflect the nurses' perspectives while living in the small remote communities. The interviews in the Joy Duncan Collection were conducted between peers, often after the nurses had retired and were no longer living in the north. The majority of the interviews were conducted with nurses who did not nurse in Northern Saskatchewan but at other nursing posts operated by the federal government across northern Canada. However, both the written correspondence and taped interviews carried out twenty-five years later are available for four nurses, which provided the opportunity to examine nurses' perceptions as events occurred as well as retrospectively, thereby adding a unique dimension to the dissertation.

Other relevant materials were obtained from the National Archives of Canada in Ottawa. The RG10 (Department of Indian Affairs and Northern Development files (DIAND) and RG15 files (Métis) were examined but little health related information was found in the files. As Indian and Northern Health Services (INHS) is part of Medical Services Branch (MSB) of Health and Welfare Canada, the RG29 records were examined and found to contain significant sources of health-related information with respect to Indian people. Similar records were not available for Métis people because they were considered part of the general Canadian population. In many instances, however, access

to files (designated as code 32) in the Indian Health records was denied because of the confidential nature of the information. Nevertheless, the RG29 files provided documents such as: correspondence (i.e. between bureaucrats, politicians, Indian leaders, physicians); interdepartmental memos; regional annual reports; conference proceedings; policy addresses, and newspaper articles, on a range of matters relating to the provision of healthcare to Indians in Canada. Resources were also obtained from the First Nations Treaty Centre in Hull, Québec. Materials included journal articles, newspaper clippings, and some previous materials found in the RG 29 files.

The Annual Reports of the Federal Department of Public Health, Division of Public Health Nursing, for Saskatchewan provided valuable statistical information related to the nursing posts, such as the number of home and office visits. The reports included births, deaths, the incidence of disease and illnesses, the number of nurses who were employed at the outpost hospital, and descriptions of the various programs being implemented in the communities. The reports also included data about the nurses themselves including the number employed in individual health districts, professional qualifications, new hires, resignations, and those on educational leave. There was some discussion about the difficulties in recruiting and retaining nurses in light of on-going nursing shortages. Lastly, Environmental Impact Assessments such as the Churchill River Board of Inquiry (1978) and the Bayda (Cluff Lake) Inquiry (1978) provided comprehensive scans of Northern Saskatchewan and the services that were introduced to residents starting in the mid 1940s.

Theoretical Explanations

As mentioned previously, the introduction of healthcare services to residents living in Northern Saskatchewan following World War II coincided with increased extraction of the region's natural resources, particularly uranium. But economic conditions in the north were abysmal and government social services were almost non-existent. With election of the Saskatchewan Co-operative Commonwealth Federation (CCF)[1] government in 1944, social regeneration of the north, "particularly the integration of the underprivileged into society, was premised on a development model in which the exploitation of natural resources would provide the wealth necessary for modernization and public services." (Barron 1997: 139-140). Public health was a key mechanism for delivering both health care *and* assisting in the process of social reform; an appropriate fit with the provincial outpost hospital system where nurses not only delivered medical care, but also promoted new and modern ways of living through educational programs and by way of their daily lifestyle (Smith 1992).

Modernization theory was founded in the historical relationships which emerged between western and non western societies, and became the central model guiding development programs and policies globally from about 1945 to 1965 (Blaut 2000: 27). Modernization theory, prompted by the decline of colonial empires, stressed the importance for societies to become more like modern western societies, and depended on the presence of social structures that were produced, promoted, and protected by the state. Furthermore, bureaucratic administration was to replace traditional forms of authority and belief systems. From a geographic perspective, modernization was seen as a process

[1] The Saskatchewan Co-operative Commonwealth Federation (CCF) government was a social democrat party responsible for introducing Medicare.

of spatial diffusion and was measured by the spread of modern institutions such as education and medical facilities (Blaut 2000; Peet 1999).

The premise of modernization theory was that once less developed traditional societies shed their customs and modernized to the standards of western countries, their development was assured (Blaut 2000; Slater 1995). The rather optimistic view did not last long though, because the model did not take into account the diverse structures of various societies that had little confidence in the model and consequently resisted its universal application (Slater 1995). Nor did it take into account the local history that shaped less developed regions (Peet 1999). Nevertheless, programs conceived under the umbrella of modernization were applied to Aboriginal people and their communities in Canada. This was certainly the case in Northern Saskatchewan, where institutions (i.e. healthcare, education, governance) and their respective programs were introduced with little recognition of the local situation.

Thus, under the umbrella of modernizing the people and institutions of the north, healthcare, education, and modern ways of living were introduced into the region. However, the *manner* in which the modernization process unfolded ultimately contributed to the region's colonization. Although many of the programs created to address the gap in living standards between northern and southern Saskatchewan were well-founded, chronic government underfunding, inappropriate programs, and a lack of local participation in decision-making kept the overall level of services well below that of the south. As a result of these factors, Northern Saskatchewan emerged as a resource rich colony of the south (Quiring 2004).

By highlighting some of the flaws of the modernization process, this research is not espousing an anti-modernity position. From a critical modernist perspective, progress and modernity have improved life for more people than ever before, and presents untapped potential (Peet 1999). Data suggest several improvements in the quality of life as a result of the introduction of modern western medicine. For example, maternal mortality rates have dropped since health care professionals attend women in childbirth. In other words, modernity holds the *potential* for positive outcomes, and serves as an example of "what might be done under the right circumstances" (Peet 1991: 11). The problem is how modernization takes place; modernization is not development and providing infrastructure and services is only the first step in the modernization *process* (Waldram 1989). The benefits of modern development initiatives must extend to the less fortunate portion of the population, not through "trickle-down" effects, but through a transformation in social relations of responsibility and control.

Nurses, as employees of the institution (i.e. government) that contributed to the region's colonial status could be viewed as an integral part of the modernization and colonization process. But empirical evidence reveals that there is more to the story. While government bureaucrats may have conceived programs directed towards the region, it was nurses working in the field that were responsible for their implementation. And there were differences between official instructions given to the nurses and what was actually done, which is often the case in large public agencies where it is difficult to keep track of how policies are implemented, when personnel (i.e. nurses) are scattered throughout a large area (Mitchell 1989). Nurses pursuing a career in public health were "hoping for autonomy, independence and a chance to use their skills in a new way – to

prevent illness rather than heal it." (Stuart 1994: 23). As such, relative to other forms of nursing, public health nurses had considerable autonomy in their delivery of health care (Duncan et al 1999). Consequently, nurses were not simply conduits of the state, delivering sub-standard programs, and blindly following instructions received from their supervisors in Regina. Rather, their letters reflect concern, opposition, and even resistance, to situations that challenged their ability to provide the same level of medical services to northern residents as those provided elsewhere.

Therefore, models such as modernization and colonization are only partial lenses through which to view regional processes. A more complete picture is revealed when on-the-ground accounts are included, and the "historical geographies of the colonized world", are more *broadly* (my emphasis) interpreted (Yeoh 2000: 146). In light of this statement I turn to the nurses' stories. I draw on Malone's (2003) theory of 'distal nursing' to help describe the informal process of care, to help enhance the explanations of region formation in Northern Saskatchewan, and to establish the spatial link between nursing care and geography.

The act of providing care is spatial at a variety of scales - from the body, to caring organizations, to health care systems (Allen 2001). In Malone's model of 'distal nursing' organizational restructuring can constrain nursing practices which in turn, can disrupt the relationship between nurses and their patients. While Malone's theory is applied to contemporary reorganization taking place at hospitals in the United States, in this paper I adapt the model for Northern Saskatchewan and show how government neglect and lack of funding challenged the relationship between nurses and their patients.

Distal nursing demonstrates how providing care requires nurses to maintain a spatial proximity with their patients. The model encompasses three types of nested proximities: *physical* proximity, the degree of closeness at which nurses physically care for their patients; *narrative* proximity, where nurses learn about their patients through the patient's stories; and *moral* proximity, the point at which nurses act of their patient's behalf. As this research shows, through chronic under funding of the nursing posts and indifference to the nurses' needs, government bureaucracy tested the three proximities at all levels, and contributed to the emergence of a fourth proximity to further challenge the situation.

Introducing Northern Saskatchewan

Based on the lack of interest in Northern Saskatchewan, government attitude towards the north can best be described as benign neglect (Young 1992). By the early 1940s, the region remained isolated, lacking many of the basic services enjoyed by residents in the south.[2] In 1941, close to half of all Indian deaths in the province were due to infectious and parasitic diseases, while the tuberculosis (T.B.) rate in 1943 for Indians was 592/100,000 population compared with 21/100,000 among the white population (Sigerist 1944). When the Co-operative Commonwealth Federation ((CCF) and forerunner of the New Democratic Party (NDP)) was elected in Saskatchewan in 1944, conditions in the north were appalling. The fur and fish industries, considered the foundation of the region's economy, were in severe decline resulting in high unemployment, and poverty. These conditions were accompanied by a high infant

[2] However, conditions even for the southern population were not all that good. For a detailed discussion of the poor national health standards of the Canadian population prior to and between World War I and World War II, see McGinnis, Janice P.Dickin 1980 *From Health to Welfare: Federal Government Policies Regarding Standards of Public Health for Canadians 1919-1945*. Doctoral Dissertation (Edmonton: University of Alberta)

mortality rate, a life expectancy of little more than 30 years, and related social problems (Barron 1997). Because of the loss of livelihood and lack of economic base, living conditions for many Aboriginal people were wretched, as indicated in the following letter in 1941 from the Superintendent of Indian Agencies in Saskatchewan to the Secretary, Department of Mines and Resources (Indian Branch):

> *The housing conditions on most of the reserves is damnable, and as the doctor pointed out to me, is it any wonder there is TB here when the roofs all leak and after the rain the Indians sit in damp huts probably with wet clothes. However, I know nothing can be done at the present time to remedy this situation but if this war ever ends we should not lose sight of this because when money could have been procured for improving the conditions on the reserves nothing was done (National Archives of Canada (NAC) - Christianson to Secretary, Department of Mines and Resources).*

Beyond their own traditional methods, medical assistance for people of Northern Saskatchewan lay with the priests and nuns, the Royal Canadian Mounted Police (RCMP), or Indian agents. In some isolated communities managers of the Hudson Bay Company (HBC) store dispensed medicines despite the men's concerns that they were not qualified to do so (Joy Duncan Collection, Grace February 5, 1977). The region was isolated, lacking even basic public services and served as a classic example of underdevelopment. It is into this landscape of hardship that the provincial government introduced the nursing outpost system in Northern Saskatchewan (see Table 1). Local residents had organized the construction of a nursing post public at Cumberland House in 1929, but the Depression and World War II stalled any further expansion of the fledging health care system in the north (Quiring 2004). In 1944 when the CCF was elected, northern medical services consisted of a mission hospital at Ile a la Crosse, the outpost hospital at Cumberland House, infirmaries at La Loche and Green Lake, and nurses attached to residential schools at Beauval and La Ronge (Stabler et al 1975).

Health care facilities, comprised of nursing stations and small hospitals operated by the federal and provincial governments, the Catholic Church, and a private mining company were established in Northern Saskatchewan in the following years.

TABLE 1
Medical Facilities in Northern Saskatchewan (1957)

Community	Established	Jurisdiction
Ile a La Crosse	1927 (although the Sisters of Charity Grey Nun began caring for people at the mission in 1860	Erected by Provincial and Federal Governments; administered by Oblates; operated by Grey Nuns of RC church
Cumberland House	1941 (1929)	Provincial
Gunnar	1944	Gunnar Mines
Buffalo Narrows	1947	Provincial
Sandy Bay	1948	Provincial
Snake Lake (Pinehouse)	1948	Provincial
Stony Rapids	1948	Provincial
La Loche	1951	Church (Roman Catholic)
Lac La Ronge	1951	Federal/Provincial
Uranium City	1952 (moved from Goldfields)	Community
Pelican Narrows	1955	Federal

Source: Government of Saskatchewan, Department of Public Health Nursing, Annual Report 1957.

Northern Nursing: Providing Care in Remote Communities

The nursing stations were established throughout Northern Saskatchewan at a time when there was a general shift in Canada from home-based care to providing care in hospital settings (Kerr 1988, McArthur et al 1996, Richardson 1996, Smith et al 1999). But because Northern Saskatchewan was so sparsely settled, providing hospital-based medical services to the people of the area was considered impossible. The belief was that little more could be done than to provide the minimum of medical care to the population through medical outposts from which patients could be evacuated to larger centres by air. Consequently, health care facilities comprised of nursing stations and small hospitals,

augmented with the first air ambulance system in North America, were established to provide medical care to residents of the northern remote region. However, when necessary, particularly during freeze-up in the fall and break-up in the spring when planes could not land, nurses cared for patients in their own homes. Nurse Broome reports:

> We were only three weeks in isolation during our break up period which we appreciated very much. During that time I had a serious burn case and as yet haven't been able to send him out as the ice this week at Ile a la Crosse was still floating around and unsafe for landing. However his condition is good and will send him out next schedule. His left arm and hand were badly burned and he was in great shock when I first saw him…I kept him in our own home for 2 days pushing fluids…I am very pleased with the condition of his arm and hand (Saskatchewan Archives Board (SAB) Broome to Smith May 17, 1951).

The term 'hospital' is used lightly when referring to the outposts, because it conjures up an image of facilities far more grandiose than those faced by the nurses. The outpost hospitals, in fact, had more in common with infirmaries or clinics (Quiring 2004). Further to the description of the new facility at Stony Rapids described in the opening quote, the first 'hospital' at Uranium City consisted of a small shack that had been moved over the ice from Goldfields to the community. The nurse working at the station reported that:

> The nursing station as it exists at present is a three roomed dwelling built in 1933 or thereabouts. Since my initial occupation in 1951 it has been moved some forty miles from its original location. It has no foundation, no storm windows, it never did have any insulation. Since it has been between 50 and 60 degrees below zero the greater part of this winter, I can assure you that the time I have spent there has been only as great as necessity demanded it (SAB Shannon to Leonard February 24, 1954).

In spite of the conditions, the nurse provided care, delivered babies, and as long as there were patients, slept at the outpost as well. But Administration Services of the provincial government viewed the arrangement differently arguing that because the nurse

sometimes slept and ate at the outpost, her Northern Allowance pay was cut by half to cover the cost of room and board, leaving the nurse extremely annoyed. She replied:

> I am at a loss to know how I could have conveyed the impression that for 50% of my time I live at the hospital…During the month of March, I will have two maternity cases which I will have to nurse over there. Their meals I will prepare here and mine I will eat here. I shall have to sleep there for as long as I keep them in, but I do not feel that can be regarded as living at the hospital. Therefore, I do wish to protest this decision on the ground that I live out, and that I provide my own maintenance (SAB Shannon to Leonard February 24, 1954).

The nurse also wrote another letter to her supervisor in Regina asking for her support and to explain the situation to Administrative Services. She was indignant that the authorities would quibble over such a small amount of money given all the meals she had lugged between the two places and the people she had cared for in her own home over the winter (SAB Shannon to Edwards February 24, 1954). It is unclear whether the nurses' full Northern Allowance was reinstated, but despite her description of the appalling conditions of the nursing station, no improvements were forthcoming. Several months later the outpost was again described as:

> This little place is very poorly equipped and as poorly furnished. There is not much around to give efficient treatment nor to keep house. During summer it might not be too bad but it must be utterly unpleasant during fall and winter. The rain comes in by the windows and through the roof. The nights are very cold already and without the oilstove going this little shack was like an icebox this morning…If it should be intended to keep this place going some drugs and other equipment are needed (SAB Augener to Edwards September 5, 1954).

Conditions at another nursing station were described in similar terms and the nurse reported that she had sincere admiration for the nurses who carried out their duties in such conditions, because it must have been anything but a pleasure to live at the hospital in the wintertime (SAB Janzen to Smith June 14, 1954).

It is difficult to understand why nurses were expected to endure such difficult circumstances, particularly given their work of providing professional medical care to northern residents. However, the fact that most, if not all of the nurses were women at the time, suggests that gender was a contributing factor.[3] The role of caring and curing was viewed as a natural extension of women's work. Nursing was also seen as a calling rather than a vocation, and requests to be treated and paid as professionals[4] were seen as selfish and demeaning (Growe 1991; Slater-Smith 1987). But the gender-based exploitation went beyond the professional with nurses expected to live in conditions that would never have been expected of doctors. For example, in response to the often shameful living conditions that nurses lived in, one nurse asked: "why women nurses should have to do it?" (Joy Duncan Collection, Evelyn, 1977). Nurses also had to put up with conditions that other people in the small communities thought unacceptable. Nurse Scriver reported: "Any of the men that come in here [the nursing station] all wonder why we have no electric lights, when the Hudson Bay have…they were all talking about it" (SAB Scriver to Smith July 22, 1946).

Clearly, in addition to the lack of government support for the outpost hospitals there was also little regard for the nurses' welfare. Interpreting the situation, one cannot help but assume that the government counted on the professional commitment of the nurses to keep them at the nursing stations regardless of the conditions. In one instance

[3] Reference to gender in the nurses' written correspondence pertaining to Northern Saskatchewan is limited, perhaps reflecting the times and the context in which the letters were written. Personal interviews in the Joy Duncan Collection contain significantly more gender-specific comments. However, with the exception of the comment provided here, others are not included as they were made by nurses that worked outside the study region.

[4] Freidson (1994: 200) defines ""profession" as synonymous with "occupation"; it refers to specialized work…not just *any* kind of work but the kind that is esoteric, complex, and discretionary…it requires theoretical knowledge, skill, and judgment that ordinary people do not possess, may not wholly comprehend, and cannot readily evaluate."

when a nurse resigned because of continuous problems with the bureaucracy in Regina, the Director of Nursing Services simply refused to accept the nurse's letter of resignation citing the community's need and the difficult situation Nursing Services would be in without the nurse's services. Instructing her to proceed to the community, the nurse was told that she would "be happier yourself if you do this rather than failing to meet this great professional need" (SAB Director of Nursing Services to Walz January 18, 1950). The state of affairs challenged the nurses and frustrated local residents who felt they and their communities were being neglected (SAB Walz to Smith October 19, 1949). As the following section shows, the lack of support also challenged the relationship between nurses and their patients.

Disrupting the Nested Proximities

As discussed above, Malone's (2003) distal nursing model encompasses three types of nested proximities: physical proximity, the degree of closeness at which nurses physically care for their patients; narrative proximity, where nurses learn about their patients through the patient's stories; and moral proximity, the point at which nurses see their patients as other and act of their patient's behalf. The degree to which nurses sustain the three types of proximity depends on the nurse-patient relationship. For example, when contact between the nurse and patient is brief, minimal proximity is required. But if the situation is more complicated and more time between the two is required, the level of proximity increases. In the northern context, nurses lived and worked in the small, remote communities twenty-four hours a day, seven days a week; therefore, the degree of proximity was high regardless of whether people were patients or not. The paradox is that the very institution (the state) responsible for supporting the

nurses and the outpost hospitals, also served as the greatest menace to the nested proximities of nursing practices.

Challenging the Physical Proximity

One overriding feature that disrupted the physical proximity between nurses and their patients was the often-overwhelming domestic workload that detracted from the time nurses spent with patients. Nurses were not only in charge of providing bedside nursing and, time permitting, public health programs, but they were also responsible for running the outpost hospital. They constantly reported having no idea of the incredible workload they would face prior to agreeing to work in the region, and it did not take long for them to reach that conclusion. For example, in one instance the nurse felt that six weeks she had spent working in the north was more than enough time to make her realize the intolerable arrangements that nurses were subjected to at the outpost facility (SAB Edwards to Smith February 10, 1949). The lack of private space, little personal time, and too many domestic chores were cited as the main problems. At times, domestic responsibilities went well beyond the boundaries of nursing. Nurse Broome reported that in addition to her nursing duties, she was responsible for preparing meals for between fourteen and eighteen workers, three times a day, who were constructing a new government store in the community. She goes on to say that she was looking forward to her holiday, but in the meantime because the responsibility and constant work left her feeling fatigued and a bit on edge, she was in need of a "booster" to supplement her energy levels (SAB Broome to Smith July 31, 1952). The supervisor replied indicating that the supplement had been sent, but no reference was made to the extraordinary workload that the nurse was carrying (SAB Smith to Broome October 4, 1952).

While the request for a tonic represented a subtle way of conveying problems with the heavy workload, other nurses were more direct recommendations to their supervisor about how to improve the situation. One nurse expressed her dissatisfaction with the workload, lack of privacy, and stress of working in the north, which she felt prevented the nurse from doing their work as it should be done. She recommended that two nurses should be stationed at each outpost, and that they should be entitled to longer holidays. The suggestions were offered "not in her own interest but in hopes that it would help the nurse-midwives who were still working for the public health department" (SAB Augener to Edwards January 31, 1954). However, the overall lack of support continued, making it difficult to recruit and retain nurses to work in the north during a time of general nursing shortages, and resulted in some resignations (SAB Augener to Edwards January 31, 1954, Shannon to Edwards August 24, 1954).

Travel and communication systems also served to interrupt the physical proximities between nurses and patients. Although the provincial government had established an air ambulance service to airlift patients to larger centres for medical care, nurses in the north were discouraged from making use of the service, and instead were told to request the plane belonging to the Department of Natural Resource located in Prince Albert (SAB Smith to Pierce October 16, 1946; Quiring 2004). When nurses did call for the air ambulance, they were sometimes reprimanded if the flight was considered unnecessary - to the point of being threatened with covering the costs.

Other than medical flights, the nurses had limited access to alternate forms of transportation, but used whatever means were available to reach people. In one instance, upon receiving a note asking her to visit and see the children in a community where there

was considerable illness, the nurse made a 100 kilometre canoe trip because she hesitated to charter a plane (SAB Broome to Smith September 12, 1952). Although advances were made in communication and access to two-way radios, telegrams, and telephone systems improved, nurses were encouraged to use the least expensive means available. One nurse reported that only letters and wires (telegrams) were allowed – no phone calls - because they were considered too costly. She went on to say that they were always made very conscious that it was government money that was being spent. In another instance the nurse was told by her supervisor that although she appreciated that the nurses needed access to the outside world especially during breakup, she was to send a wire only when absolutely necessary, because the last two messages had been very costly. She was also instructed to keep the words to a minimum (SAB Smith to Pierce April 7, 1948)! Consequently, considerable time was expended writing letters and composing wires, particularly as the messages had to be convincing.

Distance and inadequate means of transportation for the nurses were other factors that served to disrupt the physical proximities. There were few roads in Saskatchewan when the nursing posts were first established following World War II. In 1947, Lac La Ronge was the first community in Northern Saskatchewan to have an all weather road, but the 185-mile trip to Prince Albert could still take up to eleven hours (Quiring 2004). Although there was a lack of roads between northern communities, each settlement had rough roads within their immediate vicinity and cars were used. But vehicles were not provided for the nurses' use in the communities, so they either had to walk, travel by horse, or call on others to transport them. This was time consuming and inconvenient so the nurse working at Cumberland House asked for a jeep:

> Now I have a great big want. Would it be possible for the Department to get me a Jeep, I lose so much time waiting for transportation to get to any place and home again, to me its just valuable time wasted...I've had to go over to The Big Stone river to see a little boy, I walked there it took me 1 ½ hrs, I cannot go fast with my knee, it had been fine for about a week, I could hardly get home, and it kept me awake most of the night, and I could hardly get around the next day. The rough ground just nearly takes the leg off me. A Jeep could go through anything, our new Police thinks it would just be the thing for here. (SAB Scriver to Smith October 12, 1945).

But the request for a jeep was scoffed at and considered most impractical. The nursing supervisor wrote:

> I must admit I had to laugh when I read your letter asking for a jeep. I had a mental picture of you driving over those roads in a Jeep. It would be worth seeing. Do you not think that a tank would service your purpose better! Just at the moment the request seems to be a bit fantastic. However there is no telling how it will be received (SAB Nursing supervisor to Scriver October 18, 1945)

The nurse's request for a vehicle was denied. However the issue surfaced a few months later when, during a visit to the nursing station, the local Member of Parliament (MP) asked the nurse if she had any particular needs. The nurse mentioned the jeep as well as the need for a lawn mower. The request drew the ire of the Director of Nursing who wrote:

> I do wish that you would not do things like this. It is most annoying. You know that your requests sent through the office are given attention and you have been given everything for which you have asked…Why you are asking for a jeep again now when you are going out in a month's time and will not be back for a few months, I can't understand. I discussed the Jeep with Dr. Hames when you first mentioned it and he thinks it is not practical at all (SAB Smith to Scriver July 8, 1946).

Although the nursing supervisors may not have agreed with the nurses' requests, they did pass along the outpost nurses' concerns to the Medical Officer in charge, a position held by a male physician. But the outposts continued to lack basic necessities including the simplest of items such as reference books, forcing one nurse to rely on her

books from training and manuals put out by drug companies (Joy Duncan Collection, Grace February 5, 1977). Other projects clearly took precedence over the outpost stations. For example, between 1944 and 1963, the building costs associated with the outpost hospitals amounted to $76,261.04, which was less than the cost of *one* fish plant built in the mid 1950s in Northern Saskatchewan (Quiring 2004). But the strongest evidence that other priorities increased served to increase the physical distance between nurses and their patients was contained in a letter from the Medical Officer to nurses at the outpost hospitals stating that:

> Because of unsettled world conditions and the possibility of a world war, I feel that I must make an appeal for a retrenchment in our expenditures in the Northern Administrative District…More particularly I want to point out that our four hospitals are pretty well equipped and no further requests for furniture can be made at this time…In the matter of dispensing, discretion must be shown in the amount of medicine given out. Do not give medicine unless very sure that it is necessary and apt to be beneficial…Costs of transportation of patients by Saskatchewan Government Airways are very high…be sure that every trip authorized is absolutely necessary (SAB Totten to Walz August 2, 1950).

Adding to the letter's shameful assumptions and suggestions, is the ironic fact that reductions in expenditures for the outpost hospitals were sought at the same time as plans for the construction of Uranium City – a planned single industry resource community, with the infrastructure for potentially 5,000 residents – were being implemented.

Disturbing the Narrative Proximity

In Malone's concept of distal nursing, nurses learn about their patients through patients' narratives. In the north, however, language and cultural differences between the nurses and the predominantly Aboriginal population made this a challenging undertaking. If the outpost employed a caretaker or cook, they often acted as translators, but nurses did not receive any support for language instruction or cultural orientation. Many nurses

learned at least a few words in the local language, but without the ability to converse freely, learning about patients through their own narratives was difficult, although not impossible. The nurses had other sources that they turned to for assistance. For example, on one occasion help came from the local priest who knew a great deal about the people as he had worked in the community for years. He knew the family trees of everyone in the surrounding region, which not only helped the nurse in her daily practice, but ironically also made it possible to trace congenital hip problems that plagued people in the community (Joy Duncan Collection, Grace February 5, 1977).

Narrative proximities were further challenged by the amount of time that nurses were normally allowed to stay in a community. Every time a new nurse arrived, new relationships had to be built between the nurses and people, which took time. People had to tell their personal stories over again, so that the nurse could become familiar with the health conditions. But the nurses' stay in each community was not long with a one-year limit often the norm for each posting. But as one nurse claimed, because of the isolation no one knew where she was, so she stayed for two years (Joy Duncan Collection, Norma June 18, 1975)!

Nurses were also moved around seemingly at whim, despite their protests and willingness to stay in particular communities where they felt they had established good relationships with people (SAB Augener to Edwards May 15, 1954). Relocation is in keeping with Malone's (2003) model of distal nursing, where moving disrupted the three proximities (physical, narrative, moral) between nurses and their patients. Moving the nurses, I argue, was a diversion that made it more difficult to establish connections and

learn about people, which consequently hindered the nurses' ability to advocate on behalf of their patients and communities.

In one case, the local nurse and her family decided to stay in the small community rather than relocate with her husband's position to an even more remote community further north. They purchased a house, built an addition, and with a large garden, livestock, and the nurse's part-time position felt they could make a go of it. The people in the community also wanted the nurse to stay as, after taking some time to establish, they had considerable confidence and trust in her. Needless to say the nurse was more than a little surprised and irritated when she was replaced by the incoming manager's wife who was a nurse. The nurse protested strongly, stating that the nursing position should not be passed around lightly, least of all on the basis of a husband's connections.

Furthermore, she argued there was such a thing as nursing ethics and she stated that the Saskatchewan Registered Nurses' Association (SRNA) had been informed about the state of affairs. The nurse told the SRNA that regardless of how they intended to deal with the situation, she was going to continue her work and wanted to hear nothing more about it. Unfortunately, while apologies were forthcoming from the nursing supervisor, nothing was done about the situation and the nurse was instructed to hand over the nursing post and supplies to her replacement (SAB Cockburn to Smith/Smith to Cockburn October 4, 1949, October 19, 1949, December 12, 1949, December 28, 1949).

This incident described above is a prime example of the lack of power that nurses held with respect to their profession, even though they were represented by the Saskatchewan Registered Nurses' Association. The SRNA was responsible for providing the public with qualified nurses and for supporting nurses professionally. However, they

were adamantly opposed to collective bargaining since it was associated with the activities of unions, not professionals. When the new *Trade Union Act* was introduced by the provincial government in 1944, the SRNA immediately petitioned to have nurses excluded from the *Act* on the grounds that they were professionals. The basis for this decision was the belief that society would recognize nurses as professionals, and as such would pay them what they were worth (Slater-Smith 1987: 3-5). This position left nurses open to continuing exploitation until 1966 when the SRNA finally acknowledged that nurses were not being adequately compensated for their education and responsibilities, and collective bargaining was sanctioned. Until that time, however, the SRNA had little clout which they could exert on behalf of the nurses, leaving them vulnerable to the whims of employers and with little job security; a fact that Nurse Cockburn knew only too well!

Testing the Moral Proximity

The lack of support challenged the physical and narrative proximities, but the nurses advocated on behalf of themselves and their patients, in an attempt to minimize disruption to the moral proximities and preserve relationships with their patients. Despite the constant demands on their time, and the fact that the responsibility for everything fell on the nurses, they maintained that their nursing duties came first (SAB Pierce to Smith November 1, 1946). Even when they had nothing to work with, nurses would follow up on requests to visit people in their homes and at least try to give them some advice (SAB Walz to Smith October 22, 1949). In light of the paucity of resources available in northern communities, the nurses themselves took patients to larger centres to see dentists or to have their eyes examined. They also helped organize and raise funds to bring in

other much-needed health care professionals, and sought additional government assistance for communities when low fish and fur prices left people with little income (SAB Walz to Smith October 19, 1949, Broome to Smith January 21, 1953).

Attempts were also made to improve community infrastructure. Nurses were trained in holistic-based public health practices (Duncan 1999). They knew about the complex relationships between determinants of health, and that diseases such as tuberculosis which plagued the Aboriginal population, were not just due to the tuberculosis bacillus alone but also depended on other factors such as poor nutrition, crowded and poorly ventilated houses (Meade et al 2000). They were well aware that chlorinated water and sewage treatment were amongst the factors that contributed to increased life expectancy, and encouraged digging proper wells and boiling drinking water in order to prevent illness in the communities (Meade et al 2000, SAB Broome to Smith September 12, 1952). As the following example illustrates, they also noted the poor state of housing particularly for those people living on reserves.

In 1957, after seeing the deplorable conditions that prevailed on many of the reserves, the (federal) Supervisor of Nursing Services for the Saskatchewan region arranged a conference that featured "a comprehensive discussion of environmental sanitation as it affected the life and well being of the Indians" (Mellish 1957: 2). Housing issues were raised during the conference but cramped living conditions were attributed to the cultural preference and the "communal spirit of the Indian" (Mellish 1957: 10). Accusations that conditions were slum-like were met with protests that such statements were too harsh. However, field nurses confirmed that housing conditions were often deplorable, with up to 12-14 people crowded into the small one and two room

houses with bedbugs, lice, and other parasites infesting many of the dwellings. In a similar conference two years later in 1959, statements about Indian peoples' preference of living in inadequate houses were again strongly refuted, with one participant stating, "in the past it has been argued that the housing situation was a cultural problem – that Indians preferred to live in such accommodation. Recent studies, however, contend that to a large extent poor housing is the result of a depressed economic status rather than of cultural preference." (NAC Report on Saskatchewan Development November 20, 1959).

Clearly, all was not well on reserves, but by organizing conferences and speaking up about conditions, the nurses brought these issues to public attention, thereby advocating on behalf of their patients.

Diagnosing Patients: Introducing a New Proximity

In addition to the physical, narrative, and moral proximities described above, there is another proximity not addressed by Malone's model, perhaps because it is unique to isolated, remote settings – the responsibility of having to diagnose patients. This caused the nurses considerable consternation because without the appropriate training and authorization, diagnosing was dangerous and subjected people to unnecessary risks. Furthermore, nurses were also anxious that stepping beyond the bounds of their professional jurisdiction would jeopardize their licence to practice nursing (Joy Duncan Collection, Terry July 6, 1976). But there were no in-house physicians at the nursing stations, and although a physician could be contacted by radio-phone, atmospheric conditions and equipment troubles often prevented this from happening. As was often the case in northern nursing, in the end, nurses had little choice but to make a diagnosis and hope it was correct.

Similar concerns were also expressed about certain areas of nursing that nurses were qualified to practice such as midwifery. For example, a qualified midwife, pointed out that the idea that nurses worked alone, without a physician's support, was a misconception. In her letter to the nursing supervisor, the nurse-midwife made it clear that all pregnant women should have been sent out for a physical and obstetrical examination. However, her claim was considered unrealistic because the supervisor felt the nurse had the training that enabled her to know which pregnancies were normal and those that were not. This attitude did little to put the nurse's concerns to rest and she wrote:

> I have no equipment to examine them properly. Secondly, the decision is not really up to the midwife unless there is no alternative. I will do all I can under the circumstances but I can see no reason why they can't go out …In places where midwives are recognized and given a licence, they cannot take a case without a written statement from a doctor that the case can be taken by a midwife. Here where midwives are not recognized I suppose the department will take the responsibility leaving me to decide and use my judgment. I would prefer not taking this responsibility (SAB Pierce to Smith November 1, 1946).

In response to the nurses' concerns, the Deputy Minister of Public Health for the Province of Saskatchewan requested that the nurse be given a "certain amount of leeway" because she was in an isolated place and remote from other medical services (SAB Hames to McDougal October 22, 1946). This is indicative of the latitude given to nurses who had to assume responsibilities beyond the generally accepted scope of nursing practice, when it was convenient. But that flexibility quickly vanished, however, if and/or when doctors were located in communities.[5]

For some nurses, the idea of being on their own and doing things their own way was very appealing. But there was a difference between *nursing* care and *medical* care

[5] For a more complete discussion of the shifting role of nurses in western Canada see Stewart, Irene 1979 *These were our Yesterdays* (Altona: D.W. Friesen and Sons Ltd.)

and they did not expect to find little, if any professional support (Stuart 1994). For example, one nurse was "completely terror-stricken" when she was left entirely on her own after only three weeks at the nursing station (Joy Duncan Collection, Terry July 6, 1976). She reported having no supervision or seeing anyone for almost a year, except for a plumber who visited the nursing station after it was without water for six weeks and only one of four furnaces worked (Joy Duncan Collection, Grace February 5, 1977

Conclusion

> Outpost hospital nurses performed heroic feats in caring for the large populations that flocked to them for care. In addition to the challenge of providing medical services far beyond those normally required of nurses, these women dealt with ongoing trials, including stoking wood furnaces, poor water and sewage systems, and erratic electrical supplies (Quiring 2004: 227).

By examining northern nursing through two types of geography – a geography of region-making and a geography of social life - this paper shows the difficult role of nursing in Northern Saskatchewan. Although the nurses were sent to northern isolated communities to provide healthcare services, the state did not provide adequate support, in terms of living arrangements, culture and language training, transportation and communication systems, professional support, not to mention provisions for the nursing station. All of this undermined the efforts of the nurses by increasing the distance between patients and nurses, and disrupting the three nursing promixities, including the physical, narrative and moral. I introduced a fourth proximity to the model – that of diagnosing. The physical proximity was affected the most, but the nurses continued to put forth their best efforts, despite being overworked and under-resourced.

'I see and I am silent' was once the motto of a Canadian school of nursing (Bassendowski 2004:3). Although silence has been a characteristic of nursing throughout

much of the profession's history, northern nurses did not serve merely as pawns of the state. Rather, many of the nurses who worked in Northern Saskatchewan often tried to bring attention to conditions and situations that they felt hindered their work and jeopardized their patients' welfare. Unfortunately their concerns were, for the most part, ignored as attention shifted to new endeavors, leaving the nurses to 'get on with the job' despite a lack of commitment and support from government.

Looking at northern nursing through a geography of region-making and a geography of social life, helps to fill in the gaps of the historical record, and come to a better understanding of the regional processes at work, in a particular place, at a certain point in time. Applying Malone's model of distal nursing, in the northern, remote region context, shows both the spatial aspects of nursing, and how the social distance between nurses and their patients increases due to circumstances outside the profession. The evidence presented above shows that despite an agenda to modernize the region, the provincial and federal governments failed to provide adequate support for the nursing stations, thereby disrupting the nursing proximities. However, I expand Malone's model and show that if the bond between nurses and their patients are challenged, opposition emerges from within the profession to minimize the distance, and thereby counter harmful effects to the relationship. Acknowledging the presence of resistance to disruptions in present-day nurse-patient relationships provides another tool in which to explore this distinct spatial connection.

Working in northern, remote communities gave nurses considerable autonomy, which they used to maintain their professional proximities with patients. Although they were government employees and located within the institutional framework that

contributed to the modernization and colonization process in Northern Saskatchewan, nurses also had their own personal and professional tenets to uphold. As such, the nurses resisted and opposed instructions that they believed compromised those principles, thereby ensuring northern residents received the medical services that they were trained to provide. These actions reflect the nurses' professionalism which, had it been accepted and treated as such, could have defended both the nurses and their patients against the ill effects of bureaucratic colonialism. However, at the time, the ability of the professional body – the Saskatchewan Registered Nurses Association (SRNA) - to support nurses was limited, thus preventing the profession from realizing its full potential.[6]

Lastly, although the overall impact of colonialism has been looked at from the global and regional scale, this paper expands that understanding by looking at how colonialism affects, and is affected by on-the-ground events. I have shown that the processes of modernization and colonialism did not function seamlessly, because there were those working within the system who did not share the same ideals. Examining the complicated and contradictory nature of colonialism with this in mind, expands our knowledge of the social processes involved in region-making, and contributes to an increased understanding of the complex forces that shape this place.

[6] The Saskatchewan Registered Nurses' Association was adamantly opposed to collective bargaining and had nurses excluded from the *Trade Union Act in 1944* based on the believe that nurses were professionals, and society recognizing them as such, would pay what they were worth. The exploitation of nurses continued. In 1964, the Saskatchewan Registered Nurses' Association finally acknowledged that the ongoing situation was no longer acceptable and approved a collective bargaining process (Slater-Smith 1987)

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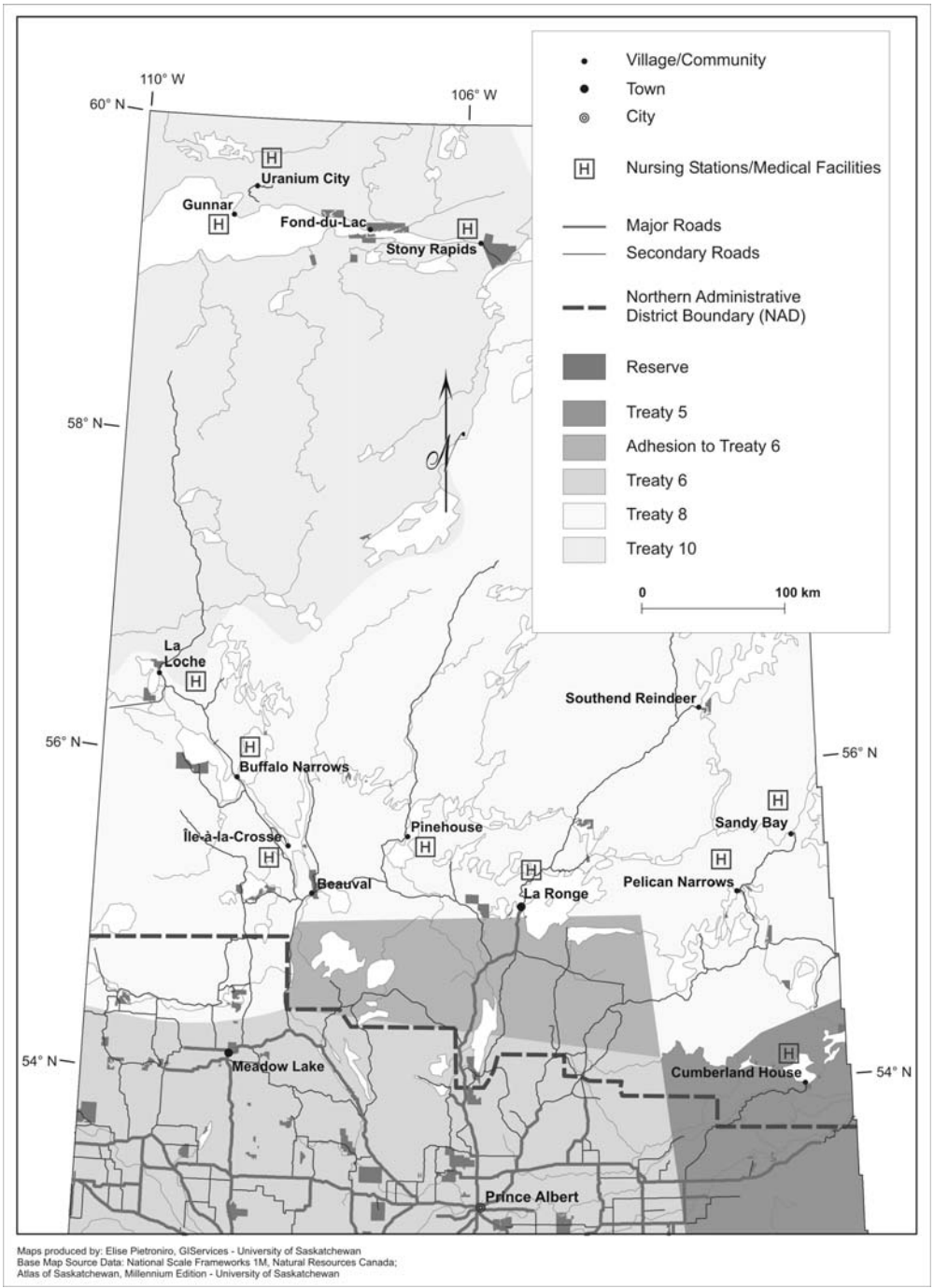
CARING, CURING AND SOCIALIZATION: THE AMBIGUITIES OF NURSING IN NORTHERN SASKATCHEWAN 1944-1957

NORTHERN SASKATCHEWAN

NURSING STATIONS



Caring, Curing and Socialization: The Ambiguities of Nursing in Northern Saskatchewan 1944-1957

Introduction

> That day at Norma Redbird's was the first time I really began wondering about a lot of things. Someone was lying and I wasn't sure who. Miss Jackson (nursing instructor) told us that part of Indian culture was close family ties, and that was why they lived in such cramped quarters...Bullshit! They were poor. They had no jobs. And nothing to do all day but watch reruns. And nothing to do tomorrow either. No prospects. I had never seen or tasted poverty before and it scared me...what did she know about Indians or family ties, or poverty or culture? All that garbage about rumpus rooms and fruit cellars...me standing there with my Canada Food Guide and sunburned nose, telling them their house was dirty or their food disgusting. Who the hell did I think I was (Lill 1986: 78)?

The excerpt from *The Occupation of Heather Rose* draws on the personal observations of playwright Wendy Lill. The play illustrates the poverty and despair of the native population and the demoralization of the non-Aboriginal individual as seen through they eyes of an idealistic, although reflective, southern nurse (Bessai et al 1987). When asked how successful she had been in bringing change to the northern community where she worked, another nurse expressed similar feelings:

> I don't think you should try and change it [Indian lifestyle], I think you should try and help them and I don't think the Indian people want white people's houses. I think they think we're crazy, scrubbing and working all the time when you can sweep the dirt down between the boards and in the summer you just move your tent around. I think a lot of them resent it because then they feel they have to work and do things and it's not their way. They want to sit around and visit and do whatever they please (Joy Duncan Collection, Yvonne February 4, 1976).

Although the above quotes are from two very different sources, they both speak to the fact that introducing health care to northern, predominantly Aboriginal communities, involved more than providing care. Health care services were based on humanitarian need and a genuine concern for people's welfare in northern remote areas of Canada[1], but

[1]For a comprehensive discussion of outpost nursing in northern Manitoba and the Northwest Territories see Hodgson, Corrine 1980 *Sitting on an Island: Nurses in the Canadian North* M.A. Thesis (Hamilton:

they also served the needs of the state[2] by drawing the primarily Aboriginal population into mainstream Canada; a complex process for both patients and nurses alike.

There is little argument that the goal of the Canadian state following World War II was to dismantle and refashion Aboriginal people's societies with the expectation that they would be assimilated into Canadian society (Morantz 2002). In Northern Saskatchewan, nursing was one of many institutions introduced into the region to modernize and improve people's lives. But inappropriate programs and inadequate support from the south hindered the process of modernization in the north, and resulted in a colonial relationship between the two regions. Nurses played an ambiguous role; they cared and cured, but they also contributed to changing the way people lived in order to improve their health. The question is what was involved in the socialization process and what role did the nurses play in shaping the region? In particular, did their socialization activities reinforce the colonial-like relations that had emerged? Based on these questions, the purpose of this paper is to examine the role of nurses as harbingers of social change in Northern Saskatchewan between 1944 and 1957, and to illustrate how the processes influenced the region.

The format of this paper is to first, provide an overview of the study area, and the sources of data used in the research. Second, I situate the paper within the theoretical frameworks pertaining to various dimensions of colonialism (Morantz 2002; Quiring 2004). Third, I present empirical evidence to highlight the contradictory nature of nursing practices and illustrate the duel role that nursing played as agents of change but

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McMaster University) 1980); Hodgson, Corinne 1982 "Ambiguity and Paradox in Outpost Nursing" *International Nursing Review* Vol. 29 (4), 108-117

[2] In this research the term "state" refers to the set of institutions (e.g. government agencies that provide public goods and services (Johnston et al 2000, 788-789)

also recipients of the same colonial attitudes as exhibited by government administrators towards the region in general.

The Study Area: Northern Saskatchewan

Northern Saskatchewan encompasses 252,430 square kilometres or about half the total landmass of Saskatchewan. The region is part of the provincial norths, a vast sub-Arctic belt running from the coast of British Columbia through the Canadian Shield and on to Labrador…an area which has long been ignored, politically weak, economically unstable, and home to substantial Aboriginal populations (Coates and Morrison 1992). Northern Saskatchewan is bordered by the Northwest Territories to the north, Manitoba to the east, and Alberta to the west. The southern boundary consists of an irregular east-west line bisecting the province just northern of Prince Albert (Figure 1).

Prior to the onset of large-scale resource development following World War II, residents of Northern Saskatchewan experienced little exposure to modern industrial development. Early excursions into the area associated with the fur trade brought about few changes as the activity was integrated into existing ways of life. However, trading did influence where and how people lived and included economic domination by the Hudson Bay Company (HBC) and psychological domination by the churches. By the early 1900s, interest and government involvement in the region included yearly visits by a single RCMP officer and an Indian Agent. Even the period between the two World Wars saw only a handful of provincial and federal civil employees become permanent residents in the area (Dobbin 1981). Following World War II, the region's relative isolation changed dramatically when growing energy demands, the "roads to resources" program, and government economic and social programs were introduced to northern

residents. The proliferation and scale at which post-war institutions and programs were implemented was vastly different from that which had taken place previously, and affected almost every aspect of life in the north (Weick 1992).

When Northern Saskatchewan became formalized as a region in 1944, living conditions for the population, who were primarily of Aboriginal descent, were appalling. Educational and medical facilities were lacking. There was little decent housing, communication and transportation systems were inadequate, and there was an almost complete absence of government-run social services. It is into this landscape of hardship that public health nurses were introduced.

Data Sources and Interpretation

This research is based on two archival collections that document the experiences of nurses working at nursing stations located in Northern Saskatchewan. The first collection consists of letter written between nurses working at outpost hospitals in Northern Saskatchewan and their supervisors in Regina from 1944 to the mid 1950s. These documents are housed in the Saskatchewan Provincial Archives at the University of Saskatchewan in Saskatoon. The records show that 20 public health nurses worked at the nursing posts between 1944 and 1957, with only 8 in the north at any one given time.

The second source of information consists of 34 taped interviews conducted by Joy Duncan in the mid 1970s. Ms. Duncan secured a Canada Council Grant, travelled across the country and records the experiences of nurses who worked in the outpost hospital system. Ms Duncan donated all of the materials to the Glenbow Museum in Calgary where it remains.

Using archival data is demanding because records are often incomplete, fragmented, and it is impossible to observe the phenomena first hand (Wishart 1997). In addition, interpreting the thoughts and experiences of others is both sensitive and difficult. Representation or "who can speak for whom", particularly when interpreting the historical record, presents considerable challenges (Harris 1997). However, while there is no disputing that interpreting the experiences of others requires considerable sensitivity and expertise (Harris 1997), there are advantages to utilizing archival materials because they "neither accuse nor excuse…and sometimes the silences in records speak as loudly as the privileged voices" (Cook 1996).

Theoretical Framework: Colonialism in Canada

Finding an appropriate framework that guides northern inquiry in Canada has plagued the research process, leaving researchers to use conventional theories and make adjustments along the way (Swiderski 1992). The continuing absence of a model, however, is not necessarily detrimental because no single framework can adequately explain the complex situation for individual communities (Wilkins 1993). In Northern Saskatchewan, attempts to modernize the region involved the introduction of a number of under-resourced institutions and programs that left the territory and its people in a subordinate position to those in the south. Therefore, I combine aspects of two "made-in-Canada" variations of colonialism – internal and bureaucratic colonialism - to examine the outcome of modernization more closely.

There are numerous definitions of colonialism. According to Johnston (2000: 93) colonialism is "the establishment and maintenance of rule, for an extended period of time by a sovereign power over a subordinate and alien people." Laliberte et al (2000: 56)

define colonialism as "the various economic, political, and social policies by which an imperial power maintains or extends its control over other areas or peoples." A similar definition is provided by geographers Knox and Marston (2004: 55) who define the process as "the establishment and maintenance of political and legal domination by a state over a separate and alien society." Wilkins (1993: 98) describes colonialism as "the establishment of domination over a geographically external political unit most often inhabited by people of a different race or culture." These definitions are helpful for providing a framework by which to explore colonial relations, particularly at the international level. Yet, they do not begin to reflect the multiple forms of colonialism. Willems-Braun (1997:4) argues that there really is "no global theory of colonial culture, only localized theories and historically specific accounts that provide insights into colonial practices". Furthermore, colonization takes place on a number of levels with many dimensions of oppression involved in the subjugation of people (Memmi 1965; Young 1990).

These models of colonialism are used most often to explain the economic and social-welfare disparities between developed and less developed countries. Application of such frameworks to the relationship that evolved between the Canadian state and Aboriginal people and their communities can be problematic, because the social and political patterns in Canada differ from those of Third World Countries. Furthermore, some Aboriginal individuals take exception to being thought of as "colonized" because it portrays them as victims, and does not account for differences between various 'colonial' voices (e.g. Slezkine 1994). Conversely, there are those who believe that Aboriginal people in Canada were "unquestioningly colonized", resulting in their marginalization

from Canadian society (Friderés and Gadacz 2005: 2). But according to Campbell (2003), the discussion needs to go further because "we've looked so hard at how colonization affected individuals that we forgot about how the places where we lived have been affected".

In Northern Saskatchewan, the majority of the population is of Aboriginal descent, which as Wilkins (1993) points out, raises different questions with respect to colonialism. Therefore, the Aboriginal people who are a majority in the region are critical to any discussion of colonialism. However, I extend the discussion to show how internal colonial processes also affected non-Aboriginal people (i.e. the nurses), government institutions, and the region's landscape. By doing so, I join the increasing number of scholars who are examining the notion of internal colonialism in Canada in an effort to find an appropriate theoretical model that fits the history and circumstances of northern regions (Morantz 2002; Quiring 2004; White 1979; Wilkins 1993). To explore dimensions of colonialism within the northern Canadian milieu, I draw from the work of David Quiring (2004) and Toby Morantz (2002) who speaks to different dimensions of colonialism.

Quiring's (2004) research pertains directly to Northern Saskatchewan. The comprehensive study examines the various agencies such as the churches, fur traders, and governments who, over time, tried to control Northern Saskatchewan. The Co-operative Commonwealth Federation (CCF) government was elected to power in 1944 with the expectation that social programs would be extended to the north and conditions for the area's residents would improve. Consequently a considerable effort was put into modernizing the region, which included replacing the traditional Aboriginal way of life

with new and different ways of living. Change did take place in the region, but the government failed to address the overall needs of the people, leaving them vulnerable and with little power to compete with a foreign infrastructure. As a result, a colonial relationship between Northern and Southern Saskatchewan emerged which continues to the present. Quiring's (2004) claim that government support and/or inappropriate programs resulted in the subordination of the north is also supported by Morantz's (2002) model of internal colonialism.

In her research focused on the James Bay Cree of northern Quebec, Toby Morantz (2002) distinguishes three models of colonialism: state, settler, and civilizing (i.e. missionary). Settler colonialism was most applicable to events in southern Canada where domination took place by force resulting in gradual appropriation of tribal lands, and emasculation of leaders. According to Morantz, civilizing or missionary colonialism involved the (impossible) objective of total destruction and reconstruction of societies and cultures. State colonialism occurred when colonial governments administered territory through indirect rule. There are no sharp divisions among the three categories but various combinations of the historical models are found across Canada.

The concept of bureaucratic colonialism is based on the governance structures of state colonialism, *minus* the settlers. It was neither settlers nor capitalism that lead to subordination of (in Morantz's case) the Cree people, but rather the combination of low-quality versions of southern-style Canadian services such as education, health and welfare, and government management that were introduced into Aboriginal communities in the 1950s. Morantz argues that the contradictions of colonialism were exacerbated by various government agencies responsible for social engineering, and cites the worst

example of bureaucratic colonialism as the government's ineffectiveness and frugality in providing the resources for Indian people to live as they saw fit. In the end, bureaucratic colonialism may have been a more insidious form of colonialism because there was no one particular colonizer, but rather many who claimed a higher concealed "boss" (Morantz 2002:242). In some respects, that absence was almost disappointing as it would have been easier to isolate and replace them, and thereby rectify the system.

The two models described above are most fitting to events in Northern Saskatchewan. However, a limitation of both theories is that they are broadly conceived, and do not acknowledge the inconsistencies inherent in colonialism. The two state-focused models provide an important 'top-down' explanation for events in Northern Saskatchewan, but they do not address the on-the-ground or 'bottom-up' processes, such as nursing, that also influenced the region. Therefore, this paper focuses on how the top-down process of internal/bureaucratic colonialism influenced the bottom-up or socialization process, which in turn expands our understanding of the complex processes involved in processes that shape regions such as Northern Saskatchewan.

Nursing Stations in Northern Saskatchewan

To address the enormous social and economic discrepancies experienced by northern residents compared to those in the south, and to pave the way for exploitation of the region's natural resources, the provincial government delineated Northern Saskatchewan as a specific geographic space through the *Natural Resources Act* of 1944. Social renewal, particularly the integration of the primarily Aboriginal population into mainstream Canadian society, was premised on a development model in which the exploitation of natural resources would provide the wealth necessary for modernization

of public services and result in improved living standards for people within the region (Barron 1997). To achieve these ends, changes were required to the way people lived in the vast, isolated and under-serviced region.[3] Therefore a variety of public institutions were introduced to not only provide education, health and social services to residents but also to replace the traditional norms with modern customs.

One such institution was public health; a service provided by nurses located at nursing stations throughout Northern Saskatchewan. Nurses cared for the ill and injured, and introduced people to modern concepts of health care through preventative and educational programs (Smith 1992). Living and working amongst their patients made the nurses effective vehicles for promoting a way of life that corresponded with modernization theories where western-based knowledge challenged traditional systems.[4]

The provincial government introduced the nursing outpost system in Northern Saskatchewan following World War II.[5] A provincial-run public health nursing station opened in Cumberland House in 1929, but the Depression and World War II stalled any further expansion of the fledging health care system in the region. In 1944 when the Co-operative Commonwealth Federation (CCF) was elected, northern medical services consisted of a mission hospital at Ile a la Crosse, the outpost hospital at Cumberland House, infirmaries at La Loche and Green Lake, and nurses attached to residential

[3] Note: These interpretations are likely those of settlers and not necessarily the views of the original inhabitants.

[4] Modernization theory stressed the importance for societies to become more like modern western societies and depended on the present of social structures that were produced, promoted, and protected by the state. The premise of modernization theory was that once less developed traditional societies shed their customs and modernized, their development was assured. The rather optimistic view did not last long though because the model did not take into account the diverse structure of various societies. Consequently, there was little confidence in the model and resistance to its universal application grew (Slater 1995).

[5] It is worthwhile to note that the marked shift that took place in the mid twentieth century with respect to the welfare of the northern population coincided with increasing awareness of the region's rich natural resources, particularly forests and uranium deposits. As a result, the state's traditional laissez-faire policy towards the region was replaced with a level of involvement that within little more than a decade made government the most important industry and major employer in the north (Rea, 1976:77)

schools at Beauval and La Ronge (Stabler et al 1975). By 1957, eleven nursing stations had been established (Table 1; Figure 2). The population of Northern Saskatchewan was so sparsely settled and dispersed, the belief was that little more could be done other than to provide basic care at the outpost facilities and transfer patients out to larger centres when necessary. Because of the distances involved and the lack of roads in the region, patients had to be flown out prompting the creation of the first air ambulance system in North America in 1946 designed specifically to provide back up services for the nursing stations.

TABLE 1
Medical Facilities in Northern Saskatchewan (1957)

Community	Established	Jurisdiction
Ile a La Crosse	1927 (although the Sisters of Charity Grey Nun began caring for people at the mission in 1860	Erected by Provincial and Federal Governments; administered by Oblates; operated by Grey Nuns of Roman Catholic church
Cumberland House	1941 (1929)	Provincial
Gunnar	1944	Gunnar Mines
Buffalo Narrows	1947	Provincial
Sandy Bay	1948	Provincial
Snake Lake (Pinehouse)	1948	Provincial
Stony Rapids	1948	Provincial
La Loche	1951	Church (Roman Catholic)
Lac La Ronge	1951	Federal/Provincial
Uranium City	1952 (relocated from Goldfields)	Community
Pelican Narrows	1955	Federal

Source: Government of Saskatchewan, Department of Public Health, Saskatchewan Public Health Nursing Annual Report 1957

So Much To Do And So Few Nurses

The establishment of nursing stations in Northern Saskatchewan coincided with significant advances in medicine such as the development of vaccines and antibiotics. The nurses themselves expressed amazement at the “near miraculous wonders of

penicillin and other antibiotics" noting that "the little ones come in here so sick, and after a few treatments, make such a quick recovery"(SAB Janzen to Edwards January 27, 1954). Tables 2 and 3 gleaned from the Department of Public Health, Public Health Nursing Annual Reports provides the annual total number of home and office visits reported by the nursing stations, and the number of nurses working at each outpost between 1947-1953.

TABLE 2
Number of Home Visits and Number of Nurses 1947-1953

	1947	**1948**	**1949**	**1950**	**1951**	**1952**	**1953**
Buffalo Narrows		136/1	309/1	134/1	324/1	122/1	223/1
Cumberland House	833/1	682/1	635/1	403/1	384/1	201/1	277/1
Goldfields					278/1	*	
Lac La Ronge					210/1 pt ***	345/1 pt	1033/1
Sandy Bay				567/1	382/1	365/1	473/1
Snake Lake (Pinehouse)		28/1 pt	101/1 pt	56/1 pt	252/1 pt	386/1 pt	**
Stony Rapids		169/1	208/1	74/1	80/1	94/1	332/1
Uranium City						346/1 pt	426/1
TOTAL	833/1	1015/3 + 1 pt	1253/3 + 1 pt	1234/4 +1 pt	1910/5 +2 pt	18594 +3 pt	2764/6

Source: Government of Saskatchewan, Department of Public Health, Public Health Nursing, Annual Reports 1947-1953
* Nursing Station moved from Goldfields to Uranium City
** pt = part time
***Services provided for Snake Lake (Pinehouse) are included in Lac La Ronge total

TABLE 3
Number of Office Visits and Number of Nurses 1947-1953

	1947	**1948**	**1949**	**1950**	**1951**	**1952**	**1953**
Buffalo Narrows		766/1	1429/1	1695/1	1381/1	1635/1	2097/1
Cumberland House	1653/1	1357/1	1538/1	1795/1	1435/1	1214/1	1457/1
Goldfields					233/1	*	
Lac La					28/1	20/1 pt	333/1

	1947	1948	1949	1950	1951	1952	1953
Ronge					pt**		
Sandy Bay				578/1	802/1	1290/1	1405/1
Snake Lake (Pinehouse)		4/1 pt	196/1 pt	249/1 pt	316/1 pt	266/1 pt	***
Stony Rapids		1	1455/1	1595/1	1314/1	1075/1	966/1
Uranium City						441/1 pt	804/1
TOTAL	1653/1	2127/3 + 1 pt	4618/3 + 1 pt	5912/4 + 1 pt	5509/5 + 2 pt	5941/4 + 3 pt	7062/6

Source: Government of Saskatchewan, Department of Public Health, Public Health Nursing, Annual Reports 1947-1953

* Nursing Station moved from Goldfields to Uranium City

** pt = part-time

***Services provided for Snake Lake (Pinehouse) are included in Lac La Ronge total

The figures in the tables can be construed in different ways, particularly the number of visits *to* the nursing station. One interpretation of the high number of office visits is that it illustrates the community's traditional health care customs were replaced. And according to Scheper-Hughes (1992) and Morantz (2002), such acquiescence to outside authority, whether voluntary or involuntary, is an indication of colonialism. However, I contend that this was not the case in Northern Saskatchewan and adopting new ideas related to, in this case, health care should not be seen as capitulation.

The people of Northern Saskatchewan had experienced more than their fair share of illnesses, diseases and the loss of life due to smallpox, tuberculosis and typhoid.[6] With memories of diseases sweeping through their communities, it is hardly surprising that people looked to the nurses for assistance with their health care concerns. The dread of diseases such as measles was stronger than even the fear of needles and nurses reported that people attended immunization clinics willingly. Confidence in needles actually grew

[6] For a discussion of (poor) health conditions of the general Canadian population at the time, see McGinnis, Janice P.Dickin 1980 *From Health To Welfare: Standards of Public Health for Canadians 1919-1945* PhD Dissertation (Edmonton: University of Alberta)

to the point where nurses complained that too many people believed that shots and pills were the answer to everything (SAB Lewis to Smith March 29, 1953, Janzen to Smith October 7, 1953). Lastly, In Northern Saskatchewan, the hospital at Ile a la Crosse (established in 1860), Indian Agents, Priests, and Hudson Bay managers had provided basic medical assistance for generations prior to the arrival of nursing stations. Therefore, the practice of seeking help was not new and people were aware of what western medicine could offer them. Community leaders were also well aware that their population could benefit from advances in medicine and some lobbied to have nursing stations situated in their communities (Linklater, PC June 2001).[7]

Overall, it is difficult to determine the extent to which the population of Northern Saskatchewan benefited from western medicine because little data were collected about Aboriginal people prior to 1960 (Weaver 1981). Furthermore, what information may have been collected was unreliable as people lived a traditional nomadic lifestyle (i.e. hunting, trapping, fishing) that required considerable movement about the region rather than residing in permanent settlements. But visits to the nurses and nursing station did not diminish people's ability to make their own decisions, and in some instances the Aboriginal population were reported as "bold and demanding" (SAB Janzen to Edwards August 11, 1954). Moreover, "it would be arrogant to assume that recipients were incapable of discriminating between those services and ideas which were useful and those which were not" (Jones 2002: 285). This position gains additional support from Reiffel (1999) and Abel and Reiffel (1996) whose work on American Indian Reservations found that people played an active role in determining what advice and treatment were

[7]Further evidence of the awareness of medical care is provided in Treaty 6 (1876) where Indians negotiated the medicine chest clause. Indians in subsequent treaties also requested the same terms. Treaty 6 encompasses a portion of Northern Saskatchewan (Brizinski 1993, 170).

accepted, rejected, or integrated with their traditional ways.

Altering Northern Space

Not only were nursing stations new to the region, but so was the idea of living year round in permanent communities. The majority of permanent northern settlements in the region was relatively young, having been established following World War II as people shifted from a nomadic hunting, fishing and trapping lifestyle to a sedentary way of living (Elias 1999). Residing in permanent communities was a new way of living that required different sets of skills. Therefore, federal and provincial government programs were implemented to instil "modern" notions of living into the population with the aim to assimilate Aboriginal people into mainstream society.

These programs had a history. For example, a field matron program was implemented in the United States between 1888-1938 that employed hundreds of white women to live on reservations and instruct Native American women about correct forms of domesticity (Domosh and Seager 2001). In Canada, Homemakers Clubs were established, in some instances, by nurses to encourage Indian women to adopt western ideals of femininity and domesticity in hopes these standards would subsequently ripple through Aboriginal society.

In Northern Saskatchewan, nurses established women's auxiliary clubs, new baby clubs, home craft clubs, girls and boys clubs, and so on. Nurses report that the local women took great pride in participating in the clubs and were more than willing to support their local nursing station (SAB Pierce to Smith January 22, 1948). Ladies' clubs were formed for educational purposes and to raise funds for work to be done on children and adults to improve their health. The money raised through fund raising activities

covered the cost for a dentist to visit the community as well as paying for toys and games to amuse the children so that the time in hospital would "not be so tedious for the wee ones" (SAB Lyons to Smith October 19, 1949). The time and effort spent on organizing various clubs is commendable; but at the same time, the activities also served to socialize people with ideas of play and adult behavioural norms. The actions of nurses who lived and worked at outpost hospitals went beyond normal nursing practices, and presented a way to change the way the primarily Aboriginal population lived their lives. This serves as a fitting example of social engineering within Morantz's (2002) concept of bureaucratic colonialism.

The "appropriate" use of time was another aspect of life that some nurses tried to instil. As Nurse Lyons stated, "In my estimation our biggest contribution to Public Health in this district is training the women and girls how to use their leisure time profitably" (SAB Lyons to Totten April 20, 1949). As a result, sewing and hobby classes were held and became popular with younger children. Nurse Lewis remarked, "hobby classes are going to begin again, they proved so popular that the last season ended with even the small boys wanting to learn to crochet, as they were getting fed up with having nowhere to go in the evenings" (SAB Lewis to Smith November 24, 1952). The lengths to which nurses went to socialize people varied, as did their techniques. Generally instructional sessions were held at the outpost, but as the following quotation demonstrates, in some instances, meeting at the nurses' home met with greater success.

> I have found that the natives get very little out of planned lectures or demonstrations but have had wonderful results, especially from the school children and some mothers of allowing them to visit in our home. They are very observant and follow our habits readily...I have been encouraging the native children to come to our home to visit hoping they may gain some knowledge of cleanliness and the ways of living properly (SAB Broome to Smith February 15,

1950; January 4, 1951).

To convey their messages the nurses used a variety of methods including filmstrips, slides, posters, and leaflets – all in English. It is significant to note that nurses never received any language instruction (nor any cultural training) and relied on interpreters to convey their messages. As the following demonstrates, however, the situation became complex at times. The nurse wrote:

> It was amusing the other day – I was doing the dressing of a French priest who could speak "Chip" but little English. A "Chip" boy came in who could speak nothing else, so I asked Adrienne in English to ask the priest in French to ask the boy in "Chip" my questions, and so gradually I got some idea of his trouble – I'm not usually so fortunate (SAB Glenny to Smith August 1, 1952).

Generally, local women in the community provided translation services but when it became necessary for them to visit the nursing station up to three or four times in an afternoon, they tired of the inconvenience and started charging for their services which was a very unpopular move (SAB Pierce to Smith April 25, 1948). As more people in the community came to speak English, demand for interpreters declined, although even today they remain essential in many northern communities in Saskatchewan. Interestingly, the nurses never mentioned the loss of language as an issue for Aboriginal people, leading one to assume that either the nurses were too busy to consider the question or they believed that the population would eventually become part of mainstream English-speaking Canadian life.[8]

Despite the language barriers, nurses covered a range of public health topics including healthy eating, hand washing, dental care, sanitation, and preventing the spread of diseases such as tuberculosis and venereal disease. Child rearing literature was also

[8] McArthur (1978) points out that an element of government policy between 1869-1945 was the assimilation of Indian people through the use of English language, culture, and an emphasis on self-sufficiency.

important and nurses relied on materials used in Canadian mainstream society such as *Canadian Mother and Child* (SAB Lyons to Smith August 18, 1947). In other words, nurses were "envoys of middle class values…teaching them the rules of 'scientific cleanliness' in order to combat ill health in the home and community at large" (Boutilier 1994:38).

The nurses' notions of cleanliness, however, were not out of step with public health practices of the time despite the position of Ehrenreich and English (1979) who claim that the obsession with cleanliness was little more than "busy work". Tomes (1997) refutes this idea and points out that at a time when infectious diseases were the leading cause of death in the general population, the emphasis on cleanliness had some utility.[9] The situation for the people of Northern Saskatchewan was no different, but as most residences lacked appropriate infrastructure such as running water and sewage systems, it was difficult for residents to adopt the recommended hygiene practices. Being trained in public health, the nurses were well aware of the health hazards associated with the lack of potable water and appropriate waste disposal and they tried to improve the situation by holding community meetings as well as raising their concerns with authorities in Regina (SAB Lacy to Smith October 1, 1953).

Influencing Northern Diets

As indicated in Lill's quote at the beginning of this paper, promoting a diet based on Canada's Food Guide was an important, although unrealistic, objective. The nurses grew and canned much of the food for their own use and that of the outpost (SAB Scriver to Smith August 3, 1946; Lyons to Smith August 3, 1948; Pierce to Smith August 11,

[9] The 2003 international outbreak of Severe Acute Respiratory Syndrome (SARS) serves as a modern-day reminder of how important basic hygiene practices such as hand washing are to the prevention and spread of disease.

1948). People in the community hunted, fished, and trapped and preserved food according to their own traditions, and some of the nurses preferred country food over that provided to them in annual shipments (SAB Broome to Smith January 4, 1951; Lewis to Smith November 24, 1952; Broome to Smith November 21, 1954).

But promoting a diet that included plenty of fresh fruits and vegetables was impractical given the northern lifestyle and personal tastes, not to mention the problems associated with growing gardens in sub-Arctic conditions. Unless people grew their own gardens, they simply did not have the financial resources to purchase the recommended foods. Meals provided to in-patients at the outpost hospital were fed Euro-Canadian style food, but relatives often took country food to their ill or injured family members as they considered it much more palatable and believed that it would help with recovery. This caused no-end of frustration for some nurses who did not see the nutritional value of country food. But perhaps the noncompliance was a source of irritation because it underscored the nurses' lack of power. In the end there was little the nurses could do beyond complaining about their patient's behaviour to their supervisors.

Some nurses, rather than dismissing the traditional diet, sought ways to enhance people's existing food. For example, when low fish prices resulted in a particularly difficult economic situation, people were taught to make nourishing soups with ingredients on hand. They were also encouraged to ration their food rather than eating it all in one day, then going without which was considered "a very native habit" (SAB Broome to Smith January 21, 1953). Another nurse displayed a great deal of initiative by seeking advice from a nutritionist on ways to improve people's diet based on the foods they already used. As a result, people were encouraged to use whole-wheat flour when

making bannock, and skim milk powder rather than evaporated milk because it was less expensive in the dry form and would keep without refrigeration. For her efforts, the nurse was praised by the Director of Nursing Services in Regina whose statement captured the essence of the contradictory nature of northern nursing: "your approach to the nutrition problem in the north seems so wise. It seems so unreasonable to expect those people to accept our way of life. Much more sensible to improve their own way of life. It is too bad that more persons do not have your attitude" (SAB Smith to Lacy September 24, 1953).

In spite of their efforts to change and/or enhance people's diet, the importance of traditional activities of hunting, fishing, trapping and berry gathering - activities that sustained people in northern communities - were recognized. When caribou were plentiful, people had enough food to eat and they kept remarkably well. One year, the nurse remarked that "the natives that were in the north this year seem to have had a very good living, the babies were all very well and they certainly looked well cared for". The following year she commented again that "the Natives are all busy fishing now they have put up their dry meat and there was plenty of caribou for all so this should be a good year for them" (SAB Lewis to Smith May 2, 1952, Lewis to Smith May 24, 1953). As mentioned earlier, the nurses also relied on country food either out of circumstances or personal choice.

However, when hunting was poor, people's health suffered. And when regulations were implemented to control access to the food supply they added to the hardship. Such was the case when the Indian Agent who held the key for the community meat locker failed to make arrangements for opening the storeroom during his absence. In her letter,

the nurse implied that she had been very busy with an outbreak of illness, which she attributed to the fact that without the key "the Natives were unable to get their meat from the freezer so they went hungry" (SAB Lewis to Edwards July 30, 1954). This event points to the increasing layers of bureaucratic power that northerners *and* the nurses had to contend with in Northern Saskatchewan.

The Nurses' Space: Homeplace – Workspace: All Rolled Into One

> The hyacinths are really making the hospital look like a conservatory. There are three pots blooming in the living room and I have 5 more in the other windows being forced along. There are some daffodils and tulips I am hoping to have for February 14th. I will have enough bulbs to keep us in fresh flowers until the end of March…I have never had so much luck and enjoyment with them on any previous attempts of growing these inspiring plants. The patients get so much pleasure out of watching them grow also (Saskatchewan Archives Board (SAB) Lyons to Director of Nursing January 19, 1948).

A unique feature of the nursing outposts was that they served as both the nurses' homeplace and workspace. The nurses' homeplaces were used as examples of modern modes of living for the local population (SAB Broome to Smith January 4, 1951; Meijer-Drees and McBain 2001). But as the outposts were the nurses' homes, it is not surprising that they tried to make their surroundings as comfortable as possible. The effort put into establishing a home setting is one of the most notable and consistent comments made by the nurses. Perhaps this is attributable to the fact that in the late 1940s and early 1950s when the nursing stations were being established, Northern Saskatchewan was considered a frontier, and "little pieces of feminine comfort" were important to women who lived and worked in pioneer-like conditions (Domosh and Seager 2001: 150).

Conditions at the nursing stations were primitive to say the least with some described as "deplorable, poorly equipped, and poorly furnished" (SAB Augener to Edwards September 5, 1954). Some nurses came from rural areas of the country so were

used to living without electricity, running water and plumbing. Nevertheless, there were many requests for dishes, furniture, paint, and items to enhance their surroundings. At one outpost hospital the nurse reported that she had finished sewing curtains "as the room looked so awful without them and the new colourful ones will look very nice for the rest of the summer". She also mentioned that the selection of pictures could wait until later although "the walls, curtains and lamps were all light colours so I would think that pictures to give colour to the room might be quite nice" (SAB Pierce to Smith August 14, 1948).

Ongoing efforts were also put into "freshening up" the nursing stations with floors and furniture being refinished and requests submitted for items to make the outposts more comfortable for both nurses and patients (SAB Janzen to Edwards August 11, 1954). Nurses also took pride in their flower gardens. There was considerable angst when an early frost or neglect left the flowers "a sorry sight and the window boxes absolutely dead" (SAB Aylsworth to Smith August 6, 1952). Lastly, tending to large gardens and preserving fruits and vegetables were other time-consuming responsibilities that not only provided food for the nursing stations but acted as examples for the local population.

But the work of producing much of their own food, added to the already heavy workload of the nurses, and at times domestic duties seemed to take precedence over their professional duties. In a letter to her supervisor, one outpost nurse reported that while she was pleased to have preserved 136 quarts of blueberries, and about 50 quarts of caribou, she needed someone to help with baking and canning as there was not enough time to do everything (SAB Lewis to Smith November 24, 1952).

Anther nurse protested outright declaring, “I am a nurse and not a housekeeper” (SAB Augener to Edwards November 25, 1953). But it was a side of outpost nursing that supervisors did not necessarily want highlighted. For example, when asked to write an article for the *Canadian Nurse*, the nurse’s supervisor replied,

> Now about the article for the *Canadian Nurse*. I do not think it necessary that you write especially about your work in the north. Why not concentrate on the scenery and the life of the people there, the garden which Miss Lyons had at Buffalo Narrows and refer just quite briefly to the work of the nurse in such a settlement (SAB Smith to Aylsworth November 24, 1950)

In the subsequent article published in the *Canadian Nurse* (see volume 47 (9) September 1951), there was no reference whatsoever about the often-difficult working conditions encountered in the north. Later, in another letter to her supervisor, Nurse Ayslworth reported light-heartedly, “you’d scarcely recognize Buffalo Narrows if you hear me describing it. You’d think it was the dawn of the golden age or something, to let me tell it. So if you hear of a group of people from Madoc district chartering a plane to Buffalo Narrows to have a look at that Utopia, don’t be surprised” (SAB Aylsworth to Edwards December 19, 1953). Although efforts were made to downplay negative aspects of northern nursing, the lack of support and professional and personal isolation did not remain concealed.

North Nurses and Social Isolation

The personal and professional isolation encountered by the nurses resulted in an often-palpable loneliness. For example, one nurse pleaded with her supervisor not to leave the same day as she arrived because “the visit is far too hurried and there is not enough time to talk about anything” (SAB Augener to Edwards November 25, 1953). In another instance, depression brought about by isolation and loneliness was cited as the

reason for leaving the north. The nurse referred to the community as "a most lonesome depressing place" and wrote:

> One needs something in a Native settlement to off-set the every day happenings…the beating of dogs and their incessant yelping. The drunks ki-yi ing at all hours. Children in the snow with bare seats. The starving horse that was driven until it dropped dead. I am rambling on and on but I want you to know how I feel. Up until this past year I have been happy in the north. I was disappointed when I came here, after the friendly people in Cumberland this was quite a shock…I am proud of my outpost…it does look nice and it was not without deep thought that I decided to leave (SAB Mlazgar to Smith February 3, 1951).

The nurse dismissed her feelings at the end of her letter by attributing her rather negative mood to the lack of someone to have a good laugh with rather than the conditions about which she had written (SAB Mlazgar to Smith February 3, 1951). But attempts to end on an upbeat note could not mask the depth of her loneliness, even though her son lived with her in the community.

Socializing with local residents may have alleviated the nurses' feelings of isolation but social boundaries between the (for the most part) white professionals (i.e. teachers, nurses, police) and the predominantly Aboriginal population of northern communities were clear. The very nature of nursing work required a certain degree of professional distance between caregiver and patient, which isolated the nurses. But at the same time, nurses as "white women in uniforms, all enjoyed a privileged community status as recognized care-givers" (McPherson and Stuart 1994: 5) which further set them apart from the local community.

Nurses were criticized by local residents for their lack of participation in community events, but they defended themselves by pointing out that it was often not possible to socialize due to their extraordinary workload and being on call twenty-four

hours a day, seven days a week. In a letter to her supervisor, the nurse claimed: "As for any lack of friendliness on my part in the settlement, I might mention that during the past 5 months, there has been scarcely a day without patients, and my time for social activities has been very limited. I have gone out a few times a week, usually for an hour or so…leaving a note on the door for anyone who might come looking for me" (SAB Aylsworth to Smith February 7, 1952). In another instance, the nurse detailed the stress of being on duty twenty-four hours a day and having to face acute emergencies and make decisions concerning patients' lives. She went on to say that the increased tensions caused nurses to become irritated by things that would otherwise not bother them, producing a situation of "unfriendly relationships with patients and other members of the community" (SAB Edwards to Townshend February 5, 1954).

The social isolation experienced by nurses was compounded by gender and the fact that as women, they had less latitude in *how* they interacted with community members. When one nurse was seen "driving around with a man" she received a "little warning…in a spirit of well meaning in order that there would be no justification whatever for injury" to her good reputation (SAB Director of Nursing Services to Walz December 14, 1949). The nurse replied that she was providing family counselling and was incensed to hear comments about her behaviour. She wrote:

> As far as I am concerned it is only business and co-operation in our work, which I think should be. And furthermore I have helped a number of families by listening to them, instead of brushing them aside and putting them further into the gutter. I feel as a nurse that this is part of my work…I have tried to help people in these difficulties and have been successful a number of times, that is there is now a happy family instead of a broken up home. And still my reputation is as good as ever in any place I have worked" (SAB Walz to Smith December 10, 1949).

The nurse originally threatened to resign her position, but after reassurances that the comments were not meant to offend her, the situation calmed down. However, in subsequent letters, reference to the event often resurfaced and relations between the nursing supervisor and the nurse never recovered. The situation became increasingly antagonistic, particularly as the nurse was constantly relocated, causing her considerable stress. As a subordinate, considerable pressure was put on the nurse to comply with whatever the Director of Nursing and Medical Health Officer requested so she would not "fail to meet her great professional need" (SAB Director of Nursing Services to Walz January 18, 1950). The situation underscores the lack of power that northern nurses had within the bureaucratic structure of the Division of Public Health. Yet, at other times, the Department imbued nurses with a sense of power in order to achieve certain results.

Nurses and Power

The physical presence of the outpost nursing stations and the nurses themselves were symbols of power. Although the Public Health Department stood behind expenses incurred in the course of providing care, the department looked for ways to encourage people into covering some of the costs. Nurses' attitudes about a fee-for-service varied. Some nurses believed strongly that those who had the resources should pay for professional nursing services, and those who did not, were expected to pay by, for example, providing wood for the nursing station. However, one nurse felt that local people should be paid for the services that they provided, and therefore paid people for providing her with fuel or transportation. The nurse who subsequently took over the nursing station was appalled when people "absolutely refused to take the 'nurse' anywhere unless they were paid" and sought direction from her supervisor about what to

do (SAB Mlazgar to Smith November 7, 1947). The letter was passed on to the Chief Medical Officer who replied that he was unhappy about the situation as it set a bad precedent. He thought that perhaps the local people were just testing out the new nurse and that with a bit of pressure, people might be shamed into paying (SAB Totten to Smith November 13, 1947). But the nurse who had paid people for their services, made it clear "that the precedent had been set and it was difficult, it not altogether impossible, to the change the attitude of the people" (SAB Director of Nursing Services to Mlazgar November 18, 1947).

Given the dire economic conditions for many northern residents, the nurses were often uncomfortable with the situation and requested that they not be put in a position of having to badger people for payment (SAB Pierce to Smith February 23, 1947). Nurses expressed their reluctance to become involved with financial issues and tried to deflect administration's requests by pointing out that people simply did not have the means to pay for much at all.

Nurses used their position in other ways to improve services for northern residents. They lobbied for dentists to visit communities, for tuberculosis screening to be conducted in all communities, and for children with special needs (i.e. deafness, physical deformities) to see specialists. They notified their supervisors about the lack of safe water supplies and improper sewage disposal and asked what could be done to help matters in the community. Advocating on behalf of their patients points out that health care workers were not simply tools of the state (Jones 2002). But there were limits to how far the nurses could go with their requests and, as the following examples shows, if they overstepped certain boundaries there were repercussions.

In a letter to the Chief Medical Officer, a nurse expressed her frustration that completion of the nursing station was taking too long and after a year of improvising, she was fed up. She asked for a carpenter to be sent to finish the building as soon as possible and described what she felt were the priorities. The letter was sent to the Director of Nursing to be forwarded to the Chief Medical Officer. However, the Director of Nursing did not forward the letter and returned it to the nurse with a warning that while the medical health officer "championed the cause of the nurses, he had complete control and could make life very unhappy and uncomfortable" for "us" (SAB Director of Nursing to Lyons October 13, 1948). This response reinforces, that while the nurses may have been perceived as important figures in northern communities, they actually held very little power, particularly when it came to dealing with the bureaucratic structures that they looked to for support.

Discussion and Conclusion

There is no doubt that the nurses' professional objectives were aimed at bettering people's health by changing customs and habits and providing them with medical care and treatments of the day. Through their daily routine, nurses tried to influence the way people lived in Northern Saskatchewan and were pleased when they gained the confidence of people and saw improvements in their health (SAB Broome to Smith January 4, 1951). At the professional level, public health practices were effective in preventing loss of life and illness but they almost always entailed ending certain practices that were "sanctioned by centuries of tradition" (Jones 2002: 285). Nevertheless, people embraced, rejected, or adjusted to the lifestyle changes as they saw fit.

The actions of nurses are not those typically associated with colonization. For example, nurses were purveyors of benevolent not oppressive structures. However, as Memmi (1965) argues, colonization takes place on a number of levels with many dimensions of oppression involved in the subjugation of people. Nurses represented the values of the state; they were employees of the provincial Public Health Department and "as such had to conform to the rules, regulations and discipline of supervisors" (McPherson 1996: 62). The socializing practices of the nurses altered the way in which people organized the knowledge of the world around them or what Paasi (1986, 1991) refers to as the "structures of expectation." While subtle, the nurses were part of the colonization apparatus as a collective, but at the individual level, attitudes and approaches varied from nurse to nurse. In all likelihood government did not view nursing as a means to advance their agenda, because if they had, the nursing posts would have been better supported, rather than chronically under-funded. At the same time, as one of the few non-Aboriginal people in northern communities, nurses represented authority, although in the end local people made their own decisions about what was/was not good for them. For example, people appeared to comply with the nurses' "ways" while in-patients at the hospital, but reverted to their own practices when discharged. When an unpopular suggestion was made to local women that they should take up needlework while attending a program at the clinic, the women expressed their dissatisfaction by simply not going (Joy Duncan Collection, Edna 1976). There was little the nurses could do in these situations except to adjust their approach, which they often did.

When it came to certain medical care and practices - particularly difficult maternity cases - the nurses, for good reason, were more assertive in trying to convince

their patients to comply with their instructions. Nevertheless, the nurses still reported that even with difficult pregnancies they could hardly force their patients to go out to larger centres for care. Yet the responsibility of having women in the community when there was likely to be complications was too much. As one nurse reported "If I had lost the mother and babe the other mothers-to-be would have lost confidence in me to say nothing of losing confidence in myself" (SAB Lacy to Smith June 20, 1953).

As indicated in the opening quote of this paper, some of the changes promoted by the nurses were inappropriate for northern communities. This is due to the fact that the public health nursing model was introduced with little, if any, consultation with the communities. Many management decisions made within government bureaucracies affecting the north during this time were made with little knowledge or understanding of northern conditions (McArthur 1978: 15). But once confronted with the realities of life in remote northern communities, individual nurses did not necessarily agree with instructions that went beyond those required to improve people's health, forcing some nurses to question their own motives.

The nursing stations and nurses did play a role in shaping Northern Saskatchewan as it emerged as a specific northern place within the provincial milieu. Nursing provided much needed professional medical care for northerners but ongoing funding and support was often lacking and also shifted as interests and political agendas changed.

The theoretical models of colonization introduced by Quiring (2004) and Morantz (2002), go some way to describe development processes in Northern Saskatchewan. While attempts to modernize the region were perhaps well intended, resources and support for the institutions responsible for transforming the traditional way of life were

sadly lacking. But delving deeper into the various layers of institutions and individuals involved in the overarching colonial process, the picture becomes complex and untidy, which the broadly conceived models cannot address. Including the nurses' experiences from an on-the-ground perspective, contributes another layer of explanation to notions about colonialism, making its trajectory more halting and thereby expanding our understanding of region building processes in northern remote regions.

The nurses' position within the process of bureaucratic colonialism was contradictory. Although well intended, they carried with them the ideas and practices of the dominant society; yet they were also sensitive to local cultural practices, advocating for the primarily Aboriginal population, and gaining their acceptance and appreciation. The nurses provided care to northerners but at the same time strongly encouraged them to adopt different ways of living believing it would result in improved health. Unfortunately, the Aboriginal population was under considerable stress due to other changes in the region (i.e. increasing levels of bureaucracy) that both they and the nurses were ill equipped to handle. Despite the contradictory nature of their activities, the nurses played a role in shaping Northern Saskatchewan by mitigating the worst of the effects of the rapid change that took place in the region following World War II. However, regardless of the good intentions of the nurses and their sincere efforts to provide well needed health care to the people of Northern Saskatchewan, political, economic, and social structures became dominant factors in determining people's everyday experience. The nurses and Department of Public Health may have "treated people with respect and decency, but the frameworks that enabled them even to decide what was dignified were powerfully defined by forces often outside of their control" (Dolgon 2005:224-225).

To conclude, the nurses' contribution is perhaps best captured in the words of Jean Cuthand Goodwill, (the first Indian women to graduate from nursing school in Saskatchewan) who stated that she "was amazed at how well the non-native nurses, with their high ideals, their curiosity, determination and strong sense of responsibility, managed to cope with the adversity they encountered in this setting…to some extent the scenery, terrain, serenity and silence comforted the nurses trying to deal with the human devastation that resulted from the imposition of another way of life on Canada's Aboriginal people" (Cuthand Goodwill 1984: 6).

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Pierce, M.E. Stony Rapid to Miss E. Smith, Director of Nursing Services, Regina August 11, 1948 SA, DPH, NSD, PH5, File 50

Pierce, M.E. Stony Rapids to Miss Smith, Director of Nursing Services, Regina April 25, 1948 SA, DPH, NSD, PH5, File 50

Pierce, M.E. Stony Rapids to Miss Smith, Director of Nursing Services, Regina January 22, 1948 SA, DPH, NSD, PH5, File 50

Pierce, M.E. Stony Rapids to Miss Smith, Director of Nursing Services, Regina February 23, 1947 SA, DPH, NSD, PH5, File 13

Scriver, Isobel, Cumberland House to Miss Smith, Director of Nursing Services, Regina August 3, 1946 SA, DPH, NSD, PH5, File 14

Smith, Miss E., Director of Nursing Services, Regina to Miss W. Lacy, Cumberland House September 24, 1953 SA, DPH, NSD, PH5, File 6

Smith, Miss E., Director of Nursing Services, Regina to G. Aylsworth, Buffalo Narrows November 24, 1950 SA, DPH, NSD, PH5, File 2

Totten, C.R. (MD), Medical Officer, Regina to Miss E. Smith, Director of Nursing Services, Regina November 13, 1947 SA, DPH, NSD, PH5, File 13

Walz, J. to Miss E. Smith, Director of Nursing Services, Regina December 10, 1949 SA, DPH, NSD, PH5, File 33

Joy Duncan Frontier Nursing Collection

Joy Duncan Collection – Edna Interview taped by Edna herself and submitted to Joy Duncan Project in 1976?

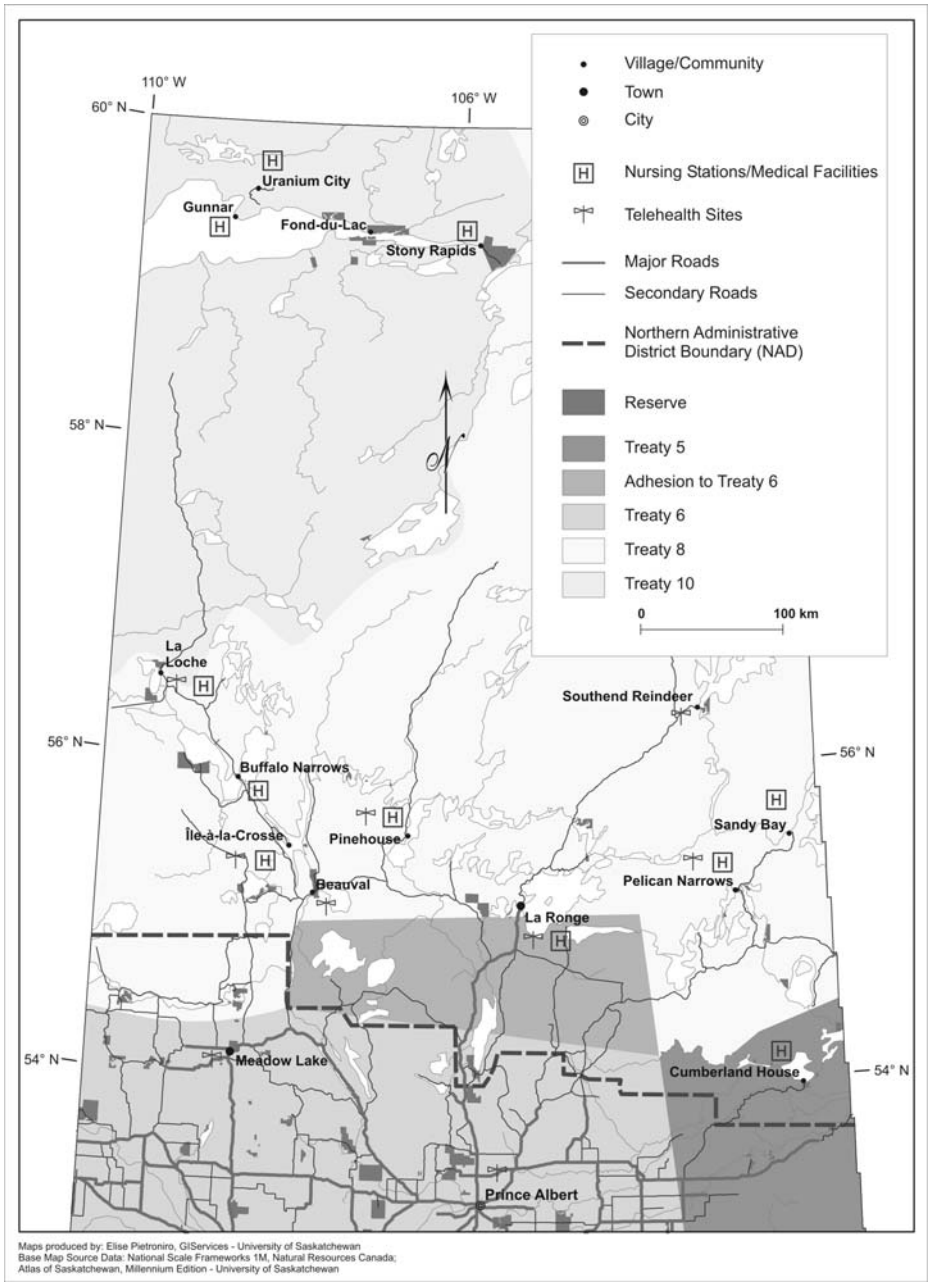
Joy Duncan Collection- interview conducted by Joy Duncan with Yvonne February 4, 1976

TELEHEALTH: CAN TECHNOLOGY OVERCOME THE CHALLENGES TO NURSING PROXIMITIES?

FIGURE 1

NORTHERN SASKATCHEWAN

NURSING STATIONS, TELEHEALTH SITES



Telehealth: Can Technology Overcome the Challenges to Nursing Proximities?

Introduction

In 2002 *The Commission on the Future of Health Care in Canada* (Romanow 2002) acknowledged that disparities in access to health care and health care providers were significant barriers to health care delivery for those living in rural and remote regions of Canada. At the same time, the report recommended three "Directions for Change": (1) establish a rural and remote access fund to support new approaches for delivering health care services and improve the health of people in rural and remote communities; (2) use a portion of the Fund to address the demand for health care providers in these communities; and (3) expand telehealth[1] to improve access to care. The difficulties, however, are even more pronounced in northern communities where problems are described as "stark" (Romanow 2002: 162). While the challenges facing isolated communities in the Arctic region (beyond 60 degrees north) are recognized in the *Future of Health Care in Canada* Report, similar problems confront communities located in what is referred to as the "provincial norths" (Figure 1).

The "provincial norths" is the vast sub-Artic belt, running from the coast of British Columbia through the Canadian Shield and on to Labrador…a region which has long been ignored, politically weak, economically unstable, and home to substantial Aboriginal populations (Coates and Morrison 1992). Distances are great in this region and access to acute care for residents is often by air ambulance. If roads are available

[1] Telehealth –Muttitt et al. (2004) define telehealth as the use of information and communication technology (ICT) to deliver health services, expertise and information over distance, geographic, time, social and cultural barriers.

they are, for the most part, unpaved, and often in poor condition. Exacerbating the situation further in the provincial norths are the jurisdictional differences between the federal and provincial governments that are responsible for providing health care services to the predominantly Aboriginal population. The jurisdictional barriers hamper the successful delivery of health services particularly in Aboriginal communities where funding for and access to health care falls under different jurisdictional realms. Although the situation presents considerable challenges, new technologies such as telehealth provide alternate ways of reaching remote communities and can play a significant role in mitigating problems associated with distance and jurisdiction.

The line between the 'social' and 'technical' is hard to distinguish in healthcare delivery because there is no concrete boundary between the two. The social realm becomes more complicated when contemporary challenges associated with health care delivery are found to exist in the past (May et al 2003). Looking specifically at Northern Saskatchewan, this paper shows that historical disparities are not overcome, but rather they are reconfigured with the introduction of new technologies such as telehealth. I show that while new services nodes become established through communication technologies, physical spaces are still far apart. Furthermore, transportation remains problematic because road networks are poor, and despite some recent progress, jurisdictional divisions remain. Using the nurses' experiences in conjunction with community consultations in the region, the question guiding this research is: can

telehealth change the effects of the institutional[2] relationships (i.e. internal/bureaucratic colonialism) that have contributed to shaping the north as a distinct region?

To pursue this question, I bring together theoretical perspectives on region-making based on the work of Paasi (1986, 1991) and Reynolds (1994), who see the formation of regions as historically contingent processes that are created by the social institutions. Regions reflect the social power, control, and governance that exist in a particular society Anssi Paasi's work in particular has advanced a view of regions that corresponds with the complex social realities of our world (MacLeod 2001). According to Paasi (1986) the state is the central apparatus involved in this stage. The state legitimizes the process through systems of socialization such as education and public health care systems. The state also endows others with the power to institutionalize people into social or geographic communities. This point is relevant to northern health care delivery because service depended on how people were classified (i.e. Status/non-Status, Métis, non-Aboriginal). This process, initiated when Treaties were negotiated and the *Indian Act* was implemented in the late 1870s, persists today as health care and telehealth technology operating *within* the region contributes to the formation of new 'virtual' geographies of healthcare provision.

Understanding these jurisdictional issues helps in understanding both the complexity of health care delivery and the institutionalization of Northern Saskatchewan as a remote region. Beyond creating regional geographies, distance, jurisdiction and technology affect the more intimate geographies – the nurse-patient relationship. To explore how this relationship is affected by technology, distance, and jurisdiction, I turn

[2] In this research " "institutions" are defined as "Sets of rules, decision making procedures and programs that define social practices, assign roles to the participants in these practices, and guide interactions among the occupants of individual roles" (Young 2002: 5).

to Ruth Malone's (2003) theory of 'distal nursing.' Distal nursing demonstrates how caring requires nurses to maintain a spatial proximity with their patients. The model encompasses three types of nested proximities: *physical* proximity, the degree of closeness at which nurses physically care for their patients; *narrative* proximity, where nurses learn about their patients through the patients' stories; and *moral* proximity, the point at which nurses begin to advocate on behalf of their patients. The context for Malone's work is hospitals in the United States, and the discussion pertains to how restructuring of medical institutions is disrupting the proximities and increasing the distance between nurses and their patients. The setting where care is carried out determines the degree to which the individual proximities are involved. In this research, I utilize the distal nursing model to highlight how distance and jurisdiction have historically increased the distance between nurses and their patients and explore how telehealth technology might address these challenges.

To illustrate these processes this paper bridges two very different time periods and consists of three sections. The entry point for the discussion is the post World War II period when nursing outposts were established in Northern Saskatchewan. Information for the first section was obtained from oral and written accounts of nurses working at the outpost stations in Northern Saskatchewan between 1944 and the mid 1950s. The written correspondence is stored in the Saskatchewan Provincial Archives and the oral accounts are part of the Joy Duncan Frontier Nursing Projects that is housed at the Glenbow Museum in Calgary. The nurses' accounts reveal not only their perceptions of the landscape, the people, and their communities, but also the daily challenges of providing care in a remote region. The nurses faced many difficulties, but some of the most

significant frustrations were caused by the boundaries that separated people into different jurisdictional realms.

I also demonstrate how the jurisdictional boundaries that nurses had to deal with almost fifty years ago, have become more ingrained over time. Here my findings are based on my participation in a Canadian Institutes of Health Research (CIHR) New Emerging Team (NET) research project that has been examining the use of telehealth in assessment, diagnosis, and management of individuals with dementia in rural and remote regions of Saskatchewan.[3] The multidisciplinary project received funding for five years and includes three "core" studies and several additional studies (Morgan et al 2005). In the summer and fall of 2003 and 2004 the team traveled rural and remote telehealth sites throughout the province and met with healthcare providers. During meetings and in general conversations we learned of a number of barriers that hindered people's access to health care facilities. In Northern Saskatchewan, however, one obstacle in particular was mentioned time and time again – the problems caused by jurisdictional divisions. It quickly became apparent that the same issue that plagued nurses more than fifty years ago continues to play a significant role in determining how present day-to-day activities are carried out. The findings were unexpected but they provide a contemporary illustration of regional health problems - that jurisdictional boundaries continue to adversely affect the delivery of health care services to northern residents.

In the last part of the paper, I connect the two points in time with a discussion of how technology has been utilized to support the nurses working at remote outpost

[3] Morgan, D. (principal Investigator), Stewart,N., Crossley, M., D'Arcy, C., Biem, J. and Kirk, A. (Co-Investigators) CIHR New Emerging Team Proposal *Strategies to Improve the Care of Persons with Dementia in Rural and Remote Areas* 2003 Canadian Institutes of Health Research and partners (Saskatchewan Health Research Foundation, University of Saskatchewan, Alzheimer Society of Saskatchewan)

stations immediately after World War II. Two-way radios and an air ambulance system provided backup for the nurses when nursing stations were established. More recently, telehealth technology – the use of information and communication technology to delivery health care across space - is being promoted as a way to overcome the on-going challenges imposed by distance. But given the entrenched jurisdictional divisions, is this possible?

Methodology and Data

As indicated above, qualitative information contained in this paper was gathered during visits to fourteen telehealth sites located throughout rural and remote Saskatchewan. Plans for the community consultation process were part of the original research proposal prepared by the lead investigators. The proposal stated that in the first six months of the study, the clinical project investigators would travel to communities to orient sites to the study and encourage referrals to the rural memory clinic (Morgan et al 2003: 6). Community consultations took place over fall and winter of 2003 *and* the summer/fall of 2004. Detailed field notes were taken during each visit and observations were later discussed amongst participants working on the project, and in subsequent meetings. The level of the team's involvement along the participant/observer continuum varied from complete observer to complete involvement (Bogdan and Biklen 1998: 81-84). The quantitative data presented in this paper (Table 4) were obtained from questionnaires provided by eight-five patients and their caregivers participating in the study, and analyzed by the team's statistician.

The Source of Jurisdictional Disputes in Northern Saskatchewan

One needs only to look at historical maps of Saskatchewan to see that the foundations for the jurisdictional disputes were in place prior to the establishment of the legal entity that we know today as Northern Saskatchewan (Hayes 2005). Saskatchewan became a province in 1905. The Northern Administrative District (NAD) was formed in 1945 with the boundaries of Northern Saskatchewan being defined by special statute, the *Northern Administration Act* in 1948 (Smith 1992). Prior to both those events, however, treaties between First Nation people and the Canadian Government were negotiated. With the signing of Treaty 6 (1876), Treaty 8 (1899), and Treaty 10 (1906) in Northern Saskatchewan, reserves were established and the Indian population became a federal "responsibility" under the *Indian Act*. It is these events that set the stage for jurisdictional divisions that have significantly affected the provision of health care in the region, both historically and presently (Figure 1).

As the population of communities in Northern Saskatchewan is primarily of Aboriginal[4] ancestry, it is necessary to outline its unique situation within the Canadian context. Far too many Aboriginal people experience the kinds of health problems associated with poverty, yet the problems are linked to their historical position in Canada's social system (Waldram et al 1995). For example, the establishment of reserves, either through treaty-making or other policies, resulted in the creation of boundaries that delineated reserve spaces of federal jurisdiction from non-reserve spaces of provincial jurisdiction. Furthermore, in the nineteenth-century, when the Canadian government assumed responsibility for Canadian Indians, a classification system established by the *Indian Act* differentiated status Indians from the general population.

[4] The term "Aboriginal" includes the three distinct Aboriginal peoples of Canada as defined in the Canadian *Constitution* (1982) – Indian, Inuit and Métis.

More recently, the *Canadian Constitution* (1982) recognizes three distinct categories of Aboriginal people in Canada: Indian, Inuit and Métis. The divisions between Aboriginal people have significant legal implications, even for health care. The following quotation provides (as clearly as possible) some of the distinctions of the Aboriginal population in Canada:

> A status Indian is a Native person who is registered under the Indian Act as an Indian, and a non-status Indian is one whose ancestors were never registered, or who lost status by various means. Being a status Indian means that the laws of the Indian Act apply. A treaty Indian is a Native person or descendant of a Native person who signed a numbered treaty. Numbered treaties were signed in all of Saskatchewan (except for the American Sioux who came to Canada). After the signing of the treaties, lists of band members were drawn up. Native people whose name appeared on the treaty list were considered as having been registered under the Indian Act as Indians. In other words, those who signed the treaties became status Indians. Therefore all treaty Indians are also status Indians. But, not all status Indians are treaty Indians. In those parts of Canada where treaties were not signed (i.e. most of British Columbia, Quebec, the Maritimes, and the Yukon) some Native people became status Indians when they registered under the Indian Act by other means (Brizinski 1993:7, see also Dickason 2002).

Because treaties were signed in all of Saskatchewan, the terms treaty Indians and status Indians are used synonymously. The rights, benefits, and restrictions of the *Indian Act* apply to treaty/status Indians but they <u>do not</u> apply to non-status Indians, Métis or Inuit people, who, with the rest of the general population, are considered a provincial responsibility.[5] Under the *Canadian Constitution*, health care is a provincial responsibility, although it is funded by both the provincial and federal governments.[6] The provinces cover the cost for physicians and hospital care for all residents within their jurisdiction, including Aboriginal people. The federal government, through the First Nations and Inuit Health Branch (FNIHB) of Health Canada, supports the delivery of

[5] In 1939 the Supreme Court of Canada decided that the federal government should assume responsibility for the Inuit. However, the *Indian Act* does not apply to the Inuit.
[6] Healthcare funding arrangements in Canada are complex. For a more complete explanation see the *Canada Health Act* at http://www.parl.gc.ca/information/library.html

primary care, public health, and health promotion services to the First Nation population residing in reserve communities across the country. Services offered outside hospitals such as mental health, community-based prevention, and home care are also generally covered by the federal government, as are the costs of health professionals such as dentists and physicians who travel to remote and isolated communities (Health Canada First Nation and Inuit Health Branch 2003). Other non-insured health benefits covered by FNIHB for Status Indians include eyeglasses, drug prescriptions, and transportation.

Thus, travel costs are generally covered for Status Indian people but *not* for the Non-Status, Métis and non-Aboriginal population. However, although travel expenses are covered for status Indians, healthcare personnel report that FNIHB constantly shifts the parameters with respect to the circumstances when travel costs are covered – a strategy that results in considerable confusion and frustration for patients and caregivers alike (Morgan et al. 2003).

While this is only a brief description of the complex constitutional and governance issues, suffice it to say the issues translate into equally complex funding structures for Aboriginal health care. However, more central to this discussion are the implications of the boundaries and divisions for the provision of care. Generally speaking, Status Indians fall within the domain of the federal government while the rest of the population is considered the responsibility of provincial governments.[7] The jurisdictional divisions are a result of state-backed institutions introduced to socialize the population with Canadian 'ways', and represent systems of socialization outlined in Paasi's model of regionalization (1986, 1991). However, while the jurisdictional

[7] The federal government views healthcare as policy rather than as a treaty right. For a full discussion see Waldram, James B., Herring, D. Ann, Young, T. Kue 1995 *Aboriginal Health in Canada* (Toronto: University of Toronto Press), 141-176

boundaries *between* Aboriginal people and the rest of the Canadian society, and *amongst* Aboriginal people, may be socially constructed, they are entrenched in the *Canadian Constitution* (1982), which constrains their flexibility and the degree to which they can be manipulated. As a result of the historical divisions, there are differences in both access to and delivery of healthcare services, particularly between Status Indians and the rest of the population.

Historical Frictions of Distance and Jurisdiction

Linking the past with the present provides a clearer understanding of processes that shape northern and remote regions, and it is important to include an historical perspective for understanding regions as part of broader processes of regional transformation (Paasi 1991, 2003). While social borders may be invisible, "they cannot be dismissed because they deeply influence contemporary events, including the attitudes of the citizens, the structure of local self government expenditures, the density and quality of infrastructural networks, the distribution on settlements, the level of welfare, and so on" (Sagan 2004).

The basis of jurisdictional divisions via treating-making and the Indian registry preceded the introduction of the nursing stations in Northern Saskatchewan, but the problems became more acute with the increased presence of both the federal and provincial governments. Prior to World War II, residents of Northern Saskatchewan experienced little exposure to western-based medicine. Aboriginal people had their own healers and ways of healing, but as the presence of the church and government institutions increased, priests, federal Indian agents, and physicians who accompanied the treaty parties, supplemented the traditional systems of healthcare (Robinson 1967, Barry

1999). The provincial Department of Public Health established a nursing station at Cumberland House in 1929 which at that time was "the most remote district and could only be reached by boat from The Pas, Manitoba" (Robinson 1967: 108). By 1957, medical facilities in the region consisted of the following:

TABLE 1
Medical Facilities in Northern Saskatchewan (1957)

Community	Established	Jurisdiction
Buffalo Narrows	1947	Provincial
Cumberland House	1941 (1929)	Provincial
Gunnar	1944	Gunnar Mines
Ile a La Crosse	1927 (The Sisters of Charity Grey Nuns provided care starting in 1860)	Erected by Provincial and Federal Governments; administered by Oblates; operated by Grey Nuns of the Roman Catholic Church
La Loche	1951	Roman Catholic Church
Lac La Ronge	1951	Federal (provincial nurses shared space)
Pelican Narrows	1955	Federal
Pinehouse Lake (Snake Lake)	1948	Provincial
Sandy Bay	1948	Provincial
Stony Rapids	1948	Provincial

Source: Government of Saskatchewan, Department of Public Health, Public Health Nursing Annual Report 1957.

Nursing stations were situated in communities across Northern Saskatchewan, and after World War II, new transportation and communication technologies came into use (Figure 1). Communication technology at the time consisted of two-way radios for nurses to use when they required assistance, although the radios were often unreliable due to atmospheric conditions and equipment failures ((SAB) Lewis to Smith November 24, 1953, Waldram et al 1995). When the radios were out of commission, or the weather prevented planes from landing, the nurses were on their own. An air ambulance system was implemented to airlift patients out to larger centres when necessary. But, with

seemingly little awareness of the distances involved to carry out their duties, the nurses were often advised by their supervisors in Regina to limit the use of air ambulances, despite the system having been established precisely for that reason. Hesitant to authorize chartered planes, nurses reported making extraordinary trips – sometimes up to 100 kilometres by canoe - to attend the sick and injured (SAB Broome to Smith September 12, 1951). During fall freeze-up and spring break-up, when planes could not land for six weeks at a time, the isolation increased and nurses had to deal with all situations including emergencies (SAB Broome to Smith May 17, 1951). While the nurses took whatever steps were necessary to provide care regardless of the circumstances, they also tried to convey the fact that their situation in the north was very different from circumstances in the south.

Adding to the challenges of tending to patients scattered across a vast region, was the constant wrangling between the federal and provincial governments over who was responsible for which segment of the population. As described above, the root of the dispute lay in earlier interactions between Aboriginal people and the state, where with the division of responsibilities, the federal government was responsible for status/treaty Indians, while the rest of the population fell within the provincial government's realm. The jurisdictional demarcations may have appeared straight forward, but as the demands and cost for health care services and facilities increased, both levels of government did their best to ensure that no expenses be incurred for individuals outside their jurisdictional responsibility. As a result, over time, the jurisdictional divides that originated in the 1870s became more entrenched, and affected the relationship between nurses and their patients.

The state, represented by the federal and provincial governments, became the central apparatus responsible for introducing healthcare in Northern Saskatchewan after 1944. In keeping with Paasi's model (1986, 1991) the nurses were endowed with the power to socialize people into 'modern' ways, which was to be achieved through the course of their daily activities. This was no easy task, however, as both levels of government failed to provide adequate support for the nurses and the nursing stations. Subsequently, the lack of awareness about northern conditions, combined with jurisdictional divisions, challenged the way nurses carried out their professional responsibilities and threatened the nurse-patient relationships.

Challenging the Nursing Proximities

Information from Health Canada indicates that physician services for 35 percent of First Nation communities (in the provinces) are greater than 90 kilometres away (Health Canada Indian and Inuit Health Branch 2003, Muttitt et al 2004). Of those communities, approximately 3.5 percent have no road access and rely either on scheduled or special flights to bring health professionals in or take patients out (Lemchuk-Favel et al 2004). What the information does not reflect, however, is how road and flying conditions in the north vary significantly according to the season and weather. Winter presents the most daunting driving conditions, but any time the ground is not frozen, unpaved roads can quickly turn to quagmires making travel conditions less than ideal. In another example, Saskatchewan Health reports that in the remote northwest portion of Northern Saskatchewan only 38% of residents are within 30 minutes of a medical facility (Saskatchewan Health 2005). But that 30-minute timeframe is most likely under ideal

conditions. As most of the roads are unpaved and susceptible to poor driving conditions, this figure is likely vastly underestimated.

Under the *Canada Health Act* (1984), Canadians are promised accessible and universal health care. Despite the *Act*'s provisions, however, rural and remote regions of Canada continue to be under serviced in terms of acute primary (disease) care and primary health (well-being) care, including disease prevention, health promotion and community health care (Canadian Women's Health Network 2004). Health indicators have consistently shown that the health status of people living in rural communities, particularly northern communities, is not as good as their urban counterparts (Romanow 2002). In non-urban communities, health information *systems* are often seen as poorly coordinated and inadequately promoted, while health *services* are reported to be infrequent, irregular and limited. In short, for those living in remote regions of Canada, seeking medical care may involve considerable cost and inconvenience. As a result, people in remote communities tend not to seek care unless they are very ill and rarely make appointments related to preventative measures (Canadian Women's Health Network 2004).

Waldram et al (1995), Canitz (1990), and O'Neil (1979) stress that the institution of nursing constitutes the backbone of healthcare provision in the north. Yet, until recently, little information has been available about how outpost nurses function in isolated northern communities. It is clear though that healthcare providers face a number of challenges including lack of power and control, isolation, gender, and cross-cultural issues (Tarlier 2003, Canitz 1990). Issues of jurisdiction and distance further strain the relationship between nurses and patients. The physical, narrative, and moral proximities,

already under pressure by virtue of living in the north, have been further stressed when problems with recruitment and retention of nurses is added to the mix. For example, in a study looking at the effects of nursing turnover in northern First Nation communities, Minore et al (2005) show that turnover has a detrimental affect on communication because patients may see a different nurse every time they visit the clinic, making it necessary for them to tell and retell their stories. Furthermore, constant changes in staff mean that nurses are often not in the communities long enough to establish the appropriate relationship necessary for caregiving. As a result, some patients feel uncomfortable exposing their bodies to nurses they do not know and resist certain examinations. Lastly, isolation and heavy workloads increase the distance between nurse and their patients. This is particularly evident in one community of 1400 residents in Northern Saskatchewan, where a lone nurse works to "assess, diagnose and treat an average of 50 clients daily" (Brazill 2002). Under such circumstances it is easy to see how the time spent caring, learning about, and advocating for patients would be limited.

The Journeys

Porter and Grossman (2004:203) point out that "the creation of knowledge is an iterative process. Geographical knowledge is created through a dialectic that involves shuttling back and forth between the observable world and the quiet place where one can think about what one has seen and experienced". When looking at a map, it is easy to see that a road connects particular communities, but there is nothing like actually traveling that road to get a sense of the landscape, the communities, and people along the way. Travel generates new knowledge, which given time and contemplation, can result in people forming different ideas about the places they have visited. This is certainly the

case in Northern Saskatchewan, where until one actually drives or flies across the region, the vastness of the landscape, the diversity of the communities, and the transportation difficulties people have to deal with are not perhaps fully realized.

Traveling to Northern Saskatchewan in 2003 and 2004, both by air and road, gave the NET members an appreciation for the distances and difficulties that residents of the region face with respect to transportation. In fact, we discovered that jurisdictional issues were as entrenched as ever. Visits by the NET group to communities in Northern Saskatchewan are noted in Table 2:

TABLE 2
NET Visits to Communities in Northern Saskatchewan

DATE	COMMUNITIES	MODE OF TRANSPORTATION
September 4, 2003	La Ronge, Pinehouse Lake, Pelican Narrows	Chartered plane
October 23, 2003	Ile a La Crosse, La Loche, Beauval	Chartered plane
August 31 – September 1, 2004	Pinehouse Lake, Beauval, Ile a La Crosse	Road
September 30, 2004	La Ronge	Road

The first trip was by chartered plane to La Ronge, Pinehouse Lake, and Pelican Narrows. The first stop was La Ronge, the largest community in Northern Saskatchewan. The immediate area consists of the communities of the town of La Ronge, the northern village of Air Ronge, and three Indian reserves. The total population of the area is approximately 5,000 residents, comprised of status and non-status Indians, Métis, and non-Aboriginal people. During our meeting, we learned of a number of challenges facing the health care providers, the most significant of which was the cost of getting patients to La Ronge from smaller communities throughout the north. Furthermore, the split between status and non-status patients defined who did/did not have access to financial

assistance for transportation expenses. For example, non-status patients were responsible for paying their own travel costs, while Medical Services Branch (MSB) of the Federal Department of Health Canada covered the costs for status Indians. However, at the same time, we learned that MSB policies were constantly changing and what expenses were/were not covered changed almost daily.

The second stop of the tour took us to the northern village of Pinehouse Lake, a primarily Métis community, with about 1,000 residents. During our discussions with health care providers, we learned that Pinehouse Lake was not a reserve community, thus transportation costs for patients were not covered. Interestingly, the meeting was interrupted when an emergency arose and the staff left to attend those injured in a car accident. A physician traveling with our group went to assist and when it was determined that one of the patients had to be flown to La Ronge for care, he decided to accompany the patient. In the meantime, the rest of the group continued to Pelican Narrows.

Pelican Narrows is a reserve community with a population of approximately 2,000 residents. Because the landing strip in Pelican Narrows was too soft to land safely, we flew to Sandy Bay, approximately 80 kilometres north. The director of the health centre arranged for taxis to take us to Pelican Narrows. Granted the community had road access, but the road was unpaved, narrow, twisty, and hilly. Driving at breakneck speeds, made for a harrowing experience! The vast majority of residents in Pelican Narrows were/are status Indians and, therefore, entitled to coverage for transportation expenses. However, transportation services are limited. Saskatchewan Transportation Company (STC) serves the community, but not on a daily basis. Furthermore, the pickup point is located almost 100 kilometres south of the community (Wolf 2005 personal

communication). Access presents considerable challenges particularly for dialysis patients, whose need for treatment does not correspond with the bus schedule. As a result, patients often travel the entire distance by taxi to larger centres, such as Prince Albert or Saskatoon for treatment. Local taxis also transport other residents to the STC pickup points along the 100 kilometre unpaved, narrow, winding, road.

While Table 3 neatly categorizes communities based on the mode of transportation, it does not reflect just how costly transportation is for both residents and government. Nor does it show the extent to which transporting people boosts the northern economy through $10.5 million in payments to air and road transportation services; 85% or $8.7 million of which is for taxis and air payments (Table 3). In 1997, $4.9 million was paid to 180 taxis (in Northern Saskatchewan) averaging $27,000 per taxi. Four point nine million dollars ($4.9) or almost 50% of the medical transportation expenditure in Northern Saskatchewan is for travel by taxis, which, not surprisingly, Medical Services Branch (MSB) considers a highly inefficient way to provide services (Elias 1998/1999). MSB[8] funding provides First Nation people with 90 full-time equivalent positions, including 20 transportation coordinator jobs. These jobs are considered to be some of the most difficult jobs in the health care provision system.

TABLE 3
Medical Services Branch Transportation Costs (1997)

Mode of Transportation	**Cost**
Taxis	$4,889,045
Air	$3,943,073
Ambulance	$1,286,507
Private Vehicle Miles	$ 226,708
Bus	$151,689
TOTAL	**$10,497,022**

Source: Elias 1998/1999

[8] Medical Services Branch (MSB) provides physician services to the on-reserve registered Indian population in the north.

The jurisdictional challenges also show up in the air ambulance system. For example, First Nation people who are covered by MSB do not qualify for the Northern Transportation Program. The Air Ambulance Program is available for First Nation People and although MSB covers the cost of transportation, individuals are expected to pay a portion (i.e. $350 in 1998) (Elias 1998/1999). Subsequent trips by the NET group to Northern Saskatchewan further reinforced the challenges caused by jurisdiction and distance.

Geography and Technology: Implications

The technological advances that have taken place since the nursing stations were first established in Northern Saskatchewan are extraordinary. For example, in the 1940s and 1950s, when nursing stations were first established in Northern Saskatchewan, support was provided by two-way radios and an air ambulance system, both of which were vulnerable to the whims of nature. More recently, revolutionary advances in telecommunications have seen the implementation of telehealth/telemedicine systems in the north, thus increasing its importance in health care. Telehealth – the use of information and communication technology to deliver health care across distance - is considered a central mechanism for improving care for individuals living in rural and remote areas of Canada. Since its introduction in 1975, the telehealth system in Canada has grown considerably, and by 2004, all the provinces and territories report having some type of system in place. Canada Health Infoway identified 34 different networks across Canada reaching 10-15 percent of rural and remote communities and approximately 5 percent of First Nation communities (Muttitt et al 2004). Thus, technology effectively changes the geography of health care delivery as well as the modes of delivery.

As technology continues to provide new ways to access health care services, the process effectively creates new nodes of service provision, but that is not to say telehealth is ineffective in reducing distances. Preliminary results from the NET study reveal that although the distance that some patients must travel remains significant, there has been a significant reduction overall (Table 4).

TABLE 4
Distance to Appointments: Telehealth vs In-Person (1-way)

	Mean Kilometres	Range
To Saskatoon from Home	269	111-595
To Telehealth from Home	49	1-183
Kilometres saved by Telehealth*	218	5-594

*multiply x 2 for round trip Source: Morgan et al 2005

In addition to reducing distance and improving access to healthcare, information and communication technology can also help to ease the professional isolation experienced by nurses working in remote communities. A recently released study on nursing practices in rural and remote Canada recommended that information technology be employed to provide continuing education to nurses working in isolated communities (MacLeod et al 2004). This extra support could reduce feelings of isolation and in turn may help to improve recruitment and retention rates in northern communities.

However, a number of factors limit the expansion of telehealth services in remote regions. The main challenge is again related to geography and the lack of road access. Access to broadband services is also limited with only 28 of the 625 First Nation communities having access to such facilities. A few communities use satellites but again, the costs are very high. The public sector through Industry Canada has launched the "Broadband for Rural and Northern Development (BRAND) and "National Satellite Initiatives" (NSI) to find a solution to the broadband dilemma (Muttitt et al 2004). The

challenges associated with implementing telehealth are not unique to Aboriginal communities but in many cases, they are more pronounced as a result of cultural, political and jurisdictional issues specific to Aboriginal people (Muttitt et al 2004). At the same time, telehealth technologies have not been thoroughly evaluated. While politically attractive, they are also contentious, as they do not necessarily resolve structural problems that affect access to health care services (Cutchin 2002, May et al 2003). Even with efforts to improve telehealth services, the need for cross-jurisdictional agreements which "recognize that information technology is making health less about geography and more about enhanced care to communities" remains crucial (Muttitt 2004: 408). However, there has been some movement on this front. For example in January 2005, an agreement between the federal and provincial governments provided the funding to install the infrastructure to deliver high speed Internet access to 35 northern communities (Prince Albert Grand Council (PAGC 2005).

Despite technological advances such as telehealth, distance, compounded by jurisdictional differences, continues to affect the nursing proximities. For telehealth to aid in minimizing the distance between nurses and their patients, the systems require support outside the technological realm, particularly in the areas of human resources and space. For example, during the NET community visits, one concern was the lack of adequately trained staff to deal with the telehealth system. In some communities, recruitment and retention of specifically designated telehealth coordinators have been difficult. Nurses sometimes step in and fill the role as site coordinators but this is not ideal because it adds to their often already heavy workload. In one community the NET visited, the equipment sat idle because no one was available or trained to operate the

system, and efforts to recruit a telehealth coordinator had been unsuccessful. Thus in this example, telehealth was unable to reduce the distance of the physical proximity.

During the community visits, nurses and other healthcare workers voiced their concerns about telehealth technology. Amongst their concerns was the lack of space. Medical facilities in northern communities are often limited space-wise making it difficult, if not impossible, to have specifically designated telehealth areas. At some of the older facilities, telehealth equipment are housed in multi-purpose rooms, where patients have little privacy, and consultations are conducted in any room that might be available, even a waiting room. Consequently, patient privacy and comfort cannot be guaranteed, which challenges the narrative relationship between patients and their caregivers (Malone 2003). But the visits also provide a venue for healthcare workers to advocate on behalf of their patients, and raising concerns about appropriate space for telehealth consultations, helped to ensure a healthier moral proximity (Malone 2003).

Conclusion

Although the provincial, and to a lesser degree, the federal governments have attempted to improve health services in Northern Saskatchewan, following World War II, jurisdictional divisions complicated their efforts, and resulted in considerable disagreements between the two levels of government. Historical agreements and policies such as the *BNA*, treaty-making, reserve policies, and the *Indian Act* have been extraordinarily important and have generated complex processes for all parties concerned. But implementation of the agreements and associated policies divided the population into federal and provincial jurisdictions, and different health care structures – one system operated by the provincial government, and the other by the federal

government. As a result, layers of internal regions were established within the space known as Northern Saskatchewan. Attempts to improve services were not well synchronized either in terms of time or quality. As a result of the jurisdictional divisions and distance-related problems, the physical, narrative, and moral proximities of the nursing relationship were disrupted.

Clearly the population of northern remote communities in Canada face significant barriers with respect to accessing health care services and programs. Jurisdictional issues compound the challenges for people living in the provincial norths. Technology cannot erase jurisdiction. Nevertheless, it may be *one* component of a multi-faceted strategy that helps to alleviate the diagnostic proximity facing nurses and patients in northern remote communities. A number of collaborative steps are emerging. For example, the formation of new umbrella organizations such as the Northern Health Strategy[9] created to improve the health status of *all* Northern Saskatchewan residents regardless of jurisdiction. Furthermore, in 2003, the Athabasca Health Authority opened the first integrated federal, provincial and First Nation health service facility in Canada. The centre, named Yutthe Dene Nakohodi "A Place to Heal Northern People" was built at Stony Rapids, just down the road from the site of the original nursing station established in 1948. Although the project took almost ten years to come to fruition, it addresses recommendations dating back to the 1950s that solutions must be found to the jurisdictional chasm that impeded

[9] The Northern Health Strategy Represents the following Northern Saskatchewan Health organizations: Athabasca Health Authority, Keewatin Yatthe Regional Health Authority, Kelsey Trail Health Region, Lac La Ronge Indian Band, Mamawetan Churchill River Regional Health Authority, Meadow Lake Tribal Council, Peter Ballantyne Cree Nation, Prince Albert Grand Council, Health Canada, First Nations and Inuit Health Branch, Northern Inter-Tribal Health Authority, Population Health Unit, Northern Health Regions/Authorities, Saskatchewan Health, Northern Medical Services

access to health care services in Northern Saskatchewan (National Archives of Canada (NAD) Report on Saskatchewan Development Conference 1959).

This paper has shown there is no clear boundary between the 'social' and 'technical' in delivering healthcare, and that historical social processes of region-making strongly influence the contemporary situation of health care delivery. This is certainly the case in Northern Saskatchewan where, despite technological advances, distance compounded by jurisdictional differences, continues to affect peoples' access to healthcare services, including telehealth itself. Distance also affects nurses both professionally and with respect to how they provide care for their patients. Jurisdictional arrangements ensure that new initiatives are subject to intensive and lengthy federal-provincial-Aboriginal negotiations, while economic development policies have left the road network inadequate, even today. These geographies create a dynamic, yet difficult, context for nurses and affect the kinds of care decisions they can make, and the follow-up they can provide. These geographies even affect nurses' decisions to remain living and working in the region. By implication any changes in service delivery must deal with the jurisdictional arrangements as well as the technological ones such as telehealth. Other elements of technology such as transportation must also be considered simultaneously, because broadband facilities do not erase problems with communication, and people still have to physically get somewhere in order to obtain services. To conclude, telehealth *changes,* rather than overcomes, the geography of access to care. Telehealth by itself will not address adequacy in recruitment, retention, training, professional isolation, and even the geographic remoteness that remain key aspects in delivering health care in Northern Saskatchewan. However, as this paper has shown, technology can reduce frictions of

distance and jurisdiction, *provided* there are adequate resources to support the systems, and a willingness to deal with the myriad of social issues that affect the geographies of care in the region.

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CONCLUSIONS

Conclusions

> Geography is a science, but it is also an art, because understanding the meaning of area cannot be reduced to a formal process. The highest form of the geographer's art is producing a good regional geography – evocative descriptions that facilitate an understanding and appreciation of places, areas, and region (Hart 1982: 1)

In his Presidential address to the Annual Meeting of the Association of American Geographers, John Hart (1982) called for an integrative approach to geography where techniques and procedures *and* places and people were included in regional analyses. He went on to say that a region could not be understood without knowing "how it came to be the way it was, and how it changed" (Hart: 1982: 23). In this research I adopted a similar approach to that advocated by Hart, and examined a northern remote region within a framework that is itself a complex mix of changing conditions and human action (Dolgon 2005). More specifically, my research examined the role of nurses and the nursing profession in region-building processes in Northern Saskatchewan.

The research was directed by two primary questions. First, what roles did nurses and the nursing profession play in shaping Northern Saskatchewan? Second, how did nurses working at the nursing outposts respond to being both part of, but also the recipients of processes that contributed to the region's subordinate position? Operating on the assumption that institutions, like the state, define regions for the sake of policy implementation, I found that the day-to-day practices of nurses working on the ground contributed to region formation, a social process that was often contradictory and complicated.

Contributions of the Research

By applying the historical record to Northern Saskatchewan and linking it to contemporary events in the same region, this research illustrates how history and

geography affects the lives of people and places over time and space. The nurses' stories provided perspectives about a region and people that, to my knowledge, have not been previously analyzed and applied to models of region formation. Consequently, I was able to advance the theoretical position that the processes involved in region-making occur at a variety of levels, ranging from the state to the individual.

The research also revealed more about the institutional structures that marginalize people and regions in Canada. In particular, I found that attempts to modernize Northern Saskatchewan contributed to the colonial relationship that emerged between Northern and southern Saskatchewan. Identifying the complex processes *within* Canada that contributed to region formation, in turn, added another layer of explanation to Paasi's (1986, 1991) theory of regional institutionalization. By delving into the ambiguities and contradictions within these structures, I was able to contribute a more nuanced interpretation to the broadly conceived colonization models of Quiring (2004) and Morantz (2002). Last, this research strengthened the link between health care and region formation by advancing Malone's (2003) model of distal nursing, and demonstrating the relevance of the framework beyond the modern-day, urban context for which is was intended.

One of the significant findings of this research was to discover that nurses continue to grapple with many of the same issues that confronted their colleagues several decades ago. These findings are significant and have implications for policy makers. Jurisdictional issues pose one of the greatest challenges in the provincial norths, not only in the past as shown in this dissertation, but also currently as governments (e.g. federal, provincial, Aboriginal) prepare to deal with possible future pandemics. For example,

there are concerns that jurisdictional confusion will result in some communities being left out of immunization programs, particularly as the chances of this happening increase with distance and extent of isolation.

The research also reinforced the critical role that nurses play in the north where they are essential for the delivery of health care. Yet recruiting and retaining of nurses remain serious problems in Northern Saskatchewan (and the north in general). The situation is chronic, but little has been done to alleviate complaints about personal and professional isolation, the lack of power, gender, and cultural issues (Canitz 1990; MacLeod et al 2004) that have prevailed since the introduction of nurses into the region, sixty years ago.

Lessons of the Research

I came away from this research with several important lessons that will serve me well in future endeavors, although two standout the most. First, although messy and fraught with tensions, the ambiguities and contradictions contained in data are where answers to research questions might be found. As stated in the introduction to this thesis, I entered this research expecting to find the nurses to be heavy-handed and authoritarian in their approach to a compliant Aboriginal population that lacked any "say" about their care. As such, the nurses contributed to colonization of the region. But as argued in this thesis, the process was far more complex. Pushing the boundaries and studying the complexities themselves enabled me to interpret the data in a more meaningful way and thereby lend a better understanding of the role of nursing in region-making processes.

Second, as a geographer, the never-ending value of fieldwork was reinforced during my research. Although my findings are based on archival materials, the field trips

to Northern Saskatchewan helped immeasurably. Travelling to the communities, speaking to patients and caregivers established a crucial link between the archival materials and present-day situation that added another dimension to my interpretations. Furthermore, the trips also informed the research methodology of the interdisciplinary NET team I was working with, as they experienced first-hand the challenges presented by the geography of Northern Saskatchewan. After considerable discussion and debate, the team agreed that for the region to be adequately represented in the study, the methodology had to be adapted. This decision served as an example of the ongoing efforts made by some researchers to be genuinely inclusive in their work, regardless of their discipline.

Limitations of the Research

As in any historical study, this research is subject to specific limitations. Organizing and interpreting the enormous amounts of information was challenging and messy at times, particularly as I did not conduct the interviews, or speak to the nurses myself. However, there was more than enough consistency in the stories upon which to make my assertions. Furthermore, the majority of interviews conducted by Joy Duncan were with nurses who did not work in the region. I listened to and recorded all the interviews but only included those in the dissertation that pertained to Northern Saskatchewan. Nevertheless, accounts from nurses who had worked in other northern, isolated parts of the country provided compelling evidence that the nurses in Northern Saskatchewan were not alone in the challenges that they faced. Therefore these additional interviews helped to validate my findings.

The most obvious omission is the lack of patients' voices. The only way to address this is to interview and document the perceptions of patients who received care from the nurses. But as almost 60 years have passed since the nursing posts were established, the number of research subjects would most likely be very small, not to mention issues related to recalling events that took place so long ago. A further limitation of the study is that 'conversations' between nurses and their supervisors in Regina were often one-sided, making it difficult to know what action was taken in response to nurses' concerns, complaints and even protests. Nevertheless, by organizing the letters according to individual nurses, and tracing topics through subsequent letters, it was possible to piece together chronological accounts.

Ongoing and Future Research

The recent release of "On all Frontiers – Four Centuries of Canadian Nursing" (Bates, et al 2005), in conjunction with an exhibition at the Museum of Civilization in Ottawa, attests to the interest and proliferation of research into the wide range of nursing topics. Several scholars are pursuing this line of inquiry. For example, Kathryn McPherson (1996, 2003) has carried out extensive research into the history of nursing including issues of gender and professionalization that has informed this research. Geographer Gavin Andrews (2003) has called for a convergence of geographical and nursing research; a timely suggestion given the recent study on registered nurses working in rural and remote regions of Canada (Andrews et al 2005). Historian Myra Rutherdale (2005) is exploring a new typology based on the diversity of the nurses who worked in the Arctic. She has identified three preliminary categories - from 'cleansers' to 'cautious caregivers' to 'optimistic adventurers'. Briefly, cleansers were those nurses obsessed

with cleanliness, hygiene, and appearance who were most interested in reshaping Aboriginal people. Cautious caregivers questioned whether they should be in the north at all, and optimistic adventurers were those nurses who approached their northern experience as an adventure and an opportunity to learn about the north and the people who lived there.

Although development of Rutherdale's typology is in its early stages, it is exciting because it provides another space where the "tensions, contradictions and paradoxes" of northern nursing can be explored more "fruitfully and dynamically" (Bondi 2004:5). However, before categorizing nurses with any degree of confidence, more detailed information about individuals beyond official letters written between themselves and their supervisors is essential. Thanks to the foresight of those responsible for collecting materials, the extensive archival materials in the Joy Duncan and Saskatchewan Archives collections provide a starting point for pursuing such research – a process that will ultimately tease out more about the role of nursing in region-making.

Nursing as a profession continues to evolve. To my knowledge, the nurses who worked at the nursing stations between 1944 and 1957 and focused on in the first three papers of the dissertation, were all women. Although women still dominate the profession, there are now a number of male nurses, some of who work in northern remote communities. However, even as the structure of the profession changes, gender and gendered relationships remain integral to any discussion of nursing. I was interested in examining what nurses did with their structural position within the health care system of the time (McPherson 1996:75). Gender, however, not only played a significant role in

constructing those structures but remains embedded in their configuration. Accordingly, gendered power relations remain pervasive in nursing and in need of on-going analyses.

Since the mid 1980s, delivery of healthcare in much of Northern Saskatchewan has devolved to individual First Nation bands. Many bands are now responsible for hiring nurses and delivering programs on reserve communities. Future evaluations of band approaches to recruiting and retaining nurses could reveal solutions that might be useful to other communities and regions faced with similar challenges.

Further assessment of the implications of telehealth on northern and remote communities is also essential if technology is to improve people's access to healthcare. A guiding question is whether technology is 'window dressing' which masks more pervasive structures of power? Barnes (1996: 226) maintains that, "those who control communication also control both consciousness and social organization." In this dissertation I examined how telehealth affected the social relations of the nursing proximities (Malone 2003). By extension, however, does telehealth affect the professional status of nurses, particularly with respect to their knowledge? Communication systems legitimate and give authority to certain kinds of knowledge (Barnes 1996:226). Therefore, will technology undermine the nurses' knowledge and thereby usurp their position in the communities?

I also believe that further inquiry into the role of health care professionals in remote regions would contribute to our understanding of region-making. Farmer et al (2003) contend that the contribution that health care providers make to community development and sustainability in remote rural communities in the United Kingdom is significant. A similar assessment of the situation in Canada would prove useful

particularly when assessing quality of life for residents of such communities. However, I recommend extending the research to examine the very core of health care professions such as nursing, because in addition to their commitment to practicing a specialized body of knowledge, professionals are also required to maintain a trust relationship with their clients (Freidson 1994: 200). As this research demonstrated, nurses upheld their professional tenets, but at the time, had limited professional power to advocate on behalf of their patients. I contend that circumstances have changed and professionalism could be used to counter bureaucratic decisions that threaten the well-being of people and society as a whole. In other words, nurses as professionals have an obligation to speak-up on behalf of the public.

To conclude, the empirical evidence presented in this dissertation provides a clearer understanding of the interaction of complex social processes involved in region formation. Operating within bureaucratic colonialism, nurses struggled with a lack of support and the challenges associated with distance, isolation, and jurisdiction, while people living in the region tried to adapt to new ways of living, but without adequate resources to do so. To varying degrees, some nurses acted as conduits for the implementation of colonial practices, while others opposed instructions and practices that did not serve the best interests of patients. Yet, despite the best of intentions of some bureaucrats and the sincere efforts of the nurses, their acts could not contend with the incoming economy, social stratification, and political structures that subsequently inscribed the physical and cultural landscape of Northern Saskatchewan with their own imprints.

Since nursing posts were first introduced into Northern Saskatchewan, efforts to improve access to health care services in the north have continued. Yet, major problems persist, particularly those associated with jurisdiction, and the lack of professional support for nurses. Furthermore, despite advances in communication and transportation systems, some communities remain beyond the reach of these improvements. Technology alone cannot eliminate the challenges facing nurses who work in remote regions, only reconfigure them. But if implemented simultaneously with a commitment to overcome the jurisdictional barriers in Northern Saskatchewan, the possibilities for better health care delivery in a northern remote region improve considerably.

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