HEALTH CARE DELIVERY IN AN INUIT SETTLEMENT: A STUDY OF CONFLICT AND CONGRUENCE IN INUIT ADAPTATION TO THE COSMOPOLITAN MEDICAL SYSTEM

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by

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ABSTRACT

This thesis is a descriptive study of health care in the Inuit settlement of Gjoa Haven, N.W.T. The purpose of the research was primarily to describe and analyse the interactional networks of health and illness related behaviour that are associated with the Nursing Station. The cultural and organizational background of the administrators and nurses who provide medical services to Inuit are described, as are the attitudes and beliefs held by Inuit about illness and about the health care delivery system.

The thesis examines the acculturation of Inuit beliefs and practices related to illness throughout the contact period and focuses particularly on the changing role of the Inuit healer, the *anqatquq* or shaman. Various influences such as epidemic diseases, missionary activity, and changing economic orientations that have contributed to Inuit dependency patterns and changed beliefs about illness, its causes and cures, are detailed.

Theoretically, the thesis is partly a study of the replacement of a traditional medical system by the cosmopolitan medical system and the gradual attenuation of the traditional curer's role. It is also an examination of the manner in which the conflict resulting from differences in attitudes between administrators, nurses and Inuit, affects the delivery and utilization of health services in Gjoa Haven. It demonstrates that where problems occur they are as much a result of conflict between administrators and nurses, as they are due to conflict between nurses and Inuit.

The substantive portion of the thesis examines specific domains of interaction such as health education, agency coordination and native

participation and points out areas where failure occurs in each of these arenas. Recommendations are included that suggest strategies for improving the effectiveness of health care delivery and ultimately the health levels of the Inuit population.

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To the remainder of the residents of Gjoa Haven I extend my gratitude for their friendship and cooperation and for making my stay in Gjoa Haven a warm, enjoyable and enriching experience. Particularly, I would like to thank the Settlement Council for inviting me to Gjoa Haven in the first place and for supporting the research project throughout.

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TABLE OF CONTENTS

LIST OF FIGURES

LIST OF MAPS

LIST OF PHOTOGRAPHS

1. INTRODUCTION

1.1 Purpose and Objectives of Research

This thesis is primarily a descriptive study of health care dynamics in the Inuit settlement of Gjoa Haven, N.W.T. It focuses on the interaction of the Nursing Station with the Inuit population and describes a range of attitudes and behaviours that affect the health care delivery process.

The stimulus for this research arose from the realization that although the health status of the Inuit population was significantly lower than the Canadian national average, very little in the way of systematic research had been conducted to examine the problems that create this situation. A review of the sociological literature indicates that the majority of attention to problems of health care amongst the Inuit has come from medical professionals who concentrate on the socio-medical problems that result from massive sociocultural change and suggest strategies for improving these conditions. Schaefer (1971, 1973, 1975), Schaefer and Metayer (1976), Hildes and Schaefer (1971), Webb (1973), Butler (1973), Bryans (1968), Martens (1964) and Rymer (1969) all suggest that socio-economic conditions caused by sociocultural change are responsible for the various morbidities that afflict the Inuit population. They argue that increased native participation in the health care delivery system and an expanded health education program are the primary solutions to the current health problems in the north. By and large, these reports recognize that health care in the

north must take a broader perspective on the social, political and economic realities that are responsible for health conditions, rather than focus narrowly on the clinical aspects of illness. However, with the exception of Schaefer's work, most of this literature is not based on systematic research.

Social scientists have paid scant attention to health and illness problems of the Inuit. Where research has been conducted, the emphasis has been on sociocultural change and mental illness. Williamson (1968), Vallee (1968), Chance (1968), Sampath (1976), Lubart (1969), and Parker (1962) have all investigated the psychological stress associated with sociocultural change. Generally, their research substantiates the conclusion that problems of adaptation to changing social, political and economic structures is responsible for the high incidence of psychopathology in the north.

Despite the importance of this research, very little of it is directly relevant to an understanding of the way in which Inuit conceptualize health and illness. Nor does it explain behaviour associated with maintaining health or seeking therapy for illness. The only exceptions would be Vallee's (1966) paper on Inuit theories of mental illness, Brigg's (1975) brief summary of Inuit attitudes towards disease and the health care delivery system and Wenzel's (1978) summation of Mackenzie Delta residents' perceptions of the health care delivery system. The data to be reported in this thesis will expand on these initial analyses.

The purpose of this research is to provide a greater understanding

of Inuit attitudes and behaviour related to illness and to examine the historical and macro-social factors that contribute to those attitudes and behaviour. Through such an understanding, the problems identified in the foregoing literature review can be better dealt with by both the Inuit and the medical personnel presently charged with providing health services to the north.

Theoretically and empirically the thesis will focus on the Inuit's transition from reliance on their traditional medical system to a dependence on the cosmopolitan medical system as represented by the Nursing Station in Arctic settlements. In this sense the study is one of comparative medical systems and the theoretical emphasis will be based on anthropological concepts, models and theoretical approaches currently employed by medical anthropologists in their comparison of medical systems in different contexts. These tools will be discussed in detail in the next chapter.

A major emphasis in the study of comparative medical systems is to concentrate equal attention on the culture, organization and behaviour of the cosmopolitan health workers as well as the culturally different clients of this service. Foster (1978) has long argued for this approach to the study of Western institutions in contact with traditional cultures and has emphasized its importance particularly with regard to health care services.

The traditional approach in anthropology towards situations of culture contact has been to assume that modern technological innovations

such as medical care are intrinsically desirable and, consequently, the job of the anthropologist was to illuminate those aspects of the traditional culture, that functioned as impediments to the smooth and efficient adoption of the supposedly much-needed innovation. This information could then be translated by culture change agents such as nurses and doctors into specific programs designed to circumvent or eliminate these impediments.

The more recent and sophisticated understanding of the dynamics of innovation acceptance or rejection suggests that the technology does not exist independently of the culture in which it was developed and that resistance by different cultural groups to programs of planned innovation is more a consequence of their resistance to the various cultural entailments in which the technology is couched.

Consequently, the values and attitudes of the culture change agents themselves, the prevailing philosophies and organizational structures of the institutions supporting the agents, and the general cultural ethos that influences individuals acting on behalf of the system, need to be examined and understood with equal significance and importance, as does the culture of the clients of the intended innovation.

Translated into the context of this thesis, a substantial portion of the data will be based on an analysis of the Nursing Station's function in Gjoa Haven, concentrating on the attitudes and behaviour of nurses, their relations with their administrative supervisors and the attitudes and beliefs held by the administrators that bear directly on health care in Gjoa Haven.

The other major emphasis in the thesis is a description of Inuit beliefs about illness from pre-contact traditional ideas until the present. One entire chapter will be devoted to a summary of traditional Inuit beliefs about illness and the various historical factors that have contributed to changes in those beliefs. Most of this material has been extracted from the ethnographic literature and relates to the Inuit as a whole and not particularly to those Inuit who now inhabit Gjoa Haven. This approach has been taken because attention to beliefs about illness was minimal in most early ethnographic accounts and modern informants recall is very much affected by acculturative changes that have resulted from colonial contact. Consequently, a broader description based on all materials available was necessary in order to provide a valid description of the traditional medical system. Because of the general nature of this chapter, a description of the background, setting and history of Gjoa Haven has been left until later in the thesis and is included in the chapter on contemporary dynamics of health care in Gjoa Haven.

This analysis of contemporary dynamics will focus on various domains of interaction between the Nursing Station and individuals and institutions within the settlement. It is here that the two themes of accultrating Inuit beliefs and behaviour and the culture and organization of the cosmopolitan medical system will be synthesized in order to illuminate areas of interaction and communication between the providers and clients of health services that both contribute to and detract from improved health levels in an Inuit settlement.

The organization of this thesis is structured according to the original intentions of the research proposal which stipulated that the findings should be available to three audiences. While the primary function of this thesis is to fulfill the academic requirements of the post-graduate degree in anthropology, it is also intended to serve both the Inuit of Gjoa Haven and the medical personnel providing health services to Gjoa Haven. Consequently, theoretical discussion has been isolated in one chapter and kept to a minimum elsewhere and a section on recommendations for improvement of health care delivery services has been included with the conclusions in the final chapter.

1.2 Field Work Methodology

The fieldwork for this research was formally carried out over a period of six months from July, 1977 until January 1978, in Gjoa Haven, N.W.T., a settlement of approximately four hundred and fifty Inuit and perhaps a dozen Whites. The selection of the location was at the same time fortuitous and planned. A typology was formulated, creating a range of settlement types from small hunting outpost camps such as Bathhurst Inlet to large cosmopolitan urban towns such as Frobisher Bay (see Appendix A). Mid-way between these two extremes was the type represented by Gjoa Haven - a medium-sized community (population 300-600) with a small White population, a mixed economy based on land activities, crafts and wage labour and serviced by a two nurse Nursing Station. It was felt that such a community combined the two important attributes of retaining

aspects of a traditionalistic lifestyle while at the same time providing a sufficiently large cosmopolitan medical presence. The research proposal was submitted to the settlement councils of ten such communities for evaluation and the fieldwork site was chosen from among the favourable replies. It was further felt that six months would be sufficient time to conduct an exploratory investigation of the type proposed, although eventually I decided to remain a resident in the community for a period of one year.

In order to partially facilitate the gathering of data pertaining to the cultural attitudes of the medical services personnel, arrangements were made to spend several days at both Region and Zone levels of administration to interview various individuals. Three days were spent in Edmonton, Alberta, at the regional head office, conducting informal interviews with most of the staff. Those interviews included the Regional Director, Regional Medical Officer, Regional Nursing Officer, Health Educator and various people in charge of speciality units. Two days were spent in Yellowknife, N.W.T., where I engaged in similar activity with Zone personnel and finally I spent one day in Cambridge Bay, N.W.T., interviewing the doctor responsible for services in Gjoa Haven. The interviews carried out during this process were extensive but obviously, the data would have been enriched substantially if more attention could have been focused in this area (see Appendix B for list of interview questions).

While residing in Gjoa Haven, a variety of accommodations were utilized. During the first four months, a six by ten foot tent, erected

on the beach area amongst a number of local tents, provided my living and working space. The next four months were spent as a boarder with an Inuit family in a three-bedroom, older home. This family was selected for me by the Settlement Council prior to my arrival. The family consisted of an old man (76), his second wife (48), their natural son (20) and three adopted children (15, 9, and 7). The blend of traditionalistic and contemporary values in the family was conducive to research and the older son was able to provide translation services to facilitate my communication with his mother and father, neither of whom could speak English. Finally, for the last four months, I lived alone in a twelve by twenty-four foot "matchbox"; one of the first government subsidized homes to be erected in Gjoa Haven, which was without plumbing facilities or running water. I felt my appreciation of the problems relating to home sanitation and public health was enhanced by this experience.

Approximately sixty-five per cent of Inuit in Gjoa Haven were functionally unable to communicate in English. Consequently, I was forced to rely on my own minimal comprehension of Inuktitut and several untrained but highly perceptive interpreters. Over the six-month period, I employed two interpreters primarily, one young man for about two months and a mature married woman with children for about three months. The second interpreter provided me with a wealth of personal data as well as facilitated an easier rapport with married women in the settlement. Both of these interpreters were paid at a standard rate of $3.00 per hour, from my own funds. Consequently, it was difficult to sustain either of their

interest when higher paying job opportunities presented themselves. It should also be noted that translating generally is regarded as a rather boring and tiresome task, aside from the social and psychological implications of having to translate a naive researcher's sometimes impertinent questions. Thus, I was fortunate indeed to maintain a good relationship with both translators for as long as it lasted.

The vast majority of data for this research derived from exploratory interviews and conversations carried out with the aid of an interpreter in most cases. Where English was the language of communication, interviews could be very informal and non-directed. However, when translation had to be relied on, a more directed, question and answer style was utilized, although at no time was a formal questionnaire employed. A schedule of questions was drawn up and this formed the basic structure of most interviews (see Appendix C). Dependent upon the interest and willingness of the informant, this schedule was sometimes abandoned or only adhered to in part, in order to allow informants to express themselves in areas of their own interest.

The research was conducted in traditional ethnographic fashion. Participant-observation in all aspects of local activity formed the basis of my understanding of Inuit culture in Gjoa Haven. Establishing rapport with several key informants such as the Settlement Council chairman and an Anglican lay preacher facilitated a profound understanding of community dynamics. Interpreter-assisted, informal interviews were conducted with twenty households out of forty-seven. These interviews usually lasted

two to three hours and included every family member where possible. The basic information gleaned from these interviews was supplemented by innumerable conversations with other members of the settlement and occasional return visits to previously interviewed families for further clarification. Oral histories and personal anecdotes contributed a substantial portion of this information.

This interview-conversation technique was combined with extensive observation of numerous health care interaction events. Throughout the period of research, I observed behaviour associated with clinic hours at the Nursing Station, home visiting by both nurses and the community health worker, health education classes in various locations, Health Committee meetings, Council meetings where the nurses were present, emergency medical evacuations and childbirth, etc. Wherever possible, participants in these events were interviewed as soon as possible.

Fieldnotes were compiled for the most part without the use of a tape recorder, although I had one available for taping public meetings, Health Committee and Council meetings, etc. It was found that rapid note-taking, either during or immediately after an interview or conversation, followed by careful transcription into journals, was the most nonobtrusive but effective method.

My data relating to Nursing Station dynamics were facilitated in part by my close personal relationship with the field nurse who joined me three months after I entered the field. While a statement such as this may seem irregular in a discussion of fieldwork methodology, the context

and nature of my research necessitates its inclusion. Because of my rapport with the personnel of the Nursing Station, I came to understand their frustrations and satisfactions with regards to the health care system and their interaction with the community to a far greater degree than if I had remained independent. While I was privy to the gossip and complaints that characterize any government agency in the North, I must stress that at no time was I given access to patient's confidential records. This restriction had been an initial condition of Health and Welfare's support of the research project and at no time was this condition neglected.

Despite the benefit to my understanding of Nursing Station dynamics provided by my personal involvement, it should also be noted that this involvement might have restricted my ability to gain the confidence of some segments of the Inuit community. Obviously, people were likely to be hesitant to openly criticize the Nursing Station when they were aware of my personal interest in the facility. However, as the research progressed this initial hesitation proved to be much less of a problem. As well, considerable rapport had been established during the first three months I was alone in the field.

In addition to interviews, conversations and observations, I collected documentary material in a number of categories. As I have already mentioned, I did not have either verbal or written access to patient's confidential records. I was however, privy to the occasional departmental memoranda that the nurses felt were relevant to my research. I collected voluminous examples of health education material, and I retained copies of

Council meeting minutes where health-related matters were discussed.

Aside from the qualifications and restrictions noted above, I would also like to comment on several other factors that affected my research. First of all, it should be stressed that a community study such as this is obviously going to be idiosyncratic in terms of its general relevance to health care in the north. As much as possible in writing up this report, I have endeavoured to emphasize those aspects that have wider applicability. However, one important qualification is in order. Despite what may appear to be a critical evaluation of the Nursing Station's efforts in the pages to follow, health care in Gjoa Haven, from a purely subjective perspective, had many features that made it superior to comparable situations in other settlements. The quality of the service is obviously largely dependent on the individual(s) providing that service and Gjoa Haven had been fortunate to have had several remarkable individuals providing health care during its short experience with cosmopolitan medicine. In particular, the nurse-in-charge during the fieldwork period was in her third year of residency and from all perspectives appeared to have extremely good rapport with a large proportion of the community. Consequently, the overall quality of health services, again subjectively speaking, may have been superior to that found in many other Arctic communities.

A second important qualification relates to the availability of data concerning the traditional Inuit medical system. As a later chapter of this thesis will describe, traditional Inuit medical beliefs were

intricately associated with shamanistic activities and supernatural belief. Because of contact with certain repressive elements in the missionary activities of the Church, contemporary Inuit are extremely reluctant to openly discuss these traditional beliefs with transient White residents. There is no doubt that to a great extent these traditional beliefs and practices are fragmented and lost, but there is also considerable evidence that the traditional system underlies much of contemporary behaviour. However, the reluctance of many individuals to discuss these matters, particularly through an interpreter, made an accurate assessment of their present relevance very difficult.

It has already been noted that the fieldwork period lasted for six months but that I was resident in Gjoa Haven for a period of twelve months. A few brief comments are necessary regarding this additional residence. For the last six months of my residence in Gjoa Haven, I accepted a consultant position with the Gjoa Haven Housing Association. My responsiblities were to coordinate a training program for their Board of Directors and Secretary-Manager in order to enable them to take increased advantage of funding opportunities to renovate and rehabilitate the older homes in the community. While the relevance of this position was not directly applicable to my research, indirectly it did make a contribution. Aside from the obvious correlation between housing standards and public health, active involvement in a community development program such as this increased my appreciation of the problems involved in such things as health education, Inuit participation in administration, etc. Naturally, I continued

to pay attention to health-related events occuring in the settlement during this period as well.

Finally, I would like to discuss the problem of anonymity as it pertains to this report. Because of the idiosyncratic nature of the research, I had originally intended to disguise the location and the identity of the individuals involved. This decision was based largely on the need, I felt, to protect the identity of the nurses whose activities, obviously in a study of this nature, are going to be exposed and subject to criticism. However, I soon discovered that protecting the identity of the settlement was impossible, since everyone even remotely connected with the research knew its name. Consequently, I have decided to identify the location of the research, but to refrain from identifying any individuals involved by name. In this way I will be able to protect the confidentiality of informants' statements. Obviously, for anyone who feels it is necessary, the identities of the nurses will be easy to determine. Those involved are aware of this and have nevertheless supported the writing of this report under the conditions noted above. I can only stress that in all instances I have endeavoured to be objective and accurate. The objective has been to provide as generally applicable a study as possible and any resulting criticism, censure or impact this report might have on the nurses involved would be both unfortunate and unwarranted.

2. THEORETICAL PERSPECTIVES ON COMPARATIVE MEDICAL SYSTEMS

2.1 Introduction

Health and illness behaviour in a modern Inuit settlement is indicative of substantial cultural change when compared to traditional modes of behaviour. In a system where the population was once almost entirely dependent on a part-time medico - religious specialist — the shaman — for assistance in coping with illness, a transformation has occurred in a relatively short timespan to the situation today where, at least superficially, it would appear that the population is totally dependent on cosmopolitan medicine. This dramatic change is especially significant when compared to the growing body of literature detailing the spread of cosmopolitan medicine to other traditional societies. These comparative accounts suggest that the traditional or local health care system usually survives and either competes or cooperates with the encroaching cosmopolitan medical system, thereby providing the clients of these systems with alternative choices when confronted with illness.

This chapter will provide insight into this seeming anomaly in the comparative medical systems literature by first discussing several theoretical and conceptual perspectives on culture change and changing medical systems and then reviewing a selection of literature pertaining to the introduction of cosmopolitan medicine to traditional societies. The section on theoretical perspectives will attempt to synthesize the major anthropological theories of culture change in an effort to provide an eclectic

theoretical framework in which to understand the specific dynamics of Canadian Inuit culture change. It will then review the development of anthropological ideas about medical systems and briefly summarize several case studies from other cultural contexts.

2.2 Theoretical Perspectives on Sociocultural Change

The fundamental problem faced when attempting to evaluate the major theoretical perspectives on culture change in anthropology, is to discern the level of analysis at which the various proponents of these perspectives concentrate their analytical focus. On the one hand, some analysts concentrate on "culture" and the "group" when describing change processes, while other anthropologists focus their attention on "behaviour" and the "individual." As a result, two major approaches have emerged among students of culture change; the structural-functional perspective that includes acculturation theory and views cultural systems as essentially conservative where dynamic processes are directed towards reintegration, balance and equilibrium; and the less clearly defined processual model with its emphasis on individual decision-making and entrepreneurial activity. These differences can be better understood and perhaps synthesized through an examination of the concepts under study.

Although culture has long been the touchstone of anthropological conjuring, no concept in the discipline has been subject to as much confusion and ambiguity. Beginning with Tylor's (1971) catchall definition of culture as "that complex whole which includes knowledge, belief, art,

morals, law, custom and any other capabilities and habits acquired by man as a member of society," anthropologists have adapted, redefined and reconstituted the term until its analytical usefulness has been threatened. Goodenough (1957, 1961) has argued that most definitions have blurred a crucial distinction between patterns for behaviour and patterns of behaviour. His plea for a more restricted definition of culture as an ideational system, referring to systems of shared ideas, conceptual designs and shared systems of meaning that underlie behaviour is the definition adopted herein.

Role theory as presented in the work of several recent theorists provides the key to understanding the relationship between the individual and the group (c.f. Goodenough 1965; Nadel 1957; Southall 1959; Keesing 1970 especially). They suggest that in the behavioural arena, each individual consists of numerous "social identities," the dimensions of which are influenced by role determinants which are shared cognitive operating norms located in the collective cultural arena of a group of people. Thus when our analysis focuses on behaviour, it necessarily must focus on the individual, but when our concern is with culture, or the shared operating norms, our interest is with the group.

Returning to the problem of culture change, further explanation of the role concept is required in order to synthesize the structural-functional and processual approaches to the study of change. For the most part the use of the role concept in social science has been primarily in structural-functional terms where the emphasis has been on role performance, role-taking

role-modeling, role-expectations, etc. Recent work in network analysis by such authors as Barnes (1972), Bott (1971), Mitchell (1971), and Boissevan and Mitchell (1974) also examines roles within a structural-functional paradigm but concentrates specifically on non-kin relations. However, in certain areas, anthropologists have utilized the role concept within a processual framework to investigate change. In economic anthropology, attention has been turned to the changing functions of enterpreneurs, traders, etc. (eg. Barth 1963, 1966; Helm, Bohannan and Sahlins 1965). In political anthropology, the work of Swartz, Turner and Tuden (1966), Paine (1971) and Boissevan (1974) focusses on the changing roles of patrons and brokers. And recently, Landy (1974) has argued for a processual interpretation of the traditional healer's role under conditions of adaptive stress.

While the conceptual and methodological orientation differs between these two approaches (i.e. processual, structural-functional) to the study of roles, underlying assumptions remain the same. In both cases, actors manipulate various aspects of their social identities for personal ends. In structural-functional terms, social identities are manifested that contribute to status reinforcement and the crystallization of status relationships. Processualists, on the other hand, concentrate on the identity manipulation that enables individual actors to persue specific economic, political and social goals. However, both approaches consider social identities as derived from shared group cultural norms. Particularly in cases of culture change, social identities are subject to

considerable confusion and manipulation as the group's shared operating norms undergo substantial reworking in response to contact with an alien culture.

Both acculturation and processual approaches can be combined to enable a more complete understanding of this process. Acculturation models provide insight into the changes in group cultural identities that influence role behaviour, while processual models facilitate behavioural analysis of role manipulation. An eclectic synthesis of both approaches is necessary to fully analyze the dynamics of health care in an Inuit settlement today. On the one hand, we are attempting to account for the apparent displacement of the traditional health care system with the modern, cosmopolitan system over a period of approximately fifty years. And concomitantly, we are attempting to analyze specific changes in the contemporary health care system which requires an emphasis on individual behavioural data. As this thesis will demonstrate, acculturated belief systems do not always correspond to contemporary behavioural strategies, yet both domains of inquiry are necessary to fully understand contemporary dynamics.

2.3 Historical Development of Anthropological Perspectives on Medical Systems

Until very recently, medical anthropology has been largely a descriptive effort, content to provide detailed ethnographies of various aspects of peoples' health and illness behaviours. Theory was, to a large extent, borrowed from the other more established subdisciplines and indeed

is conspicuously absent from a large proportion of the literature (Leslie 1978). However, as the field has expanded, the need for theoretical and conceptual rigour has also grown and several recent symposia and conferences have been devoted to synthesizing the new theoretical developments (ie. American Anthropological Association, Washington, D.C. 1976, Wenner-Gren Symposia 1975, 1976).

The focus of these theoretical discussions has been on medical systems and particularly, comparative medical systems. Interest in medical practices and beliefs as a part of a system is, however, not entirely new to medical anthropology. In the early part of this century W. H. R. Rivers (1924:51) pointed out that native medical practices "are not a medley of disconnected and meaningless customs . . . [but rather] . . . are inspired by definite ideas concerning the causation of disease." Rivers formulated a conceptual model for classifying manifestations of primitive medicine as either magical or religious. His model is a rather limited two dimensional framework that attributes all practices and behaviours for treating disease to the "world view" of people. He contends there are three essential types of world views: magical, religious and naturalistic. These world views result in three mutually independent types of medical systems. Although River's model obviously suffers from a static, culturally conservative bias, and a failure to include environment as a dynamic variable responsible for adaptive change, it did set the stage for medical anthropology by pointing out the interrelationships between native medical practice and belief and by viewing both as integral parts of culture.

The second important theoretical contribution to the study of medical systems was the monograph of F. Clements (1932). Clements' work has been characterized as an atomistic or "culture-trait" approach within a framework of historical particularism (Wellin 1978). Clements is often cited for his classification of primitive people's disease causation concepts into five categories: sorcery, breach of taboo, intrusion by a disease object, spirit intrusion and soul loss. However, as Wellin (Ibid: 27) has pointed out, Clements typology is a "conceptual morass." Three of his traits -- disease object intrusion, spirit intrusion and soul loss -- are not causes but mechanisms of disease, each the result of underlying human or supernatural causes.

Probably the most important contribution to the development of medical anthropology is the work of Erwin H. Ackerknecht. Ackerknecht was a physician turned anthropologist, trained in the Boasian tradition and he acknowledged a particular theoretical debt to Ruth Benedict (Ackerknecht 1971). Consequently, he conceived of primitive medicine not as a collection of traits, but as culturally patterned and functionally interrelated elements within the cultural configuration. His model, while focusing on the importance of culture's influence on shaping medical practices, on the patterning of medical belief and practice, and on the functional interrelationships between the medical system and the culture, suffered again from a failure to include environmental parameters and to account for change.

A significant improvement over these early formulations appeared in the work of Benjamin D. Paul (1955). Paul was primarily interested in the

applied aspects of the new discipline and based his approach in acculturation theory within a systems framework. Paul viewed society as a system with the medical pattern as one of its sub-systems. When new elements were introduced into either the overall system or the subsystem, the parts were rearranged to produce a new pattern. However, although Paul's model is a dynamic one, signifying an improvement over his predecessor's emphasis on static models, his work still suffers from a failure to include biological and environmental factors and his system is essentially a closed system.

It was not until the "ecological revolution" in anthropological theory in the late sixties and, in particular, the contribution of Alland (1970), that medical anthropology expanded its interest to include both biological and sociocultural aspects of disease. In the ecological framework, the medical system is an adaptive process through which societies attempt to cope with disturbances in the biological, environmental and sociocultural subsystems that make up the rest of the model. This more refined approach to the medical system, incorporates the emphasis on cultural patterning and system change of the earlier writers but analyzes these elements in terms of their interplay with biological factors in multivariate ecological systems.

However, as Leslie (1978:65) points out, these works are "strongly marked (and often marred) by the 'medical model' - the borrowed professional point of view of medical practitioners." He goes on to say that little internal theoretical development has occurred in medical anthropology.

Instead, medical anthropologists have borrowed biological and behavioural theories from pathology, epidemiology and ecology and have added to these concepts of cultural relativity, social function and acculturation.

2.4 Concepts, Definitions and Theoretical Approaches to the Comparative Study of Medical Systems

The conference and symposia mentioned earlier and chaired by Leslie, attempt to rectify the situation described above. In a programmatic essay designed to clarify some current semantic confusion in concepts and definitions, Dunn (1978:135) defines a medical system as "the pattern of social institutions and cultural traditions that evolves from deliberate behaviour to enhance health, whether or not the outcome of particular items of behaviour is ill health". He goes on to differentiate between different types of medical systems and introduces three definitions that will be adopted without modification in this thesis: cosmopolitan, regional and local medical systems. Dunn's effort stems from the plethora of different terms found in the literature used to refer to the same entity. The "local medical system" replaces "primitive, traditional and folk," and corresponds to the medical system of a culturally autonomous local group. Utilizing Redfield's (1947) distinctions between "little tradition" and "great tradition," Dunn contrasts the local medical system with the regional medical system. The regional medical system consists of the totality of medical traditions, texts and practitioners that are part of the larger society and is best exemplified by the Chinese or Ayurvedic medical systems. The regional medical system is contrasted with the cosmopolitan medical system

which in today's world has become a worldwide and nationless entity and replaces value-laden concepts wuch as "Western, modern or scientific." In any given community setting, Dunn argues, elements of at least two of these medical systems will be present and the job of the ethnographer is to ascertain their respective adaptive efficacy in meeting both the biological and psychosocial needs of the population. He suggests that adaptive efficacy can be approached in two ways: adaptability or the ability to respond to change, and adaptedness or the tendency to be in a state of equilibrium and adjustment. Both concepts are important when assessing a particular medical system.

Within the context of this thesis, a few qualifications are necessary regarding the cosmopolitan medical system. While Dunn's (1978) definition refers to the general characteristics of modern medicine, the features of that system specific to northern Canada are sufficiently unique to require further elaboration. While national political economies and different geographic locations create enough variation in the worldwide expression of the cosmopolitan medical system to make a general description or specific definition extremely difficult, there are several features that distinguish it. Such things as professional dominance by physicians, a bureaucratic organization, an emphasis on the biological aspects of illness, a scientific tradition, reliance on sophisticated technology, and a focus on hospital based therapy are features of the system general to most contexts.

However, as this thesis will demonstrate, even in these key areas,

variations occur that have an important impact on the overall adaptability of the system. For instance, in Gjoa Haven, the nurses fulfill the role of medical practitioner and physician dominance is entirely absent. As well, outpatient care, preventative medicine and public health receive far more emphasis than the more general emphasis on hospitalization normally associated with the cosmopolitan medical system. Therefore, although Dunn's (Ibid) conceptual contribution of the cosmopolitan medical system is a useful heuristic device, it should be understood that it does not refer to a monolithic entity that is uniform in structure in all contexts. Research must pay particular attention to the specific local expression of the system and, indeed, comparisons should be made among these local variations.

An important distinction in terms of medical systems is apparent and is articulated by the authors of the papers presented in the symposium under discussion. Some authors feel that medical systems should be compared as cultural systems (Kleinman 1978) while others suggest they should be compared as social systems (Elling 1978; Janzen 1978). This seeming dissention is perhaps artificial and would be better approached by referring to the cultural and social domains of a given medical system. While it would be an error to restrict an analysis to one domain to the exclusion of the other, each domain may require a different analytical focus and a different set of conceptual tools. The shared values, norms and attitudes affecting the experience of disease that comprise the cultural component of a medical system, will be elicited through a different methodological

approach then will the relations between patients, curers, and institutions that comprise the social dimension of the medical system.

Within the group who concern themselves with medical systems as social systems there are important philosophical and methodological schisms deriving from a macro-social versus a micro-social level of analysis. As Janzen (Ibid) indicates, the majority of current efforts at describing medical systems as social systems are variations on a structural-functional, micro-level analytic theme. This theme is severely criticized for failing to account for macro-level influences such as colonialism, political-economy and competition for resources as the larger society. I intend to discuss each of these positions in more detail below but I would suggest that more benefit would derive from a position that advocates an analysis combining these approaches rather than attempting to justify one position as superior to the others.

Kleinman defines the cultural component of a health care system as a system which "articulates illness as a cultural idiom, linking beliefs about disease causation, the experience of symptoms, specific patterns of illness behaviour, decisions concerning treatment alternatives, actual therapeutic practices, and evaluations of therapeutic outcomes" (1978:86). He is careful to point out that medical systems are both social and cultural systems and that his emphasis is merely "to understand how culture, here defined as a system of symbolic meanings that shapes both social reality, and personal experience, mediates betwen the 'external' and 'internal' parameters of medical systems" (Ibid:86). Kleinman

introduces the concept of "explanatory models (EM's)" which "contain explanations of any or all of five issues: etiology; onset of symptoms; pathophysiology; course of sickness (severity and type of sick role); and treatment" (Ibid:88). EM's vary between professional and folk practitioners and between practitioners and their patients and their patients' families and social networks. The conflicts that result from these differences are particularly important in order to understand decision-making behaviour on the part of the individuals seeking treatment. Kleinman reviews the important theoretical distinction between illness and disease (c.f. Fabrega 1973) and incorporates it into his discussion of explanatory models. Disease denotes a malfunctioning in, or maladaption of biological and/or psychological processes and is the core of the professional, cosmopolitan practitioner's EM. Illness, on the other hand, signifies the experience of disease or the way a sick person, his family, and his social network perceive, label, explain, valuate and respond to disease, and is commonly associated with the EM's of the traditional cultures and, importantly, with the EM's of folk practitioners. Kleinman uses this theoretical distinction to suggest that "one reason why indigenous folk healers do not disappear when modernization creates modern professional medical systems is *[because]* they often are skilled at treating illness," whereas the cosmopolitan practitioners treat disease (Ibid:89). One final significant conceptual contribution Kleinman makes in this paper is the process of cultural iatrogenesis which refers to sickness that occurs as a result of the conflicts and discrepancies that exist between the EM's of practitioners and their patients.

As mentioned earlier, the theoretical discussion of medical systems as social systems suffers from substantial conflict regarding what should be construed as the difference between micro and macro levels of analysis. I would contend that while a micro-analysis, where the focus is on roles, statuses, institutions and the pattern of relations between them as they are involved in medical acts and decisions, is inadequate in order to fully explain and predict the dynamic nature of changing medical systems, so also is a rigid adherence to a macro-level approach where the forces at work in the political and economic spheres of the larger society are seen as wholly responsible for the organization and dynamics of the medical system as a social system. I would contend that in the behavioural arena, a micro-analysis is required encompassing both structural-functional and processual approaches while the macro-analysis of political and economic forces at work in the society will contribute to the complete understanding of the health care system.

Janzen has suggested that contemporary micro-analytic studies of medical systems as social systems are in a Radcliffe-Brown era of development. He qualifies this analogy by disclaiming the structural-functional emphasis on static systems and contending that "the structural study of related elements does not inherently rule out an explanation of change" (1978:122). He cites the work of Fabrega (1972), Colson (1971), Pouillon (1970) and Montgomery (1976) as representative samples of micro-social analyses that seek to explain the organization of the medical system by reference to the structure of social roles, statuses and relations, the

relationships between case decisions in families, healing cults or by individual healers, the allocation and use of medical resources, and the use of institutional relations amongst specialists and their normative manner of dealing with clients. He does, however, criticize their apparent lack of concern with change in the structure of the system but contends that there is no intrinsic obstacle to the study of change in the models formulated by these authors. It is here that he suggests that references to variables in the socio-ecological environment are critical in order to understand the dynamics of the social dimension of the medical system. Finally, he suggests that the political arena at the macro-level is an important factor in determining structural change in the medical system.

However, there are those who adopt a Marxist position and who would argue that the sort of micro-level analysis defended by Janzen is useless in an analysis of the social structure of a medical system because the medical system is not an autonomous system but merely a reflection of the political and economic relations of the larger society. (c.f. Elling 1978; Navarro 1976). Indeed, they would argue that the supposed value-neutral stance inherent in the system or functionalist perspective of micro-analysis is in fact particularly injurious because it supports the conservative and dictatorial philosophy of rightist regimes by "covering over the disparities and conflicts within their nations" (Elling 1978:107).

Elling is particularly concerned with the overall impact of colonialism on the structure and dynamics of medical systems. He suggests that there is a shift in theories of culture change away from the diffusion and

consensual approach of acculturation theorists toward conflict or dependency theory that "focus on changing political-economic relationships accompanied by a shift in beliefs" (Ibid:108).

To summarize briefly, the preceding theoretical perspectives amply demonstrate that important variables affecting the structure and dynamics of the health care system exist in three conceptual domains: cultural, micro-social and macro-social. An eclectic combination of the concepts, models and theoretical approaches dealing with these three domains will best illuminate the data to be presented shortly.

2.5 Traditional Healers and the Cosmopolitan Medical System

In this section, a selection of examples from the literature on local and cosmopolitan medical systems in contact will be reviewed in order to provide a comparative framework through which the situation in an Inuit settlement can be viewed.

Landy's paper on the role adaptation of traditional curer's under the impact of cosmopolitan medicine has already been mentioned in relation to role theory and it also provides an excellent summary of the various adaptational responses that occur in different societies when cosmopolitan medicine is introduced. Landy (1978:221) suggests that the "analysis of role adaptation of curers in selected societies undergoing acculturation has suggested a model of adaptation possibilities in which the data may be grouped into three categories: adaptive, attenuated, and emergent curing roles." He defines "adaptive" as "the process of attaining an

operational sociopsychological steady-state by the occupant of a status or status set through sequences of 'role bargains' or transactions among alternative role behaviours" (Ibid:220). As examples of curers who have achieved this steady state he cites the following:

1. Erasmus (1952) found that in Ecuador, people took those illnesses thought to be supernaturally caused to indigenous practitioners first and only sought out physicians on the recommendation of the folk healer who was relied on to determine which illnesses were serious enough to require the physician's attention.
2. Gould (1957, 1965) suggests that in North India the two medical systems have worked out a syncretic cooperation where the traditional healers are responsible for "chronic nonincapacitating dysfunctions" and doctor medicine was solicited for "critical incapacitating dysfunctions." Gould further points out that pragmatic utilization of doctor medicine did not necessarily involve a change in the patients' "explanatory model" or cultural conceptions of illness and that the traditional curer was in effect a cultural broker, responsible for creating a new technocultural synthesis with regards to medical care.
3. Adair (1963) and others have described the adaptation Navaho curers or "singers" have made to cosmopolitan medicine where Navaho patients still trust their curers and usually request their presence after treatment at a hospital or clinic. Diagnosticians (hand tremblers) are consulted first and they usually advise the patient to consult both the physicians and the traditional curers. Indigenous curers

have great respect for white doctors and cannot understand why that respect is not reciprocated.

4. Fogelson (1961) has found a strong persistence of traditional medical beliefs and practices, among the highly acculturated Cherokee Indians, compounded with many Christian elements, and the role of the conjurer-curer still surprisingly valid. Some of the conjurers' other functions related to hunting, fishing and agriculture have faded but the medical aspects of his role persist and continue to function in cooperation with cosmopolitan medicine.
5. In Alland's (1970) investigation of the Abron medical system, cosmopolitan curing roles such as Western trained physicians, "medium africain", nurses and missionary doctors are paired with an array of indigenous healers in a complementary fashion and the Abron utilize both medical systems. The indigenous healers are utilized especially for magically-caused or prolonged illnesses.

Landy suggests that there are far fewer examples of attenuated curing roles in the literature but admits this may be due to methodological focus rather than actual frequency of occurence. He defines an attenuated curing role as occurring when "the expectations of (the curer's) community are such that technology, if not the values, of scientific medicine is perceived by them as so clearly superior that they distinctly prefer it to their own" (1978:236). As a result of the role strain and role conflict created, the curer is forced into one of the following alternatives: (1) Accepting marginal status and maintaining status through hostile sorcery,

(2) Adopting a nationalistic philosophy and denigrating cosmopolitan medicine as a "tool" of the oppressor group, (3) Surrendering status and attempting to secure a new role within the cosmopolitan medical system and (4) Unwillingness to adapt to a marginal role resulting in alienation from both his traditional role and his society and possibly exhibiting behavioural deviances such as neurosis, psychosis or self-exile.

Emergent curing roles are indigenous curing roles that arise as a result of the contact between the local and cosmopolitan medical systems. The best example of such a role is the Navaho health worker (Adair 1960) that was created by the Cornell University health project and has now been replicated in other parts of North America, particularly northern Canada where local Inuit and Indians are trained in the basics of public health and act as mediators between the professional cosmopolitan practitioners and their communities. Another excellent example is furnished by the "barefoot doctors" of China (New and New 1978) where rural inhabitants are instructed in both Western and traditional Chinese medicine before accepting the responsibility of providing primary medical care to the inhabitants of their home communities. As Landy (1978) acknowledges, emergent curing roles would seem to derive their stimulus from macro-social initiative.

Landy concludes that if the traditional curer is to make a successful adaptation to the impinging cosmopolitan medical system, he has to successfully act as a cultural conservative and exert considerable influence over the changing aspirations of his fellows because "the more closely it (his culture) begins to approximate the doner culture, the more vulnerable

his role becomes" (Landy 1978:235). While I find Landy's typology and his comparative summary of curing roles useful, I am critical of his rather narrow perspective. His work suffers from an attempt to extract the medical system and curing roles from their larger socio-cultural context and a tendency to ignore (with the exception of empirically derived examples of emergent curing roles) the larger macro-social forces such as colonialism that influence the role adaptations of curers outside of their medical responsibilities. For example he suggests that attenuated curing roles result from a curer's failure to adapt to the challenges of cosmopolitan medical technology. As the empirical portion of this thesis will demonstrate, I would contend that the shaman's role in Inuit society is attenuated not because of competition from cosmopolitan medical technology but more as a result of colonial suppression of traditional Inuit religious cosmology by Christian missionaries.

2.6 Summary Comments on Theoretical Perspectives

The discussion above presents an argument for the use of an eclectic theoretical model to analyse the adaptation of the Inuit to the cosmopolitan medical system. In order to emphasize the importance of this model, a brief reiteration of the objectives set forth in the introductory chapter is necessary. The thesis will account for the apparent displacement of the traditional Inuit medical system over historical time, and investigate contemporary local dynamics that both facilitate and impede the effective delivery of cosmopolitan medical services in an Inuit settlement. A broad

range of variables contributing to these situations will be looked at; including macro-social historical factors, the cultural models and social behaviours of the providers of cosmopolitan medical services, changing Inuit beliefs and attitudes about illness, and the Inuit response to cosmopolitan medicine and their interaction with health care workers.

An acculturation approach will be used to survey the changes in Inuit belief and behaviour over time with regards to illness. The attenuation of the curer's role will be discussed in this context as well. In the contemporary discussion, Inuit adaptive response to the cosmopolitan medical system will be explored from a processual perspective. Interaction between individual nurses and individuals and institutions both within and outside Gjoa Haven, will be examined utilizing aspects of role theory. The way in which nurses manage their professional and personal identities will be analyzed. This eclectic approach will facilitate an improved understanding of the apparent dissonance between persistent traditionalistic Inuit explanations for illness and observed behavioural dependence on the cosmopolitan medical system. It will also be used to expand on Landy's (1974) discussion of curer role adaptation.

Dunn's (1978) discussion of cosmopolitan, regional and local medical systems will be further explored in light of his suggestion that two of these systems are always present in any given context. The persistence of a traditional Inuit local medical system is by no means self-evident and requires careful analysis. It will also be shown that EM's within the cosmopolitan medical system are sometimes in conflict, and that congruence

between aspects of the nurses' EM and that of the Inuit is in some cases responsible for the effectiveness of the cosmopolitan medical system.

Finally, it will be thoroughly demonstrated that an eclectic analysis of medical systems as social systems from both the macro and micro perspectives, and as cultural systems, is necessary for a complete understanding of contemporary dynamics. Conflict and congruence in Inuit adaptation to the cosmopolitan medical system is influenced by historical and colonial factors; relations between nurses and administrators, nurses and Inuit, and nurses and other local Whites; and by the various cultural explanations given for illness-associated behaviour by both Inuit and White medical personnel.

3. ILLNESS IN INUIT SOCIETY: TRADITIONAL CONTEXT AND HISTORICAL CHANGES

3.1 Introduction

This chapter will attempt a comprehensive consolidation of the Eskimological literature pertaining to the context of illness in traditional Inuit society and detailing the various acculturative influences that have contributed to the changing context of beliefs and practices concerning illness.

It should be understood that the ensuing discussion of the traditional Inuit medical system does not represent something entirely unique in a cross-cultural context. The Inuit system is part of what Foster has called "personalistic medical systems" and has defined as; "one in which illness is believed to be caused by the active, purposeful intervention of a sensate agent who may be a supernatural being (a deity or god), a non-human being (such as a ghost,ancestor, or evil spirit), or a human being (a witch or sorcerer)" (1979:53). Examples of this personalistic type of medical system can be found worldwide and several excellent comparative accounts are Glick (1967) on the Gimli of New Guinea, Alland (1967) on the Abron of the Ivory Coast, Logan (1973) on Latin America and Opler (1963) on tribal India.

The Eskimological literature is replete with many scattered references to the context of illness in traditional Inuit society. The broad ethnographic efforts of such people as Boas (1888), Rasmussen (1929, 1931), Jenness (1928), Stefansson (1945) and Weyer (1962) combined with more modern

attempts to analyze specific aspects of traditional Inuit culture provide a patchwork record of variable quality and occasionally conflicting perspectives. Unfortunately, illness is usually given rather cursory attention and is described within the context of the more traditional anthropological concerns with social structure and cosmology. This chapter will attempt to extract from this record, pertinent data relating specifically to both the belief system and the socio-political context that typify the traditional Inuit adaptive response to illness. The second portion of the chapter will concentrate on the manner in which contact with Euro-Canadian society has resulted in changes in the belief system and social structure as they relate to illness. The synthesis will be based generally on the Canadian Inuit as a whole with particular reference where available and applicable to those groups who now live in the settlement of Gjoa Haven. While regional variations limit the validity of the general nature of this work to a specific locality, the dearth of material demands that a broader approach be used in order to describe the overall complexities.

3.2 Traditional Background

This section will review the ethnographic literature, highlighting those aspects of traditional Inuit culture relating specifically on the experience of illness and its treatment. Attention will be focused on the soul complex, death and dying, social organization, disease theory, and treatment and curers. A glossary of Inuktitut terms used in this discussion can be found in Appendix D.

3.2.1 The Soul Complex

Central to traditional Inuit cosmology are beliefs concerning the soul complex. The soul is the reality; corporeal existence merely transitory. All living things harbour souls which continue to exist long after the physical body has turned to dust. Souls are reinvested in new life and all beings are linked through the interchange of souls. Rasmussen underscores this belief in his description of Iglulingmiut intellectual culture. He stresses the need to appease the souls of animals when hunting and indeed suggests that rules of conduct are laid down in order not to offend the souls of animals because "human beings have to depend entirely on the souls of other beings for food" (1930:58).

However, the exact nature of the soul complex is the subject of some controvery which probably reflects regional differences (or the investigators ineptness). Boas in his study of the Inuit of Baffinland and Hudson Bay states that "the Eskimo believe man has two souls" (1964:130). Upon the death of an individual, one of these souls leaves the body and goes to reside in one of the heavens that constitute mythology. The other soul "stays with the body, and may enter temporarily the body of a child which is given the name of the departed" (Ibid:130).

Rasmussen refines this concept somewhat and suggests that the Iglulingmiut have a soul with two sides: *inu'sia* (or spirit of life) and *tarninga* (which is the most powerful part of the soul that gives life and health and which is subject to disease and sickness). As well there is the name whereby:

> Everyone on receiving a name receives with it the strength and skill of the deceased namesake, but since all persons bearing the same name have the same source of life, spiritual and physical qualities are also inherited from those who in the far distant past bore the same name (1930:58-59).

Thus, each living thing is imbued with two entities: the two-sided soul and the name.

Weyer (1962:289) confuses the issue further with his general statement that "the Eskimos distinguish three sorts of human souls." He suggests that the first or immortal soul leaves a person's body at death and takes up residence in heaven; the second soul is considered the life's breath and ceases to exist at death; and the third is the name-soul which is connected to a person's name and which, according to Weyer, is "almost entirely of this earth" (Ibid:291). This general belief system is shown to be subject to regional complexities and variations. Weyer cites Jenness (1922) and Rasmussen (1929) to demonstrate the specific differences between regional groups. The Eskimos of the Bering Sea believe in a spirit, which returns to the air, and a soul, which is destined for a future life. The Copper Eskimos believe in a soul and a shade whereby the soul, which is a man's vital force, ceases to exist at death but the shade continues as a ghost for a time after death. The Cumberland Sound Eskimos believe that one soul travels to heaven and the other soul goes to live in a child for a short time, after death. And so on.

Williamson (1974) has attempted to clarify this confusion in his discussion of the soul-compound. He contends that the soul is dualistic

consisting of the life force and the name. However, he emphasizes the link between the name and the soul as the essential element of the soul belief system: "The name, in Eskimo belief, is the soul, and the soul is the name" (Ibid:23). This interpretation suggests that the life force aspect of the soul is the force that animates the personal soul and which returns to the universal life-force upon the death of the individual. Williamson's interpretation is based primarily on ethnographic evidence from the Keewatin but he would, I believe, contend that this understanding is widespread in Inuit societies. The significant feature of his interpretation is the emphasis on the name-soul as the basis of the soul system. The other authors have emphasized the spirit-soul or life force aspect of the soul, and have varyingly accorded only secondary importance to the name-soul.

Much of the confusion over the exact nature of the soul belief complex in traditional Inuit thought probably stems from the differing personal interpretations of Inuit informants, depending on the functional importance of the belief complex to a particular matter of immediate concern. The soul belief complex is important insofar as it relates to concerns regarding insecurity, illness, death and the future, from both an analyst's and a native informant's perspective. To be specific, when an informant is attempting to explain the causes, course and cure for a particular disease, he interprets his beliefs concerning the nature of human existence as they relate to that problem. Consequently, some variation and confusion begins to appear in what the analyst might prefer to

see as an integrated, carefully structured belief complex. This conclusion will be further borne out in later sections of this chapter dealing with disease theory.

3.2.2 Death and Dying

Of fundamental concern to all human groups, the fear of death and dying elicits a broad and complex set of attitudes and beliefs that influence their behaviour. Amongst the Inuit, the conclusion reached above is particularly substantiated with regard to the relationship between belief in the soul complex and attitudes towards death and dying.

Essentially, traditional Inuit believed that death was merely a transition from one form of life to another. For the Iglulingmiut, Rasmussen states: "No Eskimo fears death in itself, for all are convinced that it is merely the transition to a new and better form of life" (1929: 93). Boas supports this notion with his description of Baffinland Eskimo belief: "Though the Eskimo feel the greatest awe in touching a dead body, the sick await their death with admirable coolness and without the least sign of fear or unwillingness to die" (1964:204). Weyer reiterates the general conclusion that "the Eskimo has an abiding confidence that at death he will go to live in another sphere" (1962:248).

The concept of transmigration of souls is the key to understanding this positive attitude towards death. This transmigration takes place on two levels but is again subject to some confusion. On the one hand there is the belief that the soul of the individual goes to live in a land of

the dead. There are differences in the exact nature of this mythological heaven dependent upon regional and dialectical variation but it would seem that the afterworld consists of two rather pleasant places for people who have died violently or of natural causes, and one not so pleasant place for people who have broken taboos and/or have led an evil life.

Rasmussen (1930) describes the afterworld of the Iglulingmiut as consisting of *Udlormiut*; "the people of the day," where life is pleasurable and hunting is confined to land animals; and *Qimiujarmiut*, "the dwellers in the narrow land," which is located under the sea, is also pleasant, and hunting is confined to marine animals. For those people who "have failed to observe the ancient rules of life" some time must be spent atoning for their sins in the land of the Great Sea Spirit.

Boas (1888) reports that the Central Eskimo believe in only two places in the afterworld, one of which is happy and the other unpleasant. *Qudliparmiut* is considered "above", is free from snow, ice and storms, and is the resting place for those who have been good or happy and/or were killed by accident or their own hand. *Adliparmiut* is "below" and is always dark, snowy and stormy and is the permanent abode of those who have been bad, unhappy, willful murderers or who have died from natural causes. Hall (1970) reports that in northeastern Baffin Island, the Eskimo believe that offenses against the Sea Goddess, *Sedna*, determine the destination of souls. Those who disobey her taboos must spend one year in her abode in a type of purgatory before travelling to *Adlivium*, the lower place. Those who have not offended her, and all who die by violence, drowning, or in childbed travel to *Qudlivun*, the higher place where life is pleasant.

For our purposes, there are two significant features of these beliefs: First, there appears to be in traditional Inuit belief a duality in the concept of an afterlife where two locations are inhabited by the souls of the departed. One of these places is quite pleasant while the other place varies in description from being not so pleasant to hellish. Secondly, the nature of death is significant for determining the destination of the departed soul. For those who die by violent accident or who take their own life, the reward is a pleasant eternal afterlife. For those who die by disease or of old age, their future is not nearly as potentially pleasurable. In our discussion of traditional disease theory we will see the further relevance of these beliefs.

The other feature of the belief in the transmigration of souls focuses on the name-soul and the reinvestment of the name-soul in another living being. When a person dies, his name-soul, or his personal essence, is transmitted, usually, to a newborn child in the kin group or community. To the Inuit, this process involves far more than merely showing respect for the deceased old one; it involves the investiture of the personality, strength, character, etc. of the dead family member into the infant.

Weyer reports that there are differences in the strength of belief, but that most Inuit believe so strongly in the transfer of the name-soul that the "namesake is treated as though he were actually the dead person, living again on earth" (1962:292). In his discussion of Inuit beliefs and practices in the Mackenzie region, Stefansson (1945) provides us with a detailed description of the strength of the name-soul beliefs. Puzzled by

the reference to young children as "mother" or "grandfather," Stefansson discovered that young children acquire the name-souls of deceased relatives and that they are very often treated as if they were those dead relatives until their own name-soul is mature enough to protect them. In this way an individual can posess any number of name-souls. Rasmussen makes a distinction between the soul and the name but reiterates the importance of the name to Inuit belief. He also hints at, but does not adequately discuss, the concept of name-sharing where the enduring qualities of a name are shared by many people:

> Everyone on receiving a name receives with it the strength and skill of the deceased namesake, but since all persons bearing the name have the same source of life, spiritual and physical qualities are also inherited from those who in the far distant past bore the same name. (1920:58-59)

Williamson (1974) suggests that this distinction between the soul and the name is unwarranted and that indeed the soul is the name and vice versa. He also emphasizes the importance that sharing a name-soul has with regards to the "sense of integration, not only with the kin group, and the society in which it functions, but with the creatures and the forces of the entire natural environment" (Ibid:251). This aspect of name sharing will be further elaborated in the sections dealing with social organization and disease theory.

From the above discussion, we can deduce that again, there is a duality in beliefs concerning death. There would appear to be two elements in the human essence that continue to exist after death. One element takes

up residence in a type of afterworld of heaven and the other element is reinvested in living beings. There are of course many other features of Inuit traditional cosmology that articulate with this core set of beliefs. However, for our purposes, only those pertaining to illness and its treatment will be dealt with subsequently in the sections of this chapter concerning disease theory and curers. Before we begin that discussion however, a brief review of traditional social organization as it relates to the cosmological discussion above and to the treatment of illness, is necessary.

3.2.3 Social Organization

The relevant dimension of social organization for our purposes, would appear to be the quality of the relationships between individuals dictated by their respective positions in the social structure rather than the structure itself. Material to be presented shortly will demonstrate that social etiquette, as determined by the social structure, has an important role to play in the etiology of disease. Consequently, in this section, the focus will be upon the behavioural dimensions of the various relationships between individuals in the social system.

At the nuclear and extended family levels of organization, social control, authority, and decision-making priority were based entirely on the principle of *naalaqtuq*, a system of dominance-subordination (Damas 1975). This principle accorded authority in an ascending manner, based on age and sex differences. Seniority amongst males in the family was the blueprint for obedience and females were subordinate to males. Williamson

(1974) argues that the male-female dominance relationship was not as rigid as Damas (1975) suggests. He contends that seniority was the dominant principle irrespective of sex differences and that extended families occasionally functioned with a matriarch as the most influential personage. He does however, agree that males dominate females within each generation with some qualification. Despite the obvious self-effacement and submissiveness of Inuit women until they reach menopause, they do exert considerable influence over the decision-making activities of their menfolk. Williamson (1974:46) states: "When a family decides to leave a camp and establish with another camp, the senior woman in the family group is very often the prime-mover in the decision."

When we move from the nuclear or extended family group to the band level of social organization, these fairly clear-cut principles of authority and decision-making become somewhat less structured and are cross-cut with a number of other social control mechanisms. Damas (1975) has argued that the principle of *ungayuq* structures the behaviour of more distantly related kin in a complementary fashion to *naalaqtuq*. His material is based on Iglulingmiut ethnographic data and he cites Stevenson (1972) to suggest that this principle also applies to Baffinland Inuit. He also states that *ungayuq* does not appear to influence Netsilik behavioural systems. *Ungayuq* refers to the degree of emotional closeness between siblings and cousins particularly, and is best expressed in the bond of solidarity found among male paternal parallel cousins.

Naalaqtuq also functions as a mechanism of social organization beyond

the extended family but is to some extent replaced by the institution of *isumataaq*. Based on the same principle of subordinance to seniority, *isumataaq* was most often applied "to the outstanding family head in a multi-extended family camp or assemblage" (Damas 1975:25). This individual had the power to influence the distribution of products from the hunt and trade, and decided where and when the group would move to a new camp. The extent to which his directives were followed depended primarily on the strength of his personality and character, his hunting skills and to some extent the size of the extended family network around him.[1] During the period of contact with Europeans it was usually this individual who was designated "camp boss" by the Europeans (Graburn 1969:59).

Complementing the *isumataaq's* leadership function was the *angatquq* or shaman. Williamson (1974:42) argues that in pre-contact times the *angatquq's* authority would have substantially superceded the *isumataaq's* and that it was only as a result of contact with Europeans, who chose not to recognize the *angatquq* that the *isumataaq* came to be recognized as "camp boss." Strangely, Damas (1975) ignores the *angatquq's* role in his summary of the authority structure of Inuit society. Graburn agrees that the shaman was a very influential member of the band and suggests that the strongest leadership existed when the powers of *angatquq* and *isumataaq* resided in the same individual, although he recognizes the rarity of this occurrence. He does however, stress the ambivalent feelings that were

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1. Damas (1975:25) states: "I found that the individual *[isumataaq]* usually so designated was the head of the largest segment of close kindred."

usually felt toward the shaman, because of his malevolent potential, and indicates this ambivalence undercut the shaman's leadership qualities. Graburn also points out that "there was generally only one shaman in each group of *nunaqatigiit [camp]* because of rivalries and jealousies over his powers and performances" (1969:60). This point is particularly relevant with regards to our problem of relating social organization to illness and we will return to it later.

Perhaps the confusion over the relative extent of the *isumataaq's* and *angatquq's* leadership otential can be best clarified by quoting a qualifying passage from Williamson (1974:42):

> Usually the *angatquq* insisted that their power derived from their helping spirits, and therefore it would be inappropriate for them to assert their own opinions and take upon themselves the overt role of secular leader, as this would offend the spirits who were in fact the source of the shaman's wisdom. Thus the shaman exerted an indirect rather than direct influence over the corporate decision-making patterns of the group, but his influence was nevertheless very significant.

In the camp group, there were as well various alliance mechanisms that cut across the authority processes outlined above. These mechanisms existed both within the kinship system and outside it and included such things as spouse-exchange partners, child-betrothal mates, adoptive pairings, name avoidance pairs, rough-joking partners, mock antagonists, seal-sharing partnerships, age mate alliances, trading partners, dancing partners, and namesake relationships (Damas 1972).

It is not my intention to detail each of these alliance mechanisms.

Most ethnographers who have studied this aspect of Inuit society attribute economic, social and political functions to these mechanisms in the sense that they provided additional economic security, enhanced social status and reduced tension and conflict (c.f. Damas 1972, 1975; Guemple 1972; Stevenson 1972; Dunning 1962). For our purposes, it is significant to note that, with the exception of the namesake relationship, none of these alliance mechanisms would appear to have any functional relevance to illness behaviour.

The namesake or name-sharing relationship is important because it reflects the cosmological beliefs in the soul. Guemple's (1965) treatment of the *saunik* or name-sharing patterns of contemporary Belcher Island Inuit represents a drastic departure from the traditional ethnographic material. Guemple describes a process whereby living members of the community share their name with younger kinfolk, thus establishing a system of reciprocal rights and obligations and in the process enhancing their status. This institution differs from the process described in the more traditional ethnographic texts whereby the namegiver is almost always recently deceased and the process of name transfer to an infant is in order to facilitate the transmigration of the soul from the ancestor to the infant (c.f. Weyer 1962; Rasmussen 1929). This does not mean that contemporaries cannot share a name — indeed this occurs frequently — but the name they share has usually been inherited separately from a deceased member of the community. One can only conclude that Guemple's analysis represents a case where modernization has effected a substantial change in the structure of the name-sharing relationships.

The relationship between namesharers of a deceased's name is however significant in that their relationship was characterized occasionally by avoidance. Informants in my field study indicated that they tried to avoid contact with namesharers because it produced a feeling of anxiety and crankiness in both parties. It was suggested that sharing a name meant that the protection afforded by the guardian qualities of the namegiver was lessened for each individual because they had to share in the strength of the name.

In the sections to follow on disease theory and curers, the sketch of traditional social and cosmological domains on Inuit culture will be integrated in order to demonstrate their relevance to illness behaviour.

3.2.4 Disease Theory

Explanations as to the cause of illness in traditional Inuit society were directly related to the cosmological belief complex. Disease was viewed as an affliction of the soul, not the body, and causes and cures were attributed to changes in the state of an individual's soul. There were numerous ways in which the soul could become afflicted and also a variety of methods for the restoration of health.

However as the earlier discussion suggested, ethnographic accounts of Inuit conceptions of the soul are not at all clear. Confusion exists in the general description of the nature of the soul or soul-complex and this confusion is also present in the scattered references to disease theory.

All authors are in agreement that illness was associated with various disorders of the soul. The question arises however, as to which soul, or which aspect of the soul, is related to illness? In the section above devoted to traditional Inuit cosmology we reached a consensus that the soul complex consisted of two distinct entities: the life-force or personal soul that took up residence in the heavens after death and the name-soul that was reincarnated in an infant. Although acknowledging this distinction, most authors ignore the importance of it thereafter and merely refer to the "soul" in their discussions of illness.

Balikci's (1970:199) summary of traditional Netsilik religion provides us with the clearest account of the distinctions between the souls as they relate to illness:

> Although the personal soul was the source of health and energy, it was also vulnerable to attack by evil spirits and malevolent shamans. All physical sickness resulted from evil spirits hurting the human soul by taking abode in the patient's body ... Quite distinct from the human souls were the name sould. Personal names were thought by the Nesilik to possess ... a distinct ability to protect the name bearer from any misfortune.

If we combine Balikci's distinction with the traditional ethnographic literature, a more elaborate picture of disease theory emerges. Weyer (1962:298) presents an argument that "since death is characterized by the absence of the soul, sickness is sometimes interpreted as its temporary departure." Weyer is unclear as to which soul causes illness when absent: he includes in the same paragraph reference to soul departure and name-changing to "gain an extension of life" (Ibid). Williamson (1974:24)

argues that the name-soul is the essential element in traditional Inuit disease theory. He suggests that illness sometimes resulted from an "imbalance in the cosmological pattern of soul transcendancies" and that, in effect, the name-soul of a person was needed elsewhere. The solution to this cosmological imbalance was for the shaman to select a new name for the patient. Weyer (1962) cites various authors to demonstrate its widespread distribution of this practice throughout the Arctic regions. Although outside the frame of reference for this study, Spencer's (1959) material on the North Alaskan Eskimo further illustrates the soul-illness complexity. Essentially, Spencer suggests that illness is primarily caused by soul loss which results from three things: theft by a malevolent shaman, careless wandering, or wandering because of a broken taboo.

Despite the very sketchy picture of illness provided in the ethnography of the Inuit, I believe a general pattern can be formulated from the material available. Illness in Inuit thought is primarily associated with disturbances of the personal soul. The name-soul's function is to provide protection to the individual from these disturbances. Soul loss is primarily associated with the personal soul and is the result of a number of factors to be discussed below. The name-soul can also leave the body if required elsewhere and when this happens, the body's 'defenses' are weakened. Therefore, traditional Inuit disease theory is predicated on the duality that each individual has a personal soul that is subject to various afflictions and disturbances and that occasionally leaves the body causing serious illness and eventually death. As a protective measure

each individual posesses one or more name-souls which afford protection to the personal soul. The question now remains: what were the causes of personal soul disturbance and how were they cured?

An initial distinction must be made between ultimate causes of, and the mechanisms that contribute to, soul disturbance. This distinction is usually absent from the ethnographic literature and consequently we find causal explanations for soul disturbances grouping together such things as taboo transgressions, spirit intrusion and theft by malevolent shamans (c.f. Weyer 1962). A more logical understanding of these processes would organize the material according to the questions "Why?" and "How?".

The ultimate cause for soul disturbance would seem to be primarily associated with taboo transgression. As stated earlier, Inuit life was closely regulated by a complex system of interlocking taboos that governed nearly every aspect of daily activity. To illustrate this point a selection of taboos particularly associated with illness is listed below (c.f. Boas 1888, Rasmussen 1929, Weyer 1962).

A pregnant woman must be quick to help others, so that her child will turn out a helpful man or woman.

Women must affect their own delivery without help, and must be alone in the snow hut because her impurity would render another woman also impure.

After birth, the child must be placed naked in the *amaut*; clothes for an infant must not be made until after it is born.

If it is desired to render a boy invulnerable from the witchcraft of shamans where the shaman removes his soul causing sickness, then a shaman must be summoned as soon as the child is out of the womb and his business is to take the soul out of the boy's body and lay it under his mother's lamp for protection.

After the birth, a woman is strictly forbidden to go visiting or to have intercourse with her husband for a considerable period of time because she is regarded as so unclean that the spirits might drive away all game.

After the birth, a woman may only eat meat caught by the husband.

For a whole year after childbirth the woman may not eat raw meat, nor may she eat flesh of any animal wounded in the heart, stomach or fetus.

When a young virgin or mother combs her hair, all children in the house must pull down their hoods. If not, they will die.

Children are not allowed to address old people by name but only by terms of relationship, or as "head of the household" in the case of an old man.

A young man must never eat the flesh of the first animal of any species he kills.

A woman menstruating, or having a miscarriage, must at once inform all others; all must know she is unclean; she must never come in to young men who have not killed one of every kind of game; she must not go out of the house; she must not eat or cut raw meat; she must not prepare the skins from the legs of caribou.

If a man's hair is cut, the cuttings must never be thrown away, but must be burned in the house or tent.

When two namesakes meet, they must exchange gifts. This strengthens their souls and pleases all their deceased "name-cousins."

Certain rules and customs separate land anaimals from sea animals. Observance of these rules is essential to prevent the souls of animals slain from harming the man who deprived their bodies.

When a seal is caught, women must not comb their hair, wash their faces or dry any footwear.

If anyone lies ill in the house, drippings from the roof must not be wiped off, nor must the rime be cleared from the window or the house cleaned because one might accidentally throw the soul out with the dirt.

A man whose child is ill must not do any work or the child will not recover.

A man who has regained his soul after illness must not do any work for five days.

When a man dies, no one is allowed to wear clothing made from animals he has caught.

A dead body must always be removed through a hole in the back of the house, never through the same hole that is used by living persons; otherwise they would follow the deceased to their death.

The above represents but a small sample of the taboo system taken from Rasmussen's (1929) study of the Iglulingmiut. Not only are there numerous other taboos but there would appear to be considerable variation

between dialectical sub-groups, although similar themes emerge frequently. Particularly important are taboos related to the bodily functions of women, taboos related to the hunting and disposal of animals, and taboos regulating sexual relations.

Although there is some indication that many of these taboos served a function, the primary reason given by Inuit informants to explain their existence was that "traditions are strict rules handed down from previous generations, and that it is dangerous to neglect them" (Ibid:180). Neglect meant that the spirits would be angered and their wrath affected not only the individual transgressor but the entire community. Consequently, their observance was a public matter. Failure to conform to any of these dictates usually resulted in sickness and/or in death.

The mechanism through which these breaches of social etiquette translated themselves into disturbances or afflictions of the soul, which were manifested as both physical and mental illness and/or death, centred primarily on spirit intervention. Balikci (1970) cites several ways this could occur in Netsilik society. If a breach of a taboo associated with death ritual occurred, the departing soul might turn into an angry ghost and create havoc in the camp. The angry ghost would attach itself to a living soul and cause illness. If the souls of animals were angered by a person's failure to observe the proper hunting taboos, they too could become angry ghosts and attach themselves to the soul of a living person. There was as well, a class of spirits known as *tupilak* and another known as *tunraq* that populated the environment and which were very dangerous if angered by a breach of taboo.

Tupilak were a group of independent evil spirits that took the form of animals and were always ready to harm anyone who broke taboos. *Tunraq* were the spirits controlled by the shamans on which his power was based. They were only dangerous when a malevolent shaman unleashed them on an unfortunate adversary.

There appears to be some conflict in the literature as to the exact nature of the spirit-intervention process. Balikci suggests that "evil ghosts and spirits ... attacked the patient in group formation and took abode in his body" (Ibid:226). Stefansson (1945) argues that the Copper Eskimo view soul-loss or theft as a separate mechanism from spirit intervention, claiming that both cause disease. Boas (1888) favours the idea that taboo transgressions attached themselves in some way to the soul. Williamson (personal communication) supports the idea that illness is a result of disturbances to the soul caused by spirit intervention and that the soul is only "lost" when death occurs. From the evidence, I must concur with the general understanding that illness results from an evil spirit's(s') attack on the soul, where the spirit's aim is to remove the soul from the body. However, actual soul-loss does not occur until death is imminent.

A second important cause and mechanism of illness is associated with malevolent shamans but does not occur as frequently as the one outlined above. Out of jealousy, envy or for revenge, a shaman may command his helping spirits or *tunraq*, to attack another individual in the camp. Sometimes this attack takes the form of object-intrusion where some foul object is implanted in the victims body by the spirits, causing illness.

Finally, an important aspect of traditional Inuit disease theory could be termed the "preventative" aspect of the system. As has been previously discussed, the name-soul is the primary source of protection and prevention for an individual. The name-soul embodies certain strengths that aid a person in his fight with evil spirits and other environmental demands. Among some Inuit groups, the Netsilik especially, a second line of defense was provided by amulets. These amulets were usually natural objects of any kind that were inhabited by a protective spirit and helped ward off the evil spirits and, consequently, prevented disease. Amulets could be very valuable and shamans particularly tried to acquire as many as possible. The more amulets a person possessed, the stronger his line of defense against the workings of evil spirits.

In summary, traditional Inuit disease theory attributed illness to disturbances of the personal soul. Taboo transgressions angered various ghosts and spirits in the supernatural world that attached themselves to the transgressor's soul, causing him to fall ill. Occasionally, malevolent shamans would unleash their power over spirits to cause an enemy to fall ill. As personal defense, individuals had the strength of protection from their name-soul(s) and could also acquire protection from amulets. In the section to follow, we will discuss the various ways that illness could be cured.

3.2.5 Treatment and Curers

Since the Inuit believed that most illness was caused by evil spirits

attaching themselves to the soul, treatment of disease necessarily relied on human intervention into the realm of the supernatural. The person with the greatest knowledge of the supernatural consequently became the healer. In Inuit society, this person was known as *angatquq* or shaman.

However, there is evidence that the shamans were not alone in their responsibility as healers to the group. There would appear to have been several para-shamanistic categories of persons of lesser supernatural power who were also called upon to intervene in the illness process and we will survey this material prior to a more detailed analysis of the *angatquq*.

In his summary study of the Netsilik Inuit, Balikci (1970) describes two other classes of curers aside from the shaman. The most widely utilized alternative was the *krilasoktoq* who performed the *krilaq* or head-lifting ceremony. According to Balikci, this ceremony was beneath the expertise of the shaman and required no special training or significant supernatural power. The *krilasoktoq* was aided by a collection of *aperksaq* or helping spirits that were weaker than the shaman's *tunraq*. The *krilasoktoq* would perform the *krilaq* on his wife usually and it involved questioning his helping spirits as to the broken taboo that might have caused the patient's illness while pulling on a thong tied around his wife's head. When the correct taboo transgression was mentioned, the spirits would answer by making it difficult to pull on the thong.

The other secondary class of curers mentioned by Balikci (Ibid) were the *angatkungaruk* or lesser shamans. These individuals possessed

weaker control over the *tunraq* and could occasionally influence the *tunraq* to drive the infecting spirits out of a sick person.

Williamson (1974) describes another group known as *iglirsurqsimajut* who were people who possessed so many protective amulets that they were able to ignore many taboos. He does not suggest that these people acted as curers, only that their personal preventative powers protected them from supernatural wrath that might cause illness in others.

A final alternate group of people involved in supernatural manipulation are described by Weyer (1962:443). Although Weyer's description of the *ilisitsut* or sorcerers is confined primarily to Greenland and Alaska, he does suggest that elements of a sorcerer's cult exist among the Central Inuit as well. The primary function of the *ilisitsut* would appear to have been malevolent with their control over spirits directed towards harming people rather than helping them. In this sense, their function was to cause illness rather than cure it. Whereas other authors suggest that illness-causing was the work of a malevolent *angatquq*, Weyer is suggesting that a sort of competition existed between the *ilitsitsut* and the *angatquq* with one group causing illness and the other curing it. He also argues that the sorcery cult may be a vestige of more ancient times and that it has widely been superceded by the cult of the *angatquq*. Further, Weyer supports Balikci's claim for a separate class of diviners known as *krilasoktoq* and provides evidence from West Greenland, Polar Inuit, Baffin Islanders, Iglulik, Hudson Bay, Labrador, Copper Inuit, Alaska and Siberia to support this claim. Apparently old men and women were able to perform this function.

In contrast, Boas (1964:185) describes the "head lifting" ceremony as part of the curing technique of the *angatquq*: "A thong is tied around the head of the sick person or of a relative, who must lie down on the bed, the angakoq (*sic*) holding the thong" (Ibid:185).

To further complicate the issue of the presence of para-shamanistic practitioners in traditional Inuit society, my own fieldwork suggested that the *krilaq* was traditionally performed by the shaman amongst both the Utkuhikhalingmiut and the Netsilingmiut. However, I believe there are three ways to explain this seeming discrepancy in the literature pertaining to categories of healers. First of all, it must be remembered that hunting and gathering societies such as the Inuit do not sustain the complete specialization of tasks that the concepts of 'healer' or 'priest' suggest. In this sense, everyone partakes to a degree in all aspects of the society. Spencer (1959:300-301) makes this point very clearly:

> The various discussions of shamanism among the Eskimo and other Arctic peoples imply a dichotomy between shaman and layman. That this existed there is no question ... however, it is clear that ... in some measure, every Eskimo of the aboriginal Alaskan Arctic slope was a shaman. He or she, at least, had a certain amount of power which could be used to advantage ... in bringing game, in controlling weather, even in curing, applied to shamans and non-shamans alike ... Shamans had such power together with everyone else. They might merely have more of it ... It was generally agreed that one could not always tell who was a shaman.

A second explanation invokes acculturation as the cause since none of the supposedly 'ethnographic' accounts were recorded prior to contact with Europeans and particularly contact with Christian missionaries.

Since the shamans were singled out by missionaries as the obvious elements of the "pagan" religion that needed to be suppressed, the flourishing of para-shamanistic practices would indeed by likely, especially for curing since no alternatives were as yet available. Finally, if we recall the discussion on the flexibility of Inuit social organization we find Graburn (1969) arguing that generally, there was only one shaman per camp group. Taken in converse, this means that not every extended family included a practicing shaman, and substantial proportions of the season cycle were spent in units consisting exclusively of the extended family. Since supernatural intervention would be required at all times of the year and a shaman's presence might be unavailable, every individual, and particularly elders, in an extended family would have to possess some knowledge of shamanistic powers and techniques.

Before we begin a detailed discussion of the *angatquq*, one final point needs mentioning regarding general decision-making patterns in the extended family and camp group. Recalling Williamson's (1974) argument that matriarchs played a key role in influencing the decision of a family to change location and either join up with other families or separate, I would suggest that a major factor influencing such decisions would be the presence or absence of a shaman in the group. In a case where serious illness was beyond the capabilities of the para-shamanistic practitioner, it would be most likely that decisions to move camp would be predicated on the need to acquire the services of an *angatquq*. Since contemporary fieldwork has indicated that concern with illness was most

often a female prerogative, it is natural to assume that female influence over decisions to relocate in traditional times was most important. This conclusion will again be significant when we discuss the acculturation trends of relocation to settlement life.

Shamans could be men or women; most often they were men but it was generally acknowledged that women were more powerful (Williamson 1974). A young man or woman was recruited by an older *angatquq* after lengthy observation. While great intellectual capabilities were a required characteristic, there is also some suggestion that physical or mental abnormality was accepted as a sign that one was suited to the calling (c.f. Frederiksen 1964; Weyer 1962; Williamson 1974). Indeed the inherent possession of supernatural power was recognized as the most important attribute of the shaman and this gift was often evidenced by dreams and hallucinations that could be considered evidence of, as some have suggested, schizophrenic mental states (Silverman 1967).

Balicki (1970:225) describes the recruitment process for the Netsilik Inuit:

> The *angatkoks* were in the habit of observing if some bright young man had received the call. Once selection had been made, the formal training started. Initially the novice joined the household of an elderly *angatkok* teacher where he observed a series of special taboos, such as abstaining from eating outdoors, from eating liver, head, heart or intestines, and from having sexual relations. The novice, assisted by a spirit, slept intermittently and began having visions. Then he moved to a separate igloo where, during a period of several weeks, he was taught the secret vocabulary together with the necessary shamanistic techniques and obtained his paraphernalia (a headdress and a belt) from his parents.

> Finally his teacher presented him with a protective spirit (*tunraq*), and they officiated together. Initially the *tunraq* was the master of the novice, and only gradually did the young *angatkok* learn to control it. Eventually, as he gained experience, the novice became a full-fledged shaman, possessing a competence and strength equal to that of his master.

As the above suggests, the shaman's power stemmed largely from his control over his *tunraq* or helping spirits. His success at intervening in the spirit world in order to cure illness thus rested on his ability to manipulate his helping spirits.

Essentially there were four ways in which the shaman could attempt to cure illness. The primary technique, and the one most widely used because if successful, it greatly enhanced his status as a curer-priest, involved direct confrontation with the *tupilaq* or evil spirits that were thought to have invaded the patient's personal soul. This confrontation involved all the classic behaviour associated with the much described trance (c.f. Rasmussen 1929; Weyer 1962; Balikci 1963). After entering into a trancelike state, the shaman would invoke his *tunraq* and, utilizing a variety of techniques such as ventriloquism, illusions, etc. convince both his patient and audience that the *tupilaq* had been driven out and killed.

The second curing technique involved the cathartic use of confession and atonement for broken taboos. Usually in a case where illness persisted, a shaman would decide that the *tupilaq* were resisting his power because they were very angry at a taboo transgression that had been kept a secret. It now became the shaman's task to elicit a public confession of the

broken taboo from either the patient or someone close to the patient. Such things as concealing a miscarriage, failing to inform everyone of a menstrual period, ignoring death taboos or failing to observe proper behaviour with regard to the hunting and butchering of animals were the most frequent and serious taboos to be broken. Although there is, as was outlined above, some debate as to whether or not some divination techniques were para-shamanistic, it is probable that the *krilaq* was a primary technique employed for this purpose.

There is also some disagreement as to whether atonement was necessary before a cure could be affected. Boas (1888) suggests that confession alone was sufficient to appease the angered *tupiliq*. Other authors agree, but qualify their agreement with the argument that in some cases the shaman would prescribe certain abstinences or food taboos as well (Weyer 1962; Jenness 1922). Graburn (1967:36) concludes that: "the release of guilt itself probably effected many cures."

A third very important technique employed by the shaman involved the replacement of the name-soul in the patient. Occasionally it was thought that the protective power of the name-soul was needed elsewhere and consequently the patient was sick because of lowered defenses. The shaman would be called upon to devine a suitable new name for the patient and to conduct the appropriate ceremony to transfer a new name-soul to the sick person.

Finally, the shaman employed various more practical techniques to assist his supernatural skills although, because of environmental austerity,

these practical skills did not involve the use of herbal medicines. This point should perhaps be emphasized. In most traditional societies psycho-social curing techniques are combined with the skilled deployment of various medicinal herbs to affect cures. The Inuit shamans were unique in that they lacked a pharmacopeia to support their supernatural skills. However they did employ techniques such as bloodletting in their therapeutic repetoire. Although not strictly a practical treatment, shamans also practiced a "sucking out" of foreign substances that were thought to have been placed in the patient by evil spirits. The shaman would appear to suck on a part of a person's body and then spit out a piece of bone, bit of flesh, worms, or some other foul substance. It is generally agreed that this practice involved some slight of hand on the part of the shaman.

3.2.6 Summary Comments on Cosmology, Social Organization and Curing

The above discussion illustrates, above all else, the complexity of the medical system in traditional Inuit society. The background of cosmological beliefs on which the theory of disease was founded, was exceedingly complex. The soul compound or complex, depending on which interpretation one accepts, illustrated the multi-faceted way in which Inuit viewed their relationship with the cosmos. In particular and especially, the interwoven fabric of religion and medicine — indeed the synonymity of the two domains — is dramatically apparent from the preceding discussion.

It is obvious that fundamental strategies for social control and structuring the social order were imbedded in the interlocking system

of taboos which were ultimately sanctioned by the presence or absence of illness. From a strictly social perspective, traditional Inuit society appears to have been a relatively flexible and fluid entity. However, when we add the religious and medical dimensions to the social perspective, we recognize the carefully regulated nature of social behaviour and organization. And, of course, the pivotal importance of the *angatquq* is obvious.

Finally, renewed emphasis is placed on the complex nature of the medical system, where despite a complete absence of any sort of pharmacopeia, alternative explanations and therapeutic and preventive techniques were available to a suffering individual. Into this intricately interrelated system came the minds, bodies and products of foreigners from another world. The impact of these intruders will be the subject of discussion in the section to follow.

3.3 Historical and Environmental Influences

This section of the chapter will briefly review the broad historical trends that have significantly altered beliefs and practices related to illness in Inuit society. As well, the impact of Western introduced disease or Inuit society will be outlined.

3.3.1 Early Contact Period: Explorers, Whalers and Traders

With the arrival of Frobisher's expedition in 1576, changes began to occur in the Inuit way of life. For the next 350 years, exploration

vessels plied the waters off Baffin Island, into Hudson Bay and eventually with Franklin's expedition in 1848, the straits and channels of the Central Canadian Archipelago. Throughout this period, sporadic contact, conflict and trading occurred between the various bands of Inuit and the Europeans on board the sailing vessels who have been described by Crowe (1974:64) as "rarely washed, their medical knowledge was poor, and many of them had the ill-health and poor physique of people from crowded filthy cities." As well, several overland expeditions such as Hearne's to Coppermine in 1771 and Back's to the Chantrey Inlet area in 1834, established widespread contact between almost all Inuit groups and the foreigners with their strange habits, technology and, importantly, diseases.

Their effect on a largely healthy and integrated Inuit population was variable by region but overall, significantly disastrous. Particularly in the Labrador area of the Eastern Arctic the "smallpox and brandy, guns and blankets, laws and religion" of the British and French explorers and traders succeeded in completely disrupting the traditional lifestyle of the Labrador Inuit by the middle of the eighteenth century when the first Moravian mission was established.

While the effect of trade and European induced disease brought by explorers was not so dramatic in other parts of the Arctic, the recognized power of such things as guns and steel knives was enough to introduce doubt and a tendency towards secularization into a system that had traditionally functioned in accordance with supernatural sanctions.

A more critical period of contact occurred with the expansion of

the whaling industry into Arctic waters in the middle of the nineteenth century. In the Eastern Arctic, the west coast of Baffin Island was being visited by Scottish whaling steamers from 1820 onward while American sailing vessels began active pursuit of whales in the Hudson Bay area from 1850 until 1915 when the last vessel left the area. In the Western Arctic, whaling crews composed largely of a mixture of lawless and irresponsible men from all over the Pacific region (ie. Americans, Hawaiians, Polynesians, Japanese, Chinese, etc.) reached Herschel Island in the Mackenzie Delta region by 1890.

The Eastern Arctic whaling period was characterized by relative sanity and a lack of gross disruption probably because of the Puritan morality of the captains of the various vessels. However, foreign-introduced disease took its toll and in 1899 an epidemic brought by three whalers wiped out all but five of the Sadlimiut who traditionally inhabited Southhampton Island. Crowe (1974) estimates that by 1900, one-third of the Baffin Island Inuit were dead of various, previously unknown, diseases.

Furthermore, the wintering practices of the American whalers in Hudson Bay disrupted the social organization of the Inuit they encountered. The practice of hiring "ships natives" and rewarding them with much-valued trade goods such as guns and whaleboats seriously undermined traditional leadership patterns where the *angatquq* and *isumataaq* shared responsibilities.

In the Western Arctic the whalers' effect was even more disastrous. Whereas the Eastern Arctic whalers forbade, for the most part, the dispensation of alcohol to natives, Western whalers not only encouraged its use

but instructed many in the art of home brew.[1] The result was a period of drunken debauchery unparalleled in northern history.

On top of a scarlet fever epidemic that had made its was up the Mackenzie Valley in 1865, decimating the Delta Inuit, the whalers introduced measles and smallpox in 1900 and 1902 respectively. By 1910, out of an estimated aboriginal population of 2000 Inuit in the Mackenzie Delta area, 130 were left alive (Jenness 1964).

The outcome that this combination of disease and social disruption brought about by physical contact and trade for new technology had on the Inuit population was the creation of a vacuum, in some cases partial and in others absolute. Traditional beliefs in the efficacy of the shaman's powers in protecting people from supernatural wrath were seriously challenged by the widespread disease and death over which the shamans had little influence. New technology that functioned to make hunting considerably easier, and not incidentally, led to serious game depletion and consequent starvation, further undermined traditional belief in the power of supernatural taboos. This secularizing trend was to be even more enhanced with the coming of the fur trade.

3.3.2 Middle Contact Period: The Trading Post

With the collapse of the whaling industry in the late 1800's, two vacuums were created in Arctic Canada. Into these vacuums came the fur

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1. To this day, people in the Central Arctic complain that alcohol problems stem from transient Western Arctic Inuit.

traders and missionaries to fill the economic and spiritual needs of a disrupted people. As Jenness (1964) has so critically demonstrated, the extent of government presence during this period was through R.C.M.P. officers who were sent to protect Canadian sovereignty and administer southern justice to the Inuit. This triumvirate of southern power eventually coalesced around the Hudson's Bay Company fur trade posts.

The fur trade period is characterized by the same boom/bust tendency as other northern ventures. During the 1920's when fox fur pelts were bringing their highest prices, trappers, in the Mackenzie Delta region particuarly, were, in some cases, earning between nine and twenty times the average national wage. The surplus of disposable income resulted in large scale Inuit entrepreneurial activity where sailing vessels were bought for cash and trading posts proliferated, often in competition with one another. However, in the thirties, the depression affected southerners and Inuit alike, and the bottom fell out of the fur market. The result was widespread starvation and destitution. Dependency on the market economy had reached the point in some places where Inuit had forgotten how to hunt in the traditional manner and were totally dependent on store-bought food for subsistence.

However, the fur trade incursion reached different parts of the Arctic at different times. In the Mackenzie Delta region and in the Eastern Arctic along the west coast of Hudson Bay and Ungava, fur trade posts and missions were being established in the first two decades of the 1900's. By 1920, Jenness (1964) argues, Inuit in the western and

eastern Arctic were already well acculturated, with trapping the primary subsistence activity and Christianity replacing their belief system. However in the region from Coronation Gulf to the Boothia Penninsula and on the northern portions of Baffin Island, fur trade posts were not established until the middle twenties. Balikci (1960) has argued that the acculturation affects of the fur trade did not really begin around Pelly Bay until 1920. Thus we have a situation where, at the same point in time, Inuit from the Aklavik region were purchasing their own sailing vessels, and radios and taking vacations to San Fransisco, while their brethren in the central regions were still living in snow houses, heated with seal oil, and appeasing their traditional deities in order to secure food.

Despite these regional disparities, the overall effect of the fur trade and the establishment of permanent trading posts was similar in all areas. Williamson has described the secularizing effect on hunting that the reliance on guns and trapping had. Compared to the symbiotic relationship of hunting to religion in traditional times, during the fur trade era, a "steady diminution in the religiosity attached to hunting" occurred (Williamson 1974:71). A second major impact was on the social organization with the tendency towards nuclear families as the primary productive and consumptive unit with little emphasis on cooperative activities. And Hughes (1966) has succinctly stated perhaps the most serious consequence - concentration of the population around fur trade posts led to the increase in exposure and susceptibility to infectious

diseases that have had such a devastating effect on the Inuit population. Starvation and malnutrition also occurred in areas where trapping for trade was the primary activity. Jenness (1964) cites examples of natives on the west coast of Hudson's Bay subsisting all winter on bannock and tea in areas abundant with caribou and seal because they had no time to hunt, and of trappers found dead of starvation in cabins piled high with fox furs.[1]

Aside from these general effects of the fur trade, the Anglican and Roman Catholic missionaries carried out a direct confrontation with the traditional religious belief system of the Inuit and in particular, with the shaman. Despite the doubt that had been introduced by the secularizing effect of the fur trade and new technology, and the overall apparent ease of conversion to Christian values, the character of the confrontation between priests and shamans is clearly detailed in a fictional work by Raymond de Coccola and Paul King (1973). The book describes a shaman from the Coronation gulf area, where two Roman Catholic priests had been murdered a short time before. The shaman claims the priests were cursed by an *angatquq*. The priest and the shaman begin to compete over the health of a sick child; the shaman entering a trance and providing amulets for protection and the priest administering aspirin. The family of the sick child appear to have faith in both systems of healing. Finally,

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1. Fortunately, the government prohibited the importing of alcohol into the Mackenzie Delta area during the twenties and thirties. If it had not, alcoholism would probably have destroyed the Inuit in that area.

when the child regains its health, both healers take credit for its recovery.

Jenness (1964:26) describes the image that the Inuit held of the missionaries:

> They regarded the missionary's prayers as magic spells, his hymns as incantations similar to those they had chanted in their dance houses during days of stress and hunger, and the command 'Remember the Sabbath day, to keep it holy' as a new taboo.

Williamson (1974) also details the various factors that eased the conversion of Inuit beliefs to Christianity. The syllabic system of writing was of great intellectual curiosity to the Inuit and the Anglicans particularly were voracious readers of the New Testament. Many previous shamans recognized the power of the new religion and rather than compete (although some did) became catechists and lay readers in the new church. The similarities between the new and traditional belief systems also facilitated acceptance:

> For example, both religions include the belief in one, great, life-giving, life-commanding, creative spirit. Both religions contain the concept of the soul, though the Eskimo soul system is more complex, and in some ways more sophisticated. Both religions emphasize the pervasive power of the creative spirit and the relative impotence of the human being. Yet both religions - (as indeed all religions) - also provide for the spiritual manipulation of the elemental powers through the use of prayer, ritual and restraints (Williamson 1974:74-75).

Williamson argues that the missionaries did their greatest damage in their attempts to devalue the name-soul, because to the Inuit it provided

the unifying identity and a sense of society. Balikci (1962) has summarized the ease of conversion from shamanistic to missionary beliefs as the result of two important factors: (1) Missionaries were agents of White society and therefore privy to the awesome power White society evidenced and (2) Missionaries resembled shamans in their spiritual endeavours and were probably more successful at curing than the shamans. Before expanding on this last point, it is worth noting that Williamson (Ibid:77) claims that despite widespread conversion to Christianity, as late as 1970, "nowhere in Keewatin can it be said that shamanism has entirely been eliminated by missionary effort ... they are still called upon in times of sickness, of fear, shortage of game, during prolonged severe and dangerous weather, when major journeys are undertaken, and still not infrequently, in the matter of naming children."

It is no coincidence that the success of the missionaries hinged to a large extent on their administering to the sick. The Canadian government during this period was content to leave matters of education and health in the hands of the two churches. The outline that follows is based primarily on Jenness (1964) with additional material from Williamson (1974) and my own fieldnotes.

When the Roman Catholic and Anglican churches began to establish missions in the early 1900's, the government supplied all missions with medicines. In 1922 the government ships *Arctic* and later the *Beothuk* began to cruise yearly in the Eastern Arctic and a medical officer was put on board to service the outposts. In 1924, this doctor reported that

tuberculosis on Baffin Island was rare but the natives were suffering from severe malnutrition. In that same year the Department of Indian Affairs established a permanent post at Panqnirtung and the resident doctor, L. D. Livingstone, conducted long journeys to Pond Inlet in the north and Lake Harbour in the south, surveying native health. In 1928 the Anglican church built a small hospital in Panqnirtung that was staffed by a doctor and a nurse supported by government subsidy. In 1928 the Roman Catholic mission established a 24 bed hospital in Chesterfield Inlet, again supported by government subsidy.

In the Western Arctic, the Department of Indian Affairs sent a doctor to Herschel Island in 1922. In 1926 the Anglicans opened a hospital in Aklavik, staffed by one doctor. The following year, the Roman Catholics also opened a hospital in Aklavik, competing for patients and overservicing the population. Both were supported by government subsidy. In 1930 the doctor at Aklavik was given a boat with which to visit Inuit as far east as Coronation Gulf.

During this period, the Coppermine area was suffering from widespread influenza and, in 1929, Dr. R. D. Martin was sent to Coppermine to open a small hospital. He left shortly after, complaining of a lack of government support and financing.

Throughout the twenties, both churches competed fiercely for both government subsidy and patient/converts. The federal government was content to allow the missions to carry out their responsibility and indeed government reports from the period gloss over the abject conditions of disease and starvation most people were suffering from.

In the thirties, the policy established in the twenties saw little change other than a belt-tightening as Ottawa reduced the financial subsidy and instituted little welfare aid. This combined with a particularly severe winter of 1934-35 to cause numerous deaths from starvation and influenza. In the Gjoa Haven-Spence Bay region, sixteen people died in one winter. Similar conditions prevailed on Baffin Island and western Hudson's Bay. Despite government reports claiming the contrary, in 1933 conditions were so bad that the government was forced to distribute 10,500 pounds of imported buffalo meat to the Eastern Arctic.

Competition between churches was so severe that a tragedy occurred in the Belcher Islands in 1941 where several people were killed or died of exposure as a result of religious fervour around a messianic cult. In 1939-40 the total government expenditure for health care in the entire Arctic region was $30,000.00, $29,480.00 of which paid the salaries of four doctors, five nurses and their supplies. This paltry sum amounted to seven dollars per head.

As the thirties drew to a close and the Second World War forced administrators to reconsider the strategic importance of the Canadian north, the government finally began to seriously involve itself in northern affairs. The impact of this involvement will be detailed in the next section.

3.3.3 Late Contact Period: Government Involvement

The effects of this period in northern history, with the relocation

of hunting camps into permanent settlements and the widespread introduction of wage labor have been described in detail elsewhere (c.f. Jenness 1964; Hughes 1966; Williamson 1974; Vallee 1962). It is not my intention to review in detail that literature but rather to isolate those factors that bear directly on the treatment of illness and its effects.

In 1944, a revolution occurred in Canada's attitude toward health administration in her northern territory. As a result of a report submitted by Dr. G. J. Wherrett, the federal Department of Health and Welfare was created which was to have responsibility over Inuit and Indian health. Dr. Wherrett's report claimed that 84% of Inuit deaths were unattended by medical personnel and that pulmonary tuberculosis was widespread. The government reaction was to apportion a large budget increase to the newly created department to institute an attack on tuberculosis and the absence of medical facilities.

At the end of the war, several hospitals were turned over to the Department of Health and Welfare, including Charles Camsell Hospital in Edmonton which was to become a referral centre for Inuit from the Mackenzie Delta and the Western Arctic. As well, a new hospital was built in Moose Factory on James Bay for treatment of Eastern Arctic Inuit and the *Nascopie* plied the waters off Baffin Island conducting x-rays and evacuating patients to southern centres. When the *Nascopie* sank a year later, the *C.D. Howe* replaced her and became essentially a hospital ship for the Eastern Arctic, x-raying Inuit when they could be located and evacuating tuberculosis patients south. This same process of evacuation was being carried out in the Western and Central Arctic by aircraft.

In 1947 the Nursing Station program was established, although very few stations were actually built until the sixties and, indeed, many communities did not receive a Station until the early seventies. For example, the Nursing Station at Baker Lake was built in 1955, at Eskimo Point in 1962 and at Gjoa Haven, 1970. The concept of Nursing Stations was based on the rural Health Centres in the Canadian Prairies. The Station provided accommodation and clinical facilities for usually two nurses who provided frontline, continual medical care in their home community and at outlying outposts. A detailed description of this era in the growth of medical facilities will be provided in the next chapter. Suffice it to say here that by 1961, for a population of 11,000 Inuit, health care expenditures had risen to a sum of three million dollars, or approximately $290.00 per head, a significant improvement over the miserly $7.00 per head of two decades earlier.

Throughout this period of expanding medical services, disease continued to devastate various Inuit populations. In 1944, diphtheria killed 48 people in Eskimo Point. In 1945, 45 people died at Cape Dorset from diphtheria. And in 1948-49 a terrifying outbreak of poliomyelitis swept from Churchill north through the Barren Grounds leaving fourteen dead and large numbers crippled (Jenness 1964). The quarantine measures established by government officials to control this outbreak had a lasting effect. Williamson (1974) describes a situation where Inuit in remote areas hid from White contact for years afterward.

In the Mackenzie Delta, which had been already devastated by earlier

influenza epidemics, a measles out-reak in 1949 left fourteen dead. Measles, combined with influenza, swept through Ft. Chimo in 1952 killing ten percent of the population, and influenza alone was responsible for sixteen deaths in Pelly Bay in 1958.

These are only examples of the kind of devastation that was sweeping through Inuit society during this time. The effect of this mortality is significant in two regards. It must always be remembered that when fifteen or so deaths are given for a particular place, the total population is likely to have been no more than one hundred individuals. Thus, every family would probably lose a member, and in an environment where interdependence was crucial, the social effects of this loss led to major realighments within kin networks. The other important feature of this mortality is the fact that these infectious diseases obviously affect older people and infants to a greater extent. Since the older people were the repositories of traditional wisdom and knowledge, vast areas of traditional lore were lost.

During this period as well, tuberculosis patients continued to be evacuated to southern sanatoria until at its peak in 1955, there were 1,356 patients in residence (Jenness 1964:144). Williamson (1974:83) contends that in the Keewatin District, 70% of the total population had spent some time in southern sanatoria for periods ranging from three months to nine years by the year 1964.

There were criticisms of this evacuation policy because of the effect it had on the morale of both the patient and his family, but

medical authorities defended it on the grounds that removal from the northern climate and complete bed rest was essential for rapid recovery. Nevertheless, the result of these evacuations were horrendous. Families had to cope without hunters or mothers for years at a time. Very often patients evacuated never returned. Those who returned had suffered the consequences of rapid acculturation and physical loss and were often unsuited for a return to life on the land.

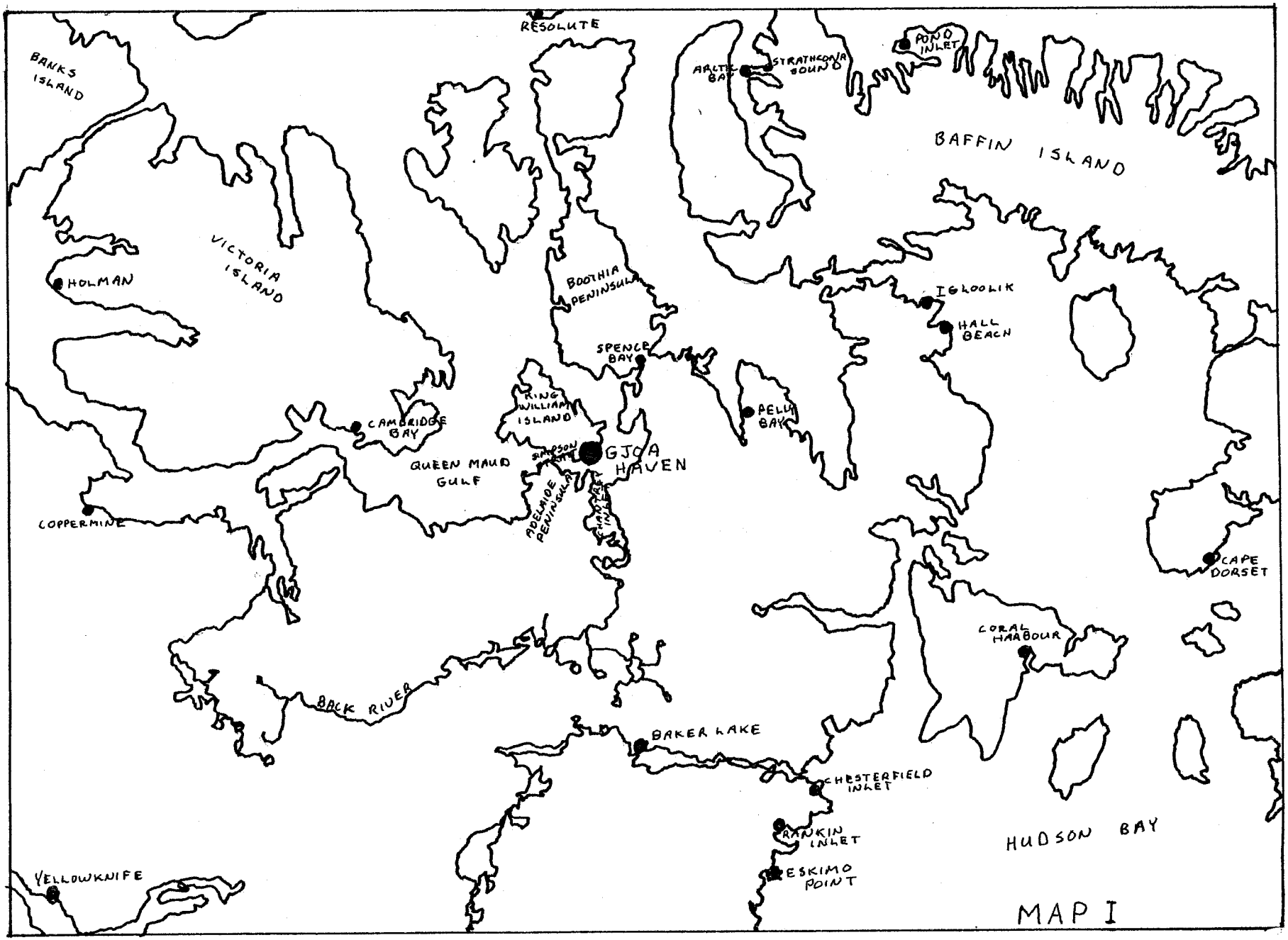
Jenness (1964:87) details the psychological effect that disease had on the Inuit where they totally lost control over their own lifestyle and were forced to watch while their family members were taken from them by the White man's diseases and medical evacuations:

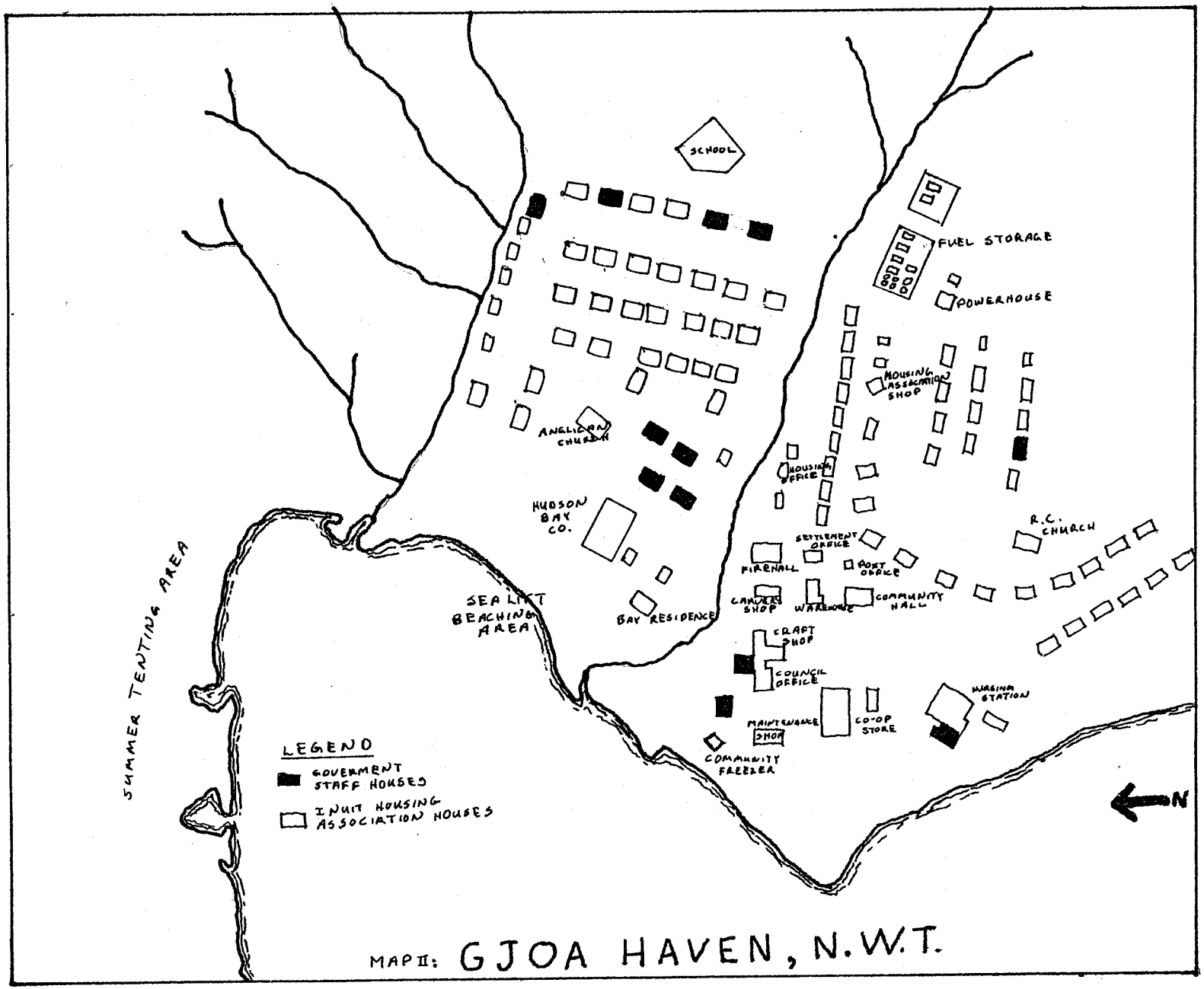
> Tuberculosis, diphtheria, influenza and other diseases of the body we can fight with drugs and surgery, but we have yet to learn how to combat the sickness of the soul which sometimes grips whole tribes or groups of people when crushed by misfortunes from which they see no issue.

In summary then, what Williamson (1979:137) has called the "dreadful decades" were traumatic because of the impact of disease on Inuit populations. The move to government administered settlements and the growing dependency on welfare and other government services were not so much stimulated by the motivation for wage labour or a more comfortable standard of living but were, instead, strongly influenced by the fragmentation and numbing effect that endemic and epidemic disease wrought.

It is little wonder that with traders, missionaries and medical personnel looking after the economic, spiritual and physical welfare of

his people when his own peers were useless in the face of the overwhelming impact of White civilization, the *angatquq* or shaman's role became attenuated.

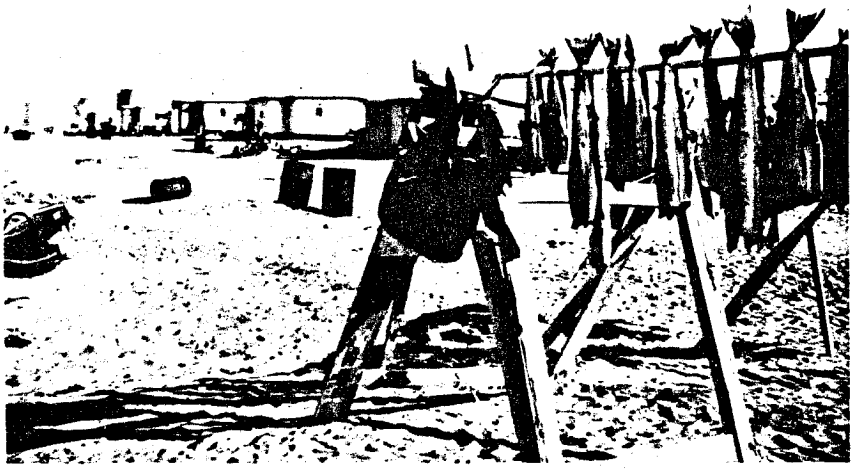

RESOLUTE
BANKS ISLAND
ARCTIC BAY
STRATHCONA SOUND
POND INLET
BAFFIN ISLAND
VICTORIA ISLAND
HOLMAN
BOOTHIA PENINSULA
IGLOOLIK
HALL BEACH
SPENCE BAY
KING WILLIAM ISLAND
CAMBRIDGE BAY
PELLY BAY
GJOA HAVEN
QUEEN MAUD GULF
ADELAIDE PENINSULA
COPPERMINE
CAPE DORSET
CORAL HARBOUR
BACK RIVER
BAKER LAKE
CHESTERFIELD INLET
RANKIN INLET
HUDSON BAY
ESKIMO POINT
YELLOWKNIFE
MAP I



MAP II: GJOA HAVEN, N.W.T.

Gjoa Haven from a distance showing summer camping area in foreground.

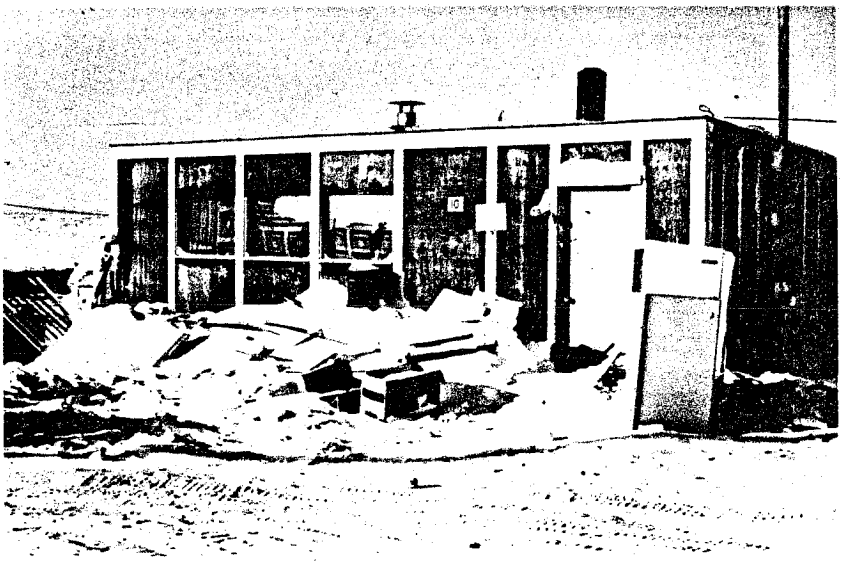
The Nursing Station showing clinical area. Residence is adjoining, of equal size and located to the right.



Gjoa Haven in summer showing
older houses and drying
Arctic Char.

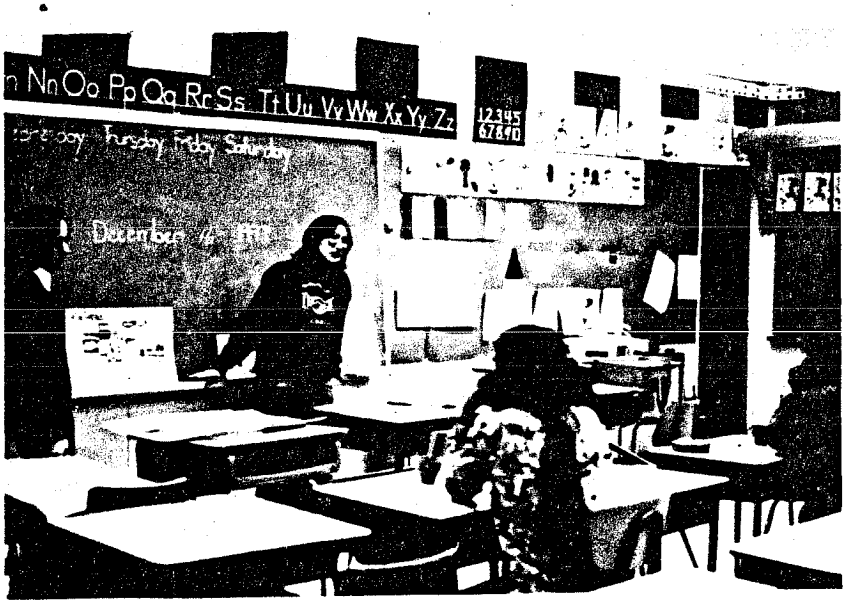
Summer camping area showing
garbage problem in foreground
because municipal services were
confined to settlement limits.

The anthropologist having "lunch" with his adopted family.



A typical "matchbox" house in which the anthropologist lived.

A scene from a medical evacuation of a patient to Yellowknife.



A nurse and the community health representative conducting a class in nutrition with the women in Adult Education.

A typical scene of young
children on their way home
from The Bay, loaded down
with pop and candy.

Chopping ice for tea.
An example of the importance
attached to the taste of water.

4. CONTEXT OF HEALTH CARE: THE ENVIRONMENT

4.1 The Community

4.1.1 Setting

Situated at 68°38' north latitude and 95°53' west longitude on the southeast coast of King William Island (see accompanying map), Gjoa Haven occupies a central location in the Canadian Arctic. The relative isolation of Gjoa Haven from its neighbouring communities is significant in several respects. Historically, the present inhabitants were remote from the foreign incursions in the Eastern and Western Arctic. And contemporaneously, Gjoa Haven is situated at a considerable distance from its primary supply centres. Government service and administration is located in Cambridge Bay, a distance of 225 air miles west, and Yellowknife functions as the major acute-care referral centre, at a distance of approximately 775 air miles southwest.

The settlement is situated on a sandy beach at the head of an inlet. The inlet is approximately a half mile long and 800 yards wide at its head, and provides a natural harbour for supply barges in the summer. The terrain is typically flat and barren with low rolling hills rising occasionally to a height of 150 feet.

The townsite is characterized by a sandy foundation, at times reaching a depth of over 50 feet, which causes considerable problems in the spring and summer when its looseness makes walking or motor

transportation extremely difficult. There are two major ravines that dissect the settlement, a smaller one (10 to 15 feet deep) that divides the community in half and a larger one (up to 40 feet deep with sides at a slope of 45°) which impedes settlement expansion in a northerly direction along the beach area at the head of the inlet.

The climate for Gjoa Haven is typical of the Arctic Island region. The mean daily January temperature is -35°c and the mean daily July temperature is +7.5°c. June, July and August are the only months when the mean daily temperature is above freezing. Annual precipitation is about 5 inches with 2.7 inches of rainfall in the summer months and up to 25 inches of snowfall from September to May, with the greatest amount of 5.5 inches falling in October. August and September are considered the stormiest months.

King William Island is relatively devoid of land animals, providing only a supply of fish in the summer and fall when nets are set along its coast and under the ice in nearby lakes respectively, to capture migrating Arctic char. Caribou is hunted on the mainland immediately south of the settlement at distances ranging from fifty to one hundred and fifty kilometres. From approximately the end of July until the end of September, the channel of water in between is open and ice-free and must be crossed in small open boats. The remainder of the year it is ice-covered.

Musk-oxen are occasionally hunted to the southwest of the island on the mainland bordering the Queen Maud Gulf and polar bear are periodically taken on the northern and western portions of the island itself in

winter. Both of these animals are, however, subject to restricted quotas and do not contribute significantly to the diet.

Compared to other areas in the Arctic, sea mammal life is insignificant to Gjoa Haven hunters. Seal is hunted during the spring and summer in the straits and channels surrounding the island but is only plentiful at considerable distances to the west and northeast. Walrus and whale are, of course, absent from the region.

Fox trapping is carried out everywhere, with some traplines located only a few kilometers from the settlement but again, the richest fur harvest comes from the mainland area to the south, particularly on the Adelaide peninsula and in the southern reaches of Chantrey Inlet.

4.1.2 Historical Background

Gjoa Haven received its name from the ship of the Norwegian explorer, Raould Amundsen, who wintered in its natural harbor in 1904 while en route through the Northwest passage. However, it wasn't considered a settlement until 1927 when the Hudson's Bay Company established a trading post there to utilize the harbour.

Prior to contact with Europeans, there is some debate as to which Inuit dialectical sub-group occupied the King William Island area. Boas (1964) argues that the Ugjulik who primarily occupied the Adelaide Peninsula also occupied the southern and western portions of King William Island as part of their territory.[1] The eastern and northern portions

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1. The proper name for Inuit dialectical sub-groups includes a suffix "miut" which means "the people of" (i.e. Ugjulirmiut). For purposes of clarity and ease of reading the proper names will be abbreviated in this account.

were occasionally frequented by Netsilik from the Boothia Peninsula. Briggs (1970) cites various explorers' references to suggest that the Utku who in more recent times were confined to the regions around the mouth of Back's River, once inhabited the entire area including Adelaide Peninsula and King William Island. Apparently, a war-like band of Netsilik drove them out of the Adelaide region and the desire for guns from Baker Lake and a famine around the turn of the century led them to abandon coastal areas and move inland to the Back's River area. At any rate, it is the remnants of these three groups, with a few displaced persons from inland tribes and western areas that now occupy the settlement at Gjoa Haven.

The first real contact with Europeans in this region occurred first among the Netsilik of the Boothia Peninsula in 1930 when the Ross expedition reached Lord Mayor Bay on the eastern end of the Boothia Isthmus. As a result of this contact, the Netsilik acquired an assortment of steel knives, sewing needles and nails.

Several years later, in 1933, George Back travelled up the river that now bears his name and established contact with a number of Utku groups including those living right at the mough.

However, the most significant European impact on the area did not occur until Franklin's expedition in search of the Northwest passage foundered on the northwestern coast of King William Island in 1848. The ships were abandoned and survivors attempted to walk out to safety in the south, only to perish in the Adelaide Peninsula area. The enormous wealth

of wood and steel implements associated with the abandoned ships was probably responsible for the dramatic territorial expansion of the Netsilik to include King William Island and Adelaide Peninsula.

The next two or three decades brought about extensive contact between Inuit throughout the area and various explorers in search of Franklin's remains. The overland expeditions of Anderson in 1955 and Schwatka in 1879, combined with the sea voyages of McClintock in 1859, Hall in 1861 and Gilder in 1881, although unsuccessful in locating any survivors of the Franklin party, succeeded in establishing widespread contact and trade. The process of secularization and disruption described generally for the Arctic in an earlier chapter was begun.

As mentioned at the outset of this section, Amundsen's stay in Gjoa Haven in 1904 also resulted in some contact with local natives and trade. For the next twenty years, Europeans were absent from the region until 1923 when Rasmussen visited the area in order to collect ethnographic information as part of the Fifth Thule Expedition. Interestingly, Rasmussen's impressions of the Netsilik as compared to the Utku were vastly different. Whereas the Netsilik appeared to him as rather an unruly, aggressive and unhealthy group, he describes the Utku as: "the handsomest and most hospitable as well as the most cultured people of all those I met with throughout the whole length of my journey; and the cleanest and most contented to boot" (1933:198).

In that same year, the Hudson's Bay Company established a trading post on King William Island in the area known as Simpson Strait. According

to an elderly informant, the Federal government ordered them to relocate the post to Gjoa Haven in 1927 because, apparently, activity around the trading post was disturbing traditional caribou migration from the mainland to the island.

Briggs (1970) also reports that a famine in 1927 destroyed many of the inland Inuit whose territory bordered on the Utku, resulting in the survivors migrating to join the Utku and the Qaiqniq further south around Baker Lake. Consequently, the Utku expanded their territory in later years into this vacated area until a series of famines between 1949 and 1958 resulted in the final abandonment of inland camps and concentration of the survivors in the Chantrey Inlet area and to settlements in Baker Lake and along the Hudson Bay coast.

The Hudson's Bay Post, established in 1927 in Gjoa Haven, led to frequent trading visits from Inuit groups on the mainland opposite so that in 1929, when the Ft. James visited the harbor while exploring the Northwest passage, there was extensive contact between the group of converted Anglican Inuit from Baffin Island who were on board the Ft. James, and a number of local Inuit. According to several informants, these Pond Inlet Anglicans attempted to convince local Inuit that shamans were agents of the devil and that Christianity should replace their religious beliefs.

Aside from this brief contact however, further contact with Whites was negligible for the next two decades. The Hudson's Bay Company replaced its first White traders with George Porter in 1941. George Porter was the son of a Scottish whaler and an Alaskan Inuit mother who had been

managing the Canalaska trading post in Gjoa Haven from 1927 until 1939 when it closed. Married to a Netsilik woman and fluent in Inuktitut and the local culture, George Porter remained the post manager until 1967 when he retired after twenty-five years of service.

The only contact with R.C.M.P. during this period was in 1941-42 when Sgt. Larsen visited the post by ship. He apparently employed several local Inuit from the area to accompany him on sledge journeys to Pelly Bay and up the Boothia Peninsula.

In 1948, the first doctor flew into Gjoa Haven to conduct chest x-rays for tuberculosis. Unfortunately, he also brought with him an influenza virus that was responsible for as many as seventeen deaths among families who had been in contact with the settlement. George Porter stated that the Hudson's Bay Post in Gjoa Haven was not stocked with penicillin and consequently, there was nothing that could be done for sufferers.

Briggs (1970) reports that people on the mainland were subjected to another famine in the following year. Also, in 1949, a R.C.M.P. post was established in Spence Bay and in 1950, Father Henry built the first Roman Catholic mission in Spence Bay. Five years later, the Reverend Donald Whitbread sledded to Spence Bay from Pond Inlet and established the Anglican mission. Whitebread was fluent in Inuktitut and according to Williamson (personal communication), waged a zealous war against shamans in the entire area. He travelled frequently to Gjoa Haven and further into the Back River area looking for converts. It should be noted that at this point in Gjoa Haven's history there were very few Inuit permanently

settled around the trading post. Most still hunted and trapped in various locations on the mainland opposite.

In 1956, Father Henry established a Roman Catholic mission in Gjoa Haven and remained in the settlement. According to a number of informants, he devoted himself to caring for the sick and the orphaned that were resulting from a number of influenza and measles outbreaks during the fifties. In 1958, the last major famine occurred in the Back River region, resulting in the permanent displacement of some families to settlements such as Gjoa Haven, Baker Lake and on the Hudson Bay coast. Indeed, the establishment of the missions and the impact of disease marked the beginning of the in-migration of Inuit to Gjoa Haven as permanent settlers.

In 1959, Whitbread built the Anglican mission in Gjoa Haven and recruited a young Inuk, originally from Cape Dorset where he had been ordained as an Anglican minister, to administer the new mission. This Anglican minister was particularly energetic in attempting to convert natives from the Back River and Adelaide Peninsula regions, and encouraged people from both areas to resettle in Gjoa Haven. Interestingly, there was a suggestion by some informants that this individual had been a practicing *angatquq* before his conversion to Christianity. He remained the Anglican minister in Gjoa Haven until 1975 when certain adulterous behaviour leading to his marriage break-up, resulted in his leaving the Church and returning to a hunting and trapping existence in the Chantrey Inlet.

Throughout the late fifties and early sixties, a number of people

were evacuated from Gjoa Haven for tuberculosis treatment in southern sanatoria. Although it was difficult to obtain accurate statistical data on the number of people evacuated, informants seemed to indicate that very few families escaped this trauma.

The first permanent cosmopolitan medical presence in the area came in 1962 with the building of the Nursing Station in Spence Bay. Local lay dispensers were trained to administer to the needs of Inuit in Gjoa Haven, Pelly Bay and Thom Bay under the supervision of the nurses in Spence Bay.

The first lay dispenser in Gjoa Haven was the son of George Porter, the Hudson's Bay manager. Apparently, he wasn't particularly interested in the job and left it to take a heavy equipment operator's course. The next young man held the position for several years until the Gjoa Haven Nursing Station was built and provided a fairly extensive description of the problems he faced.

Many people believed that all drugs were the same and demanded the same drug for various illnesses. They would become quite angry with him when he refused on the grounds that it was dangerous. He had received two months of training in Inuvik in basic diagnostic and treatment skills and many people apparently assumed he had the same skill as doctors and nurses. Although he was being paid on the basis of a ten hour week ($115.00 per month), he was expected to treat people at all hours of the day and night. He claimed that even ten years later there were still individuals in town who bore animosity towards him because they felt he had failed to treat them properly.

During the sixties, Father Gressard had replaced Father Henry as the Roman Catholic missionary and in the process, provided medical services to many people. The elementary school was built in 1963, resulting in a substantial number of households resettling themselves on a year round basis in Gjoa Haven. From this point on, only isolated family groups remained in camp with the major portion of the regional population now permanently located in Gjoa Haven. Although some of these households were Anglican converts, everyone apparently went to Father Gressard to help when sick. With the establishment of the Northern Rental Housing Program in 1965, Gjoa Haven began to rapidly increase in permanent population and pressure was exerted to replace lay dispenser's and the Catholic mission's medical aid with a Nursing Station. The first Settlement Council in 1968 established as a priority, the aquiration of a Nursing Station and it was finally constructed in 1970. According to one of the original members of the Council, people began to realize that only nurses had the power to handle medicines and most recognized the effectiveness of medicines.

It was extremely difficult to gather any evidence of shamanistic activity during this period because of informants' reticence. By and large, I doubt very much whether, inside the settlement at least, much activity was occurring. However, I was informed that on one occasion in 1970, a young man who has since become highly acculturated to cosmopolitan medical values, was the patient in a *krilaq*. It was diagnosed by the *angatquq* that the aggressive and inappropriate action of this young man's father had caused his illness. When this action was publically acknowledged, the young man regained his health.

After the Nursing Station was built there was a succession of nurses that individually had an impact on the Inuit in the settlement. Informants recalled that all together there had been eleven nurses in nine years. Three had stayed only six months, four remained for a year, one lasted eighteen months, one for two years and one for three years, for a total of thirteen man years. Evidently the Nursing Station has been markedly understaffed for a considerable portion of the time and the turnover rate has been typically high. However, throughout the history of the Nursing Station, there was one man employed as a translater and to perform janitorial duties and thus provided continuity from one nurse to another. That this individual has also been a member of the Settlement Council and indeed its Chairman for the last several years is by no means an insignificant fact. His influence on the attitude of the local Inuit towards the health care facility has been substantial.

The first nurses in Gjoa Haven established a pattern of availability that has persisted until the present. Informants stated that the second nurse to be stationed in Gjoa Haven used the living room in the Nursing Station as a dormitory for children and encouraged them to eat and sleep there. Apparently, she also worked around the clock and expected her staff to do likewise, a situation that led to considerable strain for the janitor-interpreter. The pattern of using the Nursing Station as a type of community centre continued through several more nurses until 1975 when the first attempts were made to confine clinic hours to specified times and to regulate visits. The Station also has a history of fairly abrupt

departures by nurses after relatively short tours of duty. There was several instances of nurses simply abandoning their jobs overnight after only a few months' stay.

One incident occurred just prior to my arrival in Gjoa Haven that requires mentioning here and will be discussed more fully later. A nurse, who was resident prior to the arrival of the nurse-in-charge during my fieldwork, had a reputation for encouraging extensive social contact with all segments of the local Inuit population. She not only agreed with the open-door policy established by earlier nurses, but actively encouraged it. The new nurse-in-charge had been instructed by her supervisors to attempt to establish regular clinic hours and reduce the perceived over-utilization of the facility. A consequent clash developed between the two nurses resulting in the nurse-in-charge's threatened resignation and the ultimate transfer and eventual dismissal of the previous nurse.

An attempt was made in 1976 to increase local participation in the delivery of health care through the establishment of a Health Committee and the training of a Community Health Representative (C.H.R.). It is interesting to note that when a young woman was selected for the C.H.R.'s position there were several people in town who had had previous cosmopolitan health care experience either as lay dispensers, or as C.H.R.'s in other communities. These people were not interested in the job because it paid so little money.

Finally, it should be briefly mentioned in this section that by

1974, all remaining camp groups had permanently resettled into government houses in the settlement and by 1977, snow machines had totally replaced the dog teams as the method of winter transportation.

4.1.3 Facilities and Services

By the end of the fieldwork period there were seventy-seven detached, single family, public housing units, and ten government staff houses. The average occupancy rate for the public housing units was 5.6 people per dwelling, but this figure is not particularly indicative of the degree of overcrowding.

The public housing can be sub-divided into four separate categories that more accurately describe the quality of housing conditions in Gjoa Haven. There were twenty houses built since 1975 of superior quality with running water and sewage pump-out tanks. These houses were large, well-finished and sanitary, and out of the total housing stock represent the only units that could be described as meeting basic public health or national average housing standards. The second group consisted of sixteen houses built between 1973 and 1974 that, although without running water or sewage, were large (3 bedroom) and reasonably well-finished. With the addition of adequate sanitation facilities, they would be satisfactory housing units. The third and largest category of houses consisted of twenty-eight 3-bedroom units constructed between 1968 and 1971. Running water and sewage pump-out tanks were absent from these units as well, and they ranged in quality from decrepit to barely adequate. Small in size,

drafty and poorly finished, they provided the basic necessities of shelter. Without major rehabilitation they are unfit for human habitation. The final category consists of thirteen one-room rectangular, flat-roofed structures built before 1968 and known critically as "match-boxes."[1] Fortunately, these "health hazards" are in the process of being written off and converted into warehouses.

Public housing units are rented from the Territorial government and are managed by a locally elected Housing Association. Rents vary according to income, but range from a minimum of twenty-eight dollars a month to a maximum of two hundred and five dollars a month, including all utilities. This represents a substantial government subsidy as the economic cost of some of the larger units would be in the range of six to eight hundred dollars a month.

The Housing Association is also responsible for maintenance of the units and has a full-time staff of three trained men to fulfill this task. The management has been improved recently through a training program where a community development specialist was hired to work with the Secretary-Manager and Board of Directors. As a result, significant improvements in housing quality are expected to occur in the future.

Garbage collection and sewage disposal are now the responsibility of the Settlement Council. Sewage disposal requires two systems; honey-bag collection and pump-out of holding tanks. Honey-bag collection involves

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1. The applicable terminology derived from the position of an oil stove beside the only exit from the dwelling.

the pick-up of heavy-duty plastic bags containing human waste deposited in front of each house as they are filled. Climate and human activity combine to physically abuse the plastic containers resulting in the frequent spillage of contents onto the ground. The holding tanks in the newer houses, Nursing Station and school are pumped out frequently by a wheeled truck. Although beset with engineering difficulties, this system is far more sanitary than the honey-bags. Both honey-bags and pumped-out sewage are deposited in a small lake reserved for the purpose, and located several kilometers from town.

Garbage is collected once or twice a week by dumptruck from forty-five gallon drums in front of each house and is deposited in a dump northeast of town. Careless dumping has led to serious environmental damage and unsanitary conditions.

Water is delivered to one hundred and fifty gallon holding tanks located in each house by a wheeled truck as need demands. A road extending to a nearby lake facilitates this process. Presently, plans have been proposed to build a pumping station and pipeline from the lake to the centre of the settlement.

Likewise, fuel oil is delivered by tracked vehicle from the large storage tanks replenished by barge each year, to each house on a need basis.

Road and airstrip maintenance and snow removal are again Council's responsibility and are facilitated by the use of a bulldozer, grader, front-end loader, and dumptruck. Frequent breakdown of these vehicles as

well as those mentioned above result in periodic discontinuity of service in all areas.

Commercial outlets in the settlement include the Kerkertak Co-op Store, the Hudson's Bay Company Store, an independently run hotel and restaurant, and a government funded Craft Shop.

Recreation activities primarily take place in the Community Centre, an old quonset hut with a capacity of one hundred people. The building was relocated to Gjoa Haven from an abandoned DEW line site and provides space for movies, dances, bingos and meetings. It is normally in use every night of the week. As well, the hotel has a collection of pinball machines and has begun to show movies and thus, provides alternative recreational activities, although its use primarily by teenagers has earned it a reputation as a problem area among older people. The school gymnasium is used in the evenings for sports activities such as volleyball and basketball, and the video-tape television system at the Nursing Station is an attraction especially for children, because as yet there is no television or radio in the settlement.

The Kerkertak Illihavik (Island School), with a staff of seven, provides primary education from kindergarten to grade nine theoretically, although few students progress beyond grade seven. There is also an Adult Education Centre where upgrading skills are taught by an Inuk woman as far as grade six.

There are two churches, Anglican and Roman Catholic, administered by local lay preachers and a catechist respectively. Recently, Pentecostalism has gained a foothold among some members of the Anglican faith.

Gjoa Haven does not have a permanent R.C.M.P. post, but is administered from a two-man post in Spence Bay. Infrequent visits usually coincide with particular needs such as crisis situations or emergencies. Until alcohol was prohibited in February, 1978, many people were demanding the territorial government place an R.C.M.P. officer permanently in the settlement.

Finally, health care is provided by two nurses and a community health worker through a government funded Nursing Station. This facility will be described in detail in a later section.

4.1.4 Demographic Trends

Gjoa Haven is a settlement of approximately 440 people. The age and sex characteristics of the population are provided in Figure No. 1. The graph depicts the typical northern community where sixty-four percent of the total population is under the age of twenty and indeed, thirty-nine percent is under the age of ten!

The present population is a characteristic example of the dramatic rise in population in the Northwest Territories. It reflects a rise from 276 in 1971, 162 in 1966 and 98 in 1961; percentage increases of 58, 169 and 345 respectively.[1] While fertility, morbidity and mortality statistics were unavailable for Gjoa Haven particularly, the same general trends that characterize the Canadian Inuit population as a whole are also

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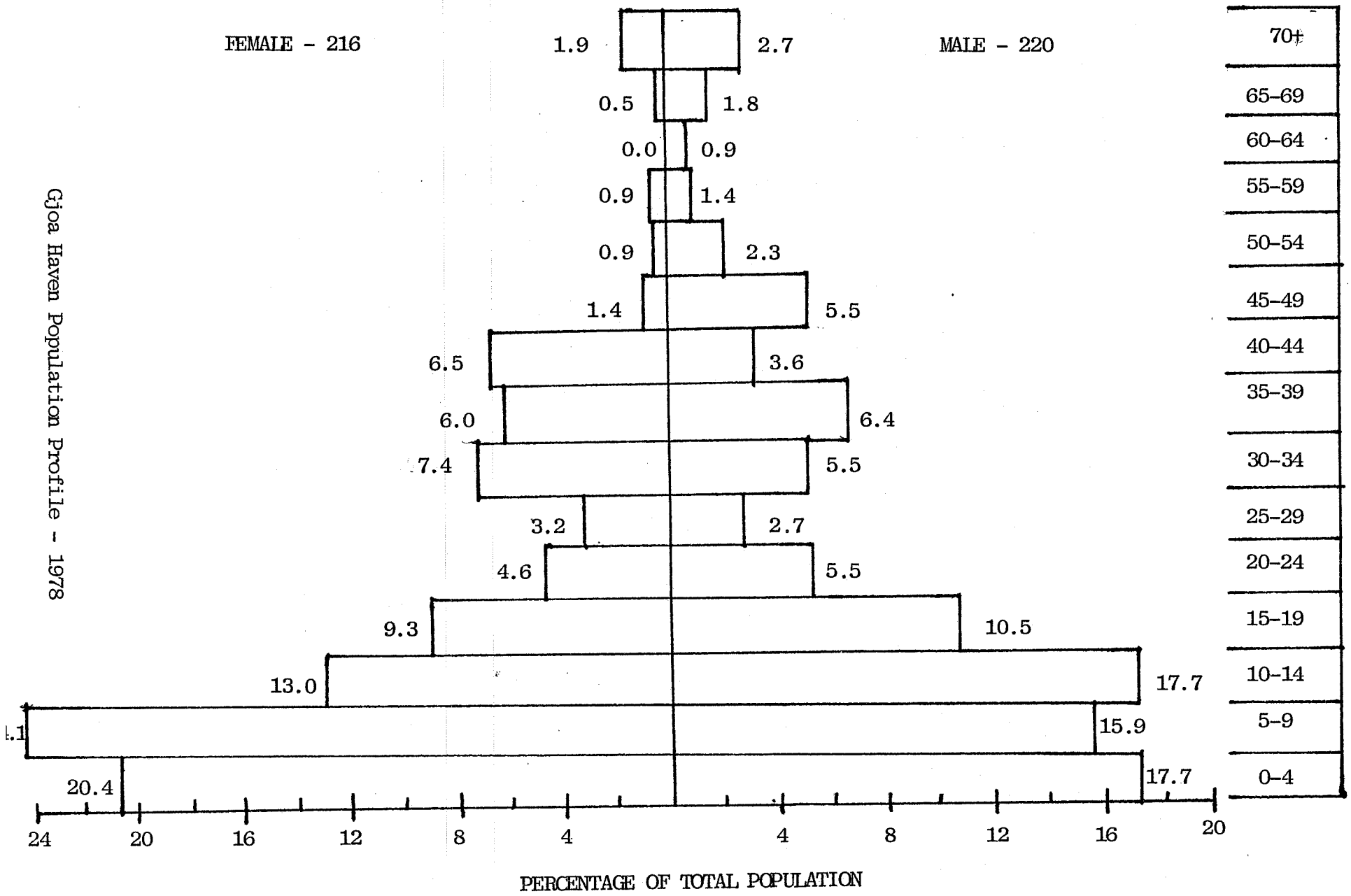
1. Source: Census Division, Statistics Canada. (Unpublished data).



Gjoa Haven Population Profile - 1978

Figure No. 1

applicable to Gjoa Haven. Indeed, the sample size for Gjoa Haven alone would make a statistical profile unreliable.

The livebirth rates for Inuit in 1976 were 36.1 per thousand, a decrease from 54.4 per thousand in 1966. The infant mortality rate per thousand livebirths was 40.1 in 1976, down considerably from 1974 when it was 70.7 and down dramatically from 1966 when it was 109.4. By comparison, the national average infant mortality rate in 1974 was 15.0.[1]

The crude death rate for Inuit in 1976 was 7.1 per thousand population. Again, the rate in the Mackenzie Zone is significantly higher at 14.0 per thousand population. By comparison, the average Inuit crude death rate was higher at 8.89 per thousand population in 1972 but lower at 6.7 per thousand population in 1974. In the same year, the Canadian national average crude death rate was 7.4 per thousand population. The similarity between national and Inuit crude death rates does not necessarily suggest improved health conditions in the North, but rather is a reflection of the abnormal proportion of young people in the Inuit population curve. Mortality figures in the N.W.T., still emphasize violence-related accidents, injuries and suicide as the leading causes of death. Interestingly, cardiovascular disease, malignant neoplasms and pneumonia have gained supremacy over diseases of infancy as causes of death.

Morbidity rates as well continue to be higher amongst Inuit than

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1. It should be noted that the Inuit infant mortality rate in the MacKenzie Zone was 66.6 in 1976, significantly higher than for the Inuit population as a whole.

than for the Canadian national average, despite recent improvements in most areas. The reported N.W.T. rate for gonorrhea in 1976 was 3,928 cases per hundred thousand population compared to a national average of 222 per hundred thousand. New or reactivated cases of pulmonary tuberculosis are significantly lower than in previous years but are still uncomfortably high. A rate of 137.8 per hundred thousand population for Inuit in 1976 compares to the national average of 30 per hundred thousand. Communicable diseases have been brought pretty much under control but are still subject to occasional erratic and dramatic outbreaks.[1]

To summarize, the above data indicate that while major advances have been made in improving health conditions for the Inuit, they still vary significantly from the Canadian national average. The data also indicate that within the Inuit population, health conditions are poorest in the Mackenzie Zone which includes Gjoa Haven. Subjective statements from nurses and administrators support this view that Gjoa Haven morbidity and mortality is somewhat higher than in other Inuit settlements.

4.1.5 Social, Political and Economic Organization

Essentially, Gjoa Haven is organized around eight large extended families and four smaller extended families. Of the eight larger families, three are from the Chantrey Inlet or Back's River area, two are from the Adelaide Peninsula region, two are from the Boothia Peninsula and one is from the western portion of the Queen Maud Gulf. Of the four smaller extended families, two are from the Back's River area, one is

1. Source - Report on Health Conditions in the Northwest Territories - 1974
- Report on Health Conditions in the Northwest Territories - 1976

from the Queen Maud Gulf region and one is from the area around Pelly Bay. It would be misleading to suggest that these families represent distinct units or cohesive economic entities because "the dreadful decades" described earlier have resulted in extensive remarriage and adoption or "compositization."[1] Consequently, boundaries between families are illusory and difficult to detect in many cases.

There is little evidence in Gjoa Haven of the Kabloonamiut-Nunamiut split or a trend towards class stratification of the sort described elsewhere in the literature (c.f. Vallee 1966). In fact, the situation is more akin to that described by Brody (1975) where everyone is very involved and dependent upon settlement life but retains a sense of *"inummariit"* or the desire to be real Eskimos. The result is that the most politically involved and successful wage earner can also pride himself on his hunting and trapping abilities.

There is, however, an emerging stratification along economic lines. Status, prestige and influence accrue primarily to those individuals or families that are best able to combine a wage earning livelihood with hunting and trapping activities, particularly with regards to middle-aged men. Older men, who rely primarily on welfare and engage principally in land-oriented activities, still command respect for their traditional skills. However, the contemporary hunting and trapping orientation requires

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1. "Composition" here refers to the process whereby extended families and bands regrouped for pragmatic reasons rather than according to kinship principles, in response to drastic population reduction resulting from famine and illness.

a considerable financial investment for equipment, gasoline and ammunition. Consequently, in order to be a good hunter and trapper, one must also be an effective wage earner. The effect of this process has been to create an incipient three class system.[1]

Those families who are unable to secure the necessary financial resources to be successful hunters and trappers form one group and consist of approximately fifteen households. They find themselves entirely dependent on welfare for subsistence and are forced to rely on store food because welfare assistance is insufficient to finance land activities. A second group, although wealthier financially, is in the Inuit social system ranked on a par with the first group. This group consists of ten households who have abandoned completely a land-oriented way of life in favour of full-time wage earning and continual residence in the settlement. They are, by and large, uninfluential in settlement affairs although Whites occasionally mistake their affluence as evidence of local influence. The third, and by far the largest group consists of approximately thirty-four households who, to a greater or lesser degree, effectively combine both land-oriented and wage earning activities. Although some may never spend that much time actually hunting or trapping because of the demands of their jobs, their skills and commitment to hunting and trapping are never in question.

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1. "Class" is used here to refer to fluid and emerging, vertically ordered groups with differential access to status and wealth that may or may not be recognized by the members of those groups.

There are of course, intervening variables that affect the classification suggested above such as religious involvement, educational training, kin relationships, and disease histories, and it should not be suggested that there are clear and distinct boundaries around these classes. Age and sex factors are influential as well. However, these emerging class differences do affect such things as diet, housing conditions, morale and physical activity, and, consequently should be recognized by health workers in their understanding of health levels in the community.

The community is fairly equally divided between the Anglican and the Roman Catholic churches with a slight emphasis on the Anglican church. Membership seems partially determined by ethnic origin and kinship factors. Some Back's River people, and people from the Adelaide Peninsula and Queen Maud Gulf regions for the most part attend the Anglican church and other Back's River families and the Netsilik extended families make up the Roman Catholic parish.

Both churches are administered by local lay preachers and catechists. The Anglican church had an Inuk reverend for the past decade but recently, personal difficulties led to his resignation and the church is presently overseen by a coterie of lay preachers who share responsibilities. The Catholic church has only recently been in the hands of an Inuk catechist and was previously the responsibility of a succession of usually Belgiun or French priests.

In the present context there does not appear to be any significant friction between the two faiths, although there is evidence that friction

once affected the settlement. The town is equally divided by the ravine mentioned earlier and until the early seventies, it appears the ravine was also a barrier between Anglican and Roman Catholic segments of the settlement. The respective missions are located on opposing sides of the ravine and when government housing has introduced to the area, construction was organized so that clusters of houses grew up around each mission, reserved for members of the associated faiths only. There is also evidence that the Anglicans possess a certain chauvinism towards the Catholics, which they express in terms of a more rigorous attendence and adherence to religious taboos such as refusing to hunt or travel on Sundays. Indeed, the Anglican church generally exerts greater influence over the moral and social life of its members. The temperance movement during my fieldwork was to a large extent the result of Anglican initiative.[1]

Administratively, Gjoa Haven has settlement status and consequently is administered by a locally-elected Settlement Council with responsibility over most municipal activities such as land allocation, garbage and sewage removal, water delivery and seasonal employment opportunities. They are, however, responsible to the Department of Local Government who allocate their budgets and oversee their activities. Unfortunately, their responsibility reflects local government's terms of reference rather than local priorities because such matters as health care, social welfare, housing, education and land claims are under the jurisdiction of various

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1. The "temperance movement" involved the prohibition of alcohol from the settlement and will be discussed more fully on p. 184.

territorial and federal departments and agencies and, consequently, have assorted other locally-elected bodies to represent their interests at the settlement level. This vertical integration of the local-level administrative structure is the source of much conflict and tension because cooperation between agencies and departments is very often dependent on the personality and whims of the White administrators rather than structurally a part of the system. However, there has been a recent trend for Council to involve themselves in matters of more general concern such as alcohol problems and appointment of committees to look into local complaints about welfare assistance, etc.

Election to the Council and other responsible associations such as the Education Committee, the Co-op Committee, the Hunters and Trappers Association, the Housing Association and the Land Claims Committee is based on a number of interrelated factors. Since the Council is the most important among settlement political associations, its members are elected primarily on the basis of their leadership qualities. Consequently, the same individuals tend to be re-elected with occasional variation. The religious leaders are always elected. The remainder of the Council is made up of mostly men and the occasional woman from their mid-thirties to late fifties. Education or command of English is a factor, but not a dominating one. All meetings take place in Inuktitut and translators are required for White visitors. However, an understanding of the complexities and machinations of government bureaucracies is required and very often this understanding is facilitated by a command of English.

Generally speaking, those elected reflect a combination of traditionalistic leadership qualities with an ability to understand and interpret the vagueness of government activities.

The other committees and associations are made up of people elected for family representation and occasionally because they bring special skills to the job. Since the various committees very often influence the allocation of scarce resources such as seasonal wage labour, part-time jobs, houses, etc., it is essential that each extended family is represented on all committees. As well, special skills like carpentry for the Housing Association or intensive interaction with the Nursing Station for the Health Committee determine candidates. Usually the most successful hunters and trappers form the Hunters and Trappers Association. Very few people under the age of thirty are ever elected to political functions with the single exception of the Recreation Committee because of its involvement in school sports, dances and movies.

As described above, the majority of families combine wage earnings and hunting and trapping as their principle economic adaptation. In strictly monetary terms, wages derived from full or part-time employment, craft production and government subsidy (i.e. family allowance, old age pension, unemployment insurance and welfare) make up the bulk of the economic productive capacity of any household. However, if measured in alternate dimensions such as emotional commitment, physical and intellectual energy expended, time invested, or contribution to the daily diet, land activities such as hunting, trapping and fishing are significantly important to the overall economy of both households and the settlement.

Sharing patterns have, typically, been disrupted by the shift in economic emphasis to wage earning, but the characteristic description of an absence of sharing in the industrial sector as opposed to traditional sharing of land-derived products is not representative of Gjoa Haven. Sharing occurs in both sectors on an informal basis. The traditionally structured sharing relationships such as the seal-sharing partnerships have for the most part disappeared to be replaced by an informal redistribution of game among kin members and especially to older people who are unable to hunt. Sharing is by no means reciprocally balanced and the better hunters tend to supply their less fortunate kinsmen on a permanent basis. It also is not necessarily the case that those men who infrequently engage in wage activities supply their thusly occupied kinfolk with country food. Because of the expense involved in hunting and trapping, very often the individuals who are only able to get away from their jobs periodically to hunt are also responsible for providing country food to their financially impoverished kinfolk.

In the monetary sector of the economy, informal sharing patterns also occur. Money itself is infrequently redistributed, except within a household where younger wage earners, with some exceptions, usually contribute their earnings to the family coffers. However, the redistribution of the products money can buy does occur with considerable frequency. Hunting and trapping equipment, store-bought foodstuffs and luxury items are recirculated through extended families. For example, one particularly successful wage earner was noted for purchasing a new skidoo nearly every

year. His old skidoos however, were still in good running condition and could be found in the possession of his less financially successful brothers and brothers-in-law.

The social, political and economic organization of the settlement is particularly effected by changing roles, expectations and opportunities for women and young people. The influence of education, mass media and White role models is leading young people to increasingly reject the values of the older generations. Although the *inummarit* image of the hunter and trapper is influential, young men are poorly prepared practically, to assume such an identity and sometimes turn to the White middle-class role models provided by the educational system in order to satisfy their needs of self-esteem and identity. Very often they reject their parents' authority and express alienated behaviour through the use of alcohol and drugs.

The opportunities for wage earning for women also are dramatically affecting expected role behaviour and aspirations. Very often, the primary contributor to a household's financial needs is the woman through a combination of craft production and part or full time employment. The influence this financial success entails is in some instances altering the traditional role relationships between men and women and indeed produces tensions and friction because of the new extroverted behaviour expected of working women.

The preceding is a brief summary of significant dimensions of the Inuit aspect of settlement social, political and economic organization.

The implications of this organization for health care will be explored more fully in a later section of the thesis. Before proceeding however, a brief description of the White component of the Gjoa Haven community is necessary.

The White community in Gjoa Haven consisted of approximately sixteen persons with occasional fluctuations as people left their jobs. Of these, two men could be considered permanent residents as they have married local Inuit women and/or have established a longterm occupational commitment. At the mid-point of my fieldwork there were six teachers, two nurses, one administrator, four commercial employees, one maintenance employee, two involved in craft shop production, training and management, and one anthropologist. Of these, five were couples, two were married to Inuit women, three were single men and three were single women.

Within this small group there were two major cliques that socialized almost exclusively of each other. Membership in the cliques had virtually nothing to do with age, sex, marital status, or indeed personal preference, but was based almost entirely on occupation and professional status. The dominant and larger clique consisted of the teachers, the nurses, and the craft shop manager and his wife, while the second clique comprised the administrator, the commercial employees, and the maintenance employee.

There were no clear lines of authority, primarily because the administrator's role was essentially a clerk with little influence. Interestingly, all the single women belonged to the first clique and all the single men belonged to the second. The first clique exhibited more

solidarity with frequent and all inclusive socializing, although there were personal preferences that, particularly in mid-winter, created some tension and conflict within the group. The second clique was more amorphous in character and indeed some individuals socialized very little with other members of the clique.

Socializing with Inuit by Whites was based largely on occupational association (i.e. teachers associated with teacher's aides) and indeed there were a few Inuit who were considered as members of the cliques. Economically successful and educated Inuit tended to socialize primarily with the dominant clique while maintenance workers, store clerks, etc. associated with the other clique. However this behaviour was by no means exclusive and considerable fluidity was observed in this regard.

Sexual contact between single White men and Inuit women was relatively frequent and somewhat transitory, while sexual contact between single White women and Inuit men occurred very infrequently, with restraint, and usually involved a complex social relationship as well.

In the chapters to follow, these dimensions of the Inuit and White communities will be articulated with the health care delivery process to demonstrate their significance.

4.2 Medical Services

4.2.1 Structure and Organization

In a previous chapter, the early history of cosmopolitan medicine's

introduction to the north was outlined. In this section, the growth of medical services from the formation of Northern Health Services in 1954 until the present will be reviewed.

The Northern Health Service was inaugurated under the auspices of Health and Welfare, Canada as a result of a cost-sharing agreement between the Federal and Territorial Governments. Its purpose was to take responsibility for treatment and public health in northern communities where physicians in private practice and/or hospitals were absent.

In addition to the six Nursing Stations opened prior to 1954, the Northern Health Service embarked on a program to establish a Nursing Station in every northern community with an approximate population between 150 and 1000 people. This program was completed by the early seventies.

For communities under 150 people, Health Stations were established under the supervision of a lay dispenser or Community Aide, as they are now known. The lay dispensers had received basic training in diagnosis and treatment in order to enable them to render effective first aid treatment and to discuss symptoms and signs of disease or injury with the nearest nurse or doctor by radio/telephone. The Health Station concept was widespread during the sixties but growth in settlement size and construction of Nursing Stations have reduced their need.

In the larger population centres such as Inuvik, Yellowknife and Frobisher Bay, hospitals have been constructed and expanded to act as the primary referral centres and are staffed by a team of doctors, usually including a surgeon. For patients who require treatment beyond the scope

of these Northern hospitals, evacuation to southern hospitals in places like Edmonton, Winnipeg, and Montreal is standard practice.

Additionally, these larger centres are serviced by a health centre responsible for the provision of public health care. The Northern Health Services have grown to the point where in 1973 they operated six hospitals, forty Nursing Stations, eleven health centres and nineteen dispensaries in the Yukon and Northwest Territories combined.

In 1974 the Northern Health Services was divided into two regions: Medical Services, N.W.T. Region with headquarters in Edmonton and Medical Services, Yukon Region with headquarters in Whitehorse. Since that time, negotiations have taken place to relocate head office for the N.W.T. Region in Yellowknife and, indeed, to transfer responsibility to the Territorial Government. These negotiations are still underway and are complicated by political, economic and personnel problems that would be associated with such a transfer.

At present, part of the Territorial Department of Health and Social Service's responsibility is to provide hospital and medical care insurance for all residents of the Northwest Territories, while Medical Services, Health and Welfare Canada, is responsible for the administration, organization and day to day functioning of all medical and public health programs. There is no doubt that tension and problems resulting from the split in jurisdiction over health care in the Northwest Territories contribute in part to some of the current health problems, and a Northwest Territories Health Services Co-ordinating Committee has been established to provide

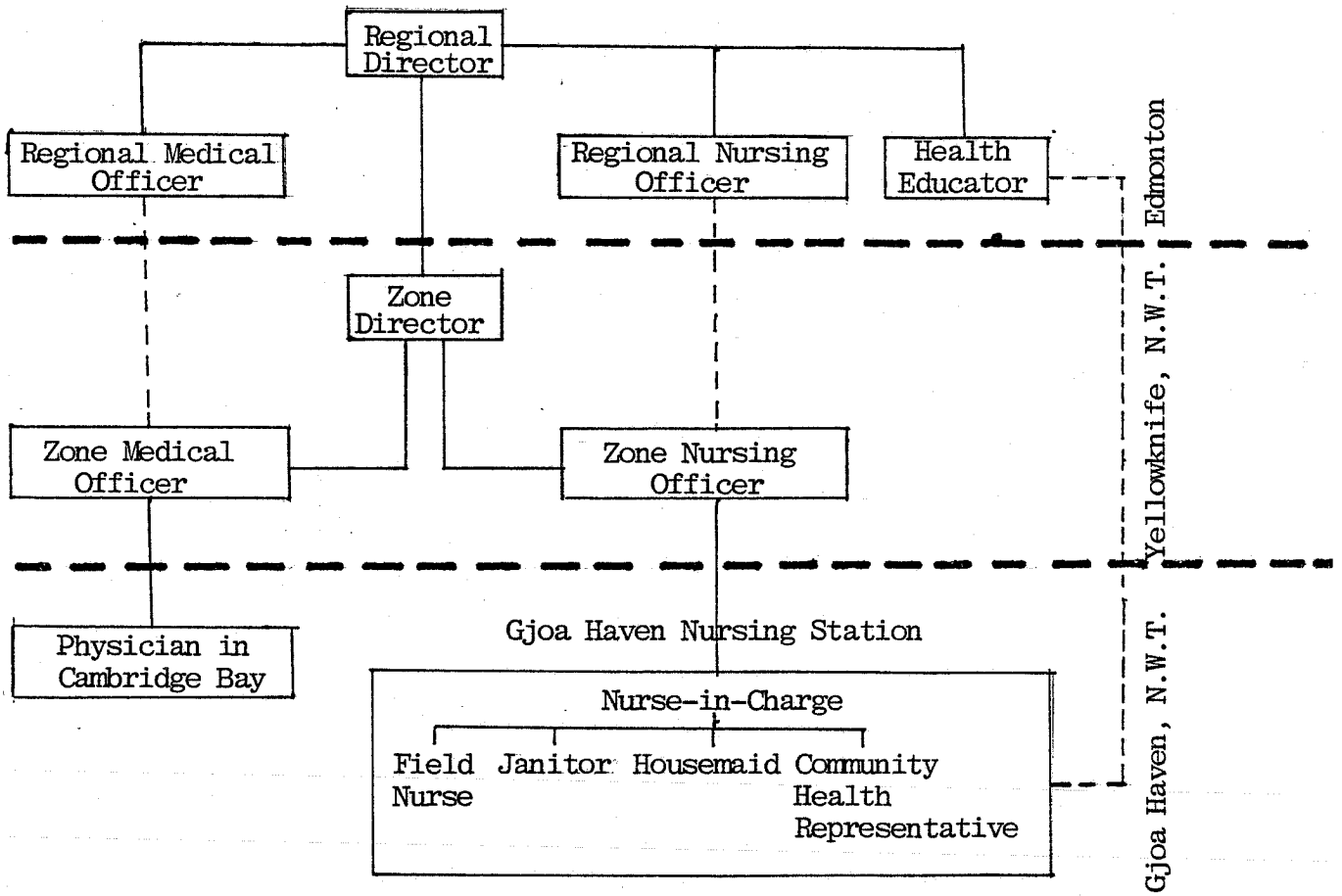
for the orderly transfer of all patient services from the Medical Services Branch, Health and Welfare, Canada, to the Government of the Northwest Territories.

Medical Services, N.W.T. Region is divided into four zones -- Mackenzie, Inuvik, Keewatin and Baffin -- which have zone offices in Yellowknife, Inuvik, Churchill and Frobisher Bay respectively. The organizational structure for the Gjoa Haven Nursing Station in the Mackenzie Zone described in the accompanying diagram is typical throughout the Region.

Theoretically, a Region is responsible for coordinating and evaluating programs across Zones, controlling budget allocations to Zones, advertising and supplying expertise to Zones on request, and implementing innovative new programs to all Zones. In practice, a Region is also involved in the day to day administration of Zone programs, because of staffing and experience problems at Zone level. As well, a Region also contains specialist programs that reflect the needs of all zones such as Regional Nutritionist, Regional Health Educator, Chronic Disease Control, Public Health Engineer and the Northern Medical Research Unit.

The significant sociological feature of the current structure is the separation of responsibilities between physicians and nurses. Nurses are in no way subordinate to the physician whose role is to provide consultative and advisory services to the various Nursing Stations in his district. Nurses are under the supervision of Zone and Regional Nursing Officers who are ultimately responsible to the Zone and Regional Director. Likewise, physicians are under the supervision of the Programs Medical Officer at both Zone and Regional levels.

Figure No. 2



Organizational Structure of Medical Services

A zone is also responsible for coordinating field operations which include medical evacuations of seriously ill patients from the Nursing Station to hospitals, physicians' periodic visits to the Nursing Stations, and visits by specialist teams such as opthamology and dental teams to the Nursing Stations.

4.2.2. Nurses and Nursing Stations

The Nursing Stations have been referred to as the backbone of health services in the Northwest Territories and this is indeed an accurate description. By far, the majority of the Inuit live in settlements ranging in size from two hundred to a thousand people and the Nursing Station provides primary care to this segment of the northern population.

Consequently, nurses are the key functional element in the cosmopolitan medical system's presence in the north, and the successes and failures of the system rest squarely on the nurses' shoulders. In North America at least, this kind of responsibility is unique.

As a result, the recruitment process of nurses to staff the Nursing Stations is theoretically rigorous, although high turnover rates and chronic staff shortages frequently result in standards being ignored.[1]

Because of the combined clinical and public health responsibilities of a Nursing Station, nurses are usually required to have one of the three following specialized skills: (1) A degree in community health nursing

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1. The average length of stay in outpost locations for nurses is less than two years.

with an emphasis in public health; (2) Completion of a Nurse Practitioner program where diagnostic and treatment skills are emphasized; or (3) Midwifery training. Attempts are made to combine personnel in Nursing Stations so that all these skills are represented.

Generally, the nurses hired are in their late twenties or early thirties who have had considerable experience in hospital or community health settings, and are single, mature and career oriented. Because Canadian nurses have only recently had midwifery training available to them, a large number of nurses are from Great Britain, Australia or New Zealand. Occasionally, these nurses have had previous cross-cultural nursing experience in other parts of the world.

The Nursing Station in Gjoa Haven combines living quarters with work space in the same building. Two nurses share a kitchen, living room and bathroom, at one end of the building while in-patient areas, treatment rooms, public health rooms, offices and storage are located at the other end. This arrangement is typical of Nursing Stations throughout the north.

Nurses hired to work in these Stations are given an orientation course at Zone headquarters that focuses on administrative tasks, familiarity with program objectives, and sometimes includes a brief overview of cultural aspects of the intended community.

The Nursing Station is ideally responsible for the following functions and objectives:

1. Primary Care and Treatment Services.
2. Maternal and Infant Health including pre-natal classes, child delivery, birth control counselling and immunization of infants.
3. Pre-school Health including immunization, and development screening.
4. School and Adolescent Health including immunization, health education and counselling.
5. Family Health including health education, counselling, sex education, and health promotion.
6. Geriatric Health.
7. Communicable Disease Control including immunization, venereal disease treatment, and epidemiological studies.
8. Nutrition Education.
9. Environment Health including inspection, education and animation of local Health Committees.
10. Health Education pertaining to above and including training of Community Health Representative.
11. Mental Health including counselling, intervention and referrals.
12. Chronic Disease Control including x-ray development and interpretation.

Typically, the nurses spend their days in the following manner. Mornings are usually spent in administrative chores, preparing various public health programs and, primarily, conducting the regular treatment clinic.

One nurse usually sees to the complaints of people as they arrive. In the afternoon, special clinics are held in such areas as pre-natal, child health, geriatric, chronic disease, and tuberculosis. Advance notice is given to people who have special problems or fall into one of these categories that their attendance at a clinic is required. Usually, health education is incorporated into these clinics where possible. While one nurse conducts these clinics, the other usually carries out home visits combining public health, health education and treatment of the infirm and seriously ill. Occasionally, evenings as well are spent presenting health education classes. The typical pattern is for nurses to share these tasks equally on an alternating basis but occasionally, a nurse with special training and/or interest will be responsible for a particular function.

4.2.3. Community Health Representative (C.H.R.)

The Community Health Representative is essentially a local person trained in community development skills with particular reference to health education who acts as a liaison between the Nursing Station staff and the rest of the community.

Originally known as the Community Health Worker Program, it was instituted in 1961 to fulfill the twin objectives of encouraging "self-help" through health education and including more native personnel in Medical Services. The responsibilities of Community Health Workers were to conduct health education in the homes of Inuit and Dene and to employ their familiarity of their people's culture and community in a liaison capacity between Medical Services staff and patients.

Over the years, there have been several minor changes, for instance, in the training program, recruitment process and the scope of C.H.R.'s responsibilities. The program has met with variable degrees of success.

Finally, a comment on the establishment of Health Committees is necessary. The Health Committees were instituted in the early seventies in an attempt to facilitate local input into Nursing Station activities and to encourage local responsibility over public health matters such as sanitation. The Committees are composed of eight locally elected members who are to meet on a regular basis. The C.H.R. is to act as secretary for the Committee and the nurses are to function in an advisory capacity.

In a later chapter, the manner in which these two entities -- the community and the cosmopolitan medical system -- interact will be analysed with the objective of understanding the processes of health care delivery that contribute to the success and failure of overall objectives.

5. BACKGROUND TO HEALTH CARE: THE CULTURAL MODELS

5.1 The Administrators

The attitudes and values exhibited by administrators at both Zone and Region levels of Northern Medical Services, suggest considerable inconsistency and greatly influence the patterns of health care delivery in the settlement.

Due probably to their respective geographic degrees of isolation and the consequent absence of first-hand contact with the clients to whom they are providing a service, Zone and Region staff collectively have different appreciations of northern realities. At the Regional level, idealistic notions associated with the "traditionalistic" approach to the Inuit are apparent. The traditional Inuit culture is romanticized and health care problems are seen as resulting from acculturation and the presence of White institutions, materials and individuals. The "job" as defined by Regional administrators is to lessen the impact of White civilization and bring the Inuit into the modern world with the least amount of disruption.

Zone level administrators, on the other hand, react to northern health care problems in a far more stereotypic manner and attribute failures in health care delivery almost entirely to the native populations. Indeed, one can detect an underlying racialist attitude in comments such as "only Inuit with White blood are motivated; both Indians and Eskimos are apathetic about health care because of a mañana attitude and because life isn't highly valued in northern environments." They tend generally

to be far more cynical about alleged attempts to improve health care through education, etc., and respond pessimistically to programs designed to include native personnel in the delivery system. Both of these attitudes, obviously, do not reflect northern realities, and neither, fortunately, is particularly characteristic of field staff who face the complexities of settlement dynamics.

Another division in general attitudes and values occurs along the split between transient staff who regard their northern employment as experience towards more general, southern oriented goals, and career civil servants who are oriented towards upward mobility in the Medical Services hierarchy. Naturally, this division occurs most notably between field staff and administrators. The tendency is for transient staff to be more open to innovative and experimental approaches to specific health care delivery in individual settlements whereas career civil servants are more defensive of established departmental programs.

More specifically, Regional and Zonal administrators exhibit other attitudes that affect northern health care delivery. Most notable is the paternalistic attitude expressed towards field nurses. This attitude was evidenced both by administrators' personal statements and by rules and restrictions applied to Nursing Station activities. For example, nurses were not allowed to have overnight male visitors in the Nursing Station and there was a five-mile travel restriction on nurses in the settlements. Furthermore, nurses were discouraged from remaining in their home settlement when taking holidays. While numerous practical reasons could be

cited for these regulations, they are nevertheless restrictions on the nurses' personal freedom and unique in that other northern agencies do not have similar restrictions. During orientation, nurses were also advised that they would be "living in glass houses" and that consequently their behaviour must be above reproach and should set a moral standard for the community. Needless to say, these restrictions resulted in considerable tension and conflict among young, single women working as nurses in isolated posts for extended periods of time.

A second important attitude exhibited by administrators was the apparent "tokenism" that characterized their commitment to such things as public health education, native involvement in the health care delivery process and the importance of culture in health care problems. I emphasize "tokenism" because while written reports and personal statements from many administrative staff acknowledged the importance of these factors, in actual practice there was minimal support given. And indeed, some administrators expressed cynicism and/or a lack of appreciation as to the relevance of these variables. Field nurses had great difficulty getting the sort of health education material they felt was necessary, orientation programs for new nurses only briefly touched on cultural factors and usually emphasized stereotypic and superficially traditional aspects of culture, and blame for lack of native involvement was placed on lack of native initiative rather than on the rather restricted opportunities for taking responsibility.

A third attitude expressed was a positive evaluation of staff

turnover in the field stations. Many administrative staff expressed the belief that nurses tended to get "bushed" easily and that a nurse who desired to remain in a community for an extended period of time was in danger of "going native." Both of these possibilities were considered as dangerous and efforts were made to transfer nurses elsewhere before either of these outcomes occurred. Other reasons given for encouraging frequent transfer of staff were deteriorating interpersonal relations among field nurses, and the hypothesis that the community did not want Whites to remain in the settlement very long.

Another important attitude expressed by administrative staff was the belief that Nursing Station activities throughout the north should be standardized and that this standardization should involve a fairly restricted approach to involvement in local affairs. It was felt that nurses should refrain from becoming involved in local politics, family disputes, etc., and should restrict their activities to specifically health related matters. It was felt that this standardization would facilitate the easy transfer of nurses from one settlement to another without undue difficulty in adjusting to idiosyncratic local demands.

A specific attitude alluded to at the outset of this discussion is the tendency to "blame the victim" where health problems arise. Indeed, many people saw the purpose of this research as illuminating those aspects of Inuit culture that were impeding the effective delivery of health services. Great pride was expressed in the acknowledged success experienced in controlling infectious disease and thereby reducing morbidity and

mortality rates, but confusion characterized attempts at understanding the current health problems in the north such as nutrition, alcoholism, suicides, violent accidents, etc. It was generally felt that the solutions to these problems were to be entirely found in Inuit culture, particularly in their difficulties to adapt to modernization.

Finally, despite the apparent division of responsibility between nurses and doctors in the administrative hierarchy of Medical Services, considerable ambiguity actually existed as to the supervisory responsibilities that physicians should have over nurses. Attitudes stemming from the traditional organization of hospitals in the south sometimes characterized newly arrived physicians in the north and many administrators as well as physicians expressed a lack of confidence in the real skills the nurses possessed.

5.2 The Nurses

The characteristics of nurses described herein obviously do not apply to any one nurse in entirety. They derive from direct experience and second-hand information applicable to numerous nurses and describe a plethora of attributes characteristic of some nurses to a greater extent than others.

Perhaps the most important attitude expressed by northern nurses is maternalism. The literature on colonialism is replete with reference to paternalistic colonial attitudes and in a sense, maternalism is the female expression of this attitude. The significant difference is the

the absence of a superordinate/subordinate power dimension. Maternalism is expressed in the assumption that the Inuit are essentially children, requiring basic education as to how to eat properly, wash themselves and go to the toilet. This basic attitude is compounded by the fact that in cases where the nurse's interaction with the members of a settlement is largely on a professional basis, only their negative biases are reinforced by this interaction. For example, if they have a negative picture of the Inuit as unhealthy, unsanitary, unhappy and uninspiring, these characteristics are only exhibited when people require the services of the Nursing Station. Consequently, the maternal response is strengthened because the Inuit appear totally dependent when contact is only through the nurse-patient relationship.

A second important characteristic of northern nurses is their expression of professional values. The independence, responsibility, and freedom of action that their role requires, allow them to express the professional values and goals inculcated during their training but usually frustrated in southern settings where they are subordinate to physicians. This expression of professionalism is particularly important as one of the key motivating factors towards a long term service in the north.

Associated with this attitude is an appreciation of the influence they possess as outpost nurses. Partially in response to the absence of a subordinate relationship to physicians and partially as a result of their status in an isolated White community where a university degree and/or professional training are rare, nurses enjoy considerable decision-making

authority, influence and prestige. These rewards are again a component of the satisfaction that motivates northern nurses to continue their service.

Among northern nurses, as among most White transients in the north, there is an exploitative quality to their presence there. Financial gain, career experience, adventure and personal growth are prime motivations in their original desire to seek employment in the north. Very infrequently is the overriding concern altruistic in the sense of "helping the people" although altruism is certainly an aspect of their character generally.

Indeed, a qualification to the above statement is the conclusion that nurses differ from other northern Whites in that the nature of their professional interaction with Inuit requires a sensitivity and openness to people's emotional and social needs that encourages the sort of altruistic dedication to health care that is needed. In this regard, many nurses who have had several years of northern experience develop an attitude very similar to the missionaries in that they become more and more committed to the welfare of their clients. This response is different from other Whites who tend to lose their idealism as frustration and pessimism set in and grow more remote from the people they originally intended to teach, administer, help, study, etc.

A further associated feature of the northern nurse is the quality of "caring" that characterizes nursing practices. It has been suggested that whereas physicians emphasize "curing" as their professional responsiblity, nurses emphasize "caring." The essential difference between the two is that curing focuses on the biological being, while caring involves the entire human being, including the phychological and social dimensions.

There are, of course, a number of attitudes and values that stem from being young, single females in an isolated location that affect both the personal lives and the professional activities of northern nurses. There is, however, enough variation in these attitudes, ranging from relatively experimentally promiscuous orientations to morally righteous and reclusive tendencies so that a general characterization is impossible. However, there is the general conclusion that despite the variety of attitudes, their overall effect does influence certain dimensions of a nurse's interaction with a community.

5.3 The Inuit

This description will be organized into two sections: one pertaining to cultural attitudes, explanations and values related to illness and the other pertaining to attitudes towards White people generally and nurses specifically.

In a previous chapter, the baseline traditional beliefs about illness, its causes and treatment were outlined. The material presented outlined a system where illness derived from supernatural causes influenced by personal behaviour. Shamanistic activity was the primary means of intervention and treatment.

That this integrated system of beliefs has changed, there is no doubt, but the extent of change is difficult to determine. In the section to follow, material will be presented that outlines some of the key elements in the changing belief system and incorporates these changes into a synthetic picture of current Inuit disease theory.

One rather confusing element of changing disease theory has been reported in the literature (Vallee 1968) and was confirmed by several informants. Apparently, disease was regarded as a quantifiable and transferable entity in that people felt a certain amount of it always existed in the environment and, consequently, only affected a certain number of people. Vallee (Ibid) describes a situation in Baker Lake where informants told him that the reason people were suffering from an influenza outbreak was because an epidemic of rabies hadn't been allowed to run its course amongst the settlement's dogs. The Inuk individual who had convinced other hunters to have their dogs immunized to prevent the further spread of rabies was held responsible for the transfer of disease from dogs to people.

In Gjoa Haven, one older informant cited several cases that occurred during the fifties and sixties during various infectious disease epidemics where older, apparently healthy individuals had committed suicide in an attempt to transfer the disease from their sick children and take it away with them when they died. Several informants also stated that people would occasionally kill a dog when a child was sick in an attempt to transfer the sickness from the child to the dog and eliminate it.

Explanations from informants regarding the etiology of disease in the "olden days" reflect the influence the contemporary Christian religious cosmology has had on traditional disease theory. People felt that illness was still fundamentally associated with soul-loss but that the mechanisms of soul-loss were somewhat different.

Whereas taboo transgression had been the primary mechanism in

pre-contact times, informants explained soul-loss in the last several decades as having resulted from breeches of moral etiquette. Such things as adulterous activities or desires, mistreating children or wives, wishing others harm, expressions of jealousy, aggressive behaviour and hostile acts all could result in the onset of illness. Apparently, committing any of these offences was regarded as succumbing to the temptations of the devil which could result in the loss of a person's soul.

Another activity that resulted in soul-loss and illness and was also associated with the devil's temptations was excessive thinking, worrying, and brooding. Informants expressed this as "thinking too much, worrying all the time or having bad thoughts." One informant stated he moved from one settlement to another because his involvement in politics in the previous settlement was causing him to worry continually and he was afraid it would kill him. Similar views were expressed by a prominent Council member in Gjoa Haven when he expressed his wish to resign from Council. People generally expressed the desire to be always happy and free from worry in order to avoid sickness. This belief is extremely strong amongst most Inuit and has important implications in terms of attempts to encourage local people to accept greater responsibility in local affairs.

Perhaps a good example of the effect this particular belief could have on an individual is found in the following anecdote. In one instance, a young, acculturated and politically active Inuk eventually escaped from the extraordinary social pressure he was experiencing by apparently suffering a heart attack. His administrative activities in local politics

had been performed in such a way that he was receiving criticism from all sectors. His White supervisors, Council members, and the community at large were generally annoyed at his behaviour and the resulting pressure on him to resign his responsibilities resulted in considerable personal stress. He was, however, extremely motivated in the sense that he wished to retain the position at all costs because of the prestige and influence he felt accrued to it. In this regard he was unique and in general exhibited a very acculturated value system. Finally, he suffered what appeared to be a heart attack and the common explanation for it given by most informants, attributed its cause to his excessive worrying and thinking about his job. By and large, most people were relieved that a very tense situation had been relieved by this illness.

However, as it turned out, the heart attack was psychosomatic. After being evacuated to Yellowknife, it was diagnosed that there was very little physically wrong with this individual. This information, however, was never made public. Most people in Gjoa Haven continued to believe he had actually suffered a heart attack as a result of excessive thinking. Because of his very acculturated value system, I did not expect him to concur with the community's diagnosis but was proven wrong. He not only maintained his invalid status after his return, but manifested his illness in such a way that most of the previous tension in the community around his activities dissolved, and he resumed a normal existence. He also strongly suggested that his illness was the result of excessive worrying and thinking and felt absolved from all previous bad feelings.

Prayer was cited by numerous informants as the major method of treatment for illness prior to the arrival of the Nursing Station. Indeed, several individuals in Gjoa Haven expressed the belief that prayer was still more effective than medicines in the treatment of illness. Particularly amongst the Anglican congregation, the belief in the efficacy of prayer was remarkably strong. Informants also stated that certain individuals in the hunting camps were noted for their success in relieving illness through prayer and their powers were called upon in times of distress. These individuals were usually described as having "been raised properly, leading a good life, kind to people, etc."; and indeed one such incidence occurred while I was resident in Gjoa Haven where the person called upon to "pray" for an injured man did indeed possess these qualities.

This emphasis on the curative powers of properly raised, morally good, and right living people was further expressed in the belief that by sharing the catch (i.e., caribou, fish, seal) of such a man, a sick person could regain his health.

Despite the overwhelming influence of Christianity on illness beliefs, shamanistic explanations also influenced recent Inuit beliefs about disease. Particularly among elderly informants and the Catholic component of the community, beliefs in the deleterious effects of spirits and shaman's curses were still present. Informants stated that prior to the Nursing Station's construction, shamans would occasionally conduct a *krilaq* (head-lifing ceremony described in an earlier chapter) in order to determine the cause of a person's illness. However, the explanations for the illness

were more often couched in terms of moral righteousness as outlined above, than in terms of the traditional taboo transgression etiology. Shamans also held seances where they battled with spirits in recent times and one elderly informant attributed his constant malingering illness to a shaman who had cursed him before dying.

I have evidence that as recently as 1970, a *krilaq* was performed by perhaps the one remaining, acknowledged *angatquq* in Gjoa Haven on a young man whose long term illness had not responded to the medicinal therapy from the newly constructed Nursing Station. The shaman proclaimed that this young man's illness was the result of his deceased father's hostile and aggressive behaviour and once this was publically acknowledged, the young man recovered.

Beliefs in the preventative powers of the name-soul seem to have persisted almost unchanged by acculturative influences, in the sense that great importance is still attached to the naming of a child so that the strengths of the namesake will protect it and there is considerable evidence of recent name changes by individuals suffering from illness. However, I was unable to ascertain the extent to which shamans were or were not involved in the naming or name changing process because informants were reluctant to discuss it.

The most often cited reason for the prevalence of disease today and in recent times is very simply the presence of Whites. Many informants claimed that whenever the plane landed in Gjoa Haven during the trading era, everyone would get sick with colds or more serious diseases. Back

River people recalled the arrival of disease whenever White fishermen visited the Chantrey Inlet. One elderly informant even remarked that when she was a young girl and the material possessions of Whites were in great demand, she was jealous of her friends who had caught colds from visiting Whites when she had not. Some people remarked that they would prefer fewer visits by various government administrators because everytime the plane arrived with them, more people would get sick shortly after their arrival. One informant stated that people had more sickness in the summer because Whites tended to visit the settlement more often then.

Belief in the efficacy of cosmopolitan medicine has strengthened during the last decade but there are some qualifications to this belief. The lay dispenser, who administered medicines during the sixties, stated that originally, people assumed all medicines were the same. This created problems when people wished to retain powerful drugs they hadn't used and give them to infants wihout consultation. Difficulties were also encountered with people who experienced an allergic reaction to penicillin and from then on distrusted or refused to take any drugs. Because the medicines administered by the Hudson's Bay manager and priests were fairly mild palliatives such as aspirin and cough medicine, people sometimes were hesitant to accept the belief that medicines could be very effective in coping with disease.

This hesitancy is still expressed today by some members of the community. In particular, one individual who is a stong believer in the power of prayer, rejects cosmopolitan medicines completely, claiming they

only weaken a person and make him dependent on Whites. He stated that nurses only give medicines to encourage this dependence.

The belief in the weakening effect of medicines was also expressed by other informants who stated that children who had taken a lot of medicine were generally weaker and more susceptible to disease. Store-bought food was also responsible for the loss of a person's strength and many mothers stated that when any of their children refused to eat country food but would only consume food bought at The Bay or Co-op stores, they would be sick more frequently then their other children. The belief in the strengthening powers of country food, particularly fresh caribou meat, was very widespread among young and old alike. This belief would seem to be associated with the notion that blood is the source of person's strength and that country food gives a person better blood.

A few more general beliefs were also expressed that relate to health behaviour. Spitting, vomiting and bowel evacuation were regarded as important processes to remove illness from the body. People were particularly concerned about young children who didn't know enough to spit when they were sick and thereby contained the illness within themselves. Many mothers felt that fat babies were to be desired because this was a sign of health and strength and served as protection from the cold and disease. Parents also felt that "love" served as a protective mechanism and several statements such as "we really loved him but he still was sick all the time" or "that child is sick all the time because his parents don't really love him" were frequent.

I was unable to elicit much information pertaining to beliefs about death except that all residents of a house where someone had died expressed an immediate wish to relocate elsewhere. Sometimes, the house would be left vacant for a short period of time but usually, given the shortage of housing, the family would simply exchange houses with someone else.

Finally, a few comments are necessary on the impact of health education in terms of people's beliefs about germ theory, sanitation, etc. For the most part, people acknowledged that the nurses were correct in attributing disease to germs but when pressed, were unable to describe with any accuracy the idea of a germ. One informant expressed probably the most widely held view that germs were the Whites' way of describing evil spirits. Another informant expressed doubt that germs and dirt were necessarily related because, in traditional times, people never washed and were always dirty but they were never sick. Although no one actually ever said it to me, probably out of politeness, I suspect most people felt germs were simply one of the things White people brought to the North along with guns, skidoos, etc.

However, a number of informants expressed the belief that the reason people were healthier on the land than in town was because of the filth and garbage associated with settlement life. Soot from chimneys, garbage, scrap wood, etc., were described as characteristic of settlement life and hence the cause of disease whereas on the land, people were constantly moving and leaving filth behind.

An interesting development occurred as a result of my research in

that generally, people stated that usually they never thought about illness or its causes except when they were sick. Because of the questions I was asking they found themselves considering its implications more often. My interpreter summed this up once by stating that he sometimes found himself thinking about how illness was caused while out sealing or travelling in his boat.

As a summary for this section, I would like to suggest the following conclusions. Current Inuit disease theory would appear to consist of two overlapping models that are by no means clearly defined but do influence health related behaviour. One model attributes illness to soul loss that is caused by improper behaviour and bad thinking and is treatable through a combination of religious prayers and traditionalistic shamanistic activities. The other model attributes disease to the presence of Whites and the filthy conditions of town life and is best treated with cosmopolitan medicines. However, these two models are by no means distinct in the minds of most people and it would be erroneous to suggest that two medical systems exist in an Inuit settlement. People with obviously psychosomatic ailments that they might attribute to soul-loss do not hesitate to seek out powerful medicines at the Nursing Station and people who have sustained a physical injury will still rely on prayer as a cure.

Inuit attitudes towards nurses are generally similar to those directed at all Whites. The main characteristic of these attitudes is known as *ilira* or "respect tinged with fear," (c.f. Briggs 1970; Brody 1976).

This attitude is reserved for the feelings one has when in the presence of someone who holds an irreversible advantage, whose actions one cannot modify or control, whose actions are unpredictable or who has a powerful but unhappy disposition. Within their own culture, feelings of *ilira* were reserved for influential old hunters and shamans, and characterized relations between children and their fathers. The term is in some senses complementary but the element of fear is given more emphasis in relations with Whites.

Aside from this essential characteristic, Inuit also regard all Whites as immensely wealthy, somewhat strange in that they seem to enjoy living alone and celibate, as not particularly intelligent in many cases, as exhibiting extremely childlike behaviour through their inability to control emotions, and as somewhat selfish because they hoard personal goods and refuse to share.[1]

As representatives of White culture, nurses are subjected to this stereotype but because of numerous factors such as their professional responsibilities, and the fact that they are usually young, single women, there are several notable differences in the way Inuit view them. By and large, nurses interact with a more representative cross-section of the local population, more frequently and more intensely than do any of the other resident Whites. For example, teachers interact primarily with

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1. It should be noted that the term "Whites" as defined by Inuit refer to all persons with a southern background including Blacks, Asians, Chinese, etc.

children, administrators with mature, politically active men, etc. However, the nature of the nurses' interaction with people is usually through the sick role and consequently people are at their weakest, most vulnerable and dependent levels.

The result of this type of interaction is twofold. First of all, the personal characteristics of nurses are usually better known by more members of the community and they are less likely to be stereotyped as quickly as other Whites. Many times, nurses have shared a personal tragedy with a particular family on a more intimate and intense level than any other White could hope to achieve and this results in close personal ties and real fondness between some families and a nurse. However, the anxiety creating atmosphere of the sick role combined with the recognition of the real power wielded by nurses with regards to curing, can sometimes exacerbate the feelings of *ilira* that are extended to Whites. The degree to which this occurs is entirely dependent on the nurse's sensitivity to the impact her personal behaviour is having on her clients.

Some older people expressed the belief that in many respects, nurses were like shamans. The efficacy of medicine was attributed to the personal power of a particular nurse, much in the same way that a shaman's curing success depended on his power of control over the spirit world. On one occasion, informants suggested that nurses also had the ability to cause sickness if they were jealous of someone in the community. It should be noted that traditionally, female shamans were generally regarded as more powerful, and this belief may influence contemporary attitudes towards nurses.

Different segments of the community reacted differently to the fact that nurses were young, single women. Older men resented the influence exerted by persons who in their own culture would have virtually no influence. They also felt embarrassment over having to expose themselves physically and emotionally for the same reason. Older women resented the suggestion implicit in public health education that they were ignorant of housekeeping and child rearing skills. They were also suspicious of nurses who desired extensive socialization within the community because they feared the possible sexual involvement of their menfolk with the nurses. Younger women particularly were sensitive to the nurses' social activities and many spoke with distaste of sexual liaisons between a previous nurse and certain men. Naturally, younger men were attracted to the potential availability of nurses and particularly single men actively sought involvements with the nurses.

People generally preferred older nurses because they seemed more serious, dedicated and powerful. Some informants expressed the view that while they appreciated the home visiting of the nurses, nurses should visit people also when they are well and should visit in the evening when the men were home. This would help to allay fears some people felt as a result of the limited interaction they had with nurses. Some women were particularly anxious about taking their children to clinic because they had been criticized in the past about hygiene or nutrition problems and they were reluctant to be subjected to this criticism again. Some women also were concerned that nurses criticized them over failing to bring their children

to the Nursing Station at the proper time. They felt very anxious about having to decide whether a child was sick enough to require attention and consequently waited until the child was so sick that the nurses again criticized them.

A very important concern expressed by many informants was directed to the length of stay of some nurses. People generally felt that when nurses first arrived they were very dedicated and helpful but that as time wore on, nurses tended to "get lazy" and become less cooperative and agreeable. It was felt that such nurses should be transferred earlier out of Gjoa Haven so as to avoid the anxiety and tension that their presence produced.

Finally, most people acknowledged that the nurses were the most important Whites in town and felt particularly grateful for their presence.

6. DIMENSIONS OF HEALTH CARE: BEHAVIOURAL DYNAMICS

In this chapter, a number of domains of interaction between the cosmopolitan medical system and Inuit community will be described. Emphasis will be placed on the nurses and Nursing Station's role in this interaction.

6.1 Staff Relations

Relations between the various personnel staffing the Nursing Station and between the Nursing Station staff in Gjoa Haven and supervisors, physicians and nurses in other Nursing Stations are crucial to an understanding of the dynamics of health care delivery in Gjoa Haven.

The relationship between the Zone Nursing Officer (ZNO) and the Nursing Station staff is the most important link between the isolated outpost and the resources and facilities in the outside world. Consequently, effective communication through this channel is necessary if the local initiatives of nurses are to have the support of Medical Services. Unfortunately, in the case of Gjoa Haven, this had not been the case with the consequence of seriously undermining a number of local health programs that might otherwise have been effective. The ZNO was more concerned with a critical assessment of the administrative capabilities of the various field nurses and ignored or interfered with locally-initiated requests for health education materials, etc. The alienation experienced by several field nurses reached the point where a delegation made a representation to the Regional Nursing Officer to have this impediment to their health care

programs removed. For reasons pertaining to bureaucratic security and alliances, such a move was impossible until a suitable promotion could be secured for the incumbent ZNO, that removed her from direct contact with field activities. Nurses frequently complained that unwavering support was required from the ZNO in order to maintain their sense of purpose and high morale and when this support was replaced by constant criticism their feelings of isolation and alienation were increased.

Another element of the relationship of nurses with their supervisors concerned the expectation of hospitality by visiting personnel from Yellowknife. At the time of fieldwork, the hotel was inoperative and the Nursing Station was without transient facilities. Consequently, visiting personnel were housed and fed in the private quarters shared by the nurses and an element of pressure was felt to entertain these guests while resident. While the nurses by no means resented social visits and enjoyed extending hospitality, there were times when weather conditions or poorly coordinated travel plans resulted in extended visits by some visitors. For example, in January and February there was a continual resident of one sort or another while the Nursing Station was staffed by one nurse.

The effect of this responsibility for hospitality was that the nurses were subjected to the scrutiny by supervisors of their private lives and indeed of any personal idiosyncracy in their health care programs. Frequently, events that the nurses would have wished remained confidential to Gjoa Haven became public knowledge at Zone headquarters through the channels of gossip initiated by personnel who had visited Gjoa Haven. The

outcome of this was that nurses came to distrust most Zone supervisory personnel in matters of personal concern.

Relations between nurses and the physician responsible for consultation in Gjoa Haven, who was permanently located in Cambridge Bay, were strained for two quite different reasons. During the period of fieldwork there had been two physicians holding this responsibility and strained relations were experienced for opposite reasons.

In the first instance, the physician philosophically supported the principles of nurse independence and responsibility but had a personal motivation to become involved in public health, health education and preventative medicine. However, he received no cooperation whatsoever from the nurse-in-charge of the Station in Cambridge Bay who had responsibility in these areas. She insisted that he concentrate his activities in clinical medicine and refrain from interfering in other Nursing Station activities. The physician cited this lack of cooperation as his primary reason for resigning.

In the second case, the new physician found it difficult to adapt to his advisory role and had serious doubts regarding the competency of nurses to diagnose and treat illness unassisted. He attempted on several occasions to interfere in decisions regarding medical evacuations, normally the responsibility of nurses. A complicating dimension of this tension was the general consensus of the nurses that his own medical competence was questionable. On several occasions opinions were expressed that a certain diagnosis or recommended treatment was in error.

The Nursing Station in Cambridge Bay was a three nurse station and, although theoretically on an equal footing administratively with the Station in Gjoa Haven, it occasionally became involved in conflict stemming from an inability to appreciate this reality. Because medical evacuations, supplies and visiting specialists had to be routed through Cambridge Bay for transportation reasons, the nurse-in-charge there took it upon herself to assume responsibility for coordinating much of this activity. This action was not appreciated by nurses in Gjoa Haven because the coordination occasionally challenged their own decisions on these matters.

Within the Gjoa Haven Nursing Station, relations between the nurses varied considerably but in all cases affected the manner in which the Station interacted with the community.

The incident alluded to elsewhere in this thesis concerning the nurse who was transferred out of Gjoa Haven and who eventually resigned from Medical Services is a reflection of one aspect of staff relations. In that instance the personal behaviour of one nurse so offended the other nurse both personally and professionally that she herself threatened to resign.

Relations between the nurses were complicated by the nature of their living arrangements and the nature of their professional attitudes towards their jobs and responsibility to the community. Two of the nurses had markedly different approaches to the concept of health care in a northern community. Whereas one tended towards total involvement in community life, the other preferred a more structured approach to interaction where

the Station provided a 9 to 5 service with the nurses able to dissassociate themselves from the community outside of these hours. Practically, this meant that while one welcomed social visits from Inuit at all hours of the day and night and was more willing to accommodate people professionally outside of scheduled clinic hours, the other preferred to visit with the White community on her off hours and was irritated by seemingly unimportant medical problems brought to her attention in the evening and at night. Both positions were quite characteristic of nurses and Whites in general in the North, but whereas most Whites have the luxury of private accommodation and are able to manage their leisure time according to their own philosophy, the nurses' shared accommodation can lead directly to tension when these two conflicting philosophies are in constant contact. One of these nurses left Gjoa Haven after a one year term of employment and stated that her inability to accommodate and resolve this basic conflict was her primary reason for seeking a transfer elsewhere.

Her replacement's approach to community involvement was more in line with the other nurse but another source of conflict stemming from Nursing Station dynamics complicated their relationship. Because of her longtime residency in the community (nearly two and a half years when the replacement arrived) both the White and Inuit components of the community had come to regard the Nursing Station as her private domain. Concomitantly, the population had come to trust her professional abilities and were quite naturally suspicious of any newcomer. Consequently, the replacement perceived that the community looked upon her as a "visitor" and/or a "student

nurse" for a considerable period of time. Again, because of the shared accommodation, it was impossible for her to establish herself independently of the other's influence and these attitudes persisted long enough to seriously threaten her professional self-esteem.

The relations between the nurses and the support staff are critical for the effectiveness of the Station. As mentioned elsewhere, the role of the interpreter is extremely important in cross-cultural health care delivery and the Gjoa Haven Nursing Station was very fortunate to have an individual who not only was fluent in both Inuktitut and English but was also greatly respected and trusted within the community. Although his job description was that of the janitor, his influence on effective communication getween the nurses and the community made his presence crucially important. Given the rather high turnover normally associated with native employment in the north, his record of ten years of continuous employment reflects the nurses' recognition of his indispensability and their willingness to support his particular needs. As an Inuk, he required considerable time off in order to hunt the food his family required, and his political responsibilities demanded frequent travel to meetings in other communities. Fortunately, the nurses made every effort to accommodate these needs and quite obviously respected his contribution to the effectiveness of health care delivery in Gjoa Haven.

Particularly with regards to sensitive psycho-social issues and in cases of personal tragedy, the role of the interpreter became extremely important. In the event described elsewhere in this thesis about the conflict

between the store clerk and the old shaman, it is highly unlikely that the nurse would ever have been consulted by the shaman's family if the interpreter had not been so remarkable. The sensitivity of this issue required far more than the mere command of two languages. The interpreter also had to have a commitment to the confidentiality of the issue and an awareness of the social and cultural dimensions surrounding the event. In other instances, rapport between the nurse and a family suffering a number of personal tragedies was only possible because of the interpreter's presence. In one particular case, a family suffered the loss of three of its members in a two year timespan and the nurse was only able to help them in their grief because of the interpreter. Other people who occasionally were employed as interpreters often refused to engage in these particularly difficult interactions.

It is worth noting, however, that the janitor-interpreter himself didn't consider his function as interpreter as the most important aspect of his job. When questioned about his aspirations for future career development, he expressed a well thought out desire to upgrade his maintenance skills to the journeyman level. On a day to day basis he also seemed to achieve more satisfaction from maintenance activities and frequently complained that his translating requirements were interfering with his work. At the same time, however, he appeared to resent the transfer of translating responsibilities to the C.H.R.

It has been noted elsewhere that translating is a particularly tedious and demanding task, where little intellectual input is required

other then a good memory and rote repetition. Since the janitor-interpreter was also called upon to translate in a variety of other contexts such as for Settlement Council (indeed whenever the translation was of importance he was utilized) his resistance to its demands are more easily understood.

Relations between the nurses and the C.H.R. in Gjoa Haven were particularly good. Proof of the quality of this relationship is evidenced by the recent use of the Gjoa Haven C.H.R. as a resource person in the training of new C.H.R.'s and by her decision to attend the University of Lethbridge to obtain a degree in nursing. The role of the C.H.R. will be discussed more fully in another section but mention should be made here of the confidence, encouragement and support shown the C.H.R. by the nurses in Gjoa Haven. There is a great danger in the C.H.R. program for the nurses to simply use the C.H.R. as an interpreter and fail to encourage their independent assumption of responsibility. When this occurs the C.H.R. usually becomes disenchanted with the job and terminates his/her employment quickly. The nurses in Gjoa Haven recognized this difficulty and made every effort to foster the C.H.R.'s independence. The mutual respect that resulted was reinforced by the close personal relationship the nurses and the C.H.R. maintained.

6.2 Utilization and Acceptance

Frequent complaints by both nurses and their supervisors were heard relating to the problem of over-dependence on the Nursing Station by the Inuit. Indeed a major concern of supervisory personnel was that the field

staff in Gjoa Haven had been and were "too soft" and new personnel were needed with a disciplinarian outlook to discourage the high degree of dependence.

Supervisory staff are currently attempting to strongly censure nurses who they feel are not meeting their objective of discouraging over-dependence on Nursing Station facilities. In Gjoa Haven, the policy adopted by nurses had generally been to treat all visitors to the Station, no matter what time of day or night, but to politely lecture people who came after hours if the problem was not an emergency. This policy received disfavour from Zone staff and there had been considerable tension between Zone Nursing Officers and some of the Gjoa Haven nursing staff. A recent contract settlement between the nurses' union and the federal government stipulating that nurses will only be paid overtime when after hours treatment can be justified as a medical emergency, will have serious ramifications at the field level. Previously, nurses were able to interpret rules about after hours treatment according to their conscience.

However, observation of actual utilization indicates that there are a number of important qualifications to the above general conclusion. The accompanying chart (Figure 3) indicates the clinical demands placed on the Nursing Station over a two-month period. The data indicate by far the majority of visits were by young and middle-aged women with children and this was particularly true with regards to after-hours visits. Visits by men were infrequent and usually involved accidents or very serious complaints. Visits by older people as well were infrequent and again

Figure 3

Patient Initiated Contact with the Nursing Station over a Period of 27 Consecutive Days

Patients Grouped by Sex, Age and With or Without Children	Type of Complaint and Time of Occurrence						Total Visits By Group
	During Clinic Hours			Outside Clinic Hours			
	Self-Limiting	Required Medication or Treatment	Total	Self-Limiting	Required Medication or Treatment	Total	
Mother 18–30 With Child 0–15	19	20	39	15	15	30	69
Mother 30 ↑ With Child 0–15	11	12	23	6	12	18	41
Woman 15–25	5	2	7	7	10	17	24
Woman 25 ↑	10	-	10	11	-	11	21
Man 15–25	4	2	6	4	6	10	16
Man 25 ↑	9	10	19	3	6	9	28

usually were of a serious nature. When one combines this data with the general understanding of the impact of culture change where young men and women are often without adequate socialization in either the skills of their parent's culture or the culture of the dominant society, the high degree of dependency among this group is more easily understood. Young women particularly lack the confidence to make diagnostic decisions about their children's welfare and consequently are in a state of high anxiety when their infants are in distress. Middle-aged women have adapted to a pattern whereby their traditionalistic child-rearing skills are inadequate for coping with settlement-derived illness. Both groups consequently rely on the Nursing Station for assurance in relieving the anxiety they experience over their children's distress.

This reliance resulted in some tension within some Inuit families when men were prepared to establish outpost hunting and trapping camps where they would permanently reside away from the settlement for considerable portions of the year. Their wives however, resisted this suggestion because they were reluctant to be dependent on their own skills and basic medicine kits where their children's health was concerned.

Interaction between some women and some of the nurses resulted in a severe disinclination to utilize the Nursing Station in times of distress but consequently, entailed considerable anxiety for the women concerned. Certain women were regarded by the nurses as public health problems in that they seemed unable to maintain their homes in a sanitary and hygienic manner. Consequently, they were subjected to a lecture on these problems

whenever they were forced into contact with the Nursing Station. Particularly, when they brought a child in with an environmentally derived infection, they were politely but firmly informed that their child was ill due to their poor housekeeping habits. While the nurses were indeed correct in their evaluation of the situation, the women involved strongly resented the criticism and occasionally attempted to avoid contact with the Nursing Station.

A further fear concerned the evacuation of seriously ill patients to Yellowknife or Edmonton for treatment. While everyone regarded these events with trepidation for numerous reasons, the evacuation of children was particularly feared because it was felt that children who were evacuated usually died. Consequently, some parents attempted to cure their sick children through such methods as prayer if they felt contact with the Nursing Station might result in the child being evacuated.

On several occasions I observed the nurses having to return to the Nursing Station in the evenings from a movie, a dinner party or a social evening at the home of another White in order to investigate a medical complaint that turned out to be trivial. On other occasions, after a particularly hectic day, a maternity delivery or the evacuation of a seriously ill patient, sometimes involving up to forty-eight hours of continuous work, nurses would be awakened from a much needed and deserved sleep to again treat a relatively minor complaint that could have as easily been treated during regular clinic hours on the following day. When these sort of events occurred several evenings in a row, the nurses' frustration

became easily detectable and seriously affected the quality of their interaction with certain segments of the population. The unfortunate outcome was that their stereotypic prejudices of Inuit as lazy, ignorant, careless, selfish, rude or ungrateful were reinforced.

Inuit, however, regarded nurses who adhered to the policy of only treating emergencies after hours as "lazy." A number of informants expressed the complaint that since nurses were sent into Gjoa Haven to look after the health of the people, they should either accede to the demands placed on them or they should leave. Certain nurses were singled out as being particularly difficult to cooperate with because they were rude and refused to look at a patient after hours.

On the other hand, a general feeling was expressed that while they recognized how difficult the nurse's job was and indeed were sorry when they had to bother them at night, they had no alternative when their own knowledge of the situation was insufficient to relieve their anxiety. An example of this concern for nurses' feelings occurred one evening when the Station was staffed by one nurse while the other was on holiday. A woman was brought down extremely inebriated and exhibiting hysterical and aggressive behaviour. The man who was acting as interpreter realized that the nurse would suffer from having to remain awake all night to monitor the sedated woman, so he arranged for the two men who had brought her in to remain in the Station and keep her under observation. On other occasions the interpreter or community health worker were approached first to determine if a complaint was serious enough to require the nurse's attention

after hours. Both of these individuals had had enough on-the-job experience to assess the seriousness of a complaint.

Many informants stated that they had no desire to visit the Nursing Station except when they were sick because it reminded them of their hospitalization experiences. These experiences usually involved separation from one's family, an inability to communicate because of language differences, and a distaste for hospital food while craving traditional foods such as caribou, fish, seal, etc. Elderly informants particularly described a situation of almost unbearable loneliness, homesickness and alienation. They expressed the view that the Nursing Station was only for sick people and one felt bad if required to visit in any other capacity. This belief reinforced observations that social visiting and attendance at health education talks usually involved a circumscribed segment of the population whereas the majority of people only contacted the Station when ill.

The quality of the interpreter also affected the utilization of medical services. As stated previously, the primary interpreter was a mature man, the head of a large family, a respected hunter and trapper and widely appreciated for his integrity and fairness in the political affairs of the settlement. He had been employed on a continual basis by the Nursing Station since its construction in the capacity of janitor, although his primary function in practical terms was as an interpreter. Consequently he had developed a remarkable ability to translate the concepts of cosmopolitan medicine into Inuktitut and vice-versa, and his understanding of the confidentiality required in medical interactions was profound. Recently,

the Community Health Representative has also been brought into service as an interpreter and because of her training is able to do an adequate job. However, the C.H.R. is younger, less widely trusted and is more likely to gossip about confidential matters pertaining to patients' problems. The nurses were also more concerned with encouraging her to take responsibility for independent health education and were disinclined to utilize her services as an interpreter.

However, both of these individuals were acceptable interpreters by and large to the entire settlement. Occasionally, however, when either of these two individuals was unavailable, other people with a knowledge of English and Inuktitut were pressed into service and it was on these occasions that the value of interpreting to effective health care delivery became obvious. People were hesitant to describe personal problems and were vocally critical of both the interpreters used and more generally, of the lack of communication between themselves and the nurses.

An important factor in the frequency of utilization during clinic hours was the use of the Nursing Station waiting room as a meeting place by certain women. "Visiting" is the primary recreational activity with the majority carried out between relatives on a house to house basis. However, during clinic hours, everyone knew most of the women would be at the Nursing Station so any excuse would be deployed to justify a visit to the Nursing Station. Although this pattern should not be overstressed, there were considerable occasions when the waiting room resembled the community hall with children playing on the floor while the women gossiped around the walls.

There was another dimension to the utilization of the Nursing Station that involved the degree to which a nurse was trusted and accepted by the Inuit. Although social counselling and mental health are theoretically objectives of Medical Services, the nurses' effectiveness in these areas was highly subjective. In Gjoa Haven, one of the nurses had the kind of necessary rapport with the people that she was sought out on numerous occasions for counselling on marital discord, generational tensions, and psychological breakdowns. One event that particularly substantiates this observation occurred when an old man allegedly attacked a White Hudson's Bay clerk with a knife. The old man was upset over the involvement of his only son with a White girl and felt the White clerk was interfering in a problem which was none of his business. The White clerk took a shot at the old man in self-defense and in the uproar that followed, the old man eventually attempted suicide, was tried and convicted of assault and was incarcerated in Yellowknife for a year. In the interim weeks that followed the incident, the family of the individuals involved called upon the nurse to counsel both the old man and the young couple in hopes of resolving the conflict. The problem was exacerbated by the widely known and acknowledged fact that the old man was reputed to be a very powerful shaman and the entire community was in a state of anxiety over the possible revenge this man might indulge in. Given the reticence with which Inuit are usually willing to discuss shamanism, the fact that the nurse was willingly brought into the conflict and taken into the family's confidence was remarkable.

On other occasions, young couples sought out this same nurse for

marital counselling or over familial problems resulting from their difficulty in meeting the expectations of the older generation. Before the institution of a Welfare Appeal Committee, the nurse was consulted by people who felt they had been unjustly treated by the Territorial Department of Social Development, and in several instances requested loans of money when in particularly dire straits. The nurse usually complied with these requests which differed from the ordinary White tendency to refuse because repayment was usually impossible within the time frame associated with transient northern employment.

Finally, the nurse was consulted on several occasions on political matters, particularly by the Council chairman who had a close personal relationship with the nurses because of his long term employment at the Nursing Station. Advice was sought on matters ranging from local municipal problems to land claims and the political evolution of the North. Indeed, when the nurse made her plans to leave the community known at the end of three years, a strong lobby was engendered in an attempt to convince her to take the position of Settlement Secretary and work for the Settlement Council.

It should be noted here that trust in the nurses can be a very fragile thing as evidenced by an incident that occurred a year or so prior to my fieldwork in Gjoa Haven. A nurse had been resident in the community who, while committed to breaking down cultural barriers between herself and the Inuit by attempting to learn the language, extensive social visiting and trips out on to the land with hunters, had seriously alienated significant

portions of the community by other aspects of her behaviour. Apparently, she was overly sociable with men whose wives had been sent to hospital in Yellowknife, was selective in whom she favoured with both her personal and professional attention, was rude and neglecting of those not so favoured, and interfered in personal family conflicts on a number of occasions without being asked. The outcome of this behaviour was that while a few selected segments of the community felt positive towards her, she alienated the substantial segment enough that they petitioned both the nurse-in-charge at the time and her supervisors in Yellowknife to have her transferred from the settlement. For a period of time after her transfer, people were hesitant to trust the new nurses until they ascertained how they were going to behave socially.

6.3 Agency Coordination

As described in another chapter of this thesis, responsibility for various arenas of activity in Gjoa Haven is divided up amongst a number of locally elected Committees, Councils, and Boards of Directors who are supervised by corresponding departments in the Territorial Government. Coordination and cooperation between these various sectors and Medical Services is without any structured mechanisms at either the local or administrative levels. The distinction between Medical Services and these other departments is further exacerbated by the fact that Medical Services is a Federal responsibility while the rest are Territorial. Consequently, cooperation between the respective departments, particularly at the local

level is dependent primarily upon the personal relations of the individuals involved.

Cooperation between the Nursing Station and Settlement Council is important because Council is responsible for a number of municipal activities that bear directly on public health such as garbage and sewage collection and water delivery. Given the problems involved in providing adequate service in these areas because of severe environmental conditions, the nurses are never satisfied with the quality of the service provided. Machines are always breaking down, budget allocations are insufficient to hire enough manpower and storms are constantly delaying activity. As a result, garbage accumulates randomly, sewage is spilled on the ground and clean-up activities are consistently postponed. While the nurses are aware of these problems, they feel it is their responsibility to urge the Council to be more conscientious in the performance of its duties.

Council's response to this urging is affected by several factors. Most importantly, the dual role of the Council Chairman as the janitor-interpreter in the Nursing Station influences Council's receptivity. It would be wrong to suggest that the nurses' concerns are easily transmitted to Council through this individual because he usually plays a non-assertive role in Council deliberations, requiring the nurses to make their complaints known personally by attendance at a meeting. Neither is he particularly assertive in defending the nurses' claims nor does he argue for their acceptance. However, he does have a facile understanding of the nature and seriousness of their concerns because of his intimate contact with them on

a day to day basis. He is able to interject this understanding into Council deliberations and this no doubt facilitates improved public health.

The Council Chairman is also sensitive to what he regards as excessive demands placed upon the nurses in areas of social welfare and assistance. He has, on several occasions, encouraged the Council to develop strategies to relieve the nurses of some of this pressure. However, it should also be noted that the reversal of his role from a subordinate in the Nursing Station to a supervisor in his capacity as Council Chairman probably negatively affects his inclination to support the nurses' complaints.

Interaction with the Council is also affected by the attitude adopted by the nurses. In one instance a nurse approached the Council with a maternalistic demeanor and was very obviously accusing Council of negligence. The Council members are by and large sensitive to criticism because they are attemtping to perform a function they do not fully understand and are easily put on the defensive when they suspect a White is patronizing them. In this instance, numerous reasons were brought out to justify Council's previous inaction.

One of the more influential Council members is an individual who epitomizes the conservative element in the settlement. His involvement with the Church has created a dependency on prayer as a curing mechanism and he actively resists any involvement with the Nursing Station. He expressed the view that medicines were only used by Whites to force the Inuit to be dependent, and considered them useless unto themselves. Consequently, he consistently introduced a reactionary or negative element in Council

deliberations over the requests or complaints of the nurses. As a heavy equipment operator as well, his pragmatic reasons for finding a particular request impossible to fulfil were usually respected.

Cooperation between the Council and the Nursing Station is also affected by the personality of the individual acting as Settlement Secretary. The Secretary is responsible to the Council for implementing their decisions. He is, in many respects, a very important gatekeeper of information because issues raised by members of the settlement are usually transmitted through him and concerns expressed by the Council to the Territorial government also go through him. Throughout much of the fieldwork period, the individual holding his responsibility was not particularly receptive to White complaints, and in many instances effectively blocked communication between the Nursing Station and the Council. This behaviour placed the Council Chairman in a difficult position because he was previously frequently informed by the nurses and was thus aware when information was not getting through to the Council. The Secretary's eventual resignation was in part precipitated by a conflict with the Nursing Station and was encouraged because the Council recognized and rejected his interference.

One incident that particularly describes some of the difficulties of cooperation between the Nursing Station and the Council pertains to the proposal to build a water pipeline from a nearby lake into the settlement. Presently, a road connects the settlement to a small lake located approximately three miles away and water is trucked into town on a regular basis.

The residents of Gjoa Haven however, are almost unanimous in their distaste for the water from this lake. As soon as freeze-up occurs they travel by snow-machine to a lake a few miles further distant and cut large blocks of ice for use in making tea and for drinking water. The trucked water is used only for washing, etc.

When the Territorial government proposed to the Council that they would be willing to fund a water pipeline, the Council expressed a very strong desire that the pipeline be extended to the further lake because the water was much preferred. The government's reaction was to ask the nurses and an environmental health officer to test the water in the regularly used lake to determine if there was any biological justification for the expense involved in extending the pipeline. The medical services staff concluded that the water in the nearby lake was perfectly adequate for personal use and thus gave the government the leverage it needed to refuse Council's request. This debate has gone on for several years now and finally concluded recently with the construction of a pipeline to the nearby lake. In the final stages of the proposal, the Council showed considerable disinterest in the project and refused to acknowledge that its construction was in any way their responsibility. As a result, the Council members, and the rest of the settlement, were somewhat annoyed at the role the nurses had played in negating Council's wishes.

Cooperation between the Nursing Station and the school is structured in the sense that standard public health visits for the purposes of immunization are required. However, health education is primarily the responsibility

of the teachers and use of the nurses or community health representative as resource personnel is left to the discretion of the principal or, in some cases, individual teachers. In Gjoa Haven, the principal was particularly uncooperative towards the idea of allowing health services personnel to provide health education to the school children as part of the school curriculum. His professional decision appeared to be an expression of his personal estimation of the incompetence of the nurses in areas other than traditional bed-side care. This problem was further complicated by the unfortunate personality clash between the principal and the woman working as the local community health representative. This woman had previously worked as a teacher's aide in the school until she could no longer tolerate the principal's rather authoritarian demeanor. This clash was unfortunate because she thoroughly enjoyed teaching children and had the opportunity been presented, would have responded very positively to conducting health education classes in the school.

This lack of cooperation at the administrative level eventually led to private arrangements being made between the nurses and individual teachers to allow either the community health representative or one of the nurses to enter their classroom for occasional health education periods. However, this program was by no means systematic or comprehensive and experienced only marginal success.

A further difficulty was encountered in the area of Adult Education. The nurses were attempting to have health education included as part of the adult education curriculum but were stymied in their efforts. The adult

education program was run by a local woman in her early thirties who concentrated her energies on teaching basic English and mathematics to people who had received little or no schooling. Students were paid a monthly stipend by the Department of Education and attendance by middle-aged women was quite high. The nurses felt this group represented the primary target for their efforts in health education and had been unable to attract them to their own voluntary classes in basic nutrition, hygiene, and home nursing.

The woman in charge of adult education was, however, uncooperative for reasons unknown, and eventually the nurses approached her supervisor, the Superintendent of Education in Cambridge Bay. Although his approval was received and an attempt was made to have a nurse and the C.H.R. instruct in health education, the resentment at the local level of this rather paternalistic strategy prevented any real cooperation from occurring and the program was eventually abandoned.

The Department of Health and Social Development was represented in Gjoa Haven by an Inuk who worked on a part-time basis assessing welfare claims and handing out cheques when appropriate, and by the occasional visits of a White administrator from Cambridge Bay who is ultimately responsible for any welfare payment problems, planning and implementation of new local programs, and actual social work.

The coordination between the Nursing Station and this department should have been essential because in many areas their responsibilities overlap. For example, while Medical Services is responsible for transporting people out to hospital, Social Development is responsible for transporting them back to their settlement. And of course, in all areas

pertaining to social work such as child abuse, emotional breakdown, alcoholism, etc., both departments are fundamentally concerned.

The essential problem that reduced the effectiveness of potential coordination was that the nurses could only advise the visiting supervisor as to local problems and the degree to which this advice was respected depended to a large extent on the personal relationship between the superintendent and the nurses. There was virtually no communication of significance between the local welfare worker and the nurses or with the C.H.R.

As an example of the difficulty that arose as a result of this lack of coordination, a case will be described involving a middle-aged woman who became severely emotionally upset. She was involved in an arranged marriage with a very elderly man and had come to find this arrangement intolerable. She was receiving no support for her problem from her family and had begun to drink heavily and to exhibit signs of emotional and behavioural breakdown. The nurses were aware of her problem and had been attempting to get Social Development to remove her to Yellowknife for counselling and treatment, a course of action she herself desired. However, Social Development did not agree with the nurses' assessment of the seriousness of the situation and refrained from acting until a crisis occurred. Needless to say, the nurses were very upset over a situation they felt could have been avoided had the Social Development Department responded sooner.

The nurses were also very critical of the low amount of welfare dispensed to needy families as they could assess the insufficient level

at which such families were maintained. As well, they were critical of health insurance rules set up by Social Development that forced nurses to fabricate reports in order to justify certain individuals and families receiving full medical benefits.

The two commerical outlets in Gjoa Haven had a significant influence on the nutrition levels of people. The tendency to purchase junk food such as pop, candy, potato chips, etc., rather than more nutritional foods (which are usually more expensive) was prevalent in Gjoa Haven as elsewhere in the north. The nurse had spent some time advising the Bay manager as to how more nutritional foods could be ordered on the annual barge delivery but for one reason or another, the advice was ignored.

The Co-op store was administered by a locally elected Board of Directors and had an Inuk as manager. They were more amenable to local influence regarding the purchase of nutritional foods but a variety of administrative problems absorbed their attention and energy, resulting in little overall effort being given to health matters.

Coordination between the Nursing Station and other agencies and groups in town was negligible; in some instances this was significant in itself. The Churches had very little to do with Nursing Station programs except for visiting priests who were occasionally consulted by the nurses. The C.H.R. was recently elected to the Housing Association Board of Directors and her influence in encouraging the rehabilitation and upgrading of older homes was being felt. The Hunters and Trappers Association operated without contact with the Nursing Station despite their activities

in the area of redistribution of country food. The R.C.M.P. from Spence Bay acted as resource personnel to the nurses in such areas as alcohol education and of course worked closely with the nurses whenever an accident occurred.

Finally, brief mention here should be made regarding the locally elected Health Committee and its involvement with other local committees. Contact was minimal in any real sense and indeed other agencies such as the Council regarded the Health Committee as ineffectual. Many of the Health Committee's so-called responsibilities such as clean-up, dog control, etc., were also within the jurisdiction of the Council and consequently they were for the most part ignored.

6.4 Health Education

Efforts in the field of health education were the joint responsibility of the nurses and the C.H.R. The nurses focused the majority of their attention on advising patients during clinical visits as to the environmental or lifestyle cause of their ailment. Scabies is a particularly effective example as people who came for treatment of this skin disease could be directly advised of the cause. Advice was given to wash clothes and bodies more rigorously and the relationship between cause and effect was easily demonstrated.

Other areas of health education were however, less amenable to direct demonstration of cause and effect. Basic lifestyle changes in areas of nutrition, hygiene and sick role behaviour were required and these

changes were the subject of classes organized by both the nurses and the C.H.R. The classes were generally organized around various themes ranging from very basic concerns such as the spread of germs from failing to wash hands to more complex subjects such as alcohol and its physical, social and psychological effects on the individual and community.

The nurses tended to focus on large group instruction and planned a complex series of talks to take place at the Nursing Station on a regular basis. Posters were placed in various locations such as the Post Office and stores, handouts were sent home with school children and word of mouth advertising was used to encourage people from all sectors of the community to attend these classes. The classes were usually scheduled for the evenings and movies were almost always incorporated into the programs to further induce people to attend.[1]

The C.H.R. also planned occasional large public talks to be held in the Nursing Station but concentrated her attention on small group instruction and individual advising, in the home. She would prepare a particular theme such as the cause of scabies or nutritional snacks and either organize a group of four or five women in the home of someone who was considered an example of good preventative or public health practices, or she would visit from house to house and advise people personally of particular problems they might have.

Both nurses and the C.H.R. occasionally visited a school classroom

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1. Movie-going was the primary recreational activity of people during the winter months.

to instruct students on such matters as dental hygiene or V.D. control but this program was subject to the problems outlined in the previous section.

These attempts at health education were subject to frustration from two levels. Requests for supporting material from zone or regional offices met with variable success and the response from the community was at best sporadic and tenuous.

Since adult education in Gjoa Haven had to cross a language barrier, audio-visual aids were considered by field staff to be extremely important if instruction was to be effective. Unfortunately, specific requests for particular materials relevant to the Gjoa Haven situation went for the most part, unfulfilled. Instead, material in general use by the Canadian public at large was provided with little or no attempt at translation. Indeed, some of the material was particularly irrelevant as evidenced by a film used in a class on disease transmission that depicted a Mexican-American family being shown how to dig latrines in their cornfields. Alcohol education material was also grossly out of date or totally unrelated to the cultural conditions of Gjoa Haven.

Aside from this fundamental problem of failing to provide appropriate educational aids, zone and regional staff undermined local health education efforts in a more direct way. In one instance, the nurses were maintaining a file that provided continuity to the health education program from one nurse to another. It contained material from previous attempts at health education and helped new nurses determine what sort of instruction had already been presented. Unfortunately, a Zone Nursing

Officer felt this file was an unnecessary demand on the nurses' time and ordered it scrapped on one of her brief visits to Gjoa Haven, despite the protestations of the nurse-in-charge at the time.

The response of the Inuit to these attempts at lifestyle alteration varied but were for the most part negative. There was a small group of a half-dozen or so regular attendants at all health education classes who responded in a very positive manner to the program. This group of women by and large maintained their houses and families in a manner most resembling White middle-class standards, and although they attended classes regularly and faithfully, they were not regarded by the nurses as being in particular need of improvement. This group also represented women whose families were particularly successful at combining wage labor and land activities and who were usually involved in local politics. They generally had had a longer period of contact with White society through such things as employment at DEW line sites, or involvement with the churches, R.C.M.P. or traders. Overall, they exhibited confidence in their capabilities to adapt to culture change.

However, the majority of the community exhibited considerable apathy towards health education attempts. While many expressed a verbal opinion that health education was necessary and valuable, their attendance at classes was at best sporadic and for the most part negligible. It should be pointed out, however, that this apathy towards health education was not representative of a more general apathy because these same people were either very active in traditional pursuits or were actively engaged

in local political and economic concerns where attendance at meetings was usually remarkably high.

The apathy shown towards other health education attempts stemmed from several areas. Primarily, people resented these direct attempts to alter very basic behaviour strategies in their lifestyle. While a woman might be willing to accept instruction in the operation of a washing machine with which she had had no previous experience, she would respond negatively to suggestions that she was incapable of keeping a house and caring for her children. These duties have always been the traditional domain of women in Inuit society and their self-image, identity and confidence stem from these activities. A frequent type of complaint is exemplified in the following:

> The nurses were always complaining about our housekeeping practices. We are trying to do our best but the nurses are never satisfied. It's easy for them at the Nursing Station because they have running water, more space and special equipment. They don't understand our problems.

The men were particularly sensitive to nurses' attempts to alter their lifestyles. In one instance, a middle-aged man was building a boat and was in the process of fibreglassing its exterior in a large government garage. A nurse happened to visit him during this activity and advised him at some length as to the health hazards involved in using fibreglass resin in a closed space without adequate ventilation. His response was atypical in that his usually polite and friendly demeanour was dropped and he became very openly resentful, hostile and uncooperative. Obviously,

despite the valid content of the nurse's message, the context of the instruction served to erase its effectiveness.

Other social factors that influenced the effectiveness of health education were role relations between men and women, and seniority. As mentioned above, the women were responsible for the care of children and the house and men were generally loathe to interfere in that domain even when they recognized a problem existed. In several cases, men who through experience and/or contact with the Nursing Station had a fairly sophisticated understanding of cosmopolitan medical theory, refused to interfere in their own domestic situations when their wives engaged in behaviour that facilitated health problems.

Recognition of the authority of old people by younger family members could however influence the acceptance of better health practices, if the nurse was able to convince the older person these changes were necessary. In one household, the nurses experienced little success in encouraging a young mother to keep a cleaner house until they approached the resident mother-in-law who promptly lectured her daughter-in-law on basic cleanliness. The situation was vastly improved within a short period of time.

A further explanation given by people to explain their reluctance to attend classes was simply that they were "too busy." Many people felt that either they were too tired in the evenings after a day's work to attend classes or that their attention was so focused on more important matters such as politics and economics that little energy or time was left available

for health education. As long as they were receiving prompt and effective treatment from the Nursing Station for illness, they were content to leave health matters to the nurses. This attitude had a particular effect on my research as I occasionally found it difficult to interest people in a discussion of health matters. They much preferred to discuss land claims or political evolution. On one or two occasions an informant stated that they had never previously thought about health and illness problems and that my questions were causing them to consider them for the first time.

Some people expressed the further opinion that health education talks were always about the same thing and consequently boring and repetitive. Despite an apparently superficial understanding of such things as germ theory, these people felt they wouldn't benefit from further attendance at health education classes.

Another attitude that affected attendance at health education classes held at the Nursing Station was the previously mentioned perspective held by people that the Nursing Station reminded them of a hospital and should only be visited when sick. There was generally better attendance when classes were held outside the Nursing Station.

The C.H.R. in particular benefitted from her orientation to holding health education talks privately or in small groups within the homes. Unfortunately, the majority of this instruction took place in Inuktitut so that I was unable to assess the response to the content of the instruction. From observation, however, it would appear the C.H.R. was having far fewer problems in terms of resentment or apathy than were the nurses. This

conclusion is partly borne out by the increasing reliance on the C.H.R. for advice in public health matters. Occasionally, the C.H.R. is approached in either of the retail outlets for advice on which of the foods are more nutritional and she is also asked for advice on hygiene and childcare.

Overall, however, the effect of health education has been to introduce a superficial understanding of cosmopolitan medical theory into most of the population. For instance, people know they require shots to prevent disease and the nurses experience little difficulty in acquiring people's cooperation for these immunization programs. However, when questioned most people are unable to offer any explanation of why the injections are needed or effective. People know germs cause disease but have little understanding of the nature of a germ or the mechanisms of transmission. Occasionally, evidence occurs indicating other aspects of acceptance of lifestyle change instruction when, for instance, raisins are purchased instead of potato chips for snacks, a washing machine is bought before a new stereo, cups and dishes are washed frequently when a person is sick in the house, etc. These indications are increasing in frequency and are evidence that, over the long term, health education is achieving some success despite the apparent apathy and lack of response on a day to day basis.

A description of the events leading up to the prohibition of alcohol in Gjoa Haven is an excellent example of how health education can be very effective. The N.W.T. has an ordinance that allows communities to prohibit the sale, consumption, or importation of alcohol in their boundaries if a

majority of the local population agrees to it. There are a number of options available, ranging from rationing of consumption, to outright prohibition.

In Gjoa Haven, alcohol consumption was not excessive by northern standards but was having a serious negative impact on local behaviour from the perspective of many Inuit. There was evidence of several accidental deaths, wife-beatings, adulterous behaviour, and general dissension and conflict within families that could all be attributed to alcohol consumption. While most people were aware of, and upset by these behavioural problems, they were initially not as aware of the connection between alcohol consumption and behavioural deviance. Indeed, many people attributed the disturbances to the absence of an R.C.M.P. officer in town and some were very angry that the Territorial government was resisting their demand that Gjoa Haven be given a permanent R.C.M.P. post.

The nurses were naturally concerned with the health-related, detrimental effect of alcohol and undertook the objective of educating the Inuit with regards to appropriate drinking behaviour and control of actions. It should be noted that, philosophically, they did not approve of outright prohibition and their approach to appropriate drinking behaviour and control was based on their own cultural standards. Their education program included several classes on the subject at the Nursing Station and, particularly, a public meeting at the Community Hall where the R.C.M.P. officer from Spence Bay was invited to answer questions. This meeting elicited an enormous turnout and witnessed some very emotional rhetoric

from many Inuit. The meeting was particularly profound because a young man had accidentally killed himself a week previous while severely inebriated. Most Inuit participants expressed very poignantly, their feelings that alcohol was a very bad thing and that they wished no one would drink in Gjoa Haven. Regular drinkers who attended the meeting, were for the most part silent, except for a few who expressed the opinion that they were unable to control their drinking behaviour and therefore wished alcohol didn't exist.

Aside from the nurses' efforts and the generalized local concerns there were two other forces that contributed to the eventual resolution of the problem. The Settlement Council and the Anglican Church were also very committed to relieving the tension created by alcohol consumption problems.

The Anglican church members placed more emphasis on morality in their approach to religion and the family tensions, adulterous activities and violence associated with alcohol consumption particularly upset them. Sunday sermons frequently were vorifegous attacks on drinking activities and the Inuit lay preachers were unanimous in their abstention from drinking. One preacher in particular delivered long and powerful diatribes against the sins of alcohol and was also outspoken on the subject at the public meetings mentioned above and at Council meetings.

Council's involvement in the prohibition process was complicated by several factors. The Settlement Secretary was himself a heavy drinker and manipulated his role as an information gatekeeper to prevent the

Council from effectively communicating their wish to the Territorial government for a prohibition plebiscite. The Council chairman, from his involvement with the nurses, had accepted the idea that outright prohibition was not in the long term interest of the community and preferred a "research and education" approach to the problem. Accordingly, the time involved between the initial concern over alcohol consumption and the eventual plebiscite was well over a year and involved lengthy debate on Council's part and several miscommunications between Council and the Territorial government.

When the plebiscite was eventually held, ninety-three percent of the potential voters cast their ballot and of those, eighty-six percent voted for the prohibition of alcohol. Thus, it is evident that a successful health education program requires more than the initiative of the nurses. Two other key ingredients are necessary: the initial concern of the local people that a problem existed and the involvement of Inuit individuals and institutions in the education process.

6.5 Native Participation

In this section, Inuit participation in the delivery of cosmopolitan medical services to Gjoa Haven will be described. This participation, theoretically, could take place on two levels. Input into the design and method of delivery of the services both extralocally and within the community is one area of involvement. The other area of participation is the degree to which individuals hold responsibility within the health care delivery system for the performance of certain tasks.

Inuit participation in the design of the delivery system is virtually absent at any level. Extra-locally, there are no advisory boards with Inuit members, nor are there Inuit personnel involved in the day to day operation of Medical Services.

The only influence Inuit in Gjoa Haven have over Medical Services is through their locally elected Settlement Council who can complain to the Territorial government if they feel wronged and this complaint will be passed on to Medical Services if deemed appropriate by the Territorial government. Needless to say, the complaint has to be extremely serious to justify the red tape and administrative hassles involved in registering the complaint.

In Gjoa Haven's history, only one such course of action has been taken. In the case of the nurse who seriously disrupted settlement life described in other sections, the Council requested her removal from Gjoa Haven. Although the nurse was eventually transferred to another settlement, it is difficult to assess the effectiveness of the Council's complaint because the nurse-in-charge at the time threatened to resign if this nurse wasn't transferred.

However, one nurse in Gjoa Haven was sufficiently impressed by the Council's power to complain bitterly that there was no security in her job because Council had the ability to force Medical Services to transfer nurses. She felt that the Council's power was unwarranted because they were unable to appreciate the difficulties experienced by northern nurses.

It should be noted however, that aside from this rather involved

complaint process, there was no mechanism whereby people in Gjoa Haven could review the performance of nurses or any of the programs or services provided by Medical Services.

Another example of the Gjoa Haven Settlement Council attempting to represent the people's views on a health related matter occurred around the design and construction of a water pipeline to the settlement described earlier in another section. Briefly, the Council rejected the proposed pipeline because it connected the settlement with a lake whose water was vehemently disliked. However, Medical Services personnel overrode this complaint by testing the water and pronouncing it drinkable. Because the Council's alternative was more costly, it was rejected.

A complicating feature of the problem of native participation in the medical services delivery system stems from the current "struggle" over transfer of responsibility of Medical Services from the Federal to the Territorial government. Despite verbal commitments to the contrary, Medical Services is resisting this transfer on the grounds that: (a) native people are against it (b) the Territorial government already has difficulty fielding other services and (c) transfer should be postponed until the Native Land Claims are settled. The Territorial government, on the other hand, is critical of the Federal government's failure to include local input into decision-making and hopes to increase coordination between departments when they have responsibility. In essence then, despite the Territorial government's better record of providing for native participation in the decision-making process in most of their departments, the

Federal government is resisting the transfer on the grounds that they are cooperating with the interests of native organizations.

At the local level the Health Committee is theoretically an advisory board that allows for input into the operations of the Nursing Station. In the past, they have made suggestions as to appropriate clinic hours and when public showers should be held. However, there is no doubt in anyone's mind that this responsibility is tokenism. The composition of the Board reflects the low importance it is accorded by townspeople. As described earlier, membership on various committees is a result of several factors, but leadership qualitites are a primary determining factor. However, with the Health Committee, the chief characteristic would seem to be extensive experience in the sick role. Most Board members are either hypochondriacs or long-term tuberculosis patients or cripples and do not particularly exhibit any evidence of decision-making ability. Most are not elected to any other committees and this is ample evidence of the insignificance of the Health Committee.

In the recent annual elections to nominate new Board members, the Health Committee had a serious problem overcoming apathy and took several months to accomplish the nominations. It is interesting to note that within the community there were several responsible individuals who had worked as lay dispensers or community health workers elsewhere, who could have provided a competent core to the Health Committee. However, none of these individuals were nominated for election. Most people in Gjoa Haven, when asked, had very little understanding of the purpose of a Health Committee and felt it was only created because the nurses wanted it.

Primarily, there were two individuals involved in the delivery system on a day to day basis -- the C.H.R. and the janitor-interpreter.

The C.H.R. had been working in Gjoa Haven for approximately six months prior to my arrival. Most people interviewed initially were unable to describe the C.H.R.'s function and felt either she was in training to be a nurse or she was merely another interpreter for the Nursing Station.

Towards the end of the fieldwork period, people began to recognize her function as a health educator and to utilize her for advice. However, with a few exceptions, most people were unwilling to consult the C.H.R. alone without a nurse being present.

The C.H.R.'s role in the health care delivery process can be seriously undermined by insensitive nurses. Fortunately for Gjoa Haven, the nurses fostered and encouraged her independence and refrained from utilizing her simply as an interpreter or even more damagingly, as a "gofor" -- relying on the C.H.R. to operate ditto machines, etc.

A primary complaint of the C.H.R. was that the job was only part-time and paid accordingly, and although she like the work, she sometimes felt her skills could be better reimbursed elsewhere, such as the school. She also felt she needed more time to effectively plan and implement the programs she was responsible for but was unable to convince administrative staff that an expansion of her position was necessary. The nurses supported her in this goal and were also attempting to convince administrators that Gjoa Haven required a full-time C.H.R.

Despite her effective functioning as part of the health care team,

the C.H.R. was not included in a structural sense and was maintained in a special status relationship. Special conferences and meetings were held exclusively for the C.H.R.'s, instead of meeting together with nurses and other health professionals. Upward mobility was not particularly encouraged, although the C.H.R. in Gjoa Haven is motivated enough to be currently attempting to train herself as a registered nurse. It will be an interesting commentary on Medical Services commitment to native participation to see if she experiences frustration and disillusionment or is encouraged in this ambition.[1]

The janitor-interpreter has been described in various contexts in other sections. The extent of his participation in the delivery of health services is idiosyncratic to Gjoa Haven but is a remarkable example of the kind of success that can be achieved.

The primary function of this individual has been to orient new nurses to the cultural features of Gjoa Haven. His important role in settlement politics particularly suits him to this task. On occasion he has also oriented new nurses administratively and technically to the procedures of the Nursing Station when previous nurses have left prior to the arrival of their replacements. His orientation tasks are now being assumed by the C.H.R. but the nurses continue to rely heavily upon his advice in crisis situations with individual patients, particularly when

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1. As this thesis was being finalyzed it came to my attention that the C.H.R. in Gjoa Haven had resigned her position with Medical Services, apparently out of frustration and disillusionment. She is now involved in a teacher training program.

the crisis is a social or emotional one. They are able to trust his confidentiality absolutely which is sometimes a difficult problem when working with interpreters.

Although without formal training, he competently operates the x-ray equipment and carries out chemical tests of the water supply. Despite his ability and involvement in the medical aspects of Nursing Station operation, he professes to find more satisfaction in the maintenance component of this work and aspires to upgrade his skills in that area. This orientation is in part a reflection of economics, because his intellectual energy is absorbed in land activities and settlement politics. His job at the Nursing Station is fundamentally a means to secure the necessary economic security to allow him to participate in these other areas of activity with confidence. Consequently, maintenance upgrading is the best way to increase the economic benefits of the job while at the same time ensuring security.

In the past, he has had some difficulty in eliciting the recognition of administrative personnel as to his wage requirements and has threatened to resign on several occasions. Fortunately, his expectations were eventually met, apparently partly through the initiative of a previous physician who recognized his overall contribution to the health care delivery process.

Currently, his renumeration is on a par with the nurses' and this has led in one instance to criticism and resentment from one nurse who felt a janitor should receive a smaller salary than a nurse. By and

large, however, most nurses and other medical personnel recognize his intrinsic importance and realize employee distinctions based on southern models are inappropriate to the northern context.

In a general sense, encouragement of young Inuit to assume responsible positions in the health care delivery process is inhibited by several factors. While the nurses provide definite role models to young girls, boys are not attracted to the profession. This is indeed unfortunate because in the current economic structure of the settlement, men are more likely to commit themselves to long-term continuous employment than are women who seek employment primarily to supplement the family's wage earning capacity and usually concentrate most of their attention on their families once they begin to bear children. Part-time work is most appropriate to the women.

Another inhibiting factor is the influence that members of the older generation have on their children's aspirations. While a younger person might aspire to White middle-class values that are necessary in order to succeed in a highly specialized career such as medicine, parents and grandparents usually view any employment as merely an opportunity to earn money. Consequently, they will pressure young people to look for work as a carpenter, heavy equipment operator or store clerk that does not require a person to leave the settlement for training.

A further factor that decreases the likelihood of young people leaving the settlement for training in the south, aside from the obvious but important emphasis on family ties and commitment, are the ambivalent

feelings some Inuit hold towards Indians. Historically, Indians and Inuit were incompatible and feelings of animosity still exist in isolated places such as Gjoa Haven. Since most training courses take place in southern locations dominated by Indians, many young people are reluctant to relocate there.

6.6. Miscellaneous

In this section, aspects of health care dynamics that aren't particularly appropriate to any of the other sections but don't justify a section unto themselves will be described.

Visits to Gjoa Haven by medical specialists such as dentists, opthalmologists, pediatricians and dental and opthalmology technicians are singular events and entail unique behaviour. The most obvious problem with these visits are that they are too rapid and too infrequent. This complaint was voiced by Inuit and resident medical staff alike. Many informants became quite upset during these visits for a number of reasons. Some didn't understand the purpose of the visit and became confused and disoriented when forced to subject themselves to very rapid examination and treatment. Others found the inadequate advance warning frustrating because, for instance, visits by dentists always seemed to coincide with their hunting excursions and they would be unable to have a painful dental problem alleviated for several years.

Occasionally, the individual specialist would focus his concentration so narrowly on performing his duties as rapidly as possible that he

would be oblivious to the effect his attitudes and behaviour were having on his clients. Particularly old people were frequently offended in this manner.

Another feature of health care not previously discussed relates to the treatment of the dead. The bodies of persons who died after being evacuated to Yellowknife were very rarely returned to Gjoa Haven. This practice was at the request of the Inuit who had no desire to see the body returned. When someone died in Gjoa Haven, the body was placed in a coffin and removed to the graveyard area as quickly as possible without ritual or formality. The community would usually grieve openly for one day and then every effort would be made to forget the event as rapidly as possible. Mention of the deceased was avoided. On one occasion I offered a photograph of a recently deceased old man to his surviving son who had previously admired the photograph. He declined the offer stating that it would only remind his children of their grandfather and make them sad.

Another aspect of health care concerns the way in which child-rearing techniques affected the health of children. Particularly with regard to nutrition, many parents found it impossible to discipline their children's eating habits other than by example. If the child wouldn't follow his parents' example and eat nutritious country foods, the parents would provide him with usually inadequate food from the stores. This was a source of frustration to the nurses who were unable to improve a child's health because of his poor nutrition.

Finally, a few instances were observed where parents used "horror

stories" about the Nursing Station in order to discipline their children. When attempting to coax a child to behave in a certain manner, parents would occasionally threaten to "have the nurse give you a needle" or "send you to Yellowknife for an operation" if they didn't cooperate. Needless to say, this behaviour exacerbated the trepidation that many children felt towards the Nursing Station.

In summary, the description above outlines the various domains of interaction in Gjoa Haven pertaining to health care. The Nursing Station provides the pivotal focus in each of these domains. It is evident from the above discussion that the nurses perform a very substantial function in settlement activity. The implications this interaction has for improving the health care system will be discussed in the conclusions and recommendations to follow in the next chapter.

7. CONCLUSIONS AND RECOMMENDATIONS

7.1 Conclusions

This thesis has met the objectives set forth early in the thesis. It has accounted for the apparent displacement of the traditional Inuit medical system over historical time and investigated contemporary local dynamics that both facilitate and impede the effective delivery of cosmopolitan medical services in an Inuit settlement. A broad range of variables affecting these objectives have been described including macro-social and historical factors, the cultural models and social behaviours of the providers of cosmopolitan medical services, changing Inuit beliefs and attitudes about illness, and the Inuit response to cosmopolitan medicine and their interaction with health care workers.

An acculturation approach was used to survey the changes in Inuit belief and behaviour over time with regards to illness. The thesis has demonstrated that while the traditional Inuit beliefs and behaviours related to illness have undergone substantial revision, in response to acculturation factors, their contemporary explanations and understandings about illness are still substantially influenced by traditional models. These acculturated models that explain illness demonstrate that while Christianity's religious influence had the greatest impact on the content of the models, other factors associated with colonial contact affected the rate of change and ease of acceptance of new ideas into Inuit models of illness explanation. For example, traditional Inuit disease theory attributed illness to

supernatural wrath over a breach of taboo and expected the shaman to cure illness by intervening in the spirit world. Contemporary beliefs by and large, attribute illness to breaches of moral and social etiquette associated with the Church's dictums and sometimes expect prayer to effect a cure.

The acculturation model also indicated that the disastrous impact of previously unknown diseases had a major effect on people's decisions to relocate in White dominated settlements. It was suggested that too much emphasis has been placed on economic factors and education in previous discussions of Inuit relocation to the exclusion of illness as an important contributing factor.

A related conclusion concerns the pattern of dependency established during these "dreadful decades" and the effect this dependency has had on current utilization behaviour and attitudes. Whereas illness was a primary motivating factor in resettlement patterns and is a major cause of anxiety and concern in the current situation, little energy and effort is expended by most Inuit towards "self-care" or personal responsibility in health matters. This dependent utilization behaviour can only be understood in terms of the historical factors that have created it and any attempts to influence these patterns must be cognizant of these factors.

An acculturation approach was also used to discuss the shaman's adaptation to colonial contact. Attention was concentrated on the way in which certain economic activities such as trading and trapping, combined with religious suppression and the impact of previously unknown diseases,

served to undermine the shaman's traditional role and eventually cause its attenuation. This analysis of the curer's role attenuation was related to Landy's (1974) discussion of traditional curers' adaptation to cosmopolitan medicine and it was indicated that Landy's dependence on competition from the cosmopolitan medical system as the key determining variable in curer adaptation was inappropriate in this situation. The acculturation model used to describe the Inuit shaman, illustrated that the various other factors listed above were far more significant.

This thesis also demonstrated that an eclectic approach to the study of sociocultural change and contemporary behavioural dynamics is necessary. A processual model was therefore also utilized to fully understand the objectives of the thesis.

The dynamics of Inuit participation in the cosmopolitan medical system were examined within a processual framework. Decisions to utilize various aspects of the system were seen to be based on a combination of cultural values, individual experiences, and situational circumstances. It was demonstrated that there was no set pattern of utilization and that various individuals and sectors of the community interacted with the Nursing Station to different degrees and in different contexts. For example, some individuals sought out nurses' aid for all manner of problems ranging from minor physical complaints through psychological trauma to social difficulties while others avoided all contact with the Nursing Station and preferred to rely on traditional and acculturated techniques for curing illness such as shamanism and prayer. The importance of this processual dimension to the study of health care

dynamics in Gjoa Haven, is illustrated by this occasional inconsistency between beliefs and behaviour. The acculturated models that explained illness were by and large consistent throughout the community but the behavioural interaction with the Nursing Station indicated considerable variation and inconsistency.

This eclectic approach also reconciles some of the problems that emerged in the conceptual discussion of comparative medical systems. It was indicated that medical systems could be studied as cultural systems, or as social systems from both a macro and micro perspective. The position taken in this thesis was that all approaches are necessary to fully analyse the complexity of medical systems in a cross-cultural environment. Particularly with regard to Dunn's (1978) argument that there are always two medical systems operating in a culture contact situation, this position is necessary. In Gjoa Haven, the traditional medical system functioned largely as a cultural system while the cosmopolitan system functioned as a cultural and social system. The thesis demonstrated that the social components of the cosmopolitan medical system required investigation at both micro and macro levels. Relations among nurses, and between nurses and patients and nurses and supervisors, were equally important as the structure of the cosmopolitan medical bureaucracy. In this regard, the thesis has demonstrated effectively that an understanding of the complexity of health care in a cross-cultural environment is best understood through an analysis of both the providers as well as the clients of the service. For example, friction among nurses and between nurses and administrators was demonstrated

to be as much of a contributing factor to health care delivery problems as were the cultural differences associated with the client Inuit population.

The thesis also describes how a particular regional variation of the cosmopolitan medical system is effective in meeting the health needs of the Inuit. The model of health care delivery based on nurses and the Nursing Station is a sufficiently unique variation of the cosmopolitan medical system to warrant the conclusion that its' features are in part responsible for the overall success of the system. The nurses' emphasis on "caring" as opposed to the standard physician emphasis on "curing," is more amenable to the Inuit approach to illness where physical, psychological and social factors are combined.

A substantial portion of the thesis is devoted to a discussion of how cosmopolitan curers manage their roles. The discussion of the professional and personal values of nurses indicates that to some degree, they are preadapted to function effectively as curers in an Inuit settlement. Depending on the manner in which they adapt to the potential roles available to them, their ultimate success is determined. For example, the thesis describes three approaches to role adaptation taken by three different nurses in Gjoa Haven. At one extreme, the nurse who was eventually transferred and dismissed ignored certain important aspects of professional role behaviour and emphasized personal interaction with the Inuit. The most successful adaptation was evidenced by the nurse who combined both personal and professional roles effectively but emphasized expanded professional role

activity. At the other end of the continuum there was the nurse who attempted to restrict both her personal and professional role involvement with the Inuit and as a result experienced considerable frustration and dissatisfaction.

Attention is focused in the thesis on the manner in which nurse role adaptation effects their success in a variety of domains of interaction and with regards to particular health problems. Examples of these discussions are summarized below.

The conflict that has arisen between administrators and some field nurses over the degree to which Medical Services should limit their involvement in community affairs has reduced the potential effectiveness of some programs in areas such as health education. The nurses generally realized that their effectiveness in non-clinical areas was highly dependent on the personal rapport they had established with the community and recognized that the quality of this rapport derived from their ability to respond as freely as possible to needs as they arose. When this freedom was restricted by Zone or Regional guidelines, problems arose.

Much of the nurses' frustration about their jobs stems from staff relations rather than difficulties with the Inuit. Lack of agreement with and support from supervisors, ambiguity over responsibility between physicians and nurses and personality clashes between nurses emphasized by restricted living and working arrangements all contribute to nurses' frustration and dissatisfaction and consequently affect the quality of health care provided.

As the data illustrate, nurses' interaction with Inuit differed significantly from that experienced by most other Whites. These differences had both positive and negative aspects because although nurses tended to interact with a greater proportion of the total population more frequently, that interaction was dominated by the illness event. This context of interaction at the same time encouraged maternalistic attitudes; reinforced altruistic behaviour and beliefs; facilitated intimacy and the sharing of grief; led to close personal involvement in personal and family problems; but sometimes ironically reinforced negative stereotypic perceptions of the Inuit. Other Whites, on the other hand, usually interacted with a circumscribed segment of the local population dictated by their professional responsibilities. The dimensions of that interaction were usually more contrained as well.

It is evident that the Inuit will rely on the nurses for a whole range of social, psychological and physical needs if the interactional climate is conducive. Nurses were generally regarded positively, and if rapport was established, Inuit utilized cosmopolitan medical facilities extensively with a few isolated cases of resistance. This extensive utilization can be regarded as a problem by some nurses and supervisory staff but must be understood as a natural result of several factors. With the possible exception of the church, there is an absence of trusted alternatives. Because of her involvement in intimate family crisis situations, a nurse is far more likely to be trusted then an occasional visiting social worker or psychologist. Utilization also results from the high anxiety

levels associated with a sick child where the mother is ignorant of any medical alternatives. To an Inuit mother, a child in distress constitutes an emergency. Finally, as long as the nurses are competently looking after the health of the community, most Inuit are content to let White nurses look after White diseases while they concentrate their energies on more important economic and political matters. Self-care has low priority although some people do resent the dependence created by cosmopolitan medicine.

Lack of coordination at the local level between various government agencies and their locally elected representatives is an effective block to improved health care, particularly in cases of public health, preventative medicine and health education. These divisions into separate responsibilities don't reflect local realities or need, particularly with regard to health care where Inuit regard physical, psychological and social illness as closely intertwined.

Health education may justifiably be regarded as a high priority area by cosmopolitan medical staff but the opposite is true from the perspective of the Inuit. Local priorities dictate that economic, social and political concerns associated with massive sociocultural change absorb most of the adaptive energy of the Inuit. Consequently, little attention is given to learning new skills in the area of health care, as long as the Nursing Station continues to do an effective job. Further, health education is unfortunately epitomized by the attitude of maternalism because of its emphasis on changing the basic life habits of Inuit. Most Inuit vehamently resent the maternalistic approach.

It is recognized that native participation in the health care delivery system is virtually absent but that where it does occur, it is crucially important. The interpreter's function in Gjoa Haven underlines this importance. The fundamental problem is a combination of different aspirations and motivations on the part of the Inuit and a failure from Medical Services to adequately encourage participation where it does occur. The minimal responsibility alloted to the Health Committee is an example of this inadequacy.

Thus, this thesis has effectively demonstrated its essential objective. Conflict and congruence in Inuit adaptation to the cosmopolitan medical system is influenced by historical and colonial factors; relations between nurses and administrators, nurses and Inuit, and nurses and other local Whites; and by the various cultural explanations given for illness-associated behaviour by both Inuit and White medical personnel.

7.2 Recommendations

The recommendations in this section are organized so that they will be of use to the three relevant domains of research community, Medical Services, and Inuit. They are based on the data and conclusions in this thesis and relate specifically to the problems that have been outlined and discussed. Although an attempt has been made throughout the thesis for wider applicability, it should also be understood that these recommendations relate primarily to Gjoa Haven and will only be useful elsewhere where similar conditions exist.

nutrition, alcohol, adult education, operations, medical evacuations, birth control, emotional disorders in order to develop orientation material for White medical personnel charged with Inuit health care.

(e) Research is required into the political relationship between locally-elected committees and government agencies. These studies should have the practical objective of devising strategies to increase Inuit responsibility and to provide information for local Inuit groups attempting to influence the overall decision-making apparatus.

(f) Sociological studies of the Medical Services bureaucracy are necessary in order to further understand how this dimension of health care affects the local efficacy of medical services. Particular attention should be focused on relations between supervisors and nurses with the objective of eliciting strategies for improved communication and increased local autonomy and responsibility.

7.2.2. Medical Services

Medical Services is meant here to include all people responsible for providing health care to Inuit settlements, be they federal or territorial employees.

(a) The cultural orientation of all personnel involved in Inuit health care is essential to avoid the stereotyping of Inuit that can result from perceptions based on interaction exclusively through the sick role. Medical staff should be aware of how they are perceived by

7.2.1 Research Community

Obviously there are numerous other areas related to native health in the north where research is required than those listed below. However, the purpose here is to focus on areas of potential research that relate to the objectives and conclusions of this thesis.

(a) Comparative studies of a similar nature to this one are needed in other Inuit communities, particularly where there are idiosyncratic differences such as an active and effective Health Committee, an ineffectual Community Health Representative, poor communication with nurses, alternative, traditional or "self-care" therapies being utilized, etc. These comparative studies should determine those variables which contribute to the functioning of the above factors.

(b) Comparative studies of a similar nature should be carried out in other native non-Inuit communities to determine the breadth of differences where the Nursing Station represents the cosmopolitan medical system in the Canadian health care delivery process.

(c) An extensive survey of Medical Services personnel should be conducted to determine the reliability of the observations reported in this thesis. Questionnaires should be administered to field staff and administrators, possibly utilizing the material in this thesis for the formulation of the quesionnaires.

(d) More detailed research is needed by persons fluent in Inuktitut and Inuit culture into Inuit attitudes towards such health matters as

their clients and require a more sophisticated understanding of the historical and cultural factors that affect the Inuit's utilization of health services. This orientation program should continue to involve Inuit advisors such as the C.H.R. and could be expanded to include written material such as this report, mandatory instruction in Inuktitut, encouraged opportunities for field staff to experience the Inuit lifestyle away from the settlement on hunting trips and ongoing orientation workshops at conferences. Orientation isn't something that should be taught in an afternoon prior to a nurse entering the field but should be an important aspect of the in-service training received by all Medical Services employees.

(b) Administrative staff need to concentrate on providing support to field nurses who are responding to local initiative. Nurses experience enough frustration in their work without also being subject to criticism and rejection from supervisors. Every effort should be made to encourage nurses to respond to local needs with more autonomy, despite the increased administrative problems and costs associated with such an approach.

(c) Attempts should be made to reduce the paternalistic and chauvinistic nature of nurses' working conditions. Nurses should be provided with the same respect, independence, responsibility and autonomy as enjoyed by other northern Whites.

(d) Discussions should be initiated with Inuit political organizations

from Inuit Taparisat to local Settlement Councils and Health Committees to design and implement a comprehensive health education program that incorporates lifestyle change without being maternalistic. Simply providing translated material from Edmonton to the nurses is insufficient and doomed to failure. The Community Health Representative should be encouraged to take autonomous local responsibility for health education, independent of the Nursing Station and responsible to local political concerns. Nurses should function primarily as resources personnel.

(e) Initiate discussions with other agencies, institutions and individuals both locally and administratively who contribute or could contribute to Inuit physical, social and psychological well-being so that services in these areas can be expanded without necessarily expanding the role of the Nursing Station. In the meantime however, nurses should be encouraged to continue activity in all aspects of health care if requested to do so by Inuit, even if this entails expanding Nursing Station staff to include, for instance, a psychiatric nurse.

(f) The Community Health Representative's training should be expanded to include other paramedical functions such as psychological counselling, preliminary physical diagnosis and treatment, etc. This expanded function may entail training more than one C.H.R. per community or combining the C.H.R.'s role with the Social Worker's. This training should also be vertically integrated

into an educational system whereby the C.H.R. can acquire training as a registered nurse with a maximum of in-service education and a minimum of academic work.

(g) Local responsibility and participation in health matters should be encouraged even when practical concerns suggest otherwise. It is always difficult to balance economic interests against cultural factors but in cases such as the contested water pipeline, local interests should be given the benefit of the doubt.

(h) The Health Committee should be given the added responsibilities of evaluating Nursing Station programs, and hiring and firing nurses. As well, in-service training programs and workshops should be introduced to improve the Health Committee's understanding of the cosmopolitan health care delivery system.

(i) Nurses should attempt to realize the full potential of their role as curers in an Inuit settlement. Emphasis should be placed on meeting health care demands as defined by Inuit. If this goal results in an excessive work load, additional staff should be provided rather than curtailing nurses' responsibilities.

(j) Nurses should seek to interact with Inuit on a non-professional basis as much as possible but should also refrain from interfering in personal and family disputes except when requested and then only in a professional manner. Nurses should seek an appreciation of the Inuit culture outside of the patient-client relationship in order to minimize maternalistic stereotypes.

(k) Nurses should concentrate on their role as community development workers, particularly with regard to encouraging Inuit health workers to assume greater responsibility. In-service training of C.H.R.'s should emphasize expanded responsibilities and encourage self-confidence. These duties cannot be performed perfunctorily but must be considered an important aspect of a nurse's daily responsibilities.

(l) The overall emphasis on Medical Services, for both administrators and nurses, should be towards recognizing the full potential of a nurse's role in an Inuit settlement and expanding health services to meet all the psycho-social health needs of the population as defined by Inuit. This expansion can be accomplished in two ways. Active encouragement of Inuit institutions (i.e. Church, Council, Health Committees, etc.) to accept greater responsibility in certain areas is essential. While this process is developing, Medical Services should recognize the expanded role of nurses as being far beyond that normally associated with nurses in the rest of Canada. Pay scales particularly, should be substantially revised to encourage nurses to assume the greater responsibility expected of them. Northern nurses are essentially a special class of medical worker, distinct from both doctors and nurses in the ordinary sense and should be recognized accordingly.

7.2.3 The Inuit

Recommendations in this section are directed at Inuit

individuals and groups and are intended to aid them in increasing their influence in the decision-making process of the cosmopolitan medical system and thereby improve health levels within their communities.

(a) Every effort should be made to increase the importance of the Health Committee in settlement activity. The Settlement Council should consider combining the Welfare Appeal Committee with the Health Committee. The Council should appoint people to this new Health and Welfare Committee who have expertise in the area. The Committee should have some people who have worked previously as lay dispensers of community health workers in other settlements where they have learned how the cosmopolitan medical system operates. This new Committee should be responsible to Council.

(b) The lay preachers and catechists with the Anglican and Roman Catholic churches should become more involved in health matters such as family disputes, marital counselling, emotional problems, or anything else they feel is important. They should try to work with the Health and Welfare Committee, the Community Health Worker and the nurses in these areas.

(c) The Housing Association should give priority to improving the sanitary conditions of the houses by installing running water and sewage facilities in all the older houses.

(d) The Settlement Council should request that nurses and the C.H.R. give monthly reports at Council meetings.

(e) The Education Committee should insist that health education be an important part of the school curriculum.

(f) The Education Committee should set up a weekly course in Inuktitut and insist that all resident Whites in the settlement attend this course. This stipulation could be written into the contracts of persons recruited for employment in the north. Negotiation with the various agencies currently hiring Whites for northern functions would be necessary to facilitate this request. Salary increments for persons successfully completing the course would be an appropriate means of encouraging compliance.

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APPENDIX A

Settlement Typology

The typology outlined below was formulated in order to select an appropriate community for the research. The typology is based on such factors as type of health care facility, size of population, degree of acculturation, and health problems and needs. Community Type C was selected as an appropriate location for the research for several reasons. It combines a sufficiently large enough cosmopolitan medical presence with a higher likelihood of traditional beliefs and practices to meet the objectives of the thesis. It is a manageable size for one fieldworker to investigate in the alloted timeframe. And it falls midway on the typology and is represented by a greater frequency of settlements than any other.

1. Type A - small, relatively homogenous Inuit community with a predominantly land-based subsistence and seasonal residence patterns.

   Population: less than 100

   Health Care Facility: lay dispenser and occasional visits from medical professionals.

   Frequency: rare, Bathurst Inlet and Bay Chimo only examples.

2. Type B - small, relatively homogenous Inuit community combining land-based subsistence with crafts and some seasonal wage labour.

   Population: 100 to 300

   Health Care Facility: one nurse nursing station.

Frequency: nine communities e.g. Sachs Harbour, Repulse Bay, Lake Harbour, Port Burwell, Sanikiluaq, Whale Cove, Grise Fiord, Holman Island, Pelly Bay. (Paulatuk - visiting nurse).

3. Type C - medium sized Inuit community with a small white population and a mixed economy based on land activities, crafts and wage labour.

   Population: 300 to 600

   Health Care Facility: two nurse nursing station.

   Frequency: ten communities, e.g. Cape Dorset, Spence Bay, Arctic Bay, Igloolik, Resolute, Broughton Island, Clyde River, Pond Inlet, Gjoa Haven, Hall Beach. (Chesterfield Inlet - Roman Catholic Mission Hospital - 30 beds).

4. Type D - larger Inuit community with influential white population and economy oriented largely to wage labour, welfare and crafts.

   Population: 600 to 1000

   Health Care Facility: three or four nurse nursing station

   Frequency: nine communities e.g. Rankin Inlet, Tuktoyaktuk, Aklavik, Baker Lake, Cambridge Bay, Coppermine, Coral Harbour, Pangnirtung, Eskimo Point.

5. Type E - larger community with significant white population and economy oriented largely to wage labour.

Population: Over 1000

Health Care Facility: hospital, clinics and regional centres.

Frequency: two communities, e.g. Frobisher Bay and Inuvik.

APPENDIX B

Medical Services Interview Schedule

The following questions are a summation of the questions asked in interviews conducted with Medical Services administrative staff in Edmonton, Yellowknife, and Cambridge Bay. They should not be regarded as a rigid interview schedule but merely as a guide to the informal conversation-interviews carried out by the researcher.

1. What do you consider to be the most important obstacles to health in the North?
2. Are there any significant aspects of Inuit behaviour that contribute to health problems in the North?
3. What is your opinion about native participation in Medical Services? Why is it required? Not required? Effective? Not effective?
4. What are the problems associated with training native personnel to work with Medical Services? What are the obstacles that must be overcome for the training to be effective? Do you feel native personnel are easily accepted into the health care delivery system?
5. Do you feel culture is an important variable contributing to northern health care problems? In what way? Is cross-cultural training and orientation necessary or important for Medical Services staff who provide health services to Inuit settlements?
6. What is your opinion about the projected transfer of control over health care services to the Territorial government? Would it affect you personally?

7. What kind of training opportunities are there for White staff in Medical Services? What are the opportunities for advancement and mobility? How do you feel about nurse turnover in the settlements?

8. What are the important criteria for selecting nurses to work in the settlements?

9. How do you feel about delegation of authority within Medical Services? Does your department have enough autonomy and independence to function appropriately?

10. What were your personal reasons for accepting a job in Medical Services? Do you plan to remain with them? Why? If you are unhappy with your present position, what are some of the reasons?

11. What do you feel should be the long term objectives in terms of northern health of your own position? The departments? Medical Services?

12. What do you think are the most difficult aspects of your job? Nurses' jobs? Medical Services activities?

APPENDIX C

Inuit Interview Schedule

This study will be asking questions about people's attitudes towards health and illness. I wish to find out what people think about many things related to health and illness. The reason for the research is so the people in Gjoa Haven have a chance to tell the people from the south who provide medical services what they think is important about keeping healthy and avoiding illness. They can tell about the way Inuit culture deals with health and illness. They can make suggestions about things that should be changed so Gjoa Haven is a healthier place to live. The research provides an opportunity for the Inuit to have a say in the decisions that are made concerning the provision of health care services in the North. It also will help the doctors and nurses to understand what the people think is important and what they think they need to stay healthy. I would like to find out the true feelings of the Inuit to these questions.

First of all I would like to have a little information about this family.

1. Where were the members of the family born?
2. Where did they live for most of their lives?
3. When did they move to Gjoa Haven?
4. Did they live in other settlements before moving here? For how long?

5. Have any members of the family been to school? How many years?
6. Could you tell me who are the relatives of the father and the mother who are living in Gjoa Haven? Brothers, sisters, uncles, aunts, grandparents?
7. Whose job is it in the family to make sure the family is healthy? The fathers? The mothers? the grandparents? Everyone? Anyone else?
8. Who looks after the house and gets the food?
9. Do the husband and wife discuss the things that need to be done to keep the house clean and to eat the right food or does each person just do their own jobs?
10. Is it hard to tell kids what they should eat? How do you get them to eat healthy things?
11. Have any members of your family been sick often? Could you tell me about them?
12. What are the different kinds of illnesses that people worry about?
13. How often do the members of your family go to the Nursing Station?
14. If you aren't sick very often, could you explain why you stay healthy? What do you do to stay healthy?
15. If you are sick often, could you explain why you do get sick? Have you always been sick?
16. When you get sick, what do you do to get better?
17. If you get sick when you are camping or hunting, what do you do?
18. If you get sick when you are camping or hunting, how do you decide to come back into the Nursing Station?

19. Do you think it is easier to stay healthy while camping than when you are in town? Why is it?

20. Do you have any suggestions that would make it healthier in town like it is on the land?

21. When you kids get sick, do you worry more than when you get sick? Why do kids get sick more than adults?

22. The nurses always say that germs make people sick? Do the Inuit think that there are other things that make people sick than germs?

23. Do you understand what germs are? Could you tell me about them?

24. The nurses always give out medicines to make people better when they are sick? Do the Inuit do other things to get better? What are they?

25. When you used to live on the land before moving to Gjoa Haven do you remember what people used to do for people when they were sick? Can you tell me any stories about it?

26. Before the Nursing Station were there other kapluna's that took care of sick people? Who were they and what did they do?

27. Did you ever think about nutrition and hygiene when you were on the land? Were they problems?

28. Can you remember if the Inuit used any medicines that didn't come from the kapluna's but came from the land? Are they still used at all?

29. Were you in Gjoa Haven before the Nursing Station was built? What did you do when you got sick then? Are you glad the Nursing Station was built?

30. Are you frightened at all when you go to the Nursing Station? Why?

31. Are you always satisfied with the treatment you get when you go to the Nursing Station? If not, can you gell me some stories about things you didn't like? What would you suggest should be done to make the treatment better?

32. When you are given medicine do you understand always what it is for? Is it easy or hard to understand about medicines?

33. When you are sick, do th nurses or interpreters explain things well enough that you understand why you are sick?

34. There have been a lot of nurses in Gjoa Haven. How many have there been? What do some nurses do that makes it easier to go to them and talk to them? What do other nurses do that makes it difficult to talk to them?

35. What advice would you give to a new nurse so that she would be able to work for the people of Gjoa Haven better?

36. What do you think about the nurses coming for home visits? Why do they come for home visits? Do you learn anything from home visits?

37. Do you understand what public health education is? Do you like the nurses to talk about personal hygiene and home sanitation?

38. Do you know why the nurses think personal hygiene and home sanitation is important? Do you agree with them?

39. What do you think about some of the things the nurses talk about? ie. Venereal Disease, Birth Control, Alcoholism, Sanitation, Hygiene.

40. Do you read the booklets that nurses give out? Do you understand them? Do you talk about them? Do you do what they suggest? Do you think they are worthwhile?

41. Do you ever go to the education classes that the nurses give? Which ones? Are they worthwhile? Why or why not do you go to them?

42. Do you know what the Community Health Worker does?

43. In what ways is the C.H.W. helpful?

44. Would you like her to do other things than what she does now? What sorts of things?

45. Are the public health education classes better because of the Community Health Worker?

46. Should the C.H.W. be a man? woman? older? younger? doesn't matter?

47. Would you like to be able to talk just to the C.H.W. or the janitor at the Nursing Station sometimes without talking to the nurses?

48. Do you ever have any difficulty with translation at the Nursing Station? Are some people better than others?

49. What do you think about the janitor's job at the Nursing Station?

50. How do you feel about the janitor at the Nursing Station also being on the Settlement Council? Is it necessary or does it matter?

51. Do you know what the Health Committee does? Could you describe it?

52. Is it doing an effective job? How could it do its job better?

53. What are the differences between the doctor and the nurses?

54. Do you feel any differently about being treated by the doctor than the nurse?

55. Do you go to see the Dental Therapist and the Opthalmology Technician when they come? Is there anything about their visits that you don't like?

56. Have you ever been evacuated? How many times? For how long? To where? For what? Other members of the family?

57. What are your feelings about being evacuated? Do you have any suggestions that would improve evacuation procedures?

APPENDIX D

Inuktitut Glossary

The following is a short glossary of Inuit terms used throughout the text of the thesis. Spellings generally correspond to authors' orthography and references are cited for this purpose. Where different spellings occur referring to the same concept in English, these are grouped together for clarity:

Adliparmiut (Boas 1888),
Adlivium (Hall 1970),
Qimiujârmiut (Rasmussen 1930) - part of afterworld that is usually unpleasant and the destination of souls who died from natural causes or illness.

angatquq (Williamson 1970) - shaman or curer responsible for mediating between the people and the supernatural.

angatkungaruk (Balikci 1970) - a lesser shaman with weaker control over the spirits who occasionally cured sick people.

aperksaq (Balikci 1970) - a type of helping spirit that aided the diviner in the head-lifting ceremony.

iglirsurqsimajut (Williamson 1970) - a group of people whose large collection of religious amulets protect them from misfortune.

ilira (Briggs 1970) - an emotional expression of fear tinged with respect that is generally felt towards Whites.

ilisitsut (Weyer 1962) - a sorcerer who manipulated the supernatural for evil purposes usually to harm or cause illness in others.

inu'sia (Rasmussen 1930) - the personal spirit component of an individual's soul.

inummariit (Brody 1975) - the "real Eskimos" who still identify with their traditional past and engage in land-oriented activity.

isumataaq (Damas 1975) - the dominant member in a band or extended family who fulfilled leadership functions when required.

krilaq (Balikci 1970) - "head-lifting" ceremony where the cause of an illness was divined with the aid of spirits.

krilasoktoq (Balikci 1970) - the diviner who performed the "head-lifting" ceremony.

naalaqtuq (Damas 1975) - principle of dominance based on age and sex that structured Inuit social relationships.

nunaqatigiit (Graburn 1969) - a group of related people camping together in one place.

Qudiparmiut (Boas 1888),
Qudlivun (Hall 1970),
Udlormiut (Rasmussen 1930) - part of afterworld that is pleasant and is the destination of souls who die violently by accident, suicide or in childbirth.

Sedna (Hall 1970) - Sea Goddess in Inuit mythology who dwells on the ocean floor, rules over sea mammals and supervises *Adlivium*.

tarninga (Rasmussen 1930) - component of the soul that provides personal strength.

tunraq (Balikci 1970) - a shaman's helping spirits.

tupilak (Balikci 1970) - evil spirts that populate the environment and cause illness.

ungayuq (Damas 1975) - an expression of emotional closeness that facilitates solidarity in extended family groups.