The Story of a National Crime

Episode 4: "So I lie on in bed till I feel I shall burst"

Written by
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Content Warning

NARRATOR

A warning before we begin: This series talks about Residential Schools, medical racism, segregated health care, and missing patients.

Support is available to Residential School Survivors and intergenerational Survivors 24 hours a day, 7 days a week through the National Indian Residential School Crisis Line. The Hope 4 Wellness Helpline is also available for mental health and crisis support over the phone or on-line. Contact information is in our show notes.

MUSIC

MIRANDA JIMMY

Many of these hospitals were actually run by religious orders. And at the Camsell there was tension between the Anglican, as well as the Roman Catholic orders, that had staff. They had chapels, they had chaplains, they had ministries running out of the hospital. What that meant is when a new batch of patients showed up, when a new airplane arrived with patients, there was a little bit of scramble to see who gets to claim them. What information came along with them? Were they already baptized? Did they have a Christian name? Could be baptized and converted, or could we scrap all that together and claim them on paper and kind of wipe [away] whatever existed before?

MUSIC

NARRATOR

In this episode, we focus on patients' lived experiences in Manitoba and Alberta in provincial sanatoria and what were called "Indian hospitals." There were almost 30 Indian hospitals across Canada – 15 in the Prairie Provinces alone. We recommend learning about the hospital or sanatorium closest to where you live using links provided on our website,

nationalcrimepod.ca.

This is the story of a national crime.

Before we proceed, a reminder that quotes from historical correspondence and descriptions of medical treatments use terms that are no longer acceptable, and the descriptions in this episode are graphic. When quoting the sources we use the original language.

MUSIC

NARRATOR

In the early 1940s, tuberculosis was still the leading cause of death among First Nation Peoples and Residential School students. The government was pushed by national and provincial tuberculosis organizations, also known as anti-tuberculosis societies or leagues, to respond by creating new racially segregated hospitals. Here’s Erin Millions:

ERIN MILLIONS

The federal government established a segregated health care system for First Nations and Inuit called Indian hospitals. That's the historical term. These were separate hospitals that were established primarily to treat tuberculosis, but soon expanded to treat other ailments as well.

NARRATOR

There were always exceptions in where people received care, and health systems differed between provinces, but Indigenous Peoples generally received tuberculosis treatment in a provincial sanatorium or a federally funded Indian hospital after the Second World War.

The terms are frequently interchanged, so what’s the difference between a sanatorium and an Indian Hospital?

ERIN MILLIONS

In Manitoba, sanatoriums treated only patients with tuberculosis.

Provincial sanatoriums, in Manitoba, treated both Indigenous and non-Indigenous patients. Two of our sanatoriums were funded by the province: the Saint Boniface Sanatorium, run by the Grey Nuns and the Ninette Sanatorium, run by a not-for-profit organization called the Sanatorium Board of Manitoba.

The federally funded Indian hospital system had both sanatoriums and general hospitals. These federally funded Indian hospitals only treated First Nations and Inuit - sometimes Métis - patients. So, in Manitoba, we had two larger Indian hospitals that were federally funded and run by the Sanatorium Board. In most places, federal Indian hospitals were administered directly by the federal government.

[The] Indian hospitals treated all ailments in addition to tuberculosis, which could become problematic when TB patients were not separated from non-TB patients.

NARRATOR

In the early days of Indian hospitals, the mixing of patients with different illnesses meant that those arriving with cancer could leave with tuberculosis, possibly transmitting TB to their community.

ERIN MILLIONS

To make it even more confusing, some Indian hospitals sometimes treated non-Indigenous patients as well!

So, the differences are primarily in who is paying for the hospital and who is the hospital treating. There could be differences in the level of care that patients received. We know that Indian hospitals were expected to operate at 50% of the cost of what it would cost to treat an indigent non-Indigenous patient, and that levels of care in those federally funded hospitals were subpar.

NARRATOR

Despite the creation of new Indian hospitals, well into the 1940s, there weren't enough beds for Indigenous People with tuberculosis.

During this early period, Indian hospitals had high rates of death and few options for TB treatment. The Clearwater Lake Indian Hospital opened in 1947. It was run by The Manitoba Sanatorium Board. In July of 1949, the Chief of Opaskwayak Cree Nation, Cornelius Bignell, advocated for improved hospital conditions. He wrote to Indian Agent Low:

MALE VOICE

"Too many persons have died and are dying too fast in such a short time. Very few leave the San cured… The Indians feel so bad about the management that they begin to believe that they are being brought to this place to die."

NARRATOR

He urged:

MALE VOICE

"Now we wish to ask the Department to do its utmost to make the poor people feel happy and proud to go to this Sanatorium."

NARRATOR

Clearwater Lake did not have enough staff to care for the dying. Patients reported excessive force when nurses administered needles. Patients were prevented from going for walks. Communication was also poor. So much so that a man who worked at the cemetery learned only after the fact that he had buried his own wife.

The Sanatorium Board agreed to conduct an inspection. The report concluded that there were not enough staff, but the hospital conditions were deemed acceptable. The Board also alleged that the community was

ungrateful.

AD BREAK

NARRATOR

In 1945, the Canadian Tuberculosis Association nominated members for a committee called: “The Advisory Committee for the Control and Prevention of Tuberculosis Among Indians”. Its mandate [also] included the Inuit. Tuberculosis was becoming an epidemic for Inuit communities, whose lives were transformed by international politics and settlements. The committee’s strategy focused on citizenship through segregation.

At the close of the Second World War, Indian Health Services was transferred from the Department of Indian Affairs to the Department of National Health and Welfare. Established in 1946, Indian and Northern Health Services was responsible for First Nations and Inuit health. The Minister of National Health and Welfare, Brooke Claxton, said that “neither law nor treaty” required the government to provide health services to Indigenous Peoples. The Department established Indian hospitals for humanitarian reasons and to protect the rest of the population of Canada.

Dr. Percy Moore was the director of INHS for the next 22 years. He did not have faith in church-run hospitals and pointed to higher deaths in northern hospitals. He was also very aware that it cost far less to transport patients south than to treat them close to their homes. As a result, northern First Nations and Inuit had to travel thousands of kilometres for tuberculosis care.

In 1946, the Charles Camsell Indian Hospital, a federally funded and operated facility, opened.

MIRANDA JIMMY

My name is Miranda Jimmy. I am a member of Thunderchild First Nation, which is on the Saskatchewan side of Treaty Six. I make my home today in Amiskwacîwâskahikan, known to many as Edmonton.

So, the Charles Campbell Indian Hospital location in Edmonton has an interesting history.

NARRATOR

Before there was a hospital on the site, there was a Jesuit College, which later served as an American military base during the construction of the Alaska Highway.

MIRANDA JIMMY

And it was turned into a veterans' hospital for returning soldiers from the Second World War. At the same time as veterans were returning from war, there were outbreaks of tuberculosis in many Indigenous communities, specifically in the North. By the late 1940s, it was serving primarily Inuit and Northern First Nation patients. Mostly for the treatment of tuberculosis, but also for any other medical needs, surgeries that were required that they didn't have access to in their home communities.

It was the northernmost medical facility that was run by the federal government at the time. So, if you think about where the patients would have come from, hundreds or thousands of miles away, multiple plane trips, car trips, they wouldn't have been direct by any means.

NARRATOR

In the 1960s, the federal government replaced the maze of former military buildings with a proper hospital.

MIRANDA JIMMY

When it was built in 1967, the current building, it was intended to

be a gift to the north. And I often look back at that phrasing that's used in many government documents and think about how… if it was a gift to the North, why didn't you build it in the north?

MUSIC

NARRATOR

By the late 1940s, First Nation and Inuit communities faced frequent screenings for tuberculosis through surveys. In places like Manitoba, tuberculosis screening was supposed to happen annually. The federal plan also included vaccinating communities with the BCG vaccine to prevent tuberculosis infection. Protection from the vaccination only lasted for two years, meaning revaccination was necessary.

Here’s Erin Millions:

ERIN MILLIONS

The way that tuberculosis cases were found was usually through tuberculosis surveys. So, a survey team would go out to communities. There was compulsion involved in the tuberculosis screening in the first place that would lead to diagnosis. Often for First Nations, this meant that they were not allowed to receive their treaty payment at treaty days if they didn't first get screened for tuberculosis. And I certainly have heard from former nurses, from former patients, and families that people hid because they knew that the result of getting screened was that they could be taken away.

When patients were taken out of their communities for TB treatment, it could be close to their home, but most often it meant a long trip. For Inuit who were being removed from the North, it often meant going by plane or boat to Churchill and then down to Clearwater Lake Indian Hospital. Sometimes staying there, but sometimes traveling on to other southern hospitals.

NARRATOR

In 1939, the Supreme Court of Canada had

ruled that Inuit should be treated as “Indians” under the Indian Act, thus becoming the responsibility of the Federal Government. In the years that followed, Canadian and American military staff headed north to take up Arctic defense. They brought infectious diseases with them, contributing to high mortality rates among Inuit.

The government of Canada was embarrassed by what American military personnel witnessed. Health funding was entirely inadequate for the population and large geography. In 1943, a federal report explained that the lack of health services to Inuit was due to the far distance [from the south], limited transportation, and “isolation” of the region.

In place of hospitals, Indian and Northern Health Services built nursing stations, and centralized care for more complex health needs in southern hospitals. In 1946, the Eastern Arctic Patrol started to facilitate tuberculosis surveys of Inuit. The Patrol was established in the early 1920s to assert Canadian sovereignty over the region, but it also brought support to RCMP posts, trade, and a ship doctor who could provide basic medical care. On the western side of Canada, missionaries took on similar roles by transporting Indian and Northern Health Services workers and patients by boat.

Here’s Kaila Johnston from the National Centre for Truth and Reconciliation:

KAILA JOHNSTON

The Inuit were brought on board to these ships and were examined. If they were discovered to have tuberculosis, they would be kept on board. Now, while some individuals were aware that they had a serious illness, many were asymptomatic. And, as a result, there was often great confusion as to why they were being brought on board to these ships and then why they were not allowed to leave. It wasn't made clear where they were being taken or if they'd be returned, contributing to that atmosphere of fear and desperation. A

lack of proper record keeping, and registration added to this confusion. Although the Eskimo disk tag system was already in use, patients were sometimes registered under the wrong name, under the wrong disk number.

NARRATOR

There was no opportunity to pack or say goodbye. The journeys were long and could involve ships, commercial and military planes, and trains. Here is Erin Millions again on what patients faced after leaving their communities:

ERIN MILLIONS

The travel itself was pretty onerous. Then they get to the hospitals where sometimes nobody speaks their language, if they don't speak English or French. They could be the only patient in the entire hospital who speaks their language. Sometimes there was a brother and a sister who are sent down, but they are kept separate and not allowed to speak to each other. Some hospitals might let them talk to each other once a week. It really differed by hospital.

There is certainly a sense of disconnect and loneliness, once they get to the hospitals. There are patients who make friends while they're in the hospitals. Some of them learn other languages. I've talked to some who developed lifelong friendships, often kept up with letter writing after they leave. And sometimes romances that sometimes led to marriage.

What is true in almost all of these cases, is that they don't see their family when they are in the hospital. That is almost universally true for every former patient I've talked to or every child whose parents went away to the sanatorium. So, this is a really traumatic experience for most patients.

NARRATOR

In the Camsell Mosaic, Kathleen Steinhauer, a former registered nurse at the Camsell Indian Hospital and member of Saddle Lake First Nation observed:

“Most of the patients demonstrated that sense of despairing resignation so

evident at Residential School.”

MUSIC

NARRATOR

Once patients settled in at the medical facilities, doctors and nurses began to administer tuberculosis treatments.

Here’s Miranda again:

MIRANDA JIMMY

I've talked to patients who were, you know, in and out in the same day, who lived in a neighboring First Nation, drove to the city, received care, and were home the same night. So, that's kind of one end of the scale. The other end of the scale is years. The longest I've heard of a stay is 12 years. 1 to 3 years was kind of generally where most people sat and those longer term [stays] tended to be for the treatment of tuberculosis.

The method of care that was accepted and used most often was surgery and bedrest. Treatment for that [TB] at the time, you know, 1950s, 1960s, when it was at its height, was bed rest. So don't exert yourself. Don't cause your lungs or your body to have that response. Therefore, it won't kind of aggravate the tuberculosis and you'll be able to manage it. The surgery was often to remove portions of the lung that were infected and allow for the body to respond to that.

NARRATOR

Tuberculosis patients admitted to the Camsell were expected to follow rest routines. Depending on the years patients were at the hospital, there were four to six routines. During routine four, patients could be out of bed during set hours, attend school, and enjoy outdoor time. In the third routine, patients could be up for short periods, have a bath in a tub, walk to church, and take a walk if they were granted “visiting privileges”. During the second routine, patients could get out of bed only three times a day for 15 minutes. The first routine consisted of full bed rest, and patients were given a

bath in bed, attended appointments in a wheelchair or stretcher, and were only allowed to sit in a chair once a month while staff cleaned their bed.

MIRANDA JIMMY

But imagine being on bed rest for months or years of your life, especially as your body is still growing, as your muscles are forming. You are intending to kind of build the systems that you're going to need for the rest of your life. For some patients, bed rest meant similar to a jail sentence: 23 hours a day, no sunshine, stuck in a bed and many of these patients were children at the time. Imagine you're a two year old and you are stuck in bed for 23 hours a day. Well, I don't know a two-year-old that can do that. So, the response from the nurses and medical staff was, [the] number one goal: keep this patient in bed. If they're not going to listen to us, then other treatment methods were put in place. I've seen images of cages, where they were caged in, so they couldn't physically leave their bed. so, that still allowed for movement and stuff, but in a seated or lying down position. I've seen the practice of casting which [was] initiated at the Camsell Hospital. Some nurse came up with this idea of let's put a cast on them. Let's start with a limb, a foot, a leg that will keep them immobile. [If] that doesn't help, then we go with both legs, go to full waist casting, to images of full body casting to the neck. It served a purpose. It kept patients on bedrest, but caused long-term damage.

NARRATOR

In 1947, Camsell staff wrote the following article for the hospital newsletter, the Camsell Arrow:

MALE VOICE

"A strange disease, Castitis, has stricken eight known people here, recently. Castitis is caused directly from Canstayinbeditis – a fever which seems to develop in almost anybody who doesn't realize how serious a disease tuberculosis is and how necessary bed rest is for cure."

NARRATOR

Agnes Bruno, an Inuk woman, and former patient at the Camsell, recalled for an NFB film crew how all the girls in her ward were put in casts after misbehaving.

If adult patients didn’t stay in bed, their pyjamas and robes would be taken away. Here’s Miranda again:

MIRANDA JIMMY

When I think about the idea of body casting specifically, I think this is also this idea of colonization in practice, we're coming from a place of wanting to do good, thinking we know the answer to the problem, coming with our own ideas of what the solution is and not thinking about the other impacts that our decisions are having on other people. And what that's going to mean for their future, their long-term growth, their ability to take care of themselves and build resilience.

NARRATOR

Patients also participated in rehabilitation activities. Hospital staff considered rehabilitation essential to recovery. The programs were designed to promote further assimilation. When patients were confined to bed, they had musical instruments, books, and occupational therapy activities, including beading, sewing, and carving. As patients’ health improved, they could participate in more activities, including school and cooking classes. Patients could also write for the Camsell Arrow, the hospital’s newsletter, which was produced by hospital staff. Patients also recorded messages or songs for their loved ones at home. The messages were broadcast by the CBC on the Northern Messenger Program.

While rehabilitation activities and other forms of entertainment kept patients busy during recovery, the rehabilitation staff wanted to prepare patients to enter “white” society. Patients were also discouraged from returning to their home communities.

Another thing to note is that Inuit patients who often did not speak English or French rarely benefited from the books and magazines provided. The hospital teachers also did not speak Inuktut. A teacher was finally hired for Inuit patients in the early 1950s.

MUSIC

NARRATOR

Miranda explained the Camsell's bed rest routines.

Now, for the more invasive tuberculosis treatments. Dr. William Barclay, who worked at the Camsell, remembered that:

MALE VOICE

"We employed these treatments more on blind faith and trust than on scientific evidence that they were effective."

NARRATOR

Doctors in hospitals with operating rooms performed surgeries on patients with tuberculosis of the lung. As antibiotics were now available to treat infections, medical practitioners were bolder in the surgeries they used. The surgeries were not always effective, but they reduced overcrowding because patients spent less time in the hospital. Before I describe the surgeries, if you don't want to hear them, fast forward 20 seconds.

One of these surgeries was the removal of up to 8 ribs, two or three ribs at a time. A related procedure involved collapsing a sick lung. To keep the lung from reinflating, a product such as wax was inserted into the patient's chest cavity. These surgeries were performed under local anesthetic, meaning patients were conscious.

Here's Miranda:

MIRANDA JIMMY

I think about one specific patient who knew he was transferred to the hospital for treatment of tuberculosis, knew that he was going to need surgery. Nothing was explained to him. It wasn't until way later in life that he found out that

in addition to his lungs being operated on, he had several ribs removed, which actually affected his ability to get employment. This is how it found out that he actually had a quote unquote disability which precluded him from doing manual labor. The only recollection he had was back to that one surgery he had.

So, the surgery specifically, it really comes down to non-consensual medical intervention. So, when assumptions or decisions are made about medical care that the patient has no say in either because they weren't asked or consented to or because they don't have the ability to communicate or self advocate for what they need.

NARRATOR

In 1941, Dr. Percy Moore, the Director of Indian and Northern Health Services, wrote an article that reflects this lack of concern for consent:

MALE VOICE

“Actual treatment I will not discuss, but as one who has spent many years on reserves and in contact with Indians, may I offer a suggestion? Try to gain his friendship and his confidence. Do not alarm him by speaking within his hearing of procedures that he does not understand.”

NARRATOR

Surgical tuberculosis treatments had long-term and permanent consequences on patients’ health, mobility, and ability to work. The surgeries were scarring. The substances that were injected could cause infection, and peoples’ lungs did not regain full function.

In 1959, Dr. Baldry, a British specialist, toured Canadian sanatoria. He reported that Canadian facilities relied too much on surgery. He noted that sanatoria treatments separated patients from their homes for long periods as well. By this point, chemotherapy was known to be an effective treatment for tuberculosis, but patients needed to continue taking

medication after they left the sanatorium or Indian hospital.

ERIN MILLIONS

The hospital stays and surgery rates for non-Indigenous patients are shrinking. That's not happening for Indigenous patients. Indigenous patients continue to be treated primarily with surgery and rest. There's two [three] reasons for this. The first is that there's this idea that Indigenous patients can't be trusted to take their medicine, so they have to be kept and treated in hospital to make sure that they are cooperating with the treatment. There's really no basis for this belief. It's just another "racism in health care moment".

The other reason is that stays in hospitals were part of the assimilation process that was led by federal government Indian policy. Long stays in hospitals operated very similarly to long stays in Residential Schools. Patients could forget their language in the years that they were there, they were disconnected from their culture in their community. They didn't see their family for years at a time. Children who were admitted as infants or as young children could fully forget who their family was. Also, there is a lack of health infrastructure in northern and remote communities. So, sometimes a patient couldn't return to their home community to recover because there wasn't a nurse in that community that could supervise their recovery, dispense the medication that they need, and things like that.

NARRATOR

Research on the Camsell also shows that staff presumed that Indigenous Peoples had higher thresholds for pain and required less anaesthesia. The Camsell also worked with the University of Alberta's medical school to train students and provide "interesting" medical cases for research.

Kathleen Steinhauer, the former nurse, also shared that:

FEMALE VOICE

“There is a thought that the hospitals were used for medical experiments. Occasionally, new treatments for tuberculosis emerged and it seemed to many people, including patients and staff, that these treatments were pioneered on patients in the Indian hospital system. When patients consented to treatment, I believe they often did not fully understand what was being asked of them.”

NARRATOR

Issues around consent to medical treatment continued. Here’s Miranda and Kaila again:

MIRANDA JIMMY

The other kind of very important thing that I think that Canadian society is just starting to talk about is forced sterilization.

KAILA JOHNSTON

We had heard of stories from Survivors talking about being brought to the Residential School and then taken directly to an institution, a hospital, being sterilized without their knowledge and then being returned to school.

MIRANDA JIMMY

In Alberta, specifically, there was eugenics legislation, and we know that that was officially repealed in the 1970s. But the practice continued until at least the 1990s. Many may argue it's still happening today. That comes back to women's right to choose about their ability to reproduce and the effects that it has on their body, their hormones, their legacy.

NARRATOR

The history of forced sterilization reveals even deeper connections between Residential Schools and the health care system.

Historians Erika Dyck, Maureen Lux, and Karen Stote have written about how Indigenous women’s reproductive rights were violated during the 1970s eugenics movements. The movements focused on

population control in poor and racialized communities. Without consent, physicians performed procedures to prevent further pregnancies on many Indigenous women who were hospitalized for childbirth in facilities like the Camsell.

NARRATOR

Erin has encountered examples of Indigenous People's resistance to enforced medical treatments:

ERIN MILLIONS

Resistance to enforced tuberculosis treatment started even before survey teams arrived in communities, before engaging with health care workers, before being removed to hospitals because people would hide from TB surveys and health care workers when they knew that tuberculosis testing was being done. Because there was this connection, of course, between getting an x-ray and being removed from the community. So, a lot of people avoided being tested at all, which led to the Department of Indian Affairs connecting tuberculosis surveys to treaty payments at treaty days and people being coerced into being tested in order to get their treaty payment.

NARRATOR

While many resisted enforced treatments, illness in First Nation populations was criminalized through legislation. In Manitoba, patients could be forcibly returned to Indian hospitals by police under the Communicable Diseases Act. The Indian Act also had the power to force people with Indian Status to undergo medical examination, treatment, and hospitalization.

KAILA JOHNSTON

The Indian Act was amended in 1953 to include the Indian Health Regulations, which made it a crime for Indigenous Peoples to refuse to see a doctor, to refuse to go to hospital and to leave hospital before being discharged. In fact,

the RCMP could go and arrest patients and return them to hospital or send them to jail.

NARRATOR

The regulations applied to all who lived on reserve, those who followed a so-called "Indian mode of life", and urban Indigenous Peoples. Violating the regulations meant a fine of $100.00, three months of jail, or both.

NARRATOR CONT'D

Once First Nation patients were admitted for treatment, some ran away from the sanatoria and hospitals. Patients also broke hospital rules by visiting their friends in other wards or sneaking in visitors. Inuit also resisted tuberculosis surveys and medical treatment. In one case, a man left a southern sanatorium and lived off the land for as long as he could survive. Unfortunately, attempts to run away from hospitals or return home on foot ended in tragedy.

MUSIC

NARRATOR

Kaila talked about how little was done to keep track of patients and inform families about where their loved ones were sent in the early days of the Arctic medical evacuation program.

Reverend Brian Burrows worked in Povungnituk for five years in the 1960s. In a 1989 interview, he remembered the disregard shown to Inuit patients:

MALE VOICE

"They did not think the Inuit were worthy of being informed of where they precisely were, and didn't think it important that relatives should be informed, that parents should know where their children were… The authorities didn't think it important that they should get their names right… Even when they were written out for them, still they'd get them wrong. Even the Christian names, which they could have got right. And the basic thing behind

that, I think, is that they refused to believe that they were people. I felt that the government should have told them precisely where they were, showed them where it was on a map, and formed some kind of communications.

NARRATOR

Reverend Burrows also recalled that he only received requests from hospitals to inform families of patients' deaths starting in 1962. It was left to police detachments to inform families, and patient forms often listed the next-of-kin as a question mark or "unknown". If a family did receive a message, the message did not include the cause of death, where the person was buried, or words of condolence.

Before the late 1950s, returning patients were also treated poorly. Staff at settlements and RCMP posts complained that discharged patients arrived in clothing inappropriate for someone who had just recovered from tuberculosis.

And the centralized health system massively disrupted families and communities.

ERIN MILLIONS

There are many different ways that disconnect happens as a part of these removals. Child patients also got sent into child welfare systems. They got sent into Residential School systems from the hospitals. This leaves a legacy in the communities and with the former patients of loneliness. For the children who are left behind when their parents go to the sanatorium, whether their parents die and never come back, or sometimes even if they do come back, there's this deep sense of abandonment.

This leaves holes in communities, and it also creates a sense of mistrust in the colonial health care system that impacts Indigenous relationships with health care providers, with health care treatment in a variety of different ways.

NARRATOR

Here's Miranda:

MIRANDA JIMMY

That's what segregated health care is also about, is removing people from community, separating them from their support systems, their cultural systems, their language, everything they know to be true in their bubble of what their world is. Placing them somewhere else, which by cutting those ties, allows for new ties to be formed. And so, that was the intent behind Residential Schools and by providing health care in the same way you're saying and putting these systems in place of "we know best, do what we say, what you knew before was wrong and we'll show you the right way." And you're surrounded by other people who are maybe further along on that journey. And also, then that assimilation starts to happen internally. The oppressed start oppressing others and demonstrating the "right" way to do things.

Related to the Camsell, there was also kind of workplace programs that existed after patients were discharged. So, it was, you know, drilled into patients that returning to communities is going to make you sick again. And the solution to that is "Stay in the city and we'll help you with that transition."

NARRATOR

Anne Lindsay, who works with Erin, added as well:

ANNE LINDSAY

The processes disrupted traditional ways of knowing, traditional health, traditional welfare, and traditional memory systems. So, we take away the knowledge. We're not just taking that piece of information, but we're disrupting the whole kind of memory and archival system that has worked for a tremendously long time for Indigenous communities.

MUSIC

NARRATOR

As you have heard throughout this series, colonial institutions were

deeply interconnected. Kaila expands on this:

KAILA JOHNSTON

So, all of these systems and institutions like Residential Schools, sanatoriums, Indian hospitals were all connected with one another. We have records in our collection pertaining to some of the medical records of students who attended Residential School who were sent to these institutions for care. When it came to these connections, children could be moved from one institution to another depending on the treatment that was required.

NARRATOR

Anne Lindsay has also worked with families trying to locate missing patients or their gravesites.

ANNE LINDSAY

One of the big takeaways that we found doing the research that we have been doing is that the Indian Residential Schools and Indian hospital systems were so enmeshed, we really need to take a look at both of the systems if we want to understand what's happened in either of them or, you know, specifically also what's happening when we're looking for missing Residential School children. Also, for some of the Indian hospital sanatorium patients that family members are looking for.

NARRATOR

In addition to the connections between the Residential School and Indian hospital systems, there were connections with the child welfare system, specifically adoption and foster care. Parents feared what would happen when they were removed for treatment, as they could not provide for their families while in a hospital.

ERIN MILLIONS

It's a triangle and child welfare is the other side of that triangle with Residential Schools and Indian hospitals and health care. And the three are all interrelated and they can't be separated.

If small children are left behind, whether it's one parent that goes or it's both parents that go, somebody has to look after those children. If there weren’t arrangements made for family [members] to step in and care for those children, children were sent into the child welfare system or they were sent to Residential Schools, sometimes both. Sometimes moving between the two.

It also happened when children went into the hospital as patients. When they came back out of the hospital, the reasonable expectation would be that they were sent home. But that wasn't always the case. Sometimes they were sent directly to Residential Schools. Sometimes they were sent into the child welfare system, and sometimes they were sent to what were essentially halfway houses, which were sort of part of the child welfare system. In any case, they're not being returned directly to their parents' care. I've heard enough accounts of it from patients and children of patients to say that it was frequent.

NARRATOR

In other instances, Inuit babies who were born in southern hospitals or who travelled south with their ill mothers were kept in hospital nurseries until they could be sent to a relative in the North. But some doctors asked the Department of Indian Affairs to place children in a family’s care in a First Nation neighboring the hospital. Some sanatoria or Indian hospital staff unofficially fostered or took babies [home] on the weekend. If a mother died while in a hospital, her infant may then have been informally adopted. It was only in 1956 that the Northern Administration and Lands Branch started to arrange foster care for orphaned or disabled children. Connections between child patients and children of patients in sanatoria and Indian hospitals and the Sixties Scoop remain unclear.

NARRATOR

Kaila Johnston from the National Centre for Truth and Reconciliation shared a story about an Inuk boy who was sent to Brandon Residential School in 1950:

KAILA JOHNSTON

Now, looking at that quarterly return, there was one student who stood out to me, on the final page of the June document. They're listed as student number 677. Their name was Susangnuk. They were five years old, and they were admitted to the school on May 10th of 1950. There was also a very interesting note added to his name. It said, "This one boy was admitted from the Brandon Sanatorium during the flood crisis to make way for evacuees from Winnipeg Hospitals. He is not TB. Band number e3-626." So, looking at that note, band number e-3626, that coupled with his name and with a note next to his home community of Coral Harbour, stood out to me, as Inuit children technically should not have been in Residential School at this time because they were not treaty status Indians under the Indian Act. And the distance between his home community and Brandon was an astonishing 1,875 kilometres. I continue to follow Susangnuk through the records. And in the September 1952 quarterly return, I found this last mention of him in these records. He's seven years old. He's still in Grade One. We get this note that says, "Returned home by Indian Health Services on August 4th of 1952". Due to cost, due to distance, due to policy, he would not have gone home in the time that he was at the Residential School, which was for two years and three months.

NARRATOR

And then there was how patients were

treated in death. This is Anne Lindsay:

ANNE LINDSAY

Maureen Lux titled her work on Indian hospitals, “Separate Beds”, highlighting the segregated nature of Indigenous health care in Canada. What we found is that segregation didn't end in death. Just as the government sought to save costs in providing health care, they worked tirelessly at keeping the cost of patient burials as low as possible. Because of this, patients’ remains were not returned to their families or home community unless it could be shown that the cost was less than the cost of burial near where they passed away.

Patients who were buried near health care facilities were often buried in sections of existing cemeteries, set aside for Indigenous burials or Indigenous patient burials, or in sections of cemeteries on reserves. Even here, the government worked to find the least expensive options for their burial, and many graves were either not marked or marked inexpensively. So that now it can be really difficult to identify where specific graves are located - even if we can identify which cemetery the person was buried in.

NARRATOR

Churches were also involved in patients’ burials in facilities like the Camsell. Here is Miranda Jimmy again:

MIRANDA JIMMY

In addition to them being baptized, or accepted into a particular faith order, if something happened to them, if they passed away in hospital, then that religious order had authority to make decisions about what happened with their remains. In most cases, the federal government did not have the funds to return the remains to community or even

let community family members know what had happened. In Edmonton, there are at least four known gravesites where patients are buried and many of those decisions are based on what order they were baptized in.

MUSIC

NARRATOR

We talked about tuberculosis as a "social" disease, caused by inequality and deprivation. The unsafe conditions in Residential Schools, First Nation reserves, and Inuit settlements remained throughout the era of Indian and Northern Health Services. Meaning the federal government did not address what caused the disease.

Governments went from doing the minimum to address tuberculosis to enforcing health care for Indigenous Peoples.

Segregated health care and tuberculosis care did successfully reduce the prevalence of tuberculosis and deaths, but it also systematically deprived many infants, children, adults, and Elders of what they needed to recover: family, community, culture, fresh air, familiar foods, spiritual practices, and knowledge about their medical condition and course of treatment in their language.

The Indigenous death rate from tuberculosis also stayed much higher than the national average.

MUSIC

NARRATOR

The Story of a National Crime Podcast is written and produced by me, Maia Foster-Sanchez, and presented by Knockabout Media. It is co-produced by Ryan Barnett with additional voices by Gabriel Maracle.

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If you are a Residential School Survivor or Intergenerational Survivor, you can access support through the National Indian Residential School Crisis Line at 1-866-925-4419. Mental health and crisis support is also available through Hope 4 Wellness at 1-855-242-3310.

Our series advisors are Teresa Edwards, Kaila Johnston, and Erin Millions.

This episode featured interviews with Miranda Jimmy, Erin Millions, Kaila Johnston, and Anne Lindsay.

Special thanks to Lindsay Gibson, Gabriel Maracle and Caleb Ellison-Dysart.

For a list of sources used in this episode and to download the listening guide, visit nationalcrimepod.ca.

On the next episode:

ERIN MILLIONS

so, in Manitoba, it's very difficult to access information about patient experiences in the hospitals because the hospitals here were administered by the Sanatorium Board of Manitoba. In Manitoba, historical health records never become unrestricted. Patient files from Ninette [Sanatorium] in 1913 are treated the same way as my records in my doctor's office right now.