Colonial Care: Medical Attendance among the Mi’kmaq in Nova Scotia*

PETER L. TWOHIG

Abstract. In Nova Scotia before Confederation, medical care for native peoples formed an integral part of the fledgling Indian administration. As the colonial authorities became more involved in all aspects of native life, an opportunity for self-advancement was presented to doctors. Practitioners among the Mi’kmaq came from the emerging medical elite. This article argues that their service to the Mi’kmaq was part of a broader and widespread reform effort. Doctors not only delivered care to the Mi’kmaq, but they also served the needs of a colonial administration actively seeking to settle natives in reserve communities. The activities of doctors, however, did not go uncontested. This study illustrates the complex interaction among the native administration, the Mi’kmaq population, and a medical community struggling to organize.

In February 1847, Dr. Edward Jennings recounted his experience treating some Mi’kmaq near Dartmouth, Nova Scotia, in a petition to the

Peter L. Twohig, Department of History, Dalhousie University, Halifax, Nova Scotia B3H 3J5.

Lieutenant Governor. Jennings wrote that a “number of the natives were successively attacked & died having no medicine administered—Save the decoction of some astringent barks, which certainly hastened the fatal termination. The first proper medical attention rendered was by Dr. Richardson.” In describing the disease, which was likely infectious hepatitis, Jennings commented that “despair and distress were pictured in the countenances of all and it was evident that fear was the chief exciting cause of the disease.” Jennings believed “that a combination of Atmospheric circumstances, owing to the variableness of the weather and assisted by local causes of Effluvia filth, poverty and its concomitant a deficiency of warm clothing and proper nourishing diet will account for the Phenomena.” To the ravaged Mi’kmaq population, Jennings and Richardson could offer only “brisk purgatives. In some cases of great debility . . . powders of Quinine, Calomel & . . . Nitrate of Bismuth were administered . . . At the same time securing a free evacuation of the bowels . . . These powders corrected the Nausea.” To those who were recovering, the doctors offered “Wine, beef tea and occasionally brandy.” The doctors also endeavored to erect a temporary hospital that may have aided their efforts. The traditional arsenal of medical therapeutics was clearly in use, but a subtle change was perhaps occurring, for bloodletting “was not resorted to in any case nor do I think it could with safety—Leeches might have been used with advantage.” By February, the disease had run its course, but not before Dr. Richardson became infected and ill, “for which one or two blisters were applied.” Alas, even doctors could not escape their own remedies.

Such provision of medical care to native peoples is a largely neglected area of study, particularly in the colonial context. A large number of works deal with the effects of epidemic disease, and an equally vast literature concerns postcontact population reduction. Another area of scholarship examines the effects of depopulation on native culture. Several authors do mention medical care, though briefly. Sally Weaver, for example, characterizes the period 1784 to 1850 as being dominated by itinerant physicians, but we learn little else. Otherwise excellent recent syntheses overlook this important component of native history. For example, Olive Dickason’s discussion of social services—including health care—does not begin until the post-Confederation period, when she deals with the negotiation of the numbered treaties in Western Canada.

This study seeks to address this gap in our knowledge of native/white relations by conducting an inquiry into the salient features of the medical care received by the Mi’kmaq in Nova Scotia at the middle of the nineteenth century. The colonial Indian affairs administration, the object of Jennings’ petition, emerged in the 1820s and gradually began
to play a significant role in many aspects of native life, including health care. In 1842, conservative Reformer and newspaper publisher Joseph Howe became Indian Commissioner, an appointment that significantly revitalized Nova Scotia’s Indian administration. From this point until Confederation—when natives and their health care became a federal responsibility in Canada—medical attendance was an important part of the early colonial administration. Local authorities came to see the provision of medical care to the Mi’kmaq as a legitimate, though costly, expenditure. An examination of the medical care provided at mid-century also exposes the concerns, desires, and insecurities of an emerging medical elite.

COLONIAL ADMINISTRATION AND POOR RELIEF AMONG THE MI’KMAQ

The provision of medical care to the poor was never generous and this remained particularly true for native communities. Colonial authorities were loath to assume any direct responsibility for relief of any but the most destitute and, as a result, relief was the meanest that could be provided. Nova Scotia and New Brunswick drew upon the English poor laws, providing for poor-rates and the institutional care of paupers only in the population centres of Halifax and Saint John. Both colonies made most poor relief the responsibility of the township and parish. Such a system led to acute deprivation. New Brunswick parishes, unable to care for their poor, auctioned paupers to those willing to provide care for the least amount of money. Early nineteenth-century Nova Scotia enacted legislation that imposed a 10 percent import duty on goods from the United States to help subsidize the Halifax Poor House. Further legislation obliged townships to call two meetings annually to vote money for support of the poor. In both cases funds fell behind need; thus Nova Scotia’s Assembly periodically voted lump sums for poor relief. In periods of crisis, requests for help could be quite substantial. By the 1830s, under the broad influence of Nova Scotia’s “intellectual awakening,” the improving spirit was heading toward enhanced public and private intervention into the lives of the poor.

By the 1830s, poor relief also came to include measures relating to public health. The threat of cholera enhanced the connection between medical care and poor relief. When cholera struck Halifax in 1834, it struck the poor, and those outside the confines of poverty found solace in this fact. Cholera, however, did not observe such boundaries for long, and attention soon turned to ameliorating the worst conditions and thereby preventing its spread. “There was an obvious ambivalence in this attitude,” Geoffrey Bilson observed, “as philanthropy and self-interest merged.” The poor, however, were not always the willing recipients of this attention. Some were reluctant to report to doctors when
ill or even to deliver the deceased. Rumors of premature burial were rampant and, in some quarters, customs dictated the presence of the body for a proper wake.\textsuperscript{14} Despite these limitations, the expansion of poor relief to include some aspects of medical care created an opportunity for self-assertion for an emerging medical community.

While the effort to combat the cholera threats of 1832 and 1834 were exemplary according to Bilson, they were exceptional in the colony. Most of the time, efforts to ameliorate the conditions of poverty were wholly inadequate. Worse still, even with the measures of ill-equipped municipalities, the peripatetic aid of the colonial legislature, and the efforts of reform-minded citizens, gaps remained, one of the most obvious being Nova Scotia’s Mi’kmaq population. Indeed, Olive Dickason has recently characterized Indian administration in the Maritimes as “haphazard.”\textsuperscript{15} Nova Scotia had retained the office of Superintendent of Indian Affairs in 1783, a “temporary expedient to tide the colony over a period of rapid transition.” As Mi’kmaq power dissipated, the office lapsed and thereafter the colony provided gifts and relief only sporadically, paid for through imperial grants. By the turn of the century, the Mi’kmaq were firmly a colonial responsibility.\textsuperscript{16} White settlement in the late eighteenth century had severely disrupted aboriginal life, and population growth and economic expansion in the first decade of the nineteenth century brought further marginalization—a marginalization dealt a final blow by the coming of peace in 1815.

There were some initiatives in native communities. Lieutenant Governor Lord Dalhousie, frustrated by the Assembly’s apathy toward the native condition, proposed establishing “reserves” in each county, not to exceed one thousand acres, and these were surveyed in 1819.\textsuperscript{17} Beginning in 1827, the Assembly regularly voted between £100 and £150 for relief of the Mi’kmaq. None of these initiatives met the objective of settling the native population in self-sufficient agricultural communities. In 1841 Chief Paussamingh Pemmenauweet penetrated this “wall of indifference” when he petitioned Queen Victoria, detailing the plight of his people. The Colonial Office responded by demanding information from Lord Falkland, the newly appointed Lieutenant Governor. Falkland immediately set about the task of collecting information, and offered the Colonial Office his own summary and criticism of past policy. The Lieutenant Governor proposed a variety of measures, including proper surveys of reserved lands, relief for the infirm, and providing implements and seed. The land was not to support year-round residences, at least not initially. Rather, Falkland saw settlement as a gradual process. By early 1842, based on recommendations from Joseph Howe, Falkland’s administration passed legislation that established an Indian Commissioner and, although the act made no explicit mention
of relief, the Assembly voted £300 annually for benefit of the Mi’kmaq from that time forward. This was the core of Indian administration in the colony: small sums for relief, an explicit policy of settling natives on reserves, and the attempt to foster agriculture, while underlying it all was a widespread belief that the Mi’kmaq were rapidly becoming extinct.18

The initiatives of Falkland and Howe marked a new beginning for Indian administration, and presented an opportunity for self-assertion by Nova Scotia’s doctors. Doctors fulfilled many functions, entering native communities to provide relief, deliver blankets and seeds, in addition to their attending to individual medical needs. At other times, doctors extended a generalized medical effort to native communities, as in the widespread vaccination effort of the poor in 1842 and 1843.19 Doctors also dealt with miscellaneous fevers, the majority of which went unidentified. Reports of tuberculosis among the Mi’kmaq appeared for the first time in 1841, with the notation that “many have died off with consumption.”20 Tuberculosis became increasingly common among the native population of Nova Scotia through the 1850s. Indian Commissioner James McLeod solemnly wrote that “Consumption I regret to state has of late become very prevalent among these poor people Several fatal cases occurred during the past season and many more are now suffering from the same cause.”21 Hereafter, tuberculosis became a regular occurrence in Mi’kmaq communities, particularly among the elderly. One final disease should be mentioned, called the “scourge of so many North American Native groups”—venereal disease. Abraham Gesner, a physician, surgeon, and inventor who would become Indian Commissioner, once declared that such afflictions were “by no means rare”23 among the Mi’kmaq. Information, however, is scant in nineteenth-century records and, where evidence does exist, it simply makes mention of the affliction. The petition of Dr. Henry D. Ruggles is typical, mentioning only that he visited a female who was “labouring under a disease termed Uteritis.” Other references include a man with inflamed testicles and a woman suffering from “clap or pox.”24

Clearly, doctors were busy among the Mi’kmaq for a wide variety of afflictions, and the Indian administration in the colony saw fit to pay for this attendance. In fact, the provision of medical care to the Mi’kmaq inhabitants started very early. In his recent book, Allan Marble indicates that Dr. Alexander Abercrombie provided medical care to Mi’kmaq near Halifax between October 1760 and September 1763.25 While there was no coherent provision of services in this early period, the latter half of the eighteenth century saw the increased involvement—albeit on an ad hoc basis—of the colonial administration in the affairs of the Mi’kmaq.26 Furthermore, compensation remained a contested issue. In 1842
James Dawson wrote to then Indian Commissioner Joseph Howe, "wishing to know whether the terms of the present Indian Grant permitted you to apply any part to medical aid" because the Mi'kmaq near Pictou were "labouring at present under dangerous diseases, and the overseers of the Poor refuse them any aid." Howe's response was that the "act contemplates no expenditure for medical attendance, and in general the Indians are better Doctors than the Whites." Howe, often critical of doctors, argued that given the example of transient paupers, "if one Doctor is put upon the Indian Civil list another must be and... the cost would be enormous." Physicians such as Ebenezer Annan of Liverpool represented the other side of the argument. In 1844, Dr. Annan provided care to the Mi'kmaq for some eight months, and he petitioned the legislature for payment, noting that if compensation was not forthcoming, he would have to discontinue his assistance.

The legislature became more reluctant to pay as the expense of health care climbed. Edward Jennings, for example, submitted an account totalling £120, of which £90 was for medical attendance. The legislature, interestingly, honored most of the other £30 charged by Jennings, including £11 for medicines, another £0.15s for medicines left with the community, £8 for travel expenses, and £9.15s for miscellaneous charges. Yet it gave him only £55 of the £90 he charged for time spent among the Mi'kmaq. Jennings complained, saying his "attendance was... for thirty four days a total sacrifice of my private practice... its average value is £2 a day. This year it must have realized more, an unusual degree of sickness Existing." There was more than a financial consideration for Jennings; he seemed genuinely hurt and offended by the Assembly's decision, saying "his professional character which hitherto has been unimpeached, was attacked. I have been represented as an extortioner and this circulated amongst my friends in the City and Country."

The legislature's response to increased disease and rising costs of medical care was an attempt, however imperfect, to control the payments to physicians. This came at precisely the same time that the Mi'kmaq population was enduring a period of severe deprivation. In his report to the Assembly for 1847, Indian Commissioner Abraham Gesner solemnly noted that nearly "the whole Micmac population are now vagrants who wander from place to place and door to door, seeking alms... Necessity often compels them to consume putrid and unwholesome food." Gesner continued:

Exposed to the inclemency of the weather, and destitute of the proper diet and treatment required by contagious diseases, numbers are swept off annually by complaints unknown to them in their original state. During my tour of inspection, I prescribed for several cases of hopeless consumption. The venereal dis-
ease, the scourge of vice contracted by the visits of the dissolute to the towns is by no means rare. . . . Infant mortality is very great. Intemperance also has done its fatal work."

Doctors responded to the increasing opportunities within native communities, with no less than 60 different practitioners in every area of the province attending the Mi'kmaq between 1845 and 1866.32 The historical record is sufficiently complete to compile a profile of the period, a profile that reveals something of the nature and extent of medical attendance, and the response of the legislature to the increasing cost.

MEDICAL ATTENDANCE AMONG THE MI'KMAQ

In 1844, medical attendance accounted for only £35.3s.3d of a total Indian expenditure of £333.33.33 This is not to suggest that this figure represented the only attendance rendered, nor that the entire account was for medicines and attendance. Evidence in petitions to the Assembly demonstrate that in addition to providing medical care and drugs, doctors often distributed foodstuffs and blankets. Nevertheless, by 1847, doctors' fees totalled £350.19s.7d, well over one third of the £813.13s.11d expended to relieve Mi'kmaq "during severe illness." In contrast to the five who were active during 1844, 14 physicians, all from the mainland, then rendered services.34 Costs were increasing at a sufficient rate by the end of the decade to bring forth the suggestion that the colonial government should "impose restrictions upon these Grants."35 The Assembly first raised the spectre of accountability in 1847, when it wondered whether "the nature of the diseases really demanded the lavish expenditure which has occurred . . . or whether the Medical Bills rendered to the Government are not, in some cases, much higher than they ought to be."36 Charges continued to come from both individual practitioners and the Overseers of the Poor, and were applied against the annual Indian grant.37 The Assembly usually paid claims in full until 1850, when a Resolution passed that agreed to pay formal medical attendance provided it was authorized by an Indian Commissioner or Overseer of the Poor. The Assembly passed a stronger resolution in 1857, which declared that it would consider only medical bills for cases of surgery or accouchement. It further restricted the activities of local Overseers of the Poor, in that the Overseers would have to pay any relief efforts in full, after which the Assembly would refund one half of the charges.38

This control quickly manifested itself. The accounts for 1851 record the petitions of four practitioners, only two of whom—Dr. Howard Hooper of Newport and Dr. Alexander McDonald of Antigonish—received remuneration.39 The other petitions were "not certified in the manner prescribed by the Resolution of the House last year—and it
does not appear that the services were rendered under any authority recognized by that resolution." The committee did not recommend any grant until such time as the doctors forwarded the appropriate certificates. One of the practitioners, Dr. James Forbes of Liverpool, did eventually receive his compensation, though it was a year later. In instances where the physician was authorized to perform services according to the Resolution, payment was usually in full. In cases where attendance was not authorized, the Assembly used its discretion. The petition of Dr. Henry D. Ruggles of Weymouth is typical. He claimed that during the month of August last year your petitioner was sent for in great haste to attend upon a female Indian a distance of 8 miles from his residence who had met with a compound fracture of the arm and a dislocation of the wrist. Also your Petitioner has since attended upon several female Indians labouring under complaints incident to the female sex.43

In an attempt to justify his attendance, Dr. Ruggles wrote that the "exigency of the cases not admitting of time to procure a special order from the Magistrates ... [he] immediately proceeded to the respective camps of the impaired and sick." The committee did not accept the doctor's explanation and did not recommend any grant. Most doctors, however, apparently adhered to the committee's regulations. Accounts for 1853 reveal a total expenditure of £27.8s.9d and that all but one doctor received payment. The cost of medical attendance remained high: £38.9s.1d in 1855, £29.16s.7d in 1856, £39.6s.5½d in 1857 and £73.5s.9d in 1858.45

Compounding the problem of payment was the lack of a systematic fee structure for the remuneration of practitioners. Dr. Edward Jennings complained in 1854 that young practitioners, or those with low standards "who value their time at a low figure may be satisfied with a small compensation which in fact would be no compensation but rather a loss to the Physician having a large practice." In a petition dated 3 March 1854, Dr. Henry Shaw of Kentville wrote that the "Indians & Indian affairs seem to me are infinite nuisances, & although I have had several applications to visit sick Indians, lately I have refused." Despite the frustrations and displeasure of Drs. Shaw and Jennings, a large number of practitioners did not refuse.

Doctors have never been the exclusive purveyors of medical care, and this was certainly true in the mid-nineteenth-century Mi'kmaq community. Though largely absent from the historical record, indigenous medicine endured. In some instances, such practices were touted as alternatives to inadequate or ineffective care. In 1852 the self-proclaimed "Indian physician" Peter Paul Toney Babey petitioned the Assembly. He described himself as a "Physician, Chemist and Alchemist" who
“from his youth has turned his attention to the nature of plants, herbs and the various roots of the Country possessing medicinal qualities.” Babey held out his herbal preparations as medicines “which renovate the system... and have a tendency to prolong life” in contrast to the medicines used by white practitioners, who utilized “minerals and noxious Medicines calculated to destroy life.” Babey concluded by stating that “your Petitioner has deserved for many years back... compensation” such as “the white men who pretend to give any assistance to the poor Indian receives.” It would appear that Babey had some knowledge of traditional herbal remedies, though he preferred to term his endeavors “scientific pursuits,” perhaps couching his petition in the language of the emerging medical elite. Nevertheless, it does offer further evidence that some Mi’kmaq retained a knowledge of traditional herbal remedies. Moreover, that pharmacopoeia, or the application of it, was not static and did not exist within an ethnic vacuum, but rather influenced and was influenced by outside currents. The Assembly greeted Babey’s petition only with ridicule, however, as the following exchange illustrates:

Hon. Pro. Sec’y would move that the Indian be standing physician to the house.
(Laughter.)
Mr Marshall—That might do very well, provided we know what party he belongs to.
Hon. Pro. Secretary—As he comes under the auspices of the learned member from Kings, our side will have to be careful.—(Laughter.)

Such derision and laughter, however, masked the reality of the embattled state of medical orthodoxy, faced with a myriad of competitors. Lacking adequate organization, licensing, or therapeutics, orthodoxy was still struggling to achieve pre-eminence within the medical community.

By emphasizing his herbal preparations over those of orthodox practitioners, Babey was appealing to a much broader competition that was rife within the medical community. Doctors in Nova Scotia, like elsewhere, enjoyed only a marginal status. By mid-century, however, a cadre of physicians largely centred in Halifax was engaged in a project of professional uplift. One of their primary objectives was the founding of a general hospital which, they believed, would enhance the treatment available not only to the poor, but to all classes. By 1851, Nova Scotia had legislation concerning quarantine, boards of health, rabid animals, infectious diseases, and health inspectors, in addition to an act regarding medical practitioners. In 1854, an elite group of practitioners had founded the Halifax Medical Society. It was aptly named—only one of the Society’s executive officers was from outside the city. The effort to
organize orthodox medicine was substantially aided by the Assembly
in 1856, when the medical act was revised to provide for the registration
of doctors. The 1856 Act prohibited unregistered persons from receiving
provincial appointments, established a fine of five pounds, and prohib-
ited unregistered persons from suing for fees for services rendered.52

R. D. Gidney and W. P. J. Millar have recently suggested that "in the
face of unsettling change"—such as the nascent medical reform move-
ment in mid-nineteenth-century colonial Nova Scotia—the effort to "re-
store or maintain traditional values" takes on new importance.53 Serv-
ce to Mi’kmaq communities, when viewed as part of a larger tradition
of rendering service to the poor, was such a value. Seen in this light, it is
not surprising that those practising among the Mi’kmaq were promi-
nent in their own communities and within the emerging medical pro-
fession. Of course, there were other benefits accruing to the orthodox
practitioner. What distinguished the medical care rendered to the
Mi’kmaq from that given to the poor generally, after all, was the pres-
ence of an annual appropriation against which claims could be made.
This provision meant that doctors could preserve an important part of
their "traditional values"—service to the indigent—while concurrently
advancing their position, however incrementally. In return for services,
physicians gained an important link with state authority and a modest
source of income. Petitions to the Assembly illustrate that there was a de
facto recognition of orthodox practitioners as pre-eminent by the colo-
nial authorities of Nova Scotia, even though the public may have been
sceptical of any such claim.

Whether the petitioners were motivated only by the potential of
financial reward is debatable, given the protests of men such as Jen-
nings and Shaw. The multiple roles of physicians active among the
Mi’kmaq further complicates the picture. Some of the doctors, like
Charles Aitken and Edward L. Brown, enjoyed other government ap-
pointments, in these cases serving as coroners. Others had exceptional
medical qualifications, including Dr. Charles Bent, who was a graduate
of the University of Pennsylvania, and Dr. Charles Tupper, a graduate
of the University of Edinburgh and member of the Royal College of Sur-
geons.54 The majority of physicians practising among the Mi’kmaq
were prominent either in their own communities or in the province.
Many were active in the provincial medical society55 and many of these
individuals were members of the Royal Colleges of either Edinburgh or
London. While their education cannot reveal anything about the quality
of care that they provided, they were at least familiar with the latest in
medical technique and theory. Medical attendance among the Mi’kmaq
was, then, provided largely by elite practitioners, sponsored by the
colonial authorities. Even those outside this select group apparently en-
joyed some standing in the community. Sebra Crooker of Liverpool was active among the Mi'kmaq, but never appears on the medical society lists. Yet, it does appear that this man, originally from Maine, was held in high esteem. Dr. James Forbes offered an endorsement of Crooker, writing that “I have known the petitioner... for the last sixteen years, during which time he has been practicing in this country & has obtained the favourable opinion of a large majority of the people.” The petition of 86 residents in support of licensing Crooker lends further credence to Forbes’ support.56

RELATIONS BETWEEN COLONISTS AND MI'KMAQ IN HEALTH CARE

The colony had its own reasons for alleviating the worst suffering among its aboriginal inhabitants. An episode from Pictou County in the summer of 1846 provides one illustration. Dr. William Anderson, the Secretary of the Pictou Board of Health, dispatched Health Officers to an encampment of Mi'kmaq. The officials visited upwards of twenty Wigwams, & that there they found ten individuals affected with a very severe form of Fever, which the Indians informed them had devastated the encampment.... Yesterday Dr. Johnston reported that there were then sixteen cases of Fever... on visiting them this afternoon, he found, one dead, about thirty prostrated with the Fever, and about twelve more complaining of premonitory symptoms.57

Some weeks later, Anderson noted that the “number of sick and severity of the disease, has varied with weather during the prevalence of rain the sick list exceeded Forty” but a spell of fine weather reduced the number of sick to thirty and “the Health Officers do not anticipate more than one fatal case.”58 By January 1847 the Health Board found the “general health and condition on the whole much improved... and complete restoration to health of the great proportion of those attacked... so far as the Board is acquainted, there is no disease among the survivors.”59 It would appear that the Board’s efforts met with some success. Yet the effort was, in part, to protect the white residents. The Pictou County Board of Health stated as much, in declaring “a malignant Fever, had been for some time past prevalent among the Indians and which, it was feared might spread among the white population. On receiving this information the Board immediately directed the Health officer to visit the encampment.”60

Fear was surely one motivating factor spurring the colonial authorities to action, but not the only one. From the time that Paul Pemmenwick petitioned the Assembly in 1783 to “occupy a Track of Land... for Hunting & Fishing as Customary,”61 the provision of land was intricately associated with Indian affairs. But while Pemmenwick petitioned
for land on which he could continue to pursue traditional economic ways, the government was looking toward agriculture. By the 1830s, the traditional economy was no longer tenable for the Mi'kmaq population, and the government promoted agriculture as a means to foster self-sufficiency (thereby controlling relief payments) and to integrate the Mi'kmaq into the colonial economy. At least one doctor, Edward Jennings, was in full accord with the colony's attempt to foster agriculture. Jennings argued that to "contribute small sums yearly must produce degeneracy as it favors idle habits. To civilize and make them independent might be slowly accomplished by affording them the means of cultivating the land & by appointing a man in each district to direct their attention to agricultural pursuits." 62 It is not clear what role doctors played in the proposed transformation of Mi'kmaq communities into self-sufficient agricultural colonies within the colony. What is clear is that they likely represented the government in a number of ways—supplying medicine and attendance to be sure, but also blankets, farm implements, seed, and the like—and therefore acted as agents of acculturation. 63 In later periods, Indian agents would make explicit connections between the health of the Mi'kmaq and the pursuit of a more traditional lifestyle, namely, hunting, fishing, and trading in handicrafts. Thus, in 1882, J. E. Beckwith noted that in Kings County, the sale of handicraft goods allowed the Mi'kmaq only "to eke out a scanty living" which was aggravated by the fact that the "game is all gone." The tentative nature of this existence, Beckwith argued, meant that when disease struck, "destitution and starvation stared them in the face." 64 Joseph Chisholm also drew a connection between a traditional way of life and the prevalence of disease or general health status, when he declared that "there has been some suffering among the nomad portion of them from chronic diseases." 65

These references are of interest not simply because they reveal the congruity between attitudes of physicians and the state, but also because they remind us of the continued persistence of a distinctly aboriginal way of life. The same persistence was undoubtedly true of Mi'kmaq notions of disease, health, and cure, although empirical evidence is scarce. 66 Some references appear, such as in the 1847 petition of Edward Jennings, in which he referred to the "decoction of some astringent barks." The Mi'kmaq evidently continued their use of traditional remedies until the twentieth century. Noted Nova Scotian journalist and author Clara Dennis documented many of these preparations. In 1920, she recorded that some of the population consulted a medicine man during illness and that he had "many testimonial[s] of people he cured with flue [sic]." Dennis also noted remedies for colds, indigestion, and other ailments. Of particular interest is that the Mi'kmaq continued to
practise a form of preventive medicine. They “make medicine & go through ceremony” Dennis wrote in her notebook, “to dry [drive] out the evil spirit before they take it... medicine is taken 2 times a year spring and fall. Everyone took it.”67 There are two very important elements contained in Dennis’s description. First, it suggests that the Mi’kmaq residents of Whycocomagh still partook in a preventive medicine ritual, attesting to both the resiliency and the strength of their beliefs. Second, it is obvious that some Mi’kmaq retained their traditional beliefs of disease causation. Together with the ethnographic evidence collected by Wallis and Wallis in the 1950s, and by current scholars such as Laurie Lacey and Frank Chandler, Dennis’s account reveals that traditional Mi’kmaq notions of illness and cure endured and continued to be practised. Moreover, as Sally Weaver reminds us, traditional methods of dealing with illness were likely the first line of defence, while “Western medicine was turned to largely as a last resort when traditional methods were perceived to be unsuccessful, or in extreme cases.”68

Medicine, disease, and health care describe a relationship of power and authority between Mi’kmaq and colonist, between those being (increasingly) ruled and those doing the ruling. Disease is a powerful signifier of broader social relations. At mid-century, the Mi’kmaq were portrayed as a dying race—the vestigial limb of an earlier age, whose only hope was the adoption of a settled, agricultural life. Later in the century, when extinction was no longer presumed, the pursuit of an aboriginal way of life became a cause of disease in the Indian agent’s discourse. Disease and the aboriginal life were linked and condemnation of continued “backwardness” became tenable. Medicine is, after all, an institution of culture, and served to extend the colonists’ values into the aboriginal world. The provision of medical care by the state, however beneficial, aided in the consolidation of colonial rule in the newly established reserve. Doctors not only treated disease, but also played a broader role as agents of acculturation.

While there is little doubt that a professionalizing group of elite practitioners seized the opportunity to benefit from the natives’ special relationship to the Crown, the relationship between doctor, state, and native was neither static nor uncontested. The medical profession’s victory was neither final nor complete in the years before Confederation. One of the most profound illustrations of the vulnerability of the emerging profession was the case of Dr. Frederick W. Morris.69 Morris had been a Vice President of the Halifax Medical Society and was the resident physician at the Halifax Visiting Dispensary. Yet, in 1861, Morris began advocating the use of a Mi’kmaq remedy in combating smallpox. One such endorsement appeared in the 29 April 1861 issue of the
Novascotian, in which Morris declared that "I have no hesitation... from what I now know of the medicine, in recommending all persons who are at all anxious in this matter, to provide themselves with the remedy with all haste." This public endorsement went a good deal further, however, with Morris writing:

I can with confidence assure the public, from the astonishing influences of the remedy I have already seen, that I have not the least misgivings as to its efficacy. I do not believe it will ever fail to cure, if given at any period of the disease up to the third or fourth day of the eruption, or as long as there is any power of reaction in the system. In the language of the Micmac, "it kills the disease." It is of so mild a nature that the smallest infant may take it with perfect safety.

Such public endorsements earned Morris the scorn of his peers, and the Medical Society expelled him. He was, however, allowed to retain his position at the Visiting Dispensary, on the proviso that he discontinue prescribing the remedy.70

At the meeting of the Nova Scotia Medical Society held on 6 May 1861, the members present, with Morris alone dissenting, passed the following resolutions:

Resolved... that Dr. Morris has not had any reliable data upon which to found any opinion in favour of its value as a remedial agent.  
Resolved that a copy of the foregoing resolution be published in two or more of the morning papers.71

Morris's endorsement of the smallpox remedy, while not costing him his position at the Dispensary, did cause difficulties at the institution. There were a number of resignations from the Board of Medical Governors, including Drs. Hume, Black, Parker, Gilpin, and Forest. Moreover, the Dispensary required Morris to sign a letter which read, in part, "I hereby pledge myself to refrain in future from the use of such remedies and such publications, whilst an officer of the Institution." It would appear that the orthodox profession was not primarily concerned with the actions of Dr. Morris, but rather with the public perceptions of those actions, evidenced through the publication of Morris's recanting. Underlying these condemnations of Morris was the "unspoken fear that regular practitioners offered less to their patients than their competitors."72

The relationship between Frederick Morris and John Thomas Lane, the supplier of Morris's remedy, was a lengthy one. Lane was a keen marketer of his product, the so-called "Indian Liniment."73 The Novascotian frequently published testimonials, attesting to the value of this preparation, which apparently offered relief to those suffering from sore throats, arthritis, and other ailments. These testimonials appeared both before and after Morris's endorsement, though the last one appeared on 6 May 1861, the day the Medical Society reprimanded
Morris. Lane and Morris, moreover, would have to defend their actions before a coroner’s inquest into the death of Mary Ann Cope. By 3 June 1861, Lane, who described himself as “Medicine Man to the MicMac Tribe,” was publishing testimonials recounting the efficacy of his smallpox remedy.

It was this “remedy” that led Lane and Morris to the inquest into the death of a Mi’kmaq child, Mary Ann Cope. The inquiry, which focused on the efficacy of Lane’s smallpox remedy and the nature of the attendance rendered, was, however, primarily concerned with the perceptions of the public. The jury did find that young Mary Ann Cope died “from the effect of small pox, [and] for want of proper attendance to keep her from taking cold, while the deceased was laboring under the disease of small pox,” which emphasized that smallpox, and not iatrogenesis, was responsible for the death. After the decision, Edward Jennings, the Coroner, addressed the jury, saying the “decision will clearly show to the public that had the deceased been under the care and treatment of a medical man, there exists every probability that life would have been saved.”

Thus even in tragedy, the medical community found a method, through the Coroner’s Inquiry, of deflecting potential criticism away from the emerging profession, while concurrently attempting to extend its authority through equating good medical care with regular practitioners.

CONCLUSION

Nova Scotia proved utterly incapable of ameliorating the conditions of the Mi’kmaq, beyond the rudiments established in the 1820s and 1830s. Squatters continued to nibble at the margins of reserved lands and, unable to curtail this activity, the colony resigned itself to selling parcels of reserve land and placing the money in an Indian fund. By 1866, only $1,531 had been set aside. The other Maritime colonies did not fare much better. Conditions were so bad in Nova Scotia and New Brunswick following Confederation that the deputy superintendent general pleaded for a “philanthropic effort” to elevate natives in the region “up at least to the standard of the more advanced Indians of Ontario and Quebec.” Not surprisingly, the heavy demands on the annual Indian grant, combined with a paltry Indian fund, fostered a desire in the Assembly to control the cost of medical care. L. F. S. Upton argued that the “disgraceful” state of the Indian affairs administration of colonial Nova Scotia “had not come about due to the Indians themselves” but rather because of the “increasing claims that Overseers of the Poor were making against the Indian grant.” He suggested, quite rightly, that the medical attendance constituted the largest proportion of these claims. But it was the colonial administration, in its effort to control
medical expenditures, that burdened the Indian grant with this expense, not physicians themselves. A different administration may have paid for medical care in another fashion, through public health appropriations, for example. The evidence from colonial Nova Scotia suggests that the fledgling Indian affairs administration did not, however, see medical care as something apart from other expenditures. Doctors were an integral component of the early Indian administration in the colony, serving at one and the same time as agents of acculturation, representing a range of state activities, and as angels of mercy.

NOTES

* This work stems from my Master's thesis, Saint Mary's University, Halifax. I am indebted to the Atlantic Canada Studies program for facilitating this work, and I am grateful to Saint Mary's for a graduate fellowship that originally funded this research. I would like to thank Colin Howell, Allan Marble, Michael Cross, and especially David Sutherland for helpful comments, and my colleagues in the graduate program at Dalhousie. I would also like to thank J. T. H. Connor and the two anonymous reviewers for many insightful criticisms.

1 Virginia Miller presented a description of the symptoms of the epidemic of 1846 and 1847 to Dr. C. Noel Williams of Dalhousie University. Williams identified the disease as infectious hepatitis. Readers are, of course, cautioned that at best, the diagnosis of infectious hepatitis is an informed guess. See Virginia Miller, "The Decline of Nova Scotia Micmac Population, A.D. 1600-1850," Culture, 2 (1982): 114.


6 For examples, see T. Kue Young, *Health Care and Cultural Change: The Indian Experience in the Central Subarctic* (Toronto: University of Toronto Press, 1988); and Dara Culhane Speck, *An Error in Judgement: The Politics of Medical Care in an Indian/White Community* (Vancouver: Talonbooks, 1987). One of the most compelling ethnographic accounts may be found in Anastasia M. Shkilnyk, *A Poison Stronger than Love: The Destruction of an Ojibwa Community* (New Haven: Yale University Press, 1985). This work deals in part with the effects of mercury poisoning on the community of Grassy Narrows. There is also an extant literature in medical journals, such as the *Canadian Journal of Public Health* and the *Canadian Medical Association Journal*, dealing with contemporary native communities. The work of David Young, Grant Ingram, and Lise Swartz, *Cry of the Eagle: Encounters with a Cree Healer* (Toronto: University of Toronto Press, 1989), provides an interesting account of a native healer interacting with Western medicine.


9 The provision of medical care to native people did not stem from legislative obligation in the federal government’s view, but rather out of “moral obligation.” Indeed, as the Indian Health Service expanded in the 1950s, nearly every federal government report generated made a point to declare that no legal precedent existed. The 1956 Department of National Health and Welfare, *Annual Report*, is typical, stating, “it must be emphasized that the Indian is not entitled by law to free medical care... nor has the State even assumed the responsibility of providing free medical attention to all, irrespective of their legal status or ability to pay. On the other hand, the government votes a certain amount of money to be spent each year for the provision of basic health and treatment services to the Indians and Eskimos. This is done on humanitarian grounds...” (Canada, Department of National Health and Welfare, *Annual Report 1956*, p. 84). Health matters were mentioned in a treaty concluded between the Wood and Plain Cree and the Crown on 23 and 28 August, and on 9 September 1876, in what was to become the Province of Saskatchewan.


11 Prince Edward Island did not adopt the poor-law model, because of its small population. Upper Canada passed poor relief legislation in 1792 that explicitly rejected the poor-law model, while in Lower Canada, responsibility for the poor was assigned to the Catholic Church. For a brief overview see Dennis Guest, *The Emergence of Social Security in Canada* (Vancouver: University of British Columbia Press, 1980).

12 Greenhous, “Paupers and Poorhouses,” and Grace Aiton, “The Selling of Paupers by Public Auction in Sussex Parish,” *Collections of the New Brunswick Historical Society*, 16 (1961): 93-110. Daniel Francis suggests that this system of poor relief had implications for health care, because “many of the victims of the auction block... would have been paupers suffering from mild forms of mental illness,” although he provides no evi-
dence to substantiate this observation ("The Development of the Lunatic Asylum in the Maritime Provinces," *Acadiensis, 6* [1977]: 24-25).


15 Dickason, *Canada's First Nations,* p. 231. Chapter 16 is entitled "Canadian Aboriginal World in the Early Nineteenth Century," and deals with the administration of natives by the colonies, including Nova Scotia. Readers may also be interested in chapter 17, "Pre-Confederation in the Canadas."


17 Reserves on Cape Breton Island, which was an independent colony from 1784 to 1820, were roughly surveyed in the 1830s.

18 Upton, *Micmacs and Colonists,* p. 81-97. Judith Fingard has recently reminded historians that "In the Maritimes, the Native population was large enough that there was no immediate chance of extinction, but the attitude of the settlers was certainly based on the perception that extinction was inevitable.... Fortunately, though ironically, the policies that were designed to ease the Maritime aborigines into oblivion had the positive effect of providing sufficient relief to enable them gradually to resume population growth and thereby ensure their own survival" ("The 1820s: Peace, Privilege, and the Promise of Progress," in Buckner and Reid, eds., *The Atlantic Region to Confederation,* p. 276). It is difficult to ascertain the accuracy of population estimates, but there are several for this period. Howe provided estimates of 1,425 in 1838 and 1,300 in 1843; Abraham Gesner suggested 1,461 in 1847; in 1852, a census of the mainland provided 1,056, plus another 500 (based on 1849 data) on Cape Breton Island; in 1861 William Chearnley estimated the number to be 1,573. The first Canadian Census, 1871, suggested a native population of 1,666. Population estimates for the period 1616-1921 have been summarized in Miller, "The Decline of Nova Scotia Micmac Population," p. 114.


20 PANS, RG1, Vol. 431, #20.

21 PANS, MG15, Vol. 5, #1, 12 January 1853.


23 Nova Scotia, *Journal of the Legislative Assembly (JLA) 1848,* Appendix 24, p. 117.


27 PANS, RG1, Vol. 432, James Dawson to Joseph Howe, 29 September 1842.

28 PANS, RG1, Vol. 432, Joseph Howe to James Dawson, 1 October 1842.

29 PANS, RG5, Series P, Vol. 44, #45. Annan’s attendance was deemed to have been useful by Howe and he was paid. See JLA, 1844, Appendix 50.

30 PANS, RG1, Vol. 431, #43, 1 April 1847.

31 JLA, 1848, Appendix 24.

32 This figure is based upon all the identifiable medical accounts recorded in the JLA; PANS, RG5, Series P; PANS, MG15, Vols. 4a, 5, and 6; and PANS, RG1, Vol. 431. The vast majority of this attendance, it must be reiterated, was for various ailments, though petitions exist for the treatment of typhus in two cases, smallpox in three, tuberculosis in three, injury in three, measles in two, and tooth extraction, venereal disease, and rheumatic fever in one case each.

33 JLA, 10 April 1845. The account was as follows: Dr. Benjamin Page (Amherst) £7; Dr. Charles Tupper (Amherst) £3; Dr. Ebenezer Annan (Liverpool) £13.4s.9d; Dr. Edward L. Brown (Horton) £3; and Dr. William Slocomb (Lunenburg) £7.18s.6d. The addition of medical accounts is my own.

34 JLA, 1847, Appendix 57. The addition is my own.

35 JLA, 1849, Appendix 88.

36 JLA, 1847, Appendix 57.


38 JLA, 29 April 1857.

39 JLA, 29 January, 12 and 14 February 1851, for the presentation of the petitions, and Appendix 91, p. 281-82 for payments rendered. Hooper and McDonald received £3.10s.

40 JLA, 1851, Appendix 91.

41 JLA, 1852, Appendix 45.

42 PANS, MG15, Vol. 4a, #119; and JLA, 11 February 1852 and Appendix 45.

43 PANS, MG15, Vol. 4a, 11 February 1852.

44 JLA, 1852, Appendix 45.

45 JLA, 1854-55, Appendix 28; JLA, 1856, Appendix 63; JLA, 1857, Appendix 63; and JLA, 1858, Appendix 68. The additions are my own.


47 PANS, MG15, Vol. 5, #30, 3 March 1854.

48 PANS, MG15, Vol. 4a, #126, 19 February 1852. For additional biographic material on Babey see Dictionary of Canadian Biography (Toronto: University of Toronto Press, 1966), Vol. 8, p. 32-33.

49 John Crellin's recent work nicely illustrates the responsiveness of "home medicine" in Newfoundland. There is no reason to believe that traditional native medicine was not equally dynamic (John Crellin, Home Medicine: The Newfoundland Experience [Montreal: McGill-Queen's University Press, 1994]). See also Laurie Lacey, Micmac Indian Medicine: A Traditional Way of Health (Antigonish: Formac Publishers, 1977).

50 Novascotian, 1 March 1852.

51 It is difficult to suggest a "typical" doctor. In Nova Scotia, education, political activities, and wealth varied greatly. Paul Starr suggested that the differences between physicians could be so great "that doctors cannot be said to have belonged to a single social class" (Paul Starr, The Social Transformation of American Medicine [New York: Basic Books, 1982], p. 81, 84).

tioners in Medicine and Surgery," establishing a Provincial Medical Board to ascertain the quality of education and training of a candidate for licensure. The Dalhousie Faculty of Medicine was founded in 1868, though between 1875 and 1911 medical education was carried out at the Halifax Medical College. The Halifax Medical Society was renamed the Nova Scotia Medical Society in 1861. The development of the medical profession in the nineteenth century has been dealt with most fully by Colin Howell (see Colin Howell, "Reform and the Monopolistic Impulse: The Professionalization of Medicine in the Maritimes," Acadienis, 11 [1981]: 2-23; Colin Howell, "Elite Doctors and the Development of Scientific Medicine: The Halifax Medical Establishment and 19th Century Medical Professionalism," in Charles G. Roland, ed., Health, Disease and Medicine: Essays in Canadian History [Toronto: The Hannah Institute for the History of Medicine, 1984], p. 105-22; and Colin Howell and Michael Smith, "Orthodox Medicine and the Health Reform Movement in the Maritimes, 1850-1885," Acadienis, 18 [1989]: 55-72).


55 Belcher’s Farmer’s Almanack 1857, p. 110. The medical society membership lists were published in the Almanack, and were consulted for the years 1857-1866. Physicians active in both the medical society and in delivering care to native communities included Thomas O. Geddes, George M. Johnston, Charles Aitken, Alexander Lane, Robert Leslie, James Forbes, Alexander McDonald, Edward Jennings, Charles Creed, Henry Shaw, and Charles Tupper.


57 PANS, RG1, Vol. 431, #41, 27 June 1846.


59 PANS, MG15, Vol. 4, #6, 16 January 1847.


61 PANS, RG1, Vol. 430, #234.

62 PANS, MG15, Vol. 4, #18, February 1847.

63 In a recent study of the Navajo, Stephen Kunitz has made a similar point. He argues that "medical therapy was of enormous value in treating some of the most important infectious diseases but is and will continue to be of questionable value in reducing mortality from the causes that are now of major significance—accidental and other violence. If this is so, then it is important to ask, what role modern medicine does play? The answer, I suggest, is that increasingly medicine acts as an acculturation agent, teaching people to define conditions that are largely psychosocial in origin and rooted in traditional patterns of ecological adaptation and social organizations as diseases for which new modes of explanation, treatment, and behavior are necessary" (Stephen Kunitz, Disease Change and the Role of Medicine: The Navajo Experience [Berkeley: University of California Press, 1983], p. 3-4).

64 Canada, Parliament Sessional Papers No. 6 (1882), p. 25.

65 Sessional Papers No. 6 (1887), p. 35.

66 Readers interested in the indigenous medical practices of the Mi'kmaq should consult the following works: Wilson D. Wallis, "Medicines Used by the Micmac Indians," American Anthropologist, 24 (1922): 24-30; Wilson D. Wallis and Ruth Sawtell Wallis, The Micmac Indians of Eastern Canada (Minneapolis: University of Minnesota Press, 1955), especially chap. 7 and p. 294-96; Lacey, Micmac Indian Medicine; Laurie Lacey, Micmac Medicines: Remedies and Recollections (Halifax: Nimbus, 1993); Arthur F. Van Wart,

67 PANS, MG1, Vol. 2867, #2, entry for 20 June 1920 and an undated entry.  
68 Weaver, Medicine and Politics, p. 40.  
69 For details of Morris’s career see Dictionary of Canadian Biography, vol. 9, p. 573-74.  

71 PANS, RG1, Vol. 431, #129, 8 May 1861.  
73 Of course the mid-nineteenth century spawned a virtual cottage industry in the area of “Indian” remedies. This included the publication of numerous books exploiting the “Indian” motif, including the following: Robert D. Foster, The North American Indian Doctor, or Nature’s Method of Curing and Preventing Disease According to the Indians . . . also, a treatise on Midwifery . . . also, A Materia Medica of Indian Remedies, or Vegetable Compounds, in the form of recipes for more than two hundred and fifty diseases, with a description of such plants as are not common (Canton, Oh.: Printed for the author by Smith and Bevin, 1838); James W. Cooper, The Experienced Botanist or Indian Physician. Being a New System of Practice, Founded on Botany (Lancaster, Penn.: Printed for the author and publishers, John Beer, printer, 1840); Daniel Smith, The Reformed Botanic and the Indian Physician: A Complete Guide to Health (Utica, N.Y.: Curtiss and White, Printers, 1855); and John Goodale Briante, The Old Root and Herb Doctor or the Indian Method of Healing (Claremont, N.H.: Granite Book Co., 1870). In a different genre were the travelling medicine shows, the most famous of which was the Kickapoo Indian Medicine Company (see James Harvey Young, The Toadstool Millionaires: A Social History of Patent Medicines in America before Federal Regulation [Princeton: Princeton University Press, 1961]).  
74 Testimonials may be found in the following issues of the Novascotian: 18 February 1861, 22 April 1861, 29 April 1861, and 6 May 1861. Morris defended his relationship with Lane in the Novascotian on 10 June 1861.  
75 Lane’s description of himself may be found in Novascotian, 22 July 1861, and the advertisement with the testimonials in Novascotian, 3 June 1861. Upton mentions Lane “had been elected medicine man of the Shubenacadie band” (Upton, Micmacs and Colonists, p. 136).  
76 PANS, RG41, Series C, Vol. 33, #1, Coroners Inquest re: Mary Ann Cope. The Proceedings of the inquest were published in the Novascotian, 22 July 1861.  
77 New Brunswick had only raised £2853.10, while on Prince Edward Island, there was no reserve land to be sold. The PEI Assembly voted only £30 in 1862 and £10 in 1864, with nothing in between (Phillip A. Buckner, “The 1860s: An End and a Beginning,” in Buckner and Reid, eds., The Atlantic Region to Confederation, p. 367).  