Pulling Up Their Sleeves and Getting on with It: Providing Health Care in a Northern Remote Region

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Abstract. Based on the written correspondence between nurses situated at northern outpost nursing stations and their supervisors in Regina, this paper illustrates the complexities of providing nursing care in Northern Saskatchewan between the mid-1940s and late 1950s. The paper begins with a discussion of the steps taken by governments to deal with what I refer to as a “landscape of hardship” in Northern Saskatchewan that precipitated creation of the nursing stations. However, government failure to provide adequate support for the nurses and nursing stations resulted in considerable hardship and frustration for the nurses to which, as their correspondence shows, they often objected.

Keywords. outpost nursing, northern development, working conditions, dissatisfaction/frustration

Résumé. Cet article s’intéresse à la complexité liée à la prestation de soins infirmiers dans le Nord de la Saskatchewan au cours de l’après Deuxième Guerre mondiale jusqu’à la fin des années 1950. Notre étude, basée sur la correspondance entre des infirmières œuvrant dans des dispensaires en régions éloignées et leurs superviseurs établis à Regina, porte sur les mesures prises par les gouvernements pour faire face, dans le Nord de la Saskatchewan, à ce que nous appelons, un « paysage de difficultés ». La création précipitée de dispensaires par le gouvernement, sans offrir un soutien adéquat aux infirmières en poste dans le Nord de la Saskatchewan, a entraîné chez les infirmières, opposées à ce type d’initiative, de nombreuses difficultés et son lot de frustrations.

Mots-clés. dispensaires, soins infirmiers, régions éloignées, conditions de travail, insatisfaction/frustration

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She was stormbound for three days on her way to Stony Rapids and had forgotten her sleeping bag. Conditions were pretty primitive when she first arrived at the new hospital. There was a furnace but no pipes, a bathtub but no water, and lamps but no coal oil.… Conditions may have been primitive but she [the nurse] pulled up her sleeves and not being a woman given to neurotic tears or the “oh, pity poor me” class of hysterics, she got on with it. Today the hospital is bright and clean as a newly minted coin, is modern right down to a built-in bathtub and dressed up with the comfortable sort of accessories that make a home and not an institution.¹

The above quote describes, in rather patronizing terms, the difficult situation faced by the outpost nurse sent to open and operate the nursing station at Stony Rapids, Saskatchewan, in 1949. The provincial government established the nursing outpost system to provide much-needed health care to primarily Aboriginal² populations whose health standards lagged considerably behind those residing in the southern part of the province. Nurses were considered key players in the plan, but as the above statement alludes to, the level of financial support and commitment necessary for the nurses to achieve such goals were simply not forthcoming.

The opening statement would have us believe that stoicism and a sense of duty compelled the nurses to get on with the job rather than dwelling on any problems. Having little choice, that is indeed what they did, although not without complaint. The nurses were far from silent about the challenging conditions that they often encountered and they voiced their dissatisfaction in letters to their supervisors. Employing a geographic lens this paper will examine the nurses’ responses to conditions at the remote nursing stations within the context of the provincial government’s drive to modernize and alleviate some of the hardships facing residents, while, at the same time, setting the stage for uranium mining activity in the region.

OUTPOST NURSING IN CANADA

Research into various aspects of northern nursing has increased significantly in recent years, resulting in a rich body of literature on a number of related topics. Some researchers have focused their attention on the mix of government departments, agencies, and organizations involved in delivering health care services to northern residents.³ However, as the majority of the northern population was (and remains) of Aboriginal ancestry, others have focused on the nurses and the impacts of nursing practices on Native communities.⁴

The literature also shows that nursing in remote locations provided the nurses with a certain degree of autonomy and professional satisfaction which many welcomed.⁵ At the same time, however, a number of
consistent themes have surfaced related to the nursing posts, including challenges of distance, transportation, weather, overwork, isolation, and loneliness. Furthermore, conditions were often very rudimentary, resulting in a blurring of boundaries between institutional and domestic spaces and a lack of privacy.⁶
Data for this paper is drawn from two archival collections documenting the experiences of nurses working in Northern Saskatchewan. The first is a collection of letters written between nurses working in outpost hospitals in Northern Saskatchewan and their supervisors in Regina on matters related to the nursing stations. The second source consists of taped interviews often conducted many years after the nurses had retired and were no longer living in the north. The two sources offer interesting differences. The letters were written as events unfolded, reflecting the nurses’ attitudes, reactions, and feelings in the present rather than retrospectively. Consequently the letters have a “raw” feeling to them where the reader actually feels the frustration, distress, and isolation of the nurses. In contrast, the nurses’ oral reminiscences, documented well after the time they took place, are very positive, with a tendency to laugh-off the challenges that they faced on a regular basis. While these differences are particularly striking when the written correspondence and oral interviews are available for the same nurse, that does not mean that either account is right or wrong, but rather it is important to consider the social context in which those perspectives were constructed.7

SETTING THE STAGE: NORTHERN SASKATCHEWAN

Northern Saskatchewan encompasses 252,430 kilometers or about half the province’s total land mass. The region is part of the provincial norths, which Coates and Morrison refer to as the “forgotten norths,” a vast sub-Arctic belt running from the coast of British Columbia through the Canadian Shield and on to Labrador—a region which has long been ignored, considered politically weak and economically unstable, but home to substantial Aboriginal populations.8

In 1944, the Co-operative Commonwealth Federation (CCF), the forerunner of the New Democratic Party (NDP), was elected in Saskatchewan. One of the first initiatives of the new provincial government was to create the Northern Administrative District (NAD), or Northern Saskatchewan as it is commonly known, as a spatial entity within the provincial milieu, thus setting the stage for extraction of the area’s natural resources, particularly the mining of uranium. However, conditions facing many people living in the region were those of abject poverty. For example, the fur and fish industries, considered the foundation of the region’s economy, were in severe decline resulting in high unemployment and poverty. Indian9 and Métis people, who were the majority population in the region, lacked education, medical facilities, decent housing, communications, and social services.10 Accompanying these conditions were a high infant mortality rate, a life expectancy of little more than 30 years, and related social problems.11
The situation was abysmal for many northern Aboriginal residents, yet, at the same time, the provincial government was intent on moving ahead with resource extraction in the region, particularly uranium mining. The CCF focused on social regeneration and integration of the Aboriginal population into Canadian society, which it believed could be achieved by modernizing institutions and introducing public services such as education and health care. Funds to accomplish the CCF’s objectives would come from exploitation of the region’s uranium resources. Public health nursing became a key mechanism for delivering both health care and for assisting in the process of social reform, which the government felt was necessary to address the less-than-ideal conditions facing residents of the region. Clearly, the nursing stations were part of an overall plan to “modernize” the region and improve conditions for the primarily Aboriginal population. However, the resources required for funding construction and support of the outpost hospitals were in direct competition with government plans to fund the construction of Uranium City, a community whose sole purpose was the mining of uranium carried out largely by non-Aboriginal employees relocated from outside the region.

“MODERNIZING” A NORTHERN REGION

Modernization was seen as a process of spatial diffusion, measured by the spread of modern institutions such as education and medical facilities. The premise was based in the historical relationships which emerged between western and non-western societies and became the central model guiding development programs and policies throughout the globe, including northern Canada from about 1945 to 1965. The premise of the theory stressed that once traditional societies shed their customs and modernized to the standards of western countries, their development was assured. Modernization has the potential for positive outcomes, but providing infrastructure and services is only the first step in the modernization process. To be successful, the benefits must extend to the less fortunate, not through “trickle-down” effects but through a transformation in social relations of responsibility and control. Unfortunately, in Northern Saskatchewan, the manner in which the modernization process unfolded ultimately contributed to the region’s colonization. Programs were implemented to address the gap in living standards between northern and southern Saskatchewan, but chronic government underfunding, inappropriate programs, and a lack of local participation in decision-making kept the overall level of services well below that of the south. As a result of these factors, Northern Saskatchewan emerged as a resource rich colony of the south.
NURSING AND MODERNIZATION

Nurses as employees of the provincial government could be viewed as integral players in the CCF’s attempts to modernize Northern Saskatchewan. But there is more to the story. The health programs were often disorganized and underfunded, while bureaucrats were frequently uncooperative and caused considerable frustration for the outpost nurses. Admittedly, nurses were government employees and located within the institutional framework that supported a specific political agenda, but they also had their own personal and professional tenets to uphold, which they attempted to do regardless of the fact that their teachings were meant to be instruments of modernization.

THE NURSING STATIONS IN NORTHERN SASKATCHEWAN

Nursing stations were established throughout Northern Saskatchewan at a time when there was a general shift in Canada from home-based care to providing care in hospital settings. Because Northern Saskatchewan was so sparsely settled, providing hospital-based medical services to the people of the area was considered impossible. The belief was that little more could be done than to provide the minimum of medical care to the population through medical outposts, from which patients could be evacuated to larger centres by air if necessary. The nursing outpost buildings, although poorly equipped at times, were constructed specifically for use as nursing stations. The exceptions were Cumberland House, where a small log cabin served as the nursing outpost between 1929 and 1941 when a new facility was constructed, and Uranium City, where a shack, hauled over the ice from Goldfields, served as the first nursing station.

The term “hospital” is used lightly when referring to the outposts, because it conjures up an image of facilities far more grandiose than those found by the nurses. The outposts lacked basic necessities including the simplest of items such as reference books, forcing one nurse to rely on her books from training and manuals put out by drug companies. The outpost hospitals, in fact, had more in common with infirmaries or clinics. For example, the nursing station at Stony Rapids mentioned earlier, was little more than an empty shell when the nurse arrived, while the first “hospital” at Uranium City consisted of a small shack that had been moved over the ice from Goldfields to the community. The nurse working at the station reported that:

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

In spite of the conditions, the nurse at the Uranium City nursing station provided care, delivered babies, and as long as there were patients, slept at the outpost as well. Administration Services of the provincial government, however, viewed the arrangement differently, arguing that because the nurse sometimes slept and ate at the outpost, her Northern Allowance pay was cut by half to cover the cost of room and board, leaving the nurse extremely annoyed. She replied that

I am at a loss to know how I could have conveyed the impression that for 50% of my time I live at the hospital … During the month of March, I will have two maternity cases which I will have to nurse over there. Their meals I will prepare here and mine I will eat here. I shall have to sleep there for as long as I keep them in, but I do not feel that can be regarded as living at the hospital. Therefore, I do wish to protest this decision on the ground that I live out, and that I provide my own maintenance.25

The nurse was indignant that the authorities would quibble over such a small amount of money given all the meals she had lugged between the two places and the people she had cared for in her own home over the winter.26 It is unclear whether the nurses’ full Northern Allowance was reinstated, but despite her description of the appalling conditions of the nursing station, no improvements were forthcoming. Several months later a new nurse described the same outpost.

This little place is very poorly equipped and as poorly furnished. There is not much around to give efficient treatment nor to keep house. During summer it might not be too bad but it must be utterly unpleasant during fall and winter. The rain comes in by the windows and through the roof. The nights are very cold already and without the oilstove going this little shack was like an icebox this morning … If it should be intended to keep this place going some drugs and other equipment are needed.27

The situation at another nursing station was described in similar terms with the nurse reporting that she had sincere admiration for the nurses who carried out their duties in such unpleasant conditions.28

THE NEED FOR A TONIC

Nurses were not only in charge of providing bedside nursing and, time permitting, public health programs, but they were also responsible for running the outpost hospital. They constantly reported having no idea of the incredible workload they would face working in the north. In one instance the nurse felt that the six weeks she had spent working at the northern outpost facility was more than enough time to make
her realize the intolerable arrangements. The lack of private space, little personal time, and too many domestic chores were cited as the main problems. Domestic responsibilities often went well beyond the boundaries of nursing. Nurse Broome for example, reported that in addition to her nursing duties, she was responsible for preparing meals for between 14 and 18 workers, three times a day, who were constructing a new government store in the community. She goes on to say that she was looking forward to her holiday, but in the meantime because the responsibility and constant work left her feeling fatigued and a bit on edge, she was in need of a “booster” to supplement her energy levels. The supervisor replied indicating that the supplement had been sent, but no reference was made to alleviate the extraordinary workload that the nurse was carrying.

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

TRANSPORTATION AND COMMUNICATION

Although the provincial government had established the first air ambulance system in North America to airlift patients to larger centres for medical care, nurses in the north were discouraged from making use of the service and instead were told to request the plane belonging to the Department of Natural Resources located in Prince Albert. When nurses did call for the air ambulance, they were sometimes reprimanded by their supervisors if the flight was considered unnecessary—to the point of being threatened with covering the costs. Despite the lack of access to alternate forms of transportation, they used whatever means were available to reach people. In one instance, upon receiving a note asking her to visit and see the children in a community where there was considerable illness, the nurse made a 100-kilometre canoe trip because she hesitated to charter a plane.

There were also long periods of time, particularly during freeze-up in the fall and break-up in the spring, when planes could not land,
leaving nurses to care for patients in their own homes. As Nurse Broome reported,

We were only three weeks in isolation during our break up period which we appreciated very much. During that time I had a serious burn case and as yet haven’t been able to send him out as the ice this week at Ile a la Crosse was still floating around and unsafe for landing. However his condition is good and will send him out next schedule. His left arm and hand were badly burned and he was in great shock when I first saw him … I kept him in our own home for 2 days pushing fluids … I am very pleased with the condition of his arm and hand.36

Although advances were made in communication and access to two-way radios, telegrams, and telephone systems improved, supervisors encouraged nurses to use the least expensive means available. One nurse reported that only letters and wires (telegrams) were allowed—no phone calls—because they were considered too costly. She went on to say that they were always made very conscious that it was government money that was being spent. In another instance the nurse was told by her supervisor that although she appreciated that nurses needed access to the outside world especially during breakup, she was to send a wire only when absolutely necessary, because the last two messages had been very costly. She was also instructed to keep the words to a minimum!37 Consequently, nurses spent considerable time writing letters and composing wires, particularly as the message had to be convincing.

Language and cultural differences between the nurses and the predominantly Aboriginal population presented further communication challenges. If the outpost employed caretakers or cooks, they often acted as translators, but nurses did not receive any support for language instruction or cultural orientation. Many nurses learned at least a few words in the local language, but without the ability to converse freely, it was difficult to learn about a patient’s history or condition. Furthermore, every time a new nurse arrived, relationships had to be built between the nurses and people—a time-consuming process. People had to tell their personal stories over again, so that the nurse could become familiar with the health conditions. Unfortunately nurses did not appear to stay very long in one community as they were often transferred to other outposts throughout the region. However, as one nurse claimed, because of the isolation no one knew where she was, so she stayed for two years!38

A BIG “WANT”

There were few roads in Saskatchewan when the nursing posts were constructed following World War II. For example, even as late as 1947, Lac La Ronge was the first community in Northern Saskatchewan to
have an all-weather road. However, the 185-mile trip to Prince Albert could still take up to 11 hours depending on road conditions.\textsuperscript{39} Despite the lack of roads between the dispersed northern communities, each settlement had rough roads within their immediate vicinity. Nurses, however, were not provided with vehicles, so they walked, travelled by horse, or called on others for a ride—an often time consuming and inconvenient process. As the following example shows, transportation options were available that would have helped the nurses access their patients more efficiently:

Now I have a great big want. Would it be possible for the Department to get me a Jeep, I lose so much time waiting for transportation to get to any place and home again, to me it’s just valuable time wasted … I’ve had to go over to The Big Stone river to see a little boy, I walked there it took me 1 \( \frac{1}{2} \) hrs, I cannot go fast with my knee, it had been fine for about a week, I could hardly get home, and it kept me awake most of the night, and I could hardly get around the next day. The rough ground just nearly takes the leg off me. A Jeep could go through anything, our new Police thinks it would just be the thing for here.\textsuperscript{40}

The request for a Jeep was scoffed at and considered most impractical. The nursing supervisor replied:

I must admit I had to laugh when I read your letter asking for a Jeep. I had a mental picture of you driving over those roads in a Jeep. It would be worth seeing. Do you not think that a tank would service your purpose better! Just at the moment the request seems to be a bit fantastic. However there is no telling how it will be received.\textsuperscript{41}

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

I do wish that you would not do things like this. It is most annoying. You know that your requests sent through the office are given attention and you have been given everything for which you have asked …Why you are asking for a jeep again now when you are going out in a month’s time and will not be back for a few months, I can’t understand. I discussed the jeep with Dr. Hames when you first mentioned it and he thinks it is not practical at all.\textsuperscript{42}

The discussion over the Jeep and lawnmower continued between the nurse and the Director of Nursing Services until the nurse’s final letter as she was leaving the community. Needless to say, her requests were denied.
GENDER, POWER AND PROFESSIONALISM

It is difficult to understand why nurses were expected to endure such difficult circumstances, particularly given their work of providing professional medical care to northern residents. At the time, all of the nurses were women, suggesting that gender was a contributing factor, particularly as the role of caring and curing was viewed as a natural extension of women’s work. Nursing was seen as a calling rather than a profession, and requests to be treated and paid as professionals were seen as selfish and demeaning. Furthermore, nurses were expected to live in conditions that would never have been expected of doctors, causing some to question why women nurses had to tolerate such difficult circumstances. Nurses put up with conditions that even other people in the small communities thought unacceptable. Nurse Scriver, for example, questioned the lack of electricity at the nursing station and reported that people coming into the nursing station also considered it most unfair given that the Hudson Bay Company store had electric lights.

In addition to the lack of government support for the outpost hospitals there was also little regard for the nurses’ welfare. One cannot help but assume that the government counted on the professional commitment of the nurses to keep them at the nursing stations regardless of the conditions. In one instance, when a nurse resigned because of continuous problems with the bureaucracy in Regina, the Director of Nursing Services simply refused to accept her letter of resignation, citing the community’s need and the difficult situation the office would be in without the nurse’s services. Instructing her to proceed to the community, the nurse was told that she would “be happier with yourself if you do this rather than failing to meet this great professional need.” The state of affairs challenged the nurses and frustrated local residents who felt that both they and their communities were being neglected.

Nurses were moved around seemingly at whim, despite their protests and willingness to stay in particular communities where they felt they had established good relationships with people. In one case, nurse Cockburn and her family decided to stay in the small community rather than relocate with her husband’s position to an even more remote community further north. They purchased a house, built an addition, and with a large garden, livestock, and the nurse’s part-time position, felt they could make a go of it. The people in the community also wanted the nurse to stay because, while she had taken a while to establish herself, they now had considerable confidence and trust in her. Needless to say nurse Cockburn was more than a little surprised and irritated when she was replaced by the incoming manager’s wife who was a nurse. The nurse protested strongly, stating that the nursing
position should not be passed around lightly, least of all on the basis of a husband’s connections. Furthermore, she argued there was such a thing as nursing ethics and she stated that the Saskatchewan Registered Nurses’ Association (SRNA) had been informed about the state of affairs. The nurse told the SRNA that regardless of how they intended to deal with the situation, she was going to continue her work and wanted to hear nothing more about it. Unfortunately, despite apologies, the nurse was instructed to hand over the nursing post and supplies to her replacement.  

This incident is a prime example of the lack of power that nurses held with respect to their profession. Although the SRNA was responsible for providing the public with qualified nurses and for supporting nurses professionally, it was adamantly opposed to collective bargaining, associating it with the activities of unions, not professionals. When the provincial government introduced the new Trade Union Act in 1944, the SRNA immediately petitioned to have nurses excluded from the Act on the grounds that they were professionals. The basis for this decision was the belief that society would recognize nurses as professionals, and as such would pay them what they were worth. This position left nurses open to continuing exploitation until 1966 when the SRNA finally acknowledged that nurses were not being adequately compensated for their education and responsibilities, and it finally sanctioned collective bargaining. Until that time, however, the SRNA had little clout to exert on behalf of the nurses, leaving them vulnerable to the whims of employers and with little job security—a fact that Nurse Cockburn knew only too well!

MOVING BEYOND THE BOUNDS OF NURSING

Despite the constant demands on their time, and the fact that the responsibility for everything fell on the nurses, their nursing duties came first. Even when they had little to work with, nurses followed up on requests to visit people in their homes and at least tried to give them some advice. In light of the paucity of resources available in northern communities, the nurses took it upon themselves to take patients to larger centres to see dentists or to have their eyes examined. They also helped organize and raise funds to bring in other much-needed health care professionals, and they lobbied for additional government assistance for communities when low fish and fur prices left people with little income.

The nurses employed at the remote nursing stations were trained in what today would be considered holistic public health practices. They were well aware that chlorinated water and sewage treatment were among the factors that contributed to increased life expectancy, and
strongly encouraged digging proper wells and boiling drinking water in order to prevent illness in the communities. The nurses also knew of the complex relationships between determinants of health, and that diseases such as tuberculosis, which plagued the Aboriginal population, were not due just to the tuberculosis bacillus alone but also depended on other factors such as poor nutrition and crowded and poorly ventilated houses. The field nurses’ reports confirmed that housing conditions, particularly on reserves in Northern Saskatchewan, were often deplorable, with up to 12-14 people crowded into the small one and two room houses with bedbugs, lice, and other parasites infesting many of the dwellings. The nurses’ assessments were influential and were used to support claims that the slum-like conditions were due to poor economic status, rather than the cultural preference of Indian people.

One responsibility that caused nurses considerable consternation was diagnosing patient illnesses. They believed that without the appropriate training and authorization, diagnosing was dangerous and subjected patients to unnecessary risks. Furthermore, they were anxious that stepping beyond the bounds of their professional jurisdiction would jeopardize their licence to practice nursing. But there were no in-house physicians at the nursing stations, and although a physician could be contacted by radio-phone, atmospheric conditions and equipment troubles often prevented this from happening. As was often the case in northern nursing, nurses were never supposed to diagnose but in reality they had little choice but to make a decision and hope it was correct.

Similar concerns were also expressed even in those areas that nurses were qualified to practice. For example, a British-trained nurse-midwife complained about having to work alone and felt that all pregnant women should be examined by a physician before she took them on. However, her claim was considered unrealistic because the supervisor felt the nurse had the training to determine which pregnancies were normal and which were not. This attitude did little to put the nurse’s concerns to rest:

I have no equipment to examine them properly. Secondly, the decision [that pregnant women travel to The Pas and be examined by a doctor] is not really up to the midwife unless there is no alternative. I will do all I can under the circumstances but I can see no reason why they can’t go out. In places where midwives are recognized and given a licence, they cannot take a case without a written statement from a doctor that the case can be taken by a midwife. Here where midwives are not recognized I suppose the department will take the responsibility leaving me to decide and use my judgment. I would prefer not taking this responsibility.
In response to the nurses’ concerns, the Deputy Minister of Public Health for the Province of Saskatchewan requested that the nurse be given a “certain amount of leeway” because she was in an isolated place and remote from other medical services. This is indicative of the latitude given to nurses who had to assume responsibilities beyond the generally accepted scope of nursing practice, when it was convenient. Such flexibility quickly vanished, however, if doctors moved into these communities, which rarely happened in Northern Saskatchewan.

For some nurses, the idea of being on their own and doing things their own way was very appealing. But there was a difference between nursing care and medical care and they did not expect to find little, or no, professional support. For example, one nurse was “completely terror-stricken” when she was left entirely on her own after only three weeks at the nursing station. She reported having no supervision or seeing anyone for almost a year, except for a plumber who visited the nursing station after it was without water for six weeks.

OTHER GOVERNMENT PRIORITIES

As outlined at the start of this paper, the CCF government clearly believed that it had a number of social and economic areas to address in order to bring about what it considered improved conditions for northern residents. Over time, however, a picture of the overall lack of support for the nursing outposts (and other northern institutions) emerges. For example, between 1944 and 1963, the building costs associated with all the outpost hospitals were less than the cost of building one fish plant in the northern region. There was also no attempt by government to construct or fund a single nursing or special care home in the vast area. In contrast by 1962, 64 facilities had been built in the southern part of the province. By the end of the 1950s in Northern Saskatchewan, the CCF government had constructed 18 new schools and remodeled or enlarged existing schools, although none were high schools, suggesting they had little expectation that northerners would move beyond basic literacy. Lastly, although the CCF encouraged Aboriginal people to move into settlements, the only communities to receive water and sewer infrastructure in the north during the 1950s were the primarily non-Aboriginal communities of Uranium City, Island Falls, and Creighton.

The CCF policies did alleviate some of the most obvious problems facing northerners, but as the nurses’ accounts attest to, insufficient resources were devoted to supporting the nurses and the outpost stations. Constant quibbling over the allocation of funds caused ongoing frustration for the nurses who, nevertheless, attempted to uphold their professional responsibilities as best they could. The attitude of the
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government towards the nurses and the outpost stations is perhaps summarized best in the following letter from the Medical Officer to nurses at the outpost hospitals:

Because of unsettled world conditions and the possibility of a world war, I feel that I must make an appeal for a retrenchment in our expenditures in the Northern Administrative District … More particularly I want to point out that our four hospitals are pretty well equipped and no further requests for furniture can be made at this time … In the matter of dispensing, discretion must be shown in the amount of medicine given out. Do not give medicine unless very sure that it is necessary and apt to be beneficial … Costs of transportation of patients by Saskatchewan Government Airways are very high … be sure that every trip authorized is absolutely necessary.70

Adding to the letter’s assumptions that nurses were working and living in well-equipped facilities, wantonly handing out medicines, and providing needless transportation for patients, is the irony that the recommended reductions in expenditures for the outpost hospitals were sought at the same time as plans for the construction of Uranium City—a planned single industry resource community, with the infrastructure for potentially 5,000 non-Aboriginal residents—were being implemented.

CONCLUSION

Under the guise of modernizing almost all aspects of northern life, new notions of healthcare and ways of living were introduced into the primarily Aboriginal communities of Northern Saskatchewan. However, chronic underfunding, indifference to the needs of nurses and their patients, and government bureaucracy kept the overall level of services available to northern residents well below those of the south.71 The nurses sent to northern isolated communities to provide healthcare services were provided with inadequate support in terms of working and living arrangements. The nursing stations were often ill-equipped, there was no culture or language training, transportation and communication systems were at times inadequate and unreliable, and there was little if any professional support. At least one author claims that outpost hospital nurses performed heroic feats in caring for the large populations that flocked to them for care. In addition to the challenge of providing medical services far beyond those normally required of nurses, these women dealt with ongoing trials, including stoking wood furnaces, poor water and sewage systems, and erratic electrical supplies.72

Interestingly, the above quote and the opening excerpt in this paper, written 55 years apart, tend to glorify the nurses who worked at the outposts, rather than examining why such conditions existed at the
same time as resources were being allocated to establish a single-industry community focused on uranium mining in the region. In all of the materials reviewed for this paper, however, the need for such accolades was never expressed. There was, however, a need for resources and supports so that the nurses could do their work. This research illustrates some of the challenges and reactions faced by outpost nurses in the course of providing care to the population of Northern Saskatchewan. In letters to their supervisors, some nurses tried to bring attention to situations particularly when they felt their ability to deliver professional care was compromised and their patients’ welfare was jeopardized. Unfortunately their concerns were often downplayed or dismissed as attention and resources shifted to new endeavors in Northern Saskatchewan, thereby leaving the nurses to “pull up their sleeves and get on with the job.”

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NOTES

2 Under Section 35 of the 1982 Constitution Act, the term Aboriginal refers to the Indian, Métis, and Inuit peoples of Canada. However there are clear jurisdictional distinctions, which had ramifications for health care delivery. A status Indian is a person who is registered under the Indian Act as an Indian and falls within federal jurisdiction. The Indian Act does not apply to non-status Indians, Inuit, and Métis people who fall within provincial jurisdiction. The federal government was responsible for providing care to the status Indian population living on reserves, while the nurses employed by the provincial government provided nursing care to the non-status, Métis, and non-Aboriginal populations. It should be noted that these distinctions were not always rigidly followed and nurses often provided care regardless of an individual’s jurisdictional realm.
in northern Quebec the population consisted of primarily resettled French Canadians rather than Aboriginal people.


9 The term “Indian” rather than “First Nation” is used to reflect the language of the time. “Indian” remains widely used in Saskatchewan. For example, the provincial organization representing Status or Treaty Indians in the province is identified as the Federation of Saskatchewan Indian Nations (FSIN). However the term “First Nation” is replacing the use of “Indian.” For example, the Saskatchewan Indian Federated College is now known as the First Nations University of Canada.


19 Riddell, “Curing Society’s Ills,” p. iii.
22 Interview conducted by Joy Duncan with “Grace,” 7 February 1977. From the Joy Duncan Frontier Nursing Collection, Glenbow Museum, Calgary, Alberta. Permission obtained from Joy Duncan to use all interviews in this research with anonymity guaranteed.
23 Quiring, Battling Parish Priests, p. 225.
24 Saskatchewan Archives (SA), Department of Public Health (DPH), Nursing Services Division (NSD), PH5, File 53, Uranium City, Ruth Shannon to Wm. Leonard, Secretary Treasurer, Regina, 24 February 1954.
26 SA, DPH, NSD, PH5, File 53, Uranium City, Ruth Shannon to Miss M. Edwards, Director of Nursing Services, Regina, 24 February 1954.
27 SA, DPH, NSD, PH5, File 54, Uranium City, C. Augener to Miss Edwards, Director of Nursing Services, Regina, 5 September 1954.
28 SA, DPH, NSD, PH5, File 6, Cumberland House, Helen Janzen to Miss Smith, Director of Nursing Services, Regina, 14 June 1954.
29 SA, DPH, NSD, PH5, File 52, Regina, Mary Edwards to Miss E. Smith, Director of Nursing Services, Regina 10 February 1949.
30 SA, DPH, NSD, PH5, File 44, Snake Lake, Mrs. Enid Broome to Miss E. Smith, Director of Nursing Services, Regina 31 July 1952.
31 SA, DPH, NSD, PH5, File 44, Regina, Elizabeth Smith, Director of Nursing Services to Mrs. Broome, Snake Lake 5 October 1952.
32 SA, DPH, NSD, PH5, File 5, Regina, C. Augener to Miss M.P. Edwards, Director of Nursing Services, Regina, 31 January 1954.
33 SA, DPH, NSD, PH5, File 53, Uranium City, Ruth Shannon to Miss M.P. Edwards, Director of Nursing Services, Regina, 24 August 1954.
34 SA, DPH, NSD, PH5, File 53, Regina, Elizabeth Smith, Director of Nursing Services to Myrtle Pierce, Cumberland House, 16 October 1946.
35 SA, DPH, NSD, PH5, File 44, Snake Lake, Mrs. Enid Broome to Miss E. Smith, Director of Nursing Services, Regina, 12 September 1952.
36 SA, DPH, NSD, PH5, IIB, File 44, Snake Lake, Mrs. Enid Broome to Miss E. Smith, Director of Nursing Services, 17 May 1951.
37 SA, DPH, NSD, PH5, File 50, Regina, Elizabeth Smith, Director of Nursing Services to Myrtle Pierce, Stony Rapids, 7 April 1948.
38 Interview conducted by Joy Duncan with “Norma,” 18 June 1975. From the Joy Duncan Frontier Nursing Collection, Glenbow Museum, Calgary, Alberta.
39 Quiring, Battling Parish Priests, p. 72
40 SA, DPH, NSD, PH5, File 15, Cumberland House, Isabel Scriver to Miss E. Smith, Director of Nursing Services, Regina, 12 October 1945.
41 SA, DPH, NSD, PH5, File 15, Regina, Nursing Supervisor to Isabel Scriver, Cumberland House, 18 October 1945.
SA, DPH, NSD, PH5, File 14, Regina, Elizabeth Smith, Director of Nursing Services to Isabel Scriver, Cumberland House, 8 July 1946.


Interview conducted by Joy Duncan with “Evelyn” 8 February 1977. From the Joy Duncan Frontier Nursing Collection, Glenbow Museum, Calgary, Alberta.

SA, DPH, NSD, PH5, File 14, Cumberland House, Isabel Scriver to Miss E. Smith, Director of Nursing Services, Regina, 22 July 1946.

SA, DPH, NSD, PH5, File 10, Regina, Director of Nursing Services to Miss J. Walz, Langenburg, 18 January 1950.

SA, DPH, NSD, PH5, File 33, Lac La Ronge, Josephine Walz to Miss E. Smith, Director of Nursing Services, Regina, 19 October 1949.

SA, DPH, NSD, PH5, File 5, Buffalo Narrows, C. Augener to Miss Edwards, Director of Nursing Services, Regina, 15 May 1954.

SA, DPH, NSD, PH5, File 45, Snake Lake, Jean Cockburn to Miss E. Smith, Director of Nursing Services, Regina, 4 October 1949 and Regina, Miss E. Smith, Director of Nursing Services to Jean Cockburn, Snake Lake, 19 October 1949; 12 December 1949; 28 December 1949.

Slater-Smith, *You Can't Eat Dedication*: p. 3-5.

SA, DPH, NSD, PH5, File 13, Cumberland House, Myrtle Pierce to Miss E. Smith, Director of Nursing Services, Regina, 1 November 1946.

SA, DPH, NSD, PH5, File 33, Lac La Ronge, Josephine Walz to Miss E. Smith, Director of Nursing Services, Regina, 22 October 1949.

SA, DPH, NSD, PH5, File 29, Snake Lake, Mrs. Enid Broome to Miss E. Smith, Director of Nursing Services, Regina, 21 January 1953.


LAC, RG10-84, Vol. 11, 580 (no file number), Report on Saskatchewan Development Conference, Saskatoon, Saskatchewan, 29 November 1959, p.80.

Interview conducted by Joy Duncan 6 July 1976 with “Terry.” From the Joy Duncan Frontier Nursing Collection, Glenbow Museum, Calgary, Alberta.


SA, DPH, NSD, PH5, File 13, Cumberland House, Myrtle Pierce to Miss E. Smith, Director of Nursing Services, Regina, 1 November 1946.

SA, DPH, NSD, PH5, File 13, Regina, Dr. Hames, Deputy Minister of Public Health, Province of Saskatchewan to Dr. A.J. McDougal, Director, Division of Medical Services, Regina, 22 October 1946.

“Terry” interview.
“Grace” interview.
For a more comprehensive discussion related to Aboriginal people’s reactions to western medicine see McBain, “Caring, Curing, and Socialization,” p. 287-88.
Quiring, Battling Parish Priests, p. 230.
Quiring, Battling Parish Priests, p. 234.
Barron, Walking in Indian Moccasins, p. 173.
Quiring, Battling Parish Priests, p. 85.
SA, DPH, NSD, PH5, File 8, Regina, Dr. Totten to Miss Josephine Walz, Cumberland House, 2 August 1950.
Quiring, Battling Parish Priests, p. 242.
Quiring, Battling Parish Priests, p. 227.