

Aboriginal Health in Canada

SCHOLARSHIP CONCERNING ABORIGINAL health intersects with major themes in history, such as aboriginal history, the history of health and state formation. Over the past 15 years, scholars have increasingly recognized this and a wonderful florescence in writing about aboriginal health in Canada has resulted. Once solely the domain of interested clinicians writing in health care journals,¹ aboriginal health now draws the attention of epidemiologists, anthropologists, historians and others interested in aboriginal ideas of illness and healing, and health services administration.² The breadth of sources used to create these works is remarkable, including a wide array of archival documents, government reports, archaeological evidence, administrative health databases and oral history.

The most ambitious and comprehensive of these new studies is James B. Waldram, D. Ann Herring and T. Kue Young, *Aboriginal Health in Canada: Historical, Cultural and Epidemiological Perspectives* ([1995] Toronto: University of Toronto Press, 2000). The authors provide a readable and thorough analysis that considers health in reserve communities and among the Métis and Inuit. As the title implies, the book takes a multidisciplinary approach and strives for “national representation” (p. xi), though coverage is predictably uneven. Any attempt to provide a national overview or synthesis of research from a number of disciplines faces several challenges, including those of cultural diversity, different contact periods and tremendous variability in the historical record. Fortunately, the authors bring a

- 1 The clinical issues among aboriginal people reported in the *Canadian Medical Association Journal* [CMAJ] before 1950 include: tuberculosis, R.G. Ferguson, “The Indian Tuberculosis Problem and Some Preventive Measures”, *CMAJ*, 30, 5 (May 1934), pp. 544-7; E.L. Ross and A.L. Paine, “A Tuberculosis Survey of Manitoba Indians”, *CMAJ*, 41, 2 (August 1939), pp. 180-4; H.W. Lewis and G.J. Wherrett, “An X-ray Survey of Eskimos”, *CMAJ*, 57, 4 (October 1947), pp. 357-9; dental health, C.S. McEuen, “An Examination of the Mouths of Eskimos in the Canadian Eastern Arctic” *CMAJ*, 38, 4, (April 1938), pp. 374-7; and nutrition, P.E. Moore, H.D. Kruse, F.F. Tisdal and R.S.C. Corrigan, “Medical Survey of Nutrition Among the Northern Manitoba Indians”, *CMAJ*, 54, 3 (March 1946), pp. 223-33; Cameron Corrigan, “Scurvy in a Cree Indian”, *CMAJ*, 54, 4 (April 1946), pp. 380-3; R.P. Vician, Charles McMillan, P.E. Moore, E. Chant Robinson et al., “The Nutrition and Health of the James Bay Indian”, *CMAJ*, 59, 6 (December 1948), pp. 505-18. General descriptions of providing health care were more frequent in the nursing literature, including Anna Asenath Hawley, “Three Years Among the Crees”, *Canadian Nurse* [CN], 8, 10 (October 1912), pp. 544-9; A.W. Tye, “Canadian Nurses on Indian Reserves”, *CN*, 22, 5 (May 1926), pp. 231-3; Kathleen Stewart, “At work in an Indian School”, *CN*, 38, 2 (February 1942), pp. 115-16.
- 2 Other recent contributions on aboriginal health in North America include: Clifford E. Trafzer and Diane Weiner, eds., *Medicine Ways: Disease, Health and Survival Among Native Americans* (Walnut Creek, Calif., 2001); Stephen J. Kunitz, *Disease and Social Diversity: The European Impact on the Health of Non-Europeans* (New York, 1994); Everett R. Rhoades, *American Indian Health: Innovations in Health Care, Promotion and Policy* (Baltimore, 2000); David E. Young, Graham Ingram and Lise Swartz, *Cry of the Eagle: Encounters with a Cree Healer* (Toronto, 1989); Peter H. Stephenson, Susan J. Elliott, Leslie T. Foster and Jill Harris, eds. *A Persistent Spirit: Towards Understanding Aboriginal Health in British Columbia* (Victoria, 1995). There are many bibliographies on health in aboriginal settings, such as Sharon A. Gray, *Health of Native People of North America: A Bibliography and Guide to Resources* (Lanham, Md., 1996). This invaluable reference includes dissertations, book chapters and conference proceedings.

Peter L. Twohig, “Aboriginal Health in Canada”, *Acadiensis*, XXXII, 1 (Autumn 2002), pp. 140-148.

breadth of expertise to this volume; it is an essential starting point for persons interested in a broad analysis of aboriginal health from pre-contact to the present.

Aboriginal Health in Canada has two major parts. The first deals with biological aspects of health. To orient the reader unfamiliar with aboriginal settings, the authors provide, in chapter one, an overview of aboriginal peoples in Canada as well as some consideration of health and disease before contact with Europeans or Euro-Canadians. The second chapter shatters the enduring myth that aboriginal communities were free of disease prior to European settlement. Using osteological data, the authors provide evidence of the range of diseases North American populations suffered prior to contact. Waldram, Herring and Young draw upon a new body of scholarship that addresses the epidemiology of the pre-contact Americas, providing a nuanced look at local experiences and patterns of morbidity and mortality.

A critical question faced by scholars of the early colonial period concerns demographic change in aboriginal communities. It is often assumed that contact with Europeans initiated dramatic depopulation. Estimates of population decline in the Western hemisphere range from more than 90 per cent to 50 per cent. The “disease and de-population” thesis has been hotly contested, generating broad studies as well as micro-studies.³ Robert Boyd’s recent book, *The Coming of the Spirit of Pestilence: Introduced Infectious Diseases and Population Decline among Northwest Coast Indians, 1774-1874* (Vancouver, UBC Press, 1999) is an example of the latter. It focuses on the Northwest Coast culture area, including peoples such as the Tlingit, Haida, Kwakaka’wakw and Nuuchahnulth. Boyd estimates the pre-contact population was approximately 180,000; after a century of Euro-American contact it had been reduced to 35 or 40 thousand. There was, however, substantial variation within the region, with different “epidemic areas” (defined as a geographically bound area of people sharing a common disease history) experiencing population decline ranging from 95 per cent to 63 per cent. The important insight here is that even within a single area, there was tremendous variability in population decline, though the impact of new diseases was certainly enormous everywhere.

Although they do not provide the depth of analysis of Boyd’s study, Waldram, Herring and Young similarly note that “a series of epidemics and famines of varying

3 There is a vast literature on epidemic disease and depopulation. One of the best-known studies of disease transmission is Alfred W. Crosby, *The Columbian Exchange: Biological and Cultural Consequences of 1492* (Westport, Conn., 1972). There are also many studies that focus on British North America, including Arthur J. Ray, “Diffusion of Diseases in the Western Interior of Canada, 1830-1850”, *Geographical Review*, 66 (1976), pp. 139-57; John F. Taylor, “Sociocultural Effects of Epidemics on the Northern Plains: 1734-1850”, *The Western Canadian Journal of Anthropology*, 7 (1977), pp. 55-81; Shephard Krech, “Disease, Starvation and Northern Athapaskan Social Organization”, *American Ethnologist*, 5 (1978), pp. 710-32; Jody F. Decker, “‘We Should Never again Be the Same People’: The Diffusions and Cumulative Impact of Acute Infectious Diseases Affecting the Natives of the Northern Plains of the Western Interior of Canada, 1774-1839”, Ph.D. thesis, York University, 1989. The literature on population decline is also large. Among the most widely cited and controversial studies is Henry F. Dobyns, *Their Number Became Thinned: Native American Population Dynamics in Eastern North America* (Knoxville, Tenn., 1983). For aboriginal population estimates in the Atlantic region, see Virginia P. Miller, “Aboriginal Micmac Population: A Review of the Evidence”, *Ethnohistory*, 23 (1976), pp. 117-27 and Ralph T. Pastore, “Native History in the Atlantic Region during the Colonial Period”, *Acadiensis*, XX, 1 (Autumn 1990), pp. 200-25.

extent, severity and duration affected different regions at different times subsequent to contact” (p. 65). With this basic point established, they turn their attention to the last century. The fourth chapter, entitled “New Epidemics in the Twentieth Century”, is primarily descriptive. The authors acknowledge that the uneven nature and quality of available studies (characterized by selective inquiry into a limited range of diseases, among only some populations and at particular times) makes it difficult to develop a narrative. The chapter reveals how elusive the evidence can be. Information about nutrition, the prevalence of specific diseases and their patterns, or even population figures is scant, even for the 20th century. Nevertheless, it is possible to identify broad trends. Infectious disease was in decline by the mid century, although tuberculosis persisted. The chief causes of morbidity and mortality since the Second World War have been chronic disease (such as cardiovascular disease, diabetes mellitus and cancer), accidents and violence, and specific new infectious diseases such as HIV/AIDS.

The second part of *Aboriginal Health in Canada* focusses on broader socio-cultural and historical dimensions of health, including aboriginal healing, the provision of health services, patterns of health service use and contemporary issues such as the move to self-determination. The fifth chapter explores “medical and healing traditions” across a number of cultural groups. This is the least satisfying chapter because there is little on aboriginal perspectives concerning health and illness. Nevertheless, the authors illustrate the ways in which health practices were embedded in other parts of aboriginal culture. They also demonstrate how “traditional medical systems of Canada’s aboriginal peoples were subjected to a variety of oppressive measures, particularly between 1880 and the mid-twentieth century” (pp. 116-17). Persistent government and church efforts to undermine aspects of spiritual and social life in aboriginal communities in an effort to promote assimilation also posed significant challenges to health practices. The authors examine two cultural traditions in depth, the potlatch and Sun Dance. Surprisingly, schooling is not mentioned in this section; instead, it is dealt with briefly in the chapter entitled “Traders, whalers, missionaries, and medical aid” (pp. 131-7).

Aboriginal Health in Canada develops a variety of case studies that provide clues to relative successes in securing aboriginal health, and to the failures. It makes a valuable contribution by linking health with state formation and exposing the limits of narrowly conceived health initiatives. The authors argue that any meaningful understanding of aboriginal health in Canada requires holistic analysis, combining historical, cultural, political, economic and clinical perspectives. Paradoxically, the political and economic dimensions of health are not as well developed as they might be in their study, in part due to its broad focus.

T. Kue Young, *Health Care and Cultural Change: The Indian Experience in the Central Subarctic* (Toronto, University of Toronto Press, 1988) is a more geographically focussed study, largely set in the Sioux Lookout region of northwestern Ontario. Young combines biological, ecological, socio-cultural and historical approaches to health and disease in analyzing why aboriginal Canadians continue to endure poor health and worse health outcomes than other Canadians despite a large and complex health care delivery system.⁴ Young maintains that improvement in health

⁴ The Royal Commission on Aboriginal People reported that in 1994, Health Canada spent approximately one billion dollars on aboriginal health. Royal Commission on Aboriginal People, *Report of the Royal Commission on Aboriginal Peoples*, vol. 3, *Gathering Strength* (Ottawa, 1996), p. 247.

depends upon “rigorous research and not passionate rhetoric”, but he acknowledges that, ultimately, health improvements “cannot be achieved solely through medical or technological means” (p. x). The first two chapters describe the Sioux Lookout region, its inhabitants and the broad changes that have occurred in health and disease in the area. Young’s epidemiological training is readily apparent in the fourth chapter – perhaps the most interesting – as he describes morbidity and mortality, noting the ways in which aboriginal health is different from that of the general Canadian population. Even though aboriginals remain five times more likely to die of infectious diseases than other Canadians, in recent decades the most common diseases have shifted from infectious disease to chronic diseases (cancer, heart disease, stroke and diabetes). Accidents and violence are another notable cause of morbidity and mortality. Young provides concise data on health conditions in the text and with graphs.

The book, though rich in description, is light on analysis. We learn, for example, that although health professionals promoted bottle-feeding through the 1950s and 1960s, breast-feeding in the Sioux Lookout Zone “has not been as seriously eroded as it has been among many other native groups in Canada” (p. 70); but the author advances no explanation for this. One health survey found that 77 per cent of children in the study area had been breast-fed, while a review of medical charts of pre-schoolers in 1980 found that 68 per cent were breast-fed – both relatively high figures. Why were breast-feeding rates higher in northwestern Ontario than in other aboriginal communities? Were Cree-Ojibwa mothers consciously resisting the (wrong-headed) advice of health professionals? Similarly, food from the land continued to be an important part of the diet of the Sioux Lookout Cree-Ojibwa into the 1970s. One study of local diets conducted in the late 1970s found that hunting, trapping and fishing contributed 67 kilograms of edible meat per person annually. Young acknowledges that such activities were a “cost-effective way of providing a nutritionally adequate diet”, though he expresses concern about the “ecological limits” of these strategies (p. 68). But he offers no further analysis of native choices. Why were residents in some communities able to continue to use the land in traditional ways while others abandoned such practices?⁵ This lack of analysis is indicative of a larger problem with the book. The last two chapters outline the history of health services to the 1980s, followed by a case study of the strengths and weaknesses of that system, using the Sioux Lookout Zone. But here the emphasis is on description, with scant consideration of alternatives for the provision of health care. Finally, and perhaps most critically, Young provides little analysis from the perspective of aboriginal peoples themselves. In what ways did they struggle to have their visions for health services represented, how did they gain control over aspects of the health care system and how did they gain representation among health service providers?

Pat Sandiford Grygier, *A Long Way from Home: The Tuberculosis Epidemic Among the Inuit* (Montreal and Kingston, McGill University Press, 1994) was the second volume in the History of Medicine, Health and Society series published with

5 Helen Buckley, for example, has argued that the family allowance programme, a programme designed for southern, sedentary populations, actually undermined the remaining self-sufficiency of Cree and Chipewyan people who were still hunting and trapping in the 1950s. Buckley, *From Wooden Ploughs to Welfare: Why Indian Policy Failed in the Prairie Provinces* (Montreal and Kingston, 1992), p. 71.

assistance from the Hannah Institute for the History of Medicine.⁶ The early chapters introduce the reader to tuberculosis, and to the setting, and are followed by tales of the hardship encountered by doctors and nurses trying to reach their patients (pp. 25-7). Strangely, these accounts come from the 1950s, and seem out of place wedged between descriptions of the initial contact of Inuit with Europeans and descriptions of the Hudson Bay Company and missionaries (“Other Players”). Grygier uses archival records, published sources and personal interviews to develop a portrait of the “human side” (p. xii) of the mid-20th-century tuberculosis epidemic. The documentation is particularly effective in reconstructing the drama of Inuit being diagnosed with tuberculosis by health care personnel serving isolated communities from visiting ships. Patients identified as having tuberculosis were not permitted to return to shore to gather their personal effects, say good-bye to loved ones or arrange their affairs. Because many of those diagnosed on shipboard had advanced tuberculosis, they never returned; thus, isolation on the ship was perceived to be akin to a death sentence.

Grygier highlights the sense of isolation that Inuit tuberculosis patients felt. Many tuberculosis patients had the experience of being the only Inuit in hospitals in Dartmouth, Montreal, Hamilton or St. Boniface. We learn of a woman too scared to smoke or to ask for water. There are excellent descriptions of how Inuit patients coped with isolation by occupying themselves with handcrafts, the radio or attending church services, but for many patients hospital life was anything but pleasant. Grygier recounts the tragic tale of 60-year-old David Mikeyook, one of four Inuit at the Mountain Sanatorium in Hamilton in 1952. On the first of October, Mikeyook left the sanatorium “wearing pyjamas, light summer pants, and a dressing-gown; he had a jackknife and some razor blades with him”. There was a search but to no avail. Two months later, his body was found in a ravine a kilometer from the hospital. Mikeyook had died of starvation and exposure only days earlier. Grygier writes: “It seems unlikely that he simply wished to die, since he had supported himself for two months in the brush on the hillside near the hospital, possibly using his hunting skills and snaring rabbits”. It also raises the question of how thorough a search authorities conducted.

As with Young’s study of health care in northwestern Ontario, the description in *A Long Way From Home* is better than the analysis. Grygier’s handling of the complex administration of health services in the North provides a good example of this. The federal government has responsibility for providing health care to some aboriginal people, although as Waldram, Herring and Young note in their study, in the mid 1940s the superintendent of Indian Health Services was insistent that “neither law nor treaty” obliged it to (p. 146).⁷ Initially, this responsibility was restricted to “Indians” but it has come to include other aboriginals, including the Inuit. Beginning in the

6 The series now has 13 books, including several studies focusing on Atlantic Canada: John Crellin, *Home Medicine: The Newfoundland Experience* (1994); Ronald Rompkey, *Labrador Odyssey: The Journal and Photographs of Eliot Curwen on the Second Voyage of Wilfred Grenfell, 1893* (1996); Ronald Rompkey, ed., *Jessie Luther at the Grenfell Mission* (2001).

7 As the Indian Health Service expanded through the 1950s, the federal government shrilly and frequently denounced its obligation. The 1956 *Annual Report* of the Department of National Health and Welfare 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

1950s and 1960s, the federal government supplied medical services for the entire Northwest Territories. Grygier does not explore the health implications of full federal responsibility for *all* health services in the Northwest Territories which, in the 1960s, had an Inuit population comprising roughly a third of the residents. Were there any substantive differences in the level or quality of care in the Northwest Territories because of this? Some comparison with other jurisdictions would have been helpful. Grygier mentions administrative and political developments elsewhere only in passing and the experience of Inuit in the provinces of Quebec and Newfoundland and Labrador is relegated to one brief chapter.

While there is much to commend in *A Long Way From Home*, there are also weaknesses. These include factual errors as well as long descriptions that meander away from the central story. As well, there are few footnotes and a lack of methodological rigour. It also fails to note important works, such as Peter Henderson Bryce's landmark publication, *The Story of a National Crime: Being an Appeal for Justice to the Indians of Canada* (1922), nor does it draw from the many articles published in journals such as the *Canadian Medical Association Journal* and the *Canadian Nurse* about health services in the north.

Mary-Ellen Kelm, *Colonizing Bodies: Aboriginal Health and Healing in British Columbia, 1900-50* (Vancouver, UBC Press, 1998), which received the Sir John A. Macdonald prize, is a challenging and engaging book, exemplifying the value of a multi-faceted research strategy. The book is divided into two parts, "Health" and "Healing". The first part of the book explores topics such as the health effects of colonization, including changes in diet and nutrition, sanitation and the environment. Kelm also uses residential schooling as a case study of the "drama of colonization" (p. 57). The second half of the book, "Healing", is devoted to aboriginal ideas of the body, disease and medicine, the role of Indian Health Services in providing care and the interaction between these two worlds.

One of the many strengths of Kelm's book, which includes her use of a splendid range of sources, is her attention to detail. For example, Kelm is able to draw clear distinctions among the variety and quality of health providers at work in First Nation communities. Physicians, for example, differed in their approach. While this seems an obvious conclusion, it is one sorely lacking in the other volumes under review, in which all physicians seem to be the same. Kelm notes that some physicians played a "strong man role" or became integral members of the community; others were incompetent or drunkards. She notes the familiar difficulties of recruiting and retaining physicians to work in aboriginal communities. Kelm also gives due consideration to other key health providers, including missionary doctors, nurses and field matrons.

In her handling of health statistics, Kelm adopts a critical approach, exploring the assumptions about health or disease that inform them and considering how those shape health policy, priorities and funding.⁸ For example, for much of the first half 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. Barbara Craig explored the issue of jurisdiction in "Jurisdiction for Aboriginal Health in Canada", L.L.M. thesis, University of Ottawa, 1992.

⁸ Her approach parallels that in George Emery, *Facts of Life: The Social Construction of Vital Statistics, Ontario 1869-1952* (Montreal and Kingston, 1992).

the 20th century, infectious disease generally, and particularly tuberculosis, was the health issue of most concern for government officials. Kelm's analysis goes well beyond the numbers to explore how women and men, different age cohorts and different communities experienced various diseases. What emerges is a complex portrait of incredible variation, even within a single province.

Maureen Lux, *Medicine That Walks: Disease, Medicine and the Canadian Plains* (Toronto, University of Toronto Press, 2001), received a 2002 Clio award from the Canadian Historical Association. The strength of this book, as with Kelm's, is its detailed description and sophisticated analysis. Lux offers a compelling description of the "desperate conditions" (p. 42) that prevailed among such groups as the Cree, Assiniboine, Siksika (Blackfoot) and Piikani (Peigan) between 1880 and 1940. She explores the provision of health services by the federal government, the activities of Christian missionaries and the residential school experience, forces which cumulatively structured health care for many aboriginal people in western Canada.

The period studied by Lux was one of enormous change. There were important ecological changes, such as diminishing buffalo herds and large-scale immigration. The federal government negotiated treaties across the Prairies, established reserves and enacted new legislation governing many aspects of aboriginal life. Health and the assault on traditional culture became inexorably linked. Good health depended upon aboriginal people abandoning traditional practices and beliefs. But the story is also one of resistance. Healing was extremely complex in aboriginal societies, involving different people and encompassing both the spiritual and physical world. Among the Cree, for example, there were individuals (*mamaxtawiyuu*) imbued with supernatural healing power, individuals knowledgeable about herbal or other remedies (*mashkikiwiyyuu*) and midwife-healers. Despite "informal policy to repress and undermine Native healers", aboriginal peoples protected some of these traditions. As well, Lux argues that aboriginal people used health care services "cautiously and selectively", though she does not explain how decisions about when (or whether) to seek care were made.

One of the great strengths of Lux's book is her earnest attempt to place health care history within the broader history of aboriginal groups and western Canadian history. For example, topics such as immigration and the resulting pressure on the land are cogently addressed (pp. 162-4). Less well developed are the links with the historiography of health. Despite presenting a solid analysis of tuberculosis that reveals changing approaches to diagnosis and care of that disease, we learn very little about developments in the world of medicine. The years that frame this study, 1880 to 1940, were years of enormous change within health care, with many important discoveries, including x-rays, diphtheria anti-toxin (and later toxoid), salvarsan and penicillin. Nurses – who were critical for delivering health services from the 1920s on – receive only brief mention. The oversight is unfortunate and will leave many readers with only a vague sense of the medical developments of these years.

The works under review share themes and approaches. All attempt to present an overview of the cultural context of health and examine contact with non-aboriginals, and all of the authors recognize that the medical practices of aboriginal people cannot be neatly separated from other aspects of their culture. One of the other features that link these books, and increasingly the historical study of health care generally, are innovative research methods, which use the different perspectives of epidemiology,

science, clinical practice, sociology, anthropology and history to enrich and contextualize our understanding of health in aboriginal communities. Health is a topic that is well suited to interdisciplinary inquiry and to wide-ranging, multi-layered analyses, such as those of Kelm and Lux.⁹

Health care is not politically neutral, either in aboriginal or non-aboriginal settings; “Western biomedicine” reflects the dominant culture and serves political and ideological ends. Health care provision for aboriginals undermined traditional approaches to health and healing, altered land-use patterns, transformed housing and separated families. Well-intentioned providers (and some who were not) were part of a broad assault on aboriginal communities. All of the books, in different ways and to varying degrees, share a tone of condemnation. Indeed, it is difficult to look at any health statistics pertaining to aboriginals without a sense of moral outrage.

While the monographs reviewed here make an important contribution to our knowledge they also highlight the need for more attention to the history of aboriginal health in Atlantic Canadian settings. Although the title of Waldram, Young and Herring’s study, *Aboriginal Health in Canada*, suggests national coverage, the authors give little attention to the Maritimes or Newfoundland and Labrador. Lacking the draw of the numbered treaties or the large aboriginal populations found elsewhere, First Nation communities in Atlantic Canada are often left out of the analysis. Many of the studies, for example, argue that the early provision of medical care was the purview of missionaries or Indian agents. Waldram, Herring and Young are typical, writing that medical services before Confederation were “largely in the hands of the fur traders, whalers, and missionaries” (p. 140). They also argue matter-of-factly that “the delivery of health services to Aboriginal peoples prior to Confederation was primarily on an ad-hoc basis by traders and missionaries” (p. 122). While this was certainly true of western Canada and northern Canada, it is not true of Atlantic Canada.¹⁰ In Nova Scotia, physicians provided medical services and routinely petitioned the colonial government for compensation for more than a quarter of a century prior to Confederation. Indeed, the cost of medical attendance was worrisome for the colonial governments.¹¹ Physicians, though, were important agents of acculturation, promoting agriculture, distributing seeds and implements and encouraging settlement.

These books leave the impression that many health care providers, particularly physicians, were incompetent or insensitive to the aboriginal communities and people they served. In Nova Scotia in the mid 19th century, many of the physicians providing

9 Here, it is probably worth noting that historians are seemingly well positioned to avail themselves of new funding opportunities within the Canadian Institutes of Health Research. While there are important concerns about the Canadian Institute of Health Research review process and the number of awards granted to researchers from the humanities and social sciences, there is little doubt that historians have much to offer in the “transdisciplinary” research environment. For a thoughtful commentary on research across disciplinary boundaries from the perspective of historians, see Chad Gaffield, “Historical Thinking, C.P. Snow’s Two Cultures, and a Hope for the Twenty-First Century”, *Journal of the Canadian Historical Association*, new series, 12 (2001), pp. 3-25.

10 Peter L. Twohig, “Colonial Care: Medical Attendance among the Mi’kmaq in Nova Scotia”, *Canadian Bulletin of Medical History*, 13, 2 (1996): 333-53.

11 L.F.S. Upton, “Indian Policy in Colonial Nova Scotia 1783-1871”, in *Acadiensis*, V, 1 (Autumn 1975), p. 25.

health care for aboriginals were prominent medical men involved with founding medical societies, organizing hospitals, advocating licensing legislation and creating the medical school at Dalhousie University. The close proximity between aboriginal and non-aboriginal communities in Nova Scotia may have enhanced the quality of care available in reserve communities. Certainly, when epidemic diseases appeared in aboriginal communities in the later 19th and early 20th centuries, local health boards were quick to ensure that they did not spread to neighbouring towns or villages.

The lack of studies of health and disease among aboriginal groups in Atlantic Canada is regrettable in itself, but it sets the stage for an additional problem: the very fine studies of health and medicine among aboriginal groups in other contexts will be assumed to be typical of *all* settings and cultural contexts, when they are not. The patterns appear to be different in the Maritimes.

The recent writing of aboriginal history is certainly full of promise. The analyses provided by Lux and Kelm and the interdisciplinary approach embodied in *Aboriginal Health in Canada* are an auspicious beginning. They draw attention to the connections between health, health services, politics, economics, race, gender and other issues that are often missing from accounts of health care history in Canada. These studies, then, serve as models not just for the study of *aboriginal* health but health care generally. Nevertheless, until we have studies in different regional settings that explore points of similarity and departure, the project of writing aboriginal health history will remain only partly done.

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