# Alberta Doctors' Digest

## Indian hospitals

### A radical revision of socially defined pathology

Operated between the early 1930s and well into the 1980s, Indian hospitals in Canada are clear examples of eugenics in practice: segregated health care anchored in Euro-white-settler, race-based ideologies and beliefs that First Peoples were fundamentally unfit for treatment and care amongst the broader non-Indigenous population.

Indian hospitals were benignly marketed as tuberculosis (TB) sanitoriums to the general Canadian public. First Peoples, and their perceived pathologies, were “treated” away from their communities-of-origin and away from mainstream society’s gaze.

Often located on-reserve, but also operated in larger, centralized urban centers, Indian hospitals subjected First Peoples to Euro-Canadian medicine while the care delivered did not reflect the best practice and evidence that was being offered to Euro-white-settler society.

Undoubtedly, TB was an epidemic among First Peoples. What the TB epidemic allowed for, however – and what Indian hospitals delivered – was justification for Canadian authorities to legislate, through the *Indian Act*, the forcible removal of Indigenous peoples from their families and communities for non-consensual “care and treatment.”

Indian hospitals are infrastructural representations of large colonial assumptions about the rights of (mostly) Euro-white settler Canadian health experts to deny patient autonomy within a larger colonial agenda of land dispossession and genocide.

Charlie gazes into the eyes of his loving mom. (Photo credit: Amanda Laliberte)

Indian hospitals represent a fundamentally flawed colonial health assumption: non-Indigenous peoples know what's best for Indigenous peoples and communities. By way of rhetoric about a disease, the TB epidemic became the logic for colonial oppression and violence.

Once in place, the logic expanded: Indian hospitals were sites of nutritional, medical, and surgical experimentation. Unindicated physical and chemical restraint of both pediatric and adult patients was routine. Apprehension at birth was a well-developed procedure. Graves went unmarked - nearby residential school students were commissioned (forced) to dig them.

Indigeneity was pathologized, institutionally segregated, "managed" and either "cured" or eliminated.

I have trained and worked in communities across two provinces. In both those provinces, I have worked with people and families deeply impacted by nearby Indian hospitals, namely the Nanaimo Indian Hospital and the Edmonton Charles Camsell Indian Hospital.

The Charles Camsell Indian Hospital was home site (ground zero) of the *Alberta Sexual Sterilization Act*. Disproportionately to their percent of the population, Indigenous peoples with gestational biology were deemed "mentally deficient" and met the diagnostic criteria for non-consensual sterilization. Charles Camsell Indian Hospital is now closed and the *Sexual Sterilization Act* has been revoked and put on trial.

Nevertheless, an increasing body of evidence, captured in research by former nurse, lawyer, and now Senator Dr. Yvonne Boyer, makes clear that forced and coerced sterilization of Indigenous women is actively practiced today in Canadian health care settings.

This unquestionably has roots in Alberta's eugenics program and is perpetuated by provider unconscious bias and through unspoken curriculum. This kind of anti-Indigenous racism and violence in the health care system is stealthy, inconspicuous, implicit and sophisticated – with purpose and progression.

Indian hospitals and eugenics have not been eliminated; their phenotypes have evolved.

While the physical infrastructure of most Indian hospitals has been dismantled, their legacies are ever-present. Arguably, the legacies reach into the present day. Certainly, as has been documented in recent months across the country, anti-Indigenous racism in the health care system is very much alive and thriving.

Canada is described by some as a "post-colonial" state. For those of us upon whom colonial violence is focused however, we are at best still surviving in a neo-colonial state. Neo (or "new") colonialism includes:

- settler economics (capitalism)
- globalization (prioritization of worldwide social relations over local community relations)
- conditional aid (exerting power and privilege)
- cultural imperialism (maintenance of unequal relationship through an imposition of settler-colonial social norms and status quo, including in health care)

Colonization, which often refers to direct imperialism and acquisition founded on force and military action, has evolved.

The role of health care in relation to colonialism has also evolved: so too have the roles of health care providers and sites of health care.

Many health care facilities across Canada today are located on both unceded lands, where no numbered treaty applies, and contested lands, where treaty obligations are frankly breeched. The very presence of these clinics and hospitals represents:

- Dispossession and displacement (including forcible confinement on reserve and coerced migration to no fixed address in large urban centers) which leads to unsafe and unstable housing.
- Chemical restraint (historically delivered by Indian Agents but now often administered by health care providers) have led and continue to lead to multi-generational polysubstance use disorder.
- Criminalization of Indigenous Peoples (including within the confines of health care facilities) can contribute to unorganized and organized illicit, and sometimes violent, effects.

Indigeneity continues to be geographically segregated, pathologized, “managed”, and either “cured,” certified or incarcerated.

These contemporary realities represent subtle yet deeply unsettling ways that ideologies and practices of Indian hospitals have shifted over time, allowing the concepts of health and health care to continue as antithetical to Indigenous personhood and wellness.

Unfortunately, we physicians who hold so much privilege and power in the health care system, along with our predecessors, have been unwitting participants in the colonial agenda. Without insight or intent, we have been trained to be tolerant of epistemic (bodies of knowledge and ways of sharing them) racism and developed dependence on a neo-colonial health care system.

We have been taught Indigeneity is a pathology.

Indigeneity is not the pathology. Coloniality is the pathology.

We have not learned how to stand against a state body that thrives on pathologizing others. Our hospitals embody and express the pathology of coloniality.

How will Indigenous peoples ever find good health outcomes when we continue to be pathologized?

As physicians, it is impossible for us to extricate ourselves from a colonial history. We are embedded within it, suffused in the ongoing legacies that our profession has been an agent of.

But like Indian hospitals, we physicians too can evolve. We can evolve in good and kind and culturally humble ways.

Before we can learn to hold space for Indigenous self-determination in health and wellness, we must first learn how to hold space for ourselves in our own recovery from the pathology of the coloniality of power and bolster protective factors against it.

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With gratitude, for their contributions, to Tibetha Kemble (Stonechild) and Sarah de Leeuw.

Banner image: For the personal story behind this and other images in her collection, view Indigenous artist Lisa Boivin'sTEDxTalks – *Painting the Path of Indigenous Resilience* (embedded in the story above).