TELLING 1922s *STORY OF A NATIONAL CRIME:* CANADA'S FIRST CHIEF MEDICAL OFFICER AND THE ABORTED FIGHT FOR ABORIGINAL HEALTH CARE

Adam J. Green
Department of History
Université d'Ottawa - University of Ottawa
Ottawa, Ontario
Canada, K1N 6N5
agreen@uottawa.ca

Abstract / Résumé

Over a seventeen-year career as Canada's first Chief Medical Officer, Dr. Peter H. Bryce accumulated statistics which suggested that Canada's Aboriginals were being decimated by Tuberculosis, and that the Federal government possessed the means to stop it. Eventually discharged for such reports, Bryce wrote, in 1922, *The Story of a National Crime*, which detailed both the evidence and the reluctance of the government to act. The resistance to his recommendations help reveal conceptual limitations in the growing professionalization of the civil service, and point to a layered and powerful set of cultural assumptions which continued to underwrite federal policy despite growing confidence in scientific and social scientific approaches.

En dix-sept ans de carrière en tant que Directeur de la santé, Peter H. Bryce a rassemblé de nombreuses données statistiques indiquant que les Autochtones du Canada étaient sur le point d'être décimés par la tuberculose, et que le gouvernement fédéral avait les moyens d'intervenir. Après avoir été congédié à cause de tels rapports, Bryce écrivit The Story of a National Crime en 1922. Il y présentait le détail des preuves accumulées, et y dénonçait la réticence du gouvernement. Cette réticence révèle les limites conceptuelles d'un service public alors en voie de professionalisation, et indique l'existence d'un ensemble de présomptions culturelles qui ont continué d'influencer la politique fédérale en dépit d'une foi grandissante dans les sciences et dans les sciences sociales.

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In 1922, James Hope and Sons Limited published a paper which they sold for 35 cents a copy. The author, Peter H. Bryce, was certain that the information the paper contained was virtually unknown among the general population of the country. Its major conclusion: Canadian Aboriginals were dying, not from alcoholism or poverty as many suspected, but from communicable disease, mainly tuberculosis. As a medical expert and Canada's first Chief Medical Officer, Dr. Bryce was on a virtual crusade to wipe out this dreaded disease in Canada. His work was laced with sadness and frustration, derived both from the government's refusal to acknowledge and deal with the problem he had so long ago identified, and because this same government was impeding his own efforts to do so.

This article examines the Federal career of Dr. Peter Bryce as it relates to Aboriginal health, a process which culminated in the publication of his 1922 work, *The Story of a National Crime*. It explores, as did Bryce himself some eighty years ago, how the same government that had hired a doctor to deal with the health concerns of Canada's Aboriginals had then reversed this commitment when the information collected revealed that much more time and money than originally planned for would be needed. The essay builds upon the body of work already completed on Bryce's findings,[1] and uses Bryce's own papers to suggest that his conclusions were both a reaction to the dominant cultural dynamics of his era, as well as an example of the growing belief in a scientific discourse in the federal civil service.

In addition, this paper adds a layer of complexity to the debate surrounding Aboriginal assimilation in the early 20th century. Although assimilation would have certainly been the goal of Bryce's Aboriginal policy, forced extinction was not. Moreover, Bryce challenged fundamental cultural attitudes towards the Aboriginal population at a time when many Canadians believed this civilization to be all but technically extinct. Such an attitude was, as other scholars have noted, a prevailing assumption of Bryce's superior, Duncan Campbell Scott.[2] Like Scott, in the absence of substantive evidence to the contrary, many Canadians believed the Aboriginals were dying out because of their own devices, and thus common opinion held that Native-government relations seemed to conform to the structures entrenched in the Indian Act.[3] Dr. Bryce's work, predicated on scientific observation instead of cultural assumption, introduced a layered approach to Aboriginal relations, namely that whether or not Canada wished them to be assimilated, the Canadian government was responsible, technically and morally, for their accelerated extinction in the late 19th and early 20th century.

Chief Medical Officer

Although eventually taking on the welfare of Aboriginals as his primary cause, Dr. Bryce's appointment as Canada's Chief Medical Officer originally had him surveying a range of public health issues. The appointment was made in 1904, and lasted—at least officially—until 1921. Having been educated in Toronto, Edinburgh and Paris, Bryce was appointed as the first Secretary of the Board of Health of Ontario in 1882. Bryce helped define the purpose and mandate of the Board itself by writing, along with Sir Oliver Mowat—Premier of Ontario—the final version of the 1884 Ontario Public Health Act.[4] In 1904, the Federal Department of the Interior, under the Honourable Clifford Sifton, appointed its first Chief Medical Officer. Given the enormous scope of the Ministry of the Interior for which he worked (it would, within three years, be split into the Department of Indian Affairs and the Department of Immigration), Dr. Bryce produced a series of papers and lectures on issues of immigration, urbanization, and ethnic relations, as well as a draft of the 1906 Immigration Act of Canada.

In all of these areas, Bryce was more akin to his original boss, Clifford Sifton, than to subsequent superiors. Like Sifton, Bryce believed that the best—and healthiest—potential immigrants to Canada came not from the cities of England and the United States, but from the Southern and Eastern European countryside. Arguing against more popular notions of "racial superiority," Bryce countered with science: his findings suggested that among the rural peasants of Europe, "we have not only an industrial asset of great value but also the assurance of a population remarkably free from the degenerative effects seen in those classes which have been for several generations factory operatives and dwellers in the congested centres of large industrial populations."[5] These individuals, whom Bryce described as "industrious and law-abiding"[6] were to be selected over British and American urbanites by immigration officials. As expressed in his *The Value of the Continental Immigrant*, Bryce believed that Canadian history was defined by a succession of immigration waves in which each new ethnic group had to overcome the limits placed on them by previous waves, but then erected the same barriers against those who came after them, leading to a new social challenge each generation.[7]

Peter Bryce also published a variety of papers which offered scientific evidence against the popular claim that immigrants were more likely to be criminals and mentally deficient. Using statistics, Bryce not only corrected the available figures on the incidence of incarceration due to mental deficiency as related to immigrants (which had failed to account for population growth and double-counting of inmates in sequential sur-

veys),[8] but suggested that the lowest rates of "insanity" actually came from Galician, Russian, and Italian populations, while much higher rates came from those who originated in England, Germany and France.[9] Moreover, in contrast to the popular charge that it was the dilution of the Canadian racial mix which was causing an increase in crime, disease, and poverty in Canada, Bryce found and publicized what he believed to be the scientific explanation for these trends: urbanization. Isolated and trapped in rapidly deteriorating and crowded urban conditions, modern urban dwellers, according to Bryce, could no longer produce for themselves the necessities of life, and were thus "not the possessors of physical, mental, and moral independence." As a result, most city-dwellers—a rising proportion of them new immigrants—were "absolutely helpless and dependent on what capital is prepared to allow them in wages."[10]

Bryce's focus on environmental factors rather than racial or ethnic characteristics in relation to immigration policy and urban development also provided the premise upon which his evaluation of the state of Aboriginal peoples was based. Moreover, Bryce arrived at his federal post at a time when elements in Canadian society were beginning to question whether or not a change in Aboriginal policy was needed. After all, in many ways, Canadian Aboriginal policy had not shifted in over half a century. Indeed, as is well established by a range of scholars, the last major shift in Canadian attitudes toward its Aboriginal population had come at the end of the colonial era, when officials moved from viewing First Nations as military allies to the weakening and withering remnant of a dwindling civilization. Although a series of uprisings, most notably the Red River Rebellion kept the possibility of both Aboriginal organization and independent Aboriginal resistance alive, for the most part the end of the 19th century and the beginning of the 20th century witnessed the pinnacle of Canada's program of Aboriginal assimilation.[11]

Assessing Canada's Aboriginal Policy

From the very first questionnaire he gave following his appointment as Chief Medical Officer, a survey which covered about three-quarters of the population, Dr. Bryce noticed two startling facts. First, contrary to popular opinion, Canada's Aboriginals in fact exhibited comparatively low levels of nervous disorders and alcoholism. Second, while most physical disorders occurred at similar rates in the Canadian population at large, those whose occurrence depended on heavy amounts of unsanitary contact, such as diseases of the eye and tuberculosis, were much higher among First Nations.[12] Although these diseases had been relatively rare in the 1880s, the early twentieth century witnessed an outbreak that reached near-epidemic proportions. Bryce set out to de-

termine the cause of this noticeable health problem, as well as the best means to prevent future difficulties among both Aboriginals and the population at large.

However, the effects of such findings have to be placed within their practical, political context. Dr. Bryce became Canada's Chief Medical Officer in 1904. Although entertaining a wider variety of opinions on ethnic determinism, Clifford Sifton, Minister of the Interior upon Bryce's appointment, placed the emphasis in First Nations' education on turning Indians into self-sufficient persons capable of adding to the productivity of the nation, pushing the adoption of agricultural and other marketable skills. Sifton firmly believed that if settled separately, the graduates of Indian schooling could have a much higher degree of 'civilized' life than if they had gone back and settled among their own peoples. Nonetheless, Sifton's thoughts on the issue of First Nations' education were quite clear: "We may as well be frank…the Indian cannot go out from a school, making his own way and compete with the White man [as] he has not the physical, mental, or moral get-up to enable him to compete. He cannot do it."[13]

Moreover, the budget for the Department of Indian Affairs while Sifton was Superintendent-General increased less than 2 percent, while the budget for the Department of the Interior under Sifton increased 391 percent in the same period.[14] This ultimately disproportionate allocation of funds came despite the fact that Sifton was made aware of the Natives' health problems as early as 1897, when a Departmental report recorded that "most school buildings were constructed without regard for basic sanitary standards."[15] Martin Benson, the report's author, still attributed the high incidence of tuberculosis among Aboriginals to a presumed hereditary disposition, but he commented on how Reserve school conditions were definitely not helping the matter, and could even be causing those afflicted to develop more serious symptoms. In 1901, Dr. G.A. Kennedy of Fort Macleod wrote Clifford Sifton at length about "the shocking conditions and inadequate care for Indians in his district" where "the death rate for the past year in [two] Reserves has been over ninety per thousand."[16] That Bryce would find the same conditions a decade later goes a long way in demonstrating just how much attention Clifford Sifton ultimately gave to the matter.

The attitude at the highest levels only grew less tolerant when Duncan Campbell Scott became the de facto head of the residential school system. To begin with, Scott was a penny-pincher, a man always in search of the least expensive route to providing services required by law. As a result, while Aboriginals were permitted to attend either day or residential schools, the support of the Department leaned heavily towards the

latter, a fact reflected in the substantially higher proportion of funds allocated to those schools during D.C. Scott's incumbency.[17] It is in these schools that Bryce would find some of the unhealthiest environments in the country. In addition, D.C. Scott was not only adamant that Indians be assimilated, and that they abandon the "older Indian professions of hunting and food-gathering in favour of industrial or mercantile occupations,"[18] but hoped to encourage the end of Aboriginal identity itself. From the very outset, Scott was very clear on his objectives: the department was to continue until there was not a single Indian in Canada that had not been absorbed into the body politic and until there was no Indian question and no Indian Department – until "the extinction of Indians as Indians" occurred.[19]

The Report of 1907

It was in this environment that Dr. Bryce was asked by Frank Pedley —Superintendent-General of Indian Affairs and Bryce's direct superior— to assess the status of Canada's residential schools. Bryce subsequently spent three months in Manitoba, Saskatchewan, and Alberta, visiting 35 of these schools. What he found was that a large number of students already infected with contagious diseases had been admitted, and that the buildings themselves were in "defective sanitary condition." Of particular note was the existence of ineffective ventilation systems, which Bryce discovered were often closed during the winter months in order to save money on the cost of heating. By ensuring the presence of infected students in an environment with insufficient ventilation, coupled with irregular physical exercise, it was "almost as if the prime conditions for the outbreak of epidemics had been deliberately created."[20] In addition, Bryce found that follow-up studies on the effects of such conditions were constantly hampered because of the reluctance of teachers and school officials to cooperate as well as to provide statistical information on the conditions of ex-pupils. Bryce would later complete a second massive study in southern Alberta in 1909, uncovering a similar problem, namely that over 28 percent of the Aboriginal students there had died, mostly from tuberculosis, while an additional follow-up study by his associate Dr. Lafferty located a school in the Qu'Appelle district of Saskatchewan confirmed that 93 per cent of the students exhibited some form of the disease.[21]

From this work came Bryce's first major report, dated 1907. The recommendations for the improvement of conditions included in this report were fairly practical: no special sanatoria would be needed. Instead, it was simply the structural problems in existing buildings that had to be fixed. In addition, Bryce suggested that each school appoint a nurse

trained in the methods for treating tuberculosis, each of whom would in turn be supervised by a district medical officer. If these measures were combined with a program of increased physical activity for the students, as well as an improved diet, the problems of diseases in the schools, Bryce predicted, would be substantially decreased. Aware that the Department would never approve such expenditures *en masse*, he suggested a trial run at one or two schools first, in order to collect the necessary data to substantiate wholesale adoption of his recommendations.[22]

Bryce's 1907 report was distributed to politicians and church officials, with the more sensational elements making their way into the Ottawa *Citizen* and the Montreal *Star.*[23] The reaction was mixed: while Indian agents were prepared to substantiate Bryce's claims, church officials responded defensively. This was likely due to the fact that Bryce recommended church officials be kept out of the new implementations; Bryce's evidence suggested the partnership between church and state often lead to confusion over jurisdiction, prompted each side to blame the other for inaction, and lead to an under-reporting of problematic areas by local field agents who feared ostracism from their church communities.[24] Nonetheless, the report stated that 24 percent of all the students who had attended the schools were known to be dead, with rates as high as 75 percent in one school. Regardless of whether or not the government wished Aboriginals to be assimilated, contended Bryce, they were dying in frightful numbers because of a disease for which some measure of treatment and preventative care was well known. In the interest of ceasing the spread of the disease among First Nations—as well as keeping it from spreading beyond the Reserves—Bryce contended that his recommendations must be implemented.

Much more important than national health for D.C. Scott, however, was the subject of the accrued cost of the new reforms. As he later remarked to Frank Pedley, his major objection to Bryce's proposed changes was that they would unfortunately "add considerably to the appropriations" of his Department. Instead of implementing Bryce's reforms, Scott enacted some less expensive measures: he added $25 to the per capita grants, which was given provided that the schools met certain conditions based mostly on proper ventilation and lighting, and ensured that there existed an "isolation ward" for infected students.[25] Though these reforms did improve conditions, they fell tragically short of bringing the health problems that were ravaging the schools under control.

In other words, Scott more or less implemented the minimum, which in Bryce's medical opinion amounted to almost nothing. This inaction

prompted another round of correspondence between Bryce and Scott, and then with Scott's superiors, in which Dr. Bryce, frustrated by Scott's refusal to dip into Federal coffers in order to alleviate a problem of potentially catastrophic dimensions, became quite irate:

> It is now over 9 months since these occurrences and I have not received a single communication with reference to carrying out the suggestions of our report. In this particular matter, [D.C. Scott] is counting upon the ignorance and indifference of the public to the fate of the Indians; but with the awakening of the health conscience of the people, we are now seeing on every hand, I feel certain that serious trouble will come out of departmental inertia.[26]

In reaction to Bryce's allegations, Scott again answered that, "when the peculiar conditions are taken into consideration, the Department is doing as well as can be expected for the Indians, and to anything further would entail a very heavy expenditure, which, at present, I am not able to recommend."[27] The tight-fisted D.C. Scott clearly took the position that any increase in spending in order to better Aboriginal conditions was only to be seen through the prism of the expenditure of federal resources. Bryce's proposals came into direct conflict with Scott's preoccupation with minimizing costs, a situation which would ultimately not change as long as Bryce worked for the Department of Indian Affairs.

The reactions of both the government and of Scott to the Report of 1907 began to confirm for Bryce the government's general unwillingness to ameliorate the situation. While the 1907 report contained much more in the way of detailed statistics, Bryce had previously written the government about the same problem. In a letter written to Wilfrid Laurier in late 1905, Bryce had already concluded that if the government would simply impose the same measures of tuberculosis prevention and care as it did for the rest of the population, "the death rate of the Bands would be no higher than that of an average Canadian community."[28] To prove the ease with which this could be accomplished, Bryce offered the Prime Minister the example of a recently-immigrated Galician community he had treated simply by vaccinating those who were not yet infected, and isolating and treating those few who were. Though the infection rates were higher in Aboriginal communities, all that was required, claimed Bryce, was a slightly larger support staff and enough space in which to quarantine the infected.[29]

From 1907 onward, Bryce became increasingly disenchanted as corroborating evidence continued to turn up, and D.C. Scott and others continued to ignore the implications. Nineteen hundred and ten in par-

ticular witnessed the release of a report on the prevalence of tuberculosis amongst First Nations by George Adami, the Head of Pathology at McGill; nonetheless, Scott refused to let the issue become a "matter of critical discussion" at the annual meeting of the National Tuberculosis Association. As the president of that organization, Scott appeased the cries of Adami and his ilk by assuring them that the Department would take "adequate action along the lines of the report,"[30] none of which followed.

Relieved of Duty

Though it seemed for a time that some progress might be made, as a new Superintendent General of Indian Affairs was appointed in the person of W.A. Roche, a medical man like Bryce, this new superior brought with him simply more of the same—inaction. Upon his arrival, Dr. Roche promised to implement Bryce's recommendations, but what followed was delay and deferral of such action on account of absence, illness, or just plain red tape. By 1914, Scott had been appointed Deputy Minister and, in a 'polite' memorandum, suggested that the following year's annual report would not be needed from Bryce, and that others (who were quite inexperienced) had taken over his functions in the inspection of schools.[31] This act of marginalization, preceded by years of complacency in the face of Dr. Bryce's recommendations, finally served to fully illustrate the functional limitations placed on Bryce's influence or lack thereof.

The removal of Bryce from his obligations at Indian Affairs, which occurred in 1914, was in fact the culmination of a program by men like D.C. Scott who worked behind the scenes to restrict Bryce's duties.[32] Bryce's compilation of data was being questioned on monetary grounds, with claims that the "cost of compiling such statistics far outweighed the benefit of the information provided."[33] Most of Bryce's recommendations were rejected by the Department, due to concerns of cost, priorities, and the prevailing views surrounding First Nations at that time. After 1914, Dr. Bryce was never asked to complete an official task for the Department of Indian Affairs again. The civil servant would thus spend the remaining seven years of his federal career concentrating his official duties on issues pertaining to immigration and immigrant health, leaving an important mark in that domain.

However, when not completing his remaining official duties, Bryce continued to arouse public debate on Aboriginal issues. During WWI, as immigration was largely suspended, Bryce had ample free time, and prepared several pamphlets intended for government publication. One such work *was The Conservation of the Man Power of the Indian Population*,

which was ultimately never published by a Federal government that wished to avoid generating further discussion on the matter. Opting to use the country's new concern with wartime production as a rallying point, Bryce used the pamphlet to point out that only 1.5 percent of the lands allotted to the Natives were under cultivation. This situation, suggested Bryce, could be altered provided First Nations were taught to utilize much more land, and provided that the proper steps were first taken to ensure that the Aboriginal students themselves were in good enough health to work that land. Furthermore, such training would be quite a worthwhile endeavour from the viewpoint of maximizing productivity, since the small amount of land utilized at that time by Aboriginals yielded a $69 per capita income, which while below the national average, exceeded areas like Nova Scotia, which brought only $40 per capita.[34]

At the same time, Bryce revealed that though the national average suggested that between the years 1904 and 1917 the population of Canada's First Nations should have grown by 20,000, it had actually decreased by over 1600.[35] Furthermore, the only significant cause Bryce could discern from the statistics was an abnormally high death rate due to disease. As Bryce began to emphasize more and more, Canada's First Nations were dying out, and not only was the federal government doing nothing about it, it was also restricting the publication of pertinent information, so that no one could address the issue.[36]

In 1918, Bryce was cut off at the source: In response to a request for the latest Aboriginal mortality statistics, he was told that such information was either not available or had not been collected. A flabbergasted Bryce could hardly believe that "after more than a hundred years of an organized Department of Indian Affairs…in a Department with 287 paid medical officers…[and with regard to a task] looked upon as elementary in any Health Department today," no one could provide him with the most basic of vital statistics pertaining to the incidence of mortality amongst these wards of the state.[37]

Although ignoring his alarming conclusions about First Nations, the Canadian government continued to make work of Bryce's medical talents. In 1918, N.W. Rowell asked him to draft a structure for a proposed Bill for a Department of Health, a special request which Bryce accepted. In this new Department of Health, Bryce included provisions for an Indian Medical Service along with the other Federal medical services which he outlined. But on the second Parliamentary reading of the Bill, the Indian Medical Service clause was omitted, and was thus never included in the new structure. This would merely confirm in Bryce's eyes once and for all, "the indifference of politicians to the needs of the Native

populations."[38]

As a final act of degradation, Dr. Bryce, who had been the Chief Medical Officer of Ontario for 22 years and of Federal Immigration and Indian Affairs for 15 years, was passed over for the position of the first Deputy Minister of Health. The appointed minister, though he championed prohibition, labour interests, and women's rights, apparently had no stance on Indians. When D.D. McKenzie asked Arthur Meighen, Prime Minister but ex-Minister of the Interior whether the Department of Health would look after Native issues, he replied that "the Health Department has no power to take over the matter of the health of the Indians. That is not included in the Act establishing the department." When asked furthermore if tuberculosis was increasing or decreasing amongst the Indians, Mr. Meighen replied, "I am afraid I cannot give a very encouraging answer to the question. We are not convinced that it is increasing, but it is not decreasing."[39]

Ultimately, D.C. Scott's decision in 1914 to "dispense with the services of the troublesome Dr. Bryce"[40] crippled Bryce's influence in the government. Scott had replaced him with Dr. O.I. Grain, whose first tour of residential schools found them to be in a "generally satisfactory situation," and provided a report which both reflected Scott's desires, and helped contradict Bryce's claims of the previous decade. Grain's work was held at the periphery of concern, and Grain himself soon turned his attention to military recruits. The position of Federal Medical Officer itself was abolished by Scott in 1918. That was the year of the Spanish Flu epidemic, in which 50,000 Canadians perished.

Bryce's *Story* is Written

Thus, by the end of Dr. Bryce's federal career, the problem of Aboriginal health had not been solved, or even seriously addressed. Health conditions had barely changed, despite numerous reports, letters and conversations with superiors and peers. With the job of improving Aboriginal health conditions left in near abeyance, Bryce continued, upon his formal retirement from the civil service in 1921, to maintain his vital statistics and to continuously update his data. This work would culminate in Bryce's major independently published study on Native affairs, *The Story of a National Crime: An Appeal For Justice For the Indians of Canada*. While many at the time of its publication charged that Bryce's true motive was to launch a bitter attack on D.C. Scott and the Ministry of the Interior for having sacked him,[41] Bryce was quite straightforward about the reasons behind the timing of the publication, as well as the implications of its contents.

Bryce was a public servant who took his responsibilities, and his

oaths, very seriously. While in the service of the Federal government, an employee was not supposed to personally disclose the contents of their reports to the general public, as there were proper channels through which such (often censored) material passed. Bryce, therefore, remained under the conviction that he *could not* discuss his findings, no matter how strongly he felt about them, until he was no longer in the service of the Federal government. *The Story of a National Crime* was published in 1922, a year after Bryce was discharged from Federal service. Although there was undoubtedly some residual anger towards the Department that let him go before he felt his time was up (a viewpoint clearly expressed in his defensive 'case' for renewed employment which occupies the later portion of his paper), his major point was that the Federal government was doing the First Nations of Canada an injustice. Bryce called for the correction of these wrong-doings, preferably with himself at the helm of such efforts.

Referring to First Nations as "The Wards of the Nation," but also as "Our Allies in the Revolutionary War" and "Our Brothers-in-Arms in the Great War," the 1922 work summarized the record of the health conditions of Canada's Aboriginal peoples from 1904 to 1921, the years of Bryce's service for the Indian Department.[42] In this paper, Bryce first recounted how he spent months systematically collecting health statistics from the several hundred Bands scattered across the country, filing a departmental report each year until 1914. He also specifically mentioned his controversial Report of 1907 for which he had received a special commission, and whose goal had been to determine the health history for the 15-year existence of the 35 schools in the Prairie Provinces. What he found most disturbing in 1922 was that the incidence rate of tuberculosis was *still* alarmingly high, especially when compared to the rates in the rest of Canada, which instead had improved substantially since the 1907 report. For example, by 1921, while the city of Hamilton had a death rate of only 10.6 per thousand, one in every seven Indians were still dying, mostly from tuberculosis.[43]

In order to deal with such continuously horrid statistics, the 1922 paper contained several recommendations: first and foremost, it called for the relocation of the boarding schools to be closer to the students' home Reserves. Moreover, it stated that the government should undertake the complete maintenance and control of the schools, establishing as well a Board on which Church officials could advise the government, given their acknowledged historic involvement with the Aboriginal population. What Bryce wanted, was that "the health interests of the pupils be guarded by a proper medical inspection and that the local physicians be encouraged through the provision of each school of [the]…methods

in the care and treatment of cases of tuberculosis."[44] These recommendations, added Bryce, were echoed from year to year in his annual medical reports, and were often backed up by local medical officers who urged greater action. Additionally, it was found that tuberculosis was equally present in children at every age, and thus it was strongly recommended that the health measures be extended not only to the 10,000 children of school age, but to the thousand new ones coming up each year and entering the schools annually.[45]

This work, which can be seen as the culmination of Bryce's efforts to solve the Aboriginal health crisis, reinforced the notions and lessons he had been stating and shaping throughout his professional career. He expressed his constant frustration with the government on several levels, re-iterating that "medical science now knows just what to do" and that all that was necessary was to "put our knowledge into practice," something the government refused to do. He then criticized the wartime Union government as one example of how partisan politics constantly shuffled the issues of Aboriginal health from department to department, but always succumbed in the end to "the desire for power [which] override any higher consideration such as saving the lives of the Indians."[46] In a clear-cut example of how little he believed the government really cared about the fate of its Native population, he noted that at last count, $10,000 had been allocated for the control and treatment of tuberculosis among the 105,000 Indians in Canada, while the City of Ottawa, which supported a nearly equal population, had been given over $33,000 to deal with the hospitalization of tuberculosis victims alone.[47]

Finally, in a re-examination of the work done (and not done) to ameliorate Aboriginal conditions over the course of his federal career, Bryce drew on statistics made available as of March, 1922. In a survey of a particular school in Qu'Appelle, Saskatchewan, Bryce noted, unfortunately without much surprise, that some 93 per cent of the Indian students had shown evidence of the tuberculosis infection in a recent medical examination. As if to serve as the most prime of examples of everything Bryce was trying to change, this was the very same school which had shown the very same rate of incidence back in 1909 in the study conducted following Bryce's 1907 Report. Despite his most ardent efforts, little had changed.

Conclusion

It has been noted by many an observer that the elements of Canadian Aboriginal policy were somewhat contradictory, trying to both protect the Natives while at the same time provoking them to become more independent and "less Native."[48] It was as though the very mechanisms

which in a sense treated First Nations like children (controlling their economies, resources, education) were also responsible for the underdevelopment in Aboriginal communities of the supposed indicators of "independence" valued so much by mainstream Canadian society. This contradiction was equally seen in the institutions themselves, such as in their system of education. While First Nations viewed cooperation in education as a partnership with Canada designed to create an environment which would "preserve Indian life, values, and Indian Government authority," Euro-Canadians and the State saw these measures and programs as instruments for assimilation.[49]

Authors have differed in their assessment of Bryce's legacy: In 1971, Morris Zaslow claimed that Bryce's efforts, though spirited, amounted to little more than a "promising beginning" to a movement that would not really make any headway until at least the 1950s.[50] In 1996, Megan Sproule-Jones, taking a different angle, noted that the policies outlined in Bryce's *The Story of National Crime* in fact anticipated the changing role of the government in the years following WWI, suggesting a system based on the responsibility of the Federal government to preserve the health of all Canadians which would fit much better into the welfare state than into the laissez-faire philosophy of his time.[51] In a sense, both Zaslow and Sproule-Jones were correct: as a health professional, Bryce was more in line with Canadian attitudes—and actions—following WWII than those preceding WWI.

Moreover, Bryce was never alone in his evaluation, and to single him out is not necessary. Toronto lawyer Sam Blake, R.P. McKay of the Presbyterian Church, and Alexander Sutherland of the Methodist Church all launched similar accusations at the federal government during the same era, and even claimed some temporary victories: At one point their combined efforts even forced Duncan Campbell Scott to temper his views and claim, "it was never the policy, nor the end and aim of the endeavour to transform the Indian into a White man."[52]

However, Bryce's position in the federal government, his scientific credentials, and his personal zeal to force the government's hand on Aboriginal issues make him an excellent example of the confluence of forces and opinions at work in early 20th century Canada. To his credit, several concrete programs also emerged out of his work. In 1922, a mobile nurse-visitor program was implemented "which would see the medical officer's work being complemented by the work of nurses at the community level,"[53] thus allowing a degree of local medical representation previously unavailable to First Nations.[54] Bryce had also succeeded in his plan to bring health care information to Aboriginals for their own educational use; circulars on tuberculosis were translated into Cree, a

program continued into the early 1930s,[55] and all Indian agents were provided with a 'Book of Regulations' on medical services. Finally, a long-lasting effort to contract local physicians was put in motion, a program which was "Bryce's idea to fill the obvious vacuum of physician services" among Aboriginal peoples.[56]

Bryce's charge that the government's treatment of its Aboriginal peoples amounted to nothing less than an infuriating and criminal disregard for the country's treaty pledges forces us to consider the limits and reach of government attitudes; the government's decision to silence him provides yet another example of Canada's mishandling of its Aboriginal population. Of most interest to many in the twenty-first century, perhaps, was the way in which Bryce's work became interwoven into a number of struggles in Canadian society, including elements of the church, of the government, and of Aboriginal society itself. Moreover, the case of Peter Bryce illustrates the ways in which the professionalization of science and medicine, as well as the creation of a 'meritocratic' public service, were filled with exceptions, pitfalls, and resistance. Finally, and without overstating the value of his work, Dr. Bryce's conviction that the government had a social and political responsibility to the wellbeing of its Aboriginal population which trumped the need for assimilation, provides us with an excellent example of how such scientific and social scientific attitudes became a small part of the greatest shifts in twentieth-century Canadian consciousness, the creation of the welfare state.

Notes

1. Which includes, most prominently, John S. Milloy, *A National Crime: The Canadian Government and the Residential School System – 1879-1986*. (Winnipeg: University of Manitoba Press, 1999), and Megan Sproule-Jones, "Crusading for the Forgotten: Dr. Peter Bryce, Public Health, and Prairie Native Residential Schools," *Canadian Bulletin of Medical Health* 13 (1996)
2. For background on Scott's view of Aboriginal peoples, see Titley, E. Brian. *A Narrow Vision: Duncan Campbell Scott and the Administration of Indian Affairs in Canada*. (Vancouver: University of British Columbia Press, 1986), and Stan Dragland, *Floating Voice: Duncan Campbell Scott and the Literature of Treaty 9*. (Concord, Ont. : Anansi, 1994). For a look at Scott's view of Aboriginals as expressed in his poetry, see D.C. Scott, "The Last of the Indian Treaties," *Scribner's Magazine*, vol. 40 (1906), 573-83.

3. Robin Fisher and Kenneth Coates, eds., *Out of the Background: Readings on Canadian Native History* (Toronto: Copp Clark Pitman Ltd., 1988), p.237
4. Suzanne Zeller, *Land of Promise: The Culture of Victorian Science in Canada*. (Ottawa: Canadian Historical Association, 1996) p.3, T. Kue Young, "Indian Health Services in Canada: A Sociohistorical Perspective," *Social Science and Medicine* 18 (1984), p.257, Margaret A. Evans, *Sir Oliver Mowat*. (Toronto: University of Toronto Press, 1992).
5. Alan Sears, "Immigration Controls as Social Policy: The Case of Canadian Medical Inspection 1900-1920." *Studies in Political Economy*. 33 (1990) p.95
6. Peter H. Bryce, *The Value to Canada of the Continental Immigrant: A Series of Articles*. (Re-Printed in Canada, 1928), p.56.
7. Ibid., p.5
8. Peter H. Bryce, *Insanity in Immigrants. A paper read before the American Public Health Association at Richmond V.A., October, 1909*. (Ottawa: Government Publishing Bureau, 1910), p.3. For example, at first glance, the fact that 142 admissions among immigrants to insane asylums in 1900 had increased to 358 in 1908 seems to suggest that the problem was getting worse. However, these figures failed to account for the 150% growth in immigrant communities over the same period, and did not take account of the 48% of inmates from 1900 who remained incarcerated in 1908.
9. Ibid., p.4. These three immigrant groups averaged out to an incidence rate of 0.185 per thousand, roughly akin to the Canadian rate of 0.19 per thousand. By contrast, British immigrants sported a rate of 0.32 per thousand, Germans 0.34, those from France and Belgium 0.52, and those from the British Possessions 0.94.
10. Peter H. Bryce, "Effects upon Public Health and natural prosperity from rural depopulation and abnormal increase of cities." *The American Journal of Public Health*. 5 (1915), p.49.
11. The range of literature on these topics is vast, but in terms of the transition points of Canadian mentalities towards its Aboriginal population as well as the ideas of Canadian officials, the following are instructive: Olive Dickison, *Canada's First Nations: A History of Founding Peoples*. (Toronto: McClelland and Stewart, 1992), J.R. Miller, *Shingwauk's Vision: a history of Native residential schools*. (Toronto: University of Toronto Press, 1996), Titley, op. cit., D.J. Hall, *Clifford Sifton*. Vol. 2 *A lonely eminence, 1901-1929*. (Vancouver: University of British Columbia Press, 1985), J.R. Miller, *Reflections on Native-newcomer relations*. (Toronto: University of Toronto Press,

2004).

12. Morris Zaslow, *The Opening of the Canadian North* (Toronto: McClelland and Stewart Limited, 1971), p.228
13. D.J. Hall, op. cit., p.45
14. Megan Sproule-Jones, "Crusading for the Forgotten: Dr. Peter Bryce, Public Health, and Prairie Native Residential Schools," *Canadian Bulletin of Medical Health* 13 (1996): 213
15. Ibid., p.216
16. Hall, op. cit., p.44
17. Titley, op. cit., p.76
18. Ibid., p.33
19. Dickison, op. cit., p.327
20. Titley, op. cit. p.84
21. Ibid.
22. Ibid., p.85 and P. H. Bryce, *Report on the Indian schools of Manitoba and the North-West Territories*. (Ottawa : Government Printing Bureau, 1907).
23. Sproule-Jones, op. cit., p.210.
24. Miller, op. cit., p.136, Sproule-Jones, op cit., p.210. This part of the recommendation also aroused the ire of D.C. Scott, who counted on strong ecclesiastical support to run the day-to-day operations of the school.
25. Titley, p.86
26. Peter H. Bryce, *The Story of a National Crime*. (Ottawa: James Hope and Sons Limited, 1922), p.7
27. Titley, op. cit., p.83
28. Laurier Papers, Queen's University Archives, Kingston Ontario, p.101061
29. Ibid.
30. Bryce, *The Story of a National Crime*, op. cit., p.6
31. Ibid., p.7
32. Sproule-Jones, p.218
33. Ibid.
34. Peter Bryce, *Conservation of Man-Power in Canada: A National Need*. (A report prepared for the Commission of Conservation Canada, 1918).
35. Bryce, *The Story of a National Crime*, op. cit., p.9.
36. Ibid.
37. Ibid., p.10
38. Sproule-Jones, op. cit., p.219
39. Bryce, *The Story of a National Crime*, op. cit., p.13
40. Titley, op. cit., p.87

41. Ibid., p.86. John Millow also suggests Bryce's narrative is a "self interested tale of his failed amibitions" in Milloy, op. cit. p. 95.
42. According to Bryce, although he was told in 1914 that his services were no longer needed, he was never officially removed from the service of that Department.
43. Bryce, *The Story of a National Crime*, op. cit., p.11
44. Ibid., p.4
45. Ibid., p.5
46. Ibid., p.12
47. Ibid., p.14
48. See Olive P. Dickison, *op. cit.*, pp.284-288.
49. Ibid., p.333
50. Morris Zaslow, op. cit., p.229.
51. Sproule-Jones, p.220
52. Miller, p.136
53. James B. D. Waldram, Ann Herring and T. Kue Young. *Aboriginal Health in Canada: Historical, Cultural, and Epidemiological Perspective*. (Toronto: University of Toronto Press, 1995), p.157.
54. T. Kue Young, "Indian Health Services in Canada: A Sociohistorical Perspective," *Social Science and Medicine* 18 (1984): 259
55. Ibid., p.159
56. Ibid., p.158