Great Adventures in Nursing: Colonial Discourse and Health Care Delivery in Canada's North

by

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No place is too remote, no climate too deadly, for the nurse to ply her ministrations. Like the soldier she obeys the call of duty, and, if need be, gives her life in the cause. In field hospital in time of war; in miner's camp or settler's hut; on Canadian prairie, in the Australian bush, or the South African veldt; on the burning plains of India and in the deadly tropics the trained nurse is to be found.

-- Sarah Tooley, The History of Nursing in the British Empire 1906.

1. The provision of health care to indigenous Canadians has a long and complex history that is deeply imbricated in the political, social, economic, and ideological structures of European imperialism. In colonial Canada, as elsewhere in the European colonies, healing was often a “technique of civilisation, carrying with it a pervasive philosophy about health and contagion, propriety and degeneracy; about the relationship of bodies and contexts, matter and morality” (Comaroff 315). Medical care was also a form of commerce, a commodity initially proffered for the economic and spiritual loyalties of “Indian” and “Eskimo” traders, and later for more general native compliance with hegemonic forms of human organisation. The terms of this commerce have long been contentious, with many government officials arguing that indigenous access to free, comprehensive health care services is not a given right, except where specifically stipulated by treaty. [1] Nevertheless, since the late nineteenth century, the federal government has taken responsibility for providing a “medicine chest” to First Nations communities, initially dispensed at the discretion of colonial representatives and later by (non-native) government employees. In the more northern regions of Canada before the end of the second world war, the keys to the medicine chest were usually kept in the firm male hands of outpost doctors, clerics, Indian Agents, Royal Canadian Mounted Police officers, and Hudson Bay Company store managers, although there were a small number of women involved in health care, mostly teachers and nurses associated with some kind of missionary venture. During this period, government interest was largely limited to budgetary matters and entailed very little health care delivery supervision. This situation began to change in 1944 when the Department of National Health and Welfare assumed responsibility for indigenous health services, leading to a rapid expansion of government health facilities and personnel, with a corresponding tightening of administrative control.

2. The systematisation of northern health care delivery in the middle of the twentieth century was based on a nursing-station model designed to treat most illness within the community via the ministrations of live-in nurses who would function more or less as physician substitutes—or, as it later came to be called, in an “expanded role.” For most nurses, this expanded role in fact encompassed the function of several health care professionals. As one outpost nurse puts it, [Northern] nurses deal with colds, pregnancy, and chest pains, in addition to employee physicals, marital problems, and depression. They also assume responsibility for pre- and post-natal clinics, immunizations, and elderly home visits. They are the resident dentist-applying temporary fillings or pulling teeth that just can’t wait for the next dentist’s visit. At night, a nurse must mysteriously transform herself into an entire emergency department—single-handedly suture, bandage, resuscitate, and console both the patients and their families. Northern nurses are X-ray technicians and radiologists; they are laboratory technicians and pathologists, as they draw blood, collect urine and take swabs to pin-point and identify disease; and they may often be public health inspectors responsible for public services in the community. (Canitz 1990, 197)

Although there has been some fine-tuning to the nursing-station model, it is fair to say that nurses have been the backbone of northern health delivery services since the 1950s. Undoubtedly, economics were initially part of the appeal of this model to government bureaucracies faced with increasing pressure to ameliorate indigenous health and bring infectious diseases such as tuberculosis under control. Nurses were considerably cheaper than doctors and, according to various reports, able to satisfactorily treat up to eighty-five percent of the cases likely to present to the nursing...
This nurse-meets-north narrative is typically styled as a travelogue of sorts, introduced with some kind of verbal or the fundamental ideological work carried out in such texts is the restaging of a heroic encounter with the North itself. regions of the country, highlighting the history, the problems, and the rewards involved. More often than not, however, some nurses have complained that the system perpetuates colonial attitudes and practices on the part of health-care givers, encourages dependency, and generally fails to make an impact on overall community wellness, even though individual cases of illness may be successfully treated. This situation is exacerbated by continually high levels of turnover in nursing staff in some regions over 100% per year and, until very recently with the creation of the Inuit territory of Nunavut in 1999, government reluctance to allow communities any real input into health policy and administration, even at the local level.

3. By the 1970s, almost all northern indigenous communities with over two hundred inhabitants had nursing stations, and there is little doubt that the intensified case-finding and treatment facilitated by this health care network led to a drastic reduction in the incidence of tuberculosis, as well as a significant decline in neo-natal mortality and morbidity rates. However, despite successful treatment of these and other specific problems, the health status of indigenous northerners has remained considerably below that of other Canadians, and there have been administrative difficulties and widespread dissatisfaction with the nursing station model. In particular, community leaders, patients, and even some nurses have complained that the system perpetuates colonial attitudes and practices on the part of health-care givers, encourages dependency, and generally fails to make an impact on overall community wellness, even though individual cases of illness may be successfully treated. This situation is exacerbated by continually high levels of turnover in nursing staff in some regions over 100% per year and, until very recently with the creation of the Inuit territory of Nunavut in 1999, government reluctance to allow communities any real input into health policy and administration, even at the local level.

4. Many of these shortcomings are now well documented in specific medical reports and published case studies as well as in sociological literature that treats broader aspects of the imperial mission of health in Canada. While critiques of the health care system collectively target not only the epistemological biases of western bio-medical science but also its coercive implementation in northern contexts, nurses themselves are curiously absent in all but a few articles, most of them written by postgraduate researchers attempting to make sense of their own prior experience as northern nurses (see Canitz 1990, 1992; Hodgson 1982; Wieler 1971). The general invisibility of nurses as a legitimate subject of academic research in this field seems to be symptomatic not only of a wider neglect of women’s roles in various aspects of the imperial enterprise, but also, and perhaps more importantly, of long-held and aggressively defended ideas about the proper division of labour in health care situations. In this respect, the North has long operated as both a liminal zone and a limit case for broader debates about health care delivery in Canada’s south, especially in relation to the licensing of nurse practitioners and midwives. [4]

5. To fully understand the limited effectiveness of the northern nursing-station model, it is necessary to look beyond individual personalities, administrative constraints, and the more general lack of fit between western and indigenous healing philosophies. In the popular imagination as well as within health care circles, northern nursing is not seen simply as a variant of general nursing for particular communities in specific geographical locations. Rather it has been discursively constructed as a very special kind of vocation reserved, in theory, for an extraordinary kind of nurse, working in a context sans pareil—the much mythologised Canadian north. Hence the outpost nurse is a priori a legendary figure, positioned at the nexus of a number of intersecting metanarratives about imperialism, gender, the north, and modern nursing itself. This positioning, I would argue, mystifies the nurse’s professional and social roles within the community and perpetuates a colonialist mindset that ultimately compromises attempts to form genuine health care partnerships with indigenous peoples. It likely also contributes to the high turnover in northern nursing staff since the “great expectations” inspired by such originary myths tend to be underwritten by the spectre of disillusionment and failure.

6. Among the discourses that collectively construct outpost nursing as the stuff from which legends are made, the metanarrative of the North has obvious mythopoetic force and is conjured time and again to stress the irresistible challenge, the thrilling magic, the unforgettability of the outpost experience. In nurses’ memoirs, various magazine articles, government recruiting advertisements and even academic accounts of northern health care, the North writ large becomes a transcendental signifier that gives outpost nursing immediate heroic dimensions. This monolithic North cathers different geographical, cultural and political zones through the use of several interrelated motifs focusing on the omnipresence of janus-faced nature, at once beautiful and inhospitable, and the more tenuous presence of indigenous peoples, traditional custodians of the land and potential conduits to its mysteries. In a sense, the nurse who enters this enigmatic realm enters history. As she implicitly follows the footsteps of the imperial explorers through terra incognita, she moves into a space in the colonial imaginary always already inscribed with promises of heroism, adventure, even romance. That this space has been mapped out as a quintessentially masculine domain intensifies the historiographic project of the outpost nursing experience while posing a number of problems and paradoxes for nurses working in the field.

7. The rhetorical purchase of the North as sign and seal of an authentic nursing adventure is perhaps best illustrated by textual examples from The Canadian Nurse, a professional magazine that has featured articles about northern nursing in almost every volume since the 1970s, with several special issues devoted solely to the topic. These articles, often written in first-person narrative mode, seem to give factual accounts of nursing practice in the arctic or subarctic regions of the country, highlighting the history, the problems, and the rewards involved. More often than not, however, the fundamental ideological work carried out in such texts is the restaging of a heroic encounter with the North itself. This nurse-meets-north narrative is typically styled as a travelogue of sorts, introduced with some kind of verbal or
visual hook, lavishly illustrated, and often elegiac in tone. A strong affirmation that the northern experience was, or will be, worth all the hardships invariably provides an up-beat narrative closure. The general model is clearly evident in a two-page 1983 feature that primes readers to anticipate a northern nursing focus issue of the magazine.

8. This particular article uses travel writing conventions to create what is essentially a clarion call to southern nurses to submit to the lure of the north. The heading and lead picture set the scene for a vicarious journey elsewhere, its appeal intensified by the journalistic technique of the “sneak preview,” while the subsequent synopsis suggests that this “elsewhere” can be packaged in “words and pictures” to inspire nurse-readers to realise their dreams. The body of the article bears out that promise, textually interpolating the active writer/subject into the arctic environment and using illustrations that feature an alien land and its exotic inhabitants as largely passive objects of the western tourist’s gaze. Details are given about the challenges and the pleasures of the job, the landscape, and the people. The story culminates in a sense of achievement as the author masters the expanded nursing role and finally closes with the assertion: "It's the toughest job I've ever had. And also the best" (Smith 21). As a whole, the piece is travel journalism *par excellence*, which actually works against the suggestion that the author will demystify northern nursing by relating her experience of "coming to terms with reality" (Smith 20). The real, in this context, is a discursive sleight of hand that ultimately leads us back to the very myths it seeks to oust.

9. Ever since the model of primary health care delivery was instigated in remote regions of Canada, recruitment personnel have clearly understood the magnetic pull of the North for would-be outpost nurses. In this respect, various advertisements for nursing station staff provide another fascinating narrative about the ways in which the North can be made to signify. The following ads, drawn from issues of *The Canadian Nurse* (1982-1999), confirm that this narrative hinges on two key motifs: the natural landscape (including the flora and fauna) and Canada's indigenous people. These motifs are rarely separable, with one often standing in metonymic relation to the other or else juxtaposed to form a collage-style meta-image that links various attributes of the North to specific attractions of the job. I do not intend to analyse these ads in any detail; my comments are simply designed to highlight some of the narrative strands and pictorial clues embedded in them.

10. As a natural environment the North is expansive and hence promises both personal and professional freedom; its distant horizon is the space of unlimited potential. Remote, pristine, spiritual, it is a realm of potential transcendence, a place that will “bring out the best in you.”

   Quintessentially wild, the North needs taming and so promises unparalleled adventure to those bold enough to take up that challenge. Northern nursing is clearly a woman's answer to the legendary "Call of the Wild."

   If the North is "naturally exciting," then it is the perfect location for nursing, a career choice that follows women's biological inclinations to nurture.

   Even the wildlife shows that northern nursing is natural by practicing a species of "médecine familiale" (family medicine).

   Nurses can access this incredible realm of adventure as long as they're hardy enough to join the team.

11. The images of indigenous culture in these advertisements are equally compelling to those nurses in search of a northern experience. True northerners are presented as exotic, authochthonous, spectacular and, above all, friendly. Nursing promises access to their culture, a rich resource they are more than willing to share.

   Premodern, the North is the "last frontier," a space wanting the civilising presence of the southern health care professional. Hence the nurse can make a meaningful contribution to the project of development.

   In this respect, most northerners are like children in need of tender nursing care-care that nurses want to give. (The insistent infantalisation of the indigenous Other is a notable feature of a good many images in this vein.)

   Thus, the nurse is the harbinger of modernity, a maker of history.

   Like the ancient inukshuk typically found overlooking Inuit communities, the nurse is a towering beacon whose broad shoulders carry more than the normal load of responsibility. (The shadowy inukshuk featured here functions as an
16. The hegemony of the heroic model of nursing was undoubtedly bolstered by its treatment in various kinds of literature, reminiscences by British outpost nurses working in Labrador in the 1920s. Canada was of course among the many countries served by the association, whose published "history" (Dickson 7), but their duties quickly came to include health care delivery to local settler and native populations. Initially, these nurses were to direct their "womanly attention" towards their brave fellow countrymen abroad the Colonial Nursing Association was begun in 1896, it looked to the Nightingale School to supply recruits for overseas boundries without peril. (It is this model nurse/woman that is evoked so forcefully in my epigraph.) Accordingly, when Martin Chuzzlewit chief sins of "drunkeness, callousness, and immorality" are immortalised in Charles Dickens's portrait of Sairy Gamp (in Designed to produce a new-style, "saintly" nurse devoted to the art of healing, as opposed to the old-style nurse whose nightingake's legendaire feats in the Crimea was matched in several ways by her practical contributions to the imperial enterprise. In 1860, with money donated in recognition of her war-time achievements, she set up the Nightingale Training School for Nurses, which soon became the model for similar establishments in distant reaches of the British Empire including in Australia, Canada, India, South Africa, and the Caribbean.

In short, these advertisements exhort the nurse to discover Otherness in order to define self.

12. This typically colonialist construction is here intensified by what has been called "nordicity" (Louis-Edmond Hamelin's term)-a widespread and deeply felt sense of northern-ness that is central to the Canadian imaginary but which in fact serves southern needs and interests (see Shields 193-95). In this context, I would argue that nordicity has functioned at governmental, community and individual levels to naturalise various relations of power that impact upon nursing practice. At the level of public policy, the vastness of the north, its remoteness, its seeming ungovernability, legitimates a vertical infrastructure that makes nurses accountable not so much to the communities in which they work as to external area supervisors, regional "zone" directors, and ultimately officials in Ottawa. This top-down organisational model, which is largely at odds with many of the principles of primary health-care, is reasonably easy to subvert at the community level (partly because of the failure of bureaucratic systems of surveillance) but only when the rhetoric of development can be replaced with more equal terms of intercultural encounter. Here again, nordicity has a particular purchase in so far as it sustains social and cultural divisions between the southern-trained health professional and a northern community whose apparently timeless traditions seem to preclude real competence in dealing with contemporary health issues. At the individual level, nordicity activates various desires, not least of which is a fantasy of seizing control over masculine space, both professionally in the field of "frontier medicine" and also more personally in the context of that much mythologised, existential confrontation between "man" and nature that has seemed central to hegemonic brands of Canadian nationalism. There is also the fantasy of "going native," another colonialist narrative whose specific trajectory I can't sketch here, except to comment that the rhetoric of maternity in this typical image of the "nativised" nurse actually points to the more insidious reality of northern nurses using their privileged access to Inuit communities to obtain children by custom adoption (a red-tape cutting procedure usually reserved for indigenes).

Taken together, the operations of nordicity produce the myth of the (white) health care professional with unprecedented power, as the following image suggests by its strategic positioning of the nurse on a hilltop overlooking "her" community.

13. If the "North" catalyses one meta-discourse about outpost nursing in Canada, the more subtle narrative running through the advertisements pictured here is the "foundational myth" of the profession itself-the story of Florence Nightingale. No account of modern nursing can afford to ignore the pervasive influence of her legendary founder, and this is particularly the case in a study that seeks to relate public and professional conceptions of nurses and nursing practices to the colonial discourses in which they are embedded. It's important to note in this respect that Nightingale's pre-eminent place in nursing history is inextricably linked to Britain's imperial campaign in the Crimea, the context in which her sanitary reforms and administrative skills first became widely known. Her well-publicised achievements in reducing mortality rates among soldiers, along with popularised accounts of her absolute devotion to her cause, gave modern nursing a fundamentally heroic dimension. In turn, the heroic nurse could then find a place for herself in other imperial ventures because, for many Victorian social reformers, she "best exemplified the ability of domestic morality and purification to move out of the home and into the tainted public domain" (Judd 22; see also Bashford 21-39). At the same time, the noblesse oblige extended by the upper-class Nightingale to the poor, working-class soldiers under her care at Scutari easily translated to colonial contexts where the self-sacrificing nurse might share the "white man's burden."

14. The ideological work of Nightingale's legendary feats in the Crimea was matched in several ways by her practical contributions to the imperial enterprise. In 1860, with money donated in recognition of her war-time achievements, she set up the Nightingale Training School for Nurses, which soon became the model for similar establishments in distant reaches of the British Empire including in Australia, Canada, India, South Africa, and the Caribbean.

15. Designed to produce a new-style, "saintly" nurse devoted to the art of healing, as opposed to the old-style nurse whose chief sins of "drunkenness, callousness, and immorality" are immortalised in Charles Dickens's portrait of Sairy Gamp (in Martin Chuzzlewit; see illustration below), the Nightingale School concentrated on teaching not only good nursing techniques but also a high order of moral rectitude that might allow nurses to traverse geographical and social boundaries without peril. (It is this model nurse/woman that is evoked so forcefully in my epigraph.) Accordingly, when the Colonial Nursing Association was begun in 1896, it looked to the Nightingale School to supply recruits for overseas postings. Initially, these nurses were to direct their "womanly attention" towards their brave fellow countrymen abroad (Dickson 7), but their duties quickly came to include health care delivery to local settler and native populations. Canada was of course among the many countries served by the association, whose published "history" features reminiscences by British outpost nurses working in Labrador in the 1920s.
17. At the same time as they stress female virtue, the popular Nightingale biographies and some of the fictional stories they inspired[11] titillate the reader by casting the nurse as a romantic heroine, admired and desired by the men she encounters but too dedicated to the wellbeing of humanity in general to waste her talents on marriage. This model of the saintly yet intensely eroticised heroic nurse is perhaps best captured in the 1959 film, *The Nun's Story*, starring Audrey Hepburn as the beautiful young woman who enters the convent in order to fulfill her dream of going to the Congo as a nurse. A thinly disguised reworking of the Nightingale legend, the film initially stresses the Hepburn character's affiliation with masculine realms of knowledge/action through her close relationship with her father, a noted surgeon. She then enters the cloisters to become Sister Luke, rejecting her devoted (but implicitly unworthy) suitor on the way. Her vocation performs the important ideological function of subordinating masculine attributes to feminine virtue, since she is not permitted to go to the Congo until she has developed the requisite moral character to resist its many temptations.

18. When she begins work in Africa, chief among these temptations is an attractive and forceful young doctor with little respect for nuns or religion in general. Their relationship unfolds through a series of conventionalised romantic images and visual innuendoes that neatly demonstrate the erotic power of the apparently unattainable woman. At one particular point, which functions as a metonym for the classic Hollywood undressing scene, the doctor tentatively removes several layers of Sister Luke's habit in order to apply his stethoscope to her chest to listen for signs of tuberculosis. Such iconography, combined with Sister Luke's philosophical battle to reconcile her vocational ideals with the petty demands of the convent hierarchy, sets up the firm expectation that she will eventually leave religious life to settle in the colonies as helpmate and wife. She does and she doesn't. That is, she does leave the convent, but presumably to carry on nursing as part of the war effort in Europe. Her rejection of the nun's role seems less to prefigure a romantic reunion with the doctor than to confirm the merits of the form of secular but saintly nursing that the Nightingale legend engendered. [12]

19. I have spent considerable time outlining the discursive construction of Nightingale as "transcendental signifier" of the model nurse because of its pernicious grip on the nursing profession, especially in fields, such as outpost nursing, which promise to perform a kind of alchemy that transforms the real into the ideal. There is evidence to suggest that early outpost nurses throughout the British Commonwealth saw themselves as fashioned after Nightingale in one way or another. In Canadian accounts of the outpost experience before the extensive government restructuring of northern health care delivery in the 1940s-50s, the fantasy of heroic nursing is textualised in a number of familiar ways to chart a psychological and professional journey from innocence to experience, hesitant experiment to confident expertise, even girlhood to mature womanhood. A good example of this kind of memoir is Hughina Harold's *Totem Poles and Tea* (1996), described on the cover as a "coming-of-age" story about the author's work as a teacher/nurse in an isolated part of northern Vancouver Island in 1935. The story, written some fifty years after Harold's two-year stint in a native community, stresses the physical and moral trials as well as the medical challenges of the author's work, in order to validate her conclusion that the experience "made a woman" of her. Much emphasis (and anxiety) is given to sanitation, not only in nursing situations but also in the classroom where one of the featured innovations was "nose blowing time." Harold also takes great pains to demonstrate that she was every bit as dedicated to her vocation as the missionary matrons with whom she worked. Indeed, the secular nurse had at least one moment of triumph when a patient dropped his pants to indicate a running sore in his groin, sending the missionaries shrieking in horror from the room. Like Celia Jowett's *No Thought for Tomorrow: The Story of a Northern Nurse* (1954), also set in the 1930s but in a remote region of northern Ontario, Harold's account ends on a wistful and elegiac note that pays implicit tribute to her own pioneering experience. While neither author explicitly invokes the Nightingale legend, they clearly consider their northern adventures to be the pinnacle of their nursing careers, indeed the only realm in which true heroism has been possible. [13]

20. The most interesting book in this genre is Betty Lee's *Lutiapik* (1975), written not by the nurse whose adventures it details but by a scribe whose relationship to the protagonist is not specified. While it purports to give an impartial account of Dorothy Knight's year in the high arctic on Baffin Island between 1957 and 1958, the book is in fact a tightly structured adventure tale in the Nightingale mode, complete with erotic elements that are both intensified and neutralised by the protagonist's absolute devotion to her profession. Knight, dubbed Lutiapik by her Inuit patients, begins as a rather green recruit drawn to the North more out of curiosity (after seeing an advertisement in *The Canadian Nurse*) than in search of heroism, but with each arduous nursing venture she gains status and confidence, eventually attaining a momentary quasi-mystical union with the people she serves. In conventional narrative terms, this experience only seems possible after she has pushed the limits of her physical endurance to the extremes (as Nightingale supposedly did in her twenty hour shifts in the hospitals of the Crimea), and, no less crucially, after she has proven her imperviousness to any kind of moral or sexual taint. An increasingly hazardous series of komatik (dog sled)
21. This book is enthralling reading, likely to elicit imperialist nostalgia in even the hardened postcolonial critic, but it seems to me to that the biographer is trying too hard to ventriloquise her subject's narrative and turn it into the kind of heroic adventure she imagines northern nursing to be. (It is interesting to note in this respect that the book is written from the perspective of a third-person omniscient narrator with all sense of the scribe's presence and identity erased.) The more fascinating counter-narrative is a tale of the outpost nurse's anxiety, not so much about facing the considerable challenges of the North or even the job, as about breaking out of the conventional strictures of her role in a thoroughly internalised Western medical hierarchy, a feudal system policed as much by nurses as by doctors. Thus Lutiapik keeps imagining the "coldly impersonal face" of her old nursing director saying, "Nurses do not, repeat, do not make independent decisions" (126). To follow this dictum is in fact impossible since the Inuit community has only occasional visits from other medical personnel and Lutiapik receives absolutely no instructions from the Department of National Health and Welfare (her employer) for the whole year she spends on Baffin Island.

22. The hesitantly articulated anxiety that permeates Lutiapik is a familiar, if often muted, feature of the more contemporary accounts of outpost work published in The Canadian Nurse. What this discourse points to is the fact that the Nightingale paradigm is a deeply conflicted one, in many ways antithetical to the demands of northern nursing because, above all, it insists on an extraordinary, indeed militarised, subservience to authority, and an absolute separation of health care roles. Nightingale herself once wrote: "Experience teaches me now that nursing and medicine must never be mixed up. It spoils both ... I would almost say-the less knowledge of medicine a hospital matron has the better (1) because it does not improve her sanitary practice, (2) because it would make her miserable or intolerable to the doctors" (qtd in Cope 121). Viewed from this perspective, the institutionalised forms of servitude and self-negation-what in nursing parlance is called "Nightingalism"—often expected in routine hospital work may be precisely what drives some nurses to the North in search of autonomy, agency, and self-respect. The advertisements shown promise such an escape, overtly or covertly.

23. The central schism in the Nightingale legend and legacy produces outpost work as something of a paradox: at once desirable because it represents the very essence of heroic nursing yet frightening because it repudiates its foundational myths. I would argue, then, that the northern nurse needs an alibi to support her bid for autonomy and this is where my final metanarrative, the trope of the medical emergency comes in. The extraordinary power of this trope can be illustrated with an anecdote (not dated but probably pertaining to some time between 1920 and 1930) taken from Bertha Dodge's book on the history of nursing (1954), which is designed for the juvenile market. Dodge tells the story of a doctor attempting to recruit nurses for a mission post in Labrador. After initially receiving a lukewarm response to his call for volunteers, he decides that the most persuasive tactic is to recount an incident in the life of one of the nurses who had been stationed there:

One of her feverish patients—a skilled fish-splitter—had gone out in a delirium, seized his fish-splitting knife, and split himself as effectively as ever he had his fish. Miraculously, he had not cut his intestines, but the situation was extremely critical.

The rivers were still too full of ice for navigation and the snow was too sticky for dog-team travel. The nurse would have to do the best she could without any medical assistance save advice telegraphed by the doctor sixty miles distant. So she went to work, after having persuaded the local priest to act as operative assistant.

That good man has such severe doubts of the outcome that he insisted upon first being permitted to administer the last rites. Then he took chloroform in hand and steadfastly administered the anesthetic while the nurse operated. She washed out the abdominal cavity with boiled water as best she could, returned the intestines more or less to their natural position, and sewed up the wound sufficiently to prevent infection.

The patient survived—first to make a trip to the hospital under the nurse's care, then to return to his family and his fishing, a well man.

When this account was finished, half the nurses in the audience were up, offering their services to the Grenfell Mission. (Dodge 217-18)

24. As the doctor's tale illustrates, the medical emergency provides the liminal space in which the narratives of the North and of heroic nursing coalesce. This trope continues to have its own popular lexicon-featuring, for instance, the medivac, intrepid bush pilots, the idea of a rite of passage, and even intimations of cannibalism (following a plane crash in the central arctic where the medivac pilot is alleged to have eaten the dead nurse's flesh to survive) but, however articulated, it functions to give sanctioned access to what I would argue is the greatest adventure in nursing: crossing that normally inviolable line between nurse and doctor. This is not just a professional line but also implicitly a gender line and in most instances a class line as well.

25. On many levels, the unsettling of the fundamentally oppressive medical hierarchy can be seen as a welcome, indeed necessary intervention, but in the context of indigenous health care (not just in the Canadian North but in other areas such as outback Australia where versions of the outpost model are also practised), we need to ask what happens to the Aboriginal Other whose medicalised body becomes site and symbol of the highly charged transgressions that nursing in an "expanded role" entails. How much room to manoeuvre remains amid the baggage of imperialism that I've
sketched all too briefly here? What kind of negotiating positions are available to the nurse and the patient, each interpellated, though obviously with unequal agency, into a set of discursive equations that replays battles about the control and legimitacy of biomedical knowledge and that elicits deep-seated anxieties about western social organisation? The health transfer policy that has been going on in the Canadian North since 1988 and the formal recognition of Nunavut as a self-governed territory seem to me to provide at least part of the political infrastructure for genuine change. The greater challenge may be for all parties concerned-health care personnel, writers, photographers, government officials, and indeed the general public-to trade in the myth of heroic nursing for a more enabling metanarrative.

**Notes**

[Many thanks to Amanda Lynch for her assistance with the visuals for this article.]

1. The only treaty to specifically mention medical care is Treaty Six, negotiated primarily with Plains Cree and Saulteaux in the late 1870s (see Waldram, Herring and Young, 142).  
2. I use the term "coercive" because the nursing station movement was bound up with the relocation of native populations and also because it has sought to displace and discredit indigenous forms of healing.  
3. The term "North" in this discussion is conceived as something more than an empirical space with definable perimeters. Because the implicitly "natural" North is constructed as the ontological Other of a cultural South, its boundaries continually shift according to historical and geographical reference points.  
4. It is worth noting here that until the late 1990s Canada was the only WHO developed country that did not legally recognise the profession of midwifery. Legislation in some Canadian provinces is still contentious with insufficient provisions for the practices of indigenous midwives who lack the accepted formal training.  
5. I acknowledge that advertisements are somewhat soft targets for a critique of the ways in which northern nursing is constructed. Nevertheless, they are highly instrumental in shaping perceptions of northern work and their typically persuasive discourses and colorful images also feature in information packages used to orient nurses newly appointed to northern posts. The ads reproduced here are not chronologically arranged because the essential messages conveyed over the period sampled don't change-the images simply get glossier as time goes on. This is not the case with ads for nursing employment in southern Canada, which usually consist of text (no visuals) referring only to the features of the job itself.  
6. Shields demonstrates at length the ways in which nordicity is centrally related to the spatial myth of a “True North Strong and Free” (as enshrined in the national anthem, Oh Canada), which is a “masculine gendered, liminal zone of rites de passage and re-creative freedom and escape.” In Shield’s formulation, the mythic North functions as “a resource and economic hinterland which is simultaneously incorporated in a social spatialization as a mythic heartland” (163). This spatial myth, he argues, operates as both a counterbalance to Canadian urban culture and a central core of Canadian identity (as distinctive from American identity) (see Shields 162-206; also Grace ix-xxi).  
7. Wendy Lill’s play, The Occupation of Heather Rose (1986), charts this schism between “South” and “North” in a deeply disturbing portrait of a young nurse sent North to work in an “Indian Reserve.” See Anderson et al. for an incisive account of the ways in which this text examines the operations of nordicity on the Canadian imagination.  
8. This history, compiled by H.P. Dickson and published under the title The Badge of Britannia: The History and Reminiscences of The Queen Elizabeth’s Overseas Nursing Service 1886-1966, is in fact a collection of memoirs with a brief introduction outlining the creation and development of the organisation.  
9. Interestingly, non-academic books about Nightingale seem prone to attract the juvenile classification, even when they are not always directed to the younger reader. At the University of Washington, for instance, of a staggering eighty odd books written about Nightingale’s work, some twenty are housed in the children’s literature collection.  
10. See, for instance, Barth (1945), Nolan (1946), Richards (1911) and Willis (1931).  
11. These include such titles as Penny Marsh finds Adventure in Public Health Nursing(1940), Ann Bartlett in the South Pacific (1944), Nancy Dale, Army Nurse(1944), and Cherry Ames, Flight Nurse (1945), all of which were part of separate series about the adventures to be had by nurses.  
12. In her excellent study of nursing in the Victorian Era, Alison Bashford argues that the principals of “poverty, obedience and chastity,” which are so easily transferred from the religious to the secular sphere in The Nun’s Story, helped nurses “to make sense of their physical hardship, their strict institutional regulation, [and] their lack of remuneration” (51).  
13. Judy Smith’s Native Blood: Nursing on the Reservation (1994) is one of the few memoirs that attempts to debunk this myth of heroic nursing, albeit with much ambivalence.


Young, T. Kue. "Indian Health Services in Canada: A Sociohistorical Perspective." *Social Science and Medicine* 18.3 (1984): 2557-64.

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Healthcare in Canada is delivered through the provincial and territorial systems of publicly funded health care, informally called Medicare. It is guided by the provisions of the Canada Health Act of 1984, and is universal. Universal access to publicly funded health services “is often considered by Canadians as a fundamental value that ensures national health care insurance for everyone wherever they live in the country.” However, 30 percent of Canadians’ healthcare is paid for through the private